

# National Seniors Strategy

2020

THIRD EDITION





**Suggested Citation:**

National Institute on Ageing. (2020). An Evidence Informed National Seniors Strategy for Canada - Third Edition. Toronto, ON: National Institute on Ageing.

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# Canada *Still* Needs a National Seniors Strategy

The year 2015 marked the first time Canadians aged 65 and over started to outnumber children under the age of 15.<sup>1</sup> This demographic shift in Canada prompted the publication of the first version of the National Seniors Strategy (NSS 2015), recognizing that Canada's policy response to an ageing population was lagging behind real, historically unprecedented changes in the make-up of our national population. Older Canadians now represent Canada's fastest growing demographic. In 2019, approximately 1 in 6 Canadians were over 65 years of age. By 2035, one in four Canadians will be over 65 years of age.<sup>2,3</sup>

As in 2015, this demographic shift still presents both challenges and opportunities to improve the social, financial, and health policy landscape for older Canadians. While Canadians 65 and older account for approximately 17.5% of the population today, they represent almost 44% of all public-sector health care dollars spent by provinces and territories.<sup>4</sup> With the population ageing faster than ever before, health care, social services, and economic systems must be continuously reviewed to ensure that they can remain sustainable and continue to meet the needs of all Canadians as they age.

Likewise, there is now even more attention on issues of social policy, especially social isolation, than there was in 2015. Researchers, governments, and Canadians themselves are increasingly aware of the importance of social and economic participation of older people. Retirement planning and income security remain a challenge too, despite the recent enhancement to the Canada Pension Plan, which will certainly help older Canadians in the future. Canadians retiring now and in upcoming years must plan for financial security on longer timelines than in any other period of Canada's history. This is good news, in that Canadians are living longer than ever before, but more work needs to be done to enable Canadians to secure their retirement finances for a longer period of time.

In the five years since the publication of the NSS 2015, notable progress has been achieved by federal and provincial/territorial governments in these and other priority areas (see progress report below). But old challenges remain and new ones have emerged.

# The COVID-19 Pandemic has Exposed Canada's Vulnerabilities in Providing Care to an Ageing Population

If any single issue can highlight the urgent need for a coordinated, national seniors strategy, it's Canada's experience with COVID-19. The COVID-19 Pandemic affected older people across the globe more than any other age demographic. Older Canadians were not spared the effects. In fact, Canada's older population fared notably worse than their counterparts in many other comparable countries. Analysis by the National Institute on Ageing showed that by the summer of 2020, over 80% of all COVID-19 deaths in Canada occurred amongst older Canadians in nursing and retirement home settings, compared to an OECD average of 42%, and despite Canada having a total COVID-19 mortality rate comparatively lower than other OECD countries.<sup>5</sup> There's widespread recognition now that COVID-19 exposed Canada's long-standing systemic vulnerabilities within its systems on long-term care (LTC), especially amongst its nursing and retirement homes.

It's been well established for over a decade that the vast majority of Canadians want to age in their own homes and communities for as long as possible. And while governments have increasingly acted on improving access and funding to home care in the years since NSS 2015 and preceding the COVID-19 pandemic, Canada's COVID-19 LTC experience may provide the consensus and impetus for governments to act with renewed urgency in expanding options for Canadians to age at home, while improving the quality of nursing home care for the people who cannot remain in their original homes as they age.

The necessary restrictions and protections placed on nursing and retirement homes to protect residents during the early stages of the COVID-19 pandemic also revealed just how important unpaid, family caregivers are to older persons needing additional care and support. As provincial governments struggled with how best to allow caregivers back into nursing and retirement homes safely, many residents suffered isolation and neglect in the absence of the reliable additional care provided by family members, friends and others. As with home care, governments in recent years have taken various policy actions to better support unpaid caregivers, but COVID-19 again provided a case for how crucial unpaid caregivers are to the health and well-being of older Canadians.

Beyond the toll that COVID-19 took on older Canadians in LTC settings, the economic consequences of the pandemic have also posed challenges for people nearing and in retirement. Some Canadians liquidated their retirement investments in the early stages of COVID-19's drastic effect on financial markets. Similar to the financial crisis of 2008, older Canadians who sold off their investments at the bottom of the market in March of 2020, will feel the effects for a long time. With shorter time horizons to recuperate realize losses, and with less ability to take ongoing financial risks, older Canadians in this situation may feel the financial ramifications of the pandemic for the rest of their lives.

COVID-19 also had a devastating effect on employment. Older workers who have - or may still lose their jobs due to the lock-down, will experience precarious employment opportunities at just the point in life when many people begin earnestly focusing on accumulating savings to help financially secure their retirements.

The full effects of the pandemic are yet to be felt, and may remain for many years to come. As devastating as COVID-19 has been, it provides a renewed focus on the precarity of ageing in Canada and reveals just how much more coordinated action is required now.

## Canada's Systems of Health Care and Financial Support Need to Continue to Evolve

Canada's population is not only ageing, but Canadians are also living longer than ever before. From 1920-2020, the life expectancy for Canadians increased from around 60 to over 82 years of age.<sup>6</sup> With this and future expected increases in life expectancy coupled with the rapid overall ageing of our society, Canadian systems will need to continuously evolve to meet the needs of these unprecedented demographic realities.

It must be emphasized, however, that the growing ranks of older Canadians are not the problem. However, our lack of appropriate policy responses as we have aged has been the problem. For example, Canada's health care system was designed and built more than 50 years ago with the passage of its *Medical Care Act* in 1966 when the median age of Canadians was 25.5 years of age and when most Canadians didn't live beyond their late 60s or early 70s.<sup>7</sup> In that context, the universal health care system Canada implemented at that time for its much younger population was appropriately focused on providing physician services and acute hospital-based health care. What is clear, is that Canada's health care system, was not built to focus on the needs of Canadians living into their late 70's and 80's with chronic health issues and greater levels of social isolation, which are now established and growing realities.

With a Canadian population that is radically different from what it was over 50 years ago, it has become apparent that its healthcare system's patients have changed while the system hasn't. While an older population will continue to need physicians and hospital care, it will also need a more comprehensive health care system that includes and emphasizes the provision of preventative care, pharmacare, and long-term care, which includes home, community and nursing home care. Currently, the demand for publicly funded long-term care in Canada has rapidly outstripped current available services such that over 40,000 Canadians are on wait lists for a place in a nursing home while 430,000 report having unmet home care needs.<sup>8,9</sup> Furthermore, to meet the growing need for publicly funded long-term care over the next three decades, the costs of doing so are expected to rise from at least \$22 to \$71 billion between now and 2050.<sup>10</sup>

Canada's retirement income system was similarly not built to sustain the longer life expectancies Canadians are enjoying today. When the Canada Pension Plan (CPP) was established along with Medicare in 1966, men typically lived to 68 years of age - only 3 years past the established age of retirement, while women lived to 75 years of age - only 10 years past the age of retirement.<sup>11</sup> Since then, Canada formally repealed mandatory retirement in 2012. And today, Canadians who now make it to 65 years of age can expect to live 19.4 additional years for men and 22.1 additional years for women, with these numbers only expected to continue to increase with time.<sup>12</sup>

With all of these extra years to account for now beyond 65 years of age, another rapidly growing concern is Canadians' ability to afford the associated costs of their growing 'longevity dividends'. Currently, approximately two-thirds of Canadians have no access to any form of work-place retirement pension plan beyond government retirement income programs like the compulsory Canada or Quebec Pension Plans (CPP/QPP), Guaranteed Income Supplement (GIS), and Old Age Security (OAS).<sup>13</sup> This is causing growing concerns about Canadians' financial security in retirement as other private savings vehicles that have been encouraged over the past few decades have not seen the uptake nor the level of wealth accumulation needed to help most Canadians avoid the potential of later life poverty. For example, it was recently demonstrated that the median family savings for Canadians entering retirement without a workplace pension was only \$3,000.<sup>14</sup> Moving forward, Canadians will require a more robust range of retirement income options to address the fact that they will continue to live longer and ensure that they do not outlive their savings.<sup>15</sup>

Unpaid caregivers also play a vital role in supporting older Canadians to age in their own homes and communities by providing alternatives to costly and publicly funded facility-based care by often supplementing the care that is available through the limited publicly-funded home and community care systems and private care providers. While the number of older Canadians who will require the support of unpaid caregivers is projected to more than double by 2050<sup>16</sup>; however, recent projection have shown that there will be 30% fewer close family members (e.g. spouses, adult children) and friends who would be available to provide unpaid care.<sup>17</sup> Furthermore, the personal costs for those who serve as unpaid caregivers include lost wages, decreased retirement income, and impacts to their physical and emotional health. Due to the growing anticipated shortage of unpaid caregivers, greater consideration must be given in how to best recognize and support this invaluable and unpaid resource.

These are just a small sample of the significant and often inter-related challenges that must be tackled head-on in the organization and provision of health care, social services, and financial security systems in the years to come for Canada's ageing population.

## Canada is Not Alone

Population ageing is by no means unique to Canada. Canada is experiencing the same accelerating ageing trends seen throughout much of the developed world. The World Health Organization's (WHO) *World Report on Ageing and Health* has called for a significant change to the ways policies and services for ageing populations are formulated, to adequately address the coming challenges and opportunities of ageing societies.<sup>18</sup> The WHO holds that population ageing should be viewed as a rich new opportunity for both individuals and societies to successfully navigate a future that looks very different than it did over 50 years ago – a future enabled by good policies and systems of support that allow older people to age with dignity and respect.

Canada's National Institute on Ageing (NIA) champions this mindset in its work. Canada's increases in life expectancy over the past century are one of its greatest accomplishments. While many see the rapidly ageing population as cause for concern, the NIA views it as an opportunity to shift prevailing attitudes and current paradigms of care and support in order to reshape the policy landscape across Canada so that ageing is viewed as a triumph and opportunity rather than a disease and burden.

Re-orienting the way services are delivered to meet new demographic realities in Canada is possible. It was done in the 1960s, when Canada's world-class health care system was built and programs like CPP/QPP and OAS were first implemented. Canada has an opportunity now to lead the world in implementing more innovative and creative policy solutions that can better meet the needs of its ageing population and make Canada one of the best places to grow up and grow old. Accomplishing such a bold agenda requires a unifying strategy. That is why the NIA and its partners first proposed one in 2015 and continue to advocate for the federal government to develop and implement a National Seniors Strategy as well.



# A National Seniors Strategy Requires Federal Leadership

Meeting the growing and evolving needs of Canada's ageing population will require concerted coordination and effort between municipal, provincial and territorial governments. Historically, Canada's federal government has played a key role as a standard-setter, catalyst, and funder of important social changes at a national level in areas such as the creation of retirement security provisions and low-income supports, affordable housing, health insurance, and caregiver supports. The NIA believes Canada's federal government can again enable the meaningful changes that will be required to meet the growing needs of its ageing population.

A coordination and mobilization of efforts and resources across all levels of government as well as between the private, public, and voluntary sectors will be required. Indeed, an integrated approach where the federal government can steward Canada in the right direction is needed. No doubt, Canadians want to age well and want to see each other age well too. The federal government can recognize this shared aspiration and display leadership by establishing a National Seniors Strategy that help to achieve these aims.

The 2015 federal election was the first in which Canada's ageing population became a prominent, consistent theme across party platforms and in political debates. It was also the year that saw the launch of the Alliance for a National Seniors Strategy, a coalition of concerned national organizations and societies that worked in concert to support the development of principles and a policy framework with distinct areas of actions that were deemed to be of strategic importance to help address key issues. The Alliance included the Canadian Medical Association, the Canadian Nurses Association, the Canadian Federation of Nurses Unions, the Canadian Home Care Association, Carers Canada, the Canadian Association of Retired Persons (CARP), and the National Association of Federal Retirees amongst others.

As a result of the Alliance's sustained efforts over the last five years, elected governments have enacted key pension reforms and other measures to improve the financial security of older Canadians, significantly enhanced the provision of funding to deliver more home care services, enacted new financial supports to better acknowledge the needs of unpaid caregivers, established new housing benefits to support affordable housing options, and began the necessary steps to enhance access to necessary medications for all Canadians, among other accomplishments. Table 1 has the full list of the Alliance's aligned accomplishments since 2015.

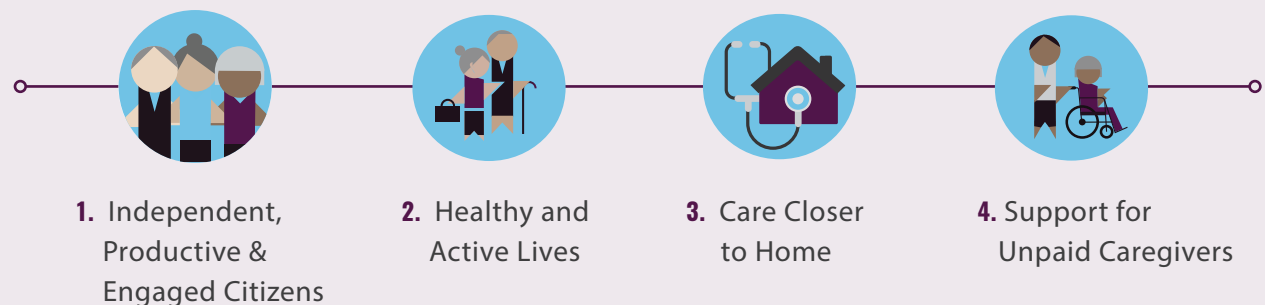
# The Origins and Ongoing Development of an Evidence-Informed National Seniors Strategy

In 2013, recognizing the growing need for an evidence-informed National Seniors Strategy, policy researchers received funding through the Canadian Institutes for Health Research (CIHR) – Evidence-Informed Healthcare Renewal (EIHR) Initiative, with the support of the its Institute for Health Services and Policy Research and Institute on Aging.

In collaboration with the European Observatory on Health Systems and Policies, the NSS team, led by Drs. Samir Sinha and Geoff Anderson, commenced their work by conducting a jurisdictional review of the evidence on strategies, approaches, and practices employed towards meeting the needs of an ageing population. Sources included published and unpublished reports, policy briefs, and analyses from Canada and beyond, with a focus on jurisdictions demonstrating leadership in these areas of focus. Also consulted were a wide range of stakeholders including the Canadian Medical Association, the Canadian Nurses Association, the Canadian Federation of Nurses Unions, the Canadian Home Care Association, Carers Canada, the Canadian Association of Retired Persons (CARP), and the National Association of Federal Retirees amongst others over a 12-month period, to inform the overall findings that would support the evidence-informed policy recommendations that this report lays out.

The work of developing an evidence-informed National Seniors Strategy has become a collaborative opportunity to build upon the expert work of others and pull together a wealth of research into a single NSS blueprint document. The main national organizations that offered advice and support and their eventual endorsement for this overall body of work are acknowledged at the end of this report, along with the growing research team that has supported the continuous development and refinement of the NSS over time.

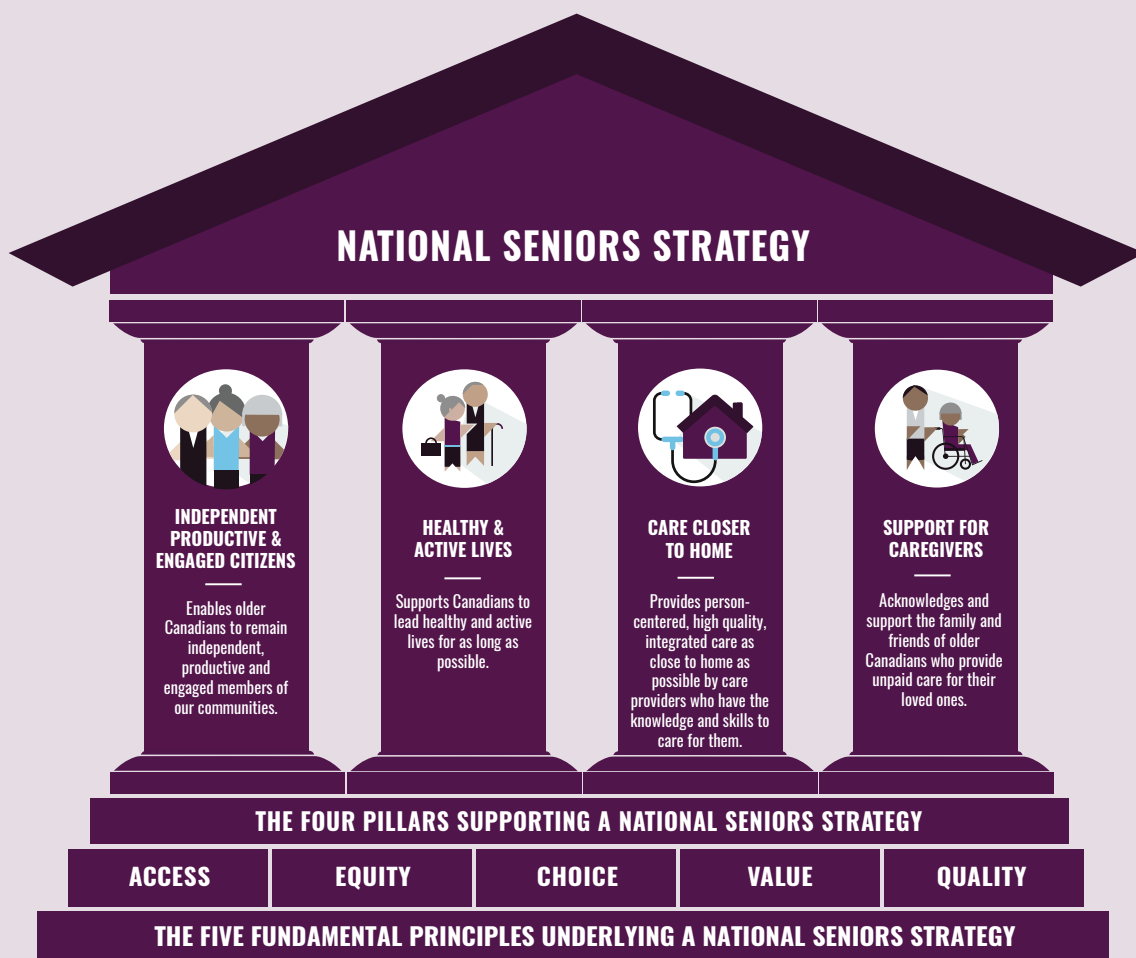
**The NSS report identified key issues that Canada faces as the population ages, and defined four supporting pillars:**



It also defined five underlying principles:

1. Access
2. Quality
3. Value
4. Choice
5. Equity

# Introducing the Four Pillars of a National Seniors Strategy



The pillars and values undergird the evidence-informed approach to the issues addressed and the recommendations made to governments. Using an evidence-based process and framework, 12 specific policy issues of national importance were originally identified and two more over time, under the four overarching pillars that should be addressed with federal leadership to meet the current and future needs of Canada's ageing population.

The NSS continues to evolve with Canada's shifting demographics, emerging issues, policy developments across Canadian jurisdictions and new evidence. It has been released and re-released publicly in updated versions on the website [www.nationalseniorsstrategy.ca](http://www.nationalseniorsstrategy.ca). The intention is to allow this work to continuously evolve as new knowledge and evidence becomes available along with advancements in government action.

The NSS has also become the foundation for the work and priorities of the National Institute of Ageing (NIA), established at Ryerson University in 2016. The NIA is now the home of the National Seniors Strategy.

The NIA is a think tank focused on meeting the realities of Canada's ageing population. It is Canada's only think tank dedicated exclusively to policy solutions at the intersections of health care, financial security, and social well-being in relation to ageing. The NIA conducts evidence and experience driven research. Its public facing reports are founded on the strongest available evidence and original research and are led by experts and practitioners in the fields of financial security, health care delivery, and public policy. It is a hub for experts, practitioners, decision makers, and the public, working to bridge the gaps between policy and practice. The NIA provides a platform and network for idea sharing and problem solving. With the backing of Ryerson University, industry, and not-for-profit partners, the institute works across private and public sectors to provide solutions that promote the evolution and sustainability of Canada's systems and programs to better meet the needs of its ageing population.

The challenges posed by an ageing society are large, complex and continuously evolving, and will require a comprehensive, collaborative, non-partisan and evidence-informed approach. As a result, the NIA provides a leadership role on behalf of the Alliance for a National Seniors Strategy to ensure that the calls for a National Seniors Strategy and its components remain relevant to the changing landscape of government action and shifting demographics. The NIA led a wide-ranging public consultation online in 2019 to further ensure that the public, as well as the noted experts and organizations, had an opportunity to apply their experience and priorities to this shared project of national importance. The consultation, which generated over 60 responses from members of the public, informed updates to this current version of the NSS.

It is hoped that this work will continue to reach and receive support from a broad community of stakeholders and citizens through media dialogue on ageing, the website, and social media campaigns. The NIA encourages everyone to join the conversation through its NSS Website – [www.nationalseniorsstrategy.ca](http://www.nationalseniorsstrategy.ca) and its Twitter handles [@NSS\\_Now](https://twitter.com/NSS_Now) and [@RyersonNIA](https://twitter.com/RyersonNIA).

2020

# National Seniors Strategy

The World Health Organization (WHO) *World Report on Ageing and Health*<sup>19</sup> outlined a clear call to action for member states to meet the evolving needs of their ageing populations through well designed and formulated policies and services. The WHO subsequently engaged in a process to mobilize member states, including Canada, to agree to five priority areas for action by 2020 which include:



**1.** Fostering healthy ageing in every country



**2.** Aligning health systems to the needs of older populations



**3.** Developing long-term care systems



**4.** Creating age-friendly environments



**5.** Improving, measuring, monitoring and understanding

The principles, pillars and 14 specific policy issues of focus identified in the NIA's latest National Seniors Strategy not only resonate with Canadians, but will also enable Canada to address the WHO's five priority areas for action. This Strategy, along with the supporting evidence briefs and recommendations will continue to evolve over the coming years.

Ultimately, the shared goal of the National Seniors Strategy is to create a future that gives all older Canadians the support and freedom to live their lives to the fullest.

## PILLAR 1

# Independent, Productive, and Engaged Citizens

## Ensuring Older Canadians Remain Independent, Productive and Engaged Citizens

With the number of older Canadians expected to double in numbers between 2010 and 2030 - and with many more enjoying their extra years in good health - older Canadians should be given opportunities to remain engaged and productive members of society. Over the last decade, the number of older Canadians who continue to work past the age 65 has doubled, allowing them to continue contributing their considerable experience and skills.<sup>20</sup> However, work experience and skills are only one part of what older Canadians' can contribute, while further strengthening their personal finances for older age.

Older Canadians continue to contribute to society in many other ways and are overrepresented as volunteers and unpaid caregivers supporting other Canadians of all ages. They also remain the most politically engaged members of our society and have the highest voter participation rates.<sup>21</sup> To ensure communities can continue to support their older residents to remain independent and engaged, access to reasonable income supports, affordable housing, and inclusive transportation services should continue to be strengthened. To combat the growing levels of social isolation and reinforce efforts to end ageism and elder abuse in society, physical environments and public spaces need to be age-friendly; and health, community, social and recreational services, and employment opportunities must be designed to be inclusive with the needs of older Canadians in mind.

The federal government can work with Canada's provinces, territories and municipalities to enable this pillar and associated activities in a variety of ways:



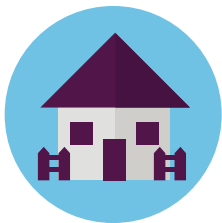
### **Making addressing ageism, elder abuse, and social isolation a national priority**

Ensuring that ageism, elder abuse, and social isolation are national priorities can be achieved by continuing to support activities and policies that value the role, contributions, and needs of older Canadians. Read more on this opportunity in [Evidence Brief #1](#).



### **Ensuring older Canadians do not live in poverty by improving their income security**

Ensuring older Canadians do not live in poverty can be achieved by enhancing existing public support systems and by providing new options to help Canadians save for themselves. Read more on this opportunity in [Evidence Brief #2](#).



### **Ensuring older Canadians have access to affordable housing**

Ensuring access to affordable housing for older Canadians can be achieved by maintaining federal commitments to development of housing infrastructure and emphasizing housing for older adults as a priority. Read more on this opportunity in [Evidence Brief #3](#).



### **Ensuring older Canadians have access to inclusive transportation**

Ensuring access to inclusive transportation can be achieved by developing an inclusive transportation infrastructure, addressing governance of accessibility, and monitoring accessibility measures. Read more on this opportunity in [Evidence Brief #4](#).



### **Enabling the creation of age-friendly communities, physical environments and spaces**

Ensuring the development of more age-friendly communities, physical environments and spaces can be achieved through the incorporation of well-established universal design standards in national building codes. Read more on this opportunity in [Evidence Brief #5](#).

## PILLAR 2

# Healthy and Active Lives

## Ensuring Older Canadians can lead healthy and active lives for as long as possible

Important advances in public health and health care over the last few decades mean that most Canadians are now living longer and with fewer health problems than ever before. In the future, more education and support for Canadians to participate in activities that promote wellness, prevention, and overall healthy ageing will allow more older Canadians to age in good health and stay independent in their communities for as long as possible.

The federal government and the Public Health Agency of Canada can work with Canada's provinces, territories and municipalities to enable this pillar and associated activities in a variety of ways:



### **Ensuring Canadians are supported to engage in wellness and prevention activities that enable healthy ageing**

Ensuring Canadians understand the importance of activities that support healthy ageing and prevention of age-related diseases and are empowered and supported to regularly exercise, develop strategies for falls prevention, and receive recommended immunizations will enable healthy ageing. Read more on this opportunity in [Evidence Brief #6](#).



### **Improving access to medically necessary and appropriate medications and vaccines**

Ensuring that all Canadians have access to medically necessary and appropriate medications and vaccines for the management of acute and chronic diseases will allow Canadians to live healthier and longer lives in their communities. Read more on this opportunity in [Evidence Brief #7](#).



### **Ensuring older Canadians and their caregivers are enabled to participate in informed health decision-making & advance care planning**

Ensuring Canadians have a better understanding of the importance of advance care planning will support a growing number of Canadians to become more engaged in decision-making around their health care and empower them to make more informed decisions. Read more on this opportunity in [Evidence Brief #8](#).



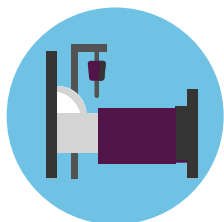
# Care Closer to Home

## **Ensuring Older Canadians Have Access to Person-Centered, High Quality, and Integrated Care as Close to Home as Possible by Providers who Have the Knowledge and Skills to Care for Them**

Currently, older Canadians constitute about 17.5% of the population, but account for nearly half of health and social care systems costs.<sup>22</sup> Medicare, Canada's national health insurance system, was established in 1966 when the median age of Canadians was 25.5 years of age and when most Canadians didn't live beyond their late 60s or early 70s. These population characteristics have significantly changed in the following 50 years, yet Canada's health care system has not fully adapted to meeting the needs of its ageing population. The majority of Canadians now see access to supportive and palliative care in or close to their homes, and a robust home care system, as top national priorities. With Canada recently experiencing the vast majority of its COVID-19 pandemic deaths in its congregate living settings, many are now advocating for strengthening the *Canada Health Act* and the *Canada Health Transfer* to ensure Canadians can feel confident that the health and long-term care systems will be ready to meet their needs.

To ensure current and future providers will have the knowledge and skills needed to provide Canadians the right care, in the right place, at the right time by the right provider, the national educational and accreditation bodies for all caring professions including doctors, nurses, social workers should mandate training around the care of the elderly in the same way as they do for other age groups, such as children.

The federal government can work with Canada's provinces and territories to enable this pillar and associated activities in a variety of ways:



### **Ensuring Older Canadians Have Access to Appropriate, High Quality Long-Term Care, Palliative, and End-of Life Services**

Ensuring older Canadians have access to high quality long-term care, palliative, and end-of life services as well as medications when and where needed can be achieved by investing and supporting the development of these essential areas of care. Read more on this opportunity in [Evidence Brief #9](#).



### **Ensuring older Canadians have access to care providers that are trained to specifically provide the care they need**

Ensuring that Canadians have access to care providers from all professions that are trained to specifically provide the care older people need can be achieved by prioritizing geriatric care skills development and training amongst Canada's national educational and care accreditation bodies. Read more on this opportunity in [Evidence Brief #10](#).



### **Developing standardized metrics and accountability standards to enable a national seniors strategy**

Ensuring that the health care system is iteratively retooled to meet the needs of an ageing population will require access to high quality information to help track performance in meeting collective goals, which can be achieved by establishing national metrics, information collection, and reporting systems through agencies like the Canadian Institutes for Health Information (CIHI) to help link funding to collective performance goals. Read more on this opportunity in [Evidence Brief #11](#).



### **Ensuring the needs of older adults are recognized and supported in emergency and disaster preparedness planning, response, and recovery efforts**

Ensuring that the older Canadians have their needs met in emergency and disaster preparedness planning, response and recovery efforts can be achieved by recognizing and ensuring their unique vulnerabilities are considered and supported, as well as those of their caregivers. Read more about this opportunity in [Evidence Brief #12](#).

# Support for Caregivers

## Ensuring that the family and friends of older Canadians who provide unpaid care for their loved ones are acknowledged and supported

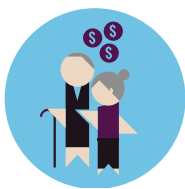
In Canada, family and friends are the greatest source of ongoing care for older people. As the number of older Canadians with chronic health conditions increases, unpaid caregiver support will become even more important. It is estimated that unpaid caregivers provided \$9 billion in care in 2019 to Canada's publicly funded health care systems, which is expected to increase to \$27 billion by 2050.<sup>23</sup> The continued dedication and contribution of caregivers provides a greater level of care and independent living options for older people. However, unpaid caregivers face an enormous toll on their personal health, well-being, and finances. Their commitment to caregiving also significantly impacts Canada's economic productivity. Providing support and recognition to meet the needs of current and future caregivers will not only keep Canada's health and long-term care systems more sustainable, it will also ensure that our national economic productivity can be improved and strengthened.

The federal government can work with Canada's provinces and territories to enable this pillar and associated activities in a variety of ways:



### **Ensuring unpaid caregivers and older adults are supported in the workplace**

Ensuring Canadian employers are informed about and have access to the tools that can help them better support the growing ranks of unpaid caregivers will enhance overall economic productivity. Recognizing employers who excel in supporting unpaid caregivers can further bring positive attention to this important issue. Read more on this opportunity in [Evidence Brief #13](#).



### **Ensuring unpaid caregivers are not unnecessarily penalized financially for taking on caregiving roles**

Ensuring Canadian unpaid caregivers are not unnecessarily penalized financially for taking on caregiving roles can be further supported through enhanced job protection measures, caregiver tax credits, and new CPP/QPP contribution allowances. Read more on this opportunity in [Evidence Brief #14](#).

## THE FIVE PRINCIPLES

# Supporting a National Seniors Strategy

The four pillars of the NSS represent its priority areas for action. The five foundational principles, derived from the result of consultations with thousands of Canadians, as well as national and internal experts, provide a principled approach to how best to advance the issues within the priority areas for action of the National Seniors Strategy.

## 1. Access

Canada is spending more on health, social, and community services than ever before, yet older Canadians, their families, and caregivers still find it challenging to access the right care and supports, in the right place, at the right time – especially for those living in rural and remote communities and those with more limited financial means. Therefore, when planning, reviewing, and delivering services, it is a priority to ensure that older Canadians, their families, and their caregivers can easily access the services and supports they need in a timely and efficient way.

## 2. Equity

Diversity is one of Canada's greatest assets. Given that diversity is both visible and invisible, equitable support across all groups must be ensured, including for older Canadians who are racialized Black, Indigenous, and people of colour (BIPOC), who are lesbian, gay, bisexual, transgender, queer, intersex, and/or Two-spirit (LGBTQI2S ), and who navigate barriers to accessibility, such as individuals who are isolated, living with disabilities, and those who have limited financial means. Therefore, when planning, reviewing, and delivering services, it is crucial to ensure that all populations of older Canadians have equitable access to publicly available care and services.

### **3. Choice**

A wide variety of supports and services for older Canadians are available; however, it is often difficult for people to understand available options and exercise their choices. Older Canadians should be provided access to information to know their options and to make informed decisions, when capable of doing so. A younger adult's right to make good decisions on their own behalf is rarely questioned. The same dignity of choice must be offered to older Canadians, even if they make decisions with which others may disagree. Therefore, when planning, reviewing, and delivering services, older Canadians, their families, and their caregivers must be empowered to make as many informed choices as is reasonably possible.

### **4. Value**

With current and future fiscal and demographic pressures, tax revenues should be spent in the most effective and efficient way to help ensure the future sustainability of systems, programs, and services. Therefore, when planning, reviewing, and delivering services, every dollar spent should provide the best value possible.

### **5. Quality**

Within the mandate to control current and future costs, quality must not be sacrificed. There is an increasing understanding that better quality care in many cases need not cost more; high quality service can be delivered in more efficient ways. Therefore, when planning, reviewing, and delivering services, a focus on quality should be central to the work at hand.

# Progress on the Original 2015 NSS Recommendations

Since the 2015 General Election and the original iteration of the Alliance's National Seniors Strategy (NSS 2015), there has been considerable progress on a number of the recommendations made.

## ADDRESSING SOCIAL ISOLATION

NSS 2015 recommended that the federal government lead the development and dissemination of both general and specifically targeted approaches to raising awareness around and preventing social isolation. The government followed suit by establishing the *New Horizons Fund*, which funds community organizations to mitigate the risk of social isolation with projects that promote social participation, mentoring, and volunteering.<sup>24</sup> In Budget 2019, the federal government announced an additional \$100 million over 5 years for the New Horizons Fund.<sup>25</sup> This new fund is expected to support local organization across the country to have a positive impact on older adults, social participation, and community development.

## IMPROVING FINANCIAL SECURITY IN RETIREMENT

NSS 2015 also recommended that the government enhance existing public pension vehicles. In 2016, the government enhanced the Canadian and Quebec Pension Plans (CPP/QPP), increased the Guaranteed Income Supplement (GIS), and reversed the age of eligibility for Old Age Security (OAS) from 67 back to 65.<sup>26</sup> The 2019 budget also announced that all Canadians will be auto-enrolled into the CPP/QPP at age 70 starting in 2020.<sup>27</sup> This will ensure that no one misses out on their earned CPP/QPP benefits. It is estimated that around 40,000 individuals over the age of 70 are currently missing out on their CPP/QPP earnings and would thus gain access to a monthly retirement pension as a result of this change. In the 2020 Throne Speech, the Government of Canada reiterated a commitment to increasing Old Age Security (OAS) commencing at the age of 75 and boosting the CPP survivor's benefit.<sup>1</sup>

## IMPROVING HOUSING AND HOME-BASED SUPPORTS

In NSS 2015, the issue of affordable housing for older adults was examined, and it was recommended that the federal government make a commitment to the development of housing infrastructure to support the independence of older Canadians. The federal government introduced its *Home Accessibility Tax Credit* in Budget 2015, which provides a maximum refund of \$1,500 for expenses of up to \$10,000 per year to support necessary housing repairs for older adults.<sup>28</sup> The government also responded with the introduction in 2017 of a National Housing Strategy with a focus on older adults. It also announced the National Co-Investment fund, which promises the construction, repair, and renewal of housing units for older adults, with at least 12,000 new affordable units specially dedicated to older people.<sup>29</sup>

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<sup>1</sup> Government of Canada. (2020). Speech from the Throne: A Stronger and More Resilient Canada. Retrieved 2020, from <https://www.canada.ca/en/privy-council/campaigns/speech-throne/2020/speech-from-the-throne.html>

In Budget 2019, a \$4 billion Canada Housing Benefit was announced to provide financial relief to those in core housing need.<sup>30</sup> These investments provide financial support to older, home-bound Canadians in need, as well as funding the retrofitting of existing housing and the building new affordable housing units. In the future, more can be done to provide needs-based rental subsidies to low-income seniors, to protect the rights of older tenants, and to support publicly delivered home and community support services, such as home care, meal preparation, and housekeeping.<sup>31</sup> The availability of a broad range of support options for housing and home-based supports will be key in better supporting older Canadians to age in place.

### **IMPROVING THE PROVISION OF LONG-TERM CARE**

In relation to the provision of home care, NSS 2015 recommended using the *Canada Health Transfer* (CHT) to earmark funding targeted to the health service provision of home, community, and palliative care. Budget 2017 invested \$6 billion to be dedicated to home and palliative care over 10 years using the CHT.<sup>32</sup> As part of the plan, federal, provincial, and territorial governments are working to develop agreements on performance indicators and mechanisms for annual reporting to citizens, as well as a detailed plan on how the funds will be spent, over and above their existing programs.<sup>33</sup> Financial support from the federal government is necessary, but it will not solve this issue if the status quo in the method of the delivery of care is maintained. Across the country, there is need to reform the provision of care and care delivery models. The NIA thus has embarked on an ongoing policy research series that examines current and future anticipated challenges and opportunities around the provision of long-term care with a focus on outlining a foundational roadmap for reform and improvement.

### **PROMOTING THE DEVELOPMENT OF AGE FRIENDLY COMMUNITIES**

To promote the development of age friendly communities, NSS 2015 recommended that the government develop robust national standards to promote accessibility for all Canadians. The government responded with the introduction of the *Accessible Canada Act* in 2019 - legislation to make all federally regulated spaces and buildings more accessible.<sup>34</sup> There are still gaps, however, in ensuring that private dwellings are accessible to all ages and abilities. A common minimum standard is needed in the national building code to bring consistency across the provinces and territories.

### **ENABLING PHARMACARE**

On the issue of pharmacare, NSS 2015 recommended that the government improve access to medically necessary medications for older adults. In Budget 2018, the government announced the Advisory Council on the implementation of pharmacare, which released its final report in June 2019 and called for the federal government to work with provincial and territorial governments, and stakeholders, to establish universal, single-payer, public pharmacare in Canada.<sup>35</sup> In Budget 2019, the government accepted a few of the recommendations of the Advisory Council, including a common national formulary, which is critical to ensuring that all Canadians have access to a common list of drugs at a common price. It also acted on the recommendation<sup>36</sup> to establish a national drug agency, which will help coordinate pharmacare

provision across the provinces and territories. The establishment of a national strategy for high cost drugs and rare diseases is meant to ensure that cost and rarity of disease do not stand in the way of Canadians getting the medication they need. Overall, the early efforts to move towards a national pharmacare program are important first steps in a much longer process that the NIA will continue to contribute to and monitor.

## IMPROVING CAREGIVER SUPPORTS

NSS 2015 also identified the need for the federal government to simplify access to financial assistance for caregivers. Budget 2017 established a new, more accessible Canada Caregiver Credit that provides up to \$6,883 (adjusted annually for inflation) of tax relief a year to family members supporting the care of a relative.<sup>37</sup> The new credit replaces three less effective caregiver tax credits. The new enhanced credit, however, has received widespread criticism as it has remained non-refundable, such that one has to have reportable income in excess of the tax credit amount to qualify for a tax refund – meaning that very low- and zero-income caregivers do not benefit. In 2017, a new Family Caregiver Benefit was introduced to give unpaid family caregivers access to up to 15 weeks of Employment Insurance (EI) benefits when taking time off to care for a relative with an acute illness.<sup>38</sup> The Compassionate Care Benefit was also improved to support unpaid family caregivers, going from 6 weeks to up to 26 weeks of EI benefits when taking time off to care for a relative with end-of-life care.<sup>39,40</sup> There remains a need to further simplify and increase access to financial support for caregivers.<sup>41</sup> The NIA welcomes the introduction of the three new streamlined benefits, however, it remains to be seen whether caregivers will actually take up the program, and would urge all levels of government to both encourage and monitor its take-up.

## OTHER AREAS OF PROGRESS

The government has also demonstrated leadership in re-appointing a Minister of Seniors in 2018, who held consultations on retirement security, dementia, and consumer protection for older adults and helped to oversee a renewal of the National Seniors Council. The government subsequently allocated \$20 million in Budget 2018 to the Public Health Agency of Canada (PHAC) to support community dementia-related investments, and \$50 million in Budget 2019 to PHAC over the 5 years to support the implementation of the National Dementia Strategy.<sup>42</sup> The National Dementia Strategy was formally announced in June 2019 and aims to prevent dementia, advance therapies and find a cure, and improve the quality of life for people living with dementia and their caregivers.<sup>43</sup> The funding will be used to increase awareness about dementia, develop treatment guidelines and best practices for early diagnosis, and improve the understanding of the prevalence of dementia.

While Canada does not yet have a formal National Seniors Strategy, a Private Member's Motion was tabled by MP Marc Serre in 2017 requesting that the federal Government ask its Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities (HUMA Committee) to conduct a study on developing a pan-Canadian National Seniors Strategy.<sup>44</sup> In June 2017, HUMA conducted two public hearings as part of a "study of



how the government can support vulnerable seniors today while preparing for the diverse and growing seniors' population of tomorrow."<sup>45</sup> Twenty-nine recommendations were presented, ranging from income supports, housing, transportation, long-term care, home care, caregivers, age friendly cities, including a recommendation to develop a pan-Canadian Seniors Strategy. A key takeaway from the Committee was finding that federal leadership is necessary on this issue.

Good policy does not happen overnight. But the federal government has shown considerable leadership in advancing core issues related to the well-being of older adults and their systems of support since 2015. The actions listed here are important first steps. The reality is that the array of policies in relation to older adults still represent a patchwork of ideas without clear, integrated goals and targets. In order to move beyond first steps, a comprehensive approach that supports sustained, integrated progress over time is needed. The issues affecting older adults and an ageing population must be liberated from government department silos. What Canadians need is federal leadership and an evidence-informed National Seniors Strategy.

With the adoption of an evidence-informed National Seniors Strategy, the federal government could be the driver of collaborative leadership to direct a coordinated effort with clearly defined and collective goals to create sustainable progress on issues related to ageing across Canada.

# Independent Productive & Engaged Citizens



## SECTION 1

# Independent, Productive, and Engaged Citizens

## Ensuring Older Canadians Remain Independent, Productive and Engaged Citizens

With the number of older Canadians expected to double between 2010 and 2030, and many more enjoying more of their extra years in good health, older Canadians must be given the opportunities to remain engaged and productive members of society. The number of older Canadians who continue to work past the age 65 has doubled over the past decade, reaching 1.1 million in 2015.<sup>46</sup> Working allows them to continue to contribute to the social and economic well-being of Canada, as well as to their own.

Older Canadians continue to contribute to society in many other ways and are over-represented as volunteers and unpaid caregivers. They are also the most politically engaged members of the society and have the highest voter participation rates.<sup>47</sup> Ensuring communities can continue to support their older residents to remain independent and engaged will mean continuous work to strengthen opportunities that ensure older Canadians have access to a reasonable income, affordable housing, and transportation services. Further fostering age-friendly and inclusive communities, workplaces, and health and social services would help to combat the growing levels of social isolation and help reinforce efforts needed to end ageism and elder abuse in society.

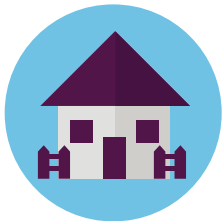
The federal government can work with Canada's provinces, territories and municipalities to enable this pillar in a variety of ways:



- **Ensuring that ageism, elder abuse and social isolation are national priorities can be achieved by continuing to support activities and policies that value the role, contributions and needs of older Canadians.**



- **Ensuring older Canadians do not live in poverty can be achieved by enhancing existing public support systems and by providing new options to help Canadians save for themselves.**



- **Ensuring access to affordable housing for older Canadians can be achieved by maintaining federal commitments to the development of housing infrastructure and prioritizing housing for older adults.**



- **Ensuring access to transportation can be achieved by developing an inclusive transportation infrastructure, addressing governance of accessibility, and monitoring accessibility measures.**



- **Ensuring the development of more age-friendly communities, physical environments and spaces can be achieved through the incorporation of well-established universal design standards in national building codes.**

# Make Addressing Ageism, Elder Abuse and Social Isolation a National Priority

## Setting the Context

### AGEISM

Older Canadians are valuable members of their communities, yet many are vulnerable to various forms of ageism, abuse, mistreatment, and isolation. Ageism is commonly understood to be, “the stereotyping of, and discrimination against, individuals or groups because of their age”.<sup>48</sup> While this can include those who are young or old, ageism appears to be a more significant issue for older members of society. Indeed, many have come to remark that this form of discrimination still appears to be the last acceptable ‘ism’ in our society.

Ageism manifests itself in multiple ways, such as prejudicial attitudes towards older people, old age, and the ageing process; discriminatory practices against older people; and institutional practices and policies that perpetuate stereotypes about older people.<sup>49,50</sup> Ageism still remains a significant problem. In a Canadian survey, 63% of respondents 66 years of age and older indicated that, “they have been treated unfairly or differently because of their age”.<sup>51</sup> Comparatively, **80% of Canadians agree with the statement, “older adults 75 and older are seen as less important and are more often ignored than younger generations”**; while 51% agree that, “ageism is the most tolerated social prejudice when compared to gender or race-based discrimination”.<sup>52</sup>

Negative attitudes regarding older Canadians can have a significant impact on their health, well-being, and involvement within their communities. Indeed, ageism can influence the way decisions are made about older people. Within health care, for example, a person’s age, rather than their overall health status, can influence medical decisions about the diagnostic tests or treatments provided to an older person. Resources and treatment options may be withheld from an older person that wouldn’t be withheld from a younger person. Ageism in the workforce is manifested when, for example, a person’s age, rather than their experience and abilities, influences hiring decisions. Mandatory retirement was ended in Canada in December 2011 when the federal government officially repealed the section of the Canadian Human Rights Act that permitted it.<sup>53</sup> Nevertheless, according to a poll, 74% of Canadians still consider age discrimination to be a problem in the workplace.<sup>54</sup>

Two specific consequences often linked to ageism are elder abuse and social isolation.

## ELDER ABUSE

The World Health Organization defines the abuse of older adults as “a single or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust that causes harm or distress to an older person.”<sup>55</sup> Elder abuse can destroy an older person’s quality of life, and significantly increase their overall risk of death. Elder abuse can take several forms, including physical abuse, psychological or emotional abuse, financial abuse, sexual abuse, and neglect. Table 1 provides a description of the different forms of elder abuse.

**Table 1. Understanding the Several Forms of Elder Abuse<sup>56</sup>**

### **FINANCIAL ABUSE**

The most common form of elder abuse, financial abuse, often refers to the theft or misuse of money or property like household goods, clothes or jewelry. It can also include withholding funds and/or fraud.

### **PSYCHOLOGICAL (EMOTIONAL) ABUSE**

The willful infliction of mental anguish or the provocation of fear of violence or isolation is known as psychological or emotional abuse. This kind of abuse diminishes the identity, dignity and self-worth of the older person. Forms of psychological abuse include a number of behaviors, for example: name-calling, yelling, ignoring the person, scolding, shouting, insults, threats, provoking fear, intimidation or humiliation, infantilization, emotional deprivation, isolation or the removal of decision-making power.

### **PHYSICAL ABUSE**

Any physical pain or injury that is willfully inflicted upon a person or unreasonable confinement or punishment, resulting in physical harm, is abuse. Physical abuse includes: hitting, slapping, pinching, pushing, burning, pulling hair, shaking, physical restraint, physical coercion, forced feeding or withholding physical necessities.

### **SEXUAL ABUSE**

Sexual abuse is understood as contact resulting from threats or force or the inability of a person to give consent. It includes, but is not limited to: assault, rape, sexual harassment, intercourse without consent, fondling a confused older adult, intimately touching an older adult during bathing, exposing oneself to others, inappropriate sexual comments or any sexual activity that occurs when one or both parties cannot, or do not, consent.

## Neglect

Neglect can be intentional (active) or unintentional (passive) and occurs when a person who has care or custody of a dependent older adult fails to meet his/her needs. Forms of neglect include: withholding or inadequate provision of physical requirements, such as food, housing, medicine, clothing or physical aids; inadequate hygiene; inadequate supervision/safety precautions; withholding medical services, including medication; overmedicating; allowing an older adult to live in unsanitary or poorly heated conditions; denying access to necessary services (e.g., homemaking, nursing, social work, etc.) or denial of an older adult's basic rights. For a variety of reasons, older adults themselves may fail to provide adequate care for their own needs and this form of abuse is called self-neglect.

## Systemic Abuse

The society, and the systems that develop within it, can generate, permit or perpetuate elder abuse. Most prevalent is discrimination against older adults, due to their age and often combined with any of these additional factors: gender, race, colour, language, ethnic background, religion, sexual orientation, ability, economic status or geographic location.

Most instances of elder abuse are committed by family members and caregivers of older people. The prevalence and severity of elder abuse is therefore difficult to ascertain since, in many instances, abuses are often underreported or go unnoticed. This is largely due to many older persons not being willing to report elder abuse because of the social stigma attached to it or their concern regarding the consequences of reporting a loved one or caregiver (see Box 1 for the definition of 'caregivers' based on Stall et al. 2019).<sup>57</sup> For instance, reporting abuse could mean the withdrawal of care or the loss of their caregiver, making their decision to report abuse much more difficult. As a result, while up to 10% of older Canadians experience a form of abuse,<sup>58</sup> it's estimated that only one in five incidents of elder abuse are reported.<sup>59</sup>



### Box 1. NIA Definitions of Caregivers

**'Unpaid caregiver'** refers to an individual who provides care to another person primarily because a personal relationship exists and can include family, friends, and neighbours of care recipients. Unpaid caregiver is henceforth also referred to as **'caregiver'**.

**'Care provider'** refers to an individual who provides care because of a financial relationship which may include licensed or unlicensed care providers.

Many forms of elder abuse are also on the rise. For example, shortly after the 2008 recession, large Canadian law firms reported seeing a striking increase in the number of challenges to Powers of Attorney, some of which constitute financial abuse.<sup>60</sup> Health Canada notes that financial abuse of older adults tends to be the most common form of abuse (62.5%), followed by verbal (35%) and physical abuse (12.5%), along with neglect (10%).<sup>61</sup> Primary caregiver stress has also been shown to significantly contribute to the incidence of elder abuse, highlighting the need to provide caregivers with increased supports.

In 2018, there were 12,202 cases of police-reported violence against older adults in Canada, 33% of which were victimized by a family member.<sup>62</sup> While older adults are the least likely demographic to suffer violent crime by a stranger, they are the population most at risk of suffering violence at the hand of a family member or relative.<sup>63</sup> From 2009 to 2018, the rate of police reported violence against older adults by family members increased by 11%, while spousal violence and violence against children either plateaued or decreased during the same period.<sup>64</sup>

Elder abuse is also more complicated than abuse in other age categories (e.g. child abuse), since older adults generally have the capacity to, and are expected to, address issues themselves. However, the hidden power imbalances that can occur in relationships of dependency between older adults and their families or caregivers further complicates these situations. The increasing prevalence of older Canadians living with dementia, functional impairments, or poverty, is placing older adults in vulnerable positions that could allow them to become victims of abuse or neglect.

Furthermore, determining when health, social and community care, and public safety professionals have a duty to report elder abuse and neglect (similar to child abuse and neglect) is another aspect that will need to be revisited. Older adults may neglect to take care of their personal health and well-being, often due to declining mental awareness or capability. Some older adults may also choose to deny themselves health or safety benefits, which may not be self-neglect, but a reflection of their personal choice. While difficult, caregivers and other responsible parties must honour an older person's choice to live at risk, especially if the older adult is capable of making such decisions for themselves.

## Percentage of older adults that experience some type of abuse in Canada:



**62.5%**

**Financial Abuse**



**35%**

**Verbal Abuse**



**12.5%**

**Physical Abuse**



**10%**

**Neglect**



As Canada's population ages, elder abuse may also increase unless it is more comprehensively recognized and addressed. At a minimum, increasing awareness among older Canadians and members of the public about elder abuse and neglect, so they can better understand when and how they should provide help is a needed first step.

## SOCIAL ISOLATION

There is a growing concern that older Canadians are particularly at risk of becoming socially isolated. Although multigenerational living is once again on the rise, people today have become less likely to live in intergenerational communities, and less likely to participate regularly in traditional faith-based or social groups. Furthermore, the growing presence of physical and cognitive limitations while ageing, along with the fact that older adults also tend to outlive their decision to stop driving by up to a decade, may all contribute to limiting one's ability and/or willingness to interact with others.

Increased social frailty can develop with time that puts older Canadians at particular risk of becoming socially isolated, especially if they outlive their spouses or partners, family members, or friends. A report focusing on ageing in rural and remote areas of Canada also emphasized that social isolation can be caused by having a lack of transportation options.<sup>65</sup>

Research shows that about 30% of Canadians are at risk of becoming socially isolated while Statistics Canada estimates that between 19-24% of Canadians over the age of 65 wish they could participate more in social activities.<sup>66</sup> Social isolation can have a significant effect on a person's overall health and well-being as it can lead to loneliness, elder abuse, and declining mental health. Finding ways to minimize this in communities should be a priority.

The National Seniors Council *Report on the Social Isolation of Seniors* (2014)<sup>67</sup> determined that older Canadians are at increased risk for social isolation when they:

- Live alone;
- Are 80 or older;
- Have compromised health status, including having multiple chronic health problems;
- Have no children or contact with family;
- Lack access to transportation;
- Have a low income;
- Have a changing family structure, such as where younger family or community members migrate for work and leave older adults behind,
- Live in isolated urban, rural or remote situations; and
- Have experienced a critical life transition (e.g. retirement, bereavement).

Social isolation is considered both a *risk factor for* as well as a *result of* elder abuse, representing the complexity and importance of the social network around the health and well-being of

older Canadians.<sup>68</sup> While the negative effects of isolation are primarily borne by older adults themselves, communities are also at risk of suffering from the lack of involvement of valued older community members as well. Indeed, missing the contributions of older adults can lead to, “a lack of social cohesion, higher social costs, and the loss of an unquantifiable wealth of experience that older adults bring to families, neighbourhoods and communities”.<sup>69</sup>

Finally, the Canadian government has made concerted efforts to raise awareness around and address issues of elder abuse and social isolation in Canada. Some key initiatives have included:

- *Launching of the **Elder Abuse - It's Time to Face the Reality** Awareness Campaign on television, print and online in 2009 followed by a public opinion survey that showed 91% of Canadians have a basic awareness of elder abuse.*<sup>70</sup>
- *Passage of the **Protecting Canada's Seniors Act** in 2013 which amended the *Criminal Code of Canada* so that age is considered an aggravating factor for criminal sentencing purposes.*
- *Adoption of the **Canadian Victims Bill of Rights** in 2014 that gives statutory rights to victims of crime.*
- *Launching of the **Government of Canada's [www.seniors.gc.ca](http://www.seniors.gc.ca)** website in 2015 as an online awareness and resource center that includes specific sections on elder abuse and social isolation.*
- *Funding of the **New Horizons for Seniors Program (NHSP)** in 2018 that provides funding annually to for-profit and not-for-profit organizations to support projects involving older adults with objectives of promoting social participation, mentoring and volunteering to mitigate the risk of social isolation.*<sup>71,72</sup>

Societal ageism manifested itself more recently at the start of Canada's COVID-19 pandemic experience with disgraceful incidents such as the appearance and widespread use of hashtags on social media, such as #boomerremove.<sup>73</sup> Furthermore, consideration of age alone in the allocation of medical treatments, without recognizing the diversity among older adults became a real concern.<sup>74</sup> The pandemic also highlighted the reality of intergenerational complacency and a general disregard for older populations due to early reports that most serious infections and highest risk of death appeared to be occurring amongst older adults.<sup>75</sup> Indeed, analyses by the National Institute on Ageing showed that by the summer of 2020, over 80% of all COVID-19 deaths in Canada occurred amongst older Canadians in nursing home and retirement home settings.

The COVID-19 pandemic also posed new health risks beyond transmission of virus. Due to significant visitor restrictions placed on those wishing to visit others in both nursing and retirement homes and acute care settings to reduce disease transmission, many older adults in these settings experienced additional social isolation, loneliness, and inactivity. Without being able to sustain frequent and meaningful social interactions with others, self-isolation and physical distancing measures can lead to rapid declines in cognitive functioning and increased rates of depression and anxiety.<sup>76,77</sup>

During the COVID-19 pandemic, elder abuse hotlines were reporting a 10% increase in calls regarding scams and frauds.<sup>78</sup> This highlighted that in times of crisis, perpetrators of financial abuse looked to prey on those most vulnerable, many of whom were older adults. One thing that the COVID-19 pandemic has reinforced is that there is an increased need for a greater awareness of and strategies to address ageism, social isolation, loneliness, and elder abuse.

## What Are the Issues?

### 1. AGE-RELATED SOCIAL ISSUES SUCH AS AGEISM, ELDER ABUSE, AND SOCIAL ISOLATION POSE SIGNIFICANT NEGATIVE HEALTH RISKS FOR OLDER CANADIANS

Ageism, elder abuse, and social isolation in all of forms negatively impact the health of older adults. While some forms of elder abuse, including physical or sexual abuse in particular, have more obvious negative health implications,<sup>79</sup> other forms of elder abuse such as emotional and financial abuse have the potential to deprive older adults of basic necessities for health and well-being. Additionally, ageist stereotypes based on perpetuated myths regarding the abilities and competencies of older adults affect their ability to remain active and valued members of society. Similarly, social isolation – whether it is self-imposed or imposed upon by others – is also known to have tangible and significant effects on the health status of older Canadians.

Social isolation has been proven to lead to engagement in adverse health behaviours such as: smoking, drinking and maintaining an unhealthy diet.<sup>80</sup> This may help explain why isolated older adults are more likely to experience a fall, coronary heart disease, stroke, suicide and depression.<sup>81,82</sup> Evidence further suggests that social isolation is a correlate of specific illnesses such as dementia. Specifically, “the lack of supportive social networks has been linked to a **60% increase in the risk of dementia and cognitive decline.**”<sup>83</sup> In a meta-analysis of 148 studies, authors demonstrated that social isolation is a significant predictor of death.<sup>84</sup> Further, as a predictor of early mortality, **social isolation was also found to be as strong a predictor as smoking over 15 cigarettes a day or excessively consuming alcohol.**<sup>85</sup> Importantly, social inclusion is a significantly **protective** factor against death and dementia.<sup>86,87</sup>

### 2. ELDER ABUSE AND SOCIAL ISOLATION HAVE SYSTEMIC COST IMPLICATIONS

The impact of ageism, social isolation and elder abuse on the individual health status of older Canadians also directly results in broader health and social system costs. For example, social isolation has been shown to be a significant risk factor for hospitalizations<sup>88</sup> and hospital readmissions<sup>89</sup> amongst older adults. In fact, socially isolated older adults are **four to five times more likely to be admitted to hospital** than older adults in general.<sup>90</sup> Disease specific costs known to be correlated to social isolation, such as heart disease, stroke, dementia and depression as well as falls are themselves significant. Finally, social isolation has been identified as one of the top four predictors for placement into more costly nursing home settings.<sup>91</sup>

### 3. CERTAIN POPULATIONS ARE MORE VULNERABLE TO EXPERIENCING SOCIAL ISOLATION AND ELDER ABUSE

Current evidence suggests that there are specific older populations of Canadians that are particularly at risk of experiencing social isolation and elder abuse. The National Seniors Council *Report on the Social Isolation of Seniors* (2014)<sup>92</sup> highlighted the following specific populations as being at greatest risk:

- Older adults with physical, mental health issues (including older adults with Alzheimer’s disease or other dementia, or multiple chronic illnesses)
- Low income older adults
- Older adults who are caregivers
- Indigenous older adults
- Older adults who are newcomers to Canada or immigrants (language proficiency issues, separation from family, financial dependence on children, low levels of inter-ethnic contact, discrimination); and, Older adults who are lesbian, gay, bisexual, transgender, queer, intersex, and/or two-spirit (LGBTQI2S).

Older immigrants currently arriving in Canada under the family class category were highlighted by the *Special Senate Committee on Aging* as a particularly vulnerable group,<sup>93</sup> mainly because they are subjected to a 10 to 20-year sponsorship period. As a result, sponsored parents or grandparents are not entitled to any form of social assistance even if they become citizens during this time. This means that these older adults will remain ineligible for the Old Age Security (OAS) and Guaranteed Income Supplement (GIS) benefits that other income-taxpaying older Canadians would receive.<sup>94</sup> In addition, many vulnerable older immigrants would not have had any employment history in Canada, thus making them ineligible for the Canada Pension Plan or Quebec Pension Plan (CPP/QPP) unless they come from a country with a reciprocal pension agreement. This also leads to sponsored older adults having limited or no access to certain forms of provincial and territorial long-term home, community, and nursing home care, until after being a resident for ten years. Many of these older adults do not have independent sources of income. As a result, they live in a perpetually dependant state due to their limited options. They are largely dependent on their families, which can place them at increased risk of abuse, exploitation, or neglect.

In 1997, the Government of Canada reduced the period of sponsorship for spouses and partners from ten to three years in recognition of the potential for abuse due to long periods of sponsorship dependency<sup>95</sup>. Therefore, many argue that a similar reduction of the immigration sponsorship period for parents and grandparents could significantly improve the settlement of sponsored older adults in Canada and reduce distress and the potential consequences that they may experience in the process of integration.

## SOME FORMS OF ISOLATION AND ELDER ABUSE VARY BY REGION

Available data on family violence demonstrates that despite the national awareness efforts mentioned above, rates of family violence against older people can vary significantly by province and territory, with a tendency to occur mostly in rural settings.<sup>96</sup> Police-reported family violence against an older adult, for example, is significantly higher in Canada's territories compared with all other jurisdictions, while Saskatchewan, Alberta, and Prince Edward Island were the three provinces with the highest reported rates of family violence against older people (See Table 2).<sup>97</sup> Taken together, these findings help point to complex social, geographic and economic factors underlying higher prevalence of this form of elder abuse in certain regions.

**Table 2. Older Adult Victims of Police-reported Family Violence, by Sex of Victim, Province and Territory<sup>98</sup>**

<b>Older adult victims of police-reported family violence and non-family violence, by victim sex and province or territory, 2016 to 2017</b>						
<b>Province or territory</b>	<b>2017</b>					
	<b>Female victims</b>		<b>Male victims</b>		<b>Total victims</b>	
	number	rate	number	rate	number	rate
<b>Family violence</b>						
NEWFOUNDLAND AND LABRADOR	30	56	38	79	68	67
PRINCE EDWARD ISLAND	14	94	10	78	24	87
NOVA SCOTIA	51	53	43	52	94	53
NEW BRUNSWICK <sup>1</sup>	54	77	52	83	106	80
QUEBEC	588	74	421	62	1,009	68
ONTARIO	649	54	402	39	1,051	47
MANITOBA	72	72	73	84	145	77
SASKATCHEWAN	102	119	83	110	185	115
ALBERTA	265	99	208	88	473	93
BRITISH COLUMBIA	316	72	213	53	529	63
YUKON	5	216	8	338	13	278
NORTHWEST TERRITORIES	23	1,427	16	1,027	39	1,230
NUNAVUT	10	1,271	14	1,980	24	1,606
<b>CANADA</b>	<b>2,179</b>	<b>70</b>	<b>1,581</b>	<b>58</b>	<b>3,760</b>	<b>64</b>

**Note** <sup>1</sup> Excludes data from the Saint John Police Service due to data quality concerns.

**Note:** Rates are calculated on the basis of 100,000 population aged 65 to 89 years. Populations based upon July 1st estimates from Statistics Canada, Demography Division. Family violence refers to violence committed by spouses (legally married, separated, divorced and common-law), children (biological, step, adopted and foster), siblings (biological, step, half, adopted and foster) and extended family members (e.g., grandchildren, nephews, nieces, cousins and in-laws). Victims refer to those aged 65 to 89 years. Victims aged 90 years and older are excluded from analyses due to possible instances of miscoding of unknown age within this age category. Excludes victims where the sex or the age was unknown or where the accused-victim relationship was unknown. Percentages may not total 100% due to rounding. Based on the Incident-based Uniform Crime Reporting Survey, Trend Database, which, as of 2009, includes data for 99% of the population in Canada. As a result, numbers may not match those presented elsewhere in the report.

**Source:** Statistics Canada, Canadian Centre for Justice Statistics, Incident-based Uniform Crime Reporting Survey, Trend Database.

## Evidence-Informed Policy Options

### 1. IMPROVE AWARENESS AROUND AGEISM, SOCIAL ISOLATION AND ELDER ABUSE

The federal government has thus far supported general awareness campaigns around issues of elder abuse. While a general awareness exists around the issue of elder abuse amongst Canadians, specific forms of elder abuse, such as financial and domestic abuse, are on the rise and require a better public understanding of how to identify and effectively mitigate these issues. The widespread issue of ageism is also one that can further contribute towards elder abuse and social isolation and requires increased general awareness to help Canadians better recognize and address it.

The federal government has also funded work that has further identified older populations that are most at risk of social isolation and elder abuse.<sup>99</sup> In particular, rural and Indigenous populations have been identified as being at particular risk of experiencing social isolation as well as violent crimes. Understanding and addressing the complex cultural and societal issues related to ageism, social isolation, and elder abuse, will require a multi-faceted approach. The federal government is in a position to lead the development and dissemination of both general and specifically targeted approaches to raising awareness and preventing ageism, social isolation, and elder abuse in partnership with provinces and territories.

### 2. ADDRESS THE HIGHER RATES OF ELDER ABUSE IN RURAL, INDIGENOUS AND IMMIGRANT POPULATIONS

Evidence suggests that social, cultural, geographical and economic factors likely play a significant role in regional patterns and presentations of elder abuse. Furthermore, rural dwelling older adults are also increasingly prone to social isolation, neglect and other forms of abuse as access to transportation and/or services are sparse or non-existent in many rural communities. As a result, when older adults in these settings outlive their ability or wish to stop driving, staying connected and accessing support and services becomes challenging. The federal government could provide leadership to prioritize work that helps to understand and address issues of social isolation, abuse, and violent crimes in these communities.

In line with the 2009 recommendation of the *Special Senate Committee on Aging*,<sup>100</sup> the Government of Canada should reduce the immigration sponsorship period for older relatives and the residency requirement for entitlement to a monthly pension under the *Old Age Security Act* from ten to three years. In 1997, the Government of Canada made the decision to reduce the period of sponsorship for immigrating spouses and partners from ten to three years in recognition of the potential for abuse in sponsorship arrangements and in line with the time it takes to become a Canadian citizen.<sup>101</sup> Older immigrants remain the only group required to have a 10-year sponsorship period.<sup>102</sup> Aligning all sponsorship periods could significantly reduce the risk of abuse they older adults may experience during their integration process.

# Ensure That Older Canadians Do Not Live in Poverty by Improving Their Income Security

## Setting the Context

Supporting older Canadians to remain independent and engaged citizens will require a concerted effort to strengthen existing and future income and savings opportunities. In Canada, great strides have been made in reducing poverty rates among older Canadians – Canada fell from one of the highest rates of poverty among older adults in *Organization for Economic Co-operation and Development* (OECD) countries in the 1960s and 1970s, to one of the lowest.<sup>103</sup>

Older Canadians, however, remain one of the most financially vulnerable Canadian populations, especially those who live alone, according to Canada’s *Federal Poverty Reduction Plan*.<sup>104,105</sup> In fact, the rate of older Canadians considered as living “in low income” is increasing. In 2012, Statistics Canada recorded 606,000 (12.1%) older Canadians living in low income according to the After-Tax Low-Income Measure (AT-LIM)<sup>106</sup>, and by 2016 Statistics Canada recorded 790,820 (14.5%) of older Canadians living in low income based on census data.<sup>107</sup>

**Table 3. Annual Low-Income Measures by Household Size in Canada (AT-LIM), 2017 (Source: Statistics Canada, 2019)<sup>108</sup>**

HOUSEHOLD SIZE	AFTER-TAX LOW-INCOME MEASURE (AT-LIM) THRESHOLD (\$)
1 person	23,513
2 persons	33,252
3 persons	40,726
4 persons	47,026

The Old Age Security (OAS) and the Guaranteed Income Supplement (GIS) programs are federally administered and publicly funded income supports for individuals 65 and older. These two programs complement the federally administered Canada Pension Plan (CPP) or Quebec Pension Plan (QPP) towards which all working Canadians must contribute. While the maximum monthly CPP/QPP is \$1175.83, the average monthly payment is closer to \$696.56 as of March 2020.<sup>109</sup> (See Table 4 for average OAS, GIS, and CPP/QPP payouts in Canada).

**Table 4. Maximum Annual OAS, GIS, and CPP/QPP Payouts in Canada**

Income Support Vehicle	(\$)
OAS (Maximum Monthly Payment)* <sup>110</sup>	613.53
GIS (Maximum Monthly Payment)** <sup>111</sup>	Single Individual:
	916.38
	Attached Individual: 551.63
CPP/QPP (Maximum Monthly Payment)** <sup>112</sup>	1175.83

\*Regardless of marital status and based on an individual annual income of \$125,696

\*\*Amounts based on also receiving full OAS

In 2016, the Government of Canada, with support from the majority of provincial and territorial governments, enhanced CPP/QPP benefits, enabling Canadians in the future to receive higher benefits in exchange for making higher contributions. The CPP/QPP enhancements will affect those who as of 2019 are working and making contributions to the CPP/QPP. The benefits are targeted to increase from 25% to 33% of a worker's average monthly pensionable earnings between 2019 and 2025, and the yearly maximum pensionable earnings will be gradually raised from approximately \$59,700 in 2019 to \$82,700 in 2025.<sup>113,114</sup>

The GIS saw a 10% increase in the total maximum benefit available to the lowest income older adults<sup>115</sup>, and the age of eligibility for OAS was moved back to 65, from 67.<sup>116</sup> Budget 2019 saw further enhancements to public income support systems, including an increase in the earnings exemption amount for the GIS, allowing working older adults to keep more of their earnings before facing a claw back. Automatic enrolment into the CPP/QPP at age 70 was also announced so that Canadians who otherwise neglect to file for their CPP/QPP will now receive it automatically at age 70. In the 2020 Throne Speech, the Government of Canada reiterated a commitment to increasing Old Age Security (OAS) commencing at the age of 75 and boosting the CPP survivor's benefit.<sup>1</sup>

<sup>1</sup> Government of Canada. (2020). Speech from the Throne: A Stronger and More Resilient Canada. Retrieved 2020, from <https://www.canada.ca/en/privy-council/campaigns/speech-throne/2020/speech-from-the-throne.html>



While the above changes are welcomed, they target only the first two pillars of Canada's Retirement Income System (RIS), while all three pillars should be monitored and built upon to ensure the RIS best meets the needs of Canadians (see Box 2).<sup>117</sup> The third pillar of the RIS, which includes private retirement savings vehicles such as registered retirement saving plans (RRSPs) and tax-free savings accounts (TFSAs), has an increasingly important role to play in the reduction of poverty for older Canadians as it supplements public income support systems and any employment-based retirement plans. However, while the need for Canadians to accumulate private retirement savings is growing, the last few decades of economic turmoil has meant that a significant decline has been seen in the number of Canadians participating in private retirement savings vehicles and workplace pension plans.<sup>118</sup>

Even after the recently announced CPP/QPP expansion, it will only create a replacement rate of 33% of pre-retirement income, up to a maximum pension earning of \$82,700 by 2025.<sup>119</sup> This will bring the future net replacement rates for a full-career average-wage worker to 53%, which is still below the OECD average of 63%.<sup>120</sup>

Workplace pension plans such as defined benefit (DB) plans, defined contribution (DC) plans, and voluntary tax assisted private savings opportunities will continue to play an important role in supplementing retirement incomes. Of these employment plans, the evidence highlights DB as the strongest vehicle for achieving secure finances throughout retirement. Research shows that collective, workplace pension plans provide a higher return on investment than individualized approaches or private savings opportunities to saving for retirement.<sup>121</sup>

A recent report, *The Value of a Good Pension*, highlighted that for each dollar contributed to a DB plan, the return on investment is \$5.32 vs \$ 1.70 from a typical individual approach.<sup>122</sup> However, the availability of these plans is declining. DB pensions remain more likely to be found in the public sector, covering only approximately 10% of private sector workers.<sup>123</sup>



## Box 2. Three Pillars of Canada's Retirement Income System (RIS)

### Pillar 1: Publicly funded Plans and Programs Administered by the Federal Government

- Canada Pension Plan (CPP) / Quebec Pension Plan (QPP)
- Old Age Security program (OAS)
- Guaranteed Income Supplement program (GIS)

### Pillar 2: Employment-based Retirement Plans

- Registered pension plans
- Retirement savings plans such as a group Registered Retirement Savings Plan (RRSP) or Deferred Profit Sharing Plan (DPSP)

### Pillar 3: Personal Retirement Plans

- Tax-assisted arrangements such as RRSP or Tax-Free Savings Accounts (TFSAs)
- Non-registered savings and investments such as annuities, bonds, guaranteed investment certificates (GICs), stocks, or mutual funds

Overall, pension coverage rates or the proportion of all paid workers covered by a registered pension plan (RPP) has declined from 42.4% in 1996 to 37.5% in 2016.<sup>124</sup> A 2020 National Institute on Ageing report shows that approximately 12 million working Canadians do not have access to a workplace pension plan.<sup>125</sup> **Canadians nearing retirement without a workplace pension plan have median savings of only \$3,000.**<sup>126</sup> Many of these Canadians will have no choice but to rely on available government administered income supports in retirement.<sup>127</sup> While the use of private savings vehicles like RRSPs and TFSA's are sound individual vehicles for retirement savings, more can be done to optimize their use to ensure more Canadians can afford to retire.

In 2018, the NIA along with a coalition of pension and advocates for older adults including Association of Canadian Pension Management (ACPM), Canadian Association of Retired Persons (CARP), Canadian Institute of Actuaries (CIA), Canadian Life and Health Insurance Association (CLHIA), Common Wealth, Pension Investment Association of Canada (PIAC), and notable pension expert, Keith Ambachtsheer, called on the federal government to improve the retirement income options available to retiring Canadians in DC pension plans. In a letter to the federal government, the group identified that employer or other group-sponsored collective solutions with DC pensions and other registered savings vehicles are legislatively blocked from setting up variable payout life annuity-type group arrangements for their employees. The coalition urged the government to amend the income tax regulations that prevent the creation of new collective variable payout programs that allow pension plans to pool the assets of their retired DC members – providing economies of scale, better investment management, and longevity risk protection. Most importantly, the change would allow Canadians to turn lump-sum savings into a lifetime income vehicle.

The coalition also identified that the *Income Tax Act* (ITA) prevented individuals from purchasing a deferred life annuity with their registered savings with a benefit commencement date beyond age 71. The coalition therefore recommended that the ITA be amended so that that the maximum allowable commencement age for a deferred life annuity be shifted from 71 to 85. This would allow individuals to cost-effectively mitigate their longevity risk by providing them with a new retirement income vehicle that could essentially provide a guaranteed income for life beginning at age 85. Taking advantage of this retirement income option would allow an individual to use the remaining bulk of their retirement savings to be managed more flexibly during the earlier part of retirement.

Budget 2019 responded to both of these appeals, by announcing approval for the creation of advanced life deferred annuities (ALDAs) and variable life payment annuities (VPLAs).<sup>128</sup> ALDAs allow one to put up to 25% of qualified registered funds into the purchase of an annuity, which can start paying an income beginning at age 85, and the VPLAs provide payments based on pooled investment risk to ensure that retirees are protected against running out of income at older ages.

## What Are the Issues?

### 1. PENSIONS CAN STILL BE REDUCED AS A RESULT OF COMPANY INSOLVENCY

There have been a number of high-profile cases where company pensions were reduced due to company insolvency and due to underfunded pension liabilities. This results in a significant pension reduction or loss for employees and retirees. Currently, the regulation of private pension plans is shared between federal and provincial governments, adding complexity to the process of resolving the issue in its entirety. There are vastly ranging opinions on what should be done and how it should be done to mitigate these risks. In Budget 2019, the Government of Canada proposed, "...to introduce legislative amendments to the Companies' Creditors Arrangement Act, the Bankruptcy and Insolvency Act, the Canada Business Corporations Act and the Pension Benefits Standards Act, 1985 to better protect workplace pensions in the event of corporate insolvency."<sup>129</sup> The budget proposed to give courts a greater ability to review payments made to executives in the lead up to insolvency and introduce changes to corporate law with the goal of increasing oversight. According to the federal government, the plan will aim to clarify in federal pension law that if a plan is wound-up, it must still provide the same pension benefits as when it was ongoing.<sup>130</sup> They will also allow benefit plans to fully transfer the responsibility to provide pensions to a regulated life insurance company through the purchase of annuities to improve plan sustainability.<sup>131</sup>

### 2. LOWER INCOME CANADIANS NEED MORE OPTIMAL WAYS TO SAVE FOR RETIREMENT

Currently, a majority of lower-income Canadians neither have access to workplace pensions plans nor do they save sufficiently on their own for retirement.<sup>132</sup> When lower income Canadians do save with savings plans, it is often done in less than optimal ways. Income-tested claw-backs within benefit calculations for GIS and provincial subsidies and post-retirement taxation of savings are two particular challenges for low income Canadians. For the nearly third of retired Canadians who receive GIS, they stand to lose money by saving. While contributions to the RRSP are tax-free, the withdrawals are taxable. As a result, the GIS repayments are reduced by \$0.50 for every dollar, along with reductions on other provincial income-tested subsidies.<sup>133</sup> While more affluent Canadians can "time" their income to minimize tax impacts, lower-income Canadians are generally in a lower tax bracket before, compared to after, retirement – and therefore actually lose by using the tax deduction associated with RRSP contributions prior to retirement. Similar to RRSPs, workplace RPP withdrawals also qualify as pension income and are taxable, resulting in reduced GIS and provincial income-tested subsidies. Lower-income Canadians, and their employers making contributions to RPPs on their behalf, face a perplexing decision to forgo government support in exchange for private savings (and reducing their current living standards), with little (or even negative) improvement in overall financial standing in retirement.

### 3. CANADIANS ARE AT RISK OF OUTLIVING THEIR RETIREMENT SAVINGS

In 2019, 2.2% (or over 770,000) of the population consisted of adults aged 85 and older.<sup>134</sup> When the oldest boomers reach 85 in 2031, this cohort will increase to 4% (or over 1.25 million); when the youngest boomers reach this milestone in 2051, a further increase to 5.7% (or about 2.7 million) is expected.<sup>135</sup> Financing the retirement years for these Canadians will be a growing challenge as life expectancy increases. In particular, few Canadians die in the year actuarial tables predict, this is because while actuarial tables can accurately predict population level mortality, at the individual level, they are less accurate. This creates uncertainty and a real risk of outliving one's money. In response, Canadians often reduce expenditure on the necessities of life, which reduces their quality of life and leaves "too much" in savings or their estate when they die.

Due to a variance in longevity, a natural risk pooling opportunity is created between those who live longer and those who die earlier than expected. This natural risk pooling principle forms the basis of collective pension plans and longevity insurance, benefitting Canadians at the individual level by ensuring that they do not outlive their retirement money. In addition, longevity insurance is beneficial at the macro-economic level as "it ensures older Canadians can contribute to maintaining aggregate demand and hence national employment levels and economic growth by consuming goods and services at rates that maintain rather than restrict their standard of living during their later retirement years".<sup>136</sup> The lack of more efficient retirement income options will place stress on older Canadians, their families, and their communities to afford necessary care later in life and a greater dependency on government income-support programs.

## Evidence-Informed Policy Options

### 1. PROTECT PENSIONS OF OLDER CANADIANS IN CASES OF COMPANY INSOLVENCY

The federal government should continue to work to resolve the issue of insolvency under its own jurisdiction as well as provide guidance and incentives for the provinces to do the same. The federal government has held consultations on enhancing retirement income with the potential of making enhancements to federal pension and governance frameworks and subsequently introduced measures to deal with the issue of insolvency. The federal government can provide leadership to encourage provinces and territories to ensure that the pensions of Canadians' are protected in cases of company insolvency.

## **2. INTRODUCE A NEW CLASS OF WORKPLACE PENSION PLANS THAT BENEFIT LOW INCOME CANADIANS TO SUPPLEMENT PUBLICLY AVAILABLE RETIREMENT INCOME: “TAX- FREE” PENSION PLANS (TFPPS)**

The Government of Canada should explore options to enable a new class of workplace pension plans that are a mirror image of current workplace pension plans with one critical difference – they target lower-income Canadian workers in particular. Rather than operating in a “registered savings” environment, this new class of pension plan would operate in a “tax-free” savings environment (after-tax contributions and pensions that do not count as income). The availability of this type of option would be especially beneficial in helping to ensure that lower income Canadians currently without pension options have better means of saving for their own retirement. The NIA’s Director of Financial Security Research, Dr. Bonnie-Jean MacDonald, explores this further in the 2019 report *Filling the Cracks in Pension Coverage: Introducing Workplace Tax-Free Pension Plans*.<sup>137</sup>

## **3. WORK IN CONSULTATION WITH PENSIONERS, STAKEHOLDERS, AND INDUSTRY ON THE IMPLEMENTATION OF ADVANCED LIFE DEFERRED ANNUITIES, AND VARIABLE LIFE PAYMENT ANNUITIES TO MAXIMIZE THEIR EFFECTIVENESS**

As mentioned earlier, after the NIA along with pension advocates called on the federal government to improve the retirement income options in DC plans, the government responded in Budget 2019 by announcing approval for the creation of Advanced Life Deferred Annuities starting at age 85 and Variable Life Payment annuities. This is a win for Canadians in DC plans. The NIA believes these measures can offer a safe way to turn their retirement savings into lifetime pensions. But, to fully deliver on the potential of these measures, the government needs to work in consultation with pensioners, stakeholders, and industry on the implementation process to ensure it helps as many people as possible.

# Ensuring Older Canadians have Access to Affordable Housing

## Setting the Context

To support older Canadians to live independently in their communities for as long as possible, access to appropriate, secure, and affordable housing options are paramount as they age. Given that housing costs continue to rise faster than inflation, enabling access to affordable housing will be central to maintaining a person's continued independence in older age.

According to the Government of Canada and the Canadian Mortgage and Housing Corporation (CMHC), affordable housing is defined as where, "shelter costs account for less than 30% of an individual's before-tax household income".<sup>138</sup> It also defines a household to be in "core housing need" if its housing falls below at least one of the adequacy, affordability, or suitability standards, and the household would spend 30% or more of its total before-tax income to pay for alternative housing (see Box 3).<sup>139</sup>

Older households in Canada have a higher proportion (14%) in core housing need when compared to non-older households (12.2%).<sup>140</sup> Core housing needs have also risen at a much faster rate for older Canadians, 21% from 2011 to 2016, compared to a 5.1% increase for younger Canadians.<sup>141</sup> Across Canada, older households account for a variable percentage households in core housing need – from a low of 8.3% in Nunavut to a high of 33.1% in Saskatchewan in 2016.<sup>142</sup> A 2010 report outlines that approximately half of older Atlantic Canadians spend 30% of their income on housing; while 1 in 5 spend over 40% of their income on housing, making them some of the most financially vulnerable individuals in Canada.<sup>143</sup>



### Box 3. Canadian Definition of "Core Housing Need"

- 1. The housing must fall below more than one of the adequacy standards**
  - a. Adequate housing:** reported by residents as not requiring any major repairs
  - b. Affordable housing:** shelter costs equal to less than 30% of total before-tax household income
  - c. Suitable housing:** has enough bedrooms for the size and composition of resident households according to National Occupancy Standard requirements.

#### AND

- 2. The household would have to spend  $\geq$  of 30% of its total before-tax income for alternative local housing that is acceptable (meets all 3 housing standards above).**

Housing options for older Canadians exist along a continuum from homeless shelters to individual home ownership (see Figure 2), and many types of public, private and not-for-profit subsidies are variably available across provinces. It is well known that a lack of access to affordable housing increases the likelihood of physical and mental health problems for older Canadians.<sup>144</sup>

## Figure 2. Canada's Housing Continuum

### THE HOUSING CONTINUUM



Source: Canadian Mortgage and Housing Corporation (2018)<sup>145</sup>

The **Homelessness Partnering Strategy** (HPS) was initiated by the federal government in 2014 to prevent and reduce homelessness by funding local projects.<sup>146</sup> The HPS 2018 final report noted that rates of homelessness are increasing for those over age 50, despite few shelter users over the age of 65.<sup>147</sup> Factors such as living alone, poverty, and changes to their health place older Canadians at increased risk of homelessness, and this is a serious problem faced by many in Canadian communities.<sup>148,149</sup> The HPS represented the formal adoption of the '**Housing First**' approach, which involves providing services and supports to homeless people to empower them to move into independent and permanent housing.<sup>150</sup> Housing First is an evidence-based service delivery model to ending homelessness that has reduced homeless by 40% over 10 years in Finland by building 7,000 affordable homes.<sup>151</sup> The strategy was found to be more effective than rent controls as it focused on housing supplies for those in need and did not discourage investment in rental properties.<sup>152</sup> In addition, the Housing First approach has been shown to be cost-effective. The *At Home/Chez Soi* study involving 2,000 homeless individuals with mental illness in five Canadian cities found that the Housing First approach could offset much of the average cost of homelessness in Canada. In 10 per cent of participants with the highest service use cost, the study found that while Housing First cost \$19,582 on average per person per year, it simultaneously results in an average reduction of \$42,536 per year by preventing the over-consumption of health services, legal services (i.e. incarceration), amongst others.<sup>153</sup> In 2019, the federal government launched its **Reaching Home: Canada's Homelessness Strategy**, a redesigned federal homelessness program to replace the HPS.<sup>154</sup> Reaching Home will continue the existing community-based approach by providing funding to municipalities and local service providers.<sup>155</sup> Following the feedback from consultations, the new strategy will support an outcomes-based approach by establishing directives to assist communities in preventing and reducing homelessness.<sup>156</sup> It also provides communities with more flexibility to address local needs by removing all Housing First investment targets.<sup>157</sup>

Simply having a place to live may not be sufficient to support ageing in place, homes need to be ability-appropriate and meet accessibility requirements to enable people to remain as independent as possible in their homes and communities (see Age-Friendly Environments Evidence Brief #5 for more information). There are many innovative financial policies that have been developed across Canada to better enable ageing-in-place. For example, many provinces and municipalities across Canada have established property tax deferral programs to allow older homeowners, especially lower and fixed-income earners, to put-off paying their property taxes or tax increases until they are more financially able to do so or until they sell their homes.<sup>158</sup> Additionally, home accessibility and modification programs have been introduced at the federal and the provincial levels to financially assist older adults in renovations to increase the accessibility of their homes. These include the federal government's *Home Accessibility Tax Credit (HATC)* introduced in Budget 2015 which provides a maximum of \$1,500 for expenses of up to \$10,000 per year.<sup>159</sup> While the HATC tends to favour higher-income older adults who can afford the expenditure minimum, more accessible options exist. These include Nova Scotia's **Senior Citizens' Assistance Program** which provides grants of up to \$6,500<sup>160</sup> and the **Seniors Safe @ Home Program** introduced by the Prince Edward Island government in 2015 which allows up to \$5,000 in grant, both of which support necessary health and safety related home repairs for low-income older adults specifically.<sup>161</sup>

A great example of research-informed policy relates to the work that the University Health Network's Toronto Rehab iDAPT Centre for Rehabilitation Research conducted related to understanding how to make stairs safer and reduce the risk of injury. They determined that increasing the National Building Code of Canada's minimum step depth from 8.25 to 10 inches, or 210mm to 255mm, would result in 13,000 fewer stair-related injuries per year.<sup>162</sup> Their rigorous research was so compelling that Canada's National Building Code was amended to accommodate this recommendation in 2015.

Innovative housing models are becoming increasingly popular across Canada and can lead to significant health, economic, and social benefits. These include the Life Lease housing model, which is a combination between a rental and ownership model that gives people the right to live in a unit rather than owning it by having residents own an 'interest' in the property for a lump sum up-front cost and monthly payments.<sup>163</sup> HomeSharing is an innovative arrangement that allows two or more people to live together under a mutually beneficial arrangement.<sup>164</sup> It allows the landlords to age-in-place while tenants pay a subsidized rent in exchange for weekly support activities such as groceries. Other examples include Co-Housing, whereby residents own their housing unit but share common areas to help curb social isolation and allow for mutual support.<sup>165</sup> Legislative steps are currently being taken in Ontario to allow unrelated older adults to live together with the introduction of a private member's bill titled the '*Golden Girls Act*' in February 2019.<sup>166</sup>

Overall, for a growing number of older Canadians, these innovations in policy, housing options and practical changes to the building code that better enable ageing-in-place have demonstrated what progress looks like when more attention is focused addressing the evolving housing needs of an ageing population.



## What Are the Issues?

### 1. FEDERAL SUPPORTS FOR AFFORDABLE HOUSING HAVE IMPROVED BUT EXISTING FUNDING MODELS AND NEEDS ARE COMPLICATED

As the population ages, so will the demand for affordable housing options. The previous iteration of this report in 2015 identified declining investments in affordable housing across Canada as a key contributor to driving older Canadians into potential situations of being under and poorly housed, homeless or prematurely requiring placement in a publicly subsidized nursing home. The previous iteration of this report also recommended prioritizing investments into the provision of more affordable housing for older adults.

In 2017, the Government of Canada announced its *National Housing Strategy* (NHS), a \$40 billion plan over 10 years to address the issues of affordable housing across the country.<sup>167</sup> According to the Government of Canada, the plan recognizes distinct housing barriers faced by older Canadians. The NHS proposes to better support low-income renters through a new \$4 billion Canada Housing Benefit (CHB) being launched in 2020, a plan that requires provinces and territories to contribute half of the costs. In December 2019, Ontario became the first province to sign a \$1.46 billion joint funding deal with the federal government to help roll out the Canada Housing Benefit over the next eight years.<sup>168</sup> Bilateral agreements remain to be signed between the federal government and other provinces and territories, with varying funding amounts for each jurisdiction based on the level of need to supplement rent for low-income households.

The NHS has also announced funding to support provincial and territorial community housing initiatives. A National Co-Investment Fund was announced to support the construction, repair and renewal of housing units, with a goal of creating at least 12,000 new affordable units specifically for older adults. In addition, the HPS that began in 2014 (renamed *Reaching Home*) to target homelessness has been renewed as a part of the NHS in 2019.<sup>169</sup> It continues the efforts of the federal government to help communities reduce homelessness.<sup>170</sup>

While the introduction of the NHS represented a major first step in better addressing the housing needs of vulnerable populations such as older adults, more detail will be required from the federal government on its overall \$40 billion plan, and its annual implementation plans for the proposed initiatives. In particular, the \$4 billion CHB is a transformative initiative that provides a monthly supplement to low-income households that rent, regardless of housing type.<sup>171</sup> However, the number of older adults who will be assisted and how the CHB will interact with existing income assistance frameworks remain to be defined.<sup>172</sup> In addition, while CHB will average \$208 per month for the 300,000 households who will receive this benefit, there are concerns that this will still not be sufficient to make many rental units affordable, especially in larger cities.<sup>173</sup> Lastly, the \$40 billion NHS will require the collaboration and support from provinces and territories, who are responsible for contributing \$20 billion of the total funding.<sup>174</sup> This suggests that the NHS is vastly dependent on the provinces and territories for the funding and ultimately the implementation of the plan.

## 2. CERTAIN GROUPS OF OLDER CANADIANS ARE PARTICULARLY CHALLENGED IN ACCESSING AFFORDABLE HOUSING AND TRANSPORTATION

According to Statistics Canada, older Canadians who live alone, are 85 or older, are female, have lower incomes, rent rather than own their homes, reside in large cities, or have mental health and addictions problems, are more likely to experience housing affordability issues than other Canadians.<sup>175</sup> In 2016, it was noted that 53.8% of older households in core housing need were women who lived alone.<sup>176</sup>

Older adults who live in the 10 provinces are more likely to face affordability issues, which was their primary reason for having a core housing need in 2016.<sup>177</sup> However, older adults living in the 3 territories were more likely than those living in provinces to live in housing that did not meet suitability or adequacy standards. The percentages of older households that lived in housing that failed the adequacy standard alone were 35.6% in Nunavut, 42.4% in the Northwest Territories, and 22.7% in Yukon.<sup>178</sup> A comprehensive housing strategy, therefore, should not only address affordability issues, but also the adequacy and suitability of housing especially in northern Canada.

### Evidence-Informed Policy Options

#### 1. MAINTAIN AND GROW FEDERAL COMMITMENTS TO THE DEVELOPMENT OF AFFORDABLE AND ADEQUATE HOUSING INFRASTRUCTURE FOR OLDER CANADIANS

Maintaining and growing the federal government's longstanding investments in the development of affordable housing has allowed many older Canadians to remain independent. Given that housing affordability and adequacy is a growing issue across the country, continuing to prioritize investments that support more vulnerable groups of older Canadians to access the right housing supports will enable more individuals to age with housing security, and ideally, in the community of their choice. Identifying and promoting other enablers to support ageing in place, such as home renovation subsidies and property tax deferral programs - especially for low-income older households, will increase choice and availability of housing options and housing security.

The NHS is an important and much needed investment. As this strategy rolls out, it will be important for all levels of government and stakeholders to be engaged in the process as housing subsidies and funding work across all levels of government and are governed by multiple interwoven agreements among governmental and non-governmental organizations.<sup>179</sup> Even with this investment, better information on current and projected needs for affordable housing among older Canadians are needed for the development and support of evidence-informed responses in the most cost-effective way.

Housing needs extend beyond just repairing and building affordable housing units. For example, in British Columbia, rental subsidies, assisted living subsidies, the protection of older persons' rights as tenants and supporting publicly delivered support services to help older adults age in place such as meal preparation, and housekeeping were identified as important components of an affordable housing strategy by the Canadian Centre for Policy Alternatives.<sup>180</sup> Some provinces also offer property tax deferral programs, home modification programs, and home sharing / co-housing options. These are all key enablers that can ensure the availability of and choice in housing options that support Canadians to age in their place of choice.

## 2. EMPHASIZE HOUSING FOR OLDER ADULTS AS A PRIORITY TO SUPPORTING THEIR INDEPENDENCE

While many of the proposed initiatives from the NHS apply to older adults - and it notes that older Canadians are amongst the most vulnerable - few proposals in the NHS have been made specifically for older people. The 12,000 new housing units for older adults over 10 years only represents 12% of the total new units being planned even though older adults represent 17.5% of Canada's current population, and older households represent a higher and faster growing proportion in core housing need when compared to younger households.<sup>181,182,183,184</sup> Between 2006 and 2016, the population of older Canadian increased by 21.7%, which was more than double the rate of growth in the supply for housing for older persons.<sup>185</sup> To adequately support the growing housing needs of older Canadians, the number of new housing units dedicated to them must increase to also reflect the rapidly growing numbers of older adults, which will increase to approximately 23% of the Canadian population by 2030 and their concomitant needs.<sup>186</sup>

No proposals were made in the NHS for projects that could target middle-income older adults, which represents another policy gap. These projects can include co-operative housing models, where housing can be jointly-owned by their members who co-operate to lower housing costs.<sup>187</sup> Co-housing models, where households are designed to share certain public facilities<sup>188</sup>, as well as *HomeSharing*, where two or more people who are typically not related choose to reside together in the same residence under a mutually beneficial arrangement<sup>189</sup>, fit this approach as well. Older adults across the socio-economic spectrum could benefit from a variety of housing supports to support healthy ageing in the places of their choice. Thus, they must be included as a part of future housing development plans to ensure that their housing needs are also addressed and not overlooked.

# Ensuring Older Canadians Have Access to Inclusive Transportation Options

## Setting the Context

An inclusive transportation system supports equitable access to all users, including older adults. Current demographic shifts present imminent and serious implications for transportation infrastructure planning considerations across the country, especially in rural and remote communities. Older adults have a range of travel preferences, abilities, and obstacles they may foresee over the course of a journey. Not only do they use multiple modes of transportation (e.g. air, rail, and road transportation), they also use transportation for a variety of activities, including day-to-day trips (e.g. grocery shopping) and longer trips (e.g. vacations). Ensuring that older adults have access to an inclusive transportation system will enable more to better engage in different types of travel that can cater to their unique needs and preferences, which can also improve their overall wellbeing.

Travelling in automobiles remains the primary method of transportation for most older Canadians regardless of age, sex, geographic location, health or functional status.<sup>190</sup> This is especially true in small and rural communities where public transit is limited or non-existent. Across Canada, 93% of those aged 65 to 74, 85% of those aged 75 to 84, and 68% of those aged 85 and over have a driver's licence.<sup>191</sup> Therefore, being able to drive remains an important way of staying active, independent, and socially connected with others. When older adults in Canada give up driving, it is most commonly due to a physical condition or deteriorating vision (37%), followed by no longer needing or enjoying driving (20%), and feeling it is no longer safe to do so (15%).<sup>192</sup> As they age, older adults do not transition to using public transit more often as their main form of transportation – with only 5% using it as their primary mode of transportation.<sup>193</sup> Rather, travelling as a passenger in a private vehicle becomes their main form of transportation either out of preference and/or necessity. This was found to be the case for around half of adults aged 85 and over (with or without a licence).<sup>194,195</sup>

When older adults decide to or are forced to stop driving, it is imperative to ensure that various alternative and accessible transportation options are available. Therefore, programs that help older adults maintain their independence and mobility and allow them to travel wherever they want to go in the community safely, and in an accessible and affordable way, are extremely important. Without these, the burden of having to provide transportation supports is likely to fall on family members, friends or other unpaid caregivers – which is an unsustainable solution. A 2008 Statistics Canada report noted that 80% of the unpaid caregivers surveyed reported assisting the older person they provided support to with their transportation needs.<sup>196</sup>

In 2012, Statistics Canada published a detailed report on the transportation habits of older Canadians which identified five key findings<sup>197</sup>:

- 1. The vast majority of older Canadians hold drivers' licences up to and beyond 85 years of age.** At least 3.25 million Canadians over 65 years of age, or three quarters of all older Canadians in 2009, had a driver's licence. This number will dramatically increase over the coming decades. While older adults are in general safe drivers and are involved in fewer collisions than young drivers, as they age, they are more likely to experience cognitive or physical changes that could significantly affect how well they drive;
- 2. On average, older Canadians reside in communities where cars remain the primary mode of transportation;**
- 3. The vast majority of older Canadians do not take public transit and express a preference for driving** – 84% of men aged 64 to 75 use their own vehicle as their primary form of transportation;
- 4. Accessible transit and taxis are considered a “last resort” for getting around up to age 85.** For adults aged 64 to 75, only 1.2% used them as the main form of transportation. Even for adults age 85 or older, only 9% of women and 4% of men indicate it as their primary mode of transportation; and
- 5. Over a quarter of individuals diagnosed with Alzheimer's disease or some form of dementia hold a driver's licence, and nearly three quarters of them reported driving a vehicle in the month prior.**

Not only does access to transportation enable older adults to meet their essential needs (e.g. grocery shopping, attending health appointments), it also improves health and quality of life through discretionary travel for pleasure and visits to family and friends. Indeed, more accessible transportation infrastructure has been demonstrated to bring greater economic benefit by enabling tourism from older travellers, who tend to make more overnight trips and spend more money compared to younger travellers.<sup>198</sup> A lack of accessible transportation options negatively impacts social participation rates, which in turn negatively impacts one's overall health outcomes (see Social Isolation Evidence Brief #1 for more information).<sup>199</sup> Therefore, understanding the importance of having access to transportation should also be viewed within the larger context of ensuring the health and well-being of older Canadians and the promotion and development of successful 'ageing-in-place' and 'age-friendly communities' policies.

Overall, adequately supporting the transportation needs of older adults will require accounting for reasons for travel, available travel modes, and preferences. Policy challenges identified and recommendations made should focus both on those who drive and those who use alternative and accessible transportation options. Supporting the creation of an inclusive transportation system will support more equitable access to all users and encourage a more age-friendly society.

# What Are the Issues?

## 1. OLDER ADULTS FACE A DIVERSITY OF TRANSPORTATION OBSTACLES

Due to the heterogeneity of abilities and preferences amongst older adults, the obstacles they may face can occur at any stage of a journey. These can include challenges in “planning a trip, travelling from home to a terminal or station, getting to transport vehicles, boarding and mobility on board, and post-trip travelling”.<sup>200</sup> These difficulties can arise from a range of sources such as physical abilities and preferences related to technology, to ageism and stress.

While almost 80% of adults aged 65 years and over in private households in Canada rate their health positively, ageing is associated with sensory (e.g. hearing and vision), cognitive, and physical changes (e.g. reduced dexterity, balance, and range of motion).<sup>201</sup> The Canadian Longitudinal Study on Aging (CLSA) found that the most common tasks that challenge older adults include standing up after sitting in a chair and standing for 15 minutes or more.<sup>202</sup> In addition, environmental factors such as weather, travel distances, and socioeconomic factors create obstacles that are more pronounced for older travellers.<sup>203</sup> Due to their increased rates of frailty, older drivers involved in a multi-vehicle collision usually suffer more severe injuries and fatality rates than their younger counterparts.<sup>204</sup> The heterogeneity of obstacles encountered must be taken into account in future planning of transportation infrastructure.

## 2. WOMEN AND THOSE LIVING IN RURAL AND REMOTE COMMUNITIES ARE PARTICULARLY CHALLENGED IN ACCESSING TRANSPORTATION

Certain groups of older Canadians are disproportionately affected when they are no longer able to drive. Older women are the most likely to have their daily activities limited by transportation challenges because they are less likely to have or maintain a driver’s licence and less likely to access public transportation as they age.<sup>205</sup> Indeed, amongst those aged 85 and over and living in private households, only 26% of older women, compared to 67% of older men in this cohort were found to have driver’s licences.<sup>206</sup> The inability to get around on one’s own makes it difficult to age at home and become socially connected. Statistics Canada reported that 14% of women aged 65 and over and 54% of women aged 90 and over reported needing assistance with transportation.<sup>207</sup> For women aged 85 and older, transportation problems were second only to health problems as the reason for not participating in more social, recreational or group activities.<sup>208</sup>

Similarly, older Canadians living in rural and remote communities have difficulties in accessing inclusive transportation alternatives. Current municipal strategies that aim to provide transportation subsidies or services for older adults are largely focused in metropolitan areas where economies of scale support the provision of subsidies and services, putting those older persons living in rural areas at further risk of social isolation. However, evidence also shows that even in areas where public transportation services are available, fewer than 1 in 10 of older Canadians use public transit.<sup>209</sup> The reliance on personal vehicles and inter-city buses remains

high in rural communities. While a growing number of community agencies are developing subsidized community transportation programs that offer older adults rides in private cars and vans, these may be only available in communities large enough to host them, and for specific transportation needs (e.g. transportation to medical appointments). Overall, 49% of those living in rural and remote communities reported that they did not use accessible forms of transit because it was unavailable where they lived.<sup>210</sup>

### **3. THERE IS INADEQUATE FEDERAL ENFORCEMENT OF ACCESSIBILITY MEASURES AND ACCOUNTABILITY**

A traveller may use infrastructure regulated and governed by any of the three orders of government: federal, provincial/territorial, and municipal. Those in the federal transportation system (i.e. air, rail, inter-city bus, and inter-provincial ferries) are governed by the *Canada Transportation Act*, which lays out an individual's right to accessible transportation in Canada and empowers the Canadian Transportation Agency (CTA) to make regulations and review complaints to eliminate unnecessary barriers.<sup>211</sup>

The CTA has developed six codes of practice related to accessibility and can monitor compliance with the codes; however, it has no power to enforce them.<sup>212</sup> This issue was identified by the CTA in its 2015 formal review of the Canadian transportation system and the legal and regulatory frameworks that govern it.<sup>213</sup> According to the Canadian Council on Disabilities, the absence of legal enforcement abilities contributes to systemic obstacles that remain in place in the federal transportation system.<sup>214</sup> In addition, the term 'disability' is not currently defined in the *Canada Transportation Act*, which hinders the development of a more inclusive transportation system.<sup>215</sup>

### **4. THERE IS A LACK OF DATA ON TRANSPORTATION NEEDS IN REMOTE OR NORTHERN COMMUNITIES**

Significant knowledge gaps continue to limit the understanding of the evolving transportation needs of older adults in Canada. While there is data on both accessibility and obstacles related to individuals with disabilities, there is no tracking of complaints or issues frequently encountered by older travellers using the federal Canadian transportation system.<sup>216</sup> In particular, there is a lack of research into transportation needs and challenges of older adults in rural or remote communities including those who are Indigenous.<sup>217</sup> This is because research into essential and day-to-day travel habits of older adults focuses primarily on those in urban settings. However, about one-fifth of older adults live in regions outside census metropolitan areas<sup>218</sup>, where public transit is limited or unavailable. This represents a significant gap in information.

## Evidence-Informed Policy Options

### 1. MAINTAIN AND PRIORITIZE FEDERAL COMMITMENTS TO THE DEVELOPMENT OF INCLUSIVE TRANSPORTATION INFRASTRUCTURE

Meeting the evolving transportation needs of older Canadians will not be solved simply through the provision of more public transportation services, especially when less than 10% of older Canadians currently choose to use it.<sup>219</sup> Therefore, supporting the provision of research and funding that can enable the development of more popular, accessible, and dignified transportation strategies for both urban and rural older adults will be integral to supporting older adults to maintain their independence in their communities.

Due to the diverse needs of older adults and personalized obstacles that can be faced at an individual level, an *Expert Panel on the Transportation Needs of an Aging Population* convened by the Council of Canadian Academies (CCA) suggests that solutions to address these issues may need to be broad in scope, such as the adoption of principles of ‘inclusive’ or ‘universal’ design to focus on the accessibility of infrastructure.<sup>220</sup> In addition, a ‘door-through-door’ approach must be taken, which involves examining obstacles from the door of one’s home to the door of their destination. This is because obstacles may arise at any point in the journey and may encompass multiple segments using different transportation modes.<sup>221</sup> To support the development of an age-friendly transportation system, the CCA *Expert Panel* recommended that the federal government tie infrastructure and other investments to projects that support inclusive, multi-modal transportation.<sup>222</sup> Overall, an inclusive transportation system requires a holistic approach to adaptation – one that can evolve with the shifting needs and preferences of older adults.

### 2. ADDRESS THE GOVERNANCE OF ACCESSIBILITY IN THE FEDERAL TRANSPORTATION SYSTEM TO INCREASE ACCOUNTABILITY

The federal government can play a central role in creating an inclusive transportation system through better governance. The 2015 CTA Review noted that there is a systemic lack of accountability under the current structure of the federal government’s transportation accessibility governance system.<sup>223</sup> Its accessibility section allows it to make recommendations related to strengthening regulations. It further advocates for the inclusion of a formal definition of ‘disability’ in the *Canada Transportation Act*.<sup>224</sup> While not all older adults have accessibility issues, defining “disability” can bring clarity to relevant transportation legislation and policy and facilitate the development of regulations and codes of practices related to improving accessibility.<sup>225</sup>

In addition, stronger legal mechanisms must be present to address non-compliance issues with accessibility codes of practice. The 2015 CTA Review recommends the voluntary Codes of Practice be converted to regulations which will be legally binding on transportation service providers.<sup>226</sup> Giving the CTA the legislative authority on accessible transportation matters and an ability to initiate investigations and broaden complaints made by users can support a more inclusive transportation system for older adults across Canada.<sup>227</sup>



Since the 2015 CTA Review, the federal government has introduced the *Accessible Canada Act* in 2019, which mandates all infrastructure in the federal transportation system to develop an accessibility plan within one year. It also assigned an Accessibility Commissioner under the *Canadian Human Rights Act* as an enforcement and accountability mechanism. While commendable progress has been made, implementation of these plans and their compliance to the CTA Codes of Practice remains to be monitored.

### **3. IMPLEMENT FORMAL MONITORING OF TRANSPORTATION ACCESSIBILITY MEASURES WITH AN EMPHASIS ON RURAL AND REMOTE COMMUNITIES**

The 2015 CTA Review recommends that the CTA report on transportation accessibility measures every three years to ensure transparency of compliance rates, complaints received, and encourage best practices.<sup>228</sup> In particular, complaints or issues frequently encountered by older travellers using Canadian government regulated transportation should be specifically tracked to identify areas for development and improvement. Since finding and developing solutions for older adults living in rural and remote communities are more challenging, having accurate and up-to-date data will be imperative to identify targeted solutions to meet their unique transportation needs as well.

# Enabling the Creation of Age-Friendly Physical Environments and Spaces

## Setting the Context

With a growing number of older Canadians expressing their desire to remain in their homes and communities for as long as possible, also referred to as ‘ageing-in-place,’ the federal government along with its provincial, territorial, and municipal counterparts have been increasingly promoting and supporting the creation of World Health Organization (WHO) designated Age-Friendly Cities and Communities across Canada.

In 2007, the WHO launched its **Age-Friendly Communities** (AFCs) initiative to promote a more thoughtful approach to the development of communities that could promote the health and well-being of people of all ages, and especially the ageing population. An age-friendly community is defined as one that recognizes the great diversity amongst older persons, promotes their inclusion and contributions in all areas of community life, respects their decisions and lifestyle choices, and anticipates and responds flexibly to ageing-related needs and preferences. Essentially, they are places that encourage active ageing by optimizing opportunities for health, participation, and security in order to enhance quality of life as people age.<sup>229</sup>

Making communities more age-friendly should be understood as a practical response to promote the contributions and well-being of older residents who keep communities thriving. Adapted environments and services that are accessible to, and inclusive of older people with varying needs will further encourage them to engage more frequently in community activities. Furthermore, creating a culture that respects and includes older people will foster strong connections and personal empowerment.

Across Canada a number of communities have taken part in age friendly community development activities at various levels. Through these activities, participating communities have learned to assess their level of “age-friendliness,” how to integrate ageing perspectives into urban planning, and how to create age friendly spaces and environments. To date, all ten provinces are promoting some level of AFC initiatives.<sup>230</sup>

The WHO has identified eight domains of community life that influence the health and wellbeing of older persons, and serve as the basis around which AFCs are expected to focus their efforts:

### Figure 3 – Age Friendly Communities:



1. Outdoor spaces and public buildings that are pleasant, clean, secure and physically accessible



2. Public transportation that is accessible and affordable (see goal on transportation and housing)



3. Housing that is affordable, appropriately located, well built, well designed and secure (see goal on transportation and housing)



4. Opportunities for social participation in leisure, social, cultural and spiritual activities with people of all ages and cultures



5. Older people are treated with respect and are included in civic life



6. Opportunities for employment and volunteerism that cater to older persons' interests and abilities



7. Age-friendly communication and information are available



8. Community support and health services are tailored to older persons' needs (see goal on appropriate practitioner training)

While this evidence brief focuses on the AFC domain related to development of age-friendly buildings and spaces, other briefs focus on the other AFC domains, such as respect and social inclusion, social participation, communication and information, civic participation and employment, transportation, housing, and community support and health services.

The WHO's approach to the development of age-friendly physical environments acknowledges the importance of meeting the needs of individuals across all ages to encourage integration and interaction across generations. For example, the benefits of developing accessible and age-friendly playgrounds can create a valuable space for older Canadians to interact with their grandchildren and younger community members, a concept that the City of Edmonton has widely embraced in their plan for the creation of an 'Age-Friendly Edmonton'.<sup>231</sup> The WHO also recommends that, "the availability of clean, conveniently located, well signed, accessible toilets is generally regarded as an important age-friendly feature of the built environment."<sup>232</sup> Access to public washrooms is imperative in order to better meet the needs of older adults living with incontinence. There is evidence that there tends to be greater community support if the development of age-friendly buildings and spaces are not targeted at older people alone, but are recognized as being of value to people of all ages.<sup>233</sup> Finally, the WHO's AFCs initiative is a reminder that personal living spaces must also be considered as part of age-friendly environments and must be built with this notion in mind to create truly accessible and welcoming environments.

Thus far, the Public Health Agency of Canada (PHAC) has played a significant role in advancing the WHO's AFC Initiative. PHAC provided funding towards the development of the original *WHO Age-Friendly Cities Guide*<sup>234</sup> and the *Pan-Canadian Age-Friendly Communities Milestone Guide*<sup>235</sup> to help communities implement age-friendly requirements in their local settings. The Canadian Institutes of Health Research (CIHR) Institute of Aging, and the Canadian Association of Gerontology have also provided significant support to research and knowledge synthesis/translation activities to inform the evaluation of age-friendly communities.<sup>236</sup> Finally, the Canadian Mortgage and Housing Corporation (CMHC) has also sponsored initiatives to provide guidance around the development of physical environments for individuals with specific age-related limitations such as dementia as well as their *FlexHouse Checklist*<sup>237</sup> to support the development of accessible, affordable, and adaptable housing plans.

## What Are the Issues?

### 1. NOT ENOUGH EMPHASIS IS PLACED ON THE ACCESSIBILITY OF BUILDINGS AND SPACES

Addressing accessibility is a significant factor in the development of AFCs. While accessibility can be considered in a variety of ways, from a physical design standpoint, the spaces and buildings used for living, work, and recreational purposes must be, at a minimum, accessible to older Canadians to ensure they can actively navigate their environments. Accessibility encapsulates not only the mere ability to access an environment, but that such an environment is safe to access for individuals with any form of physical and even some cognitive limitations. While there are specific considerations for older people, more 'universal' design standards are now being promoted that consider the common needs of all members of the communities.

While individual provinces have made legislative commitments towards ensuring greater accessibility standards (for example, see the 2005 *Accessibility for Ontarians with Disabilities Act*,<sup>234</sup> or the more recent 2013 *Accessibility for Manitobans Act*,<sup>239</sup>) not all Canadian jurisdictions have made this level of commitment towards improving accessibility. Furthermore, the legislation that currently exists extends mostly to public environments and/or businesses and less to private dwellings and spaces. While the National Building Code of Canada<sup>240</sup> does outline safety and some accessibility requirements for private dwellings, provinces vary in their interpretation and implementation of these requirements.<sup>241</sup> For example, design standards and requirements for the creation of barrier-free or accessible residential units vary by jurisdiction. In Alberta, for example, a minimum percentage of publicly funded housing must have accessible units, while in Ontario and Nova Scotia, this applies to privately-funded dwellings as well.<sup>242</sup> Legislated minimum percentages of accessible units developed also varies by province. For example, 5% of all multi-family buildings in Nova Scotia must be accessible versus 10-20% in Alberta.<sup>243</sup>

The federal government recently introduced the *Accessible Canada Act*,<sup>244</sup> with the mandate of making areas under federal jurisdiction barrier-free. The *Act* applies to a number of areas in relation to physical spaces - it applies to the built environment including buildings and public spaces as well as transportation under federal jurisdiction (i.e. air, rail, intercity bus, and interprovincial ferries). It also assigned an Accessibility Commissioner under the *Canadian Human Rights Act* as an enforcement and accountability mechanism.<sup>245</sup> While this is a step in the right direction, once again it only covers publicly regulated spaces and not private spaces or homes. A federal commitment to the development of a national standard on building accessibility in Canada is needed.

## 2. RURAL AND REMOTE SETTINGS STRUGGLE THE MOST WITH CREATING ACCESSIBLE ENVIRONMENTS

While the WHO's AFCs initiative focuses primarily on adapting urban settings, the standards it promotes are still applicable in any community setting. Despite this, the need to create more age-friendly physical environments and spaces is particularly acute in rural areas. PHAC highlighted that older adults and caregivers from rural and remote settings consider walkability to be one of the most important features of their communities; however, it is often lacking in rural communities.<sup>246</sup> A common barrier is a lack of sidewalks (or continuous sidewalks), resulting in the need to walk or use mobility devices on streets and highways.<sup>247</sup> This lack of proper sidewalks also exacerbates the reliance on driving to get around, worsening transportation issues for rural older Canadians. With more than 6.3 million Canadians<sup>248</sup> currently living in rural areas, which tend to be ageing faster than urban areas, ensuring older rurally dwelling Canadians are able to age-in-place will need to be a focus of any efforts to improve the accessibility of Canadian communities.

## Evidence-Informed Policy Options

### 1. DEVELOP ROBUST NATIONAL STANDARDS THAT PROMOTE ACCESSIBILITY FOR ALL CANADIANS

Given the growing diversity of the Canadian population and the fact that as they age, more will be living in their communities with physical and cognitive limitations, there is a clear opportunity for federal leadership to help align existing national standards and frameworks. The efforts of current provinces and territories to enable a common minimum standard in their building codes has thus far been variable across the country. Setting standards such as minimum percentages of accessible units are only *minimum requirements*. To foster truly age-friendly spaces, the federal government should exercise leadership in encouraging provinces and municipalities to aim beyond minimum standards.

### 2. SUPPORT THE DEVELOPMENT OF MORE AGE-FRIENDLY COMMUNITIES

Building on the prior work and investments by federal agencies such as PHAC, CIHR, and the CMHC, there needs to be a renewed federal mandate to assess progress on the implementation of the AFC agenda across Canada and to understand what needs to be done to support the development of additional Canadian AFCs. While certain provinces have made AFCs a greater provincial priority, there is a clear opportunity for the federal government to renew and strengthen its roles in advancing AFCs across the country using its strength as an enabler and convener.

Finally, nearly a decade ago, the federal, provincial, and territorial ministers responsible for older adults came together to create a guide to promote the development of *Age-Friendly Rural and Remote Communities*.<sup>249</sup> In addition to general universal design principles and initiatives that the federal government can promote, more should be done in rural and remote communities, which require more support and guidance to eliminate barriers and promote the adoption of age-friendly activities.

# Healthy and Active Lives



## SECTION 2

# Healthy and Active Lives

## Ensuring older Canadians continue to lead healthy and active lives for as long as possible

Important advances in public health and health care over the last few decades mean that most Canadians are now living longer and with fewer health problems than ever before. In the future, more education and support for Canadians to participate in activities that promote wellness, prevention, and overall healthy ageing will allow more older Canadians to age in good health and stay independent in their communities for as long as possible.

The federal government and the Public Health Agency of Canada (PHAC) can work with Canada's provinces, territories and municipalities to enable this pillar and associated activities in a variety of ways:



- **Ensuring Canadians have access to high quality information that helps improve their overall understanding of how to engage in wellness and prevention activities that support healthy ageing. Specifically, preventing age-related diseases like dementia through regular exercise, falls prevention, promoting the better management of hearing and vision issues, and encouraging uptake of recommended vaccinations for older people will enable healthy ageing.**



- **Ensuring that all Canadians have access to medically necessary and appropriate medications and vaccines for the management of acute and chronic diseases will allow Canadians to live healthier and longer lives in their communities.**



- **Ensuring Canadians have a better understanding of the importance of advance care planning will support a growing number of Canadians to become more engaged in decision-making around their health care and empower them to make more informed decisions.**



# Ensuring Canadians are Supported to Engage in Wellness and Prevention Activities that Enable Healthy Ageing

## Setting the Context

Supporting healthy ageing requires emphasizing wellness and prevention opportunities for all Canadians, especially when earlier life health activities can make a real difference to later-life health-related outcomes and costs. All Canadians, and not just older Canadians, can benefit from a greater understanding of how the things they do earlier in life can affect their overall health and wellness in their later years. Proper nutrition, regular physical exercise, proactively addressing hearing and vision issues, and avoiding certain activities such as smoking have been shown to reduce the likelihood of developing a variety of chronic diseases and extend overall life expectancy as well. In fact, through better management of vascular risk factors (e.g. diabetes, high blood pressure), an overall decline in the prevalence of certain forms of dementia has been seen in the population.<sup>250,251</sup>

The greatest barrier to advancing healthy ageing is that the ‘health literacy’ skills, or the ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course<sup>252</sup>, remain extremely low. In fact, it was recently shown that **only 12% of older adults have adequate health literacy skills to support them in making basic health-related decisions.**<sup>253</sup> Therefore, any broad efforts to support healthy ageing will need to place an equal emphasis on improving the health literacy skills of Canadians to ensure they can both appreciate and understand the things they can do to stay healthy and independent for as long as possible.



**Only 12% of older adults have adequate health literacy skills to support them in making basic health-related decisions.**

With respect to accessing information and resources that promote healthy ageing, although ‘online’ options can be very effective, only 61% of Canadians age 65 to 74 report that they use the internet daily and this drops to 35% for those over 75.<sup>254</sup> While the older adults are amongst the fastest growing demographic using the internet, improving health literacy and overall awareness of important issues will need to incorporate a variety of channels to ensure that all older adults can have access to information, including resources tailored to the full diversity of the population.

## What Are the Issues?

### 1. A MAJORITY OF OLDER CANADIAN ARE STILL NOT RECEIVING ALL OF THEIR RECOMMENDED VACCINATIONS

The vast majority of Canadian children and young adults are receiving their recommended vaccinations. However, the recommended vaccinations for older Canadians, such as influenza, pneumonia (pneumococcal), and shingles (varicella/herpes zoster) vaccinations have uptake rates below recommended levels, despite the proven benefits to older individuals. Additionally, the tetanus vaccination is recommended at regular intervals across the lifespan, but this is not emphasized adequately for older adults. Overall vaccination rates among adults in Canada remain stubbornly low, and for some diseases, such as influenza, appear to be declining in some parts of the country (See Table 1). Specifically, Canada remains below the *Public Health Agency of Canada’s* (PHAC) national immunization target of having 80% of the population vaccinated against influenza and pneumonia vaccinations.<sup>255</sup> With evidence showing the overall positive benefits of annual influenza vaccinations,<sup>256</sup> Canadian public health authorities have made progress in increasing the uptake of the influenza vaccine in older adults. Yet, the uptake of other vaccines such as pneumonia, shingles and tetanus are well below the recommended rates for older Canadians (See Table 6).

**Table 6. Estimated Rates of Recommended Vaccination Coverage Among Older Canadians**

Risk Group	Seasonal Influenza <sup>257</sup>	Pneumococcal <sup>258</sup>	Varicella/ Herpes Zoster	Tetanus and Pertussis <sup>259</sup>	
<b>65+ years of age</b>	70.7%	41.6%	3.9%* <sup>260</sup>	45.8%	8.7%
<b>General Population</b>	38.3%	-	-	54%	9.7%
<b>Additional coverage needed to meet the PHAC 80% target for those 65+</b>	<b>9.3%</b>	<b>38.4%</b>	No target set	No target set	

\* - Canadian coverage rate not available. Figure reflects US Herpes Zoster vaccine uptake rates among older adults.\* - Updated numbers from the Public Health Agency of Canada in 2019 report that 28% of **Canadians age 50 or older** are estimated to have been vaccinated against the herpes zoster virus<sup>261</sup>

Low vaccination rates among older Canadians is of concern, especially in the context of COVID-19 and the ongoing concern for older people who are more susceptible to acquiring multiple infectious illnesses than is the general population. There are approximately 3 to 5 million severe cases and 290,000 to 650,000 deaths worldwide due to influenza each year.<sup>262</sup> In Canada, it is estimated that influenza is responsible for approximately 12,000 hospitalizations and 3,500 deaths annually.<sup>263</sup> Influenza also has a serious economic impact leading to an estimated 1.5 million lost work days each year in Canada.<sup>264</sup> Influenza, along with all cases of pneumonia, is the 8<sup>th</sup> leading cause of death in Canada.<sup>265</sup> Individuals over 65 years also account for one-third of all community acquired pneumonia cases,<sup>266</sup> many of which are preventable as they are caused by a strain of pneumonia that the pneumonia vaccine targets. Despite this, less than half of older Canadians have received the pneumonia vaccine. Finally, **90% of Canadians are at risk of developing shingles,**<sup>267</sup> yet only 28% of **Canadians age 50 or older are estimated to have been vaccinated against the herpes zoster virus**<sup>268</sup>, which causes a painful and sometimes permanently debilitating skin and nerve condition. Low vaccine uptake may help explain why 130,000 Canadians are still diagnosed with shingles each year, resulting in 252,000 physician consultations and 2,000 hospitalizations a year, along with significant treatment-related costs, many of which could have been prevented.<sup>269</sup> Older adults are at an increased risk for developing Shingles infection. In Canada, over two-thirds of cases occur in adults over 50 years of age.<sup>270</sup> The Shingles incidence also doubles for adults 80 years and above (8 to 13 cases per 1000 persons per year) compared to those 50 years and above (4 to 6 cases per 1000 persons per year).<sup>271</sup>

There is a great opportunity to further advance the promotion of vaccinations among older adults through focused awareness campaigns and leveraging health care providers and points of care to offer this vaccination. Indeed, pharmacists are now given training and support to deliver influenza vaccinations in 9 of Canada's 10 provinces. In addition, all provinces and territories except for Quebec have universal funding in place to cover the cost of an influenza vaccine for adults aged 65 or older.<sup>272</sup> In Quebec, individuals aged **60 to 74 do not have access universal access to publicly funded influenza vaccinations.**<sup>273</sup> Where vaccines recommended for older Canadians by the PHAC are generally provided at no cost to older Canadians, barriers to their uptake remain, and need to be addressed. Research shows that promoting life course vaccination schedules that include older adults would be beneficial as it would aid in streamlining messaging and practices for providers and the general public.<sup>274</sup>

Canada currently has a *National Immunization Strategy* (NIS) that outlines immunization as a shared responsibility among the federal, provincial and territorial governments.<sup>275</sup> The strategy was initially established in 2003 by federal, provincial and territorial deputy ministers of health to facilitate inter-jurisdictional collaboration to improve the relevance, effectiveness and efficiency of immunization programs across Canada.<sup>276</sup> In 2016, the federal budget outlined a commitment by the Government of Canada of \$25 million over 5 years to increase immunization coverage rates. This would fund PHAC to update national immunization coverage goals and disease reduction targets to improve the ability to identify under- and un-immunized Canadians and develop programs to increase vaccine uptake.<sup>277</sup>

While there are some mechanisms to address immunization at a national level, there remains a patchwork of immunization strategies across the country with different policies and coverage among the provinces and territories. For example, across Canada, it is difficult to capture how pneumococcal vaccines are being administered through physician billing data due to differences in billing codes among provinces.<sup>278</sup>

## 2. FALLS AMONGST OLDER CANADIANS ARE COMMON, COSTLY, AND YET LARGELY PREVENTABLE

For older Canadians, falls were the leading cause (81%) of injuries that landed them in hospital and represented 60% of all reported emergency room visits and over half of all injury-related hospitalizations from 2017 to 2018.<sup>279</sup> Out of all causes, falls also had the largest increase (9%) for hospitalizations due to sustained injuries over the past 3 years.<sup>280</sup> Falls amongst older Canadians not only threaten their independence and overall well-being, they also account for an estimated \$2.3 billion annually in related health care spending across Canada.<sup>281</sup> Furthermore, Canadians who are hospitalized for falls remain hospitalized for an average of 14.3 days, while the average length of hospital stay in general is 7.5 days.<sup>282</sup> In Canada, between 20% to 30% of older adults fall annually,<sup>283</sup> making it one of the most common preventable health care issues for older Canadians.

Causes of falls among older adults are multifactorial. Some of the leading causes of falls include: the presence of chronic and acute health conditions that can negatively impact a person's strength and balance, independent balance or gait deficits, decreased sensory abilities, inadequate nutrition, social isolation, and challenges with the existing environment.<sup>284</sup> There has been a concerted effort on behalf of PHAC to raise awareness of falls prevention strategies nationally, along with many provincial and local falls prevention programs (see Box 4).<sup>285</sup>

The federal government introduced a *Home Accessibility Tax Credit*<sup>286</sup> in Budget 2015, which provides up to \$1,500 (15%) towards home renovations, once \$10,000 has been spent.<sup>287</sup> Individuals aged 65 years or older, or those holding a valid disability tax certificate, as well as those supporting others who directly qualify, are entitled



### Box 4. Fall Prevention Program Case Example – Government of Ontario

In 2014, the Government of Ontario began offering 2000 free exercise and falls prevention classes for anyone 65 or older as part of its overall Seniors Strategy. These classes are designed to address physical factors causing falls and provide older adults with the opportunity to socialize with others in their community to help combat social isolation. The initiative is operated with extremely low overhead costs, as it is funded with a small annual provincial investment and delivered in publicly accessible locations by existing community support services agencies.

to claim this tax credit.<sup>288</sup> A more accessible home renovations support program for lower income older adults is the *Seniors Safe @ Home Program* introduced by the Prince Edward Island government in 2015 which allows up to \$5,000 in grants to lower income older adults to support home renovations.<sup>289</sup> Occupational Therapist (OT) led home-safety assessments and related home renovation programs have been shown to be effective and are currently recommended by PHAC for the prevention of falls among community dwelling older adults.<sup>290,291,292</sup> Therefore, making these services available and accessible at little or no cost for all older Canadians should be considered an essential component of any national falls prevention strategy.

Nevertheless, in Ontario and other jurisdictions where falls prevention activities are being provided at no out-of-pocket cost to participants, identifying other barriers to participating (such as having suitable complementary transportation services to get people to the classes) is still required to address this significant issue. Falls awareness and prevention activities should also be provided to older adults in a way that is most accessible. Additionally, the federal government should make use of existing investments, such as PHAC's *Participation Program*, to focus on falls prevention for older adults.

## Evidence-Informed Policy Options

### 1. BROADEN THE MANDATE OF AND FUND THE NATIONAL IMMUNIZATION STRATEGY IN COLLABORATION WITH PHAC, TO BRING TOGETHER THE PATCHWORK OF PROVINCIAL IMMUNIZATION STRATEGIES. INCLUDE A LIFE COURSE VACCINATION APPROACH.

With prevention being one of the most important tools in the health care system, immunization is a key public health policy that requires national leadership. Canada's current patchwork approach to immunization is not as effective as it could be, and should be supported by national coordination. Through the *National Immunization Strategy*, there is already a method to bring federal, provincial and territorial governments together. The federal government should properly fund the *National Immunization Strategy* in collaboration with the PHAC to support building national frameworks with collective and consistent policies across the country including the promotion of life course vaccination schedules for older adults.

### 2. FURTHER SUPPORT PROVINCES TO BETTER ADDRESS FALLS PREVENTION

PHAC has recently begun to focus more of its attention on raising awareness of the significant impact falls have on the health and wellbeing of older Canadians and the health system as a whole. While the federal government has made substantial investments in programs such as PHAC's *Participation Program* it is almost exclusively focused on promoting physical activity amongst younger Canadians. There is an opportunity to leverage the media reach of *Participation* to include healthy ageing, falls prevention, and the benefits of physical activity at all ages. Furthermore, supporting the provinces and territories to advance the adoption of successful, low cost and evidence-informed falls prevention programs has the potential to

generate significant savings related to current falls-related health care spending, while also addressing related issues like social isolation. As such, PHAC could play a strengthened role as the key knowledge translation mechanism to spread the adoption of falls prevention best practices across the country.

### 3. ADVANCE THE RECOMMENDED ACTIONS IN THE NEW NATIONAL DEMENTIA STRATEGY

More than 419,000 Canadians (6.9%) aged 65 years or older are living with diagnosed dementia.<sup>293</sup> The impacts of dementia on the patient, caregivers, and the health care system are significant. With the increasing number of older adults, the main demographic group with dementia, the total health care costs and out-of-pocket caregiver costs of dementia is expected to double between 2011 to 2031 from \$8.3 to \$16.6 billion in Canada.<sup>294</sup> As understanding of the causes of dementia improve, approaches to dementia care must increasingly emphasize preventative measures. In 2020, the life-course model published by the *Lancet* Commission found that 12 modifiable risk factors in early life (e.g. education), midlife (e.g. hypertension, obesity, hearing loss) and later life (e.g. depression, physical inactivity, social isolation) account for around 40% of dementia worldwide.<sup>295</sup> The modification of these risk factors necessitate action through both public health programmes and interventions at an individual level across the life course.

In June 2019, the National Dementia Strategy was released by the Canadian government to identify common principles and national objectives to support people living with dementia and their caregivers, with \$70 million in federal investments over five years.<sup>296</sup> One of the three key national objectives was to prevent dementia through advancing research and expanding awareness on modifiable risk and protective factors, establishing an evidence base on effective interventions, and improving access to built and social environments to support healthy living. The federal government plays a key leadership role in ensuring that the recommended actions will be implemented cohesively at regional levels, including for those facing barriers to equitable care, such as older Canadians who are racialized Black, Indigenous, and people of colour (BIPOC), who are lesbian, gay, bisexual, transgender, queer, intersex, and/or Two-spirit (LGBTQI2S), and who navigate barriers to accessibility, such as individuals who are isolated, living with disabilities, and those who have limited financial means.

# Improve Access to Medically Necessary and Appropriate Medications

## Setting the Context

As health issues become more frequent as one ages, the ability to access medically necessary and appropriate medications becomes increasingly important. The majority of Canadians 65 years and over are currently living with at least one chronic disease, while a growing number are living with multiple.<sup>297</sup> In fact, a recent report found that 1 in 4 older Canadians in 2016 were prescribed medications belonging to **10 or more medication classes**.<sup>298</sup>

Older Canadians typically receive some level of provincial or territorial support for access to prescription medications. But the provincial and territorial drug programs for older adults vary across Canada. In most cases, co-pays and deductibles are still in place, which can reduce access.<sup>299</sup> While older adults account for only 17.5% of the Canadian population, they account for **57.4% of the total spending within the provincial and territorial medication programs**.<sup>300</sup> With the number of older Canadians set to significantly increase in the coming decades, it is clear that this will place greater funding pressures on the publicly funded prescription medication coverage programs.

The Government of Canada announced in Budget 2018 that the Advisory Council on the Implementation of National Pharmacare would lead a national dialogue on how to implement pharma care.<sup>301</sup> It released its final report in June 2019, calling upon the federal government to work with provincial and territorial governments, and stakeholders, to establish a universal, single-payer, public pharmacare program in Canada.<sup>302</sup> In Budget 2019, the government accepted and agreed to fund the Advisory Council's recommendations to establish a national formulary, a common list of drugs at a common price, and to establish a national agency to coordinate efforts amongst the provinces and territories.<sup>303</sup>

## What Are the Issues?

### 1. DEDUCTIBLES AND CO-PAYMENTS LIMIT ACCESS TO IMPORTANT MEDICATION

Despite having access to publicly funded prescription medication coverage programs, minimum income requirements, deductibles, co-payments, and prescription medications covered vary by province and territory. In some regions, low-income older adults are still required to pay a co-payment or deductible for their prescription medications (see Table 7). However, there is widespread consensus from policy and research evidence that an individual's access to prescription medications is directly influenced by factors related to their ability to pay, such as their income and ability to pay out-of-pocket costs like co-pays and deductibles. Specifically, **co-payments in prescription medication coverage plans has consistently been found to lead to a decreased utilization of prescribed medications; whereas the reduction or elimination of co-pays and deductibles has consistently resulted in increased adherence.**<sup>304,305,306,307,308</sup>

It also well recognized that the inability to access essential prescription medications often has far more severe health implications for older adults than for other populations, and significantly contributes to increased hospitalizations, re-hospitalizations, as well as premature nursing home placements.<sup>309</sup> The negative impact of co-pays and deductibles on prescription medication access has been recognized and addressed in other universal health care systems such as the National Health Service in the United Kingdom, where individuals over 60 years of age do not pay out-of-pocket for their medications.<sup>310</sup>

### 2. BETTER PROCUREMENT PRACTICES COULD HELP MANAGE THE COSTS OF THE PUBLICLY FUNDED PRESCRIPTION MEDICATION COVERAGE PROGRAMS.

In 2018, **Canadians spent about \$33.4 billion, 15.3% of total health spending, on prescription medication.**<sup>311</sup> Prescription drug expenditures are now higher than physician fees with the main cost drivers being the overall use of prescription drugs and the use of newer more costly drugs.<sup>312</sup> Canada's drug prices are the third highest among OECD countries and are approximately 22% above the OECD average.<sup>313</sup> Currently, the vast majority of the prescription medications covered by publicly funded programs are purchased from pharmaceutical manufacturers at the provincial or territorial level. In negotiating at a provincial or territorial level, the current evidence shows that the prices publicly funded programs pay for the medications they cover are significantly higher than other jurisdictions around the world who negotiate their prices at the national level. Evidence suggests that if nationally coordinated procurement approach for medications was implemented, provinces and territories could collectively save billions of dollars.<sup>314</sup>



### 3. COSTS RELATED TO THE INAPPROPRIATE PRESCRIBING OF MEDICATIONS TO OLDER CANADIANS

Ensuring older Canadians are taking the correct medications is not only important to ensuring their overall health, but also helps to manage health care expenditures.<sup>315</sup> Indeed, the use of inappropriate prescription medications among older adults is correlated with avoidable hospitalization and hospital readmissions due to adverse drug events (ADE).<sup>316</sup> Furthermore, while evidence-based lists of inappropriate medications for older adults, such as the *Beers List*, are widely accepted, published, and accessible, **nearly 50% of older Canadians are currently taking at least one inappropriate medication with an additional 18% taking multiple inappropriate medications.**<sup>317</sup> Mounting evidence supported by the Canadian Geriatrics Society suggests that discontinuing certain potentially inappropriate medications among older Canadians will not lead to adverse health outcomes and will reduce costs associated with ADEs.<sup>318</sup> **In fact, older Canadians account for 57% of all hospitalizations due to ADEs; representing approximately \$35.7 million (over 80% of costs related to hospitalization).**<sup>319</sup> Importantly, with proper oversight, it is estimated that 40% of ADEs are preventable.<sup>320</sup> To address this, health professionals should be trained in how to ensure the proper prescription and monitoring of appropriate medications for older adults will be vital to promoting their health as well as better addressing the avoidable related costs of ADRs.

**Table 7. Current Prescription Medication Coverage by Province for Older Canadians**

PROVINCE	COVERAGE
<b>BRITISH COLUMBIA</b> <sup>321</sup>	<p>Individuals pay their full prescription costs until they reach a threshold level known as their deductible. Once their deductible level is reached, BC PharmaCare begins assisting them with their eligible prescription medication costs for the rest of the year.</p> <p><b>N.B</b> This program applies for all individuals in BC and not just older adults.</p> <p>To ensure annual drug costs do not exceed one's ability to pay, families are also assigned a family maximum, based on a % of one's net income. If an individual reaches their maximum, BC Pharmacare covers 100% of their eligible drug costs for the rest of the year.</p> <p>For individuals born before 1940, their family deductible is waived if their net annual family income is less than \$33,000. BC Pharmacare then covers 75% of eligible prescription medication costs beyond the level of the deductible. For individuals born before 1940 with family income less than \$14,000, BC PharmaCare pays for 100% of their eligible prescription costs.<sup>322</sup></p> <p>Despite the universal nature of the BC Pharmacare Program, mounting evidence is showing that it now routinely achieves the lowest adherence rates of older adults towards filling their prescriptions due to the associated out-of-pocket expenses related to required deductibles and co-payments.</p>
<b>ALBERTA</b> <sup>323</sup>	<p>Older Albertans and their dependents are automatically provided with premium-free drug coverage. Under this program, older adults pay only 30% of the cost of prescriptions up to a maximum of \$25 per prescription.</p>
<b>SASKATCHEWAN</b> <sup>324,325</sup>	<p>Under the Saskatchewan Seniors' Drug Plan, eligible adults 65 years and over pay up to \$25 per prescription for medications listed on the Saskatchewan Formulary and those approved under Exception Drug Status claims. The cost of a prescription was increased from \$15 to \$20 in March 2012, and from \$20 to \$25 on June 1<sup>st</sup>, 2019.</p>
<b>MANITOBA</b> <sup>326</sup>	<p>Manitoba's pharmacare coverage is income based and is calculated using Canada Revenue Agency information. The minimum deductible for the Manitoba Pharmacare program is \$100, with no maximum deductible. Eligible applicants must reapply every year for pharma care coverage.</p>
<b>ONTARIO</b> <sup>327</sup>	<p>Ontario's Drug Benefit Program employs a co-payment system. Single older Ontarians with an income of more than \$19,300 a year, or individuals who are part of a couple with a combined income of more than \$32,300 a year, pay a \$100 deductible every year for prescriptions filled per person. After that, older adults pay up to \$6.11 towards the dispensing fee for each prescription depending on their income levels. Older Ontarians whose incomes fall below the above thresholds pay up to \$2 for each prescription filled and no deductible.</p>
<b>QUEBEC</b> <sup>328</sup>	<p>In Quebec, the Public Prescription Drug Insurance Plan is administered by the Régie de l'assurance maladie du Québec and is intended for persons who are not eligible for a private group insurance plan covering prescription drugs, for persons age 65 or older, and for recipients of last-resort financial assistance and other holders of a claim slip (carnet de réclamation). Children of persons registered for the public plan are also covered by that plan.</p> <p>All persons covered by the public plan must pay an annual premium of between \$0 and \$616, based on net family income, whether or not they purchase prescription medications under the plan. Older individuals receiving 94% to 100% of the Guaranteed Income Supplement are exempt from paying the annual premium.</p>

PROVINCE	COVERAGE
<b>NEW BRUNSWICK</b> <sup>329</sup>	Older beneficiaries receiving the Guaranteed Income Supplement are required to pay a co-payment of \$9.05 for each prescription, up to a maximum of \$500 in one calendar year. Older adults in New Brunswick otherwise have 2 options, they can either enroll in New Brunswick's Drug Plan and pay a premium and a 30% copayment up to a maximum per prescription based on income levels or enroll in the Medavie Blue Cross Seniors Prescription Drug Program where they pay a monthly premium of \$115 and \$15 co-pay per prescription.
<b>NOVA SCOTIA</b> <sup>330</sup>	<p>Older adults contribute to Nova Scotia's Seniors' Pharmacare Program through premiums and co-payments. Older adults must pay a premium each year to join the Seniors' Pharmacare Program which is calculated based on one's income and the number of months remaining in the program year. Currently, the maximum annual premium for an older adult is \$424.</p> <p>For single older adults with an annual income below \$22,986 or receiving the Guaranteed Income Supplement, there is no premium. If the annual income is between \$22,986 and \$35,000, the premium will be reduced from the annual maximum. For couples, if the joint annual income is below \$26,817, there is no premium. If the joint annual income is between \$26,817 and \$40,000, the premium will be reduced from the maximum.</p> <p>Everyone has to pay a co-payment of 30% of the total cost of each prescription. Currently, the annual maximum co-payment an older adult would pay is capped at \$382.</p>
<b>NEWFOUNDLAND</b> <sup>331</sup>	In Newfoundland, under the 65 Plus Plan, costs of prescription drugs are paid for by the province while the charge for dispensing fee is paid by the older adult. The maximum dispensing fee is \$6. Individuals over 65 who receive Old Age Security and the Guaranteed Income Supplement are eligible for coverage.
<b>PRINCE EDWARD ISLAND</b> <sup>332</sup>	In Prince Edward Island, at the age of 65, all older adults are automatically enrolled in the province's pharmacare program that only requires them to pay the first \$8.25 of the cost of their prescription medication plus \$7.69 of the pharmacy professional fee.
<b>YUKON</b> <sup>333</sup>	Yukon residents at least 65 years of age or aged 60 and married to a Yukon resident who is at least 65 years of age, are eligible for Yukon Pharmacare benefits through the Yukon Health Care Insurance Plan (YHCIP). The Yukon Pharmacare program pays the total costs of the lowest priced generics of all prescription drugs listed in the Yukon Pharmacare Formulary, including the dispensing fee.
<b>NORTHWEST TERRITORIES</b> <sup>334</sup>	<p>Residents of the Northwest Territories (NWT) aged 60 or over are provided pharmacare coverage through Alberta Blue Cross which administers benefits for older adults on behalf of the NWT government.</p> <p>This program provides older adults with 100% coverage for eligible prescription drug products as defined in <a href="#">Health Canada's Non-Insured Health Benefit (NIHB) Drug Benefit List</a>, when the drug is prescribed by a recognized health care professional and dispensed by a licensed pharmacist.</p>
<b>NUNAVUT</b> <sup>335</sup>	All individuals over 65 are eligible to apply for the Nunavut Seniors' Coverage Plan under the Extended Health Benefits Full Coverage Plan (EHB). The EHB pays the full costs of approved prescription drugs.

## Evidence-Informed Policy Options

### 1. IMPROVE ACCESS TO MEDICALLY NECESSARY MEDICATIONS FOR OLDER CANADIANS

Older Canadians should never have to make choices about taking necessary prescription medications based on their ability to pay. With the evidence clearly demonstrating a negative relationship between co-payments and deductibles to overall medication adherence, the federal government should provide leadership in partnership with its provincial and territorial counterparts to ensure that that older Canadians, or at least low-income older Canadians as a start, do not need to pay out-of-pocket for their necessary medications.

The federal government's recently announced commitment to national formulary - a common list of drugs at a common price - and a national agency to coordinate efforts amongst the provinces and territories should enable this overall agenda.<sup>336</sup> Indeed, savings that could be achieved through a national prescription medication purchasing program - and avoidable health care costs related to prescription medication non-adherence - could more than offset the costs related to eliminating current out-of-pocket payments within provincial and territorial plans.<sup>337</sup>

### 2. ENSURE APPROPRIATE PRESCRIBING OF NECESSARY MEDICATIONS FOR OLDER CANADIANS

Older Canadians should not be prescribed medications that are known to be potentially harmful to their health, when safer alternatives exist. The federal government should provide leadership in partnership with its provincial and territorial counterparts to address this issue in two ways. First, the creation of standardized and evidence-based prescribing policies around common provincial and territorial formulary medications could influence overall prescribing practices. Second, ensuring that national curriculum guidelines for both entry-to-practice and currently practicing health care professionals, such as doctors, nurses and pharmacists who prescribe and dispense prescription medications are strengthened to include comprehensive training in medically appropriate and inappropriate prescribing, as well as the related principles on de-prescribing medications for older adults. With the availability of more evidence-based prescribing information and training, health care professionals across Canada will be able to contribute to better patient and system outcomes.

# Ensuring Older Canadians and their Caregivers Are Enabled to Participate in Informed Health Decision-Making & Advance Care Planning

## Setting the Context

Advances in medical treatments and care practices have allowed more Canadians reach advanced ages with complex health conditions. As a result, patients, families, and health care providers will be called upon to make increasingly difficult ethical and medical decisions about treatment and intervention options.

The scope of these decisions can vary widely, including:

- Whether to take a proposed medication that may not cure but prolongs life
- Whether and when to move into a long-term care home
- Whether and when to use and/or withdraw a feeding tube
- Whether and when to consider Medical Assistance in Dying (MAID) as a care option

Often, these questions don't have simple medical answers. Rather, they involve things at the heart of health care: an individual's values and preferences. These are weighty matters. Yet, families and the individuals requiring care and support often need to make choices and decisions in uncomfortable circumstances, nudged by busy health and social care professionals who are focussed on providing medically appropriate care, but who may not otherwise know the wishes of patients and their families. This experience can be stressful for all involved, especially when patients and their loved ones may not have the luxury of long, open discussions with medical professionals.

Informed consent is a basic ethical principle of health care. Individuals are entitled to know the risks and benefits of a given treatment or care option being offered to them, and to decide whether they want to pursue it, free of coercion. Sometimes, due to illness, an individual may be incapable of deciding, and their loved ones may have to decide for them as their legally designated substitute decision maker. That person's role is to carry out wishes expressed in advance, or, if these are absent, make judgments about what the individual requiring care would have wanted.

Occasionally, despite everyone's best efforts, these choices don't reflect what the individual, with the benefit of full information and sufficient time, would have chosen. In these cases, it may be difficult to tell whether the principle of informed consent has been fully satisfied. For this reason, it's important for all Canadians, and especially older Canadians, to inform themselves about relevant health and care issues and to think about treatment and care options, values and preferences well in advance. This includes management of chronic conditions, what kind of supportive or life-saving care is acceptable in the event of a terminal illness or condition, and where a patient will live and who will look after them if they are no longer able to live independently.

Advance Care Planning (ACP) is the process by which a person expresses what they wish to take place should they become incapable of consenting to or refusing treatment or personal care, including deciding who will make decisions their behalf if this happens.<sup>338</sup> The process should include discussions with family members, friends, and other trusted sources, and should cover a wide range of scenarios and treatments, including end-of-life care, chronic conditions, and long-term care needs. Other people who may be involved include health care providers and lawyers who can help to facilitate and document the person's decisions in the form of an advance directive.<sup>339</sup>

The evidence is clear that ACP makes a big difference. Studies show that ACP – especially formal programs involving trained facilitators – improves the quality of end-of-life care.<sup>340</sup> A review of studies found that patients who had an advance care plan in place were less likely to be admitted to an intensive care unit, and those who were admitted stayed there for less time.<sup>341</sup> Some studies even suggest that just having an advance directive in place reduces the risk of hospitalization and one's chances of dying in the hospital.<sup>342</sup>

ACP also helps to support loved ones in a difficult time. Formal ACP counselling has been shown to significantly reduce stress, anxiety, and depression in family members, and patients and family members who received the counselling were more satisfied in general.<sup>343</sup> Finally research also suggests that ACP may reduce health care costs by avoiding unwanted treatment.<sup>344</sup>

Following Carter V Canada in 2015, the federal government passed legislation to allow eligible Canadians request medical assistance in dying (MAID).<sup>345</sup> MAID is available to older Canadians with a grievous and irremediable medical condition and who are able to provide informed consent with two important exceptions: advance requests (i.e. not near death) are not permitted, and mental health cannot be the primary issue, although both exceptions are being challenged.<sup>346</sup>

With increasing options at end-of-life, every effort must be made to ensure that as many Canadians as possible, particularly older Canadians, engage in timely and comprehensive ACP, and are supported in doing so. While many provinces and territories have also begun encouraging ACP, the "2019 Pan-Canadian Framework for ACP in Canada" noted that infrastructure supports required to facilitate widespread ACP implementation have yet to be

developed. These include training for health care providers, effective ways to document and transfer people's wishes, and a system of accountability for ACP.<sup>347</sup>

The COVID-19 pandemic has heightened the importance of participating in ACP prior to experiencing a potentially serious illness. Individuals who developed a more acute and severe illness due to COVID-19 requiring interventions were more likely to be older and have greater comorbidities, similar to those who may wish to forgo certain treatments and would desire a 'goal of care' discussion, especially if the outcome was survival but with severe functional impairment or cognitive impairment.<sup>348</sup> As a result, ACP is particularly important to support our collective pandemic preparedness and to avoid intensive life-sustaining treatments that patients may not wish to experience, especially in a time of low health care capacity. Furthermore, although unwanted or non-beneficial CPR under any circumstance may risk increasing psychological distress for a patient's family members, inappropriate CPR during a pandemic is especially stressful and potentially dangerous for health care workers.<sup>349</sup>

As a result of the pandemic, the provision of palliative care services at the community level has been strengthened out of necessity, albeit unevenly, leading to an increased number of evidence-based guidelines for managing patients at end-of-life.<sup>350,351</sup> The pandemic has highlighted a greater need for improved policies to support the greater provision of ACP and end-of-life care.

## What Are the Issues?

### 1. CANADIANS AREN'T SUFFICIENTLY INFORMED, ENCOURAGED, AND EMPOWERED TO INITIATE AND PARTICIPATE IN ACP DISCUSSIONS

Recent surveys show that many Canadians are either not aware of the need for ACP or find it difficult to start and sustain the often-challenging conversations involved. A 2019 Speak Up Canada survey found that 8 in 10 Canadians have thought about end-of-life care, but only less than 2 in 10 have an ACP.<sup>352</sup> Some reasons include being afraid of death and not wanting to upset family members.<sup>353</sup> This problem is not unique to Canada. A survey of experts in Australia concluded that similarly low uptake of ACP was due in large part to "inadequate awareness, societal reluctance to discuss end-of-life issues, and lack of health professionals' involvement in ACP."<sup>354</sup> The Canadian Bar Association similarly observed that "a reluctance to contemplate and speak about illness and death often stands in the way of effective ACP."<sup>355</sup>

### 2. HEALTH AND SOCIAL CARE PROVIDERS LACK THE EDUCATION AND TRAINING TO EFFECTIVELY FACILITATE ADVANCE CARE PLANNING

Health and social care professionals play a critical role in initiating and facilitating ACP in a range of settings. As such, engaging in sensitive conversations with care recipients and their family members needs to be part of the core skill set of all clinicians. No one profession can be solely responsible for ACP, and all health and social care team disciplines need to be educated and supported to play their role. In addition to formal instruction, health and social care providers require continuing education and practical training.

ACP requires ongoing and evolving conversations, not just documenting an individual's choices at a given point in time. It's an ongoing process that threads through the continuum of care from primary to acute to long-term care settings. It's the responsibility of every health and social care provider to continually discuss care plans with patients, family members, and caregivers. Individuals, including the severely ill and/or cognitively impaired, need to be as involved in decision-making as possible, and they should be provided the health literacy information required to make truly informed decisions and goals for their care. Providers must also recognize that these goals, along with a person's values and preferences, may change over time.

Given the importance and complexity of the ACP process, formal and experiential education is required, starting early in providers' professional development and education. In many cases, however, professionals don't have access to adequate training in ACP.<sup>356</sup> For instance, **a 2014 survey found that only 25% of Canadian primary care providers felt they had the experience and comfort levels needed to confidently discuss ACP about illness and end-of-life care with patients.** A further 52% felt somewhat uncomfortable, while 24% reported no experience or comfort. A 2009 national roundtable that convened a wide range of stakeholders revealed that many health care providers were reluctant to engage in ACP discussions, emphasizing a need for a "culture shift – that should be focused on re-educating the public and health care providers and providing them with the tools they need to do this."<sup>357</sup>

While core ACP competencies for health and social care providers have been identified,<sup>358</sup> there is currently no central resource that provides ACP education materials or standards to individual providers, health care organizations, or educational institutions.



**Only 25% of Canadian primary care providers felt they had the experience and comfort levels needed to confidently discuss ACP about illness and end-of-life care with patients.**



### 3. ORGANIZATIONS DON'T HAVE READILY ACCESSIBLE GUIDELINES, STANDARDS, AND POLICIES TO SUPPORT ADVANCE CARE PLANNING

ACP is most effective when the individual care recipient's decisions are well documented and readily accessible in the full range of health care settings. An ideal health care system would include "a consistent, transferable and seamless mechanism for all care providers to share information about advance care planning and ensure conversations continue throughout an individual's care journey across all care settings."<sup>359</sup> For example, in 2015, Quebec created a provincial registry for documenting preferences about accepting or refusing specific medical interventions if patients ever become incapable of giving consent.<sup>360</sup> Although this is a great step towards implementing a centralized way to ensure wishes are reflected in end-of-life care, the questionnaire reduces advance medical care decisions to a limited set of choices and it does not adequately reflect the full range of values people may have about end-of-life preferences.<sup>361</sup> To facilitate ACP implementation, proper documentation protocol is needed to facilitate accessibility of ACPs in many care settings.

At present, despite many recently developed ACP tools and strategies,<sup>362,363,364,365</sup> there is no consensus on the best way to document ACPs, or on how to design medical information systems so that care providers have access to patient ACPs when its needed most. Nor are there best-in-class evidence-based frameworks that institutions can look to when designing and evaluating an ACP program. These are all significant system-level obstacles to a "consistent, transferable and seamless" ACP regime.

## Evidence-Informed Policy Options

### 1. RAISE AWARENESS AND EDUCATE CANADIANS ABOUT ACP

Existing, well-studied ACP initiatives have emphasized public outreach in order to “engage capable adults and their families, as is appropriate, in ACP through raising awareness, initiating dialogue about ACP and connecting people to the means of engaging in ACP.”<sup>366</sup> A number of groups have organized large-scale, nation-wide campaigns to raise awareness and educate the public about ACP. For example, **Advance Care Planning Canada** is a campaign organized by a diverse set of stakeholders.<sup>367</sup> One of its main goals is to increase the number of Canadians who engage in ACP with family and friends by 10%. It includes a well-designed, easily navigable website (<https://www.advancecareplanning.ca/>) and engages in outreach to community organizations, the general public, patients with acute and/or chronic illness, families/caregivers, health care professionals, and policymakers. Building on such initiatives, the federal government can be a highly effective partner in awareness-raising over the short, medium, and long term.

In the short term, the federal government can encourage Canadians to access the many existing resources developed by provinces and territories, which range from “how to” guides to straightforward, standard ACP forms (see Table 8). For instance, the federal government’s services for seniors portal, [www.seniors.gc.ca](http://www.seniors.gc.ca), could include materials promoting the advantages of ACP in simple, accessible terms, with links to key resources.

In the medium term, the many federal organizations involved in the care for older adults could use their portals and communications channels to direct them and their caregivers to ACP resources, and make ACP awareness a clear goal at the service delivery level, supported by the necessary training for all client-facing staff.

Over the longer term, ACP engagement could be emphasized as a clear priority in health care discussions between the federal and provincial/territorial governments, and resources dedicated to the development of a joint promotion strategy around an issue of collective importance.

### 2. SUPPORT HEALTH AND SOCIAL CARE PROFESSIONAL EDUCATION IN ACP

The federal government can lead the way by putting health care provider ACP training on the agenda in all conversations about national health care delivery and education. In particular, it can emphasize the need for professional bodies to set mutually consistent national standards, and for universities and colleges to align their curricula with corresponding training standards and support these organizations in achieving these objectives in a consistent and coordinated way.

As it has done with respect to many other critical health policy issues, the government can convene and facilitate discussions between stakeholders involved in health care education. It can sponsor research, e.g., through targeted Canadian Institutes of Health Research grants, to identify effective ACP education strategies and further support ACP education initiatives. In 2002-2003, the Canadian Institutes of Health Research deployed over \$19 million in funding for palliative care research studies and capacity building. And as part of the development of the 2007 Canadian Strategy on Palliative and End-of-Life Care, the federal government sponsored and contributed to the creation of an interprofessional ACP education module.<sup>368</sup>

### 3. PROMOTE ACP BEST PRACTICES

The federal government is actively involved in promoting and disseminating end-of-life care and palliative care best practices.<sup>369</sup> For instance, the Palliative and End-of-Life Care Unit at Health Canada ensures that these issues are taken into consideration in relevant federal health policy initiatives. The Public Health Agency of Canada (PHAC), through the Division of Aging and Seniors, provides federal leadership and serves as a focal point for information on public health issues related to ageing and older Canadians.

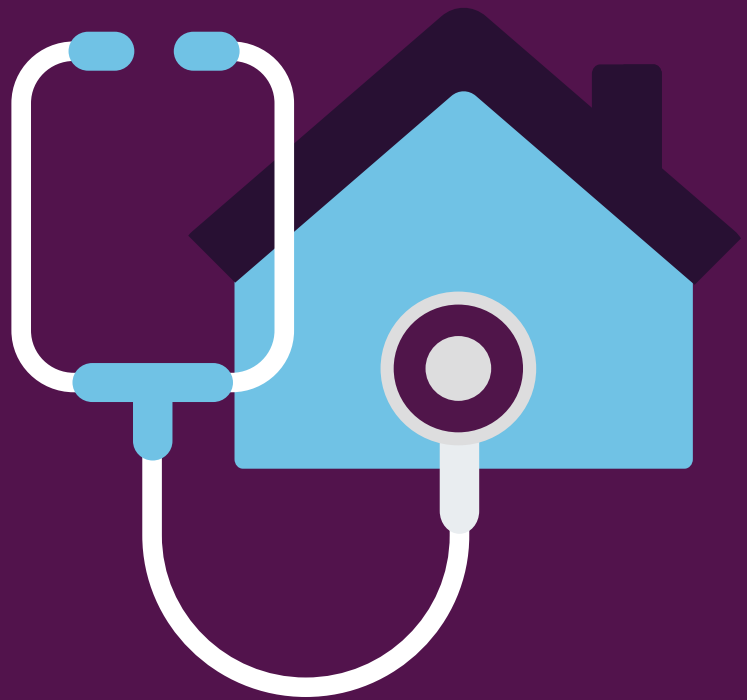
As it does in the area of palliative care generally, the federal government can play a critical leadership role in ensuring that the findings from ACP research and experiences are distilled and shared among health care institutions and practitioners. For instance, in 2008, Health Canada collaborated with two health authorities, Alberta Health Services and Fraser Health Authority (British Columbia), that had successfully implemented regional ACP strategies to create an implementation guide to help other authorities “develop or enhance their own advance care planning initiatives.”<sup>370</sup> Health Canada also helped fund the production of a 2009 report on a national roundtable on advance care planning.<sup>371</sup> Expanding the scope and scale of these collaborative activities would be worthwhile, especially with federal leadership, given that recent surveys show there is still much to be done to make sure all Canadian and care providers can become more routinely familiar with ACP.

**Table 8: Selected Provincial/Territorial ACP Resources Available to the Public**

<b>JURISDICTION</b>	<b>RESOURCE</b>	<b>DESCRIPTION</b>
<b>BRITISH COLUMBIA</b>	Making Future Health Care Decisions	Includes “My Voice: Expressing My Wishes for Future Health Care Treatment,” the B.C. Government’s user-friendly guide to advance care planning.
	Comox Valley, “Advance Care Planning”	Dedicated website explaining need to ACP and linking to helpful resources.
<b>ALBERTA</b>	Alberta Health Services, “Conversations Matter”	Interactive online guide to advance care planning, organized around helping patients to clarify their values and wishes.
<b>SASKATCHEWAN</b>	Regina Qu’Appelle Health Region, “Advance Care Planning”	Contains forms and brochures, as well as details about the Region’s ACP information sessions.
	Ministry of Justice & Attorney General, “Planning Ahead”	Detailed memorandum about how to ensure an ACP is effectively documented, with emphasis on legal considerations.
<b>MANITOBA</b>	Manitoba Health, “Health Care Directive”	Brief overview of health directives, together with a directive template and accompanying guide.
	Winnipeg Regional Health Authority, “Advance Care Planning”	ACP workbook and educational materials. Also includes resources for health care professionals, including forms, policies, and videos of simulated ACP scenarios.
<b>ONTARIO</b>	Advance Care Planning, “ACP Workbook – Ontario Version”	Detailed, comprehensive ACP workbook for patients and families, accompanied by easy-to-follow forms.
	Ontario Seniors’ Secretariat, “A Guide to Advance Care Planning”	Comprehensive guide to ACP. Also includes a printable wallet card to identify the patient’s substitute decision-maker.

<b>QUEBEC</b>	Curateur Public Québec, "My Mandate in Case of Incapacity"	Background and forms to complete a provincial "Mandate in Case of Incapacity."
	Éducaloi, "Mandates in Anticipation of Incapacity"	Overview of provincial Mandates of Incapacity.
<b>NOVA SCOTIA</b>	Nova Scotia Department of Justice, "Personal Directives in Nova Scotia"	Booklet explaining personal directives, including a simple checklist.
<b>NEW BRUNSWICK</b>	Public Legal Education Information Service of New Brunswick, "Powers of Attorney"	Overview of powers of attorney and testamentary planning in general.
<b>PRINCE EDWARD ISLAND</b>	Health PEI, "Health Care Directives"	Short summary of health care directives, accompanied by a form with explanatory notes.
	Health PEI, "Advance Care Planning"	Advance care planning workbook, including reflective writing exercise on values and beliefs. Also has links to a number of educational resources.
	Community Legal Information Association of PEI, "Health Care Directives"	Plain language overview of health directives and the legal process for obtaining one.
<b>NORTHWEST TERRITORIES</b>	Northwest Territories Health & Social Services, "Personal Directives: Choosing for the Future"	Brief guide to personal directives, as well as sample directives.
<b>YUKON</b>	Yukon Health & Social Services, "Advance Directives"	Booklet explaining advance directives, as well as simple checklist for required steps.
<b>NUNAVUT</b>	Nunavut Department of Family Services, "Guardianship"	Explains services available to protect adults who are unable to make care decisions for themselves.

# Care Closer to Home



## SECTION 3

# Care Closer to Home

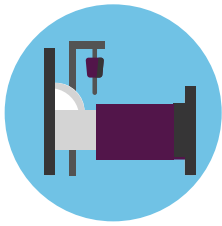
## **Ensuring older Canadians have access to person-centered, high quality, and integrated care as close to home as possible by providers who have the knowledge and skills to care for them**

Currently, older Canadians make up 17.5% of the population, but account for nearly half of our public spending on health and social care.<sup>372</sup> Medicare was established in 1966 when the median age of Canadians was 25.5 years of age and when most Canadians didn't live beyond their late 60s or early 70s. Since then, population characteristics have significantly changed, yet Canada's health care system has not fully adapted to meet the needs of its ageing population. The majority of Canadians now see access to supportive and palliative care in or close to their homes, and a robust home care system, as top national priorities.

The *Canada Health Act*, created in 1984, does not address the universal provision of long-term care or pharmacare. With Canada experiencing the vast majority of its COVID-19 pandemic deaths in its congregate living settings, many are now advocating for strengthening the *Canada Health Act* and the *Canada Health Transfer* to ensure Canadians can feel confident that the health and long-term care systems will be ready to meet their needs. With the majority of Canadians making it clear that they want to access care in or as close to their homes as possible, investing in creating a robust home care system is becoming a national priority.

To ensure current and future providers will have the knowledge and skills needed to provide Canadians the right care, in the right place, at the right time, the national educational and accreditation bodies for all care professions should mandate training around the care of the elderly in the same way as they do for other age groups, such as children.

The federal government and the federal Ministry of Health can work with Canada's provinces and territories to enable this pillar and associated activities in a variety of ways:



- **Ensuring older Canadians have access to high quality long-term care, palliative, and end-of life services, and medications, when and where needed, can be achieved by further investing in and supporting the development of these essential areas of care.**



- **Ensuring that Canadians have access to care providers from all professions that are trained to specifically provide the care older people need can be achieved by prioritizing geriatric care skills development and training amongst Canada's national educational and care accreditation bodies.**



- **Ensuring that the health care system is iteratively retooled to meet the needs of an ageing population will require access to high quality information to help track performance in meeting collective goals, which can be achieved by establishing national standardized metrics, information collection, and reporting systems through agencies like the Canadian Institutes for Health Information (CIHI) to help link funding to collective performance goals.**



- **Ensuring that older Canadians and their caregivers have their needs met in emergency and disaster preparedness planning, response and recovery efforts can be achieved by recognizing and ensuring that their unique vulnerabilities and needs are considered and supported.**



# Ensuring Older Canadians Have Access to Appropriate, High Quality Long-Term Care, Palliative, and End-of Life Services

## Setting the Context

Supporting older Canadians to age in their place of choice depends on having access to appropriate care services when and where they need them. Over the last decade, there has been a significant re-orientation of health care delivery from institutional settings, like hospitals and nursing homes, toward more home and community-based settings (see Figure 4).<sup>1</sup>

A poll conducted by Ipsos Reid on behalf of the Royal Bank of Canada (RBC) on Canadians and retirement revealed that **88% of retired older adults reported wanting to stay at home.**<sup>373</sup> Despite this, there is a general recognition that the home and community care needs of older Canadians are inadequately met.

One survey found that approximately 919,000 (3.3%) of Canadians over the age of 18 were receiving formal home care services in the preceding 12 months, with 433,000 reporting having perceived unmet needs.<sup>374</sup>

The above estimated number of Canadians receiving formal home care services figures may also be an underestimate, given that a number of Canadians who could benefit from the support of government-funded home care services may not even know how best to access them or choose not to access whatever is available because they don't feel it would adequately meet their needs.

### Case Study 2. Innovative Approaches to Home and Community Care with Community Paramedicine

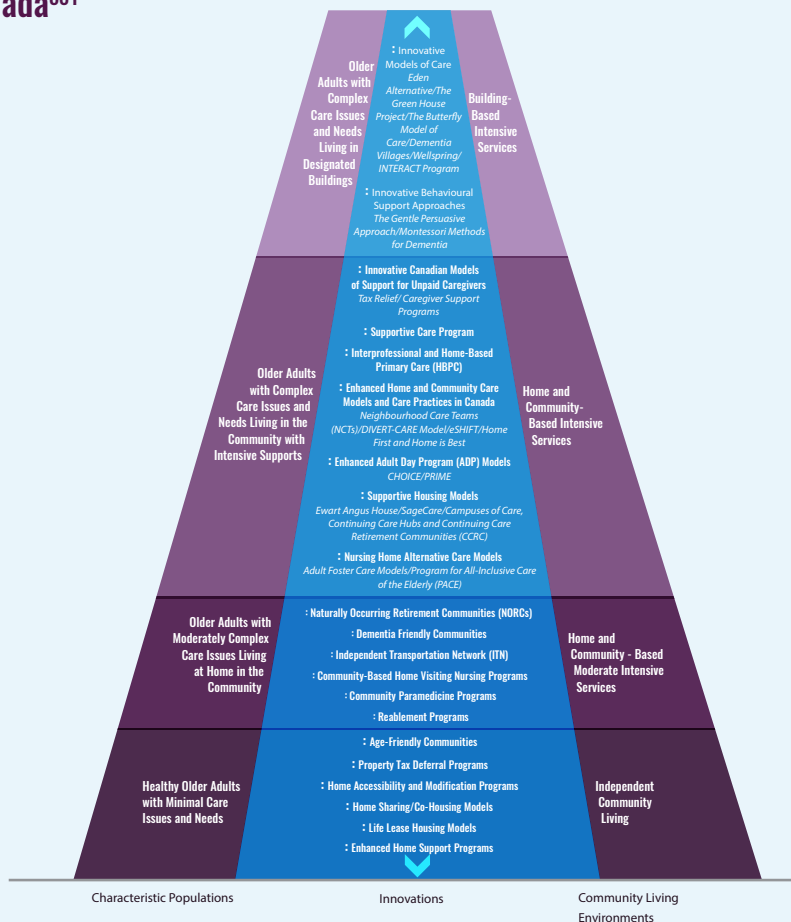
While waiting for placement in a nursing home, some older adults make frequent contact with the health care system and have high rates of emergency department use. As a result, in the rural town of Deep River, Ontario, the County of Renfrew Paramedic Service launched a unique community paramedicine program with funding from the Champlain Local Health Integration Network (LHIN) to support older adults who are eligible for or awaiting a nursing home placement to stay in their own homes longer. Through this cost-effective program, paramedics in association with other community partners, developed a system to provide 24-hour flexible and proactive supportive and enhanced home-based primary and community care services to these older adults – with impressive results. The program reduced overall emergency department and hospital utilization and improved the health status of individuals such that it delayed or even completely avoided admissions to the local nursing home. This paramedicine program is not the first or last of its kind, with a growing number of similar initiatives being developed across the country.

<sup>1</sup> For the purposes of this brief, we're considering the paid activities referred to in Figure 4. See Unpaid Caregivers brief for unpaid home and community care information.

Furthermore, it has been demonstrated that there are still many older Canadians who are prematurely institutionalized in nursing homes due to challenges in accessing even basic home and community care supports or other more general appropriate support services. Indeed, the lack of adequate home and community care services that can support individuals' activities of daily living (ADLs) is not only a strong predictor of institutionalization, but also an extremely strong predictor of overall utilization of health care services for older adults.<sup>375,376,377</sup> Across Canada there have been varied approaches to bridging the unmet needs gap to support older Canadians' health and ADL needs in their homes. One of the latest promising approaches to address access to care issues is the development of models of care leveraging community paramedics, especially in more rural and remote communities (See Case Study 2<sup>378,379,380</sup>).

The population of older Canadians is growing, and many are living far longer and with more complex and often inter-related health, social, and functional issues than in previous generations. Meeting the rapidly growing need for home and community care services is becoming increasingly challenging. Additionally, the growing need for more robust home and community care services must be understood relative to the need for institutional-based care, such as assisted living, acute and long-term care services.

**Figure 4. Conceptual Framework Supporting Future Long-Term Care Provision in Care in Canada<sup>381</sup>**



Avoiding inappropriate nursing home admissions and inappropriate stays in acute care settings amongst older Canadians has become a significant policy and health services research focus across Canada. It is estimated that 14% (7,500) acute care hospital beds per day in Canada are being occupied by individuals identified as alternative level of care (ALC) patients – referring to individuals who no longer require the intensity of care services where they are located.<sup>382</sup> The vast majority of ALC patients are older Canadians who are ready to be discharged from hospitals but for whom no appropriate home and community support or nursing home services are available.<sup>383</sup> Current estimates predict that **freeing acute care resources through providing more appropriate levels of care for older Canadians could result in \$2.3 billion in annual savings for use elsewhere in the health care system.**<sup>384</sup> Several examples of program and policy interventions targeting ALC issues are emerging throughout Canada. For example, Ontario's *Home First* policies, which were subsequently adopted in a number of other parts of the country, aim to, "identify individuals at high risk for institutionalization in order to provide adequate supports to enable successful transitions back to one's home or for people to remain in their homes in the first place".<sup>385</sup> Within the first two years of its Home First initiatives, Ontario saw its overall supply of nursing home beds decline by 2.7% amongst its fastest growing segment of the population aged 75 years and over. At the same time, demand for nursing homes declined 6.9%, while the placement rate into nursing home beds had declined 26% amongst Ontarians 75 years and over.<sup>386</sup>

While understanding the interface of services across the continuum of care is complex, legislative factors further complicate realizing the potential role of home and community care, and nursing home services in reducing ALC days. The *Canada Health Act* specifically focuses on the provision of hospital and physician services and does not address the universal provision of home, community, and nursing home care including the provision of palliative care. Thus, policies must be strengthened to ensure their regulation, organization, and funding can meet the needs of older Canadians.

Table 9 summarizes descriptions of income-based home care services, public expenditure on home care, as well as proportion of individuals over 85 years of age in nursing homes and the number of nursing home beds by province/territory. Unexpectedly, increases in the proportion of public spending for home and community care do not always correspond with lower rates of nursing home placement. For example, while provinces such as Prince Edward Island spend a very low proportion on home and community care and have the highest rates of nursing home placements, other provinces (e.g. Newfoundland and Labrador) spend a higher proportion on home and community care yet still have higher than average rates of nursing home placement. These figures demonstrate the importance of understanding context in health system capacity planning.

While there are many capacity challenges, the unmet palliative and end-of-life care needs of Canadians run across the continuum of care with respect to home, community, and institutional-based services. Palliative, hospice, and end-of-life care can be understood as services which, "aim to relieve suffering and improve the quality of living and dying".<sup>387</sup> The Canadian Hospice

Palliative Care Association cite that, “**only 16-30% of Canadians who die currently have access to or receive specialist hospice palliative and end-of-life care services**”.<sup>388</sup> Beyond helping individuals to die with dignity and in less discomfort, evidence for the provision and accessibility of palliative care services – be they delivered in the home or in an institutional setting – suggests there are significant overall systemic cost savings that could be realized for the health, social and community care systems by providing these services.<sup>389</sup>

With the advent of the unanimous ruling in 2015 by the Supreme Court of Canada that individuals have the right to a provider-assisted death also known as Medical Assistance in Dying (MAID)<sup>390</sup>, end-of-life care service provision must be reimagined. Future research must be directed toward understanding resource allocation and the systemic implications of providing universal coverage for MAID, as universal coverage and access towards palliative do not exist across Canada, especially in many rural and remote areas. Currently, research shows that physician-assisted death could save between \$34.7 million and \$138.8 million annually in Canada, which exceeds the estimated \$1.5–\$14.8 million in direct costs associated with its implementation.<sup>391</sup>

Exploring how to leverage knowledge and evidence from other jurisdictions where physician-assisted death has been available for some time (e.g. the Netherlands, Belgium, Luxembourg and various U.S. States) may also go some way to inform how to better plan and support the provision and right balance of MAID and palliative care.

Across all levels of health care service delivery, access to appropriate and high-quality care for older Canadians not only directly impacts the quality of life of individuals, it can also deliver significantly improved patient and system outcomes and costs.



**Only 16-30% of Canadians who die currently have access to or receive specialist hospice palliative and end-of-life care services.**

**- Palliative Care Association**

**Table 9. Income-based Home Care Service Delivery Models in Canada & Nursing Home Use by Province/Territory (2011)**

Province/ Territory	Description of Income-Based Model of Funding where In Place <sup>392</sup>	Public Expenditure on Home Care (\$ millions), percentage of total HEALTH CARE SPENDING as of 2012 <sup>393</sup>	Proportion of population over 85 yrs in NURSING HOMES by province (male %, female %) <sup>394</sup>	Total number of publicly funded Nursing HOME beds by province (N) <sup>395</sup>
<b>BRITISH COLUMBIA</b>	Home support is income tested with the exception of two weeks post-acute home support or palliative care.	\$721, 4.5%	(10.6, 17.3)	24,616
<b>ALBERTA</b>	Assessed professional case management, professional health, personal care and caregiver support services are provided without charge. A consistent provincial process and fee schedule is under development to determine client charges for home and community support services.	\$402, 2.4%	(13.1  , 19.7)	14,654
<b>SASKATCHEWAN</b>	For meals, homemaking and home maintenance, fees are charged (according to income testing) to clients after their first 10 units of service in a month. Subsequent units of service are charged based on client's adjusted monthly income.	-	(14.7, 21.5)	8,944
<b>MANITOBA</b>	-	\$290, 5.8%	(14.5, 24.6)	9,833
<b>ONTARIO</b>		\$1,988, 4.4%	(14.3, 24.4)	75,958
<b>QUEBEC</b>		\$1,407, 5.4%	-	46,091
<b>NEW BRUNSWICK</b>	Income testing for long-term supportive and residential care services according to net income. Client contribution required based on income testing for home support services through Social Development.	\$187, 6.4%	(15.8, 24.1)	4,391

<b>NOVA SCOTIA</b>	Has no fees for clients whose net income falls within or below the designated Home Care Nova Scotia client income category or who are in receipt of income-tested government benefits (e.g., Guaranteed Income Supplement, Income Assistance, Family Benefits). No fees charged for nursing services or personal care services provided by RNs or Licensed Practical Nurses or for physician services provided through Medical Services Insurance.	\$196, 5%	(10.4, 20.9)	5,986
<b>PRINCE EDWARD ISLAND</b>	-	\$13, 2.3%	(21.3, 32.8)	978
<b>NEWFOUNDLAND</b>	No income testing for those requiring professional health services or short-term acute home support but applies a financial assessment for long-term home support services.	\$136, 5.6%	(22.5, 33.3)	2,747
<b>NORTHWEST TERRITORIES</b>	-	\$4.6, 1.6%	-	-
<b>NUNAVUT TERRITORY</b>	-	\$7.8, 2.8%	-	-
<b>YUKON TERRITORY</b>	-	\$4.5, 2.2%	-	-

In the 2015 iteration of this report, it was recommended that the federal government use the CHT agreement as a vehicle for incentivising targeted plans for health services provision in the areas of home, community, and palliative care. It was also recommended the federal, provincial, and territorial governments work together to set national standards, targets, and benchmarks with comparable and meaningful measures that can clearly illustrate progress. In the 2020 Throne Speech, the Government of Canada committed to working with provinces and territories to create National Standards for long-term care, in light of the devastating impact of the COVID-19 pandemic on Canada's long-term care homes.<sup>1</sup>

In Budget 2017, the federal government announced \$6 billion over 10 years to support the expanded provision of home care services across the provinces and territories tied to the CHT. As part of this plan, governments agreed to develop common performance indicators and mechanisms for annual reporting to citizens, as well as a detailed plan on how the funds will be spent, over and above existing programs.<sup>396</sup>

<sup>1</sup> Government of Canada. (2020). Speech from the Throne: A Stronger and More Resilient Canada. Retrieved 2020, from <https://www.canada.ca/en/privy-council/campaigns/speech-throne/2020/speech-from-the-throne.html>

As such, the Federal/Provincial/Territorial health ministers have since endorsed a set of indicators for measuring access to home and community care recommended by the Canadian Institute for Health Information (CIHI) and were to begin public reporting on those that are available beginning in 2019-2020.<sup>397</sup>

In November 2019, CIHI released its first report on initial results for three indicators, including the indicator on hospital stay extension due to untimely access to home care.<sup>398</sup> The results showed that between 2017 to 2018, 1 in 12 hospital patients in Canada had to stay in hospital until home care services or supports were ready. The median length of extended stay for patients discharged to home care was seven days. However, there was a large variation in length of stay between each territory and province depending on the availability of home services and supports, ranging from 3 days in Manitoba to 24 days in the Northwest Territories.

One criticism of the current investments in the expansion of home and community care occurring across the provinces and territories is the apparent focus around supporting hospitals in managing ALC patients while neglecting to focus on the active development of more preventative models of home and community-based care.<sup>399</sup>

## What Are the Issues?

### 1. A LACK OF ACCESS TO SUPPORT SERVICES FOR INDIVIDUALS' ACTIVITIES OF DAILY LIVING (ADLS) NEGATIVELY IMPACTS HEALTH, CAUSES ADDITIONAL STRESS FOR FAMILY AND FRIENDS, AND HAS SYSTEMIC COST IMPLICATIONS

While health care services are extremely important, evidence suggests that older adults who have inadequate access to home and community care supports for activities of daily living (ADLs) – such as personal care, cooking, cleaning, and transportation – ultimately end up requiring more health care resources.<sup>400</sup> Much of this care is provided by family members, friends, unpaid caregivers, and lower paid and less regulated health care providers like personal support workers or health care aides.

For families and friends of older Canadians, meeting needs that are under-supported by local home and community care providers can lead to increased caregiver burden, stress and anxiety. Furthermore, unmet needs can present significant out-of-pocket costs to friends and family. For example, the Canadian Hospice and Palliative Care Association estimate that 25% of palliative care costs associated with providing care in the home are covered by family members.<sup>401</sup> The NIA's recent report *The Future Co\$ of Long-Term Care in Canada* also estimated that **about 75% of total home care hours are currently being met by unpaid caregivers**, and the demand for potential unpaid caregivers will grow by 43% from 2019 to 2050.<sup>402</sup>

Negative outcomes associated with unmet care needs have far reaching effects. Most immediately, individuals with unmet home care needs are more likely to experience injuries (specifically increased risk of falls), depression, reduced morale, lower self-reported health status,

feelings of decreased control, smaller social networks and an inability to prepare food. It has been also well-documented that having unmet needs and having to depend on others for one's ADLs have been associated with more doctor visits, greater numbers of emergency department visits, hospital admissions, ALC days, institutionalization, overall morbidity and mortality, and premature death.<sup>403,404,405,406,407,408</sup> For certain age-related illnesses such as dementia, the effects of unmet care needs increase the likelihood of an individual's premature placement into a nursing home, and earlier death.<sup>409</sup>

Understanding that supports for daily living are just as important as more clinically-oriented forms of home care will be important in considering the current and future provision of home care services. Furthermore, understanding the need to support families and caregivers in order to alleviate caregiver burden whenever possible, will increase the chances that a person will be able to continue ageing in place.

## **2. CANADA IS FACING SIGNIFICANT AND UNPRECEDENTED WORKFORCE CHALLENGES TO DELIVERING CARE**

Human resources are a particularly challenging issue when it comes to the delivery of care for older adults in Canada. This includes both the paid and unpaid workforce. Specifically, attracting and retaining care providers for older Canadian is a well-documented challenge.<sup>410</sup> According to a survey by the BC Care Providers Association, 71% of continuing care sector respondents identified recruitment to be extremely challenging and 74% believed that retention was very or extremely challenging.<sup>411</sup> A recent in-depth series examining the future of long-term care in Canada identifies the following challenges around the paid workforce: turnover/retention/recruitment; job satisfaction; poor working conditions, including understaffing and violence; training; and, compensation.<sup>412</sup>

The role of unpaid caregivers is also key: CIHI reports that 98% of older adults receiving publicly funded care also had one or more unpaid caregivers involved in their care.<sup>413</sup> Recall that 'unpaid caregivers' (and 'caregivers') refer to individuals who provide care to another person primarily because a personal relationship exists while paid 'care providers' refer to those who provide care due to a financial relationship (see Box 1 in Evidence Brief #1 for full definitions).<sup>414</sup> According to the Government of Canada, there are approximately 6.1 million Canadians (35% of employed Canadians) working and balancing caregiving duties.<sup>415</sup> Despite high and increasing rates of labour participation amongst women in Canada, women still take on a larger share of caregiving duties. It is estimated that 54% of Canadian caregivers are women and have reported spending 20 hours or more per week providing care, while men average less than one hour per week<sup>416</sup> (Read more about this in Evidence Brief #12 and #13).



### 3. POOR FINANCING OF LONG-TERM CARE RESULTS FROM UNSUSTAINABLE FUNDING AND INAPPROPRIATE FUNDING RULES

Across Canada, there is an increased demand for services while capacity and resources remain limited. Governments are balancing many challenges including escalating costs due to increased acuity of clients, increasing public expectations for home care services, ensuring equitable services across jurisdictions and geography, and maintaining the supportive/preventive elements of home care and community services within current cost-cutting environments.<sup>317</sup> A lack of resources and funding to address these challenges put the sustainability of the system as a whole at risk.<sup>418</sup> One area of interest when looking at the financing of care is funding models for delivery of care. In Canada, the delivery of health, social, and community care services has traditionally been through non-means-tested universal programs.<sup>419</sup> Given that the current care being made available is often not adequate to meet current or future demand, a review of the appropriateness of current funding models would be beneficial.<sup>420</sup>

Inappropriate funding rules are also an area of interest when looking at sustainable funding for the provision of care.<sup>421</sup> Currently, funding rules do not appropriately align with the requirements of care provision. For example, according to the Registered Nurses Association (RNAO), if a resident is incontinent, funding is provided for the care and the supplies, but not provided for the staff hours required to implement more appropriate practices, such as prompted toileting at regular intervals to reduce the frequency of incontinence.<sup>422</sup> The RNAO also argues that the current funding rules disincentivize improved patient outcomes as nursing home, in some case, may be financially penalized for delivering improved patient outcomes.<sup>423</sup>

## Evidence-Informed Policy Options

### 1. ENABLE EVIDENCE-INFORMED PERSON-CENTERED SYSTEMS OF HOME, COMMUNITY, AND NURSING HOME CARE

Enabling evidence-informed person-centered systems of care will require meeting the needs of both care recipients and their unpaid caregivers.<sup>424</sup> Care models need to be more flexible, adaptable, coordinated and inclusive of the needs of older adults and their unpaid caregivers. Utilizing the concept of ageing in place requires the use of a person-centered lens and the recognition that care must be uniquely centered around the individual. The WHO highlights that for some, ageing in place may mean staying in the same home, but for others it may mean moving to a safer or adapted home where care is available; however, the focus should always remain on the older adult and what is right for them.<sup>425</sup> Caregivers' needs should also be recognized on an individual basis. Therefore, governments should commit to a foundational principle of ensuring that home, community, and nursing home systems of long-term care prioritize the needs and preferences of both caregivers and care recipients.<sup>426</sup>

## 2. SUPPORT SYSTEM SUSTAINABILITY THROUGH NEW FINANCING ARRANGEMENTS AND A STRONG WORKFORCE

The home, community, and nursing home systems of long-term care do not currently meet the needs of Canadians who wish to age in place. As it stands, a recent NIA report that examined the current and future costs of long-term care in Canada using microsimulation methods projected that **costs of long-term care could rise from \$22 billion in 2019 to at least \$71 billion by 2050.**<sup>427</sup> **Unpaid care caregivers will need to increase their efforts by 40% to keep up with care needs,** as the number of seniors needing support is projected to grow by 120% by 2050.<sup>428</sup> Strengthening the workforce tasked with the care of older adults will therefore require addressing the issue of paid and unpaid caregivers (see Evidence Brief #13 and #14 for recommendations on unpaid caregivers). In relation to care providers, the government should consider improving immigration policies to enable recruitment and retention of international care providers to increase capacity in the system.<sup>429</sup>

Despite significant investments in the provision of home, community, nursing home, and palliative care services, it is thought that more spending may be required to achieve growth and build capacity in the sector to support a health care system that works for Canadians.<sup>430</sup> To further support system sustainability, it is recommended that all levels of government come together with stakeholders to strengthen the financing of home, community, nursing home, and palliative care services to enable care that is preventative and supportive.<sup>431</sup>

## 3. LEVERAGE TECHNOLOGY TO IMPROVE DELIVERY OF LONG-TERM CARE

Technological solutions can also play a role in supporting the overall sustainability of healthcare systems. However, the research around them also stresses that new technology must be co-designed with care providers and care recipients to improve its overall effectiveness, efficiency and intended outcomes.<sup>432</sup> Canada has invested in tele-homecare programs to allow providers such as nurses or paramedics to monitor patients living with chronic health conditions such as congestive heart failure and chronic obstructive pulmonary disease<sup>433</sup>, in addition to other telemedicine networks that connect patients to providers virtually, such as the Ontario Telemedicine Network.<sup>434</sup> There are also a growing number of technologies that can address functional challenges to enable more independent living for older adults, such as apps that help individuals monitor and manage chronic conditions and motion sensors that can detect falls.<sup>435</sup> Assistive technologies are important to support care transitions and assist in a person's ability to perform their daily activities in a way that also improves their function, safety, independence, participation and social inclusion. In times when visitors were not being allowed to visit residents in care home settings, such as during the COVID-19 pandemic, technology such as video-conferencing became one key way to assist residents in staying connected to their families.

Equitable access to assistive technologies across Canada remains an issue, as different definitions for assistive technologies exist across provinces and territories, leading to confusion in eligibility and funding.<sup>436</sup> A standardized definition for assistive technologies in legislation, policies and

programs across Canada will allow for increased awareness of what is available and what is covered within each jurisdiction.<sup>437</sup> Governments can fund further research and development into technologies to enable older adults at increased risk of losing their independence to live at home. In addition, jurisdictions can develop an integrated approach to include assistive technologies as a part of the solutions available in home and community care settings, such as adapting government procurement strategies with larger buying power to allow for scale, spread, and reduction in costs for home and community care.

#### **4. SUPPORT ALTERNATIVE CARE MODELS TO ALLOW AGING IN THE COMMUNITY**

The COVID-19 pandemic has highlighted an increased need for alternatives to LTC or nursing homes as the primary means of supporting older adults. Several alternative LTC models have been well-researched. The United States' *Program for All-Inclusive Care of the Elderly* (PACE) is one such example that was first developed in San Francisco and has since spread to more than 133 organizations across the 31 U.S. States.<sup>438</sup> This model allows older adults to remain living in their home or in an assisted living environment while care is provided through an adult day health centre that consists of an interdisciplinary team (e.g. driver, dietician, physiotherapist, nurse) as well as in-home services as required.<sup>439</sup> The PACE model has reduced future LTC home placement and enabled more older adults to live in their own communities for less overall costs despite experiencing increased cognitive and overall impairment.<sup>440</sup>

Future LTC policies in Canada should encompass alternative models of care to facilitate a shift from expensive institutionalized care towards more cost-effective home and community-based models of support for older adults that require more intensive care.

# Ensuring Older Canadians Have Access to Care Providers That Are Trained to Specifically Provide the Care They Need

## Setting the Context

While there are many personal and environmental factors which impact healthy ageing, it is essential to have available and appropriate health, social, and community care providers, with the knowledge and expertise needed to care for older Canadians. Unfortunately, there are still no mandatory training requirements around providing care for older adults for most future health and social care professions in Canada. As a result, many of the current core and postgraduate training programs for health and social care professionals provide insufficient exposure towards understanding and managing the specific issues in caring for an ageing population.

Care providers represent a variety of professional backgrounds, beyond doctors and nurses, such as occupational therapists, physiotherapists, pharmacists, social workers, recreational therapists, personal support workers or care aides and others. In an assessment conducted on behalf of the Council of Ontario Universities of the core training curricula of 76 training programs for health and social care professionals, only half indicated having, “a required seniors care, gerontology, or geriatrics course”.<sup>441</sup> The survey also demonstrated that only half of the programs reported offering, “a required clinical or practicum experience with a focus on seniors care, gerontology or geriatrics”.<sup>342</sup> This Ontario report, however, reflects the variability and general lack of standardized training requirements related to the care of older adults that exists across Canada.

Furthermore, these findings illustrate that training in the care of older adults in Canada is lacking across the spectrum of care professionals, and not merely limited to physicians and nurses. There is a fundamental mismatch between the current training provisions and the fact that older Canadians are the greatest users of the health care system. Therefore, ensuring that Canada has a health human resources strategy that educates and trains professionals in care of older people will be essential.

## What Are the Issues?

### 1. CANADA DOES NOT HAVE A NATIONAL HEALTH AND SOCIAL CARE HUMAN RESOURCES STRATEGY TO MEET THE NEEDS OF THE AGEING POPULATION.

Current Canadian demographic trends estimate that the numbers of Canadians 65 and over and 85 and over will respectively double and quadruple over the next two decades. Compared to other developed countries around the world, Canada noticeably falls behind in both recognizing and preparing its health and social care professionals to meet the growing need for geriatrics expertise. When looking at the supply of physicians with training in geriatrics for example, both larger and smaller countries such as the United Kingdom and Iceland, have prioritized the training and hiring of geriatricians (see Box 5 for an Iceland vs Canada Comparison<sup>443,444,445</sup>). In 2018, the Canadian Medical Association reported that there are 304 geriatricians in Canada.<sup>446</sup>

While Canada has **1 certified geriatrician for every 14,689 older Canadians**<sup>447</sup>, the disparity becomes even more pronounced at the provincial and territorial level – with four provinces and territories having either none or only one geriatrician to serve their entire population.<sup>448</sup> Another way of illustrating the existing health human resources mismatch can be understood by looking at the ratio pediatricians to geriatricians. For example, in 2018, there were approximately 304 geriatricians serving 6.6 million older adults in Canada, while at the same time, 2,887 pediatricians served 8.1 million children and adolescents under the age of 20.<sup>449,450,451</sup> As the number of older adults already exceeds children under 15, planning for this shift is essential. Geriatricians play an essential role in supporting older adults to remain healthy and independent for as long as possible. Geriatricians often provide more appropriate cost-effective care when supporting people with more complex and inter-related health and social care needs.



#### Box 5. International Case Example – Access to Geriatricians in Iceland and Canada

##### ICELAND

Population: 330,000

Individuals >65: Approximately 44,000

Number of Practicing Geriatricians: 24

**Geriatrician to > 65 Population Ratio: 1:1,833**

##### CANADA

Population: 37 million

Individuals >65: Approximately 6.6 million

Number of Practicing Geriatricians: 304

**Geriatrician to >65 Population Ratio: 1:21,686**

For example, evidence suggests that geriatric assessments in hospital have the ability to, “reduce short-term mortality, increase the chances of living at home at one year and improve an older person’s physical and cognitive function”.<sup>452</sup> Each of these outcomes can save costs within the health system, which is an important factor in determining whether geriatric training and resources should be prioritized.

The reasons behind the shortage of geriatric specialists are multifactorial. Geriatricians were traditionally some of the lowest paid specialists, until recently. In addition, the lack of focus on geriatric medicine in medical school curricula as well as the insufficient number of residency training programs are also barriers. Only 11 of the 17 Canadian medical schools offer an accredited geriatrics residency program.<sup>453</sup> No Ontario medical school, for example, currently offers core training in geriatrics, but every school offers core training in pediatrics despite that the majority of patients in the health system are likely to be older people.<sup>454</sup>

A lack of geriatricians, however, is only part of the larger health human resources and training challenge related to meeting the future care needs of older Canadians. Across the health care system and within the communities, other health and social care professionals interact with older Canadians with a much higher frequency than specialized physicians such as geriatricians or family physicians with additional training in care of the elderly. However, many professional training programs have no stated mandatory training requirements in care of older adults. Table 10 illustrates this finding for occupational therapy, pharmacy, nursing, and paramedicine as examples. In addition, health and social care trainees are provided with limited exposure to geriatrics, and to care settings such as nursing homes, rehabilitation and home and community care settings, where older adults are often the main recipients of care.

**Table 10. Summary of Professional Accreditation Bodies, Competency Statements Sources and Requirements for Training around the Care for Older Canadians**

<b>PROFESSION &amp; ACCREDITING BODY</b>	<b>COMPETENCY STATEMENTS</b>	<b>GERIATRIC TRAINING AS A REQUIREMENT?</b>
<b>Occupational Therapists; Association of Canadian Occupational Therapy Regulatory Organizations</b>	1. Essential Competencies of Practice for Occupational Therapists in Canada (3 <sup>rd</sup> Ed.)	<ul style="list-style-type: none"> <li>• Expectation for competency across the lifespan</li> <li>• No specific geriatrics competencies required</li> </ul>
<b>Pharmacists; National Association of Pharmacy Regulatory Authorities</b>	1. 1) Professional Competencies for Canadian Pharmacists at Entry to Practice: Second Revision	<ul style="list-style-type: none"> <li>• No specific geriatrics competencies required</li> <li>• Across the lifespan not explicitly stated</li> </ul>
<b>Registered Nurses; Canadian Nurses Association</b>	Framework for the Practice of Registered Nurses in Canada <sup>455</sup>	<ul style="list-style-type: none"> <li>• No specific geriatrics competencies required</li> </ul>
<b>Paramedics; Canadian Medical Association (CMA)</b>	<ol style="list-style-type: none"> <li>1. Guiding principles for national entry-level competency profiles used in the CMA conjoint accreditation process</li> <li>2. Guidelines for paramedic programs on the use of the Paramedic Association of Canada's 2011 National Occupational Competency Profile in the CMA conjoint accreditation process</li> <li>3. Revised advisory to paramedic programs re: revision to competency profile</li> </ol>	<ul style="list-style-type: none"> <li>• No specific geriatrics competencies required</li> <li>• No specific geriatrics competencies required</li> <li>• No specific geriatrics competencies required</li> </ul>

*Adapted from McCleary, Boscart, Donahue & Harvey (2014)<sup>456</sup>*

As Table 10 illustrates, national accreditation standards do not adequately emphasize training in the care of older adults. Given this lack of emphasis in national accreditation standards, many of the publicly funded training programs have not prioritized this training in their curricula. An adequately trained workforce that has the knowledge and skills needed to care for an ageing population needs to become a national priority. Encouraging and supporting the development of continuing educational opportunities for the existing workforce that focus on care for older people needs to occur as well.

Compounding the lack of appropriately trained health care professionals is an overall lack of care workers to adequately meet the needs of the older population. The health and social care sectors face serious human resource shortages. Therefore, in addition to curricula changes, sufficient numbers of professionals will be required – in particular geriatricians, geriatric psychiatrists, family physicians, nurse practitioners, nurses, physician assistants, social workers, pharmacists, therapists, paramedics, and personal support workers. Continuing to support the development of team-based care environments will also be integral to promoting the inter-professional care that older adults particularly benefit from.<sup>457</sup> And with an ageing workforce, ensuring that barriers to training are removed and that compensation for specialists trained in the care of the elderly is adequate will be just as important as ensuring that nurses and personal support workers, upon whom much of the care for this population will depend, are valued and supported.<sup>458</sup>

## 2. COVID-19 REVEALED SYSTEMIC VULNERABILITIES IN THE STAFFING OF CANADIAN LTC HOMES

The COVID-19 pandemic has revealed how vulnerable the staffing of Canadian LTC - or nursing homes - are to pandemics. As of September 2020, COVID-19 has killed 9,238 people, with 76.4% of them residing in 1,280 Canadian nursing or retirement homes. The case-fatality rate of residents who contracted COVID-19 in these settings has been a stunning 37.45% compared to an overall rate of 6.5%.<sup>459</sup> Furthermore, NIA researchers determined that during Canada's first wave of COVID-19, older Canadians had a 73.7 fold greater chance of dying from it if they lived in a nursing or retirement home versus their own private dwelling.<sup>460</sup>

The reasons stem from the demographic features of the close to 500,000 Canadians who live in residential care homes that make them highly vulnerable to dying from COVID-19.<sup>461</sup> While the average age of a Canadian nursing home resident is 82 years of age, the majority live with dementia and multiple comorbidities requiring them to take more than 10 medications on average.<sup>462,463</sup> Furthermore, 86% of Canadian nursing home residents require support with their basic activities of daily living such as dressing, toileting and feeding.<sup>464</sup> The high prevalence of dementia makes it further challenging for them to recognize and report symptoms their own of COVID-19.

The frail nature of those Canadians living in LTC settings is not aided when the majority of these settings report chronic staffing recruitment and retention challenges.<sup>465</sup> In Quebec, the provincial objective of having one staff member per eight residents in both hospitals and LTC homes was not met, especially during the pandemic, which witnessed ratios as low as 1 staff to 16 residents.<sup>466</sup> Overall in Canada, the Canadian Institute for Health Information reported the total direct care hours per resident day was 3.30.<sup>467</sup> As of 2018, the Ontario nursing homes report an average of 3.73 direct hours of care per resident, per day, short of the recommended minimum daily average of 4.1 hours of direct care per resident.<sup>468</sup> The Canadian Centre for Policy Alternatives estimates that it would cost around \$1.6 billion to meet this gap in care hours.<sup>469</sup> While demand for LTC has increased, shortages exist in the workforce for nurses and personal support workers, as a result, staff do not have enough time to provide high-quality care to residents.



Those who staff LTC settings also consist of a higher percentage of immigrant and visible minority women compared to other professions.<sup>470</sup> Furthermore, the share of Canadian immigrants that characterize this workforce has grown more quickly than other occupations, from 22% in 1996 to 36% in 2016. In larger metropolitan areas such as Toronto and Vancouver, over 70% of these workers are immigrants.<sup>471</sup> Despite this, these workers are more likely to have post-secondary education compared to their non-immigrant colleagues and tend to be paid less than their counterparts working in a hospital for similar work.<sup>472</sup> In addition, they are more often employed on a part-time basis without benefits or paid sick leave, and prior to the pandemic they would often work across multiple care settings.<sup>473</sup> Historically, provincial legislation such as Bills 29 and 94 introduced in 2001 and 2003 in British Columbia violated the collective bargaining rights of non-hospital health care workers. Over the last decade in British Columbia, more than 10,000 health care workers were laid off and then subsequently rehired at lower wages.<sup>474,475,476</sup> Finally, the high staff turnover that exists in LTC settings made pandemic preparedness difficult to implement and maintain, such as ensuring all staff were properly educated around infection prevention and control methods.<sup>477</sup>

## Evidence-Informed Policy Options

### 1. DEVELOP A NATIONAL HEALTH HUMAN RESOURCES AND EDUCATION STRATEGY TO MEET THE NEEDS OF AN AGEING POPULATION

The planning and delivery of health and social care services is largely a provincial and territorial responsibility, while the training curricula for the regulated professionals are largely guided by national accreditation standards developed by professional colleges and societies. There is a clear disconnect between health human resource training and employment strategies at both the regional and national levels. There is an opportunity for the provinces and territories to partner with the federal government to understand and collectively address current and future health human resources issues. While the federal government is not in a position to create mandatory training requirements, they can nonetheless emphasize the importance of appropriate geriatrics knowledge and skills acquisition in entry-to-practice and continuing professional development programs – especially when the training and employment of Canada’s health and social workforce is largely funded by the taxpayers.

### 2. STABILIZE THE WORKFORCE IN LTC HOMES THROUGH THE IMPLEMENTATION OF BETTER EMPLOYMENT POLICIES

The health care provider staff in Canadian LTC settings make up the backbone of this system and are responsible for the overall health and wellbeing and in supporting the daily activities of living for residents, whose care needs have only been intensifying over the past decade.<sup>478</sup> Prior to the pandemic, provinces and territories struggled with chronic staffing issues as a result of employment policies that have supported the provision of lower wages, and more part-time work with fewer to no benefits for LTC providers compared to their acute care colleagues.

Over the pandemic, all provinces/territories have implemented policies to limit staff from working in more than one care setting. Provinces like British Columbia went the furthest in announcing their strategy early in the pandemic to offer every LTC worker full-time pay with a standardized wage rate during the pandemic.<sup>479</sup>

Beyond the pandemic, greater consideration should be given to the offering of mostly full-time employment with wage parity and benefits, such as pensions and sick leave in LTC settings at the same level that may be done in local publicly-funded hospitals. This can help reduce the significant recruitment and retention problems that exist in this sector. According to the Canadian Foundation for Healthcare Improvement (CFHI) and the Canadian Patient Safety Institute (CPSI), nurses are not at wage parity with their hospital counterparts, with the exception of jurisdictions like Saskatchewan. Other jurisdictions like Alberta, Ontario and Quebec have either made across the board increases in salaries or offered hazard pay bonuses during the pandemic.<sup>480</sup> In addition to wage parity, single-site staffing should be continuously enabled to help minimize the possibility of transmitting infections between multiple care settings. Indeed, home care workers in Ontario, B.C., and Nova Scotia have also noted that being offered a work schedule that could minimize travel between clients and gaps in their workdays would help them provide better care.<sup>481</sup>

# Developing Standardized Metrics and Accountability Standards to Enable a National Seniors Strategy

## Setting the Context

The availability and accessibility of high-quality performance information will be vital to measure, monitor and report on the advancement of the goals established as part of a National Seniors Strategy. Currently, however, there is little in the way of an established set of common indicators and metrics that are routinely used to monitor performance as a nation in comparison with others or between provinces and territories.

In areas where measures do exist, such as within health care, they are not fully harmonized within and amongst provinces, territories, sectors and providers, making it challenging to develop comparisons around performance and to establish even baseline standards.

Previously, the metrics available reflected the priorities placed on health care, such as acute, episodic care for single conditions within primarily in institutional settings. In 2019, the Federal/Provincial/Territorial health ministers have endorsed a set of indicators for measuring access to home and community care recommended by the Canadian Institute for Health Information (CIHI)(see Box 6 for key measures and rollout dates).<sup>482</sup> CIHI released its initial report on the first three indicators in 2019, including hospital stay extended until home care services or supports ready.<sup>483</sup>



### Box 6. CIHI Indicators Measuring Pan-Canadian Progress Towards Improving Home and Community Care

- Hospital stay extended (in alternate level-of-care days) until home care services or supports ready (2019 and onwards)
- Caregiver distress (2020 and onwards)
- Long-term care provided at the appropriate time (2020 and onwards)
- Wait times for home care services, referral to services (2021 and onwards)
- Home care services helped the recipient to stay at home (self-reported, 2021 and onwards)
- Death at home/not in hospital (2022 and onwards)

Metrics should be developed that adequately assess the growing complexities related to caring for older and more complex patients across all settings. Overall, it is still recognized that the system performance metrics that are currently aimed at the provision of health care and other services and supports in home and community care settings – also the fastest growing segment of the current health care system - is more rudimentary still and not yet standardized.

## What Are the Issues?

### 1. THERE ARE NO NATIONAL STANDARDS, GUIDELINES OR A CONSENSUS AROUND WHAT APPROPRIATELY MEETING THE NEEDS OF OLDER CANADIANS SHOULD ENCOMPASS

Although there is a pressing need, there is no national consensus as to what represents a society that is 'ageing well' or providing 'optimal delivery' of care, services and supports for older adults and those who care for them. This includes how quality care for older adults is defined – the existing clinical practice guidelines and practice standards rarely take into account the challenges that many older Canadians living with multiple chronic diseases and functional limitations currently face and can even be conflicting at times.<sup>484,485</sup> A lack of national standards, guidelines, or a consensus around what appropriately meeting the needs of older Canadians should encompass means that it remains difficult to hold systems, providers and citizens accountable to themselves and others.

### 2. YOU CANNOT MONITOR AND IMPROVE WHAT YOU CAN'T OR DON'T MEASURE

Measurement is a key enabler in allowing organizations, systems, as well as the public to assess and understand their overall performance and progress towards achieving their aims. While this sounds straightforward, what is being measured must be carefully considered, as there can easily be unintended consequences to measuring one outcome measure over another.

A great body of research from the United Kingdom has repeatedly demonstrated that the drive to achieve and demonstrate improvement in government selected indicators for health system performance around areas such as wait times, also created a number of unintended consequences related to 'gaming' the overall system that sometimes led to the worsening of other un-monitored outcomes.<sup>486</sup> This is why it is important to design a set of measures that can provide a 'balanced' view of system performance as well.

Finally, in choosing what is measured, metrics and indicators selected must reflect aspirations towards achieving standards of health and wellbeing for older adults and the future provision of care, services and support. For example, as it relates to the future care of older adults, measures and indicators must better reflect the ability to deliver more integrated and community-based care that today's older and increasingly diverse Canadians want and need.

### 3. CURRENT RESEARCH AND INNOVATION PRIORITIES ARE NOT ROUTINELY FOCUSED IN THE RIGHT AREAS

The bulk of current research and innovation initiatives are still focused on the old ways of delivering services and care, and do not address the growing heterogeneity of the population, let alone the growing challenges of effectively meeting the needs of an ageing population.

An increasing number of older adults are not just more 'chronologically mature' but are also increasingly living with growing rates of hearing, visual, cognitive and functional limitations. It is clear that traditional approaches to developing research and innovation initiatives for them must better reflect their increasingly diverse needs. Indeed, the delivery services, care, and support for older Canadians requires a more complex, nuanced, multi-sectoral and context-specific approach. This requires different research methodologies and approaches to develop and evaluate new and more effective ways of delivering services, care and support. Ensuring that future research and innovation activities are more inclusive of the intended users in the design, implementation and evaluation phases will further help to ensure their chances of being successful.

## Evidence-Informed Policy Options

### 1. ESTABLISH A FRAMEWORK FOR THE DEVELOPMENT, COLLECTION AND REPORTING OF ENABLING PERFORMANCE MEASURES AND INDICATORS THAT CAN PROMOTE SHARED ACCOUNTABILITY IN ADVANCING A NATIONAL SENIORS STRATEGY

A considerable amount of literature is devoted to lists of indicators that are or could be measured around assessing the health and well-being of older adults, or the provision of care, services and support for older adults. In some areas, no widely accepted measures have been established. Therefore, in order to enable a National Seniors Strategy, the federal government should convene and facilitate the creation of a framework for the development of common metrics and indicators to help monitor progress around common initiatives established to enable the health and well-being of older Canadians.

Within the domains of health care, these metrics and indicators should focus around the delivery of care, services, and supports across the *entire* continuum of care, with a particular emphasis on metrics that can assess system integration and transitions. The framework should also encompass metrics that can monitor the different perspectives that providers, individuals, and their caregivers may have. The early work that the Canadian Institute for Health Information (CIHI) has been leading on behalf of the federal government with the support of Canada's provinces and territories in the creation of some common home and community care metrics is a positive example of cross-jurisdictional collaboration to measure progress around common national aims.<sup>487</sup>

As noted above, the federal government has already established agencies such as the CIHI, Statistics Canada and others to collect and analyse information and data relevant to Canadians as a whole. Therefore, these organizations in particular could be given a clear mandate to not only collect data, but also report it back in ways that can allow all levels of government, researchers, health professionals, and members of the public to promote a shared or mutual sense of understanding and responsibility for ensuring that established performance targets are achieved.

## **2. CONSOLIDATE AND SCALE RESEARCH AND INNOVATION ACTIVITIES TO IMPROVE THE HEALTH AND WELL-BEING OF OLDER CANADIANS**

In recognizing the demographic and fiscal challenges and opportunities that will come with an ageing population, there remains a clear opportunity to invest further in research and innovation projects that better address current and future issues. While a number of large funding initiatives (e.g. Canadian Institutes of Health Research (CIHR) Institute of Aging, AGE-WELL Networks of Centres of Excellence (NCE), Canadian Frailty Network (CFN), National Initiative for the Care of the Elderly (NICE) have been created to conduct ageing-related research and knowledge-translation projects, greater consolidation would help to advance learning and the spread of innovations. Opportunities should be maximized to invest in research and innovation activities that support ageing. For example, the Government of Canada's Advisory Panel on Healthcare Innovation's report *Unleashing Innovation: Excellent Healthcare for Canada* emphasizes clear opportunities to help focus, consolidate, fund and most importantly, scale innovations that can better address ageing, equity and sustainability for all Canadians.<sup>488</sup>

# Ensuring the Needs of Older Adults are Recognized and Supported in Emergency and Disaster Preparedness Planning, Response, and Recovery Efforts

## Setting the Context

Public Safety Canada has reported that natural disasters are increasing in frequency and severity across Canada.<sup>489</sup> As a result of climate change, Canadians can expect to experience more extreme weather events such as heat waves, heavy rainfalls and related flooding, droughts, forest fires, serious winter storms, hurricanes, and tornados with greater frequency and severity than in the past.<sup>490</sup> Over the past decade between 2009 and 2019, there were 157 major disasters identified in the Canadian Disaster Database (CDD), including both natural and manmade disasters.<sup>491</sup> These include Hurricane Igor in Newfoundland in 2010, the 2011 Prairie floods, the 2011 Slave Lake fire, the 2013 Lac-Mégantic rail disaster, the 2013 Southern Alberta floods, the 2013 Toronto urban flood, the 2014 Saskatchewan and Manitoba flooding, the 2016 Fort McMurray wildfire, the 2017 Atlantic Canada telecommunications outage, and the 2017 British Columbia flood and wildfire seasons.<sup>492</sup> Disaster preparedness refers to the capacity to respond to a range of public health threats. In addition to natural disasters, preparedness is crucial for infectious disease outbreaks, such as the COVID-19 pandemic.

The Public Health Agency of Canada (PHAC) acknowledges that before, during and after a disaster, older adults are more vulnerable and more likely to experience adverse outcomes as a result of improper emergency planning, preparation and management, and a lack of training for health care professionals and front-line responders with regards to the special needs of the older population.<sup>493</sup> Research shows that older adults are always disproportionately affected, with people over the age of 60 having the highest death rates of any group during a natural disaster.<sup>494</sup> In 2010, for example, more than half of all deaths from the Quebec heat wave were people aged 75 and older.<sup>495</sup> Case studies from the World Health Organization have shown that in large scale disasters, older adults have higher mortality and morbidity.<sup>496</sup> For example, 71% of deaths during Hurricane Katrina occurred in people over the age of 60.<sup>497</sup> These outcomes have also been linked to the fact that the occurrence of a natural disaster can disrupt access to essential home and community services and have a marked impact on quality of life and independence for older adults. More recently, the COVID-19 pandemic recorded the highest number of deaths and hospitalizations among adults ages 75 years and older.<sup>498,499</sup>

Around 1,280 outbreaks were reported in LTC and retirement homes across Canada, accounting for approximately 80% of all COVID-19 deaths in Canada.<sup>500,501</sup> Age-related challenges such as chronic health conditions, co-morbidities, social isolation, and declines in sensory, cognitive and physical functions are also exacerbated during a disaster and can put older adults at risk of harm.<sup>502,503</sup>

In emergency situations, people often come to rely on their support networks such as family, friends, and neighbours for help. A survey in 2014 conducted by Statistics Canada found that older adults were less likely to have a large support network to turn to in an emergency. While a quarter of people between ages 15 to 34 report having at least 5 people to turn to in an emergency, only 13% of older adults reported having more than 5 people to turn to.<sup>504</sup> A lack of support networks adds to the challenges that older adults may face during a disaster. Emergency preparation and management that includes special consideration for older adults will be important in the face of increasing frequency of crises and disasters, and their greater impact on older people. While the International Federation of the Red Cross (IFRC) released interim guidance for staff and volunteers on working with older adults during the COVID-19 pandemic, older adults and their unpaid caregivers should be provided with easy-to-access information and resources related to emergency preparedness for future pandemics.<sup>505,506,507</sup> The NIA and the Canadian Red Cross will publish 29 evidence-informed expert recommendations to improve disaster preparedness, response and recovery for older adults across Canada in their upcoming 2020 white paper.

## What Are the Issues?

### 1. CURRENT FEDERAL LEGISLATIVE AND REGULATORY FRAMEWORKS DO NOT ADEQUATELY RECOGNIZE THE NEEDS OF OLDER ADULTS, AND DATA COLLECTION IS INSUFFICIENT

Canada's legislative and regulatory frameworks around disaster management are complex. Canada's system of managing emergencies is a bottom-up approach, starting at local levels of government with first responders and local authorities who then request assistance from provincial and territorial governments if required. The provinces and territories can then seek assistance from the federal government if needed. The *Emergency Management Act* is currently the only federal legislation in place addressing emergency planning, it designates roles and responsibilities of federal departments in emergencies and identifies Public Safety Canada as a main coordinating body.<sup>508</sup>

To supplement the *Emergency Management Act*, Canada also has an *Emergency Management Framework* whereby all provincial and territorial governments have agreed upon principles set out in the framework. The framework was revised and approved by federal/provincial/territorial Ministers in 2017. It establishes a common approach for a range of collaborative emergency management initiatives in support of safe and resilient communities.<sup>509</sup>



However, each province and territory has its own emergency management process, and these vary. Neither the federal framework nor the federal legislation contains a clear recognition of the unique needs of older adults in emergency management.

Currently data collection regarding disasters in Canada is managed by Public Safety Canada in the Canadian Disaster Database (CDD). The CDD is a publicly accessible website containing information on disasters since 1990. The database contains information on where and when a disaster has occurred, who was affected and a rough estimate of the cost which could include various government (federal, provincial, territorial) relief and recovery payments, municipal costs, insurance claims, and cost of supplies and assistance provided by non-governmental organizations.<sup>510</sup> While the database does provide information on injuries, evacuation and deaths associated with a disaster, it does not break down data demographically to understand which particular sub-populations are being most impacted and in what areas services may need to be more tailored to better meet the unique needs of communities.<sup>511</sup>

## **2. OLDER ADULTS WITH SENSORY AND PHYSICAL IMPAIRMENTS, CHRONIC HEALTH ISSUES AND DEMENTIA REQUIRE MORE SUPPORT DURING EVACUATION**

There are many challenges experienced in evacuations during emergencies. Many older adults still live in regions or communities with little or no capacity for the provision of routine emergency services, and no system or capacity to locate older people who are unable to be evacuated from the area.<sup>512</sup> In addition to this, older adults may be isolated or housebound, frail, and may have continuing care needs that cannot be easily met during an evacuation putting their health at risk by making evacuation especially difficult.<sup>513</sup>

In particular, older adults with chronic health issues, sensory and/or physical impairments and dementia require more support during evacuation. Impairments in vision and hearing can affect an older adult's ability to effectively perceive an emergency warning or to respond appropriately during a disaster. Older adults with sensory impairments may have difficulty hearing disaster updates, emergency instructions and communicating in noisy environments.<sup>514,515</sup> Individuals with visual or mobility impairments may experience challenges in navigating surroundings and unfamiliar places during evacuation, resulting in a slower response.

For individuals with chronic health issues, power outages can interrupt medical interventions such as the ongoing operation of life support devices and medications that require refrigeration. Evacuation for older adults with dementia can be particularly challenging. There are over half a million Canadians living with dementia with approximately 25,000 new cases diagnosed every year.<sup>516</sup>

**The Alzheimer’s Society of Canada predicts that by 2031, 937,000 Canadians will be living with dementia, which represents a 66% increase from 2018.**<sup>517</sup> Dementia impacts cognitive functions causing decline in memory, and impairment in ability to filter information making it difficult for people with dementia to identify a disaster situation, comply with instructions for disaster preparedness, adapt to changes in routine or environment or follow emergency warnings and instructions.<sup>518</sup> Older adults living with dementia can also experience behavioral problems that may become exacerbated or rapidly deteriorate due to interruption of medication during an emergency.<sup>519</sup> In addition, dementia can be compounded by delirium, whereby there is an onset of a state of confusion resulting in a lack of ability to think clearly, pay attention, and maintain awareness of surroundings.<sup>520</sup>



**The Alzheimer’s Society of Canada predicts that by 2031, 937,000 Canadians will be living with dementia, which represents a 66% increase from 2018**

It is necessary for those who provide care who usually assist individuals with dementia in carrying out activities of daily living (ADLs) to have proper knowledge of emergency management principles and procedures when caring for an individual living with dementia. Those who provide care need to be aware of best practices for mitigating upset feelings, anxiety, wandering, confusion and agitation. Overall, there are many complex health needs prevalent amongst the ageing population that must be considered in emergency management to ensure the safety and wellbeing of this population during a disaster.

### **3. GERIATRIC EDUCATION AND TRAINING FOR HEALTH CARE PROFESSIONALS AND EMERGENCY RESPONSE PERSONNEL ARE NEEDED**

Geriatric education and training in disaster management are also important for health care professionals and emergency management and response personnel. Geriatric training will ensure that health care professionals and emergency response personnel understand the needs of older adults and best practices for assisting older adults with complex needs during a disaster. It is important for health care professionals and first responders to be trained in dealing with cognitive decline and how to mitigate associated impacts, especially in situations where medical records and resources are unavailable.<sup>521</sup>

In a 2012 study assessing the disaster knowledge of nurses working in a nursing home, the participants had no formal disaster planning and response training and scored 28% on average based on their proficiency ratings.<sup>522</sup>

After completing training, however, their proficiency ratings increased to 76% with a majority of participants reporting that they planned to include the training in future workshops and courses for students, colleagues and clients. This study suggests that health care professionals would benefit from geriatric training when caring for older adults in disasters.<sup>523</sup>

In a 2008 report by PHAC, *Building a Global Framework to Address the Needs and Contributions of Older People in Emergencies*, it is outlined that the development of integrated training approaches are needed for emergency managers, responders, service providers, and volunteers to gain a firm understanding of the special needs and capacities of older people.<sup>524</sup> The report recommends that training be built on expertise from the emergency management, health, and gerontology sectors with input from allied agencies and service sectors such as social services, home care, community care, and nursing homes, along with the perspective of older adults as well.<sup>525</sup>

#### **4. CURRENT LICENSING PROCEDURES FOR OUT OF PROVINCE SUPPORT CAUSES DELAYS IN THE AVAILABILITY OF SERVICES FROM HEALTH CARE PROFESSIONALS**

During disasters or emergencies, rapid response and deployment of medical and nursing services personnel is vital and often lifesaving. In Canada, licensing of medical and nursing professionals is provincially and territorially regulated with all 13 jurisdictions having separate licensing requirements and fees.<sup>526</sup> In emergencies, these jurisdictions usually utilize their own medical service personnel resources first; however, if their resources are overwhelmed, out of province or territory resources can be activated through PHAC. PHAC has the mechanisms to call on extra resources, and clear health professionals; however, additional measures can be undertaken to remove licensing procedure barriers that result in the delay in availability of health care professionals to ensure a more rapid response, such as a national licensure process for medical and nursing personnel. To better address this issue in the United States, an Interstate Medical Licensure Compact (IMLC) has been agreed to by 29 states and the District of Columbia<sup>527</sup> while an enhanced Nursing Licensure Compact (eNLC) has been agreed to by 34 states, and 20 states<sup>528</sup> are licensure compact states for emergency management services (EMS) personnel.<sup>529</sup> These help create a voluntary expedited pathway to licensure for qualified physicians, nurses, and EMS personnel who wish to practice in multiple states. These compacts allow them to quickly and easily respond to provide medical and nursing services during disasters in other compact states.

## Evidence-Informed Policy Options

In collaboration with the Canadian Red Cross (CRC), the NIA conducted a systematic review of existing gaps in emergency and disaster preparedness and management efforts for older Canadians. After extensive consultation with experts, the following policy recommendations were made to improve emergency and disaster preparedness and response for older Canadians.

### 1. A NATIONAL ADVISORY COMMITTEE SHOULD BE ESTABLISHED TO INFORM EMERGENCY AND DISASTER PREPAREDNESS STRATEGIES FOR OLDER CANADIANS

The Government of Canada should look for ways to embed a recognition of the needs of older adults and their caregivers in emergency management planning in Canada. It is recommended that a federal advisory committee be created to inform the development of a disaster/emergency preparedness program and strategies for older Canadians at the national level. Federal groups such as Public Safety Canada may also have a role in the management and operation of this committee. The representation of older adults and their caregivers must be included in the committee to ensure the perspectives of older adults are reflected. The committee should work to identify strategies to support emergency preparedness and infection/disease prevention at various levels - older adults and their caregivers, community-based services and programs, care institutions, provinces and territorial governments. This work could be supported by enhancing current data collection procedures that feed into the Canadian Disaster Database (CDD) to collect more demographic information, which would enable a better understanding of which particular sub-populations are being most impacted to better inform what areas services may need to be more tailored to better meet the unique needs of communities.

### 2. PROVINCIAL AND TERRITORIAL GOVERNMENTS SHOULD REQUIRE CONGREGATE LIVING ENVIRONMENTS SUCH AS NURSING HOMES, ASSISTED LIVING FACILITIES, AND RETIREMENT HOMES TO REGULARLY UPDATE AND REPORT THEIR EMERGENCY PLANS

Current rules and regulations around emergency and contingency plans differ across the country. It is recommended that all provinces and territories create and enforce legislation that will mandate congregate living spaces for older adults to regularly update and report their emergency and contingency plans in the event of an emergency or disaster in accordance with Public Safety Canada's 2019 Report *Emergency Management Strategy for Canada: Toward a Resilient 2030*.<sup>530</sup> Consultation with experts on this issue concluded that the plans should include the provision of backup generators in the event of power outages and coordinated plans with relevant community agencies in the event that an evacuation is required. While in Ontario, the 2017 *Long-Term Care Homes Act*<sup>531</sup> mandated all nursing homes to have air conditioning and backup generators to provide power for all support and life-supporting equipment in the case of an emergency, not all provinces and territories have included this in their legislation.

Care institutions and other organizations should strive to develop comprehensive emergency plans that include effective response strategies for protecting older adults against communicable disease outbreaks and reflect evidence-based standards supported by organizations such as Infection Prevention and Control Canada (IPAC).<sup>532,533,534,535</sup> To ensure effective pandemic response, community-based programs that provide in-home health and personal care for older adults should integrate strategies that minimize unnecessary personal contact and leverage resources (e.g. personal protective equipment such as gowns, masks, gloves, hand sanitizer etc.) in their emergency preparedness plans and protocols.<sup>536,537,538</sup> An outline of staffing levels that should be maintained during emergencies to minimize care and/or service interruptions. Care institutions should also regularly assess and address any barriers they identify that could affect the implementation of their emergency plans that build on their routine practices.<sup>539,540</sup> All provinces and territories should work towards standardizing requirements for emergency plans in congregate living settings and ensure the requirements are aligned with directives outlined in their provincial/territorial pandemic and emergency plans.

### **3. PROVINCES AND TERRITORIES SHOULD SUPPORT THE CREATION OF A NATIONAL LICENSURE PROCESS FOR PHYSICIANS, NURSES, ALLIED HEALTH PROFESSIONALS, AND OTHER EMERGENCY MEDICAL SERVICE PERSONNEL TO ALLOW THEM TO EASILY PROVIDE VOLUNTARY EMERGENCY MEDICAL SUPPORT ACROSS JURISDICTIONS DURING DECLARED STATES OF EMERGENCY**

In order to create more rapid response to emergencies where extra resources and out of province health professionals maybe required, it is recommended that all provinces and territories support the creation of a national licensure process or program for nurses, physicians, and other emergency medical service personnel who want to volunteer to allow them to provide emergency medical support across provincial/territorial boundaries during declared states of emergencies.

In response to infectious disease outbreaks, Health care providers and emergency management and response personnel should receive training on providing geriatric care relevant to their discipline and how best to assist older adults and their unpaid caregivers before, during, and after disasters emergencies. The additional education and training should also increase their awareness of best practices and precautions to minimize the risk of infectious disease transmission or spread while responding to emergencies.<sup>541,542,543,544,545,546,547</sup>

# Support for Caregivers



## SECTION 4

# Support for Caregivers

## Ensuring that the family and friends of older Canadians who provide unpaid care for their loved ones are acknowledged and Supported

The family and friends of older Canadians continue to provide the majority of care in our society. With the rising number of older Canadians who will develop chronic health conditions, including dementia, more older adults will need the support of others to remain as healthy and independent as possible in their communities. Unpaid caregivers provided approximately \$9 billion worth of care in 2019, which is expected to increase to \$27 billion by 2050<sup>548</sup> (see Box 7 for the definition of unpaid caregivers<sup>549,550</sup>). The continued dedication and contribution of caregivers provides a greater level of care and independent living options for older people. However, unpaid caregivers face an enormous toll on their personal health, well-being, and finances. Their commitment to caregiving also significantly impacts Canada's economic productivity.

Providing appropriate support and recognition to meet the needs of current and future unpaid caregivers will not only keep Canada's health care systems more sustainable, it will also ensure that our national economic productivity can be improved and strengthened.



### Box 7. NIA Caregivers Definitions

The NIA has adopted the Change Foundation definition of **'caregivers'** as 'the people - family, friends, and neighbours - who provide critical and ongoing personal, social, psychological and physical support, assistance and care, without pay, for loved ones in need of support due to frailty, illness, degenerative disease, physical/ cognitive/mental disability of end-of-life circumstances'.

The NIA also pairs the term **'caregiver'** with **'unpaid'** as Stall et al. 2019 helped to determine this pairing of words is most preferred by those providing unpaid care. Stall et al. 2019 also note that the term **'informal'** caregiver should be avoided as many unpaid caregivers may find this term insulting and invalidating.

When referring to a caregiver who is paid for their services, the NIA uses the term **'care provider'**.

The federal government can work with Canada's provinces, territories to enable this pillar and associated activities in a variety of ways



- **Ensuring Canadian employers are informed about, and have access to, the tools that can help them better support the growing ranks of unpaid caregivers will enhance the overall economic productivity. Recognizing employers who excel in supporting unpaid caregivers can further bring positive attention to this important issue.**



- **Ensuring Canadian unpaid caregivers are not unnecessarily penalized financially for taking on caregiving roles can be further supported through enhanced job protection measures, caregiver tax credits, and new Canada Pension Plan (CPP)/ Quebec Pension Plan (QPP) contribution allowances that all have good evidence to support their broad implementation nationally.**



# Ensuring Canadian Employers Are Informed About and Have Access to the Tools That Can Help Them Better Support Unpaid Caregivers and Older Adults in the Workforce

## Setting the Context

The past decade has seen a steady increase in the number of older Canadians participating in the workforce, especially since mandatory retirement was formally repealed in 2012. In 2001, approximately 12% of individuals 65-69 were participating in the Canadian workforce – a number that more than doubled to nearly 26% in 2013.<sup>551</sup> By 2015, one in five Canadians (1.1 million) aged 65 and over reported working that year, the highest proportion recorded since 1981.<sup>552</sup>

Supporting the participation of older Canadians in the workforce derives many benefits for Canada as whole, including stemming the premature loss of experienced, skilled and knowledgeable workers; further supporting intergenerational knowledge exchange; and driving the overall economic productivity of the country. Indeed, from a macroeconomic perspective, the continued and sustained participation of older Canadians in the workforce beyond the traditional age of retirement may go some way to curtail some of the negative predicted economic effects of a rapidly growing cohort of ‘baby boomers’ who are getting set to retire.<sup>553</sup>

Many common reasons why employers report not considering older Canadians in the workforce have been found to be based solely on myths related to ageing. Specifically, associations of age and overall productivity and cost-effectiveness of older workers; the receptivity of older adults to working in new or challenging environments; and the ability to train older workers in new skills.<sup>554</sup> The federal government has recognized the importance of supporting both employers and older adults who wish to remain in the workforce by collating materials to support both parties in the creation of more ‘age-friendly workplaces’ (visit [www.seniors.gc.ca](http://www.seniors.gc.ca) for more information). Beyond addressing common workplace myths that surround older workers, encouraging and supporting the participation of older Canadians in the workforce recognizes the need for other practical measures like creating more flexible working schedules or adapting physical work environments to accommodate physical or sensory limitations that may be present as well.

While an ageing workforce requires and benefits from special supports to ensure success, a growing number of working Canadians – who are ageing themselves – are also trying to balance unpaid caregiving duties with their work commitments. In fact, it is currently estimated that between 35%-60%<sup>555,556</sup> of the Canadian workforce or at least **six million working Canadians are currently juggling unpaid caregiving with their employment duties.**<sup>557</sup>

Despite the economic importance of their continued participation in the workforce, unpaid caregivers often end up earning less and foregoing advancements in their own careers than others without these additional responsibilities. According to the Carers Canada, 15% of unpaid caregivers reduce their work hours, 40% miss days of work, 26% take a leave of absence, 10% turn down job opportunities, and 6% eventually quit their jobs.<sup>558</sup> While the cost to unpaid caregivers includes lost wages, and decreased retirement income, 19% further report that their physical and emotional health suffers as well.

For Canadian employers, productivity losses become substantial, with estimates totalling a **loss of 18 million work days per year due to missed days and increased employee turnover.**<sup>559</sup> Indeed, it is estimated that the cost to the Canadian economy from lost productivity **due to caregiving responsibilities is \$1.3 billion per year.**<sup>560</sup>

Finding ways to better accommodate the needs of older Canadians including those who may be balancing unpaid caregiving duties can result not only in improved workplace productivity, and reduced employee turnover, but an opportunity to retain highly skilled older workers whose experience and expertise are highly appreciated in the Canadian workforce.<sup>561</sup>

There are many employer-led workplace practices that can be leveraged to support older workers and specifically unpaid caregivers (see Table 11). While workplaces that are more conducive to older workers and helping those managing the work-care balance do exist, many still require employees to choose flexible work environments in exchange for less advantageous conditions or salaries.<sup>562</sup> Ensuring that conditions and salaries are supportive of both workplace performance and unpaid caregiving roles needs to be better addressed.

**Table 11. Inventory of Employer-led Flexible Workplace Practices that Support Employed, Unpaid Caregivers<sup>563</sup>**

<b>Paid and Unpaid Leave Practices</b>	
<b>EMERGENCY CAREGIVING LEAVE</b>	Employees can request up to five days paid leave to care for a family member or friend
	Employees can request up to five days paid leave for emergencies which could be health related but not for chronic health issues
<b>COMBINATION OF LEAVE</b>	Employees can request to use a combination of leave (personal/family, vacation or sick leave) to help care for a family member or friend
<b>PERSONAL/FAMILY LEAVE</b>	Policies vary within organizations (federally vs non-federally regulated employers). Non-federally regulated employment standards vary by jurisdictional legislation
	Non-federally regulated employees receive a range of 0 to 12 days per year. Some employers combine personal/family leave with sick leave
	Employees have three floating days (additional paid leave)
<b>SICK LEAVE</b>	Policies vary within organizations (federally vs non-federally regulated employers). Non-federally regulated employment standards vary by jurisdictional legislation
	Non-federally regulated employees are provided with a range of sick leave from one day to 26 weeks
	Employees may request to use sick leave for family illnesses
	Self-insured medical leave where employees accumulate sick leave credits that they can use when they are ill or injured or in some cases to care for a gravely ill family member or a critically ill child
	Unlimited sick leave
<b>VACATION TIME</b>	Policies vary within organizations (federally vs non-federally regulated employers). Non-federally regulated employment standards vary by jurisdictional legislation
	Employees may purchase additional vacation time (up to a maximum number of weeks)
	Ability for employees to take leave in hours rather than full days (e.g. two weeks' vacation made available in hours over an eight-month period)
<b>BANK OF LEAVE</b>	Employees who have exhausted his or her available paid leave can establish a leave bank under which a contributing employee can donate leave to the bank and recipient employees' draw leave to cover time out of the office due to a personal or family medical emergency

<b>BEREAVEMENT</b>	<p>Policies vary within organizations (federally vs non-federally regulated employers). Non-federally regulated employment standards vary by jurisdictional legislation</p> <p>Employees may receive a minimum of three to seven days of leave following the death of a family member. Some employers provide a combination of paid and unpaid leave</p>
<b>COMPASSIONATE CARE BENEFITS</b>	<p>Under the federal Compassionate Care Benefits, employees could have up to 26 weeks of Employment Insurance benefits up to 55% of income, to maximum of \$573 weekly, when a family member who requires end-of-life<sup>564</sup></p> <p>Employers may provide a top-up benefit for employees bringing their salary back to their full salary levels for part or all of the leave</p>
<b>LEAVE TO ARRANGE CARE</b>	<p>Employees may take up to three days paid leave to make arrangements for care</p>
<b>LEAVE WITH INCOME-AVERAGING</b>	<p>Employee may request to take leave without pay for a period of a minimum of five weeks and a maximum of three months</p> <p>Employee's salary is reduced over a 12-month period</p>
<b>LEAVE WITHOUT PAY</b>	<p>Employees may take up to 12 months of leave without pay. This type of leave can be used for both short and long-term leave</p> <p>Arrangements between employers and staff are discretionary</p>
<b>FAMILY CAREGIVER BENEFIT</b>	<p>The federal Family Caregiver Benefit for adults provides employees up to 15 weeks of Employment Insurance benefits up to 55% of income, to maximum of \$573 weekly, to provide care or support to a family member with a serious medical condition<sup>565</sup></p>
<b>FLEXIBLE WORKPLACE ARRANGEMENTS</b>	
<b>ANNUALIZED HOURS</b>	<p>Allows employees to choose (within boundaries) their days and hours of work for a set period of time</p> <p>The period of time could be weekly (e.g. work 12 hours for three days and two hours for two days); or monthly (e.g. 60 hours one week and 20 hours the next week)</p> <p>This may be ideal for employers with peak hours or seasonal peaks</p>
<b>COMPRESSED WORK WEEKS/BANKING OF HOURS</b>	<p>Employee works for longer periods per day in exchange for a day off</p> <p>Employees may start earlier or finish later than the normal work day</p> <p>Common arrangements for 40 hours per week could include working an extra hour per day in exchange for one day off every two weeks</p>
<b>FLEXIBLE WORK LOCATIONS</b>	<p>Employees can be transferred to alternate locations across the country and in some cases internationally (depending on the organization)</p> <p>Allows employees to choose their work location or choose to work off-site (e.g. from home)</p>

<b>FLEX-TIME SCHEDULE / FLEXIBLE HOURS/BREAKS</b>	Employees work a full day but they set a range of start and finish times with their manager. Total hours of work per week are not affected
	Allows manager to establish core hours where all employees will be at work (e.g. 9:30 am – 3:30 pm)
	Employers provide flexible breaks where employees can undertake care responsibilities during their lunch hour. Provide preferred parking spaces for caregivers who are caring for a parent or child who are in critical condition and who may need to leave work urgently
	Employees do not need to take formal leave but can make up the time off required another day (e.g. if an employee needs to leave for an hour during the day, they can stay 30 minutes extra over the next two days)
	Employers can offer their employees different options for their work assignments (e.g. a truck driver who works long distances could temporarily move to shorter routes to allow him or her to be closer to home)
<b>JOB SHARING</b>	Allows two or more people to share one or more positions or duties
	Job sharing must work effectively for the team and expectations around pay, benefits and holidays must be well-communicated
	This is an option for employers who do not have many part-time positions available
<b>NO SET SCHEDULE</b>	Have colleagues assigned as “back-ups” to files when an employee has caregiving responsibilities and who might need to be absent for a longer period of time.
	Allows employees to work the hours they choose, no questions asked, as long as work deadlines are met
<b>PART-TIME/REDUCED HOURS</b>	Employees can choose to work less than 37.5 or 40 hours per week
	Arrangements can be on a permanent or temporary basis
	Hours can be negotiated between employer and employee to ensure coverage at peak workload hours
<b>PHASED RETIREMENT</b>	Employees may reduce their working hours or workload over a period of time leading to full retirement
	Pension legislation allows for partial pension benefits to commence with formal phased retirement
	Phased approach could be used to train the replacement employee or adjust the redistribution of work among remaining employees

<b>SHIFT-WORK</b>	<p>Employees can work a type of shift-work schedule where a person's work day is split into two or more parts (e.g. employee can start at 4:00 am, provide care responsibilities during the day and do a second shift at night). Employees who work split shifts need to manage their schedule so that they don't get burned out (especially if they are providing care during the day)</p> <p>In some cases where spouses work at the same company, they can stagger their shifts for one spouse to provide care while the other is working</p> <p>Employees can change their work shifts (e.g. can switch from a night shift to a day shift or exchange a Monday shift to Tuesday)</p>
<b>TECHNOLOGY</b>	
<b>TELEWORK/ TELECOMMUTING</b>	<p>Allows employees to do some of the regular work from home instead of going into the office</p> <p>Employer and employees need to establish details such as hours of work, communications between teleworker, co-workers and clients</p> <p>Dependent on employee's roles and responsibilities</p>
<b>TOOLS/DEVICES (HARDWARE)</b>	<p>Depending on employees' roles and responsibilities, employers provide access to technology to enable them to work outside the office include hardware such as a laptop (with remote access), smart phone, tablet, teleconference/ videoconference capabilities</p> <p>In special circumstances, allow employees to have their cell phone close by while they are working in case of emergency (e.g. for employees who do not have direct access to a work phone)</p> <p>Loaner equipment available for employee use (e.g. smart phone, laptop, tablet, etc.)</p> <p>Establish policies around technology such as "technology free-time" or "smart phone free-zone" to allow employees to focus on work/home priorities (e.g. no answering emails from 6:00 pm to 6:00 am)</p>
<b>TOOLS/DEVICES (SOFTWARE)</b>	<p>Web application that enables collaborative work (e.g. sharing of documents, access to intranet portals, document and file management, social networks, extranets, websites, enterprise search and business intelligence)</p> <p>Instant messaging software to allow employees to connect with colleagues regardless of their work location</p> <p>Ability to work from home through an internet platform that allows employees access to their work emails without being connected to the network (e.g. from home through a virtual private network). Provide access to a secure channel to access work emails from employee's mobile device (smart phone or tablet)</p>

	<p>Employees on shift-work can take advantage of scheduling software that allows employees to log-in to an online account to view and amend their schedule from home. This scheduling software also takes into consideration other variables such as vacations, leaves, etc. Provide employees with online access to HR policies, services, collective agreements, etc.</p> <p>Blogs/chat programs to stay connected</p> <p>Applications with EAP information</p> <p>Email notifications, online calendar to indicate regular hours and planned absences of employees</p>
<b>OTHER PROGRAMS AND SERVICES</b>	
<b>EMPLOYEE AND FAMILY ASSISTANCE PROGRAM</b>	Offerings vary by provider but can include referral services for community care options as well as counselling for the employee and/or their immediate family
<b>EMERGENCY ELDER CARE</b>	<p>Some employers offer emergency elder care (similar to emergency child care) at minimal cost to the employee (employers cover the cost up to a maximum amount per year)</p> <p>Back-up care is provided as an alternative when regular care is not available</p>
<b>ONSITE SEMINARS/ LUNCH AND LEARNS</b>	Varies by employer, but can include internal or external speakers discussing various aspects of caregiving such as community services available or the health of the care provider
<b>ONLINE NETWORKS/ APPLICATIONS</b>	<p>Online tools that help caregivers access information on programs and services available and connect them to existing networks</p> <p>Health application (and general phone line) that directs users to medical and community supports as well as providing user health assessments and general information</p> <p>Also provides information to employers via plan administrators such as a snapshot on the health of their workforce</p>
<b>SUITE OF BENEFITS/ CAFETERIA-STYLE PLANS</b>	Web-based benefits platforms that connect employees to a menu of services and allow them to manage their own selections that are tailored to their needs and unique situation; similar to the ability of a customer to choose among available items in a cafeteria

## What Are the Issues?

### 1. UNPAID CAREGIVERS REMAIN LARGELY INVISIBLE AND THEIR ROLE IS INADEQUATELY RECOGNIZED

Increasingly, older Canadians are participating in the workforce beyond the traditional age of retirement. Employers, however, have been slow or unsure around how best to accommodate the needs of older workers with policies and practices to support their overall productivity in the workforce. This lack of support often results in premature or forced workforce exit, or early retirement.<sup>566</sup> While there are many recommendations set out by the National Seniors Council for the support of older adults in the workplace<sup>567</sup>, supporting older working Canadians who are doubly disadvantaged with unpaid caregiving duties must be particularly recognized. Comprehensive evidence supports that unpaid caregivers are at increased risk of negative psychological, social, and health outcomes due to the burden of balancing their work-care responsibilities.<sup>568,569</sup> It follows that the benefits of paid employment also go beyond providing income and also plays a large role in providing opportunities for unpaid caregivers to obtain a form of respite for themselves, to belong to a social network, and to experience personal fulfillment.<sup>570</sup> Rigid work environments which do not recognize that work-care balance is essential to caregiver wellbeing – and hence continued work-care participation – are therefore neglecting benefits of employment for Canadians beyond merely providing incomes.

### 2. LACK OF SUPPORT FOR UNPAID CAREGIVERS AFFECTS BOTH CANADIANS AND ECONOMIC PRODUCTIVITY

Unpaid caregivers forego salary and workplace advancement in order to maintain their caregiving duties. It is well-documented that unpaid caregivers often have lower annual incomes, forego career advancement opportunities and take early or involuntary retirement due to their caregiving roles compared to non-caregiving counterparts.<sup>571,572,573</sup> While this in and of itself is an issue, lower wages and slowed career advancement are compounded by the potential for caregiving responsibilities to present significant out-of-pocket costs to unpaid caregivers.<sup>574</sup> A 2017 CIBC report found that on average a caregiver will spend \$3,300 per year on out-of-pocket costs.<sup>575</sup> Taken together, reduced disposable income also impacts the ability of unpaid caregivers to save for their own eventual retirement. A lack in their own ability to save will eventually result in a heavier reliance on federal and provincial benefits programs which will in turn be under-supported due to reduced extended health and other benefit contributions usually contributed to over the course of a career.<sup>576</sup> In addition to this, the failure to balance caregiving and work can increase absenteeism and decrease workplace productivity.<sup>577</sup> Unpaid caregivers report higher rates of reduced/restricted work hours, feeling distracted, passing up promotions, and early retirement.<sup>578</sup> It is clear that it is in the best interest of both governments, employers, and the Canadian economy to help support unpaid caregivers for as long as possible to ensure they do not feel disenfranchised and can continue to participate in the workforce to the best of their abilities for as long as they wish.



### 3. CANADIAN EMPLOYERS LACK CLEAR GUIDANCE ON HOW TO SUPPORT OLDER WORKERS AND UNPAID CAREGIVERS

The 2015 federally sponsored *Employer Panel for Caregivers Report* acknowledged that Canadian employers indicate a clear lack of knowledge around how best to support older Canadians and unpaid caregivers in the workplace.<sup>579</sup> Participants indicated that the main barriers for employers in providing support for unpaid caregivers include: lack of awareness, the nature of certain jobs, and a lack of leadership and support to advance best practices and supports.<sup>580</sup>

A lack of communication among employers and employees was also considered among the major barriers to supporting unpaid caregivers. Fostering a workplace culture that views older workers and caregiving positively must include providing clear information about employer guidelines, policies, sources of information on best practices to support older workers, caregiver benefits available, and leadership and training opportunities which encourage flexible work environments. There are some resources available to organizations as guides to creating more accommodating workplaces for unpaid caregivers. In 2017, the Standards Council of Canada produced CSA B701-17: Carer-Inclusive and Accommodating Organizations, a standard that specifies organizational requirements to support working unpaid carers providing long-term care to adult and child care recipients.<sup>581</sup>

## Evidence-Informed Policy Options

### 1. PROVINCIAL, TERRITORIAL AND FEDERAL GOVERNMENTS SHOULD FORMALLY RECOGNIZE UNPAID CAREGIVERS WITH A COMMON DEFINITION THAT ACKNOWLEDGES THEIR ROLE AND PROVIDES THE FOUNDATION FOR MORE FORMALIZED SUPPORT

Currently, there is a need for a common definition in legislation that recognizes or acknowledges the role of unpaid caregivers in Canada. The lack of a common definition critically hampers the ability to adequately address the needs of unpaid caregivers. Canadian governments and employers are addressing issues related to unpaid caregivers in a piecemeal approach as a result. Formally recognizing unpaid caregivers with a common definition not only recognizes their role and value in the provision of services and supports but also allows for their needs to be addressed by supporting workers' rights and improved delivery of health and social services. There is precedent for such a move in Canada with Manitoba enacting, *The Caregiver Recognition Act*, in 2011. The Act provides a clear definition of an unpaid caregiver, which guides the provincial government when implementing, providing, or evaluating any type of unpaid caregiver supports.<sup>582</sup>

In Canada, the majority of the available financial assistance, including the new Canada Caregiver Credit introduced in 2017, and various work leave allowances for unpaid caregivers are allotted to 'family' caregivers. For example, job-protected and compassionate leave only applies to family members of individuals. Additionally, the definition of a family member in the context of unpaid caregivers and care recipient varies by province and by benefit or work leave allowance.

Specifically, inclusion of extended family members (aunts, uncles, cousins, spousal parents or grandparents) or other dependents often require separate or alternate applications for benefits, while the recognition of friends and neighbours who are increasingly taking on caregiving roles is seldom acknowledged either.

Federal leadership around revising and standardizing the definitions of ‘caregivers’ – be they family, friends or neighbours – and ‘dependents,’ be they relatives or not, would support and recognize the increasingly changing nature of caregiver and care recipient relationships in Canada. Amendments to existing policies, that could also support the streamlining of existing assistance application processes, would likely encourage more individuals to take on and feel supported in caregiving roles regardless of a direct family relationship to a care recipient.

## 2. CREATING NATIONAL STANDARDS OR A FRAMEWORK TO SUPPORT MORE FLEXIBLE WORKING ENVIRONMENTS FOR OLDER WORKERS AND UNPAID CAREGIVERS

Addressing inequities among older workers and unpaid caregivers is an issue that must be supported by both the federal and provincial/territorial governments and Canadian employers themselves. As expressed by Canadian employers in the 2015 Employer Panel for Caregivers<sup>583</sup>, guidance is needed to successfully support unpaid caregivers in the workforce. The federal government is in a position to support the creation of national standards for workplace inclusivity/participation of older workers and unpaid caregivers. In addition to the many recommendations set out by the National Seniors Council for the support of older adults in the workplace<sup>584</sup>, the federal government should consider advancing those along with the recommendations made within the 2015 *Employer Panel for Caregivers Report* using the latter’s framework for positive action:

- **Developing Standards for Assessing the Needs of Older Employees** – Doing so will better support employers to address the knowledge gap between Canadian employers and older employees around how best to support them in the workplace.
- **Engaging Employers to Consider the Organizational and Employee Benefits of Supporting Older Workers and Unpaid Caregivers** – Helping employers understand the business case for supporting older workers and unpaid caregivers in the workforce (e.g. potential cost savings, recruitment and retention etc.) can better encourage and spur activity in this area.
- **Supporting the Understanding of Current and Needed Resources** – Allows access to necessary information about company policies and guidelines around supporting older workers and unpaid caregivers to be addressed but also enables the identification of existing gaps in support.

- **Leading and Managing** – Encourages the need for leadership training and education to foster an ‘age-friendly’ workplace environment that positively views older workers and caregiving responsibilities.
- **Encouraging Flexible Approaches to Supporting Older Workers and Unpaid Caregivers** – Acknowledges that not all employee caregiving responsibilities and the needs amongst older workers look the same and that each may require unique ways of addressing identified needs (e.g. making physical adaptations to a workplace, providing support for acute vs. episodic care duties).

### 3. FEDERAL RECOGNITION OF EMPLOYERS WITH BEST PRACTICES FOR ENGAGING AND SUPPORTING OLDER WORKERS AND UNPAID CAREGIVERS

Many Canadians are familiar with ranking lists of top Canadian employers. Since 2010, *Canada’s Top 100 Employers* recognition program has held its competition for *Top Employers for Canadians Over 40* which celebrates employers who excel in eight evaluation criteria, namely whether:

1. They offer interesting programs designed to assist older workers;
2. They actively recruit new workers aged 40 years or older;
3. Their HR policies consider the unique concerns of older workers, such as by recognizing work experience at previous employers in determining vacation entitlement;
4. They offer a pension plan with reasonable employer contributions;
5. They assist older employees with retirement and succession planning;
6. They create opportunities for retirees to stay socially connected to former co-workers through organized social activities and volunteering;
7. They extend health coverage and similar benefits to employees after retirement; and
8. They offer any programs, such as mentorship and phased-in retirement, to ease the emotional challenges of retirement and ensure older employees’ skills are transferred to the next generation.

This and other types of public recognition programs should be leveraged to heighten the profile of employers who excel at supporting older Canadians and unpaid caregivers and to celebrate and spread knowledge and uptake of best practices that enable older workers and unpaid caregivers in the workplaces.<sup>585</sup> Engaging the federal, provincial and territorial governments in these activities will further advance overall economic productivity and the ability of employers to maintain a competitive advantage around the recruitment and retention of experienced and skilled older workers.

# Ensuring Unpaid Caregivers Are Not Unnecessarily Financially Penalized for Taking on Caregiving Roles

## Setting the Context

Canada's unpaid caregivers play a vital role in supporting older Canadians and their desire and ability to age in their place of choice. While caregiving can be personally rewarding, it can also be stressful and expensive. As the number of older Canadians continue to increase, so too will the need for and numbers of unpaid caregivers and the demands placed on them. Statistics Canada recently estimated that **8.1 million Canadians over the age of 15** are serving as unpaid caregivers to family or friends; with age-related health problems being one of the most significant drivers of caregiving needs.<sup>586</sup>



**8.1 million Canadians over the age of 15 are serving as unpaid caregivers to family or friends; with age-related health problems being one of the most significant drivers of caregiving needs.**

While the number of older Canadians requiring the support of unpaid caregivers projected to more than double by 2050<sup>587</sup>, recent projections show there will be 30% fewer close family members – namely, spouses, adult children – who would potentially be available to provide unpaid care.<sup>588</sup> Unpaid caregivers will need to increase their efforts by an average of 40% to keep up with care needs, on account of fewer children per senior.<sup>589</sup> This will also result in the majority of working Canadians over the age of 45 playing unpaid caregiving roles as well. Despite the economic importance of their continued participation in the workforce, unpaid caregivers often end up earning less and foregoing advancements in their own careers than others without these additional responsibilities. According to Carers Canada, 15% of unpaid caregivers reduce their work hours, 40% miss days of work, 26% take a leave of absence, 10% turn down job opportunities, and 6% eventually quit their jobs. While the cost to unpaid caregivers includes lost wages, and decreased retirement income, 19% further report that their physical and emotional health suffers as well. For employers, the productivity losses to them become enormous with the loss of 18 million work days per year, due to missed days and increased employee turnover. Indeed, it is estimated that the cost to the Canadian economy from lost productivity is 1.3 billion per year.

Unpaid caregivers also play a vital role in ensuring the overall sustainability of the health systems by providing alternatives to costly and publicly funded facility-based care by often supplementing the care available through the limited publicly funded home and community care systems. It is currently estimated that nationally, unpaid caregivers provided approximately \$9 billion of care in 2019, and this number is estimated to rise to \$27 billion by 2050.<sup>590</sup>

## What Are the Issues?

### 1. ACCESS TO EXISTING FINANCIAL AND OTHER SUPPORTS FOR UNPAID CAREGIVERS VARIES SIGNIFICANTLY ACROSS CANADA

In 2013, a study found that only 14% of unpaid spousal caregivers, and 5% of unpaid caregivers to their parents reported receiving any government financial assistance.<sup>591</sup> These low assistance rates had been attributed to a variety of issues including a general lack of awareness of available supports and how to easily access them; the requirements to qualify for financial assistance being overly restrictive when some programs disqualified spousal partners, neighbours or friends serving as unpaid caregivers or those not living with the care recipient from accessing assistance.

Meanwhile, there exists a growing body of evidence that demonstrates that financial support for unpaid caregivers can **reduce the probability that their dependents will be admitted to a nursing home by 56%**.<sup>592</sup> With a growing recognition of their overall importance, **93.8%** of Canadians have indicated their support for a greater federal involvement in improving financial assistance available for unpaid caregivers who support ageing relatives and friends.<sup>593</sup>

Currently, both the federal (See Table 12) as well as provincial and territorial governments (See Table 13) in Canada provide a variety of financial and other supports for unpaid caregivers, although the levels of support and eligibility criteria are not standardized across Canada. Some provinces offer tax credits for unpaid caregivers that are refundable while most Canadian jurisdictions and the federal government only offer non-refundable tax credits that are treated as income. However, to claim a non-refundable credit, individuals must be employed and/or earning a sufficient income through other sources to claim this credit as a deduction.

While commitments to unpaid caregivers were made in Budget 2015, there was criticism that they failed to target those unpaid caregivers who are most in need of support. For example, the federal government announced the creation of a new tax-free Family Caregiver Relief Benefit for unpaid caregivers of veterans. While this was a welcome development, veterans are among the best financially supported older adults in Canada.<sup>594</sup>

Progress came in Budget 2017, when the federal government established a new, more accessible Canada Caregiver Credit - replacing three less effective caregiver tax credits<sup>595</sup>, as well as a new EI-based Family Caregiver Benefit and an enhanced EI-based Compassionate Care Benefit. The newly created EI-based Family Caregiver Benefit that would support unpaid family caregivers

with up to 15 weeks of Employment Insurance (EI) benefits when taking time off to care for a relative with an acute illness. Interestingly, provincially and territorial job-protected family caregiver leave currently ranges between eight to 28 weeks across Canada. Finally, Budget 2017 announced that the EI-based Compassionate Care Benefit would be extended from six weeks to 26 weeks when taking time off to care for a relative with end-of-life care needs.<sup>596</sup> This is a welcomed move and a step in the right direction, however there is a need to further simplify the process around other credits that exist to increase access to financial support. Much criticism remains, however, around the new Canada Caregiver Credit as it neglects to consider the increasing unpaid caregiving contributions of non-relative friends and neighbours to better meet the needs of other Canadians, and the tax credit remains a non-refundable credit which still does little to support low-income unpaid caregivers.

In addition to financial supports, respite services are understood to be very important to support the health and well-being of unpaid caregivers. Coverage for respite services across Canada, however, varies widely. Many provinces use an individual's income or income plus assets to assess eligibility of home-based respite services with a proportion of costs to be shared by families; namely, Nova Scotia, New Brunswick, Saskatchewan, and British Columbia. Provinces and territories where no direct costs are incurred by the user for home-based respite care include Ontario, Quebec, Alberta, Manitoba, Prince Edward Island, Newfoundland & Labrador, Yukon, Northwest Territories, Nunavut, as well as First Nations and Inuit Health Branch programs.<sup>597</sup>

Finally, some provinces have additionally recognized unpaid caregivers through the creation of specific legislation and granting programs, such as Manitoba and Nova Scotia respectively.<sup>598</sup> Manitoba's legislation is particularly noteworthy as it provides the most inclusive definition of a caregiver, specifically recognizing the important role that friends and neighbours often play in caring for others.<sup>599</sup>

**Table 12. Federally Available Financial Supports for Unpaid Caregivers and their Eligibility Criteria**

CREDIT	CRITERIA
<b>CANADA CAREGIVER CREDIT<sup>600</sup></b>	<p><i>Eligible Claim:</i> Provides up to \$7,140 (unless the dependent’s net income is above \$23,906) in assistance related to the care of dependent relatives – parents, brothers, sisters, adult children, and other specific relatives. It also provides up to \$2,230 (unless the dependent’s net income is above \$23,906) in total for care of a dependent spouse/ common-law partner or minor child. When the dependent’s net income is over \$23,906, the credit is reduced and indexed to inflation.</p> <p><b>*Non-refundable</b></p>
<b>FAMILY CAREGIVER BENEFIT FOR ADULTS<sup>601</sup> (EMPLOYMENT INSURANCE BENEFIT)</b>	<p><i>Eligible Claim:</i> <b>Maximum of 15 weeks</b> of benefits payable to eligible individuals. Payable to those temporarily away from work to care for or support a family member who is critically ill or injured, defined as someone whose baseline state of health has changed significantly and need the care or support of at least one caregiver. If the person is already living with a chronic medical condition, caregivers are not eligible for benefits unless the person’s health changes significantly because of a new and acute life-threatening event.</p> <p>Must be able to demonstrate that normal weekly earnings have decreased by more than 40% and that the claimant has accumulated 600 hrs of work in the last 52 weeks (or since last claim).</p> <p><b>(NB:</b> A family member includes immediate family as well as other relatives and individuals considered to be like family, whether or not related by marriage, common-law partnership, or any legal parent-child relationship)</p>
<b>COMPASSIONATE CARE BENEFITS<sup>602</sup> (EMPLOYMENT INSURANCE BENEFIT)</b>	<p><i>Eligible Claim:</i> <b>Maximum of 26 weeks</b> of benefits payable to eligible individuals. Payable to those temporarily away from work to care for or support a <u>family member</u> who has a serious medical condition with a significant risk of death within 26 weeks (6 months). The person also requires the care or support of at least 1 caregiver.</p> <p>Must be able to demonstrate that normal weekly earnings have decreased by more than 40% and that the claimant has accumulated 600 hrs of work in the last 52 weeks (or since last claim).</p> <p><b>(NB:</b> A family member includes immediate family as well as other relatives and individuals considered to be like family, whether or not related by marriage, common-law partnership, or any legal parent-child relationship.)</p>
<b>MEDICAL EXPENSE TAX CREDIT<sup>603</sup></b>	<p><i>Eligible Claim:</i> expenses that <b>exceed</b> the lesser of either <b>3%</b> or taxpayer’s net income OR <b>\$2,352</b></p> <p>Applicable to medical expenses for individuals, spouses or common-law partners, and dependents (children, grandchildren, parents, grandparents, brothers, sisters, uncles, aunts, nephews, or nieces who lived in Canada at any time in the year)</p> <p><b>*Non-refundable</b></p>

**Table 13. Provincial/Territory Available Supports for Unpaid Caregivers and their Eligibility Criteria:**

Province or Territory	Job Protected Compassionate Care Leave	Funded Respite Services Available <sup>604</sup>	Grants Specific for Family Caregivers <sup>605,606,607</sup>	Caregiver Specific Legislation <sup>608</sup>	Provincial Caregiver Tax Credit <sup>*609,610,611,612,613</sup>
BC	27 weeks <sup>614</sup>	Y			\$4,674 at net income threshold of \$20,494
AB	27 weeks <sup>614</sup>	Y			\$11,212 at net income threshold of \$29,038
SK	28 weeks <sup>616</sup>	Y			\$9,464 at net income threshold of \$25,628
MB	28 weeks <sup>617</sup>	Y	\$1400/year**	Bill 42, The Caregiver Recognition Act (2011)	\$3,605 at net income threshold of \$15,917
ON	28 weeks <sup>618</sup>	Y			\$4,987 at net income threshold of \$22,051
QC	16 weeks <sup>619</sup>	Y	\$925/year for those caring for spouses; \$1,154/year for those caring for relatives**		\$1,032 for spouse \$1,205 for housing or cohabiting with an eligible relative \$532 for supporting an eligible relative No income threshold defined**
NB	28 weeks <sup>620</sup>	Y	\$106.25/month		\$4,848 at a net income threshold of \$21,402
NS	28 weeks <sup>621</sup>	Y	\$400.00/month**		\$4,898 at a net income threshold of \$18,575
PEI	28 weeks <sup>622</sup>	Y			\$2,446 at a net income threshold of \$14,399
NL	28 weeks <sup>623</sup>	Y			\$2,990 at a net income threshold of \$17,599
YK	28 weeks <sup>624</sup>	Y			\$7,140 at a net income threshold of \$16,766
NU	8 weeks <sup>625</sup>	Y			\$4,910 at a net income threshold of \$21,676
NWT	27 weeks <sup>626</sup>	Y			\$4,910 at a net income threshold of \$21,676

\* Indicates Net Income of Dependent not Caregiver

\*\* Indicates Credit is Refundable



## 2. CANADIAN WOMEN IN CAREGIVING ROLES ARE PARTICULARLY FINANCIALLY VULNERABLE

Certain subsets of unpaid caregivers are particularly financially vulnerable within our society. While men are increasingly taking on unpaid caregiving duties, women are still more likely to take on caregiving duties than men.<sup>627</sup> Women are also more likely to dedicate more time to unpaid caregiving duties and are more likely than their male counterparts to spend 20 or more hours per week on unpaid caregiving tasks such as providing personal care (e.g. bathing and dressing).<sup>628</sup> The subset of unpaid caregivers that end up facing the greatest level of financial hardship are older women.

One study of Canadian unpaid caregivers found that **74.9%** of female unpaid caregivers reported a personal income of **\$39,999 or less** annually.<sup>629</sup> Lower incomes, compounded with more missed work and career advancement opportunities or premature retirements, have far reaching effects for unpaid female caregivers. For example, Canada Pension Plan (CPP) benefits are derived from workforce participation-related contributions, making inconsistent workforce participation or early retirement detrimental to accruing future long-term pension benefits through this program. Furthermore, while a current provision exists within the CPP program to alleviate the financial penalty related to time spent out of the formal labour force caring for a young child, a similar provision for unpaid caregiving for others does not exist<sup>630</sup>; although, other countries do recognize the importance of this activity in their programs. Countries like Australia and Norway have created a carer pension for those who are unable to support themselves through paid employment due to care responsibilities, while others such as France, Germany, and Sweden have pension plan contributions for family caregivers.<sup>631</sup>

In 2009 the Swedish parliament passed a law stating, “Municipalities are obligated to offer support to persons caring for people with chronic illness, older adults, or people with functional disabilities”.<sup>632</sup> What’s more, the definition of caregiver in the Swedish statutory context includes family members, relatives, neighbors, or friends that, “provide support to someone regardless of whether they live together”.<sup>633</sup> Unpaid caregivers report the financial burden of caregiving as one of their greatest sources of stress, and finding ways to alleviate this issue more equitably should be considered a priority.

## 3. PROJECTIONS SHOW THERE WILL BE 30% FEWER AVAILABLE UNPAID CAREGIVERS IN CANADA IN 2050 COMPARED TO 2019

Canada is facing lower fertility rates and socio-economic shifts that will decrease the availability of unpaid caregivers. The 2019 NIA Report: *The Future Co\$ of Long-Term Care in Canada* projects that **between 2019-2050 there will be 30% fewer unpaid caregivers available in Canada**.<sup>634</sup> The report also finds that Canadian unpaid caregivers would need to increase their efforts by 40% to keep up with the current levels of unpaid care.<sup>635</sup> Finally, the report projects that if all home care provided by unpaid caregivers were paid publicly, it would add \$27 billion to public sector costs by 2050.<sup>636</sup>

## Evidence-Informed Policy Options

### 1. IMPROVING ACCESS TO INFORMATION AROUND AVAILABLE FINANCIAL SUPPORTS FOR UNPAID CAREGIVERS

The previously low reported numbers of unpaid caregivers receiving any government financial assistance<sup>637</sup> was partially attributed to a lack of awareness of available financial supports for Canadian unpaid caregivers. Therefore, ensuring that all Canadians can easily understand the benefits they are eligible for as caregivers, would especially benefit those who are particularly financially vulnerable within society. Indeed, although the federal, provincial, and territorial governments have made some significant improvements in its available financial supports for unpaid caregiver, most Canadians remain unaware of them.

Although the federal government's website serves an excellent starting point to access information for unpaid caregivers; many of its links redirect users to federal and provincial tax sites that use confusing and less accessible language to explain the eligibility criteria to access financial assistance. Therefore, enabling awareness of and access to user-friendly information and tools about available financial assistance for unpaid caregivers should be prioritized and has already been designated by the Carers Canada<sup>638</sup> to be a key strategic priority to better address this issue.

### 2. APPROPRIATE AND INDIVIDUALIZED NEEDS ASSESSMENTS OF UNPAID CAREGIVERS, ALONG WITH THE ADEQUATE PROVISION OF RESPITE SERVICES NEEDS TO OCCUR

Unpaid caregivers must have their needs separately recognized and formally assessed from the care recipient in order to better access services that reflect the needs of both unpaid caregivers and care recipients. Establishing such a process would enable unpaid caregivers to better access services which reflect the needs of both them and their care recipient(s). To better support unpaid caregivers, access to respite is important. While all provinces and territories do provide some form of respite supports for unpaid caregivers, services can vary regionally and in availability as some jurisdictions use co-payment models to manage access to these services. Establishing a national minimum standard of services and care that all unpaid caregivers and their care recipients could expect to receive would ensure that services are more streamlined, better reflect needs, and increase overall access.

### 3. REMOVING FINANCIAL ASSISTANCE BARRIERS FOR LOW INCOME UNPAID CAREGIVERS

Federal and provincial/territorial assistance for unpaid caregivers varies significantly. There are particular populations of low-income unpaid caregivers, often older women, who experience disproportionate financial hardship due to their more long-standing caregiving duties.

Most commonly, benefits for unpaid caregivers are means-tested and based on the annual income of care recipients or 'dependents' rather than the financial means of unpaid caregivers themselves.<sup>639</sup> Furthermore, while some tax-credits are 'non-refundable', meaning that if a caregiver is not employed or earning a sufficient income to qualify for these credits, then their inability to access even these basic levels of financial assistance puts them at greater risk of having to give up their caregiving role.<sup>640</sup> Understanding the outcomes of more targeted methods developed to support unpaid caregivers in: Manitoba - with its broader definition of unpaid caregivers<sup>641</sup>; Nova Scotia - with its targeted caregiver benefit for low income unpaid caregivers<sup>642</sup>; and Quebec - with its refundable caregivers tax credit<sup>643</sup>, may better inform the best Canadian strategies to ensure those most financially vulnerable in caregiving roles are adequately supported, given the significant annual savings they generate for the publicly funded health, social and community care systems.

# About the Authors

The National Institute on Ageing's (NIA) *National Seniors Strategy* research and development team includes a constantly evolving team of health, social and financial policy researchers – working with the objective of providing evidence-informed strategic thinking to promote, debate and explore policy options that can support the development and ongoing evolution of a National Seniors Strategy.

We are grateful that this work was originally financially supported by a Canadian Institutes of Health Research (CIHR) Evidence-Informed Health Care Renewal Grant entitled, *Creating a Sustainable System of Care for Older People with Complex Needs: Learning from International Experience* that was granted to Drs. Samir Sinha and Dr. Geoffrey Anderson in 2013.

The following paragraphs provide more details on the members of our current research team.

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Arianne Persaud is a communications and government relations professional, well-versed in the varied political landscapes throughout Canada. She has extensive experience in legislative and regulatory affairs, stakeholder relations, policy development, political communication, and crisis management. Prior to joining the NIA, Arianne held key positions at Queen's Park in the Ministry of Children and Youth Services, Ontario's Anti- Racism Directorate, and the Ministry of Tourism, Culture and Sports. While in government, she played a pivotal role in the passing of legislation, serving as a trusted advisor to respected cabinet ministers. Arianne earned her BA in Political Science and Governance from Ryerson University. Arianne was the lead policy researcher on updating the 2020 National Seniors Strategy, as well as conducting public consultations on the strategy.

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Caberry W. Yu is a medical student at Queen's University and a researcher in health policy and geriatric medicine. As a Junior Research Fellow, she supports the NIA in its research across health, finance, and social service sectors. Caberry has led medical student efforts in health policy across Canada, including representing Kingston and the Islands as a Daughter of the Vote in 2019. She continues to advocate for improving care for older adults in her community. Caberry holds a BHSc from McMaster University. She was the research lead and author for the Affordable Housing (Evidence Brief #3) and Inclusive Transportation (Evidence Brief #4) sections of the National Senior Strategy. Caberry was a main editor of the updated 2020 National Seniors Strategy.

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Ivy Wong is a Senior Advisor for the NIA. She is also Senior Lead, OHT and System Integration for North York Toronto Health Partners, an Ontario Health Team, and is based at North York General Hospital in Toronto.

Previously, she was the Network Director for BeACCoN (Better Access and Care for Complex Needs), a federal initiative funded by CIHR (Canadian Institutes for Health Research) SPOR (Strategy for Patient-Oriented Research) connecting research and evaluation to policy and practice to improve outcomes, quality and efficiency of care for high needs, high cost patients and their caregivers in the community. Ivy spent several years as a senior civil servant in the UK, including at Her Majesty's Revenue and Customs, the Department of Health in the UK, as Head of Commissioning Policy and Incentives for the National Health Service (NHS) in England. Her focus was on funding reform, integrated care and financial incentives. Before working in health policy, Ivy was an IT consultant, specializing in financial services, and also worked as an Account Director in digital marketing and advertising. Ivy holds a Master of Public Administration from the London School of Economics, a Master of Public Affairs from L'Institut d'études politiques de Paris (Sciences Po) and a BA cum Laude from the University of Pennsylvania. Ivy provided policy advice on the development of the 2015 and the updated 2020 National Senior Strategy.

### **Michael Nicin, MA, MPP**

Michael Nicin is the Executive Director of the National Institute on Ageing. He served as Chief of Staff and Senior Policy Advisor to the Ontario Minister of Seniors Affairs, leading the design and launch of the \$155 million provincial seniors strategy - the first government led seniors strategy in Canada. He also served as the Senior Policy Advisor to the Ontario Minister of Children and Youth Services, where he oversaw the design and launch of the \$500 million Ontario Autism Program. Prior to this he also served as the Director of Policy and Strategic Planning for CARP, a 300,000 member-based advocacy organization for older Canadians. Michael provided policy advice on the development of the updated 2020 National Senior Strategy.

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Stephanie Callan is a Communications Specialist with Choosing Wisely Canada and supports the campaign's external and digital communication efforts. Stephanie received her Honours Bachelor of Arts from McMaster University, double majoring in Communications and Multimedia and completed her post-graduate studies in Corporate Communications at Sheridan College. She has a special interest in creating and supporting various multimedia projects, specifically for health and education initiatives. Stephanie has provided all of the graphic design work for the 2015 and Updated 2020 National Senior Strategies as well as the ongoing National Senior Strategy social media campaign.

## **Original Contributors to the 2015 National Seniors Strategy**

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Dr. Geoffrey M. Anderson is a Professor in the Institute of Health Policy, Management and Evaluation (IHPE), Dalla Lana School of Public Health, University of Toronto. Dr. Anderson has been involved in health services research for over 30 years. His research has been funded by provincial, national and international research agencies and he has published over 200 articles. . He is actively involved in research on health and social care for older people and is the Research Lead for BeACCoN a CIHR-funded network that is focused on innovations in primary and community-based care. Dr. Anderson along with Dr. Samir Sinha were the Principal Applicants for the CIHR funding opportunity which originally supported this work.

### **Bailey Griffin, MSc, BHSc**

Currently based in Accenture Canada's Health and Public Service practice in Toronto, Bailey acted as overall research lead for the National Senior Strategy, first edition in 2015. During this time, she was based at the Institute for Health Systems Solutions and Virtual Care (WIHV) at Women's College Hospital and oversaw a number of key long-term initiatives, including acting as Program Manager of Virtual Care, and the Network Manager for the Ontario-wide Better Access and Care for Complex Needs (BeACCoN) Network, Ontario's CIHR SPOR initiative in primary and integrated health care innovation.

### **Thom Ringer, Hon BA, MPhil JD, MD**

Thom Ringer is a medical student and award-winning medical researcher in geriatric medicine at McMaster University. In 2015, he received McMaster's 2015 Medical Student Research Award and the Canadian Geriatric Society's Willard & Phoebe Thompson Award. Previously, Thom served as a Senior Consultant in the strategy practice of a global management consulting firm, with a focus on health care and public sector engagements across Canada. He has also held managerial roles in the Ontario government, advising its senior leadership on a range of strategic initiatives. Thom has a law degree from Yale University, and a Master's from the University of Oxford, where he was a Rhodes Scholar. Thom acted as the research lead and author for the Informed Health Decision-Making & Advanced Care Planning Brief (Evidence Brief #8) within the National Senior Strategy.

### **Christina Reppas-Rindlisbacher, Hon BSc, MD**

Christina Reppas-Rindlisbacher is a geriatric medicine resident and researcher at the University of Toronto. Her work has been published in the Journal of the American Geriatrics Society and she has received awards for her scientific presentations at various conferences. She is completing graduate training in clinical epidemiology and pursuing a career as a clinician scientist with a focus on studying the interface between delirium and dementia. Previously, she advised on a strategic plan for enhancing access to specialists at the University Health Network and helped develop policy recommendations for the Ontario Ministry of Health in support of unpaid caregivers. She obtained a BSc in Life Sciences from Queen's University. Christina acted as the co-research lead for the Support for Caregivers Policy Briefs (Evidence Briefs #13 and #14) within the National Senior Strategy.

### **Dr. Emily Stewart, Hon BSc, MD, MHA (c)**

Dr. Emily Stewart is a PGY-5 Emergency Medicine resident physician at the University of British Columbia who is passionate about the interface of evidence-based policy, health administration, and acute care medicine. She obtained her BSc at Dalhousie University and her MD at the University of Toronto. She recently served resident physicians nationally as the 2019-2020 President of Resident Doctors of Canada (RDoC). Dr. Stewart is also a graduate student in UBC's Master of Health Administration program. She received the Leadership Education and Development (LEAD) scholarship in medical school to pursue graduate courses in policy, clinical leadership, and health systems. As a medical student, she worked in the Office of the Premier of Ontario with the senior policy advisor to develop policy recommendations for the Ministry of Health in support of unpaid family caregivers. She has been recognized for her research about policies on access to care for refugees by the Federation of Medical Women in Canada (FMWC), and her work was used in the Federal Court of Appeal. Dr. Stewart acted as the co-research lead for the Support for Caregivers Policy Briefs (Evidence Briefs #13 and #14) within the National Senior Strategy.

### **Alliance for a National Seniors Strategy**

The Alliance for a National Seniors Strategy believes Canada urgently needs to establish a plan to meet the growing and evolving needs of our ageing population. The work of developing an evidence-informed National Seniors Strategy has become a collaborative opportunity to build upon the expert work of others. The main national organizations that offered advice and support and/or their endorsement for this overall body of work are also acknowledged below. These organizations in particular broadly represent a growing group now being increasingly recognized across Canada as the Alliance for a National Seniors Strategy.

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