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CANADIAN HEALTH SERVICES  
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FONDATION CANADIENNE DE LA  
RECHERCHE SUR LES SERVICES DE SANTÉ

# BETTER WITH AGE: HEALTH SYSTEMS PLANNING FOR THE AGING POPULATION

SYNTHESIS REPORT

JULY 2011

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This report is one in a series produced by the Canadian Health Services Research Foundation on the *Better with Age* roundtables hosted in October and November of 2010.

## ACKNOWLEDGEMENTS

CHSRF is grateful to the participants who attended and made these roundtables engaging and meaningful, Lillian Bayne who facilitated the roundtables, as well as Dr. Marcus Hollander, Dr. Jo Ann Miller, and Louise Cherry, of Hollander Analytical Services for contributing to the planning of the roundtables, participating in the roundtables and writing the reports. We are also grateful to Dr. Michael Rachlis, our keynote speaker and all of our speakers for their integral role in setting the stage for dialogue at each roundtable. We also sincerely appreciate CHSRF staff members who made the events happen, especially the Jennifers (Jennifer Major, Jennifer Verma and Jennifer Ellis), Kelly Ripley, Stephen Samis, Alexandra Constant, Diane Gagnon, Gillian Mulvale, Erik Markhauser, Alison Hebbs and Beth Everson.

This document is available at [www.chsrf.ca](http://www.chsrf.ca).

This research report is a publication of the Canadian Health Services Research Foundation. Funded through an agreement with the Government of Canada, CHSRF is an independent, not-for-profit corporation with a mandate to promote the use of evidence to strengthen the delivery of services that improve the health of Canadians. The views expressed herein are those of the authors and do not necessarily represent the views of the Government of Canada.

*Synthesis Report—Better with Age: Health Systems Planning for the Aging Population.*

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## FOREWORD

Demographers have predicted for decades that the proportion of older adults in Canada would grow as the baby boom generation ages, yet our healthcare system has not yet sufficiently adapted. Calls for policies and sustainable reforms to address the needs of older Canadians—which would also better serve the needs of the overall population—abound. There is general consensus around what needs to be done—but the question of how to get there remains.

To help address this issue, the Canadian Health Services Research Foundation (CHSRF) convened a series of roundtables—five regional and one national—called *Better with Age: Health systems planning for the aging population*. More than 200 policy-makers, healthcare executives and professionals, researchers and citizens from across Canada participated in the roundtables, which aimed to bring clarity to the impact of population aging on the financial sustainability of our health system; raise the profile of the most pressing policy- and decision-making challenges; identify research gaps; and offer ideas and strategies for delivering high-quality care to older adults.

Several overarching messages emerged from the roundtables. First, the problems expected to arise from population aging can be mitigated by making smart changes now to the way healthcare is managed and funded in Canada. The necessary steps include identifying who needs to be involved in effecting health system change, developing funding mechanisms that promote integrated and coordinated systems of healthcare delivery, and strengthening the management of Canada's healthcare systems. Second, Canadians need to challenge the conventional approach to delivering healthcare. Our current system is centred on acute care, whereas today's population requires a system that is focused on health promotion, chronic disease prevention and management and palliative care. Healthcare services should be delivered in community settings when it is cost and quality effective to do so. Third, citizens and patients should be consulted in discussions, decisions and initiatives to reform healthcare. What citizens actually want in their healthcare as they age is too often neglected in health system planning, but their engagement is necessary to create the political will to facilitate sustainable, patient-centred reform.

The main message from the roundtables was very clear: now is the time to formulate policies and implement sustainable reforms that will improve healthcare for the growing number of older Canadians. These reforms will improve the care available to Canadians of all ages.

Building on the findings of these roundtables and other initiatives related to healthcare transformation, CHSRF will continue to gather innovative approaches from Canada and around the world to promote policy dialogue on ways to achieve the healthcare system Canadians need. CHSRF will pay particular attention to the challenge of improving access to culturally appropriate and technologically advanced care for people living in northern, rural and remote locations, and to addressing the particular needs of many Aboriginal people, including lack of transportation, inadequate housing and sanitation and higher-than-average incidence of chronic disease. CHSRF will also commission policy-relevant research to examine initiatives that have the potential for cost savings, improved efficiencies and, most importantly, improved health for Canadians.

## EXECUTIVE SUMMARY AND KEY MESSAGES

Health services and associated policies must adapt to address the needs of Canada's aging population. But what needs to change? When? How? And does the argument that the demographic shift will overwhelm Canadian medicare have any truth to it?

To help respond to these questions, the Canadian Health Services Research Foundation (CHSRF) hosted one national and five regional roundtables in six cities as part of its series "*Better with Age: Health systems planning for the aging population*" in October and November 2010. The roundtables brought together more than 200 policy-makers, regional healthcare executives, researchers and citizen representatives from across Canada. The goal was to bring clarity to the impact of population aging on the financial sustainability of medicare; raise the profile of the most pressing policy- and decision-making challenges; identify research gaps; and offer ideas and strategies for delivering high-quality care to older adults. Each roundtable consisted of a keynote speech, presentations by experts, a question-and-answer period and group dialogues.

Invited speakers, including members of the Special Senate Committee on Aging, health policy analysts, economists, government representatives, and researchers, set the stage by providing information on various topics related to the aging population. Participants then engaged in plenary and small group discussions to identify:

- ▼ Policy successes in meeting the needs of older adults
- ▼ Policy issues and challenges affecting the efficiency and effectiveness of health services for older adults
- ▼ Actions required to better meet the needs of older adults, and barriers that prevent change
- ▼ Research issues and knowledge gaps associated with health systems planning for the aging population

This synthesis report provides an overview of the key themes that emerged from all six roundtables (separate reports on each roundtable are available at [www.chsrf.ca](http://www.chsrf.ca)). The views reported reflect the comments made by the participants in the sessions; the accuracy of these views has not been determined by CHSRF.

Most of the key messages from participants relate to policy issues they believe need to be addressed to support sustainable improvements to healthcare for older adults. They include:

- ▼ Promote a positive view of aging and address ageism.
- ▼ Adapt the acute-care-centred model of healthcare to address the new reality of health (longer life with more chronic disease) by, in part, placing more emphasis on population health issues (such as adequate housing and nutrition) and implementing more initiatives to prevent injury and disease and promote health.
- ▼ Clarify leadership roles of the federal, provincial and territorial governments with respect to improving the health system for older adults and identify who is accountable for system management and change.
- ▼ Move to a client-centred model of care, whereby health and social services are provided and coordinated in ways that better meet the needs of older adults.
- ▼ Consult with citizens to better understand what patients want in their healthcare; citizens can provide important insights into how to improve healthcare and public pressure creates the political will to change.

- ✦ Move to an integrated system of care that would coordinate health and social services, improve communication between patients and service providers and offer more timely access to the appropriate services. This includes improving access to community care and long-term care to improve health outcomes, save money, and decrease “alternate-level-care” patients in hospitals.
- ✦ Address issues unique to specific population groups. For example, many Aboriginal people have limited access to transportation and housing and have higher than average incidence of chronic disease. Recent immigrants and Francophone Canadians in minority settings may not be able to receive care in their language of choice.
- ✦ Adopt better quality-control measures related to prescription drug practices and long-term care settings.
- ✦ Promote healthcare financing models that support more flexible, cost-effective service delivery, quality and access to health services.
- ✦ Address health human resources issues, including improving the recruitment, retention and training of professional and unpaid caregivers who work with older adults.

Participants voiced the need to overcome barriers that impede improvements to health service delivery, including creating the political will to facilitate change, increasing access to health data and increasing the opportunity for policy-relevant research. In terms of research, participants identified specific topics (for example, research to counter ageism, planning for the expected increase in the number of dementia patients, and designing national strategies for home care and pharmacare), but focused on knowledge gaps associated with broad system change. For example:

- ✦ Health services managers and providers need support in the implementation of evidence and new practices related to health system change.
- ✦ There is a need for an inventory of best practices in healthcare—national and international—to identify promising innovations and associated implementation considerations. Participants recommended formation of provincial partnerships and called for organizations such as CHSRF to convene pan-Canadian meetings to share information and evidence.
- ✦ A review of existing research is required to better determine research gaps and priorities.
- ✦ Researchers need to better understand how policies are made.
- ✦ More support for researchers to conduct policy-relevant research is required.
- ✦ There is a need for better research to evaluate improvements in healthcare; for example, to identify measureable outcomes for gauging healthcare quality, as well as longitudinal research to assess change over time.
- ✦ There is a need for improved access to health data.

The *Better with Age* roundtables found general agreement on what should be done to create a system that meets the needs of aging Canadians. The challenge is how to get there. CHSRF will continue to gather innovative approaches from Canada and around the world and to promote dialogue among stakeholders, with the goal of building the high-quality, sustainable healthcare system Canadians need for the future.

# 1 INTRODUCTION

Without question, Canada's population, as in most developed countries, is aging. By 2015, Canada will have more people aged 65 and older than people aged 15 and younger. By 2050, the proportion of the elderly will be one in four. What is questionable is the evidence base that suggests this demographic shift will overwhelm Canadian medicare, ultimately threatening its financial sustainability. This argument—long debunked in health services and policy research circles—continues to surface in popular press and public discourse.

This focus on medicare's sustainability threatens meaningful and productive discussions related to delivering high-quality healthcare to seniors. There is no shortage of pressing issues that demand the attention of health system managers and planners in this area. To help raise and address these issues, the Canadian Health Services Research Foundation (CHSRF) hosted the *Better with Age* series of roundtables—six regional and one national<sup>1</sup>—that brought together more than 200 policy-makers, regional healthcare executives, researchers and citizen representatives from across Canada in October and November 2010. The objectives of the series were to:

- ▶ Bring clarity to the impact of population aging on the financial sustainability of medicare
- ▶ Raise the profile of the most pressing policy- and decision-making challenges and research gaps
- ▶ Offer ideas and strategies for delivering high-quality care to older adults

## Purpose of the synthesis

The purpose of this synthesis report is to provide an overview of the key themes that emerged from discussions about policy successes, policy issues and research issues associated with health systems planning for the aging population. The views reported reflect the comments made by the participants in the session; the accuracy of these views has not been determined by CHSRF.

## Roundtable process

Each roundtable consisted of a keynote presentation, additional speaker presentations made by experts in aging, a question and answer period with speakers, group dialogues and a networking lunch.

## *Setting the stage for dialogue*

Invited speakers set the stage for the dialogue by presenting on various topics related to the aging population. Speakers included members of the Special Senate Committee on Aging, health policy analysts, economists, government representatives and academic and community-based researchers. The goal of the presentations was to provide participants with a wide range of perspectives that would serve to provide a foundation for informed discussion.<sup>2</sup>

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1 *Better with Age* series schedule:  
October 7, 2010—Calgary, Alberta (British Columbia and Alberta)  
October 15, 2010—Winnipeg, Manitoba (Saskatchewan and Manitoba)  
October 20, 2010—Ottawa, Ontario (national roundtable)  
October 27, 2010—Halifax, Nova Scotia (Atlantic region)  
November 4, 2010—Toronto, Ontario (Ontario)  
November 10, 2010—Montreal, Quebec (Quebec)

2 A full list of presenters is provided in Appendix 1.

In his opening remarks to roundtable participants, health policy expert Dr. Michael Rachlis, argued it's not population aging that threatens to precipitate a financial crisis in healthcare, but a failure to examine and make appropriate changes to our healthcare system to meet the needs of the aging population. Dr. Rachlis identified the main elements of a high-performing health system for older adults—one that is driven to excel across all quality domains (safe, effective, patient-centred, accessible, efficient, equitable, integrated, appropriately resourced and focused on population health); provides access to a range of continuing care services (chronic disease management and primary healthcare support for health assessment and promotion, home care, long-term care, end-of-life care and acute care); and is embedded as a part of a broader, intersectoral initiative for achieving improved population health, emphasizing the need for supportive housing, reliable transportation and access to nutritious and affordable foods.

Similar points were raised by representatives of the 2006–2009 Special Senate Committee on Aging, chaired by the Honourable Sharon Carstairs and the Honourable Wilbert Joseph Keon (Deputy Chair). The Committee had consulted with expert witnesses and citizens across the country over a two-and-a-half-year period, in an effort to determine whether Canada is providing the appropriate services and programs, at the right time, to the individuals who need them. After the consultations, the Committee called for system-wide transformation based on five overarching recommendations<sup>3</sup> that reflected the report they tabled in 2009. The report recommended that the federal government:

- ▶ move immediately to take steps to promote active aging, healthy aging and combat ageism
- ▶ provide leadership and coordination through initiatives such as a national integrated care initiative, a national caregiver strategy, a national pharmacare program and a federal transfer to address the needs of provinces with the highest proportion of the aging population
- ▶ ensure the financial security of Canadians by addressing the needs of older workers, pension reform and income security reform
- ▶ facilitate the desire of Canadians to age in their place of choice with adequate housing, transportation and integrated health and social services
- ▶ act immediately to implement changes for those population groups for which it has a specific direct service responsibility and in relation to Canada's official language commitments.

Other speakers at the roundtables echoed the long-standing need for health system reform, particularly integrated care delivery, which evidence shows can achieve substantial cost-savings, create efficiencies and improve quality of care and caregiver satisfaction (Denton and Spencer, 2010; Hollander and Chappell, 2002; Hollander, Chappell, Prince and Shapiro, 2007). Many pointed to existing evidence-based models of integrated care—for example, the Program of Research to Integrate the Services for the Maintenance of Autonomy (PRISMA) model from Quebec (Hébert, Durand, Dubuc and Tourigny, 2003) and the Hollander-Prince framework from B.C. (Hollander and Prince, 2007).

### *Engaging in dialogue*

The roundtable sessions were attended by more than 200 participants representing a wide range of organizations that have a role in caring for older adults or advocating for seniors' issues.

These included:

- ▶ not-for-profit health, social services and seniors' organizations
- ▶ professional organizations

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3 Special Senate Committee on Aging. (2009). *Canada's aging population: Seizing the opportunity*. Committee's final report, at <http://www.parl.gc.ca/Content/SEN/Committee/402/agei/rep/AgingFinalReport-e.pdf>

- ▼ federal health and human resources-related agencies
- ▼ provincial health, community services, seniors' and policy and planning departments
- ▼ local and regional health and social services organizations and Francophone organizations
- ▼ for-profit and private sector interests
- ▼ First Nations and Inuit organizations
- ▼ universities and research institutes.

Following the presentations and a question-and-answer session with the speakers, participants engaged in a plenary dialogue session to examine the key challenges affecting the efficiency and effectiveness of health services for the aging population. After a networking lunch, participants were divided into groups of six to eight that included representatives from each province (where possible) and a variety of perspectives. The groups were asked to discuss several major issues, including these questions:

- ▼ What have been the policy successes in health systems planning for the aging population?
- ▼ What policy changes/actions are needed to improve health services for the aging population and what are the barriers to health system change?
- ▼ What knowledge gaps/research issues need to be addressed to improve healthcare services for older adults?

The key points raised during the discussions outlined policy successes, policy issues and research issues.

## 2 POLICY SUCCESSES

Participants at all of the roundtable sessions were invited to identify what they considered to be successful policy initiatives related to health systems planning for the aging population at local, regional, provincial, national and international levels. Below is a summary of the key policy successes identified, each of which is explored in further detail in this section.

- ▼ Strategies for meeting the needs of an aging population
- ▼ Integration and delivery of services
- ▼ Promotion and prevention approaches
- ▼ Aging in the community
- ▼ Access to acute care services
- ▼ Technology
- ▼ Benefit programs for unpaid caregivers

### 2.1 Strategies for meeting the needs of an aging population

Nova Scotia has developed a Strategy for Positive Aging, a provincial initiative that includes a framework for action with a vision, guiding principles and positive aging goals. The strategy considers different levels of government, businesses, not-for-profit organizations and community groups and focuses on how all sectors can work together across the province. It also serves as a guide to help all sectors create senior-friendly communities.<sup>4</sup>

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4 For more information, see Nova Scotia Seniors' Secretariat. (2005). *Strategy for positive aging in Nova Scotia*, at [www.gov.ns.ca](http://www.gov.ns.ca)

Alberta's continuing care strategy is intended to improve health and personal care services for older adults and individuals with disabilities to enable them to live within their communities. The strategy identifies five directions to help people to "age in the right place:"<sup>5</sup>

- ▶ investing in community supports
- ▶ building infrastructure to support aging in the right place
- ▶ changing the way long-term accommodations are paid for
- ▶ providing options to fund individuals based on needs and/or funding providers
- ▶ providing equitable drug coverage for people wherever they live in the province.

## 2.2 Integration and delivery of services

Several provinces are making efforts to better coordinate and integrate healthcare services (usually for the general population, not only older adults). For example, in British Columbia, initiatives are underway to integrate primary care and home and community care at a provincial level. In Alberta, a primary care initiative established in 2003 is improving access to family physicians and other front-line healthcare providers. Through this initiative, Primary Care Networks have been created, whereby family physicians work with other healthcare providers and Alberta Health Services to deliver health services. This initiative has created over 40 Primary Healthcare Networks to date. The goal is to have 80% of Albertans receive care from Primary Healthcare Networks in 2011.<sup>6</sup>

All provinces provide health services at a regional level, although the types of services, service providers and organizational structures may differ within and between provinces. The goal of a regional structure is to make it easier for all individuals, not only older adults, to receive the best care in the most appropriate setting closer to home.

## 2.3 Promotion and prevention approaches

Participants at the roundtables discussed the need to adapt the acute-care-centred nature of healthcare to address the new reality of health (longer life with more chronic disease) and the associated service delivery challenges (e.g. chronic disease management). To this end, participants identified successful programs for older adults that emphasize health promotion and disease prevention activities—for example, falls prevention programs and greater access to immunizations for little or no cost. Participants in Atlantic Canada spoke about fitness facilities that are specifically for older adults, as well as successful initiatives to raise awareness of elder abuse. There was a call from all participants, including the speakers, to enhance efforts for health promotion and prevention to create better health outcomes and to save money in the healthcare system.

## 2.4 Aging in the community

Age-friendly communities aim to be responsive to the needs of older Canadians by providing access to recreational, social and community activities. Such environments empower older Canadians to remain independent for as long as possible while allowing them to remain active members of society. Participants

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5 For more information, see Alberta Health and Wellness. (2008). *Continuing Care Strategy. Aging in the Right Place*, at [www.health.alberta.ca](http://www.health.alberta.ca)

6 For more information about Alberta's primary care initiative, see <http://www.albertapci.ca/AboutPCNs/Pages/default.aspx>

referred to several age-friendly communities across the country (in Quebec, Manitoba, British Columbia and Nova Scotia, for example) that are designed to promote policies, services and structures that optimally support older adults.<sup>7</sup>

The Veterans Independence Program (VIP) is a national, community-based home and residential care program funded by Veterans Affairs Canada.<sup>8</sup> The program, which complements local and provincial home care programs, is intended to provide clients (primarily veterans) with increased independence, improved long-term health and improved quality of life. The goal is to ensure that clients receive the most appropriate care in the most appropriate setting. Benefits and services for individuals living at home include:

- ▼ housekeeping and nutritional services
- ▼ health and support services
- ▼ personal care
- ▼ grounds maintenance
- ▼ home adaptations
- ▼ ambulatory healthcare
- ▼ transportation

Importantly, clients manage the funds they receive through the program; for example, they can choose to use their funding to pay for home support services or respite care. Clients may also access intermediate care beds in a long-term care facility. Several research studies have indicated that the program is an effective way to support eligible individuals.<sup>9</sup>

The federal government, through the Canadian Mortgage and Housing Corporation (CMHC), has recently invested \$1 billion to renovate and energy-retrofit social housing to help vulnerable Canadians make needed improvements to their homes. It is anticipated that the program will improve the quality of life for individuals by keeping their homes safe and affordable. An additional \$75 million has been allocated for new rental housing for people with disabilities. A further \$400 million has been allocated for new rental housing for low-income seniors to enable them to live independently in their own communities.<sup>10</sup>

## 2.5 Access to acute care services

Participants at all of the roundtables noted that public funding of emergency services and other acute care services was good, in that it ensured access would not be impeded by inability to pay.

Participants at the Quebec roundtable in particular discussed promising initiatives designed to improve access to acute care services. In Quebec, a program “Accueil clinique” (clinical point of entry/reception), in use at some of the local health and social services centres, is proving to be beneficial for individuals,

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7 For more information about the government of Canada’s Age Friendly Communities initiative, see <http://www.phac-aspc.gc.ca/sh-sa/ifa-fiv/2008/initiative-eng.php>

8 For more information about the program, see <http://www.veterans.gc.ca/eng/sub.cfm?source=services/vip>

9 See, for example, Hollander, M.J., Miller, J.A., MacAdam, M., Chappell, N., & Pedlar, D. (2009). Increasing value for money in the Canadian healthcare system: New findings and the case for integrated care for seniors. *Healthcare Quarterly*, 12 (1), 38-47; Miller, J.A., Hollander, M., & MacAdam, M. (2008). *The Continuing Care Research Project for Veterans Affairs Canada and the Government of Ontario*. Synthesis report. Available at [www.veterans.gc.ca](http://www.veterans.gc.ca); Pedlar, D., & Walker J. (2004). Brief report. The Overseas Service Veteran at Home Pilot: How choice of care may affect use of nursing home beds and waiting lists. *Canadian Journal on Aging*, 23 (4), 367-369. For more information on the VIP program see [www.vac-acc.gc.ca](http://www.vac-acc.gc.ca)

10 The first two programs do not focus specifically on seniors. For more information on all of these programs, see [www.cmhc.ca](http://www.cmhc.ca)

including older adults, who require healthcare services in hospitals. Individuals coming from medical clinics with sub-acute symptoms can quickly access diagnostic and specialized services in the hospital and other specialized centres by using this point of entry, rather than by using the emergency room route. At the Accueil clinique, a nurse facilitates the patient's flow through the system and ensures a more effective liaison between the medical clinic (the patient's family physician) and the services in the hospital.

In some regions of Quebec, a pilot partnership program between the public and private sectors is enabling some older adults to be discharged earlier than normal from the hospital after surgery and sent to a private residential facility that offers nursing services during the recovery and convalescent period. The daily cost to the government for this type of residential care is about \$180 per day, which is substantially lower than the cost for recovery in a hospital. As well, this arrangement frees beds for more acute cases.

## 2.6 Technology

Telehealth, or telemedicine, refers to the transfer of clinical information through information technologies like interactive audiovisual media, for the purpose of consulting. These services have been used in several provinces in an attempt to increase access to health services (especially for individuals living in rural and remote locations), decrease the number of visits to hospital and deliver distance education to healthcare professionals. Services can include physician/patient consultations to conduct medical examinations or consultations between medical specialists.

The Ontario Telemedicine Network<sup>11</sup> is one of the largest telemedicine networks in the world. The network uses two-way videoconferencing to provide access to care for individuals in every hospital and hundreds of other healthcare locations across the province.

Participants noted that technological innovations, such as telehealth and telemedicine, should be further advanced to improve service delivery for older adults, but noted that ease of use is critical for ensuring uptake. Other technological innovations—including devices that remind people to turn off their stoves, assistive devices and computer-based web support for family members and friends—while not considered high-tech, were identified as important inventions that have enabled older adults to remain at home for longer.

## 2.7 Benefit programs for unpaid caregivers

Unpaid caregivers (family and friends) contribute the majority of care to people who have care needs. The annual economic contribution of unpaid caregivers is estimated to be over \$25 billion.<sup>12</sup>

Participants discussed several successful policies that assist unpaid caregivers, particularly those that offset the cost of caregiving at home. These initiatives do not specifically target older individuals, but a substantial proportion of the caregivers who receive the benefits are likely assisting older adults. For example, in Manitoba, the Primary Caregiver Tax Credit provides up to \$1,020 per year for people who serve as primary unpaid caregivers for spouses, relatives, neighbours or friends living at home. To be eligible, individuals requiring care must be assessed as level 2 or higher under the Manitoba Homecare Program guidelines and must require assistance with tasks such as eating, bathing, dressing, mobility

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11 See <http://www.otn.ca/> for more information about the Ontario Telemedicine Network.

12 Hollander, M.J., Liu, G., & Chappell, N.L. (2009). Who cares and how much? The imputed economic contribution to the Canadian healthcare system of middle-aged and older unpaid caregivers providing care to the elderly. *Healthcare Quarterly*, 12(2), 42-49.

and/or medical care.<sup>13</sup> In Nova Scotia, the Caregiver Benefit Program gives support to unpaid caregivers who provide assistance to low-income clients with disability or require a high level of care over time. If both the client and caregiver qualify for the program, the caregiver receives a taxable benefit of \$400 per month.<sup>14</sup>

Participants voiced the need for more benefit programs for caregivers, including direct services such as respite support and direct and indirect compensation such as payment and tax credits.<sup>15</sup>

### 3 POLICY ISSUES

Participants discussed the key policy issues affecting the efficiency and effectiveness of health services for the aging population and the policy actions required to improve health services for older adults. This list—presented here in no particular order—synthesizes the key policy issues identified by participants from across the country.

- ▼ Age and ageism
- ▼ Population health and prevention initiatives
- ▼ Government leadership and accountability
- ▼ Client-centred care, citizen engagement and advocating for change
- ▼ Integrated systems of care delivery
- ▼ Specific population groups
- ▼ Assessing and promoting high-quality care
- ▼ Healthcare financing
- ▼ Health human resources

#### 3.1 Age and ageism

Participants discussed several issues related to promoting a positive view of aging and addressing ageism. For instance, it was noted that there should be a greater recognition of the economic and social contributions of older adults.

Roundtable participants felt the following topics required policy action.

- ▼ More information is needed on the nature and scope of the contribution of older adults in Canada as well as on the diversity of older adults. It was noted that many individuals are healthy and mobile into their later years and should be seen as a resource for, rather than a burden on, society.
- ▼ It is important to understand how Canadians (including government, the general public, healthcare providers and older adults themselves) view aging. This is essential for shaping policy and for determining which healthcare services are wanted and needed, who should provide them and in what setting(s), what barriers to access may exist and what policy changes may be required to ensure that appropriate services can be provided at the right time and in the right place. In addition, participants

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13 For more information, see [www.gov.mb.ca](http://www.gov.mb.ca)

14 For more information see [www.gov.ns.ca](http://www.gov.ns.ca)

15 Caregiver tax benefits are available in some provinces.

felt that attitudes toward aging should be monitored on an ongoing basis, because beliefs may change substantially as the population continues to age, people become more informed about their own health and access to resources, such as unpaid caregivers, changes.

- ▶ The perception and treatment of older adults in the healthcare system needs to change. Older adults need to be treated as individuals with healthcare needs rather than as people in beds. It was suggested that a “seniors’ bill of rights” should be developed that would support older adults who want to be more involved in making decisions regarding their own healthcare (with an acceptable degree of risk).
- ▶ There was considerable discussion about the so-called “gray tsunami” notion that the aging population will place an increasing burden on the healthcare system. Evidence indicates that the aging population will increase healthcare costs in Canada on average by 1% per year between 2010 and 2036.<sup>16</sup> Blaming older adults for the perceived healthcare fiscal crisis is a misconception and a form of ageism. It is important to understand and address the full range of cost drivers in healthcare.
- ▶ Governments and healthcare organizations should review their policies to ensure they do not contribute to ageism. In addition, there should be public awareness campaigns to counter ageist attitudes in society and among older adults themselves.

### 3.2 Population health, prevention and health promotion initiatives

Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development and health services. Population health approaches recognize that health is impacted by interrelated determinants of health, such as income and social status, social support networks, education, employment and working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetics, health services, gender and culture.<sup>17</sup>

Participants at the roundtables felt that more could be done to use the broad determinants of health to guide and shape policy for older individuals. This could include, for example, addressing policies related to more affordable housing, transportation and assisted living opportunities. The importance of better communicating information about proper nutrition was also discussed.

Participants indicated that the healthcare system must become less centred on acute care and place more emphasis on prevention and health promotion initiatives. Such initiatives can, for example, reduce the incidence of chronic illness and obesity and thus reduce hospital admissions. The need for more initiatives that target primary, secondary and tertiary prevention was also discussed. Primary prevention aims to avoid the onset of a disease and includes health promotion activities such as encouraging healthy diet and exercise. Secondary prevention refers to the importance of detecting a disease before it becomes symptomatic and includes health promotion activities such as communicating the importance for regular check-ups. Tertiary prevention focuses on reducing disability and preserving functionality in individuals already inflicted with a disease. At least one participant noted that a policy focus on tertiary prevention could result in substantial cost-savings, in part because such initiatives can yield results faster than primary and secondary prevention initiatives.

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16 MacKenzie, H. & Rachlis, M. (2010). *The Sustainability of Medicare*. Retrieved June 2 2011 at [http://www.nursesunions.ca/sites/default/files/Sustainability.web\\_e.pdf](http://www.nursesunions.ca/sites/default/files/Sustainability.web_e.pdf)

17 The Public Health Agency of Canada. <http://www.phac-aspc.gc.ca/ph-sp/approach-proche/appr-eng.php#health>

### 3.3 Government leadership and accountability

Participants called for more government leadership in improving the health system for older adults and for clearer roles for the federal, provincial and territorial governments. For example, participants saw a need for more federal leadership in:

- ✦ Establishing a clear framework on aging to ensure government programs and services (the tax system, social services and healthcare, for example) are coordinated
- ✦ Developing initiatives to combat ageism and increase the positive perception of aging among the public
- ✦ Developing pan-Canadian programs such as community care and pharmacare, and a national dementia strategy
- ✦ Creating consistent terminology for healthcare services across Canada and ensuring standardized methods of data collection and analysis (e.g., to measure health outcome and health services efficiency) to facilitate evaluations of change
- ✦ Improving the perception of long-term care as an important part of the healthcare continuum.

Participants called for leadership from all levels of government in several domains, including:

- ✦ Improving the management, collection and monitoring of health-related data. The government role could include initiatives to address policy and privacy barriers that limit access to health data and may impede health service delivery improvements.
- ✦ Promoting policy integration and program coordination among federal, provincial and territorial governments and service providers.

In addition to voicing the need for more government leadership, participants discussed the importance of identifying who is accountable for managing and changing the healthcare system. Initiatives put forth to improve the healthcare system require appropriate management, which at present is often not clearly defined within the healthcare system. For example, some participants argued there is no overarching management of primary healthcare and there is a lack of public policy regarding health systems planning for seniors. Participants indicated that governments can play a critical role in defining or re-defining who is accountable for managing the healthcare system. Some participants suggested that separate government structures, such as a ministry of human services, could be instrumental in creating shared accountability and leadership for healthcare within government.

### 3.4 Client-centred care, citizen engagement and advocating for change

Participants recommended moving to a more client-centred model of care, whereby health and social services are provided and decisions regarding policies, programs and human resources are coordinated according to what is best for patients. For example, initiatives to allow adults to remain in their homes for as long as reasonable and safe to do so should be expanded. Also, services should be provided at times that are convenient for clients and not only providers and there should be a greater emphasis on talking to clients and family members about the type of care they want. If applicable, unpaid caregivers should be partners with case managers and family physicians in developing care plans for patients.

In addition, the services provided should match the needs of the client. For example, young adults with disabilities or brain injuries and people (of all ages) with chronic mental health problems should not—as they frequently are now—be placed in long-term care facilities designed primarily for physically frail older adults. Such actions reduce the quality of care for all patients involved.

To achieve a more client-centred model of care, participants suggested including citizens in health systems planning discussions and in their own care plans. For instance, the public is generally not involved in deciding where public healthcare dollars are spent or in conversations related to the expiry of the 2004 health accord. Including citizens in such dialogue could provide critical insights into ways to improve services to create a more effective healthcare system.

To actually bring about improvements, champions are needed to help create the political will for change. Participants identified a need for a strong national voice for older adults in Canada (like the American Association for Retired Persons in the U.S). It was noted that Canada does not have a strong advocacy group for older people at the national level, because there is a greater focus on the provincial level. Coalitions may be a way to address this. It was also noted that, in the United States, former presidents have been advocates for seniors' issues. There is a need to identify someone in Canada who can command people's attention.

### 3.5 Integrated systems of care delivery

There was a general consensus among roundtable participants that a move to a system of integrated care is necessary. Such a system would:

- ▶ Integrate and better align a broad range of health and social services, such as primary healthcare, case management, home and community services, assisted/supportive living and long-term care services and improve transitions between different types of care. One step toward achieving that goal would be to remove administrative and financial impediments to transitions between types of services and creating shared responsibilities and stewardship.
- ▶ Improve communication and coordination of care within and across departmental, organizational, regional, provincial/territorial and federal levels.
- ▶ Support improved healthcare quality and cost savings by increasing the flexibility of funding at the organizational level (for example, enable resource reallocation from acute alternate level of care beds to long-term care or home care).
- ▶ Enable individuals to access the right care at the right time in the right setting.

Some participants argued that integrated systems allow substitution of lower cost care (such as home care) for higher cost care (such as acute care or long-term care), thus increasing value for money for the overall healthcare system. Participants also referred to a number of Canadian frameworks and models of integrated care that could be adopted, as policy, to bring about greater efficiencies in the healthcare system.<sup>18</sup>

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18 Current frameworks include: Hollander, M.J., & Prince, M. (2008). Organizing Healthcare Delivery Systems for Persons with Ongoing Care Needs and Their Families: A Best Practices Framework. *Healthcare Quarterly*, 11 (1), 42-52; Béland, F., Bergman, H., Label, P., Clarifield, A.M., Tousignant, P., Contandriopoulos, A-P., & Dellaire, L. (2006). A system of integrated care for older persons with disabilities in Canada: Results from a randomized controlled trial. *Journal of Gerontology*, 61A (4), 367-373; Hébert, R., Durand, P.J., Dubuc, N., Tourigny, A., & PRISMA Group. (2003). Frail elderly patients. New model for integrated service delivery. *Canadian Family Physician*, 49, 992-997.

Related to the need to better coordinate and integrate care, participants also noted the following.

- ▶ It is difficult for clients and unpaid caregivers to navigate the healthcare system. Case managers and central placement managers and centres (such as Community Care Access Centres in Ontario) can help patients find appropriate (and likely more cost-effective) healthcare services.
- ▶ Support services (home support and respite care, for example) have not been as well supported as acute care services. Some research suggests that increasing the availability of support services can result in better quality care and cost savings.
- ▶ Separating health and social support services can lead to problems with access. For example, in rural communities where there is no public transportation, alternate methods of transportation may be required to ensure older adults can access necessary healthcare services. Further, home and community support services have not responded to other changes in the system, such as a shift to ambulatory care, outpatient tests and day surgeries. Better integration of health and social services could help solve these problems.
- ▶ The lack of electronic health records in many areas means that individuals must repeat their care history to different care providers. Greater use of electronic records can improve patient-provider communication.
- ▶ Physicians need to be actively engaged in integration initiatives.

### 3.6 Specific population groups

Participants noted several population groups with unique needs, including Aboriginal people, immigrants and individuals with lifelong disabilities or chronic illness such as dementia. Several initiatives were proposed:

- ▶ For Aboriginal people, address issues such as lack of transportation, inadequate housing and higher-than-average incidence of chronic disease.
- ▶ For immigrants and francophones in minority settings, the ability to obtain healthcare in the language of one's choice was identified as a barrier to access.
- ▶ For the increasing number of older adults experiencing cognitive problems, formulate a national dementia strategy.<sup>19</sup> Such strategies exist in the United Kingdom.<sup>20</sup> Participants recommended that a Canadian strategy should include measures to enable individuals with dementia to remain at home longer and obtain services in other healthcare sectors when home care is no longer appropriate.

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19 The Alzheimer Society of Canada has documented evidence from a variety of Canadian sources which can be used to develop a comprehensive national plan for dementia. See Alzheimer Society of Canada. (2010). *Rising tide: The impact of dementia on Canadian society*. Available at [www.alzheimer.ca](http://www.alzheimer.ca)

20 With respect to the national dementia strategy, see the following documents: Department of Health. (2009). *Living well with dementia: A National Dementia Strategy*; Department of Health (2010). *Quality outcomes for people with dementia: Building on the work of the National Dementia Strategy*; and Department of Health (2010). *'Nothing ventured, nothing gained': Risk guidance for people with dementia*. With respect to the national end of life strategy, see Department of Health. (2008). *End of Life Care Strategy: Promoting high quality care for all adults at the end of life*. All documents are available at [www.dh.gov.uk](http://www.dh.gov.uk).

### 3.7 Assessing and promoting high-quality care

Participants discussed ways to promote and assess high-quality care within health services such as:

- ▶ Improving the collection of, and access to, data that illustrate the current state of quality. This may entail changing policy and privacy barriers that limit access to data or implementing measures to ensure data is collected.
- ▶ Review current practices for prescribing prescription drugs. Participants expressed concern that older adults, particularly those in long-term care institutions, are prescribed too many medications. Further, participants discussed instances where incompatible drugs were prescribed together, raising the possibility of sickness or death. It was recommended that a review of drug prescription practices take place and strategies be put in place to better monitor prescription drug practices—electronic health records, for example.
- ▶ Set a consistently high standard of care within long-term care homes. Improving the standard of care within long-term care homes will involve encouraging positive attitudes among administration and staff, which can be dealt with in part by addressing understaffing and by ensuring the facilities are as home-like as possible rather than institutional.
- ▶ Develop national accreditation standards for those working in geriatrics.

### 3.8 Healthcare financing

Participants noted that current funding models do not promote flexible service delivery. Participants argued that changes in the way healthcare is financed have the potential to improve cost-effectiveness, quality and access to health services. For example, by:

- ▶ Enabling approaches to healthcare delivery that do not require the physician as the first point of contact, such as team-based approaches to care.
- ▶ Re-examining fee-for-service and other forms of physician payment and encouraging payment models that promote team-based approaches to care.
- ▶ Making it possible to redirect funding from acute care to other sectors, such as home care and long-term care. Such flexibility could reduce the high rates (20% to 30%) of alternate level of care (ALC) patients in acute care wards and could reduce the trend of shifting costs from the public system to the individual (which currently occurs through increased user fees or co-payments for home support services and long-term care facilities).
- ▶ Improving access to home care and other community services to reach a broader population. For instance, participants discussed the current policy focus to restrict home care services for people with low-level care needs.

### 3.9 Health human resources

Participants identified human resources issues as a key consideration, including the need to better accommodate the needs of unpaid caregivers and the need to improve the recruitment, retention and training of professional personnel to work with older adults.

Participants noted that there are very few geriatric physicians in Canada and expressed concern over the high turnover rates for professionals, such as nurses and personal support workers, in long-term care and the home care sectors. To improve recruitment and retention, participants suggested:

- ✦ Increasing the recognition that careers in gerontology are challenging and rewarding, especially for some traditionally undervalued professions, such as home care and personal care work. Related to this is the need to clarify the role of the education system in preparing the health human resources required to meet the needs of an aging population.
- ✦ Ensure compensation for personnel working with older population groups is comparable to that provided in the acute care sector. Currently, personal support workers in home care with similar training to those working in long-term care facilities receive lower pay (however, there is quite a range in pay rates across jurisdictions for home support workers). In addition, there is a large turnover of staff in home care and long-term care.

To better train professional personnel and unpaid caregivers to improve the quality of care of older adults, participants recommended the following:

- ✦ Provide unpaid caregivers with appropriate supports (such as financial reimbursement to account for missed employment and educational opportunities to enhance healthcare provision skills) so they can continue to play a critical role in the provision of care and thereby address the expected decrease in the number of unpaid caregivers in the future.
- ✦ Improve education and training opportunities for all professionals working with older adults.
- ✦ Give training and experience in caring for older adults to healthcare providers, such as physicians, nurses and allied health professionals, as members of multidisciplinary teams.
- ✦ Improve regulations to ensure that home care workers have an appropriate level of education (although it was noted that some regulations already exist).

## 4 RESEARCH ISSUES

One of the purposes of the roundtables was to discuss issues related to evidence-informed decision-making, including the generation of useable new knowledge to support policy development. Participants discussed specific needs (e.g., research on ageism and planning for the expected increase in the number of dementia patients). Appendix 2 identifies several policy-relevant research questions based on roundtable presentations and the group discussions. Participants focused on issues associated with broad system change. The key research needs included:

- ✦ Knowledge transfer, implementation and understanding of how policy is made
- ✦ Support for policy-relevant research
- ✦ Data access
- ✦ Evaluation of healthcare improvements

### 4.1 Knowledge transfer, implementation and understanding how policy is made

It was noted that while a lot of policy-relevant research has already been conducted, it does not seem to be used by decision-makers. Participants felt there was a substantial disconnect between what is already known and the impact that knowledge has on policy-making. They identified a need to determine what knowledge needs to be translated and for whom, what barriers affect uptake and how to encourage and facilitate uptake and implementation. Participants recommended the creation of an inventory or synthesis of best practices in healthcare for older adults nationally and internationally to illustrate, for example,

promising innovations and associated implementation considerations and evidence. To facilitate such an endeavour, participants recommended formation of provincial partnerships and called for organizations like the Canadian Health Services Research Foundation to convene pan-Canadian meetings with researchers, academics, policy-makers, decision-makers, politicians and citizen representatives on this issue.

It was also noted that researchers or people translating knowledge often do not know how policies are made. Although evidence-based summaries may be useful for some individuals, others may not find them useful because of a “disconnect” between the presentation of the information and the way policies are made. For example, documents may be too long or knowledge may be conveyed that has little relevance for policy-makers. Thus, more research on efficient and effective ways to transfer knowledge is required. It was cautioned, however, that more knowledge translation research will not necessarily result in greater uptake. Participants argued that organizations to assist health services providers and managers implement research evidence to create health systems improvements are essential.

Finally, participants pointed out that a better understanding of how policy- and decision-makers currently make decisions and the information required to assist them in making more evidence-based decisions is needed. Researchers need to ensure that relevant evidence is provided in a timely fashion in a manner that policy- and decision-makers can use. Related to this, a strategy for engaging advocacy groups to help create the political will for health systems change is necessary. Advocacy groups have the power to put ideas for change into the “political spectrum.”

## **4.2 Support for policy-relevant research**

Some participants discussed difficulty getting funding for policy-relevant research. It was noted that the Canadian Institutes for Health Research (CIHR) provides funding for academic researchers who build up the national store of knowledge on health and healthcare. The contribution of academic researchers was clearly recognized and respected. However, it was also noted that the emerging health services and policy researchers who can conduct high-quality, applied community research to answer specific policy questions are often not university based and are therefore excluded from CIHR funding programs. This practice makes it more difficult to conduct policy-relevant research.

Some participants recommended more rapid response research that brings researchers and decision-makers together and results in quick answers to relevant policy questions. It was noted that this could be achieved with embedded, or external, research capacity, such as having time and resources for external researchers, providing time within the organization for research activities and/or having individuals with joint clinical/ research appointments. Participants recognized that organizations such as Canadian Health Services Research Foundation and Nova Scotia Health Research Foundation provide needed funding for policy-relevant research and encouraged other health services research organizations to adopt this model.

## **4.3 Data access**

Participants discussed policy and privacy barriers that limit access to health data. It was felt that privacy concerns, while important, may stifle access to administrative data for research and analytic purposes. Funding for developing large-scale, timely, provincial data sets is lacking, with the exceptions of the Institute for Clinical and Evaluative Studies (ICES) in Ontario<sup>21</sup> and the Manitoba Centre for Health

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21 For more information about the Institute for Clinical and Evaluative Studies (ICES) in Ontario, please see <http://www.ices.on.ca/>

Policy.<sup>22</sup> There are also some limitations on community researchers having access to some Statistics Canada administrative datasets based at universities. Participants also expressed concern about the decision to stop conducting some national health-related surveys.

#### **4.4 Evaluation of healthcare improvements**

Participants identified a need for better measures of outcomes in order to gauge healthcare quality, as well as for longitudinal research to assess change over time. Part of the solution would be to develop a research culture for the Canadian healthcare system in general. Evaluation of the health and social service system, using pertinent and reliable indicators, should be conducted on an ongoing basis to assess the outcomes of the various programs and determine what needs to be changed to better meet the needs of the population. Robust, computerized information systems that integrate clinical guidelines and decision-making algorithms would help professionals provide better care to all patients, particularly those with chronic conditions.

Policy-makers, administrators and other decision-makers require more robust and sophisticated data to address complex policy questions and operational challenges.<sup>23</sup>

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22 For more information about the Manitoba Centre for Health Policy, see [http://www.umanitoba.ca/faculties/medicine/units/community\\_health\\_sciences/departmental\\_units/mchp/](http://www.umanitoba.ca/faculties/medicine/units/community_health_sciences/departmental_units/mchp/)

23 Hollander, M.J., Corbett, C., & Pallan, P. (2010). Time for a paradigm shift: Managing smarter by moving from data and information to knowledge and wisdom in healthcare decision-making. *Healthcare Quarterly*, 13 (2), 49-54.

## 5 CONCLUSION

The *Better with Age* roundtables aimed to solicit suggestions on ways to adapt health services and associated policies to meet the needs of Canada's aging population. There was general agreement on what needs to be done to create a system that meets the ongoing needs of aging Canadians. The challenge is how to get there. Dialogue at the roundtables suggests that success will require initiatives such as:

- ▶ creating the political will to change
- ▶ creating more opportunities for collaboration among researchers, policy-makers, decision-makers, politicians and citizen representatives to plan and execute policy-relevant research and exchange promising practices in health services improvements
- ▶ helping health services providers and managers implement improvements and health system change
- ▶ planning health systems changes with citizens rather than without them.

Addressing many of the policy and broad system-level issues related to providing appropriate health services for the aging population will require a long-term collaborative approach involving many different organizations.

### Next Steps for CHSRF

In response to the message from roundtable participants that citizens need to be included in the dialogue about health system improvement, CHSRF hosted a small, structured public consultation in Vancouver, British Columbia on February 21, 2011. Fifteen citizens who represented a variety of perspectives participated, including patient advocates, unpaid caregivers and retired health professionals. A summary of the discussion will be disseminated to help inform efforts for health systems change among decision-makers, policy-makers, healthcare providers and administrators and politicians.

CHSRF is also working with stakeholders in the North to address the unique challenges related to population aging in that region. Through our extensive program in the area of Healthcare Financing and Transformation, we will continue to commission policy-relevant research and conduct dialogues to explore initiatives that have the potential to achieve cost-savings, more effective service delivery and, most importantly, improved healthcare for Canadians.

For more information about the *Better with Age* series, the roundtable and synthesis reports, as well as an updated issue of CHSRF's *Mythbusters*, *Myth: The Aging Population is to Blame for Uncontrollable Healthcare Costs*, please visit [www.chsrf.ca](http://www.chsrf.ca).

## APPENDIX 1—LIST OF INVITED SPEAKERS

SPEAKER	AFFILIATION	ROUNDTABLE(S)
Professor François Béland	Université de Montréal and McGill University	Quebec Regional Roundtable
Mr. Roger Carriere	Executive Director, Community Care Branch, Saskatchewan Ministry of Health	Saskatchewan and Manitoba Regional Roundtable
Senator Sharon Carstairs	Senate of Canada	Ontario Regional Roundtable National Roundtable
Dr. Neena Chappell	Canada Research Chair in Social Gerontology, University of Victoria	British Columbia and Alberta Regional Roundtable
Senator Maria Chapat	Senate of Canada	Saskatchewan and Manitoba Regional Roundtable
Mr. Michael Decter	President and Chief Executive Officer of Lawrence Decter Investment Counsel Inc.	Ontario Regional Roundtable
Dr. Michel Grignon	Associate Professor, Department of Economics and Department of Health, Aging and Society, McMaster University	National Roundtable
Dr. Marcus Hollander	President, Hollander Analytical Services	British Columbia and Alberta Regional Roundtable
Dr. Janice Keefe	Canada Research Chair in Aging Research and Policy Analysis, Mount Saint Vincent University	Atlantic Regional Roundtable
Dr. Margaret MacAdam	President, The Age Advantage	National Roundtable
Senator Terry Mercer	Senate of Canada	Atlantic Regional Roundtable
Dr. Brian Postl	Professor and Dean, Faculty of Medicine, University of Manitoba	Saskatchewan and Manitoba Regional Roundtable
Dr. Michael Rachlis	Health Policy Analyst	All Regional Roundtables, except Quebec National Roundtable
Mr. Shawn Russell	National Manager, Veterans Independence Program, Veterans Affairs Canada	National Roundtable
Dr. Michael Wolfson	Canada Research Chair in Population Health Modelling/Populomics, University of Ottawa	National Roundtable

## APPENDIX 2—POTENTIAL AREAS FOR FURTHER RESEARCH

This section presents select policy-relevant research questions based on an analysis of information needs identified through the roundtable presentations and discussions.

- ▼ Is there ageism in healthcare policy and delivery and among public attitudes? If so, what initiatives to combat such ageism have been taken in Canada and internationally? Have such initiatives been evaluated and are they transferable to Canadian jurisdictions?
- ▼ What is the care trajectory (including costs and utilization) for individuals who receive services through a home maintenance program (like the Veterans Independence Program), home care services and/or care from an unpaid caregiver compared to people in the community who do not receive such services?
- ▼ What policies and procedures exist to foster client-centred care? Are such policies and procedures effective and transferable?
- ▼ Integrating health and social services can improve health service delivery (through, for instance, improving transitions across acute and community care sectors) and ultimately can improve health outcomes. Provide a review of the following:
  - ▼ How have health and social services been integrated within Canada and internationally?



- How can improving transitions across sectors of care more generally improve access to LTC and home care?

## **APPENDIX 3—PARTICIPANT EVALUATION**

An evaluation survey conducted after the roundtables indicated that they succeeded in promoting dialogue that may help participants identify priorities for healthcare improvement, build relationships and partnerships, promote internal and external information-sharing and ultimately, promote evidence-informed changes in policy and practice. A total of 110 participants completed the survey questionnaire.

Many participants agreed that the information they gained at the roundtable would be useful to their work. For example, some researchers indicated that they would consider knowledge gained through the roundtables when defining research priorities, questions, ideas and topics to guide future papers and consultations. Some public sector workers, managers and policy-makers claimed the information would be helpful in guiding future program development and policy development as well as discussions, planning and evaluation of programs and policies. One participant indicated that the information would help identify funding priorities.

The majority of the participants who completed the evaluation survey indicated that the roundtables allowed them to build relationships that expanded or helped maintain their existing network. Close to half of the survey respondents claimed that they would use contacts they established to enhance relationship building through, for example, further engagement in dialogue. Some cited plans to request more in-depth information on particular programs, policies and ongoing changes and improvements in a new contact's respective jurisdiction. About one-third planned to use the established contacts as resources from which to seek input, advice, or simply a different perspective on future initiatives, activities and/or projects, particularly those involving policy and program development, as well as their own research work. Several stated that the contacts they established will help validate actions and activities relevant to their work and in advising on the effectiveness of programs. Others revealed a desire to collaborate with other participants on projects and/or policy initiatives of joint concern.