



Manitoba's Seniors

A Companion to the 'Manitoba Fact Book on Aging'

by

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Why This Report?

This report is intended to provide an overview of issues and challenges around seniors in Manitoba. The main source of information for the report is the Manitoba Fact Book on Aging (2005), published by the Centre on Aging at the University of Manitoba. The Fact Book contains tables and figures that tell us about the lives of Manitoba's seniors, and also a little about the lives of the population of Manitoba as a whole. We use the information collected in the Fact Book and information from other sources in order to expand the meaningfulness and reach of the Fact Book.

We do not attempt to provide a comprehensive literature review; that is beyond the scope of this document. Rather we want to provide a broad sense of what is happening "out there". What are those numbers from the census telling us about seniors in Manitoba? What conclusions can we draw from those numbers? When appropriate, we also compare the next cohort of seniors to the current cohort in order to clarify or highlight certain issues. In many cases the intent is only to highlight issues, rather than drawing definitive conclusions.

Sometimes the conclusions are not obvious, and in those instances we need to refer to basic values and principles. In March of 1998, the provincial ministers responsible for seniors (except Quebec) adopted a voluntary National Framework on Aging, which espouses five basic principles (Division of Aging and Seniors, 1998).

The Manitoba Seniors and Healthy Aging Secretariat, the provincial governmental department that ensures that government policies, programs and legislation reflect the needs of seniors, also espouses the framework and its principles:

- Dignity
- Independence
- Participation
- Fairness
- Security

These principles provide a value system against which to analyse statistics and appraise policies and programs.

Definition of the Principles of the National Framework on Aging Accepted by Ministers Responsible for Seniors

Dignity

Being treated with respect, regardless of the situation, and having a sense of self esteem e.g., having a sense of self-worth; being accepted as one is, regardless of age, health status, etc.; being appreciated for life accomplishments; being respected for continuing role and contributions to family, friends, community and society; being treated as a worthy human being and a full member of society.

Independence

Being in control of one's life, being able to do as much for oneself as possible and making one's own choices e.g., decisions on daily matters; being responsible, to the extent possible and practical, for things that affect one; having freedom to make decisions about how one will live one's life; enjoying access to a support system that enables freedom of choice and self-determination.

Participation

Getting involved, staying active and taking part in the community, being consulted and having one's views considered by government – e.g., being active in all facets of life (socially, economically, politically); having a meaningful role in daily affairs; enjoying what life has to offer; participating in available programs and services; and being involved and engaged in activities of daily living (decisions/initiatives in all spheres, not just those specifically oriented to seniors).

Fairness

Having seniors' real needs, in all their diversity, considered equally to those of other Canadians e.g., having equitable access (socially, economically, politically) to available resources and services; not being discriminated against on the basis of age; and being treated and dealt with in a way that maximizes inclusion of seniors.

Security

Having adequate income as one ages and having access to a safe and supportive living environment e.g., financial security to meet daily needs; physical security (including living conditions, sense of protection from crime, etc.); access to family and friends; sense of close personal and social bonds; and support.

Source: Division of Aging and Seniors, Health Canada. 1998. *Principles of the National Framework on Aging: A Policy Guide*. Ottawa, ON: Minister of Public Works and Government Services Canada.

How this Report is Organized

The document is organized around some of the priorities of the Manitoba Seniors and Healthy Aging Secretariat's *Advancing Age: Promoting Older Manitobans* strategy. The approach is a social determinants of health approach, thus we will attempt to draw links between health status and social and economic issues.

The priorities outlined in the *Advancing Age* strategy that we will focus on here are:

- Transportation
- Housing
- Economic issues
- Safety and security
- Health
- Healthy living
- Health care

Thus, that is the order of the discussion in this document. But first we start with some basic demographics.

Some Basic Demographics

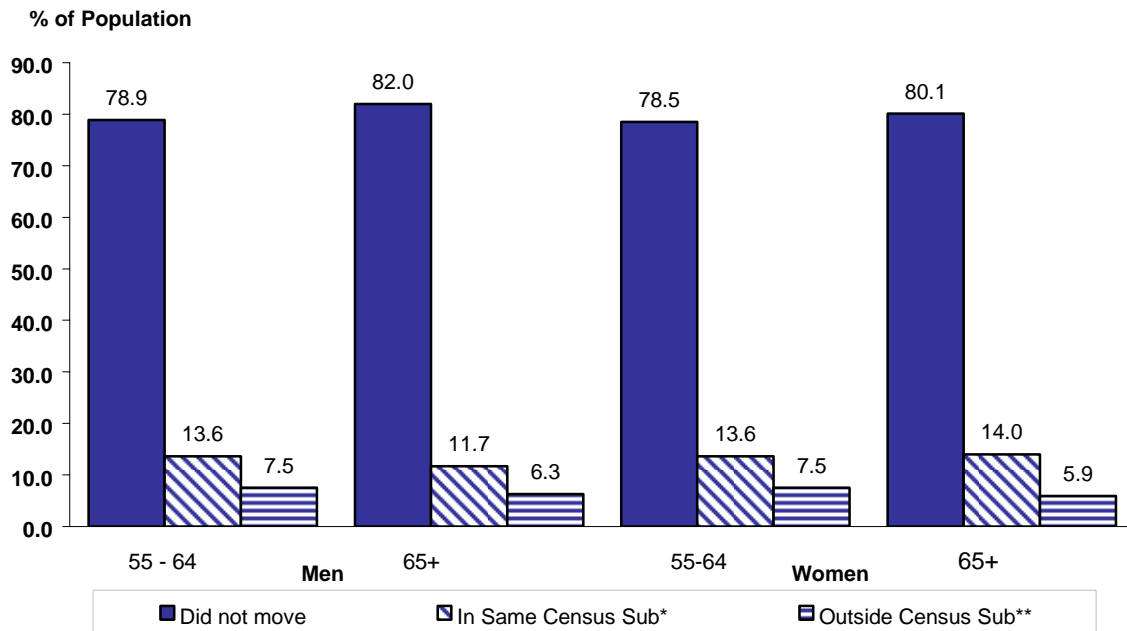
The Population, Now . . .

Manitoba, with 14 % of its population over 65, currently has the second largest proportion of seniors in its population of all the Canadian provinces except Saskatchewan. Thus, seniors form a large proportion of Manitoba's population.

It is also evident and rather striking that seniors don't leave the province: they stay. Less than 8% of men or women over 55 moved from their census subdivision between 1996 and 2001 (Figure 1). Only

3,400 Manitobans over 65 left the province between 1996 and 2001, that is about 1.5% of the population over 65 (Manitoba Fact Book on Aging, 2005, pp. 40-41). Is it because they regard Manitoba as a good place to live? Or is there a sense that incomes are not high enough to move elsewhere? We do not know the answer to these questions; but having a stable population means that seniors can become the real pillar and the memory of communities.

Figure 1: Change in Residence Between 1996 and 2001, Population in Selected Age Groups by Gender, Manitoba, 2001



* Moved within the same census sub-division.

** Moved outside of the census sub-division, including moving out of the province.

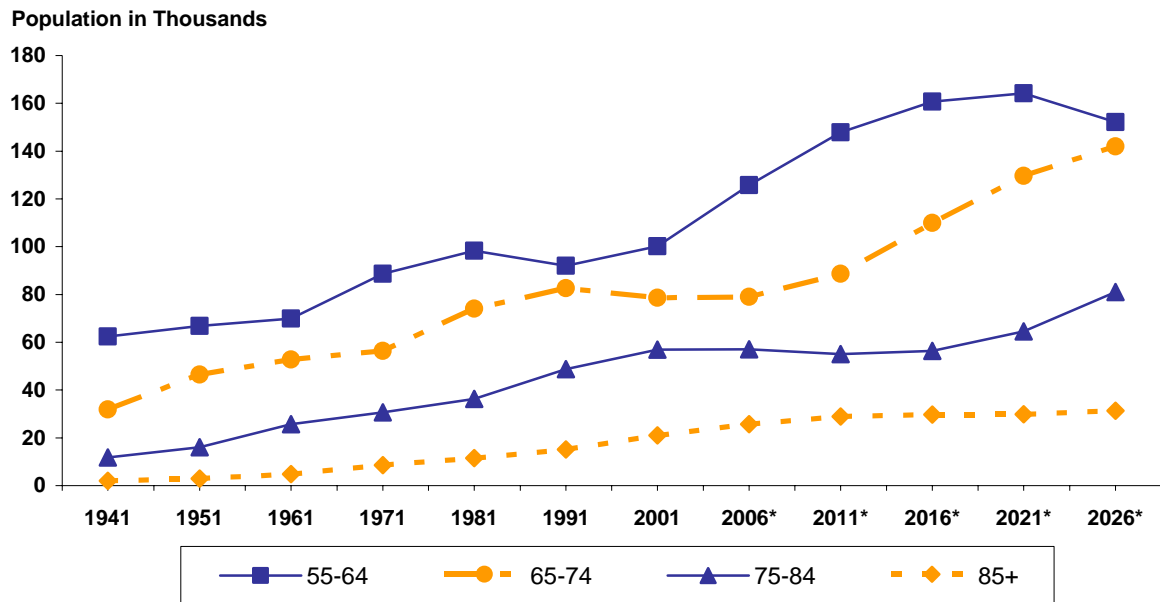
Source: Statistics Canada (December 10, 2002). Mobility Status 5 Years Ago (9), Legal Marital Status (6), Common Law Status (3), Age Groups (16) and Sex(3) for Population 5 years and over, for Canada, Provinces, Territories, Census Metropolitan Areas and Census Agglomerations, 2001 Census - 20% Sample Data. 2001 Census of Canada, Catalogue number 97F0008XCB01002.

. . . and Then, Population Projections

The overall number of Manitobans is increasing. Population projections tell us that by 2011, 17.7% of the population will be over 65, and by 2021, 18.8%. Within that population the greatest single increases

will be amongst those 85 and over; a 37.8% increase by 2011 (Figure 2). That magnitude of increase implies a need for services required by those over 85.

Figure 2: Population in Selected Age Groups, Manitoba 1941-2026



* Projected population based on medium growth scenario.

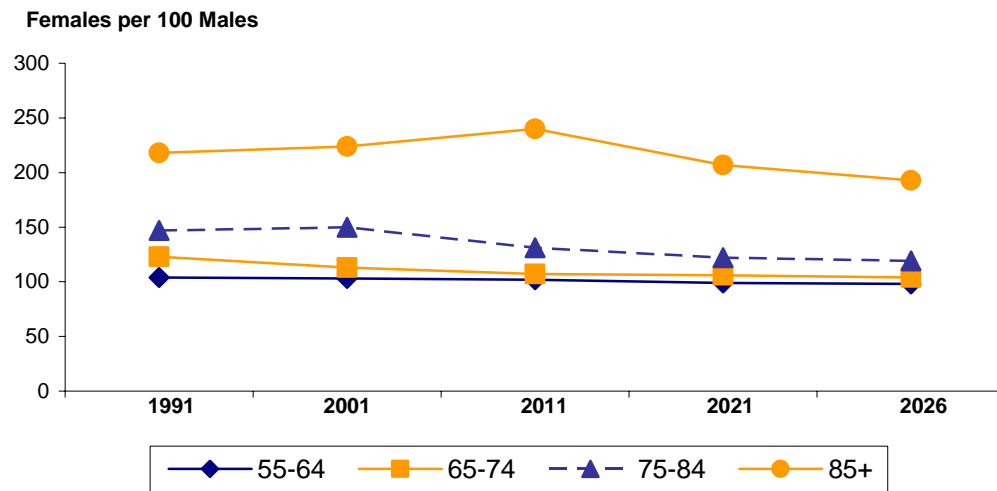
Sources: Statistics Canada (July 16, 2002). Age Groups (12) and Sex (3) for population for Canada, Provinces and Territories 1921-2001 Censuses - 100% Data. 2001 Census of Canada. Catalogue number 97F0003XCB01002.
George, M.R., Loh, S., Verma, R.B.P., Shin, Y.E. (2001). Population Projection for Canada, Provinces and Territories 2000-2026, (Catalogue number 91-520-XPB) (Table A3, pp 158-162). Ottawa, On: Ministry of Industry.

The Predominance of Women

There are more women than men aged 65+. For every 100 men in this age group there were 137 women in 2001 (Manitoba Fact Book on Aging, 2005, pp. 18-19). The predominance of women is even greater in older age groups. Among those over 85, there were 2 or more women for every man (Figure 3). This “femaleness” of the very elderly population is noteworthy for several reasons. Almost 90% of women 85+ are

widowed, divorced or single; single/widowed women are likely to be poorer than they were while married. Women are also more likely to be admitted to personal care homes than men, which are in part linked to their marital status; the presence of a spouse keeps many of the married seniors out of personal care homes, because the partner can provide informal care (Maxwell, Leger, Hirdes et al., 1998).

Figure 3: Females per 100 Males, Population in Selected Age Groups, Manitoba, 1991-2026



Sources: Statistics Canada (1992). Age, Sex and Marital Status (Catalogue No. 93-310) (Table 1 p.13). 1991 Census of Canada - 100% Data. Ottawa, ON: Ministry of Industry, Science and Technology.

Statistics Canada (July 16, 2002). Age (122) and Sex (3) for Population, for Canada, Provinces, Territories, Census Divisions and Census Subdivisions, 2001 Census - 100% Data. 2001 Census of Canada. Catalogue number 95F0300XCB01006.

George, M.V., Loh, S., Verma, R.B.P., Shin, Y.E. (2001). Population Projections for Canada, Provinces and Territories 2000-2026. (Catalogue number 91-520-XPB) (Table A3, pp. 158-162). Ottawa, ON: Ministry of Industry.

Women will continue to outnumber men, so the population projections tell us. There are still expected to be almost 2 women to every man among those aged 85 or over. Thus the economic issues faced by many older women and the need for programs and services specifically targeted to this group, such as transportation will need to remain issues to be addressed.

The Increasing Number of Older Men

We would be remiss if we did not mention older men at this point. Population projections suggest that the gap between men and women is narrowing for the 75 to 84 year olds. While there are expected to be 119 women in this age group per 100 men, this is a lot less than the current 150 women per 100 men, a finding that can be attributed to the increasing life expectancy of men. Policies will need to take into account the increasing number of older men.

Aging in Rural Areas

Manitoba is unique among Canadian provinces in that almost two thirds of the population lives in one city, Winnipeg, where infrastructure is available and where services and programs are more developed than in rural areas, such as recreation programs.

We have noted earlier that Manitobans don't move far. This is also the case for seniors living in rural areas who are bucking the trend to move to urban areas; they are retiring in place in rural areas. The growth of the senior population in rural areas has been described

“ . . . as the result of a naturally aging population combined with three types of older in-migrants: urban people retiring to a rural setting; farmers and others from outlying areas coming into town to live; and people retiring to towns where they grew up ” (McFarlane, 2003).

These older people moving into the small towns become an important part of the community network and of its economy.

What may come as a surprise to some is that over the coming 15 years it is expected that the population of rural areas (including small rural towns) will increase, while there will be a small decrease in the population of Winnipeg (Stewart, Tate, Finlayson et al., 2002).

Perhaps one of the most important issues faced by current and future seniors living in rural areas is the question of support services, both informal and formal. What services are needed? What is and/or will be available in rural communities? What is only likely to be available in urban areas? And at what cost?

Keefe, Fancey, Keating et al. (2004), in a report on support to seniors in rural communities across Canada, state that the prairies have the highest proportion of the population providing unpaid care such as personal care or assistance (e.g. with shopping, taking medications, banking) to seniors.

In addition, the characteristics of rural communities with the highest proportion of the population providing help to seniors include those *“that are relatively smaller in size, further from a service centre, higher proportion of seniors and widowed persons, lower household incomes, a greater proportion of long-term residents and a greater proportion of persons providing unpaid child care.”* These characteristics may be indicative of communities where residents have had the opportunity to get to know one another over time and have established patterns of helping. They also caution, however, that

“ . . . an over-reliance on aging seniors in creating supportive communities, without access to formal support services, may place some communities at risk. ”

Will there be enough health care providers, for example home care providers, nurses, physicians, in rural areas? It is difficult to predict from the population projections, in terms of professions, who will live in the rural communities, but if the population base remains strong, one would expect that the supply of permanent workers would also be available.

The Special Case of the North

Perhaps the most interesting population projections are those for the North. Currently seniors are only a very small proportion of the population of Burntwood, Churchill and Norman health regions, yet all three regions are expected to grow substantially, with a tripling of the population over 80 in the Burntwood and Churchill health regions (Stewart, Tate, Finlayson et al., 2002). Will this be mainly aboriginal people? Or are the various workers in mining regions also staying in the north? Who will be providing services for the northern populations? What will be their access to health care services? What of the costs of medical transportation if people must be flown out for emergency care? We also know that medical evacuation is extremely costly, and at times contentious. In order to meet the accessibility criteria of the Canada Health Act, who really needs to be evacuated?

Among First Nations populations the aged dependency ratio (the population aged 65 and over divided by the population aged 15 to 64) was 6.3% in 1999 compared to the Canadian rate of 17.9%. Although this rate is lower than the Canadian rate, it still suggests that First Nations populations aged 15 to 64 are dealing with the burden of care for those aged 65 and over (Health Canada, First Nations and Inuit Health Branch, no date).

Health Canada, through the First Nations and Inuit Health Branch, ensures the provision of home care services on reserves. Federal nursing homes provide care for First Nations' people whose care needs exceed those that can be provided through

home care. Will existing resources be sufficient for the rising number of seniors? Will they provide culturally appropriate and safe care? These are all questions that need to be addressed as the number of seniors in the North grows.

Tomorrow's Seniors

The so-called population pyramid – the pyramid that shows the number of people in different age groups - has not been a pyramid in northern, wealthy countries for many years; not since the boomers were born. The baby boomers are the people now in their 40's and 50's, the seniors of tomorrow, the bulge in the middle of a double ended pyramid. By 2026 there will likely be as many 70-74 year olds as there are children under 4; one hopes that home care will not be pitted against day care, further increasing the generational divide.

There is a pronounced change in the socio-cultural history of today's seniors and those who will join the ranks of the 65+ in 5 year's time. People over 80 remember the war years; those who are now 65 were affected by the war in their early childhood, but have no direct memory of the war. The 1945 born will look upon the war as a distant memory. Those over 80 remember the depression, particularly on the prairies, while the post-war boomers have only experienced generally increasing prosperity and no war in which Canada was involved as a combatant. They have also experienced the implementation of both Canada/Quebec Pension Plan and Medicare; universal programs that provide some element of security for the future.

The new cohort is also changing in other ways. The first seniors of the baby boom will be 65 in 2010. Many will have had better formal education than today's

seniors; more than 50% have completed some post secondary education as opposed to the seniors of today, of whom some 30% went beyond high school (Table 1).

Table 1: Highest Level of Formal Education, Population Aged 45-64 and Population Aged 65+, Manitoba, 2001

Highest Level Completed	% of Population Aged	
	45 - 64	65+
Less than Grade 9	9.8	32.7
Grade 9 - 13	34.8	37.2
Some non-university *	31.0	18.1
Some university	24.4	12.0

* Some non-university includes trades certificates or diplomas; certificates or diplomas from community colleges; courses at non-universities without certificates or diplomas, etc.

Source: Statistics Canada (March 11, 2003). Detailed Highest Level of Schooling (20), Age Groups (13B) and Sex (3) for Population 15 years and Over, for Canada, Provinces, Territories, Census Metropolitan Areas and Census Agglomerations, 2001 Census - 20% Sample Data. 2001 Census Canada. Catalogue number 97F0017XCB01001.

The coming generation of seniors is certainly going to have more women drivers, there are fewer children and grandchildren to support that generation; women are more likely to have their own pensions from their own years in the work force. They are also more likely to be demanding of improved services. Many of them are people who have organized for improved services from government agencies.

Tomorrow's seniors will also be more culturally diverse. Currently 84.3% of Manitobans aged 65 and over report English as the language most often spoken at home (Manitoba Fact Book on Aging, 2005, p.31). However, 12 % reported German, 10% reported Ukrainian and 6% reported French as their mother tongue (the language first learned at home and still

understood) (Manitoba Fact Book on Aging, 2005, p. 30). These proportions are slowly changing, as the impact of immigration is felt on the language groups. According the 2001 Census, the highest proportion of immigrants in the 45 to 64 year old age group (30%) came from Asia (Manitoba Fact Book on Aging, 2005, p. 28).

Some services for specific ethnic groups are available in Manitoba. For example, Winnipeg currently has a personal care home for Asian seniors; thus people can retire in their own language. Are personal care homes for specific cultural groups the way of the future as Manitoba becomes a more culturally diverse province? Or will cultural expectations that children take care of aging parents reduce the need for personal care home beds? And what care

burden will this bring for the “sandwich” generation of employed women; those who still have children at home and also take care of aging parents or family members, while at the same time working in paid employment? These are all issues that require attention.

Rosenberg (1998) in a study of the determinants of seniors’ independence highlighted the need for better access to information as an important issue which transcended all of the focus groups that they conducted. He states in his final report:

“While the seniors participating in the focus groups recognized that there is a tremendous range of services in their communities, they also commented over and over again about how difficult it is to identify the appropriate services and where to get them especially in times of crisis and especially those services and supports outside the formal systems of health and home care.”

Computer use will certainly increase in the next cohort, which has been using computers in working life. Will the “digital divide” increase the inequities between those who have access to personal computers and those who don’t? Currently

we see that only some 9% of seniors over 65 use computers, while 42% of those aged 55-64 do so. Yet 100% of senior men and 83% of women using a computer use it for e-mail: a communication mechanism growing in popularity on a daily basis (Manitoba Fact Book on Aging, 2005, pp. 143-144).

So will increased access to computers and the internet assuage some of the information problems? Or will it increase isolation as interaction with banks, with libraries, with friends, decreases? Does the use of computers actually break the cycle of isolation? Silver (2001) reported that according to data from the 2000 General Social Survey conducted by Statistics Canada older people who surf the Internet tend to be an “elite group, with higher education levels and higher incomes than other older people.” He also states:

“As society uses the Internet for many different purposes more and more, older people are being excluded from the main stream. This exclusion has significant economic and social implications insofar as it may place limits on plans for business and government transformations made possible by the new medium.”

Key Points

- ▶ The increase in the senior population is substantial, therefore, the need for planning is essential.
- ▶ Issues surrounding aging in rural and remote areas require special attention, as the number of seniors who stay in rural communities is increasing.
- ▶ Very elderly women are a particularly vulnerable population. Supports for these women who may have lost a spouse are needed, such as income supplements, social support, as well as home-based care to avoid institutionalization.
- ▶ As the number of older men is increasing, programs and services sensitive to their needs and interests will need to be planned and developed.
- ▶ As baby boomers age, there will need to be increasing flexibility in the provision of programs and services to address the greater diversity within the aging population (e.g., culturally appropriate services, services to meet the increasing information needs).

Transportation

“*Transportation is key to independence*” as stated by senior participants in an Aging in Manitoba study on social isolation (Hall and Havens, 1999). Transportation also emerged as a key priority area for research in a regional seniors’ workshop on research, conducted by the Canadian Institutes of Health Research, one of the major research funding agencies in Canada. At this workshop, seniors from Manitoba noted as a key issue: “*transportation, especially in winter for isolated rural seniors, and financial benefits to assist volunteers (e.g., tax credit)*” (Canadian Institutes of Health, Institute of Aging, 2004).

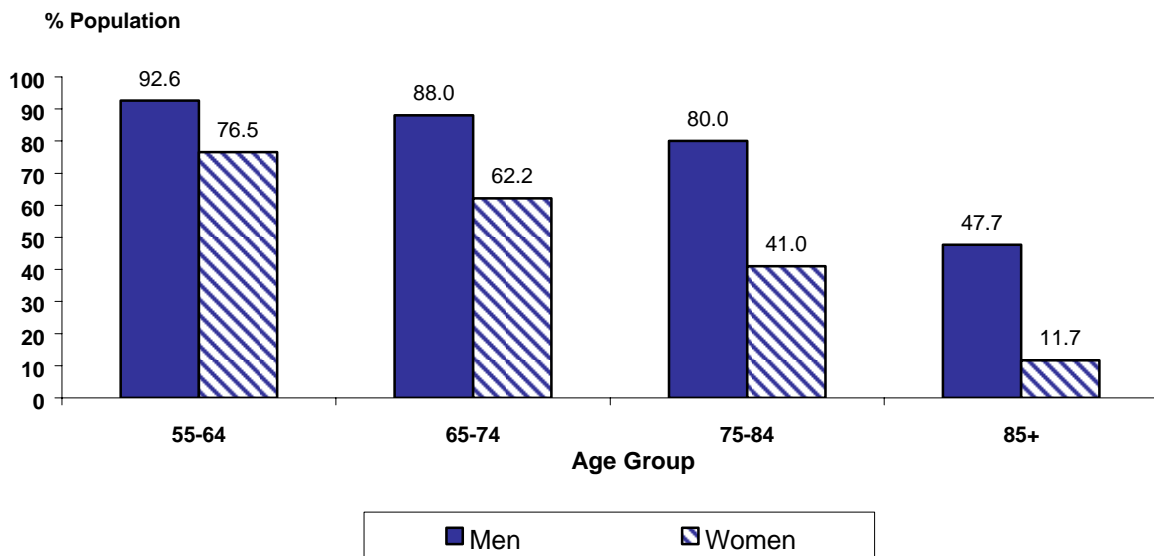
Thus transportation may lie at the heart of the need for appropriate policy responses in order to allow seniors to remain active members of their community. We discuss here some of the issues around driving,

public transit, and other transportation programs.

Driving

A total of 81.3% of men over 65 versus only 46.1 % of women, had valid drivers licences (Manitoba Fact Book on Aging, 2005, p. 149). As shown in Figure 4 the difference between men and women in the 55-64 age group was less. It appears that amongst the current cohort of seniors many women wait to learn to drive until they are widowed (Bess, 1999). All indications are that this is changing as the social climate of the male as family driver and family car maintainer becomes a more equal relationship. But meanwhile, we need to ensure that social isolation does not overwhelm the non-driving widows and low-income seniors.

Figure 4: Valid Driver’s Licenses Held by Population Aged 55+ by Age Groups and Gender, Manitoba, 2001.



Sources: Manitoba Health. Manitoba Population Report, June 1, 2001.
 Manitoba Highways and Transportation. (2001). Traffic Collision Statistics Report (Section 2, p. 13). Winnipeg, MB: Manitoba Highways and Transportation.

Driving in Rural Areas

According to data from the 1996 General Social Survey conducted by Statistics Canada, rural and small town seniors were most likely to be drivers, since the car and the ability to drive it were of vital importance to the ability to shop, go to appointments, to participate in community activities, etc. Seniors in rural areas spent some \$4,800.00 annually, while urban seniors spent \$2,800.00 annually on the purchase on operation of a car (Bess, 1999). Thus although incomes in rural areas are typically lower (Singh, 2004) a much larger proportion of those incomes goes into private vehicle purchase and maintenance.

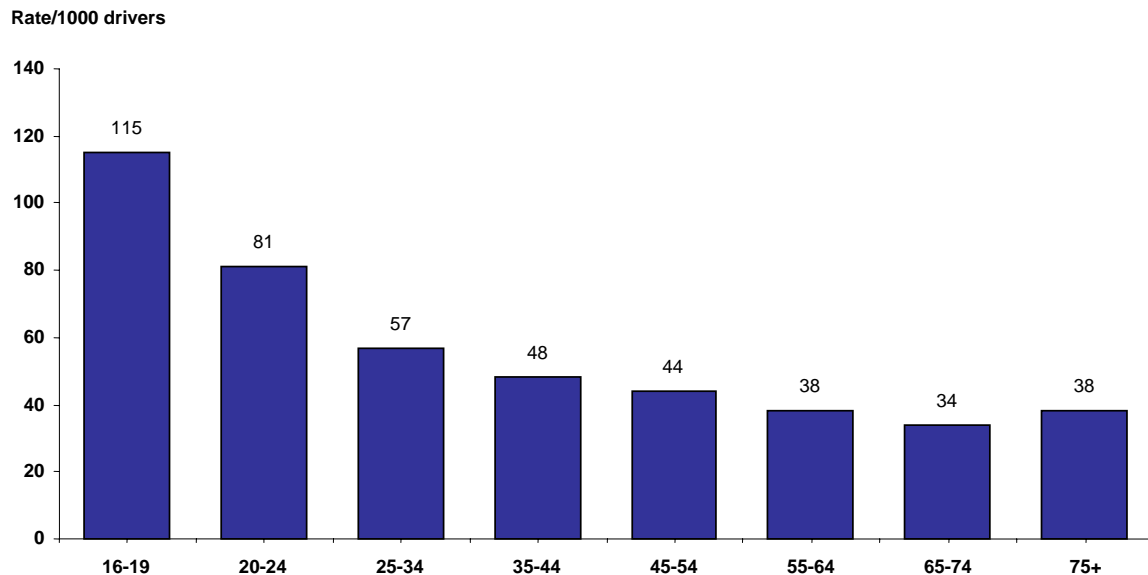
Given the importance of driving in rural areas, one would expect that no longer being able to do so would have a significant impact on seniors living there, perhaps

more so than on seniors in urban areas, who have access to a wide range of modes of transportation. It brings to the forefront the need to have a variety of transportation options available for seniors.

Seniors are Safe Drivers

Statistics and analyses of accidents amongst seniors are not easy to interpret; the number of collisions per 1000 drivers actually decreases with age as shown in Figure 5. These rates, however, do not take into account the number of kilometres or miles driven by an age group. In addition, many seniors with valid driver's licenses may no longer drive, thus the collision figures may be lower than they would be if they were based on actual drivers.

Figure 5: Relative Involvement in Collisions per 1000 Drivers by Age Groups, Manitoba, 2001



Source: Manitoba Highways and Transportation. (2001). Traffic Collision Statistics Report (Section 8, p. 10). Winnipeg, MB: Manitoba Highways and Transportation.

Many studies have examined the implications of seniors' driving and driving habits as a public and social policy issue as noted in Millar (1999). There seems to be a consensus emerging that functional measurements rather than diagnostic factors should be the base for decision making around licensing of seniors thus the role of occupational therapists, physiotherapists and social workers may become more important than the current, purely diagnostic role of the physician.

The role of medication that improves mobility from arthritis or rheumatism may also be important in maintenance of driving capacity. Alternatively, other medication may play a role in lowering driving capacity. It is possible that re-training of older drivers may need to be reconsidered, but there needs to be recognition of the changing technology of car manufacturing, of highway design which may also impact on seniors' ability to continue driving.

Public Transit

Obviously, loss of driving ability also implies a public policy question around provision of alternate transportation. What is the best kind of public or assisted transport? Are health regions or provinces

prepared to invest in such transport, particularly in rural areas?

There is little in the literature about seniors' use of public transport; the public transport literature is largely concerned with costs and general use. It appears that transit ridership on the whole is not elastic, that is it does not vary with the cost, but that revenues for public transit go up when fares are raised (Kohn, 1998).

Finlayson and Kaufert (2002) explored the nature of older women's community mobility and the influence of risk perception on their mobility. They pointed out that the perception of risk, whether risk was real or not, was an important factor in the use of public transit. A great deal of research remains to be done on the use of public transit, by seniors and by other community members.

Almost a quarter of Manitobans over 65 were somewhat concerned about their safety in public transportation (Table 2). Almost a third of women, who are more likely to use public transport, reported safety concerns. These perceptions will need to be taken into account in policy discussions and decisions.

Table 2: Feelings of Safety, Population Aged 65+ by Gender, Manitoba, 1999

Feelings of Safety	% of Population Aged 65+		
	Total	Men	Women
Satisfaction with personal safety from crime:			
Satisfied	84.1	81.5	86.0
Dissatisfied	6.1	4.8	7.1
Don't know/not stated	9.8	13.7	6.9
While waiting for/using public transportation alone after dark¹:			
Not at all worried	67.3	66.8	68.6
Somewhat/very worried	22.6	18.7	31.4
Don't know/not stated	10.1	14.6	0.0
When walking alone in your area after dark¹:			
Very safe			
Reasonably safe	46.4	51.9	37.9
Somewhat/very unsafe	37.1	35.6	39.4
	16.5	12.5	22.7
While alone in your home in the evening or at night²:			
Not at all worried	81.2	79.9	82.2
Somewhat/very worried	18.5	19.9	17.4
Don't know/not stated	0.2	0.0	0.4

¹ Based on responses for people who engage in these activities, i.e. only those who use public transportation, and those who walk alone after dark.

² This excludes people that are never home alone.

Source: Statistics Canada (1999). General Social Survey, Cycle 13. Public Use Microdata File.

Handi-transit and Other Transportation Programs

We are only touching here on the question of Handi-transit, of Para-transpo, or whatever the method of subsidized transportation exists in a particular area. These modes of transport require a physician recommendation, and are thus not available to people who simply require

some form of transport to reach a particular activity or appointment. To meet transportation needs, Community Seniors Resource Councils and Seniors' Organizations provide, among other programs, escorted transportation for seniors.

There is little research on the use of these transportation methods. So we cannot comment on whether current transportation programs meet needs, who uses them, and who does not and why not. Rural areas present another challenge. Perhaps that coming cohort of seniors will organize to improve transport in those areas.

The Manitoba Association on Gerontology (2000) wrote a position paper whose objective was “to provide support and guiding principles for the development of alternative transportation solutions that address the mobility limitations of seniors in Manitoba”, but not to make any recommendations. Recommendations by the Winnipeg Seniors Transportation Working Group (2001) included:

- *“Improvements to the walking environment.*
- *Identification of resources to maintain an older person’s ability to drive.*
- *Creation of incentives to promote rides by friends and family.*
- *Amendments to the organizational structure of formalized volunteer ride systems for seniors.*
- *Improvements in accessibility to scheduled bus service.*
- *Improvements in accessibility to Handi-Transit.*
- *The incorporation of private, public and community-based transportation services to develop a new senior transportation service.”*

Both these groups recommended a great deal more work and research on special transport needs for seniors.

Key Points

- ▶ Transportation emerges again and again as a key issue for seniors. It is critical to seniors' independence, quality of life, and even health.
- ▶ Driving is an important mode of transportation for seniors, particularly in rural areas. The issue of how cars can be adapted to the needs of seniors (e.g., special windshields, adaptations in steering ease, in gear shifts adjusted for disability) is an important one that needs to be explored.
- ▶ Determining who should drive also needs examination. Should examinations, particularly road examinations be a requirement after 80, or for individuals taking certain prescription drugs? Any policies must be sensitive to the diversity of seniors.
- ▶ A wide range of affordable transportation options should be available for seniors, such as safe and easily accessible public transit, handi-transit, shared taxis, volunteer drivers, etc.
- ▶ Access to and delivery of transportation should occur in a coordinated fashion to provide seniors. Currently, the availability of transportation (e.g. Handi-transit) is often fragmented and has strict eligibility requirements.
- ▶ Transportation cannot be examined in isolation. Other issues must be considered, such as side walks, as one has to get to the bus in the first place.
- ▶ Transportation in rural areas must be treated as a unique issue requiring in depth examination. As more seniors age in place in rural areas, this is a particularly pressing issue.

Housing

The term “housing” probably invokes images of bricks and mortar in most of us. But housing needs to be considered in a much broader context that reflects the values we mentioned at the beginning of this report: dignity; independence; participation; fairness; and security. Only recently has housing been accepted as a determinant of health (Bryant, 2002).

Moloughney (2004) notes three potential health dimensions of housing; house, home and neighbourhood. *House* refers to the physical aspects of housing including structural and design features such as housing type, warmth. *Home* represents the psychosocial dimension of housing such as sense of permanence, security, and *neighbourhood* influences the availability of health and social services.

The notion of “aging in place” is another concept that is very much linked to housing.

” Aging in place as a principle means not having to move from one’s present residence in order to secure necessary support services in response to changing health- and life management-related needs. It supports the choice of individuals to maintain the maximum possible level of independence in their day-to-day living” (Manitoba Health, 2005).

In other words, aging in place implies remaining in one’s home or community as long as possible without having to move. To make this possible, having formal and informal supports need to be available.

Is caregiving a health, health care or a housing issue? Or is it a larger issue testing our community and interpersonal values? We discuss caregiving here in the context of

housing, because it closely tied to aging in place; but first, some definitions.

What is Acceptable Housing?

In gerontology there is a great deal of discussion about the appropriateness of various housing types. According to Jakubec and Engeland (2004), Canada Mortgage and Housing Corporation (CMHC) define acceptable housing as housing that meets three core standards:

- *“Adequate dwellings are those reported by their residents as not requiring any major repairs.*
- *Suitable dwellings have enough bedrooms for the size and make-up of resident households, according to National Occupancy Standard (NOS) requirements.*
- *Affordable dwellings cost less than 30% of before-tax household income.”*

“A household is said to be in core housing need if its housing falls below at least one of the adequacy, suitability or affordability standards and it would have to spend 30% or more of its before-tax income to pay the median rent of alternative local housing that is acceptable (meets all three standards)” (Jakubec & Engeland, 2004).

Home Ownership

Home ownership is often the major financial asset of families in Canada. Sixty percent of Canadians own their own homes compared to 64% of Manitobans who were home owners (Statistics Canada, 2001a). The proportion of Canadians 65 and over owning their own homes is 67%, and since Manitoban's ownership rates were generally as high if not higher than the rest of Canada, we can assume that a large majority of Manitoba seniors own a mortgage free home. Elderly Canadian families in which the major income recipient was 65+ tended to have the highest net worth, in part because of the mortgage free home (Statistics Canada, 2001a). Whether this housing is adequate or suitable would require further research.

The above optimistic portrait of seniors housing must be tempered by the fact that some 54% of seniors who live alone in rented accommodation are in core housing need. And for elderly women, the percentage increases to some 58% (Engeland, Lewis, Ehrlich & Che, 2005). That is, seniors who do not own their own homes are much more likely to live in inadequate housing. And elderly low income seniors who do own their own home pay a greater proportion of income on

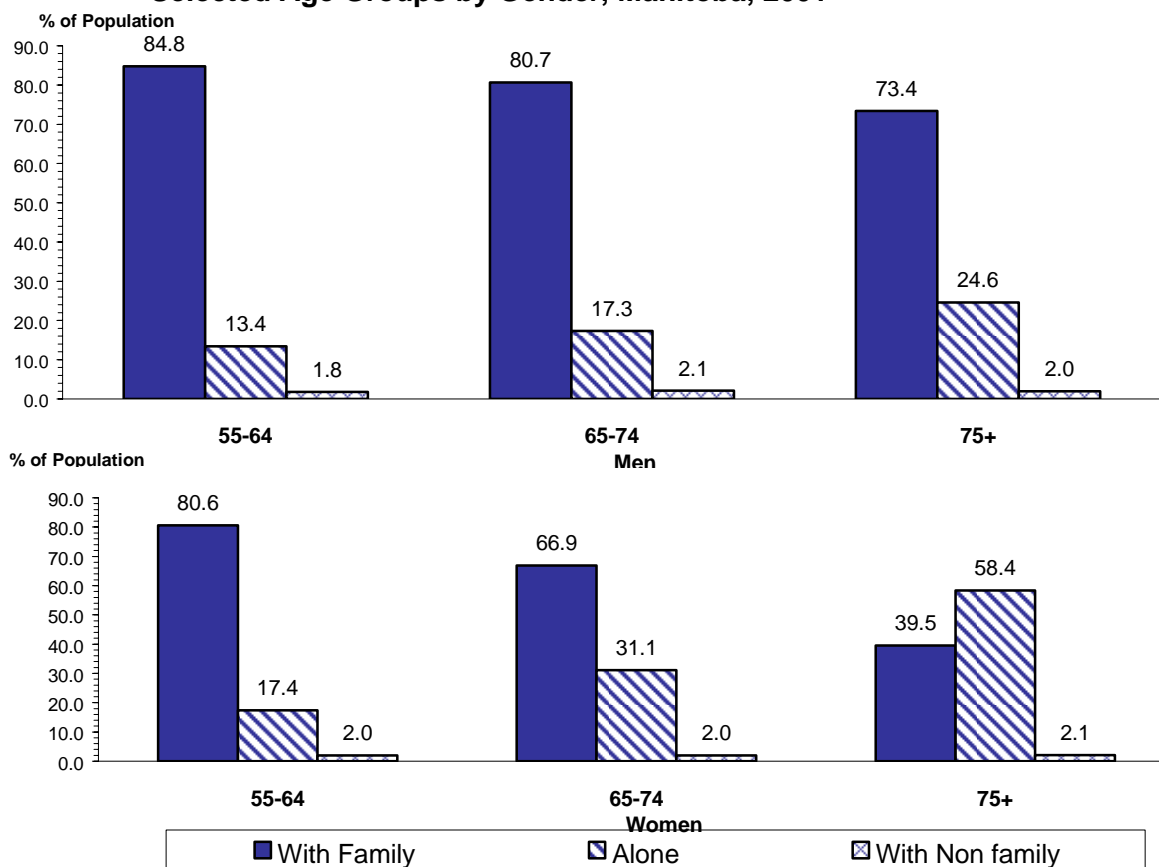
property tax than their non-low-income counterparts (Chawla & Wannell, 2004a).

Living Arrangements

The majority of people between ages 65 to 74, in Manitoba, live either with their spouses or with other family, but those proportions drop off as the populations ages and women 75+ are more likely to live alone (Figure 6). In contrast, 73.4 % of elderly men over 75 live with a spouse, or family member, while only 39.5% of women live with spouse or family. The earlier mortality for men explains some of this. Thus as women age, and become frailer they are the ones most often left alone. And the net worth of those elderly single women declines substantially.

The foregoing means that solitary elderly women, who may not have access to transportation, or who perceive themselves as unsafe, who are more likely to be isolated and lonely, are also more likely to also live in housing that is not acceptable. However, it has been argued (McCracken & Watson, 2004) that access to adequate housing (safe, stable & affordable) has allowed women to be independent and to break isolation and have some social support.

Figure 6: Household Living Arrangements for Population Living in Private Households, Selected Age Groups by Gender, Manitoba, 2001



With family includes spouse, common-law partner, lone parent, and other family.

Source: Statistics Canada (October 22, 2002). Household Living Arrangements (10) Age Groups (17A) and Sex (3) for Population in Private Households for Canada, Provinces, Territories and Federal Electoral Districts (1996 Representation Order), 2001 Census - 20% Sample Data. 2001 Census of Canada. Catalogue number 95F0315XCB01003.

Seniors' Apartments

Most seniors want to stay in their own home as long as possible. At some point though many do move into seniors' apartments, where there is some support (e.g., meals) and there is greater security and company of others. Seniors apartments vary greatly in the kind of services provided; some provide all meals and nursing care as well as social activities.

In Manitoba, seniors apartments can be categorized into three types: independent living facilities, assisted living facilities and supportive housing. Independent living facilities are places designed for seniors who are mobile and can take care of themselves.

“Independent living facilities offer private accommodations ranging from a studio or bachelor suite to a full-

sized one, two or three bedroom apartment with a kitchen. In many places residents may prepare their own meals or they can eat with other seniors in a common dining room. Some independent living facilities may offer a recreation program, transportation, housekeeping and/or laundry services” (Age and Opportunity, 2003).

On the other hand, assisted living facilities combine independent living with services such as meals, housekeeping and laundry, without the 24-hour home care component available in supportive housing (discussed below). In Manitoba, assisted living residences are independently owned, which means that they are neither licensed nor regulated by a governing body, and the level of services provided varies from facility to facility. To access this type of housing, the senior must contact the organization that manages the residence (Age and Opportunity, 2003).

Shapiro and Tate (1988) found that living in a senior’s apartment was a predictor of nursing home admission. Is this because people who move into seniors’ apartments have admitted to losing touch with their communities? Are they already frailer than those who live in their own homes? Yet there is little literature on the attitudes of those who have moved. Did they move because they felt there was no alternative? Did they move because sons and daughters insisted they would be safer? For a fictionalized discussion of this topic James Michener and Doris Lessing in their personalized novels about older people, might be good guides. Michener (1995) describes a group of elderly men bored with their lives in a Florida retirement community, who refuse to accept the passive roles that both society and family

have handed them. Lessing (1984) describes the trials and tribulations of “friendly visiting” in Thatcher’s Britain.

Supportive Housing

The NACA position paper on supportive housing provides a definition of supportive housing in Canada, as obtained from Canada Mortgage and Housing, although it is also noted that there is no official or good working definition.

“Supportive housing is the type of housing that helps people in their daily living through the provision of a physical environment that is safe, secure, enabling and home-like and through the provision of support services such as meals, housekeeping, and social and recreational activities. It is also the type of housing that allows people to maximize their independence, privacy, decision-making and involvement, dignity and choices and preferences” (National Advisory Council on Aging, 2002).

In Manitoba, supportive housing is an option for people who can no longer manage in their own home but are not ready to move into a Personal Care Home (WRHA, 2005). *“Supportive Housing combines apartment living with services such as meals & housekeeping while providing 24-hour support care and supervision. This combination of services, health care, and independence enables people to live safely and comfortably in the community” (Age and Opportunity, 2003).* Eligibility for supportive housing is determined through an assessment by a Home Care Case Coordinator from the Winnipeg Regional Health Authority who will then determine which supportive housing location best fits the individual’s needs. In 2003, there were four Supportive

Housing locations in Winnipeg, with a total of 212 available spaces.

NACA also states in their position paper that there is a need for a "bridge" in the seniors' housing market so that seniors who can no longer live fully independently have additional housing options than long-term care institutions. Evidence suggests that supportive housing can effectively provide this "bridge" (National Advisory Council on Aging, 2002).

Strain, Grabusic and Goerz (2000) reported on data collected from two demonstration supportive housing sites in Winnipeg that targeted cognitively impaired individuals. Family caregivers interviewed in this study identified both advantages to themselves as caregivers (e.g. peace of mind and/or less stress, knowing that the tenant was well cared for or physically safe) and the tenants (e.g. opportunities for social interactions, a homelike environment).

Other Models of Housing

Various other models for seniors' housing, in addition to the types of seniors housing just discussed, have been developed. "Life Leases" offer an alternative mechanism to create seniors housing. Residents of life lease projects purchase a 'right to occupy' a dwelling for life. Most life leases in Canada have been sponsored by community-based non-profit organizations such as churches, service clubs, or ethnic groups" (Gullison, 2003).

The Abbeyfield model provides an alternate form of cooperative type housing, where a small group of people share a larger remodelled home, with separate rooms, but cooperative eating and shared help for cooking or other services.

Other models exist in communities like Elliot Lake where mine housing has been converted to seniors housing and the community is centred on seniors' needs.

The 2002 General Social Survey has also noted a trend of growing popularity of age-restricted residences, such as condominiums which cater to the 55 and over population (Canada Mortgage and Housing, 2003). Does this mean that people as they age want to live in communities of people like themselves? Or is it that the age restricted residences can supply security without loss of independence or assistance in the whole gamut of everyday tasks that some people begin to find onerous? Those seniors fortunate enough to live in the same communities as their adult children, or other close friends or relatives may be able to choose to live in "granny flats"; separate units attached to the main household by one entry.

Again one senses that as the baby boom cohort ages, and as new housing models are developed all around the world and shared via the internet, people will begin to be more creative in designing their own housing solutions.

Home Adaptations

In the sections above we have discussed various types of housing. But the reality is that most seniors remain in their homes into old age. As stairs become difficult to manage, and getting into and out of the bathtub becomes a challenge, home adaptations may be critical to allowing seniors to live in their own home as long as possible.

In Manitoba, the Home Adaptations for Seniors' Independence Program exists, which provides financial assistance in the

form of forgivable loans to homeowners and landlords:

“to carry out minor home adaptations/changes that help low-income seniors experiencing difficulties with daily living activities in the home (Manitoba Family Services and Housing, 2005a).

The concept of “visitable housing” also needs to be mentioned at this point. It refers to designing and building houses that provide access to everyone, including people who use wheelchairs or walkers. At a minimum, visitable housing involves:

- *One level, no-step entrance — minimum 36 inches (91.4 centimetres) wide — on an accessible route;*
- *Wider doorways — minimum of 32 inches (81.3 centimetres) clear passage throughout;*
- *A wheelchair accessible bathroom on the main door (Manitoba Family Services and Housing, 2005b).*

There is now increasing awareness that the concept of visitable housing is important. One hopes that all new housing will be built accordingly. But what of the existing housing that has not been built with these standards in mind? Home adaptation programs such as the one described above are key in this case if seniors are to age in their own homes.

Formal Supports - Home Care Services

A section on housing would not be complete without some discussion of home care. Manitoba has been a leader in home care and in planning of home care services.

The Provincial Home care program provides three types of services:

- post-acute recovery services at home;
- maintenance or palliative home care to functionally disabled or frail individuals who need help to remain at home; and/or
- services to individuals awaiting personal care home placement.

Access to home care is determined by a professional assessment of needs. If the individual is assessed as requiring home care, the home care services are provided free-of-charge. Based on assessed need and other available supports, services provided through the program may include: assessment/care coordination/ management and care planning/nursing services, personal care assistance (such as bathing and dressing), home support services (such as cleaning and preparing meals), rehabilitative therapy assessment, health education, assistance with facility-based respite care, and access to adult day.

Table 3 illustrates a rather interesting point about the distribution of home care in the province: it appears that in most of the health regions home care use by seniors is approximately equivalent to their representation in the population. In other words, there is no regional variation in home care use; the system appears to be working, at least in terms of access to home care (Peterson, Shapiro & Roos, 2005).

Research shows a growth in home care (Mitchell, Roos & Shapiro, 2005), and there will be pressure for continued growth, as more seniors age in place. According to various studies in Manitoba, home care extends the amount of time clients can live in the community before entering a nursing home (Roos, Stranc, Peterson et al., 2001).

Table 3: Manitoba Health’s Provincial Home Care Clients by Region, Manitoba, March 31, 2003

Region	Number of Home Care Clients Aged 65+	% of Home Care Clients Aged 65+	% of Population Aged 65+
Winnipeg	9,955	60.9	57.8
Assiniboine	1,341	8.2	8.5
Interlake	1,131	6.9	6.8
Parkland	1,053	6.4	5.1
Central	1,017	6.2	8.3
South Eastman	738	4.5	3.8
Brandon	494	3.0	4.3
North Eastman	374	2.3	3.2
Norman	166	1.0	1.2
Burntwood	67	0.4	1.0
Churchill	6	2.1	2.1
Manitoba	16,342	99.8	100.0

Sources: Manitoba Health. Provincial Home Care Program Case Count by Age Group and Region, March 31, 2003, unpublished data provided by Manitoba Health.
 Manitoba Health. Manitoba Population Report, June 1, 2003.

As the current cohort of baby boomers reaches 60 and 65, the expectations of those who have grown up with medicare, with public services, will likely encourage provincial governments to increase the availability of services that allow for independent living in ones own home. This is also a cohort that has become sophisticated in pressuring and lobbying for change that will benefit them, thus they will seek new avenues to ensure improvements to their lives.

Fundamentally there is also need to think about what “aging in place” really means. Does it mean staying in one’s home (with the help of home care)? Or does it mean aging in the community? People may not necessarily stay in their home but move to a

seniors’ apartment or some congregate living environment in their community.

The home care program is also not expected to break some of the loneliness or isolation encountered by seniors who live on their own. Other agencies fill some of these gaps. For example, the Community Resource Councils provide outreach services such as friendly visiting. However such services may not reach everyone, and it is often expected that seniors themselves will break the isolation. Sometimes one sees the churches fulfilling that function: will there be a move to greater church attendance as people age? Who does not receive any services? Again, we do not have the answers to these questions, but rather raise them as issues that need exploring.

Informal Supports – Family and Friends

The Home Care Program cannot provide for all the instrumental activities of daily living that are required in order to maintain a home. Who will shovel that snow or clean those gutters? Seniors who used to perform those tasks may no longer be capable of them, they may not have children nearby who can perform those chores, and their income may not allow for them to pay someone to perform all these tasks. Yet, should the inability to perform those tasks require that they move to other surroundings? Many people have long ceased to perform those tasks, and simply pay to have them done by someone else; but this is all too often not possible.

In the 2000-01 Canadian Community Health Survey, respondents were asked: “Because of any condition or health problem, do you need the help of another person in preparing meals, shopping for groceries or necessities, doing normal everyday housework, doing heavy household chores such as washing wall or yard work, in personal care such as washing, dressing or eating and moving about inside the house” (Statistics Canada, 2001b).

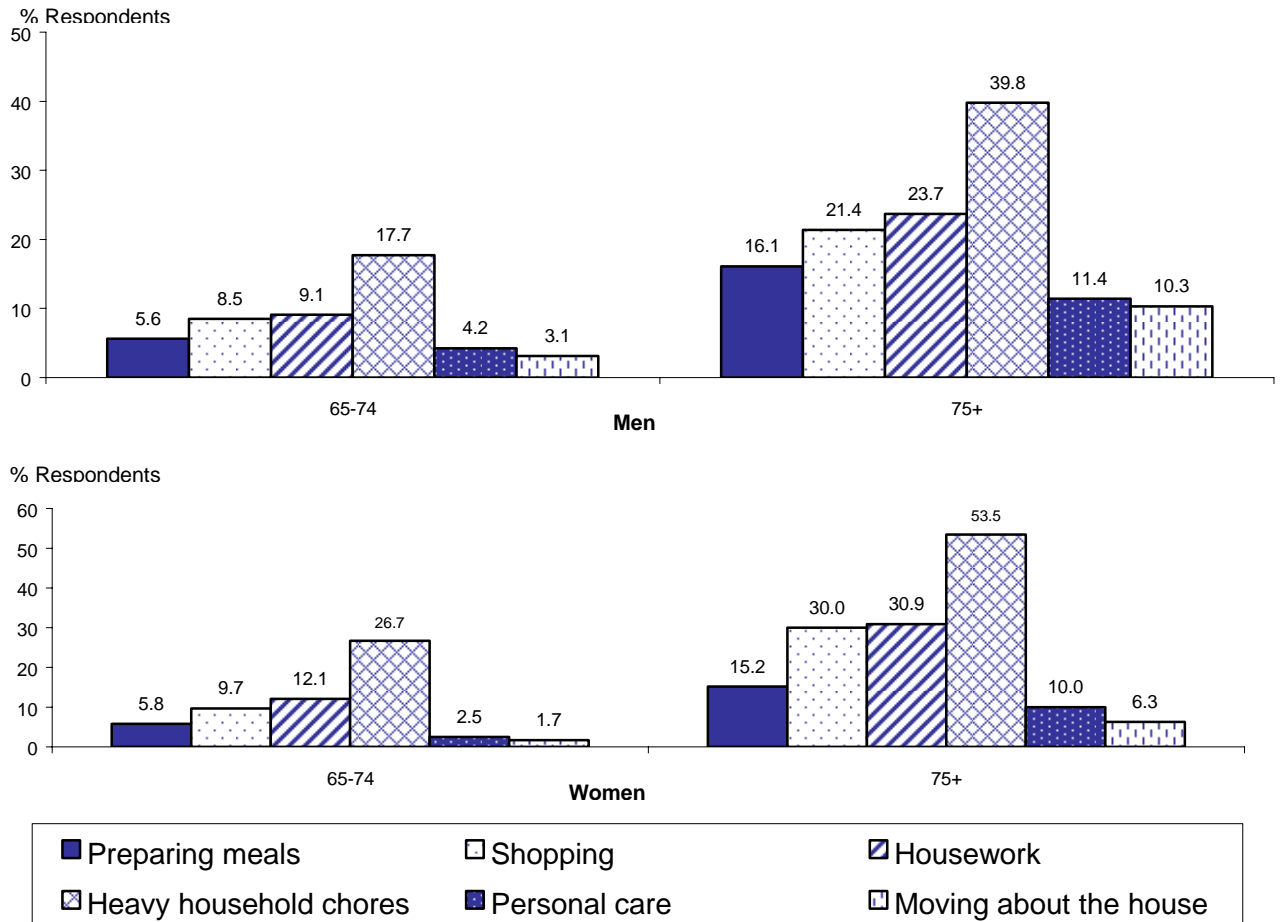
According to data from this survey, women need considerably more help than men: 41% of women between 65 and 74 stated that they did require help with one activity of daily living, versus on 18 % of men.

Among individuals aged 75 and over, 57% of women and 27% of men required some assistance (Manitoba Fact Book on Aging, 2005, p.88). Furthermore, as shown in Figure 7, the tasks clearly requiring the most assistance are the heavy household chores.

A lot of support for these activities is provided by networks of family and friends. Among caregivers aged 45 to 64, 40% provide informal support to their mother, whereas caregivers aged 65 and over are more likely involved in providing support to a spouse (23%) or a close friend (27%) (Manitoba Fact Book on Aging, 2005, p. 107). Women are more likely to provide care than men; 19% of women aged 45-64 provide care or informal support, versus 11% of men (Cranswick, 1997). Women in this age group also tended to provide more care: some 29.6 hours per month versus 16.1 for men (Stobert and Cranswick, 2004).

The challenges arise, not in stopping that support, but in providing supports for the caregiver, such as that provided by Revenue Canada in terms of tax credits for care giving or in terms of respite care, to relieve the caregiver temporarily, whether provided in the home or through temporary admission to a personal care home. As the need for home care will increase with the aging population so will the need for respite care.

Figure 7: Assistance with Specific Tasks in Selected Age Groups by Gender, Canadian Community Health Survey, Manitoba, 2000-01



Source: Statistics Canada. Canadian Community Health Survey, 2000-01. Public Use Microdata File.

In Manitoba, Manitoba Health’s Respite Care in Personal Care Program provides planned short term, one time or intermittent admission to a personal care home in order to provide a period of relief or respite to the informal caregiver. In 2002-03, there were 55 personal care homes providing respite care through this program with a total of 62 beds available for use (Manitoba Health, 2004).

Another service aimed at providing respite for caregivers is Manitoba’s Adult Day Program. This program is a specialized

service administered by the Regional Health Authorities Home Care Program whose purpose is to provide recreational, social and peer group interaction, health maintenance and promotion to frail at risk or disabled individuals in addition to respite for caregivers. In 2003-04, there were 73 Adult Day Program sites in Manitoba; a total of 2,145 individuals were enrolled in this program (Manitoba Health, 2004). Whether this meets current needs is not known. But what is clear is that it will not meet future needs as the number of seniors increases.

The next cohort may have greater difficulty accessing the luxury of having younger family members to help or to take care of them. The boomers have tended to have fewer children, and have had them at a later age, thus those children will be caring for their own children, and perhaps unable/unwilling to assist in care for aging parents. But Manitobans, in that they do stay in the province, have an advantage over other provinces, where many of the younger people tend to have moved. Thus proximity alone may ensure that there will be some care giving by children and other relatives. Will governments perhaps expand the definition of home care to replace some of the services that families are no longer there to provide?

Perhaps at this point it is valuable to quote from a report prepared by Norah Keating and associates (Keating, Fast, Forbes & Wenger, 2002). Dr. Keating has written and researched extensively on caregiver issues. In their report, it is suggested:

“The assumption made by policymakers that seniors are surrounded by large networks of family, friends, and neighbours who provide care if needed, is not supported by our research. Care network type is strongly related to outcomes such as type and amount of care received, health, and quality of life, suggesting the importance of providing different kinds of supports to seniors depending on their care network type.”

Keating and her colleagues further comment that:

“Finally, it is important to recognize that some care networks seem better positioned to meet the needs of frail seniors than do others. Networks that provide high levels of care need particular attention. Policies meant to support caregivers would benefit from an analysis of how public policies are supportive to different care network types.”

A recent report on caregiving published by the Canadian Policy Research Network (2005) yet again highlights the critical role that informal caregivers play, as well as the substantial burden that is placed on them. They provide a number of guiding principles for developing policies and programs to support caregivers, including among others:

- *“Care should be provided in an environment that meets the needs of both the caregiver and the care receiver. We cannot assume that the home is the most appropriate or desirable location for care.”*
- *Caregivers must have access to and awareness of alternatives and appropriate supports. If they do not, caregiving will not be voluntary and caregivers will not have choices.*
- *Caregivers need a continuum of services and supports, such as training and education, respite and other care services, paid leave to provide care, job security and income programs.”*

Key Points

- ▶ Housing is a complex issue that is not just about buildings per se, but is closely tied to values we have in terms of seniors (e.g. the notion of aging in place).
- ▶ Housing also cannot be looked at in isolation, but needs to be thought of in relation to other issues, such as formal support (e.g., home care) and informal supports (e.g., family and friends).
- ▶ Housing must be affordable and safe.
- ▶ Home adaptations are an important aspect of being able to age in place. Programs should be available that allow people to make minor adaptations to their homes (e.g., handrails in hallways and stairways). New homes should be built to be accessible to everybody, that is according to visitability principles.
- ▶ More variety in housing options will be needed, ranging from informal living arrangements between friends to assisted living and supportive housing. Regardless of the choice, formal supports need to be available, such as home care.
- ▶ Caregiving by family or friends is a critical issue. A variety of options must be available to support these informal caregivers, such as respite care to provide temporary relief from caregiving, tax relief, etc.

Economic Issues

Education and Income

As mentioned in the section on Basic Demographics, education is a major determinant of net worth since it impacts so greatly on both occupation and income (Statistics Canada, 2001a). Occupation and income are also the decisive factors in housing, transportation, general choice of healthy leisure and ultimately in health status. Thus it is interesting to note the improving education of the next seniors' cohort. Only 9.8% of the Manitoba's population between ages 45-64 have less than grade 9, whereas some 32.7% of current seniors have less than grade 9 (Manitoba Fact Book on Aging, 2005, p. 32). This trend is similar for men and women. Will we thus see improved pensions in those who will turn 65 by the next census?

Changing Economies

It must be mentioned at the outset that Manitoba's economy too seems to be changing. According to the 2001 Census of Canada, primary industry occupations (farming, fishing, forestry and mining) were the most frequently mentioned (34.0%) as the major occupation among Manitobans aged 65 and over in the labour force. On the other hand, only 10.4% of Manitobans aged 55-64 in the labour force reported

primary industry occupations as their major occupation (Manitoba Fact Book on Aging, 2005, p.52). Furthermore, few women aged 55-64 (6.3%) worked in primary industry occupations. Is this because women on farms are employed in other paid jobs (such as teaching or jobs in other areas)? The existence of those occupations, with salaries attached, would thus imply pensions and pension plans beyond C/QPP and OAS and would likely increase the proportion of seniors who can avail themselves of private pensions.

As reported in the 2002 General Social Survey, the most prevalent reason for retirement indicated by Manitobans was that retirement was financially possible (65.5%) followed by wanting to do other things (54.2%) (Manitoba Fact Book on Aging, 2005, p.50). Interestingly enough this figure needs to be coupled with the 17.9% of women who stated that they retired in order to care for a family member. When those women retired were they also able to financially do so? As noted by Schellenberg, Turcotte, and Ram (2005): "Having to retire earlier than anticipated because of health problems or job interruptions detracts from the enjoyment of retired life."

Sources of Income

Manitoba, like other provinces has a provincial income supplement program (55 Plus) which can supplement the income of those Manitobans which falls below a certain level. However eligibility for this supplement is determined by the level of benefits received from the federal government income supplement program

(GIS) (Government of Manitoba, 2005a). Income supplements are included in the government transfer payments which make up 80% of the income of women over 65 and 61.9 of men's incomes (Table 4). Thus it is evident that transfer payments of one kind or another make up a large proportion of the older adult's incomes.

Table 4: Major Sources of Income by Age Groups and Gender, Manitoba, 2000

Major Source of Income	% of Respondents in Age Group			% of Respondents Aged 65+	
	45-54	55-64	65+	Men	Women
Government transfer payment	10.0	20.8	72.1	61.9	80.0
Other income (e.g. Private pension)	2.2	16.5	16.4	24.4	10.3
Investment income	2.4	5.8	5.6	4.5	6.4
Wages and salaries	76.8	48.6	4.2	6.1	2.7
Self-employment	8.6	8.3	1.6	3.0	0.6

Source: Statistics Canada (October 14, 2003). Total Income Group (20) in Constant (2000) Dollars, Sex (3), Age Groups (7), and Major Source of Income (6) for Population 15 Years and Over with Income for Canada, Provinces and Territories, 1995 and 2000 - 20% Sample Data. 2001 Census of Canada. Catalogue number 97F0020XCB01042.

Manitoba families fall almost on the Canadian median (\$81,000) in terms of net worth at \$79,300 (Statistics Canada, 2001a). The main asset is the principal residence; however other assets such as farm land are also included in the calculation. Of interest in these calculations of net worth and in the changes in net worth over the last 15 years is the substantial increase in the gap between the highest and the lowest income quintile. And research has shown us that a society in which the differences between the highest and lowest quintile are smaller, are societies in which health status tends to be better (Ross, 2004).

Pensions ARE Important

It is clear from the income tables that more women in the next cohort of seniors are currently working and are more likely to have pensions. Manitoba has the highest proportion of workers with a registered pension plan in all of Canada: 60.6% (Morissette & Zhang, 2004).

In Canada, almost all workers belong to either the Canadian Pension Plan or Quebec Pension Plan (C/QPP). The relationship between C/QPP benefits and low income is noted by Chawla and Wannell (2004b):

“In 1981, 42% of all recipient families would have fallen into low income if not for their C/QPP benefits. By 2001, this proportion of vulnerability reached 85%.”

And just as today’s seniors rely more on C/QPP than the seniors of 10 years ago, who relied more on OAS, so tomorrow’s seniors will likely receive an even higher proportion of their benefits from the C/QPP as both members of a family work, or one has access to a defined pension.

The concern with the C/QPP is of course that the numbers of beneficiaries is increasing while the numbers of those paying into the plans is decreasing. However it would appear that immigration in Manitoba is increasing slightly thus providing some increase in younger age groups to the provincial population (Manitoba Fact Book on Aging, 2005, p.28). The number of immigrants from Asia and Latin America is substantial. Some have argued that Canada requires more family friendly policies in order to encourage young people to have more children who will then support the non-working, aging population (Policy Research Initiative, 2004).

Seniors continuing to work well past the normal retirement age is perhaps another way for people to cope with concerns over availability of financial resources. The proportion of seniors working rose from 1996 to 2001 in all provinces; the proportion of Manitoba seniors working went from 8% in 1996 to 10% in 2001 (Duchesne, 2004). The arguments about mandatory retirement continue to swirl, with concern about protecting older

workers, concerns about pension investments etc., in addition to the knowledge that it is the better educated who continue to work past the normal retirement age. The new technologies are expanding the opportunity for work as “knowledge workers”; economic change means that there are more service jobs available. Thus, perhaps the concern that there will not be a large enough working population in Canada is unfounded.

Widowhood

This section on economics cannot be closed without mentioning the impact of widowhood on women. Almost two-thirds (64%) of the senior women experienced a decline in their family income after widowhood.

“Five years after they were widowed, median family income declined 9.8% for widows. This was more than six times greater than the 1.5% decline among senior women who remained married during the same time frame”(Li, 2004).

Furthermore Li, 2004 notes: “Not only did the standard of living of widows decline; more of them also fell below the low-income threshold as a result of widowhood. Five years after widowhood, 9.4% of widows were living in low income, almost three times higher than the proportion of women (3.6%) who were in low income in the year before they were widowed.” One wonders if, given current employment trends, if this particular trend will continue. But it does remind us that older widows are a particularly vulnerable group of seniors.

Key Points

- ▶ The work force is changing; those in their 50's will now likely have pensions.
 - ▶ Whether the Canadian Pension Plan or Quebec Pension Plan is sustainable as the population age is a controversial issue. A variety of factors may affect its sustainability, such as immigration patterns and changes in retirement patterns.
 - ▶ Issues around retirement require continued investigation. Will we continue to see retirement at age 55?
- What are the reasons for retirement?
Will people be able to maintain their lifestyle, given that individuals who live to 65 can expect to live another 20 years post-retirement?
- ▶ We must never lose sight of the most vulnerable; older women, widowed seniors, and low-income seniors. Programs must be in place to protect these seniors.

Safety and Security

The declaration of human rights talks about the right to “security of person” in the same breath as the right to life and liberty (General Assembly of the United Nations, 1948). When we talk about safety and security we may be discussing many issues from physical safety in the home, to security when walking, to economic security or to the perception of security in one’s surroundings. In the first section we focus on security of the person: that is the right not to be abused or physically hurt.

Elder Abuse

The Government of Manitoba through the Manitoba Seniors and Healthy Aging Secretariat provides information sheets about the safety of seniors including elder abuse. According to these fact sheets “*elder abuse is any action or lack of action by someone in a position of trust that harms the health or well-being of an older person*” (Government of Manitoba, 2005b).

Elder abuse exists in many different forms. These different forms are most commonly grouped into four categories:

- **Physical abuse** involves physical discomfort, pain or injury: pushing, shaking, hitting, sexually molesting, rough-handling, deliberate over- or under-medication, or improper use of restraints;
- **Psychological abuse** diminishes the identity, dignity and self-worth of the individual: threatening, bullying, name-calling, humiliating, or treating an older person like a child;
- **Financial also known as material or property abuse:** withholding money, forcing the sale of property or

possessions, theft, coercing changes in wills, or the misuse of power of attorney responsibilities;

- **Neglect** is the failure of a caregiver (paid or unpaid) to meet the needs of an individual who is unable to meet those needs alone: not being provided with adequate food, drink or medical attention, or being left in an unsafe or in isolated conditions (Public Health Agency of Canada, 1999; Waterloo Region Committee on Elder Abuse, 2000).

It has been frequently noted that available information on the prevalence of elder abuse is likely understated because abused older adults are reluctant to identify themselves. This may be because they are embarrassed, unsure that anyone will take them seriously, worried about rejection by loved ones or afraid that they may have to leave their home (Public Health Agency of Canada, 1999). Canadian prevalence rates from a 1990 national telephone survey suggest that approximately four percent of older adults living in private homes report experiencing abuse or neglect (Podnieks, Pillemer, Nicholson et al., 1990).

In Manitoba, The Seniors Abuse Line collects statistics on the telephone calls made to them regarding abuse. As indicated in the Manitoba Fact Book on Aging (2005), based on telephone calls to the elder abuse line, almost 54% of reported abuse cases were as a result of abuse by a family member. It is also evident from these figures that women are the majority of those abused: just as they are the majority of those in the older age groups.

Perhaps the worrisome point here is that all too often elder abuse goes unnoticed, since unlike older children, elders may be isolated and quite dependant upon the abuser. In Manitoba a law, *The Protection for Persons In Care Act*, exists to help protect adults from abuse while receiving care in personal care homes, hospitals or any other designated health facility. The reporting of abuse is mandatory.

One of the limitations is that the Act does not currently extend to home care clients. As we showed earlier (see Table 3), some 16,000 seniors currently receive home care. These individuals are not protected by the Act.

Recently, a caregivers network that allows people to ask questions and voice their concerns, has been created via the internet in the Waterloo region: (<http://www.cnetwork.ca/about/elderabuse.asp>). People who are concerned about abuse can join the network and receive free information about the issues and also participate in discussions with others. But the question remains: who can protest abuse? How best can it be protested? Who protects the vulnerable senior? It may be that a strong community network is one assurance against abuse.

Safety in the Home

The issue of physical safety in housing will need to be confronted. And safety in the home is closely tied to some of the housing issues discussed earlier. Falls are a serious concern to seniors: some 50% of seniors die within 6 months of a hip fracture. Falls are also a major cost driver to the health system. Yet often minor adjustments inside homes could have prevented falls (Canada Mortgage and Housing Corporation, 2004).

Should public policy begin to examine ways of ensuring safety in seniors' homes?

Dr. Fernie (Canada Mortgage and Housing Corporation, 2004) suggests a number of strategies for making homes safer:

- falls prevention;
- increasing accessibility in the home to help people move around safely and independently; and
- provision of context-sensitive, intelligent monitoring and reminding systems.

The latter point does not mean so-called 'smart' house features, such as automated thermostats, but rather, a different way of applying artificial intelligence to housing, such as for example context-sensitive technologies to ensure monitoring and timely intervention without infringing on an individual's privacy. Examples under development include toilet monitors, intelligent 'eyes' on computers, and 'spy-walkers' that are instrumented to record how a person is coping with the environment. Specific issues can be reported to a health facility without infringing over-all on privacy. Finally, prevention of caregiver injury and fatigue can be addressed. As we discussed earlier in the Housing section, caregiver support is critical and, as noted by Canada Mortgage and Housing (2004), "many seniors have to leave their homes because their caregivers can no longer cope".

"Environmental modifications, such as bath bars, rug removal and stair bars to the home have been shown to reduce falls requiring medical attention by 55% over 24 months" (Division of Aging and Seniors, 2002).

Improved recreation facilities, increased exercise and wellness programs for seniors in order to improve strength and balance have been suggested as ways to prevent falls. There are of course income issues, since not all seniors can afford to modify their homes, nor join particular fitness centres. However, Canadian Mortgage and Housing does have some special programs to assist seniors to make modifications that would allow them to stay in their own homes. As this generation ages, there will likely be increased pressure to improve both fitness programs and funding for home refurbishment.

Safety and Security in the Environment

We have touched briefly already on security: the whole issue of falls at home is one that bears watching and requires a multiplicity of interventions. Prevention of falls via environmental changes in housing was discussed above. But we also need to mention the possibility of changes in the built or designed environment: city sidewalks that are kept clear, public transport with easy access, doors to public buildings that allow easy entry.

But security is also a perception: a perception of the neighbourhood, of our home, of our person. In a study on the determinants of seniors' independence in two communities, Brandon and Kingston, a high percentage of seniors indicated that they were concerned about their security and safety especially at night and outside their neighbourhoods and that this was limiting their activities (Rosenberg, 1998).

As indicated earlier in the section on public transit, the majority of older people in Manitoba felt safe in terms of crime; even in bus shelters: 67.3% were not worried about their safety, and only 16.5 % felt unsafe walking alone at night (Table 2, p. 17). But more senior women than men perceived that walking alone and using public transport at night were somewhat unsafe activities.

In 1999, about one-third of Manitoba seniors felt that crime in their neighbourhoods had increased (Manitoba Fact Book on Aging, 2005, p.141). Yet these beliefs are often belied by actual figures from police departments: seniors may perceive threat where statistics show there is a decrease in violent crime. Although the perceptions may not necessarily be based on the true figures, they do affect people's behaviour and thus make it rather difficult for public policies to dispel certain fears. Should the dispelling of fears be a public function? Should police be more involved in assuaging seniors' fears? What are the fears based on?

Exploring these issues is important because perceptions of safety can lead seniors to restrict their activities. In a later section we will be discussing the notion of active aging. Active aging is influenced by a variety of factors, safety being one of them. A study by Cranswick and Menec (2004) shows that older women who felt unsafe were less likely to go for a walk than those who felt safe. They were also less likely to go to the library. One wonders what other activities these women did not participate in because of concerns over their safety.

Key Points

- ▶ The prevalence of elder abuse is largely unknown; but elder abuse is a serious concern that should not be ignored.
- ▶ Elder abuse often goes unnoticed and unreported; more needs to be done to ensure there are policies and laws to ensure the safety of seniors.
- ▶ In Manitoba, the Protection for Persons in Care Act protects people from abuse while in personal care homes, hospitals or other designated facilities. Extending the Act to include individuals receiving home care should be considered.
- ▶ Falls are a major concern for seniors. Home adaptations that can prevent falls are therefore an important aspect of keeping seniors safe in their home.
- ▶ We need to gain a better understanding of the concerns seniors have about safety in their neighbourhoods and community. This is not only a quality of life issue, but also has implications for seniors' health; seniors who are afraid of leaving their home are also less active.

Health

The health of seniors is the area most written about and analyzed. And many of the housing and transportation issues cross over into the domain of what we call health: falls in unsafe housing; isolation and mental health; transportation for needed medical care or to break isolation. Often, needed care giving is provided by family members, whose health may also suffer because of care giver burden. In this section we summarize some of the more common discussions taking place in the health arena.

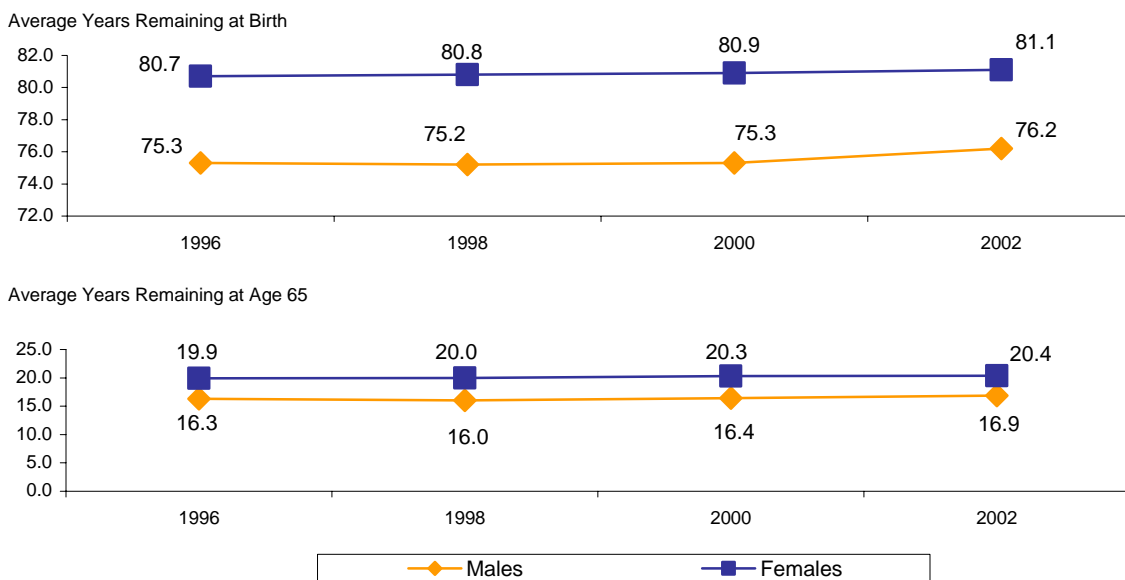
The Rising Life Expectancy

In the discussion of basic demography, it was not mentioned that as people reach age 65 they are more likely to survive to a later age. Individuals who reach age 65 have a greater likelihood of surviving 4 years beyond initial life expectancy (81.1 years)

for women and 5 more years beyond 76.2 years for men (Figure 8). Thus the men and women who survive to age 65 are more likely to live well into their eighties.

When the life expectancy after age 65 is adjusted for perfect health or normal health as measured by the Health Utility Index (HUI) (Furlong, Feeney, Torrance et al., 1998) it decreases to an average of 77 years for men and 79 for women (Manitoba Fact Book on Aging, 2005, p. 64). Thus most men alive at 65 can expect to live another 12 years in good health, women another 14 years (Table 5). These are the active and healthy seniors who can (and possibly should) participate in policy making discussion both for themselves and for future seniors.

Figure 8: Average Years of Life Remaining at Birth and at Age 65 by Gender, Manitoba, 1996-2002



Source: Statistics Canada. Cansim Table 102-0511 - Life Expectancy Table at Birth and Age 65 by Sex, Canada, Provinces and Territories, 1996-2002.

Income and Life Expectancy

It is well known that income is related to health; wealthier people are in better health than those who are less affluent. This has been shown again and again in the research literature. The same trend is evident in life expectancy (see Table 5). The least affluent men aged 65 or older – those in the lower third in terms of income – had on average

11.3 more years to live, compared to the 12.7 and 12.4 years among older men in the higher income groups. There is not much difference between those in the middle and highest income groups. Thus it may be important to maintain the issue of a “decent” income at the heart of the health determinants/population health discussion.

Table 5: Life Expectancy¹ and Health-Adjusted Life Expectancy² at Age 65 by Gender and Income Group³, Manitoba, 2001

Income Group	Average Years Remaining at Age 65			
	Non-Adjusted		Health-Adjusted	
	Men	Women	Men	Women
Lowest third of incomes	15.7	20.4	11.3	14.0
Middle third of incomes	16.7	20.9	12.7	15.0
Highest third of incomes	17.3	19.6	12.4	13.8
All income groups	16.6	20.4	12.2	14.3

¹ Life expectancy refers to the number of years a person would be expected to live starting from age 65.

² Health-adjusted life expectancy is the number of years in perfect health than an individual can expect to live given the current morbidity and mortality conditions. Health-adjusted life expectancy uses the Health Utility Index (HUI) to weigh years lived in good health higher than years lived in poor health.

³ To calculate income groups, all the units of a population are ranked from lowest to highest by the value of their income. The ranked population is divided into three groups of equal numbers, representing the lowest third of incomes, the middle third and the highest third.

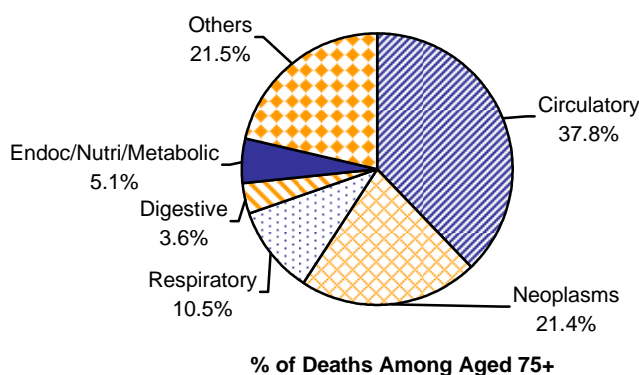
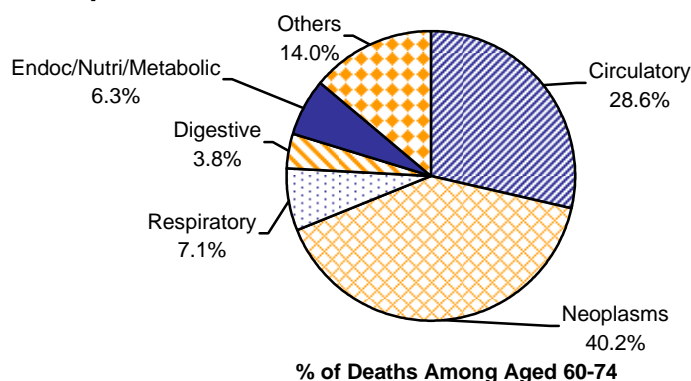
Sources: Statistics Canada. Cansim Table 102-0121 - Health-adjusted Life Expectancy at Age 65, by Sex and Income Group, Canada and Provinces, 2001.

Leading Causes of Death

Before moving on to discussions of more complex health issues, we should examine the leading causes of death amongst Manitobans. Cancers are the leading cause of death for people between 60 and 74, and circulatory diseases are the second. Among people over 75, circulatory diseases become

the main cause of death (Figure 9). The question then becomes: how much of this illness is preventable? We do believe that some proportion of circulatory diseases is preventable, as is a certain proportion of cancers with obvious relations to smoking or to occupational exposure.

Figure 9: Leading Cause of Death (ICD-10 Diagnostic Categories) in Selected Age Groups, Manitoba, 2003



Source: Manitoba Health. Provincial Deaths by Diagnosis, 2003, unpublished report provided by Manitoba Health. Manitoba Health . Manitoba Health Population Report, June 2003.

Mortality rates among younger seniors generally decreased in the population, especially among men (Manitoba Fact Book on Aging, 2005), which is simply the other way of saying that life expectancy has been increasing. But we also know that everyone must die at some time: What are the illnesses of tomorrow? The increasing prevalence of dementia suggests that neurodegenerative disorders may be among the leading causes of death in the future. What implications will this have for both families and friends and the health care system? What kind of treatments will be

available? Can we make the end of life more comfortable for everyone concerned? These are some of the questions that need addressing.

Most Seniors Say they are Healthy

As noted in the Manitoba Fact Book on Aging (2005), almost three-quarters (71.8%) of all seniors 74 and under report their health as “good,” “very good” or “excellent.” Even amongst those over 75, more than half of both men and women still

report their health in one of those three categories. So the image of the fragile senior, pushing pills in his/her home, unable to go out due to health problems is not the picture of the majority that emerges as we look at the statistics. But we also know that it is the unwell, those in poor health who are less visible and who require most attention that must receive our policy attention.

Most Seniors Have No Mobility Problems

When seniors in Manitoba were asked about mobility in the Canadian Community Health Survey 2000-01 we find that more than 80% of all seniors over 65 reported no mobility problems (Table 6). Among the younger seniors, aged 65-74, 90% had no mobility problems and after the age of 75, 73.8% had no mobility problems. Thus, again, Manitoba has a large proportion of healthy and able bodied seniors, a strength that could be built on in terms of promoting wellness and/or healthy aging.

Table 6: Mobility by Gender, by Age Groups, and by Age Groups and Gender, Canadian Community Health Survey, Manitoba, 2000-01

Mobility	% of Respondents Aged 65+			% of Respondents in Age Group	
	Total	Men	Women	65-74	75+
No mobility problems	82.8	85.4	80.8	90.8	73.8
Mobility problem but no aid required	1.3	1.5	1.0	1.7	0.7
Mobility problem - mechanical support or wheelchair required	10.7	9.9	11.2	4.8	17.3
Mobility problem - cannot walk or help from people required	5.3	3.1	6.9	2.7	8.2

Source: Statistics Canada. Canadian Community Health Survey, 2000-01. Public Use Microdata File.

The functional health status of most seniors, as measured by the Health Utility Index (Furlong et al., 1998) is good; 72.2% of Manitobans aged 65 to 74 have very good or perfect functional health status. Interestingly enough, women in this age group have better functional health status than men (75.1% vs.69.1%). It is in later years that women's functional status falls

slightly below that of men (Table 7). Thus again, at the same time as women are more likely to be left alone, their functional status decreases. Who supports or cares for these women? Yet once more it is evident that there exist a large number of active capable seniors who can participate fully in the life of their community.

Table 7: Functional Health Status by Age Groups and Gender, Canadian Community Health Survey, Manitoba, 2000-01

Functional Health Status	% of Respondents Aged 65-74		% of Respondents Aged 75+	
	Men	Women	Men	Women
Moderate or severe functional health problems ¹	30.9	24.9	50.8	52.0
Very good or perfect functional health ²	69.1	75.1	49.2	48.0

¹Health Utility Index (HUI) score of below 0.8.

²Health Utility Index (HUI) score of 0.8 to 1.0.

Source: Statistics Canada. Canadian Community Health Survey, 2000-01. Public Use Microdata File.

Chronic Diseases are Common

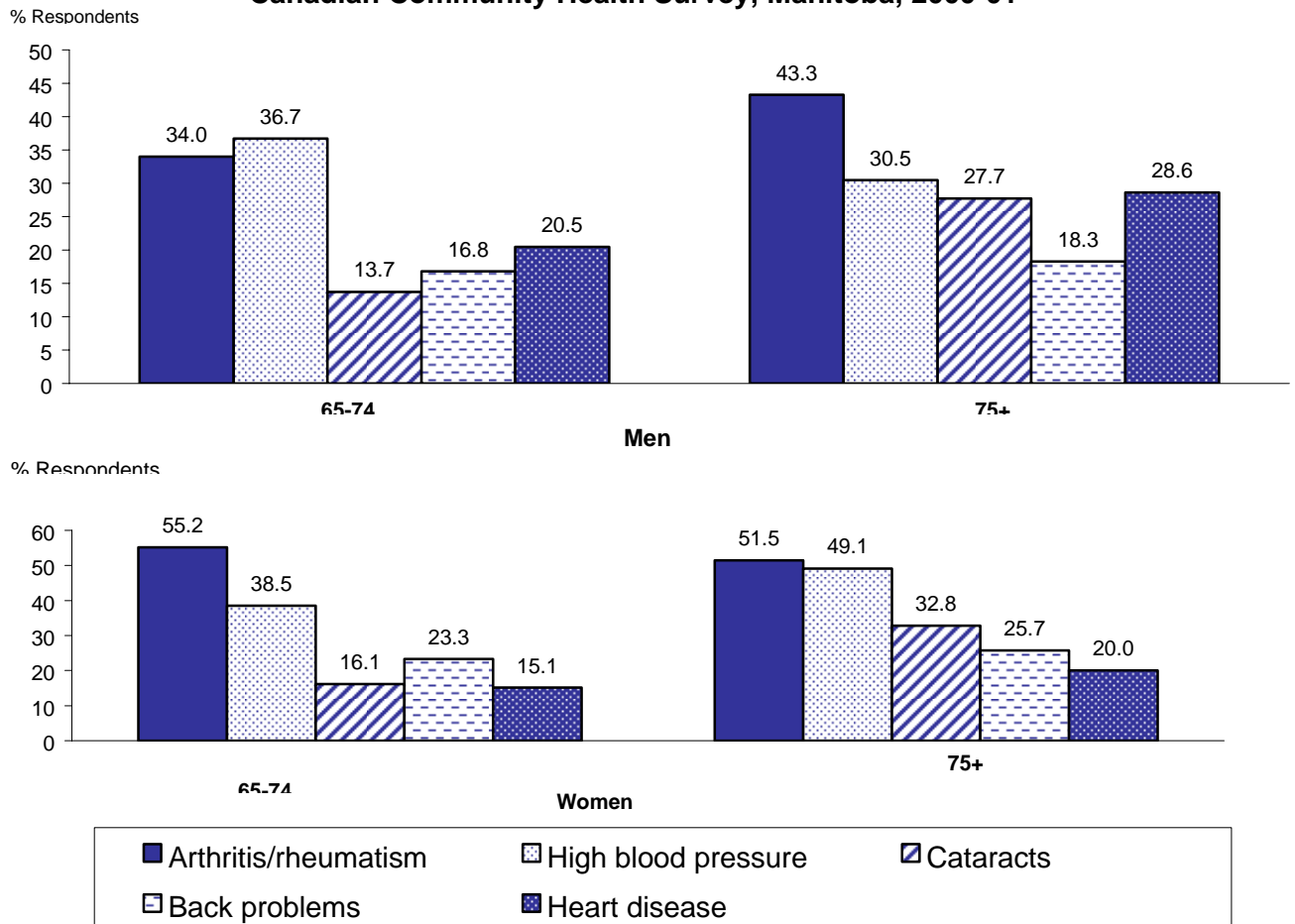
According to data from the Canadian Community Health Survey, the majority of seniors report two or less diagnosed chronic health conditions (Manitoba Fact Book on Aging, 2005) Furthermore, 15% of seniors between 65 and 74 reported no chronic health conditions, and 46.7% reported only one or two chronic conditions. The chronic conditions most often mentioned are (in descending order of occurrence): arthritis/rheumatism; high blood pressure; cataracts; back problems; heart disease. And with the exception of heart disease, a higher proportion of women reported these chronic health conditions than men (Figure 10).

Yet some of these conditions too, like cataracts are amenable to reasonably simple and effective treatment. From 1995 and 2003 the proportion of seniors across

Canada with cataracts rose from 14% to 20% (Millar, 2004). Millar also suggests that “greater awareness of treatment possibilities among seniors, resulting in a higher demand for surgery, may be a factor in increased reporting of cataracts”. Unrecognized and/or unreported vision problems may of course be closely intertwined with issues of driving and of licensing.

And despite the prevailing image of seniors with hearing aids, less than 15% of all seniors over 65 reported hearing problems, corrected or not (Manitoba Fact Book on Aging, p. 86). One could query the prevalence of 4% with uncorrected hearing problems: is this a cost factor or an unwillingness to admit that there is a problem that requires correction?

Figure 10: Diagnosed Chronic Health Conditions in Selected Age Groups by Gender, Canadian Community Health Survey, Manitoba, 2000-01



Source: Statistics Canada. Canadian Community Health Survey, 2000-01. Public Use Microdata File.

Dementia

One of the major issues feared by seniors and by their caregivers is the issue of cognitive functioning whether it is the ability to remember things, loss of memory, or dementia. Turning first to self-reported cognitive problems, approximately two-thirds of Manitobans (67.6%) reported no cognitive problems or little difficulty thinking and/or solving day-to-day problems (Manitoba Fact Book on Aging, 2005, p. 99). Not unexpectedly Manitobans aged 75 and over were more likely to report

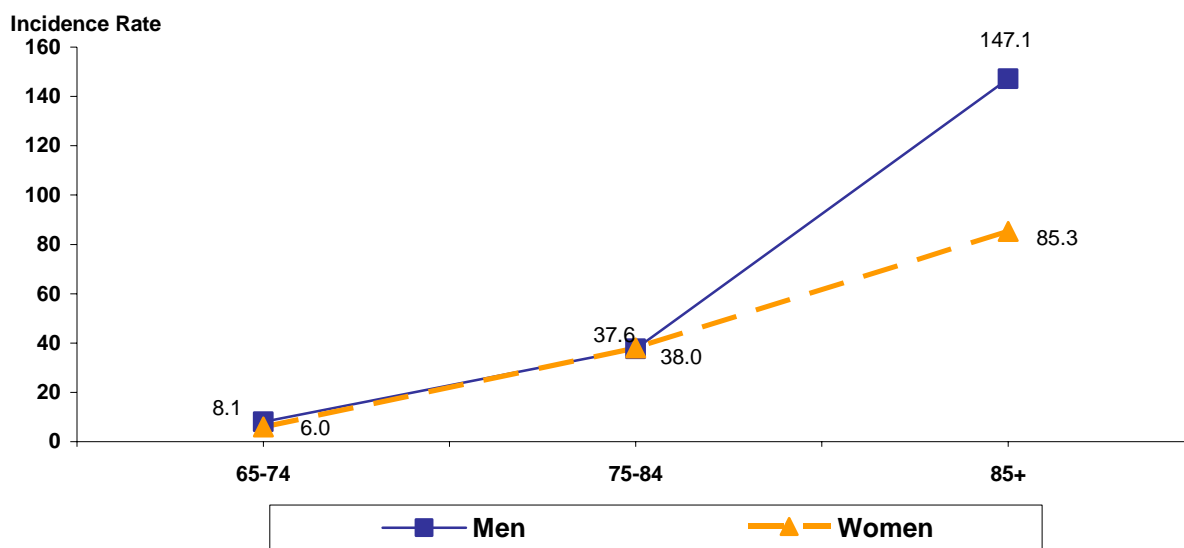
cognitive problems compared to those aged 65 to 74.

Incidence rates of dementia, the number of newly diagnosed cases (which includes Alzheimer's disease), calculated from the 1991-92 and 1996-97 Manitoba Study of Health an Aging, reveals that the overall incidence rate for men aged 65 and over is slightly higher than the rate for women aged 65 and over. Also, the age-specific incidence rates rose with age. More

specifically, the incidence rate of dementia for men aged 85 years and was 147.1/1000 person years compared to 85.3/1000 person years for women 85 years and over (Figure 11). In other words, many more 85+ year old individuals develop dementia than younger seniors; and men are much more likely to develop dementia in old age than women.

What implications this has for formal and informal care supports needs to be explored. What support is there for that elderly woman who is looking after her husband who has dementia? What options are available to avoid having to admit individuals with dementia into personal care homes? As the number of seniors with dementia is expected to grow, these are the kinds of issues that need to be addressed.

Figure 11: Incidence of Dementia per 1000 Person-years, Community and Institutional Respondents, Manitoba Study of Health and Aging, 1991/92 - 1996/97



Source: Centre on Aging, University of Manitoba. 1991-92 and 1996-97 Manitoba Study of Health and Aging, unpublished data provided by the Centre on Aging.

In early 2000, Manitoba’s Minister of Health directed Manitoba Health to develop a provincial strategy for dealing with patients with Alzheimer’s. The Strategy (Government of Manitoba, 2002) identified the following key issues to be addressed:

- “Education for professionals, paraprofessionals, family, individuals, communities and the general public.
- Guidelines for diagnosis.
- Standards across all programs and services.
- Family and individual support.
- Comprehensive programs and services for individuals at the community and facility levels.
- Case management and interdisciplinary collaboration.
- Equitable access to programs and services across Manitoba.

- *Human and financial issues including recruitment, retention and remuneration.*
- *Ongoing rigorous research and evaluation.”*

Yet in 2004, the Minister of Health was accused in the legislature of not having

implemented any of the recommendations (Legislative Assembly of Manitoba, 2004). The issue remains a contentious one, since dementias probably account for a greater caregiver burden than any other illness. An Alzheimer Strategy Overview Committee has been set up to start addressing some of the issues identified in the Strategy.

Key Points

- ▶ As seniors are healthier and live longer, and live in the community longer than ever, the question of what supports and housing will be needed becomes an increasingly pressing one.
- ▶ Although the majority of seniors function well on a day-to-day basis, there need to be programs and services for those experiencing difficulties with functioning, particularly for those with low income.
- ▶ The health of seniors today is better than that of seniors in the past. But chronic diseases are common and their prevalence is on the rise. Disease prevention and healthy living must not be considered as an issue just for the young; there are benefits at any age.
- ▶ Dementia is a major issue that requires input from family, friends, and the health care system. It is an issue that must be addressed on various fronts; for example, from educating physicians to diagnose and treat dementia, to having sufficient supports for informal caregivers such as family and friends, to having formal care options available.

Healthy Living

Healthy living is a broad concept. The definition provided by Manitoba's Ministry of Healthy Living is a useful one, according to which:

“Healthy living is about creating conditions and supporting behaviours that promote the best possible health for everyone. This includes individual decisions we make to eat healthy, be physically active, and avoid harmful substances or activities. It includes actions taken by all of us together to create supportive environments. These could include safe and healthy homes, meaningful employment and healthier work conditions, community and building design that promotes physical activity, smoke-free spaces, and access to nutritious and safe foods” (Manitoba Government, 2005).

Healthy living is therefore as much about people and the kinds of things they do (e.g., eat healthy, be physically active), as it is about the environment in which they live (e.g., the household, neighbourhood, or community). How can we encourage seniors to remain at home, and also encourage less sedentary lifestyles to

increase health and prevent obesity related diseases? It is beyond the scope of this paper to enter into the whole health promotion debate, but we now know that if cities or communities are safe (both from attack danger and from slipping or falling) people are more likely to walk; good accessible recreation facilities make exercise more attractive and can assist in prevention of falls; the social stimulation of group activities helps not only prevent loneliness and isolation, but also has health benefits and contributes to quality of life.

According to data from the Canadian Community Health Survey, the most frequent leisure activities reported by Manitobans aged 65 and over were those of a sedentary nature; TV/video watching (95%) and reading (87%) (Table 8). Although almost two-thirds of those between age 65 and 74 participated in walking and/or gardening activities. The 55- 64 age group is somewhat more active, but one is unable to interpret whether this is a function of age or of a different approach to leisure and lifestyle. Yet active leisure activities still involve less than half of this cohort.

Table 8: Participation in Leisure Activities, Population Aged 65+ by Gender, and Population in Selected Age Groups, Manitoba, 2000-01

Activity	% of Population Aged 65+			% of Age Group		
	Total	Men	Women	55-64	65-74	75+
Watch TV or videos	95.0	96.9	93.7	95.3	95.4	94.6
Read papers, magazines or books	87.0	86.0	87.7	90.8	90.0	83.8
Walking	55.4	56.0	54.9	65.5	61.8	48.3
Gardening/Yard work	33.1	43.4	26.2	65.5	61.8	48.3
Home exercises	15.3	13.4	16.5	20.6	15.8	14.6
Spend time on a computer	8.9	11.3	7.2	32.6	13.0	4.4
Golfing	7.4	13.6	3.3	9.5	11.4	3.2
Bicycling	7.0	10.9	4.4	12.4	11.8	1.8
Swimming	4.9	6.4	3.8	5.9	7.3	2.2
Popular/Social dance	4.8	4.7	4.9	11.5	6.5	2.9

Activities participated in by less than 4% of the population aged 65 and over included ice hockey, ice skating, in-line skating, jogging or running, exercise class/aerobics, skiing/snow boarding, bowling, baseball/softball, tennis, weight training, fishing, volleyball, and basketball.

Source: Statistics Canada. Canadian Community Health Survey, 2000-01. Public Use Microdata File.

We have not begun to discuss leisure activities which break down isolation, or assuage loneliness. Can public policy take responsibility for these issues, apart from housing, recreation and transportation? Should public policy be aimed to encourage community organization, which subsequently can be more active in promoting physical activity particularly amongst people with low income?

A useful concept to introduce at this point is the notion of active aging (World Health Organization, 2002). The World Health Organization (2002) uses the following definition:

“Active aging is the process for optimizing opportunities for health, participation and security in order to enhance quality of life as people age”
(WHO, 2002)

Activity is very broadly defined and includes not just physical activity or participation in the labour force, but also the broad range of other activities that seniors engage in and are important to them, such as social activity (e.g., visiting family or friends, participating in seniors programs, attending cultural events), cognitive activity (e.g., taking courses, reading), spiritual activity (e.g., attending

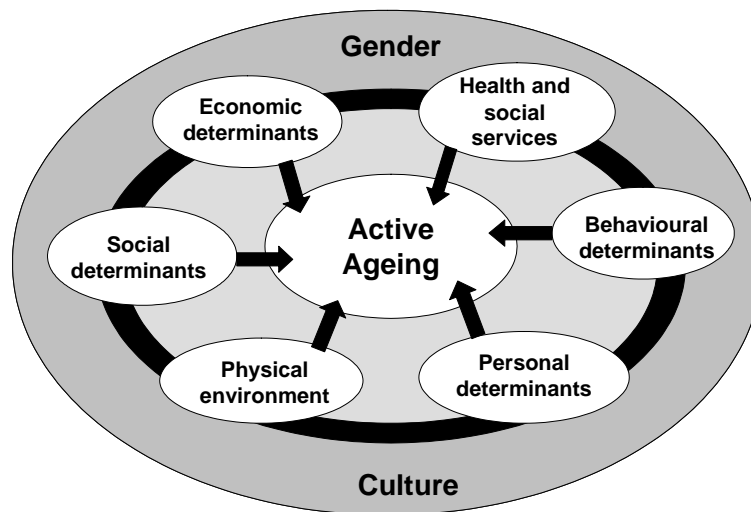
religious events, engaging in spiritual activities), and “productive” activity (e.g., volunteer work, providing care for family members and grandchildren, being politically active).

Consistent with the thinking that population health has a variety of social influences or determinants, active aging is also thought to depend on a variety of determinants (see Figure 12). Understanding these factors that affect active aging,, and how they interact, will help us design policies and programs for older adults.

Putting active aging, rather than health, at the forefront represent an important shift in thinking. To quote the WHO Life Course Program:

“It is time for a new paradigm, one that views older people as active participants in an age-integrated society and as active contributors as well as beneficiaries of development.”
(WHO Ageing and Life Course Programme)

Figure 12: The Determinants of Active Ageing (WHO, 2002)



Key Points

- ▶ Healthy living is more than an individual choice; a whole range of factors affect it, such as the community, policies, economics, transportation, and housing.
- ▶ We need to start thinking of healthy living in a holistic way; the notion of active aging is a useful concept, as it incorporates more than just healthy eating and exercise.
- ▶ The notion of active aging is also useful because it highlights that activity is more than participation in the labour force or physical activity, but includes the broad range of activities that seniors engage in and are important to them, such as social activities. Programs must be available to support these activities.
- ▶ Rather than treating seniors as recipients of services and a burden to society, the concept of active aging highlights the contributions that seniors make to their families, community and society.
- ▶ It is important to start exploring what healthy living or active aging means for different populations (e.g., 80 versus 65 year old, men versus women, seniors from different cultural backgrounds), in order to target programs appropriately.

Health Care

Health care, like health, has been studied extensively. We have already discussed home care under the topic of housing; here we focus on the other services, including hospital use, prescription drug use, personal care home use, physician use, and use of other health care providers.

Hospital Use

Seniors over 65 incurred 35.2% of all hospitalizations in Manitoba in 2002-03, although they made up at this time only 13.6% of the population (Manitoba Fact Book on Aging, 2005, p.114). Does this mean that the aging population will drain our health system, and prevent the system from being sustainable? Menec and associates (2002) argue that this is likely not the case: the improved health status of most seniors, their ability to live independently will likely reduce the impact of the aging population on the system. Currently it also appears that both increased use of technology and increased capacity to diagnose have led to some of the increased costs.

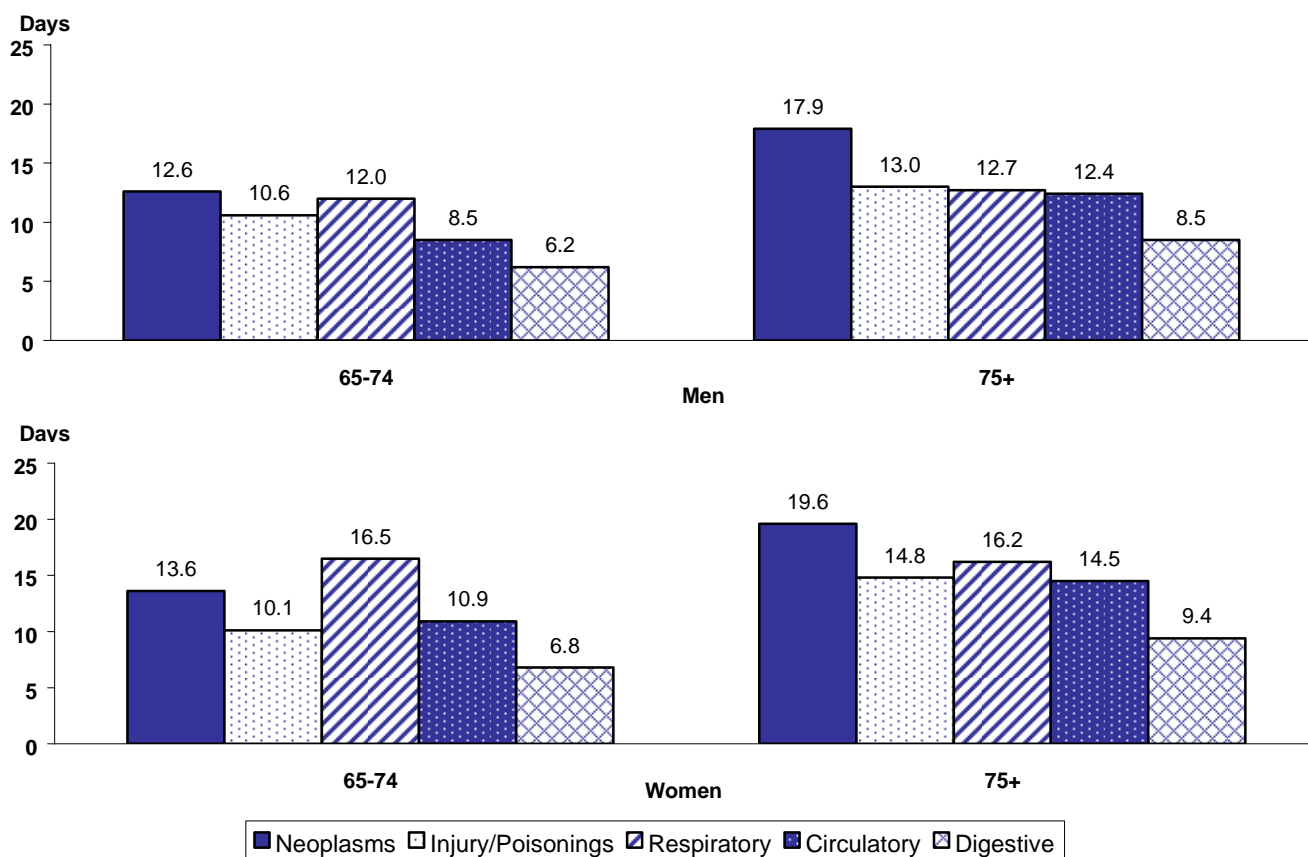
As the population ages decisions about what is necessary or beneficial versus what is possible, will likely increase in

importance. Hip and knee replacement surgeries have risen by 81% since 1992, and cataract surgery by 61%. Have these procedures allowed for greater independence/ mobility amongst seniors? The assumption is that they most certainly have. At the same time, preventing the need for hip and knee replacement should be a top priority. Many could be prevented by reducing obesity.

Some 5% of seniors use 78% of all hospital days (Menec, MacWilliams, Soodeen et al., 2002). Further analysis is required in order to examine whether alternatives, such as home care, or supportive housing might have decreased those hospital days for people over 65.

Average length of stay in hospital for various conditions among Manitobans in 2002-03 is shown in Figure 13. Neoplasms (cancers) are the reason for the lengthiest stays, except for women between 65 and 74 who stayed longer with respiratory ailments. The literature tells us that much of the hospitalization for cancer includes end of life care, which might have as appropriately been in palliative or hospice care.

Figure 13: Average Length of Hospital Stay in Days for Selected ICD-9 Diagnostic Categories by Age Groups and Gender, Manitoba, 2002-03



Source: Manitoba Health. Hospital Abstract System - Number of Hospitalizations and Total Days Spent in Hospital in Manitoba for 2002/2003 by Diagnostic Category, Gender and Age Group, unpublished report provided by Manitoba Health.

What's in store in the future? Finlayson, Stewart, Tate et al. (2005) state that most projections of hospital use have been based on projecting from population and use in 1990, whereas if actual trends are taken into account, which also take into account the shift from inpatient to outpatient surgery, there could actually be a decrease in the need for acute care hospital beds. Although the situation has changed since the 80's when the impression was that many people who really required long term care were filling acute care hospital beds, there still appears to be some use of hospital beds

which might be freed if other, more appropriate alternatives were available.

Home care has been suggested as a solution to hospitalization. According to Hollander and Chappell (2002) home care is less costly than residential care. They also report that "hospital costs accounted for about 30 to 60 percent of the overall health costs for home care clients". In addition, "the major cost for home care clients who die is the use of hospital services."

Personal Care Home Use

Only 5.6% of Manitobans aged 65 and over resided in personal care homes in 2002 although almost one-quarter (23.9%) of seniors over 85 did so (Manitoba Fact Book on Aging, 2005, p.130). In 2002 there were 122 personal care homes in Manitoba. Under the provincially funded program these homes provide everything from accommodations to meals to nursing services and occupational and physiotherapy.

The use of personal care homes perhaps indicates that other housing and health models need to be examined that better meet the requirements of seniors requiring care. In this respect 27% of personal care home residents were classified as Level 1 or Level 2 (Manitoba Fact Book on Aging, 2005, p.133). Level 1 means that the person had: “minimal dependence on nursing time for at least one of the following categories: for bathing and dressing, feeding, treatments, ambulation, elimination and support, and/or supervision.” Level 2 means that the person had partial dependence for at least one of those categories.

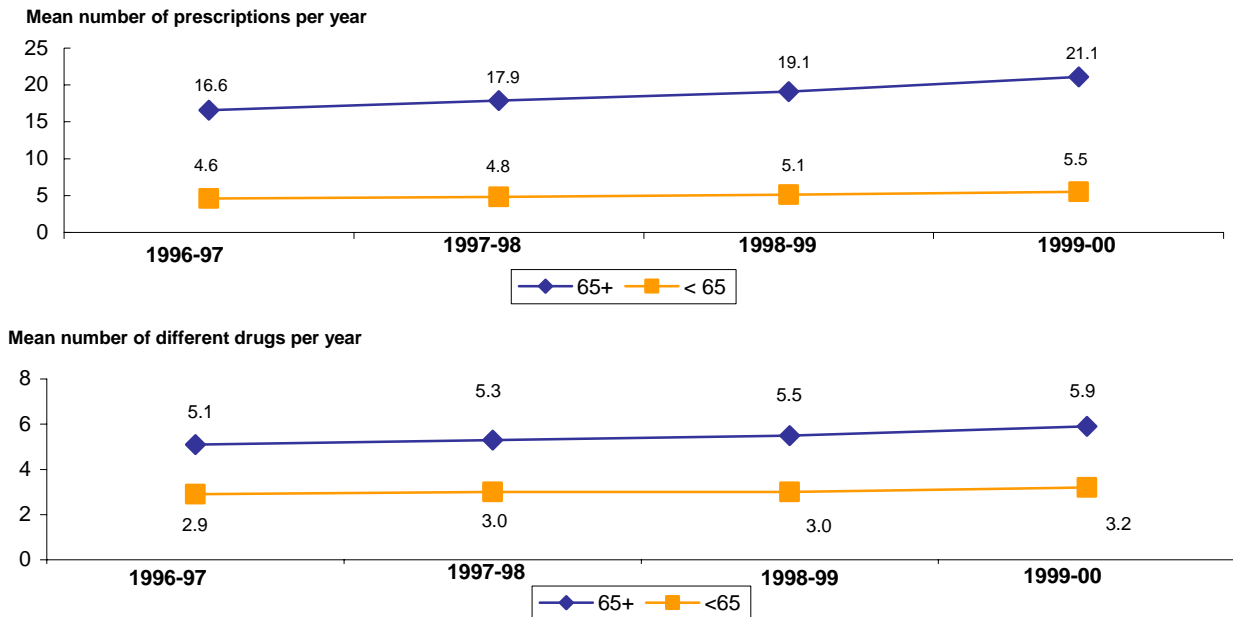
Should these 27% of residents be in personal care homes? Probably not. But the appropriate support services or housing must be available to keep these individuals

out of personal care homes. Some models have been discussed in the housing section, but perhaps other forms of assisted living, where caregiving or enhanced home care is available also need to be considered. It should be noted that while a small proportion of older Manitobans reside in personal care homes, there were 1032 people awaiting placement in a personal care home in 2004 (Manitoba Fact Book on Aging, 2005, p.134). Would these people have been waiting for personal care home beds had other home care or assisted living been available?

Prescription Drugs

Prescription drugs have been both a bane and a boon to the health of seniors. Many of the drugs people take help to keep them out of hospital, yet drug interactions and reactions, may result in serious health problems. Drug use and drug cost are both increasing. Most (87%) of seniors in Manitoba were taking at least one prescription drug in 1999-2000 (Manitoba Fact Book on Aging, 2005, p.120). Furthermore, in 1996, the mean number of prescriptions for persons aged 65+ was 16.6; by 2000 this had increased to 21.1 (Figure 14). Similarly, seniors were taking an average of 5.1 different drugs per year in 1996, and that number had risen to 5.9 by the year 2000.

Figure 14: Prescription Drug Use in Selected Age Groups, Manitoba, 1996-97 to 1999-00



Source: Metge, C., Kozyrskyj, A., Dahl, M., Yogendran, M. & Roos, N. (2003). *Pharmaceuticals: Focussing on Appropriate Utilization*. Winnipeg, MB: Manitoba Centre for Health Policy.

Given the preponderance of chronic health problems, such as arthritis, high blood pressure and heart disease among older adults, it is assumed that prescription drugs are most often being taken for these conditions.

What is not clear, and is impossible to analyse is how many of the prescription drugs were combined with over the counter medications. The American Academy of Family Physicians publishes bulletins concerning the interactions of over the counter medications, herbal remedies and prescription drugs. The adverse effects of these interactions are largely unknown as manufacturers of herbal products are not required to submit proof of safety to the U.S. Food and Drug Administration. Cupp (1999) suggests that “physicians must be alert for adverse effects and drug interactions associated with herbal

remedies, and they should ask all patients about the use of these products.”

What has been made clear over the years is that because medications increase survival and improve quality of life, they are among the most widely used and most valued therapeutic tools of health care providers (Murray & Callahan, 2003). However, as noted recently in a CBC radio series aired in April 2005:

“In 2004 1.5 million Canadian seniors – more than one-third – were given drugs that are either ineffective in the elderly or put seniors at an unnecessarily high risk when safer alternatives are available” (CBC Radio Series, April 2005a).

Furthermore, there has been an over reliance on some of the psychotropic medication (e.g. benzodiazepines such as Ativan, Valium) in order to deal with what are essentially social issues: loneliness

following widowhood; depression and agitation over the aging process. Generally, these drugs are not recommended for long term use (CBC Radio Series, April 2005b).

That there are inappropriate prescriptions for some drugs (e.g. benzodiazepines) was confirmed in a Manitoba study. The study found that a significant proportion of new users of benzodiazepines were still prescribed a long-acting version (over 10%), signifying potential inappropriate use (Metge, Grymonpre, Dahl et al., 2005). Meanwhile an article in the British Medical Journal stated unequivocally that

“Anxiolytics, hypnotics, and antidepressants are the only classes of drugs that are independently associated with falling. Use of hypnotics or anxiolytics and use of antidepressants were associated with an increased odds of falling, even with adjustment for chronic disease status (including ever having had a diagnosis of depression) and other potential confounding factors”
(Lawlor, Patel & Ebrahim, 2003).

We know that pharmaceutical issues can play an important role in the ability to drive; in the ability to process food or alcohol. One wonders if pharmaceuticals might also play a role in abuse issues: do they calm down an agitated person who is being “difficult?” Are some of the psychotropic drugs provided more for the benefit of a caregiver than they are for the benefit of the person taking the drugs? One would hope for more thorough investigations of the reasons for prescribing and the results of those prescriptions.

Physician Use

In 2000-01, 90% of older Manitobans consulted a family doctor or general practitioner in the previous 12 months (Manitoba Fact Book on Aging, 2005, p.108). Access to family physicians has been a growing concern in Canada. According to a Canadian Institute for Health Information report “the supply of physician services was influenced by the fact that the proportion of women in the physician workforce rose steadily, from 13% in 1981 to 29% in 2000. However, women practiced about one-fifth less intensely than males, as measured by health service billing data and self reported work hours” (Chan, 2002). This resulted in a decline in the 'real' physician-population ratio (after accounting for an aging population and the entry of more women in the workforce) between 1993 to 2000 of 5.1%; the same level as in 1987.

The issue is more complex than that, however, as a Manitoba study shows. Watson and colleagues (2005) points out that it is actually the aging of the family physicians that will affect the availability of family physicians as the current cohort retires. Specifically they study found that family physicians (FPs) aged 60 to 69 years (11% of the workforce) to be providing, on average, 1.5 times the number of services relative to FPs aged 30 to 39, and shouldering the heaviest workload. The researchers conclude that:

“Should trends in age-specific workloads persist following retirement of the oldest cohort of [family physicians], we would expect substantial declines in the availability of [family physician] services in the coming years. Given the long lags between some changes to physician supply policy and changes in effective supply (e.g., due to the length of time

to train physicians), current perceptions of [family physician] shortages and complaints of high workloads are likely, on the basis of this analysis, to get worse before they get better. That is not to say that the situation is hopeless. The use of alternative primary care providers, or other mechanisms to enhance the efficiency of [family physician] patterns of service delivery, will be required to compensate for the trends exposed here.”

Thus, new initiatives will be needed to meet the needs of an aging population. For example, provinces are encouraging new practice groupings which they hope will draw physicians to family practice and to assist in the delivery of primary care (Government of Ontario, 2005).

Other Health Care Providers

There is little research on the use of other health care providers: occupational therapists, nurses, social workers: people whose skills might very well be more appropriate in certain cases than those of a physician. Research on cost-effectiveness, quality care and client outcomes confirms that nurse practitioners could improve access to high quality care at a reduced cost to the health care system (Canadian Nurses Association, 2003).

What is of interest and perhaps concern is that only one-third of older Manitobans reported visiting a dentist in the previous 12 months (Manitoba Fact Book on Aging, 2005, p.108). Is this because seniors tend to have dentures? Is it a lack of insurance to cover dental visits? Since dentition is so important to digestion and general health, this is a question that could be explored further. Obesity, for example linked to

diabetes, could also be partially due to improper digestion of food. Chewing food well often prevents gulping and over eating. Dentists claim that as much as 50% of digestion takes place in the mouth, thus allowing for improved nutrition.

End of Life

“...death, a necessary end, will come when it will come” says Julius Caesar. Similarly one of the characters in Macbeth states of a king who has just died that “Nothing in his life became him like the leaving of it.” Everyone recognizes that death does come, and most people would like to have our friends be able to speak in such a manner about us; to die in a dignified way, with family/friends nearby.

Palliative care can be defined as *“care aimed at alleviating suffering – physical emotional, psychosocial, or spiritual -- rather than curing”* (Subcommittee to Update “Of Life and Death”, 2000).

Often palliative care has been associated with a specific disease such as cancer. It has been suggested that the term ‘quality end of life care’ would include the same aspects of palliative care for all end-of-life situations and not just specific diseases (Subcommittee to Update “Of Life and Death”, 2000).

Although most people want to die at home surrounded by family and friends, it still appears that most deaths occur in hospital or long-term care institutions. Almost half, (47%) of all deaths occurring in Manitoba between April 1, 2000 and March 31, 2001 took place in a hospital; 24% took place in long-term care institutions (e.g. nursing homes) (Menec, Lix, Steinbach et al., 2004). What we don’t know is what kind of

care they received before death and under what circumstances they died. Were family member present? Was pain controlled? Were people able to die in the place they wanted to die? Answers to these questions are more important than knowing the location of death.

Are there ways in which the high costs can be avoided, while people can die in a dignified manner, without the pain that could possibly be managed? Dying accounted for approximately 21% of the total provincial health care costs (Menec et al., 2004). These researchers also ask the question: why are so many of people who are receiving homecare hospitalized two or more times. Are there other, better ways of providing care for them?

Health departments are seeking ways in which to improve palliative care. The differential rates in the percent of cancer deaths in hospital for Winnipeg residents versus residents in the rest of Manitoba provide some evidences of this (47% versus 72%). Furthermore, in Winnipeg, 34% of cancer deaths took place in one of the two palliative care units, where supportive staff, adequate pain relief, assisted sleep and feeding are part of a normal regimen (Menec et al., 2004).

Each regional health authority has a palliative care coordinator, working to make services available and easily accessible. Palliative care can now be provided in people's home as part of the Home Care Program. Hospice and

Palliative Care Manitoba is a community based, non-government organization that provides information and resources on palliative care and bereavement services.

Manitoba Health's Palliative Care Drug Access Program, introduced in November 2002, strives to uphold the dignity of patients who are near the end of life by supporting their decision to choose where they would prefer to spend their final days. It supports

- patients who choose to spend their final days in a hospital or a public personal care home will have their drug expenditures covered by the health care system
- patients who choose to spend their final days at home or in another residence (perhaps with family or friends), they will have their medications completely paid for through the palliative care program (no deductible required)

The Palliative Drug Access Program is an important step in allowing people who wish to die at home to do so.

The issues of end of life care are unlikely to disappear, particularly as this baby boom generation requires more care. Will the pressure to improve palliative care increase as the parents of the baby boom face death? Will palliative care improve, as it has for persons living with cancer and HIV/AIDS? Will we be willing to face our own mortality, rather than speaking only about healthy aging?

Key Points

- ▶ Health care is and will remain a key issue. The real question is, though, how can we improve health and prevent disease so that less health care is needed? Policies in the area of healthy living and active aging are therefore just as important.
- ▶ An increase in the aging population requires governments to plan for health care resources to meet the needs of this population.
- ▶ This issue of prescription drug use among seniors is complex and requires ongoing research. Polypharmacy, the taking of many drugs simultaneously, and inappropriate prescribing are some of the key issues to address.
- ▶ Surgical procedures such as knee/hip replacements are important to the quality of life of seniors. However, it is also important to focus on programs that prevent the need for such surgeries in the first place.
- ▶ End of life care is a critical issue. Although palliative care programs are expanding, we must ensure that the needs of all individuals are met, including those of the many seniors who die in hospitals and personal care homes who are not “typical” palliative care patients (e.g., the frail elderly).
- ▶ It is important to keep in mind that access to health care services is but one of the many determinants of health. The key to planning for the aging population may therefore not lie in the health care system; planning in the areas of transportation, housing, economics, safety and security, and healthy living are just as, or perhaps even more important.

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