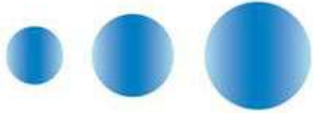
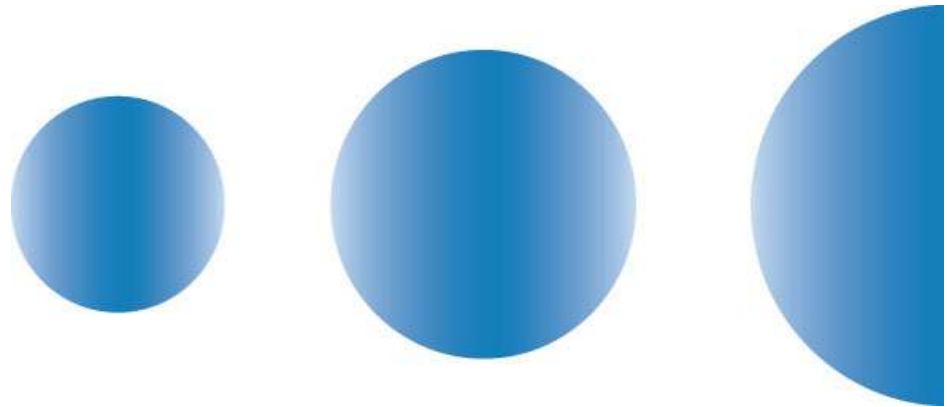


IFA



INTERNATIONAL FEDERATION ON AGEING
Global Connections

CURRENT AND EMERGING ISSUES FACING OLDER CANADIANS



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CONTENTS PAGE

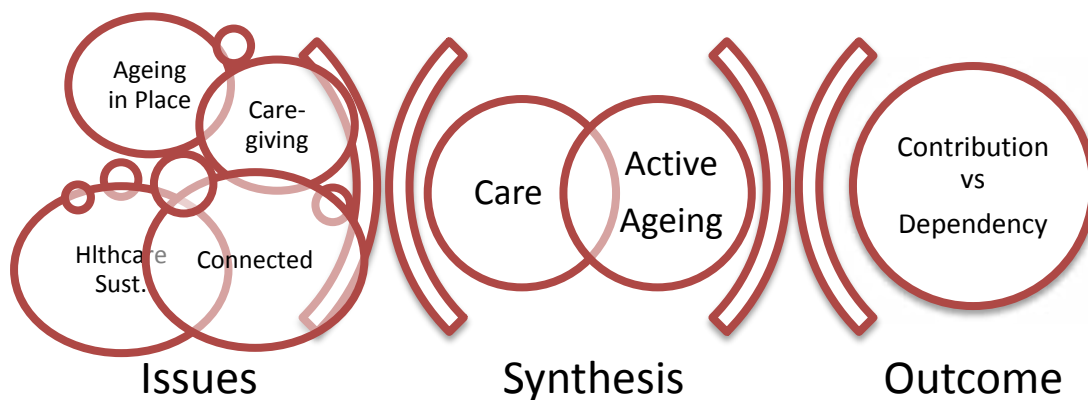
Executive Summary	3
Background	7
Methodology	9
Current and Emerging Issues for Older Canadians	11
1. Ageing in Place	14
• Ageing in Place – Policy responses from other countries	19
2. Support Caregivers	29
• Canada Good Practice	34
• Support to Caregivers – Policy responses from other countries	35
3. Ageing Workforce	44
• Canada	45
• International Trends	48
4. Health Care Sustainability	60
• Canada	62
• Our Approach to NCD's	64
• Alzheimer's Disease	66
• International Strategies	67
5. Keeping Older People Connected and Active	71
• Examples of Promising Practice	73
6. Elder Abuse	78
• Elder Abuse Policy and Initiatives - Canadian Milestones	79
• Policy Progression in Europe	82
• Addressing Elder Abuse in Israel	85
7. Ageism and Discrimination	90
• Ageism in Canada	91
• Protecting the Rights of Older People	92
• International Practices	93
About the International Federation on Ageing	99

Elder abuse is not a new phenomenon but policy and practice responses to the problem are still in the early stages. There is no universally accepted definition of elder abuse although work by the National Initiative for the Care of the Elderly (NICE) appears to be at the forefront in many respects. Instruments and tool boxes for the prevention of elder abuse and the protection of older people are numerous yet the evaluation of such interventions is less prevalent.

Discreet subjects such as elder abuse are layered and have sub themes such as sexual abuse, financial abuse and physical abuse that can be examined through the lens of the victim / the perpetrator, culture and gender and also the socio-economic milieu of the victim. Policies for sexual abuse of older people are not necessarily appropriate to protect against financial abuse of older people. The same could be said for policies related to abuse by a paid care worker in a nursing home facility. These may be developed and administered by different Ministries and also by different jurisdictions.

Policies within the broad areas of elder abuse could also be related to caregiver burden, poor access to health and social care or being ineligible for respite.

For instance every Canadian is likely to give or receive family care at some stage during their life. However the impact of being a caregiver on an individual and their immediate or extended family may be greater (or lesser) depending upon their socio economic status, culture, living arrangement and capacity to access appropriate services.



Several important carer-related themes were evident in the interviews and validated through policy developments. These included the tension between being a caregiver and being in paid employment; evidence based interventions such as the Reitman Method; carer-specific entitlements and the NGO role in collaborating with government in policy development.

Carer entitlements in the form of paid and unpaid leave, respite and flexible work arrangements are being considered by employers predominantly for example BMO, British Gas and Intel. Carer UK, Carers Australia and the International Caregiving Alliance have worked successfully with government to create the necessary evidence to underpin specific policies in the United Kingdom, Australia and some states in the United States, e.g. the Continence Aids Payment Program (CAPs) and the programs which have evolved from the Report entitled Caring at a Distance: bridging the gap (Cares UK, 2011).

Non-communicable diseases (NCDs) are in epidemic proportions globally, fact which does not go unnoticed in Canada. In 2011 the Minister of State (Seniors) said in the plenary speech at UN NCD Summit on Non Communicable Diseases that the “Government of Canada is concerned about rising rates of chronic diseases. They are the leading causes of death in Canada”.

NCDs were used in this project as the vehicle to explore the concept of healthcare sustainability in relation to other issues. Demonstration of the interrelationship between healthcare sustainability issues and the impact on family and society is difficult.

However in regard to the impact that non-communicable diseases (for example) could have on an individual and society as a whole consider an older woman living alone after caring for her husband for a number of years following a stroke brought about through obesity. The older woman could now be at risk of premature admission to an acute care setting if various factors converge including: poor nutrition > leads to a fall in the home > she is admitted to an acute care setting > she is discharge to a transitional bed > her family are unable to provide informal care > she is admitted to nursing home > and dies shortly after.

There are a variety of scenarios that are more favourable such as family live close to mother and visit daily > services are provided (via government or community agencies) or can be purchased so that ageing in place continues > transport is available to the community centre where she is connected with other seniors > continues to live at home by herself until she dies.

Each of the scenarios is common in Canada and other like-nations that have advanced social policy and programs. The societal shift from increasing numbers of people with significantly low levels of functional capacity to active healthy seniors has been demonstrated in countries which have aged at a faster rate than Canada (e.g. France, Netherlands and Sweden). Screening and prevention programs focussing on non-communicable diseases (diabetes, cancer, cardiovascular disease and Alzheimer’s disease) underpin the latest evidence based information and are rigorously and systematically evaluated.

The consequences of this investment cannot be underestimated. Improvements in healthcare sustainability but also the nature of ‘care’ required along the continuum of care, older people choosing to remaining in the workforce longer, decreases in elder abuse have been noted. Denmark is a fine example of creating a housing environment that not only supports older people in their homes (ageing in place) but gathers, mobilises and strengthens the generations of youth through intergenerational homes.

The issues identified and their inter-relationship to one another is intricate. However the issues can also be considered as transition points on the life continuum – extending the social and economic productivity of an older person and / or responding to the continuum of care.

The starting premise lies in being able to *create an environment that enables older people* to be in control of their future while at the same time recognising that all adults have a responsibility to their own health and well-being. [The caveat on this statement is in reference to older adults with diminishing cognition].

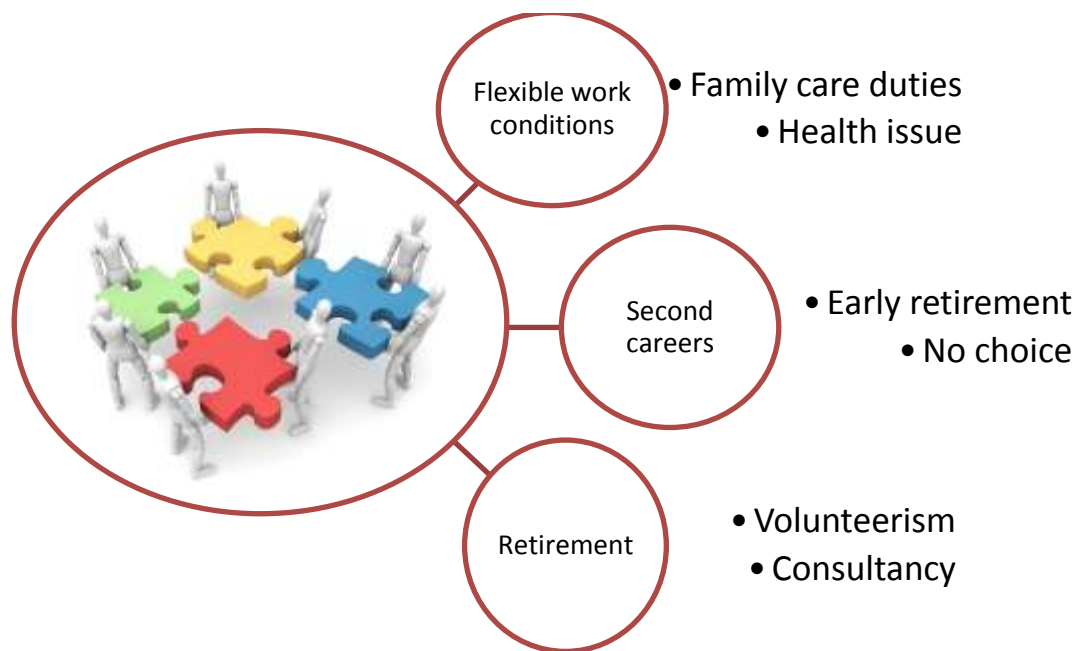


Figure 2

The ageing workforce is a current and also an emerging issue not only in Canada but also in countries where the fertility rate is close to, or below replacement rate. The starting point in this set of scenarios is ‘being active and connected.’

One myth that older people contend with on a regular basis is that ‘they are taking the jobs’ of younger people by remaining in the workforce – *not so* stated the International Labour Organization (ILO). In fact because of the labour market shortages and the significant number of potential retirees it is critical that older people remain in the workforce from both a fiscal and productivity perspective.

Alongside this ‘new’ conversation is the need to design different ways of working such as location independent work sites; flexible hours (e.g. 6 months paid work followed by 6 months unpaid leave); and optional entitlements including carer leave.

Older people want to continue to work for a variety of reasons – it may be a choice however for many older people there is a need especially with recent changes in the economy and increasing cost of living.

Advance policy development in Europe and Australia encourages the extension of the work life with a special focus on the anticipated outcomes in later life. There is less focus on ‘what are you going to do in retirement’ but rather what does the environment (social, physical, economic) need to look like to maximise the contribution of adults in their 70s, 80s and 90s.

The issues identified in the study are not independent of one another but are more of a reflection of the complexity of individuals, the opportunities and the choices made as individuals, within a family and in the community. Sir Michael Marmot in the final report “Fair Society Health Lives” positioned older people with a life course approach to policy while highlighting the need to ensure to especially focus on that which will be transformative across generations while responding to vulnerable groups.

To understand the most effective means to enable older people to remain active and socially connected the starting point was revisiting the social determinants of ageing within the WHO Active Ageing Policy Framework and the life course approach in which the framework is embedded.

Social networks across the life span have value which is the central premise of social capital. Although the general concept of social capital is not new in Canada it has not usually been central to the seniors portfolios and policy development. There is also a plethora of programs in Canada and internationally that respond to the matters isolation, marginalization, being connected and being active – community development through seniors organizations and NGOs is generally flourishing.

The Seniors Horizons Program has had a profound impact in many communities and the lives of many older people. As with programs in Europe and Australia the degree to which some programs have been evaluated and these results collated is not at this stage as promising. In an effort to bring the best evidence to the decision makers the European Commission have provided funding for existing project to connect and build on the power of project results. An example of this pattern of funding is BRAID (Bridging Research in Ageing and ICT Development) <http://www.braidproject.eu/>.

Ageism and discrimination is a cross cutting issue and could have been woven through the identified issues. However by discussing in a manner similar to mainstreaming would not have given due respect to the current international conversations at the United Nations, Organization of the America States, the European Union and Council of Europe as to whether the rights of older people are indeed being protected with current human rights mechanisms.

While the ageism and discrimination paper is not about the ‘human rights’ conversation it does highlight some important emerging trends that Wales, Ireland and Australia have embarked upon namely Commissioners for Older People and the first Age Discrimination Commission.

There is a new emphasis on building inclusive societies where all individuals, regardless of age, can exercise and enjoy their fundamental rights and freedoms without discrimination. Multiple discriminations require comprehensive policies and a multi-sectorial approach to old-age, but also specific efforts to combat stereotypes, which lead to direct and indirect discrimination.

BACKGROUND

Ageing is one of the most challenging megatrends of the 21st century. Turning this challenge into an opportunity requires a systematic examination of not only the empirical research on population ageing but also successful policy responses. Preparing for an ageing society is now a vital part of the policy agendas across the world; and countries, depending upon the extent to which a nation has aged, must respond to different issues and trends and external drivers such as urbanization and globalization. Understanding the impact of population ageing on and in our societies and in particular the benefits from specific cross-national analysis is critical.

Canada’s population is experiencing three demographic upheavals: globalization, urbanization and population ageing. The acceleration of Canada’s ageing process and the subsequent number of seniors is expected to increase dramatically over the next 25 years; today one in every seven citizens is over the age of 65 years. While the total numbers of older people is undeniably so is the shift in expectations of the next generation of seniors and the life transition points such as retirement. 2011 marked the year when Canadians born in the first demographic birth boom (often referred to as baby boomers) reached 65 years of age.

In 2036 more than one-quarter of all Canadians (10 million citizens) will be over the age of 65 years. With every projection scenario, the proportion of oldest-old Canadians (over the age of 80 years) will also increase sharply.

Between 2015 and 2021, Canada could see for the first time in its history, more seniors than children under the age of 14 years. One of the consequences of demographic change not often highlighted in the conversation of population ageing is the significant impact on labor market forces. The proportion of the working-age population, (traditionally defined as 15 years to 64 years) will decline steadily between 2010 and 2020. By the beginning of the 2030s, it will decline to 62%, then plateau to ~60%.

As a consequence of demographic change, to some extent brought about by low fertility rates, increased life expectancy as well as immigration, older people as a growing cohort present the most complex socioeconomic and 'care' challenges of our time not only by the sheer numbers but also by the unknown demands and expectations.

More than three decades ago in 1968, Dr Robert Butler coined the term ageism or age discrimination. It wasn't until 2006 that he led a task force that analyzed the impact of age prejudice resulting in a report, "Ageism in America." It addressed age discrimination in the workplace, elder abuse and the media's role in perpetrating such bias – these remain several key issues that governments struggle with today.

Demographers and academics from numerous disciplines as well as practitioners have written widely from both evidence and policy-base perspectives about the challenges, the burden and also the contributions related to an ageing population. While the dynamic nature and influence of the social, economic, cultural and political landscape in large part underpins seniors as citizens, members of the community, and society, this interplay and interaction across generations is poorly understood. It is this lack of a coherent understanding of the interrelationships among age-related issues, the changing environment and expectations of future generations that form the missing building blocks that may at times prevent good policy.

The demographic wave has been sweeping the globe for decades and many European countries have grown older before Canada. These countries may by their very age afford necessary insights into the effectiveness of a policy and program responses that may be useful in the roadmap for Canada.

All levels of government, civil society, industry, academia and individual citizens domestically and internationally are concerned enough to be part of the dynamic response necessary to ensure that seniors now and in future generations have the opportunity to be part of society. The life course approach on ageing defined as “a process of progressive change in the biological, psychological and social structure of individuals¹” represents an important occasion to view 'ageing' in the mainstream of policy development rather than the responsibility of a particular Ministry, Department or level of government.

For any nation to be in a position to effectively respond to the needs of ageing population up to date information on current and emerging issues arising from and impacting this cohort and the generational effect is critical. Moreover the issues must to be examined in the broader global context (drivers such as globalization and urbanization) and through the gender and cultural lenses in order to fully appreciate the social and economic contribution and consequences of the demographic change.

The primary goal of the project is to improve the policy responses to critical age-related issues through the identification, investigation and analysis of specific country trends and responses that are applicable to the Canadian context and population trends. The specific objectives of the project were:

- To gain new insights into the current and emerging age-related issues in Canada

¹Claudia Stein and Inka Moritz, *A life course perspective of maintaining independence in older age*(Geneva: World Health Organization, 199p), 4.

- To inform decision makers on successful policy responses to the identified issues relevant to the Canadian context and population
- To provide baseline information on current and emerging issues in countries similar to Canada in terms of demographic profile/demographic shift
- To develop a resource base of publications, individuals, agencies and industry that reflect the principles of innovative policy responses to age-related issues
- To provide leadership in positioning the policy-related issues in Canada within an international context

METHODOLOGY

The primary goal of the project was to improve the policy responses to critical age-related issues through the identification, investigation and analysis of specific country trends and responses that are applicable to the Canadian context and population trends. This project could not be viewed as a complete comprehensive body of work which would require substantially more in depth analysis however it does provide a snapshot of the interrelationship between issues and responses.

Attention was given to the policy and practice responses that 'enable' seniors to remain functionally independent as well as those responses that support frail and vulnerable seniors to live and die gracefully. In essence we wanted to go beyond 'naming the problem' to that of investigating policy responses that have been deemed as successful.

OBSERVATIONS AND LIMITATIONS

The proposed methodology was comprehensive in nature yet highlighted potential bias from respondents in their specific fields of interest and study. For example numerous respondents in Canada were experts or practiced in the field of elder abuse. Elder abuse is both a current and an emerging issue in Canada and globally but it was necessary to examine the distinguishing differences in legislation and public policies to validate the priority position of the topic.

The degree to which one country could be viewed as a leader in the protection of older people against abuse (or in other fields) is beyond the reach of this project. There is also some conjecture as to whether promising or good practice as perceived by the consumer or decision maker provides the mantle to measure excellence.

It could also be argued that the some examples and data documented in the report is not the latest or the best, and that may be true. However what is abundantly clear is: the complexity of the interrelationships among the issues; the limited policy connections between and among the issues and finally the paucity of evidence that underpins policy in most countries.

Several countries were identified for closer examination in the project however there was a general inconsistency in the effectiveness and not all of the issues were addressed. It was for that reason that there was an exploration of certain policy areas e.g. 'ageing in place' in Denmark was made. Countries other than Denmark could have been selected, yet many of the innovative practices were identified by respondents.

The terms 'successful', 'good practice', 'promising practice' are not well defined in government policy. To some extent this could be explained by somewhat limited evaluation of pilot projects and program. Another possible explanation concerns the lack of clarity as to what could or should be expected of funded programs. Finally very few countries in the industrialised world have the capacity to link disaggregated data across portfolios and systems that form the necessary evidence for targeted policy reform which is the 'good practice'.

The interpretation of terminology and language is also worthy of note. “Culture” is a cross-cutting issue and an unmistakable variable that must be considered when examining policies and practices in countries within regions and across regions. For example the term ‘intergenerational solidarity’ is not familiar to Australians and Australian policy yet 2012 is the European Year of Active Ageing and Intergenerational Solidarity.

The issue of healthcare sustainability provided a different set of variables for reflection. The importance of ‘health’ and ‘care’ was common however the diverse nature of models and approaches varied within countries and even across levels of governments. For this reason the paper focussed on the most important contemporary public health issue, i.e. non-communicable diseases. The focus on NCDs provided the platform from which observations could be made about the nature of investments and the position of priorities along the continuum of care.

Notwithstanding these differences it was apparent from the respondents and the environmental scan of policies and plans at the country level and the United Nations and World Health Organization that in the main countries are working to create innovative responses to a core set of complex issues that arise not because of the older population but because of the consequence of demographic change.

Many countries in Europe, Oceania and to a lesser extent Asia have faced or do face similar challenges and opportunities associated with an ageing population so it is envisaged that new learning and essential connections with governments and civil society could be forthcoming notwithstanding the differences in demographic change.

GATHERING DATA AND DETERMINING PRIORITIES

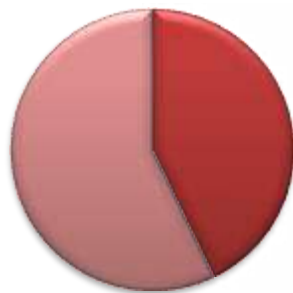
Over the course of the project period a number of different methods were used to gather perspectives, opinions and policy data. Then a number of mechanisms were used to validate these viewpoints.

Central to this methodology and the project notation is the word ‘perspective’ -- this project was not a scientific study with the rigour that one could anticipated over a period of time; it is a snapshot of the age-related issues that are upper most in the minds of a small sample academics, industry, persons from the non-governmental sector and seniors who responded to the question: *“What do you consider to be the 5 current and emerging issues in your country?”*

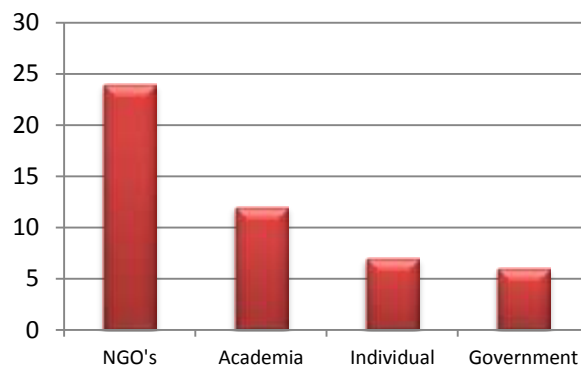
Even though the approach could not be labelled “scientific” there was remarkable consistency in Canada and in various countries of the world in the identification of issues and the prioritization. A tiered approach to data gathering was implemented commencing with a formal request to the 28 Directors of the IFA Board from 14 countries to seek responses through their networks and member bases. Relationships and networks formed one of the primary vehicles used to undertake the proposed work.

An article in the IFA enews which is disseminated to over 6,500 subscribers captured the interest of readers who responded to the question, some in great detail. Over the course of the project the Enews was used not only as a vehicle to gather opinions but also to validate the findings and order of the priorities.

■ Canada ■ International



Percentage of Respondents



Percentage of Respondents

In January 2012, IFA Canadian members (82) and the IFA Board of Directors (28) were again contacted and confirmed that the current and emerging issues as identified were the appropriate areas of priority and focus.

These findings were then published in an article in the February IFA eNews in order to gain additional input and final opinions before preparing the full report. Seventy six (76) responses agreed with the classification of current and emerging issues with some respondents adding additional information and identifying further issues. No respondent indicated that the priority listing was incorrect.

In addition to the electronic gathering of data, a number of respondents from various parts of the world requested a more in-depth discussion which was conducted by telephone. As a corollary to this request as the issues were finalised and priorities a number of experts in gerontology, the NGO sector and to a lesser extent governmental members (external to Canada) were sought to assist in the interpretation of sub theme issues and the inter-relationships.

The nature of current versus emerging issues required an appreciation of the demographic upheavals that had and were impacting on the development of policy. For example as many countries in Europe have aged at a faster rate than Canada, Australia and New Zealand could expect that family ca-themes leading to themes and prioritisation

Policy analysis is rarely exhaustive and in most cases, cannot be prescriptive. It provides baseline information, points out major linkages between decisions and outcomes, and provides a starting point for consideration of more robust and sustainable policy options. In regard to the process, the IFA examined both government and non-governmental policy priorities as a means to appreciating the nexus of the convergences.

Desk top research was also undertaken through an environmental policy scan of recent publications, press releases and internet resources that identified issues and trends affecting older people. Through this research and responses from over forty six (46) individual and organizations responses were amalgamated into the 5 current and emerging issues in Canada as well as 5 current and emerging issues worldwide.

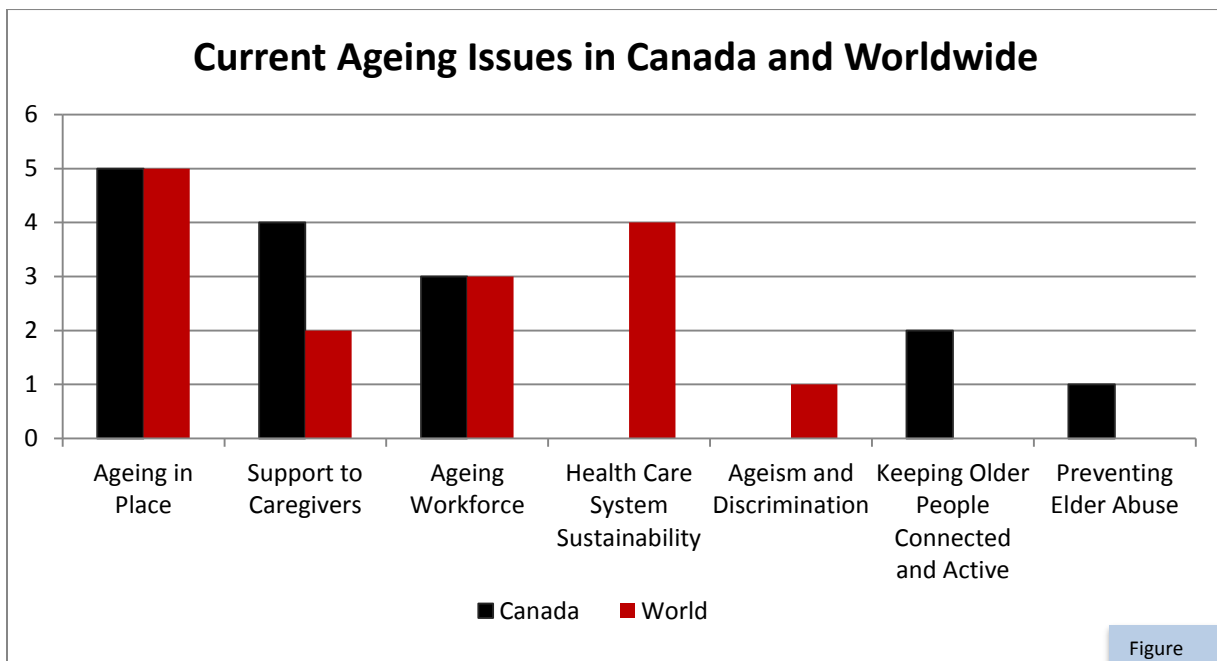
CURRENT AND EMERGING ISSUES FOR OLDER CANADIANS

Over the course of three months the IFA reached out to members, colleagues and subscribers, from Canada and across the globe seeking input into the top 5 current and emerging issues as they relate to

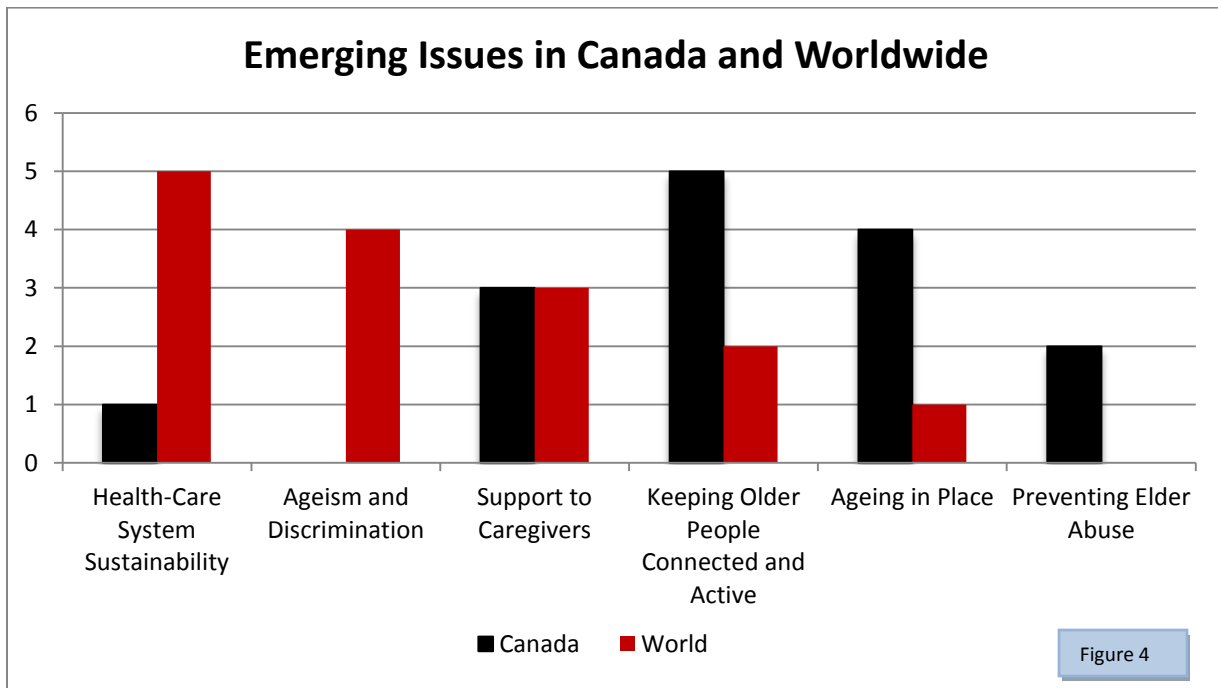
ageing. Over 250 responses were received with the current and emerging issues being defined into a total of seven key areas. Following the initial prioritization of the issues (see Figure 4 and 5) the information were disseminate to 6,500 global subscribers of the IFA eNews for validation. The identified headings in some cases are self-explanatory, however in other cases a number of sub-themes were incorporated within a large related issue area.

1	Ageing in Place	<i>Home and Community Care, Staying at Home, Age Friendly Cities/Communities, Home Care Services, Ageing at Home Technology and Housing</i>
2	Support to Caregivers	<i>Informal Carers, Family Carers, Financial and Psychological Support</i>
3	Ageing Workforce	<i>Pensions, Retirement, Workforce Participation, Older People's Incomes</i>
4	Healthcare Sustainability	
5	Ageism and Discrimination	<i>Rights and Responsibilities</i>
6	Keeping Older People Connected and Active	<i>Falls Prevention, Mobility, Health Promotion, Active Ageing, Volunteering, Life Long Learning, Technology, Intergenerational Programs, Preventing Social Isolation</i>
7	Preventing Elder Abuse	

CURRENT ISSUES



EMERGING ISSUES



AGEING IN PLACE

Definitions of ageing in place have varied across settings and over time. For the purposes of this report the definition in the New Zealand Positive Ageing Strategy (Minister for Senior Citizens, 2001) which has informed recent policy initiatives will be used.

Ageing in place is defined in the strategy as people's ability to "make choices in later life about where to live, and receive the support to do so" (Minister for Senior Citizens, 2001, p. 10). The main components of this definition are choice, location and support.

Ageing in place refers to a *person's ability to remain dwelling in the community*. Residential care in the form of nursing homes, transitional care facilities or hospitals is specifically excluded.

Population ageing is a significant phenomenon of the 21st century which manifest in economic, social and personal challenges and pressures for societies world-wide. Nowhere is this truer than in regard to accommodation for older Canadians. No longer just the subject of academic discussions, it is increasingly a subject which gives rise to robust political discussions and strong government and private sector responses.

Fiscal burden for government and challenges for older persons and their families necessitates serious and urgent attention. As a result many countries are adopting policies supporting the ideology of Ageing in Place. There are many models and visions about how homes and the associated financial costs can adapt and be more flexible to the changing needs of older citizens.

Countries around the world differ significantly in the changing nature of accommodation for older person (as their level of physical and cognitive function changes) whether it is as a consequence to a clinical condition or general frailty and vulnerability. As such the role of governments varies from country to country.

In developed countries, the role of government is increasingly linked to a private sector response and / or a multiple sector response to changing demands and expectations of the older population and their families. Despite this trend, the relationship between national and state policies and the methods of implementing effective programs that have minimum standards and accreditation is a challenge, but one which needs to be explored with a sense of openness and purpose for solutions.

In contrast, it is easy to assume in developing countries that the extended family will care for older people as has been the general tradition. This is no longer the case. As older people live longer, more women work outside of the home, adult children migrate for work opportunities, and there is the loss of many adult children especially in Sub Saharan regions to HIV/AIDS. The reliance on the extended family whether in the country of origin or whether it is in Canada with immigrants who are 'ageing in a foreign land' cannot be assured? Hence the terms and models of ageing in place take on new significance in all regions of the world.

Information on the number of older people wishing to remain at home in Canada does not appear to exist. Stats Canada in its report entitled A Portrait of Seniors in Canada (2006) noted a data gap in "information about factors potentially contributing to the actualization of these important values for seniors, such as their capacity to age at home, involvement in significant social relationships, and so on."

Canada's economic neighbors in the western world appear to have gathered in depth data on the issue. For example Australia's Treasury's Intergenerational Report (2010) formally recognized that older people want to stay independent and in control of their lives. In their response to the wide ranging report Ms Barbara Squires from the Benevolent Society stated "It puts the spotlight back on what this is

really all about. It's really all about older Australians. It's not about the livelihood of (aged-care) providers. It's about older Australians living well. It's about all of us eventually.

Notwithstanding the substantive differences between developed and developing countries and those in countries transition, there is generally common misperception that government and family will remain traditional providers. There is a strong move away from government being a direct provider; more often than not government will facilitate initiatives in the areas of housing, health and care.

It is both relevant and important for government to reflect on the interface between housing systems, care systems and related financial incentives and the role of state authorities now and the future.

Preceding the IFAs 9th Global Conference on Ageing in Montreal (2008) the IFA convened meeting of Senior Government Officials focused on the subject of 'Ageing in Place'. Over 100 government officials represented 42 countries at the 1-day meeting. Four key elements underpinned the presentations as they relate to ageing in place:

1. The basic right to make choices does not change with age. Older people have the right to choose where and with whom they will make a home.
2. Relationships with family, friends and caregivers are an important component of the continuing health and well-being of older people.
3. To age in place successfully requires early individualized planning.
4. Creating choice for older people to remain in the community requires a whole of government response across portfolios.

Finding more efficient and cost effective service models and their delivery to support an ageing population cannot be developed without weighting the needs and wishes of its older citizens. Increasingly the emphasis has tended towards programs and services that enable people to stay in their home of choice commonly referred to as ageing in place or ageing at home, despite this not always being the most cost effective for families due to the out of pocket expenses incurred. Several studies over the last decade (e.g. National Alliance for Caregiving, National Center on Women and Aging and Metlife Market Insurance Institute, 1999) revealed that caregivers can incur significant losses in career development, salary and retirement income, and substantial out-of-pocket expenses as a result of their caregiving obligations. In 2009 the Department of Work and Pensions (DWP), United Kingdom introduced legislation so that service users and carers may be reimbursed out-of-pocket expenses without risk of affecting their benefits.

There is also a growing recognition that the health and housing needs of an older person are often interrelated. Health concerns can create or compound the problems of an ageing housing stock, and in turn housing concerns can create or compound health problems for seniors. To develop an efficient method of service delivery, residential and care systems in the community must reflect the interrelationship between health and housing and also living and care arrangements.

Customized models of care avoid the inefficiencies that may arise from programs that are “service type”-- matching services and facilities to an individual’s need rather than matching an individual to an existing service or facility.

Ageing in place is only successful with an appropriate assessment, targeted services tailored to the individual while taking into account the living arrangement and family support. Successful strategies minimize inappropriate care, and therefore the overall costs, by offering a range of flexible services and calibrating those services to fit the needs and function of the individual. Rather than a rigid service-delivery system, good practice in ageing in place strategies means attention to both health care and housing options that provide support at the margin of need as defined by a person’s desire and efforts to live independently.

For many countries the shifting focus towards ageing in place is clearly evident. Countries such as Australia, United States, Denmark, Sweden and many others in Western Europe have embraced the concept and mapped program implementation for over two decades. Policies and programs are well developed to support older people to remain in their own homes and communities for longer.

Difficulties in Reporting Home Care

Home care services can be paid for by both public funds and private funding; and the anonymity of family caregivers and other volunteers.

All provinces and territories have distinct home care programs, which provide different types of services and levels of care in the home.

All jurisdictions have different reporting systems.

“Canada's publicly funded health care system is best described as an interlocking set of ten provincial and three territorial health insurance plans. Known to Canadians as "medicare", the system provides access to universal, comprehensive coverage for medically necessary hospital and physician services” (Health Canada, 2009).

“The demand for home and community care services has been increasing dramatically in recent years. According to the Canadian Home Care Association, approximately 850,000 Canadians received homecare services in 2002. Despite a 60% increase in the number of homecare recipients since 1995, only 3.5% of total public health expenditures went towards homecare” (Canadian Home

Care Association, 2004).

The Canadian Health Association in the report Home Care in Canada: From the Margins to the Mainstream (2009) reported the difficulties to obtain up-to-date and comprehensive statistics on users of homecare.

“The Canada Health Act recognizes home care as an element in the category of “extended health services”, and as such, it is not an insured health service to which the principles of the Act apply, but, is subject to conditions of reporting.

Currently nine provinces have legislation related to public home care through various acts and policies. Other provinces and territories have orders-in-council, or guidelines that direct the delivery of their home care services”(CHCA, 2010).

For older Canadians access to programs and services to support activities of daily living such as personal hygiene are delivered from both the public and private sectors. The public sector delivery is generally linked with the Canada Health Act(1984) with the primary objective being "*to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.*"

Services often identified as ageing at home initiatives are more often post-acute, emergency or short term care services focused on the medical needs of an individual rather than the social determinants of health.

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.(WHO, 2008)

With or without a legislative framework, all provincial and territorial governments in Canada recognize that 'care in the home' is an important component to the health system and have signaled a shift in policy focus from provision of care in an acute care setting to provision of care closer to home.

For older Canadians who require clinical and support care in their home over an extended period of time

"While there will always be a need for long-term care facilities, the country urgently needs a national home-care strategy to support seniors who want to grow old in familiar surroundings.

Opportunities must be provided for all seniors to have access to services such as mowing the lawn, snow shoveling and grocery delivery that will support their ability within their own homes."

Dr Sandra Hirst, President of the Canadian Association on Gerontology, 2008

the options are often limited to the private sector on a user pays basis. This in large part excludes citizens who are financially disadvantaged. Without legislated home care services to support activities of daily living in the public system, inappropriate admission to long term care facilities is often the result.

In September 2004, Canadian First Ministers agreed to a 10-year plan to strengthen health care across Canada. The 10-Year Plan recognized that in order to address issues of access to care and to reduce wait times, there was a need to invest in a number of key areas. Home care was identified as an essential part of modern, integrated and patient-centered care. It was declared that the quality of life for those in need would be enhanced by improving access to home and community care services. The Plan committed governments to provide first dollar coverage by 2006 for specific home care services based on assessed need. A core set of services were identified for acute, palliative and acute mental health home care.

While this commitment is an important first step in the process to strengthen home care across Canada, the limited scope of services articulated in the Plan does not appear to address the future challenges or realize the full potential of an evidence based home and community care system.

Appropriately legislated and resourced home care programs play a critical role in, health promotion and chronic disease management, minimizing hospital admissions, reducing admission to long-term care facilities and at the same time enabling frail older people to live independently in their own homes.

In a [poll undertaken](#) by a national private provider of home care services (Revera Inc.) in October 2011, 85 % of citizens born between 1945 and 1964 are expecting a different, more positive experience than their parents and grandparents.

Results revealed that two-thirds of those surveyed are not confident that the current health care system can meet the needs of older people. In 2021 the first of the baby boomers will turn 75 years of age. Numerous studies (e.g. Guberman, Lavoie, Blein, Olazabal, 2012) have reported that expectations and

the demand for innovation in home care, technology, and different ways to stay physically and socially active will be demanded.

More than one-half respondents identified more access to home care as the most important change that has to happen to the Canadian health care system to meet the needs of older people. Moving from a system focused on episodic acute care to one focused on comprehensive care of chronic illness as well as sophisticated social supports must be front and center as health care system decisions are made in the coming years.

In April 2009, the Canadian Special Senate Committee on Aging released a report entitled “Canada’s Aging Population: Seizing the Opportunity” in which a number of findings and recommendations (Integrating Care) related to the concept of ageing in place. The commentary highlights that most Canadians want to stay in their communities as they grow older while others want to move closer to family and friends, or to communities which provide the retirement environment they seek.

Some older people will choose to stay in their own homes, while others will want to move into housing that requires less maintenance or provides supports to daily living such as personal hygiene and shopping. The choice of care and accommodation depends on many factors, including their health status; where they live in Canada; whether they live in an urban or rural area; whether they have the support of family and friends in the vicinity; and their financial situation,.

Various supports make it possible for the majority of seniors to have viable choices about where they live. These include housing and renovation programs, supportive housing options, home care, and palliative care. However the Senate Report also states that too many older people are not being well served by this continuum of supports to age in place of choice. A health system designed to deal with episodic illness is not well prepared to deal with the rise in chronic illness associated non-communicable diseases (NCDs) within an ageing population.

There has been overwhelming support for better ageing in place strategies at the Federal, Provincial and Territorial levels of government, yet movement to embrace such propositions have not yet been realized. More often provincial governments provide short term or one-off funding for demonstration projects that rarely translate to mainstream policy.

The interface between health, housing and wellbeing of older people has been clear; established (e.g. Walker, Sinfield and Walker, 2011), as has the contribution of ‘well’ older people who are often referred to as the glue of society, bringing together life experiences, knowledge and skills, and sharing these across generations.

The ability of seniors to play this role and contribute often depends on their access to affordable, secure and suitable housing. Seniors can contribute more effectively when they have access to good health and housing. The home environment can facilitate functional independence and even be designed to assist seniors in monitoring their health. Much of the fiscal wealth of the ageing Canadians is not accessible to meet changing circumstances, primarily as residential property, often in the post-war housing stock of a single house on a suburban block.

Seniors are no different to younger people – they value their independence, they value having choice and they value contributing to the community. Home environments, both in terms of overall design and set up, can either facilitate or create barriers to maintaining independence when someone is experiencing functional limitations. It is important that accommodation can adapt to changing levels of activity and capacity. Along with changes in housing preferences, a longer life expectancy will require additional planning and financing. Housing that is senior friendly and affordable enables a healthier

lifestyle. Good planning and design can reduce isolation and disengagement, helping people stay in touch with the community.

AGEING IN PLACE – POLICY RESPONSE FROM OTHER COUNTRIES

AUSTRALIA

CONTEXT - Australia is a constitutional democracy based on a federal division of powers between Commonwealth, State, Territory and local levels of government. The Commonwealth and each of the six States and two Territories have their own constitution found in legislation.

Under the constitutional arrangements significant powers are retained by the States. State administrative responsibilities include (inter alia) public health (including hospitals) and community services, and the oversight of local government. The formal powers of the Commonwealth are constitutionally limited to areas of national importance, such as (inter alia) trade and commerce, taxation, foreign relations, defense, immigration and associated matters.

Through High Court decisions, Commonwealth-State Agreements and the use by the Commonwealth of the constitutional power to make grants to the States and Territories, the Commonwealth has influence in regard to matters such as health and welfare. Local government has limited powers in these portfolios but moreover tend to common services include management of sanitary services and town planning.

FIGURES -Australia has both a growing and an ageing population. Of the 21 million people living in Australia in 2007, 13% were aged over 65 years. Data projections from the Australian Bureau of Statistics (ABS) estimate that by 2030, Australia's population will be between 27 and 31 million people; of these, 19-21% will be aged over 65 years.

WHO IS RESPONSIBLE FOR AGED-CARE? - All levels of government together with consumers and the non-government sector have some role in funding, administering or providing care for seniors which is known in Australia as 'aged care'.

LEGISLATION - Two main pieces of legislation govern the Australian Government's 'healthy older Australians' and aged care programs and services:

- **THE AGED CARE ACT (1997)** governs the provision of residential care, flexible care and community aged care to older Australians. The Aged Care Act sets out matters relating to the planning of services, the approval of service providers and care recipients, payment of subsidies, and responsibilities of service providers. There are also sets of Principles, which provide further detail regarding the matters set out in the Aged Care Act.

Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia packages have been established under the Flexible Care Subsidy Principles of the Aged Care Act, and Community Aged Care Packages (CACPs) under the Community Care Subsidy Principles.

- **THE HOME AND COMMUNITY CARE ACT (1985)** provides the framework for the operation of the Home and Community Care (HACC) Program. This Act sets out the original agreement for the Home and Community Care Program entered into between the Australian, State and Territory Governments, which covers the objectives of the program, the types of projects that can be funded, and arrangements for Australian Government financial assistance to be paid to the States and Territories for the operation of the program.

The funding and regulation of aged care services is predominantly the role of the Australian Government. Aged care services are subsidized from general taxation revenue, not by a specific taxation levy or through a social insurance program.

The Australian Government directly funds and regulates, within a legislative framework, care in the community, mostly in the form of Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) packages. These care packages provide low and high levels of care, respectively, in people's own homes. The Australian Government also jointly funds care in the community with the States and Territories, through the Home and Community Care (HACC) Program which provides basic services to people with disabilities as well as to older people.

The Federal Government contributes approximately 60% of 'aged care' funding and maintains a broad strategic policy role. The State and Territory governments are responsible for the day-to-day management of the program. These governments also fund program services through block grants to organizations, and establish the fees policy for care recipients.

Residential care (high and low care) is in the main financed and regulated by the Federal Government. Care recipients (who can afford it) make means-tested contributions to the costs of their care. Some State and Local Governments have a direct role in providing residential care and make a contribution to funding the facilities they operate.

Over 1,750 approved providers deliver residential and community aged care services directly subsidized by the Australian Government. Providers must be approved and authorized under the Age Care Act to deliver care services. Community care services are mostly delivered by not-for-profit, non-government organizations although some State and Territory governments also deliver these services.

Residential care (high and low care) is mostly provided by the non-government sector (by religious, charitable and for-profit providers). State and local governments, with funding from the Australian Government, operate a small number of aged care homes that deliver around 8% of residential care places. In 2010-11 there were 45,179 Community Aged Care Packages (CACPs) provided to older Australians.

GOOD PRACTICE

Four main programs provided by the Commonwealth Government to support ageing-in-place have been recognized by OECD colleagues as good practice to the extent that elements of the models have been replicated in several countries in Europe. Australia has one of the most advanced linked health research data sets in the world which has resulted in revered evidence base practice in this field.

The programs are Home and Community Care (HACC), Consumer Directed Care (CDC), Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH). The programs aim to provide assistance and support to people in their own homes, particularly if people choose to stay at home rather than move into residential aged care (known as nursing homes in Canada). All programs are designed on a co-payment model however no individual can be denied a service they need (under legislation) if unable to pay the fees.

As of 20 September 2011 the maximum fee for a CACP, EACH, EACHD or CDC community care package for people on the basic rate of pension is \$AUD 8.61 per day.

- **HOME AND COMMUNITY CARE PROGRAM (HACC)** The objective of the HACC Program is to support people in their own homes and communities by providing services to maintain and promote independence and help avoid premature admission to long term residential care.

The HACC Program began in 1985 by bringing together a group of community care programs, variously funded by Commonwealth and State Governments under a single administrative umbrella. The Program is jointly funded by Commonwealth and State/Territory governments and administered within each State and Territory. It funds a range of services in the community and in people's homes for frail older people and their carers.

Services are generally provided at a modest level, to people living at home. The Australian HACC Program Budget for 2010-11 was more than \$2 billion. The federal government contributes 60% of the funds to the program with State and Territory governments contributing 40%. In 2009-10 approximately 850,000 people received services provided by ~ 3,500 organizations across Australia.

- **CONSUMER DIRECTED CARE (CDC)** places provide the care recipient and carer with greater control over the design and delivery of formal and informal care and services they receive. There are three levels of subsidy for CDC Packaged Care places that depend on the assessed level of care to be provided.

An aged care assessment is made by one or two members of the Aged Care Assessment Team (ACAT) to assess how well a person is managing with daily living activities and personal care.

Under the Act person with an ACAT approval for high care will not need to be reassessed. However, a person with an ACAT approval for low care will be reassessed if the care needs change, particularly if care has not been received within 12 months of receiving the approval.

These three levels broadly align with the existing subsidy levels of the current Packaged Care programs:

CDC LOW CARE –CDC 'Low Care' is similar to a CACP in that it will provide care services to people living in the community who have low level complex care needs. It may provide services such as personal care, social support, and transport to appointments, home help, meal preparation and gardening.

CDC HIGH CARE -CDC 'High Care' is similar to an EACH package in that it will provide care services to people living in the community who have high level complex clinical and care needs. Services may include nursing, domestic assistance, in-home respite, personal care, transport to appointments and social support.

CDC HIGH CARE DEMENTIA -CDC 'High Care Dementia' is similar to an EACHD package and will provide care services to people living in the community who have high level, complex care needs and also experience behaviors and symptoms associated with dementia that affect their ability to live independently.

- **THE COMMUNITY AGED CARE PACKAGE (CACP)** program provides a planned and managed package of community care for persons with complex care needs who wish to remain living in their own home. The CACP care manager's role is to plan and manage the care package and tailor it to the person's needs taking into consideration the living arrangements and family care.

Types of services that may be provided in a CACP include meal preparation, laundry, assistance with continence management, transport, personal care, social support, home help, gardening and temporary in-home respite care.

As at 1 July 2011, the daily subsidy for CACP and CDC Low Care packages is \$36.73 AUS.

- **THE EXTENDED AGED CARE AT HOME (EACH)** program was introduced as a pilot in 1998. From 2003, the EACH Program was mainstreamed with 'residential places' being included in the national provision ratio.

EACH packages aim to provide an alternative to high level residential care (vis a vis nursing home) in a person's home.

As of 1 July 2011, the daily subsidy for EACH packages and CDC High Care packages is \$122.79 AUS. Oxygen and enteral feeding supplements are also payable in some circumstances.

- **EXTENDED AGED CARE AT HOME-DEMENTIA (EACHD)** packages were introduced in 2004-05. These packages are targeted to people with dementia who exhibit behaviors of concern and psychological symptoms due to their dementia.

As at 1 July 2011, the daily subsidy for EACHD packages and CDC High Care Dementia packages is \$135.41 AUS. Oxygen and enteral feeding supplements are also payable in some circumstances.

- **THE TRANSITION CARE PROGRAM** commenced in 2004-05. The Program has been developed and jointly funded by the Australian Government and the State and Territory governments. It aims to help improve independence and confidence after a hospital stay. It provides a package of services including low intensity therapy and personal and/or nursing care as part of an ongoing but slower recovery process. This means that the individual and family or carer have time to consider long-term care arrangements, which may include returning home with community support or accessing the level of care provided by an aged care home.

Transition care can be provided for a period of up to 12 weeks, with a possibility to extend to 18 weeks if assessed by the Aged Care Assessment Team (ACAT) as needing an extra period of therapeutic care. The average period of care is expected to be about seven weeks.

The transition care provider may charge a fee as a contribution to the cost of care. The maximum fee is 84% of the basic daily rate of a single pension for care delivered in a live-in setting or 17.5% of the basic daily rate of single pension for care delivered at home.

Once the program is fully established, it is expected to assist up to 30,000 older Australians annually.

- **THE ASSISTANCE WITH CARE AND HOUSING FOR THE AGED (ACHA) PROGRAM** is designed to help those frail, low income older people (who are renting insecure or unsafe housing or who are homeless) to remain in the community.

Organizations are funded by the Australian Government to provide paid workers and/or volunteers who link clients to appropriate mainstream housing and/or care services. The providers of care services work closely with State Government Housing authorities and have a key role in assisting eligible clients to obtain secure housing.

Where secure accommodation is arranged, the program worker can then link the client to either a Community Aged Care Package (CACP) or the Home and Community Care (HACC) program to meet the person's care needs.

In rural and remote areas where mainstream programs are not sustainable, flexible funding and delivery arrangements enable support for ageing in place.

- The Australian, State and Territory governments jointly fund **101 MULTI-PURPOSE SERVICES** to provide integrated and cost-effective health and aged care services for small rural communities

which are unlikely to attain separate services such as an acute hospital, residential care or community health and home care services.

- **THE NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER FLEXIBLE AGED CARE PROGRAM** provides flexible places through 30 services, mainly in rural and remote areas. These culturally specific programs help to ensure that Aboriginal and Torres Strait Islander people can access appropriate care services as close as possible to their communities.
- **PARTNERS IN CULTURALLY APPROPRIATE CARE (PICAC) PROGRAM** provides cross-cultural training and information sessions for culturally and linguistically diverse (CALD) communities. The program also encourages ethnic communities to form partnerships with aged care service providers for the purpose of establishing more culturally appropriate facilities.

OTHER SERVICES THAT SUPPORT THE CONCEPT OF AGEING IN PLACE

INFORMATION -Accurate and appropriate information and support services are important enablers for making informed choices about accessing the appropriate care when it is needed while maintaining a healthy and active ageing approach.

The Australian Government has in place a range of information products in various media (phone lines, booklets, fact sheets, websites and shop fronts) and in the most common community languages. Assistance is available for speech or hearing impaired people to access information, and interpreter services are available to assist people from non-English speaking backgrounds.

To assist with all aspects of growing older and remaining healthy and active, individuals and families can access information on such matters as pensions, housing options, tips on maintaining health and enjoying better quality of life, volunteering, home safety, and advice about maintaining independence. Information is also provided on accessing assessment for care services and how to locate services that best suit their care needs.

PEOPLE IN THE COMMUNITY LIVING WITH DEMENTIA - In addition to the care and support through specific care packages, mainstream residential aged care and health services, people living with dementia receive support through:

- **THE NATIONAL DEMENTIA INITIATIVE** which funds dementia research, prevention initiatives, early intervention and support programs, and dementia specific training for community care staff and residential care workers, carers, and community workers such as police;
- **DEMENTIA BEHAVIOR MANAGEMENT ADVISORY SERVICES** which provide clinical support, mentoring and behavior management advice where the behavior of a person with dementia impacts on their care; and
- **ALZHEIMER'S AUSTRALIA** and Alzheimer's Associations in States and Territories which implement the National Dementia Support Program to provide: information, advice and referral; education and training; Dementia and Memory Community Centers; early intervention programs such as the Living with Memory Loss Program; counseling and support services; and support for people with special needs.

Deloitte Access Economics was commissioned by Alzheimer's Australia to provide updated dementia prevalence estimates and projections for Australia. Specifically this report estimates the number of people with dementia in Australia in 2011, and in the future from 2012 until 2050 (Alzheimer's Australia, 2011).

A National Framework for Action on [Dementia](#) 2006-2010, endorsed by Australian Health Ministers, provides a vision for a coordinated national approach to improve the quality of life of people living with dementia and their carers and families.

THE NATIONAL CONTINENCE MANAGEMENT STRATEGY - An estimated four million Australians (of all ages) are affected by some degree of incontinence; the proportion on older people with symptoms is substantial. The strategy supports information materials, research and service development initiatives aimed at prevention and treatment.

Initiatives include projects such as the National Men's Continence Awareness Project and the National Public Toilet Map <http://www.toiletmap.gov.au/> and a dedicated website promoting bladder and bowel health (<http://www.bladderbowel.gov.au>).

THE CONTINENCE AIDS PAYMENT SCHEME (CAPS) -The CAPS is an Australian Government payment that assists eligible people, who have permanent and severe incontinence to meet some of the cost of their continence products. It is a direct payment administered by Medicare, to clients providing flexibility and choice about where and when they purchase their continence products. It enables access to subsidized continence products up to the value of \$506.30 AUS a year (indexed annually).

DAY THERAPY CENTERS – The Centers assist frail older people to remain as independent as possible. Some 148 centers, mostly located at aged care homes, offer a range of therapy services including physiotherapy, occupational therapy and podiatry. Centers may charge clients a modest fee for these services. Services are available to the residents of those homes and to frail older people living in the community.

NATIONAL EYE HEALTH INITIATIVE—Evidence suggests a high prevalence of sensory impairment among older persons transitioning from independent community living to institutionalized care (Jee, Wang, Rose, Lindley, Landau and Mitchell, 2005).

In response to a resolution by the World Health Assembly, Australia developed the National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss which was endorsed by all Australian Health Ministers in 2005, A report of progress was presented at the Australian Conference of Health Minister in 2008. During the next reporting period an evaluation strategy will be instigated to measure national performance against the Framework objectives

Consistent with this framework, the Australian Government through Vision 2020 The Right to Sight is implementing a National Eye Health Initiative which aims to reduce the incidence of preventable vision loss by raising public awareness of eye health issues and improving the quality and delivery of eye health care <http://www.visioninitiative.org.au/national-framework>.

DENMARK

CONTEXT - It is typical of Nordic traditions that the federal government assumes responsibility for the welfare of the elderly. This means that the state, regional council districts and the municipalities are responsible for organizing efforts that protect the needs of older people. The federal government establishes a budgetary limit for each district and municipality. Local leaders formulate policies and services within budgetary constraints according to the special needs of the community. Generally this effort is organized through an "institutionalized" setting, where care is offered and given in either special institutions or at home.

Current policy aims at providing conditions that enable older people to stay in their homes for as long as possible. The trend is to bring the care to the person instead of expecting the person to seek out care. When assistance or specialized care is needed, a network of nurses and physicians employed by the municipality visits the person in their home or senior living unit. If an older person is not able to remain in their home, several residential options in senior care are offered.

Danish and Swedish policies are designed to help people stay at home as long as possible through a variety of home-care services and regular house calls by doctors. Regular monitoring of a person's needs begins with a visit by a nurse on reaching 75 years of age.

In 1974 the Danish Government established a National Committee for Health Priorities (known as the Priority Committee). It was established with a broad range of representatives from governmental agents, local authorities and professional organisations -- a unique initiative by the Danish Government at the time. In 1977 the Priority Committee suggested shifting the main responsibility of caring for the elderly from the hospital to the public healthcare sector with special emphasis on health promotion and preventive efforts. This suggestion led in 1985 to improvements of conditions for older people in their own homes, during hospital admission, discharge and during follow-up care.

In 1981 under the proposal of elderly housing (Ælderboliger (Almeneælderboliger) the Danish government promoted the idea of ageing in place. This proposal was based on a number of different factors including a deeper understanding of the disconnection between the function of 'care' as it was provided in the traditional intramural/residential facilities and homelife. The building of nursing homes was prohibited in Denmark in 1988 "Plejhjem" and replaced by the promotion of elderly housing with flexible community based care as frailty increased.

In 1984 Denmark adopted the World Health Organization's goals for health in "Health for all in the year 2000," prioritizing prevention and supportive care. Goal 6 refers to healthful ageing adding years to life as well as life to years. Adequate care within an acceptable economic framework was enforced, and new programs and facilities for long term care introduced at this time. The basic philosophy was and still remains to maintain the mental and physical capacities of an older person for as long as possible by offering the appropriate care and support.

The "Roedovre project" (1984) created the basis for the new law on Preventive Home Visits (PHV) to the Ageing (July 1996) by carefully and convincingly documenting the effect of prevention on illness, weakness, and psychological and social problems. Today in Denmark all persons over 75 years of age are entitled to receive at least two home visits from health professionals annually.

Mandated by law since 1998 the introduction of preventive home visits (PHV) by a health profession to community-dwelling older persons represents one example of proactive societal action that has received growing attention. The purpose of PHV is to promote overall health and wellbeing in old age, to identify people at risk for health problems, to prevent further decline, to enhance the possibility for the individual to maintain activity and participation, to be in control of everyday life, and to experience life satisfaction.

While it is difficult to conduct a comparative study of the outcome of PHV a recent study in Sweden by Lofqvist, Eriksson, Svensson and Iwarsson (2012) showed protocol validly identified health risks among older people with different levels of ADL (activities of daily living) dependence. Associated studies in Denmark suggest a value added proposition in the response to long term health costs lies in primary care and preventative home visits.

A further change in social service and healthcare practice in the 1990s at the national level was that all persons, 70 years or older, can receive a public health nurse visit no later than three days following

discharge from a hospital. The nurse is responsible for follow up and ensures that adequate help is available in the home.

The Danish social service and health-care system is based on free comprehensive medical and social care benefits financed by the government through a relatively high personal tax of 50% to 70% and a tax on goods and services of 25%. Approximately 5.6% of Denmark's gross national product is spent on healthcare costs (including day care, sick leave, hospitalization, and general health care) compared with 10.7% in the United States.

From 1981 to 1993, there was a concerted effort toward building communication and cooperation between the hospital, family practitioner, and the public health-care system. In 1989 the Health Care Committee, in The Capital Region of Denmark, 2009 (which serves as the venue for political collaboration between the municipalities and the Regional Council relating to healthcare agreements) introduced a model that integrated nursing homes and public health nursing. In 1983, only 39 local communities offered 24-hour services, a number that increased to 269 in 1995.

FIGURES -The average life expectancy in Denmark today is 76 years. Of Denmark's total population of 5.2 million persons, approximately 790,000 (16%) are 65 years or older. Danish citizens who are 80 years or older account for 189,000 persons (3.6%) of the population; Estimations suggest that over the next 19 years, this 20% increase in this cohort. The number of people aged 65 to 79 years of age will remain stable.

Of those older than 65 years of age, 20% require home health visits/care, whereas 50% of those older than 80 years require this support. Approximately 80% of the elderly live independently in the community, and 40% receive state-subsidized social and health services.

GOOD PRACTICES

To accommodate the preference of senior citizens to remain in their own homes, the municipality has developed a wide range of services aimed at helping people to help themselves. Services include assistance with cleaning, shopping, washing, preparation of meals, and personal hygiene and care.

Home care can be used to assist or relieve family members caring for a person with a disability or illness. Two forms of home care are available - long term care and temporary help. Long-term care is provided free of charge, whereas temporary help in the form of home care visits may warrant individual payment depending on the income of the recipient.

The public health nurse offers free around-the-clock services including patient education, care, and treatments, in addition to assistance in completing applications for various services such as change of residence, emergency help senior centers and senior day-care facilities. All persons (sick, infirmed or with a disability) can have an emergency or safety phone-calling system installed, with direct 24-hour contact to the public health nurse.

HOUSING OPTIONS – There is an array of housing options based on the functional needs and desires of the individual and their immediate family care. Senior citizen residences, gated-communities, assisted living units, and nursing homes are designed especially for the elderly and those people who have a disability and can no longer care for themselves.

Senior citizens receive a full pension while being monetarily responsible for individual services received, such as meals, cleaning, care, and rent. The safeguard in this policy is that no more than 15% of the pension is expected to go toward the rent.

The range of accommodation options and management style is diverse. Accessible one or two-room apartments with an emergency contact system and social activities for the residents are usual. This

package of services is to some extent guided by the Resident councils which represents the needs of the occupants. Some residences are linked with nursing homes and offer health aides as a service whereas others are of a more independent style.

To accommodate all levels of a person's functional capacity a variety of community services are also aligned to the residences. These include a day-care center for those who do not wish to move permanently, but for a shorter or longer period require extra care; transportation to and from the day-care center; and use of a nursing home for a shorter period, to provide a respite for the family.

PENSION AND OTHER FINANCIAL ASSISTANCE -At 67 years of age Danish people automatically receive a state pension. In addition to the pensions there is a further social safety net known as the supplemental labor market pension. This is paid by the employers and designed to supplement the state senior citizen pension.

A retiree is entitled to a tax-free monetary supplement to their pension fund based on individual or marital total income. Expenses such as heating bills and those related to illness, medications, dental procedures, and eyeglasses are often financed publicly.

All retirees can apply for monetary supplements or loans for their housing rent whether they rent or own their residence. Seniors living in a collective housing community can also apply as long as five of the residents are at least 55 years of age. Supplements for foot care and treatment for persons with diabetes, scar tissue, and ingrown toenails are provided.

The general practitioner's referral to training centers for rehabilitation purposes is free of cost, and physical therapy sessions are provided at a 40% subsidized rate. Special dental home care visits can also be arranged in many districts. A food service is available, with meals being delivered to the home at a subsidized rate. Additional home and yard services are available to senior citizens through their municipality at a low rate.

"SENIORS HELP SENIORS" PROGRAM - Volunteerism is a new phenomenon in Denmark. The Social Service Law of July 1998 administered 700,000 dollars yearly for developing and expanding social volunteer efforts in Denmark. In 1999, regional and municipal districts used as much as 46% of the funding to reach 120 of the 275 municipals.

The primary intention of the volunteer program is to respond proactively to the new fight against loneliness by creating a network for senior citizens. The aim of the program is to broaden the volunteer profile by integrating volunteer work into the senior citizen's daily life regardless of the volunteer's age, profession, or ethnic background. It is the development of a "shared social understanding" that is expected to strengthen Denmark's social welfare profile.

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SUPPORT CAREGIVERS

According to the Canadian Caregiver Coalition, *“Informal caregivers are individuals who provide ongoing care and assistance, without pay, for family members and friends in need of support due to physical, cognitive, or mental conditions”*.

In Canada, support to caregivers (also referred to as carers) has been identified as a major national issue as it relates to a major element of the Canadian health care and social support system. By 2030 almost one in four Canadians will be carers over the age of 65 years. Low birth rates, changing family structure (women working) and higher life expectancy, all characteristics of population ageing, will inevitably result in fewer family carers.

Ageing in place is a policy trend associated with developed regions in North America, Oceania and Europe that have ‘aged’ faster than less developed regions such as Latin America. The choice older people are making is to remain in their own homes with formal services and the support of family. The nature of chronic conditions and high level clinical care, in addition to the changing face and form of family, means that the once solid commitment of family is now not guaranteed.

It is estimated that ~ 4 million Canadians provide care to a family member or a relative. Increasingly family who are undertaking a prominent caring role are also employed and have their own families. The impact of being a carer is well documented (Whalen and Buchholz, 2009) – exhaustion, stress and anxiety are common physical and mental consequences as is the growing financial impact of the carers’ family and also that of the person they are caring for.

In some states and countries carers are formally recognized through legislation (e.g. South Australia Carers Recognition Act 2005). Numerous studies have calculated the dollar value of family care within the healthcare system (e.g. The Carers Association, Ireland reported that family carers save the Irish State €2.5 billion each year, 2011).

In Canada it has been estimated by Stats Canada that the projected economic contribution of family caregiving is 25 to 26 billion dollars per year, representing a significant contribution to the sustainability of the Canadian healthcare system (Hollander, 2009).

The increased prevalence of chronic health conditions, such as dementia, diabetes and arthritis, will drive the need for family caregivers. The World Health Organization estimates that chronic diseases accounted for 89% of all deaths in Canada (WHO, 2005). Approximately 40% of Canadians report having one or more chronic health conditions (Health Council of Canada, 2010).

Over the next 25 years, the impact of chronic disease on society and the health system is expected to grow significantly. Today, just over 500,000 Canadians have been diagnosed with some form of dementia and this number is expected to double by 2038. The economic burden of the disease will escalate to \$153 billion (Alzheimer Society of Canada, 2009). By 2020, one in ten Canadians will have diabetes, costing the country almost \$17 billion (Canadian Diabetes Association, 2009). It is estimated that by 2031, approximately seven million Canadians will have arthritis. In 2000 the economic burden of arthritis in Canada was estimated at \$6.4 billion, a number expected to rise with the increasing prevalence (Public Health Agency of Canada, 2010).

In Canada, \$192 billion per year is spent on health care. Approximately 70% is government funded (\$134.4b), with the remaining 30% covered by private health insurers and individuals (\$57.6b). Canada was in the top five highest per-capita spenders on health care, along with other OECD countries (United States, Austria, Germany, and France). In 2009, Canada spent 11.9 % of gross domestic product (GDP)

on health. Although Canadians over the age of 65 years account for less than 14% of the population, 44% of the health care dollars (Canadian Institute for Health Information, 2010a) is utilized.

Health system in general are a set of complex systems which are particularly challenging for people with ongoing care needs, such as those with chronic health conditions and the frail elderly who rely on comprehensive care and support to properly manage their health and social needs. This is no different in Canada (VON Canada, 2008). Research has shown integrated delivery systems designed to meet the needs of particular populations are more care efficient and cost effective (Hollander M et al., 2007).

While home and community care is seen as a cost-saving alternative to institutional care, it assumes family members are available and willing to provide care, sometimes over an extended period of time. It also in most cases transfers the costs from the system to the family. Access to community supports and services such as home care, respite programs, transportation, meal programs, and information to navigate the health care system has been viewed as helpful to caregivers cope with their responsibilities (Social Development Canada, 1999).

In 2008 the Canadian Caregiver Coalition (CCC), a national body representing and promoting the voice, needs and interests of family caregivers, developed a Canadian Caregiver Strategy that aimed to acknowledge family caregivers' work on a public level as well as offering an opportunity to express their needs and receive support from the government.

The CCC promotes the idea that family carers should have a choice to become partners in care and have the right to choose the degree of their involvement at every point of the continuum of care. This CCC Strategy presents several issues such as:

- Safeguarding the health and wellbeing of family caregivers and increasing the flexibility and availability of respite care.
- Minimizing excessive financial burden placed on family caregivers.
- Enabling access to user friendly information and education.
- Creating flexible workplace environments that respect caregiving obligations.
- Investing in research on family caregiving as a foundation for evidence-informed decision making.

WHY IS SUPPORT TO CAREGIVERS AN ISSUE IN CANADA? WHAT ARE THE GAPS?

UNIFORMITY OF SERVICES

In Canada, support to caregivers in general is not being addressed on a federal level as home health care is not insured under the Canada Health Act. It is important to appreciate though that being a carer is not a health issue; it is a wider socio economic issue that cuts across labour market, service development, long term care as examples.

Therefore the organization, nature and delivery of services and support to carers (as opposed to the persons being care for) vary widely. The availability and accessibility of appropriate direct carer services managed by provincial and territorial governments and delivered by local, regional and municipal authorities is also diverse and appears not to be well connected and coordinated.

National programs in Australia and the United Kingdom rely considerably on disaggregated data to develop coordinated policy responses for respite service this is not the case in Canada. There appears to be a less coordinated reaction to respite needs provincially and nationally in Canada. A comprehensive

multifaceted respite program that is planned and part of an overall national strategy is evident in countries where the role of being a carer (caregiver) is formally recognised.

Respite services ranging from 24 hours emergency respite care at the local level to longer term systematic respite where the care recipient is admitted into a facility for a period of 6 weeks cannot be assured in the current system of care in Canada. As a consequence the likely and increasing outcome is admission to an acute setting for the carer because of burnout. This then necessitates an emergency admission of the care recipient to long term care or a general hospital.

Today in Canada there is a variety of carer specific and carer related programs, some funded federally, some funded provincially and then some funded through the municipality.

A national coordinated response that brings together the disparate program pieces may facilitate communication between provinces/territories and create more efficient networks for caregivers. The current system seems to be too complex to foster a clear comprehension of the issue.

Over the last decade the community care sector has seen a decrease in funding and an increase in the demand for services. This shift from institutional care to community care with a special focus on 'ageing in place' has added to the strain on family carers not necessarily trained or available to provide care.

Little support can be provided through home care workers as Canada is currently experiencing a shortage. Most care workers earn the minimum wage, work irregular hours under difficult conditions and endure increasing pressure, demand and complex tasks.

A variety of tax credit options have been offered in Canada as a means to support carers however there is little evidence in Europe and Oceania to suggest that this line of action is equitable especially as many carers are elderly. Carers earning a little money, or those working part-time, those who simply do not work or those who are retired will not benefit significantly from a tax credit. Out of cost expenses remains a worrying outcome for all caregivers.

A study by the National Alliance for Caregiving in the United States (2007) reported that out-of-pocket cost of caring for an ageing parent or spouse averages about \$5,500 USD per year, a sum that is more than double previous estimates and more than the average American household spends annually on health care and entertainment combined.

Increased caregiving responsibilities signal that work-life-care conflict will become a growing reality for workers – one that may impact their health, financial situation, productivity and, ultimately, their decision to stay in the labor market (Lilly M. B., Laporte A. and Coyte P., 2007). Many caregiving employees are struggling to juggle work, family, and caregiving responsibilities.

Older workers, in particular, may experience unique challenges related to work-life conflict when caring for an ageing parent or relative. In addition to these caring responsibilities there may be concerns about personal health and finances, changing family situation and a need to reassess priorities in later life (Uriarte-Landa J and Hébert B-P, 2009). In turn, the impending labor shortage brought on by a wave of

"Care stands alongside the other great challenges, such as climate change, that we must face in our own lives and at the global level.

We learn from history that we can meet these challenges – just as slavery is now history, no longer are we facing nuclear extermination or global overpopulation as we did only a few decades ago.

We must start by acknowledging the work of carers amongst us, and from their inspiration, move on. Without care we cannot continue. Are we up to the challenge?" (2010)

Associate Professor Michael Fine,
Macquarie University, Australia

retiring baby boomers will place significant pressure on employers to engage in recruitment and retention strategies that support the needs of caregiving employees.

The need to facilitate and extend the participation of older workers in the labor force is to some counterproductive to the growing reliance on family and friends to care for an aging population. As two competing policy issues converge, the onus is placed on governments, businesses and employers to be part of creative solutions that will have a marked impact on the economy, communities, productivity levels, labor supply, health systems and caregiving employees.

Employers in Canada, in general, do not recognize the business and productivity imperative to support employees who may be in a primary or intense caregiving role. An increase in the demand for part time work, absenteeism, a loss of concentration at work, loss of wages and higher levels of stress are characteristics emerging in the workforce due to caregiving responsibilities. Furthermore there is an increasing threat of a withdrawal of caregiving employees from the professional sphere. Flexible employment policies that respond to caring obligations are progressively viewed as an imperative.

Governments have an important role to play in creating conditions that will promote workplace, family and community responses to the changing social and economic fabric of our society. Yet, the traditional assumption persists that work-life issues related to family caregiving are the sole responsibility of individuals and their employer. While there are some promising developments in Canada (such as the introduction of the Compassionate Care Benefit in (2004), governments, businesses, and employers generally have caregiving policies have not been a focus of attention.

The Employment Insurance Compassionate Care Benefit (EICCB) pays up for 6 weeks of leave to provide end-of-life care to a family member or close relative. This program does not cover a temporary leave due to a sudden medical crisis or illness. To qualify for Employment Insurance the onus is on the employee caregiver to have worked the necessary number of hours during the last 52 weeks. The eligibility criteria is challenging for many carers who have been forced to take time off work caring. The EICCB compensation ceiling is set to a maximum of 55% of the income which is most often than not insufficient.

The effect of demographic and economic changes are evident in the shifting care mix for older people as families, governments and the community search for new and effective ways to meet the competing demands projected onto them. Carers face a constant struggle in their own lives, just as governments and the community confront the tensions at the macro level. For employed carers and would-be carers, the clash between demographic and economic pressures is manifest as a personal problem. At the level of nations the same demographic equations apply, leading to identified existing or impending 'care gap'. Other commentaries focus on the restructuring of services or the failings of public support.

Canada is one of the most diverse ethno cultural nations in the western world and is viewed by its OECD neighbors as inclusive, respectful and committed to strengthening the diversity. Ageing in a foreign country is a complex multidimensional process for individuals, families and society as a whole. Across the course of the last two decades the shape and form of family, the role and the generational expectations have changed to such an extent that the joint family structure is not assured. Neither is the expectation that sons and daughter will care for their parents and grandparents. For this reason alone it is increasingly important for culturally and linguistically diverse 'carer specific services' be considered as an element in an overall strategy.

The frequency with which both family care and formal care are seen as in crisis is indicative of the contemporary dilemmas that care presents and of the way that care can no longer be understood as simply a private or personal responsibility. It is a public issue requiring public solutions.

CANADA GOOD PRACTICES

FINANCIAL ASSISTANCE TO CARERS

- **CANADA PENSION PLAN (CPP) DROP-OUT PROVISION** provides an exemption on the lowest earnings of up to 15% on the pension calculation. Starting in 2012, the percentage of low earnings will increase to 16%, allowing up to 7.5 years of a person's lowest earnings to be dropped from the calculation. In 2014, the percentage will increase to 17%, allowing up to 8 years of the person's lowest earnings to be dropped from the calculation.
- **CAREGIVER TAX CREDIT** is a Federal program for carers that recognize the costs associated with caregiving by reducing a claimant's overall tax burden such as the infirm tax credit, the dependent tax credit. To be eligible for the tax credit the carer must live with the dependent person.

EMPLOYMENT AND EDUCATION ISSUES

- **EMPLOYMENT INSURANCE (EI) COMPASSIONATE CARE LEAVE BENEFIT** provides more flexible work arrangements for a caregiving employee. Compassionate care benefits are available for up to a maximum of six weeks if the carer has been absent from work to provide care to a gravely ill family member at risk of dying within 26 weeks.

The income replacement rate has been established at up to 55% of the previous earnings and is taxable. To be eligible for the EI the carer must prove that his/her weekly income decreased by more than 40% and also prove that they have worked at least 600 insured hours during the last 52 weeks.

HEALTH AND WELLBEING OF THE CARER

The nature and assessment for services specific to the needs of carers varies within provinces and across the nation.

To date there has not been a uniform agreed carer assessment at a provincial level or nationally. The very limited and inconsistent gathering of data of the needs of carers on the front line is somewhat of an impediment to sound policy development.

Inevitably the lack of accurate data impacts on the degree to which services can be developed and targeted with confidence of an outcome that maintains the wellbeing of carers and in tune their ability to continue being 'a carer'. Presented below are several examples of programs aimed to provide support and relief for carers.

HOME CARE PROGRAMS

Home care programs with varying names are evident in all provinces in Canada and represent the main sources of information on Seniors' care. The centres in Ontario known as CCACs (Community Care Access Centres) were launched by the Ministry of Health and Long-Term Care in 1996 in order to help carers and older people access up-to-date and relevant information concerning their rights and the services available to them in their area. Examples of services within a home care program are:

- **IN-HOME RESPITE** is provided for family caregivers by a home support worker in the home as a way to provide respite to the carer. The need for respite is assessed by a case manager as part of the overall care assessment for the care recipient and family. The usual respite period is two to four hours once or twice per week.

In Ontario if a person is eligible for services this is coordinated by the CCAC and in-home respite is funded by the Ontario Ministry of Health and Long-Term Care. If the carer is not eligible various providers provide a fee for service.

Funded respite programs are not uniform in Canada which brings to the fore the potential for inequity in the system – those who are social or economically disadvantaged may not have the means to access essential respite services.

- **FACILITY-BASED RESPITE** is also provided in Provinces with the usual period being 30 days, although shorter periods such as weekends or 14-day periods are possible. The share of costs paid by the family for a facility-based respite bed varies widely in Ontario from \$8/day to \$147/day with most costs in the range of \$30/day or \$800/month.
- **DAY PROGRAMS** are also offered in most jurisdictions with a mix of public and voluntary sector services but are not specific to carers and care recipient. These services are often used by family members who want to or have to continue working. Day programs usually charge a small fee to cover the cost of a meal and transportation (less than \$10).

Fees may be waived if the user's income is low, or paid according to a sliding scale based on income. Day programs can be used from 1 to 5 days a week, but demand is high in most jurisdictions with frequent wait lists. High demand often limits the number of days per week that an individual client may use the program.

- **CAREGIVER BENEFIT PROGRAM** formerly known as the Caregiver Allowance was approved in Nova Scotia in 2009 and revised in 2010. The Benefit is provided to eligible caregivers to acknowledge their contributions in providing assistance to a family member or friend and to assist the caregiver in sustaining the support they provide.

The program is targeted at low income care recipients who have a high level of disability or impairment as determined by a home care assessment. If the caregiver and the care recipient both qualify for the program, the caregiver will receive the Caregiver Benefit of \$400 per month.

POLICY RESPONSES FROM OTHER COUNTRIES

AUSTRALIA.

CONTEXT – According to the Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers, Australia registered more than 2.6 million unpaid family carers in 2009. As with Canada, carers play an essential role in the functioning of the health and social care system. In 2010 it was estimated that carers saved the Australia Government more than 40.2 billion through informal caregiving.

Australia's aged care program within which carers' policy and program are embedded is managed and coordinated on a national level. There is a national caregiving strategy developed in consultation with the peak body organizations (e.g. Carers Australia) other carer-related non-governmental organizations (e.g. Alzheimer's Association) and service providers (e.g. Catholic Care). The programs are planned and delivered in the context of the carer populations in every State and Territory. The same range of services is available to every Australian citizen regardless of the State they reside.

LEGISLATION – Several specific pieces of carer legislation have been enacted at the federal level and in some States in recent years. These laws must however be viewed in the context of Acts that underpin the aged care system, namely the Aged Care Act (1997) and the Home and Community Care Act (1985).

- **THE CARER RECOGNITION ACT (2010)** formally acknowledges the valuable social and economic contribution and complements carer recognition legislation in place in some states and territories.
- **THE NATIONAL CARER STRATEGY** is a direct implementation of the Carer Recognition Act and represents a long term commitment to carers.

The Strategy aims to improve on what the Government already funds for carers and complement reforms occurring, or being considered across, the aged care, disability, mental health, primary health care, hospital and community care systems.

While the National Carer Strategy is the responsibility of the Australian Government, all state and territory governments have committed to identifying strategies and activities that complement the Strategy, or identify areas that can be worked on cooperatively.

GOOD PRACTICES

FINANCIAL ASSISTANCE

- **CARER PAYMENT** is a government grant aimed at supporting people caring for a dependent person, either a sick or disabled child, adult or a frail older person, who are unable to fulfill their professional obligations because of their caring responsibilities. The carer can work, study or train up to 25 hours a week without losing eligibility to the Carer Payment.

Respite care options are available for the carer, allowing he/she to be relieved of family care duties for up to 63 days per year without losing Carer Payment eligibility.

The Carer Payment is income and assets tested and dependent on the carer's financial situation. It may not be cumulated with another income support payment such as the Age Pension.

- **CARER ALLOWANCE** is a supplementary payment which is not income or asset tested and can be received in addition to the Carer Payment. The current rate of the Carer Allowance is \$114 AUS per fortnight. If the carer is eligible for the Carer Allowance then the person may also receive a Carer Supplement of maximum \$600 AUS per year to help meet the costs of caregiving.

HEALTH AND WELLBEING OF CARERS

- **THE NATIONAL RESPITE FOR CARERS PROGRAM (NRCP)** aims at enabling carers to take care of themselves by offering them the possibility of a break from caring. The program encourages carers to accept assistance offered in a variety of respite program (at home and external) in order to alleviate part of their caring burden.

To assist in identifying the most appropriate and available respite options a network of Commonwealth and Carelink Centres were established across Australia that provide relevant information around caregiving as well as information concerning all services available in the area such as respite care services, providing advice and offering a 24 hours emergency line. <http://www.health.gov.au/internet/main/publishing.nsf/content/ageing-carers-respcent.htm>

- **THE NATIONAL CARER COUNSELING PROGRAM (NCCP)** provides emotional and psychological support to carers through short term counseling. The program was developed in response to evidence-based research on carer stress.

High levels of stress are known to impact on a carer's personal and professional life. Feelings of guilt and exhaustion are seen to be precursors to depression or isolation. In each state and

territory the NCCP is delivered through the Network of Carer Associations (e.g. Carers Western Australia, Carers Queensland).

- **CONSUMER DIRECTED RESPITE CARE (CDRC)** provides carers with a variety of respite care options in order to choose a tailored respite approach, either for them or for the person they care for. Carers can choose from different CDRC packages, spending their individual budget of 4,200 AUS over a period of 12 months.

EMPLOYMENT AND EDUCATION ISSUES FOR CARERS

- **JOB SERVICES AUSTRALIA** is the national employment service system funded by the Australian Government. It offers tailored training opportunities, skills development or work experience to carers wishing to enter or re-enter the workforce after having cared for a relative.
- **THE FAIR WORK ACT 2009** provides the right to request flexible working arrangements for employees caring for a dependent relative or having to face an unexpected medical emergency. The carer employee is entitled 10 days of paid carer's leave for each year he / she has been working for the employer.
- **THE PENSION EDUCATION SUPPLEMENT** partially assists carers who are already receiving an income support payment to pay for their studies so as to avoid them leaving school prematurely. This grant of up to 62.40 AUS per fortnight is not asset or income tested, nor taxable.
- **THE YOUNG CARERS RESPITE AND INFORMATION SERVICES PROGRAM** supports young school aged carers to cope with their studies and their caring responsibilities at the same time, providing them with multiple respite services such as tutoring, skills development and other educational activities. Counseling services are also available.

CARING FOR SOMEONE WITH PARTICULAR NEEDS

- **THE NATIONAL DISABILITY AGREEMENT, 2009** aims at guiding the development of policies, programs and services to better meet the needs of people with disability, their families and carers. From 1 January 2009 to 30 June 2015, \$7.6 billion is being provided to state and territory governments to increase and improve specialist disability services provided under the National Disability Agreement.
- **THE SUPPORTED ACCOMMODATION INNOVATION FUND** has been developed in response to the shortage of appropriate accommodation and respite centres for people with a disability. More than 60 million dollars is to be invested in building community-based and innovative accommodations.
- **THE MENTAL HEALTH RESPITE INITIATIVE** provides a range of flexible respite and support options for carers of people with severe mental illness as well as carers of people with intellectual disability.

UNITED KINGDOM

CONTEXT – There are currently ~ 6 million people in the United Kingdom caring for someone who is disabled or chronically ill.

The United Kingdom also has a universal health system which provides free services to British citizens through the National Health Service (NHS). The NHS is funded through general taxation and is managed directly by the central government.

The Service is implemented on a local level by Strategic Health Authorities (SHA) that is responsible for providing services and for enacting the directives of the Department of Health. SHA can also discharge part of this responsibility to deliver services to non-profit or private companies.

The Department of Work and Pensions is responsible of the protection of their rights and wellbeing, either by implementing supportive and flexible employment policies, by supporting them financially through the Carers Allowance or by creating supportive services. In April 2008, the Pensions Service and the Disability and Carers Service merged as a mechanism to streamline the management of benefits for carers.

Carers UK is the non-governmental organization in the United Kingdom which is the 'voice of carers. It is an independent charity and advocate on behalf of all family carers. Through its many campaigns Carers UK and close collaboration with the government tremendous strides have been made in influencing carers policies.

LEGISLATION

- **THE CARERS (RECOGNITION AND SERVICES) ACT 1995** recognizes the legal status of carers and their rights. The ability of the carer to "provide a substantial amount of care on a regular basis" to a dependent person must be assessed by local authorities. Local authorities are required to take into account the results of that assessment in making decisions about the type and level of community care services to be provided to the person receiving care.
- **THE CARERS AND DISABLED CHILDREN ACT 2000** allows carers over 16 years of age to receive direct payments from local authorities. This provides younger carers the opportunity to personally plan and handle their caring responsibilities, giving them more freedom in their choices.
- **THE CARERS (EQUAL OPPORTUNITIES) ACT 2004** aims at offering fair access to training, work or leisure activities to carers. When assessing the needs of carers, local authorities have a legal obligation to inform carers of their rights and must consider their personal wishes concerning work, training or leisure activities. This Act facilitates the cooperation between local authorities and service providers relevant to carers.
- **THE WORK AND FAMILIES ACT 2006** amended and widened the scope of the Employment Act of 2002. Flexible working regulations which applied to working parents now applies to employees caring for a dependent or disabled person who is 18 years of age or over. The employee must have been continuously employed for more than 26 weeks and must have some relationship with the person he or she cares for.

GOOD PRACTICES

FINANCIAL ASSISTANCE

- **COUNCIL TAX BENEFIT AND HOUSING BENEFIT FOR CARERS, 1982** aimsto assist people on a low-income to pay their rent or Council tax. If the person is also eligible for the Carers' Allowance the tax and housing benefit benefits may be increased.
- **INCOME SUPPORT (1989)** scheme assists carers with nil or very low income. Depending on the personal situation and the age of the carer the income support grant can be up to £105.95 per week.
- **HEALTH AND SOCIAL CARE ACT (2001)** provides for carers to receive direct payments from the social services departments to manage their own care.

[Direct payments are cash payments given to persons entitled to social services in lieu of services that would otherwise have been arranged for them by social services departments. Social services clients are then expected to arrange their own care.]

- **CARERS' ALLOWANCE PROGRAM (2003)** provides financial assistance up to £55.55 per week for persons who provide family for at least 35 hours a week. To be eligible for the Carers' Allowance the carer has to be 16 years or over but doesn't necessarily have to live with the person he / she cares for, or even related to this person.

Carers are not eligible to receive the Carers Allowance if already in receipt of the State Pension, however, if the pension is less than the Carer's Allowance, it can be topped up to the level of Carer's Allowance. The Carers' Allowance is not means-tested but is taxable.

- **CARER PREMIUM** is an additional amount of money up to £27.15 per week receive if the carer is eligible for the Carers' Allowance and another kind of income-support such Pension Credit, income-related Employment and Support Allowance, income-based Jobseeker's Allowance, Housing Benefit or Council Tax Benefit.
- **CARER'S CREDIT** is a national insurance credit for people of working age who are caring for someone for more than 20 hours per week. It is not a cash benefit but is intended to assist carers to protect future basic State Pension and additional State Pension.

HEALTH AND WELLBEING OF CARERS

- **CARERS GRANT (1999)**- As part of the 1999 National Strategy for Carers, the Government announced the creation of a special grant for carers which was paid to local authorities 'for the enhancement of services to allow carers to take a break from caring'. The grant was worth £240m in 2009-10. [Data was not available for 2011-2012]
- **CARING WITH CONFIDENCE** is a training program dedicated to helping carers manage their caregiving responsibilities by providing financial and respite advice, counseling and improving their understanding how the care system operates. The program is available online as a free interactive learning course.
- **CARE QUALITY COMMISSION**- is established to ensure that care provided by hospitals, dentists, ambulances, care homes and services in people's own homes and elsewhere meets government standards of quality and safety.

The Care Quality Commission began operating on 1 April 2009 as the independent regulator of health and adult social care in England. It replaced three earlier commissions: the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission.

- **FIRSTSTOP** is an independent national service funded by the Department of Communities and Local Governments providing information and advice to older people and carers about housing, finance, care and rights issues. Local First Stop partnerships are developed to offer more intensive local support and advocacy services for older people and their carers.
- **COMMUNITY CARE ASSESSMENTS** are provided to carers by local authorities that have a duty to assess their needs and arrange appropriate services in response.

EMPLOYMENT AND EDUCATION ISSUES

- **CARERS EQUAL OPPORTUNITIES ACT, 2004** compels local authorities to inform carers of their rights as well as to consider their unique needs during the assessment, such as whether or not the carer wants to work, or undertake training, education or another activity.
- **JOBSEEKER'S ALLOWANCE (JSA)** supports people who are actively looking for work or those working less than 16 hours a week. The payment of up to £105.95 per week is dependent on the personal and family situation, income, savings and age. The JSA represents another financial contribution to workers who have had to reduce their working hours to fulfill caring responsibilities.
- **EMPLOYMENT AND SUPPORT ALLOWANCE (ESA) (2008)** is provided to people whose ability to work is reduced by a certain disability or sickness. The ESA can apply to caregivers suffering from health issues which are additional to their caring responsibilities.

After being assessed, the carer will receive either the employment allowance or the support allowance, depending on the recipient's medical condition. Most carers receive the employment allowance which then entitles them to undertake work-related activities, attend interviews and take part in assessments.

- **THE WORK AND FAMILIES ACT 2006** gives carers the right to request changes to their working patterns to better manage their caring responsibilities.

There are no specific employment programs for carers. However the House of Commons Public Accounts Committee in 2009 sought to improve the employment support for carers now and in the future taking into consideration the changing profile of carers.

- **JOBCENTRE PLUS** which is part of the Department of Work and Pensions supports people of working age from welfare into work and helps employers to fill their vacancies. Over a period of time the Centre noted its inability to provide necessary attention to carers returning to work. A range of measures were introduced to improve the carers' employment support including:
 - the Carers Portal, which is an on-line reference guide;
 - specialist training for Personal Advisers about carer issues such as benefits, employment support and external sources of help; and
 - an enhanced 'vacancy taking system' to identify more clearly those vacancies which offer flexible terms attractive to carers.
 - Care Partnership Managers in every Jobcentre Plus district whose role is to provide specialist advice to Personal Advisers supporting carers and to build relationships with third sector organizations in order to improve Jobcentre Plus support for carers who seek employment

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AGEING WORKFORCE

The issue of the employment of 'older workers' and the ageing workforce has featured prominently in policy documents for more than a decade. Defining what is meant by an 'older worker' however is becoming more problematic in the context of employment laws, and also financial protection including pensions and social security.

Generally speaking, researchers have tended to view people aged 50 years and over as 'older' based on a sharp decline in labor force participation rates after this age. However, it is also clear that what is defined as 'old' varies markedly between industrial sectors and occupational groups. It is also sometimes argued that women are considered by employers as 'old' at younger ages than men (Gregory, 2003). In public policy terms, measures targeting 'older workers' often tend to apply at different ages and may have cut-off ages for certain entitlements. This practice constitutes a growing trend known as 'employment discrimination based on age'.

The Stockholm target for the employment of workers defines "old" workers as being 55–64 years (European Commission, 2010). The value of the term is frequently questioned, and the risk of stigmatisation acknowledged, yet among researchers and policymakers it has been fixed as convenient yet outdated shorthand – the same could be said for the 'old age dependency ratio' which assumes that working age stops at 64 years. .

Occasionally, the term 'elderly workers' is used, but 'older workers' is usually preferred. It is increasingly recognised in western countries that greater attention needs to be paid to the process of ageing and the transitions into second and third careers as well as unpaid work which manifest in the form of volunteerism.

Policy attention and reference to ageing of the workforce has increased markedly in the last decade in many developed countries. As the consequences of demographic change have already been experienced in many European countries attention is drawn to consider the development of policies related to the sustainability of pensions, economic growth and the future labor supply. These policy responses aim at supporting the goals of longer working lives and later retirement.

The impact of demographic change and the employability of older workers do not appear to have resonated strongly with all employers or with all national policymakers. Given the trend towards the offshoring industry segments and continued pressure on immigration policy from industry, there may be value to draw the different threads together of current and future policy into a strategic and coherent vision of managing future labor supply.

Challenges either present or foreseen imminently include:

- the maintenance and promotion of the health and working capacity of workers as they age;
- the development of skills and employability of older workers; and,
- the provision of suitable working conditions as well as employment opportunities for an ageing workforce.

It is in this frame of reference that the 'ageing workforce' is one of the five current issues (and arguably also an emerging issue).

CANADA

In the face of rapid population ageing and the trend toward early retirement, there is a need to promote better employment opportunities for older people. Much has been said about the need for reform of old-age pensions and early retirement schemes, but this may not be sufficient to raise employment rates for older people or to reduce the future risk of labor shortages. Both government and business are developing active measures to adapt wage-setting practices to ageing workforces; to address the extent to which other welfare schemes act as pathways to early retirement; to respond to age discrimination; and, to improve the job skills and working conditions of older workers. The industry and legislation changes are to some degree external drivers of social change trending toward working longer and acquiring new skills across the life course.

Stats Canada (2011) reported that in 1981 six people were in paid employment per retiree and by 2031, the ratio will be three to one. The participation rate in the labor force by 2031 could be as low as it was in the 1970s, with less than 63% of Canadians over the age of 15 years at work. The unspoken words and inference in the population projections are ones of dependency, care, burden and impending doom.

The statistics are clear - Canada is 'ageing' through a number of external factors including a fertility rate below replacement levels and an increasing life expectancy. Furthermore Canada will continue to be more ethnically diverse and this will also impact on the nature of the labor force and the nature of industry.

The changing demographics pose an added challenge to all levels of governments as attempts are made to erase deficits created by global economic recession while planning for rising health costs over a period when the pool of taxpayers will grow much slower than the rise in retirees.

With the increasing numbers of older people approaching the age of retirement in Canada, as with many other industrialised countries, governments have or are considering increasing the eligible age for retirement. In January 2010 the Social and Economic Dimensions of an Aging Population (SEDAP) released a report entitled "Strengthening Fairness and Funding in the Canada Pension Plan: Is Raising the Retirement Aged and Option?" in which it stated that raising the age from 65 year to 67 years would strengthen fairness and funding in the Canada Pension Plan (CPP). While the report suggests that an increase in the age of retirement is appropriate it does not consider additional incremental adjustments, beyond the age of 67 years that may need to be considered in future years as the life expectancy of older Canadians increases further.

In Canada, life expectancy at birth increased by about 30 years in the 20th century. From 1966, when the CPP was introduced, to 2010, life expectancy has increased by about 10 years for males and 8 years for females (Denton and Spencer, 2010). For those born in the 21st century, life expectancy is estimated to be between 90 and 100 years (Oeppen and Vaupel 2002). Programs that were expected to fund people for 15 years cannot adequately support people for 25 or 30 years.

Countries that have already, or are proposing, transitions to higher eligibility ages in OECD countries include: Australia, Denmark, France, Germany, Ireland, Netherlands, Spain, United Kingdom and the United States. External and internal drivers require thoughtful examination when considering 'the ageing workforce' as a current and (arguably) an emerging issue in Canada.

Giving Canadians more opportunity to remain in the workforce longer is expected to benefit both the economy and the workers themselves. If Canadians continue to retire early, population ageing will lead to a pronounced slowdown in labor force growth and hence to weaker economic growth. There is also the human dimension - many older Canadians would prefer to remain in paid employment for longer if the necessary policies and workplace practices were in place.

The McMullin and Cooke study (2004) while being enlightening did not anticipate the changes in the world economy and the pending recession of many strong European countries already grappling with an ageing population.

Each of the issues however are still relevant today yet must be viewed in the context of a comprehensive strategy to improve employment of older workers. The strategy requires not only government policies at different levels but new social partners and social dialogue with companies as well as older workers themselves.

Older Canadians also make an important contribution to the paid economy. More than 556,000 Canadians 65 years or older were in the labor force in 2011. As demographic shifts reduce the ratio between the proportion of employed and unemployed Canadians (i.e., children and retired people), governments and some employers are also encouraging individuals to work longer. Remaining in the workforce and actively participating in civic affairs depends, in large part, on staying in good health.

The general challenges are in many respects the same:

- to provide suitable working conditions as well as employment opportunities for an ageing workforce;
- to maintain and promote the health and working capacity of workers as they age; and
- to develop the skills and employability of older workers.

The OECD series on Ageing and Employment Policies outlined the main barriers in Canada to employment facing older workers, an assessment of the adequacy and effectiveness of existing measures to overcome these barriers and policy recommendations for further action by the Canadian government, employers, trade unions and older workers themselves.

Canada is better placed to meet the challenges of population ageing, than many other OECD countries because the population is not expected to age as rapidly or as extensively as in Japan and many European countries. Past reform has strengthened to some degree the financial sustainability of public expenditures on old-age pensions. The labor market situation of older Canadians has improved considerably in recent years.

According to "Older Workers Stampede Into The Labour Market," a special report published by TD Economics, older workers have dominated the gains in the Canadian labor market in recent years. Canadians aged 60 years and over have accounted for about one-third of all net job gains since the economic recovery began in July 2009, even though they only account for 8% of the total labor force. It is suggested that some of these gains can be attributable to the fact that many older Canadians are delaying retirement and staying in the workforce longer (TD Economics, 2012).

While the arguments outlined in the OECD report are sound it is also somewhat flawed as Canada has yet to experience the equivalent population ageing as other OECD countries such as France and the economic climate is markedly different than it was in 2006. Canada was called upon in the OECD report to do more to improve employment opportunities for older Canadians whose participation rates are still

Key Issues
- An Ageing Workforce-

Immigration
Encouraging higher rates of labor market participation
Phased retirement, workplace flexibility
Life-long learning and active ageing
Seeking an age-balanced workforce

McMullin and Cooke (2004)

below the levels in several other OECD countries. A coordinated and comprehensive package of measures to encourage older workers to work longer was viewed as imperative including:

1. FLEXIBILITY IN COMBINING PENSIONS WITH WORK INCOME

Allow older workers to combine pension income with salaries by:

- Abolishing the stop-work clause in the Canadian Pension Plan (CPP)
- Reviewing the income tax and private pension systems.
- Allowing people to accumulate future pension rights

2. ADDRESSING AGE DISCRIMINATION IN THE WORKPLACE

Age discrimination exists not only in the workforce but also in trying to re-enter the workforce. If negative attitudes persist, federal and provincial/territorial governments should work with social partners and employers to champion good practices in the workplace. The United Kingdom's Age Positive campaign <http://www.dwp.gov.uk/age-positive/> and its guidelines for employers, the Code of Practice on Age Diversity in Employment are examples of what could be considered good practice.

3. STRENGTHENING AND REMODELING EMPLOYMENT SERVICES FOR THE UNEMPLOYED

- Extend eligibility of Employment Benefit and Support Measures
- Increase participation of older job seekers in employment programs
- Build upon the lessons learned from the Older Workers Pilot Projects Initiative
- Increase resources available to employment programs

In order to support older adults to succeed in the labor market, further education, career retraining and life-long learning are of crucial importance as is fostering innovation and enhancing exchange and communication between different generations.

GOVERNMENT POLICY

Older workers people who want to remain active in the workforce should have the freedom to make that choice—not have one forced on them. The “Next Phase of Canada's Economic Action Plan” introduced in 2011 is intended to change federal rules to eliminate the mandatory retirement age for federally regulated employees, unless there is an occupational requirement.

The Plan also extends the Targeted Initiative for Older Workers program until 2013–14 and ensures older workers have access to training and employment programs to help them find their new career. Training and employment programs for displaced older workers are also envisaged to help in job relocation.

TAX RELIEF

Since 2006, the Government has moved to ensure seniors are financially secure. Actions taken by the Government mean that seniors and pensioners are expected to receive about \$2.3 billion in additional targeted tax relief for the 2011–12 fiscal year.

Since 2006, the Government has:

- Increased the Age Credit amount by \$1,000 CAN in 2006, and by another \$1,000 CAN in 2009.
- Doubled the maximum amount of income eligible for the Pension Income Credit to \$2,000 CAN.
- Introduced pension income splitting.
- Increased the age limit for maturing pensions and Registered Retirement Savings Plans to 71 years of age from 69 years of age.

In 2011, a senior can earn at least \$19,064 CAN and a couple at least \$38,128 CAN before having to pay any federal income tax. Seniors are also major beneficiaries of the broad-based tax relief measures that have been introduced by the Government, such as the Tax-Free Savings Account.

PENSIONS

Pension reform is at the heart of the conversation around an ageing workforce, retirement and burdens of care. There is a body of research suggesting that many Canadians may have inadequate savings to maintain standards of living in retirement. Finance ministers have been urged to expand the Canada Pension Plan through an already existing administrative structure and framework to improve retirement benefits for working Canadians at relatively low cost.

In 2009, the Government introduced important measures to improve federally regulated private pension plans by:

- Requiring companies to fully fund pension benefits on plan termination
- Making pensions more stable
- Making it easier for members to negotiate changes to their pension arrangements
- Modernizing investment rules for pensions

Other courses of action include:

- An enhanced Guaranteed Income Supplement for more than 680,000 seniors
- An enhanced Guaranteed Income Supplement for more than 680,000 seniors
- Increased funding for the New Horizons for Seniors Program
- More freedom in deciding when to retire
- An extension of the Targeted Initiative for Older Workers.

PRIVATE PENSION OPTIONS

The federal Government, along with provincial and territorial governments are working to introduce a new kind of pension plan called the Pooled Registered Pension Plan, (PRPP) (December 2010). The PRPP is aimed at the self-employed and workers at small- and mid-sized firms, companies that often lack the mechanisms to administer a private sector plan. PRPPs is expected to improve the range of retirement savings options available to Canadians by providing a low-cost, well-regulated private sector retirement savings opportunity.

INTERNATIONAL TRENDS

Higher participation of older workers in employment is an important factor that contributes to smart, sustainable and inclusive growth. Raising the employment rate for older women and older men requires a multidimensional and integrated approach.

This necessary yet transformational change requires a systematic strategy to confront and resolve age discrimination in employment and occupation, given that ageism is an important exclusion factor for older workers on labor markets.

At the same time, investments in life-long learning initiatives, adapted to labor market needs could be of consideration in a long term strategy. Such initiatives will enable older persons to remain productive, maintain their physical and social mobility, and develop skills. In its vision the Council of Europe invited Member States to fight stereotyping of older people and older workers by developing effective communication schemes and raising awareness about the issue <http://conventions.coe.int/>.

Fundamental to sustainable change is a deeper understanding of job quality. Job quality takes into account the need to reconcile work, family and private life, and the anticipation of changes that occur with age. The ageing workforce and rising retirement age highlights the need for adequate occupational health and safety measures for all workers and the importance of promoting healthy lifestyles.

Demographic change brings with it impacts on the financing of pensions and healthcare, as well as the labor market - the ageing of the population represents an opportunity for job creation in care and personal services sectors.

Governments are being urged to anticipate an increase in demand for these services, which represents a challenge in terms of training to develop the required skills and qualifications. Working conditions in this sector such as the work environment, wages, working hours, job stability and career development are crucial factors contributing to the ability of the care and personal services sectors to attract and retain workers. Lastly, affordable access to care (e.g., healthcare for the elderly and for children) and personal services is an important factor contributing to the higher participation of older workers,

AUSTRALIA

Older Australians are being encouraged to work longer – there is a revolution in attitudes and opportunities, along with the ageing of the baby boomer.

Treasury forecasts that by 2050, Australia's ageing population will require an extra \$60 billion a year of spending, paid for by extra taxes yet Mr. David Gruen (Treasury Deputy Secretary) has estimated that the gap could close if Australia's workforce participation rates rise to match the best in the Western world.

The Australian Bureau of Census and Statistics (ABS, 2012) shows that, on average, 1.93 million workers aged 55 years and over were employed in 2011, almost double the 1.01 million employed a decade earlier.

The growth in workers in their early 60s has been massive. From 274,000 a decade ago to 634,000 now. The number of women working at that age has roughly trebled, from 90,000 to 268,000. In perhaps the most startling development, 25% of Australians aged 65 to 69 years of age are still working and more of them full-time than part-time.

Employment and participation rates are also growing among people aged 70 years and over, although at a less dramatic pace. In 2011, 102,000 people were working into their 70s, 80s or 90s – this was from 59,000 a decade earlier.

The report from Randstad's latest Global Work Monitor, surveying employees in 29 countries showed that 52% of Canadian workers anticipate working beyond the age of retirement, nearly one-half reported intent work for an additional two years beyond the official retirement age, a percentage that's even higher in the United States (59%). Just 32% of Canadian workers expected to stop working before reaching retirement age.

The fast-rising participation rates among older workers in Australia reflect changes in the economy, employer attitudes and aspirations. Three recessions in the 20 years to 1991 saw 1 million workers forced into early retirement. By contrast, with comparatively less economic upheaval in Australia and rising skills shortages since then, employers have consolidated their workforce with older workers, even in the depths of the global financial crisis.

The Australia government led by Prime Minister Keating (1991-1996) instigated a gradual reform to align the pension ages of men and women. The female pension age has been raised from 60 years to

64.5 years, rising to 65 years in 2014 which has removed an incentive for women to take early retirement.

Aspirations have risen since then. Surveys have found that people donot want to just retire on the pension, but to live well in their retirement.

POLICY DEVELOPMENT

Australia has been far from complacent in addressing the barriers to employment faced by older workers. A number of disincentives to continue working embedded in the social security system, such as the Mature Age Allowance, have been eliminated. Age discrimination legislation has been introduced at the Federal, State and Territory levels. In addition, opportunities for training for older people have improved through the expansion of the college system, as well as through several training initiatives for older job seekers.

Encouraging older workers to stay in the workforce has become a policy priority. At the same time, the life expectancy of Australians has increased dramatically over the past several decades, effectively inserting a new stage in the life course, often called the 'third age'.The removal of barriers to the continued labor force participation of mature age Australians remains an important policy priority. This priority carries significant weight when considering the demographic and labor supply futures for Australia.

Individuals, firms and all levels of government can benefit from the economic contribution of older persons through paid employment. The recent Intergenerational Report (2010) identified strengthening the labor force participation of older persons as a key priority to better manage the policy challenges presented by population ageing.

In response the Government tasked the Consultative Forum on Mature Age Participation (the Consultative Forum) to provide advice to the Australian Government on practical solutions to address the barriers to labor force participation of older Australians.

“Ageing and the barriers to labor force participation” commissioned by the Australian Government highlights not only the barriers and the context but also policy responses.

Population ageing as an issue was described in components namely numerical, structural, timing and locational which independently and interrelated pose important planning priorities for industry and government, specifically in relation to labor supply.

The specific areas that the Consultative Forum, consisting of seniors’ organisations, business, and training, and trade union representatives provided advice on were:

- employer and community attitudes toward mature age people; age-based discrimination; and
- re-skilling and career transitions for mature age people; suitability of training; and, personal barriers to

Importance of Barriers

<i>Physical Illness, injury, disability</i>	100
<i>Discrimination in employment on the basis of age</i>	87.5
<i>Issues around private recruitment firm practices</i>	87.5
<i>Mismatch of skill and experience with industry demands</i>	85.7
<i>Re-training and up-skilling barriers</i>	85.7
<i>Care-giving responsibilities</i>	85.7
<i>Flexibility of employment arrangements</i>	75
<i>Superannuation</i>	71.4
<i>Tax-transfer system</i>	71.4
<i>Re-entry of the very long-term unemployed</i>	71.4
<i>Mental Health</i>	66.7
<i>Job search assistance</i>	62.5
<i>Leisure time trade-off</i>	37.5
<i>Workplace barriers</i>	16.7

participation (health, injury and disability or care-giving responsibilities).

An understanding of the barriers preventing more mature age people from engaging economically was seen necessary to develop appropriate policy and programmatic responses, with a view to increasing their labor force participation. Research from Australia and internationally identified a number of such barriers. In the context of current and emerging trends the following barriers reported in Australia have been selected for further attention.

AGE DISCRIMINATION

Age discrimination in the workplace is being addressed in a number of ways in Australia through legislation and funded programs.

LEGISLATION

- In 2009 the Commonwealth Age Discrimination Act (2004) was strengthened to remove the 'dominant reason' test. Discrimination may now be established if a person's age is just one of the reasons (rather than 'the main reason') for a discriminatory act that causes disadvantage.
- The provisions of the Fair Work Act 2009 also provide protection against unlawful age discrimination, making it unlawful to take adverse action against an employee (or potential employee), including by choosing not to offer them employment, because of their age.
- The Australia Government appointed the first dedicated Age Discrimination Commissioner, the Hon Susan Ryan in July 2011.

PROGRAMS

THE PRODUCTIVE AGEING PACKAGE

The Productive Ageing Package (PAP) provides training and support for older Australians who want to stay in the workforce, and includes training packages for employers to allow eligible mature age workers to retrain as supervisors or trainers of young apprentices or as workplace assessors; grants for **Golden Gurus organisations** to connect mature age people who are retired, semi-retired or not working full-time with employers of trade apprentices; and face-to-face job support and training for mature-age workers with a health condition or injury which impacts on their ability to do their job.

The programs are aimed at informing mature age workers of their options to assist them to make successful career transitions, and pass on their skills and experience to other workers. Below is a sample of some of the programs in the PAP:

The EXPERIENCE+ CAREER ADVISERS PROGRAM within the Department of Human Services is a free telephone based service that provides professional, informed career advice by qualified Career Advisers to assist all mature age Australians who are 45 years and over.

- Career Advisers help identify a person's transferrable skills, explore career options and develop a plan of action to help you achieve your employment goals. The Advisor will also review résumés and provide detailed feedback and suggestions about presentations to employers.
- The program aims to help mature age people build motivation and confidence to counter ageist attitudes and to market themselves competitively to prospective employers. It also focusses on preventing mature age people from 'self-selecting' out of the labor market because they believe they will not be successful.

- **Investing in EXPERIENCE EMPLOYMENT CHARTER AND TOOL KIT** is a policy direction from the Federal Department Education, Employment and Workplace Relations.

- The Tool Kit is a one stop practical guide for employing people over 45 years of age. It provides practical help for employers to assess the demographics of their workforce, to identify and address potential skill and knowledge gaps, and to recruit and retain experience staff. The kit includes a mature age employment self-assessment tool, Action Plan template, recruitment tips and information and practical suggestions to retain mature age staff.

The complainant, aged 55, used a private employment agency to apply for a position of graduate information technologist in the large government department where he had worked for the preceding ten years.

His application was rejected, and he claimed it was due to age discrimination. According to his complaint, the employment agency had told him that he should not be applying for graduate positions.

(Complaint to Australian Human Rights Commission, 2011)

- The Kit is supported by the **INVESTING IN EXPERIENCE EMPLOYMENT CHARTER** aimed at helping employers implement positive age management practices. The Charter includes nine principles and actions that employers can use to strengthen age-management practices in the workplace.

1. We know our workforce and plan for the future
2. We recruit the best, regardless of age
3. We believe in lifelong learning and we encourage skills and knowledge transfer
4. We are proactive in retaining our staff
5. We support our employees in the transition to retirement
6. We practice age diversity
7. We provide a safe working environment
8. We involve our staff
9. We promote and share better practice

- **EXPERIENCE+ TRAINING** program provides funding to eligible employers to pay for the cost of training at the Certificate III level or above for mature age workers (aged 55 years and over) to increase the capacity of those workers to supervise or mentor an apprentice or trainee

CAREGIVING RESPONSIBILITIES

Studies show that living arrangements and caregiving responsibilities significantly impact the ability for mature age to secure and retain employment (National Seniors Productive Ageing Centre, 2011). Many women have disrupted employment plans due to child care and other caring responsibilities, and as a result have lower income and superannuation savings in retirement. Men also contribute considerably to caregiving, and often face difficulties facilitating this care by adjusting their work arrangements.

Overall, the labor force participation rate of primary carers is substantially lower than for all Australia, especially for full-time employment.

LEGISLATION -It is unlawful under the Federal Disability Discrimination Act 1992 to discriminate against a person because that person is a carer of a person with a disability.

PROGRAMS -Support services for carers include MyTime Peer Support Groups that provide peer support to assist parents and carers of young children with disability or chronic medical conditions.

- **HOME AND COMMUNITY CARE (HACC)** services can provide respite care as relief for carers. [HACC is a joint Commonwealth/State Government program which provides services to support frail older people, younger people with disabilities living at home or in the community, and their carers].
- The 2011 Budget announced \$1.2 million over four years for a **NATIONAL NETWORK OF PEER SUPPORT GROUPS FOR GRANDPARENT CARERS**. Dedicated grandparent advisers will also be established in selected Centrelink offices and this forms part of a larger National Carers Strategy.
- The **NATIONAL EMPLOYMENT STANDARDS** (introduced in 2010) allow parents or carers of a child under school age or of a child under 18 years of age with a disability to request a change in working arrangements to assist with the child's care, 10 days paid personal/carer's leave, two days unpaid carer's leave (if paid personal / carer's leave is not available), and two days paid compassionate leave per occasion.

Additional conditions to assist employees with caregiving may be provided for in awards or agreements, and sometimes in individual flexible arrangements between an employer and individual employees. For example, in the State of Victoria, employers have been required to make reasonable accommodation for staff to carry out caring responsibilities since 2008, which is enforceable.

Similar arrangements have been implemented in the United Kingdom and New Zealand; in the United Kingdom the right to request flexible working arrangements has significantly increased access to flexible working options.

PRIVATE RECRUITMENT FIRM PRACTICES

Private recruitment agencies used as intermediaries between job seekers and employers is an emerging trend. Early findings suggest that age-based discrimination is increasingly likely to be experienced at the earlier recruitment stage. Studies have found that some agencies are reluctant to accept older workers as clients or recommend them to employers. This appears especially prevalent within the Information and Communications Technology (ICT) industry.

"In particular, we need to ensure that working conditions and the quality of work is such that the people are not worn out by their jobs and forced to quit early.

And we have to ensure that their skills are kept constantly up-to-date, over the life cycle. In these terms, the way in which periods of work, leisure, learning and caring are distributed over the life cycle should be rethought by policymakers. People should have some freedom, for instance, to take longer holidays in exchange for later retirement."

(Quintin, 2001)

LEGISLATION - While the Government is not party to commercial arrangements between private recruitment agencies and employers' recruitment, companies are required to comply with all relevant Commonwealth and state and territory laws, including age discrimination legislation.

There are a number of private (non-government funded) recruitment firms that specialise in assisting mature age people (for example, olderworkers.com, DOME, SilverTemp, BeNext, Grey Hair Alchemy, 40plus, Adage). These are promoted on the Experience+ website.

Members of the Recruitment and Consulting Services Association (RCSA), a leading industry and professional body for the recruitment and human resource services sector, are required to comply with a code of practice that includes not jeopardise a candidate's engagement or interfere in work relationships.

The Australian Human Resources Institute (AHRI) is the national association representing human resource and people management professionals. Members are required to comply with a code of ethics and professional conduct. Members of the AHRI must act lawfully and foster equal opportunity and non-discrimination. This will include seeking to establish and maintain fair, reasonable and equitable standards of treatment of individuals.

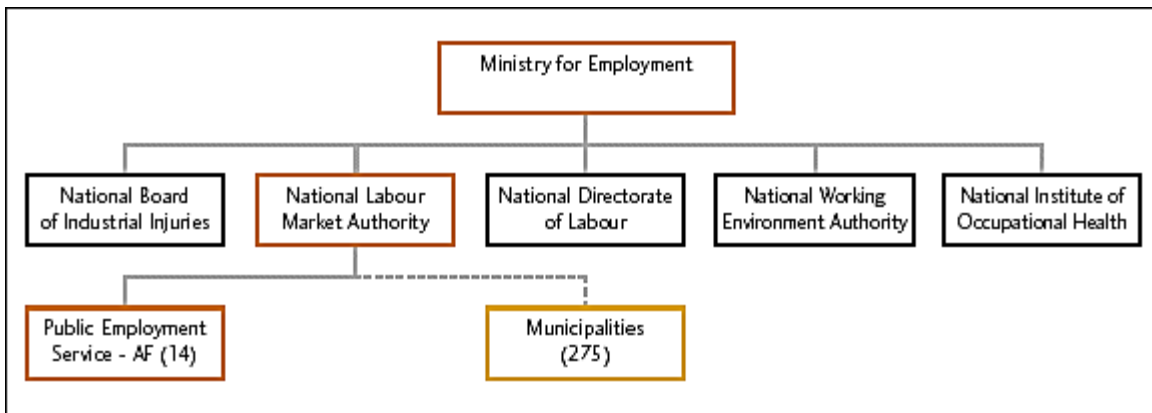
The prolongation of working life can be seen as an appropriate answer to the age/employment paradox if it is complemented by a policy of promoting the employability of the ageing workforce. As Ms. Odile Quintin (Director-General for Employment and Social Affairs, European Commission) stated “The aim must be to share the gains in life expectancy between the employment and retirement phases of life -- a realistic option as people are, on average, healthier and fitter at 65 years of age than they were 40 years ago.”

DENMARK

As a result of population ageing, Denmark faces a risk of slower economic growth, labor shortages and rising public expenditures that would be financed either by significantly higher taxes on a smaller number of workers or by substantial cuts in social security benefits. Responsibility for employment and labour market policy is devolved across several portfolios and to the Municipalities (see figure below).

The proportion of the population in Denmark aged 65 years and over is expected to rise from 24% in 2004 to 40% in 2035. While the number of those in this sub population is projected to increase by 50% over the next three decades, the size of the labor force could fall by as much as 10%, or close to 300,000 people (compared with an increase of almost 450,000 or 22%, over the past three decades).

In some respects, Denmark is relatively well placed to meet these challenges. Population ageing is occurring less rapidly than in many other OECD countries. This phenomenon partly reflects a relatively slower increase in longevity but also somewhat higher fertility rates. Labor market participation rates of women and men (aged 50 years -64 years) are, respectively, the 4th and 9th highest in the OECD area.



Despite this favorable position, age-related public spending already accounts for almost 30% of GDP (the highest in the European Union). It remains essential to encourage cohorts of older people to remain in the work force.

LEGISLATION

- In 1999, major reform of the **VOLUNTARY EARLY RETIREMENT PENSION (VERP)** was adopted. Since then a tax-free bonus of up to DKK 122,000 has been made available for individuals continuing in employment after the age of 62, while VERP benefit levels have been reduced by around 10% for the age group 60-62 years. A higher contribution rate to the VERP has also been introduced, and the minimum contribution record for benefit entitlement has been increased from 20 to 25 years. Even with these marked changes, the system is far from being actuarially neutral; it still represents a significant incentive to retire early.
- A new **DISABILITY PENSION SCHEME** came into force in January 2003. A disability pension can now only be granted on a full-time basis to people with a permanently reduced working capacity who are neither able to become self-supporting by working part-time nor in a subsidized job (i.e. a “flexjob”). Under the old rules, benefits were often awarded to people aged 50 years and over on less strict medical grounds.
- In 2006 the Danish government brought about an unusual welfare reform. It increased the **PENSION AGE** from 65 years to 67 years between 2024 and 2027, with the age for early retirement rising from 60 years to 62 years between 2019 and 2022. This reform means that people who are now under 50 years of age will not be able to qualify for an early retirement until they are 62 years. Similarly, they will also not be able to claim a state pension until they turn 67 years.

Furthermore, from 2025, the age limits in the retirement system will be indexed to the mean life expectancy of 60 year olds. This means that the average length of time that people spend on early retirement and public pension will be around 19 years. If life expectancy does not change, the early retirement age will stay at 62 years and the pension age at 67.

IMPROVING THE RETENTION AND HIRING OF OLDER WORKERS

The **CONFEDERATION OF DANISH EMPLOYERS** and **DANISH CONFEDERATION OF TRADE UNIONS** agreed that for many older people being part of the ordinary labor market is perfectly reconcilable with maintaining a high quality of life.

Several measures have been taken by both the government and social partners to encourage greater retention and hiring of older workers. For example,

- The Confederation of Danish Trade Union (LO) launched a project to promote senior policies (i.e. work practices that ensure adequate work arrangements for older workers). The National Labor Market Authority (AMS) also supports employers with senior policies by providing free consultancy assistance.
- In January 2012 Denmark launched the European Year of Active Ageing and Solidarity between Generations and focused its message on the importance of ending stereotypical perceptions of older people and promoting initiatives helping them to age healthy and actively.

Government agencies are encouraging older workers to remain in employment through special part-time work arrangements and improved working-time flexibility. For example, civil servants over 62 years old are offered one day off per month without any cut in pay or pension entitlements.

PROMOTING THE EMPLOYABILITY OF OLDER WORKERS

Recent measures to promote employability are aimed at all workers, but would help older workers as well, for example:

- The package **MORE PEOPLE IN WORK**, which came into force in July 2003, has reduced the number of labor market programs and developed a more focused approach, including: guidance and support for improving qualifications; job training programs or internships; and wage subsidies.
 - The package is intended to increase the re-employment chances of unemployed persons and promote labor market participation.
 - Within the first year of unemployment, job seekers are provided with an individual action plan as well as an opportunity to participate in an activation program. For unemployed persons older than 60 years (as well as younger), these measures will be available after an unemployment spell duration of six months.
- In addition, the Danish government, together with the social partners, introduced in January 2004 a **NEW ADULT VOCATIONAL TRAINING SYSTEM**. (<http://www.eng.uvm.dk/Education/Adult-Education-and-Continuing-Training/Adult-vocational-training-in-Denmark>)
 - An important aim of this measure is to make training more responsive to labor demand, while also improving coherence with initial vocational education and training.
 - To further enhance training opportunities for older workers, the government raised the upper age limit for obtaining a state grant for adult education from 59 to 64 years.
 - Since the 2004 collective agreements, all employees who are dismissed due to enterprise-related circumstances should be entitled to participate in relevant training courses of up to two week's duration. This training should take place during the period of the dismissal and expenses should be covered at least partly by the employer.

The National Labor Market Authority has introduced a project through which unemployed people aged 50 or older can form local senior networks with the aim of obtaining ordinary employment faster. Currently, there are 25 such networks operating throughout Denmark, each of which receives a yearly subsidy of around EUR\$27,000 intended to cover the costs of different activities to promote employment chances. (<http://www.ams.dk/Ams/English.aspx>)

FRANCE

France, like other OECD countries, faces the challenge of an ageing population. By 2050, the population aged over 65 years could rise to 58% of the population aged 20 to 64 years, double the current percentage. If labor market behaviour remains unchanged, France's labor force begins to shrink and age significantly from 2010.

In response to this demographic challenge, France's 2003 pension reform gave priority to extending people's working lives in order to finance pensions in the long term. However, the risk on raising employment levels among older people is not certain to deliver the required outcome. At present less than 50% of all wage-earners go from employment into retirement; for the remainder, pathways include various early retirement schemes, unemployment or, to a lesser extent, invalidity with a very low probability to go back to work. The average age of workers exiting the labor force is low in France in relation to other countries and has plummeted over the last 40 years.

Employment rates for those over 50 years of age are also low in France relative to other OECD countries, especially among less-skilled workers. Endeavouring to improve the employment rates among older people is even more difficult as overall unemployment is ~10%. Past policies which encouraged older workers out of the labor market has however not created much needed job opportunities in other age groups. International experience shows that any policy that seeks to increase employment among older people will be more likely to succeed in a favourable economic environment conducive to a more vigorous labor market.

Policy development and legislative changes in France is a slow and laborious process as it requires a general shift in attitudinal perceptions and practices with regard to age in addition to preparing wage-earners for the prospect of working longer. OECD recommendations are only elements of an overall strategy with four mutually supportive main thrusts:

- Better mobilising the players on the ground
- Promoting employment for older people and offering them greater choice when they take retirement
- Removing obstacles to continuing employment and recruitment after the age of 50
- Promoting the *employability of workers*

Decades of early retirement has resulted in a self-fulfilling prophecy regarding the attitudes, aspirations and motivations of older workers. A general lack of investment in older workers has resulted in a lack of job opportunities and an orientation towards early retirement. An 'early retirement' mindset prevalent among management, trade unions, and older workers has also resulted in alternatives not often being considered.

Tackling this set of issues alongside pension reform is the responsibility of each stakeholder group. Success is conditional on co-responsibility. However, as shown, the behaviour of managers and older workers is strongly shaped by public policy. Cultural change is expected to emerge as governments set out a fresh map of working lives; however as demonstrated, it is a highly contentious conversation that affects the livelihoods of the current workforce and generations after.

Organisational policy now goes beyond the narrow confines of older workers and moving towards life course perspectives. It includes lifelong learning, career management and long-term workforce planning. It raises important questions about the ability of social policy to support such a development. The national overviews point to some progress in this regard.

A narrow focus on issues associated with the employment of older workers will serve neither the needs of industry nor employees.

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HEALTH CARE SUSTAINABILITY

Health care services represent a high and growing share of government spending and total age-related expenditure. The rate a nation is ageing may almost necessitate additional government expenditure which then puts the issue of public spending on health care and long-term care at the centre of the debates on the long-term sustainability of public finances.

Public expenditure on health care is determined by a complex set of demand and supply side factors including:

- the population size, age and, more importantly, population health status
- economic growth and development (national income)
- new technologies and medical progress
- the organisation, financing and delivery of the health care services (institutional features of the health system)
- health care resource inputs, both human and capital

A further set of interrelated factors are also considered in light of the growing costs of long term care whether it is from the 'health funding bucket', the 'age care funding bucket' as in the case in Australia or spread across a number of different portfolios as is the case in Sweden . These include:

- the population projections of older people;
- the population projections of dependent older people (changes to the prevalence rates of dependency);
- the balance between formal and family care provision (assuming a given shift in demand or changes in the availability of family carers);
- the balance between home care and institutional care within the formal care system; and
- the unit costs of care.

The scenarios in calculating the cost effectiveness and sustainability of various models of health care and social care is highly complex but worthy of further exploration in a Joint Report prepared by the European Commission (DG ECFIN) and the Economic Policy Committee (AWG) entitled such as The 2012 Ageing Report (2011).

Canadians are generally concerned about the nation's health care system whether it is from the perspective of its universality or its sustainability. The debate over whether the healthcare system is sustainable or not is entwined with opposing positions on how healthcare should be paid for and by whom should it be delivered (Stuart and Adam, 2007).

Rather than dwell on describing ideological positions which ultimately must be considered within a framework that deals ethically with the issue of sustainability, the focus of this paper will be on the impact non-communicable diseases (NCD) has on current and future systems of health and care. This focus has been selected after reviewing evidence based reports of the United Nations and World Health Organization, global trends and most recently the focus of the European Union.

According to the World Health Organization (WHO), in 2008, an estimated 36 million of the 57 million global deaths were due to non-communicable diseases (NCDs) principally cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, including ~ 9 million before the age of 60 years and during the most productive period of life. Notwithstanding the fact that these diseases are reaching epidemic proportion each can be significantly reduced through reduction of risk factors, early detection and timely treatments. A population wide approach is viewed by public health experts as insufficient if

not complemented by healthcare interventions for individuals who either already have a NCD or those who are at high risk, namely older people.

The socio-economic impact of NCDs is staggering particularly when one considers the link between inequalities and NCDs. Socio-economic inequalities lead to NCDs and health inequalities in turn lead to impoverishment, loss of work and other forms of inequity.

New data has been released that estimates that NCDs exert the equivalent of a 4% tax on economic output in low and middle income countries (WHO, 2011). Because of the magnitude of the illness, the disabilities and premature deaths they cause and the long-term care required, NCDs reduce productivity and increase health-care costs, thereby weakening national economic development. Health spending to control NCDs outpaces economic growth.

Health systems are historically shaped around acute care and are therefore relatively inadequate when dealing with NCDs, which require chronic care. The long-term nature of many NCDs demands a comprehensive multi-system response that brings together a trained workforce with appropriate skills, affordable technologies, reliable supplies of medicines, referral systems and empowerment of people for self-care, all, over a sustained period of time.

For overall health-system strengthening national health programs should be based on sound situation analyses and a clear understanding of national health priorities.

The delivery of effective NCD interventions is largely determined by the capacity of healthcare systems. Gaps in the provision of essential services for NCDs often results in high rates of complications such as heart attacks, strokes, renal disease, blindness, peripheral vascular diseases, amputations, and the late presentation of cancers. This can also mean larger than expected spending on healthcare and impoverishment for low income families.

While the magnitude of the NCD epidemic has been rising in recent years, so has the knowledge and understanding of its control and prevention. Evidence shows that NCDs are to a great extent preventable. Countries can reverse the advance of these diseases and achieve quick gains if appropriate actions are taken in the three components of national NCD programs: surveillance, prevention, and health care. Improvements in country capacity are particularly needed in the areas of funding, health information, health workforce, basic technologies, essential medicines, and multi sectoral partnerships.

If the assumption is made that there is (or will be) an epidemic of NCDs in Canada as a consequence of population ageing then it would seem reasonable this socioeconomic burden could substantially impact the degree to which healthcare can be sustainable. Webster (2011) in a commentary in the Canadian Medical Association Journal suggested that Canada may not be leading the way in a global strategy against NCDs.

All age groups and all regions are affected by NCDs. NCDs are often associated with older age groups and account for an enormous burden—to individuals, their families, to the health care system and to the nation's economy.

Many Canadian seniors are living with chronic conditions. Almost 90% seniors aged 65 and over have at least one chronic disease or condition with the top three causes of death being cardiovascular disease, cancer, and respiratory disease; and one-quarter of seniors are living with two or more of these diseases or conditions.

The majority of hospitalizations, disability and premature death in Canada are related to chronic disease and injuries. Chronic diseases cost the Canadian economy \$190-billion annually for medical treatment and for large scale loss of productivity (Smith, 2011)

CANADA

The definition and measurement of sustainability is important because it defines the scope of the policy problem and what the eventual solutions may be. A publicly funded health system with spending that grows at a rate that is equal or less than economic growth and/or tax revenue growth may be fiscally sustainable from a strict financial point of view, but not if it is delivering a standard of service that is unacceptable to the public and/or that negatively affects economic growth/competitiveness.

Fiscal sustainability therefore refers to the extent to which spending growth matches growth in measures of a society's resource base.

The fiscal sustainability of the publicly funded healthcare system in Canada is a tireless policy issue. Recent estimates by the Canadian Institute for Health Information (CIHI) put total nominal healthcare spending in Canada in 2010 at \$191.6 billion, reflecting an annual nominal growth rate of 5.2% in 2010. Since 1975, real per capita government health spending in Canada has risen at an average annual rate of 2.3%, in excess of the growth in real per capita GDP, government revenues, federal transfers and total government expenditures.

Di Matteo and Di Matteo (2012) in a report on healthcare financial sustainability, innovation and transformation commissioned by the Canadian Health Services Research Foundation (CHSRF) concluded that public healthcare spending cannot continue to grow faster than the resource base.

Potential policy solutions to make public healthcare spending more sustainable include controlling and restructuring expenditure, raising additional tax revenues, creating a federal health tax to generate revenues for a national health endowment fund, and allowing for a greater private role in healthcare spending. Despite these potential solutions none could be expected to resolve the issue of sustainability independently given the diversity of health spending and health systems across the Canadian federation.

GLOBAL AGING PREPAREDNESS INDEX

Sustainability can be considered not only through fiscal sustainability but also income adequacy. The Global Aging Preparedness Index (or GAP Index) (CSIS, 2010) was developed by the Centre for Strategic and International Studies for the purpose of providing a comprehensive assessment of the progress that countries are making in preparing for global ageing, and particularly the 'old-age dependency' dimension of the challenge.

Canada is one of the twenty countries examined through the lens of the GAP Index in addition to most major developed countries and a selection of economically important emerging markets including India Brazil and China. The GAP Index consists of two separate sub-indices -- the "fiscal sustainability index" and the "income adequacy index." The Index analysis revealed that most countries are more successful on one dimension of ageing preparedness than the other. This finding may suggest that retirement policies often entail a trade-off between fiscal sustainability and income adequacy.

Two strategies are of special importance—extending work lives and increasing funded pension savings—since they appear to at least mitigate the trade-off between fiscal sustainability and income adequacy and offer the best means for ageing societies to maintain the living standard of older people without imposing a steeply rising burden on the younger generations.

Contrary to what could be expected the Gap Index revealed that pensions and other cash benefits—not health benefits—account for most of the total projected old-age spending burden in 2040 in most countries. In Canada, Mexico and the United States the burden associated with health costs was more than 50% of the projected old-age spending burden. There is undoubtedly a complex set of variables and relationships that realize such an outcome. It could also be suggested that the disproportionate

share of health care costs in the projected growth of total old-age benefit spending is associated with inefficiencies in the planning, coordination and evaluation of the systems that form the continuum of care.

The more important story, however, may be told by the trend indicator. The median income trend indicator is negative in more countries than the total income trend indicator and the projected declines are also larger. In eight countries—Canada, Chile, China, Korea, Japan, Italy, France, and Mexico—median elderly income is projected to fall by more than 10% relative to non-elderly income. This projection should be of immense interest to Canadians and all levels of government as it directly affects the ability of citizens to pay for care and support services.

Low elderly poverty rates in most continental European countries reflect overall low levels of income inequality as well as the generous minimum public pension benefits and other cash support. Among the other fully developed economies in the Index, Canada has an elderly poverty rate under 10%. The rates are much higher in the other Anglo-Saxon countries and in Japan - just over 15% in the United Kingdom and just over 20% in Australia, Japan, and the United States. The higher poverty rates in these countries suggest a higher degree of income inequality and less generous public old-age poverty floors.

Countries that are able to leverage immigration effectively enjoy important demographic and economic advantages. It has been suggested (Reiz, 2007) that given the low fertility rate in Canada and the ageing of the population, immigration will be the primary source of labor force growth in the future. Without immigration, Canada's demographic future would resemble Germany; with immigration, it looks more like Sweden. At the same time, it is important to recognize that immigration is a strategy with limitations. Some countries are culturally and economically better prepared to assimilate migrants than others. Arresting the ageing trend in today's fastest ageing countries, moreover, would require vast increases in immigration over today's levels.—and it is not the solution.

Older worker participation rates have also begun to rise in many countries, with especially large increases in some continental European countries long known for generous early retirement benefits. The lesson of the GAP Index is not that governments are doing nothing to respond to the challenge of global ageing, but that they are not yet doing enough and this will affect the degree to which healthcare can be sustainable.

CANADA'S STATEMENT TO THE UNITED NATIONS on the occasion of the 5 year review of the Madrid International Plan of Action on Ageing (MIPAA) emphasized its efforts to better understand the implications of the ageing population on health and long-term care needs and costs (2002). Three issues were addressed within the section on 'Action on Health and Wellbeing' namely falls prevention, disabilities and emergency response and preparedness. NCDs were not discussed.

In 2009 the **SPECIAL SENATE COMMITTEE ON AGING FINAL REPORT**, entitled Canada's Aging Population: Seizing the Opportunity the issue of a sustainable health care system was implicit yet the chronic conditions and the consequences on families and the broader community were not explored.

This is neither a criticism of the Senate Report or the Statement to the United Nations but moreover an observation that the fundamental elements giving rise to the conversation about health care sustainability do not appear to be a cross cutting topic of conversation in the development of future policy. Neither is this wrong however the approach of joined up government (Bogdanor, 2005) which seeks to coordinate the development and implementation of policies across government departments and agencies especially with the aim of addressing complex social problems has in some countries been successful in responding to the social and economic impact of NCDs.

In 2010 the Canadian Nursing Association (CNA) in a fact sheet noted the consequences of population ageing, the social and economic impact of chronic conditions associated non-communicable diseases and a healthcare system and workforce which were being forced to examine trade-offs and good practice.

In May 2011 the CNA launched a **NATIONAL EXPERT COMMISSION** “to take a hard look at how the practice, experience, knowledge and research expertise of the nursing profession can guide and inform policy decisions about the future shape and sustainability of the health care system. “

It is laudable that the CNA’s Commission’s recommendations will target innovations and solutions beyond acute care that fall within a broad primary health-care framework – particularly as they relate to healthy ageing across the lifespan, health promotion, illness/injury prevention and management of non-communicable diseases. However the apparent absence of a government voice over the period of the Commission’s work is a stark reminder of the sometimes incoherent manner in which disciplines, sectors and levels of government operate. The report will be publically available in June 2012.

CANADA’S RESPONSE TO NON-COMMUNICABLE DISEASES

The WHO NCD Summit to shape the international agenda in Geneva 2011 focused on four NCDs (cancer, cardiovascular disease, chronic obstructive airways disease and diabetes) and five risk factors (tobacco use, unhealthy diet, harmful use of alcohol, and physical inactivity).

A further range of other non-communicable diseases and conditions linked with NCDs were a focus of attention in the final report namely mental and neurological disorders, including Alzheimer’s disease, and renal, oral and eye diseases which pose a major health burden share common risk factors and can benefit from common responses to non-communicable diseases.

Healthcare sustainability cannot be separated from the social determinants of active or healthy ageing. As with other priority health issues prevailing social and economic conditions influence people’s exposure and vulnerability to NCDs as well as related health outcomes and consequences.

TOBACCO

Increasing NCD levels are being influenced by many factors including the use of **TOBACCO** as well as the cost and marketing of foods high in fat, salt and sugar.

TOBACCO CONTROL PROGRAMS remain a public health priority in Canada with the best strategies through tobacco control tax and price interventions providing information about the dangers of using tobacco products (with packaging health warnings being a simple and cost-effective intervention); promoting smoke-free environments; and banning advertising, promotion and sponsorship; followed by treating tobacco dependence. Smoking prevalence was highest in the 20-24 year age group and substantial differences in prevalence by education level persisted (Reid, Hammond, Burkhalter and Ahmed, 2012).

The Federal Control Strategy due to be completed in March 2011 had ambitious objectives. Several areas of focus remain at the present time namely, highest moking prevalence in the 20-24 year age group and substantial differences in prevalence by education level persisted (Reid, Hammond, Burkhalter and Ahmed, 2012).

INSUFFICIENT ACTIVITY

Approximately 3.2 million people die each year due to physical inactivity (WHO, 2011). People who are insufficiently physically active have a 20% to 30% increased risk of all-cause mortality. Regular physical activity reduces the risk of cardiovascular disease including high blood pressure, diabetes, breast and

colon cancer, and depression. Insufficient physical activity is highest in high-income countries such as Canada and the United States.

OBESITY has taken center stage as a major risk factor for chronic diseases. Obesity is one of the most significant contributing factors to many chronic conditions, including heart disease, hypertension, and type 2 diabetes—type 2 diabetes accounts for 85% to 95% of all diabetes cases in high-income countries.

The share of overweight or obese Canadians continues to increase with almost two-thirds of Canadians considered to be either overweight or obese in 2008, and 24% were considered to be obese. Particularly troubling is the growing share of children who are overweight. More than one in four Canadian children are considered overweight—a share that is higher than the OECD average.

Lifestyle choices such as physical activity and diet affect health outcomes and therein impact the health care system. Canadians do not appear to be moved to action on evidence suggesting that one-third of cancers could be prevented with increased vegetable and fruit consumption, increased physical activity, and maintenance of a healthy body weight.

Recent data from the Public Health Agency of Canada (PHAC) is of concern.

- On the basis of measured height and weight more than one in four adults in Canada is obese.
- Self-reported obesity is lower (17.4%) than measured estimates, but both show increases since the late 1970s.
- Significant increases in self-reported obesity have also been reported between 2003 and 2008.
- Obesity is more prevalent in older age groups, up to approximately 65 years.
- Obesity tends to be more prevalent among males than females; however, this depends to some extent on the age group and whether obesity is self-reported or measured.

A comprehensive, multi-sectorial response and investment to lifestyle choices is necessary not only to reverse the rising prevalence of obesity in Canada but to underpin critical social and economic drivers. One should not see the lower prevalence of obesity in people over the age of 65 years of age as a success but rather as a function of broader social issues.

HARMFUL USE OF ALCOHOL

Approximately 2.3 million die each year from the harmful use of alcohol, accounting for about 3.8% of all deaths in the world. More than one-half of these deaths occur from NCDs including cancers, cardiovascular disease and liver cirrhosis as well as the less associated incidence of falls. Studies in high income countries show older people in general to be less likely than younger people to consume alcohol however there is a strong link between alcohol and elder abuse. In general there is a dearth of information on effective primary prevention of alcohol related elder abuse and only a limited understanding of secondary and treatment interventions.

- Individuals with alcohol problems may be financial dependent on relative including older people which may financial and material coercion to support the dependency.
- Some caregivers who consume excessive amounts of alcohol may neglect caregiving responsibilities
- Impaired judgement and memory through harmful use of alcohol may leave older people more vulnerable
- Abused older people may use alcohol as a means of coping with abuse or neglect

CONSEQUENCES OF AN UNHEALTHY DIET

Adequate consumption of fruit and vegetables reduces the risk for cardiovascular diseases, stomach cancer and colorectal cancer. Most populations consume much higher levels of salt than recommended by WHO for disease prevention; high salt consumption is an important determinant of high blood pressure and cardiovascular risk. High consumption of saturated fats and trans-fatty acids is linked to heart disease.

Federal and provincial policies support and endorse 'healthy living and seniors' (PHAC, 2010). Targeted programs and information incorporating healthy eating, food safety, physical activity, cessation of smoking, oral health and vision care and centre to public health messages nationally and provincially.

There are several sub-populations of older people that have received less attention in the public health messaging. For example seniors who are homeless (Power, 2008), seniors who are asset rich (i.e. own their home) but cash poor and may therefore be predisposed to a poor diet and malnutrition. Lipski (2008) reported that when arriving for admission to hospital 80% of elderly patients are malnourished or "at risk" but their hospital stay could be halved by implementing a nutritional care program. Malnutrition worsens the outcomes of chronic diseases, dramatically increases morbidity and mortality, is associated with fractured neck of femur and increases overall healthcare costs and premature to long term care facilities.

Clinical and epidemiological data shows that proper nutrition plays an important role in maintaining health and combating the danger of developing some chronic diseases in the elderly population. Nutrition is an important factor in many physiological and pathological changes that accompany the aging process.

Ramic, Pranjic, Batic-Mujanovic, Karic, Alibasic and Alic (2011) studied differences in the nutritional status of elderly people living alone compared to those who live in family surroundings. Due to various factors, older people were a potentially vulnerable group at risk of malnutrition. Loneliness, isolation from society and neglect of parents by children were viewed as predictor to the risk of malnutrition and anorexia nervosa in the older population.

CARDIOVASCULAR EVENTS

Evidence from high-income countries shows that a comprehensive focus on prevention and improved treatment following cardiovascular events has led to dramatic declines in mortality rates; and this has been the case in Canada. The Canadian Heart Health Strategy is a corner stone to the national strategy linked to various provincial strategies such as the British Columbia BC Guildines.ca intervention funded by the Ministry of Health.

CANCER

Age is the single biggest risk factor for cancer – the older you are, the more likely you are to develop cancer. Nearly two-thirds of all cases of cancer diagnosed in the United Kingdom occur in people over 65 years old. This is because the longer we live, the more cancer-causing faults we accumulate in our DNA.

Advances in public health and the prevention of infectious diseases have improved our life expectancy and also the probability of a diagnosis of cancer.

Although cancer mortality rates have fallen, cancer will continue to place an increasing burden on Canadian society and the health care system in the future. Like other developed countries the number of new cancer cases is rising as the Canadian population grows and ages. Lung cancer remains the leading cause of cancer death for both men and women in Canada. The most prevalent form of cancer

among men is prostate cancer, and, for women, breast cancer incidence is nearly double lung cancer incidence.

Progress in cancer treatment combined with early detection and screening interventions have improved survival rates for many cancers in high-income countries. A combination of population-wide and individual interventions can reproduce successes in many more countries through cost-effective initiatives that strengthen overall health systems.

ALZHEIMER'S DISEASE

The Political declaration of the High-level Meeting of the UN General Assembly on the Prevention and Control of NCDs (United Nations, 2011) made particular mention of the challenge of epidemic proportions that Alzheimer's disease posed globally.

The World Alzheimer Report 2010 reported the total estimated global costs of dementia were US\$604 billion in 2010 with 70% of the costs in Western Europe and North America. Costs were attributed to informal care (unpaid care provided by family and others), direct costs of social care (provided by community care professionals, and in residential home settings) and the direct costs of medical care (the costs of treating dementia and other conditions in primary and secondary care).

Data on the direct costs of dementia is relatively limited. Canadian data which is readily available appears to be somewhat subjective or more than a decade old (Ostbye and Crosse, 1994). Furthermore there appear few reliable estimates of the proportion of people with dementia living in facilities, as opposed to their own homes in the community. Estimates for the United Kingdom vary between 35% - 50% while for Canada the estimate was 45% -50% which equates to a high risk situation not only for families but also the burgeoning health care costs.

The Alzheimer Society of Canada has estimated a total national societal cost of 14.9 billion Canadian dollars (US\$14.1 billion) for 2008, arising from 481,000 people with dementia, with a tenfold increase, to 153 billion over the thirty years to 2038. In Australia the costs are somewhat similar with the exception of findings reported by Australian Institute of Health and Welfare (AIHW) that computed lower costs, based upon a smaller estimated number of people with dementia, and using a net costs approach.

As has been widely studied and reported Canada's health care system appears unprepared for the unprecedented increase in the prevalence of Alzheimer's disease. The report "The Rising Tide" produced by the Alzheimer Society of Canada called for a national action plan to match those evident for other NCDs such as cancer, heart disease and mental health.

While it is not appropriate to ask why Canada does or does not have a National Dementia Strategy it is clear that increasing prevalence of Canadians with dementia and the associated social and economic consequences cannot be left out of the dialogue when trying to understand whether or not health care sustainability is attainable in Canada. It may be useful to examine the nature and focus of several national strategies on dementia, examples outlined below.

INTERNATIONAL STRATEGIES

UNITED KINGDOM

LIVING WELL WITH DEMENTIA: A NATIONAL DEMENTIA STRATEGY: PUTTING PEOPLE FIRST is the Governmental plan for improving health and social care services in England for everyone with dementia and their carers from 2009 - 2014.

There are 17 objectives each with corresponding measurable outcomes ranging from raising awareness to effective national and regional support for local services to help them develop and carry out the national strategy.

NEW ZEALAND

MAKING LIFE BETTER FOR ALL PEOPLE LIVING WITH DEMENTIA is the National Dementia Strategy and action plan to ensure the needs of people with dementia are recognised and supported.

Dementia is a national health priority recognised through a five year plan that addresses eight objectives including an appropriate workforce, research, family support, accessible and affordable medications to name a few.

SCOTLAND

The Scottish Government and its partners in local government, and the voluntary and private sectors are committed to delivering world-class dementia services in Scotland through six main objectives.

The objectives include developing and implementing standards of care for dementia; to enable them to have better access to information and support; and improving staff skills and knowledge in both health and social care settings. A report on progress is expected in 2012.

The cost of providing healthcare is increasing globally, proving unsustainable for lower income countries and many higher income countries. Numerous studies are examining innovative ways to deliver essential healthcare at lower cost while maintaining or improving effectiveness and safety.

For example the George Centre for Healthcare Innovation, Oxford Martin School, University of Oxford, England convened a leading healthcare innovation conference in March 2010 bringing together the leading thinkers and academics in Europe to grapple with the issue of innovation and sustainability. While the argument can be made that all health care systems are structured and funded differently one indisputable fact is that each government is trying to understand how the health care system can be robust and effective to respond to the unprecedented numbers of older people.

The degree to which Canada's health care system will be sustainable is a complex multidimensional and multi-sectorial issue. Evidence from several more advanced 'ageing countries' (e.g. United Kingdom) and Scandinavian countries (e.g. Denmark) known for the focus on healthy lifestyle suggests that the consequences of the epidemic of NCDs in Canada will have a crippling effect on the health care system and moreover the economy.

Reforms, based on strengthening the capacity of primary health care, and improvements in health-system performance seem to be a promising effective strategy to improve NCD control outcomes, ensure early detection and care using cost-effective and sustainable health-care interventions across the life course.

According to The Conference Board of Canada the nation ranks "middle-of-the-road" in health care systems globally. Universal access to health care services, highly skilled and committed health care professionals, and internationally recognized health care and research institutions is an achievement. However the Canadian system also has challenges including limited availability of comprehensive health information systems, wait times for some health care diagnostics and treatments, and management systems that do not focus enough on the quality of health outcomes (Conference Board of Canada, 2007).

Given the rising rates of chronic diseases and the impact that lifestyle choices have on these diseases, active participation of citizens in setting their own health goals and management plans is more relevant than ever before. Greater emphasis on evidence-based approaches, greater use of collaborative inter-professional care, and increased self-management hold great promise for Canada's health care system in the future.

A model that focuses on sound primary care practices and population health approaches—particularly preventing and managing chronic diseases may warrant consideration as a response to the increasing health care expenditure.

Targets set by governments in the Public Health Agency of Canada's **INTEGRATED PAN-CANADIAN HEALTHY LIVING STRATEGY** are the building blocks of a prevention-oriented strategy.

British Columbia's internationally respected **ACT NOW PROGRAM**, which encourages citizens to exercise more and eat healthier food, is a particularly promising model of intra-governmental collaboration to develop health policy. Developing a report card that assesses Canada's progress on its health care goals would be an important component of a new business model for health care.

Population health strategies must target funding for improved information technology, electronic patient records, training and development, and innovation that will allow Canada to renew its health care system and make it among the best. Greater receptivity to innovative technologies and delivery systems—together with supportive environments and policies to speed of their adoption—is essential to implement new approaches to wellness and disease prevention and management that will optimize Canada's health care resources and improve population health outcomes.

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KEEPING OLDER PEOPLE CONNECTED AND ACTIVE

Remaining active and socially connected are important determinants for the health and wellbeing of older people. To understand the 'how to' to keep older people active and connected it is useful to return to some fundamental work conducted by the World Health Organization in 2002, Active Ageing, A policy framework (WHO, 2002) and more recently the work of Sir Michael Marmot at the University College London (UCL) Institute of Health Equality, reported in the publication entitled Fair Society Healthy Lives (Marmot, 2010).

WHO defines active ageing as 'the process for optimizing opportunities for health, participation and security in order to enhance quality of life as people age. There is an emphasis on individuals realizing their potential throughout 'the life course'; participating in society according to not only their needs but their functional capacity while providing them with adequate protection, security and care when they require assistance.

The notion of a life course perspective was introduced more than a decade ago yet is seeing resurgence in the context the labor market strategies, the work-life balance and the role of family caring. Older people are not a homogenous group - individual diversity tends to increase with age (Zelenev, 2006).

Research has shown that when health, labor market, education, employment and social policies support the end point of active ageing there are fewer disabilities associated with chronic conditions; more people enjoy a positive quality of life as they grow older; more people participate actively as they age; and there are lower costs of medical treatment (WHO, 2002).

To further understand how being active and connected manifests, it is also useful to re-consider the determinants of active ageing – economic, health and social services, behavioral, personal, physical and social. Each of these determinants can be viewed through the cross cutting determinants of gender and cultural lens.

For instance, malnutrition in older people can be caused by limited access to food and socio economic hardships but equally as a long term consequence of loneliness and isolation. Declines in cognitive function can also be triggered by disuse, illness, and use of alcohol and medications yet also as a result of isolation and marginalization rather than the ageing process.

The case of a physical environment being a barrier to participation is quite often easier to understand and manage in a policy brief. Older people living in an unsafe environment or encountering areas of multiple barriers are more prone to being isolated, have poor mobility, reduced fitness and depression.

Older people who live in rural and remote areas encounter triple jeopardy - migration of younger people, poor access to health and care services and often a downturn in the economic conditions of their community.

Sir Michael Marmot in his work on health equity examined the relationship between the social environment and communities and the development of social capital. Using data from the British Household Panel Survey (BHPS) Gray (2009) examined how 'social capital' inherent in social networks provide contacts through which older people access practical and emotional support. Relatively poor support was found amongst older people who were childless or had been continuously without a partner. Relatively rich support was found amongst those who had frequent contact with other people, who interacted frequently with neighbors, and who regarded their neighborhood as a positive social environment.

Being active in organizations had less effect on social support than informal social contacts. Amongst many different forms of organizational activity, the only ones that had a positive association with social

support were being in contact with others through religious activities, and engaging in sports clubs. The social support of working-class older people, even those 'well networked' in formal or informal ways, was strengthened less by their social capital than was that of the professional and managerial occupational group.

Building social capital at a local level ensure that policies are developed and owned by those most affected and shaped by their experiences. Therefor all levels of government have a responsibility and a level of accountability to its citizens.

CANADA

The concept of social capital is not new in Canadian life and policies. Measurement of Social Capital, a project of the Policy Research Initiative (PRI) of the Federal Government (2005) reported social ties as important ingredients of well-being and prosperity (Frank, 2005). The Report provides a comprehensive picture of the components and operational models of social capital. Various methods of examining social capital are suggested for the specific needs of different policy areas including: populations at risk of exclusion (older people); major life transitions (the transition to retirement and loss of autonomy are times of uncertainty and instability); and community development and rural revitalization.

Overall the federal government implements many social policies to build the capacity of individuals to overcome obstacles to their full integration into society. There is considerable interest in the social economy as a sector of activity that can offer solutions adapted to local community issues.

One government priority has been to support cooperation networks established between various community players at the local, regional, and national levels, as well as with the private, para-public and public sectors. While the concept of social capital has not always been used, various studies now exist on the benefits and limitations of community organization networking to address various questions related to community development or rural revitalization. What is not well understood is the certain specific dynamics that may explain the growth or decline of certain communities.

KEEPING OLDER PEOPLE CONNECTED AND ACTIVE is a complex concept that entails a multi-faceted policy response. At a micro level all adults want to be healthy and active regardless of their age. Changes in a person's functional ability and capacity may result in less and less participation and increasingly lead to isolation. Evidence based policy that responds to the broad yet life-threatening consequences isolation, exclusion, deterioration of mental and physical functioning and a devaluing of one's contribution in the community is challenging especially in Canada.

Canada is one of the most ethnically diverse in the western world, has significant geographical barriers to inclusion in rural and remote areas, with unique provincial characteristics and culture. It is also unclear as to what is / are the triggers and what are the best responses.

Building healthy and more sustainable communities involves choosing to invest differently. Economic growth is but one important measure of a nation's success. The fair distribution of health, well being and sustainable growth are important social goals which underpin the degree to which people feel connected, active and belonging in a community.

Programs, policies and directives are abundant in the area of healthy ageing. Serious investment has supported many promising initiatives at all levels of government, federal, provincial and municipal government. Healthy Aging in Canada: A New Vision, A Vital Investment (Public Health Agency of Canada, 2011) underpinned by The National Framework on Aging, principles outlined in the Framework and the Framework Planning for Canada's Population Ageing, presents five key areas of focus: social connectedness, physical activity, healthy eating, falls prevention and tobacco control.

The new vision on healthy ageing speaks to valuing and supporting the contributions of older people; celebrating diversity, refuting ageism and reducing inequities; and providing age-friendly environments and opportunities for older Canadians to make healthy choices, which will enhance their independence and quality of life. As a means to achieve the vision five key areas of focus were identified namely: social connectedness, physical activity, healthy eating, falls prevention and tobacco control. Each of these areas can be linked to the priorities and global concerns discussed at the WHO NCD Summit in 2011.

Studies suggest that people who are in better physical and mental health are more empowered to cope effectively with change and life transitions (PHAC, 2009). Distress, isolation and social exclusion are said to increase substantially the risk of poor health and loneliness, and may even act as predictors of death (Wilkins, 2006; World Health Organization (WHO), 2003).

Alongside community involvement, promoting social participation has been identified as a key strategy of fostering empowerment, one of the central tenets of the health promotion movement. Engagement in social and productive activities appears to be particularly beneficial to older adults, as it has been found to be associated with positive outcomes on a variety of health indicators. It is therefore critical to identify factors that might lead to greater social participation within more vulnerable sub populations such as seniors.

Seniors are often addressed by social policy as the recipients of services. While this is important, it is not the whole picture. This growing cohort also embodies much accumulated social capital, and exercising local leadership and providing a major source of voluntary effort.

The presence of older people are being seen as a source of enhanced social capital through the wealth of experience of seniors made available to the community if given appropriate outlets; and the time seniors have available for active participation in the community. Programs that make use of the experience and time of seniors within an explicitly intergenerational framework may constitute a useful part of a community building strategy however much of the early evidence based policy and research tends to be on the needs of older people as recipients of care.

An extension of the grand parenting role that has gradually developed is that of older volunteers acting as mentors to young people who are at risk. Rogers and Taylor (1997) provide an overview based on evaluations of American projects aimed to achieve these outcomes, with specific mention of Across Age' and Linking Lifetimes.

EXAMPLES OF PROMISING PRACTICE

UNITED STATES - NET LITERACY ALLIANCE is a digital alliance that promotes inclusion collaboration, sharing and best practices founded by students in 2003. The Alliance has developed an integrated series of digital literacy programs including Senior Connects, Safe Connects, Computer Connects, Community Connects, the Net Literacy Alliance, Financial Connects, and the Digital Literacy “best practices” website.

Senior Connects is a program of the Alliance that focuses on increasing computer access and digital inclusion at senior centers, retirement apartments, and independent living facilities. Through the programs, over 11,000 residents received computer and Internet access by 2004; computers were supplied to over 100 senior citizen facilities impacting 44,000 residents by 2008; and by 2010, the number of senior citizens impacted by the Senior Connects program exceeded 50,000 individuals. <http://www.netliteracy.org/>

CANADA - SENIORS FOR KIDS SOCIETY is a community based and community driven not-for-profit organization that promotes intergenerational relationships.

The programs aim to improve self-esteem and attitudes with the desire to reach one's full potential across two generations. A unique characteristic of Seniors for Kids Program is the community commitment. The entire community of Cochrane and western M.D. of Rocky View: students, senior volunteers, staff, and families own and shape the program.

A special element of the program is 'Stoney Elders'. Elders from the Stoney reservation come into the schools to meet with native students on a one-one basis. The main objective is to enhance the ability to speak in their native language, that being Stoney. Culture and traditional values are taught and shared with the native students as well as non-native students. <http://www.seniorsforkids.ca/index.html>

IRELAND - BEALTAINE ARTS FESTIVAL

Bealtaine is coordinated by Age & Opportunity, the Irish national organisation working to promote greater participation by older people in society. The arts festival is unique in the wide range of arts-related activities it includes and the different types of organisations involved, such as local authorities, libraries, educational institutions, health and social care organisations, and voluntary bodies for older people. It includes both long-standing professionally facilitated arts programs and one-off events at local and national levels.

In 2008 the Irish Centre for Social Gerontology, assessed the contribution of the Bealtaine festival to:

- To promoting the participation of older people in the arts in Ireland; and
- To improving the health and well-being of the people who participate.

The study showed that the Bealtaine Festival has a profound and visible impact on arts practice in Ireland at national and local level, improves feelings of well-being, psychological outlook and morale among participants, enriches the experience of ageing by creating an outlet for social connections and enhances self-confidence and self-esteem of participants and nurtures social cohesion and social capital.

AUSTRALIA - INDIGENOUS COMMUNITY VOLUNTEERS)

In 2008, Indigenous Community Volunteers (ICV) changed from a volunteer organisation focused primarily on skills transfer to an organisation that joins with Aboriginal and Torres Strait Islander people to work on their community and human development projects.

It assists Aboriginal and Torres Strait Islander people to improve their quality-of-life, wellbeing and social inclusion. Volunteers, many of them being older people, work on community-owned and driven projects such as helping to improve the numeracy and literacy in the Adult Martu community. <http://www.icv.com.au/home/>

AUSTRALIA - BROADBAND FOR SENIORS

The Burrunju Aboriginal Corporation Broadband for Seniors Kiosk comprises two computers with broadband access for use by older members of the local community and offers training and support to those who are new to computers and the internet.

The aim of the kiosk is to enable older people in the community to be better connected, to discover a whole new social experience on the web and to help them to stay in touch online with friends and family, along with offering access to information available online

The Seniors Kiosk not only provides the basis for seniors to gain better access to the internet, it also promotes both indigenous and non indigenous community to work together to attain a common goal. <http://www.indigenoussupport.org.au/bfs.html>

EUROPE

Through directives from the European Union planned research programs have influenced the nature and shape of social inclusion policies and programs. Many traditional social policies were driven by social inclusion motivations (though it may have been phrased somewhat differently), others turn out to have a 'socially inclusive' effect even without being intended to be social inclusion policies.

The contemporary programs are unique and contextual to the country, its cultural nuances and the social and economic profile. Funded programs in the field of social inclusion have in the main been evaluated and refined to ensure the best possible outcomes for individuals and communities. In addition academic rigour has been used to assess the projects and community development programs (Walker, 2011) from the perspective of replication in other environments. Below is a selection of contemporary EU programs within the field of social inclusion.

AUSTRIA - HOME SHARE

The 'Housing for Help' (*Wohnen für Hilfe*) scheme in Graz is jointly run by the GEFAS older people's association and the Students Union of the University of Graz. The intergenerational project benefits both old and young people by making specific resources available to each other. Older people who live in large flats but require help with their requirements of daily living provide students with accommodation in exchange for practical assistance.

The project extends the concept of intergenerational family support to a wider community. The older people's association and the students union set up a co-ordination centre where older people and students interested in the scheme can meet. <http://homeshare.org/germany.aspx>

AUSTRIA - 'ADOPT AN OLDER PERSON'

Older Austrians who have no next of kin and live in the rural areas of the mountainous Alp regions are particularly affected by social exclusion and poverty. In this scheme, the older person lives with a farmer's family on a farmstead.

The scheme is of mutual benefit to both parties. The older person receives care from the family he / she is living with in an environment that is familiar and the farmer has an income source which adds to agricultural business.

Various quality assurance measures are in place to make sure that there is appropriate accommodation available for housing an older person in need of care.

http://www.youngfoundation.org/files/images/novating_better_ways_of_living_in_later_life.pdf

CYPRUS - 'PARLIAMENT FOR THE ELDERLY'

The 'Parliament for the Elderly' meets annually with the President of the Parliament, the Minister of Health, and the Minister of Labor and Social Insurances. Major problems faced by older people are discussed and recorded.

The Ministers are bound to respond to the issues stated during this formal meeting. The aim of the Parliament for the Elderly is to improve the circumstances of the elderly and to avoid social exclusion. At the local level, district committees for the elderly are established in close co-operation between the government and voluntary organisations for the elderly. The National Plan for the Elderly is a first outcome of this.

FRANCE - INTERGENERATIONAL LEISURE PROGRAMS

Intergenerational leisure programs enable pensioners to spend their vacations with their families in a holiday resort, an activity from which older people in need of care would be excluded otherwise.

The French retirement pension system has funds devoted to the construction of vacation centres where the older people can spend their vacations together with their families, also with young children. Generally people have to pay for using these facilities however if they do not have sufficient resources assistance from the so-called complementary system can be sought.

http://www.unece.org/fileadmin/DAM/pau/docs/age/2011/Good-Practice-Database-2011/Good%20Practices2011_2_16.pdf

IRELAND - OLDER PEOPLE'S INVOLVEMENT IN RUNNING SERVICE PROVIDERS

A particularly interesting advocacy project is operating within the older person's unit in the 'Mead Hospital' in Dublin. Older people in the unit are involved in the running of the facility creating transformational change in the unit and the wider community

Nursing homes can be isolated from the communities in which they are located and this project has made the link between the people outside the unit and those inside the unit – social integration was mutually encouraged.

http://www.hse.ie/eng/services/Publications/Your_Service,_Your_Say_Consumer_Affairs/Strategy/Service_User_Involvement.pdf

SPAIN - "ADOPT AN ELDERLY!"

In northern Spain where the rural population is extremely dispersed and access is limited because of the mountains a programme called "A family can adopt an elderly" was introduced. A family will have an older person who has no family ties of her/his own living in their household in exchange for part of their pension.

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ELDER ABUSE

Elder abuse is not a new phenomenon but policy and practice responses to the problem are still in the early stages. The concept of elder abuse was first described in the United Kingdom in scientific journals in the 1970s. Since then, there has been a growing body of international literature relating to prevalence, risk factors and attitudes. However, it has also been argued that responses in preventing abuse and protecting people at risk have been slow (McAlpine, 2008).

Elder abuse exists in both developing and developed countries yet is typically underreported globally. Prevalence rates or estimates exist only in selected developed countries - ranging from 1% to 10%. Although the extent of elder abuse is unknown, its social and moral significance is obvious.

In many parts of the world elder abuse occurs with little recognition or response. Until recently, this serious social problem was hidden from the public view and considered mostly a private matter. Even today, elder abuse continues to be a taboo subject, mostly underestimated and ignored by societies across the world. However evidence is accumulating to signpost that elder abuse is an important public health and societal problem. It demands a global multifaceted response, one which focuses on protecting the rights of older persons.

From the health and social perspective, unless both primary health care and social service sectors are well equipped to identify and deal with elder abuse it will continue to be underdiagnosed and overlooked.

Awareness of elder abuse has grown significantly over the past 25 years and Canada has played a central role in positioning the issue in a policy context globally. Elder abuse was recognized as a serious issue in the Madrid International Plan of Action on Ageing (MIPAA) (2002). In 2002, the WHO and the International Network for the Prevention of Elder Abuse and Neglect (INPEA) gathered data on elder abuse in eight countries. The resulting publication *Missing Voices* described how elder abuse cannot be viewed outside social and cultural contexts.

Through the combined efforts of the WHO, academics, service providers, NGO in the development of the Toronto Declaration on the Global Prevention of Elder Abuse a definition of elder abuse was developed and adopted by Action on Elder Abuse in 1995, namely:

'Elder abuse is a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.'

Over the past twenty-five years academics, policy makers and practitioners have paid increasing attention to elder abuse. In 2010 the European Commission funded **THE EUROPEAN REFERENCE FRAMEWORK ONLINE FOR THE PREVENTION OF ELDER ABUSE AND NEGLECT** (EUROPEAN). The objective of the project was to contribute to the protection of older people from abuse and neglect and develop a reference framework that spreads information and links relevant stakeholders and experts.

The Background and Position Paper (BPP) of the study outlines basic understandings of elder abuse which exist in eleven countries, nine of which are represented on the project steering group. The "Reference Framework of Good Practices" presents information from 77 European expert(s) and organizations across a range of disciplines in Austria, Germany, Greece, Ireland, Italy, Poland, Portugal, The Czech Republic, The Netherlands, Slovenia, and Slovakia.

Respondents and agencies completed a questionnaire on how elder abuse is addressed in their respective countries, covering topics ranging from risk factors, recognized forms, prevalence rates and legislation relating to elder abuse.

While the findings from EUROPEAN showed various perspectives on definitions the most complete description of elder abuse was the aforementioned one developed by Action on Elder Abuse and subsequently adopted by the WHO and INPEA.

However, it was also noted that the definition is not complete as it implies an expectation of trust or a relationship should exist between the victim and offender. It also excludes forms of abuse where these two indicators do not exist, such as financial or material abuse by a stranger or a company (e.g. coercing an older person into subscribing to a service that is of no use to them). Victims, offenders and/or witnesses may not recognize the term elder abuse or identify with it, especially when abuse is unintentional.

The definition of elder abuse also varies between cultures. It has been suggested that different indicators of elder abuse (e.g. relationship between victim and offender, different forms, situational factors.) should be identified and a definition incorporating these aspects be developed.

ELDER ABUSE POLICY AND INITIATIVES - CANADIAN MILESTONES

- 1973 - Newfoundland passes the Neglected Adults Welfare Act, creating a mandatory reporting obligation for "any person who has information which leads him to believe that an adult is a neglected adult...".
- 1980s - Early mention of abuse and neglect in Canadian literature in the 1980s. Local service providers in some communities are beginning to identify family violence as an issue affecting older adults.
- 1980 - New Brunswick's Child and Family Services and Family Relations Act addressing child and adult welfare and includes disabled and older adults.
- 1985 - First elder abuse conference held in British Columbia (SPARC Committee on Elder Abuse)
- 1986 - Nova Scotia enacts the Adult Protection Act, creating a mandatory reporting duty for "every person who has information, whether or not it is confidential or privileged, indicating that an adult is in need of protection...".
- 1988 - Prince Edward Island enacts the Adult Protection Act.
- 1989 - Formation of an informal coalition in British Columbia to begin addressing abuse and neglect of older adults. Subsequently becomes the BC Coalition to Eliminate Abuse of Seniors.
- 1989 - The Ryerson Study, 1st national study of the prevalence of abuse and neglect in later life in Canada.
- 1992 - Establishment of the Ontario Network for the Prevention of Elder Abuse.
- 1990s - Development of New Horizons and other Health Canada family violence prevention initiatives. The initiatives provided many Canadian communities with their first opportunity to explore abuse issues in later life.
- 1990 - Ontario Nursing Home Act sets out some of the rights of residents living in nursing homes.
- 1991 - Annual Canadian Association on Gerontology discussion meeting in Toronto: "Do We Need a Canadian Committee for the Prevention of Elder Abuse".
- 1993 - First national conference on elder abuse.
- 1994 - B.C. Coalition to Eliminate Abuse of Seniors becomes a non-profit provincial organization to raise awareness of abuse and neglect in later life. The organization develops from 5 years of work by interested seniors and community agencies.

- 1998 - Roundtable discussion at Canadian Association on Gerontology in Halifax, NS. "Creating a Canadian Network for the Prevention of Elder Abuse". Bylaws established and criteria developed.
- 1999 - 2nd National Conference on Elder Abuse held in Toronto, ON. Fifty-six members signed.
- 1998 - Alberta enacts Protection for Persons in Care Act.
- 1999 - 2nd National Conference on Elder Abuse, Toronto, Ontario, March 21-23, 1999.
- 2000 - Canadian Network for the Prevention of Elder Abuse is created as a legal entity.
- 2000 - British Columbia proclaims Part 3 of Adult Guardianship Act, which provides support and assistance for abused or neglected adults who are unable to seek it on their own. Voluntary reporting of abuse encouraged and recognized in community networks.
- 2001 - Manitoba proclaims Protection for Persons in Care Act.
- 2002 - Yukon launches first Elders Conference.
- 2002 - Canada is the host location for the development of the Toronto Declaration on the Global Prevention of Elder Abuse. Declaration is based on the recommendations of the United Nations International Plan of Action adopted in Madrid, 2002.
- 2003 - Quebec Network for the Prevention of Elder Abuse is created.
- 2003 - Manitoba establishes "Expect respect" initiative to help raise awareness of abuse and promote respect of older adults in the province.
- 2003 - Regional senior abuse prevention network develops in Alberta.
- 2003 - 1st official recognition (proclamation) by the City of Toronto of Elder Abuse Awareness Day. Other cities in Ontario follow in 2003 and 2004.
- 2003 - 1st provincial senior abuse awareness campaign (Alberta).
- 2003 - Yukon passes the Adult Protection and Decision Making Act, Dec. 17, 2003. Proclamation is planned for April 1, 2005.
- 2004 - Newfoundland and Labrador holds their first provincial conference on senior abuse.
- 2004 - (October 19) Ontario marks its first Elder Abuse Awareness Day.
- 2007 – Government of Canada announces major elder abuse awareness funding and policy responses.
- 2008 – World Elder Abuse Awareness Day celebrated in Ottawa
- 2010 – Quebec publishes a 5-year Action Plan to Counter Elder Abuse
- 2012 – New legislation announced by the Government of Canada to amend the *Criminal Code* to better protect seniors.

Elder abuse and neglect have been identified as important social problems in Canada. While research has become increasingly systematic in attempting to clarify the nature, extent, and causes of the problem, there is limited evidence related to what constitutes promising policy responses.

The global body of literature now available outlines the debilitating effects of abuse and neglect of the elderly and offers strategies for responding to elder abuse and reducing age discrimination.

One of the key messages is that there needs to be stronger legal protections for older people globally. The Report of the National Seniors Council on Elder Abuse (2007) suggested that a number of legal remedies exist in Canada to deal with elder abuse and neglect. Alongwith federal criminal law defined in the Criminal Code of Canada, there are provincialand territorial frameworks pertaining to adult protection legislation, adult guardianship,family violence statutes, human rights statutes and long-term care facilities regulation.

During regional meetings of the Council, participants debated whether or not the Criminal Code should be amended to further facilitate dealing with elder abuse. Legal experts at the meetings advised that

changes to existing legislation were not necessary indicating that “what is lacking is awareness of these tools and the steps that should be taken by social workers and law enforcement professionals who are often the first to encounter situations of elder abuse”.

Four years have lapsed since the report was published and it is timely to revisit the findings and assumptions. For example one could argue that social workers and law enforcement professionals are not in the front line to encounter and respond to some situations of elder abuse.

In the area of financial abuse (in many cases) it would be frontline workers within the banking sector that would see the indicators of abuse yet there are limited if not no avenues for front line workers to report such abuses within the banking policy framework.

It has been argued that more research is needed to determine with certainty how best to respond to the mistreatment of older Canadians in a legislative framework. Without an agreed national framework, response variations will remain as a barrier.

Canada has invested significant research and programs to combat the issue of elder abuse. The primary emphasis has been on educational programs and awareness campaigns.

As part of Canada’s policy response, since 2007, the New Horizons for Seniors Program has provided funding for both community-based and pan-Canadian projects to help raise awareness of and address elder abuse, including the development of tools and resources for front-line professionals. In addition, Veterans Affairs Canada, FNIHB have also developed tools and protocols for front-line staff.

\$175,990 - The Canadian Dental Hygienists Association will create a professional development program for dental hygienists on elder abuse.

Components include: an online course; interactive Webinars; and educational print resources to increase awareness and understanding of elder abuse among its association members and to enhance their capacity to respond to situations of abuse.

Federal Elder Abuse
Initiative Funding

Therefore it was somewhat surprising, when one considers the investment and proliferation of projects and initiatives focused on elder abuse awareness in Canada that elder abuse was identified as both a current and an emerging issue. A large number of academics, NGOs and community organizations have received grants to address the issue over the past 3-5 years.

From 1 April 2008 to 31 March 2011 funding allocated to the Federal Elder Abuse Initiative (FEAI) equaled \$13.05M. The main objectives of the FEAI was to raise awareness of elder abuse

\$200,000 - The Canadian Nurses Association will develop education sessions on elder abuse prevention and deliver them to frontline service providers in five long-term care homes across Canada.

These education sessions, with complementary resources, will increase frontline service providers’ awareness and understanding of elder abuse.

(Federal Elder Abuse
Initiative Funding)

throughout society, particularly among seniors, their families, and key professional groups; and to ensure the availability of appropriate elder abuse-related information, resources and tools. Generic information and resource materials for frontline workers (medical and legal, etc.) has been developed to provide key professional groups with the information necessary to identify cases of elder abuse, access the appropriate resources, and take measures to provide assistance to victims.

In order to capitalize on the investment and resources developed through the FEAI consideration could be given to the development of an on-line repository that

warehouses the materials and educational tools.

A repository may also include resources developed as a result of grants across all levels of government within Canada. In the future a condition of funding could be that outputs are deposited in the repository. This initiative could in large minimize the ongoing duplication of project methodology, curriculum, toolkits, handbooks and resources. It may well enable the identification of best practice examples (including best practice from outside Canada) to the broader Canadian community and others from across the globe.

Without efforts to capture details of the materials already developed unnecessary duplication will occur in the development of resources. As an example, in August 2010 the U.S. Department of Justice released a publication and training package (including DVD) entitled “In Their Own Words – Domestic Abuse in Later Life” that presents five compelling stories of abuse in later life conveyed by the survivors themselves. It is a comprehensive resource and applicable to professionals who may encounter and respond to abuse situations. Despite the availability of this evidence based resource and its applicability within Canada substantive grants in recent times appear to duplicate these resources recognized as best practice.

POLICY PROGRESSION IN EUROPE

In December 2007, the European Commission published a special **EUROBAROMETER REPORT ON HEALTH AND LONG TERM CARE IN THE EUROPEAN UNION**. This report presents the views of citizens in 27 Member States on several issues concerning health and care within their countries. Findings show that although Europe-wide elder abuse is believed to happen ‘fairly often’; perceptions on elder abuse differ between countries. This sentiment underlines again the fact that elder abuse must be viewed within a social and cultural context.

The 2008 Breaking the Taboo study, funded under the European Commission’s Daphne II program dealt with the issue of elder abuse. The study is a compilation of seven country specific reports addressing the context of elder abuse such as whether it is identified within families or within institutional settings, the risk factors that are most common and the way in which it is perceived. Findings show that these vary from country to country with some cross-country similarities.

The WHO (2008) project **A GLOBAL RESPONSE TO ELDER ABUSE AND NEGLECT** aimed to develop a reliable instrument applicable in different geographical and culturally diverse contexts to increase awareness of elder abuse and neglect among Public Health Centre (PHC) professionals. It was believed that the capacity of PHC workers could be built to deal with elder abuse and neglect through evidence-based education for the development of prevention strategies.

In 2011, WHO produced a further report entitled “European Report on Preventing Elder Maltreatment” developed with many international collaborators to provide policy-makers, practitioners and activists with the facts needed to integrate the agenda for preventing elder maltreatment both within and outside the health care sector.

Additional contributions to the policy debate in Europe include the ABUEL, Elder Abuse Multinational prevalence survey, a collaborative effort across seven (7) countries that commenced in 2008 and concluded in 2010. The aim of the project was to provide data on the extent and nature of the abuse of older persons; examine the determinants of the abuse of older persons; and examine the effects of the abuse on the health and quality of life of older persons. The survey results indicate that physical abuse is a severe problem in the ageing Europe and that to address this public health challenge collective actions should be facilitated. Among the many approaches to solve this problem the study emphasized:

- investment in human capital,
- creation of effective social support systems,
- increase accessibility to health care,
- psychological and legal help.

It also recommended that only multi-sector collaboration and common efforts will reduce the prevalence of abuse and create a safer environment.

The **EUSTACEA** project funded under the European Commission's Daphne III program addresses elder abuse from a rights perspective. It is argued that the debate on elder abuse is essentially a human rights one; in older age people still have these rights both at home and in institutions.

Running in parallel to these projects and associated publication were several European conferences on elder abuse. These were organized under different European Presidencies. For example, during the European Commission's **Conference on PROTECTING THE DIGNITY OF OLDER PERSONS** on the 17th of March 2008 it was recognized that new challenges are arising to protect the dignity of older people as populations' age. Healthy ageing was also a point of discussion during the 2008 Slovenian Presidency's Conference Together for Mental Health and Well-Being and the 2008 Europe against Alzheimer's disease conference under the French Presidency.

With the frame of the Czech Presidency in 2009 a conference on the protection of older citizens, entitled **THE DIGNITY AND HAZARD OF THE ELDERLY** was convened. The topic of elder abuse was of specific interest at several workshops during this conference. The Swedish Presidency in 2009 organized the conference **HEALTHY AND DIGNIFIED AGEING**. According to recommendations made at this conference cooperation at an EU-level and within Member States between social and health sectors should be enhanced to promote healthy and dignified ageing (Council of the European Union, 2009).

To address the issue of elder abuse, the European Commission facilitated the pilot project **EUROPEAN** (2009 – 2011). Partners involved in the project included The Netherlands, Austria, the Czech Republic, Greece, Ireland, Italy, Poland, Slovenia, and Slovakia.

There were four main objectives:

1. The development of a Background and Position Paper afforded information for the project, compiling research from previous studies and facts and figures from the nine participating partner countries. The paper gives a first impression of the problem of elder abuse in order to build a more in-depth understanding of elder abuse and the prevention of elder abuse in the different countries.
2. Conduct research on the backgrounds of elder abuse in participating countries to give a comprehensive overview of good practices in policy approaches to prevent elder abuse taking into consideration the cultural and individual specifics of different situations of elder abuse.
3. Conduct research on good practices in policy approaches to prevent elder abuse in participating countries through a contribution of national information.
4. Compilation of information from first three objectives for input into a comprehensive framework of good practices in policy approaches for the prevention of elder abuse.

INSIGHTS AND OUTCOMES FROM THE EUROPEAN PROJECT

Policies and programs in partner countries differ widely in many aspects, including the definition, the level of recognition of the various forms of elder abuse, the risk and protective factors and the theories on elder abuse that are applied.

These differences can in large part be explained by social and cultural differences, including the stereotyping of older people, the role of the family, and the role of the state and the organization of care. In many countries, elder abuse still remains hidden within the private realm of the family. For this reason, some governments are reconsidering their roles within this private domain in order to protect vulnerable people and ensure their human rights are not violated.

On the other hand, the partnership found common elements across Europe, including a lack of data on the phenomenon of elder abuse and a lack of dedicated legislation that considers the specificities and complexity of abuse towards older people. The project partners agreed on the need for national programs regarding elder abuse. At present, national programs only exist in Austria, Ireland and the Netherlands.

GOOD PRACTICES

As part of the project, 40 good practices for the prevention of elder abuse were selected. They can be found in an online database: www.preventelderabuse.eu. These practices have been described, and they are transferable. Each is classified according to various characteristics (e.g. activities, target groups, operational levels and types of prevention).

The database contains examples of successful practices in the areas of education and training, quality improvement, empowerment and participation, network development and awareness raising.

‘One-size-fits-all’ solutions do not exist, and each practice must be customized to new settings. Nevertheless, national and international experiences can offer a source of inspiration and a way of transferring knowledge between countries.

RECOMMENDATIONS

The European Union(EU) does not have the authority to develop legislation on elder abuse. Nevertheless, the European level can play an important role in supporting the efforts of national stakeholders towards the development and implementation of an action plan to prevent elder abuse. Partners in the EUROPEAN PROJECT recommended that the EU:

- press for the recognition of elder abuse in all settings as a political issue in each member state of Europe;
- promote integral national policies and programs on preventing and combating elder abuse in each member state of the European Union, including the promotion of the EuROPEAN checklist proposed in the report;
- address the problem of elder abuse as an undivided political issue at the European level, thus ensuring an integral and comprehensive approach to the issue of elder abuse; and
- should explore the possibility of coordinated legislation on aspects of elder abuse upon which the EU has undisputed competence, for example financial elder abuse in the area of consumer protection.

LEGISLATION: UNITED KINGDOM, SCOTLAND, WALES AND NORTHERN IRELAND

Over the past twelve years there has been significant debate in the United Kingdom over the necessity to introduce specific adult protection legislations. [‘No Secrets’](#) guidance in relation to Adult

Protection was issued by the Westminster Government in 2000, with a similar nation-specific document, [‘In Safe Hands’](#), issued by the Welsh Assembly at the same time. In Northern Ireland the Adult Protection Forum issued the Association of Directors of Adult Social Services (ADSS) document [‘Safeguarding Adults’](#), subsequently approved in 2006.

In a consultation paper produced by Action on Elder Abuse (AEA) in 2007, AEA was envisaging the introduction of new all-encompassing legislation that would cut across health, social care, and the criminal justice system establishing a single definition of ‘vulnerable adult’ and addressing the issue of age – i.e. when is a young person an adult?

It also recognized that legislation by itself is not the panacea that can guarantee safeguarding in each and every situation. It can only be one option among a range that includes education about perceptions and responses to vulnerability and challenges discriminatory practices. In the consultation paper AEA recommended a new Act of Parliament to work within the following parameters toward a comprehensive approach that:

- integrates the work of health, legal, and social service agencies and organizations;
- emphasizes the need for prevention, reporting, investigation, assessment, treatment, and prosecution of elder abuse, neglect, and exploitation at all levels of government;
- ensures that sufficient numbers of properly trained personnel with specialized knowledge are in place to treat, assess, and provide services relating to elder abuse, neglect, and exploitation, and carry out elder and vulnerable adult protection duties;
- is sensitive to ethnic and cultural diversity;
- recognizes the role of mental health, disability, dementia, substance abuse, medication mismanagement, and family dysfunction problems in increasing and exacerbating elder abuse, neglect, and exploitation; and,
- balances adults’ right to self-determination with society’s responsibility to protect elders and vulnerable adults.

While Scotland has paved the way for further debate on the issue with the introduction of the Adult Support and Protection (Scotland) [Act 2007](#), introduction of similar legislation has stalled in the United Kingdom despite overwhelming community support for legislation.

ISRAEL

The “idealistic” picture of Israel as an “elder-abuse-free society” started to shatter in the 1990s through a series of serious academic research. Studies conducted by Lowenstein and Ron (1999, 2000) and Sharon and Zoabi (1997) that linked the ageing population of Israeli population, to the phenomenon of family violence in general, and elder abuse and neglect in particular raised concern among the professional community and policy-makers.

Since this time, Israel has been characterized by swift transitions and dynamic changes regarding elder abuse and neglect. Research, policies, legislation, and social interventions have flourished, especially during the last decade. The phenomenon has moved to the forefront of public and political awareness.

The major development and point of reference in scientific research took place in 2005, when the first National Survey of Elder Abuse and Neglect in Israel, funded by ESHEL (The Association for Planning and Development of Services for the Aged in Israel) and the National Insurance Institute was published (Lowenstein et al., 2009). The survey findings were presented at the President of Israel’s residence in a highly publicized meeting.

The findings were also presented and discussed in a meeting of the Parliamentary Committee of Labor, Social Affairs, and Health (Protocol No. 364, 28 February 2005). A workshop organized to present the results of the study and to highlight the activities in the field attracted more than 200 professionals from all parts of the country. The findings of this national survey provided, for the first time, a stark scientific picture of the state of elder abuse and neglect in Israeli society.

Since the publication of these findings there have been several developments. In 2006, for the first time, a national conference was held in Tel-Aviv with the participation of government ministers and senior officials to mark the International Elder Abuse Awareness Day. This conference placed the issue clearly on the public agenda.

POLICY AND PRACTICE RESPONSES

The national survey prompted the following governmental actions:

- A national forum(inter-ministerial) for inter-organizational coordination
- New regulations and protocols for general hospitals, long term care institutions, and community health organizations.
- Special units for prevention and intervention in elder abuse
- A “help line” for victims of elder abuse
- Case materials for professionals in the field
- Training programs for professional staff and volunteers

ESTABLISHING A NATIONAL FORUM(INTER-MINISTERIAL) FOR INTER-ORGANIZATIONAL COORDINATION

The Ministry of Social Affairs (www.molsa.gov.il) has initiated a forum - an inter-ministerial inter-professional coordinating committee dedicated to the discussion of fundamental issues and the formulation of procedures for inter-organizational coordination for coping with the phenomenon of elder abuse and neglect. The forum is composed of representatives from: the Ministries of Welfare and Health, the National Insurance Institute, ESHEL, social workers from the major local authorities, the Police, the Attorney General Office, and NGO's.

As part of its advocacy efforts, other voluntary organizations that operate to meet the needs of the older population in general, have begun to work also in the areas of elder abuse and neglect, much of the work focusing on legal interventions and elders' rights.

COPING WITH ELDER ABUSE IN THE HEALTH SYSTEM

The Director General of the Ministry of Health issued a detailed procedure for identifying and reporting elder abuse and neglect in the health-care system (community clinics, hospitals, and long term care institutions). The procedure requires establishing a special 'violence' committee in each setting, usually headed by a physician and a social worker.

The committee is responsible for receiving reports, reporting to a welfare officer for the court or to the police, and informing the Ministry of Health about cases of elder abuse. Persons subjected to abuse and neglect are referred for continued treatment. In addition, the committee is responsible for training the organization's staff in this area.

ESTABLISHING SPECIAL UNITS FOR PREVENTION AND INTERVENTION IN ELDER ABUSE

The Ministry of Welfare, the National Insurance Institute, and ESHEL developed programs for abuse prevention in most municipalities around the country. A unique aspect of the program is the collaboration between the Center for Domestic Violence Prevention and the Welfare Department for the Elderly. The units include a social worker (coordinator), a para-professional, an advising geriatric physician and a lawyer/legal expert.

The units employ various models of individual and team work, establishing multi-disciplinary teams (involving, for example, the police, the legal system, and voluntary organizations) and working with hospitals and homes for the aged. In addition, the teamwork models by their nature raise public awareness in general, among various professional groups and recruiting partners in the community for advancing actions on elder abuse at the community level. Some of the municipalities activate specific support groups, such as for older abused women. An associated activity to the program is the establishment of a “mobile” multi-disciplinary team aimed at assisting in diagnosis and recommendations for interventions.

A special model for intervention was developed for rural councils in view of the large incidence of cases of economic exploitation and abuse related to the status of “inheriting son.” This project stems from legal regulations that allow only one son to inherit the family agricultural holdings, which often leads to acts of abuse, exploitation, and neglect of older parents (Danon v. Eshed, 1999).

HELP LINE FOR VICTIMS OF ELDER ABUSE AND FOR FAMILY MEMBERS

The help line enables older victims of abuse to call anonymously and obtain advice and practical information through a special telephone help line service. The service is operated by Eran, an organization employing 1,000 volunteers that maintains a crisis hot line. ESHEL trained 300 of these volunteers to deal specifically with issues of elder abuse and neglect, and the service is publicized by them <http://www.eran.org.il/?CategoryID=226&ArticleID=190>.

CASE MATERIALS FOR FIELD WORKERS

A manual on topics concerning elder abuse and case materials has been prepared for professionals to be used in training programs and during supervision.

EDUCATION AND TRAINING

Education and training are important components of an effective response to elder abuse. Training has been and remains integrated into all aspects of elder abuse prevention and intervention. For example, 150 social workers and officers for the court received a one year training course, to identify and intervene in cases of elder abuse.

LEGISLATION

There are several legislative avenues to deal with elder abuse and neglect including Mandatory Reporting - Amendment 26 to the Penal Code, 1989. The law requires individuals to report any case, or suspected case, of abuse to a welfare officer of the court, or to the police.

This obligation applied to all members of the public, but particular emphasis was placed on the fact that professional care workers were specifically mandated to report any abuse or neglect of older persons. Further details of the legislative area and an explication of the situation of elder abuse and neglect in Israel is outlined in: Lowenstein and Doron (2008).

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AGEISM AND DISCRIMINATION

The term “ageism” was first coined in 1968 by Dr Robert Neil Butler, a physician, gerontologist and psychiatrist known for his work on the social needs and the rights of the elderly. According to Dr Butler

“ageism allows the younger generations to see older people as different, thus they subtly cease to identify with their elders as human beings”.

The Ontario Human Rights Commission describes “ageism” as *“a tendency to structure society based on an assumption that everyone is young, thereby failing to respond appropriately to the real needs of older persons.”* Some agencies extend this definition even further to include any kind of discrimination or prejudice perpetrated against someone because of their age.

What is complicated about ageism is that it can be both implicit and explicit. The kind of discrimination older people may face is not always obvious. Older people may have to deal with prejudices of a more subtle nature such as disrespectful attitudes, being ignored, which might in the end undermine their own self-esteem.

Ageism can be detected through external factors such as policies, services, education and media. Ageist attitudes can be so deeply rooted in a society that older people will themselves have ageist opinions or behaviors, which might not even be conscious, but may restrict their activities and engagement in their own communities. When ageist stereotypes are internalized, they become part of a sub-conscious framework of society.

Ageism and discrimination are closely linked. Like racism or sexism, ageism is a source of numerous discriminations. In the modern and somewhat youth-obsessed society a belief is conveyed through media, medicine and politics, that ageing and being older is a burden.

The term “discrimination” is a cross-cutting issue covering various topics, some are treated in this report, such as elder abuse, debates around an ageing workforce and mandatory retirement, as well as support to caregivers.

On reaching a certain age, especially in an industrialized society like Canada, individuals can experience a slight change in the way society treats them. Ageism is a social attitude. Many people note that as they grow older and as they reach certain age milestones, (age 65 years being one of them) they are treated or responded to in a different way.

Even after a lifetime of contributions older adults who are no longer in paid employment can often feel disposable and pressured to let younger generations take on their responsibilities. Older adults often feel as though they are “disposable citizens” having outlived their usefulness in adding to the social and fiscal economy. Alternatively older people can be characterized as a well-off unconcerned group draining the working-age population.

While ageism and discrimination are often referred to as cross cutting issues the practice of discrimination impacts negatively on the ability of a person to fully contribute in a way that is meaningful to their community and society.

Age should never hinder people from trying new things and stretching their potential.

“We must ease the stigma associated with the ‘senior’ and the notion that 65 years of age magically equates to withdrawal from productive life.

We call for the removal of barriers, disincentives and discrimination perhaps unintentionally imposed.”

Rock Lefebvre, of the Certified General Accountants Association of Canada, 2007.

CANADA

“Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, color, religion, sex, age or mental or physical disability.” Charter of Rights and Freedom 1982.

Discrete legislation addressing aged discrimination at the national level does not exist. However there are two Acts which in part respond to the issue namely The Canadian Human Rights Act (CHRA) of 1977 and the Charter of Rights and Freedom of 1982. The CHRA deals with equality and discrimination whereas the Charter is much broader, aimed at protecting citizens against possible infringements of their personal freedom in all sectors of society.

It appears that from time to time certain types of discrimination are tolerated as long as these differential treatments aim at improving the situation of a certain group. For instance the absence or reduction of fees to certain activities or services for a certain age group may be considered positive discrimination.

In order to implement Acts, Canada has Human Rights Commissions at federal and provincial levels as well as Tribunals which investigate and determine settlements of discrimination cases. Provinces have strong powers in human rights legislation. In 1964 British Columbia was the first province to legally consider age discrimination as a serious kind of discrimination.

The Canadian Human Rights Commissions Annual Report of 2010 described the changes in population ageing as a trend to be cautiously aware of. Data collected from the Commission’s Dispute Resolution Branch, suggests that age discrimination has already had a significant impact on Canadian workplaces. Over the past five years, the Commission referred 273 complaints of age discrimination to the Canadian Human Rights Tribunal. Almost all were related to mandatory retirement.

Mandatory retirement has been a major issue in Canada and in other industrialized countries for several decades. It refers to setting parameters of a specific age after which a person’s employment status will be terminated without evaluation. It has been a controversial topic among government officials and legal counsel in order to determine whether or not mandatory retirement should be considered as a form of discrimination.

“We’re not born with date stamps saying our fitness for work expires at 65.

Age discrimination is discrimination, pure and simple”

David Langtry

Canadian Human Rights Commission

Canadian provinces have jurisdictional responsibilities and as such legislation has not evolved in an entirely uniform manner. Ontario was the first province to prohibit mandatory retirement in 2005.

The abolition of mandatory retirement has been a long term process finally achieved in 2011 when the Canadian Human Rights Act and the Canadian Labor Code were amended under the Budget Implementation Act which received Royal Assent in 2011. Until 2011, employees employed in federally regulated industries or institutions were not protected from mandatory retirement. It is now considered a human right for every Canadians to be able to choose when to retire, with an assessment based on ability and not on age.

A study undertaken by the British Department for Work and Pensions (2010) comparing different approaches to mandatory retirement across eight countries, including Canada, made a number of key finding that may be relevant when considering the issues in Canada:

- Age legislation, with no accompanying policies to encourage older working, is unlikely to increase the participation rates of older workers significantly.
- Age legislation is more likely to increase the participation rates of older workers when enacted in conjunction with an increase to the pension age and other policies to support older people.
- Employers often believe banning mandatory retirement will increase their costs. It is unclear whether this is actually the case in countries that are comparable to the United Kingdom.
- Age legislation can act as a catalyst for employers to provide more opportunities and flexible conditions for older workers, particularly when led by government initiatives.
- When it is made easy – and satisfying – for employees to make a phased transition into retirement, employees can be encouraged to continue working.
- There is little research evidence that banning mandatory retirement impacts upon the employment opportunities of younger people.
- Employers' and society's negative attitudes to older workers can act as a barrier to working later, irrespective of the age legislation in place. These attitudes can be overcome.
- The retirement benefits structure plays a significant role in a person's decision to retire – or continue working.
- There is little research evidence as to the impact of age legislation on the economy or public sector spending.

Canada has worked towards developing fair policies as well as strong services and programs supporting older people. Implemented in 2004, the NEW HORIZONS FOR SENIORS PROGRAM (NHSP) is an excellent example of a program that can minimize ageism and discrimination. The 2012 NHSP allocated ~35-40 million dollars towards initiatives that support projects led or inspired by seniors who want to make a difference in the lives of others and in their communities. The NHSP promotes the role of older people and enables a stronger social participation and a better integration through intergenerational activities and volunteerism.

Many campaigns and activities have also been organized around the theme “elder abuse” in order to raise awareness. Some funded public service announcements (PSA) such as those on elder abuse awareness, while compelling, may portray older people as victims. PSA initiatives are an important vehicle in promoting the positive aspects of growing older - older people portrayed as positive and engaged members of the Canadian society.

Some survey respondents suggested that the funding logic of the NHSP was not based on a long-term perspective and was more inclined to give funding to new projects every year rather than building on existing projects which had demonstrated promising progress. The challenge is to mainstream some of the promising practice initiatives derived from such funding.

PROTECTING THE RIGHTS OF OLDER PEOPLE

In December 2010 (resolution 65/182) the United Nations Human Rights Office of the High Commissioner established an Open-Ended Working Group on Ageing to consider the existing international framework of the human rights of older persons and identify possible gaps and how best to address them, including by considering, as appropriate, the feasibility of further instruments and measures.

At the open-ended working group's (OEWG) first and second sessions of April and August 2011, Canada highlighted its efforts and initiatives towards the improvement of older people's quality of life in the past few years. In its Statement programs such as the recent Federal Elder Abuse Initiative, the New Horizons for Seniors program implemented in 2004, as well as the Canadian longitudinal study on Ageing

officially launched in 2011 were highlighted together as was the main governmental advisory body concerning seniors' issues, the National Seniors Council .

In its written statement to the 2nd session of the Open Ended Working Group (OEWG) Canada also underscored the importance of working within and implementing the existing framework of human rights protections for older people. The statement highlighted that the proportion of older people living under the poverty threshold declined from 21.3% in 1980 to 4.8% in 2007, making most of older Canadians financially secured.

While Canada supports the work and initiatives of the OEWG statements to date suggest Canada does not support the implementation of a new framework through a UN Convention focusing solely focused on older people or the appointment of a Special Rapporteur.

“Canada wishes to underscore the importance of promoting, protecting, and implementing the existing framework of human rights of older persons. We believe that this framework both supports meaningful participation of seniors within community life and contributes to the strength of our economies”.

While recognizing the work of the UN OEWG the creation of a new convention on the rights of older people does not seem to appear to be a priority. However, some facts seem to contradict this statement. According to the 2010 Report of the Canadian Human Rights Commission 27% of the complaints accepted in 2009 were related to age-discrimination matters (227 out of 853 complaints), which represents a significant part.

INTERNATIONAL PRACTICES

COMMISSIONERS FOR OLDER PEOPLE

The appointment of Commissioners with specific responsibility for older persons is an emerging trend.

A Commissioner for Older People is the spokesperson through whom older people can express their concerns in a united voice. Its work is inspired directly by seniors' testimonies in order to correspond to their true needs, and constantly tries to involve older people in policy debates and development.

The **OLDER PEOPLE'S COMMISSIONER FOR WALES** came into being on 21 April 2008 when Ms Ruth Marks was appointed. The Commission for Older People (Wales) Bill was passed through Parliament and received Royal Assent on 25 July 2006. The Bill was the result of extensive research, consultation and debate in the government and strong advocacy efforts by the Advisory Group on the Strategy for Older People in Wales.

By giving older people their own delegate, their own true voice, age-related discriminations are seen to be better identified and dealt with as the Older People's Commissioner makes listening and working closely with older people in the community a priority. The Commissioner can investigate and challenge various public bodies such as health bodies, local authorities or, concerning the Older People's Commissioner for Wales, the Welsh Assembly Government.

The role of the Commissioner is to ensure that the interests of older people in Wales, who are aged 60 years of age or more, are safeguarded and promoted. Specifically the Commission:

- Provides information, advocacy and support for older people in Wales aged 60 years or older
- Promote the rights and welfare of older people throughout Wales
- Promote the provision of opportunities for, and the elimination of discrimination against, older people in Wales
- Review the adequacy and effectiveness of law, policy and strategy affecting the interests of older people in Wales

- Review and monitor the operation of complaints, advocacy, advice and whistle blowing arrangements to ascertain whether and to what extent Wales is effective in safeguarding and promoting the rights and welfare of older people
- Report annually to the First Minister on the manner in which responsibilities are carried out

Since assuming the post, the Commissioner has held several consultation events across Wales. Many of the concerns raised draw attention to the underlying issue of dignity and respect for older people. Dignity and respect must be central to policies that are supposed to serve people in their latter years.

The Commissioner's aim is to see that older people are treated fairly, to challenge age discrimination and promote awareness of the interests of older people in Wales. In the past year two key themes have emerged -- challenges of living on a fixed income and information about and access to services.

In November 2011, Ms. Claire Keatinge, former Director of the Alzheimer's Society was appointed as **COMMISSIONER FOR OLDER PEOPLE, NORTHERN IRELAND.**

The appointment fulfilled the Programme for Government commitment to 'deliver a strong independent voice for older people'. The key message from the government was one of challenging discrimination against older people, promoting positive attitudes towards older people and encouraging their participation in public life.

In 2011 the Australian Government appointed the Hon. Susan Ryan as the first **AGE-DISCRIMINATION COMMISSIONER.** By creating an Age-discrimination Commissioner entirely dedicated to the ageing cause, the Australian Human Rights Council formally recognized that ageism should be treated just as seriously as racism or sexism.

AUSTRALIA

In Australia any kind of age discrimination are strictly prohibited under the Age Discrimination Act(2004). Whether concerning employment, education, accommodation, information, transport, access to services or premises, it is against the law for individuals to be treated different because of their age, whether young or older.

"I will be challenging age discrimination, promoting the best in health, social care and public service; and making sure that the views and experiences of older people are widely understood by government so that their rights can be best promoted and protected."

Ms Claire Keatinge Commissioner for Older People, Northern Ireland

The Act was amended in May 2011 in order to appoint for the first time at a federal level an Age Discrimination Commissioner working within the Australian Human Rights Commission.

In the same vein, the Disability Discrimination Act(1992) protects anyone from discrimination because of their physical or intellectual disability. The Disability Discrimination Commissioner is entitled to protect their rights.

AGE POSITIVE CAMPAIGN

In Australia, governmental strategies aim at emphasizing positive images of ageing throughout various advertising campaigns, awards, and the media in general in order to promote solidarity and understanding between generations. For instance, the Age Positive Campaign launched recently by the Australian Human Rights Commission aims at gathering different stories and testimonies of older people about their lives in order to remind society of their daily contributions.

AWARDS

Medias are being strongly encouraged to portray older people in a positive way and showcase their work and some of their achievements. By awarding **the OLDER PEOPLE SPEAK OUT (OPSO) NATIONAL MEDIA AWARD** for instance, the government aims to break down stereotypes of older people and communicate a different more positive image of ageing among younger generations.

Similarly the **SENIOR AUSTRALIAN OF THE YEAR AWARD**, sponsored by the Federal Department of Health and Ageing, is made annually to a person aged over 60 years who has made a significant contribution to the Australian society and illustrated his or herself as an outstanding citizen.

Australia is also celebrating the **NATIONAL DAY FOR OLDER AUSTRALIANS** on the 1st of October each year. Many campaigns and events are organized on this day to acknowledge the invaluable contribution older people bring to the Australian society. In 2011 the Minister for State (Seniors) the Honourable Alice Wong joined with fellow parliamentarians and Canadian in celebrating the inaugural "National Seniors Day."

Fighting ageism is also about ensuring that older people have access to all the information they need and are able to keep on learning and study if they wish to. The Australian government developed the University of the Third Age known as **U3A**, the first online university for the third age, delivering online courses and other useful resources which are particularly suited to isolated older people.

Fighting ageism and strengthening intergenerational relationships has been defined as top priorities by Australia and many OECD colleagues manifested in 2012 with the European Year of Active Ageing and Intergenerational Solidarity.

LESSONS FROM EUROPE

According to the European Social Survey conducted by the Eurage (European Research Group on Attitudes to Age) team in 2011, more than 39% of Europeans have experience a lack of respect because of their age; and 29% reported previous insults, abuse or denial of services on the grounds of age. Of the 55,000 respondents surveyed in 28 European countries 44% reported age discrimination as a very serious problem in Europe.

EUROPEAN POLICIES

In Europe the directive 2000/78 implemented in 2000 gave 3 years for every government of the European Union to develop national anti-discrimination laws. A further 3 years was agreed during which time implementation of specific age-discrimination laws would take place.

Member countries may have either not had an age discrimination policy or needed to strengthen the existing policy to align it with the Framework Directive. By 2006 most member countries of the European Union had a national legislation prohibiting age discrimination.

EUROPEAN PROJECTS

SEELNERNETZ (Seniors in Europe Learn in Networks) is a European program encouraging seniors to use social networks in order to be actively involved in their community's life. The aim of the program is to convince older people that social networks can contribute to significantly improving their quality of life as well as intergenerational solidarity.

IRELAND - «SAY NO TO AGEISM WEEK»

The Equality Authority organizes annually the «Say No to Ageism Week» in order to stop discrimination and ageist attitudes against older people. To break down stereotypes and fight prejudices several

campaigns and events are launched during this week to raise public awareness on the risks of ageism and the necessity of “age-friendly” services.

TURKEY – CONSTITUTIONAL AMENDMENT

The Turkish Constitution has been recently amended in 2010, approving that the principle of positive discrimination, notably for the elderly, was not anti-constitutional and did not violate the principle of equality.

DENMARK - SENIOR CITIZEN’S COUNCIL

In Denmark every local authority has a senior citizen’s council providing an interactive platform for seniors to express themselves and to be part of the decision making process, enhancing their contribution and active participation and ensuring that their interests are taken into account while developing policies.

THE NETHERLANDS - Movisie

Movisie is the Netherlands Centre for Social Development and funded for a major part by the Dutch Ministry of Health, Welfare and Sport. It aims at empowering citizens, encouraging them to take action in their communities and to develop their potential and capabilities through social participation. Movisie developed a whole campaign dedicated to promoting older people’s contribution to society named “Value of Silver” in cooperation with the Dutch Social and Cultural Planning Office in order to foster a positive image of ageing.

UNITED KINGDOM - CARE QUALITY COMMISSION

The Care Quality Commission (CQC) ensures that every older person is being treated equally with dignity and respect. The CQC aims at protecting older people against any kind of discrimination that they might be confronted to in long-term care institutions or hospitals and to see that their basic human rights are not being infringed.

BELGIUM, FRANCE – RIGHTS COMMISSIONER

The Center for chances’ equality and eradication of racism (Centre pour l’égalité des chances et la lutte contre le racisme), as well as the Rights Commissioner of France (Défenseur des Droits), are currently using a tool developed online by a Dutch company which allows employers as well as potential employees to screen their employment ads in search of any age-discriminatory terms.

FRANCE – GÉNÉRATIONS & TALENTS

Alcatel-Lucent and APEC, French companies, launched an intergenerational program called “Générations and Talents” aiming at promoting an intergenerational spirit at work. Employees of all ages are encouraged to develop their skills and share their knowledge.

GERMANY – GRAFFITI CLASSES

In Germany, many seniors have the opportunity to be creative and interact with others in an unconventional way – through graffiti classes. Graffiti classes for seniors are now gaining popularity and aid in the promotion of intergenerational solidarity and active ageing. In their classes, seniors and young people have the opportunity to paint graffiti alongside each other, which allows for intergenerational exchange through social interaction. The classes promote increased community involvement for seniors.

SWEDEN – MEETING PLACES FOR EVERYONE

The project Meeting Places for Everyone is being led by Sveriges Makalösa Föräldrar, a Swedish NGO for single parents. The goal of this project is to promote intergenerational solidarity by creating a medium through which single-parent families can meet and form friendships with people who are 60 years or older.

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ABOUT THE INTERNATIONAL FEDERATION ON AGEING

The International Federation on Ageing (IFA) is an international non-governmental organization with a membership base of NGOs, the corporate sector, academia, government, and individuals. The IFA believes in generating positive change for older people throughout the world by stimulating, collecting, analyzing, and disseminating information on rights, policies, and practices that improve the quality of life of people as they age.

Through its work, the IFA works to influence and promote positive change for older people globally and strives to be a point of:

- Connection – linking together NGOs, academia, policy makers, and the private sector
- Information sharing and exchange – facilitating knowledge exchange through our networks
- Research and advocacy – collaborating in research and providing a repository of information
- Policy knowledge – around areas with global implications: age discrimination, engaging seniors, financial protection, and age-friendly communities

The IFA takes a lead to inform, educate and promote policies and practice to improve the quality of life of older persons around the world. Other responsibilities include:

- Building, facilitating and strengthening bridges between government, non-government and the corporate sectors concerned with ageing issues;
- Strengthening non-government organizations through collaboration toward a common goal; and
- Improving the understanding of ageing policies and practice and their impact on the lives of older people.