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When it comes to seniors, it's not all about health care

If we want to improve our support programs for seniors, our primary focus should be on income support to ensure access to affordable housing. That is the key to their independence and, utimately, their good health.

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March 4, 2015

When the government of British Columbia created the position of seniors advocate—the first in Canada—it recognized the broader determinants that affect the health of seniors by enshrining in legislation that the scope of the advocate's work includes transportation, housing, income support and personal supports, as well as health care.

Those of us who work with seniors have long recognized that their strongest desire is to remain as independent as possible for as long as possible. We also know that independence is facilitated as much (or more) by the broader determinants of health as by the provision of traditional health services. Further, we know that the ability to access the programs and supports that impact these broader determinants of health depends, to a large extent, on seniors' disposable income.

As well, we know that the image, portrayed by some media, of the rich retiree soaking up the sun while bleeding the working taxpayers of their hard-earned dollars is not supported by the facts. Statistics Canada (2011) reports the median income in Canada for those over 65 is $23,700, compared with the median income of $43,300 for those aged 35 to 44. And while there are a number of programs and subsidies available to seniors, almost all are income-tested, thereby ensuring that those seniors who do have higher incomes receive less or no subsidy as their income climbs.

> *If they face ancillary health care costs seniors with incomes below the median may face serious financial challenges.*

In fact, the income data show that most seniors have modest incomes, and those living at or below the median potentially face serious financial challenges, depending on other circumstances in their life. Gross income (as reported by Statistics Canada) is still a fairly blunt measurement; a more accurate barometer is the disposable income available to seniors. This depends on how much of their income seniors are directing to necessities such as housing, food and what might be called ancillary health care needs, which include dental care, eyeglasses, hearing aids, mobility aids and drugs. The challenge for policy-makers is that the disposable income available to a senior living on an income of $24,000 per year differs substantially depending on whether they live alone, where in the country they live and whether they have a benefit plan to cover costs of ancillary health care needs not covered by a provincial plan.

My office recently completed a random survey of 500 seniors (age 65 and over) in BC and found that 65 percent of those with low incomes (less than $30,000 per year) reported they had no benefit plan to cover ancillary health care needs, while only 40 percent of those with middle incomes ($30,000 to $60,000 per year) reported no coverage. This presents the challenge that those with more income are also more likely to have a broader range of ancillary health care needs covered by a benefit plan than are lower-income seniors. In this same vein the survey also found that low-income seniors were more likely to report they live alone (69 percent) than middle-income seniors (38 percent). These two indicators alone have a significant impact on personal finances, and they further widen the gap in disposable income among seniors.

Once we recognize the limited income of many seniors we can begin to understand the challenges they might face in providing for the broader determinants of health. For example, social engagement in healthy aging has long been recognized as one of the determinants of health. Social engagement,

however, usually requires getting out of the house and enjoying the companionship of other people in the community. This is not achieved without spending at least some money.

Take the example of a senior in Vancouver who wants to go to the local seniors' centre to play bingo every Tuesday and participate in chair yoga on Thursdays. First, there is likely the cost of the HandyDart, a door-to-door shared ride service for passengers with physical or cognitive disabilities provided by TransLink, the public transportation agency ($5 round trip), and a $2 drop-in fee per activity. This becomes $56 per month or $672 per year to play two hours of bingo and do two hours of chair yoga once a week. Add a cup of coffee ($1) and a muffin ($1) each time, and it becomes $864 a year. Most of us would not see two trips a week to the local seniors' centre with a cup of coffee and a muffin as extravagant, nor would we see a toonie drop-in fee or snack price as prohibitive. Yet, for some seniors, that $864 annual cost competes with the need for a new pair of eyeglasses, a tooth repair or fixing the plumbing. For others, a benefit plan will take care of the glasses and tooth repair.

The income gap can also have a significant impact on living arrangements. Affordable, accessible and appropriate housing is not just a major determinant of seniors' health, it is crucial for their independence. In a recent survey conducted by my office, we found 75 percent of seniors believed that they could remain in their homes with the assistance of home support if they began to need care. However, 36 percent of low-income (less than $30,000) seniors believed they would probably need to move in the future because they would be unable to afford their current homes. This may be a revelation to some of us who have focused solely on the provision of home care and home support as the key to keeping seniors at home. Regardless of the services governments provide, if they cannot meet the costs of basic home occupancy, seniors could have to move to subsidized assisted living or long-term care for economic reasons, not health.

For the most part, provincial governments do try to recognize the added burden on low-income seniors, and most offer a basket of programs and subsidies aimed at low-income seniors. These programs vary a bit from province to province, but they mirror to some extent what we have in British Columbia. They include rental subsidies, property tax deferral, a drug program, assistance with -Medical -Services Plan (MSP) premiums, grants for home adaptations and transit subsidies. These programs generally face two challenges. First, there is the need to ensure awareness of and access to the programs and subsidies. Second, there is the need to provide adequate coverage to address the broader determinants of health.

In that same survey we asked BC seniors if they were aware of a number of the programs and subsidies available to them. The results were very surprising. A significant number said they were not aware of some of them. Most startling was the number of low-income seniors reporting they were unaware of the Guaranteed Income Supplement (GIS) (23 percent); MSP premium assistance (60 percent); SAFER rent subsidy (42 percent); home adaptation grants (67 percent); and PharmaCare (42 percent). These are long-standing programs and subsidies aimed directly at low-income seniors, and yet it seems that these benefits are not always reaching their intended target. The GIS is important not only for the income that it can provide, but also because receiving it is often a requirement for the waiving of user fees and copayments for a number of health services. In BC, the MSP premium assistance alone would provide a single low-income senior (net income $22,000 per year or less) with an additional disposable income of $864 per year " enough to cover a twice-weekly

outing to the seniors' centre. This is a reminder that it is not sufficient to provide supports; we must also connect seniors directly to those programs and services.

While there is debate about the need for national home care, drug coverage and long-term care programs, they are provided for seniors in some government-subsidized form in all provinces and territories. Yes, they should be standardized across Canada, and yes, they could be better, but a safety net does exist in these areas. What does not exist is some form of safety net for the broader determinants of health. Ironically, it is these broader determinants that can influence the degree to which seniors will require home care, long-term care and drug therapies in the future. In the population at large we have long acknowledged that health status links to income, as it is our income that influences the broader determinants of health. This influence does not abate once we cross the age threshold of 65. It is high time decision-makers ensured that reality was better reflected in the array of public policies designed to support seniors, from coast to coast to coast.

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