

2019

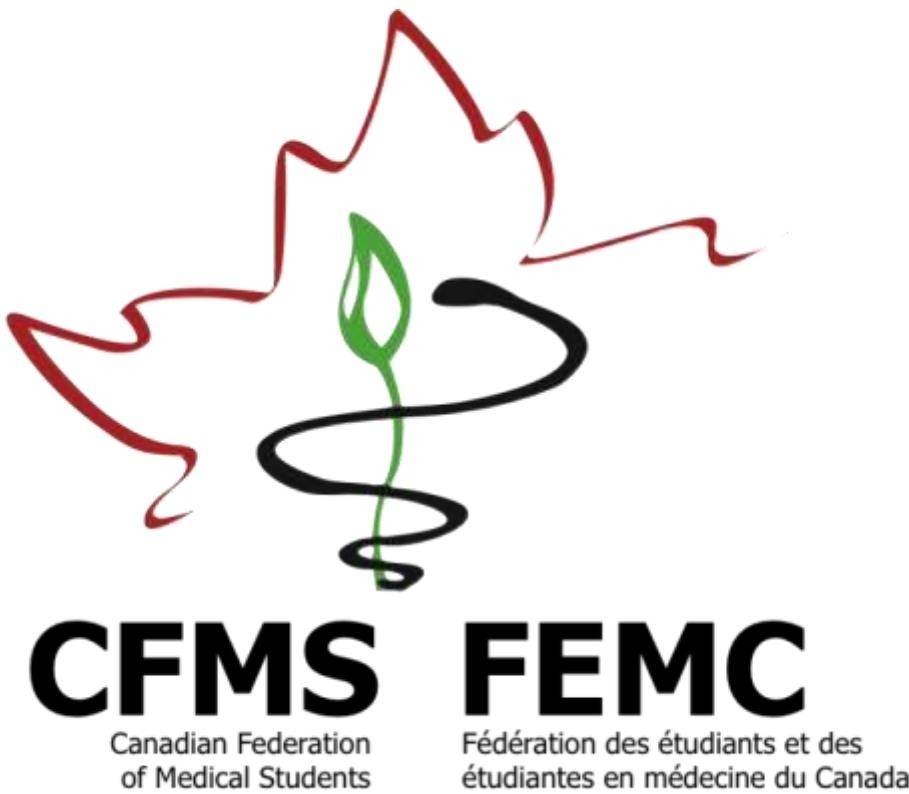
CFMS

DAY OF **ACTION**



SENIORS CARE & AGING

BACKGROUNDER



About Us: The Canadian Federation of Medical Students (CFMS) is the national organization representing over 8,000 Canadian medical students from 15 medical schools across Canada. We represent medical students to the public, to the federal government, and to national and international medical organizations.

Our Mission: The Canadian Federation of Medical Students (CFMS) is the national voice of Canadian medical students. We connect, support, and represent our membership as they learn to serve patients and society.

Our Vision: Tomorrow's physicians leading for health today.

Acknowledgements

We would like to thank the community leaders and health experts whose expertise and guidance helped shape the direction of this document. Without you, this would not have been possible.

Dr. Soham Rej, Investigator, Geriatric Psychiatrist, McGill University

Dr. Thomas Hadjistavropoulos, Research Chair in Aging and Health, University of Regina

Dr. Janet Kow, Geriatric Specialist, Providence Health Centre, British Columbia

Susan MacDonald, Physician, Palliative Care Medicine, Newfoundland and Labrador

Dr. Rose Hatala, General Internist and Palliative Care Physician, St. Paul's Hospital, British Columbia

Dr. Howard Bergman, Chair, Department of Family Medicine, Professor, Geriatric Medicine, McGill

Dr. Eric Anderson, Communications Leader, Sherbrooke Community Centre

Dr. Olivier Beauchet, Senior Investigator, McGill University, Dr. Joseph Kaufmann Chair in Geriatric Medicine, McGill University and Geriatrician, Jewish General Hospital

Brian Harris, Member at Large, Saskatchewan Seniors Mechanism

Michel Sorensen, Program Coordinator, Saskatchewan Seniors Mechanism

Norma Kirkby, Program Director, Alzheimer's Society of Manitoba

Tia Chiasson, Ubuntu Program Coordinator, TAIBU Community Health Centre

Mike Cass, Patient Safety Improvement Lead, Canadian Patient Safety Institute

Diane A. Ducas, Geriatric Psychiatrist, University of Manitoba

Elizabeth Macnab, Executive Director, Ontario Society of Senior Citizens Organizations

Larry Chambers, Research Director, McMaster University

Jan Legeros, Executive Director, Long Term and Continuing Care Association of Manitoba

Connie Newman, Executive Director, Manitoba Association of Senior Centres

Julie Turenne-Maynard, Executive Director, Manitoba Association of Residential Care Homes for the Elderly

Mary Ennis, SeniorsNL

Dr. Frank Molnar, Geriatrician, Ottawa Hospital and President, Canadian Geriatrics Society

Pat Irwin, President, ElderCareCanada

Dr. Suzanne Brake, Seniors Advocate, Newfoundland and Labrador

Dr. Samir Sinha, Geriatric Medicine Specialist, Lead of Ontario's Senior Strategy and Member, Federal Ministerial Advisory Board on Dementia

Dr. Amina Jabbar, Resident Physician, Geriatric Medicine and PhD student, Health Policy, McMaster University

Dr. Roger Butler, Geriatric Medicine and Family Medicine, Memorial University

Naheed Dosani, PEACH Program, Inner City Health Associates

Sabrina Akhtar, Family Physician, Toronto Western Hospital Family Health Team

Dorina Simeonov, Policy and Knowledge Mobilization Manager, AGE-WELL NCE Inc.

Melissa Anderson, Advocacy Lead, Canadian Physiotherapy Association

We would like to extend thanks to every Canadian medical student across the country who participated in the community consultation process. It was your dedication that ensured that the process was a success.

Sheetal Pundir, McGill University

Jessica Froehlich, University of Saskatchewan

Reem Aziz, University of British Columbia

Maggie O'Dea, Memorial University of Newfoundland

Kaitlyn Schick, University of Saskatchewan

Peter Hoang, McMaster University

Alicia Mah, University of Saskatchewan

Amy Lam, University of Manitoba

Chantal Phillips, University of Toronto

Kaleigh Ducas-Mowchun, University of Manitoba

Hilary Pang, University of Toronto

Rebecca Matthews, Memorial University of Newfoundland

Joseph Asaminew, University of Manitoba

Brooke Turner, Memorial University of Newfoundland

Yipeng Ge, University of Ottawa

Caroline Leps, University of Toronto

Monisha Persaud, University of Toronto

Linda Lam, University of Manitoba

Finally, we would like to acknowledge the members of the Day of Action Research Committee for the tremendous amount of time and effort that you have dedicated to researching, compiling and writing this backgrounder.

Alexandra Killian, University of Toronto

Catherine Caldwell, Memorial University of Newfoundland

Chantal Phillips, University of Toronto

Helen Teklemariam, University of Manitoba

Hilary Pang, University of Toronto

Jessica Froehlich, University of Saskatchewan

Maham Bushra, University of Toronto

Matthew Yau, University of Toronto

Mithila Somasundaram, University of Toronto

Monisha Persaud, University of Toronto

Reem Aziz, University of British Columbia

Wenxuan Wang, Western University

Yu Fei Xia, McMaster University

With deepest appreciation and gratitude,

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1.0 Executive Summary

A 90-year-old female living independently in a retirement residence who enjoys bowling two nights a week, playing bingo, and visiting friends. A 78-year-old newcomer male living in an inter-generational home with depression after the passing of his siblings, mistaken for dementia. A 67-year-old with multiple comorbidities requiring assistance for all activities of daily living (ADLs), living in a long-term care home.

Aging is a continuum impacted by care, services, policies, and the social determinants of health. Planning and designing communities that can support healthy aging will significantly benefit every member of society. This is why the 2019 Canadian Federation of Medical Students' (CFMS) National Day of Action will focus on advocating for federal health policy that positively supports healthy aging with dignity.

CFMS Policy Recommendations

Every Canadian deserves to age with dignity, with access to necessary supports and appropriate resources. As such, the **Canadian Federation of Medical Students (CFMS)** calls upon all Members of Parliament to:

1. Commit to targeted funding and development of a **National Seniors Strategy** for the 2019 Federal Election.
2. Commit to the development of a **national evidence-based formulary** as a first step towards implementing a universal, comprehensive, and cost-effective **National Pharmacare Program**. Work in collaboration with national experts to promote targeted deprescribing and minimize polypharmacy.
3. Support national leadership on *developing and tracking quality indicators to measure availability and quality of home care, palliative care, and community care* at the next Federal/Provincial/Territorial Ministers Responsible for Seniors Forum.

The purpose of this document is to provide students with a multifaceted understanding of the urgency of aging policy reform, and with the levers necessary to influence federal policymakers.

Through a review of the literature, we have collected information regarding the impacts of aging on health and society, as well as documenting evidence-based interventions to promote healthy aging. The political landscape with regards to aging policies is distilled from discussions with key stakeholders, summaries of partisan positions, and analysis of current federal legislation.

It is our hope that this document will enrich your discussions and maximize your impact during the 2019 CFMS Day of Action on Seniors Care and Aging. Thank you for taking the time to advocate for this worthwhile cause – we wish you the best of luck.

Linda Lam
National Officer of Political Action

2.0 Why is Seniors Care and Aging a Priority

One of the challenges of planning for an aging population is the heterogeneity in our needs and abilities as we age. Unsurprisingly, the prevalence of chronic conditions increases as we age, which accounts for a disproportionate usage of the healthcare system (Canadian Institute for Health Information 2011). Compared to adults ages 18 to 24, individuals 65 years-old and older were 4 times more likely to report having a chronic condition, and about 1.5 times more likely compared to the 45-64 age group (Canadian Institute for Health Information 2011). The result is that the average cost of healthcare for the average senior is 4.4 times greater year than the rest of the population, at \$12,000 per year compared to \$2,700 per year (CBC 2018). This accounts for nearly half of healthcare dollars despite seniors only making up one-fifth of the population (The Conference Board of Canada 2018).

A higher prevalence of chronic conditions is closely related to increased medications. Statistics show that seniors with 1-2 conditions take an average of 3-4 prescription medications, which increases to an average of 6 prescription medications in the group of seniors with 3 or more conditions (Canadian Institute for Health Information 2011).

For the first time ever in Canada, the number of seniors exceeded the number of children aged 14 and younger (Grenier 2017). This is a positive reflection that advances in public health, medical innovation and social supports have allowed people to live longer and healthier. We are seeing that seniors are active, with 80% participating at least once a month in at least one social activity, and contributing an average of 223 volunteer hours annually, which is 1.4x greater than the total average of 156 hours across all ages in Canada (Sanmartin 2015; Government of Canada 2014). Given the opportunity, an aging population has a lifetime of knowledge, experiences, skills and history to share with the rest of society.

National leadership from the federal government on seniors' care would tell Canadians that we care about you as you age, and we are here to support you and older loved ones. A National Seniors Strategy would coordinate best-practices, and targeted funding would equalize care across the country. In anticipation for a growing senior population, it is timely to prioritize seniors care and aging. It offers us an opportunity to be proactive and intentional in the care, services and policies designed. With foresight and planning we can support healthy aging throughout the lifespan for a diverse population, allowing us to live well into our older years in a dignified way that is acceptable to us and sustainable for the health care system.

The federal government has leadership, infrastructure and resources and as medical students, we believe that the federal government can have a real impact on seniors' care and aging.

3.0 Background

3.1 Epidemiology

Canada's senior population (ages ≥ 65) is growing at a rapidly progressive pace; by 2037, it is expected to increase by 68% (Canadian Institute for Health Information 2017). The oldest seniors population (seniors of age 75 and above) is growing even faster – this population is expected to double in Canada over the next 20 years (Canadian Institute for Health Information 2017). Specifically, the population growth of seniors ages ≥ 75 is projected to be the lowest in Saskatchewan (1.9x its current size) and the highest in Nunavut (5.7x its current size) by 2037 (Canadian Institute for Health Information 2017). Seniors could represent between 23% and 25% of the total population in 2036 (Sanmartin 2015). According to Statistics Canada's 2016 census, the number of seniors exceeded the number of children aged 14 and younger for the first time ever (Grenier 2017). The aging of the Canadian population is due to a multitude of factors, such as increasing life expectancy, baby boomers turning 65 over the last five years, and a low fertility rate (Grenier 2017).

In 2009, 56% of individuals aged 65 and older reported being in good health (Statistics Canada 2011). The World Health Organization's definition of good health is all encompassing - it involves a state of complete physical, mental and social well-being, and not just an absence of disease. Individuals aged 65 and older are more likely to have one or more chronic health conditions such as hypertension (53%), arthritis (43%) and back issues (29%) than those aged 45 to 64 (Statistics Canada 2011). According to the Canadian Community Health Survey in 2009, 21% of Canadians over 71 years of age have 3 or more high-impact, high prevalence chronic health conditions (Sanmartin 2015).

Increasingly, older Canadians are choosing to stay in the workforce. From 2000 to 2010, senior employment increased from 9% to 15% for men and from 3% to 7% for women (Statistics Canada 2011). Senior families are defined as those in which the highest income earner is 65 years of age or older; these types of families had a median after-tax income of \$57,800 in 2016, which is a 4.7% increase from 2012 (Heisz and Gustaitis 2018). Seniors living without a family to support had a median after-tax income of \$26,100 in 2016. In 2016, there were 828,000 (14.2%) Canadian seniors living in low income, as defined by the after-tax low-income measure (Heisz and Gustaitis 2018). Low income was especially high for unattached seniors. Disparity between senior men and women in lower income classes was also seen; senior men not in an economic family had a low-income rate of 32.5%, compared with 34.3% for women in the same demographic group (Heisz and Gustaitis 2018). Low income among seniors has been steadily increasing since the mid-1990s.

According to the 2011 Census, 30% of seniors in Canada are immigrants (Statistics Canada 2011). The majority of them arrived before 1967 and aged in Canada (Dempsey and South 2009). A small percentage (5%) were recent immigrants and contributed directly to the growth of the Canadian senior population (Dempsey and South 2009). Over the last three decades, there has been a significant shift in the origin country of Canada's immigrant seniors. Almost half of recent immigrant seniors came from South Asia and East Asia instead of from West Europe countries (Dempsey and South 2009). This increase in diversity in the ethnic demographic of Canadian seniors has implications on the prevalence of chronic and genetic diseases.

Since 1981, there has been a continuous rise in the number of seniors living in the community. The majority of those aged 65 and over live in the community, but 7% live in special care facilities—long-term and residential care facilities (Sanmartin 2015). According to the 2011 census, 4.5% of seniors are living in nursing homes, chronic care or long-term care hospitals, while 2.6% live in residences for senior citizens (Statistics Canada 2011). In addition, 1 in 4 of Canada's caregivers provide care specifically related to aging (Sanmartin 2015). According to caregiver self-reports, there are higher levels of stress and poor health associated with increased hours of care provided (Sanmartin 2015).

3.2 Role of the Federal Government

Under the Canada Health Act, the federal government is responsible for setting and administering national principles for the health system (Government of Canada 2018a). Specifically, they are responsible for providing funding to the provinces and territories, and for the delivery of services to certain groups of people including First Nations people living on reserves, Inuit, serving members of the Canadian Forces, eligible veterans, inmates in federal penitentiaries, and some groups of refugee claimants. The Canada Health Act operates under the five principles of public administration, comprehensiveness, universality, accessibility and portability. Unfortunately, the Canada Health Act is limited to coverage of expenses within the hospital and to care by physicians deemed “medically necessary” (Government of Canada 2011).

Additionally, the federal government is responsible for (Government of Canada 2016a):

- 1) regulating products (ie. food, medical devices);
- 2) supporting health research, promotion and prevention, disease monitoring and prevention;
- 3) as well as provide tax supports for health-related costs.

Provincial and territorial governments are responsible for implementing and managing delivery of health care services and social programs (Government of Canada 2016a).

The federal government provides funding to provinces through the “Canada Health Transfer” and “Canada Social Transfer” (Department of Finance Canada 2014). These two streams of funding were derived from the restructuring of the Canada Health and Social Transfer (1996-2003), with 62% allocated towards health and 38% allocated towards post-secondary education, programs for children and other social programs. Additionally, in 2003, \$16 billion over five years was committed towards primary health care, home care and catastrophic drug coverage through a Health Reform Transfer.

In summary, all levels of Government have a role to play in ensuring adequate seniors care and promoting healthy aging. While the provincial/territorial governments are responsible for implementing health and social programming, the federal government is looked upon for leadership and funding on issues of national importance.

4.0 Federal Legislation and Action

In recent years, there has been several initiatives by the federal government to support an aging population. This section serves as a summary of current Federal legislations and actions that supports seniors.

4.1 Coordination

The National Seniors Council is an advisory panel that advises the federal government (specifically to the Minister of Employment and Social Development and the Minister of Health) about senior care (Government of Canada 2016b). The council consists of representatives from interdisciplinary fields, including seniors, representatives of seniors' organizations, and experts on aging. The National Seniors Council has released a series of reports on topics such as elder abuse, senior volunteerism, and senior isolation (National Seniors Council, n.d.).

The federal government is also a part of the Federal/Provincial/Territorial Ministers Responsible for Seniors Forum. This intergovernmental body was established to "share information, discuss new and emerging issues and work collaboratively on key projects" (Government of Canada 2014).

4.2 Legislation

The Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities released a report - Advancing Inclusion and Quality of Life for Seniors (May 2018). This report lists 29 recommendations for the federal government to improve senior care, including increasing resources to Service Canada, preventing financial abuse of seniors, and creating national guidelines for home care services.

Bill C-81 Accessible Canada Act has passed third reading in the House of Commons and recently completed first reading in the Senate (November 2018) (Parliament of Canada 2019). It was presented by the Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities to promote accessibility in Canada for all persons in order to enhance full and equal participation. The bill proposes the development of a Canadian Accessibility Standards Development Organization to create accessibility standards, the authorization of the Accessibility Commissioner to provide advice to the Minister in regards to enforcement of the Act, and the appointment of a Chief Accessibility Officer to advise the Minister on emerging accessibility issues (OpenParliament 2019). It is a comprehensive document that encompasses accessibility in broadcasting, telecommunications, transportation, labour and public service employment, information and finances.

4.3 Funding at the Federal Level

Finances and Retirement Income (Government of Canada 2014)

- Canada Pension Plan
- Registered Retirement Savings Plan (RRSP)
- Old Age Security (OAS)
- Guaranteed Income Supplement
- Allowance and Allowance for the Survivor

The availability of finances plays a large role in allowing seniors to receive the supports that they need. The federal government of Canada is responsible for the Old Age Security pension, which is given in full amount to individuals age 65 and older who have lived in Canada for 40 years since the age of 18 years. Partial pensions are offered to those who have been in Canada for 10 years past the age of 18 years. Low-income seniors receiving an OAS pension are additionally eligible for a Guaranteed Income Supplement. These benefits were estimated to rise from \$50.9 billion (2017-2018) to \$67 billion (2022-2023) in 2018 Federal Budget. The Canadian Pension Plan is regulated through the federal government, but is distributed through an individual's employer, offering a portion of the individuals' income once retired. The Allowance and Allowance for Survivor provides financial support for partners and widows aged 60-64 years-old who would otherwise not qualify for OAS and GIS funding.

Caregiver Support

- Caregiving Benefits (Government of Canada 2019)
 - Family Caregiver Benefit for Adults
 - Provides caregivers with up to 15 weeks of paid leave (max \$562 a week) to care for a critically ill or injured person 18 years old or over
 - Compassionate Care Benefits
 - Provides caregivers with up to 26 weeks of paid leave (max \$562 a week) to care for a person of any age who requires end-of-life care
- Tax credits (Government of Canada 2018b)
 - Canada Caregiver Credit
 - Non-refundable tax credit to support caregivers providing care to an individual with a physical or mental impairment
 - Medical Expenses Tax Credit
 - Tax return on eligible medical expenses
 - Disability Amount Tax Credit
 - Non-refundable tax credit for persons with disabilities or their support person to reduce the amount of income tax that would otherwise have to be paid

Federal to Provincial Transfer for Senior Care

The federal government of Canada has committed to transferring \$40 billion of funds for healthy aging and chronic disease prevention and management to provinces by 2021. While 2011 saw a \$1.4 billion investment in affordable housing for all Canadians, it is unknown if a certain portion was designated for seniors.

Additionally, in the 2017 Federal Budget, federal funding of \$11 billion over 10 years was earmarked to provinces and territories specifically to improve access to mental health and addiction services (\$5 billion), as well as to home care and community care (\$6 billion) as part of the Shared Health Priorities agreement (Health Canada 2017).

Federally Funded Programs

- War Veterans Allowance: War veterans
- Assisted Living Program: for First Nations people and Inuit
- International Benefits Program: for Canadians living in another country
- Home Adaptations for Seniors' Independence Program
- Residential Rehabilitation Assistance Program
- New Horizons for Seniors Program

Home Adaptations for Seniors' Independence Program

The federal government hosts several programs dedicated to assisting seniors with home repairs (Government of Canada 2014). The Canada Mortgage and Housing Corporation (CMHC), a Crown corporation, administers the Home Adaptation for Seniors' Independence Program (Canada Mortgage and Housing Corporation 2018). Designed for First Nation seniors with low income living on a reserve, this program provides \$10,000 to install home adaptations that promote safe, healthy aging, including handrails, grab bars, and lever handles.

New Horizons for Seniors Program

Employment and Social Development Canada administers the New Horizons for Seniors Program (Canada 2018). This funding platform provides grants to community-based organizations and national organizations that empower seniors.

Palliative Care

Recent financial contributions to seniors, from the federal government include \$3 million in 2012 to study the development of palliative care models in the community, and \$3 million to the Pallium Foundation of Canada to train health care providers involved in end-of-life care.

Research

In addition to these programs, the federal government is engaged in research initiatives relating to improving senior care.

Budget 2018 allocated \$75 million from 2018-2019 to fund a Healthy Seniors Pilot Project in New Brunswick (Morneau 2018). The funding supports research aiming to improve quality of care for seniors, with the goal of creating a series of best practices for healthy aging.

Budget 2018 also allocated \$20 million from 2018-2019 and \$4 million per year in perpetuity for community-based projects focusing on dementia (Morneau 2018).

5.0 Stakeholder Perspectives

5.1 Consultation Summary

CFMS Consultations and Findings

In developing the 2019 CFMS National Day of Action research and documents, community leaders and health experts across the country were engaged by medical students to participate in a consultation process. The purpose of the process was to learn and receive insight from those that see and understand first hand the gaps impacting seniors, and how we, as medical trainees, can add our voice as allies to a growing conversation.

Our Process

The CFMS coordinated medical students across the country to identify and engage with community leaders and health experts on the topic of Seniors Care and Aging. Medical students connected with stakeholders in several ways including in-person meetings, phone calls, and communication through email. Qualitative analysis using an inductive approach was utilized to identify emerging themes from the consultations to guide the development of recommendations.

Our Major Findings

Previous efforts to address senior's health has been criticized for an overemphasis on the health concerns of aging and an underappreciation of seniors as people. The consultation themes identified reflect the values that underpin the various concepts discussed by stakeholders: 1) Wellness, 2) Quality of Life and Dignity, 3) Choice, 4) Innovation, and 5) Support. The five themes are inter-related in many ways. The theme of wellness advocates for holistic, comprehensive medical and social care with emphasis on health promotion and prevention. This in turn promotes quality of life and dignity through the way that we care for others. Innovation using technology and research also has an impact on one's quality of life and choice/autonomy. By providing appropriate supports we are empowered with choice and opportunity to live in a way that we deem to be acceptable.

1. Wellness - Promoting a healthy lifestyle throughout one's life and preventing illness and disease through optimizing the social determinants of health, quality and access to community health resources, and strong primary care, all contributes and leads to healthy aging and wellness
2. Quality of Life and Dignity - Patient centered care ought to promote and enhance quality of life and dignity, through addressing how we care for individuals, how we tackle stigma and ageism, and how we acknowledge the importance of belonging and purpose.
3. Choice - Accessibility and equity ought to be foundational in how we design the built environment, end-of-life care considerations, and comprehensive pharmacare to support choice, autonomy, and help individuals focus on what matters most in their lives.
4. Innovation - Technology ought to complement and enhance health care and provide ease of accessibility, and research coordination to better understand dementia in its pathophysiology and its impacts on caregivers.
5. Support - Those that care for and work with seniors, including personal support workers and formal/informal caregivers need proper support to provide the support they do on a regular basis for individuals as they age.



Figure 1. Gears. Depicting the interconnectedness of the five values: wellness, quality of life and dignity, choice, innovation, and support, that underpin the various concepts discussed by stakeholders. These values work together to achieve healthy aging, with each subcomponent making up various sized gears within the greater connected system. The size of the gears corresponds to the importance of each theme as emphasized by the stakeholders throughout the consultation process.

5.2 Deficiencies and Gaps Identified by Stakeholders

We had the privilege of interviewing 31 stakeholders who represent a set of diverse organizations across Canada. While diverse in their mandate, each organization represented through our consultations was committed to supporting equity and quality of life for seniors across the country.

The consultations focused on eliciting an understanding of current systemic gaps, as experienced by those that function within the system a daily basis. The deficiencies outlined in this section do not specifically apply to the federal government, but rather to multiple systems under the purview of multiple governmental bodies. As such, responsibilities for addressing

these gaps can further be distributed to the federal, provincial, and municipal levels of government, the health system and organizations, and to medical students and physicians.

It is important to note that the deficiencies and gaps identified by stakeholders are from their personal and professional perspectives and experiences, and therefore may present a bias. This was mitigated by compiling common themes and topics that arose from multiple consultations. Finally, this section is an abbreviated summary of the results of the consultations. For a more comprehensive compilation of the stakeholder perspectives, please refer to the Consultation Report.

While it is important to acknowledge the surge in social and clinical senior programs that have been implemented over the last two decades, current system inadequacies cannot be ignored. Many stakeholders reinforced barriers to **accessibility**, which included health literacy, transportation, and socioeconomic status. Inaccessible resources become unused resources. Therefore, prioritizing access, in the form of improved health literacy, assisted health system navigation, and robust financial supports should be prioritized.

In the context of **clinical services**, there are a few key areas that require additional attention. Commonplace polypharmacy results in both health consequences, through medication interactions and poor adherence, and exacerbates the financial burden on seniors. Furthermore, with fewer seniors using dentures than in the past, dental care is necessary to maintain oral health. While some cities provide free services to seniors through funded public health programs, this is not congruent across the country. Home care is a valuable service that allows for patients to be treated at-home rather than in-hospital, but is limited in terms of the needs that it meets and the number of hours provided. Activities of daily living such as shopping, laundry, and cleaning are often excluded from eligibility requirements for home care. Additionally, hours of home care provided are distributed based on equality rather than equity, which underservices individuals with complex medical and social issues. Finally, home care services are currently not suitable for individuals who live in unsafe or suboptimal housing, or those who are homeless. This negatively impacts the health status of seniors who desire to live at home while also meeting their healthcare needs.

Social programming is a key aspect of holistic care that tends to be neglected in light of clinical care. Without social activities and opportunities for community engagement, there is a greater likelihood of social isolation and its subsequent consequences, such as cognitive impairment and depression. In addition, simply implementing a social program without the input from local seniors is unfortunately common, but ineffective. For future programming, incorporating senior needs into the design and implementation should be of utmost consideration.

Oftentimes, **caregivers** may be neglected in considerations of funding and social support. While caregiving by a family member or close friend can allow seniors to remain in their homes, it can result in burnout and various mental health challenges for caregivers. Notably, the problem does not necessarily lie with the inherent nature of caregiving, but with the lack of

support to simultaneously provide care and maintain personal well-being. Stakeholders identified the gap in tax credits, therapy, and home care provided to alleviate some of these stressors for caregivers that should be considered by the government.

Intersectionality is a concept that impacts each of the areas previously mentioned. When considering accessibility, clinical services, social programming, and caregiver support, identifiers such as race, religion, sexual orientation, gender, language, immigration, and Indigenous identity have been historically neglected. In cases where these perspectives have been ignored, they tend to further perpetuate disparities and reduce the likelihood of healthy aging in these communities.

5.3 Rural Perspective

Population studies have shown that 35% of seniors in Canada live in rural areas and small towns (Atlantic Health Promotion Research Centre, n.d.). Similarly, they also make up approximately 25% of the general population who resides in small villages and rural towns. These senior citizens face healthcare problems associated with rural living that are much more exacerbated in comparison to their corresponding counterparts in urban areas. A big barrier to the identification and treatment of their health problems, especially those of mental health origin, is the disinclination for disclosure by the patient. This is by large due to the increased scrutiny within the community due to familiarity between residents as a result of the small population size. In some instances, such resistance to disclosure is accompanied by a general distrust of formal services and health professionals, and a reluctance to rely on help from members outside the immediate family. Three major barriers to treatment of mental and physical health of rural seniors include: access to services, rural attitudes and ageism. While some of these barriers were externally imposed, others appeared to arise from rural culture itself.

Access to Services

Access to services refers particularly to geographic and social isolation. This is largely a by-product of transportation being the biggest barrier to treatment. Specific barriers included distance from neighbours and family, distances to be traveled by service providers, and the problem of effectively managing resources for a sparse population spread out over a large geographical area. Many of the services needed by rural seniors do not exist in their communities. This problem is further amplified by the fact that healthcare providers are hesitant to relocate to rural communities due to the significant lifestyle changes. Similarly, many seniors who relocate to urban areas for ease of access to necessary care, end up leaving behind their family and social network, and are thereby at greater risk for depression.

Rural Attitudes

The second main barrier in the receipt of adequate healthcare was collectively termed as 'rural attitudes'. Rural attitudes refer to the lack of knowledge of available services and traditional thinking that affects a patient's understanding and treatment of illness. In other words, attitudes that are typically characteristic of rural populations may at times present barriers to

treatment of the patient. For example, some rural men have a strong sense of independence which discourages them from accepting home care and other services that may be necessary for their treatment and improvement of quality of life. Additionally, confidentiality is often difficult to ensure in small rural settings, since patients are typically close acquaintances and thus familiar with the events in each other's lives.

Ageism

Finally, ageism was identified as the third major barrier to treatment of the rural senior population. Popular depictions of the elderly over time have subtly implied a devalued body and mind image, and have conceptualized aging as moving toward a position of disempowerment. Many seniors have trouble accepting the aging process because they have been conditioned to believe that aging is shameful, and that death is tragic. Furthermore, ageist attitudes can also be found among a few health professionals who believe that depression is an understandable process that occurs when patients age. Given such pervasive ageist attitudes, seniors in rural populations may be inclined to 'accept their lot' and defer from seeking services when needed.

Other Barriers

Other barriers to access of adequate healthcare, particularly amongst seniors living in rural settings, included: illiteracy and intergenerational miscommunication.

5.4 Indigenous Perspective

The Indigenous seniors population of Canada was reported to be 121,665 as of 2017 and is expected to double over the next two decades (Press 2017; Roshanafshar and Hawkins 2018). It is important to address barriers to health, largely due to Canada's colonial history, and to consider the unique needs of Indigenous seniors in terms of cultural and holistic health.

The health barriers faced by Indigenous seniors are often exacerbated through income gaps, inadequate housing, and lack of access to culturally safe, trauma-informed care. Housing, food insecurity, and social supports are issues outlined in the 2012 Aboriginal Peoples Survey which have a particular impact on Indigenous seniors and elders (O'donnell 2012). The 2016 meeting on seniors' issues attended by the Ministers of Health and Social Development, respectively, recognized "unsafe communities and overcrowded housing units" as an issue of inadequate housing for Indigenous seniors (Press 2017; O'donnell 2012). 9% of Indigenous seniors living in city centers report that one or more members of their household do not have access to sufficient food quality. This is more than four times the prevalence of non-Indigenous counterparts (2%) (Roshanafshar and Hawkins 2018). Furthermore, food insecurity is associated with self-reported poor functional health and long term physical and mental disabilities limiting daily activity (Roshanafshar and Hawkins 2018). It is also associated with multiple chronic conditions including major depression and perceived lack of social support (Roshanafshar and Hawkins 2018). 88% of Indigenous senior women and 86% of Indigenous senior men reported at least one chronic condition diagnosis in 2012 (Roshanafshar and Hawkins 2018). Lastly, social supports are important for one's health and are associated with reduced risk of mortality, disability, and depression (Roshanafshar and Hawkins 2018). However, 8% of Indigenous seniors reported "no one" in response to the question of, "Who do

you turn to for support in times of need?”. This is a higher percentage than all other age groups (Roshanafshar and Hawkins 2018).

Call to Action 18 in the Truth and Reconciliation report empathizes that colonization has contributed to poorer physical and mental well-being: “to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties”. (TRC 2015). As such, in addition to the barriers outlined above, many Indigenous seniors carry the burdens of colonialism, societal racism and trauma of the Residential School systems and the Sixties Scoop, where substandard health care, as well as abuse and neglect were pervasive (Health Council of Canada 2013)

When considering these topics it is important to frame the ideas within positive health and resilience, which works to encompass an Indigenous perspective on aging (Walker 2015). This prevents misrepresentation of the feelings and concepts of aging in Indigenous communities and understands aging as something valuable for a community and its members. We suggest working to integrate culture into care through funding new and existing Indigenous healing centers, and providing ways to access these centers. Acting to support Indigenous traditional and cultural ways of knowing and understandings of health and healing aligns with Call to Action 22: to effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients (Health Council of Canada 2013).

Adapting the Non-Insured Health Benefits (NIHB) to better suit the needs of Aboriginal seniors is vital. Lack of communication and problem-solving between government departments and funding agencies has contributed to inadequate supports and/or policies and paperwork that are difficult and extremely time consuming to navigate (Canadian Medical Association 2017a). The health priorities of Aboriginal communities must be matched with access and funding for the appropriate professionals. For example, physiotherapy should be included in NIHB coverage, including for Metis and non-Status First Nations and Inuit people living on or off reserve. Physiotherapy is an important component of both acute and chronic care for seniors, and has a role in treatment and prevention management (Canadian Physiotherapy Association 2013).

6.0 Evidence-Based Interventions

This section outlines innovative evidence-based interventions that have had a positive impact on seniors care and/or aging. In the epidemiology section we mentioned that in 2009, 56% of individuals aged 65 and older reported being in good health. However, as we age, we are more likely to experience chronic health conditions, require more support for self-care activities and activities related to independent living, and support to prevent social isolation.

Initiatives in this section are organized into the following categories: community-based initiatives, home-based primary care, alternative to traditional long-term care, falls, social isolation, depression and dementia.

6.1 Community-Based Health Care Initiatives

Medical Adherence

Medicine non-adherence is common in senior patients with polypharmacy and/or declining cognitive function. Kröger et al. (2017) completed a meta-analysis to determine successful interventions for improving medication adherence for seniors with cognitive impairment. They found that these patients should be managed by an inter-professional team with the goal of optimal prescribing and deprescribing. Strategies that improve medication adherence include: decreasing the number of doses per day (BID vs. QID); prescribing transdermal patches rather than pills; audio/visual reminders (such as voicemail); and educating patients about their medications through their pharmacist (Kröger et al. 2017).

Alex Seniors Health Clinic, Calgary

The Alex Seniors Health Clinic is a subdivision of Alexandra Community Health Clinic, that caters to marginalized seniors with complex healthcare needs and complex social factors such as: low income, limited education, lack of social support, under employment, sub-optimal physical environments and health behaviours (Shaw et al. 2015). Community-based primary health care teams provide transportation and support to attend appointments, telephone and written reminders for appointments, satellite clinics in vulnerable neighbourhoods, home visits, and housing and food security programs. A qualitative study conducted by Shaw et. Al. found that the care aims of the clinic are in line with participant perceptions of need. However, it also revealed that despite the clinic's efforts to reduce accessibility as a barrier to healthcare, participants felt that accessibility continued to be a problem reflecting the need to address broader structural barriers. The Alex Seniors Health Clinic is an example of a holistic approach to primary care delivery that can be applied outside of the city of Calgary.

Acute Care for the Elderly (ACE) Collaborative

The ACE Collaborative employs evidence-informed models and point-of-care interventions to improve care for older adults (Canadian Foundation for Healthcare Improvement 2019). ACE is designed to provide seamless care across all levels of patient care in the hospital (emergency department, inpatient) and in the community (outpatient). The patients are managed by inter-professional teams including geriatricians, geriatric psychiatrists, nurses, social workers, pharmacists, dieticians and volunteers. Over the last six years of implementation at Mount Sinai Hospital in Toronto, the program has reduced total lengths of stay by 28 percent, lowered readmission rates by 14 percent, and saved health system \$6.7 million in avoidable costs in 2014. It is an example of innovation that is rethinking the traditional hospital model to improve outcomes.

6.2 Home-Based Primary Care

Because of multiple factors, such as decreased mobility, disability, or ill health, community-dwelling seniors often become housebound. Because of this, accessing community-based primary care can be difficult for these individuals. Instead, these individuals tend to seek health care from the emergency department and hospitalization once they are in a health crisis. In response to this problem, Stall, Nowaczynski, & Sinha (2014) did a systematic review to determine if home-based primary care (HBPC) programs for this patient population decreased emergency department visits, hospitalizations, long-term care admissions, and/or long-term days of care in hospital/long-term care. They found that eight of the nine HBPC programs resulted in reductions in at least one outcome. These beneficial HBPC programs involved interprofessional health care teams that met weekly to discuss patient care. Additionally, successful programs gave patients comprehensive geriatric assessments when the patient joined the program and provided patients with an after-hours urgent care telephone service. Other positive benefits of the HBPC programs were: increased screening for geriatric syndromes, improved quality of life and satisfaction with care for both the patients and their caregivers, increased vaccination rates, and increased end-of-life discussions (Stall, Nowaczynski, and Sinha 2014).

One specific home-based primary care model is the GRACE (The Geriatric Resources for Assessment and Care of Elders) intervention. The GRACE model includes home care and assessment by a nurse practitioner and social worker, the use of care protocols for the evaluation and management of geriatric syndromes, electronic medical records, and mental health resources. Based on a randomized control trial by Counsell et al. (2007), the seniors who participated in the GRACE model had: fewer ER visits, improved documentation of care received, adherence, continuity of care, preventative care, and end-of-life planning. These patients also reported improved general health, vitality, social functioning, and mental health. However, there was no significant difference between the treatment and control for hospital admissions, ADL status, satisfaction with care, or time to death (Counsell et al. 2007).

Another systematic review looked at studies that compared home support with independent living at home (Boland et al. 2017). Most studies found that patients who received home support by an interdisciplinary team had reduced nursing home and hospital admissions, decreased falls, and improved physical function compared to those living independently at home.

Community Paramedicine Clinic

In Alberta, Nova Scotia and Ontario, paramedics make house calls in the community to reduce the number of visits to the emergency department by seniors (CBC News 2018). These paramedics have weekly walk-in clinics in social housing buildings. Patients can have their blood pressure checked, be assessed for fall risk, monitored for Type 2 diabetes, and be referred to a physician if needed. A recent cluster randomized trial evaluating the utility of paramedic-led community-based health promotion programs reported that the three intervention buildings in the study had significantly lower monthly ambulance calls (-0.88, 95% confidence interval -0.45 to -1.30) compared to the three control buildings (Agarwal et al. 2018).

Additionally, there was a significant improvement in quality-adjusted life years, ability to perform

usual activities and a significant decrease in systolic and diastolic blood pressure in the control group.

6.3 Alternatives to Traditional Long-term Care

The advent of the modern “nursing” home emerged as a solution to hospital beds being filled up by older people with chronic illness and dependencies (Gawande 2014). As such, nursing homes arose as a system necessity rather than as an innovation developed with individuals in mind, which explains why traditional nursing homes lack the “hominess” that people desire. Alternatives to traditional long-term care reframe our perceptions of aging into a positive one, challenging us to reconsider how we want to live as we age.

Kipling Acres Long-Term Care Home in Toronto

In addition to housing seniors, the Kipling Acres long-term care home also houses an early childhood education center (Monsebraaten 2016). Integrating children into rehabilitation not only increases seniors’ movement but also socially engages seniors and children in intergenerational relationships. Socially engaged seniors have been shown to have better health outcomes (discussed below).

Dementia Village in Langley BC

Set to open in April, 2019, this village will contain six, single-storey cottages and a community centre (Griffin 2018). It will house 78 patients with dementia who will be cared for by 72 specially trained staff. This differs from a traditional nursing home model as the environment provides more freedom to the residents and resembles life in the community. It is based off the first dementia village in the Netherlands. This initiative is privately funded and will cost residents \$190-245 per day, or \$6,000 to \$7,000 per month.

Senior-Student Co-Housing

In both Toronto and Hamilton, these projects match a university student with an older adult with a spare room (Regional Geriatric Program of Toronto 2018; McMaster University 2017). The student has reduced rental cost in exchange for offering the senior help with their day to day activities as well as providing them with support and company.

Hospital at Home

Implementing this program in Canada is proposed by OpenLab. It involves providing patients with acute, hospital level care at home for individuals with conditions that typically result in admission to hospital such as Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Community Acquired Pneumonia (OpenLab 2019). Similar programs in the UK, US, and Australia have shown shorter hospital stays, lower costs, better patient and provider satisfaction, and improved patient outcomes.

6.4 Falls

One major cause of morbidity and disability in seniors is falls (Ontario Health 2008). Over the course of a year, 30% of individuals over 65 and living in the community will have a fall. Since falls in the elderly are multifactorial (decreased sensation in feet, reduced mobility, visual impairment, sedating medications, polypharmacy, decreased muscle tone, rushing to the bathroom caused by incontinence), interventions should also be multifactorial. A review for the Ontario Health Technology Assessment Series found that the most effective interventions for decreasing risk of falls are exercise programs and modifications to the home environment (Ontario Health 2008). Effective exercise programs were done in a group (also beneficial for social isolation, discussed below) and focused on improving balance and coordination, along with strength, endurance and flexibility. For home modifications, studies suggest removing tripping hazards such as loose rugs and electrical cords, wearing supportive footwear at home, adding handrails, and improving lighting. Three other suggested interventions were vitamin D and calcium supplementation to reduce risk of fracture from a fall, using gait-stabilizing devices outside during the winter, and deprescribing psychotropic medications.

Falls in the elderly are an example of a situation where patients encounter the acute care setting but present the opportunity to address health prevention and promotion. As medical students becoming tomorrow's physicians, it is important to recognize the underlying factors at play and to realize the potential for preventative medicine in any clinical setting that we work in.

The Public Health Agency of Canada identified four key areas to reduce falls (Butler-Jones 2010):

- 1) Developing fall prevention guidelines.
 - a. Examples of existing guidelines: Safer Healthcare Now! Falls Prevention/Injury Reduction Getting Started Kit (Safer Healthcare Now! 2013) and Registered Nurses Association of Ontario: Preventing Falls and Reducing Injury from Falls (Registered Nurses' Association of Ontario 2017)
- 2) Increasing education and awareness programs
- 3) Supporting healthy behaviours and choices
- 4) Preventing falls with safer environments

6.5 Social Isolation

Seniors' social isolation and subsequent feelings of loneliness typically progress as individuals age, peaking at age 80. Loneliness has been associated with many health problems such as Alzheimer's disease and heart problems (Cohen-Mansfield and Perach 2015). These individuals are also at risk for mental health issues such as depression and suicide. Overall, loneliness is a predictor of mortality. The factors contributing to the social isolation of seniors include: high burden of chronic disease, impaired hearing, and decreased mobility.

Cohen-Mansfield & Perach (2013) did a systematic review of interventions for seniors aimed to decrease loneliness. They found that technology-based interventions such as e-pal programs, videoconferencing, and computer training were effective in both institutionalized and community dwelling seniors (Cohen-Mansfield and Perach 2015). There were also effective education-based interventions. The scope of these programs was varied. Some of the interventions focused on teaching the seniors social skills such as group participation, developing social networks, and optimizing relationships with caregivers. Others involved health promotion or self-management lessons. Group activities that were found to be effective were indoor gardening, exercise, and art discussion groups. In terms of therapy, studies have found both assisted animal therapy and humour therapy to be helpful for loneliness.

Another review document for the Ontario Health Technology Assessment Series (2008) identified three helpful interventions. The first was a support group for seniors on the waiting list for senior housing. At this support group, seniors on the waiting list could socialize with seniors already living in the facility. This allowed for the establishment of social networks to ease the transition (Medical Advisory Secretariat 2008). As in the above review, community-based exercise programs were identified as an effective intervention. The final intervention noted by this review was rehabilitation for hearing loss, as this decreased difficulties with communication.

Findlay (2003) documented the three elements common to successful interventions for social isolation among seniors as (Findlay 2003):

- 1) High quality approaches to the selection, training and support of the facilitators or coordinators
- 2) Involve older people in the planning, implementation and evaluation stages
- 3) Utilize existing community resources - example cited is Niagara Gatekeepers program- open telephone line to identify at risk seniors and connects with resources (Niagara Region, n.d.)

6.6 Depression

It has been shown that depression in seniors can be effectively (60-80% response rate) and safely treated with SSRIs (Eli 2012). Psychosocial therapy, either alone or combed with SSRIs, is also an effective treatment for depression in older adults. Therapy is especially helpful for those with low social support or environmental stressors. Three types of psychosocial therapy that have been found to be effective in older adults: Cognitive-Behavioral Therapy (challenges pessimistic or self-critical thoughts, emphasizing rewarding activities, and decreasing behavior that reinforces depression); Problem-Solving Treatment (teaches patients to address current life problems by identifying smaller elements of larger problems and specific steps toward solving these); Interpersonal Therapy (combines elements of psychodynamic-oriented and cognitive therapies to address interpersonal difficulties, role transitions, and unresolved grief).

There are significant barriers to seniors receiving treatment for their depression. This results in many seniors who are undiagnosed and untreated for depression. Patient barriers include social stigma, lack of understanding of mental health, and culture. Barriers caused by physicians also exist, such as multiple patient comorbidities and the assumption that depressed mood is normal in the aging process. Health system barriers include drug coverage and lack of coordination between primary care, long-term care (LTC), and mental health services. Inventions that address these multifactorial barriers are required.

6.7 Dementia

Dementia is associated with reduced quality of life (QOL) and depression largely resulting from reduced engagement both socially and in enjoyable activities.

Logsdon, McCurry, & Teri (2007) reviewed interventions aimed at increasing QOL for individuals with dementia. The successful interventions involved training the patients' caregivers to better meet the unique needs of a patient with dementia. One study trained the caregivers in behavioural therapy (Logsdon, R., McCurry, S., Teri 2011). Specifically, caregivers were trained to increase pleasant events for the person with dementia. Additionally, they were given strategies to engage the patient in meaningful activities, and they learned how to prevent and reduce the patients' depressive behaviours. They found that, the patients in the treatment group showed significant improvement in mood. Another study aimed to decrease problematic behaviours in patients with dementia. They taught the caregivers strategies to identify activities appropriate for the individual's current level of functioning and then how to engage the patient in these activities. The caregivers in this study were also taught to modify the patient's environment such that the individual was better able to perform their ADLs independently. The study found that these interventions succeeded in decreasing behavioural problems. In another three studies, caregivers were trained by OT to maximize patient functioning and decrease behavioural disturbances. These studies found that the patients in the treatment group had less decline in ADLs and fewer behavioural disturbances.

In LTC facilities, antipsychotic medications are often given to residents with challenging behaviours because they have sedating effects. However, these medications are a risk factors for falls, which themselves result in significant morbidity (discussed above). The Canadian Foundation for Healthcare Improvement (CFHI) began a quality improvement collaborative in 2014 aimed to reduce inappropriate use of antipsychotic medications (Canadian Foundation for Healthcare Improvement 2017). CFHI provided training, funding, and coaching for the involved health care teams. Health care professionals involved in the initiative used patient-centred and data-based approaches to manage challenging behaviours associated with dementia. Consequently, medications were increasingly replaced with therapies such as pet therapy, music, or recreation therapy. This quality improvement strategy resulted in a 44% reduction in antipsychotic use at the Camilla long-term care home (Mississauga), a 62% reduction at the Streetsville long-term care home (Mississauga), and a 58% reduction at the Cheltenham long-

term care home (Toronto). This solution offers a sustainable approach to reducing the use of antipsychotic medications that can be upscaled to other long-term care facilities.

7.0 Other Advocacy Efforts to Date

In 2013, a group of researchers, consisting of practicing physicians, medical students, and leaders in business, policy and administrations conducted a Jurisdictional Review funding by a Canadian Institutes of Health Research (CIHR) Evidence-Informed Health Care Renewal Grant. The aim of this Jurisdictional Review was to explore the various on strategies, approaches, and practices aimed towards meeting the needs of an aging population as well as the supporting evidence behind these elements. Subsequently, the team consulted with stakeholders to inform evidence-informed policy recommendations for **a National Seniors Strategy (NSS)**. Since the first iteration of the NSS, the team continues to conduct research into this topic and release re-iterations of the strategy based on new evidence and a changing political, financial, and social landscapes.

The current strategy can be summarized by four pillars summarized below (Alliance for a National Seniors Strategy 2016):

1. Ensuring older Canadians remain independent, productive and engaged citizens by
 - a. Addressing ageism on a national level
 - b. Improving income security and fighting poverty among Older Canadians
 - c. Ensuring accessible and affordable transportation
 - d. Promoting Age-Friendly Physical Environments and Spaces
2. Ensuring older Canadians continue to lead healthy and active lives for as long as possible by
 - a. Supporting Wellness and Prevention Activities
 - b. Improving medication access
 - c. Ensuring Older Canadians and their Caregivers are Enabled to Participate in Informed Health Decision-Making & Advance Care Planning
3. Ensuring older Canadians have access to person-centered, high quality, and integrated care by:
 - a. Improving access to high quality home and community care, long-term care, palliative and end-of-life services
 - b. Ensuring appropriately trained providers
 - c. Developing Standardized Metrics and Accountability Standards to Enable a National Seniors Strategy
4. Assuring support for caregivers through
 - a. Work place support
 - b. Enhanced job protection measures, caregiver tax credits and enhanced CPP contribution allowances

These four pillars are supported by the fundamental values of access, equity, choice, value and quality.



Figure 2. *Proposal for a National Seniors Strategy – four pillars and five fundamental principles* (Alliance for National Seniors Strategy 2016).

The consultations that resulted in the development of the NSS resulted in several national organization recognizing their common advocacy priorities. These organizations, including the Canadian Medical Association, the Canadian Nurses Association, the Canadian Homecare Association, the Canadian Caregiver Coalition, the National Institute on Aging, and the Canadian Geriatric Society, are now cohesively referred to as the Alliance for a National Seniors Strategy.

In addition to the principles outlined by the NSS, the **Canadian Medical Association** is advocating for the following principles (Canadian Medical Association 2017b):

1. Targeted funding for a pan-Canadian seniors strategy
2. Improved capital investment in residential care infrastructure
3. Amended and improved awareness of the Canada Caregiver Credit
4. The development of explicit operating principles for home care funding
5. Research into the appropriate use of acute care for the elderly

On an international level, the **World Health Organization (WHO)** released an inaugural World Report on Ageing and Health, which encourages member states to develop policies and services to meet the needs of ageing populations through. The WHO has named five priority areas for action by 2020, which include (World Health Organization 2015):

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

These calls to action align with Canadian advocacy efforts to date, in particular the National Seniors strategy. The national emphasis on this issue emphasizes the timeliness and urgency of action on optimal aging in Canada.



Figure 3. WHO eight age-friendly domains to better meet the needs of older people.

8.0 CFMS Policy Recommendations

CFMS Policy Recommendations

Every Canadian deserves to age with dignity, with access to necessary supports and appropriate resources. As such, the **Canadian Federation of Medical Students (CFMS)** calls upon all Members of Parliament to:

1. Commit to targeted funding and development of a **National Seniors Strategy** for the 2019 Federal Election.
2. Commit to the development of a **national evidence-based formulary** as a first step towards implementing a universal, comprehensive, and cost-effective **National Pharmacare Program**. Work in collaboration with national experts to promote targeted deprescribing and minimize polypharmacy.
3. Support national leadership on *developing and tracking quality indicators to measure availability and quality of home care, palliative care, and community care* at the next Federal/Provincial/Territorial Ministers Responsible for Seniors Forum.

1. Commit to targeted funding and development of a **National Seniors Strategy** for the 2019 Federal Election

As medical students, it is reassuring to see that the federal government has supported several initiatives for older adults. A National Seniors Strategy would unite these resources under one plan and facilitate the coordination of best-practices for seniors' care. With dedicated and targeted funding, seniors care can be equitably improved across the country.

We amplify the Canadian Medical Association's call for targeted funding for a pan-Canadian seniors strategy, and stand in agreement with the Alliance for a National Seniors Strategy (Canadian Medical Association 2017b; Alliance for a National Seniors Strategy 2016).

Key stakeholders in the field of aging that we consulted with were concerned with the health system's "fractured nature of care" (Dr. Janet Kow) – particularly how it favours acute care and cures rather than prevention and long-term functionality. As medical students, we believe a National Seniors Strategy that promotes health and prevention, coupled with an investment to address the social factors that affect healthy aging, would be immensely beneficial. We emphasize the value of the World Health Organization's eight age-friendly domains in creating a society that is accessible for all ages (World Health Organization 2015).

2. Commit to the development of a **national evidence-based formulary** as a first step towards implementing a universal, comprehensive, and cost-effective **National Pharmacare Program**. Work in collaboration with national experts to promote targeted deprescribing and minimize polypharmacy.

A drug formulary contains a list of medications that is approved for coverage under a health insurance policy as well as criteria for their use and cost-sharing provisions (Government of Canada 2018c). Currently, it is the responsibility of the provincial/territorial governments to make decisions on whether or not to include new drugs to their public formulary, this decision is partly informed by the Common Drug Review.

The Common Drug Review was developed in 2003 and is administered by the Canadian Agency for Drugs and Technologies in Health (Gamble et al. 2011). It is made up of an interdisciplinary team of experts that conducts a systematic review of the literature and prepares reports to the Canadian Expert Drug Advisory Committee evaluating the cost and benefits of potential drugs for listing on respective formularies. Federal drug plans, and all provinces and territories, except Quebec, participate in the process. These reports serve as a recommendation to respective decision makers considering the listing of the potential drug. Despite receiving the same recommendations, there is divergence in the agreement rate between provinces/territories and the Common Drug Review, ranging from 60.4% in Ontario to 90.6% in New Brunswick and Nova Scotia (Gamble et al. 2011). Accounting for this variation are differences in the way drug plans and review processes are organized, local values, competing priorities and available resources (Gamble et al. 2011). Additionally, the Common Drug Review does not capture the effectiveness of the drug in the real-world (Paterson et al. 2006).

There are many factors that influence the listing of drugs across Canadian provinces/territories, including scientific evidence, judgment, self-interest, and politics (Young 2005). As a result, one person may need to pay out-of-pocket for a medication in one part of the Country, while it is covered in another. Another complicating factor is the option for pharmaceutical firms to submit unpublished data to the Common Drug Review for their consideration in making their recommendation, however, the results of this data cannot be reported and shared with provinces (Young 2005). This represents a gap in the evidence at the provincial level.

The development of a national formulary informed by evidence, would equalize the drugs that Canadians have access to no matter where they live. An evidence-based formulary

emphasizes the need to base decisions on available evidence, safety, and financial cost (The Council of Canadians 2016). The strength of a national formulary would be a common investment in setting clear principles and criteria for listing drugs.

Coupled to this discussion is the acknowledgement that polypharmacy (taking five or more medications daily) affects nearly 70% of all seniors (The Council of Canadians 2016). Polypharmacy is associated with an increased risk of falls, hospital admissions, longer lengths of stay, and adverse effects from drug-to-drug interactions (Masnoon et al. 2017). As tomorrow's physicians, we have a key role to play in prescribing appropriate medications for our patients and engaging in adequate medication reviews to deprescribe medications where the benefits no longer outweigh the harms. We advocate for the federal government, through the Public Health Agency of Canada, to work in collaboration with national experts such as, the Canadian Deprescribing Network, the Canadian Patient Safety Institute, Choosing Wisely Canada, and the Institute for Safe Medication Practices, to elevate public awareness, engagement, and action on targeted deprescribing and minimize polypharmacy.

3. Support national leadership on *developing and tracking quality indicators*, to enhance the quality of and access to **home care, palliative care, and community care** provided in the provinces/territories, at the next Federal/Provincial/Territorial Ministers Responsible for Seniors Forum.

Home care, palliative care, and community care are common resources utilized by individuals 65 and over to support healthy aging. Home care supports individuals to age in their homes, and to live as independently as possible; palliative care offers services designed to provide comfort and dying with dignity as one approaches the end of their life; community care encompasses primary health care which is an essential part of the healthy aging process, a common model for community care is inter-professional geriatric care teams that address barriers to attending appointments by providing care through home visits. In the 2017 Federal Budget, the federal government earmarked \$6 billion over 10 years for community and home care to Provinces/Territories. Equally important was the federal government's commitment of \$53.0 million over 5 years to address data gaps to support the collection and reporting of quality indicators.

The next Federal/Provincial/Territorial Ministers Responsible for Seniors Forum is an opportune time to renew a shared commitment to developing common indicators to measure progress in home care, palliative care, and community care. It also offers an opportunity to address the challenges that Provinces/Territories have faced in tracking these key indicators. The federal government can provide leadership in renewing this commitment and addressing challenges continuously, to progress the quality of these services forward for Canadians.

9.0 Conclusion

Seniors face unique challenges that can impact their ability to live independently and to age in a healthy way. The demographics of Canada are quickly changing. We live at a time where we must be proactive and intentional in the care, services, and policies that we design. Prioritizing seniors care and aging now will have a strong impact on supporting a diverse

population of individuals age in a healthy and dignified way, that is acceptable to us and sustainable for the health care system. We believe that the federal government has the leadership, infrastructure and resources to unify supports for seniors under a National Seniors Strategy.

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Appendix

10.0 Positions of the Federal Political Parties

11.1 Bloc Quebecois

The Bloc Quebecois' platform outlines, with regards to seniors' care and aging, an increase in the Guaranteed Income Supplement (GIS) by \$600 a year and increasing benefits from the Canada Pension Plan. Furthermore, they plan to create an income support benefit for older workers, to restrict income splitting, to create a home care tax credit, and to invest \$400 million into social housing.

11.2 Conservative Party

The Conservative Party's platform outlines various strategies for improving seniors' healthcare. These include improving financial security at retirement by expanding the annual contribution limit into Tax-Free Savings Accounts, increased GIS and Old Age Security (OAS), potentially removing RRIF withdrawals, reducing the impact of inflation on seniors' living, and improving the security of corporate pension plans. Furthermore, they plan to reduce taxes, via abolishing carbon taxes, taking away GST and HST on essential items like groceries, medications, and energy bills, and allowing for income-splitting amongst seniors. They also plan to initiate caregiver tax credits and possible allowance, as well as increase affordable housing.

11.3 Green Party

The Green Party plans to create a national pharmacare program as well as a national housing strategy which champions the CMA-endorsed National Seniors' Strategy to help seniors maintain a healthy and active life at home. Additionally, they plan to modify the Canada Health Transfer to more accurately reflect the average age of each province, to review current policies on elder abuse to prevent occurrences and enforce consequences, and to improve access to preventative and complementary medicine, public transit, and age-friendly and safe communities. Finally, they plan to enhance the Canada Pension Plan (CPP) benefits to provide adequate financial support by increasing the target income replacement ratio to 50%, raising the year's maximum pensionable earnings to \$90,000 over 47 years, and increasing the security of pension benefits, without increasing employer contributions or employee wage deductions.

11.4 Liberal Party

The Liberal Party states that they will restore OAS and GIS eligibility to 65 years of age, with an average of \$13000 annually given to lowest income seniors. Furthermore, they plan to develop a Seniors Price Index which will serve as a reference point to gauge the price of living for seniors, to enhance the CPP, and invest \$20 billion in seniors' facilities (long term care and community-based services) and affordable housing.

11.5 New Democratic Party (NDP)

The New Democratic Party plans to invest in homecare, help provinces build 5,000 more nursing-home beds, improve palliative care, and lower drug prices.

11.0 Funding at the Provincial Level

Various funding programs and benefits exist at the federal and provincial level. However, a lack of consistency between medical, drug, and community care coverage between provinces and territories leads to inequities of care. For instance, British Columbia, Alberta, Prince Edward Island and Yukon are the only provinces with coordinated palliative care programs that are structured to provide specialized services to patients across the health care system, and include the provision of medications and supplies. Other provinces offer limited access to palliative care with varying coverage between health services. The extent of drug coverage and community-based care available to seniors are also dependent upon the residential province. Furthermore, there is currently disproportionate funding in home care, which is considered an extended health service, rather than a medically necessary service, under the Canadian Health Act. Although the demand for home care and community care has increased by a substantial 58% between 2008 and 2011, the allocation of funding has not been proportionally matched to this heightened demand. This lack of funding greatly limits access to long-term care and palliative care, resulting in increased utilization of acute hospital resources. Contrasting to hospital services covered by the Canada Health Act, there are currently no formal requirements for home care services to be provided by provincial governments (Canadian Healthcare Association. 2009). This has led to considerable variations of home care legislation across the country, which contributes to variable availability and accessibility of home care services that Canadian seniors can receive (Parent et al. 2000). A national senior strategy should unify and strengthen the patchwork of services offered for senior care across provinces, including but not limited to, palliative care, home care, and caregiver support.

<u>Province</u>	<u>Medical Coverage</u>	<u>Drug Coverage</u>	<u>Community Care Coverage</u>	<u>Financial Benefits</u>
Ontario	Ontario Health Insurance Program (OHIP)	Ontario Drug Benefit (ODB) program for 65+ Low-Income Seniors Co-Pay Drug Program	Assistive Devices Program Ontario Guaranteed Annual Income System (GAINS) Local Health Integration Network - allocates funding for medical and interdisciplinary health services (e.g. nursing home care, Meals on Wheels, Wheel Trans) OHIP covers Assisted Device Program – up to 75% of equipment cost (e.g. wheelchair), no dental services or eye care	Guaranteed Annual Income system Provincial land tax deferral programs and electricity support programs for low income seniors Ontario Trillium Benefit (OTB) Ontario Senior Homeowners' Property Tax Grant Several caregiver tax credits
British Columbia	Medical Services Plan (MSP) Travel Assistance Program (TAP)	PharmaCare program covers eligible prescriptions under MSP	Home and Community Care program Palliative care programs	Income assistance for seniors Seniors supplement

Alberta	Alberta Seniors Benefit Alberta Health Care Insurance Plan (AHCIP)	Premium-free benefit administered by Alberta Blue Cross (Co-payment of 30% up to max \$25)	Extended health coverage by Alberta Blue Cross Dental and Optical Assistance does not cover hearing aids Special needs assistance for seniors Home care coverage	Alberta Seniors Benefit Supplementary Accommodation Benefit Seniors Property Tax Deferral program Seniors Home Adaptation and Repair
Saskatchewan	Saskatchewan Health Coverage	Seniors Drug Plan Palliative Care drug coverage	Personal Care Home Benefit	Saskatchewan Aids to Independent Living (SAIL) program Seniors Income Plan (SIP) SHC Life Lease Program Seniors Housing Program
Manitoba	Manitoba Health, Seniors and Active Living	Manitoba Health, Seniors and Active Living Prescribed drugs approved by Manitoba Health	Manitoba Health, Seniors and Active Living Home care Nursing, assistance of ADLs, PT, OT, medical and surgical supplies, meals, laundry, linens Self and Family Managed Home Care Program	Manitoba Income Supplement Senior Eyeglass program Rent Supplement Program School Tax Assistance
Quebec	Quebec Health Insurance Plan	Public Prescription Drug Insurance Plan	Financial assistance for domestic help services Home Support Meals on Wheels Home Adaptation Program	Home Adaptation for senior independence Quebec Pension Plan Death Benefit Caregiver tax credits
Nova Scotia	Medical Services Insurance (MSI) – does not cover wheelchair, hearing aid	Seniors Pharmacare Community Services Pharmacare program Palliative Care Drug Program	Home Care Services including home support and nursing	Property Tax Rebate for Seniors
Prince Edward Island	Health PEI provincial healthcare plan – covers ambulance and home care, does not cover hearing aids	Seniors Drug Program/Seniors' Drug Cost Assistance Program	Health insurance covers home care: assessment, nursing care, home support, palliative, PT/OT, long term care assessment	Property Tax Deferral Program Seniors' Housing Program Seniors' Home Repair Program

New Brunswick	New Brunswick Health Insurance Plan – does not cover walkers, dental and eye exam	New Brunswick Prescription Drug Plan New Brunswick Drug Plan	Residential services and Long-Term Care for persons 65 and over Standard Family Contribution Policy	Low Income Seniors Benefit Property Tax Deferral Program for Seniors
Newfoundland and Labrador	Medical Care Plan – does not cover medical equipment, dental and eye exam	65Plus Plan Foundation Plan	Provincial Home Support Program Long-term care, personal care homes, protective community residences	Newfoundland and Labrador Income Supplement Newfoundland and Labrador Seniors' Benefit - based on income
Yukon	Yukon Health Care Insurance plan – covers medical equipment Hearing Services - coverage for hearing aids Medical Treatment Travel	Pharmacare and Extended Health Benefits	Palliative Care, Regional Therapy and Home Care programs Alzheimer and mental health caregiver support groups First Nations Health Program	Chronic Disease and Disability Benefits Program Financial assistance for prescription drugs and medical supplies
Northwest Territories	NWT Health Care Plan – does not cover medical equipment or hearing aids	Extended Health Benefits for Seniors Program via Alberta Blue Cross	Home care services covered by the NWT Health Care Plan, including Long Term Care and supported living	NWT Senior Citizen Supplementary Benefit Senior Home Heating Subsidy
Nunavut	Nunavut Health Care Plan - 65+ Extended Health Benefits, covers hearing aids	Pharmacare	Health insurance covers nursing and home care, medically required hearing aids, medical equipment	Senior Citizen Supplementary Benefit (SCSB) Senior Fuel Subsidy Senior Citizens and Disabled Persons Property Tax Relief Senior Citizen Home Repair Program (SCHRP)