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Health Care and Aboriginal Seniors in Urban Canada: Helping a Neglected Class

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Health Care and Aboriginal Seniors in Urban Canada: Helping a Neglected Class

Abstract
Canadian researchers and policymakers have paid limited attention to the health care needs of Aboriginal seniors. This lack of attention is problematic, as the situation of Aboriginal seniors – including both status and non-status First Nations, Métis and Inuit – is particularly bleak. Using Winnipeg, Regina and Saskatoon as examples, this paper analyses the health care challenges facing Aboriginal seniors in urban Canada. We ask, what policy approaches are needed to improve the health and wellbeing of urban Aboriginal seniors so that they can have good quality living reflective of their needs and culture? We suggest that, in thinking through present and future health services for urban Aboriginal seniors, policymakers should consider four key factors: socioeconomic conditions; underutilization of urban health services; jurisdiction; and elder abuse.

Keywords
Aboriginal Seniors, Urban, Canada

Introduction

Canadian population aging means that the demands for seniors' health care services will increase over time. Although today's seniors live longer and enjoy more active lives than those of generations past, Canadians aged 65 and over remain more susceptible to progressive chronic health problems leading to disabilities, and have higher levels of dependence on both formal and informal caregivers and health systems.

Population aging and its health implications is an important issue for Canada's Aboriginal peoples, and particularly for Canada's urban Aboriginal seniors. Demographic analyses typically focus on the relative youth of Canada's Aboriginal population: compared to the total population, Aboriginal people have a lower median age, and individuals aged 65 and over make up a smaller proportion of the total Aboriginal population. Aboriginal seniors are also younger, on average, with Aboriginal seniors being more likely than non-Aboriginal seniors to be aged 65-74, as opposed to 75 and over (Turcotte and Schellenberg 2007, 221).

Due to the fact that the Aboriginal population is, on average, considerably younger than the non-Aboriginal population, Canadian researchers and policymakers have paid limited attention to the health care needs of Aboriginal seniors (see Rosenberg et al. 2009). This lack of attention is problematic, as the situation of Aboriginal seniors – including both status and non-status First Nations, Métis and Inuit – is particularly bleak. Aboriginal seniors are among the most neglected societal class because their increasing multiple physical and mental health problems and increasingly poor socio-economic supports have forced them into even more challenging and dependent situations at an age when they should expect to be well treated and taken care of properly by both their families and governments. Also, the number of Aboriginal seniors is growing more rapidly than the non-Aboriginal senior population. By 2017, Statistics Canada projects that seniors will make up 6.5% of the total Aboriginal population, and 8% of the Métis population; 6% of the First Nation population; and 4% of the Inuit population (Turcotte and Schellenberg 2007, 223).

While Aboriginal seniors in all locations deserve their own distinct focus, for brevity's sake, this paper analyses the health care challenges facing Aboriginal seniors in urban Canada, as Aboriginal seniors are increasingly being forced into the cities due to the lack of healthcare services and facilities in their rural and northern communities. Social determinants of health generally refer to living conditions, which for the elderly are often compromised and beyond their control. We ask, what policy approaches are needed to improve the health and wellbeing of urban Aboriginal seniors so that they can have good quality living reflective of their needs and culture? Three prairie cities – Regina, Saskatoon and Winnipeg – are discussed as examples throughout the paper due to their relatively high proportion of Aboriginal residents and due to the presence of some Aboriginal-specific programming in these cities.

After outlining the specific health care challenges, we make recommendations to improve health care services for Aboriginal seniors in Canada's urban centers. Some

ideas are drawn from a recent study on elderly care services in northern Saskatchewan where initial findings observed that gaps in local healthcare services and lack of long-term facilities in the communities were increasingly forcing the elderly into the cities, and into culturally foreign and institutionalized settings where they were essentially divorced from familiar contacts with family and community health systems.

Readers should note that we have chosen to use the word "seniors" and "elderly" interchangeably in order to avoid potential confusion with the word "elders," which may have different usages. Furthermore, we are referring to Aboriginal persons aged 65 and over, although some agencies may, as noted by Health Canada (1998, 32), define Aboriginal seniors as those aged 55 and over.

Health Challenges Facing Aboriginal Seniors

National analyses suggest a number of specific health concerns for Aboriginal seniors:

- *Self-Reported Health Status.* A number of studies indicate that Aboriginal seniors report a poorer health status than the general senior population. In 2001, Aboriginal seniors living off reserve (24%) were less likely than seniors in the total Canadian population (36%) to report very good or excellent health, and more likely to report fair or poor health (30% and 4%, respectively) (O'Donnell and Tait 2003, 13-14; see also Wilson et al. 2010), and Métis seniors were more likely than First Nations seniors to report fair or poor health (Wilson et al. 2011, 361). In 2006, Métis seniors (32%) were less likely than seniors in the total Canadian population (39%) to report very good or excellent health (Janz et al. 2009, 10).
- *Chronic Conditions and Disabilities.* In 2001, almost nine in ten Aboriginal seniors reported living with a chronic condition, such as arthritis or heart problems, and seven in ten reported having disabilities (Turcotte and Schellenberg 2007, 248-9). In 2001, Aboriginal seniors living off reserve (22%) were more likely than seniors in the total Canadian population (13%) to report being diabetic (O'Connell and Tait 2003, 14), and in a 2003 report on the health of Canadians, it was noted that the major chronic diseases, including diabetes, heart problems, cancer hypertension and arthritis/rheumatism, was significantly higher and growing in Aboriginal communities (Public Health Agency of Canada, June 2003). However, Janz et. al (2009, 13) found that in 2005/6, Métis and total population seniors reported a similar prevalence of arthritis and/or rheumatism (52% and 46% respectively), high blood pressure (48% and 44%, respectively) and asthma (12% and 7%, respectively).
- *Tobacco and Alcohol Use.* In 2001, Aboriginal seniors were more likely than non-Aboriginal seniors to report daily smoking and heavy drinking; however, it is important to note that one in two Aboriginal seniors report not drinking at all,

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and the vast majority reports either never smoking or having quit smoking (Turcotte and Schellenberg 2007, 253-4).

In light of the health differences between Aboriginal and non-Aboriginal seniors, policymakers should be aware of, and making adjustments for, the relatively rapid growth in Aboriginal senior populations. These trends are seen in the three prairie cities. Although Aboriginal peoples comprise a rather small percentage of the total senior population, with roughly 3% of Winnipeg and roughly 2% of Regina and Saskatoon seniors reporting an Aboriginal identity, the Aboriginal senior populations in these cities are growing at a much faster rate than the non-Aboriginal senior populations (see Table 1). In Regina, home to 430 Aboriginal seniors in 2006, the Aboriginal senior population grew by 16.4% between 2001 and 2006, while the non-Aboriginal population grew by 7.5% over the same period. In Saskatoon, home to over 500 Aboriginal seniors in 2006, the Aboriginal senior population grew by 34.2%, while the non-Aboriginal senior population grew by 9.6%. Finally, in Winnipeg, home to over 2,500 Aboriginal seniors in 2006, the Aboriginal senior population grew by almost 40% between 2001 and 2006; in contrast, the non-Aboriginal senior population grew by less than four percent over the same time period. Given the growth in the Aboriginal senior population, it is imperative that policymakers take steps to ensure that health care services in the urban centers meet the needs of Aboriginal (irrespective of status) and non-Aboriginal seniors alike.

Table 1

Aboriginal and Non-Aboriginal Age Demographics by City, 2006

	Regina	Saskatoon	Winnipeg
Population Aged 65+ (count, % of total population)			
Aboriginal Identity Population	430 (2.5%)	530 (2.5%)	2,525 (3.7%)
Non-Aboriginal Identity Population	23,555 (13.4%)	26,715 (12.8%)	87,370 (14.1%)
Percentage of Senior (65+) Population			
Aboriginal Identity Population	1.8%	1.9%	2.8%
Non-Aboriginal Identity Population	98.2%	98.0%	97.2%
Percentage Change Aged 65 and Over, 2001 to 2006			
Aboriginal Identity Population	16.4%	34.2%	39.5%
Non-Aboriginal Identity Population	7.5%	9.6%	3.8%

Sources: Statistics Canada 2008a, 2008b, 2008c.

Health Services for Urban Aboriginal Seniors: Issues

Policymakers today rightly acknowledge that health research has to examine the broad scope of factors that affect a person's health (determinants of health) and that it should motivate appropriate interventions. The Public Health Agency of Canada (2010) advocates the need to focus on the root causes of a problem and illustrate evidence for supporting appropriate interventions. In thinking through present and future health services for urban Aboriginal seniors, policymakers should consider four key factors, among others: socioeconomic conditions; underutilization of urban health services; jurisdiction; and elder abuse.

Socioeconomic conditions. There is growing evidence that the two most important determinants of health are social and economic status (Public Health Agency of Canada 2003). Aboriginal seniors often lack socioeconomic supports, placing greater pressure on their health and wellbeing. The poorer economic conditions of Aboriginal Canadians are well documented, and this pattern is evident in Aboriginal seniors in the prairie census metropolitan areas (CMAs). Despite similar labour force participation rates, Aboriginal seniors had lower median incomes than non-Aboriginal seniors in 2006, and received a higher proportion of their income from government transfers. Additionally, the prevalence of low income is higher among Aboriginal seniors (in and not in economic families) than non-Aboriginal seniors (see Table 2). (Statistics Canada defines an economic family as two or more persons living in the same dwelling and related by blood, legal or common law marriage, or adoption.)

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Table 2

Socio-Economic Demographics, Seniors (65+), 2006

	Manitoba CMAs (Winnipeg)		**Saskatchewan CMAs (Saskatoon and Regina)**	
	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal
Labour force participation rate	8.2	9.6	12.9	11.7
Percentage 2005 income government transfer payments*	60.5%	39.9%	55.3%	35.2%
Median income	$17,100	$22,872	$16,311	$27,885
Prevalence of low income before tax in 2005 for economic family members	17.8%	6.3%	15.0%	1.6%
Prevalence of low income before tax in 2005 for persons not in economic families	70.7%	43.8%	57.5%	29.8%

* Government transfer payments include Old Age Security pensions and Guaranteed Income support, Canada/Québec Canada Pension Plan benefits, child benefits, Employment Insurance benefits, and other income from government sources.
Source: Derived by authors from Statistics Canada Census 2006, Aboriginal Peoples of Canada (92-593-XCB)

These economic differences are of particular note when it comes to the issue of publicly versus privately funded eldercare services, as Aboriginal seniors are often less able to pay for private or co-funded services. Issues like residency requirements and waiting times are particularly onerous for First Nations who come from reserves and cannot fulfill the residency requirements and get bumped to the back of long waiting lists. Home care, nursing home care and pharmaceutical services are funded under provincial health insurance plans. Whatever the province does not pay must be covered by the patient/client or family (Stadnyk 2002). Furthermore, cost variations across the country has created healthcare inequities in nursing homecare for many seniors (Stadnyk, 2009). This is especially true for First Nation seniors who do not have alternative income savings to supplement higher nursing home costs besides their senior's allowance. Studies suggest that the number of people receiving homecare has risen and will continue to do so, with subsidized care generally for higher levels of care, but health budgets still emphasize post-acute care rather than long-term care that is focused on maintenance of skills and preventative care. Underfunding has raised many concerns with increasingly higher costs of private and public care being unaffordable and inaccessible to Aboriginal seniors.

Housing conditions should also be considered. Studies on urban homelessness in the prairie cities suggest that poor housing conditions and high housing needs are pervasive among Aboriginal people (Saskatchewan Indian Institute of Technologies 2002; Distasio et al. 2005; Hanselmann 2001). Compared to non-Aboriginal seniors, in 2001 Aboriginal seniors were more likely to be residing in a home in need of significant repairs (22% versus 6%) and/or an overcrowded home (9% versus 2%) (Turcotte and Schellenberg 2007, 238, 242-3). Such housing conditions may contribute to lower health statuses and/or place strains on the ability of Aboriginal seniors to use homecare services. Homelessness is also a concern: homelessness is increasing in urban centers due to poverty, racism, and federal-provincial jurisdiction issues among others (Saskatchewan Indian Institute of Technologies 2002; Hanselmann 2001), with elders and increasingly families being listed as among the vulnerable 'hidden homeless," or those without permanent shelters (Distasio et al., 2005).

There are limited Aboriginal senior care nursing homes both on and off reserve. Saskatchewan has no Aboriginal nursing homes in either Saskatoon or Regina, but Winnipeg has a $21 million, 80-bed personal care home (Winnipeg Free Press 2009). On reserve housing is among the poorest in Canada, and for the frail or disabled elderly, living on reserve generally means living in overcrowded and multiple-deficient homes (Kuran 2002; Health Canada 2009). Federal funding policies have not allowed for the building of long-term care homes on reserves. Any initiatives undertaken by First Nation Bands are privately funded by First Nations, and because they do not have operational subsidies like the off-reserve long-term care facilities, they face many challenges. This was the case of a 30-bed, long-term care home on the Muskeg Lake Cree Nation, closed in August 2010 after four years of operation due to insufficient funding, among other reasons.

An additional challenge is the fact that Aboriginal seniors face important education and literacy barriers. In Winnipeg in 2006, 65% of Aboriginal seniors reported less than a high school diploma – considerably higher than the 38% of non-Aboriginal seniors with less than a high school diploma. A similar pattern is found in the Saskatchewan CMAs, where 62% of Aboriginal and 39% of non-Aboriginal seniors have less than a high school diploma. Nationally, the majority of Aboriginal seniors had less than a grade nine education in 2001 (Turcotte and Schellenberg 2007, 233), and 17% of Aboriginal seniors living off-reserve reported attendance at a residential school (O'Connell and Tait 2003, 23).

Further, the 2003 International Adult Literacy and Skills Survey (Statistics Canada) found that, in urban Saskatchewan and Manitoba, Aboriginal seniors have, on average, lower literacy levels than non-Aboriginal seniors, with the majority being below a "Level 3 Prose Literacy" rating, which is considered by many to be "the minimum level of literacy proficiency that is needed for an individual to successfully cope in a complex knowledge- and information-based society" (Bougie 2008). In urban Saskatchewan, 61% of non-Aboriginal persons aged 55 and over had a Level 1 or 2 prose literacy rating, compared to 76% of Métis persons and 87% of First Nations persons. In urban Manitoba,

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66% of non-Aboriginal persons aged 55 and over had a Level 1 or 2 prose literacy ratings, compared to 79% of Métis persons and 85% of First Nations persons (Bougie 2008).

Together, the lower educational and literacy levels of Aboriginal seniors have policy implications. Older people who have low literacy skills in English have problems with reading and writing and tend to rely on trying to comprehend what they see or hear. This is important as they must be able to understand medicine prescriptions and other health-related instructions (Kuran 2002). Issues such as communication problems, cultural disconnect, lower living standards, poor quality of life, and avoidance of the existing services result in undue stress and isolation for the elderly, placing them in at-risk situations. As significant social supports for their families and communities, governments need to acknowledge that the elderly are an important part of our society and need to put more efforts into ensuring a better quality of life for them in the cities.

Underutilization of services. Studies suggest that, even in cities, Aboriginal seniors are underutilizing elderly care services and facilities. This phenomenon has been observed among seniors in other minority groups, and the issue is not unique to Canada (Damron-Rodriguez et al. 1994). Why are minority seniors, including Aboriginals, underutilizing elderly care services? A number of barriers must be considered, including culture (Hampton 2007), language, affordability, jurisdiction and problems navigating the health services system. Limited policymaker and caregiver knowledge of the needs of minority seniors, including Aboriginal seniors, exacerbate these barriers.

Addressing issues of underutilization will require identification of the barriers faced by urban Aboriginal seniors and then taking specific actions to address these barriers. While much policy work has been done on improving competency skills and communications between the professional caregivers and minority seniors, there has been limited work done on the larger issues surrounding institutional structures, addressing issues of racism in gerontological settings (Brotman 2003), and building Aboriginal elderly care facilities.

Jurisdiction. One of the greatest challenges facing urban Aboriginal seniors in the health care system is the issue of jurisdiction. These jurisdictional challenges are specific to Inuit and status Indian peoples. Although provinces and territories provide health care services, the federal government is responsible to pay for status Indian and Inuit health care. Despite being declared Aboriginal under the *Constitution Act, 1982*, to date Métis and non-status peoples are not recognized as a federal responsibility. Thus Métis and non-status Indian peoples receive the same provincial benefits as all other Canadians.

Political jurisdiction and administrative or procedural blocks between federal, provincial and regional authorities are at the root of ongoing jurisdictional disputes in health regarding the provision of health services to Aboriginal people (Cameron 2003). The issue of whether or not the federal government is responsible for providing health services to status Indian and Inuit peoples, wherever they reside, is clouded; usually the

lines drawn in the sand involve the on and off reserve scenarios. Notwithstanding the Treaty promises of comprehensive healthcare (O'Neil et al. 1999), the federal policy position is that they are not responsible for providing health services off reserve using the justification of being "last resort payer" (Romanow 2002). Consequently, health services off reserve and in the cities are largely the jurisdiction of the provinces delivering health services through the regional health authorities. Furthermore, residency requirements attached to long-term care facilities prevent access and cause problems for those elderly with high level care needs from northern communities.

At present, the federal government carries out its health responsibilities by providing limited non-insured health benefit (NIHB) coverage for Inuit and status Indian peoples. Coverage by the NIHB includes prescription drugs, over the counter medication, medical supplies and equipment, crisis counseling care, dental and vision care, and medical transportation (Health Canada 2009). Status Indian and Inuit persons do not qualify for coverage under provincial seniors drug plans. It is possible that the provincial programs may provide greater coverage. For example, Health Canada coverage for prescription drugs is limited to formulary drugs, whereas under the Saskatchewan Seniors Drug Plan (for which status Indian and Inuit persons are ineligible) formulary and exception prescription costs above $15.00 are covered for seniors. There are also programs for seniors who are low income or have high drug costs in relation to their annual income (Government of Saskatchewan 2011). In general, the problems and benefits are faced by people trying to access the various seniors programs remain unclear although for First Nations, problems have been identified with access, lack of coordination, and fragmented funding for Aboriginal health between federal and provincial health providers (Romanow 2002).

The issues extend into the broader care of seniors. Federal departments, including First Nations Inuit Health Branch (FNIH) and Indian and Northern Affairs Canada (INAC), argue that senior care services are a provincial responsibility, but provincial authorities maintain there is no additional funding or special care bed designation policies for Aboriginal peoples that would allow them to get funded. The effect of these unresolved issues places seniors, especially those without proper family supports, in stressful and at-risk health situations. Not all rural or remote communities have Continuing Care or homecare services and institutional housing for seniors wanting to remain in their home communities or close to family (Health Canada 2008). To access publicly funded eldercare services requires many Aboriginal seniors to leave their homes and communities and be placed in institutions where they may have their medical needs cared for but at the expense of their mental and cultural well being, which in itself is a stressor that places them in an at-risk health situations (Assembly of First Nations 2005). As well, payers for service (government, insurance, the individual) are dependent on the province or territory of the senior and whether the person qualifies for a subsidy or can be covered by other organizations (Indian and Northern Affairs Canada 2003).

Although the February 2009 Federal Stimulus Package, Canada's Economic Action Plan, targeted $475 million across the country to support the construction of new

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housing units for new on-reserve housing, it is uncertain to what extent this addressed the housing shortfalls for Aboriginal seniors in the prairie region (INAC 2009). Currently, Aboriginal people are still struggling with housing problems, and elderly care facilities, which could alleviate some of the pressures, are still not being built in numbers sufficient to accommodate the needs of the elderly.

Elder abuse. Elder Abuse is another troubling problem affecting Aboriginal people. It is not something that just happens in remote areas or with people who have limited access to services; it can happen to anyone who is in a vulnerable position. Aboriginal seniors are a population that is often a target of abuse. Studies suggest that the medically compromised and dependent elderly are especially vulnerable to potential physical-emotional-financial abuse and neglect (Cyr, 2005; Government of Canada, 2009), whether they are cared for at home or in semi-private and public institutions. Aboriginal elder abuse takes various forms. Three principle categories of abuse are domestic elder abuse, institutional abuse, and self-neglect or self-abuse (Dumont Smith, 2002). The three most cited types of elder abuse are physical, psychological and financial, which includes neglect (Dumont-Smith 2002). Another power and control issue that is often disregarded when it comes to eldercare in Canada as well as in other locations is the elderly and families' preference for self-determination of care. Self-determination of services involves the desire to be included in medical decisions and to have a say in the care they receive, but this is often marginalized due to administrative pressures between rising needs, different expectations between health providers and elderly clients, and under resourced health facilities.

There are many contributing factors often associated with elder abuse including intergenerational violence, degree of dependency, frustration by caregiver, stress and ageism (Dumont-Smith 2002). While the level to which these occur in the Aboriginal community and the extent to which the elderly may be at risk at home or in institutional care is uncertain, risks are likely higher for Aboriginal seniors due to their generally poor socio-economic conditions.

Moving Forward: Short-Term Considerations

The challenges faced by urban Aboriginal seniors with respect to socioeconomic conditions, underutilization of health services, jurisdictional problems and elder abuse indicate that policy changes are required to address the growing healthcare problems with the Aboriginal elderly and more needs to be done with what is currently available.

Steps have been taken to improve services in Canada, with some success. With the First Nations and Inuit Home and Community Care program that was developed and implemented by Health Canada across First Nation communities in the late 1990s, services were improved with more focus on case management, nursing care at home, some respite care and personal care services. The current gaps in this program include

the lack of palliative care, rehabilitative services, respite and mental health services, along with the services being limited to working hours (AFN 2005). Indian and Northern Affairs plays a limited role in elderly care besides the Assisted Living/Adult Care program that includes assistance with homemaking services, foster care, and reimbursing for institutional care for minimum care clients. In both cases, the greatest gap is the exclusion of specialized care needs for the elderly, and the lack of policies to address the issues around the building of First Nation personal care homes. Improving these on-reserve elderly care issues will go far in alleviating the increasing forced migration of vulnerable elderly into the cities.

A recent study highlights a number of innovative elderly care services programming efforts on the Peter Ballantyne Cree Nation (PBCN) communities in northern Saskatchewan.[1] The PBCN Health agency augmented the First Nations and Inuit Home and Community Care nursing program by enhancing support services to the elderly. This included the assistance of trained, Cree-speaking local homecare health aides and elder coordinators, as well as opportunities for seniors to engage in social activities. However, both the healthcare providers and the elderly receiving these services identified gaps in services caused by fragmented and insufficient funding, the lack of needed palliative, respite and after hour care services, and lack of coordinated access to city services. The major overwhelming need identified was the need to build long-term care facilities in the communities so that the elderly would not have to move out to the cities and be isolated. Some elderly who had to move to the city found themselves lonely, fearful and not treated very well.

Overall, health providers and the elderly themselves experience undue frustration with jurisdictional funding policies that prevent innovation and force people into program and information silos. The isolated policy and program developments by governments and health agencies without Aboriginal community engagement are not effective. There is a need to work through the primary healthcare model values that support a more integrated, better coordinated and holistic healthcare system, one that recognizes the social and economic value of informal (families, friends) and formal caregivers (health professionals, governments) and one that strives to reconcile the existing fragmentation of services to Aboriginal people.

While there are many issues requiring innovation, a number of key recommendations stand out. These include the need to:

1. Establish Aboriginal long-term care facilities in the major prairie cities;
2. Establish First Nation long-term care facilities on-reserve;
3. Ensure coordinated elderly care funding initiatives for Aboriginal caregivers;
4. Ensure Aboriginal elderly access to all health benefits; and
5. Establish culturally responsive programming and employment in healthcare systems.

[1] For information on this research, please contact Bonita Beatty at bonita.beatty@usask.ca.

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These broad recommendations would greatly help to reduce the challenges faced by Aboriginal seniors living in the prairie cities.

Publicly Funded Elderly Care and Caregiving: Options for Consideration

Given the concerns about Canada's current policy frameworks, it is useful to consider how other countries have used policy tools to address the needs of seniors. Of particular interest are the publicly funded Elderly Care programs in the Scandinavian countries of Sweden, Denmark, and Iceland; while these models may not fit entirely with Canadian needs and political preferences, they do offer alternative ways of thinking through the options for elderly care in Canada.

The Swedish elderly care policy focuses on ensuring the elderly economic security, comfortable housing, and good services and care. Legislative measures emphasize the right to receive public health and medical services for help at all stages of life, with all elderly having equal access to health services, regardless of age, sex, ethnicity, place or purchasing power. There is a broad spectrum of welfare supports in Sweden that are paid for through taxes levied at national and municipal levels, and the social security offered to seniors is available to everyone. Most services are subsidized in Sweden, and high-cost-limit caps ensure that fees remain low in the private services that are available (National Alliance for Caregiving 2002; Ciocirlan et al. 2009). Services within this system involve informal caregivers who are paid by the government through a Paid Caregiver Program, and the salary is determined according to the needs of the senior and the proportion of hours worked. The paid caregiver is subsidized through a social insurance program including pension credits potentially lost in regular employment and employees are allowed up to 60 days paid time off to care for family members (Thorslund and Parker 1994; Curry 2003). Some concerns with the Swedish model of elderly care is the growing trend in Europe to push public responsibilities to the private sector, due to the worsening economic situation, which could lead to service inequities and increased costs (Thorslund and Parker 1994).

The Iceland model is a mixture of family and state involvement. Iceland's health service responsibility is decentralized to local governments (municipalities), and most services are publicly provided, but private companies and organizations are on the rise, creating a mixed system, although services by the public sector still dominate healthcare. Sheltered housing in Iceland comprises of various types and home help services. This includes respite care, day care help, local health providers and cash support for family caregivers (Daatland 2007). Demographics suggest that 13% of the elderly in Iceland live in nursing homes classified according to skilled and unskilled or residential care. Admissions to nursing homes are regulated through preadmission evaluations issuing certificates of need as determinants to admission into nursing homes (Riebbe 1997).

Denmark elderly care is largely state funded. There has been a slight shift towards privatization of home healthcare, but only in selected areas, such as meals and

cleaning services. Specialty units were set up within county hospitals for the elderly to deal with illnesses like dementia, stroke, and general internal medicine among other programs (Jarden and Jarden 2002). The publicly funded services emphasize independence and self-determination supporting the elderly to remain in the homes as long as possible (Riebbe 1997) To accommodate this, municipalities have developed a range of services to help the elderly help themselves. Assistance includes cleaning, shopping, washing, preparation of meals and personal hygiene and care. There are two types of home care available to the elderly, one being long-term and the other, temporary help. When an elderly person can no longer live in their own home, another living arrangement is offered, based on the individual's needs. Options include: senior citizen residences, gated communities, assisted living units, and nursing homes. Day care is also offered for those who do not wish to move permanently. Meals are available for delivery at subsidized rates (Jarden and Jarden 2002). Health reforms in 1993 called for better planning and coordination of social and health-care system services with emphasis on the elderly achieving the highest levels of independence (Jarden and Jarden 2002).

These models suggest a public push for governments to take on more responsibility for long-term care with increased support for families as a means of empowering personal control among the elderly and their families. The stresses facing all countries are to balance family, private and public responsibility within a global economic downturn. It is likely that elderly support needs will increase in the future because of longer life expectancy, and seniors will be less able to rely on their working-age families (Reibbe 1997). This is worrisome for many, but in particular for Aboriginal people who fall into the lower income brackets. They will simply have difficulty affording the increasing costs for caring for their elderly without help, even though culturally they may wish to do so. Research findings suggest that Canadians taking care of their elderly are having troubles balancing work and family responsibilities, with many caregivers experiencing mental, physical and financial problems (Ciocirlan and McKay 2009). Given the potentially high health, income and social impacts of not addressing elderly care in general, a better blend of intergovernmental cooperation will need to be developed to support the elderly and their caregivers; these may include targeted subsidies for primary caregivers, paid leaves or flexible scheduling, among other initiatives.

The three Scandinavian policy models presented here have some useful ideas towards the development of more positive and holistic Aboriginal eldercare models in Canada. They advocate the need to acknowledge the significance of culture, community, and mixed systems. Furthermore, the models treat community involvement as integral to proper health care.

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Conclusion

Aboriginal seniors are among the most vulnerable and politically voiceless in Canada. The health care of Aboriginal seniors – be they on- or off-reserve, northern, rural or urban – is a matter of increasing concern due to the poor socio-economic conditions in Aboriginal communities and among Aboriginal peoples (Assembly of First Nations 2007). Chronic health conditions take over a large part of the lives of the elderly as they interact with the various health care systems in their communities and in the cities. In the communities, they interact with the health clinics when they see a nurse or doctor. From there, they are referred to medical specialists in the major city centers. This is where concerns for long-term care, homecare and community health care take on a more visible profile as the seniors and their families struggle to navigate the health system (Public Health Agency of Canada 2007).

Given the growing Aboriginal senior populations in Canada, and particularly in prairie cities like Winnipeg, Saskatoon and Regina, policymakers should give consideration to how elderly care services can be best adapted to meet the needs of Aboriginal seniors. Winnipeg now has its first Aboriginal personal care home. This sets a hopeful precedent for other cities like Saskatoon and Regina to work with Aboriginal people in addressing the healthcare and housing needs of their elderly.

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References

Assembly of First Nations. June 2005. *First Nations Action Plan on Continuing Care*. Ottawa, Ontario: AFN

Bougie, Evelyne. 2008. *Literacy profile of off-reserve First Nations and* Métis *People living in urban Manitoba and Saskatchewan. Results from the International Adult Literacy and Skills Survey 2003.* Education Matters, Vol. 4, no. 5. Ottawa: Statistics Canada.

Cameron, Lorraine. April 2003. First Nations Health in Saskatchewan, 1905-2005. In *Western Development Museum/Saskatchewan Indian Cultural Centre Partnership Project.* Saskatoon, SK: Saskatchewan Indian Cultural Centre and Western Development Museum.

Ciocirlan, Cristina, Ed Chung, and Ruth McKay. 2009. *Elder Care as a Policy Priority: Lessons from Around the World*. Retrieved from www.midwestacademy.org/Proceedings/2009/papers/Ciocirlan_52.pdf

Curry, Natasha. 2003. "Elder Care Across the Globe." In *CareGuide@Home – Care for Caregivers.* Retrieved from http://www.eldercare.com/modules.php?op=modload&name=CG_Resources&file=article&sid=965

Cyr, Ruth. September 2005. *2004 Breaking the Cycle of Violence: Preventing Violence against Seniors in the Aboriginal Community.* Toronto, Ontario: The Native Centre of Toronto & The Ontario Society (Coalition) of Senior Citizens Organizations.

Damron-Rodriguez, J.A., Wallace, S., & Kington, R. (1994). "Service Utilization and Minority Elderly: Appropriateness, Accessibility and Acceptability." *Gerontology and Geriatrics Education*, *15*(1), 45-63.

Daatland, Svein Olav. 2007. *Dependency and Care – the role and power of self-determination.* Paper Presented at the I Congreso Internacional 'Dependencia y calidad de vide', Valencia 2007. www.edad-vida.org/Congres2007/Modulo1/Ponencia%20%20Svein%20Olav%20Daatland.pdf

Distasio Jino, Gina Sylvestre and Susan Mulligan. 2005. *Home is Where the Heart is and Right Now that is Nowhere… An Examination of Hidden Homelessness Among Aboriginal Peoples in Prairie Cities.* Winnipeg, Manitoba: University of Winnipeg, The Institute of Urban Studies (IUS).

Dumont-Smith, Claudette. 2002. *Aboriginal Elder Abuse in Canada.* Retrieved from www.ahf.ca/downloads/ahfresearchelderabuse_eng.pdf

Government of Canada. 2009. *Elder Abuse: It's Time To Face The Reality*. Ottawa, Ontario: Seniors Canada. Retrieved from http://www.seniors.gc.ca/c.4nt@.jsp?cid=154

Government of Saskatchewan. 2011. *Personal Health Services: Seniors Health.* Regina, SK: Saskatchewan Health. http://www.health.gov.sk.ca/seniors

Hampton Mary. 2007. *Improving End of Life Care for Aboriginal Families.* Vol. 14, No.1, March 2007. Edmonton, Alberta: Alberta Centre for Active Living Research. Saskatoon, Saskatchewan: Saskatchewan Population Health & Evaluation Research Unit (SPHERU), University of Saskatoon.

Hanselmann Calvin. September 2001. *Urban Aboriginal People in Western Canada: Realities and Policies*. Calgary, Alberta: Canada West Foundation.

DOI: 10.18584/iipj.2011.2.1.10

Health Canada. 1998. *Reaching Out: A Guide to Communicating with Aboriginal Seniors.* Ottawa, Ontario: Public Works and Government Services Canada.

Health Canada. 2008. *First Nations, Inuit and Aboriginal Health: Summative Evaluation of the First Nations and Inuit Home and Community Care*. Ottawa, Ontario: Health Canada.

Health Canada. 2009. *First Nations, Inuit and Aboriginal Health: Non-Insured Health Benefits – Reports and Publications.* Ottawa, Ontario: Health Canada

Health Canada. 2009. *A Statistical Profile on the Health of First Nations in Canada: Determinants of Health 1999 to 2003.* Ottawa, Ontario: Health Canada.

Indian and Northern Affairs Canada. 2003. *Assisted Living Program National Manual*. Ottawa, Ontario: Minister of Public Works and Government Services Canada

Indian and Northern Affairs Canada. 2009. *Implementing Canada's Economic Action Plan: Impacts for Aboriginal People and Communities – June 2009.* Ottawa, Ontario: Indian and Northern Affairs Canada.

Janz, Teresa, Joyce Seto and Annie Turner. 2009. *Aboriginal Peoples Survey, 2006: An Overview of the Health of the Métis Population.* Statistics Canada Catalogue no. 89-637-X-No. 004. Ottawa: Minister of Industry.

Jarden, Mary E, and Jens Ole Jarden. 2002. "Social and Health-Care Policy for the Elderly in Denmark." In *Global Action on Aging. Retrieved from* http://www.globalaging.org/elderrights/world/densocialhealthcare.htm

Kuran Heidi. 2002.The Barriers to Healthy Living and Movement for Frail Aboriginal Elders: Coming Full Circle in *In Touch* Vol 25 Winter 2002. Retrieved from www.niichro.com/2004/pdf/INtouch/in-touch-vol-25.pdf

National Alliance for Caregiving. 2002. International Caregiving Legislation: Eldercare Policy in Sweden. Retrieved from www.caregiving.org/intcaregiving/sweden/sweden2.htm

O'Donnell, Vivian and Heather Tait. 2003. *Aboriginal Peoples Survey, 2001, initial findings: Well-Being of the non-reserve Aboriginal Population.* Statistics Canada Catalogue no. 89-589-XIE. Ottawa: Minister of Industry.

O'Neil John, Laurel Lemchuk-Favel, Yvon Allard, and Brian Postl. 1999. Community Healing and Aboriginal Self-Government in Editor John Hylton, *Aboriginal Self-Government in Canada 2nd Edition: Current Trends and Issues.* Saskatoon, SK: Purich Publishing Ltd. 130-156

Public Health Agency of Canada. 2003. *Population Health Approach: What Makes Canadians Healthy or Unhealthy?* Ottawa: Public Health Agency of Canada.

Public Health Agency of Canada. 2010. *What Determines Health?* Ottawa: Public Health Agency of Canada.

Rajnovich, Beth, Janice Keefe, and Janet Fast. 2005. *Supporting Caregivers of Dependent Adults in the 21st Century: CRPN Background Paper*, September 2005. Maritime Data Centre for Aging Research & Policy Analysis. Retrieved from www.cewh-cesf.ca/PDF/acewh/SupportingCaregivers.pdf

Ribbe, Miel W. 1997. "Nursing Homes in 10 Nations: A Comparison Between Countries and Settings – Continuing and Rehabilitative Care for Elderly People: A Comparison of Countries and Settings." *Age and Ageing* 26, no. 6.

Romanow, Roy. 2002. "A New Approach to Aboriginal Health." In Commissioner Roy J. Romanow, *Building on Values: The Future of Health Care in Canada - Final Report*. Commission on the Future of Health Care in Canada, 211-232.

Rosenberg, Mark W., Kathi Wilson, Sylvia Abonyi, Adam Wiebe, Kelsey Beath and Robert Lovelace. 2009. *Older Aboriginal Peoples in Canada: Demographics, Health Status and Access to Health.* SEDAP Research Paper No. 249. Retrived from http://socserv.mcmaster.ca/sedap

Saskatchewan Indian Institute of Technologies. 2002. *Urban First Nations People Without Homes in Saskatchewan.* Saskatoon: Saskatchewan Indian Institute of Technologies.

Stadynk Robin. 2002. *The Status of Canadian Nursing Home Care: Universality, Accessibility and Comprehensiveness.* Atlantic Centre of Excellence for Women's Health.

Stadnyk Robin L. 2009. "Three Policy Issues in Deciding the Cost of Nursing Home Care." *Healthcare Policy* 5(1), 132-144.

Statistics Canada. 2008a. "Aboriginal identity population by age groups, median age and sex, 2006 counts, for Canada and census metropolitan areas and census agglomerations - 20% sample data (table)." Aboriginal Peoples Highlight Tables. 2006 Census. Statistics Canada Catalogue no. 97-558-XWE2006002. Ottawa. Released January 15, 2008.

Statistics Canada. 2008b. "Population by age groups, sex and Aboriginal identity groups, percentage distribution (2006), for Canada and census metropolitan areas and census agglomerations - 20% sample data (table)." Aboriginal Peoples Highlight Tables. 2006 Census. Statistics Canada Catalogue no. 97-558-XWE2006002. Ottawa. Released January 15, 2008.

Statistics Canada. 2008c. "Population by age groups, sex and Aboriginal identity groups, percentage change (2001 to 2006), for Canada and census metropolitan areas and census agglomerations - 20% sample data (table)." Aboriginal Peoples Highlight Tables. 2006 Census. Statistics Canada Catalogue no. 97-558-XWE2006002. Ottawa. Released January 15, 2008.

Statistics Canada. 2008d. *Aboriginal Peoples in Canada in 2006: Innuit,* Métis *and First Nations, 2006 Census.* Catalogue no. 97-558-XIE.

Thorslund, Mats and Marti G. Parker. 1994. "Elder Care in the Priorities Discussion." *The Hastings Center Report* 24 (5), 29-32.

Turcotte, Martin and Grant Schellenberg. 2007. *A Portrait of Seniors in Canada, 2006.* Statistics Canada Catalogue no. 89-519-XIE. Ottawa: Minister of Industry.

Wilson, Kathi, Mark W. Rosenberg and Sylvia Abonyi. 2011. "Aboriginal peoples, health and healing approaches: The effects of age and place on health." *Social Science & Medicine* 72, 355-364.

Wilson, Kathi, Mark W. Rosenberg, Sylvia Abonyi and Robert Lovelace. 2010. "Aging and Health: An Examination of Differences between Older Aboriginal and non-Aboriginal People." *Canadian Journal on Aging* 29 (3), 369-382.

Winnipeg Free Press. 09/24/2009. *Ground Broken on Aboriginal Care Home.* Retrieved from www.winnipegfreepress.com

DOI: 10.18584/iipj.2011.2.1.10