

Ontario Trillium Foundation

# Ontario's Aging Population

Challenges & Opportunities

Stacey McDonald  
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## Introduction

The Senate Committee on Aging views population aging as a success story and seniors as a rich and vibrant part of our country. As Ontarians, we have a choice. We can increasingly focus on the challenges that an aging population present or we can embrace the opportunities. We can choose not to see seniors as burdens to be problematized, but rather fellow Ontarians that continue to contribute to society in meaningful ways, while needing services and support.

While many seniors are active and engaged members of society, there are a number of vulnerable groups in Ontario that may require special services and attention. These are immigrant seniors, senior women, seniors living in rural and remote areas, Aboriginal seniors and unattached seniors. These groups are most likely to suffer from poor health, lower income and isolation.

Ontario will also face a number of challenges, including health care provision, affordable housing, reliable transportation choices, supportive services for caregivers, combating ageism and elder abuse and helping seniors age in their place of choice. These challenges present the province with an opportunity to redesign services and build community.

The not-for-profit sector will be called upon to meet much of the growing demand for services from seniors. Currently, the sector is underfunded, understaffed and unprepared to provide long-term planning and programs, as funding is often tied to short-term projects. However, the sector, here and across the globe, is providing a number of innovative initiatives to meet the changing needs of individuals and communities. Perhaps the most important step forward is ensuring that success stories are shared with other communities, so that all of Ontario's communities are prepared to meet the upcoming challenges and take advantage of future opportunities.

## Context

### Canada's Aging Population

Longer life expectancy and lower fertility rates have led to aging populations in a number of countries around the world. While Canada is still younger than a number of other G8 countries, such as Japan and Spain, the number of Canadians aged 65 years and over is growing rapidly. The 2006 census revealed that the 65-and-over population made up a record 13.7% of the total population of Canada, while the proportion of the under-15 population fell to 17.7%, its lowest level ever. It is expected that within the next 25 years the proportion of seniors in Canada could nearly double.

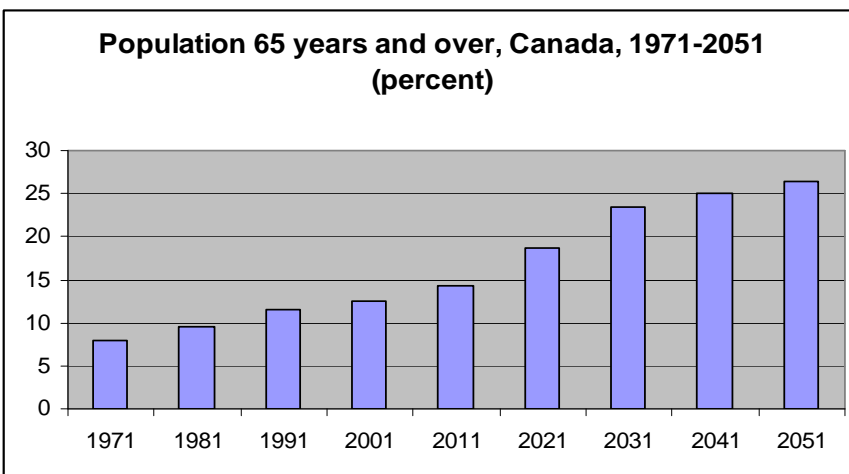
As baby-boomers, people born between 1946 and 1965, are between 45 and 64 years of age, there is a greater number of workers approaching retirement than ever before. The increase in the number of people close to retirement will have considerable effects on the labour force. As baby-boomers age, the growth of the elderly population will accelerate and within a decade it is expected that seniors will outnumber children under 15, leading to more people leaving the workforce than entering it. As a result of these demographic changes, Canadian employers will have to face a number of challenges, including a higher rate of turnover among their employees, knowledge transfer, employee retention, the health of older workers and continuous training for employees.

Next to the 55 to 64 age group, the very elderly group (80 years or older) experienced the largest increase in population compared with 2001 (+25%). In 2006, 1.2 million Canadians were aged 80 and over and there were 4,635 centenarians. The number of centenarians rose 22% since 2001, and is expected to triple by 2031. These demographic changes will have a

major impact on Canada's labour force, public pensions, health care and economic growth (Statistics Canada).

### Aging in Ontario

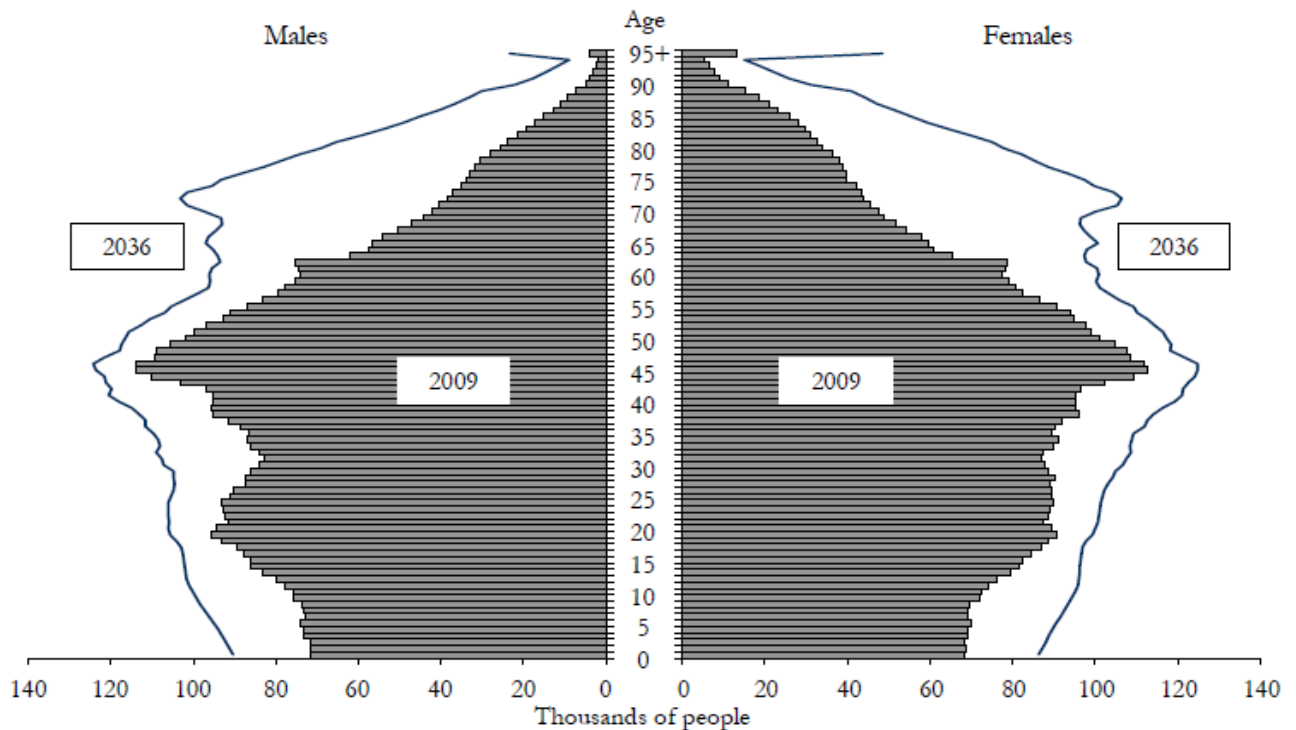
While the increase in older Canadians and decrease in the number of children was felt in every province and territory, there are regional differences, especially between growing urban centres and rural and remote communities. Ontario is one of the youngest provinces; its proportion of children under 15 is above the national average and its proportion of people aged 65 and over is under the national average. However, Ontario's population is nevertheless aging, and quickly. The number of seniors aged 65 and over in Ontario is expected to more than double, from 13.7% or



Note: Population projections use a medium-growth and medium-migration trends scenario. Source: Statistics Canada. Estimates of Population, Canada, the Provinces and Territories (Persons). CANSIM Table no. 051-0001; and Statistics Canada. Population Projections for Canada, Provinces and Territories (2005-2031). CANSIM table no. 052-0004.

1.8 million people in 2009 to 4.2 million or 23.4%, by 2036. The older age groups will experience the fastest growth, with the number of people aged 75 and over projected to rise from 847,000 in 2009 to almost 2.2 million by 2036. The number of seniors aged 90 years and over will more than triple in size, from 73,000 to 261,000 during the same period. Since the growth in the number of seniors is led by the aging of baby boomers, after 2031, the growth in the number of seniors is expected to slow significantly (Ministry of Finance, 2010).

## Age pyramid of Ontario's population, 2009 and 2036



Sources: Statistics Canada, 2009, and Ontario Ministry of Finance projections.

The share of seniors in Ontario's cities and towns varies greatly. Ontario's large urban centres tend to have a lower share of seniors than smaller census agglomerations (urban areas that have an urban core with a population of at least 10,000) and rural areas, yet they still hold the majority of Ontario's seniors. However, the majority of seniors (83.8 percent) live in large urban centres.

In 2009, the share of seniors aged 65 and over, ranged from a low of 12 percent in the GTA to a high of 17 percent in the Northeast region. By 2036, the share of seniors in these regions is projected to range from 20.4 per cent in the GTA to 30.6 per cent in the Northeast (Ministry of Finance, 2010).

In 2006, Ontario's oldest census metropolitan areas (CMAs) (urban areas with adjacent municipalities that have an urban core of at least 100,000), with their proportion of residents aged 65 and over, were Peterborough (18.2%), St. Catharine's-Niagara (17.7%) and Thunder Bay (16%), while its youngest were Barrie and Oshawa. Along with having the highest proportion of children less than 15 years of age, Barrie and Oshawa had, in 2006, the 3<sup>rd</sup> and 4<sup>th</sup> lowest proportion of

seniors, at 11.2% and 11.5% respectively, amongst all of Canada's CMAs (Statistics Canada).

Within census metropolitan areas, the suburbs, or peripheral municipalities, tend to have younger populations and a lower proportion of seniors, than the downtown areas. For example, Toronto's population is older than Brampton's, one of its surrounding suburbs. The municipality of Brampton had a much lower proportion of seniors in 2006 (7.8%), than the City of Toronto (14%). The larger proportion of seniors in central municipalities, like Toronto, may be due to the increased presence of senior residences and health services available to meet the special needs of this age group (Mohanty and Muhaji, 2010).

Mid-size urban centres, or census agglomerations (CAs) tend to grow more slowly, and are on average older than CMAs. In 2006, 15.5 percent of their residents were aged 65 and over, compared to 12.9 percent of residents in CMAs. Elliot Lake is the second oldest mid-size urban centre in Canada, with 31.6% of its residents aged 65 and over (Statistics Canada).

Due primarily to the internal migration of young

adults, who leave rural communities to pursue higher education or find work in urban areas, and international immigration, which is concentrated to large urban centres, rural communities tend to have older populations. According to the 2006 Census, remote rural areas had a much higher proportion of people aged 65 and over (16.1%) than metropolitan areas (13.2%) or rural areas close to urban centres (13.9%). As of 2006, Ontario's oldest rural community is Perth with 28 percent of its residents aged 65 and over (Statistics Canada).

### Seniors groups at risk

The quality of life for Ontario's seniors varies greatly. Not all older Ontarians have the same access to goods and services or the same choices available to them regarding their care, housing, and ability to participate as active members of society. Inequalities experienced throughout life have led to different health outcomes for different groups. The life expectancy for aboriginal peoples is substantially below that of non-aboriginal peoples. Urban and rural areas face different challenges in supporting senior populations. Some segments of the senior population, such as unattached seniors, immigrants, and the very frail, face particular challenges (Senate Committee on Aging, First Report, 2006).

*Economic insecurity is most severe for immigrant seniors who have been in Canada for less than 10 years. In fact, the older the age at immigration, the more likely one will live in poverty, since one's chances of being able to access public income support programs for seniors depend on length of residency in the country.*

*(Senate Committee on Aging, First Report)*

### Immigrants

The diversity of those who are aging will change in Ontario. While today about 5% of seniors in the province arrived in the last 20 years, this proportion will increase. As a collective group, immigrants are older, as one in five (19.7%) is aged 65 years and over; a significantly higher proportion than the provincial share of seniors (13.7%). Among immigrants, 15.6% of seniors state that they cannot converse in English or French. Among seniors in racialized groups, nearly one in three (31.2%) say they cannot hold a conversation in English or French.

Immigrant seniors, especially women, face higher rates of poverty than seniors born in Canada. In 1995, 17.5% of immigrant senior men and 26.5% of immigrant senior women had low incomes compared to 11.5% of non-immigrant senior men and 23% of non-immigrant senior women (Senate Committee on Aging, First Interim Report). Lower income earned by immigrants will diminish their ability to adequately save for retirement and limit their choices in seeking the services, housing and care best suited for them.

Barriers to gaining access to health care and services, including language and cultural differences, lower income and discrimination put the health of immigrant seniors at risk. Since culturally-specific belief patterns about illness and health, attitudes about dependency and self-sufficiency can impede or reduce access to health and long-term care, family support and community services, there will be a greater demand for culturally-sensitive services, activities and programming for newly arrived seniors. The Senate Committee on Aging also heard evidence about the difficulty that some care institutions can have in adapting to the different needs, illnesses and disabilities of immigrant seniors.

Increased vulnerability resulting from ageism has exposed many seniors to forms of abuse and neglect. Witnesses testifying before the Senate Committee identified immigrant seniors as a particularly vulnerable group given the financial dependency on their sponsor.

### Women

Lower wages throughout life, greater time spent caregiving and longer life expectancy for women may mean that they experience greater difficulty saving for later in life. Due to a longer life expectancy, women should save a greater amount for retirement, yet they continue to receive lower wages than men for equivalent work and are more likely to take a leave from work to provide caregiving duties, for both

children and the elderly, making greater savings extremely difficult to achieve. Since benefits are tied to employment earnings, a gender gap still exists in benefit coverage. In 2002, only 83.8% of female tax filers 65 or older reported income from the C/QPP, compared to 94.5% for men (Senate Committee on Aging). It is not surprising then that senior women are more likely to experience low-income than senior men.

Seniors experienced the greatest rate of growth in poverty as a result of the recent economic downturn. After a continuous decline in the number of seniors living in poverty since the mid-1970s, in 2008 the number grew to 250,000 seniors, up from 204,000 in 2007 – a nearly 25 percent increase. Women represented the majority of the increase of seniors living in poverty, accounting for 80 percent of the increase in seniors' poverty (Friesen, 2010).

### **Rural & Remote Seniors**

With fewer young adults and more seniors, rural areas are faced with challenges meeting the needs of their older residents, including adequate health and home care services, appropriate housing and transportation. Rural communities are also at risk of having inadequate services due to their geographic isolation. The Romanov (2001) report entitled *Building our Values: The Future of Health Care in Canada* identified access to health care in rural areas and remote communities as a major problem due to both distance and retention of health workers. The Kirby report noted that access issues were the most serious problems for residents of rural and remote areas, and also that the health of rural residents was worse than that of their urban counterparts. Using the Canadian Community Health Survey 2.1, a study examined the determinants of various measures of health services use by Canadians aged 55 or older across a range of urban and rural areas of residence. The analysis showed that older residents in rural areas made fewer visits to a general practitioner, to a specialist, and to a dentist relative to urban residents. Furthermore, the ratio of physicians per 1,000 residents in rural areas has been forecast to fall from 0.79 in 1999 to 0.53 in 2021 (McDonald and Conde,

2010). Seniors in remote communities also often have to travel to urban areas to access specialists and long-term care facilities. The greater difficulty accessing these services means that seniors may not seek the care or services they need, which would be detrimental to their health.

Rural municipalities, especially those with a shrinking proportion of young workers, may have difficulty in collecting the necessary revenue to fund new programs and services. Rural communities may also need to find alternative transportation and housing options, as urban solutions may not always translate to rural settings.

### **Aboriginal peoples**

Since the fertility rate among Aboriginal groups is higher than the general population, it should not be a surprise that a dramatic increase in the number of Aboriginal seniors is expected. Current statistical data from Statistics Canada projects that by 2026, the percentage of Aboriginal seniors will triple.

There is disturbing evidence that Aboriginal Canadians have significantly lower life expectancy than their non-aboriginal counterparts. Some have suggested that when thinking about Aboriginal seniors and aging, to think about 55 years of age as being equivalent to 65 years of age. Programs and services may need to be provided for a younger chronologically aged group for Aboriginal seniors due to differing health and social conditions (Senate Committee on Aging, First Report, 2006). The different health outcomes experienced by Aboriginal seniors is often a result of a number of inequalities throughout life. Inuit, Métis and First Nations communities continue to face critical housing shortages, high rates of unemployment, lack of access to basic health services, and low levels of education attainment, all of which affect both life expectancy and quality of life in senior years (Senate Committee on Aging, First Interim Report).

Among First Nations and Inuit, chronic diseases usually associated with older age

## Life Expectancy in years

	Canada	Registered Indians	Inuit Regions
Males	77	70	65
Females	81	76	70

<sup>1</sup> Source: Health Canada, *First Nations and Inuit Health Branch Fact Sheet*, November 16, 2006

such as diabetes, rheumatoid arthritis or cardiac conditions, are more prevalent than they are in the general population and have an earlier onset (Senate Committee on Aging, First Interim Report). Evidence from Manitoba shows that the Aboriginal population there has drastically worse health outcomes than the non-Aboriginal population. First Nations people in Manitoba have a premature mortality rate double that of all Manitobans; an incidence of diabetes 4 times all Manitobans, and of amputations related to diabetes 16 times all Manitobans; and hospitalization rates double that of all Manitobans (Silver, 2010).

The needs of the aboriginal population may also vary from those of the non-aboriginal population. However, the small size and remote location of many Aboriginal communities translate to an absence of the necessary formal medical services they may need. Aboriginal seniors are often required to travel to urban centres for care; care that may not be culturally sensitive.

### Unattached seniors

The number of seniors living alone has greatly increased over the past two decades, with nearly three quarters of them being senior women (Senate Committee on Aging, First Interim Report). As of 2006, slightly more than one quarter (25.7%) of all seniors in Ontario lived alone. Seniors living alone can experience greater levels of isolation, neglect and elder abuse by health and home workers. The lack of spousal and family support, including the absence of informal caregivers, can also lead to poorer health.

Unattached seniors are also much more likely to experience low income. According to Statistics Canada, unattached seniors had a low-income rate of 15.5% in 2004, compared to 5.6% for all seniors (Senate Committee on Aging, First Interim Report). Unfortunately,

receiving only Old Age Security (OAS) and the Guaranteed Income Supplement (GIS) is insufficient to allow an unattached senior to live above the low-income cut-off. In 2004, an unattached senior had an annual income of \$12,239 if they were dependent on the OAS and GIS – an amount notably less than the low-income cut-off for urban areas (Senate Committee on Aging, First Interim Report). In 2008, the low-income cut-off after tax was \$15,538 for urban centres with a population between 100,000 and 499,000 and \$18,373 for urban centres with a population greater than 500,000 (Statistics Canada).



## Challenges

Many of the following issues intersect in a number of ways, so that successes in tackling the challenges associated with one issue may benefit other issues. For example, improving transportation options can lower the level of isolation that seniors feel, bettering health outcomes and also allow Ontarians to stay in their homes longer, maintaining their independence and enjoying a higher quality of life. By providing services that enables seniors to stay in their own homes longer, the share of seniors that move into a retirement home or long-term care facility prematurely declines, which then reduces healthcare costs.

### Healthcare

The change in the province's demographics has caught the attention of citizens, the media and policymakers alike. The increase in the number of seniors has many worried about the ability to manage the changes that will come. The greatest issue that has people worried is the effect the aging population will have on the health care system. There is much talk in the media about a looming health care crisis, and much of the blame is put upon seniors. While the growth in the number of seniors will certainly affect the health sector, growing costs cannot solely be attributed to this demographic trend. The cost of drugs has doubled over the past 35 years, according to the Canadian Institute for Health Information (CIHI). However, the elderly are responsible for a large share of drug costs. CIHI recently studied Canadians 65 and older in six provinces, and found that two-thirds are using five or more classes of prescription drugs, and about one-fifth use 10 or more types of prescription drugs (Geddes, 2010). To manage the costs of drugs, it is essential to focus on prevention, healthy aging and the promotion of exercise for all Ontarians.

Many argue that integrated care delivery systems are the best solution when it comes to increasing the efficiency and effectiveness of care delivery for the elderly. Currently, studies show a lack of integration and fragmentation of healthcare delivery systems for seniors, as well as fragmentation between health services and other services such as education, social

services and transportation. Meanwhile, there occurs significant overlap for various care delivery services. An integrated system helps keep track of the needs of clients and allows for substitutions in care. It also allows the proper allocation of resources. Substitutions, such as home care instead of residential care, are much harder to make in fragmented care delivery system, in which there are several organizations providing care, competing for funding and setting their own policies and priorities in isolation from each other (Hollander et al, 2007).

Research in Italy (Landi et al., 2001) on the effect of an integrated home care program, including social and health services, on hospital use showed a significant reduction in hospitalizations, hospital days and costs. Researchers concluded that an integrated home care program based on the implementation of a comprehensive geriatric assessment instrument guided by a case manager has a significant impact on hospitalization and is cost-effective.

Studies also show that Denmark's integrated system of care delivery for the elderly and persons with disabilities, which puts a priority on home care and includes a home support component, has led to significant savings since 1985. By reducing nursing home beds and increasing the proportion of people that received care in their homes, Denmark's per capita expenditures on continuing care services for persons aged 65 and over increased by only 8 percent between 1985 and

#### Denmark: A Country of Best Practices

- Established a moratorium on building new nursing home beds in 1987
- The moratorium was accompanied by giving all benefits of long term care to home care clients
- A history of public responsibility for housing with increased construction of supportive housing
- 1998 country-wide policy of home visits and assessments for people older than 75
- In 2007, Denmark spent 9.7% of GDP on health while Canada spent 10.1%
- 16.1% of Denmark's population is 65+

(Rachlis, 2010).

1997, compared to a 67 percent increase in the United States (Hollander et al., 2007; Stuart and Weinrich, 2001).

### Exercise & Healthy Eating: The most important interventions?

While exercise and healthy eating is beneficial at all ages, it is especially important to be active later in life. Research shows that exercise can greatly improve the quality of life and health outcomes of seniors, including very strong evidence that being physically active can reduce the risk of dementia, Alzheimer's, cardiovascular disease, osteoporosis, arthritis and certain cancers. A study in the *International Journal of Clinical Practice* shows that regular exercise reduces the risk of different 25 health conditions (Alford, 2010; Llyod, 2010). A study over nine years also shows that walking a relatively long distance each week, 6 to 9 miles, is associated with greater gray matter volume, which is in turn associated with a reduced risk of cognitive impairment, including the onset of memory problems and dementia. The more physically active participants, who had retained more gray matter, saw their chances of developing a cognitive impairment cut in half (Erickson et al, 2010).

*“Supportive socioeconomic and physical environments play a major role in enabling seniors to integrate physical activity into their daily lives. For example, safe pedestrian crossings, well-maintained sidewalks and access to indoor walking programs in winter enable seniors to walk on an everyday basis. Moderate activity, such as walking and gardening, may be the most important thing seniors can do to maintain mobility and prevent disability” (Edwards and Mawani, 2006).*

Healthy eating provides essential energy and nutrients for general well-being, the maintenance of health and functional autonomy, and a reduced risk for chronic diseases at older ages. Unfortunately, many seniors have difficulty maintaining a healthy diet, either due to the difficulties they face in accessing fresh and healthy food choices or due to the lack of affordability. Seniors require fewer calories but more

nutrients to promote and protect health, and contribute to independence and quality of life. A recent survey found that 62 percent of seniors who reported consuming fruits and vegetables at least five times a day were in good health compared with 52 percent of seniors who consumed fewer fruits and vegetables (Edwards and Mawani, 2006). Malnutrition among seniors is often unrecognized and does not always receive the attention it deserves. Seniors (and particularly those aged 75 and over) face a number of barriers to healthy eating that can lead to malnutrition, including poor oral health, inadequate finances, isolation, chronic illnesses and compromised nutrient absorption (Edwards and Mawani, 2006).

### Enabling seniors to age in their place of choice

While studies show that many seniors wish to age at home, it is important that seniors have available to them a range of affordable housing options that meet their varied needs. For those that do wish to stay at home, this decision should not be defined by financial means or physical limitations.

### Aging at home

For seniors to successfully age at home, they require support. Home care, including shopping, cooking and help bathing, can allow the elderly to maintain their independence for as long as possible and remain healthy. There are a number of services, often offered by the not-for-profit sector, which can help seniors age at home. Adequate homecare and healthcare services, accessible transportation and support in making modifications to their home will greatly improve an older adult's ability to continue living independently in their home. Community programs and support systems also assist older adults' abilities to live well at home. If seniors can easily shop, participate in adult learning programs and meet with friends in their community, they are more likely to stay active, healthy and at home.

### Home & Health Care delivery in home

Homecare services help clients to maintain their safety, health and independence while living at home. Homecare services help people who cannot fully function independently

because of a disability, illness or other limitations due to aging, mental health or addictions. According to the Ontario Community Support Association, there are 688 community support service providers (those that provide both in-home and community-based services to people) in Ontario who receive funding from the Local Health Integration Networks (LHINs) (Ontario Community Support Association, 2010).

In 2009, CARP polled 2300 of their readers. When respondents are asked what one factor could improve life in their towns for older people, the most common response was “more home care services” (CARP, 2009). In its presentation to the Special Senate Committee on Aging (2009), the Royal Canadian Legion, identified “the biggest challenge facing Canadians over age 75 is bridging the gap between independent residential living and moving to a care facility.” Home support and home care can help bridge that gap.

Home care services not only greatly improve the quality of life for seniors, but are also a cost effective service. A study in 2001 revealed that there are significant health care cost savings associated with essential, yet underfunded, home care services. The study examined the effects of the elimination of funding for social support services (housekeeping, meal preparation, shopping, etc.) in British Columbia. Social support services were cut from clients at the lowest level of need in the home care program to save money. Three years later, data shows that clients cut from service cost the healthcare system \$3500 more per person compared to those not cut (MacAdam, 2010).

### Home Safety

While many seniors would like to age at home, they may find as they age that getting around their home is increasingly difficult. The major cause of injury among seniors in Canada is falls (Edwards and Mawani, 2006). Among older adults, injuries due to falls threaten health status, independent living, autonomy, mobility and functional ability. Injuries can lead to premature institutionalization and even death. If a fall does not lead to an injury, it can still result

in increased and on-going fear and negative behaviour changes, including increased isolation and a reduction in physical exercise, both of which can have negative consequences for overall health. Seniors who are injured from a fall seldom recover fully. They often experience chronic pain, reduced mobility, loss of independence and confidence, and a compromised quality of life (Edwards and Mawani, 2006).

Assisting with the modification of homes to meet the needs of seniors as they age can greatly increase the quality of life and length of time that seniors choose to stay in their home. The Canadian Mortgage and Housing Corporation’s Home Adaptations for Seniors’ Independence (HASI) program offers financial assistance for minor home adaptations that will help low-income seniors to perform daily activities in their home independently and safely. For seniors that do not qualify for financial assistance, there are private organizations that also provide home safety inspections and sell products to make homes safer. The Ontario Seniors’ Secretariat’s website provides a [listing](#) of initiatives for falls prevention among seniors.

### Transportation

A key aspect in helping seniors age at home is ensuring that there are a number of affordable, reliable and accessible transportation options. Baby boomers grew up with cars as symbols of independence and personal freedom. As baby boomers grow older and the number of senior drivers will grow, there is significant concern and media attention over public safety and the driving ability of elderly drivers. For many seniors, the loss of a license signifies the loss of independence and for many seniors, especially those living outside of urban centres, losing the ability to drive would mean losing their autonomy and compromising their quality of life. This loss of independence can lead to isolation and an increase in elder abuse.

Insurance experts assure the public that the risk to public safety posed by senior drivers is low. While the crash rates per km increases for drivers aged 75 and over, this is mainly due to less kilometres driven. Older adults are usually cautious, safe drivers with good driving records

and are generally risk averse, so they do not drive at excessively high speeds, on high volume highways, at night, for long distances or in poor weather conditions. Older adults have the lowest automobile insurance rates for one reason: on a driver-by-driver basis, they are among the safest drivers on the road (Webb, 2010).

Without proper transit options seniors may find themselves in nursing homes prematurely, which is more costly and unwanted. Offering affordable transportation options is key to helping seniors age with dignity in their place of choice. Health care authorities, community groups and all levels of governments can develop creative solutions for driving retirees. Possibilities include: financial incentives to carpool; mandate urban planners to consider seniors' needs in public transit, housing and shopping area planning; subsidize shuttle van services; or use school buses off-hours on scheduled grocery or shopping runs for seniors (MacDonald and Hébert, 2010).

Many cities do provide accessible public transportation to get people with mobility challenges to appointments. However, often "para-transit" services often present barriers that compromise their utility for the very people they serve. For example, some services prohibit caregivers from accompanying older clients to their appointments. In some cases, accessible transportation is only available for medical appointments and therefore prevents people from accessing other community supports and activities. At the same time, the physical requirements of taking public transit (such as walking long distances between transit stops) may limit the accessibility of public transit for people with mobility challenges. CARP suggests that public transit systems could extend services to provide consistent and reliable service even in off-peak hours and establish a stop request program that allows seniors travelling alone during non-rush hour times to be dropped off in between official transit stops, provided it is safe to do so (CARP, 2010).

### **Retirement & Long-Term Care Facilities**

There are different types of housing facilities for seniors that offer a range of services and

### **Helping Seniors Get Around**

- **Senior Bus Pass Programs.** The State of Illinois' Seniors Ride Free program requires mass transit agencies state-wide to allow senior citizens, aged 65 and older, to use main line and fixed route public transit service for free.
- **Issue taxi vouchers to low income seniors.** British Columbia's taxi program gives people with a permanent physical or cognitive disability discounted transit cards (Handy Card) and Taxi Saver coupons. Handy cardholders can purchase discounted taxi vouchers known as "taxi savers." A booklet of tax vouchers worth \$50.00 is sold for \$25.00.
- **Free shuttle buses.** Vancouver's regional transportation authority's Shuttle program successfully operates small buses, known as "community shuttles," that run through neighbourhoods and deliver passengers to transit hubs (bus stations, Skytrain stops, etc.).

(CARP, 2010; State of Illinois, 2010)

levels of care. Supportive housing provides 'assisted living' accommodations, usually with housekeeping, laundry, meals and recreational opportunities. This option allows seniors to live independently, with some assistance. The Senate Committee on Aging heard evidence supporting that not-for-profit community organizations, including religious and cultural groups, are increasingly building residential facilities for seniors. Some are intergenerational, offering accommodation to those of all ages that would benefit from 'assisted living' services. The facilities often address a variety of health care needs. To date, many have been quite successful, as they offer a less expensive alternative to private care homes.

Long-term care facilities provide accommodation for people who require on-site delivery of daily, 24-hour, supervised care. With the growing diversity of seniors, care in these facilities is becoming more complex, and institutions are having difficulty adapting to the needs of all seniors. Since the range of issues facilities are faced with may be difficult to address in each facility, the Canadian Association on Gerontology has suggested that culture-specific facilities be encouraged (Senate Committee on Aging, First Interim Report).

Residents of retirement homes are a potentially vulnerable group as they are often dependent on the institution that provides their care and shelter, as well as “out of sight” and sheltered from public scrutiny. Moreover, it appears that the level of care provided in retirement homes is increasing due to demand and lack of available beds in long-term care homes. At present, the quality of care in retirement homes cannot be guaranteed because there is little or no oversight (ACE, 2010).

### **Affordable Housing**

Affordable housing for seniors is a challenge across the country. According to a poll of CARP readers, just one quarter of respondents replied that housing is easy to find (27%), including very few (4%) who responded that it is “very easy” to find (CARP, 2009). Unattached seniors disproportionately face core housing need – ‘core housing need’ refers to households that are crowded, in poor condition or did not have affordable shelter. Senior-led Inuit households faced the highest core housing need in 2001, with 31% in need. Seniors with disabilities, recent senior immigrants and the broader Aboriginal senior population also have high levels of core housing need (Senate Committee on Aging, First Interim Report).

Homesharing is an emerging option for homeowners wanting to remain their homes, yet need some form of assistance to do so. Homesharing occurs where two or more unrelated people share a home, with their own private space and common living areas. It can work well in rural areas, where organized caregiving can be harder and more expensive to deliver. Frequently coordinated by a local not-for-profit, the homeowner benefits by receiving 10 to 15 hours per week of household help, like cooking, shopping, or cleaning, and the roommate receives free rent. Having someone in the home informally increases awareness of changes in the homeowner’s wellbeing, while allowing seniors to remain at home and independent longer, enjoying the help and the informal companionship (EPA, 2009).

### **Informal Caregivers**

Informal caregivers, generally family and

friends that provide unpaid assistance, play a critical role in supporting seniors, contribute billions of dollars of unpaid work and severely lack support. Studies show that informal caregivers provide the majority of home care for seniors. When examining the total number of hours of services being provided, it was found that for four activities mostly linked to chronic home-care support (housework, shopping, meal preparation, personal care), more than 70% of hours had been provided by members of the informal network (Keefe et al, 2007). The National Advisory Council on Aging argues that informal caregivers provide about 80% of all home care to seniors living at home and up to 30% of services to seniors living in institutions.

Polling completed by CARP reveals that a quarter of Canadians reported that they had cared for a family member or close friend with a serious health problem in last 12 months. Of these caregivers, 22% took upwards of one month off work and 41% used personal savings. As a result of their caregiving work, almost 8 in 10 caregivers report suffering emotional difficulties, 7 out of 10 reported they needed respite, 54% reported financial difficulties and 50% reported weaker physical health (CARP, 2008). Evidence from Statistics Canada supports the results from this polling. They found that two thirds of women and nearly half of men who combined more than 40 hours of employment with four or more hours of caregiving per week experienced substantial job related consequences such as reduction in hours or income or change in work patterns.

Other developed countries have recognized the importance of providing financial support to their caregivers and have developed more comprehensive financial schemes that may provide strong examples for Canada. Caregiver strategies abroad have succeeded in creating points of interaction and cooperation between the informal and formal care systems. Financial supports must be made available to family caregivers to allow them to continue devoting their time to caregiving as needed. Various mechanisms have been employed, including tax credits, allowances, or pension enrichment.

## Support for Caregivers

- Sweden, Germany, Australia, France and the United-Kingdom all provide generous needs and income tested allowances to caregivers.
- Sweden's direct compensation rates are based on and equal to formal home care worker compensation rates. Germany's benefits vary between \$318-\$1033/monthly.
- Germany contributes up to \$584 monthly to a caregiver's pension insurance while the United-Kingdom has initiated a State Pension for Caregivers. It began in 2002 and will be payable by 2050.
- Australia's Caregiver program is an extension of their formal Home and Community Care Program. It is jointly administered by federal and state governments and treats the caregiver as a client. The program provides caregivers with access to information, advice, counseling and respite services.
- France and Germany connect caregivers with the formal system by requiring health professionals to evaluate the care being provided and the level of care needed by the care receiver. This evaluation also determines the rate of the allowance that will subsequently be delivered to caregivers.
- German caregivers have the ability to register as "informal caregivers" which provides them with special entitlements and benefits.

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(CARP, 2008)

Providing support for informal caregivers makes them less likely to burnout and more likely to provide these services longer. Support for informal caregivers can be provided through sitter attendant services, adult day programs, respite, and short-term beds within long-term care institutions. Respite care is consistently identified as an absolute need. Some caregivers may not have adequate transportation or have mobility issues themselves, so home-based respite programs may be crucial for certain Canadians (CARP, 2008). Efforts should also address the differing needs of lower income Canadians and women, which comprise the vast majority of caregivers.

A recent study, "The Influence of Community-Based Services on the Burden of Spouses Caring for Their Partners with Dementia" found that day programs for care recipients are a very effective respite care delivery mechanism. In-home services, as they are currently offered,

appear to do little to reduce the burden of spouses caring for their partners with dementia. Rather the study found that the most effective service is the provision of adult day programs, which provide not only respite for the spousal caregiver, but also opportunities for social interaction for their partners with dementia.

Caregivers often report feeling frustrated by the difficulties they face receiving training and information, as well finding the resources available to help them provided the necessary care to their loved ones. Caregivers would greatly benefit from information on all aspects of care being made available in one easily accessible site or location. Nurses and doctors should ensure that new caregivers know where to access this information (CARP, 2008).

Home care is less expensive – but families contribute one half or more of the overall care costs of home and community care (Keefe et al, 2007). All Ontarians benefit from the cost savings from the informal caregiving provided to seniors. This contribution must be recognized and caregivers must be better supported, so they can better balance their numerous responsibilities, including work, caring for elderly family members, and supporting children, all the while maintaining a healthy and active lifestyle.

## **Mental Health & Isolation**

Seniors are faced with a number of substantial changes as they grow older, including retirement, having a fixed income, widowhood, the loss of friends to illness or death, new caregiving responsibilities, new housing, deteriorating health and the loss of one's driver's license and subsequent transportation difficulties. Facing some or all of these changes can be extremely trying and lead to social and emotional isolation. Mental health promotion—including encouraging social connectedness—is essential to maintaining the health of seniors.

The Canadian Mental Health Association (CMHA) lists the following mental disorders as those that may affect seniors: depression, late-onset schizophrenia, bipolar disorders, anxiety disorders, dementia and addictions. While

depression and dementia are the most common mental health problems associated with seniors and it is less common for seniors to develop bipolar disorders, late-onset schizophrenia and anxiety disorders, caregivers should not assume that a change in behaviour is simply a result of aging.

Depression in seniors is common, but it is often difficult to recognize, and therefore tends to be under-diagnosed. Friends and family members may assume that an individual is sleeping more, eating less and more withdrawn simply because they are aging and require more rest. An older adult can become overwhelmed when providing care to an aging spouse or family member. This is true especially for women, who tend to experience more caregiving

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*Between 15% and 25% of nursing home residents have symptoms of major depression.*

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*The incidence of suicide amongst men 80 years of age and older is the highest of any age group (31 per 100,000).*

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*Dementia affects approximately 8% of all people aged 65 and over, and almost 35% of persons aged 85 and over.*

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*(Senate Committee on Aging, First Report)*

demands than men do, and as a result women caregivers may be more likely to be depressed (CMHA website).

Doctors, service providers and caregivers may dismiss symptoms as a natural part of the aging process, or incorrectly view depression as a normal response to deteriorating physical health. Many seniors may not even realize that they need mental health treatment, or may feel too embarrassed to ask for help due to the stigma associated with mental illnesses (CMHA website).

According to CMHA, dementia is a term used for a group of symptoms associated with non-treatable, irreversible, progressive illnesses that affect the brain. Alzheimer's disease is the

most common form of dementia. Late-life dementia interferes with a person's ability to function normally in social and occupational settings.

Essential in maintaining the mental health of seniors, and identifying when changes in mental health occur, is ensuring that older adults stay socially connected. Data from the Canadian Community Health Survey show that seniors who report a strong sense of community belonging are 62 percent more likely to be in good health, compared to 49 percent who feel less connected (Edwards and Mawani, 2006). Being socially connected positively affects one's well-being and ability to cope effectively with change. Research has shown that socially engaged seniors, those that regularly interact with friends and family members, are more likely to have better health behaviours, such as maintaining a healthy diet and sufficient physical activity (Edwards and Mawani, 2006). It is clear that isolation negatively affects health.

Research on social isolation, commissioned by the Federal- Provincial-Territorial Ministers Responsible for Seniors identified a number of factors that contribute to the likelihood of social exclusion. They include being an older senior woman, having less education, dwelling in an urban area, being an immigrant senior, being unmarried and having one's activity level limited by health conditions (Senate Committee on Aging, Second Interim Report). The research suggests that isolation can be reduced through better urban planning.

Social inclusion and increased civic participation can be enhanced by fostering and creating neighbourhoods centred on community hubs that reduce the need for travelling around the city. By locating recreational and social services within communities where people live rather than in commercial clusters accessible only by car or transit they become more accessible and utilized. Rethinking the way the city uses existing spaces, such as schools and community centers, for example, can spur creation of new community hubs. Co-locating services and social outlets could help foster civic inclusion without requiring extensive travel

by car or on transit. More inclusive communities can re-imagine the use of current resources, such as public schools, as spaces for all community members to meet, greatly enhancing access to services.

Adult day programs often provide meals, social interaction for older adults, physical activity and opportunities for learning, while providing free time to caregivers. Adult day programs are not a new innovation; some community centres have offered programs for years, yet have been underused and found uninspiring. More and more communities across Canada are offering a wide variety of adult day programs, with some focused on assisting seniors with specific conditions. In Ottawa, The Good Companions day program provides meals, non-denominational worship services, exercise and entertainment for 25 seniors three days a week. The centre's director, Sharon Oatway, says that for some seniors, their participation might be the only source of social interaction (Proudfoot, 2010). These programs provide opportunities for seniors to stay active and engaged in their community.

### Ageism

What it means to be a senior is changing.

Despite all that seniors continue to contribute to society, there are still a number of stereotypes and barriers that exist. It is essential to shift societal attitudes around aging and seniors. Seniors must no longer be seen as simply a potential burden, but also as a great resource.

Seniors can also no longer be considered as one homogenous group. "Younger seniors" – those 65 to 74 – are entering their golden years healthier and wealthier, with higher expectations around maintaining their independence and continuing to live life to the fullest. "Older seniors" – those 75 or older – are experiencing poverty and health challenges.

The literature on seniors often refers to three broad age categories that should be distinguished: the "young old" who are healthy,

fit and reasonably affluent; the "middle old" who are starting to slow down and have less money and resources; and the "frail old" who are very elderly and have special social and physical needs (Senate Committee on Aging, First Report, 2006). While age brackets may be associated to these categories, they often may not hold true. The 'real' age of an older adult may vary as a result of a variety of factors intervening over an individual's life course. The recognition of these different stages of life, with their corresponding levels of capability and needs, can be of help when considering different services and supports for persons over the age of 65.

One step towards combating ageism is reforming policies that rely on age to determine eligibility. Rather than questioning the driving ability of individuals based on their age, driving ability could be assessed periodically over one's life. Declining driving ability is based on advancing medical conditions that affect driving. A medical condition that adversely

affects driving ability can happen at any age. Focussing on age alone will not help make roads safer; effective programs to screen and test medically impaired drivers of all ages will.

*"It is time for a new vision on healthy aging – a vision that: values and supports the contributions of older people; celebrates diversity, refutes ageism and reduces inequities; and provides age-friendly environments and opportunities for older Canadians to make healthy choices, which will enhance their independence and quality of life."*

*(Edwards and Mawani, 2006)*

### Elder Abuse

Elder abuse can take many forms, including physical, mental or financial abuse, or neglect. Research suggests that between 4 and 10 percent (65,000 to 130,000) of Ontario seniors suffer from some form of elder abuse (Ontario Seniors' Secretariat webpage). According to the National Advisory Council on Aging, most abuse carried out against seniors is perpetrated by someone known to the victim. In the case of seniors, it is often a family member, friend, caregiver, landlord or staff in a facility. The Council also informs that seniors who are at greater risk of abuse include older seniors, women, socially isolated seniors, dependent seniors with disabilities, seniors with reduced cognitive capacity, and seniors whose caregivers have a drug or alcohol problem.



The Ontario Network for the Prevention of Elder Abuse (ONPEA) has launched a new province-wide hotline to assist abused and at-risk seniors. The Seniors Safety Line will provide information, referrals, and support 24 hours a day, seven days a week, in over 150 languages. [The Ontario Trillium Foundation awarded ONPEA a three-year, \$415,700 grant in June 2008 to help with the set-up of the hotline.] The hotline is a toll-free, confidential resource for seniors suffering abuse, including financial, physical, sexual and mental abuse and neglect (OSS website).

# Impact of an Aging Population on the Not-For-Profit Sector

## The State of the Not-For-Profit Sector

With 45,360 organizations, Ontario's not-for-profit sector is the largest in Canada (Clutterbuck and Howarth, 2008). Most not-for-profit organizations rely on three different revenue sources: charitable donations, earned income and government funding. With large deficits expected at the federal and provincial level of government this year, and recurring deficits expected for at least the next several years, the recent economic downturn is making it increasingly difficult for organizations to secure funding from traditional sources. As a result, not-for-profits are struggling with increasing competition for an inadequate pool of funds, too many restrictions on how grants and donations can be used, and a short-term focus that makes long-term investments nearly impossible (Brodhead, 2010). A growing rural-urban gap may also limit the government's ability to ensure the delivery of adequate services in sparsely populated regions, which will increase the demands on the community sector in those areas (Brodhead, 2010).

*The most innovative and politically transformative ideas – ideas in the defense of greater equity and justice – of the last 200 years have not only emerged in, but have been driven by civil society. (Dr. James Orbinski, former president of Médecins Sans Frontières)*

The sector will have to devise innovative ways to meet their funding needs. The United Kingdom and the U.S. have developed flexible legal frameworks to facilitate the development of blended-value enterprises, which generate both a social and a financial return. In 2005, Britain introduced Community Interest Companies (CICs), which operate like businesses but must demonstrate that they create a community benefit. CICs may issue shares to raise capital but there is a cap on returns and an "asset lock," which means that profits and assets must be retained by the community, not distributed to shareholders. By the end of 2009, some 3,300 CICs had been set up and were doing business in fields such as low-cost housing and home support. The

U.S. has created similar entities called low-profit limited liability companies, or L3Cs, that can raise private capital by issuing shares or through other financial means, and their purpose is to use market mechanisms to meet community needs (Brodhead, 2010).

The sector is not only plagued with funding problems, but also staffing issues; organizations are having difficulty attracting and retaining staff. The lack of job security due to irregular and short-term project funding, limited opportunities for advancement within organizations, long hours (often unpaid), and sometimes poor personnel practices, are cited as reasons for this difficulty. Surveys of job-seekers also suggest that expectations are changing; entrants into the labour market want a better balance between work and personal lives, which is at odds with the ethos of selfless service that permeates many charities (Clutterbuck and Howarth, 2008).

Stretched resources leading to a hollowed out administrative infrastructure for organizations, reliance on part-time staff, increased service demand, lack of internal capacity and increased reliance on project funding are all increasing the level of strain on the not-for-profit sector (Clutterbuck and Howarth, 2008).

## Ageing-Related Challenges

While not-for-profit organizations are faced with the increasingly difficult challenge of funding their programs, many organizations are facing a growing demand for services, which is intensified by population aging. The not-for-profit sector, if supported, can play a critical role in ensuring that future healthcare costs are manageable. Much of the support needed by the elderly need not be provided for by medical professionals. Assisting seniors with cooking, cleaning, shopping and bathing can allow individuals to remain in their own home as long as possible, keep their independence and stay healthy. By providing home care services, the not-for-profit sector can actually save the healthcare system money by avoiding repeated

hospital admissions and premature entry into long-term care facilities (Hollander et al, 2007). However, organizations focused on providing healthcare and wellness related services, including the community sector, have been operating in an especially challenging funding environment, as recently funding has been focused on the improvement of acute care (hospital and institutional) (Ontario Nonprofit Network, 2008). The Senate Committee on Aging also heard evidence that the greatest current weakness in home care services across the country is the provision of home support services delivered primarily by non-professional or paraprofessional workers that provide most of the paid home care services in the country.

Homecare and healthcare services are possible, in large part, to a large number of volunteers and often low-wage workers. The Ontario Community Support Association's (OCSA) historical data shows that these agencies have an estimated workforce of 25,000 staff and 100,000 volunteers and that the median income for personal support workers and attendant care workers is \$29,000 and \$30,000 respectively (Ontario Community Support Association, 2010). While the wages of support workers are above the low-income cut-off used by Statistics Canada, they do not meet the living wage established by Hugh Mackenzie and Jim Stanford with the Canadian Centre for Policy Alternatives. MacKenzie and Stanford (2008) argue that a living wage of \$16.60 per hour for each parent in a two-parent, two children family, provides a family living in the Greater Toronto Area and working full-time (37.5 hours a week, year-round) with the sufficient earnings to pay for the necessities of life, to enjoy a decent quality of life, and to be able to participate fully in the economic, political, social and cultural life of the community. A support worker, with a family of four, earning \$29,000 or an equivalent \$13.94, in the GTA will not meet the living wage established by MacKenzie and Stanford.

As research has shown, seniors are not a homogenous group, nor do they experience the same problems or require the same level of care. As care is becoming more complex, support workers are not being adequately

trained for the provision of complex care. Evidence presented to the Senate Committee on Aging has shown that many workers have little training and are paid on a per-visit basis to a home. Unfortunately, there is no consistent standard of care nationally as to how we actually give physical, psychological and emotional care to older adults. Furthermore, many personal care workers without any specialized education or training are hired by families, nursing homes and long-term care institutions to assist seniors (Senate Committee on Aging, First Interim Report). Support workers are charged with the care of society's elders and if they are denied proper compensation and training, staffing shortages are unlikely to end.

For many, the experience of later life for adults is changing and with it the expectations for the variety and quality of services available to them. The not-for-profit sector will need to grapple with growing demand for services, higher expectations for the quality of services, a wider range of deliverables and increasingly complex needs. An aging population will require greater efforts to improve their health, well-being and independence in later life. This includes a greater need for transportation choices, engaging physical and social activities, and affordable housing. The not-for-profit sector will be called upon to facilitate the participation of older people in all aspects of society and to strengthen the supportive environments within communities.

### ***Volunteerism & Post-Retirement Work***

The large number of retiring workers expected in the upcoming years has the potential to greatly impact the stability, growth, and potential of the not-for-profit sector in the coming years. The retirement of baby boomers raises staffing concerns for not-for-profit organizations, as they are already experiencing staffing shortages and recruiting challenges. Research by the HR Council for the Nonprofit Sector (2010b) shows that nearly half (47.1%) of employers in the sector reported that the recruitment of qualified people was either "difficult" or "very difficult" for their organization. In the health and social services sector, the percentage of employers reporting difficulty recruiting qualified staff was the highest at

54.8%. A study of 32 nonprofit leaders conducted by Imagine Canada shows an even greater concern regarding recruitment, with 70% of respondents identifying finding skilled staff as the biggest challenge facing the sector (Zarinpoush & Hall, 2007). Another pressing concern for the sector is the future retirement of many of the sectors leaders. At present, the majority of nonprofit leaders are baby boomers and they head 'flat' organizational structures with few mid-level managers able to take up the future leadership of their organizations (HR Council for the Nonprofit Sector, 2010b). There is also apprehension over the possibility of the loss of organizational knowledge as a result of the retirement of baby boomers.

However, baby boomers are re-defining retirement. Many now view retirement as a new start in life and are eager to start new careers or opportunities. Research based on Statistics Canada's annual General Social Survey (GSS) shows that Canadians over 65 years of age get the greatest satisfaction from paid work, when asked to rate their enjoyment of a selected set of activities, such as going to the cinema, cooking and grocery shopping (Wolfson, Rowe and Sharpe, 2009). Being valued is one of the most important sources of wellbeing, and this sense of being valued and contributing to society can be even more profound when working for an organization in the not-for-profit sector.

The large number of retirees provides opportunities for organizations to recruit a wealth of new knowledgeable, skilled and engaged volunteers and "sector switchers" (who are aged 50 and over and transitioning to nonprofit employment). When surveyed, many older workers expressed an interest in seeking an "encore career," that is the pursuit of a purpose-driven career in the second half of life (HR Council for the Nonprofit Sector, 2010b). For many reasons, 57% of respondents to an HR Council for the Nonprofit Sector survey indicated that they plan to continue working after retirement. However, almost half of respondents (47%) felt that inadequate compensation and benefits would be a barrier to a job in the nonprofit sector (HR Council for the Nonprofit Sector, 2010b).

The retired want to remain active contributors to society, using their knowledge and skills to enhance their communities. They want to feel they matter, that they are not just treated as cheap labour. Not-for-profits that can understand the needs, value and interest of these workers may have at their disposal a number of new engaged mature workers or volunteers (Casner-Lotto, 2007; Clutterbuck and Howarth, 2008). Employers in the nonprofit sector looking for experienced and skilled staff willing to accommodate for flexible work arrangement and offer significant benefits, may entice workers looking for challenging and meaningful employment to overlook a salary reduction. When the HR Council for the Nonprofit Sector (2010a) surveyed baby boomers and asked them what they were looking for in their late career, they responded that they were looking for flexibility in work arrangements, a better work/life balance, meaningful engagement, the opportunity to learn new skills, the ability to make a difference and to be recognized for their accomplishments.

While many Canadians may consider changing careers and sectors, the HR Council for the Nonprofit Sector identified the lack of information and awareness about employment opportunities in the nonprofit sector as a major barrier to recruit "sector switchers." They found that two-thirds of survey respondents had never thought of, or considered, a job in the nonprofit sector prior to completing the survey (HR Council for the Nonprofit Sector, 2010a). Workers considering changing career paths later in life might also be dissuaded to do so because they fear that they may face discrimination based on their age, including assumptions that they may not be able to adapt quickly to a new environment or new technology.

Many seniors are still healthy and make a significant contribution to the richness of Canadian life and to the economy. Seniors can provide a wealth of experience, knowledge and support to younger generations. The unpaid work of seniors makes a major contribution to their families and communities. In 1998, some 42 percent of Canadians aged 55-64 and 44 percent of Canadians over 65 spent an

average of 2.2 hours a day as volunteers. The economic value to our communities is thought to be \$60.2 billion each year (Edwards and Mawani, 2006). Engaging in volunteer activities or beginning an “encore career” can provide an important opportunity for seniors to continue using skills and feel a sense of purpose. Organizations in the not-for-profit sector can maximize the chance that they recruit skilled and knowledgeable late career workers by offering meaningful volunteer experiences to executives and managers in the public and private sector. By establishing relationships with leaders in a variety of sectors, organizations may then successfully recruit new employees to fill the leadership deficit.

## Innovations & Solutions

### Community-based Solutions

Not all communities will be faced with the same challenges. Canada is aging, urbanizing, and becoming more diverse, and there are vast differences between communities. Some parts of the country are aging rapidly, highlighting the need to build the infrastructure and human services to support the elderly, while others are maintaining a more balance demographic mix. Cities are experiencing rapid rates of immigration and a significant shift in their ethno-cultural mix. These demographic shifts change not only the needs of the communities that not-for-profit organizations serve, but also the capacity of communities to meet their own needs. Each community will likely be most successful at assessing its own needs and threats. Municipal governments have a central role to play in responding to these demographic shifts, but they are likely to require assistance when tackling complex problems, including addressing the stress on human service organizations to meet the needs of an aging population. Working with local public institutions and not-for-profit organizations can generate leadership on these issues, coordinate action and build trust among the community (Maxwell, 2010).

*Most sustainable improvements in community occur when citizens discover their own power to act...when citizens stop waiting for professionals or elected leadership to do something, and decide they can reclaim what they have delegated to others. (Peter Block, Community: The Structure of Belonging, 2008)*

Rural communities are vulnerable to receiving inadequate services due to their geographic isolation and small revenue base. Research has indicated that the diversity in rural communities requires tailored approaches to health care that consider the geographic, cultural and health aspects of residents in order to optimize care. Research on the effectiveness of different communities to provide palliative care has shown that tailored approaches developed in conjunction with rural communities provide the best care for residents. Despite being situated in rural communities, at considerable distance from specialists, each unique community studied was remarkably resourceful in relation to palliative care (Robinson, 2010). Although rural communities are somewhat generically referenced, it is crucial to acknowledge and

account for the multitude of social, geographic, and economic factors that contribute to the uniqueness of each community in order to respond to the needs of the residents.

### Age-Friendly Communities

In response to a number of countries around the world experiencing the significant aging of their populations, and to support governments in developing and strengthening health and social policies in an aging world, the World Health Organization (WHO) released a Policy Framework on Active Ageing in 2002. The WHO defines an active aging policy as “optimizing opportunities for health, participation and security in order to enhance quality of life as people age.” This approach is grounded in the UN-recognized principles of independence, participation, dignity, care and self-fulfilment and it acknowledges the importance of gender, life experiences, and culture on how individuals age (WHO Brochure). The WHO believes that making cities age-friendly is one of the most effective policy approaches for responding to demographic aging. Since countries are becoming more and more urbanized, and major urban centres are more likely to have the

economic and social resources to make changes to become more age-friendly, the WHO developed the Global Age-Friendly Cities project to engage cities worldwide to make their communities more age-friendly.

While assessing to degree of age-friendliness of one’s community, one may question whether their community has the physical, human, and social structures and relationships in place to support residents to live meaningfully in their community over the life course. Older people face increasing challenges due to the changes that age brings. In an age-friendly community, policies, services and structures related to the physical and social environment are designed to support and enable older people to “age actively” – that is, to live in security, enjoy good health and continue to participate fully in society (WHO Brochure).

Age-friendly neighbourhoods have different types of homes for people at different stages of life; walking paths and public transit to make it easy to get around without a car; and parks, shops, services, and homes that are closer together (EPA, 2009). Age-friendly communities not only make it easier for residents to access services and move around their environment, they encourage healthier lifestyles. Communities can be built to encourage walking, biking, and active use of parks, so that people of all ages get exercise in the course of daily life. Residents are also more likely to be socially engaged when they live in communities that have easily accessible transit, welcoming public spaces and opportunities to shop and meet people near their homes. Having grocery stores, restaurants, and cafés within walking distance — along with sidewalks to walk on — is the best predictor of how much older adults will walk, according to a recent Seattle study led by Abby King. By designing neighbourhoods differently — as well as redeveloping existing neighbourhoods and roadways — communities can make places that are healthier for residents and the environment (EPA, 2009).

One of the main benefits of addressing the challenges posed by an aging population within the age-friendly community framework is that age-friendly policies, programs and services

AGE-FRIENDLY COMMUNITY
<i>Participation</i>
<ul style="list-style-type: none"> <li>• Positive images of older persons</li> <li>• Accessible and useful information</li> <li>• Accessible public and private transportation</li> <li>• Inclusive opportunities for civic, cultural, educational and voluntary engagement</li> <li>• Barrier-free and enabling interior and exterior spaces</li> </ul>
<i>Health</i>
<ul style="list-style-type: none"> <li>• Places and programs for active leisure and socialization</li> <li>• Activities, programs and information to promote health, social and spiritual well-being</li> <li>• Social support and outreach</li> <li>• Accessible and appropriate health services</li> <li>• Good air/water quality</li> </ul>
<i>Security and Independence</i>
<ul style="list-style-type: none"> <li>• Appropriate, accessible, affordable housing</li> <li>• Accessible home-safety designs and products</li> <li>• Hazard-free streets and buildings</li> <li>• Safe roadways and signage for drivers and pedestrians</li> <li>• Safe, accessible and affordable public transportation</li> <li>• Services to assist with household chores and home maintenance</li> <li>• Supports for caregivers</li> <li>• Accessible stores, banks and professional services</li> <li>• Supportive neighbourhoods</li> <li>• Safety from abuse and criminal victimization</li> <li>• Public information and appropriate training</li> <li>• Emergency plans and disaster recovery</li> <li>• Appropriate and accessible employment opportunities</li> <li>• Flexible work practices</li> </ul>

benefit all residents; they ensure that all residents have equal access to supports and services, no matter their age or where they live. Another key benefit of following this framework is that it allows residents to assess their community’s needs across a number of sectors - including housing, transportation, health and social services, civic participation and employment, buildings, parks and other outdoor spaces, recreation, education, arts and culture – and devise an integrated response.

## How Age-Friendly Are Ontario's Cities?

In an online poll in 2009, CARP polled 2300 *CARP ActionOnline* readers on the age-friendliness of their city. Respondents were asked questions that dealt with the ease of overall life in the respondent's town, using transit, obtaining low-cost housing, being a pedestrian and accessing health care and home services.

### CARP's Age-Friendly Communities Index

	Overall	Transit	Housing	Pedestrian	Health	Index
Peterborough	77%	64%	30%	53%	64%	288
London	68%	28%	-22%	20%	42%	136
Kitchener/Waterloo	62%	21%	-40%	26%	34%	103
ALL CITIES	58%	35%	-58%	20%	24%	75
Ottawa	60%	34%	-68%	28%	10%	64
Mississauga	36%	32%	-64%	10%	48%	62
Hamilton	51%	36%	-40%	24%	-10%	61
TOTAL	54%	6%	-47%	18%	24%	55
Toronto	44%	34%	-78%	12%	10%	22 <sup>1</sup>

Of the 17 Canadian cities with populations of 400,000 or more studied, Peterborough was found to have by far the highest CARP Age-Friendly Index™ score. From the table showing the results from the poll, it is clear that many respondents find that obtaining low-cost housing is not easy. The results of this poll confirm that affordable housing is a pressing concern for many older adults (CARP, 2009).

### Innovative Initiatives

Countries around the world are grappling with significant demographic changes and are creating innovative programs and services to meet the changing needs of their citizens. The dilemma may not lie in creating new and innovative programs, but rather sharing successes with other communities and countries. Here are only a few interesting examples from Ontario and around the world of how services and needs can be met in a variety of ways to ensure that all citizens age

with dignity and in good health. A longer list of initiatives is provided in Appendix B.

#### On Staying Engaged:

- In Burlington, VT, the **McClure MultiGenerational Center** houses the Champlain Senior Center, which provides meals, educational, health, social, and recreational programs for those 50 and older. Across the shared hallway is Burlington Children's Space, which runs early child care and preschool programs. This intergenerational shared space helps connect older adults with children both informally and in more structured tutoring, classes, and storytelling (EPA, 2009).

#### On Encouraging Active Living:

- The **PedFlag Program** in Kirkland, WA placed yellow flags at over 60 crosswalks that walkers pick up and carry across to remind drivers to yield to pedestrians, and then return flags to another holder after crossing. The **Flashing Crosswalk Program** incorporates flashing lights embedded into the pavement for 30 crosswalks at busier intersections (EPA, 2009).

#### On Comprehensive Community Care:

- Older adults in the Chicago area can find a new kind of gathering place that fits active lifestyles in a community setting. **Mather LifeWay Cafés** are more like typical coffee shops than senior centers, with attractive, inviting, hip interiors to appeal to 50+ adults and their friends. Usually located in a downtown storefront-type building, they are technology-friendly to connect older adults with Internet, e-mail, and computer classes, and often have learning centers and gym/exercise facilities. Some even have full restaurants with entertainment (EPA, 2009).

#### On Integrated Community Care Models:

- Australia's **Home and Community Care Program** offers services that range from community-aged care packages, established in consultation with senior citizens and family members, to EACH packages (Extended Aged Care in the

<sup>1</sup> Questions used a four point semantic scale ranging from 4 (very easy) to 1 (not at all easy). To derive the Index, CARP subtracted the bottom two negative responses from the top two positive responses to yield an index score on each attribute. Index score on each attribute. Index scores are summed across attributes to yield a Total Index Score. (CARP Age-Friendly Cities Poll Report, 2009)

Home), which include intensive nurse care in the home. Over the years, the program has been extended to rural and remote areas, the indigenous population and culturally specific programs called Culturally and Linguistically Diverse (CALD) programs, in different languages (Senate Committee on Aging, First Interim Report).

- New-Brunswick's **Extra-Mural Program** (also known as 'Hospitals without Walls') is a comprehensive and coordinated hospital-at-home service that serves all residents. It provides a wide range of services to residents in their home for the purpose of promoting, maintaining or restoring health within the context of their daily lives, as well as palliative services to support quality of life for individuals with progressive life-threatening illnesses. The program includes assessments, interventions (including treatment, education and consultation), service planning and coordination. Professional service providers, including nurses, registered dietitians, respiratory therapists, occupational therapists, physiotherapists, rehabilitation aides and social workers visit the home to provide any or all of the following: acute care, palliative care, home oxygen program aid, long term care assessment and rehabilitation services (The New Brunswick Extra-Mural Program webpage).

#### *On Aging at Home:*

- In 2001, long-time residents of Boston's Beacon Hill neighbourhood decided they wanted to age in place in their own homes — but with the same access to services, maintenance help, home care, and social activities they might receive in a retirement community. They founded **Beacon Hill Village**, a member organization that links area seniors to 'discounted, vetted and guaranteed' service providers, home health care, classes, and activities (EPA, 2009).

#### *On Housing:*

- **Silver Sage Village** in Boulder, CO, is a 50+ cohousing community with 16 accessible homes around a common

courtyard and an accessible two-story, common house with a guest bedroom for friends and family and a large great room for community meals and celebrations. Ten homes are market rate; six are permanently affordable (EPA, 2009).

- **Finlandia Village** in Sudbury, ON was built to provide a continuum of care and housing options to help residents age in place while maintaining a high quality of life. The Village includes townhouses, senior apartments, supportive housing, shared seniors housing and a nursing home. By providing a continuum of care and housing needs in one location, it allows residents to remain within the village and a part of their community, while adjusting their accommodations to meet their care needs (Finlandia Village webpage).

#### *On Supporting Caregivers:*

- German caregivers have the ability to register as "informal caregivers" which provides them with special entitlements and benefits, including a contribution of up to \$584 monthly to a caregiver's pension insurance (CARP, 2008).

#### *On Transportation:*

- British Columbia's plan to ensure the continued mobility of its seniors includes a bus pass program and taxi vouchers. The **BC Bus Pass Program** provides affordable transportation to low-income seniors and persons with disabilities in 44 communities in British Columbia and benefits more than 60,000 persons per year. To be eligible for the yearly \$45 pass, a senior must be receiving Old Age Security and the Guaranteed Income Supplement. The province's taxi program gives people with a permanent physical or cognitive disability discounted transit cards (Handy Card) and Taxi Saver coupons. Handy cardholders can purchase discounted taxi vouchers known as "taxi savers." A booklet of tax vouchers worth \$50.00 is sold for \$25.00 (CARP, 2010)



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## Appendices

### Appendix A – Demographic Information

The 2006 Census shows that Ontario's oldest census metropolitan areas (CMAs), with their proportion of residents aged 65 and over, are Peterborough (18.2%), St. Catharine's-Niagara (17.7%), Thunder Bay (16%), Kingston (15.3%), Hamilton (15.1%), Sudbury (14.9%), Brantford (14.6%) and London (13.8%). Along with having the highest proportion of children less than 15 years of age, Barrie and Oshawa had, in 2006, the 3<sup>rd</sup> and 4<sup>th</sup> lowest proportion of seniors, at 11.2% and 11.5% respectively, amongst all of Canada's CMAs (Statistics Canada).

Mid-size urban centres, or census agglomerations (CAs), are urban areas that have an urban core with a population of at least 10,000. CAs tend to grow more slowly, and are on average older than CMAs. In 2006, 15.5 percent of their residents were aged 65 and over, compared to 12.9 percent of residents in CMAs. Elliot Lake is the second oldest mid-size urban centre in Canada, with 31.6% of its residents aged 65 and over. Other CAs with a notably higher proportion of seniors are Cobourg (24.5%), Tillsonburg (23%), Collingwood (20.6%), Hawkesbury (20.4%), Kawartha Lakes (19.5%), Orillia (19.1%), Owen Sound (18.8%), Brockville (18.6%), Pembroke (18.5%), Temiskaming Shores (18.1%), Sault Ste. Marie (18%), Port Hope (17.9%), Midland (17.8%), Cornwall (17.6%), Norfolk (17.4%), Sarnia (17%), Belleville (16.7%), Stratford (16.4%), Kenora (16.2%) and Woodstock (16.2%) (Statistics Canada).

Due primarily to the internal migration of young adults, who leave rural communities to pursue higher education or find work in urban areas, and international immigration, which is concentrated to large urban centres, rural communities tend to have older populations. With fewer young adults and more seniors, rural areas are faced with challenges meeting the needs of their older residents, including adequate health and home care services, appropriate housing and transportation.

According to the 2006 Census, remote rural areas had a much higher proportion of people aged 65 and over (16.1%) than metropolitan areas (13.2%) or rural areas close to urban centres (13.9%). Nine of Canada's rural communities with the highest proportion of persons aged 65 and over are in Ontario: Perth (28%), Wasaga Beach (24.9%), Minden Hills (24.9%), Blue Mountains (24.8%), Parry Sound (24.4%), South Bruce Peninsula (24.1%), Brighton (23.2%), Dysart and Others (23.2%) and Lambton Shores (23.2%) (Statistics Canada).

Census Agglomeration	Proportion of the population aged 65 and over
Elliot Lake	31.6
Cobourg	24.5
Tillsonburg	23
Collingwood	20.6
Hawkesbury	20.4
Kawartha Lakes	19.5
Orillia	19.1
Owen Sound	18.8
Brockville	18.6
Pembroke	18.5
Temiskaming Shores	18.1
Sault Ste. Marie	18
Port Hope	17.9
Midland	17.8
Cornwall	17.6
Norfolk	17.4
Sarnia	17
Belleville	16.7
Stratford	16.4
Kenora	16.2
Woodstock	16.2

## **Appendix B – Innovative Initiatives**

### *On Staying Engaged:*

- In Burlington, VT, the **McClure MultiGenerational Center** houses the Champlain Senior Center, which provides meals, educational, health, social, and recreational programs for those 50 and older. Across the shared hallway is Burlington Children’s Space, which runs early child care and preschool programs. This intergenerational shared space helps connect older adults with children both informally and in more structured tutoring, classes, and storytelling (EPA, 2009)

### *On Encouraging Active Living:*

- The **PedFlag Program** in Kirkland, WA placed yellow flags at over 60 crosswalks that walkers pick up and carry across to remind drivers to yield to pedestrians, and then return flags to another holder after crossing. The **Flashing Crosswalk Program** incorporates flashing lights embedded into the pavement for 30 crosswalks at busier intersections (EPA, 2009).
- NESTA is the National Endowment for Science, Technology and the Arts - an independent body with a mission to make the UK more innovative. It encourages active aging by providing support and up to £50,000 to develop and test new service ideas to help individuals in their fifties and sixties to stay active and engaged in their community (NESTA’s Age Unlimited webpage).

### *On Comprehensive Community Care:*

- Older adults in the Chicago area can find a new kind of gathering place that fits active lifestyles in a community setting. **Mather LifeWay Cafés** are more like typical coffee shops than senior centers, with attractive, inviting, hip interiors to appeal to 50+ adults and their friends. Usually located in a downtown storefront-type building, they are technology-friendly to connect older adults with Internet, e-mail, and computer classes, and often have learning centers and gym/exercise facilities. Some even have full restaurants with entertainment (EPA, 2009).

### *On Integrated Community Care Models:*

- Veterans Affairs Canada’s Veterans Independence Program is a comprehensive home care program. It provides personal care, housekeeping and grounds maintenance in order to help veterans and their families remain healthy and in their own homes for as long as possible (Senate Committee on Aging, First Interim Report).
- Australia’s Home and Community Care Program – Services range from community-aged care packages, established in consultation with senior citizens and family members, to EACH packages (Extended Aged Care in the Home), which include intensive nurse care in the home. Over the years, the program has been extended to rural and remote areas, the indigenous population and culturally specific programs called Culturally and Linguistically Diverse (CALD) programs, in different languages ((Senate Committee on Aging, First Interim Report).
- New-Brunswick’s Extra-Mural Program (also known as ‘Hospitals without Walls’) is a comprehensive and coordinated hospital-at-home service that serves all residents. It provides a wide range of services to residents in their home for the purpose of promoting, maintaining or restoring health within the context of their daily lives, as well as palliative services to support quality of life for individuals with progressive life-threatening illnesses. The program includes assessments, interventions (including treatment, education and consultation), service planning and coordination. Professional service providers, including nurses, registered dietitians, respiratory therapists, occupational therapists, physiotherapists, rehabilitation aides and social workers visit the home to provide any or all of the following: acute care, palliative care, home oxygen program aid, long term care assessment and rehabilitation services (The New Brunswick Extra-Mural Program webpage).
- Calgary’s Comprehensive Community Care (C3) operates ten sites aimed at helping people live more independent lives. They offer a spectrum of care to adults of all ages, including day programs, rehabilitation and sub-acute care for those recuperating from neurological or



musculoskeletal impairments, transition programs for people needing assessment, recuperation and therapy before moving to another community setting, palliative and hospice care for people with terminal illnesses, and respite services for home caregivers.

[http://www.carewest.ca/index.php?page=about\\_carewest](http://www.carewest.ca/index.php?page=about_carewest)

#### *On Aging at Home:*

- In 2001, long-time residents of Boston's Beacon Hill neighbourhood decided they wanted to age in place in their own homes — but with the same access to services, maintenance help, home care, and social activities they might receive in a retirement community. They founded **Beacon Hill Village**, a member organization that links area seniors to 'discounted, vetted and guaranteed' service providers, home health care, classes, and activities (EPA, 2009).
- **Southwark Circle** mobilizes public, private, voluntary and community resources to help older people enhance their quality of life. They do so by providing a membership organization that helps people take care of household tasks through local, reliable Neighbourhood Helpers and forge social connections to foster teaching, learning and sharing. Members can buy tokens to get help from Neighbourhood Helpers and earn tokens by helping others (Southwark Circle webpage).

#### *On Housing:*

- **Silver Sage Village** in Boulder, CO, is a 50+ cohousing community with 16 accessible homes around a common courtyard and an accessible two-story, common house with a guest bedroom for friends and family and a large great room for community meals and celebrations. Ten homes are market rate; six are permanently affordable (EPA, 2009).
- **Finlandia Village** in Sudbury, ON was built to provide a continuum of care and housing options to help residents age in place while maintaining a high quality of life. The Village includes townhouses, senior apartments, supporting housing, shared seniors housing and a nursing home. By providing a continuum of care and housing needs in one location, it allows residents to remain within the village and a part of their community, while adjusting their accommodations to meet their care needs (Finlandia Village webpage).
- Homesharing is an emerging option for homeowners unwilling to leave their homes, yet needing some form of assistance. Homesharing occurs where two or more unrelated people share a home, with their own private space and common living areas. It can work well in rural areas, where organized caregiving can be harder and more expensive to deliver. Frequently coordinated by a local nonprofit, the homeowner benefits by receiving 10 to 15 hours per week of household help, like cooking, shopping, or cleaning, and the roommate receives free rent. Having someone in the home informally increases awareness of changes in the homeowner's wellbeing, while allowing seniors to remain at home and independent longer, enjoying the help and the informal companionship (EPA, 2009).

#### *On Sharing Information:*

- Age Concern and Help the Aged merged to create AgeUK, which now aims to improve later life for everyone. They work to achieve this goal by providing information and advice on numerous topics, including health and housing, through a toll-free number. They also produce public information campaigns to change the way people view the aged and provide training and research. It helps over 5 million British citizens every year (AgeUK website).

#### *On Supporting Caregivers:*

- Sweden, Germany, Australia, France and the United-Kingdom all provide generous needs and income tested allowances to caregivers (CARP, 2008).
- Sweden's direct compensation rates are based on and equal to formal home care worker compensation rates. Germany's benefits vary between \$318-\$1033/monthly (CARP, 2008).
- Germany contributes up to \$584 monthly to a caregiver's pension insurance while the United-Kingdom has initiated a State Pension for Caregivers. It began in 2002 and will be payable by 2050 (CARP, 2008).

- Australia's Caregiver program is an extension of their formal Home and Community Care Program. It is jointly administered by federal and state governments and treats the caregiver as a client. The program provides caregivers with access to information, advice, counseling and respite services (CARP, 2008).
- France and Germany connect caregivers with the formal system by requiring health professionals to evaluate the care being provided and the level of care needed by the care receiver. This evaluation also determines the rate of the allowance that will subsequently be delivered to caregivers (CARP, 2008).
- German caregivers have the ability to register as "informal caregivers" which provides them with special entitlements and benefits (CARP, 2008).

*On Transportation:*

- The State of Illinois' Seniors Ride Free program requires mass transit agencies state-wide to now allow senior citizens, aged 65 and older, to use main line and fixed route public transit service for free (State of Illinois, 2010).
- The Calgary Transit Senior Citizen's Transit Pass provides unlimited access to transit services for persons 65 years and over for \$35 per year. Low-income seniors can get a Transit Pass for \$15 per year (CARP, 2010).
- British Columbia's plan to ensure the continued mobility of its seniors includes a bus pass program and taxi vouchers. The **BC Bus Pass Program** provides affordable transportation to low-income seniors and persons with disabilities in 44 communities in British Columbia and benefits more than 60,000 persons per year. To be eligible for the yearly \$45 pass, a senior must be receiving Old Age Security and the Guaranteed Income Supplement. The province's taxi program gives people with a permanent physical or cognitive disability discounted transit cards (Handy Card) and Taxi Saver coupons. Handy cardholders can purchase discounted taxi vouchers known as "taxi savers." A booklet of tax vouchers worth \$50.00 is sold for \$25.00 (CARP, 2010).
- Vancouver's regional transportation authority's Shuttle program successfully operates small buses, known as "community shuttles," that run through neighbourhoods and deliver passengers to transit hubs (bus stations, Skytrain stops, etc.) (CARP, 2010).

*On Elder Abuse:*

- The Cavendish Health and Social Services Centre and the Sureté du Quebec collaborated to create Senior Aware, a program that will advise seniors and the general public about what constitutes elder abuse and what can be done about it. After the success of a pilot program in Saguenay earlier this year, the program be instituted across the province and will involve information sessions with seniors groups who request them. A senior who is a volunteer and well-versed on the topic will accompany a Sureté du Quebec officer to the sessions, which might be held in community centres or seniors residences.