Canadian Geriatrics Society

Geriatrics and Health Care in Canada

More than 13% of Canadians are over 65 years of age. Over a million Canadians are 80 years of age and older. While the majority of older people are doing quite well, a number have multiple chronic diseases and are at risk for hospitalization, institutionalization and loss of their independence.

Despite a better understanding of how to promote health and prevent diseases, the increasing number of seniors in Canada means that there will be an ever-increasing number of vulnerable, older Canadians needing skilled medical care.

The Canadian Geriatrics Society represents physicians and other clinicians who focus or restrict their practice to the health care of seniors. The objectives of the Society are to improve care of older Canadians by education, research and advocacy.

Most physicians care for older people but specialists in geriatric medicine, geriatric psychiatrists, and family physicians with training in the care of Elderly programs have taken additional training in the care of older persons, especially those who have complex health issues.

- Specialists in geriatric medicine are internal medicine specialists who have completed two additional years of training in geriatrics.
- Geriatric psychiatrists have taken additional training in this sub-specialty of psychiatry.
- Family physicians with Care of the Elderly training have taken six to twelve months additional education focusing on older persons. In addition to their clinical activities, these physicians often provide medical leadership to clinical programs designed to deal with the health care needs of older Canadians.

Although specialists in geriatric medicine and physicians with Care of the Elderly training focus on improving the function of vulnerable seniors who have multiple health problems, physicians with this training also promote health and provide preventative care to the seniors they see.

Working with interdisciplinary teams to improve the health and function of older patients in a variety of settings is an important part of geriatric practice. These teams should include specialists in geriatric medicine, geriatric psychiatrists, and/or physicians with Care of the Elderly training and must work closely with older people, their families (or caregivers), their family physicians, and the other clinicians and/or health care programs involved in their care.

Specialists in geriatric medicine have expertise in the care of hospitalized older patients who are acutely ill.

Specialists in geriatric medicine and family physicians with Care of the Elderly training are skilled in dealing with medical complexity and to care for older people with multiple health problems and frailty.

Specialists in geriatric medicine and physicians with Care of the Elderly training are adept in the management of common problems encountered in the care of older patients such as falls, impaired mobility, incontinence, delirium, dementia and the management of multiple medications.

Specialists in geriatric medicine and in Care of the Elderly are skilled at the medical aspects of geriatric rehabilitation.

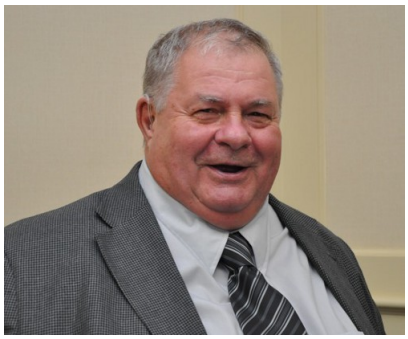
Geriatric psychiatrists are trained to provide expert specialist care to seniors with mental health problems.

Geriatric psychiatrists, specialists in geriatric medicine and physicians with Care of the Elderly training all care for people suffering from dementia such as Alzheimer's.

Specialists in geriatric medicine, geriatric psychiatrists and Care of the Elderly act as advocates for older persons within the health care system.

The benefits of specialized geriatric care shown in research include increased patient, family and staff satisfaction; decreased length of stay in hospital; decreased health care utilization; decreased rates of depression; improved survival; and, improvements in patient functioning.

Specialists in geriatric medicine and Care of the Elderly play an important role in educating undergraduate and postgraduate medical trainees about the appropriate care of seniors.



Member at Large

Jack Morrison

Older and Wiser

When you are wintering in the south you can be oblivious to how cold it is in Canada.

The day before I arrived in Ottawa for our annual executive board meeting and presentation of our brief, I was in Mexico eating tortillas and drinking margueritas. It sure was a shock to the human body (the cold) but how quickly the body adjusts.

Our executive board meeting was productive and it was so good to see all my colleagues again. This is the only opportunity we have to get to know each other and it is always a pleasant experience. Just listening to the executive board members speaking about the issues concerning seniors with such knowledge and solutions reminds me that we seniors know what is best for us. I only wish that governments know that we know what we need, just ask us! But they don't they only tell us how to deal with the problems we face. I will explain.

First, the conservatives made it quite plain they didn't want to meet with us, I'm sure that Barry will attest to this. But they conceded probably because of the announcement by Harper that seniors might have to work to 67 and their constituents were in an uproar.

We met first with the Liberal caucus; they were extremely attentive and sympathetic to our issues. They reminded us that we had to let seniors know that they have to call their MP'S and let their views known about the proposed changes in the age at which seniors would receive their OAS. They listened intently to our four main objectives set out by convention. They were Pensions, Housing, Dental and Pharmacare.

The meeting with the NDP was very chaotic because the vote on the gun registry was going to take place. It looked like the Members were going out one door and then coming in the other. This is not a complaint, I just want the reader(s) to know that they wanted us to know that our concerns were important to them, but they had an obligation to be present for the vote.

Our meeting with the Honourable Alice Wong was cancelled; she was off with the Prime Minister to China. Fortunately we were able to meet later with Shelly Glover who is the Parliamentary Secretary to Finance Minister. I found her to be very aggressive. Instead of letting her know why we were there she let us know that if we were there to say something we had better back it up with facts and sources. We don't go into discussions unprepared and if we don't know the answer we know where to find them. I'm sure that she realized that when she received a report from Jim Stanford on job creation. Jim is a very well known economist and sent us documentation for our comments. Will they ever learn that we are older **and** wiser.

Don't get Scammed!! If someone calls and tells you that your computer has been infected by a virus, hang up. Scammers trying to get access to personal computers (and the information in them) have been calling people and offering to fix the problem remotely - all you have to do is help them get into your computer. Don't fall for it!!

RESOLUTIONS

At the 2011 NPSCF conference in Charlottetown, the delegates approved these changes to the process for submitting resolutions.

First, "Resolutions presented to the NPSCF AGM should be national in scope and should direct the federation to specific and achievable actions."

In the past we have had resolutions that dealt with local problems, issues specific to only one area or province. As a national group our focus should be on national issues, like national drug plans or Canada Pension Plan concerns. Additionally, it may be possible to ask the NPSCF to support in principle some resolutions that have a regional aspect.

Our resolutions should also ask for actions that are attainable. While world peace is a wonderful goal, what would a resolution ask our officers to do to attain it? Our resolutions should direct our officers to write letters, to lobby, to inform members, to consult, to seek information -- actions that our officers can do.

Second, "Resolutions to the AGM should be presented to member groups via e-mail or on the NPSCF website well in advance of the annual conference."

The intention here is for members to be able to read over the resolutions before coming to the conference and to discuss with their own groups how to vote on the issues presented.

Third, "Resolutions should be submitted at least six weeks before the conference date."

The intention here is to allow time for the resolutions to be prepared and presented to the members of the federation. Six weeks ahead of the October 3, 2012, start of the next conference is August 22, 2012. Resolutions that arise from conventions held after the deadline will be accepted certainly, but they might not be published prior to the conference in Richmond, B. C.

The Resolutions Committee would like to have a contact name and e-mail address or phone number submitted with each resolution. In the past sometimes the intent of a resolution has not been clear, and the committee would like to help present a series of unambiguous resolutions.

The resolutions that are presented to our AGM show the scope and depth of the laudable concerns that our members have for their communities, for the less-fortunate, and for our country. Dealing with these resolutions is an important part of our conference, and hopefully, these changes in procedure will make it easier to communicate our concerns.

Doug Edgar
on behalf of the Resolutions Committee

National Pensioners' and Senior Citizens Federation
Policy Brief to the Government of Canada

February 2012

TO:

The Right Honourable Stephen Harper, Prime Minister of Canada
The Honourable Leader of the Opposition
The Right Honourable Jim Flaherty, Minister of Finance
The Honourable Alice Wong, Minister of State for Seniors
The Honourable Leona Aglukkaq, Minister of Health
The Honourable Members of Cabinet
The Honourable Members of Parliament
The Honourable Members of the Senate

EXECUTIVE SUMMARY

The National Pensioners and Senior Citizens Federation (NPSCF) is a democratic, nonpartisan, non-sectarian, and non-racial organization, formed in 1945. We are comprised of 350 seniors' chapters and clubs across Canada, who have a collective membership of 1,000,000 Canadian seniors. The Federation is dedicated to stimulating public interest in the welfare of older Canadians: helping seniors maintain a life of dignity and independence; and educating, counseling, and advising governments on what seniors think about issues in Canada.

This brief presents the resolutions passed at the 67th NPCSF Convention in Charlottetown October 20-22, 2011. Since we cannot hope to cover all of the many issues currently being faced by our fellow seniors, we will focus on four priority areas: Poverty, Healthcare and Pharmacare, Housing, and Dental Care.

Poverty

While some significant poverty reduction has occurred in the past, the recession has had a devastating impact on Canadians of all ages – from the very young to the very old. Family poverty is the critical issue for the very young and it occurs primarily among working families. Among the older population, the lack of pensions, the loss of jobs late in life, marginal wages, interrupted labour force participation, illness and the onset of chronic illness and disabilities are just some of the factors leading to poverty. Recent immigration status is also affecting levels of poverty among people whom we brought to Canada because of their potential to the social and economic well-being of our country. Why are we not giving them the opportunities to work and contribute that we pretended to offer when accepting them as newcomers?

Healthcare and Pharmacare

In our *Brief* we are paying particular attention to the need to create a National Pharmacare Program linked to the protection of the *Canada Health Act.*

We believe that all Canadians must have access to a universal pharmacare program. As members of the Congress of National Seniors Organizations in 2004, we called for the creation of such a program based on the growing costs of prescription drugs and the challenge this was creating for private and public expenditures on healthcare. It is clearly wrong that individuals should have to choose between food or medications or rent and medications. The health status of individuals should not be based on their ability to pay. Prescription drugs are covered when a person is in hospital, but not covered under the *Canada Health Act* when he or she leaves.

The European Union, in its negotiations with Canada regarding the Comprehensive Economic and Trade Agreement (CETA), is arguing for greater patent protection for pharmaceuticals or prescription drugs. The large European-based pharmaceutical drug companies want extended market exclusivity for approximately 3.5 more years. Such a move would delay the manufacturing of lower cost generic drugs and increase the cost for all Canadians. A recent report estimates the additional drugs costs to Canadians would be approximately $2.8 billion annually.

Housing

One of the critical factors in the "Determinants of Health Model" is access to safe and secure housing. Individuals cannot focus on education, job training or employment if they lack access to permanent accommodation. Safe and secure housing is essential to human development. In recent years it has been well-documented that investment in housing has a social and economic role that is central to both social and national development and wealth.

Dental Care

The 2008 Canadian Dental Association's *Report on Seniors' Oral Health Care* stated that "Although there is no representative data to profile the oral health status of community dwelling older Canadians, studies consistently indicate poor oral health and limited access to professional care among residents of long term care (LTC) facilities."

A number of barriers exist for seniors in accessing appropriate needed dental and oral health care, including: limited access to care for institutionalized elderly; barriers for homebound and institutionalized seniors in rural areas; financial barriers for a growing number of seniors who have lost dental insurance benefits at retirement; and physical barriers in dental offices, such as lack of wheelchair accessibility.

A good strategy for Seniors' oral care is necessary for health and quality of life.

Conclusion

We call on the Government of Canada to embrace the resolutions adopted at the NSPCF convention in October of 2011 – particularly those concerning poverty, healthcare and pharmacare, housing, and dental care. Implementing those resolutions will go a long way in improving the lives of seniors in Canada.

Additionally, our Federation has to express, in the strongest terms possible, that the Federal government must take a leadership role on health care issues with our Provinces and Territories. We cannot agree that the recent decision in December 2011 to take a "hands-off" approach to the 2014-2024 Health Care Accord is a responsible one.

Do not let our issues be ignored. We look forward to what the political parties have to offer by way of leadership in this Parliament towards improvements in the areas of poverty, healthcare and pharmacare, housing, and dental care for Canada's seniors.

1. INTRODUCTION

The National Pensioners and Senior Citizens Federation (NPSCF) is a democratic, nonpartisan, non-sectarian, and non-racial organization, formed in 1945. We are comprised of 350 seniors' chapters and clubs across Canada, who have a collective membership of 1,000,000 Canadian seniors. The Federation is dedicated to stimulating public interest in the welfare of older Canadians: helping seniors maintain a life of dignity and independence; and educating, counseling, and advising governments on what seniors think about issues in Canada.

This brief presents the resolutions passed at the 67th NPCSF Convention in Charlottetown October 20-22, 2011.

2. BACKGROUND: GROWING ECONOMIC AND SOCIAL INEQUALITY

The concerns of our membership, as reflected in the resolutions, are grounded in our belief that our country's future depends on tackling the growing economic and social injustice developing in Canada. This issue of growing inequality is a worldwide problem as the World Health Organization (WHO) has noted in its Commission on the Social Determinants of Health. It is also clear that our country's level of economic and social equity, or lack of it, will play a critical role in ensuring our future as a nation. The Standing Senate Committee on Social Affairs, Science and Technology, *Report of the Subcommittee on Cities: In from the Margins: A Call To Action on Poverty, Housing and Homelessness* (December 2009) noted the following:

Poverty expands health care costs, policing burdens and diminished educational outcomes. This in turn depresses productivity, labour force flexibility, life spans and economic expansion and social progress, all of which takes place at huge cost to taxpayers, federal and provincial treasuries and the robust potential of the Canadian consumer economy. […]

We believe that eradicating poverty and homelessness is not only the humane and decent priority of a civilized democracy but absolutely essential to a productive and expanding economy benefitting from the strengths and abilities of all its peoples. […] (p.3)

In order for Canada to thrive, we must be able to maximize the opportunities for all Canadians to thrive, to contribute their skills and talents to society and, in turn, to benefit from the contributions of their fellow citizens. We have seen through the "Occupy" movements, a significant increase in social awareness of the growing gap between rich and poor. These movements also have drawn attention to the disappearing middle class who have lost well-paying manufacturing jobs with the out-sourcing of work. We also see the rising despair among younger people about never finding good non-contract work in Canada.

3. FOUR PRIORITY AREAS

In our *Brief* we cannot hope to cover all of the many issues currently being faced by our fellow seniors so we will focus on four priority areas: Poverty, Healthcare and Pharmacare, Housing, and Dental Care (while recognizing they are all inextricably linked to many other social and economic concerns).

3.1 Poverty

At our AGM in October of this year, we passed a number of resolutions that tackled factors that we believe affect the economic well-being of Canadians. Our resolutions covered a number of policy areas that could ameliorate the incidence of poverty among Canadians. We will just highlight a number of the issues here.

When both private and public (or social) costs are combined, poverty costs the residents of Ontario a staggering $32 billion to $38 billion a year – the equivalent of 5.5 percent to 6.6. percent of provincial GDP…. This immense sum of money would obviously be better spent removing the source of these dead-weight costs – widespread poverty – than continuing to treat the devastating symptoms of its effects. If properly spent, what this money would ultimately buy is a healthier, better educated and more productive workforce, in which far more Ontarians would have a stake in making the province work for the benefit of all. (Building A Resilient Ontario: From Poverty Reduction to Economic Opportunity, Nov 29, 2011)

Imagine what those costs are when you extrapolate the Ontario figures to the whole of Canada.

Poverty costs in economic, social and personal terms. People who live their lives in poverty tend to achieve lower levels of education, higher levels of unemployment and live shorter lives. One example of the impact on health of low levels of household income combined with low educational

achievement is the link to the early onset of type 2 diabetes. Low-income women were far more likely to develop this type of diabetes than women in higher income households. ("The Role of Socio-Economic Status in the Incidence of Diabetes", Statistics Canada The Daily, August 18, 2010)

While some significant poverty reduction has occurred in the past, the recession has had a devastating impact on Canadians of all ages – from the very young to the very old. Family poverty is the critical issue for the very young and it occurs primarily among working families. Among the older population, the lack of pensions, the loss of jobs late in life, marginal wages, interrupted labour force participation, illness and the onset of chronic illness and disabilities are just some of the factors leading to poverty. Recent immigration status is also affecting levels of poverty among people whom we brought to Canada because of their potential to the social and economic well-being of our country. Why are we not giving them the opportunities to work and contribute that we pretended to offer when accepting them as newcomers?

We know that incidence of poverty is higher in racialized communities, among Aboriginal people, and among those living with lifelong disabilities. Poverty is also coloured by gender. Women in general, and single unattached women, especially single mothers and older women, carry a higher burden of poverty than men. In the study *Women in Canada: Economic Well-Being (Statistics Canada the Daily,* December 16, 2010*)* women earned between 70-72 percent of the income of men, and even women who worked full-time, worked fewer hours than their male counterparts, which also impacted their income levels.

In that same study, it was noted that the low-income rate among seniors (65 years and older) has declined rapidly since 1976 when the rate for women was 34 percent falling to 8 percent in 2008. For men, the change over the same span of time was a drop from 23 percent to 4 percent. However, one must take into account the fact that one of the largest factors in the decline in low-income rates for seniors is the significant role government transfers play. In 2009, the median income for senior families was $46,800, comprising $25,000 in market income, $24,700 in government transfers. The median income tax was $1,900. The government transfers for seniors were approximately four times that for economic families of two persons or more. *(Statistics Canada, The Daily, June 15, 2011)* Any change in government transfers as part of the deficit reduction would have a significant impact on the well-being of seniors, changes such as increased penalties for taking Canadian Pension Plan (CPP) payments early, limiting increases in Old Age Security (OAS) and Guaranteed Income Supplement (GIS). Both OAS and the GIS need to be increased.

We know that the CPP was intended to provide about 25 percent of a retiree's income. However, we now know that increasingly fewer people have savings beyond their CPP investment and this is clearly leading to increased struggles for older people to live with some security. We believe that the federal government must increase its contribution to CPP so that the CPP can reach payout levels that would be at least double what it is today. We urge the next meeting of the First Ministers to go back to the table and develop a plan for a more robust Canada Pension Plan.

3.2 Healthcare and Pharmacare

The Need for Pharmacare - In our *Brief* we are paying particular attention to the need to create a National Pharmacare Program linked to the protection of the *Canada Health Act.*

We believe that all Canadians must have access to a universal pharmacare program. As members of the Congress of National Seniors Organizations in 2004, we called for the creation of such a program based on the growing costs of prescription drugs and the challenge this was creating for private and public expenditures on healthcare. It is clearly wrong that individuals should have to choose between food or medications or rent and medications. The health status of individuals should not be based on their ability to pay. Prescription drugs are covered when a person is in hospital, but not covered under the *Canada Health Act* when he or she leaves.

The Canadian Institute for Health Information (CIHI) reported that, in 2010, total expenditure on health care would be approximately $191.6 billion dollars of which $135.1 billion would be government expenditures. The public sector accounts for roughly 70 percent and the private 30 percent. It is interesting to note that while the average growth in health expenditure from 1985 to 2008 rose 6.6 percent the rise in expenditures for drugs rose 9.1 percent on average, while 9.5 percent was the expected increase for 2010.

In 2010, per capita expenditure on drugs is forecast to have accounted for 16.3 percent of total health expenditure in Canada (*Drug Expenditure in Canada, 1985 to 2010*, CIHI, p.16*).* It is unnecessary for provinces to be under pressure to increase co-payments for prescription drugs when we know there is a public policy solution.

We believed in 2004 that a strategy was needed to deal with this rapid rise in costs and the need for action is more urgent today! We are calling on the federal and provincial governments to move now on this agenda.

In 2004 we wrote that all Canadians should have access to a universal pharmacare program which provided medically necessary prescription medications, regardless of province of residence or whether the drugs are delivered in hospital or in the community. The program should be based on the five principles of the *Canada Health Act* (public administration, comprehensiveness, universality, portability and accessibility), and the cost incorporated in to the tax system on a progressive basis.

Cost containment is a key issue and that is why we suggest a National Federal / Provincial /Territorial Prescription Drug Purchasing Body that can negotiate lower prices through bulk purchasing. This would also reduce overhead costs through a single-payer or a consortium
There should be a National Testing and Evaluation Program of all new prescription drugs. Once a drug is approved, it should be eligible for listing on all Provincial, Territorial and Federal Formularies.

We need to have a National Electronic Data base that would help to ensure more effective containment of drug costs through the development of “best prescribing practices” by physicians and provide a greater monitoring of drug utilization and prescription compliance.
Finally, we would like to see a policy for drugs that would reject new prescription drugs that are not substantially different from existing drugs by not listing them on National, Provincial or Territorial Formularies.

The EU and the Comprehensive Economic and Trade Agreement (CETA) and Drug Costs

The European Union, in its negotiations with Canada, is arguing for greater patent protection for pharmaceuticals or prescription drugs. The large European-based pharmaceutical drug companies want extended market exclusivity for approximately 3.5 more years. Such a move would delay the manufacturing of lower cost generic drugs and increase the cost for all Canadians. A report prepared by Paul Grootendorst of the University of Toronto and Aidan Hollis of the University of Calgary estimates the additional drugs costs to Canadians would be approximately $2.8 billion annually.

The European Union negotiators are threatening that if they do not get this extension for their companies, they will stop investing millions of dollars on research and development (R&D) in Canada. However, we know that, despite a commitment these companies made to the Mulroney government in the early 1990s, they have regularly failed to invest at least 10 percent of their earnings in Canada in research and development.

The 2010 *Annual Report* of the Patent Medicine Prices Review Board (PMPRB) 1 [1] shows that research and development spending as a percentage of sales has dropped to its lowest level since 1988 (p. 32). In 2010, brand-name drugs spent only 6.9 percent of their Canadian revenues on R&D in Canada, marking the tenth consecutive year that brand-name drug companies have broken their promise to spend at least 10 percent of their domestic sales on R&D (p. 32). Why would we believe

anything they say now? Why would we agree to anything that would increase our drug costs?

The provincial governments, insurance companies, employers, workers and all ordinary citizens must insist that these demands from the European Union negotiators be blocked. If it is not stopped the impact on all of us will be serious and the cost in Medicare will be substantial. (The website for the Patent Medicine Prices Review Board is **www.pmprb-cepmb.gc.ca**)

3.3 Housing

One of the critical factors in the Determinants of Health Model is access to safe and secure housing. Individuals cannot focus on education, job training or employment if they lack access to permanent accommodation. Safe and secure housing is essential to human development. In recent years it has been well-documented that investment in housing has a social and economic role that is central to both social and national development and wealth.

We know that having safe and secure housing reduces premature death and illness, fosters healthy living, educational success and employment opportunities. Access to employment and education affects the likelihood of better incomes and productivity. The absence of secure accommodation is a critical factor in homelessness or precarious housing, low educational achievement, early onset of chronic illness and lower life spans – all the attributes of those living in chronic poverty. Since a healthy workforce can directly influence productivity, and productivity is essential to economic growth, then even just on economic grounds we should have a strong national housing policy. More of the national budget must be allocated to housing. The proportion of the budget allocated is an important indicator of housing's importance and, therefore, determines its level of contribution to economic development.

We believe that the comprehensive report released by the Standing Senate Committee on Social Affairs, Science and Technology*, Report* of the Subcommittee on Cities, *In From the Margins: A Call to Action on Poverty, Housing and Homelessness,* presented a clear link between poverty and housing. The Foreword states:

What does this mean for the millions of Canadians that live with these daily hardships? It means making tough decisions about putting enough food on the table or paying the rent. It means making the decision to stay in school or to drop out to find a job to help the family. It means that by just struggling to get by, these families cannot even dream about getting ahead. […]

Poverty expands healthcare costs, policing burdens and diminished educational outcomes. This in turn depresses productivity, labour force flexibility, life spans and economic expansion and social progress, all of which takes place at huge cost to taxpayers, federal and provincial treasuries and the robust potential of the Canadian consumer economy.[…]

We believe that eradicating poverty and homelessness is not only the humane and decent priority of a civilized democracy, but absolutely essential to a productive and expanding economy benefitting from the strengths and abilities of all its people. (p.3)

Unfortunately, federal policy towards housing has significantly changed over the past 15 years. It has been a change for the worse for low to lower middle income Canadians and their accessibility to safe and secure housing. We need to cite some of the changes in order to make the case for a significant reversal of policy.

In 1973, through amendments to the *National Housing Act*, the federal government committed to a national housing plan. That plan supported the development of more than half a million good quality, affordable homes, over the following two decades. Unfortunately, in the mid-1990s, the federal government, facing a major budgetary deficit, began the process that dismantled the plan. In 1996 the

government transferred federal social housing programs to the provinces and territories. Then, in 1998, the government amended the *National Housing Act* to commercialize the mortgage insurance fund of the Canadian Housing and Mortgage Corporation (CMHC), further eroding the national role in housing. It meant that Canada was without a comprehensive national housing strategy. (Wellesley Institute, *Precarious Housing in Canada,* Summer, 2010)

What is the recent picture? We will touch on a few facts.

1. Of the 12 million households in Canada, about 1.5 million are in "core housing need" – CMHC's definition of those who are in the greatest need. (Wellesley Institute, *Precarious Housing in Canada,* Summer, 2010, Executive Summary, p.5)

2. An estimated 3.3 million households live in homes that require repairs and 1.3 million of these households report the need for major repairs (those that affect the health and safety of the people living in the housing).(Ibid)

3. Housing affordability continues to erode as both rental and ownership costs continue to rise. 1.5 million households are involuntarily paying 30 percent or more of their income on shelter. (Ibid)

4. By the year 2013, federal housing program spending will drop by 18 percent from $2.3 billion to $1.9 billion.(Ibid)

5. The federal Affordable Housing Initiative will be cut from $164 million to $1 million. (ibid)

6. Households receiving federal housing support will drop by seven percent from 621,700 to 578,479.(Ibid)

7. By 2008, less than 18 percent of the 623,750 homes assisted through federal housing programs are still being administered by CMHC (mostly co-op and Aboriginal housing). *(Source: Canada Mortgage and Housing Corporation)* (Wellesley Institute, *Precarious Housing in Canada,* Summer, 2010)

8. Historically, 20 to 25 percent of projects developed under social housing programs were co-operatives. Under the Federal/Provincial Affordable Housing Program, that has dropped to under 4 percent. (CHF Canada Ontario Region 2011 Pre-Budget Submission, Ontario . p.6)

9. In Ontario alone, Ontario renter households – or 20% of all renter households in the province – pay more than 50% percent of their income on rent. Over 580,000 households, about 45 percent of renter households, spend more than 30 percent of their income on rent.

10. In 2006, CMHC reported that 20 percent of Canada's First Nations, Inuit, and Métis populations were in core housing need, significantly higher than the 12.7 percent of non-Aboriginal Canadians. (Canada Mortgage and Housing Corporation. *Housing in Canada Online* data table).

11. Canada has a legacy of some 630,000 units of social housing, most developed under federal housing programs over the past sixty years. The funding agreements that allow the providers of these units to offer rents geared to income (RGI) for low-income Canadians are beginning to expire, including the agreements for some 57,000 units of co-op housing. The occupants of those homes are at risk as the co-operatives will no longer receive the special subsidies they received from CMHC to offer rent geared to income. Those at risk include seniors, people with disabilities, working families and new Canadians. It is estimated that close to one-third (200,000) of the social housing units are at risk of losing subsidy streams without the capacity to replace them. (Co-operative Housing Federation of Canada. *Pre-Budget Consultations,* 2011).

12. Finally, we note that in 2009 the United Nations *Special Rapporteur on the Right to Adequate Housing* reported to the United Nations Human Rights Council (UNHRC) that Canada was failing to meet its international housing rights obligations and that housing rights were being eroded. The federal government included in its response to that report a promise to do more on housing and poverty issues.

The recession that started in 2008, the loss of jobs, the collapse of many companies and their private pension funds, all have hurt many citizens but especially older Canadians who were no longer in the labour force. To protect the economy, the federal government injected stimulus programs into the economy. Those programs targeted towards the housing sector primarily focused on households who did not need help, with relatively little going to those in greatest need – low to moderate income people. (Federal Department of Finance, *Tax Expenditures Report*, 2009.) Waiting lists for affordable housing grew longer. We need to have CMHC back providing funding for the creation of affordable and supportive housing. The net income at CMHC, its annual surplus, is projected to rise to a record high of almost $1.9 billion in 2013, primarily through its business of insuring mortgages. Money is there to invest in affordable housing.

We believe that there must be an over-arching goal for housing policy in Canada, that is, the creation of a National Housing Policy. We know that this can be achieved working with the provinces and territories within the constitutional division of powers. We also believe that such a policy must tackle the issues of affordability and availability while ensuring all housing meets the standards of safety and security. We also believe that housing is more than shelter; it provides support and protection to people so that they can participate in, contribute to and benefit from the communities in which they live. The federal government needs to ensure that all the current rent geared to income housing supply continues and recognize that more needs to be added. In addition, from children to the very old, we all need supportive programs that ensure our capacity to live and function as citizens.

3.4 Dental Care

The 2008 Canadian Dental Association's *Report on Seniors' Oral Health Care* stated that "Although there is no representative data to profile the oral health status of community dwelling older Canadians, studies consistently indicate poor oral health and limited access to professional care among residents of long term care (LTC) facilities. In recent years, some progress has been made in selective areas of Canada to deal with access needs of the institutionalized elderly. Regrettably, these programs are sparse and reliant on a limited number of highly dedicated professionals with limited support from government. These programs remain the exception rather than the rule." They defined the issues for care:

1. There is a rapidly increasing need for dental care for the failing, complex dentition of some seniors, and for maintenance and palliative oral health care for many others who are becoming increasingly frail and dependant.

2. A number of barriers exist for seniors in accessing appropriate needed dental and oral health care, including but not limited to:

a. Limited access to care for institutionalized elderly due to lack of public policy and guidelines related to standards for the provision of oral health care; lack of proper facilities and remuneration for oral health care providers; and, a shortage of providers with the interest and willingness to provide care in these settings
b. Geographic access creates enormous barriers for homebound and institutionalized seniors in rural areas
c. Financial barriers exist for a growing number of seniors who have lost dental insurance benefits at retirement, have limited income or who no longer qualify for government sponsored plans
d. Physical barriers in dental offices, such as lack of wheelchair accessibility, limit access for many seniors

3. There is inadequate educational preparation of dental professionals for the provision of appropriate life-span (including end of life) oral health care, and lack of competencies (knowledge, skills and attitudes) related to interprofessional care for team-based, collaborative practice critical to the care of the elderly.

A subsequent CDA document (2009), *Optimal Health for Frail Older Adults: Best Practices Along the Continuum of Care,* supports the best oral care practices for this population.

Background

In 1996, Ann Silverside advised the Canadian Medical Association that, "As governments attempt to off-load health care costs in an attempt to cut budgets, the bills are being passed to business that provide supplementary health care coverage. Business representatives attending a recent conference heard that employers experienced a 26 percent increase in the cost of providing supplementary health and dental benefits between 1990 and 1994." (*Canadian Medical Association Journal, Vol. 155[*8]) The preponderance of the cost was for prescription drugs. At the time, Canada had a 72:28 ratio of public to private spending on health care. Added to that are the economic factors of aging. "Retirement is generally accompanied by a decrease in income and the loss of employer-sponsored dental coverage."

Six years later, Weir noted that in Canada "The burden of oral disease is carried by poor children, people without dental insurance, homebound elderly people, developmentally disabled people, medically compromised people, Aboriginal children, homeless people, HIV-positive people and new immigrants." She goes on to state that there are regional differences, with the north being particularly at risk. "Dental care is not covered under most provincial health care plans. According to the 1996/97 National Population Health Survey, only 53% of the population aged 15 or older reported having dental insurance and only 59% reported visiting a dentist in the past year." *(Canadian Medical Association Journal, Vol. 167[*9])

Dr. Ahluwalia, DDS, makes the case for the state of seniors' dental care in the USA, stating that

"we have failed, as a society, to provide quality and accessible dental care for our elderly. Partly because of improved tooth retention and partly because access to care is problematic, we are witnessing increased rates of dental diseases in seniors. The treatment, management, and prevention of oral diseases in seniors will improve not only the conditions of their mouths, but also their overall health and well-being. Recent data indicate that periodontal diseases are associated with chronic diseases such as cardiovascular disease, cerebrovascular diseases, and diabetes. In addition, oral cancer-which is primarily seen in adults older than 60 years-can be physically, emotionally, and economically devastating. Oral diseases and dysfunction can be extremely painful, and they have an acute impact on quality of life, affecting chewing, eating, speaking, and social interactions." (American Journal of Public Health, Vol. 94[5])

Ahluwalia's first recommendation to remediate the situation is to ensure that "the financing and provision of oral health care [is] integrated with the mechanisms used to ensure overall health and well-being for the elderly." His colleagues agree. "A primary barrier to proper oral health and preventive maintenance among older adults is lack of dental insurance. Dental insurance coverage is a strong correlate of dental care use, particularly among older adults."

Dr. Ship DMD notes that

"Older people represent the fastest growing segment of the [North] American population. The world economy in the future will need to accommodate to an environment of fewer individuals in the work force and more retired adults requiring a gamut of services for a substantive and fulfilling life. The host of risk factors for health problems from "age-related recession ' include 'salivary gland hypofunction and its accompanying xerostomia [in] one-third of the elderly, increasing their susceptibility to

caries, gingivitis, and oral mucosal infections, and to experiencing difficulty with mastication, gustation, and swallowing. Olfactory and gustatory changes in the elderly, which may be related to both aging and disease, contribute to altered nutritional selections, thereby complicating certain medical conditions. Finally, oral mucosal conditions, such as infections (eg, candidiasis), vesicullobullous diseases (eg, lichen planus), and neuropathic conditions (eg, burning mouth syndrome) can be uncomfortable and even debilitating, while neoplastic diseases (eg, squamous cell carcinomas) are life -threatening." (Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology, and Endodontics, Vol. 98[6])

He concludes that, one factor that is missing is adequate finances. "Reimbursements from government and other health care insurance programs for oral health procedures have been negligible for decades." Other writers also emphasize the issue of xerostomia. "Xerostomia leaves the mouth without enough saliva to wash away food and neutralize plaque, making teeth more susceptible to decay and periodontal disease. Saliva is essential for proper digestion and absorption of nutrients. Salivary flow naturally decreases with age but is also affected by micronutrient deficiencies, dehydration, and medications."

"Chewing or swallowing difficulties and mouth pain have been associated with increased frequency of hospitalization and health care costs in elderly individuals. Acute MI has been associated with periodontal disease, presumably because of the viral and bacterial contributions to a thromboembolic event. A strong association has been made between oral health problems and diabetes mellitus. Results from the Pitt Oral Health Collaborative show individuals with diabetes have a five times greater likelihood of tooth loss and are at seven times higher risk for periodontal disease. Eating with others is a social outlet for many older adults, but the burden of pain or embarrassment may limit this activity. Withdrawal from pleasurable activities, such as dining with others, has been associated with depression. Older adults are typically at greater risk for malnutrition than other segments of the population. Older individuals with missing teeth had particular difficulty eating meat, fresh fruits and vegetables, and nuts. Impaired mastication and oral health problems also have been consistently associated with lower intakes of fiber. Lower intakes of antioxidant nutrients, such as vitamins A, E, and C, have also been associated with tooth loss and poor oral health." (Journal of Gerontological Nursing, Vol. 31[7])

The general health implications are well supported. It has also been shown that professional oral care also decreases the incidence of fatal pneumonias in seniors in Long Term Care. A good strategy for Seniors' oral care is necessary for health and quality of life. (*Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology, and Endodontics, Vol. 94[*2])

4. CONCLUSION

We call on the Government of Canada to embrace the resolutions adopted at the NSPCF convention in October of 2011 – particularly those concerning poverty, healthcare and pharmacare, housing, and dental care. Implementing those resolutions will go a long way in improving the lives of seniors in Canada.

Additionally, our Federation has to express, in the strongest terms possible, that the Federal government must take a leadership role on health care issues with our Provinces and Territories. We cannot agree that the recent decision in December 2011 to take a "hands-off" approach to the 2014-2024 Health Care Accord is a responsible one.

Co-operation, negotiation and compromise with the provinces is what we need. So many of seniors' issues in the areas of health care are at stake. Two of our priorities (noted above) are pharmacare and dental health. These go hand in hand with the overall vision of better health care that was formally articulated at the Federal level in Justice Emmitt Hall's 1964 Report. Subsequent reports have confirmed the absolute need for federal action and leadership, not abandonment.

We look forward to a renewed sense of responsibility for action on our many health issues. We need only to look South of the border to witness the destructive costs of abandonment of responsibility for a nation's needs in health care protection for its citizens. Our system is proven to be more effective in terms of efficiency, GDP costs, and universal coverage.

Do not let our issues be ignored. We look forward to what the political parties have to offer by way of leadership in this Parliament towards improvements in the areas of poverty, healthcare and pharmacare (including the Health Care Accord), housing and dental care for Canada's seniors.

NPSCF Executive in Ottawa

Canadian Employment Quality Index

CIBC World Markets Inc. • PO Box 500, 161 Bay Street, Brookfield Place, Toronto, Canada M5J 2S8 • Bloomberg @ WGEC1 • (416) 594-7000
Economics
January 25, 2012

Quantity and Quality of Jobs Falling in Tandem

Benjamin Tal
benjamin.tal@cibc.ca

Regardless of how you look at it, the pace of job creation in Canada is weak. In fact, on a three-month moving average basis, the job market is currently weaker than any non-recessionary period. The sharp softening in the job market in the second half of 2011 made the past year a highly asymmetrical one in terms of job creation—with the first six months accounting for almost all the jobs created during the year.

The impact of a softening pace of job creation is exacerbated by a worsening level of job quality in the Canadian labour market. Our index of employment quality focuses on three quality measures: part-time/full-time distribution, the composition of paid employment and self-employment, and the relative compensation of a given full-time paid employment job. While our index is well above the level seen during the recession, it is down by more than one point over the past year.

By province, the largest drop was observed in Ontario, followed by British Columbia. In contrast, Alberta continues to generate high quality jobs at a rapid pace. With both quantity and quality of employment falling in tandem, it is hardly a surprise that real disposable income was unchanged in the first three quarters of 2011—the worst showing in fifteen years.

Full-Time vs. Part-Time Jobs

Full-time employment rose by 1.5% in 2011, accounting for all the jobs created in the year. The number of part-time jobs fell by 0.3%. This composition of job creation is a positive factor in terms of overall employment quality.

Self-Employment on the Rise

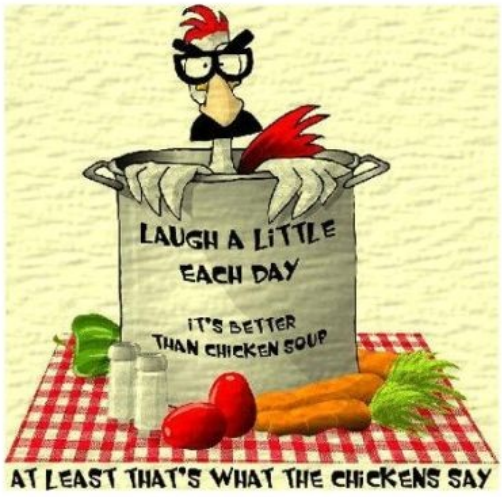
The number of self-employed Canadians rose by 2% in 2011, double the rate of growth seen in paid employment. Self-employment is resuming its traditional late cycle behaviour, and in many ways is now working to mask some of the softening in the Canadian labour market. From a quality perspective, the surge in self-employment reduces the overall quality of employment—largely due to the fact that, on average, a self-employed person earns 10%-15% less than a regular employee.

Compensation

Not all full-time jobs are created equal. In fact, looking at the distribution of job creation by compensation in 2011 reveals that the number of high-paying full-time jobs rose by only 0.4%—only a quarter of the pace seen among low-paying jobs. The worsening composition of the compensation sub-index reflects strong growth rates in relatively low-paying sectors such as Accommodation Services, Restaurants, Wood and Miscellaneous Manufacturing and Personal Care. Several higher-paying sectors, including Public Administration, Chemical Manufacturing, Computer and Electronic Manufacturing, Petroleum and Coal Manufacturing, Transportation, and Mining experienced a net job loss during the year.

Looking ahead, the likelihood is that employment quality in the coming few quarters will remain subdued. While a housing market crash is not in the cards, it's likely that real estate activity will level off soon. But even if house prices land softly, the impact on the economy in general, and construction jobs in particular, will be far from gentle. Real estate has been an important engine of economic activity, with the number of high quality construction jobs rising by 3.5% in 2011. That is more than double the pace of employment gains seen in the economy as a whole. That momentum will be lost when the housing market levels off. Furthermore, public sector employment is already starting to fall, and the likelihood is that overall employment in that sector will continue to fall in 2012—a significant potential negative to overall employment quality.

Seniors are an Asset not a Burden to Society



BCRTA

Opportunities and Challenges of Increased Longevity Conference

Sponsored by: Council of Senior Citizens' Organizations of BC
October 1 & 2, 2012, Richmond, BC

Contact: Pat Brady - patbrady@uniserve.com

Saluting the National Pensioners & Senior Citizens Federation

The Executive & Membership of the Retired Workers Chapter of Canadian Auto Workers Local 222

President - Les MacDonald
Secretary Treasurer - Art Field
Vice President - Gord Vickers
Sergeant at Arms - Karl Zimmerman
Member at Large - Ron Gay
Female Member at Large - Wendy Rolfe
Trustee - Don Revoy
Trustee - Chris White
Trustee - Ed Dwyer

CAW TCA
LOCAL 222
MANUFACTURING MATTERS

1425 Phillip Murray Ave., Oshawa, ON L1J 8L4
905-723-1187 1-800-465-5458
www.cawlocal.cz/222 local222@idirect.com

1945 STRIKE RAND FORMULA
CAW TCA
LOCAL 200
UNION SECURITY

Local 200 Retired Workers Chapter Salutes
The National Pensioners and Senior Citizens Federation

Membership-Retired Workers of Ford Motor Company, Windsor, ON
Chairperson – Herb John
Vice Chairperson – Jack Gibbons
Financial Secretary – Mike Lepine
Recording Secretary – Rob McLean
Sergeant-at-arms – Elzie Banks
Guide – Ernie Spickett

Windsor Essex/Chatham Kent
Area
CAW Retired Workers Council

RETIRED FROM THE JOB NOT THE FIGHT!
RETIRED WORKERS
CAW TCA
CANADA
www.caw.ca

Representing Retired Workers from

CAW Local 89	CAW Local 127	CAW Local 195	CAW Local 200	CAW Local 240
CAW Local 444	CAW Local 1498	CAW Local 1769	CAW Local 1941	CAW Local 1959
CAW Local 1973	CAW Local 2027		CAW Local 2098	CAW Local 2458

CAW TCA
CANADA
www.caw.ca

RETIREES AREA COUNCIL

AJAX, OSHAWA, PETERBOROUGH

CAW LOCALS 1090, 222, & 524

Bill Woodbeck - Chairperson	Joan Fowler	Art Field
Bart MacNeill - Vice Chair	Roger Lathangue	Lyle Hargrove
Sandy Carricato - Financial Secretary	Norm Wedlock	Armindo Vieira

Buy Canadian Union Made Products

If Not Delivered Please Return to:
Sandra Carricato
2389 Head Road
Port Perry, ON
L9L 1B4