



**CANADIAN SENIORS AND HEALTH  
DETERMINANTS**

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## TABLE OF CONTENTS

	<b>Page</b>
INTRODUCTION .....	1
HEALTH AND HEALTH CARE .....	1
SENIORS AND KEY DETERMINANTS OF THEIR HEALTH.....	2
A. Age.....	3
B. Socio-Economic Factors .....	4
C. Gender .....	6
D. Ethnicity.....	7
E. Family Status.....	9
F. Geographic Location .....	9
POLICY IMPLICATIONS FOR HEALTHY SENIORS.....	10
CONCLUSION.....	12



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## CANADIAN SENIORS AND HEALTH DETERMINANTS

... there is more to health in later life than age itself.<sup>(1)</sup>

### INTRODUCTION

Who are Canada's seniors and what determines their health? How do these determinants of health vary from those of other age groups? Why might some of these determinants require the health sector to be organized differently to meet their needs? This paper considers these questions and their implications for health policy.

### HEALTH AND HEALTH CARE

Along with changes in the organization of Canada's health care system, there have been changes in the concept of "health" and various methods for achieving it. The greater understanding of key determinants of health forced a renewed look at the value of health services in maintaining and improving overall health status among seniors as well as other groups in the population.

The Lalonde Report of 1974 was the first to recommend goals or strategies for health. For the older population, the report envisaged that the focus on curing illness should change to a focus on caring for chronic diseases. Its overall approach was two-pronged; it proposed, on the one hand, the reduction of mental and physical hazards for groups (such as the elderly) perceived to be at greatest risk, while, on the other hand, improving access to health care services for these groups.<sup>(2)</sup>

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(1) Health and Welfare Canada, *The Active Health Report on Seniors*, Supply and Services Canada, Ottawa, 1989, p. 5.

(2) Marc Lalonde, Minister of National Health and Welfare, *A New Perspective on the Health of Canadians*, Ottawa, 1974, pp. 66-72.

A decade later, the Epp Report identified three national health challenges: reducing inequities, increasing prevention of illness, and enhancing people's capacity to cope. The particular needs of the elderly were to be addressed by three health-promotion mechanisms (self-care, mutual aid and healthy environment) to be implemented through public participation, strengthened community health services and a coordinated healthy public policy.<sup>(3)</sup>

By 1994, Canada's federal, provincial and territorial ministers of health had adopted a population health framework that saw the health status of the elderly, along with other groups, as determined by social and economic environment, physical environment, personal health practices, individual capacity and coping skills, and health services.<sup>(4)</sup>

Increasingly, the health of older Canadians depends not only on formal provision of medical care but also on factors experienced over a lifetime. Factors in their social and physical environment such as housing, nutrition, occupation, and social and environmental circumstances will have influenced their health by the time they reach their sixties and will continue to influence it as they age further.

## **SENIORS AND KEY DETERMINANTS OF THEIR HEALTH**

People who fall into the category of the elderly are not a homogeneous group. The process of biological aging is continuous from birth to death and varies considerably from one individual to another. Age is one of the principal factors determining the nature and extent of an individual's health and social needs, but within the elderly population the oldest members have lived through and been influenced by different economic, social and political events than those experienced by the younger members.

Older people live longer and healthier lives as a result of preventive measures such as better sanitation, effective vaccines, and more healthful diets, as well as curative measures involving pharmacological and technological intervention. In spite of advances in

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(3) Jake Epp, Minister of National Health and Welfare, *Achieving Health for All: A Framework for Health Promotion*, Supply and Services Canada, Ottawa, 1986, p. 10.

(4) Federal, Provincial and Territorial Advisory Committee on Population Health, *Strategies for Population Health: Investing in the Health of Canadians*, Supply and Services Canada, Ottawa, 1994.

public health, education, standards of living, sciences and technology, however, disparities remain among different groups within the older population, with such variables as age, socio-economic conditions, gender, ethnicity, family status and geographical location all affecting health status.

### **A. Age**

As far as the practical, physiological and psychological aspects are concerned, the choice of a threshold for old age is open to discussion. In Canada, the age of 65 years is used for the collection of statistical data and thus provides the most common reference point. In 2001, there were 3.9 million people in the 65 years and over age group in Canada, meaning that one in eight of the overall population was a senior. It is projected that seniors could make up one out of every four Canadians by 2031.<sup>(5)</sup>

Currently, observers speak of three categories of old people: those 65 to 74 years are “young-old”; those 75 to 84 years are “middle-aged old”; and those 85 and over are “old-old.” According to Statistics Canada, although the number of seniors aged 75 to 84 years almost doubled from 1981 to 1998, those aged 85 and over represent the fastest-growing segment of the senior population.<sup>(6)</sup>

Some diseases such as Alzheimer’s, Parkinson’s, strokes, and osteoporosis are age-dependent in that their origins and development are directly related to age. The presence of these diseases suggests two things: that ways of preventing them must be found, and that existing services must be adapted to address them. For example, osteoporosis, which affects about 25% of postmenopausal women, and the hip fractures that are a major consequence, may be preventable. Greater attention to preventive action is required, given that mortality in the first year after a hip fracture may be as much as 20% for women and 34% for men, with disability affecting half of the survivors.<sup>(7)</sup> Alzheimer’s Disease provides another example requiring system changes. This disease, which commonly affects the population over 65 years of age, has a probability of increasing with age from a low of 1% among those aged 65 to

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(5) Health Canada, *Canada’s Aging Population*, Public Works and Government Services, Ottawa, 2002, p. 3.

(6) Statistics Canada, *A Portrait of Seniors in Canada*, Industry Canada, Ottawa, 1999, p. 13.

(7) National Advisory Council on Aging, “Barriers to Seniors’ Autonomy: Musculoskeletal Disorders-Osteoporosis,” *Aging Vignette 71*, Ottawa, 1997.

74 years to 26% for those aged over 85 years. Within five years of diagnosis, 79% of people with Alzheimer's have been institutionalized.<sup>(8)</sup>

Other diseases are chronic in nature, with severity progressing slowly and marked by long duration. In 1996-1997, 82% of all people aged 65 years and over living at home reported having been diagnosed with at least one chronic disease. Arthritis and rheumatism were reported by 42% of people, high blood pressure by 33%, food or other allergies by 22%, back problems by 17%, heart problems by 16%, cataracts by 15% and diabetes by 10%.<sup>(9)</sup> The current focus on medical and institutional solutions may not be appropriate for some of these conditions where functional abilities are impaired but not acutely disrupted. It has been noted that while 80% of persons aged 65 years and over acknowledge one or more chronic conditions, a much smaller number, about 20%, report that their daily activities are so restricted that they must seek assistance.<sup>(10)</sup>

## **B. Socio-Economic Factors**

On average, seniors have lower incomes than most age groups under 65 years. Senior women, however, have the highest incidence of low income of any age group in Canada, at 24% of the total female population aged 65 years and over in 1997. Unattached women living alone are the primary reason for this large proportion: 49% had low incomes. Lack of financial resources makes them more vulnerable to ill-health because of factors such as inadequate nutrition, and makes it more difficult to access uninsured health care such as home nursing and medications when ill.<sup>(11)</sup>

Recent literature continues to suggest that low-income seniors have more physical and mental health problems than those with more economic and educational resources. For example, some chronic conditions such as arthritis and hypertension are more prevalent among seniors who have not graduated from high school and who have lower levels of income. In addition, seniors who did not graduate from high school have increased odds of dying at an

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(8) National Advisory Council on Aging, "A Quick Portrait of Dementia in Canada," *Aging Vignettes 42 and 50*, Ottawa, 1996.

(9) Statistics Canada (1999), *A Portrait of Seniors in Canada*, p. 62.

(10) National Advisory Council on Aging, "A Quick Portrait of Canadian Seniors: How Healthy? For How Long?" *Aging Vignette 6*, Ottawa, 1993.

(11) Statistics Canada (1999), *A Portrait of Seniors in Canada*, p. 279.

earlier age, while seniors with lower incomes have increased odds of being institutionalized.<sup>(12)</sup> In general, health problems begin to appear much earlier for those with lower education.<sup>(13)</sup>

Analysis of Canada's 1985 Health Promotion Survey revealed that the self-rated health of seniors varied strongly with social and economic background, and not just with age itself. According to this survey, "those in the upper-middle income group are far more likely to report excellent or very good self-rated health than those in the poor or very poor income categories. Those in the very poor income group are more than five times as likely to report fair or poor health."<sup>(14)</sup> It also found a very strong relationship between education and self-rated health: 34% of people over 65 years of age with elementary education or less reported health that was only fair or poor, compared to only 7% of those with complete post-secondary education.

There is continuing confirmation that some of the relation between the health and the socio-economic status of people aged over 65 years derives from their occupational histories, indicating that "health differences among people with varying levels of education may have more to do with subsequent employment history than with educational level itself."<sup>(15)</sup> Thus, professionals of both sexes, who were able to choose their field of work, enjoyed better health at retirement than those in unskilled work facing less choice. This finding applied also to self-reported health assessments, where elderly women in the top income category at age 80 enjoyed better health than their semi-skilled or unskilled counterparts at 70 years of age.<sup>(16)</sup> In addition, a study using Canada Pension Plan data revealed a strong relationship between average earnings in the 30 years before retirement and death rates after retirement. The men with the lowest average earnings were twice as likely to die between 65 and 70 years of age as the men in the highest earning groups.<sup>(17)</sup> A 2001 study noted that the increases from 1991 to 1996 in income inequality among those in the labour force years has

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(12) Statistics Canada, "Health among older adults," *Health Reports*, Winter 1999, 11(3), pp. 47-61.

(13) Steven Prus, *The Relationship between Age, Socio-Economic Status, and Health Among Adult Canadians*, SEDAP Research Paper No. 57, McMaster University, Hamilton, 2001.

(14) Health and Welfare Canada, (1989), pp. 18-19.

(15) *Ibid.*, p. 20.

(16) Pierre-Joseph Ulysse, *Population Aging: An Overview of the Past Thirty Years – Review of the Literature*, Health Canada, Ottawa, 1997, p. 36.

(17) M. C. Wolfson, G. Rowe, J. F. Gentlemen and M. Tomiak, *Career Earnings and Death: A Longitudinal Analysis of Older Canadian Men*, Canadian Institute for Advanced Research, Toronto, 1991.

significance for population health, which tends to be cumulative and reflective of longer-term circumstances.<sup>(18)</sup>

### C. Gender

In Canada, life expectancy at birth has increased steadily. By 1997, life expectancy at birth reached 75.8 years for men and 81.4 years for women, with gender differences in health outcomes.<sup>(19)</sup> The senior population in Canada is predominately female; in 1998, women represented 57% of those aged 65 years and over. Women also account for large portions of the older segments of the population, making up 70% of those aged 85 and older and 60% of those aged 75 to 84 years.<sup>(20)</sup>

The longer life span of women and their overall greater poverty increases their problems of access to adequate resources for health, including food, housing and support services. Many women over 65 years, especially those who were unattached, experienced problems with housing affordability. In 1996, 62% of unattached female seniors who rented had difficulty affording their housing. Even when unattached seniors owned their homes, 20% had concerns about affordability as well as about needed repairs. In addition, less than half of these unattached senior women were likely to own an automobile, one factor contributing to greater social isolation.<sup>(21)</sup>

As women age, they constitute a significant proportion of the population vulnerable to diseases that lead to institutional care. Thus, senior women are almost twice as likely as their male contemporaries to live in an institutional setting: 9% of women compared with 5% of men aged 65 years and over in 1996. This increases sharply for women in older age ranges, where 38% aged 85 and over were in an institution in 1996.<sup>(22)</sup> Hospitalization rates provide a slightly different picture for the 65 years and over age group, with women being less

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(18) Eric G. Pacey and Michael A. Pacey, *Changing Income Inequality and the Elderly in Canada 1991-1996: Provincial, Metropolitan and Local Dimensions*, SEDAP Research Paper No. 63, McMaster University, Hamilton, 2001.

(19) Steven Prus, *Gender Differences in the Influence of Economic, Lifestyle, and Psycho Social Factors on Later-life Health*, SEDAP Research Paper No. 76, McMaster University, Hamilton, 2002.

(20) Statistics Canada (1999), *A Portrait of Seniors in Canada*, p. 14.

(21) Statistics Canada, *Women In Canada 2000: A gender-based statistical report*, Ottawa, 2000, p. 160.

(22) Statistics Canada (1999), *A Portrait of Seniors in Canada*, p. 37.

likely to be hospitalized than men. However, when they are hospitalized, they stay in hospital longer than their male counterparts.<sup>(23)</sup>

The different medical care for women and men raises concerns for those who note that women are generally under-represented in health research. For example, although cardiovascular disease is the major cause of death and disability among Canadian women, the lack of data and the consequent difficulty in determining appropriate preventive and treatment interventions for women limit the medical responses.<sup>(24)</sup> Stroke or cerebrovascular disease provides an interesting example of how age in combination with gender makes a difference. It is reported that “the relative risk of stroke is greater for males at all ages. However, due to the preponderance of women among the oldest age groups and the dramatic increase in stroke incidence with age, a greater absolute number of women die from stroke. Sixteen percent of women will eventually die of stroke, compared to only eight percent of males.”<sup>(25)</sup>

#### **D. Ethnicity**

Ethnicity affects health status in several ways. Some studies have reported differences in the prevalence of certain age-related diseases among different racial groups. For example, rates of Parkinson’s disease have been lower among blacks than whites in the United States, while cerebrovascular disease has been higher among the Japanese and Chinese than among the population in Western countries.<sup>(26)</sup> Diabetes among Aboriginal people over 65 years of age is now estimated to be almost double that of the overall Canadian population.<sup>(27)</sup>

Among Aboriginal peoples, seniors constitute a smaller proportion than in the general Canadian population. In 1996, when 12% of the Canadian population was 65 years of

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(23) Statistics Canada (2000), *Women In Canada 2000*, pp. 58-59.

(24) Health Canada, *Women and Heart Health: Factsheet*, Ottawa, 1999; Barbara Sibbald, “Unique health needs of elderly women ignored, symposium told,” *Canadian Medical Association Journal*, 161(10), 16 November 1999, p. 1309.

(25) Mary Gordon, “Monograph Series on Aging-related Diseases: III. Stroke (Cerebrovascular Disease),” *Chronic Diseases in Canada*, 14(3), Summer 1993, p. 68.

(26) Judith Seidman-Ripley, “Monograph Series on Aging-Related Diseases: II. Parkinson’s Disease,” *Chronic Diseases in Canada*, 14(2), Spring 1993, p. 40; and Gordon (1993), p. 68.

(27) Health Canada, *Diabetes among Aboriginal People in Canada: The Evidence*, Ottawa, 2000, p. 1.

age and older, this was true of only 4% of the Aboriginal population.<sup>(28)</sup> Growth in the over-65 group is expected to increase rapidly as life expectancy continues to rise; for example, in the registered Indian population alone, life expectancy between 1975 and 2005 is projected to rise from 59.2 to 69.8 years for male registered Indians and from 65.9 to 77.5 for female registered Indians.<sup>(29)</sup> Older Aboriginal people have many preventable health problems that currently contribute to a lower life expectancy. Poverty, inadequate nutrition and substandard housing are major contributors to the diabetes, tuberculosis and diseases of the circulatory system that are of current concern.

People who move from one country and culture to another, especially as seniors, may suffer particular stresses and difficulties with adjustment. Various studies focused on ethnic seniors' problems with access to mainstream health care services, especially the language barriers to services for those who do not speak either English or French. As well, the health habits, expectations and preferences of seniors from some ethnic groups may differ significantly from those of the general population in Canada.<sup>(30)</sup>

According to one report on mental health issues affecting immigrants and refugees in Canada, elderly newcomers have particular needs: "They exist as an isolated minority within each ethno-cultural community, depending heavily on younger relatives for financial, social and psychological support."<sup>(31)</sup> In 1996, 27% of the population aged 65 and over were immigrants, of whom about 90% were uniting with families.<sup>(32)</sup> One of the outcomes for immigrants from developing regions is that up to half of them may live in overcrowded conditions in multi-generational households, some because of cultural preference but others because of ineligibility for government benefits.<sup>(33)</sup>

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(28) Statistics Canada (1999), *A Portrait of Seniors in Canada*, p. 20.

(29) Indian and Northern Affairs Canada, *Basic Departmental Data 2001*, Ottawa, 2002, p. 23.

(30) Canadian Public Health Association, *Ethnicity and Aging: Report of the National Workshop*, Ottawa, 1988.

(31) Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, *After the Door Has Been Opened*, Supply and Services, Ottawa, 1988, p. 79.

(32) Statistics Canada (1999), *A Portrait of Seniors in Canada*, p. 17.

(33) K. G. Basavarajappa, "Living Arrangements and Residential Overcrowding: The Situation of Older Immigrants in Canada, 1991," Analytic Studies Branch Research Paper, Statistics Canada, Ottawa, 1998.

## E. Family Status

The family status of the elderly person is one of the broader social factors linked to health status and the need for health and social services. In 1996, the large majority of seniors, almost 70%, lived with family members, either with a spouse or with extended family. However, factors such as the increase in divorce rates, lower remarriage rate for women, greater longevity of women and higher mobility of family members mean that about a third of the elderly live alone. Of these, senior women in older age ranges are more likely than their male counterparts to be living on their own.<sup>(34)</sup>

Older people who live alone are more likely to have fewer social, emotional and financial supports, all factors that affect their health status. For example, unattached seniors are far more likely to have low incomes and the associated problems, with women being more affected than men. It has also been indicated that senior women are more likely than their male contemporaries to live in an institution. The implications of this for health and social costs had been noted in an OECD report in the late 1980s which pointed out “a substantially lower institutionalization rate of married couples who can provide each other with mutual support.”<sup>(35)</sup>

## F. Geographic Location

Where seniors live can affect their access to factors influencing their social and economic welfare. Variables such as proximity to family, links to a stable community and access to health and social services can determine their health. This is especially significant in several regions across Canada, such as southern Saskatchewan and Manitoba and the Atlantic provinces, where higher rates of migration of younger people to other areas have left older populations. Generally, it has been noted that “rural areas and small towns tend to have higher proportions of elderly than do the larger cities, while newer suburbs are considerably younger than inner city areas.”<sup>(36)</sup>

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(34) Statistics Canada (1999), *A Portrait of Seniors in Canada*, pp. 30-31.

(35) Organisation for Economic Co-operation and Development, *The Future of Social Protection*, OECD, Paris, 1988, p. 47.

(36) Eric Moore and Mark Rosenberg, “Canada’s elderly population: the challenge of diversity,” *The Canadian Geographer*, 45 (1) 2001, pp. 145-150.

The large numbers of seniors, almost one third, who live in rural areas and small towns often find themselves without access to physicians and other health care professionals who specialize in geriatrics, and without access to supportive health and social services.<sup>(37)</sup> A Manitoba study, finding that “seniors who reside outside Winnipeg are 1.6 times more likely to be hospitalized than their Winnipeg counterparts,” noted two contributing factors particular to rural communities – the lack of availability of alternatives to hospitalization along with the higher hospital-bed-to-population ratio.<sup>(38)</sup>

## **POLICY IMPLICATIONS FOR HEALTHY SENIORS**

What are the implications for policy directed at achieving health when the health needs of seniors are so varied and a reflection of so many variables? Whether connected by age, gender, socio-economic factors, ethnicity or otherwise, Canadians aged 65 years and over are not a homogeneous group. The factors affecting the health of seniors can relate to experiences from earlier periods of their lives or to ongoing influences in their social and physical environments.

The diversity within the older population points to a requirement for flexible and collaborative policy and program responses. One of the key challenges for improving the health of all Canadians, including that of the elderly, is to reorient the overall health sector and to seek integration with other relevant sectors. According to the Advisory Committee on Population Health and others, this can happen only if there is a collective effort that includes some of the following elements.<sup>(39)</sup>

- 1) To accomplish the goal of maintaining and enhancing the health of Canadian seniors, public policy must balance the range of needs created by this diversity against the requirements imposed by Canada’s established system of health insurance for medical and hospital services. This means assessing and giving support to emerging demands from health

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(37) Thérèse Jennissen, *Health Issues in Rural Canada*, BP-325E, Parliamentary Research Branch, Library of Parliament, Ottawa, December 1992.

(38) Neena Chappell and John Horne, *Housing and Supportive Services for Elderly Persons in Manitoba*, Canada Mortgage and Housing Corporation, Ottawa, 1987, p. 62.

(39) Federal, Provincial and Territorial Advisory Committee on Population Health, *Toward a Healthy Future: Second Report on the Health of Canadians*, Public Works and Government Services, Ottawa, 1999, chapter 8; Dr. H. Zollner and S. Lessof, *Population Health – Putting Concepts into Action*, World Health Organization Regional Office for Europe, Copenhagen, 1998.

promotion, disease and injury prevention and health protection services as well as those from treatment services.

- 2) The need for increased accountability through improved public reporting and better evaluation of actions is central to ensuring greater health for seniors as for other groups. This involves establishing and using performance measures that will assess health gains and provide information that can be used to hold decision-makers responsible for unintended or undesirable outcomes.
- 3) More research is required to understand how the basic determinants of health influence the collective and personal well-being of older Canadians. Beyond access to treatments for disease and disability, the elderly need services to support social and financial security and reduce any sense of isolation and vulnerability experienced as physical infirmity increases and mobility is reduced. To fully understand an appropriate distribution between the expansion of health care institutions and a growth in community resources, more research into the relation between health and aging and more systematic information collection and interpretation of any data on the health status of older people are needed. Only a strong base of well-founded evidence will secure necessary changes.
- 4) One of the toughest challenges will be the attempt to influence sectors outside of health that can significantly affect health status. This means reducing inequities in income distribution, housing, literacy and other factors affecting the health of seniors. Some observers see the current approach to population health as one that ignores the way that many health determinants are created and maintained by economic and social forces; they argue that, until it develops a more political and sociological analysis, such an approach removes health from its community and societal context.<sup>(40)</sup>

Although many support the movement toward health for seniors, it is not without its obstacles.<sup>(41)</sup> Like other areas of health policy, a focus on seniors can be thwarted by fiscal restraints and federal, provincial and territorial jurisdictional issues. Furthermore, seniors' needs for immediate, specific health care (such as physician services, medication or hospitalization) can dominate the agenda, pushing analysis and action on health enhancement and maintenance to a secondary rank. The greatest barrier, however, may be the focus on funding narrow, issue-specific, time-limited strategies rather than long-term, broad approaches aimed at all citizens. In particular, the current attention being given to children has meant

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(40) Dennis Raphael and Toba Bryant, "Putting the Population into Population Health," *Canadian Journal of Public Health*, 91(1), January/February 2000, pp. 9-10.

(41) Barbara Legowski and Lindsey McKay, *Health beyond Health Care: Twenty-five Years of Federal Health Policy Development*, CPRN Discussion Paper No. H|04, Ottawa, 2000; Susan A. McDaniel, "Health Care Policy in an Aging Canada: The Alberta 'Experiment,'" *Journal of Aging Studies*, 11(3), Fall 1997, pp. 211-227.

reduced funding and consideration of the health needs of other groups at other stages of life, including those over 65 years of age.

## CONCLUSION

Canada is committed to improving the health of its overall population, including its seniors.<sup>(42)</sup> Health policy-makers are seeking to determine the most effective way to integrate concern for the health of the elderly with concern for a strong national health care system. National support for a population health approach is growing. There is increased recognition that many factors that affect health most significantly operate independently of the traditional health care budget and physician and hospital services. Consultation with various levels of government, with the private and voluntary sectors and with individual citizens will help to identify and develop the most effective types of intervention. The debate is already being waged on ways to reorganize services aimed at enhancing and maintaining health as well as services to take care of health conditions, in order to reduce costly demands while meeting seniors' needs.

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(42) Health Canada, "Minister McLellan announces Canada's participation at United Nations' World Assembly on Ageing," *News Release*, 8 April 2002; Health Canada, *Workshop on Healthy Aging*, Public Works and Government Services, Ottawa, 2002.