

A Policy Framework to Guide a National Seniors Strategy for Canada

August 2015

CONTENTS

Executive summary.....	5
Introduction	7
Stakeholder engagement	7
The issue.....	7
Principles for a national strategy for seniors' health in Canada	10
Principles	11
Enhance the health care experience	11
Improve population health	11
Value for money.....	12
Challenges for seniors' health care in Canada: cross-cutting themes.....	12
Sectors in the continuum of care	14
1. Wellness and prevention	14
2. Primary care.....	16
3. Home care and community support.....	18
4. Acute and specialty care	20
5. Long-term care	22
6. Palliative care	24
Federal policy levers to support a national seniors strategy	26
Appendix A.....	32
Appendix B.....	33

EXECUTIVE SUMMARY

Canada's population is in the middle of a demographic shift. In 2011 the first of the baby boomer generation turned 65 and Canada's senior population reached 5 million.¹ Seniors are Canada's fastest growing demographic — the proportion of seniors is expected to reach up to 25% of the population by 2036.² It is projected that between 2015 and 2021, seniors will outnumber children under 14 for the first time.³ The Canadian Institute for Health Information reports that today, with seniors accounting for less than 15% of the population, they consume approximately 45% of public health spending. If current trends and approaches continue, the proportion of spending on care for seniors will grow by over 15% to almost 62% of health budgets by 2036.

The aging of Canada's population is one of the most pressing policy imperatives of our time, as concern grows the country is ill-prepared for the impact an aging population will have on the health care system, social services and the economy. We are faced with the prospect of a health system that cannot sustain our seniors, and is not itself sustainable. Canada must take action to avert that reality. The Canadian Medical Association (CMA) is therefore calling on governments to make development of a national seniors strategy an immediate priority.

But this is not action for governments alone. A meaningful seniors strategy must be the work of a broad coalition of stakeholders. Isolated efforts, however professional and well-intended, will not produce the integrated system of health and social services Canada and its seniors so badly need. In 2014, to start the cooperative effort needed, the CMA invited 35 organizations representing medical, patient and community stakeholders to join in outlining a policy framework that can guide governments in developing that national strategy.

To develop the strategy, we adapted the CMA and the Canadian Nurses Association's set of principles to guide health care transformation in Canada.⁴ The principles call for a high-quality health care system that is centred on individuals and their families and emphasizes health promotion and illness prevention. It must be equitable, sustainable and accountable.

To do the work the stakeholder representatives were divided into six groups, one for each of the sectors on the continuum of care: wellness and prevention, primary care, home care and community support, acute and specialty care, long-term care and palliative care. Each group discussed the key issues, challenges and enablers for seniors' health and care in their sector and identified promising practices in it from across Canada and internationally. Here is a very brief summary of their thoughts on what a national seniors strategy must contain:

Wellness and prevention

Efforts to improve wellness and prevention must go beyond the health care system to encompass the life factors that shape each person's overall health and wellbeing — the social determinants of health. Income security, safe housing and access to good food and social connections are all issues to be addressed by a national seniors strategy.

Primary care

An effective primary care system is crucial for keeping seniors out of hospitals.⁵ Primary care providers could manage the complex needs of seniors better if primary and specialist care were more integrated and greater training in geriatrics and palliative care was available. Stronger links between providers and the community services their patients need would also help.

Home care and community support

Looking after seniors at home is cost-effective and what most people want, but social policy and funding are not sufficient. Care, and funding for it, vary greatly across Canada; the seniors strategy should include national standards. Most care is provided by unpaid family and friends; the strategy must offer them more support such as tax breaks, leave and respite.

Acute and speciality care

Acute-care hospital stays are often preceded by long waits for specialists and treatment. After, poor coordination between acute and community often traps seniors in hospital, awaiting a long-term care bed or home care. These poor transitions between levels of care are known to put patients at risk. The strategy must emphasize better coordination of care.

Long-term care

Most residents of long-term care are over 85 and frail. Many have considerable cognitive and health challenges. As Canadians live longer, demand for long-term care increases, but older care homes are not designed for today's high-need patients. Long-term care is also expensive. The strategy should include national standards of care and a plan for funding it.

Palliative care

Demand for end-of-life care that focuses on quality of life and death, rather than treatment, is increasingly in demand, but access to it is limited and poorly coordinated. A team approach and more training for health care providers, supported by national standards, would increase availability. Patients, families and providers need help to openly discuss end-of-life decisions.

NEXT STEPS

The CMA and the 35 stakeholder groups that worked with us on this framework believe that this country must act now to create a health strategy that will ensure for our seniors the effective, integrated health care and supportive community care they need to enjoy the best quality of life possible. This framework is an outline of what we believe that strategy must contain. There is one other, very important ingredient needed, however: a broad, hard-driving coalition, committed to make this work come to fruition. We will be there.

INTRODUCTION

Canada's population is in the middle of a demographic shift. In 2011 the first of the baby boomer generation turned 65 and Canada's senior population reached 5 million.¹ Seniors are Canada's fastest growing demographic — the proportion of seniors is expected to reach up to 25% of the population by 2036.² It is projected that between 2015 and 2021, seniors will outnumber children under 14 for the first time.³

The aging of Canada's population is one of the most pressing policy imperatives of our time, as concern grows the country is ill-prepared for the impact an aging population will have on the health care system, social services and the economy.

Recognizing the demands this demographic shift will present, the Canadian Medical Association (CMA) is calling on governments to make the development of a national seniors strategy a priority. To support that work, the CMA invited a broad cross-section of stakeholders⁴ to outline a policy framework to guide governments in developing that strategy. This report presents that framework.

STAKEHOLDER ENGAGEMENT

The CMA initiated the stakeholder consultation in 2014, inviting 35 organizations representing medical, patient and community stakeholders to participate in six working groups, modelled on the components of the continuum of care.

The working groups were:

- Working Group on Prevention and Wellness;
- Working Group on Primary Care;
- Working Group on Hospital Care (acute and specialty care);
- Working Group on Home Care and Community Supports;
- Working Group on Long-Term Care; and
- Working Group on Palliative Care.

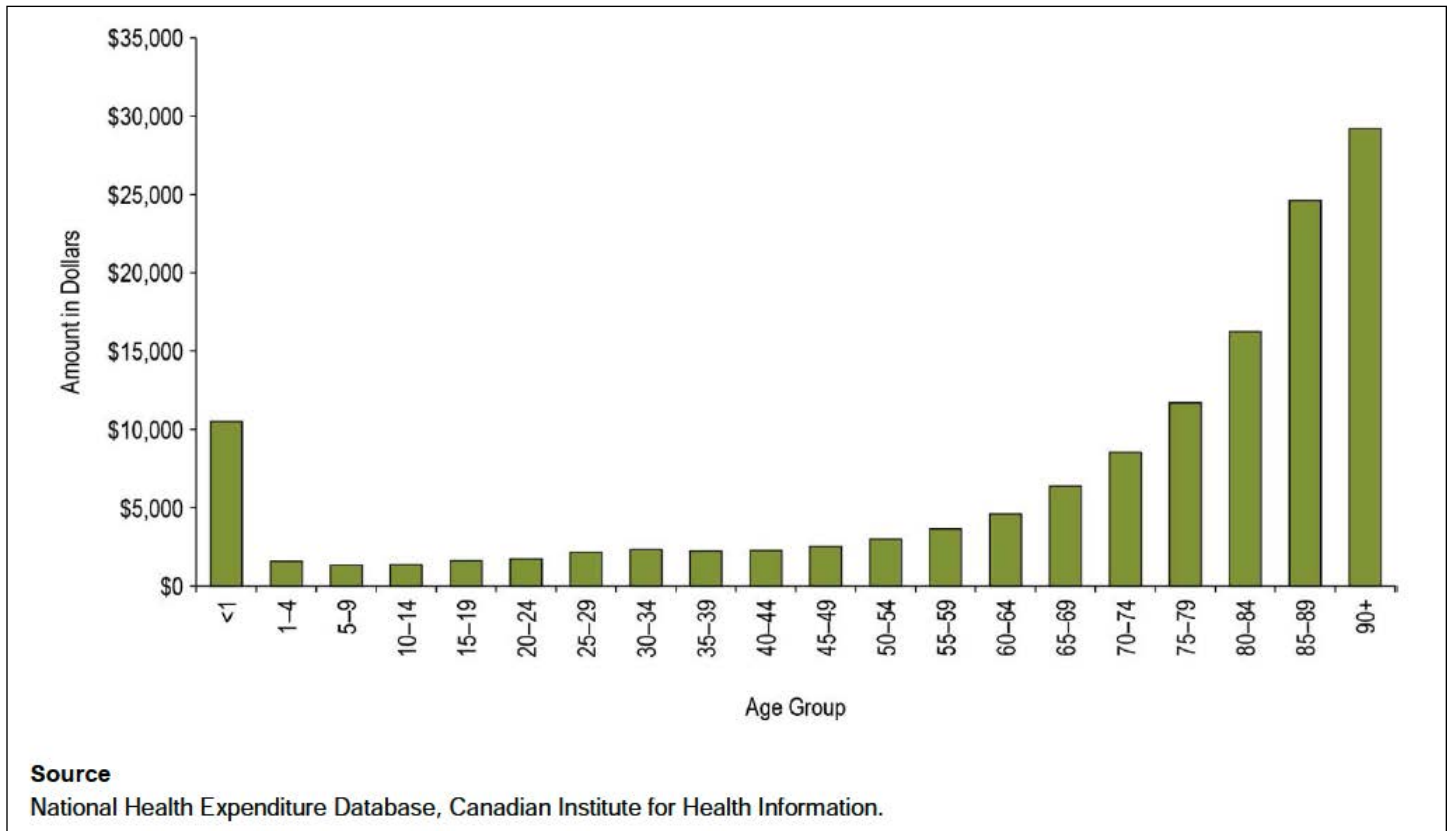
The central role of the working groups was to review and validate the principles of a national seniors strategy for Canada; define each element of the continuum of care with a focus on seniors; identify key issues, challenges and enablers, both cross-cutting and for each area of the continuum; and identify leading and promising practices in seniors care in Canada and internationally.

THE ISSUE

Canada is undergoing a shift in the structure of the population. As part of that overall increase in the senior population to 9.8 million and 25% of the population by 2036, the number and proportion of older seniors — those 75 and older — will increase significantly as well. According to Statistics Canada's medium-growth population projection, the population aged 80 years and over will increase 2.6 times by 2036 — to 3.3 million persons.⁵ A Finance Canada report on the economic and fiscal implications of the aging population says it will increase pressure on public finances.⁶

The Canadian Institute for Health Information (CIHI) reports that while seniors account for less than 15% of the population, they consume approximately 45% of public health spending.⁷ The amounts are significant: health spending per person is \$6,368 for those aged 65 to 69, and increases across higher age bands: to \$16,231 for those 80 to 84, and to more than \$24,590 for those 85 and older.⁸ Figure 1 below demonstrates how average per capita health spending increases with age. On the basis of current trends and approaches, the CMA forecasts that the proportion of provincial/territorial health spending associated with seniors care will grow by over 15% to almost 62% of health budgets by 2036.

Figure 1: Provincial/territorial health spending per capita, 2012⁹



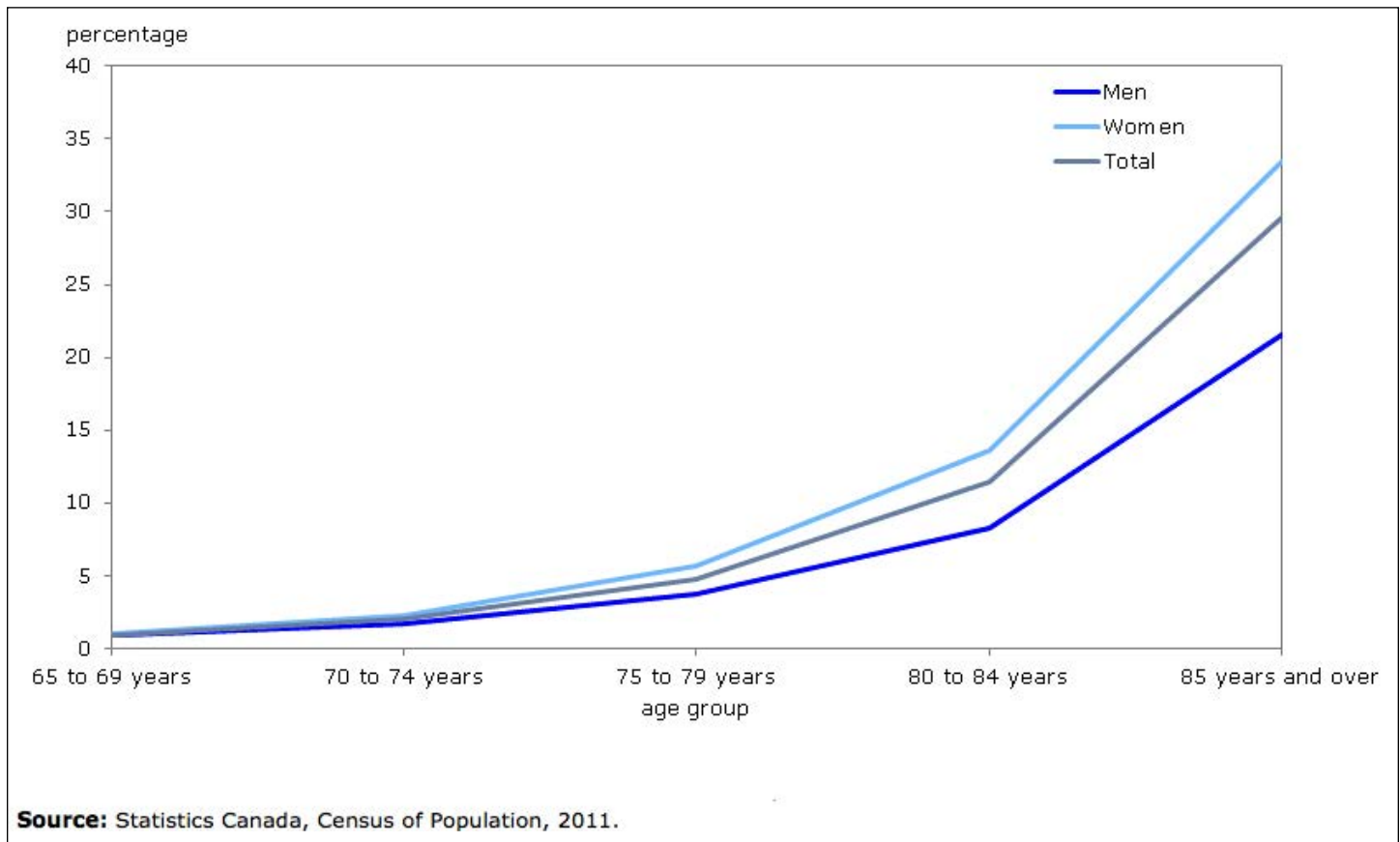
However, as members of the working groups pointed out, people do not inherently have greater needs for health and social services because they are old; it's the fact that older adults are more likely to have complex chronic conditions that will place greater demands on health care and social services as the population ages. Consider the following:

- People who are aged 85 or older and have no chronic diseases use half as many health services as people aged 65 to 74 who have three or more chronic diseases (e.g., diabetes, hypertension and heart disease).
- The 24% of seniors who have at least three chronic diseases account for 40% of all health care use among seniors.¹⁰

The rate of seniors residing in long-term care facilities has been declining. However, the demand for residential care will nevertheless increase significantly over the near term, because the proportion of seniors living in special care facilities increases with age, and the number of elderly seniors will grow as the aging of the population accelerates. As Figure 2 shows, about 1% of people between 65 and 69 live in special care facilities, while 29.6% of seniors 85 and older live in them.¹¹

Reasons cited for institutionalization include increasing frailty and care needs that exceed the capacity of family or friends. In many cases, family and friends continue to provide care after institutionalization.¹²

Figure 2: Proportion of the population 65 and older living in a special care facility¹³



Not only is the size of the elderly population increasing, its health needs are changing too, particularly among those requiring residential care. Long-term care residents are older than in previous years and have more complex health needs than ever before. The Canadian Institute for Health Information (CIHI) compared home care clients with seniors living in residential care and found the latter were more likely to require extensive assistance with activities of daily living, such as bathing and toileting (74% versus 18%). People in residential care were also more likely to have moderate to severe cognitive impairment (60% did, compared to 14% of home care clients). The number of residents with dementia is expected to increase. In 2011, 747,000 Canadians were living with cognitive impairment, including dementia — that’s 14.9% of Canadians 65 and older. It is projected that by 2031 there will be 1.4 million people with dementia.¹⁴

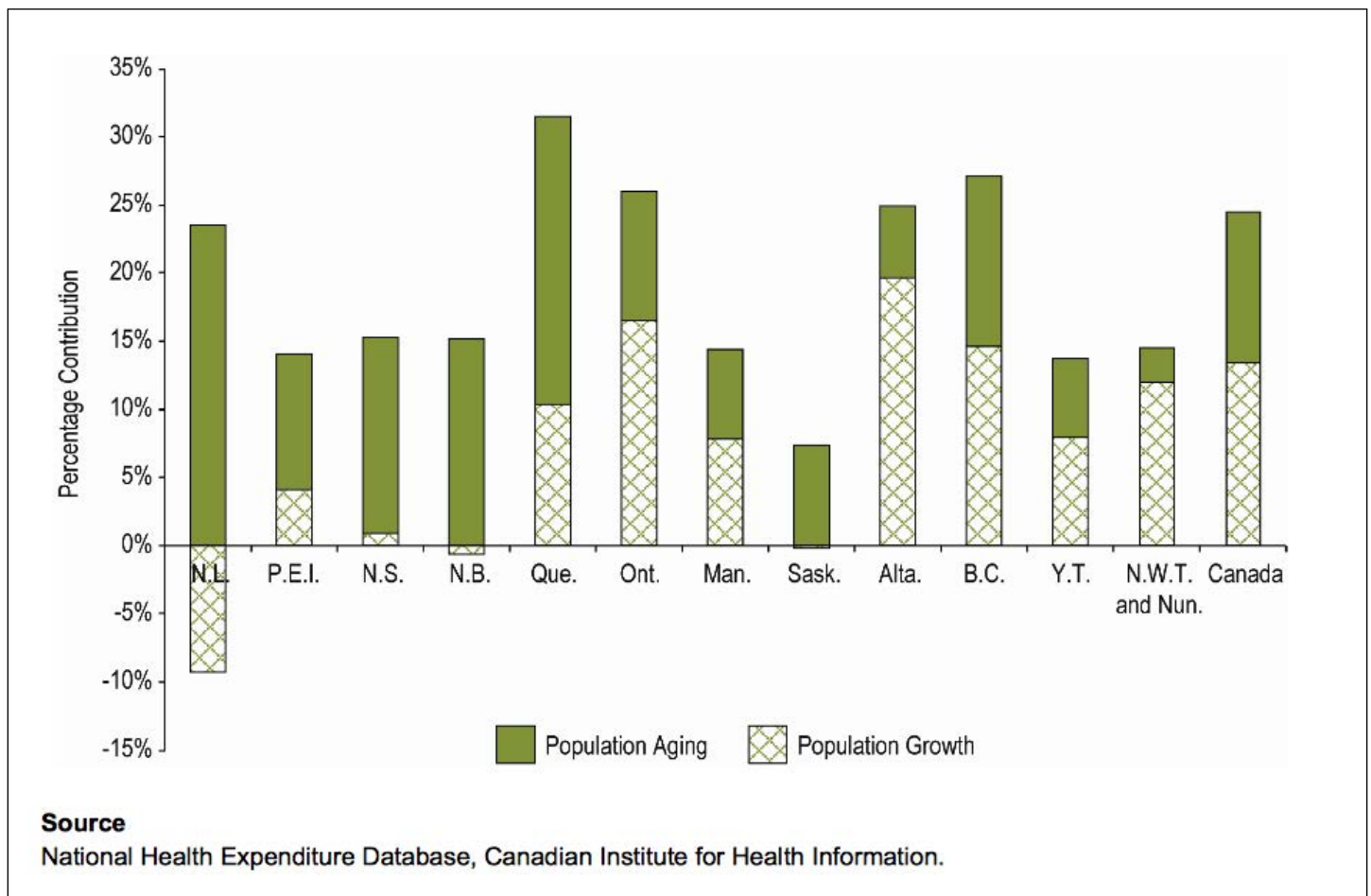
Evidence is mounting that seniors and their families are experiencing significant challenges getting access to the full range of health care and social services. A recent report by the Conference Board of Canada, commissioned by the CMA, provides a startling overview of the current state of care for seniors across Canada. The report found that in 2012, 461,000 Canadians were not getting the home care they thought they required; wait times for access to a long-term care facility in Canada ranged anywhere from 27 to more than 230 days; and as few as 16% of Canadians requiring palliative care actually received it.¹⁵

Several threats to the financial sustainability of the health system can be expected to affect seniors, including more patients with chronic medical conditions, increasing demand for more expensive drug therapies and government efforts to control health care spending by restricting health care budgets. Given that services to people aged 65 and older account for nearly half of Canada’s health care spending, seniors could be particularly vulnerable to spending cuts.

The impact of demographic change will not be distributed equally across the country. A recent report by CIHI examining the cost drivers of the health care system found “there is a noticeable east–west gradient in Canada, in which the impact of aging is more significant in the Atlantic region and Quebec than in Ontario and Western Canada.”¹⁶ Figure 3 below demonstrates this gradient, which reflects how the demographic shift is occurring earlier in the east than the rest of the country. This report found population aging was a modest cost driver between 1998 and 2008 (responsible for 0.8%

increase of the total 7.4% increase in costs). However, the report noted that the modest change was reflecting aging of the pre-baby boom population.¹⁷

Figure 3: Proportion of the contribution of population growth and aging to health sector cost increases, by province/territory (1998–2008)¹⁸



CIHI’s report *Health Care Costs Drivers: The Facts*, says older seniors consume more health care dollars largely for two reasons: health care costs tend to be higher in the last few months of life, and the minority of the population with chronic illnesses tends to require more intensive medical attention with age.

The impact of the aging population on health care budgets can be more fully appreciated by applying the current age-sex profile of provincial-territorial spending on health to the 2014 and 2036 population projections. If, as expected, people aged 65 years and over make up 23.9% of total population in 2036, its share of total provincial-territorial health spending will increase by 15.4 percentage points to reach 61.9%.

PRINCIPLES FOR A NATIONAL STRATEGY FOR SENIORS’ HEALTH IN CANADA

In 2011, the CMA and the Canadian Nurses Association developed a set of principles to guide health care transformation in Canada.¹⁹ These principles were based on the Institute for Healthcare Improvement’s Triple-Aim framework of “better care for individuals, better health for populations, and lower per capita costs.”²⁰ The principles have since been endorsed by 138 organizations. As part of the development of this framework, the principles were updated in consultation with key stakeholders. These principles must be followed to ensure a seniors strategy adequately addresses the health and social needs of Canada’s seniors.

PRINCIPLES

Enhance the health care experience

PERSON- AND FAMILY-CENTRED CARE

The person and family must be at the centre of health care delivery. A person- and family-centred strategy for Canada's seniors must place value in the following characteristics:

- Person-centred choices
- Informed decision-making
- Autonomy
- Meaningful participation in care
- Health literacy
- Dignity
- Quality of life

QUALITY HEALTH CARE

Canada's seniors deserve quality services that are appropriate for their needs, respect individual choice and are delivered in a timely, safe and effective manner, according to the best available evidence, expertise and experience. Quality includes:

- Timely access
- Appropriate care (defined by the patient and family in consultation with care providers)
- Optimal prescribing
- Continuous quality improvement
- Seamless transitions across health care, community and social services

Improve population health

HEALTH PROMOTION AND ILLNESS/INJURY PREVENTION

The health system must be designed to support Canada's seniors in preventing/managing episodic and chronic illness and disease (both physical and mental), while recognizing that improving the health of this population goes beyond the efforts of the health care system. It must include:

- Promoting healthy aging
- Helping seniors to thrive
- Providing age-friendly environments, including health care settings
- Making efforts to ensure participation and reduce social isolation
- Preventing abuse and neglect
- Minimizing and managing risk

EQUITABLE

Members of the health system have a duty to Canadians, regardless of age, to provide and advocate for equitable access to quality care and multi-sectoral policies to address the social determinants of health. Canadians should be assured of:

- Comparable access to care across regions and boundaries, including those related to language, culture and ethnicity
- Access to services (insured and uninsured)
- Portable eligibility of services, including efforts to reunify families across provincial-territorial and regional or municipal boundaries

- Adequate income
- Adequate nutrition
- Housing, employment and transportation

Value for money

SUSTAINABLE

Sustainable health care requires universal access to quality health services that are adequately resourced and delivered along the full continuum in a timely and cost-effective manner.

To support Canada's seniors and ensure the sustainability of the system for all Canadians, the following areas must be addressed:

- Providing adequate finances, human resources and infrastructure
- Integrating team-based health delivery across the continuum
- Supporting caregivers
- Funding research

ACCOUNTABLE

All stakeholders — public/patients/families, providers and funders — have a responsibility for ensuring the system is effective and accountable. This includes:

- Good governance
- National standards
- Transparency, including measuring and strong public reporting
- Continuous quality improvement
- Mechanism to hear and act on patient complaints
- Engagement of patient and family in planning of care
- Demonstration of value to patients

CHALLENGES FOR SENIORS' HEALTH CARE IN CANADA: CROSS-CUTTING THEMES

With input from various stakeholders, the CMA has identified several themes that cross all six sectors of care: primary, acute and specialty care, home care and community support, wellness and prevention, long-term care and palliative care. Any health care strategy must address these themes if it is to be successful.

1. **Quality of life.** Good quality of life for seniors should be a fundamental objective of a national seniors' health strategy. Supporting wellness, preventing illness and building resilience in seniors must all be priorities, and living well should be the goal. Most of Canada's seniors live healthy, fulfilled lives, and a seniors strategy must ensure that remains the norm.

To maintain a good quality of life, seniors need lifestyle options and supports that will help them live as independently as possible. Income security, transportation, and social and recreational activities tailored to seniors are essential for them to continue to get the most out of life.

2. **Social determinants of health.** The conditions in which people are born, grow, live, work, age and die are called the social determinants of health. Housing, income and social support are among the factors that determine about 50% of individual and population health. Any strategy to address the health of seniors must include efforts to ensure the social and economic conditions people experience. Secure incomes, safe housing and degree of social connection are critically important in determining whether Canada's seniors live healthy and rewarding lives.
3. **Caregivers.** Canada relies heavily on unpaid caregivers to look after its seniors. The Conference Board of Canada

estimates that unpaid caregivers provided 10 times more hours of home care than paid caregivers in 2007 — around 1.5 billion hours, provided by nearly 3.1 million people. Unfortunately, social policy does not do enough to support people who provide unpaid care for seniors. Employment flexibility is limited and tax credits for unpaid caregivers are insufficient to cover costs; unpaid caregivers can also burn out because of a lack of resources and supports. To be successful, the national seniors strategy will need to plan for the needs of these valuable members of the care team.

4. **Senior-friendly communities.** Designing and modifying environments to make them more senior-friendly and easier to navigate will help seniors to remain active and facilitate access to services and care. In particular, health care settings should be designed with the needs of seniors in mind.

Canada is a diverse country with seniors from a wide variety of cultural and ethnic backgrounds, so communities and health care settings should also be culturally safe for seniors. Background, culture and language can all affect whether people get proper care.

5. **Accessibility.** Access to appropriate care providers and care settings when needed is critical to ensuring seniors achieve the best outcomes. The stakeholders agreed Canada must transition to an age-appropriate, needs-based model of care, that gives access along the full continuum from health care to community supports to social and economic enablers. Small populations in rural and remote areas need to be assured of access to services if they face transportation problems or other physical barriers to care.

Services such as physiotherapy, out-of-hospital pharmaceuticals and medical equipment not covered by public insurance also need to be considered. Financial constraints are often a barrier to care and services that are not publicly funded.

6. **Integrated team-based models of care.** To improve communication among caregivers and with patients and their families, and to ensure patients receive appropriate diagnostic assessment, testing and care, implementing integrated team-based practice is essential. Team-based models of care enhance accountability and encourage collaboration. They should be comprehensive, integrating primary care, home care, community supports and specialist care both in the community and in acute care settings.

Integrated teams are effective at managing chronic disease and for early diagnosis and intervention in catastrophic illnesses. They can also facilitate care planning, which evaluates patients' personal needs and desires and ensures they are met. An integrated system will help health providers to provide the right care in the right place at the right time as well as ensuring that patients receive care in the most appropriate facility as their health declines.

7. **Financial sustainability.** The allocation of financial resources needs to be examined. Spending money inappropriately can lead to reduced service and delays that have negative impacts on seniors care. For example, because the availability of long-term care and publicly funded home care in many communities is limited, many seniors must stay in a hospital while waiting for the appropriate level of care. At the same time, spending more money, but more effectively — for example, to expand system capacity and infrastructure to include more options for care in the community and better access to health care providers — would help keep people out of expensive hospital beds and be more economical in the long run.

Other expanded spending that would lead to efficiencies includes developing better communication and assessment and documentation tools, such as electronic health records, which help improve patient outcomes and seamless, integrated care among health care teams and community supports.

Good care for seniors requires that supports must be in place at various levels throughout the system to ensure access to care is not impeded — for example ensuring patients have transportation to and from appointments, or can be referred for treatment out of their area.

8. **Health human resources.** To properly serve the needs of Canada's seniors, there must be an adequate supply of qualified health care providers for the whole continuum of care. Insufficient health human resources and funding lead to unpredictability, rationing and lack of availability of services.

Training is an important aspect of ensuring sufficient human resources for the senior population. All health care providers require education in geriatric and palliative care to ensure seniors' needs are identified and managed appropriately. More emphasis on training for advance care planning is also required. Finally, interdisciplinary leadership training across all sectors should be boosted to deal with increasing demands for team-based care.

9. **Quality improvement and accountability.** Successful health care programs collect data and measure their results, in order to be sure they are consistently meeting quality improvement goals and are accountable for their performance. A national seniors strategy must engage patients, families and caregivers to ensure the system is meeting their expectations. It should also promote consistent use of continuous quality improvement, and use forecasting models to determine future needs and drive improvement in all segments of the system.
10. **Seniors' mental health, including dementia.** The system needs to evaluate whether health providers have the necessary resources to assess, diagnose and manage seniors' mental health needs, including dementia. Care and services for psycho-geriatric care clients are often inadequate. Many elderly patients in acute care hospitals who are waiting to be discharged either for placement at home or for residential care have a diagnosis of dementia.²¹ Innovative models to address emerging mental health needs and age-appropriate care should be considered. If this issue is not addressed across the continuum of care, it could result in significant health declines for seniors. Any new mental health services should integrate with existing systems.

SECTORS IN THE CONTINUUM OF CARE

To provide a strong framework for a comprehensive strategy, six sectors that make up the continuum of care are highlighted: wellness and prevention, primary care, home care and community support, acute and specialty care, long-term care and palliative care.

As described earlier, 35 organizations representing medical, patient and community stakeholders participated in six working groups, one for each of these sectors of the continuum of care. In addition to reviewing and validating the principles for a national seniors strategy and identifying cross-cutting themes, each working group addressed the following three topics for their sector of the continuum of care:

- Define this sector of the continuum of care with a focus on seniors.
- Identify key issues, challenges and enablers specific to this sector of the continuum.
- Identify leading and promising practices in seniors care in Canada and internationally.

The following sections summarize the working groups' thoughts with an overview of each of the three topics for each sector. The promising practices were identified by the members of the working groups, and including them here is not intended as an endorsement of their effectiveness or scalability; rather, they are included as examples of what's being done to address the many challenges facing seniors across Canada.

This next part of the report lists issues, challenges and promising practices for each of the six sectors of care. This was done only to organize the report; a successful health system that works for seniors will integrate services all across the health and community care sectors. It is important to note many of the promising practices listed here involve providers and services from a number of sectors working together for integrated care.

1. Wellness and prevention

BACKGROUND

A focus on wellness and prevention is essential to maintain and improve quality of life, promote health, and prevent disease, disability and premature death. Seniors continue to contribute to society and need to be recognized and included in the decisions that affect their lives and their health.

Wellness and prevention activities are basic components of the continuum of care. Health promotion and health protec-

tion are provided by public health services, but they must also be integrated throughout the continuum, at every level of care, to keep seniors well and reduce demands on the health care system.

Efforts to increase wellness and prevent disease, disability and premature death must go beyond the health sector to address the social determinants of health. Sometimes called “the causes of the causes,” they encompass the conditions in which people are born, grow, live and work and range from income and safe, stable housing to social connections, education and meaningful work. They have tremendous influence on health status and are estimated to be responsible for about 50% of the disease burden. If we are to ensure that Canada’s seniors remain healthy and independent as long as possible, the social and economic conditions they live in must be addressed. Addressing the social determinants of health is also key to increasing resiliency when seniors face illness and disabilities.

The ability to make healthy choices, such as eating well, being physically active and reducing sedentary behaviour, is profoundly affected by the social determinants of health. Seniors need nutritious food and opportunities for physical activity. Programs for healthy living are key to reducing the burden of chronic disease; this is critically important, given most seniors live with at least one chronic condition.²²

Staying socially connected is another integral part of healthy aging. Social support has a positive effect on longevity, helping to slow cognitive decline, the onset of dementia and the progression of physical disabilities. Social interaction among seniors requires public and private spaces that facilitate engagement, so the built environment is also an important part of wellness and prevention. The World Health Organization’s initiative for age-friendly communities recommends policy-makers and urban planners consider the needs of an aging population when designing neighbourhoods.²³ Adapting private and public spaces and transportation to make them accessible for seniors facilitates social inclusion and independence. Barrier-free environments (e.g., building wheelchair ramps, retrofitting housing units for accessibility, installing arthritis-friendly door handles and removing ice and snow) are also important in the prevention of injuries.

WELLNESS AND PREVENTION KEY ISSUES AND CHALLENGES

Top issues and challenges in wellness and prevention are:

1. **Lack of senior and community engagement.** Engaging seniors in the decisions that affect their lives, both individually and collectively, is critical. Engagement includes allowing seniors to define the issues they are concerned about and working with them to generate solutions they can embrace.
2. **Need for multi-sectoral collaboration.** A seniors strategy will require strong partnerships in and among different sectors in society, including health care, housing, parks and recreation, transportation, social services, faith-based organizations and more. Local, provincial and federal governments must facilitate initiatives to create environments that support seniors.
3. **Need for healthy public policy.** In addition to being based in multi-sectoral collaboration, public policies must be explicitly designed to promote and improve health. Ways to do that include constructing affordable and accessible housing and supporting urban design that makes communities more senior friendly — for instance, by facilitating access to healthy food and places that foster social inclusion.
4. **Integrating wellness and prevention strategies.** Effective integrated care should not have silos, and wellness and prevention programs in disconnected pockets will also fail seniors. Every setting on the continuum must consider its role in promoting integrated wellness and prevention programs.

PROMISING PRACTICES

We have identified promising practices in wellness and prevention that tackle some of the challenges presented above. They are designed to involve seniors and help keep them out of hospital.

1. The **Healthy Cities/Healthy Communities initiative** is an international public health approach to land use and

urban design intended to improve the health of communities' older citizens. The initiative encourages communities to create age-friendly physical and social urban environments, which better support seniors in making choices that enhance their health and well-being — and allow them to participate in their communities, contributing their skills, knowledge and experience. After consulting with older citizens and their caregivers and service providers in 33 cities and 22 countries, the World Health Organization created a resource called the [Global Age-Friendly Cities Guide](#) for any government, organization or individual interested in identifying and improving the age-friendly status of a city.

2. The Ottawa Public Health Community Connect Program links socially isolated or at-risk older adults with services and supports to ensure safety and independence in their home. It provides training for people who are often in contact with seniors, supplying them with information on signs older adults may be at risk of social isolation.
3. **Get Up and Go!** is a collaboration between the Fraser Health Falls and Injury Prevention Program and OSTEOFIT (BC Women's Hospital & Health Centre's Osteoporosis Program). It provides an entry-level exercise program for seniors with balance and mobility impairment who would otherwise be unable to attend a community-based exercise class. It is a safe exercise program specially designed to improve strength, balance and coordination as well as functional ability, independence and quality of life.
4. Lack of adequate transportation can be a barrier to social inclusion and access to services for seniors. Many cities offer free or subsidized public transport for older people. One example is the **North Delta Seniors Bus**, a free transportation service offering easy access to local medical services, recreation centres, shopping and community amenities. It is funded by an Age-friendly Grant, offered by a partnership between the Government of British Columbia and the Union of British Columbia Municipalities.
5. The Royal Canadian Legion has produced a guide called "Seniors Support Program: [The Home Away Initiative](#)" to help Legion branches develop programs for seniors either independently or in collaboration with other branches or organizations. The guide suggests a wide variety of programs related to nutrition, health, security, safety, independent living and leisure activities and includes information on how to set up a program, obtain funding, develop communications and carry out an evaluation.
6. The [McMaster Optimal Aging Portal](#) is an information hub providing scientific evidence about healthy aging. There is content for citizens as well as clinical, public health and policy professionals.
7. [Eye Health Council of Ontario \(EHCO\)](#) was established in 2010 with the support of the Ontario Ministry of Health and Long-Term Care to provide a forum for interprofessional collaboration in the delivery of evidence-based eye care. EHCO includes representation from ophthalmology, optometry, family practice, their regulatory bodies, their professional associations, the academic communities and representatives from government.

2. Primary Care

BACKGROUND

Primary care is not a defined program but rather an integrated and comprehensive system of care that includes health promotion; illness and injury prevention; first contact and triage services; and the diagnosis and management of emergency, acute and chronic health concerns.²⁴ Primary care is person-centred and easily accessible, and it enables patients to work with health professionals to design care plans suited to their needs and wishes.

Primary care providers can help seniors navigate the continuum of care and overcome some bureaucratic hurdles. Family physicians are the most common point of first contact for seniors with health care and related needs, and they often act as gatekeepers to more specialized services, including home care and long-term care. Primary care providers can make sure seniors are not just being treated for what ails them but are also aware of and following wellness and health promotion practices that enhance their independence. An effective primary care system is crucial for keeping seniors out of hospitals.²⁵

PRIMARY CARE KEY ISSUES/CHALLENGES

The top issues in primary care that require action in a national seniors strategy are:

1. **Access.** Seniors are more likely than other Canadians to have a family physician. In 2013, 95% of seniors reported having a regular medical doctor, compared with 82% (on average) of non-senior adults.²⁶ However, having a family physician does not guarantee timely access to health care. Over one-third of Canada's seniors (37%) reported that they had been to an emergency department for a condition that could have been treated by their doctor.²⁷ Almost a third of seniors have had to wait two months or more to see a specialist in the past two years.²⁸ There are access challenges across the country, especially in areas with critical shortages of health care providers.

Access to non-insured services such as physiotherapy and occupational therapy can also be problematic as patients often have to pay for these services out of pocket. These fees prevent some patients from receiving care that could help them live healthier lives.

2. **Chronic disease management.** Preventing and managing chronic disease is a key activity of primary care. Chronic diseases are one of the leading causes of death and disability, especially for people with multiple chronic diseases. Poor management of chronic conditions can lead to declining health, reduced independence and, ultimately, death, yet in 2014, almost a quarter of Canada's seniors with at least one chronic condition did not have a daily treatment plan.

Disease management needs strengthening. In 2009, one-third of seniors did not get an influenza vaccination or an eye exam, and half of those with diabetes failed to receive a foot examination. Many seniors also feel that they do not get sufficient advice on managing their weight.

3. **Increasing complexity of patients.** The complexity and acuity of senior patients is increasing, and their providers need knowledge and resources to help them. Poly-pharmacy is a particular challenge: more than half of seniors claim they take five or more drugs from different classes, and 20% report no health care professional had reviewed their medications in the last 12 months.²⁹ Between 2006–07 and 2010–11 there were almost 140,000 hospitalizations for adverse drug reactions among seniors in Canada.³⁰

There are a variety of improvements that would help primary care providers manage the increasingly complex needs of their senior patients, including integrating primary and specialist care; greater availability of advanced training in geriatrics and palliative care; developing clinical guidelines for optimal prescribing; increasing awareness of community services, financial supports and other government support programs for medical equipment; and building knowledge of how to facilitate advance care planning.

PROMISING PRACTICES

These promising practices in primary care should be considered when addressing the challenges of providing primary care for seniors:

1. [Patient's Medical Home](#) is a new vision for the future of family medical practices in Canada developed by the College of Family Physicians of Canada. It is built around 10 pillars that emphasize patient-centred and team-based health care. Health care providers are connected to one another and to social services, with appropriate distribution of resources.
2. Winnipeg's geriatric program assessment teams were launched in 1999. Specially trained staff visit seniors in their homes to check on their health and well-being. Following an assessment, a clinician can file a report recommending "support from groups such as home care, day hospital or Meals on Wheels."³¹ The program has reduced costs and improved quality of care, partly by lowering rates of medication overuse, according to Accreditation Canada.³²
3. Winnipeg introduced PRIME in 2009. It's for seniors thought to need weekly health monitoring at home from a case manager. After-hours support, education, exercise and therapy, counselling and personal care are also provided

through the program. Some of PRIME's extended services are only available to participants whose income is below a certain threshold.³³ PRIME is meant to keep seniors out of hospitals and other expensive facilities. Referrals to the program are accepted from family physicians, other health care professionals, the home care program and hospitals.

4. The [bestPATH program](#) is offered through Health Quality Ontario. It includes evidence-based tools and recommendations to assist health care providers with integrated chronic disease management.
5. The [Taber Clinic](#) in Alberta identified the need for primary care, home care, public health and acute care to work together. It built a model with integrated multidisciplinary teams, common navigational systems and a mix of physician payment methods.
6. Ontario's primary care councils are formal networks of a community's physicians, health care providers and institutions, which meet regularly with health system administrators and planners, hospitals, community care access centres, local health integration networks, public health and others to seek solutions to service issues. These councils are active in many areas and developing in others. Over time they are expected to provide valuable insight and expertise on improving service integration and delivery at the community level.
7. Detection, diagnosis, treatment and continuity of care: management of Alzheimer's disease and related disorders in Family Medicine Groups in Quebec. This program's objective is to provide people with Alzheimer's disease and their caregivers access to personalized, coordinated assessment and treatment services. It focuses on enabling primary care providers to detect, diagnose and treat Alzheimer's disease and related disorders, with support from specialty memory-clinic and psychogeriatric teams. The plan, launched in 2009, is being introduced in 40 family medicine groups, where primary care physicians and nurses (or social workers) work in partnership with the patient and family to provide personalized and proactive care.

3. Home care and community support

BACKGROUND

Home care is an array of services provided in home and community settings that encompasses health promotion and teaching, curative intervention, rehabilitation, support and maintenance, social adaptation and palliative end-of-life care, and integration and support for the family caregiver.

Home care provided by nurses and allied health professionals, such as convalescent care, rehabilitation, physiotherapy, occupational therapy and speech therapy, is typically covered by public insurance. Personal care services, such as meal preparation, bathing and laundry usually have a fee, which often depends on income, so many seniors pay a subsidized amount or nothing at all.³⁴ Some clients receive direct state funding to purchase private services.³⁵

Looking after seniors in the community is one of the most cost-effective ways for health care systems to meet the needs of elderly patients who are not fully demented or critically ill. In 2011, Home Care Ontario estimated the daily cost of care at home at \$42, of a long-term care bed at \$126 and of a hospital bed at \$842. That difference in cost has prompted a shift from acute to home care in recent years. Apart from the potential savings, most seniors — around nine out of 10 — want to live at home as long as possible.

HOME CARE AND COMMUNITY SUPPORT KEY ISSUES/CHALLENGES

Key issues and challenges in home and community care include:

1. **Limited support for families and caregivers.** Most home care in Canada is provided informally by unpaid family, friends and neighbours. The Conference Board of Canada estimates that unpaid caregivers provided 10 times more hours of home care than paid workers in 2007 — around 1.5 billion hours from nearly 3.1 million people.³⁶ The economic value of informal caregivers is enormous: the Conference Board estimated total public spending on home and community care in 2010 was between \$8.9 billion and \$10.5 billion, and private spending between \$1.87 billion and \$1.89 billion.

The Conference Board report warned that social policy and programs do not adequately address the needs of families and caregivers for more support and flexibility to care for their seniors. Most provinces and the federal government offer limited tax credits to support caregivers, although Nova Scotia gives direct grants (but only 1,700 people have accessed the program). All the provinces offer unpaid compassionate care leave of between 8 and 12 weeks, while the federal E.I. Compassionate Care Benefit program provides financial support for individuals caring for a family member. Those benefits, however, are only for six weeks; they are intended to cover care at the end of life. (The recent federal budget has expanded that coverage to six months.) According to Employment and Social Development Canada, claimants on average used 4.7 weeks of compassionate care benefits or 78.3% of the maximum entitlement in 2012/13.³⁷ A national seniors strategy should ensure a comprehensive care plan is in place for families and caregivers when patients need it. It should take into consideration both the financial needs of individuals who provide this invaluable service and the stress and burnout they often feel.³⁸

2. **Lack of funding.** Under the *Canada Health Act*, home care is considered an extended health service rather than a medically necessary service, which means it is not subject to the principles of the Act (public administration, comprehensiveness, universality, portability, and accessibility). The number of people getting home care increased 55% from 2008 to 2011, but demand has not been matched by a proportionate increase in funding. Home care has received between 1.6% and 6.4% of total public health expenditure in recent years. In some provinces the proportion of funding for home care has actually gone down.³⁹ It is not surprising, therefore, that many Canadians, including seniors, have unmet home care needs. A 2012 Statistics Canada report indicated that around 461,000 Canadian adults who needed help did not receive any care, and a further 331,000 received some help, but not all they thought they needed.⁴⁰
3. **Lack of national legislation on home care access.** The federal, provincial and territorial governments should establish a legislative framework and policies on national standards for home care. Standards are needed for access, volume, frequency and types of services (e.g., nursing, personal support). However, only four provinces have home care standards and the lack of national standards means home care services are not equitable across Canada.
4. **Lack of health providers specialized in geriatrics.** Home care clients have complex needs, and they need links with specialists and primary care providers who may not be available in their community. Pay disincentives exist for most providers who choose to work in home and community care, and this exacerbates the health human resources problem in home care. Many health care providers are not aware of the availability of home care services and the eligibility criteria for them, making referrals difficult.
5. **Low income and isolation.** Poverty among seniors is rising in Canada. A low income can be a barrier to getting home care services and make it difficult for seniors to stay in their homes. Isolated low-income seniors face increased risks of deteriorating physical and mental health.
6. **Managing risk in the home.** Seniors who want to stay in their homes may be choosing to live with some risks. The house or apartment they have occupied for years may no longer be suited to their needs, especially if they are ill or frail enough to need home care. Physical adaptations — such as stair lifts, or renovating the bathroom — may be necessary to make people safer. Other issues — such as controlling infections, managing medication and preventing abuse — must be addressed by health care providers. It is important to recognize, however, that people have the right to live as they want, including choosing to live at risk. Canadians must recognize, protect and support the dignity of seniors, and ensure a full spectrum of care for those who choose to stay at home. The infrastructure to support this, however, is lacking.

PROMISING PRACTICES

Below are some promising practices in home care and community supports that seek to address some of the challenges identified above.

1. [BreatheWELL at Home](#), a short-term program in British Columbia's Fraser Health district is a partnership of home health, acute, residential and primary care, designed to let clients with chronic obstructive pulmonary disease gain

more control over their disease and reduce their need for acute care. Clients set their own goals for managing their symptoms and acute episodes, while receiving advanced clinical nursing support, coaching and education through home visits and telehealth.

2. In the [Home First Program](#) provincial governments in Nova Scotia, Ontario and New Brunswick provide support for both caregivers and patients so they can return home after a hospitalization, rather than moving to an institution.
3. The [TAPESTRY](#) program (Teams Advancing Patient Experiences: Strengthening Quality) is a project funded by Health Canada to help older adults in a family medicine practice in Hamilton stay healthy at home, functioning independently, for as long as possible.
4. A project of the European Commission, [SILVER](#) (Supporting Independent Living for the Elderly through Robotics) project searches for new technology to assist elderly people in their everyday lives. Robotics-based technologies can help the elderly continue to live independently at home even if they have physical or cognitive disabilities.
5. [Home Share Newfoundland](#) is a program that pairs Memorial University students with residents in the community who are 50 years of age and older. The students provide home maintenance or other services to older homeowners and in exchange the students pay a reduced rent. The program helps seniors maintain their independence and stay in their homes while providing a safe and affordable place for students to complete their studies.
6. The United Way's [Better at Home](#) program helps seniors with simple day-to-day tasks so that they can continue to live independently in their own homes and remain connected to their communities. The Government of British Columbia funds the program, the United Way of the Lower Mainland manages it and local non-profit organizations provide the services.
7. In Prince Edward Island, the Enhanced Home Care for Frail Seniors Program was piloted in 2012 as a partnership between Queens Home Care and the Queen Elizabeth Hospital. Thirty-six clients were admitted to the program during the one-year pilot. At a system level, the pilot resulted in 2,064 fewer days of long-term care and 1,876 fewer days of community care. Patients in the pilot were able to stay at home longer. The program is continuing.

4. Acute and specialty care

BACKGROUND

Acute care is largely provided in hospitals, and is usually a short stay for treatment of a severe condition. Recovery after acute episodes should take place in the community or a non-acute setting, with seamless transitions between types of care made possible by effective communication.

ACUTE AND SPECIALTY CARE KEY ISSUES/CHALLENGES

There are several key issues in acute and specialty care:

1. **Wait times.** Long waits for care are the most commonly debated issue around acute and specialty care. Wait times need to be improved across the board, from the emergency department to procedures and specialist consultations. Delays result in increased morbidity and mortality. In its 2014 report card the Wait Time Alliance said long waits for long-term care mean patients occupy hospital beds long after they have ceased to need acute care, which limits access to specialty hospital care for others who need it.⁴¹ The Wait Time Alliance suggests that this large and growing issue needs to be addressed with both a national seniors strategy and a more focused national dementia plan.
2. **Alternate level of care.** A large percentage of hospital beds are used by patients, many of them seniors, who no longer need acute care but are waiting for a long-term care place or a plan for their care at home. This situation, of people waiting for an "alternate level of care," will only increase as the population ages, and a greater proportion of Canadians require home care or long-term care services.

Provinces and territories have been trying to cope with increasing numbers of alternate level of care patients, but challenges remain. These waits in hospitals often lead to complications, such as hospital-acquired infections, which cause patients to suffer, put more stress on the health system and add to health care costs.

The Canadian Home Care Association has reported the percentage of acute-care beds being used by people waiting for an alternate level of care; it ranges from 3.5% in Manitoba to 16.6% in Ontario. The latest public analysis and reporting of Canada-wide data on alternate level of care days dates back to 2007–2011.⁴² However, there remain differences in how alternate level of care patients are defined. Given the societal and economic burden of alternate level of care in Canada, public, timely, periodic and standardized reporting should take place.

- 3. Integrated transitional care and communication.** Transitions in care are known to be potentially high-risk times for patients. Poor communication between hospitals, primary and specialty care and community care providers leaves patients vulnerable to mistakes and oversights (such as forgotten medications, overlooked tests and failure to follow up). Inconsistent communication does not always take into account what is best for patients and discharge planning is often done late in the care process, while information about in-patient care is rarely shared with primary care providers. Patients need integrated hospital, specialty and primary care providers to integrate care with home and community providers. Smoother transitions in care will benefit patients and help keep them from return visits to hospital. Integrated care would be greatly helped by interoperable electronic health records, which could facilitate early discharge planning and appropriate prescribing and support transitional care planning and communication.
- 4. Lack of support for shifting seniors to community-based care.** Creating a more cost-effective and sustainable health care system requires a shift from hospital-based care to a community-based system. But today's community care is not an integrated system capable of taking on the bulk of health care. Instead, it is largely made up of distinct silos — home care and primary care — with specialist care run out of hospitals. Until specialist care is “dehospitalized” by getting specialists to work in the community and long-term care, the health system will never be able to care for seniors with complex health problems outside of hospitals.

PROMISING PRACTICES

Here are some promising practices in acute and specialty care:

- 1. [Health Links](#)** is an initiative of the Ontario government to assist patients with complex health and social needs. Health Links encourages greater collaboration between existing local health care providers, including family care providers, specialists, hospitals, long-term care, home care and other community supports. By bringing local health care providers together as a team, Health Links will help family doctors to connect patients more quickly with needed services. For patients being discharged from hospital, the Health Link will allow for faster follow-up and referral to services like home care, helping reduce the likelihood of re-admission to hospital. All Health Links have a coordinating partner such as a Family Health Team, or Community Care Access Centre. One of the goals is to reduce repeat emergency department visits for high-risk patients.⁴³
- 2. [The Champlain Geriatric Emergency Management Plus\(GEM Plus\) Program](#)** is an evidence-based partnership, where geriatric nurses in nine emergency departments across eastern Ontario work with an integrated partnership of over 20 geriatric and community-service organizations. The goal of the program is early identification of geriatric syndromes in high-risk seniors, who are not being admitted to hospital, so they can be given appropriate referrals for geriatric and community services, which will help prevent return emergency visits and hospital admissions.
- 3. Paramedic Intervention.** In Halifax, specialized geriatric paramedics are experienced in dealing with acute-care issues for seniors. The paramedics go to long-term care facilities and patients' homes and assess whether residents need to be taken to emergency, rather than automatically taking them there. Toronto's Emergency Medical Services has a similar program that identifies high-need patients who are frequent users of emergency services; paramedics try to connect them with family physicians and other services, so they can remain healthy and out of hospital. In Calgary, the OPTIC EXACT program avoids inappropriate transfers from long-term care homes to emergency departments.

4. Sinai Health System in Toronto is a recent amalgamation of Mount Sinai Hospital, a large academic health centre, with Bridgepoint Health, a complex continuing care hospital and Circle of Care, a home care organization. The system is focused on providing comprehensive care to patients (including seniors) with chronic health conditions.
5. The Integrated Comprehensive Care Project of St. Joseph's Health System in Hamilton, Ontario, integrates hospital and community care services for patients. It links seniors to housing supports, works with marginalized populations and addresses clients' spiritual needs.
6. Winnipeg is piloting a hospital health team providing 60-day intensive case management for users of emergency departments to keep them out of hospitals and help them transition to care programs in the community.

5. Long-term care

BACKGROUND

Many seniors require residential care — accommodation that offers 24/7 supervised care, including professional health services and high levels of personal care. The people who live in long-term care are generally old and frail, but not sick enough to require acute care. Most residents in long-term care are over 85 years old, unmarried and frailer than people who receive care at home or in the community. Their cognitive capabilities and physical health are usually moderately or severely impaired, and they have difficulty with activities of daily living. They either have little informal support or they have needs that cannot be looked after by informal caregivers.⁴⁴

Most provinces are seeking to cut back on long-term beds, both because of costs and the preference of seniors for living in other settings. Several provinces are trying initiatives to find a middle ground between home care and long-term care, such as assisted or supportive living arrangements, where seniors, including people with mild dementia, receive 24-hour attention, but at a lower level than offered in nursing homes.

LONG-TERM CARE KEY ISSUES/ CHALLENGES

Within the area of long-term care the top issues/challenges identified are as follows:

1. **Lack of infrastructure.** Although the rate of seniors residing in long-term care has been declining, demand for residential care will nevertheless increase significantly over the near term because there will be higher numbers of elderly seniors. Much effort has been made to keep down wait times for long-term care. The Conference Board of Canada gathered data on wait times from a variety of sources and found that the areas in Quebec for which they could get data have the longest wait times in the country and the Western provinces the shortest.^{45,46,47,48} Median and average values for provincial wait times hide the range that may exist between regions or different facilities. For some very highly regarded facilities, like Baycrest in Toronto, wait times are so long many people die before they get a bed.

Many older residential care homes are poorly equipped to meet the care needs of their residents, which are more complex now than when the facilities were built. Also, there are insufficient units with space for better support of residents with dementia, and there is a shortage of appropriate units for residents who are disabled or obese. Renovations are also required to enable facilities to use space for other purposes, such as providing short-stay respite care or transitional care.

2. **Inadequate funds to cover long-term care.** Determining individuals' eligibility for long-term care and what they will have to pay varies considerably across the country. The procedures and formulas are complex and sometimes opaque. Income is often taken into consideration; those who cannot afford minimum rates can apply for exemptions. Most long-term care funding comes from public sources.⁴⁹

About half of Canadians have considered some kind of long-term or supportive living arrangement in their future.⁵⁰ If nothing changes, there will be a funding gap for long-term care over the next 35 years. A recent report by the Canadian Life and Health Insurance Association claims that the cost in current dollars of providing long-term care over

the next 35 years is conservatively estimated to be almost \$1.2 trillion; current levels of government program and funding support will cover approximately half of that (about \$595 billion). That leaves Canadians with an unfunded long-term care liability of \$590 billion, which is the equivalent of about 95% of all individual registered savings plans in Canada today.

3. **Standards of care.** Long-term care is one of the most regulated industries in Canada. All provinces require that privately run facilities be inspected and licensed by one or more agencies, and standards or guidelines are typically in place for publicly run facilities. Inspection reports are written and may include recommendations, but they are not always made public unless an express request is made. More than one piece of legislation and more than one agency are often involved in long-term care regulation, which can lead to confusion about oversight.

Further, the standards are so prescriptive that immense efforts are required to implement them and any opportunity for continuous quality improvement is reduced or eliminated. Future standards need to be pan-Canadian to ensure they are adaptive and responsive, and they must allow for the time and capacity to implement continuous quality improvement. In addition, to support the best possible care, appropriate data need to be collected for the purpose of forecasting needs and planning and delivering services.

4. **Resident acuity.** Acuity is the level of severity of an illness; individuals with higher acuity need more specialized care, and more of it. As the seniors population grows, long-term care facilities are finding they lack the services and resources to manage the increasing acuity of their residents.

PROMISING PRACTICES

Here are some promising practices in long-term care:

1. [Care by Design](#) is improving care for nursing home residents in Nova Scotia's Capital Health Region. Residents are the centre of a collaborative, on-site health care team that includes physicians, facility medical directors, nurses and paramedics. This allows them to be cared for in the comfort of the place they call home, instead of being transferred to a hospital.
2. [Behavioural Supports Ontario](#) encourages non-pharmaceutical interventions to address aggressive behaviour by residents of long-term care who have cognitive impairments. More than 600 front-line staff have been hired across the province to work on the program, and more than 300 long-term-care homes have increased in-house behavioural supports. An estimated 14,000 new and existing front-line staff have received specialized training in techniques and approaches applicable to behavioural supports.
3. [Aven Cottages](#) — This facility was specifically designed to care for people living with Alzheimer's disease and related dementia in Yellowknife. The facility opened in March 2010. The Philosophy of Care Principles is based on the Supportive Pathways model which includes:
 - Respect, dignity and self-worth
 - Privacy and independence
 - Control, choice and autonomy
 - Social interaction
 - Safety and security
 - Residential home-like environment
 - Trained and supportive staff, and
 - Resident focused care

The facility consists of two cottages, each having 14 private rooms situated around a central core consisting of a dining room, kitchen and living room area.

4. Ontario Appropriate Prescribing in Long-Term Care Homes is a pilot project conducted by a joint working group of

the Ontario Medical Association and the Ontario Ministry of Health and Long-Term Care, which started in August 2014. The goal of the project, which is being conducted in 30 facilities, is to reduce the use of antipsychotics, benzodiazepines and opiates to control violent behaviour by residents. The pilot is using academic detailing, audit and feedback and educational interventions to change prescribing behaviour.

5. Two clinical networks in Alberta, Seniors Health, and Addiction and Mental Health, are conducting a project to promote appropriate use of antipsychotic drugs in long-term care and to teach staff other ways to care for persons with dementia.
6. In a pilot project at a long-term care home in Prince Edward Island, two dementia units are being developed to use a variety of non-pharmacological approaches to managing confused patients. The approaches include the Montessori method (engaging patients' senses to reconnect them to the world around them), and setting up diversional activity zones.

6. Palliative care

BACKGROUND

According to the World Health Organization, palliative care "is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual." Starting palliative care early, combined with treatment, provides better pain and symptom management, better patient and family satisfaction, an increased likelihood of the person dying in the setting he or she prefers, and lower system costs.⁵¹

Palliative care is delivered by an interdisciplinary health care team, volunteers, families and caregivers. Palliative care providers emphasize whole-person care and quality of life, clarify goals, manage symptoms, stress good communication and address the psychosocial issues of the patient and his or her loved ones. Palliative care recognizes death as a normal life event and provides services such as bereavement support for families.

PALLIATIVE CARE KEY ISSUES/CHALLENGES

1. **Lack of access to affordable, equitable palliative care.** There is not enough affordable palliative care in Canada. Access often depends on a person's diagnosis; patients who do not have cancer are unlikely to receive palliative care.⁵² Access also depends on where a patient lives⁵³ — people who live in rural or remote areas or living with disabilities have severely limited access to palliative care.⁵⁴ Only British Columbia, Alberta, Prince Edward Island and Yukon have coordinated palliative care programs whose specialized teams assess, treat and follow patients across the health care system, providing them with fully covered or heavily subsidized medications as well as supplies. The other provinces and territories offer a patchwork of palliative care, with coverage often varying between hospitals, long-term care facilities, home care and hospices.⁵⁵

The Canadian Hospice Palliative Care Association says Canadians need better access to coordinated palliative care at home and in hospices, which are the preferred settings of end-of-life patients.⁵⁶ Improvements have been made since the 1980s, but palliative care was one of the 10 most common reasons for seniors going to hospital in 2009–10.⁵⁷

2. **Need for enough trained workers, supported by national standards.** The delivery of consistent, high-quality palliative care depends on having sufficient workers with appropriate training in palliative care, an integrated performance accountability framework that includes providers, educators and the health system overall and research and knowledge translation on palliative care.

There are basic palliative care competencies for medicine, nursing and social work, but they have not been consistently integrated into the curricula of academic institutions across the country; steps should be taken to see they are adopted by all training institutions. Palliative care needs a national set of competencies for other health care work-

ers. Competencies should address all levels of expertise, ranging from basic competencies for all health care providers to expert skills for specialists.

There are not enough palliative care experts in Canada to do the service delivery, education, and research that are needed. Integrated workforce planning for health care should include meeting the needs of quality end-of-life care across the country.

3. **Lack of a common approach to palliative care across settings.** Approaches to palliative care should be integrated across all sectors of the health care continuum. In addition, palliative care needs to be considered earlier in the treatment process, instead of being left to the end of the patient-care journey as it is now. The lack of integration and coordination of palliative care across services and programs is a serious problem. In 2011, the Parliamentary Committee on Palliative and Compassionate Care called for a national palliative care strategy and made 11 recommendations to strengthen the health care system's ability to deliver care to end-of-life patients and their families. Little progress has been made since then.
4. **Insufficient support for family caregivers.** Family caregivers are essential in the delivery of palliative care, but they get little support. Often, they have to take time off work to care for a loved one, which is a financial hardship. Many family caregivers are older themselves, and the burden of caring for a loved one can exacerbate stress and physical illnesses. Acknowledgment of their spiritual and psychological needs is also limited. Family caregivers need more support.
5. **Lack of advance care planning.** Planning is an important part of palliative care; families and patients need time to reflect and communicate what they want and expect from palliative care, so they can make informed decisions about the extent of treatments they want at the end of life. However, many health professionals do not discuss plans for care in advance, which may deny patients some important choices.

PROMISING PRACTICES

CMA staff and past president Dr. Louis Francescutti spent the better part of the past year examining the issue of palliative care across Canada, challenging physicians, other health care providers, policy makers, administrators and community leaders to be more active in palliative care, whether by working in the area or advocating for improved access and quality. "Palliative Care: CMA's National Call to Action: Examples of innovative care delivery models, training opportunities, and physician leaders in palliative care,"⁵⁸ was launched at the Advanced Learning for Palliative Medicine Conference in May 2015.

The working group identified some promising practices designed to address the challenges of palliative care:

1. The [PATH program](#), offered through the Palliative and Therapeutic Harmonization (PATH) Clinic in Nova Scotia, assesses older adults and consults with them and their families so they understand the true state of their health and the outlook for the future. It creates time and space for frail, older people to make complex health care decisions.
2. The [Improving End of Life Care in First Nations Communities project](#) (Lakehead University, Ontario) offers advance care planning for First Nations communities. It was inclusively created by First Nations community members.
3. The ["Speak Up"](#) program encourages Canadians to have the conversation around end-of-life care.
4. The [The Way Forward](#) program (Alberta, Ontario and New Brunswick) focuses on an integrated palliative approach to care.
5. The [Canadian Virtual Hospice](#) provides support and personalized information about palliative and end-of-life care to patients, family members, health care providers, researchers and educators.
6. [Hospice for the Homeless](#) (Ottawa) is a partnership between the Ottawa Mission and Ottawa Inner City Health to provide palliative care to terminally ill people who are homeless or street involved.

7. [Integrated Palliative Care Strategy from Nova Scotia](#) includes the use of advance care paramedics to support patients at home.
8. The [National Gold Standards Framework Centre in End of Life Care](#) in the United Kingdom is a national training and coordinating centre that helps generalist front-line staff provide gold-standard care for people nearing the end of life. The centre improves the quality, coordination and organization of care, leading to better patient outcomes, in line with their needs and preferences. It is also more cost effective because there is less hospitalization.

FEDERAL POLICY LEVERS TO SUPPORT A NATIONAL SENIORS STRATEGY

The CMA hosted a full-day workshop with key stakeholders in Ottawa on Feb. 18, 2015, to explore federal policy levers that could support a national seniors strategy. The workshop was hosted by CMA President Dr. Chris Simpson and President-elect Dr. Cindy Forbes.⁵⁹ Key components of the workshop (further described below), were:

- An overview and discussion of the evolution of the federal role in health
- A presentation by Dr. Samir Sinha, who reflected on his experiences with the Ontario Seniors Strategy
- Breakout groups to identify federal policy levers specific to (i) wellness and prevention, (ii) services within medicare and (iii) services outside of medicare
- Broad discussion on the considerations in identifying federal policy levers

A. Evolution of the federal role in health

This introductory session of the workshop was chaired by Dr. Alex Himelfarb, former clerk of the Privy Council. The meeting began with an overview of the history and evolution of the federal role in Canada's health care system.

Dr. Himelfarb explained that the relative silence of the Constitution on the division of health and social policy powers was because at Confederation, these were matters for churches and communities to manage and that view persisted for decades. The health care system began to evolve in the middle of the twentieth century, in response to significant events such as the Depression, the two world wars and the emergence of Keynesian economics, with the role of the federal government expanding exponentially from 1950 to 1977.

Originally, Dr. Himelfarb said, the Constitution established the explicit responsibility of the federal government for five patient groups and quarantines, from which its authority over public health is in part derived. Dr. Himelfarb explained that through the development of the taxation system, the government established responsibilities for vaccines, the safety of medicines, food and medical devices. He further explained the most significant lever the federal government has is its spending power, because through it, the government can incentivize provinces to do things they might not otherwise have done, as well as endorse national objectives and standards. The federal government's spending power, he said, can also promote universality and consistency, with an essential role placed on the promotion of shared citizenship and access to essential services. For further reference, the Library of Parliament's publication *The Federal Role in Health and Health Care* summarizes the Constitutional basis of the federal role.⁶⁰

In 1977, Dr. Himelfarb said, the federal government moved away from the initially established cost-sharing framework for health care, where 50 cents of every dollar was originally pledged to the provinces. Provinces now cover health expenditures, and the federal government has withdrawn from participating in health policy-making and reform. However, as Dr. Himelfarb explained, when the Constitution was repatriated in 1982, a new special federal responsibility under Section 36 was established to ensure equitable access to essential services. He described three fundamental tensions the federal government must keep in balance. These are:

- to promote our common citizenship;
- to respect the diversity of each province and territory; and
- to accommodate Quebec's distinct role within the federation.

Finally, Dr. Himelfarb raised the issue of federal financing, explaining that federal tax revenue as a portion of GDP is at a 70 year low. Still, he added, there is room for significant federal investment.

B. Presentation by Dr. Samir Sinha

Dr. Samir Sinha presented his work leading the development of an Ontario seniors strategy and recent initiatives to develop recommendations for federal action. His work was supported by a grant from the Canadian Institutes of Health Research for improving the care of elderly. Dr. Sinha said a national seniors strategy is needed, and considered an issue of importance by the majority of Canadians of all ages.

Dr. Sinha proposed the following themes for consideration for a national seniors strategy:

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

C. Workshop discussion on federal policy levers

During this portion of the workshop, participants were organized into three groups to identify the federal policy levers needed to address issues related to (i) wellness and prevention, (ii) services within medicare (primary, specialist and hospital care) and (iii) services outside of medicare, such as home care, long-term care and community support.

Each group considered and discussed three questions:

- **Question 1:** Discuss and validate the top issues and challenges that have been identified in your area. Would you make any modification to the list?
- **Question 2:** What action can the federal government take to address the issues and challenges that have been identified?
- **Question 3:** Can the issues and challenges be addressed by another approach?

The table below presents an overview of the key discussion points for each of these groups.

	Question 1	Question 2	Question 3
Group (i) Wellness and prevention	<ul style="list-style-type: none"> • Incorporating the concepts of aging in a healthy way and quality of life • Workplace as an opportunity for seniors engagement • Need to define the term "senior" • Need for cross-sectoral and intergovernmental collaboration on key social determinant issues such as housing, income, transportation 	<ul style="list-style-type: none"> • Develop a health promotion framework • Coordinate and disseminate information • Data collection, identifying best practices, developing standards and guidelines • Income security beyond traditional pensions • Affordable social housing via the social housing agreements 	<ul style="list-style-type: none"> • Need for an official seniors representative • Stakeholder engagement with local members of Parliament • Incentivizing individual savings
Group (ii) Services within medicare	<ul style="list-style-type: none"> • Understanding the legal requirements under the Canada Health Act of all licensed health providers • Discussion of a need for upstream alternate level of care related initiatives to "plug the hole rather than bail out the boat" • Overcoming the institutional barriers to changing funding structures • Health care providers are also aging • New models of care to reflect patient needs • Need for funding to support training such as geriatrics 	<ul style="list-style-type: none"> • Federal funding needs to reflect population demographics, not just size • Lead with health standards and accountability • Manage a central repository of leading practices to inform provincial/territorial action 	<ul style="list-style-type: none"> • Provincial/territorial funding and payment models to support change and innovation • Medical training in cross-competencies • Arm's-length body to deliver greater accountability

Group (iii) Services outside of medicare	<ul style="list-style-type: none"> • Need for guaranteed funding models for long-term care, palliative care and pharmaceuticals • Health lens for urban planning and support • Ensure population coverage and culturally sensitive approaches 	<ul style="list-style-type: none"> • Expansion of the Canada Health Act beyond current coverage • Canada Health Act should cover comprehensive home care • Expansion of federal data collection • Expanding the role of the Public Health Agency (e.g., seniors immunization standards) 	<ul style="list-style-type: none"> • Provincial territorial expansion of electronic medical records to more care settings • Arm's-length body to report on provincial/territorial performance
--	--	---	---

D. Considerations in identifying federal policy levers

Dr. Himelfarb opened the final portion of the meeting with a brief overview of political strategic issues for the CMA and other stakeholders to consider while developing a national seniors strategy. Then each of the three working groups gave summaries of what they had said, and the group discussed key advocacy considerations.

Dr. Himelfarb suggested three areas to consider when identifying federal policy levers to support a national seniors strategy. They were:

1. The concepts with widespread support
2. Areas with an established constituency, even though may be limited
3. Areas where there is no constituency and where stakeholders would need to build the constituency

In each of these areas, he encouraged participants to consider the "sine qua non," that is, issues without which there could not be a strategy. These policy levers were discussed:

- addressing the differential cost of aging facing the provinces through a federal transfer (to offset higher health care costs);
- recognizing the role of the federal government as an information broker (e.g., the Canadian Institute for Health Information); and
- supporting informal caregivers through the tax system and other means.

Participants also discussed the value of universal programs in securing broader support, as all tax bases are included. All agreed on the value of, and need for, a clear vision for seniors care.

REFERENCES

1. Statistics Canada. Generations in Canada. Ottawa: Statistics Canada; 2012. Available: www12.statcan.gc.ca/census-recensement/2011/as-sa/98-311-x/98-311-x2011003_2-eng.pdf
2. Statistics Canada. Canada year book 2012, seniors. Available: www.statcan.gc.ca/pub/11-402-x/2012000/chap/seniors-aines/seniors-aines-eng.htm
3. Statistics Canada. Canada year book 2012, seniors. Available: www.statcan.gc.ca/pub/11-402-x/2012000/chap/seniors-aines/seniors-aines-eng.htm
4. See Appendix A for a list of participating organizations.
5. Statistics Canada. Population projections for Canada, provinces and territories 2009 to 2036. 91-520-X. Ottawa: Statistics Canada; 2010 June.
6. Finance Canada. Economic and fiscal implications of Canada's aging population. Ottawa: Finance Canada; 2012. Available: www.fin.gc.ca/pub/eficap-rebvpc/eficap-rebvpc-eng.pdf
7. Canadian Institute for Health Information. National health expenditure trends, 1975 to 2014. Ottawa: CIHI; 2014. Available: www.cihi.ca/web/resource/en/nhex_2014_report_en.pdf
8. Canadian Institute for Health Information. National health expenditure trends, 1975 to 2014. Ottawa: CIHI; 2014. Available: www.cihi.ca/web/resource/en/nhex_2014_report_en.pdf
9. Canadian Institute for Health Information. National Health Expenditures 1975 – 2014. http://www.cihi.ca/web/resource/en/nhex_2014_report_en.pdf
10. Canadian Institute for Health Information. Seniors and the Health Care System: What is the Impact of Multiple Chronic Conditions. Ottawa, 2011. Available: https://secure.cihi.ca/free_products/air-chronic_disease_aib_en.pdf
11. Statistics Canada. Living arrangements of seniors: Families, households and marital status. Structural type of dwelling and collectives, 2011 Census of Population. http://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-312-x/98-312-x2011003_4-eng.pdf
12. Ramage-Morin P. Successful aging in health care institutions. *Health Rep* 2006;16(Suppl):47–56.
13. Figure taken from: Statistics Canada. Living arrangements of seniors: Families, households and marital status Structural type of dwelling and collectives, 2011 Census of Population. http://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-312-x/98-312-x2011003_4-eng.pdf
14. Alzheimer's Society Ontario. Facts about dementia. Available: <http://www.alzheimer.ca/en/on/About-dementia/Dementias/What-is-dementia/Facts-about-dementia> (accessed 15 May 2015)
15. 1Conference Board of Canada. Understanding health and social services for seniors in Canada. Ottawa: The Board; 2015.
16. 1Canadian Institute for Health Information. Health Care Cost Drivers: the Facts. https://secure.cihi.ca/free_products/health_care_cost_drivers_the_facts_en.pdf
17. Canadian Institute for Health Information. Health Care Cost Drivers: the Facts. https://secure.cihi.ca/free_products/health_care_cost_drivers_the_facts_en.pdf
18. Taken from Canadian Institute for Health Information, Health Care Cost Drivers: the Facts. https://secure.cihi.ca/free_products/health_care_cost_drivers_the_facts_en.pdf
19. Canadian Nurses Association, Canadian Medical Association. Principles to guide health care transformation in Canada. Ottawa: The Associations; 2011. Available: https://www.cna-aiic.ca/~media/cna/files/en/guiding_principles_hc_e.pdf
20. Institute for Healthcare Improvement. IHI Triple Aim Initiative. Available: <http://www.ihl.org/Engage/Initiatives/TripleAim/pages/default.aspx>
21. McCloskey, R, Jarrett, P, Stewart, C. Alternate level of care patients in hospitals: What does dementia have to do with this? *Canadian Geriatrics Journal*. Vol. 17, Issue 3, September 2014. Available: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4164681/pdf/cgj-17-88.pdf>
22. Public Health Agency of Canada. *The Chief Public Health Officer's report on the state of public health in Canada, 2010: Growing older—adding life to years*. Ottawa: The Agency; 2010. Available: http://www.phac-aspc.gc.ca/cphorsphc-res-pcacs/2010/fr-rc/pdf/cpho_report_2010_e.pdf
23. World Health Organization. *Global age-friendly cities*. Geneva: The Organization; 2007.
24. Conference Board of Canada. *Final report: an external evaluation of the Family Health Team (FHT) Initiative*. Ottawa: The Board; 2014
25. Drummond D. *Therapy or surgery? A prescription for Canada's health system*. C.D. Howe Institute Benefactors Lecture.

- Held in Toronto, 17 Nov 2011. p. 10.
26. Statistics Canada. *CANSIM table 105-0501*. Population with a regular medical doctor, by age group and sex. Available: www.statcan.gc.ca/tables-tableaux/sum-som/101/cst01/health75b-htm
 27. Canadian Institute for Health Information. *How Canada compares: results from the Commonwealth Fund 2014 International Health Policy Survey of Older Adults*. Ottawa: The Institute; 2015.
 28. Davis K, Stremikis K, Squires D, Schoen C. 2014 update: *Mirror, mirror on the wall: how the performance of the U.S. health care system compares internationally*. New York and Washington (DC): The Commonwealth Fund; 2014 June. p. 20–21.
 29. Canadian Institute for Health Information. *How Canada compares: results from the Commonwealth Fund 2014 International Health Policy Survey of Older Adults*. Ottawa: The Institute; 2015.
 30. Canadian Institute for Health Information. *How Canada compares: results from the Commonwealth Fund 2014 International Health Policy Survey of Older Adults*. Ottawa: The Institute; 2015.
 31. Winnipeg Health Region. *What Is GPAT?* Available: www.wrha.mb.ca/wave/2011/05/gpat.php
 32. Accreditation Canada. *Geriatric Program Assessment Teams*. 2013. Available: www.accreditation.ca/node/6492
 33. Winnipeg Health Region. *Is PRIME right for you?* Available: www.wrha.mb.ca/wave/2010/10/prime-info.php
 34. Sun Life Financial. *What does long-term care cost?* Available: www.sunlife.ca/Canada/sunlifeCA/Health/Long+term+-care+insurance/What+does+long-term+care+cost?vgnLocale=en_CA
 35. Spalding K, Watkins JR, Williams AP. *Self managed care programs in Canada: a report to Health Canada*. Ottawa: Health Canada; 2006 June. p. 6. Available: <http://www.hc-sc.gc.ca/hcs-sss/pubs/home-domicile/2006-self-auto/index-eng.php>
 36. Conference Board of Canada. *Understanding health and social services for seniors in Canada*. Ottawa: The Board; 2015.
 37. Employment and Social Development Canada. *EI Monitoring and Assessment Report 2012/13*. http://www.esdc.gc.ca/en/reports/ei/monitoring2013/chapter2_4.page#h4-2
 38. Conference Board of Canada. *Understanding health and social services for seniors in Canada*. Ottawa: The Board; 2015.
 39. Canadian Home Care Association. *Portraits of home care in Canada 2013*. Ottawa: The Association; 2013. Available: <http://www.cdnhomocare.ca/content.php?doc=274>
 40. Turcotte M. *Canadians with unmet home care needs*. Ottawa: Statistics Canada; 2014. Available: <http://www.statcan.gc.ca/pub/75-006-x/2014001/article/14042-eng.htm>
 41. Wait Time Alliance. *Time to close the gap: report card on wait times in Canada*. 2014.
 42. Canadian Institute for Health Information. *Seniors and alternate level of care: Building on our knowledge*. November 2012. Available: https://secure.cihi.ca/free_products/ALC_AIB_EN.pdf
 43. Ontario Ministry of Health and Long-Term Care. *About Health Links*. Available: http://news.ontario.ca/mohltc/en/2012/12/about-health-links.html?_ga=1.203436311.643802506.1424983524
 44. Canadian Institute for Health Information. *Health care in Canada 2011: a focus on seniors and aging*. Ottawa: The Institute; 2011. p. 89–93.
 45. Health Quality Ontario. *Long-term care*. Available: www.hqontario.ca/public-reporting/long-term-care
 46. Manitoba Health, Health Information Management. *Annual statistics, 2012–2013*. p. 70. Available: www.gov.mb.ca/health/annstats/as1213.pdf
 47. Vérificateur général du Québec. *Vérification de l'optimisation des ressources, printemps 2012: services d'hébergement*. p. 18. Available: http://www.vgq.gouv.qc.ca/fr/fr_publications/fr_rapport-annuel/fr_2012-2013-VOR/fr_Rapport2012-2013-VOR-Chap04.pdf
 48. Prince Edward Island. *Backgrounder on long-term care*. Available: www.gov.pe.ca/photos/original/hw_speechback5.pdf
 49. Conference Board of Canada. *Understanding health and social services for seniors in Canada*. Ottawa: The Board; 2015.
 50. Canadian Institute for Health Information. *How Canada compares: results from the Commonwealth Fund 2014 International Health Policy Survey of Older Adults*. Ottawa: The Institute; 2015.
 51. Hodgson, C. *Cost Effectiveness of Palliative Care: A Review of the Literature*. Canadian Hospice Palliative Care Association. Available: <http://hpcintegration.ca/media/24434/TWF-Economics-report-Final.pdf>
 52. Canadian Society of Palliative Care Physicians. *Highlights from the National Palliative Medicine Survey*. Available: <http://www.cspcp.ca/wp-content/uploads/2015/04/PM-Survey-Final-Report-EN.pdf>
 53. Canadian Institute for Health Information. 2007. *Health care use at the end of life in western Canada*. Available: https://secure.cihi.ca/free_products/end_of_life_report_aug07_e.pdf

54. Canadian Medical Association. *Euthanasia and assisted death (update 2014)*. Ottawa, 2014. Available: https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/CMA_Policy_Euthanasia_Assisted%20Death_PD15-02-e.pdf
55. Conference Board of Canada. *Understanding health and social services for seniors in Canada*. Ottawa: The Board; 2015.
56. Canadian Hospice Palliative Care Association. *Fact sheet: Hospice palliative care in Canada. October 2014*. Available: http://www.chpca.net/media/400075/fact_sheet_hpc_in_canada_march_2015_final.pdf
57. Canadian Institute for Health Information. *Health care in Canada, 2011. A focus on seniors and aging*. Available: https://secure.cihi.ca/free_products/HCIC_2011_seniors_report_en.pdf
58. <https://www.cma.ca/Assets/assets-library/document/en/advocacy/palliative-care-report-online-e.pdf>
59. Appendix B of this report lists the participating organizations.
60. Library of Parliament. *The Federal Role in Health and Health Care*. <http://www.parl.gc.ca/content/lop/researchpublications/prb0858-e.pdf>

APPENDIX A

List of organizations participating in the working groups:

WORKING GROUP ON WELLNESS AND PREVENTION

Canadian Association of Social Workers
Canadian Diabetes Association
Canadian Public Health Association
Royal Canadian Legion
The Canadian Ophthalmological Society

WORKING GROUP ON PRIMARY CARE

Canadian Association of Community Health Centres
Canadian Pharmacists Association
Canadian Physiotherapy Association
College of Family Physicians of Canada
Society of Rural Physicians of Canada
The Arthritis Society

WORKING GROUP ON HOSPITAL CARE (ACUTE AND SPECIALTY CARE)

Canadian Association of Community Health Centres
Canadian Pharmacists Association
Canadian Physiotherapy Association
College of Family Physicians of Canada
Society of Rural Physicians of Canada
The Arthritis Society

WORKING GROUP ON LONG-TERM CARE

Bruyère Continuing Care
Canadian Academy of Geriatric Psychiatry
Canadian Dental Association
Neurological Health Charities of Canada
Revera

WORKING GROUP ON HOME CARE AND COMMUNITY SUPPORTS

Canadian Association of Physician Assistants
Canadian Geriatrics Society
Canadian Home Care Association
Canadian Nurses Association
FADOQ
Parkinson Society Canada

WORKING GROUP ON PALLIATIVE CARE

Bruyère Continuing Care
Canadian Cancer Society
Canadian Hospice Palliative Care Association
Canadian Society of Palliative Care Physicians
West Island Palliative Care

APPENDIX B

List of organizations participating in the Feb. 18, 2015, workshop meeting:

Alzheimer Society of Canada
Arthritis Society
Asthma Society of Canada
Brain Injury Association of Canada
Canadian Association of Social Workers
Canadian Breast Cancer Network
Canadian Cancer Society
Canadian Diabetes Association
Canadian Epilepsy Alliance
Canadian Federation of Nurses Unions
Canadian Geriatrics Society
Canadian Hospice Palliative Care Association
Canadian Labour Congress
Canadian Nurses Association
Canadian Public Health Association
Canadian Society of Palliative Care Physicians
CARP
CNIB
Coalition Priorité Cancer au Québec
College of Family Physicians of Canada
Congress of Aboriginal Peoples
Conseil de Protection des malades du Québec
FADOQ
Fédération des Aînées et Aînées francophones du Canada
Federation of Canadian Municipalities
Gastrointestinal Society
Health Charities Coalition of Canada
HealthCareCAN
Heart and Stroke Foundation
Mood Disorders Society of Canada
Mount Sinai Hospital
MS Society of Canada
National Association of Federal Retirees
National Pensioners Federation
Parkinson Society Canada
Royal Canadian Legion
Spinal Cord Injury Canada
Women's College Hospital
YMCA Canada