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Designing a National Seniors Strategy for Canada

IRPP Task Force on Aging

October 7, 2015

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With improvements in health and life expectancy, more of us are living into old age, and for longer than ever before (Sinha 2012). This fact will take on even greater significance over the next two decades as the number of Canadians aged 65 years and older is expected nearly to double. Indeed, 2015 is the first year Canadians aged 65 and over outnumbered those who are younger than 15 years of age.[1] And by 2035 there will be more than 10 million older adults living in Canada, who will also account for roughly one-quarter of Canada's population, up from 16 percent in 2015.[2]

We have known that this demographic reality was coming for some time. The first wave of the baby boom generation turns 69 this year. Over the last two decades, decision-makers at all levels of government have been grappling with the challenges associated with an aging population and debating the most appropriate policy responses:

- How should we rethink the manner in which we provide care for our aging population, and how can we ensure that our health system is responsive to their evolving needs?
- What impact will the aging of our population have on our workplaces, in terms of both how they are structured to accommodate older workers and how they support all workers when they need to care for aging relatives and friends?
- What are the consequences for how we organize our communities and local services to allow individuals to remain engaged and active members in their communities for as long as possible?

The growing number of older Canadians will exert new and different pressures on the health care system. Patients aged 65 or older already account for nearly half of Canada's health care spending (CIHI 2014), including more than 60 percent of spending on acute care (Sinha 2011). While it is true that Canadians are living longer and better lives than

in past generations, the natural effect of a larger and older population is that many conditions commonly associated with older age have become more prevalent. According to data from the 2012 Canadian Community Health Survey, 85 percent of older Canadians aged 65 to 79, and 90 percent of those over the age of 80, reported living with one or more chronic conditions. Nearly a quarter of older adults reported having at least three chronic conditions (PHAC 2014a). Effectively managing the complex and interrelated needs this reality presents will be a major challenge for the health system of the future.

Our aging population will also bring about important changes in the economy. The diminishing ratio of Canadians who are active in the workforce, the growing number of older adults who choose to work longer, and the added burden on those who must care for aging relatives while they work will have an impact on businesses and the organization of work. And with a growing number of governments adhering to the principles of "aging in place" and "age-friendly communities," we have yet to articulate fully what that will mean for how we organize our public spaces, local services and infrastructure.

We know this new reality is coming at us — the question now is what to do, and whether we can summon the political will to address it head on. As noted by then-deputy governor of the Bank of Canada, Jean Boivin:

> *As our society ages, we can either accept a lower standard of living or we can be proactive and adjust. The stakes are high and we cannot afford to ignore them… The decisions we all make are largely influenced by what we think the future will bring, if we are aware and pay attention to it. Acceptance of the demographic challenges before us should lead the way to proper planning. Part of aging gracefully is accepting the inevitable and making the best of it. Getting older should be about getting better — it's about being wiser and more thoughtful about the future and what lies ahead. There are various options available to individuals and families, businesses, and policy-makers to ensure that we continue to improve our standard of living.* (Boivin 2012)

So far, we have been slow to adapt. For too long we have witnessed all three levels of government tackling these problems differently and in isolation while individual departments within governments have tended to operate in silos, limiting our ability to align policies, programs and services to deal with complex issues associated with

population aging in a comprehensive, integrated manner. Recognizing that all three levels of government must engage actively in designing our response to an aging population, it is time to rethink our approach to better support older Canadians. Canada needs a national seniors strategy, and the federal government must play a leadership role in designing and implementing it.

About the Project

In 2007, the IRPP launched a multidisciplinary research program to shed light on the impact of this demographic trend on a number of public policies and programs. Since then, the Institute has published 23 studies and papers on issues relating to pensions and retirement, health care services, drug coverage, caregiving, municipal services and building age-friendly communities.

Over this same period, a number of organizations have called on governments across Canada to address the growing needs of our aging population in a more comprehensive way. Many of them have responded with new policy frameworks, advisory bodies and dedicated mandates for departments and ministers, and more than a few such initiatives are showing promising early results. However, no national framework exists that defines common goals and standards from coast to coast to coast on how we should support older Canadians and promote the sharing of best practices. On a host of issues, the existing research already indicates the way forward. In the words of one task force member, the challenge now is to bridge the knowing/doing gap.

In the lead-up to the federal election now under way, the IRPP created a Task Force[3] whose mandate was to lead a consultation exercise to articulate an evidence-based agenda for decision-makers. This process had two key questions in mind: *How can a national seniors strategy be created and what issues should it address?* The report draws on a comprehensive review of the latest research on issues that affect older Canadians,[4] a series of interviews with academics and other experts, and a stakeholder round table held in Ottawa in March 2015.[5]

While the Task Force's deliberations have been tremendously enriched by the expertise and insights of those who took part in the consultation process, the conclusions drawn from those consultations and the recommendations made are those of the Task Force members.

Why Do We Need a National Seniors Strategy?

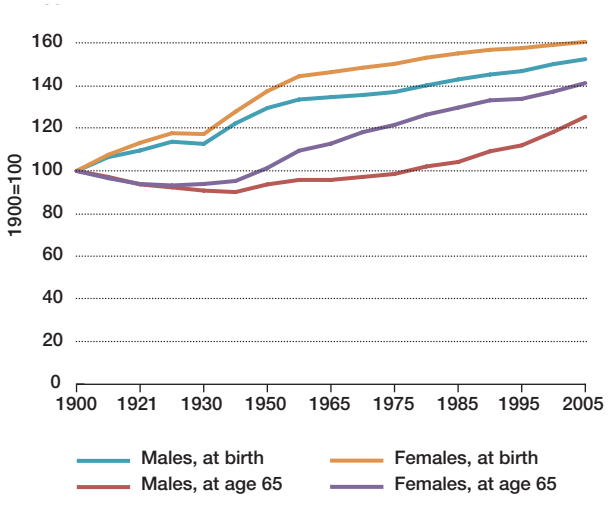
The life expectancy of Canadians has increased significantly over the last century (figure 1). Today, someone reaching the age of 65 is expected to live, on average, for another two decades, until about age 85 (Statistics Canada 2013).[6] As an illustration of just how much health care and living standards have improved, the Chief Actuary of Canada now projects that five out of ten Canadians aged 20 today will live to the age 90; 20 percent of them will even reach 100 or older (McFarland 2014).[7] We are living in a period in which the social concept of "age" is being redefined in a major way.

Combined with slower population growth among younger cohorts, Canada faces a very different demographic structure than ever before. Older adults are now the fastest-growing segment of our population, with their numbers expected to grow significantly over the next two decades. By then, approximately one in four Canadians will be older than 65 years of age.

This new demographic reality is putting pressure on the design of public policy and the delivery of public services in a host of ways.

According to the Canadian Institute for Health Information (CIHI), health care costs for older Canadians represented 45 percent of provincial and territorial spending on health care in 2012, even though older adults made up only 16 percent of the population (CIHI 2014). The Conference Board of Canada estimates that these costs will rise by 1 percent each year over the coming decades as the proportion of Canadians over the age of 65 continues to increase (Stonebridge 2013). Although other factors, such as the

FIGURE 1. CHANGE IN AVERAGE LIFE EXPECTANCY, 1900-2005 (INDEXED TO 1900 LEVELS)



Source: Calculations by author, Office of the Chief Actuary (2009, table 1).

price of medical services, are likely to play a somewhat larger role in setting the pace of expenditure growth in health care, aging will be an important contributor. Because the majority of Canadians want to age in place, most of us expect these services to be there for us (Philips Lifeline 2011) even though the provision of home, community and long-term care services was never enshrined in the *Canada Health Act*. Governments are beginning to move in this direction, but transformation of the health system away from a model focused heavily on hospital-based services will not be quick or easy.

Pressure is also growing on our local and regional governments to ensure that local public spaces and services, including community transportation services, are well adapted to meet the needs of older adults. With a growing number of Canadians providing care for a loved one, including 35 percent of those who are employed (Employer Panel for Caregivers 2015), how we support caregivers is now an important question of both social and labour market policy. Finally, with a growing number of working Canadians no longer benefiting from a workplace pension, many are becoming increasingly concerned regarding the adequacy of current and future retirement savings and savings vehicles.

Notwithstanding these potential challenges, the increase in life expectancy should be recognized as a triumph rather than a problem. Individuals are not just living longer but are remaining healthier and more active for longer. Older Canadians are creating new and different demands on government services, but they also constitute a significant resource that can be deployed to address them.

Meeting the growing and evolving needs of our aging population will require concerted coordination and effort between municipalities and provinces, with the federal government playing a key leadership role. It will require contributions from the private and not-for-profit sectors and the active participation of citizens themselves.

Basic Principles to Underpin a National Seniors Strategy

Flowing from this, four ideals emerged from our consultations that should become the principles that underpin the development of a national seniors strategy:

The strategy must be national

Historically, our federal government has been able to play a key role as a standard-setter, catalyst and funder of important social change. As was the case in the creation of the health care system a half-century ago, the federal government can mobilize the necessary resources and coordinate the efforts across departments, regions and tiers of government, as well as with the private and voluntary sectors, that will be essential if we are to succeed. While fully respecting the roles and jurisdictions of other governments, only the federal government can compel all actors to adopt an integrated approach and ensure the resulting programs and services are comparable across the country. Within reasonable parameters, and with flexibility to reflect local preferences and priorities, the support available to older Canadians should not be determined by the region of the country in which they live.

For the federal government, therefore, the underlying challenge is not one of substance but one of process. How does Ottawa provide national thought leadership while respecting provincial jurisdiction and autonomy? And how do different levels of government provide accountability to the public and to each other for joint initiatives? These are quintessentially Canadian questions and can be resolved. At a minimum, they are not a reason to refrain from trying to come to a national consensus on these issues.

In our view, "federal leadership" should be thought of as:

1) The power to convene and forge a consensus on our understanding of the issues and our commitment to minimum standards;
2) The unique ability to compel the sharing of information and the transfer of knowledge;
3) The authority to support "have-not" provinces in meeting those minimum standards through equalization; and
4) The ability to create a national system of mutual accountability among governments and public accountability to citizens.

The strategy must put the individual at the centre

Related to the first two ideals, it is critical that any effort to create a national seniors strategy avoid turning into an intergovernmental tug-of-war. If the starting point of

the discussion is jurisdiction, there is little chance of success. If, on the other hand, the starting point is the individual, rigid insistence on maintaining silos of whatever kind will be more difficult to defend to a public seeking only better support and care as we all age. In fact, decisions on how best to align the countless programs, allocate resources and coordinate efforts across jurisdictions should be made on the basis of the needs and experiences of the individuals who must navigate the system. Let us first determine the needs of older Canadians and then determine how the system should be organized around those needs.

The strategy must be comprehensive and integrated

While health care considerations will figure prominently in any discussion about better supporting older Canadians, there is a risk in setting too narrow a frame around these issues. While a national seniors strategy must address the evolving health needs of seniors, it should be based on the World Health Organization's (WHO) definition of "health": "health is a state of complete *physical*, *mental* and *social* well-being and not merely the absence of disease or infirmity" (emphasis added).[8] Similarly, our approach should take a cue from how the Oxford Dictionary defines care: "the provision of what is necessary for the *health*, *welfare*, *maintenance*, and *protection* of someone or something" (emphasis added).[9] From this perspective, the strategy must incorporate a variety of elements, including health care, the built environment, social and economic policy, and the social determinants of health. These must be addressed in a comprehensive and integrated way.

The strategy must ensure policy-makers treat aging as a lens through which all policy decisions are assessed, and not as an isolated policy issue

There is a significant difference between treating aging as a policy issue, and treating it as a lens through which decision-makers should assess the policy choices they must make. The former compartmentalizes the issue — "puts it in a neat little departmental box" — and limits its scope of consideration. The latter, on the other hand, frees it from such barriers and makes everyone responsible to ensure it is reflected in the full range of decisions. In keeping with the values that have guided so many municipalities to strive to become "age-friendly communities," let us choose the latter.

Priority Areas of Focus of a National Seniors Strategy

Consistent with an approach that puts the individual at its centre, the Task Force resisted the urge to group its recommendations to mirror the standard departmental structures of modern governments. Rather, we recommend that the goals of the strategy be articulated in a manner that relates to the needs of the individuals it is intended to support.

In recent work conducted prior to the launch of this IRPP initiative, Task Force member Samir Sinha, with the support of the Canadian Institutes for Health Research, led an evidence-informed initiative that sought to define four areas of focus that could enable a national seniors strategy to support outcomes that matter to older Canadians.[10] Rather than reinvent the wheel, the Task Force opted to use those four goals as the organizing principles for this report.

Inspired by that earlier work, therefore, we believe a national seniors strategy should aim to:

> Ensure older Canadians remain independent and engaged members of our communities for as long as possible.
> Ensure older Canadians continue to lead healthy and active lives for as long as possible.
> Ensure older Canadians have access to person-centred, high-quality, integrated care as close to home as possible, provided by those who have the knowledge and skills to care for them.
> Ensure that the family members and friends of older Canadians who provide unpaid care for their loved ones are acknowledged and supported.

While certainly not an exhaustive list of all options available to, or issues facing, governments, what follows is a list of recommended policy changes that would set us on the path toward reaching the four goals. They are meant to illustrate that there are very concrete actions that governments can take — many of them in the short term, if the will exists — that can significantly improve the lives of older Canadians and those who care for them.

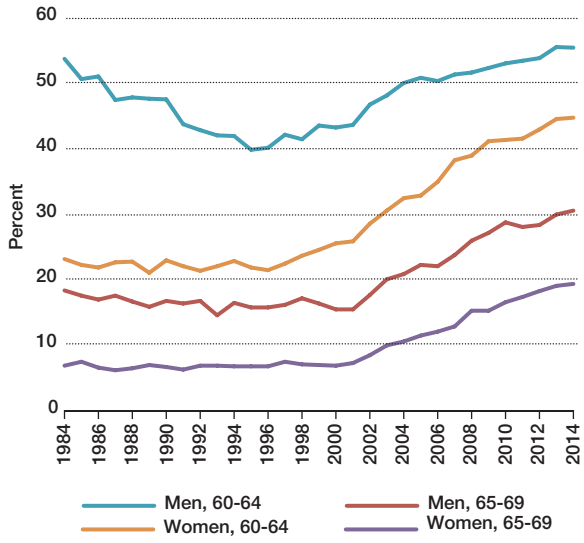
GOAL 1: Ensure older Canadians remain independent and engaged members of our communities for as long as possible

Ensuring older adults remain independent and engaged means ensuring they have access to adequate income, affordable housing and accessible transportation services. It means ensuring that our built environment and public spaces are age-friendly and that our community, social and recreational services are designed with the needs of older Canadians in mind. These efforts can help combat social isolation among older adults, as well as ageism and elder abuse.

With regard to income, governments can take practical steps to ensure older Canadians have the financial resources necessary to maintain their independence, both while they remain in the workforce and after they retire.

As life expectancy has improved and mandatory retirement has been eliminated across Canada, older workers have become more engaged in the workplace later in life. As illustrated in figure 2, there has been a significant increase in the proportion of Canadians continuing to work well into their 60s, a trend that ranks among the most important developments in the Canadian labour market since the year 2000 (Hicks 2015). Because these workers can continue contributing their considerable experience and skills, Canada has been able to avoid a lot of the labour market pressure that many believed would occur once baby boomers began to enter their early 60s (Drummond 2014).

FIGURE 2. EMPLOYMENT RATES AMONG PEOPLE IN THEIR 60S, 1984-2014



Source: Hicks (2015).

In many sectors of the economy the continued participation of older workers can help to fill labour shortages or skills gaps. In addition, the transfer of experiential knowledge to younger workers can play a major role in developing and preparing the workforce of tomorrow.

Although the trend toward later retirement has helped to defer some of the effects of demographic change, there remain important implications to be sorted out

within the workplace. For example, older workers' expectations regarding flexible work arrangements or part-time employment may present challenges for employers, especially for smaller organizations. Older workers may also face ageism in the workplace or find themselves being pressured to leave the workforce for the benefit of younger workers.

In 2007 the federal government convened the Expert Panel on Older Workers to examine the various policy implications of an aging workforce (Expert Panel on Older Workers 2008). While many of the program-level changes called for by the panel have been acted upon, a number of the critical knowledge gaps cited in its report still remain. For example, Canada lacks good labour market information to understand how population aging is affecting Canadian economic competiveness, and how older workers and employers are adjusting to this significant demographic conjuncture. A better understanding of how these issues are being addressed at both a micro- and macro-level within the labour market is important for future policy development in this area.

To grasp how these issues are playing out and what the impacts are for all the actors involved, the Task Force recommends that the federal government:

> Engage employer groups, unions and older workers themselves in an open dialogue to better understand these dynamics, share experiences with flexible work arrangements and promote best practices among individual employers;
> Conduct additional research on the relationships between an aging workforce, sectoral labour shortages and skills gaps, and productivity; and
> Building on recent initiatives, promote financial literacy and advance planning to support retirement security.

Of course, many older adults still face financial challenges in retirement. While the trend toward delayed retirement and more flexible work arrangements have likely reduced some of the pressure on retirement saving, there are nonetheless troubling signs that some Canadians are not adequately prepared. Precise estimates of this problem vary considerably between analysts, depending on the assumptions that are used about the amount of income replacement that is required upon retirement.

Looking at the retirement income system as a whole, a wide body of research points to three sets of issues that require the attention of policy-makers: 1) small but significant pockets of poverty that remain among certain populations of older Canadians; 2) gaps in pension coverage across the labour market; and 3) ensuring that

Canadians and public benefit programs are well prepared for the changing dynamics of longevity and retirement (Meredith 2015).

First, while it is true that the proportion of older Canadians living in poverty has declined dramatically in recent decades, poverty rates among those who are single, divorced or widowed remain quite elevated, and have even increased slightly in recent years. In 2011 approximately 15 percent of older Canadians living alone fell below the low-income cut-off, compared to 5.2 percent among all elderly households (Meredith 2015). This disparity is due to a number of factors, including economies of scale in how costs can be shared in multi-person households and the fact that many of the income benefits used by older adults do not compensate for these differential costs very well (e.g., Old Age Security and the Canada Pension Plan).

Although Canada's retirement income system does a fairly good job of ensuring that most older adults enjoy a comfortable, secure retirement, a large and growing share of workers today (future retirees) do not have access to a formal workplace pension plan. This gap is important because access to a pension makes saving easy — households in which at least one member participates in a workplace pension plan tend to accumulate more wealth over the course of life and experience higher rates of income replacement upon retirement (Messacar and Morrisette 2015; Ostrovsky and Schellenberg 2010). Approximately 62 percent of workers today do not have access to a workplace pension (Statistics Canada 2015). As a consequence of these and other factors, various studies suggest that between one-third and one-half of middle- and high-income workers over the age of 40 today are at risk of seeing a material drop in their standard of living upon retirement (McKinsey and Company 2015; Wolfson 2013).[11]

The consequences of under-saving for retirement are significant for both the individual and society. Some may be forced to retire later than they had originally planned, while others may face hardship if their health no longer enables them to work later in life. In the context in which the ratio of older adults to the working-age population will increase dramatically over the coming decade, reduced consumption possibilities among older Canadians is also a potentially major economic problem that will put a drag on overall GDP. Older adults who outlive their savings will also become more dependent on income transfers like the Guaranteed Income Supplement (GIS) and Old Age Security (OAS), programs which are not prefunded.

An important policy question going forward is whether the current trend toward later retirement will continue and, if so, how this will offset the risk that people may outlive their savings. Though we do not yet know how this will play out, the changing trends in work and retirement underscore the need for greater flexibility in how the retirement income system is designed. Over the last decade, the federal and provincial governments have taken a number of steps in this direction by incentivizing workers to begin drawing Canada Pension Plan (CPP) and OAS benefits at an older age. These steps have been helpful, but for many Canadians age 65 still represents an important psychological milestone.

No single policy instrument can address all of these issues. Ensuring that Canadians are adequately prepared for retirement will require a number of reforms across the retirement income system and within each component program. Given the overlapping jurisdiction in this area, it is critical that federal and provincial governments be on the same page.

In the last several years, there has been an important debate as to the need for additional, mandatory saving among certain groups within the labour market. There are various ways this can be implemented — either through the CPP and Quebec Pension Plan (QPP), or as part of individual saving accounts. The critical point is that both approaches can lead to the same place. What is imperative is that governments act. Canada's retirement income system has succeeded over the last half century because governments have been committed to ensuring a high degree of coordination and harmonization, even as regulatory jurisdiction overlaps. The recent impasse between the federal government and the government of Ontario over the future of the CPP undermines that tradition and is harmful to a well-functioning retirement income system for all Canadians.

To this end, the federal government should engage the provinces to:

> Come to a pan-Canadian consensus on the future of the CPP/QPP, and ensure any alternative provincial initiatives aimed at providing supplemental pension coverage (e.g., the Ontario Retirement Pension Plan and Quebec's Voluntary Retirement Savings Plan) are adequately coordinated with a common vision;

> Focus future enhancements to GIS/OAS on the goal of ensuring no older Canadians fall below the poverty line. This will require targeted efforts to enhance the generosity of GIS/OAS for certain groups, particularly those who live alone;

- Examine options to adjust eligibility for retirement benefit programs, with a view to potentially shifting away from parameters that are based on a fixed age (e.g., age 65) and toward a formula that changes in relation to mortality and life expectancy; and
- Align these initiatives with other measures related to private, voluntary savings (e.g., RRSPs and TFSAs) to ensure Canada's retirement income system remains cohesive.

Older Canadians also contribute to our society as volunteers and unpaid caregivers to Canadians of all ages, and are the most politically engaged members of our society. The federal government would do well to continue to support volunteerism and other forms of community engagement. We too often think of older adults only as recipients of age-related services, when in fact they are also a large, dedicated and qualified resource to deliver them.

With regard to the built environment, the ability to age in place plays a major role in the health and well-being of older adults (Dupuis-Blanchard et al. 2014), a reality that has been observed in Canada as well as in most other OECD countries. The aim of the "Age-Friendly Communities" (AFC) initiative is therefore to make communities more favourable to older adults by improving access to services and infrastructure and enhancing civic participation (WHO 2007). In Canada, many local governments have formalized their efforts to help older adults live at home longer by assessing their community's "age-friendliness" according to the eight areas defined by the WHO,[12] building action plans to improve on those measures and reporting publicly on the progress made over time (Plouffe et al. 2013).

In support of these local initiatives, and to expand them further, several provinces have decided to launch AFC initiatives and incorporate AFC principles into their public policy agendas. In 2014, it was estimated that approximately 560 communities in eight provinces were participating in the AFC movement (Golant 2014), and 17 cities and communities in Canada have been formally recognized by the WHO as "Age-Friendly Cities" (WHO 2015).

The involvement of provincial governments has been an important determinant of success. Indeed, several researchers have suggested that AFC initiatives require strong leadership at the local level but also at the provincial and federal levels (Menec et al.

2014; Cerda and Bernier 2013). To further expand AFC initiatives across Canada, working in collaboration with provinces, territories and municipalities, the federal government should:

> Conduct more robust evaluations of existing AFC initiatives and enable the sharing of best practices across municipal and provincial jurisdictions;
> Dedicate a higher proportion of federal infrastructure dollars to affordable housing and transportation options that will allow older Canadians to remain more independent in their communities; and
> Incorporate well-established universal design standards in our national building codes to support the development of more age-friendly physical spaces.

GOAL 2: Ensure older Canadians continue to lead healthy and active lives for as long as possible

Significant advances over the years in public health and health care have ensured that not only do Canadians live longer, many are also living in better overall health for longer. To be able to live well, Canadians must understand the factors that contribute to aging in good health and participate in those activities that promote wellness, prevention and overall healthy aging. Moreover, older Canadians must be more engaged in decision-making around their own health care and must be empowered to make more informed decisions in accordance with their values and wishes.

Health literacy is vital for all aspects of decision-making, from managing nutrition and personal health day to day, to making informed decisions about treatments and care. As we age, our ability to find, assess and weigh health information diminishes due, among other things, to the loss of cognitive skills, dementia and impairments in hearing and vision. Estimates by the Canadian Council on Learning and the Public Health Agency of Canada suggest that only 12 percent of older adults have sufficient health literacy skills for many basic health-related decisions (PHAC 2010).

For major decisions and life events, it is critical for Canadians to be actively involved in thinking about and planning for their health-related needs at earlier stages of the aging process. One such step involves advance care planning (ACP), the process by which individuals articulate their wishes should they become incapable of consenting to or refusing treatment or personal care at a later time. Increasingly, this concept

is understood in the context of end-of-life decisions, but its purpose is much broader than that. For professionals, family members and individuals themselves, this planning process can be quite helpful to clarify how people think about the kind of care they desire, and how they want to live in situations where they may not be fully independent. Indeed, a growing body research shows that this process is associated with a lower risk of hospitalization, lower rates of death in hospital, reduced usage of intensive care and a reduction in unwanted treatments (Brinkman-Stoppelenburg, Rietjens and van der Heide 2014; Khandelwal et al. 2015). For family and loved ones, this planning process has also been found to increase rates of satisfaction and peace of mind when major health events eventually arise (Zhang et al. 2009)

Although, comparatively, Canadians are more likely than their peers in other developed countries to communicate their wishes, most still do not (CIHI 2015). A recent survey suggests that 61 percent of Canadians do not have a written plan detailing their wishes, and about 40 percent have not even had a conversation with family members about these issues (CIHI 2015). Reluctance and anxiety to approach the subject, coupled with limited access to supportive informational resources and tools, mean that, for too many Canadians, planning never even begins.

As at all ages, but particularly for older adults, promoting regular immunization, exercise and injury prevention is critical. For example, because of the higher prevalence of chronic conditions in older age, older adults are often considered to be a "high-risk" group for influenza, pneumonia (pneumococcal) and shingles (varicella/herpes zoster). While immunization rates for these illnesses are generally higher among older adults than in the general population, Canada has consistently failed to meet its national vaccination targets. The Public Health Agency of Canada estimates that in 2012, 65 percent of older adults received the seasonal flu vaccine, well below the target rate of 80 percent. Canada has consistently fallen short of targets for the last decade and a half (PHAC 2014b). This failure in prevention and health promotion comes at a major cost to the health system.

Led by the Public Health Agency of Canada, the federal government can support this goal by:

> Ensuring high-quality information about healthy aging and the prevention of age-related diseases — such as regular exercise, fall prevention and routine vaccinations — is widely available and can be accessed in one place;

- Supporting research and experimentation on the use of incentives to encourage such behavioural changes;
- Promoting health literacy, informed decision-making and ACP;
- Supporting communities to provide opportunities for exercise (such as safe walking areas), nutritious food (healthy, affordable options), and socialization (buildings and outdoor spaces that naturally bring people together, gathering spaces, support for informal and formal groups); and
- Creating more formal partnerships that bring together governments, disease-specific organizations, caregiver organizations and community groups to coordinate the promotion of a healthy/active living agenda.

GOAL 3: Ensure older Canadians have access to person-centred, high-quality, integrated care as close to home as possible, provided by those who have the knowledge and skills to care for them

Although the health care needs of older Canadians have evolved over the years, the system that is supposed to provide for them has not.

The Canadian health care system was designed 50 years ago, when the median age of Canadians was approximately 25 (Statistics Canada 2007) and average life expectancy (at birth) was the late 60s for men and the mid-70s for women. At that time, patients with acute rather than chronic care needs were the primary users. Today, although our health needs have changed significantly, the system remains focused on delivering acute, specialty-oriented care in institutional settings and is ill equipped to deliver more complex, chronic care in community-oriented settings. That the *Canada Health Act* does not encompass coverage of home, community and long-term care services, or prescription medications, significantly limits the levers by which we can ensure equitable and consistent access to key health services for older Canadians.

Not surprisingly, Canadians themselves are not confident in their own health system's ability to meet their needs. In a recent international survey of how well populations of older adults are being served in different highly developed countries, only 34 percent of Canadian respondents gave our system the highest possible rating (CIHI 2015). This was the second-lowest proportion of any jurisdiction in the 11-country survey, surpassing only the United States. This research, which comprises a compendium of work undertaken by The

Commonwealth Fund, also noted that Canadian seniors face particularly long wait times to get medical care outside of a hospital setting, including the longest wait times for primary and specialist care of all 11 countries (CIHI 2015; Osborn et al. 2014). Given that Canada also has one of the most expensive health systems in the developed world, this performance is simply not acceptable.

To better meet the needs of today's older adults, and indeed all Canadians, federal efforts toward health system reform should focus on four key areas:

1) The transition away from hospital-based care toward community care;
2) The collection and sharing of data about health care systems in Canada;
3) The scope of practice of service providers and their integration into multidisciplinary and interprofessional teams; and
4) Integration of the silos in the system to enable greater efficiencies and more coordinated care.

While the provision of health care services is a provincial/territorial responsibility, there is a growing need for national leadership on health system transformation. Creating a more consistent and robust community care system that better supports Canadians who want to age in their place of choice is a top priority, and the federal government could enable it. Specifically, the federal government should:

> Collaborate with the provinces and territories to redefine "community care" beyond home and long-term care to include other support and community services that contribute to the continuum of care;
> Use the Canada Health Transfer, if necessary, to compel the provinces and territories to come to an agreement on minimal service standards for home, community and long-term care. To be clear, these should not be dictated by Ottawa and should emerge from provincial/territorial consensus. And while each province and territory must be free to determine how best to deliver services that respect local preferences and realities and to provide additional services beyond those agreed to by the group, recognizing and adhering to some form of common standards should not be optional;
> Conduct a thorough review of the *Canada Health Act* to determine whether any changes to the federal legislative framework might encourage provincial and territorial partners to engage in this type of structural reform;

> Ensure that all Canadians have access to the medication they need through the creation of a national pharmacare program, which would improve comparability of coverage and create an "economies of scale" cost advantage, where coverage is based on evidence as assessed by an impartial group with no real or apparent conflict of interest.

In the recent March-April issue of *Policy Options* magazine, health care expert Stephen Lewis argued that the federal government should reimagine its role in the provision of health care to Canadians (Lewis 2015). He argued that, beyond its important constitutional obligations to certain groups, Ottawa should not concern itself with the specific manner in which services are provided. But that is far from saying that it should not be interested in the results our provincial/territorial health systems should achieve. Instead, he stressed that Ottawa should focus on ensuring that information about the performance of these systems is collected, understood and shared. The federal level is the only tier of government that can make this happen: it is in a unique position to play this essential role in improving system performance across the country.

While Lewis did not specifically focus on care for older Canadians, the same logic applies. To make sure older Canadians have access to the highest-quality care, the federal government should:

> Establish national metrics, information collection and reporting systems through agencies like CIHI; and
> Ensure provinces report publicly and annually on how they measure up.

The federal government should engage the provinces, territories and national accreditation bodies for doctors, nurses, therapists, pharmacists, social workers and other service providers with two objectives in mind: reducing the barriers to multidisciplinary and interprofessional coordination and collaboration among professions; and ensuring there is a high level of awareness across all professions of how to support the unique needs of an older adult population. Specifically, it should:

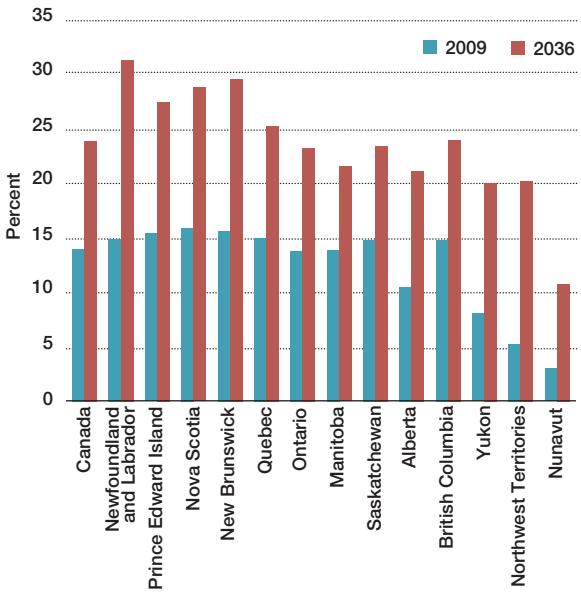
> Encourage national accreditation bodies to mandate entry-to-practice training and continuing professional development activities around the care of the elderly to ensure current and future providers have the knowledge and skills needed to provide care for older Canadians;

> Encourage the provinces to review the scopes of practice for health care providers to ensure Canadians get the right care, in the right place, at the right time, delivered by the most appropriate health care professional; and
> Work with provinces and territories to help develop pan-Canadian training and appropriate prescribing standards for all those who prescribe and dispense medications in the care of older adults.

Of course, the predictability of funding greatly enhances our capacity to plan. Without expressing a view on the specific amount of federal funding that has been committed until fiscal year 2023-24, the fact that provinces and territories can expect growing and predictable transfers over many years is welcome.

However, within the overall envelope of federal health transfers, there remains an unavoidable question of equity that must be addressed if Canada is to adequately respond to the challenges of an aging population. As we know, population aging will not occur uniformly across the country. While all provinces will experience an important demographic shift, the central and Atlantic provinces will be the most significantly affected (figure 3). Combined with what are now some of the highest median ages in the country, Atlantic provinces also face the grave prospect of a potential decline in their total population base, a phenomenon which is projected to occur at the same time as many baby boomers move into retirement over the coming two decades.

FIGURE 3. PERCENTAGE OF PERSONS AGED 65 YEARS OR OVER, OBSERVED (2009) AND PROJECTED (2036)



Source: Statistics Canada (2010), table 3.5
Note: The projection for 2036 is based on the "M1" medium growth scenario.

In the most extreme example, Statistics Canada projects that the population of Newfoundland and Labrador will decline by slightly more than 10 percent between now and 2035. The population of the Atlantic region as a whole is projected to decline by 1.3 percent. This compares to projected growth of 12.3 percent in Quebec, 17.7 percent in Ontario and 29.1 percent in the four

western provinces over the same period. If these forecasts materialize, the Atlantic provinces will experience a decline in the purchasing power of health transfers as the population decreases, the costs of care begin to accelerate, and provincial and local fiscal capacity erodes. In order to maintain the principles of fairness and comparability of services, the time has come for policy-makers to consider a more needs-based approach to how the Canada Health Transfer is designed and distributed.

With respect to funding of the health system, the federal government should:

> Ensure funding for health care is "de-siloed" so as not to encourage specific behaviour by tying funding to specific services or transactions, and encourage the provinces and territories to do the same;
> Move to a funding formula that is at least partially linked to the demographic structure, so that regions with a higher proportion of older adults have comparable capacity to meet the overall health needs of their populations;
> Lead a comparative analysis of the pros and cons of provincial funding and organizational models, with the aim of identifying which practices are more likely to encourage "dehospitalization" in favour of community care, and whether certain models foster innovation more effectively; and
> Carefully consider how implementing the recommendations of the Advisory Panel on Healthcare Innovation (commonly referred to as the Naylor report) can ensure the health system adapts to the needs of an aging population.

Finally, no review of health care service for older adults would be complete without an acknowledgement of the uncertainty around the future of palliative and end-of-life care in Canada. The Supreme Court of Canada's decision in *Carter v. Canada* has set the stage for a national dialogue to take place on how we want to proceed as a society. As a result, the federal government recently announced the creation of an expert panel to advise it on options for a legislative response to that decision.

While the panel's mandate includes a consultation with Canadians, the process is limited (at least so far) to the online submission of briefs and position papers to panel members. Such a process will undoubtedly serve panel members well as they formulate their advice to the government. However, it is unlikely to create a broad national consensus on how Canadians want to deal with end-of-life issues and what is the appropriate legislative and policy response. In addition to the expert panel, therefore, the federal government should:

- Launch a broad public engagement process to determine how Canadians want to deal with end-of-life issues and what is the appropriate legislative and policy response. This process should be led by Parliament, not government, and should be one of the first major actions of the 42nd Parliament when it convenes; and
- Consider replicating the all-party public consultation process used by the Quebec National Assembly in its own report on this same topic.

GOAL 4: Ensure that the family members and friends of older Canadians who provide unpaid care for their loved ones are acknowledged and supported

The family and friends of older Canadians are their greatest source of care. Today, 93 percent of older Canadians continue live at home, despite the inaccessibility of home health care services. Older Canadians do this because their family members provide the necessary support (Dupuis-Blanchard et al. 2014; Peckham, Williams and Neysmith 2014). In fact, it is estimated that families overall provide 75 to 80 percent of the care that older adults require at home (Chappell 2012; Martin-Matthews, Sims-Gould and Tong 2013). Thus, the health of older Canadians who are aging in place depends in large part on the direct cooperation and support of unpaid caregivers. The sustainability of home care programs is therefore closely tied to the development of funding and technical support programs for unpaid caregivers as well as the recognition of their role (Martin-Matthews, Sims-Gould and Tong 2013).

Few societies keep data on unpaid caregivers (Courtin, Jemiai and Mossialos 2014), and even fewer do so on the unique challenges faced by those who are employed. Though we have a general idea of how many individuals in Canada are balancing work and caregiving — in 2012, 6.1 million working Canadians were caring for a family member or friend, which represents 35 percent of the Canadian workforce — little is known about their quality of life (Employer Panel for Caregivers 2015). For employers, too, this is a challenge. The Conference Board of Canada estimates, for example, that the loss of productivity resulting from employees attempting to balance work and care is $1.28 billion dollars per year (Employer Panel for Caregivers 2015).

In Canada, the majority of unpaid caregivers provide care for a member of their immediate family. They provide an average of four hours of care per week. As in most countries, most unpaid caregivers are female and most spend more hours caring for a

family member than do their male counterparts (Sinha 2013; Hoffmann, Huber and Rodrigues 2014).

The psychological effects (stress, depression), social effects (social isolation, feelings of abandonment) and financial effects stemming from a person's role as an unpaid caregiver have been well documented (Amirkhanyan and Wolf 2006; Cooper et al. 2008; Courtin, Jemiai and Mossialos 2014; Pinquart and Sorensen 2003). Several studies also show that the responsibilities associated with the role of a caregiver can have repercussions for the caregiver's job (Evandrou and Glaser 2004; King and Pickard 2013; Kotsadam 2012).

That said, balancing care-related tasks and paid work produce significant benefits for the caregiver, as long as the appropriate support is provided. Agreements with employers, adequate support from the community and family, and programs adapted to their situation allow unpaid caregivers to keep their jobs and maintain their physical and psychological well-being. For instance, paid employment provides respite for unpaid caregivers (Zarit et al. 1998). It also provides tangible benefits such as income and, possibly, social benefits as well (Edwards, Zarit and Townsend 2002). In addition, employment provides caregivers with an opportunity to belong to social networks and to experience fulfillment beyond their responsibilities as caregivers (Arksey 2003; Cannuscio et al. 2004; Dunham and Dietz 2003; Hoffmann, Huber and Rodrigues 2013; Naiditch 2012; Swanberg 2006; Yang and Grimm 2013).

The Canadian Compassionate Care Benefit (CCB), which has been available since January 2004, is an example of such a model. The primary aim is to offer the security of employment and supplementary income to individuals who take a temporary leave from their job to care for a terminally ill family member who is likely to die within 26 weeks. The CCB currently lasts a maximum of six weeks, which can be taken in several increments. Only 2 percent of employed caregivers providing end-of-life care in 2011-12 made use of compassionate care leave (Sinha 2013).

As part of its 2015 budget, the federal government announced an enhancement to the CCB in order to provide more flexibility to claimants. Starting in January 2016, eligible recipients will be able to claim the CCB for up to 26 weeks over the course of the full year. While the person being cared for must still be at risk of death within six months of beginning a claim, this change allows caregivers to take the CCB in different increments throughout an entire year, as needed. Consequential amendments

to the federal labour code have also been made, and provinces and territories are expected to follow suit.

Programs such as this are examples of how we can better support caregivers, but many gaps remain in the system. To remedy the situation, the federal government should:

- Treat the caregiver and the older adult in need of care as one unit for the purposes of policy design and service delivery;
- Remove the cohabitation requirement for caregivers to be eligible for caregiver tax credits;
- Extend eligibility for the CCB and other benefits so that those caring for individuals suffering from chronic or episodic illnesses, but whose condition is not considered terminal, also qualify;
- Ensure that the CCB is well aligned with other support and job protection offered by provinces; and
- Explore ways in which additional — and more flexible — income support and enhanced job protection measures can be provided to caregivers.

The changes to the CCB also follow on the 2014 federal Employer Panel for Caregivers, an initiative undertaken by the federal government to engage employers in a conversation about the needs of caregivers. A key focus of the panel's work was to begin documenting the various ways in which employers can and do respond to accommodations. The panel underscored the need for further research and dissemination in this area (Employer Panel for Caregivers 2015).

In support of this effort, the federal government should:

- Give employers more information about the tools that can help them better support the growing ranks of working caregivers; and
- Recognize employers who excel in supporting working caregivers, which in turn draws further positive attention to this important issue.

Conclusion

The time has come for a national seniors strategy. A recent survey of Canadians (Ipsos Reid Public Affairs 2013) reveals that:

- 93 percent of Canadians believe we need a pan-Canadian strategy to address the needs of seniors;

- 88 percent believe this will require the collaboration of all levels of government; and
- 78 percent believe the federal government has an important role to play in the development of such a strategy.

Moreover, there is growing support among advocacy groups and experts to allow for a little "rule breaking" to help us get there. When Canadians decide something needs to be done, they don't much care about whose mandate it is to do it; they just want it done. With ongoing communication and collaboration among the three orders of government, the perennial challenge of jurisdiction can be managed and overcome.

Over the course of the consultation, Task Force members heard about a number of other considerations of a provincial or local nature that flow from the national conversation.

These debates should occur in every province and territory. If we are lucky, best practices will be identified and, more importantly, shared and applied elsewhere. Our aim, however, was to focus on the national conversation.

Of the three main approaches the federal government could take, the one we propose is undoubtedly the most challenging. Each in its own way, the centralized "command and control" approach and the "laissez-faire" approach present fewer risks. But they also diminish the potential of what can be achieved. For Ottawa, engaging its partners in Confederation in a process it does not fully control and whose outcome is not fully known is guaranteed to get messy at times, but the prospects of a lasting resolution if it is successful should encourage our leaders to aim for something beyond what is safe.

This report is a call to action for governments and citizens across Canada who believe a new approach is needed to meet the needs and challenges of an aging population and who want to ensure the public debate that must take place is national in scope and informed by evidence. In this report, we have outlined the components of a strategy that we believe is achievable if there is the will to make this a priority. Other groups will have their own frameworks to propose, and they, too, should be considered. But as we stated in our introduction, it is time to move from discussion to action. Let us bring together the various proposals for a national seniors strategy, choose the elements on which we want to build and decide together on the best way forward.

We believe this debate can — indeed should — happen now. We look forward to it.

Appendix A: Task Force Members

Graham Fox is President and CEO of the Institute for Research on Public Policy, Canada's leading independent think tank. Prior to joining the IRPP in 2011, Mr. Fox was a strategic policy adviser at the law firm Fraser Milner Casgrain (now Dentons LLP), where he provided public policy analysis and government relations advice in the fields of telecommunications, economic development, international aid, foreign investment, energy and aerospace. He is a former vice-president of the Public Policy Forum, and executive director of the KTA Centre for Collaborative Government. In politics, he contested the 2007 Ontario general election as a candidate in the constituency of Ottawa-Orléans. He was chief of staff to the Rt. Hon. Joe Clark, and adviser to Members of Parliament. A policy entrepreneur, his research interests include parliamentary and democratic reform, citizen engagement and federalism. He holds an undergraduate degree in history from Queen's University, where he was a Loran scholar, and a master's degree in political science from the London School of Economics.

Scott Haldane has been President and Chief Executive Officer of YMCA Canada since 2010. His YMCA career, however, extends back more than three decades. Beginning on Montreal's West Island as a lifeguard, youth worker and branch executive, he then progressed to the YMCA national office, where he directed employment initiatives before moving on to Hamilton/Burlington as president and chief executive officer. He later held the same role for the YMCA of Greater Toronto for seven years. Today, he oversees a federation of 45 YMCAs and 6 YMCA-YWCAs serving more than 2 million people in hundreds of communities across Canada. He has a graduate degree in management from McGill University. He continued his education through Harvard Business School's Advanced Management Program and the Director's College at McMaster University

The Honourable A. Anne McLellan is a senior adviser at Bennett Jones LLP. She joined the firm after a distinguished career in federal politics, where she served four terms as the Liberal Member of Parliament for Edmonton Centre from 1993 to 2006. During her political career, she was deputy prime minister of Canada, minister of public safety and emergency preparedness, minister of health, minister of justice and

attorney general of Canada and minister of natural resources and federal interlocutor for Metis and non-status Indians. As deputy prime minister, she chaired two Cabinet committees: the Operations Committee and the Security, Public Health and Emergencies Committee. Prior to entering politics, she was a professor of law at the University of Alberta, where she served at various times as associate dean and acting dean. An Officer of the Order of Canada, she became Dalhousie University's seventh chancellor in May 2015.

Samir Sinha currently serves as the director of geriatrics at Mount Sinai and the University Health Network Hospitals in Toronto and holds the Peter and Shelagh Godsoe Chair in Geriatrics at Mount Sinai Hospital. He is also an assistant professor in the departments of medicine and family and community medicine, and the Institute of Health Policy, Management and Evaluation at the University of Toronto, and an assistant professor of medicine at the Johns Hopkins University School of Medicine. A Rhodes Scholar, his breadth of international training and expertise in health policy and the delivery of services related to the care of the elderly have made him a highly regarded expert in the care of older adults. In 2012 he was appointed by the Government of Ontario to serve as the expert lead of Ontario's Seniors Strategy. He has further consulted and advised hospitals and health authorities around the world. In 2014, *Maclean's* proclaimed him to be one of Canada's 50 most influential people and its most compelling voice for the elderly.

Mark Taylor is Deputy Mayor of the City of Ottawa and since 2010 has served as City Councillor for Bay Ward, home to the highest number of older adults in the Nation's Capital. He is the policy sponsor for Ottawa's Older Adult Plan for the 2014-2018 term of Council and served as the original cochair of Ottawa's Older Adult Plan. He also represents Ottawa as a board member on the Association of Municipalities of Ontario, where he serves on the Task Force on Affordable Housing. Throughout his time as councillor, he has been a champion for building an age-friendly Ottawa, eradicating chronic homelessness and improving access to the services people need, especially those living in affordable housing. He has a background in business, the non-profit sector, the post-secondary sector, politics and community building outside his time as city councillor. He is a champion for the rights of older adults and for building an inclusive, accessible community.

Appendix B: Summary of Recommendations

Ensure older Canadians remain independent and engaged members of our communities for as long as possible.

1. Engage employer groups, unions and older workers themselves in an open dialogue to better understand these dynamics, share experiences with flexible work arrangements and promote best practices among individual employers;
2. Conduct additional research on the relationships between an aging workforce, sectoral labour shortages and skills gaps, and productivity;
3. Building on recent initiatives, promote financial literacy and advance planning to support retirement security;
4. Come to a pan-Canadian consensus on the future of the CPP/QPP, and ensure any alternative provincial initiatives aimed at providing supplemental pension coverage (, the Ontario Retirement Pension Plan and Quebec's Voluntary Retirement Savings Plan) are adequately coordinated with a common vision;
5. Focus future enhancements to GIS/OAS on the goal of ensuring no older Canadians fall below the poverty line. This will require targeted efforts to enhance the generosity of GIS/OAS for certain groups, particularly those who live alone;
6. Examine options to adjust eligibility for retirement benefit programs, with a view to potentially shifting away from parameters that are based on a fixed age (e.g., age 65) and toward a formula that changes in relation to mortality and life expectancy;
7. Align these initiatives with other measures related to private, voluntary savings (e.g., RRSPs and TFSAs) to ensure Canada's retirement income system remains cohesive;
8. Conduct more robust evaluations of existing AFC initiatives and enable the sharing of best practices across municipal and provincial jurisdictions;
9. Dedicate a higher proportion of federal infrastructure dollars to affordable housing and transportation options that will allow older Canadians to remain more independent in their communities; and
10. Incorporate well-established universal design standards in our national building codes to support the development of more age-friendly physical spaces.

Ensure older Canadians continue to lead healthy and active lives for as long as possible.

11. Ensure high-quality information about healthy aging and the prevention of age-related diseases — such as regular exercise, fall prevention and routine vaccinations — is widely available and can be accessed in one place;
12. Support research and experimentation on the use of incentives to encourage such behavioural changes;
13. Promote health literacy, informed decision-making and ACP;
14. Support communities in providing opportunities for exercise (such as safe walking areas), nutritious food (healthy, affordable options), and socialization (buildings and outdoor spaces that naturally bring people together, gathering spaces, support for informal and formal groups); and
15. Create more formal partnerships that bring together governments, disease-specific organizations, caregiver organizations and community groups to coordinate the promotion of a healthy/active living agenda.

Ensure older Canadians have access to person-centred, high-quality, integrated care as close to home as possible, provided by those who have the knowledge and skills to care for them.

16. Collaborate with the provinces and territories to redefine "community care" beyond home and long-term care to include other support and community services that contribute to the continuum of care;
17. Use the Canada Health Transfer, if necessary, to compel the provinces and territories to come to an agreement on minimal service standards for home, community and long-term care. To be clear, these should not be dictated by Ottawa and should emerge from provincial/territorial consensus. And while each province and territory must be free to determine how best to deliver services that respect local preferences and realities and to provide additional services beyond those agreed to by the group, recognizing and adhering to some form of common standards should not be optional;
18. Conduct a thorough review of the *Canada Health Act* to determine whether any changes to the federal legislative framework might encourage provincial and territorial partners to engage in this type of structural reform;

19. Ensure that all Canadians have access to the medication they need through the creation of a national pharmacare program, which would improve comparability of coverage and create an "economies of scale" cost advantage, where coverage is based on evidence as assessed by an impartial group with no real or apparent conflict of interest;
20. Establish national metrics, information collection and reporting systems through agencies like CIHI;
21. Ensure provinces report publicly and annually on how they measure up;
22. Encourage national accreditation bodies to mandate entry-to-practice training and continuing professional development activities around the care of the elderly to ensure current and future providers have the knowledge and skills needed to provide care for older Canadians;
23. Encourage the provinces to review the scopes of practice for health care providers to ensure Canadians get the right care, in the right place, delivered by the right provider;
24. Work with provinces and territories to help develop pan-Canadian training and appropriate prescribing standards for all those who prescribe and dispense medications in the care of older adults;
25. Ensure funding for health care is "de-siloed" so as not to encourage specific behaviour by tying funding to specific services or transactions, and encourage the provinces and territories to do the same;
26. Move to a funding formula that is at least partially linked to the demographic structure, so that regions with a higher proportion of older adults have comparable capacity to meet the health needs of their population;
27. Lead a comparative analysis of the pros and cons of provincial funding and organizational models, with the aim of identifying which practices are more likely to encourage "dehospitalization" in favour of community care, and whether certain models foster innovation more effectively;
28. Carefully consider how implementing the recommendations of the Advisory Panel on Healthcare Innovation (commonly referred to as the Naylor report) can ensure the health system adapts to the needs of an aging population;
29. Launch a broad public engagement process to determine how Canadians want to deal with end-of-life issues and what is the appropriate legislative and policy

response. This process should be led by Parliament, not government, and should be one of the first major actions of the 42nd Parliament when it convenes; and

30. Consider replicating the all-party, public consultation process used by the Quebec National Assembly in its own report on this same topic.

Ensure that the family members and friends of older Canadians who provide unpaid care for their loved ones are acknowledged and supported.

31. Treat the caregiver and the older adult in need of care as one unit for the purposes of policy design and service delivery;
32. Remove the cohabitation requirement for caregivers to be eligible for caregiver tax credits;
33. Extend eligibility for the CCB and other benefits so that those caring for individuals suffering from chronic or episodic illnesses, but whose condition is not considered terminal, also qualify;
34. Ensure that the CCB is well aligned with other support and job protection offered by provinces;
35. Explore ways in which additional — and more flexible — income support and enhanced job protection measures can be provided to caregivers;
36. Give employers more information about the tools that can help them better support the growing ranks of working caregivers; and
37. Recognize employers who excel in supporting working caregivers, which in turn draws further positive attention to this important issue.

Appendix C: Contributors to the Consultation Process

Members of the Task Force would like to thank the following individuals for their contribution to the consultation process, through the interview process, the round table and/or by providing resource materials and comments in writing. Our deliberations were greatly enriched by their insights, but responsibility for the conclusions drawn and the recommendations made in this report remains our own.

Debbie Abfalter, Seniors Solution
Owen Adams, Canadian Medical Association
Sarah Anson-Cartwright, Canadian Chamber of Commerce
Stephen Bent, Public Health Agency of Canada
Charles Bergeron, Canadian Medical Association
Diane Bergeron, Canadian National Institute for the Blind
Louise Bergeron, National Association of Federal Retirees
Nicole Bernier, Institute for Research on Public Policy
Maryanne Brown, Clinical Leadership Services in Gerontology
Neena Chappell, Health Policy for Aging Population, University of Victoria
Candace Chartier, Ontario Long Term Care Association
Connie Côté, Health Charities Coalition of Canada
Susan Eng, CARP
Carolyn Gasser, Royal Canadian Legion
Bailey Griffin, Women's College Hospital
Colleen Hendrick, City of Ottawa
Nadine Henningsen, Canadian Home Care Association
Genevieve Hladysh, YMCA of Hamilton/Burlington/Brantford
Sherri Huckstep, Victorian Order of Nurses (VON) Canada
Eric Lamoureux, Alzheimer Society of Canada
Mike Luff, Canadian Labour Congress
Graydon Meneilly, Department of Medicine, University of British Columbia
Tyler Meredith, Institute for Research on Public Policy

Vytas Mickevicius, YMCA Canada
Frank Molnar, The Ottawa Hospital
Michael Nolan, Ontario Association of Paramedics Chiefs
David O'Toole, Canadian Institute for Health Information
Daniel Sansfaçon, Status of Women Canada
Anne Sutherland Boal, Canadian Nurses Association
Jean-Pierre Voyer, Social Research and Demonstration Corporation
Joanne Yelle-Weatherall, Bruyère Continuing Care
Ivy Wong, Women's College Hospital

Notes

1. Statistics Canada, CANSIM table 051-0001.
2. Statistics Canada, CANSIM table 051-0001 and table 052-0005, M1 scenario projection.
3. Please see Appendix A for the list of task force members.
4. The Task Force would like to thank Alexandra Charette for conducting the literature review that formed the basis of the consultation process and IRPP Research Director Tyler Meredith for his significant contribution to drafting the report.
5. The IRPP would like to thank the Canadian Medical Association for its financial support for this project.
6. Men, on average, will live another 18.8 years, compared to 21.7 years for women.
7. It is important to note that, although gains in longevity were quite robust throughout much of the 20th century, many actuaries expect that this trend will slow down somewhat in the future.
8. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
9. http://www.oxforddictionaries.com/definition/english/care?q=CARE#CARE
10. For more information on this initiative, readers are directed to: http://www.nationalseniorsstrategy.ca/.
11. Based on an assumed target replacement rate of 75 percent.
12. The WHO has defined the following eight criteria concerning the development of age-friendly communities: (1) outdoor spaces and buildings, (2) transportation, (3) housing, (4) social participation, (5) respect and social inclusion, (6) civic participation and employment, (7) communication and information, and (8) community support and health services (WHO 2007).

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