THE SCHOOL OF PUBLIC POLICY

MASTER OF PUBLIC POLICY CAPSTONE PROJECT

Advanced Training for Healthcare Aides: A Solution for the Sustainability of Canada's Healthcare System in the Face of an Aging Population

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Capstone Executive Summary

This paper examines senior citizen demographics in Canada, their impact on the healthcare system, and what can be done to minimize the strain on public finances, of providing seniors with the best quality of care possible. The paper examines statistics surrounding senior healthcare usage, future projected usage, the complex health issues that ail seniors, and how advanced training for healthcare aide workers can address cost issues, health provision, disease, mental illness, and injury prevention through education, advocacy and an increased physical presence.

The paper proposes changes and amendments to the current healthcare aide curriculum. Information on the current certification requirements are provided, as well as components of the competency profile used to design the healthcare aide program, followed by the recommended changes. Evidence is provided as to why advanced healthcare aide training is the best option for governments to choose when considering the options needed to keep the public healthcare system sustainable, efficient, and innovative, as opposed to maintaining the status quo.

1. Introduction

"Youth is wasted on the young"
-George Bernard Shaw

As of July 2015, nearly 1 in 6 Canadians (approximately 6 million) were senior citizens. They are the fastest growing demographic group in the country (Statistics Canada, 2015). Over the next three decades, these numbers are expected to increase significantly, adding substantially to rising national healthcare costs. In the coming years, the federal and provincial governments must address the issues this cohort will pose for the future sustainability of Canada's healthcare system. To effectively decrease outlays in the largest cost drivers of government health spending, other alternatives regarding senior care must be assessed and implemented.

In 2015, the three largest expenditures in public healthcare were hospitals, physicians and pharmaceutical drugs. Sixty percent of the $219 billion healthcare budget was spent on these three largest sectors: 29.5% for hospitals, 15.5% for physicians and 15.7% for pharmaceuticals (CIHI, 2016). Of these sectors, senior citizens were the highest users, despite comprising only 14% of the population (CIHI, 2011). From 2009-2010 seniors accounted for 40% of acute stays in hospitals country wide (CIHI, 2016). Most acute care stays result from chronic conditions, many of which can be reduced in number or severity (CIHI, 2011). This can be accomplished by: identifying risk factors and susceptible groups, providing education for seniors, and increasing the presence of residential healthcare workers. These workers provide direct care to seniors and help them to remain longer, and more safely, in their homes.

It is important for Canada's healthcare system to adapt to shifting population needs, specifically the senior cohort, and the exclusive needs for each tier of the senior population. The tiers included in the senior age groups are: 65-74 years, 75-84 years, and 85+. As the population evolves and ages, so do the needs of each tier. The adaptation of the healthcare system to senior

issues is increasingly important as advances in technology and social spending have led to prolonged life for seniors (CIHI, 2011). Seniors are healthier than they have ever been. In addition to advances in medical and other technologies, over the past forty years public health initiatives and increased funding to programs like CPP, OAS, and GIC have contributed to an overall increased standard of living for seniors in Canada. This has contributed to population longevity and wellness (CIHI, 2011).

Although seniors are enjoying increased longevity and wealth, there are still many health and social issues seniors face that affect their overall health and quality of life. As social issues affect health outcomes, both must be addressed together. Many of the health and social problems are preventative and can be mitigated with proper education, access to governmental and community supports, home safety measures, and increased residential healthcare support. Some of the health and social issues include: chronic conditions, social isolation, frailty, loneliness, depression, elder abuse, poverty, and palliative care issues. Each of these issues has: risk factors; a sub group of seniors that are more susceptible than others; are inter-related; and have solutions that can help decrease the negative effects of each issue. This paper proposes a solution to intensify healthy aging for seniors now, while increasing sustainability measures for the healthcare system.

There are several solutions being explored to promote healthy aging, like the adaptation of age-friendly cities[1], and the integration of internet and other technologies. However, each of these solutions poses significant problems for the baby boom generation, and their parents. The

[1] "In an age-friendly community, the policies, services and structures related to the physical and social environment are designed to help seniors "age actively…"the community is set up to help seniors live safely, enjoy good health and stay involved (Public, 2016)."

most significant problems encompass implementing the policies. So-called age-friendly cities have complex frameworks and require all levels of government, public and private stakeholders, NGOs, homeowners, renters, entire communities, and co-operation on many fronts (Menec, V. H., Means, R., Keating, N., Parkhurst, G., & Eales, J. 2011). Age-friendly cities take years to develop, and resultantly the benefits would take years to be realized; nor would they have a significant effect on a wide pool of seniors because not every community would adapt the frameworks. In Canada, there are only a handful of urban centers that have launched age-friendly designs (Plouffe, L. A., Garon, S., Brownoff, J., Eve, D., Foucault, M., Lawrence, R., Toews, V. 2013).

The adaptation of technology is also not a viable solution. Technologies like mHealth would require that many seniors own smart phones, which poses a myriad of logistical problems, as well as technical issues for seniors (World, 2012). Other technological solutions include health record accessibility for patients, but this option is years away from being realized on a system wide scale and poses security issues (Phifer, 2016). Physical technologies like alarms and sensors that can monitor the movements of dementia patients at home are not the reality for many seniors, either due to cost or access to these types of equipment (World, 2012). Another technology is portable vans that travel throughout the province with medical equipment and supplies needed to treat rural patients (Jean, Ktytor, and Talbot, 2015). But like age-friendly cities, these are piece-meal solutions which are difficult to execute on a system wide basis. More importantly, they would only reach a small number of seniors, and do not address the substantial and unique types of health and social problems seniors encounter.

A more viable option for improving senior health and well-being, while alleviating healthcare costs would be to integrate advanced training for healthcare aides (HCAs). Healthcare aides are unregistered workers trained to work directly with all population demographics, but who specialize in gerontology. Basic HCA courses are attractive because they teach comprehensive skill sets, their duration of training is short compared to nurses, HCAs are not high cost drivers, training requires basic education, students can be easily recruited, and the courses are provincially accessible. Expansion of the program would be especially beneficial as HCAs could alleviate the burden for informal caregivers (friends, family, and neighbors), take on more in-home responsibilities (technical, educational and social), assist a larger number of seniors and reduce healthcare costs. This option is fitting, as 92.1% of seniors reside in their homes, and HCAs currently spend more time caring for senior citizens than any other healthcare professional in the system (Government of Alberta, 2001).

The rest of the paper is outlined as follows:

Section two “Why the Healthcare System Fails to Meet the Needs of Seniors” provides background on how the current healthcare system has evolved and why the system fails to meet the needs of seniors. This section discusses the inception of Medicare, the division of powers between the federal and provincial governments in relation to healthcare, and the Canada Health Act and how it influences healthcare delivery.

Section three, “Defining Baby Boomers and the Senior Population,” demonstrates the dire situation Canada’s healthcare system faces by providing background information on the baby boom generation, parents of the boomers, and the statistical figures associated with these

generations. Knowledge of these numbers illustrates the looming number of Canadians set to enter senior hood.

This section continues to provide a snapshot into Canada's healthcare system and the effect seniors citizens will have on the sustainability of the system in years to come. It also demonstrates why the utilization of highly trained HCAs is a cost-effective tool for governments to invest in, given the soaring costs of acute care and long-term care.

The fourth section, "Baby Boomers, Seniors and their Related Health Issues," describes the physical, mental and social issues that ail seniors. This section is provided to give the reader a full understanding about the complexities of the issues and ailments seniors face; and to illuminate the areas where well trained HCAs can alleviate risk factors, educate seniors, prevent injury, promote safety and exemplify healthy aging. The issues outlined in this chapter include chronic conditions, social isolation, frailty, elder abuse, loneliness, depression, poverty and palliative care.

The fifth section, "Home Is Where the Heart Is," focuses on the existing living arrangements of seniors. It also discusses the predicaments faced by informal caregivers and how HCAs can be an effective tool for caregiver respite and other related issues. Most importantly it stresses the desire seniors have, to remain in their homes.

Section six, "The Need for Healthcare Aides," discusses current and upcoming labor participation rates and the effect the retiring population will have on the healthcare system. An anticipated labor downturn will create a need for abundant, quickly trained, skilled workers-- who are also cost effective-- to enter the workforce.

The seventh section, “Policy Recommendation- Advanced Training of Healthcare Aides,” proposes HCAs as a solution to the problem. It highlights the existing benefits of HCAs, and showcases the current curriculum. It argues why HCAs are an attractive resource to invest in, when compared to doctors and nurses, for direct in-home support. This section also provides recommendations for the expansion of the healthcare aide curriculum, including the integration of new courses.

Section eight is a conclusion and summary of why advanced training for healthcare aides is a viable and cost-effective option.

This paper outlines many types of issues seniors face from the physical to the mental, the emotional, social, financial, and cultural. It may appear broad, but as we look more closely, we will see that the issues are not so broad as first glance; many of the problems are inter-related. And many can be rectified, prevented and mitigated by identifying risk factors, pinpointing susceptible populations, and teaching HCAs a wide spectrum of information which in turn, can be taught to seniors. The integration of advanced learning for healthcare aides is an effective way to reach many home dwelling seniors, at an affordable cost, to the advantage of the healthcare system. And more importantly, to the benefit of senior citizens and the aging population.

2. Why the Healthcare System Fails to Meet the Needs of Seniors

The division of powers between Canada's federal, territorial and provincial governments influences how healthcare is delivered throughout the country. The federal government is responsible for the delivery of health services to groups within their jurisdiction, like: veterans, aboriginal people, members of the Canadian forces, and federal penitentiary inmates. As per the Constitution Act, Section 92(7), the delivery of healthcare services for all other individuals falls under the jurisdiction of the provinces (1867). The federal government still exerts some influence over the provinces however, as they are responsible for disbursing the transfer payments required for provinces to finance their healthcare systems.

Provinces are responsible for managing their public healthcare insurance plans and are also responsible for the delivery of their healthcare systems. Some of these responsibilities include: the operation of hospitals; the number of beds available, the approval of hospital budgets, etc.; terms of employment for healthcare professionals: negotiating fees, how many, and what type of staff to hire; the structure of healthcare insurance and determining how the system will serve the population (Commission, 2002).

The Canadian healthcare system, also known as Medicare, is mandated by the Canada Health Act (CHA). The act outlines the conditions provinces must abide by to receive their health funding payments from the federal government, through the Canada Health Transfer. The five required conditions set forth by the CHA in Section 7 of the act are as follows[2]:

- public administration;
- comprehensiveness;

[2] Canada Health Act, RSC 1985, c C-6, <http://canlii.ca/t/51w33> retrieved on 2017-09-10

- universality;
- portability; and
- accessibility.

The condition for comprehensiveness reads[3]:

> "In order to satisfy the criterion respecting comprehensiveness, the healthcare insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other healthcare practitioners."

According to Section 2 of the CHA, "insured health services" are "medically necessary services" that provincial healthcare insurance plans must cover and include all hospital services aimed at: maintaining health, disease prevention, diagnosis of illness and injury, treatment of injury, illness, and disability; accommodation and meals; physician and nursing services; drugs administered in hospitals; all medical supplies and equipment; any medical services provided by medical practitioners; and medical and dental procedures that must be performed in a hospital (Canada, 1985).

Separate from "insured health services" are "extended health services." Section 2 defines "extended healthcare services as more particularly defined in the regulations, provided for residents of a province, namely,

(a) nursing home intermediate care service,

(b) adult residential care service,

(c) home care service, and

(d) ambulatory healthcare service[4];

[3] Canada Health Act, RSC 1985, c C-6, <http://canlii.ca/t/51w33> retrieved on 2017-09-10
[4] Canada Health Act, RSC 1985, c C-6, <http://canlii.ca/t/51w33> retrieved on 2017-09-10

Extended healthcare services do not fall under the umbrella of the five program criteria outlined in the CHA: public administration, comprehensiveness, universality, portability or accessibility and resultantly, do not have to be provided by provinces within these parameters. They are also not contingent upon the requirements related to user charges and extra billing, which means provincial administrative bodies can charge, at their discretion, full or partial payments of extended health services (Commission 2002). Summarily, the CHA requires provinces to pay for hospitals, physicians, and drugs. Anything outside this realm is left for the province to financially allocate from their health budgets, including extended health services.

What we have then, because of Canada's legislations, is a system designed to funnel its resources and delivery of care through hospital settings which means, there is a greater priority placed on acute care, rather than chronic care. This is problematic, as many health ailments contracted by seniors are chronic conditions and other issues that cannot be cured by acute care. Rather, they require long term care and different interventions that can be delivered outside of hospital settings. The deliverance of care outside of these settings, however, may be considered extended care, and the province is not required to cover these costs. A more ideal scenario for senior health, would be for provinces to allocate funding towards education and disease prevention, and promote home healthcare delivery. These measures would minimize instances of chronic illness, further decrease the use of hospital resources, and thus generate significant savings.

Medicare was enacted in 1966, at a time when the Canada's population was only twenty million people, and the median age was 25.4 years (Statistics, 2009a). In 2016, the population was 35.2 million people, nearly double the 1966 numbers, and the population had a median age of forty (Grenier, 2016; ArcGIS, 2016). The healthcare system that was established in 1966, and

the CHA passed in 1984, both promote a framework for healthcare delivery that does not work in our current world. Canada's population is experiencing a demographic shift that will require the provincial governments to redirect resources from acute care to chronic care and from hospital settings to community settings. As such, home care and advanced training of healthcare aides should be invested in, prioritized, and recognized as a publicly insured service, so that the needs of seniors will be met now, and in the coming decades.

3. Defining Baby Boomers and the Senior Population

The baby boom generation is the most well-known generation in Canada (Statistics, 2011). A baby boom is a noticeable increase in the number of births during a given period and a generation is defined as a "a group of individuals who are about the same age and have experienced, most often as children or young adults, specific historical events, such as an economic crisis, an economic boom, a war, or significant political changes. These events may influence their views of the world (Statistics, 2011))." Though baby boomers are the most well-known group, their parents also make up their own generational group named parents of boomers (Statistics, 2011).

This information and the following dates are important for projecting future healthcare trends. In Canada's case, the parents of boomers' generation are marked from 1919-1940. As of 2011, their generation comprised 3.1 million of the population, and the average ages were 71-92. The baby boom occurred in the post WWII period from 1946 until 1965 (Statistics, 2011). The first year of the baby boom was marked by a 15% increase in births and in the last year, 1964-1965, there was an 8% decrease which witnessed the end of the period. During the twenty-year frame, 8.2 million babies were born in Canada. The average number of children per woman

during the boom was 3.7, compared to the 2008 average, which was 1.7 children per woman (Statistics, 2011).

As of 2011, the number of baby boomers in Canada was 9.6 million, or 29% of the population (not all boomers are currently seniors). The number is higher than the initial 8.2 million babies born during the boom due to increased immigration, and includes "baby boom" aged immigrants, whose numbers have been constant since the end of the 1980s. In 2011, the first wave of boomers, born in 1946, turned age 65 (Statistics, 2016a). This brought the total numbers of seniors in Canada in 2011, which included the first wave of baby boomers and the parents of boomers, to 5.0 million seniors. In 2031, all baby boomers will have turned age 65 and between 2031-2036 it is projected that 9.9-10.9 million Canadians, or 25% of the population, will be seniors (Statistics, 2016b).

Seniors and Canada's Healthcare System

The high number of baby boomers set to enter the 65+ cohort will present serious implications for the sustainability of Canada's healthcare system due to: the increasing health needs of seniors, the inefficient hospital and physician-centered system Canada currently has, and to the type of care required for the aging population. There are many different and complex facets of aging. One facet being that not all seniors are equal; a person does not instantly become infirm and decrepit once they turn sixty-five. Rather, a combination of factors evolves as they age further to change their health trajectories: the health needs of an 85-year-old are different than those of a 65-year-old. It is also essential to understand that there are many determinants which affect how one ages. It is not simply a matter of good genes; but involves factors like income, gender, geography etc. The age groups and health determinants of seniors in turn impact the effects elderly individuals will have on the healthcare system.

There are generally three groups that make up the senior cohort. Younger seniors are from ages 65-74 and currently make up 53% of the senior population. The middle-aged group of seniors are from ages 75-84 and currently make up 33% of the senior population (CIHI, 2011). The oldest group, ages 85+, make up 13% of the senior population, or 2% of Canada's population. In fourteen years' time, the 85+ group will comprise 3% of the population and by 2050, their cohort will double to make up 6+% of the population.

The 65-74-year-old cohort is similar in health to the 45-64-year-old cohort, who have little, if any, limited functional capacity (CIHI, 2011). The 65-74 group may, however, have a higher chance of developing a chronic condition; an ailment or illness lasting for more than 3 months. This cohort reports an average of one to three conditions, but after age 84, the reports tend to lessen (CIHI, 2011). Despite the 65-74 cohort being similar in health to non-seniors aged 45-64, those with chronic conditions will still utilize more hospital services as demographics shift toward an aging population. Even if the proportion of seniors affected by chronic conditions remains the same, the increasing senior population means the total number of seniors seeking hospital treatment will increase (CIHI, 2011).

The main reasons for acute care among senior citizens are due to chronic conditions and the main reasons for long term hospital care, are usually due to usually terminal illness, by way of palliative care. A recent study found that seniors with acute care conditions deteriorate the longer they remain in the hospital, which hinders their ability to return home. However, their conditions would improve if they were placed back in their homes with proper home support mechanisms, provided by integrated care teams (CIHI, 2011). If seniors do deteriorate in the hospital, or become gravely ill, they are likely to be moved to palliative care. The costs for

housing a patient in acute care and long-term care averages $1,000+ per day as opposed to $130+ per day for nursing homes and $55+ for receiving care at home (Boyle, 2013).

The three largest areas in health spending are physicians, hospitals and pharmaceuticals and as it stands, seniors currently:

- use hospitals, physicians and drug treatments more than any other demographic group in Canada
- account for 40% of hospital visits across Canada, despite comprising 14% of the population
- stay, on average, three days longer in acute care settings than non-senior adults
- stay, on average, two hours longer in emergency departments than any other age group (CIHI, 2016).

Resource Intensity Weights (RIWs) also demonstrate the impact seniors have on healthcare costs. RIWs are calculated from hospital cost data; they measure resource use from in-patient visits and assess a patients' treatments based on demographics and clinical backgrounds. Senior citizens' RIW from 2009-10 was 70% more than non-senior adults, due to specific medical conditions and required procedures. Chronic conditions, age, and complex needs all contribute to more resource use and longer stays (CIHI, 2011). The Canadian Medical Association calculated annual healthcare spending per person in 2013 and published the following costs:

- Age 65 to 69: $6,298
- Age 70 to 74: $8,384
- Age 75 to 79: $11,557
- Age 80 and older: $20,917 (2016, 4)

The 85+ cohort uses hospital services more than their younger senior cohorts. And as mentioned earlier, the younger cohort, who currently make up 53% of seniors, will become the older cohort in the coming decades. This cohort will develop chronic conditions and due to the sheer number of boomers, medical resource use in terms of hospitals, drugs, and physicians will dramatically increase (CIHI, 2011).

A rural Ontario study cited by Canadian Hospice Palliative Care Association found that, when home-based homemaking teams and nursing services were carried out in the private residences of terminally ill patients dying from cancer, heart disease, and COPD, the costs were far less. The costs averaged $117.95 a day– much less than the average $1,100 daily cost of acute and long-term hospital care (Canadian, 2015) and $155+ per day for long term residential care homes. Care homes are also not as viable an option considering "a CD Howe paper projects that over the next 40 years the annual total cost of long-term care will triple, from approximately $69 billion in 2014 to about $188 billion in 2050. The "most rapid increase in costs occurs between 2025 and 2040, when aging baby boomers are expected to dramatically expand the number of frail elderly (Canadian, 2016)." This is nearly tantamount to the entire federal healthcare budget today, which is just over $200 billion.

Healthcare aides are a cost-efficient solution to both hospitals and long term residential care homes. If the provinces were to provide more in-home supports, such as highly trained HCAs, the number of seniors who could safely remain in their homes would increase, thus reducing costs for provincial health budgets.

4. Baby Boomers, Seniors and their Related Health Issues

"As your care recipient's advocate, be involved, don't accept the status quo, and don't be afraid to voice your concerns"
— Nancy L. Kriseman (Good Reads Quotes, 2017)

The following section describes the various health and social issues that are both commonly and solely related to people as they age. It is important to understand the common diseases, health ailments and social issues that affect aging people. These include: the risk factors; susceptible elderly populations; preventative measures; and the inter-relatedness of the topics. By understanding the issues seniors face, policy makers and governments can better comprehend the complexity and magnitude of the problems and realize why immediate and direct-care intervention is necessary.

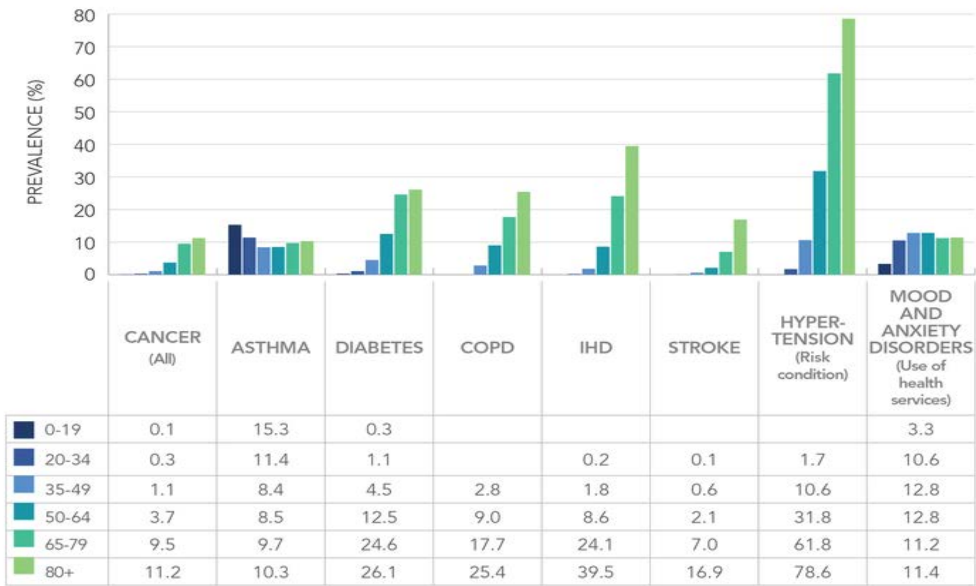
Chronic Conditions

For both the parents of boomers and the baby boomer generations, the aged and aging population faces unique health issues, increased health issues, and their growing demographic requires considerable challenges for Canada's health system (Public, 2007). Many seniors suffer from chronic conditions, also known as chronic diseases. The World Health Organization defines these conditions as being "of long duration- over three months- and result from a combination of genetic, physiological, environmental and behavioral factors (World, 2017b)." The development of chronic conditions is not solely attributed to elderly and aging populations, but certain conditions tend to increase with age.

Chronic conditions include: cardiovascular diseases, such as ischemic heart disease and stroke; cancer, of which there are almost 100 types; chronic respiratory diseases, such as chronic obstructive pulmonary diseases like emphysema and chronic bronchitis, and asthma; as well as

diabetes, hypertension, and mood and anxiety disorders. Of these conditions, all but mood and anxiety disorders increase until the population reaches age 65, at which time there is a slight decrease in mood and anxiety disorders (Public, 2017). Despite the decrease, the highest number of age groups that suffer are 35-64 and 65-80+. The following table demonstrates chronic diseases and risk factors by age in Canada.

Figure 1. Prevalence (%) of major chronic diseases and risk conditions in Canadians, by age group, Canada (2011/12)



	CANCER (All)	ASTHMA	DIABETES	COPD	IHD	STROKE	HYPER-TENSION (Risk condition)	MOOD AND ANXIETY DISORDERS (Use of health services)
0-19	0.1	15.3	0.3					3.3
20-34	0.3	11.4	1.1		0.2	0.1	1.7	10.6
35-49	1.1	8.4	4.5	2.8	1.8	0.6	10.6	12.8
50-64	3.7	8.5	12.5	9.0	8.6	2.1	31.8	12.8
65-79	9.5	9.7	24.6	17.7	24.1	7.0	61.8	11.2
80+	11.2	10.3	26.1	25.4	39.5	16.9	78.6	11.4

Source: Canadian Cancer Registry, Chronic Disease and Injury Indicator Framework (2015 update), Canadian Chronic Disease Surveillance System (Public, 2017)

Chronic conditions affect Canadians of all ages but contracting a chronic condition tends to increase dramatically with age. In addition to chronic conditions increasing as one ages, the number of conditions a person may have also increases with age (Public, 2017). The presence of multiple chronic conditions is known as co-morbidity (or multi-morbidity) (CIHI, 2011). Co-morbidity is linked with lower self-perceptions of health and increased use of medical resources. Seniors with co-morbidity use three times more medical resources than seniors with one, or no

chronic conditions: 13.3 million visits annually throughout Canada versus 4.5 million visits annually (Public, 2017).

The Public Health Agency of Canada cites the most common primary risk factors associated with contracting a chronic condition as follows[5]:

- smoking
- alcohol abuse
- high blood pressure (or hypertension)
- physical inactivity
- high cholesterol
- overweight/obesity
- poor diet/nutrition
- high blood glucose levels

Not surprisingly, most of the risk factors that are directly responsible for one chronic condition are also indirectly responsible for other conditions (Public, 2015). Smoking increases the risk of cancer, cardiovascular and respiratory diseases, while alcohol consumption increases the risk of organ failure, injury, and depression. A poor diet and lack of physical activities lead to a host of risk factors that increase co-morbidity of conditions such as cardiovascular diseases, diabetes, and obesity; as a result, the prevalence of other conditions such as high blood pressure, depression, isolation and anxiety rises. The minimization or elimination of these risk factors can drastically decrease the onset of many chronic conditions (Public, 2007). Healthcare aides can be trained to identify and mitigate these risk factors, learn disease management, and further be

[5] Public Health Agency of Canada. 2015. Chronic Disease Risk Factors: What are the Primary Risk Factors?

taught to train elderly populations on risk factors, disease management, and how and where to access supports and information.

Social Isolation

Senior citizens are essential to society. They have considerable wisdom and a lifetime of experience to offer; they compose a large part of the volunteer sector, which keeps communities and organizations vital and thriving; they also aid loved ones and friends, and many continue to contribute to the labor force (MacCourt P., Wilson K., & Tourigny-Rivard M-F, 2011).

When the health and well-being of senior citizens suffer, so does the fabric of our society (National Seniors, 2014). However, chronic conditions are not the only serious health ailments facing aging populations. Social isolation has become a widely recognized, valid and serious discussion among health professionals and policy makers, as the impacts of social isolation have far reaching effects. Social isolation increases the risk of physical and financial abuse to seniors, negatively affects their mental and physical health, and, like chronic conditions, is responsible for considerable direct and indirect costs to society (National Seniors, 2014).

Social isolation is defined "as an individual lacking a sense of belonging, social engagement and quality relationship with others (Dury, 2014)" where "situations of social isolation involve few social contacts and supports, few social roles, as well as the absence of mutually rewarding relationships (National Seniors, 2014)." Social isolation is not the same thing as loneliness. Loneliness is more subjective and often associated with loss of relationships. A person can feel lonely even when they are amongst many people (National Seniors, 2014)," whereas social isolation is objective. A likely scenario of loneliness would include seniors who

live in residential care homes. In theory, they should not be lonely because they are surrounded by other residents yet reports dictate otherwise.

Seniors who are at risk of, or suffer from social isolation, experience poorer health and a decreased quality of life. They have higher instances of negative cognitive and mental issues like depression, anxiety, and loneliness, which lead to engagement in harmful behaviors such as drug and alcohol abuse, self-neglect such as poor hygiene, skipping medication and suicide. They also have increased physical disabilities, increased falls and other accidents, have a four to five times higher likelihood of hospital visits (National Seniors, 2014), and higher mortality rates (Chen, 2016). Worse, feelings of isolation exacerbate both ill health and negative perceptions of self and society, which creates a cycle that causes seniors to become even more isolated (Dury, 2014).

Social isolation is not unique to elder populations, nor are all seniors at risk of becoming isolated; but there are certain groups among elderly populations more susceptible to social isolation. These groups include[6]:

- Aboriginal seniors
- seniors who are caregivers
- immigrant seniors
- LGBT seniors
- seniors living alone
- seniors living in rural or remote areas
- low-income seniors and those living in poverty
- seniors with mental health issues (including Alzheimer's and other dementias); and
- seniors with health challenges or disabilities

[6] National Seniors Council & Canadian Electronic Library. 2014. Report on the social isolation of seniors, 2013-2014. National Seniors Council, October 2014. 1-52. Page 10.

Among these more susceptible groups, there are further complex and multi-faceted risk factors that contribute to the likelihood of social isolation which include the following[7]:

- having no children, or little to no contact with family
- being age 80 or older
- lack of affordable housing suited to the special needs of seniors
- lack of accessible and affordable transportation options for seniors
- being left behind by children or youth who migrate for work
- increasing urbanization, shrinking rural communities, and changing community values which create a sense of loss regarding what community means for seniors
- limited knowledge of/or access to community services and programs
- senior's perceptions, fears and stigmas of age/ageism may cause them to become alienated from being socially active in their communities
- ageism
- fear of becoming incontinent or falling, in public
- technological changes and the "computation" of basic services such as banking, parking meters, telephone services (prompts), communication (social media) etc.
- life transitions common with ageing: bereavement, moving into long term care facilities, loss of driver's licence

The various types of seniors susceptible to isolation, coupled with the many risk factors and the impending wave of baby boomers entering their twilight years, means that the instances of social isolation among the elderly are going to increase considerably in the next three decades. If HCA curriculums incorporate training that enhances positive health determinants for isolated seniors such as education, improved physical environment, increased social supports, access to

[7] National Seniors Council & Canadian Electronic Library. 2014. Report on the social isolation of seniors, 2013-2014. National Seniors Council, October 2014. 1-52. Page 9.

health services, and *simply spending quality time with seniors*, healthcare aides can greatly improve health outcomes for those suffering, or at risk of social isolation (World, 2017a).

Frailty

There are currently 1.1 million seniors suffering from frailty in Canada today. By 2035, that number will increase to more than 2 million (Wilson, Michael G., Kerry Waddell, 2016). But what is it? Frailty is "an age-related physiological state of increased vulnerability (Hoover, M., Rotermann, M., Sanmartin, C. and Bernier, J, 2013 10)" which often results from co-morbidity of chronic conditions. It is categorized by indicators such as sudden weight loss, decreased physical activity, feeble grip, low energy levels or endurance, and a slow gait (Hoover et al., 2013). Seniors with little emotional or social supports and those who suffer from social isolation have a higher likelihood of becoming vulnerable and, resultantly, are at greater risk of illness or injury (Wilson et al., 2016). If they do contract an illness or injury, the recovery process is slower, and worse: frailty often precedes hospitalization, institutionalization, ailing health and death (Hoover et al., 2013).

Frailty is assessed based on a clinical frailty scale demonstrated below (Wilson et al., 2016, 3):

Clinical Frailty Scale*

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 Managing Well – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Gill, Thomas M., Dorothy I. Baker, Margaret Gottschalk, Peter N. Peduzzi, Heather Allore, and Amy Byers found that with early home-based intervention, conditions of moderate frailty can be improved (2002, 1072). The interventions focused on solutions for impaired mobility, unstable balance and range of motion, and physical household hazards (Gill et al., 2002). Frailty issues require high priority in all levels of healthcare and government as seniors are at increased risk of chronic diseases, decreased ADLs, and in general need more services like home care, long term care facilities, hospitalization and hospital-based resources (Wilson et al., 2016). Preventative measures to keep people from becoming frail include education, exercise,

and safe environments (Gill et al., 2002). Once more, a HCA course taught specifically on frailty, and educating and mitigating risk for susceptible seniors, could go a long way to alleviate injury, health deterioration, and institutionalization.

Elder Abuse

There is an emergent pattern among most ailments aging populations contend with; interconnectivity. Just as co-morbidity and isolation can lead to frailty and vice versa, so can frailty, chronic illness and isolation lead to elderly abuse, which can lead to depression and deepen isolation and injury and so on and so on. Elder abuse can be defined as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person (Edwards 2012, 10)." These acts include physical and sexual abuse, emotional and psychological, financial abuse, neglect, self-neglect and for aboriginal seniors: spiritual abuse, which encompasses mental distress and cultural loss due to foreign institutionalization (Beatty, B. B., Berdahl, L, 2011).

In 2002 Statistics Canada reported that 7% of seniors in Canada were victims of abuse (Alberta Council 2012) and in 2011 reported that 8500 seniors were victims of reported violent crimes throughout Canada (Statistics, 2013). Without intervention, these numbers will only increase as the number of seniors increases in the next three decades. The ability to identify key causes and seniors most at risk are two factors essential for mitigating abuse. Patriarchy and ageism were identified as two main key causes but also include[8]:

- sexism
- colonialism

[8] Alberta Council of Women's Shelters. 2012. Abuse of Older Adults: Guidelines for Developing Coordinated Community Response Models. Page 6.

- racism
- power
- authority
- paternalism
- dominance
- privilege
- autonomy
- empowerment

Seniors most at risk are[9]:

- females
- Metis
- Inuit and First Nation
- immigrants and refugees
- lower socio-economic seniors
- gay, lesbian and transgender seniors
- institutionalized and socially isolated seniors
- and those residing in rural settings

Abuse alleviation includes addressing issues such as housing, caregiver respite, cultural and language barriers, poverty, awareness, and social interaction (Alberta, 2012). HCAs should be trained to identify elder abuse, educate seniors on elder abuse, and advocate on their behalf.

[9] Alberta Council of Women's Shelters. 2012. Abuse of Older Adults: Guidelines for Developing Coordinated Community Response Models.
Edwards, Peggy. Public Health Agency of Canada. 2012. Elder Abuse in Canada: A Gender-Based Analysis. Government of Canada.

Loneliness

Loneliness is a subjective and common state, predominant in society, most common among adults aged 65 and over, youth under 25 years, and may not be a permanent condition (NG, C. F., Northcott, H. C., 2015). Loneliness occurs when the individual's perceptions of social engagements and relationships are insufficient in quality or quantity (Grenade, Linda, and Duncan Boldy, 2008). The element of perception means that people can feel lonely even when surrounded by others. Reasons for loneliness among seniors are like those of social isolation, such as bereavement and widowhood, retirement, grown children leaving, and living alone and so on (Grenade et al., 2008). Some sub groups of seniors appear to suffer more from loneliness, such as[10]:

- those who live in urban centers and are poor;
- seniors with chronic health conditions, such as urinary incontinence
- those with mental issues
- being female
- being 85+
- and being widowed

Loneliness is a factor in depression, poor sleep, heart disease, functional decline, hypertension and morality (Grenade et al., 2008; Ramage-Morin, Pamela L., and Heather Gilmour, 2013). Healthcare aides can carry out similar duties for those suffering from loneliness and depression, as those suffering from social isolation; mainly, spending quality time with seniors, solely, as an actual and valid work duty.

[10] Brittain, K., Kingston, A., Davies, K., Collerton, J., Robinson, L. A., Thomas B L Kirkwood, Jagger, C. (2017). An investigation into the patterns of loneliness and loss in the oldest old - Newcastle 85+ study. Ageing and Society, 37(1), 39-62.

Depression

Depression, along with loneliness, is another mental ailment whose likelihood increases with age; it is the most prevalent of all psychological impairments to materialize among seniors (Ell, 2006). The Canadian Coalition for Seniors Mental Health (CCSMH, 2009) describes depression as causing "people to feel persistently low in spirits and lose interest in things that used to give them pleasure. This is sometimes triggered by stressful events in a person's life that impact their state of mind, their health, or their ability to connect with other people. However, sometimes it can happen for no apparent reason (CCSMH, 2009)." Currently 1 in 4 seniors lives with a mental health issue or disorder and by 2041 seniors will have the highest rate of mental illness in Canada (MacCourt et al., 2011).

Common depressive impairments are due to mood and anxiety disorders: obsessive compulsive disorder; post-traumatic stress disorder; general anxiety disorder; post fall syndrome, and mental disorders like dementia and Alzheimer's, abuse of prescription/illegal drugs and alcohol, and psychotic disorders like schizophrenia (MacCourt et al., 2011). But depression is also a result of geographical, economic, cultural, linguistic, physical, and emotional issues as well as social stigmas and inequities. The CCSMH has identified risk factors and life events that may trigger depression among seniors. They are as follows[11]:

- being depressed in the past
- having other biological relatives with depression
- being female
- being widowed or divorced
- changes in the brain resulting from other illnesses such as a stroke

[11] CCSMH. Canadian Coalition for Seniors' Mental Health. 2009. Depression in Older Adults: a guide for seniors and their families. Page 7.

- trouble developing close relationships or having low self-esteem
- illnesses that last a long time and cause difficulties like pain and disability
- certain medications
- sleep problems that last a long time (either too much or too little sleep)
- no strong social networks and being isolated
- taking care of a family member who has a serious illness such as dementia

Relevant life events are as follows[12]:

- The death of a loved one which causes despair so deep one cannot function and their symptoms do not improve over time,
- Downsizing to a smaller residence or moving to a long-term care facility may cause a sense of loss if one is moving away from their friends, family and other supports,
- Going through a separation or divorce, reduced financial security, and other losses may also trigger states of depression.

One in four Canadian seniors suffer from some form of depression and 5-15% of seniors report high levels of loneliness while up to forty percent of seniors report occasional levels of loneliness (NG et al., 2015). The complexities of loneliness and depression among seniors must be addressed by governments and policy makers, as these numbers are abashedly high, and in the coming decades, will only increase.

Poverty

Statistics Canada does not have a definitive "poverty line" in which to measure low income levels among its citizens, instead it uses: low-income cut-offs (LICOs), defined as "income thresholds below which a family will likely devote a larger share of its income on the necessities of food, shelter and clothing than the average family…at which families are expected to spend 20

[12] CCSMH. Canadian Coalition for Seniors' Mental Health. 2009. Depression in Older Adults: a guide for seniors and their families.

percentage points more than the average family on food, shelter and clothing (Statistics, 2015b)" and; the low-income measure after tax (LIM-AT), defined as "a fixed percentage (50%) of median adjusted after-tax income of households observed at the person level, where 'adjusted' indicates that a household's needs are considered (Statistics, 2015c);" last is the Market Basket Measure (MBM) which does not apply as the survey only considers ages up to 49 (Statistics, 2015d).

Senior poverty rates have decreased steadily from the 1980s until the 1990s, at which rate the trend levelled out. In recent years, though overall income has increased, the number of seniors in the low-income level has also increased (Milligan, 2008). The LIM-AT demonstrated that in 2012, the number of low income seniors living in economic families was 225,000 and for low income seniors not in an economic family, the number was 315,000. In 2015, the number of low income seniors in an economic family was 388,000 and for low income seniors not in an economic family the number was 485,000 (Statistics, 2017). This brings the number of seniors living in low income in 2015 to 873,000- keeping in mind that homeless seniors, seniors on reserves, and seniors in the territories are usually not accounted for in general surveys.

Seniors derive their incomes from public pension plans like old age security (OAS) and guaranteed income supplement (GIS); the Canada and Quebec pension plans (CPP/QPP); and private savings and pensions (RRSPs, etc.) (NACA 2005). In 2005 44% of seniors depended on the OAS and CPP/QPP as their main source of income, and 32% of OAS and GIS payments were the main income source for women (National, 2009). Some senior sub groups are more vulnerable to living in poverty. These are[13]:

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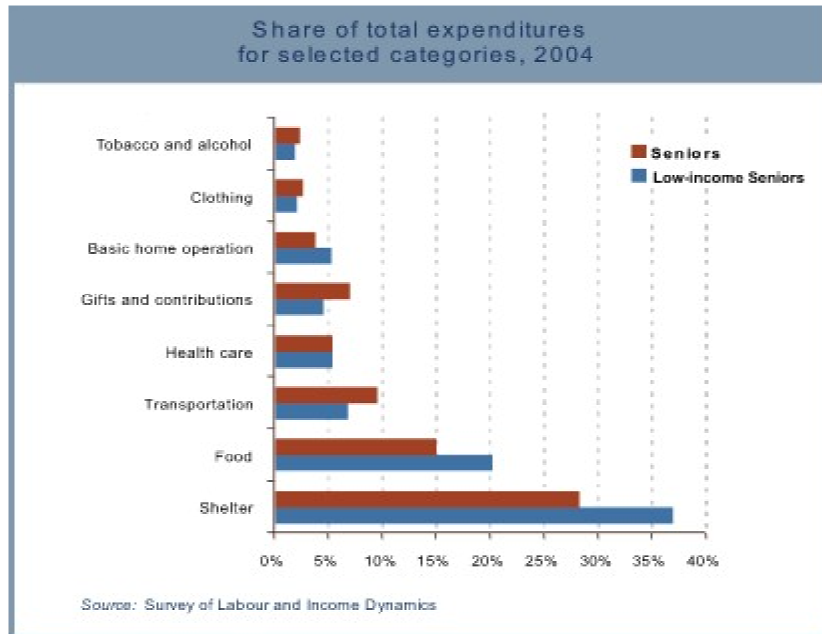
[13] National Seniors Council. (2009). Report of the national senior's council on low income among seniors. National Seniors Council, February 2009. 1-41.

- the unattached
- recent immigrants
- seniors with less than ten years in the labor force
- Aboriginal seniors, and
- females

Unattached seniors are at highest risk with 77% relying on OAS and GIS as sole incomes, and one-third of these unattached are females (National, 2009). Sadly, in 2004, 300,000 seniors eligible for GIS; 50,000 eligible for OAS and; 55,000 eligible for CPP had not applied, simply because they were uninformed (United, 2011).

Low-income seniors spend most of their money on housing, food, transportation and health-related costs (National, 2009). The following graph is a look at the top two expenditures (National 2009, 8):



NACA. National Advisory Council on Aging. 2005. Aging in Poverty in Canada. Seniors on the Margins. Government of Canada. 6-32.

Housing is the highest cost for seniors. Senior renters and homeowners face challenges that affect health. Renters often spend more than 40% of their income on rent and homeowners have maintenance costs and property taxes to pay. When maintenance costs are avoided, homes fall into disrepair and become hazardous, or are not outfitted properly to meet the changing physical needs of seniors (National, 2014). Renters are often forced to live in core areas, where crime rates are high and dwellings are likely of lesser quality, likewise in disrepair, hazardous and ill fitted for their needs (United, 2011). Overall, homeowners are in the better position as they have a major asset to draw upon if needed. High housing costs lead to exacerbated poverty, social isolation, depression, homelessness, and increased injury; all which negatively impact health (Ivanova, 2017; United, 2011).

Food is the second highest cost for seniors at 20% of their total expenditures. Seniors who live in the community as opposed to long term care are more likely to suffer from food insecurity- a lack of safe, nutritious, adequate amounts of food to maintain a healthy, active life (Ivanova, 2017). Since 92.1% of Canadian seniors lived in private dwellings as of 2011, the number of food insecure seniors is significant (Milan, A and Bohnert, N, 2012). Of the 92.1%, 34% are not meeting their nutritional needs. When seniors do not meet their basic food requirements their chance of hospitalization increases by 50%. The risk factors for food insecurity includes the following[14]:

- being female
- being low income
- having a disability
- having few social supports

[14] Ivanova, Iglika. 2017. Poverty and Inequality Among British Columbia's Seniors. CCPA: Canada Centre for Policy Alternatives. Page 49.

- being depressed
- having poor oral health (painful or difficult to eat) and,
- taking prescription drugs (side effects which affect appetite)

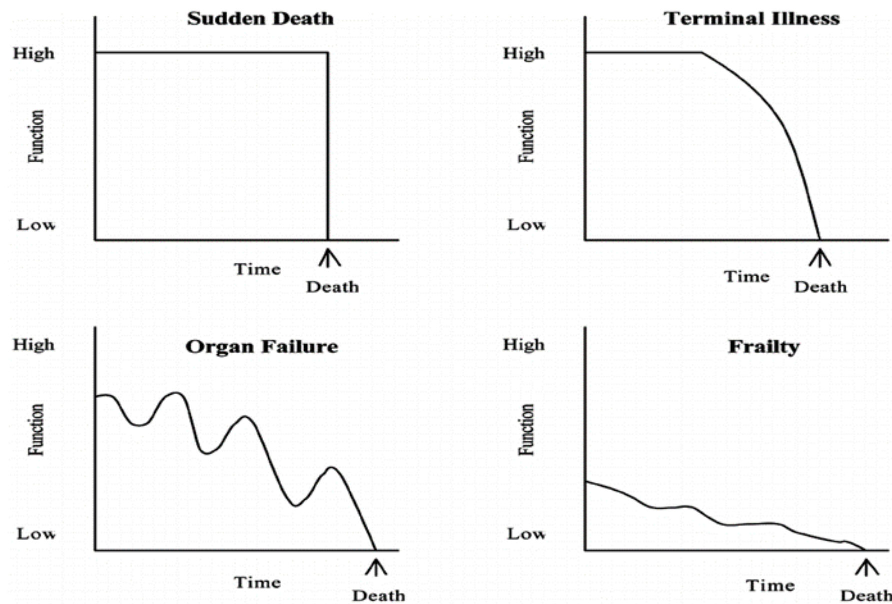
Malnourishment and lack of proper nutrition can cause poor mental and physical health outcomes; they are linked to chronic conditions such as diabetes and hypertension, depression, and fibromyalgia. Resultantly, it affects people's ability to manage their well-being and places higher costs on the healthcare system (PROOF, 2017). Educating seniors on their rights (accessing pensions), and all available supports including government programs, local NGOs, local health provisions and positive health outcomes, is an area that can be implemented by HCAs given their working proximity to senior populations.

Palliative Care

Humans today are living longer, healthier lives. This is largely due to technological and medical advancements which have revolutionized not only how we treat ourselves, but how we view death. For a millennia, palliative care, or palliation (meaning comfort), was intended to relieve symptoms of the terminally ill and make their natural journey into death as comfortable as possible (Duffin, 2014). But with the advent of new inventions, antibiotics and other drugs, diseases became the focus of cures, rather than conditions to be managed until death's natural occurrence (Duffin, 2014). Today, palliative care is inclusive of a wider range of conditions, as opposed to only "death bed" care.

Historically, an infectious disease, heart attack or cancer would guarantee an instant or quick demise but this no longer the case. The four trajectories of death demonstrate the importance of palliative care for those not only in terminal situations, but for those suffering from frailty, and chronic conditions as well (Canadian. 2015). These trajectories demonstrate the

type of death, and duration into death, all humans will inevitably experience. Sudden death is instant but only happens to 10% of the population, which means 90% of us will experience one of the other three trajectories: terminal illness, organ failure, or frailty (Canada, 2010). Often, these trajectories occur with the aging process.



(Canada, 2010)

Cancer patients who do not go into remission can live an unpredictable number of years before their end stage, but once they enter the terminal stage of their disease, patients do not usually live for more than two months (Canada, 2010). Living with organ failure from chronic diseases like COPD constitutes a slow demise with periodic life-threatening emergencies followed by a quick death; people with organ failure can live on average anywhere from 2-5 years upon diagnosis. Frailty, as we've seen, is a condition of slow demise and includes disorders like dementia; patients diagnosed as being frail can live on average from 8-10 years (Canada, 2010). For each of these conditions, and for the duration of time people suffer from them,

patients should have access to palliative care. Palliative care should also include pain and symptom management of co-morbidity and frailty (Duffin, 2014).

Most seniors want to die in the comfort of their own homes. But sadly almost 70% of Canadians still die in hospitals and less than 30% have access to hospice care (Duffin, 2014). In Ontario, a 2010-12 study found that 51.9% of patients who died had one treatment of palliative care in their final year, that medi-care was only provided for 20% of dying patients, and fewer than 10% of the dying had a home visit from a doctor. Additionally, those dying of cancer had were more than twice as likely to receive palliative care than those dying from other causes, even though chronic diseases account for 70% of all deaths (Canadian 2015; Canadian, 2016). Some reasons for these shortcomings include[15]:

- Lack of access to palliative care
- *Lack of skilled staff, educated in palliative care curriculum*
- Lack of system integration
- *Deficiency of supports for caregivers of the dying*
- No proper advanced care planning in place

There is a clear need for increased funding, awareness and action in the field of palliation. The national framework put forth by the Canadian government suggests the following recommendations[16]:

- Promote and support a shift in practice culture
- Establish a common language
- Educate and support provider
- Engage Canadians in advance care planning
- Create caring communities

[15] Canadian Medical Association. 2016. The State of Seniors Healthcare in Canada. 3-17. Page 14.
[16] Canadian Medical Association. 2016. The State of Seniors Healthcare in Canada. 3-17. Page 8.

- Adapt an integrated palliative approach to provide culturally-safe care, including with and for Canada's First Peoples
- Develop outcome measures and monitor the change

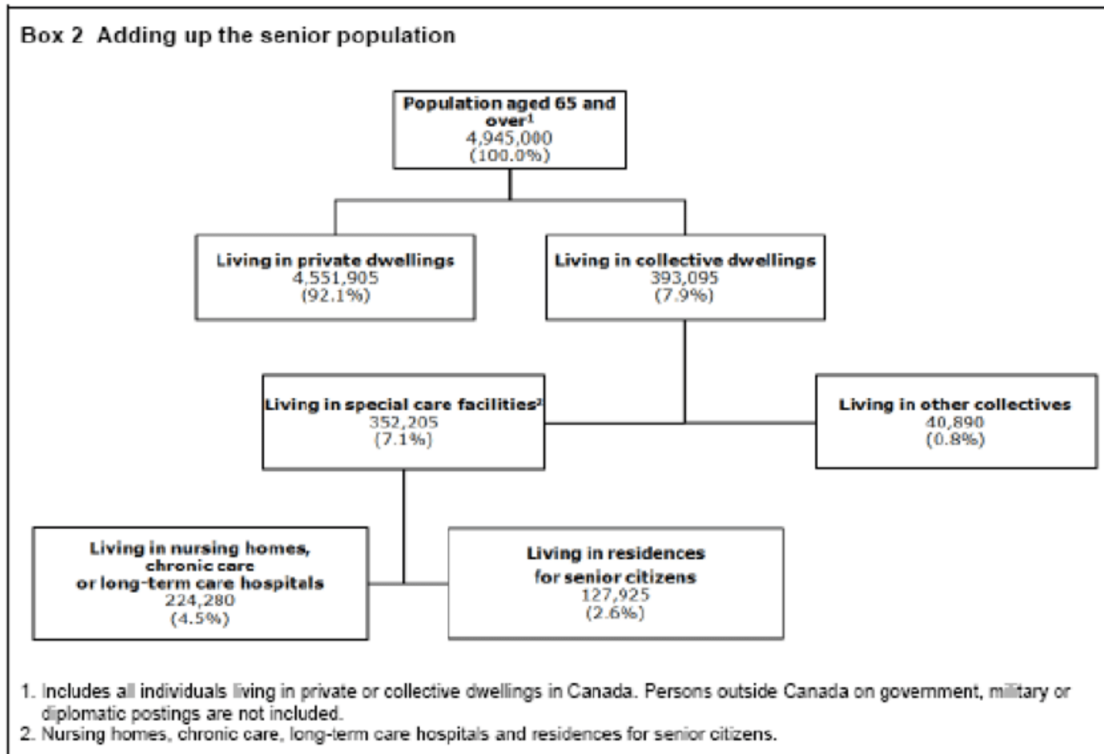
HCAs should receive advanced training in palliative care. Important components should include: psychological, spiritual and cultural training regarding death; and instruction on informal caregiver stress and respite. Training should also include the five key indicators of compassionate care for the dying, which are: 1. Safety; 2. Comfort; 3. Respect, 4. Support, and 5. Ability to tell their story (Canada 2010, 2).

As mentioned in the section on Seniors and the Sustainability of the Healthcare System, the needs of seniors are chronic, complex and not bound by age generalizations or standardized health needs. Their health needs result from a variety of external factors that include social issues as well as physical, mental and emotional aspects. This section has provided a small peek into the complexities that ail and affect the health of seniors, and why HCAs should receive advanced training to address these issues. The first wave of boomers turned 65 in 2011. To sufficiently meet the numerous and compounded health needs of seniors now and in the coming decades, changes must be initiated immediately. There must be a re-direction of funding from acute care to chronic and community based care and residential homecare. By investing in disease prevention, education, and home care, governments can better meet the needs of the aging population; lest they risk Canadian seniors to suffer gravely in the winter of their lives, due to an overwhelmed, inefficient healthcare system.

5. Home Is Where the Heart Is

"The comfort of home is the best gift we could give them as their children.... It's not because we're wealthy but rather because this is the rainy day (Change, 2011)."
— A daughter about her parents who are both frail and elderly

The 2011 Census of population calculated that 92.1% of seniors lived in private dwellings while the other 7.9% lived in collective dwellings (Milan, A, and Bohnert, 2012). This calculates to 4,945,000 seniors living in private residences compared to 393,000 living in collective dwellings such as nursing homes, long term care hospitals, and other arrangements like living with older children. At the age of 65, around 1% of the senior population lived in collective dwellings, but as they reached the age of 85, the likelihood of residing in a facility increased to 29.6% (Milan, A, and Bohnert, 2012); still not a significant number compared to those living in private dwellings. Since many senior health ailments are preventative, it stands to reason that more education and in-home supports can keep the elderly population living at home longer, more safely, and in better health, while being a more cost-effective option for governments. More importantly, home is where most seniors want to be.



(CIHI, 2011)

Seniors want to live in their homes for as long as possible (CIHI 2011; Turcotte 2014). A 2011 report found that most younger seniors live with a spouse or co-resident but as time goes on the likelihood of living alone increases. This is usually due to the death of a spouse and is more likely to be women who survive (although this trend is changing and males are living longer) (CIHI, 2011). Resultantly, many people end up alone as they age towards the 85+ senior group. Being alone increases the risk for financial instability, higher housing costs, and inability to access supports and formal/informal care (CIHI, 2011). When seniors have unmet needs such as these it leads to health deterioration, loneliness, stress, social isolation, lower well-being and precipitates institutionalization. (Turcotte, 2014). These risks are mitigated by informal caregivers: neighbors, spouses, and children, but the work is often highly stressful and costly for the caregiver (Change, 2011).

Informal, unpaid caregivers number 1.2-1.5 million, or make up 75-80% of in-home care while only 18% of care given to seniors is received formal home care, which includes paid workers and volunteers (Statistics, 2009b; Canadian, 2013). Sadly:

> "There is no formal obligation on the part of provincial or territorial governments to provide a minimum basket of home care services, as there is for physician or hospital services covered by the Canada Health Act Canada Health Act. As such, home care legislation varies considerably across the country (CIHI 2011, 24)."

Resultantly, informal caregivers are essential for seniors to live independently in their homes. Caregivers assist with activities of daily living (ADLs) like toileting, hygiene, and mobility. They also help with instrumental ADLs such as meal prep, shopping, transportation, and financial management (CIHI, 2011). But their help comes at a cost: a physical, mental, emotional and financial cost.

Informal caregivers provide $25-26 billion in services annually and spend $80 million annually in out of pocket costs (CHPCA). The financial burden of care goes beyond the 41% of caregivers who accessed their savings to subsist, and the 22% who missed more than a month of work: 41% said it had an adverse-effect on their mental health and 38% on their physical health; 22% expressed feelings of distress, anger, depression, feelings of being overwhelmed, and the inability to continue to care (CHPCA). Negative effects were also correlated with the number of hours required for care, since care is sometimes carried out around the clock; the most stress ensued when caregivers assisted 21+ hours (CIHI, 2011). The type of care required also had negative effects as caregivers are often untrained and uneducated on the duties they carry out. Some of these duties include: death bed care; psychological, spiritual and social care; medical care, including: the administering of medication and injections; hygienic care; advocacy; and healthcare delegation (CHPCA).

When we consider that 92.1% of seniors in Canada *live* at home, and they want to *be* at home, and home is the most *cost-efficient* option for governments to house seniors, the most obvious solution is to assist seniors to remain in their homes for as long as possible. But governments cannot rely mainly on informal caregivers, because while the number of seniors is increasing, thanks to the shrinking nuclear family, the pool of informal caregivers is shrinking as well. What we have then, is: a burgeoning sector of the population who encompass a complex range of health needs and issues; a situation where the number of seniors will rise dramatically in coming years; a high number of seniors in private dwellings; an over worked, highly stressed, unpaid, informal caregiver predicament; a piece-meal home care system of public/private home care provision; and a healthcare system that will be heavily taxed in the coming decades. The following sections will address HCAs as a solution to these issues.

6. The Need for Healthcare Aides

The influx of baby boomers who will be turning 65+ in the coming decades does not only have implications for the healthcare sector, but other sectors as well. The labor force is one such area. The overall participation rate is expected to decline steadily until 2031, from its current rate of 65.70%, which has held steady at an average of 65.72% from 1976-2017 (Trading, 2017). The participation rate is projected to plummet to numbers hovering from 62.6-59.7% (Martel et al., 2011); numbers not witnessed since the all-time low participation rate of 61.40% in March of 1976 (Trading, 2017). Other factors include low fertility rates and longer life expectancy but nonetheless, what this means is an overall decline in workers across all sectors, including healthcare (Martel et al., 2011; Canada, 2010). There already exists a shortage of physicians and nurses in Canada, and as more boomers employed in the healthcare sector retire, newly trained

professionals will not be able to keep up with the rate of demand (Canada, 2010). This scenario exacerbates the potential for the neglect seniors already experience in the healthcare system.

The following section recommends provincial health bodies incorporate advanced training to existing certified healthcare aide courses. As we will see, the demand for healthcare workers can be fulfilled by providing advanced training for HCAs, as they could take on more responsibilities, reach a larger pool of seniors, and require less training time to make up for the projected number of workers set to leave the healthcare sector.

7. Policy Recommendation- Advanced Training for Healthcare Aides

This paper proposes advanced training for Healthcare Aides (HCAs), also known as home care aides, home care attendants or nurse's aides. In the hierarchy of healthcare, the chain of command generally begins with physicians, then nurses, therapists and social workers and finally, healthcare aides. Due to the low position HCAs occupy on the chain, healthcare aides are the most over looked, underutilized, and valuable resource the healthcare system has for addressing the many and complex needs of senior citizens. The existing benefits HCAs offer are as follows:

- they can be trained in a fraction of the time nurses and doctors can,
- they can be trained in colleges that are spread throughout the provinces, as opposed to sparsely dispersed technical institutes and universities,
- they have geriatric training; knowledge of chronic conditions, dementia, and other related health issues,
- they have palliative care training,
- they have extensive training in ADLs and instrumental ADLs,
- they are trained in WHIMIS, safe food handling and First Aid/CPR
- they are trained by nutritionists on the special diets of seniors,

- they are certified by the government, so there are no liability issues, as with volunteers,
- they are paid, unlike informal caregivers,
- funding can be provided for their education,
- basic education is required for course acceptance, attracting a larger pool of aboriginal students and immigrants,
- aside from informal caregivers, HCAs spend more time with seniors than any other healthcare professional or volunteers.

In fact, for the 75-84-year age groups, HCAs spent almost double the time with elderly patients than nurses did, and almost triple the amount of time with the 85+ age group than nurses (see Table). It is partly due to this very reason that HCAs should receive advanced training, with responsibilities that include: critical assessments, documentation and reporting; skills to educate and train seniors; advocacy; socialization (as a specific purpose for a home care visit); and technical medical duties. The costs realized for a faster trained, highly skilled, provincially dispersed, lower paid worker would: alleviate long term costs to the healthcare system; reduce the burden for informal caregivers; improve access for seniors; improve health outcomes, and improve quality of life. This report proposes a re-allocation of funding from acute care in hospital settings to chronic care in residential and community settings, aggressive marketing to targeted demographics, changes to the current HCA curriculums, and a wage increase.

Figure 17: Variation in Services Received by Long-Term Home Care Clients, by Age Group, 2009–2010

Type of Home Care Service	Age Group 20–64 (%)	65–74 (%)	75–84 (%)	85+ (%)
Home Health Aides	42	47	53	59
Visiting Nurses	40	31	21	19
Homemaking Services	23	27	33	42
Meals*	5	5	9	15
Volunteer Services	1	1	1	1
Physical Therapy	8	8	7	7
Occupational Therapy	9	8	7	5
Speech Therapy	1	1	0†	0†
Day Care or Day Hospital	3	3	3	2
Social Worker in Home	4	1	1	0†

Home Care Reporting System, 2009–2010, Canadian Institute for Health Information

GRT 2100: Psychosocial Aspects of Aging

(CIHI 2011, 75)

Current Certification

The current length of full time study required to obtain a healthcare aide certificate in Alberta is four months of in-class and two weeks of clinical training (Bow Valley, 2017). The length of time required to obtain a nursing degree is four years and to become a physician it is a minimum ten years of education and residency (UBC, 2014). There are currently 29 locations throughout Alberta to train as a HCA including smaller centers like Fort McMurray, Lloydminster, Red Deer, Medicine Hat, Lethbridge, and Cardston. There is also provincial wide training for HCAs that can be offered via distance/online education, which requires only internet access (Alberta, 2017). There are eleven locations to train to become a nurse where you must be physically present (CARNA, 2015), and two locations to train as a medical doctor (Royal, 2017). HCAs earn an average pay of $19.35-24.46 per hour, nurses earn on average $36.86-48.37 per hour (Alberta, 2017) and for medical doctors the average annual pay is $354,492 (Gerein, 2015). It is

far more quick, accessible, and less expensive, to acquire certification as a HCA, and is also more cost effective for employers.

The admission requirements to Bow Valley College for a CHCA are either English 10-1or 10-2, completion of the GED, or a satisfactory Bow Valley College score. Applicants must also submit a recent Police Information Check (PIC) and Vulnerable Sector Search (VSS), as well as updated immunization records. They are also required to obtain their First Aid/CPR (Bow Valley, 2017). Upon acceptance, students partake in the following government mandated course curriculum[17]:

HCAD1103 - Communication in the Healthcare Environment (2 credits, 30 hours):
This course will focus on the roles and responsibilities of a healthcare aide working in a variety of employment settings, as well as professional communication with other team members, clients and client families. The healthcare environment requires competent verbal, written and electronic skills. Strategies for overcoming communication barriers caused by disease and aging will be discussed. In addition, the course will provide problem solving strategies and tools to handle conflict.
HCAD1102 - Structure and Function of the Human Body - Health and Chronic Illness (3 credits, 45 hours): In this course, the twelve systems that make up the human body will be studied and the milestones of growth and development across a lifetime will be discussed. The concepts of healthy aging and maintaining independence will also be addressed. Learners will gain knowledge about the most common chronic conditions the Healthcare Aide may encounter and how to provide safe care based on best practices according the client's diagnosis, needs, and care plan.
HCAD1101 - Working as a Healthcare Aide (3 credits, 45 hours): This course will focus on safety - safety of the client, the healthcare worker and the work environment in a variety of employment settings. The course provides information that will result in safe care, based on the needs of the client.
HCAD1104 - Providing Client Care and Comfort (4 credits, 60 hours): This course encompasses the skills needed to assist clients with daily grooming, hygiene, bathing, elimination, bed making, and nutritional needs. Learners in this course will learn to support clients to maintain independence and to meet their care needs according to individual care plans. This course is designed to develop confidence and competence while providing basic client care.
HCAD1202 - Meeting Complex Care Needs (3 credits, 45 hours): The skills introduced in this course are sometimes referred to as advanced skills for healthcare

[17] Bow Valley College. 2017. Healthcare Aide Certificate. Programs and Courses.

aides. The opportunity to learn the skills for supporting care activities such as ostomy care, respiratory care, catheter care, tube feeds, and vital signs are taught in this course.
HCAD1203 - Special Activities for Diverse Clients (3 credits, 45 hours): Healthcare Aides may have the opportunity to work with families to provide care for infants and children. Information and skills to assist with these care assignments are included in this course, as are care strategies for assisting other diverse client groups, such as clients with a mental health diagnosis, developmental delays, and physical disabilities. Course information will provide the learner with care strategies to support the client, the client's family, and self through the process of a client's dying and death.
HCAD1201 - Assisting with Medication Delivery (1 credit, 15 hours) [Online Only]: This course includes comprehensive materials to train the learner to assist with medication delivery within the scope of practice of the healthcare aide.
HCAD1301 - Client Care Clinical Experience (4 credits, 120 hours): This course provides opportunity for the learner to incorporate and demonstrate previously acquired skills in a hands-on setting. For three weeks in an extended care setting, a facilitator supervises and guides the learner in the application of skills and knowledge. The following documents must be submitted at least FOUR weeks prior to the start of the course: Police Information Check, proof of immunization status, SCM certificate of completion.
HCAD1999 - Client Care Practicum (2 credits, 80 hours): This course provides a two-week opportunity for the learner to adapt learned skills to an acute home/community setting under the direct supervision of a preceptor. The following documents must be submitted at least FOUR weeks prior to the start of the course: Police Information Check, proof of immunization status, SCM certificate of completion.

These courses are approved by the government of Alberta and required for formal certification. However, registration is not required to become a HCA, meaning that in some instances, untrained workers can be hired to carry out basic care duties. These workers must be supervised and signed off as competent by trained professionals like RNs, LPNs and RPNs (Alberta, 2017).

Alberta Health and the Health Workforce Planning and Accountability developed the Healthcare Aide Competency Assessment Profile (CAP). The competencies have been divided as follows[18]:

[18] Government of Alberta. 2001. Healthcare Aide Competency Profile.

- Basic: These are competencies that all HCAs working in Alberta need to be proficient in, regardless of the setting, even if they are not performed in your work area.
- Acute Care: These competencies are required for all HCAs employed in acute care settings in Alberta. They may be applicable in other work settings as well. If the competencies are required in your setting, ensure they are assessed.
- Setting specific: The competency outcomes identified in this category may not be applicable to all work settings. These competencies are only assessed if they are required in your setting of employment

To serve senior populations best, highly educated healthcare aides are a streamlined, cohesive option that addresses the highest number of interests. Therefore, certification should be a requirement for any person executing healthcare duties in Alberta and throughout all provinces. Further, all three competency levels should be included in the HCA curriculum since the acute care setting and the setting specific category both have components that are senior specific. The three competency levels would be beneficial training for HCAs to possess, as an increased skillset would assist senior clients to receive better care at home.

The Government of Alberta Healthcare Aides Competency Profile is a prerequisite for the development of standardized educational programs. It was last updated in 2001 and lists each component required for HCAs to competently carry out certain duties for healthcare system clients (Government, 2001). In 2001, competencies required for basic dementia care were added into the competency profile. This was the last time any

amendments were made to the profile that mandates HCA training. The total competencies as of 2001 are as follows[19]:

A. Function Effectively in Role
B. Function Effectively as Team Member
C. Communicate Effectively
D. Safety
E. Documentation and Preparation of Reports
F. Client -Centered Focus
G. Dementia Care
H. Implement Care Plans
I. Assist Clients with Household Management Duties
J. Assist with Child Care
K. Assist with Palliative Care

In Manitoba, HCAs are called Comprehensive Healthcare Aides (CHCA), and for a reason: the list of competencies required to work as a certified HCA are extensive. However, some aspects of the course- despite being included in the competency profile, are lacking and should be expanded. For example, section F includes "support emotional, cultural and spiritual needs of client" and likewise "social" and "cultural" terminology is used throughout several sections but there is no dedicated training outlined for HCAs to acquire knowledge of cultural and social specific areas (Government, 2001). The next section outlines courses that should be expanded upon or added to the HCA curriculum. Additional courses would not be difficult to implement as HCA courses are standardized.

[19] Government of Alberta. 2001. Healthcare Aide Competency Profile.

Expanding the Curriculum

The HCA competency profile should incorporate basic, acute, and specific setting training for all HCA curriculums. In addition, there should be a larger focus on social, cultural, safety, and educational components. Just as dementia basic care competency was added to the 2001 competency profile, so too should competency training for frailty, social isolation, depression and loneliness, elder abuse, locale specific advocacy and supports, sociological and anthropological training and palliative care (expansion) be included. What we have learned from examining senior specific ailments and issues is that many of the problems are intertwined, and social; as opposed to being strictly medical. The expansion and incorporation of social, cultural, safety, advocacy, and educational training for HCAs to learn- *and further teach their clients*- is essential for disease and injury prevention, and ultimately, decreased overall costs for the healthcare system. The following are the proposed courses and course amendments:

Frailty: A course taught to inform, identify and alleviate instances of frailty**.** The course should include education for HCAs to learn and further educate seniors on post-fall syndrome, low impact exercises and range of motion techniques, and home assessment training via “The Safe Living Guide—A guide to home safety for seniors” published by the Public Health Agency of Canada to recognize and reduce potential household dangers (2005). HCAs should also educate seniors and their families on risk factors and prevention measures for frailty, and provide locale specific advocacy. Advocacy may include education on how to contact ombudsman or government agencies, and NGOs to assist with grants for age appropriate home improvements, how to report and deal with slum landlords, how to access equipment such as walkers, wheelchairs and adjustable beds, as well as access to transportation.

Social Isolation/Loneliness/Depression: A course taught to inform, identify, and alleviate causes of social isolation, loneliness and depression. This course should educate HCAs about issues seniors and marginalized seniors face: poverty, discrimination, alcoholism, drug addiction, lack of empathy/sympathy from healthcare workers, incontinence related issues, cultural-linguistic sensitivity, urbanization, technology, ageism, life transitions, changing values and community, and the effect these issues have on seniors. The course should emphasize that social activities are a valid purpose for home visits by HCAs, and should be recognized by healthcare administrators as sole and valid reasons for home care, which addresses the mental, emotional, social, and physical well-being of seniors. Therefore, training should include the types of activities HCAs can engage in and teach seniors. These can include: playing games; reading books with them; going for walks; swimming; shopping; teaching how to use the internet technologies like email, other forms of social media and online games like solitaire and Pacman; manicures; gardening; going for coffee, etc. The course should also have HCAs teach seniors on locale specific advocacy measures like suicide help-lines, AA and NA groups, poverty alleviation groups, food banks, and educate on social supports like activity clubs, seniors clubs, and government pensions like the GIS/OAS.

Sociological and Anthropological Training: This course should be offered in tandem with the Social Isolation/Loneliness/Depression course and should emphasize the different cultural, linguistic, and social demographic groups in Canada. The course should include training on LGBT seniors, aboriginal populations and the major immigrant groups in Canada, including; their religious and spiritual beliefs, their cultural and social norms, their challenges and brief histories. Empathy, patience and understanding should be a crucial component of the curriculum.

This course should not only emphasize clients but should also discuss the importance of recruiting immigrant and aboriginal students into the program.

Elder Abuse: A course taught to inform, identify and alleviate instances of elder abuse. This dedicated course should educate on the different types of abuse seniors face as well as incorporate a greater emphasis on identifying the signs of abuse, advocacy and reporting. Locale specific interventions should be taught to HCAs, and passed onto seniors, for all forms of abuse. For example, knowledge of access to: The R.C.M.P and local police services; social workers and other healthcare workers like doctors, nurses and psychologists; legal aid workers; emergency shelters; knowledge of legal rights and protection; and fraud education and protection measures as provided from the government of Canada. This component should include instruction regarding the attitudes and cultural norms seniors might have grown up with, at times when abuse was shrouded in cloaks of secrecy and shame. HCAs should be taught an educational component in which they can offer supports, and skills for assisting seniors to break down stereotypes and stigmas regarding abuse.

Locale specific advocacy and social supports: A course designed specifically to educate HCAs on the utilization of all local support systems. To be as effective and efficient as possible in assisting seniors, local health regions should create the advocacy and support literature for the healthcare aide curriculum based on their geography. Standardized formats work for the majority of HCA training, however: healthcare provisions, contacts (phone numbers, etc.) and agencies, NGOs, government supports, and poverty alleviation measures will not be the same in Peace River, AB, as they are in Calgary, AB. Therefore, this specific course must be tailor made to communities and regions across the provinces, and in the case of distance education, local packages provided to HCAs, for where they live and work.

Likewise, all the educational literature designed for senior clients and their families, which would be provided by HCAs, should published and distributed by the local health regions. Information would include but not be limited to: physical risk factors for chronic conditions; common injuries, and age-related ailments (incontinence), smoking, alcohol abuse, high blood pressure (or hypertension), physical inactivity, high cholesterol, overweight/obesity, poor diet/nutrition, and high blood glucose levels to name a few. Literature should also include the mental, social, and emotional ailments that seniors may face like informal caregiver stressors, abuse, depression, loneliness, social isolation, poverty, and palliative care.

Palliative Care: HCAs possess the skills to address the physical care of the dying, they are also trained to understand the five stages of death[20]. However, the palliative care component for the course should be expanded to include a section on informal caregivers, the stressors they face; physically, emotionally, mentally, financially, and how HCAs can alleviate these burdens. HCAs should understand that informal caregivers often provide round the clock care for the terminally ill or frail, and it is exhausting for caregivers to retrain new HCAs who work on constantly rotating schedules. As such, informal caregiver alleviation measures should include full time 8-12-hour palliation shifts, so HCAs may truly allow caregivers much needed respite, and 1-2 dedicated workers per client (this is at the discretion of the healthcare provider). Expansion of palliation education should also include increased psychology training for processes of grief, learning the four trajectories of death, learning the five key indicators of compassionate care for the dying: 1. Safety; 2. Comfort; 3. Respect, 4. Support, and 5. Ability to tell their story, with a

[20] The five stages are denial, anger, bargaining, depression and acceptance, proposed by Elisabeth Kübler-Ross in her 1969 book On Death and Dying.

focus on the importance of point number five, and palliative care techniques for those suffering from the other trajectories of death.

The incorporation of these courses into the current HCA curriculum would provide a broader understanding and skillset for HCAs, and the specific skills most needed to satisfy the needs of seniors identified earlier. These skills and educational components are predominately senior specific and are essential qualities HCAs must possess to care for the aging population. Training in the proposed areas include both a technical and social component currently lacking in the HCA curriculum. In addition to the proposed recommendations which included: allowing only formally trained, certified healthcare aides to work in healthcare settings; incorporating basic care, acute care and setting specific care training for all HCAs; new and expanded courses; dedicated social visits from HCAs; dedicated informal caregiver respite which includes: full shifts (8 or 12 hours) for respite, the same HCAs for respite patients, there are two more recommendations for consideration.

Recruitment and Wages

The issues outlined in this paper are relevant concerns that are addressed in much of today's health, social and economic literature, media, roundtables and public policy. But if nothing is done to tangibly address the aging population, senior's health issues, and the sustainability of the healthcare system, then all the research is in vain. Likewise, changing and expanding the educational curriculum of HCA workers is futile if there are not enough workers to more than adequately address the number of seniors who currently require healthcare resources, and those yet to come.

Recruitment

Federal, provincial and municipal governments must actively recruit students to enroll in the HCA program. Recruitment should target qualified marginalized populations. Qualifications may include a grade 10 education, a GED certificate, or passing a college entrance exam. Additionally, the required criminal record checks should be changed to “satisfactory” criminal record checks, where offenses are considered on a case by case basis and do not include violent crimes or abuse charges, but rather summary offenses like fraud or DUIs, and which occurred 5 or 10 years prior to enrollment. Urban and rural Aboriginal students should be recruited as many can relate to their cultural norms, speak native languages, and are likely to live or move back to reservations, Metis settlements, and other isolated areas, especially if they are from these communities. There are other economic benefits as well to recruiting aboriginal students, such as alleviating costs on the welfare system.

Immigrants should also be actively recruited as they are another group who may not be as highly educated as the mainstream population or whose qualifications may not be recognized in Canada. Immigrants workers, like aboriginal students, should be paired whenever possible, in working with elderly people who are of the same ethnicity. The benefits realized are cultural, religious, and linguistic solidarity, which can alleviate stress and mistrust on behalf of clients. There is nothing wrong with being more comfortable around people who share your ethnicity, and pairing workers and clients according to race should be encouraged. Additionally, since the baby boomer cohort will retire in high numbers in the coming years, and Canadians in general are having less children, the recruitment of immigrants to health industry jobs will benefit the economy, as the need for healthcare workers will only increase.

In addition to recruitment, the three levels of government should provide financial incentives to make the HCA programs more attractive. This can happen through increased funding for program changes and instructors, increased funding for scholarships and bursaries, waiving tuition fees upon completion of the course or full tuition and cost of living payments provided upon successful completion and job placement.

Wages

HCA wages are posted on the Alberta Health Services site as ranging from $19.35-24.46 per hour (Alberta, 2017), however Payscale.com averages the pay between $14.82 - $21.50 per hour (Pay scale, 2017) and alis.alberta.ca averages the pay out as $18.68 per hour (Alis, 2017), while some jobs currently advertised on Indeed.ca in Calgary offer as much as $25-26 per hour (Indeed, 2017). By increasing the wage to average out at $25-27 per hour and having a legislated price floor of $22 per hour rather than the lowest government average of $19.35, the incentive for individuals to enter the program based on their financial returns alone will increase.

Competitive wages, coupled with minimal entrance requirements, plus aggressive recruitment of targeted populations will result in higher enrollment numbers, much like the competition seen in sonography and dental assistant courses (due to short program duration and high wages). The economic benefits realized through preventative health measures among senior populations, and a shift to home-based care will decrease high cost drivers such as acute and long-term care, which will be more beneficial to the system than maintaining the status quo. The status quo includes: a basic HCA curriculum that hasn’t been updated in nearly seventeen years (at a time when modern technologies and certain social conversations were non-existent among mainstream populations) and mediocre wages.

8. Conclusion: Why It Works

In conclusion Canadians, and the Canadian healthcare system are facing a sustainability crisis. The baby boom generation, the largest generation in Canada, along with their parents, are aging rapidly and fall into one of three categories: young seniors aged 66-74, older seniors aged 75-84 and the oldest group aged 85+. The senior cohort will make up 25% of the population by 2030. Seniors currently make up 14% of the population but use 40% of hospital resources. Hospitals are one of the three highest cost drivers for the federal health budget, along with drugs and physicians. If something is not done soon to address the multi-faceted issues seniors face, a sustainability crisis will cause seniors to needlessly suffer for the next 33 years, at which time the elderly population will decrease.

Seniors face many issues, some of which are unique to their demographic and some which are not. Frailty, for instance is unique, while cancer is not. Many common and highly underscored senior issues in mainstream discussion today surround chronic conditions, co-morbidity, social isolation, loneliness, depression, frailty, elder abuse, poverty, and palliative care. Many of these health-related issues have risk factors and are not related solely to innate, biological causes. Rather, there are many social, emotional, and mental causes and risk factors that contribute to lower health outcomes for seniors. Many of these causes and risk factors are inter-related. The increase of highly educated HCA workers, and increased focus on education, social supports and services, and a focus on prevention, will alleviate the severity of many of the issues.

Although seniors face more health-related issues, it does not mean they want to be in hospitals or long-term care facilities. In fact, 92.1% of seniors live in private dwellings and more

importantly, they want to be at home. Taking care of seniors with co-morbidity or terminal illnesses can take a physical, emotional and financial toll on informal caregivers. Educating and hiring well trained HCAs is a cost-effective solution to the problem. As more boomers retire, more healthcare jobs will need to be filled.

HCAs are an attractive solution because they can be trained quickly, a larger number of the population qualifies for training, there are more places throughout the provinces to train, HCAs have excellent, comprehensive training, with extensive training in geriatric issues, they are a more stable option to volunteers (as they are paid), they can alleviate informal caregiver stress, they are certified, they cost much less to utilize than other healthcare professions, and they currently spend more time with seniors than any other healthcare professionals.

The standardized curriculum for HCAs was last updated in 2001 when a course component on dementia was introduced. A look at the current certification requirements demonstrates room for improvement and enhanced training. A faster trained, highly skilled, HCA would alleviate long term costs to the healthcare system; reduce the burden for informal caregivers; improve access to supports for seniors; improve health outcomes and improve quality of life. Courses on modern issues that have more awareness and greater social acceptance must be incorporated, such as LGBT seniors, abuse, dying at home, poverty, addictions, technology and so on.

The healthcare system will soon face a cost intensive surge in use. Preventative measures such as education for seniors, providing seniors extensive support systems, an increased presence of highly trained healthcare aides, who implement a range of technical skills, advocacy and one on one support can ease the cost surge. Specific changes and amendments to HCA program

should include: hiring only certified HCAs to work in healthcare settings; incorporating basic, acute and setting specific care training in the curriculum; six new and expanded courses; dedicated social visits from HCAs; dedicated informal caregiver respite; full 8 or 12 hours shifts for respite; and dedicated caregivers who work with the same clientele as determined by their level of need.

The healthcare system that was established in 1966, and the CHA passed in 1984, worked for the times in which they were established. However, the world is changing. Canada is experiencing a demographic shift in which the population is rapidly aging. The aging population will not only mean an increase in the number of seniors but also an increase in healthcare resources. Senior specific illnesses and ailments tend to require chronic care rather than acute care. Unfortunately, much of the provinces budgets and resource allocations focus on acute care. This needs to change. Funds must be re-allocated to chronic care and other senior health issues, and to community care and residential settings. As such, home care and advanced training of healthcare aides should be invested in, prioritized, and recognized as a publicly insured service, so that the needs of seniors will be met now, and in the coming decades.

In addition to advanced training for HCAs, there should be aggressive recruitment of marginalized populations, financial incentives for HCA education, and an increase in wages that also includes a price floor. Advanced HCA training is the easiest, most cohesive, cost-effective option to reach the largest number of seniors compared to ineffective, piece-meal solutions like age-friendly cities, and mhealth, which are currently being offered.

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