NEWSLETTER

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2007 CONFERENCE AND AGM MAY 23–25

IN THIS ISSUE

The 2007 CURAC/ARUCC Conference and AGM will be held at the University of Windsor on May 23-25, 2007. A reception will be held on the evening of Wednesday May 23. The main conference sessions will be scheduled on Thursday May 24 and Friday May 25. Some post-conference activities will be planned for Saturday May 26. The conference will be co-hosted by the retiree organizations at the University of Windsor and St. Clair College. Excellent on-campus facilities will be available.

A new residence center with suites of two double bed rooms and en suite kitchen and bath will be available for $70.00 per suite with breakfast included. The meetings will be in the same building and parking is adjacent. There will be several optional tours-wineries, casino, River boat, historic sites – planned for socializing. Those attending are encouraged to stay for the weekend at these prices!

Transportation is available by train (4 per day from Toronto), air (Windsor – Air Canada; Detroit Metro – many airlines) and auto. An online registration procedure will be available through the University of Windsor conference services. Once this is operational a direct link will be provided on the CURAC website.

A reception, banquet, and snack breaks will be included in the registration fee, which will be modest. For updated program and other information please visit the CURAC website at <www.curac.ca>.

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President's Message

As this will be the first President's Message in the inaugural CURAC Newsletter, Chief Editor Ken Rea has instructed me to "make it interesting." This is currently difficult for me, challenged as I am by the eloquent, ironic style of Roy Jenkins, as he recounts the life and times of Winston Churchill in his illuminating biography.

Nevertheless, that volume has suggested an interesting opening. Jenkins recounts how Churchill, as First Lord of the Admiralty in the first weeks of WW1: "…needed an outstanding First Sea Lord. The prospect of bringing Admiral John Fisher back excited him. He thought that he would dilute the danger of Fisher's impetuosity if not of his age (seventy-three) by also bringing back as a special advisor Admiral Sir Arthur Wilson. Wilson was seventy-two. Prime Minister Asquith did not resist this gerontophilia."

In my own seventy-third year, this wise "gerontophilia" (in Jenkins's felicitous term) of Churchill (himself then barely forty) encourages me. Seems to me that such understanding of our value by our juniors is what CURAC members need: As retirees we're not spring chickens—but as senior citizens, in the full rich meaning of that phrase, we share the stored experience of many decades of service, and that seniors' wisdom (as Churchill wisely appreciated) can be invaluable to our society. CURAC exists to nurture and disseminate this wisdom and encourage its use—as much as to work at our other priorities—the protection of our hard-earned situations as retirees, and of our health.

It was in the autumn of 2001 that our first President (to be), Peter Russell, sat in my living-room and for four hours, glass of scotch in hand, related his detailed vision of an effective national federation of post-secondary retiree associations. Five very busy years later, we have weathered the normal organizing crises, to make that vision (shared by our founding colleagues, too numerous to mention here) grow into a mature and confident pan-Canadian organization; with member-associations on more that fifty campuses, including the vast majority of the major Canadian colleges and universities—and in every province; with a network of competent and productive Board Committees; with settled traditions of annual conferences; and with a record of achievements in many of the priority areas which we have collectively identified.

This publication of our national CURAC Newsletter marks one of the most important of these achievements. Led by Ken Rea, the dedicated and enthusiastic if informal Newsletter team has worked for over a year to develop it. I won't attempt to describe it, (since I expect that Ken will be doing that more accurately below), except to emphasize that we conceive of this e-publication as a truly proactive instrument of communication for our Federation, a necessary addition to our annual Conferences and our web-site. The Newsletter will help us all to more frequent contacts, and will promote even greater understanding between the CURAC Board and our Associations—as well as their individual members. An urgent reminder to all members: we can't be "proactive" without

your active involvement. Roll up your sleeves, and share the news and ideas with the Newsletter editors.

Congratulations and good luck to Ken and to all the editorial committee.

FEATURES

Getting to Know Us: This Issue's Featured Member Association

By Joan Cunnington

The Ontario Colleges Retirees' Association, a member of CURAC, was established on April 19, 2001, with 13 founding members. Since then, the membership has grown to over 1,700 college retirees representing all 24 of Ontario's colleges of applied arts and technology.

There is an executive of ten members:

President	Bob Pando (academic retiree, Mohawk College)
Vice President	Derrick May (administrative retiree, Mohawk College)
Secretary	Stella Pulkinghorn (administrative retiree, Sir Sandford Fleming College
Treasurer	Gil Callingham (administrative retiree, Seneca College)
Communications	Linda Choptiany (academic retiree, Centennial College)
Membership Co-ordinator	Hilda Moessner (administrative retiree, Seneca College)
Director	Lorna Plunkett (academic retiree, Sir Sandford Fleming College)
Director	Dorleen Allen (academic retiree, Mohawk College)
Director	Bev Walden (academic retiree, Humber College)
Director	Newman Wallis (administrative retiree, Seneca College)

Executive meetings take place regularly throughout the year to address issues of concern to all Ontario college retirees. General meetings of the membership are held every 15 months approximately. So far general meetings have been held at Mohawk and Humber College, and on May 27, 2006, at Seneca College.

Instead of each college providing its own health and pension benefits for active and retired employees, these benefits are provided system-wide to all employees of all 24 colleges. The College Compensation and Appointments Council (a branch of the Ontario Ministry of Colleges

and Universities) has overall responsibility for the administration of health benefits, and the Colleges of Applied Arts & Technology Pension Plan administers the colleges' pension plan. Each college has, of course, its own human resource specialists who handle benefits for local college employees.

Health benefits for academic and support staff employees are the subject of negotiations between academic and support staff representatives of OPSEU (Ontario Public Service Employees Union) and management, and until July 1, 2005, there were three separate plans for academic, support staff, and administrative retirees. OCRA™ achieved a major breakthrough in persuading "the powers that be" that there should be ONE plan for all retirees, regardless of their employee group as active employees. OCRA™ continues to monitor the health benefits and pension plans as matters of major interest to college retirees.

As a retiree of Seneca College and founding member and secretary of OCRA™, I am delighted to bring the Ontario community college perspective to the board of CURAC.

The Op-Ed Pages

What Ails Healthcare for University/College Retirees? — What is the Prescription?

By Dr. Tarun Ghose, Professor Emeritus, Department of Pathology, Dalhousie University

I am starting with the arguable assumption that the problems that university/college-retirees face with Canada's healthcare delivery system (i.e. Medicare) are not different from those faced by seniors at large. This assumption is based on the observation that the majority of CURAC Member Associations is open to all university/college retirees and thus, CURAC's clientele represent a fairly representative cross section of the senior population of the Canadian Society with the probable exceptions of the very rich and the very poor. However, this territorial demarcation excludes that miniscule fraction of retirees who take early retirement and are probably looked after by their work-place Employee Associations or Unions.

So what (if anything) ails the existing healthcare delivery system for seniors in Canada?

I shall first consider the systemic problems of Medicare faced by all members of our society including seniors (who also have their own age-related problems). The systemic problems of Medicare include long waiting times; overcrowding in Emergency Rooms; shortage of physicians and other healthcare professionals; lack of space in nursing homes resulting in unacceptably long waiting times; and the rising cost of healthcare in general but more specifically the rising cost of prescription drugs.

What can we suggest for remedying these systemic problems of Medicare? What should CURAC advocate?

Canadians are divided about the future of Medicare and the reforms necessary to make Medicare more effective. The June 2005, (3 against 2 majority) Supreme Court ruling on Chaouilli v. Quebec not only generated intense discussion on Medicare but also further sharpened the divide. For example, at least 927 articles including 290 editorials appeared in the Canadian press within six months of the Supreme Court ruling. A small but significant majority of these opinion pieces

favoured private health insurance (Quesnell-Valle A, Bourque M, Fedick C, Maioni A. In the aftermath of Chaoulli v. Quebec: Whose opinion prevailed? CMAJ , 175:1051-52, 2006) . However, this might reflect more the opinion of the editors and owners of newspapers than the majority Canadian public because : i) Ralph Klein's Health Policy Framework, introducing substantial privatization in Medicare, had to be hastily retracted in April, 2006, just two months after it was made public, because of the outrage it provoked among Albertans and in Klein's own conservative party, and ii) Quebec's Bill 33, that followed the Supreme Court decision, allowed private insurance only for three surgical procedures and imposed strict restriction on further intrusion of private care and "double dipping" i.e. simultaneous participation in public and private healthcare by physicians.

The terrain of healthcare policy debate is crowded with myths created by ideologues and lobbyists. Productive discussion about Medicare is possible only after evaluating existing evidence and the facts on the ground. Let us begin by visiting two Canadian "holy cows" tethered to the opposing edges of the ideological divide.

The first holy cow bellows out the mantra that privatization or "two tier" medicine will cure Medicare's ills.

The problems of private and two tier medicine are best seen in the US, where private medicine coexists with federally funded Medicare and Medicaid. In spite of the highest governmental expenditure for healthcare in the world (~ 13.6% of the GNP), 46 million Americans, including over 11 million children, remain uninsured. In the US it now costs ~$500/person/month (and many co-payments) to have Canadian-standard health care. Health-insurance premiums are soaring at ~ 13.5% per year. It is no wonder increasing numbers of Americans are remaining uninsured or under-insured and the California legislature passed a bill this year proposing a Canadian model universal-access health care scheme only to be vetoed out by the Governor on the ground that it was "socialist medicine".

"For-profit" hospitals spend only half their money on patient care. The rest is spent for administration and generating profit. To augment profit, they cherry-pick low-risk, high volume diseases leaving the most needy and seriously ill for public care. Yet, for comparable procedures, private hospitals have higher mortality and morbidity rates than accredited public hospitals.

The Canada Health Act does not prohibit "for-profit" private clinics but they siphon off trained personnel from the public system. This may be very detrimental in the context of Canada's current state of serious health-worker shortage.

From the above we can conclude that privatization is unlikely to cure the current ills of Medicare. Furthermore, a recent study (Hsu J, Price M, Huang J et al. Unintended consequences of caps on Medicare drug benefits. New England Journal of Medicine 354:2349-2359, 2006) confirms the conclusion of several previous studies that users' fees and caps only discourage the poor and the elderly to seek necessary help resulting in suffering and increased expense for treating more advanced disease.

The second holy cow embodies the belief of the of majority of Canadians that Canada's publicly funded single-tier, single-payer health care system, where access is determined by need and not the ability to pay, is economically efficient and ensures the best medical outcome.

One criticism of Medicare, in this context, is it's "out of control cost" and the corollary that many European countries provide comparable care at much lower costs. A CIHI (Canadian Institute for

Health Information) bulletin reveals that in 2005 (the latest available data) Canada's health expenditure amounted to 10.4% of its GDP thus ranking Canada in the middle of an OECD (Organization for Economic Cooperation and Development) listing of countries based on healthcare expenditure. Canada is preceded by France, Germany, Switzerland (all with equivalent levels of care) and the US which spends ~15% of its GDP on healthcare with much worse outcome. Furthermore, many countries pay larger shares of their healthcare expenses than Canada does. A perusal of OECD data from 1990 to 2004, reveals that in 2004 Canadian Governments paid 69.8% of total healthcare expenses compared to 85.5% by the UK, 78.4% by France, 79.5% by Ireland, and 76.4% by Italy. 17 out of the 28 countries listed in the Report pay higher proportions of total healthcare expenses than Canada. On a per capita basis, the USA spends twice the amount of money for healthcare than Canada does. A surprising finding is that all levels of Canadian Government have been slowly offloading healthcare expenses on the public. For example, Canadian governments paid 74.5% of its total healthcare expenses in 1990 but only 69.8% in 2004. As a result private insurance payments rose in Canada from 8.1% of healthcare expenses in 1990 to 13% in 2004. The OECD average of governmental share of healthcare expense has remained unchanged. Interestingly, the proportion of Governmental payment in healthcare has been steadily increasing in the USA e.g. from 39.7% in 1990 to 44.7% in 2004 (also see: Gross D. National health care? We're halfway there. The New York Times, Dec. 3, 2006, BU p. 4).

Nevertheless, there has been a steady increase in the inflation adjusted average annual rate of growth of healthcare expenditure both in the public and private sectors of Canada over the last three decades (CIHI Bulletin, Nov. 2006). The annual rate of growth of healthcare expenditure has accelerated over the last five years i.e. 6.05% in the private sector and 4.9% in the public sector. The rate of growth of healthcare expenditure is faster in the young and the old. Hospitals (30%), retail drugs (17%) and the compensation for physicians (13%) are the three most expensive items in our healthcare budget. The cost of drugs is the single most rapidly rising item of our healthcare budget.

From the above, we can conclude that Canada's healthcare expenditure is roughly on par with that of other OECD countries with comparable levels of care and outcome. Nevertheless, as pointed out by the Romanow and Kirby Commissions, the rising cost of healthcare needs to be controlled and reforms are necessary to remedy Medicare's current problems. However, the consequences of any major cut in healthcare budget should be properly examined because a number of studies including one by CIHI show a positive correlation between healthcare spending and life expectancy (also see the well-researched article: Cutler DM, Rosen AB, Vijan S. The value of medical spending in the United States. New England Journal of Medicine 355: 920-927, 2006).

It may be appropriate now to briefly discuss the age-related healthcare problems of seniors in Canada. Canada's population has been growing and graying since the twentieth century. For example, in 2001, ~ 4million Canadians were 65 years or older, ten years later their number will be ~7 million. By 2031, 1 in 5 Canadians is projected to be a senior.

There are two contradictory scenarios regarding the impact of Canada's aging population on healthcare delivery (see CIHI Bulletin, 2005). The "doom/gloom" school worries that the growing number of seniors will overwhelm the existing healthcare system. The "sun-shine" school points out that today's seniors are much healthier, and Canadians' use of healthcare facilities, especially hospital use, has dropped in spite of the aging population. This school believes that any extra demand due to Canada's aging population could be accommodated within our evolving Medicare system. Past evidence favours the "sun-shine's." Statistics Canada's 1970s

projections on hospital use, based on 1970s morbidity experience, widely overestimated the current use of hospitals.

Still there are several healthcare related matters concerning seniors that need further attention of CURAC. These include:

- Comprehensive Homecare for seniors
- Access to nursing homecare and quality control of nursing homes for seniors
- Advanced and Terminal Care
- Combating the culture of "benign neglect" towards seniors that permeates our present healthcare system
- Healthcare for persons with disabilities
- Evaluation of "fitness to drive"

In an article published by CARP (Canadian Association of Retired Persons) on April13, 2006, Cynthia Cravit points out that over 2 million Canadians over the age of 45 are looking after seniors in addition to doing their regular job and saving Medicare over $ 5 billion /yr. These caregivers do not get any financial compensation even though Mr. Romanow pointed out that Medicare would simply collapse without these unrecognized caregivers. Canada lags behind the UK, Australia, Germany and several other countries, including the US, in developing a national care-giving strategy.

CURAC should consider joining CARP in urging federal, provincial and territorial governments to take immediate fiscal and legislative action creating a national home and community care system as outlined in CARP's open letter of April 2003 to Canada's various levels of government.

Unfortunately, there is an ingrained culture in medical practice that regards seniors as second-class citizens. This ill-concealed prejudice becomes manifest in the written and unwritten codes of many hospitals for considering the suitability and prioritization of transplant recipients. This prejudice also surfaced in the preparation of triage protocols for pandemics. In one model protocol, persons over 65 years were automatically excluded form receiving ICU (Intensive Care Unit) care. Such brazen utilitarian approach to healthcare framed by "experts" should be challenged (see Melnychuk RM and Kenny NP. Pandemic triage: the ethical challenge. CMAJ, 175:1393-94, 2006). This prejudice is also quite blatant in cancer care. Even though cancer largely affects people over 65, older patients are often denied adjuvant chemotherapy which might be beneficial. In fact, older cancer patients are routinely excluded from clinical trials of anticancer-drugs on the wrong assumption that these drugs are too toxic for the elderly (for concise reviews see, Journal National Cancer Institute. 98: 1516-1518, 2006 and Trimble EL and Christian MC. Cancer Treatment and the Older Patient. Clinical Cancer Research. 12:1958-59, 2006).

One in eight Canadians lives with disabilities and many disabilities increase with aging. There is evidence that people with disabilities are less likely to have access to their basic healthcare needs. The problem is deep and cannot be resolved simply by building more wheel-chair ramps. The present culture of medicine is oriented more towards curing acute diseases than managing disabilities and chronic conditions. Patients with disabilities usually have complex medical afflictions and need longer examination by properly trained physicians. Even though some provinces have favourable fee schedules for chronic care services, trained man power is lacking . (Marks MB, and Teasell B. More than ramps. CMAJ 173:329-330, 2006). Targeted deployment of "hospital on wheels" may help healthcare access for persons with disability.

In Canada, car crashes kill ~3000 and injure another 250,000 persons per year. Even though the majority of car crashes involve the 15-55 age group, the crash rate increases after the age of 75 and more so after 80. The primary cause of such crashes is medical conditions that impair driving. CURAC should encourage retirees to cooperate with their physicians and licensing authorities for establishing and implementing proper licensing regulations for the safety of retirees themselves and the public at large (also see DJM Butcher. Fitness to drive. CMA J 175:575-76, 2006).

I am summarizing below a few thoughts as to how some of the current problems of Medicare can be temporarily resolved. I shall emphasize the importance of the recommendations in the Romanow and Kirby Reports, 2002, and in the National Waiting-time Advisor, Brian Postl's report (July, 2006) that only fundamental changes can make Medicare effective and sustainable.

Emergency room overcrowding and long waiting lists are the results of systemic deficiencies, compounded by inappropriate management, improper deployment of resources and past and current under-funding.

Determining priority in waiting lists is difficult because there are no reliable data on the effect of waiting on the quality of patients' life and outcome. Auditing and pooling of waiting lists and the use of internet have considerably reduced waiting times. Patients' watch-dog committees and patient-evaluation by third parties may reduce waiting list abuses. In Canada, the Armed Forces, the RCMP and Employee Insurance-patients receive automatic priority. This practice should be challenged.

The use of Physician Assistants (PA), Nurse Practitioners (NP) and Trainees (under supervision) along with the use of "Clean Rooms" in Outpatients and Primary Care Centres (instead of operation theatres) for minor surgeries and simple procedures would cut cost and waiting times, improve the utilization of operation theatres, and increase the productivity of surgeons, ophthalmologists and anesthetists. In contrast to the UK experience, in the US both PAs and NPs have improved productivity and decreased workload of physicians especially in the rural setting (Hooker RS. Physician assistants and nurse practitioners : the US experience. MJA 185:4-7, 2006).

Recently, hospitals in Edmonton and Halifax have demonstrated that waiting for joint-surgeries can be substantially reduced by temporarily focusing available resources to overcome bottlenecks. The surprise was that all resources already existed within the public system. Waiting queues have also been eliminated in other facilities by identifying and removing the cause of bottlenecks. The cost for overcoming blocks is offset by eliminating treatment during waiting. Patients also suffer less.

The proposed national or regional centres for cataract and cardiac surgeries and joint replacements would avoid future bottlenecks. " For-profit" clinics do not significantly cut down waiting in public hospitals.

One cause of Emergency Room overcrowding is that, outside family practice office hours, healthcare is delivered via expensive Emergency facilities. It is necessary to establish 24/7 Primary Care Centres manned by teams of family physicians with diverse expertise, PNs, psychiatrists, pharmacists and public health workers.

Approximately 10,000 patients die every year in Canada because of prescription errors. The inclusion of pharmacists in health care teams will eliminate prescription errors as well as the prevalent practice of over-prescription for seniors.

Primary care centres would filter off patients who do not need major interventions or acute care and thus cut cost. If necessary, they would provide chaperones to guide patients through the maze of tertiary care hospitals and help them to use information technology for making treatment related decisions. Primary care centres would also provide vaccinations along with information on preventive healthcare and lifestyle; and maintain patients' records for future reference and studies.

Another cause of Emergency room overcrowding is the scarcity of beds in long term facilities. More space must be created in nursing homes and homecare should also be extended.

"The hospital at home" model of homecare provides acute healthcare at home (either after early discharge or after assessment) to relieve demand on inpatient acute care; and avert hospital hazards. There is no difference in patient outcome between "at-home" and inpatient models. At-home models do cut cost but stress caregivers.

The manpower shortage in healthcare was created by cuts in the intake of medical students, residents, nurses and medical technicians during Mr. Martin's cost-cuttings. Recent federal funding has reversed the situation but physician shortage persists. Uneven distribution also causes physician shortage. According to a recent OECD study Canada has now the lowest number of physicians/per capita among the OECD countries and per capita, there are far fewer family physicians in rural Canada than in cities. As regards the quality of training and education, Canadian doctors have been found to be lacking in health literacy (Rootmn I. Health literacy: Where are the Canadian doctors? CMAJ 175: 506-8, 2006) and especially in modern information technology. This needs prompt attention and appropriate remedial measures.

About 40% of Canada's 60,000 working doctors are scheduled to retire in 15 years. In addition to increasing the intake of medical schools (which take ~7 years to produce family physicians), this gap can be filled by increasing physicians' productivity by transferring a part of physicians' responsibility to PAs, nurses, audiologists, optometrists etc.

Another way of relieving physician shortage is licensing foreign medical graduates (FMGs). They now constitute ~ 25% of working Canadian physicians. The existing pool of unutilized FMGs in Canada can readily fill the gaps in Medicare. However, the will to do so is lacking in certain quarters.

The rising cost of Medicare must be controlled. The price of prescription drugs and physicians' compensation are two fast growing items in Medicare's budget. The pricing of patent medicines is based on "what markets can bear". In Canada, the cost of prescription drugs (including the cost of over-prescription) is rising by 10 to 15% per year, was $20.6 billion in 2005, and is projected to be $30 billion in 2010.

Cost of prescription drugs can be controlled by bulk purchase, discouraging over prescription and the use of the less expensive but equally effective generic drugs. Only drugs of proven effectiveness should be provided by public funding.

The best way of controlling the price of drugs is to reintroduce compulsory licensing which would allow marketing cheaper generic versions of patent drugs after paying reasonable licensing fees. Drug patents are protected by WTO agreements but negotiated pricing is possible especially under government pressure.

Medicare is beset with a contradiction: it assures up-to-date diagnostic procedures and surgical interventions, but prescription drugs are only provided in the hospital setting. The paradox deepens with the almost exponentially decreasing hospital-stays (which is desirable) and the increasing use of ambulatory and homecare. The worst victims are the 3.5 million Canadians who cannot afford drug insurance and suffer until they are ill enough for hospital admission.

The "catastrophic drug program", an important addition to Medicare, is of little help to the poor. There is a need for a federal strategy for universal and affordable access to prescription drugs. CURAC should consider advocating such a strategy.

The salary of physicians is an important component of the rising cost of healthcare. Replacement of the inefficient "fee for service" method of compensating physicians by well-structured scales of salary would cut cost and render rational deployment of physicians possible. Computer literacy and electronic medical records may save ~$6 billion /year.

Healthcare delivery via ambulatory care, homecare and community-based Primary Care centres would also cut cost.

The elderly, the poor and the homeless are most vulnerable to illness and are also the least capable of accessing healthcare. Canada should consider adopting Scotland's "health coaching" innovation in which workers get out into communities, identify persons and groups at risk and take early preventive measures.

In conclusion, the experience of the OECD countries supports the contention that Canada's Medicare has the potential for delivering universal high quality health care. However extensive systemic changes are necessary to make Medicare sustainable and optimally effective. The areas that need reform include the method of healthcare delivery (i.e. emphasis on care delivery through primary care centres and multidisciplinary healthcare teams instead of Emergency Rooms); control of the price for prescription drugs; replacement of the present fee-for-service method of compensating physicians by the employment of salaried physicians; and an urgent need for increasing the number of healthcare professionals.

CURAC should consider joining other senior citizens groups and healthcare activists in formulating and advocating the necessary reforms.

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CROSS COUNTRY CHECK-UP

CURAC's member associations span the country from Memorial in Newfoundland in the east to the University of Victoria in the west. While this geographical diversity means that many issues and concerns of member groups will vary, experience at the annual CURAC conferences has shown that there are also many areas of common interest and that there is much we can all learn from one another. We hope that local association newsletter editors, executive members of local associations, and all the others active in local association affairs will become involved in feeding news and views into this section of the Newsletter, either by email or regular post to the addresses shown at the bottom of the front page.

British Columbia

Anne Piternick writes: The University of British Columbia has begun revision of its Campus Plan. This is a very large undertaking, and is expected to take eighteen months to complete. The help of emeriti has been requested. Since most emeriti have spent many years on campus (some are also alumni), we have seen many changes, both good and bad. We have been asked to submit our memories of developments on campus, and especially to comment on those we consider to be good, as well as mistakes that should not be repeated. A request for help was made at our last General Meeting on November 15. Since only a comparatively small number of our total membership attend our meetings, a plea for help has also been posted on our website – <www.ubcemeriti.org>. A request will also appear in our next Newsletter, to be mailed out in January. Anne Piternick has agreed to collect material submitted by e-mail or snail mail, including photographs.

Prairies

The University of Saskatchewan will be hosting the 2007 Congress of the Humanities and Social Sciences, May 26 – June 3. Billed as the "largest conference ever held in Saskatoon", the multi-disciplinary event is expected to bring more than 5000 delegates to the Saskatoon campus. The theme of the conference will be, "*Bridging Communities: Making public knowledge – Making knowledge public*". Particular emphasis will be placed on equity issues, Saskatchewan's aboriginal heritage, and U of S partnerships with Aboriginal Peoples. It will also serve as the centrepiece of the U of S centennial celebrations.

Ontario

The Public Policy Committee of RALUT, the retiree organization at the University of Toronto, has recently found itself investigating an interesting concept which appears to conflate a number of issues in which retirees from post-secondary institutions have an interest. The following report is based in part on the recent work of the committee.

The Campus-related Continuing Care Retirement Community Concept
by Ken Rea

Retirees from colleges and universities share a host of interests and concerns with retirees of all kinds. They may, however, have some specific ones which arise from the nature of their previous

employment. For example, many wish to retain some kind of relationship to the institution where they spent their working years. They may also wish to find housing accommodation of a particular type in a particular location. And they may hope to be able to obtain access to a changing array of services – including long-term care as they pass through their senectitude. It happens that all three of these considerations are conjoined in a type of retirement community gaining popularity in the US – the campus-related Continuing Care Retirement Community or CCRC.

As usually defined in the US, a CCRC typically combines three types of accommodation – "independent living", "assisted living", and "nursing care" – in a single facility, the objective being to provide residents of the community a "continuum of care" throughout their retirement years. Such developments historically were built with proximity to golf-courses or similar attractions which made them marketable to persons seeking certain kinds of retirement life-styles. More recently the idea of building CCRC's having some kind of relationship to a post-secondary institution has been attracting attention and a number of such projects have now been completed in the US. Several companies have emerged which specialize in this particular type of development. One of the better known is Rees Associates of Dallas, Texas (www.rees-associates.com).

The independent living part of a CCRC, usually the largest part, may be a collection of town-homes, apartments, or cottages for retirees who remain active and capable of looking after themselves, although some basic services such as grounds maintenance, security, cleaning and the like are typically available. The assisted living facilities provide a broader range of services to meet the needs of residents who require more help with daily activities – provision of meals, assistance with medications, maintaining personal hygiene, dressing, and the like – but who do not require nursing care. The third level serves the needs of those who do require nursing care and may also provide specialized facilities for those suffering from Alzheimer's or other conditions requiring 24-hour supervision.

The "continuum of care" concept implies that the appropriate services can be made available as the needs of the resident change. This may entail physical relocation within the community, for example from an independent living to an assisted living floor or wing. In some cases the facilities may have been designed in such a way that the additional services can be delivered without the resident having to move, but in all cases the idea appears to be that once a person has entered a particular retirement community, he or she can expect to find the appropriate level of care within that community and not have to move out into some other facility as needs change.

Incorporating this third level of care in a retirement community of course always complicates things. It is much more challenging, physically, financially, and administratively, to incorporate nursing care rather than develop a project providing only residential and assisted living facilities. Not surprisingly, even in the US, it is much easier to find examples of retirement communities which lack the third tier of care facilities than those which have it. Here in Canada there may be a further difficulty implementing such a full spectrum of care – in particular ensuring a smooth progression from level two to level three.

Although the situation varies from one part of the country to another, all the provincial and territorial governments in Canada have established systems to regulate access to so-called "uninsured" or "extended health care services" (nursing homes, long-term residential care, home care, and ambulatory health care services). Because the Canada Health Act does not require that such services conform to national standards the way hospital and physicians services are required to, there is considerable variation in the regulatory arrangements among jurisdictions.

So far as long-term care is involved all the provinces and territories seem to make a distinction between the provision of residential care (basic housing accommodation, sometimes called "hotel" services) and nursing care. While none (directly) subsidize the former, all subsidize the latter – although the level of subsidization and the terms governing eligibility to receive it vary greatly from one jurisdiction to another. In some provinces (most of those in Atlantic Canada) residents of nursing homes are required to pay the full cost of such care, if they can. In others (mainly in Western Canada) most nursing services are paid for by the province. The other side of the coin, however, is that the degree of control exercised over access to nursing care appears to be inverse to the extent to which it is subsidized. In provinces where the level of subsidization is low, access to nursing care facilities tends to be relatively unrestricted. In provinces where the subsidies are more generous, a case-by-case assessment must be made to determine eligibility for admission. Such assessment procedures can be controversial and the agencies involved must be at pains to demonstrate that they are allocating space in nursing care facilities in a fair and objective manner.

This is where difficulties may arise for CCRC's. Given that in many jurisdictions there appears to be a chronic excess of demand for such services over the available supply, local "coordinated assessment" agencies find themselves rationing access to available nursing care beds within their jurisdiction, ensuring that admission is based on the degree of "need" – not necessarily on whether or not the applicant has been living in an associated assisted living facility. When waiting lists for admission to nursing care facilities are long and queue-jumping not allowed it is possible that access to third level care in a particular CCRC may be unavailable to a resident of that CCRC when needed. Anecdotal evidence suggests that in some jurisdictions such instances may be rare, perhaps because of informal understandings or other *ad hoc* arrangements, but it is difficult to find data to support any generalized conclusions on this matter.

While the "access to third level care issue" may complicate the development of full-fledged CCRC's in Canada, it has not prevented them from being established. Many have been built as commercial for-profit ventures, others by religious, ethnic or other special interest organizations. Financing and payment arrangements differ greatly, as do locations, architectural features, and management systems. However, while the idea of establishing CCRC's having some kind of affinity with an institution of post-secondary learning has become well-established in the United States (more than thirty such communities have been built there), it is currently difficult to find examples in Canada. (The "Village by the Arboretum" in Guelph is a retirement community located on land leased by a private developer from the University of Guelph, but it does not appear to have been designed as a specifically campus-related venture. Some of its residents are, however, former faculty or staff. UBC is developing an ambitious residential development on its extensive land-holdings which will incorporate some type of retirement-living housing, but not, apparently, a full CCRC type of development.)

In the US, campus-related living arrangements have been built in the belief that they appeal to people who have some kind of interest in maintaining (or re-establishing) an involvement in the life of a post-secondary institution. Retired faculty and staff, alumni, and others who seek the cultural, intellectual and social experience of university or college life (as well as the specialized health-care, athletic and other facilities available in university settings) are seen as potential subscribers to this kind of offering. While geographic proximity may not be essential – some of the US developments have been built at some distance from the related campus – it does appear to be desirable. It may not, of course, always be feasible. Most of the US developments seem to be associated with colleges or universities located in smaller cities, towns, or in suburban locations. Few, if any to date, have been built in large cities. There may be several reasons for this. One, obviously, is the availability of suitable land to build on. Taxes and other expenses also

make it more challenging to develop affordable accommodation in such places. Another is the availability of alternative amenities and attractions. The benefits of access to campus-based cultural and other facilities may be more obvious in suburban or other less adequately supplied areas than in the downtown core of a big city.

Some, but by no means all, campus-related CCRC's developed in the US have been in some way supported by the college or university. In some cases they have been built on land owned by the institution and made available on terms ranging from outright gift to leasing under varying conditions. This raises the question of what possible benefits a college or university might expect from having a campus-related retirement facility. Apart from the possibility of some income from land leasing, it has been suggested that the institution could benefit from having direct access to the members of a community who would be well disposed toward "planned giving" to the institution, who might provide a pool of part-time teaching or other inputs, who could provide a "clinical base" to support medical, geriatric and other research and teaching activities, and who could serve as a base for alumni association activity. It is also possible that an institution would consider such a community an added attraction for prospective faculty, staff and students who might view it as an indication of the institution's commitment to "community" and the possibility of a life-time involvement therein.

The CURAC Housing Committee would like to hear from anyone having an interest in pursuing this topic. You may contact Anne Pitenernick, Chair of the committee, at <annebp@interchange.ubc.ca> directly, or respond to this article by contacting Ken Rea at <reak@chass.utoronto.ca>.

Quebec

La situation des retraités au Québec
Rapporteur : Roch Meynard

The Retirement Situation in Québec

The Québec government has two bills which have pertinence for Québec retirees. Bill 27 will create a board of directors for the Commission administrative des régimes et retraite et d'assurances (CARRA). The board would have one slot reserved for a representative from one of the pension plans covered by CARRA. The large union federations (CSN, CSQ, FTQ, FIIQ and SFPQ) propose a different arrangement of the board and neglect to include a representative from retiree associations.

The Association des retraités de l'enseignement du Québec (AREQ) maintains its focus on pension indexation and proposes that a permanent working group be struck with the object of « looking at ways to protect the purchasing power of retirees ».

Bill 30 is particularly appreciated by associations of retirees because it brings in the notion of equity for retired members of pension plans when making decisions concerning allocation of pension surpluses.

A study by professor Louis Ascah (Université de Sherbrooke) has found that in workplace pension plans « the initial proceeds of pensions is often times too low, indexation of the pensions

is nil or only partial, and pension paid for people leaving before retirement age is often worth little money ».

Deux projets de loi du Gouvernement du Québec touchent particulièrement les retraités au Québec.

Le projet de loi 27

Un projet de loi 27 visant à modifier la Loi sur la Commission administrative des régimes de retraite et d'assurances (CARRA) a été déposé par la minitre Jérôme-Forget le 13 juin 2006. Pour l'essentiel, ce projet de loi consiste à doter la CARRA d'un conseil d'administration. Il faut savoir que la Commission administrative des régimes de retraite et d'assurances (CARRA) gère le Régime de retraite des employés du gouvernement et des organismes publics (RREGOP), le régime comptant le plus grand nombre de membres au Québec, dont les retraités de certaines université du réseau de l'Université du Québec. Le RREGOP représente 86 % de la clientèle de la CARRA et 80 % de son financement.

Le projet de loi prévoit un conseil d'administration de 15 membres, dont un représentant des pensionnés de l'un ou l'autre des régimes de retraite administrés par la Commission. Dans un mémoire présenté par les plus grandes centrales syndicales (CSN, CSQ, FTQ, FIIQ et SFPQ), on propose plutôt un conseil d'administration de 17 membres, sans prévoir explicitement la représentation de retraités.

De même, le projet de loi prévoit la présence au Comité de retraite du RREGOP de deux personnes retraitées, au lieu d'une seule comme présentement, nommées après consultation des associations de retraités les plus représentatives. Les centrales syndicales préconisent plutôt qu'un représentant de l'Association des retraités de l'enseignement du Québec (AREQ) représente les retraités.

Pour sa part, l'Association des retraités de l'enseignement du Québec (AREQ) se dit en accord avec le projet de loi, mais propose quelques améliorations. On souhaite en particulier que « les associations de personnes retraitées les plus représentatives soient consultées lorsqu'il est question de modifier le régime, notamment en regard de l'utilisation des surplus ». Soucieuse de maintenir son action dans le dossier de l'indexation, l'AREQ réclame la formation d'une table de travail permanente « pour assurer la protection du pouvoir d'achat des personnes aînées et retraitées ».

Le projet de loi 30

Le projet de loi 30, déposé le 14 juin 2006, émane de la ministre de l'Emploi et de la Solidarité sociale, Mme Michelle Courchesne, et vise les régimes de retraite couverts par la Loi sur les régimes complémentaires de retraite.

Le projet de loi vise d'abord à améliorer le provisionnement des caisses de retraite de façon à sécuriser les rentes des participants et des bénéficiaires.

Il introduit toutefois aussi un concept qui plaît aux associations de retraités, celui de l'équité entre les participants actifs et les participants non actifs et bénéficiaires du régime dans le cas de l'affectation de l'excédent d'actif d'un régime (art. 146.3.1). L'Association québécoise des retraités des secteurs public et parapublic (AQRP) s'en est réjouie dans son mémoire, la déclarant « une modification fort importante et très positive ». La plupart des associations de retraités se sont aussi réjouies de cette « percée ».

Le projet de loi 30 devrait être approuvé avant Noël.

Le dossier de l'indexation
Depuis 1982, les crédits de rente des régimes du secteur public ne sont indexés que lorsque l'indice des prix à la consommation (IPC) dépasse 3 %. Les crédits de rente acquis depuis 2000 sont indexés à la moitié de l'IPC jusqu'à 3 % et pleinement par la suite.

Une étude de l'économiste Gérald Leblanc, de l'Université Laval (commanditée par l'AQRP), a établi qu'il en aurait coûté 215 millions en 2005 pour indexer les rentes des 645 000 retraités du Québec, mais que les gouvernements auraient récupéré 40 millions grâce aux revenus fiscaux.

Par ailleurs, une autre étude commandée par l'AQRP, celle-là du professeur Louis Ascah, de l'Université de Sherbrooke, en vient à la conclusion « que la retraite dorée est un mythe pour un trop grand nombre de retraités ». Dans le cas de régimes de retraite à l'emploi, « la rente initiale de retraite est souvent insuffisante, l'indexation de la rente est généralement nulle ou partielle et la rente acquise en cas de départ avant la retraite a souvent une petite valeur ». En 2001, près de 80 % des retraités avaient un revenu individuel de moins de 25 000 $.

Atlantic Canada

A Report from the University of New Brunswick Retired Employees Association
by Jim O'Sullivan

The University of New Brunswick Retired Employees Association (UNBREA) has achieved two important breakthroughs for the University's retired employees: a 15-month vacation from health plan premiums and the opportunity for all retired employees to provide detailed feedback on the kinds of connections they want to maintain with the University after retirement.

Premium Holiday for Health Plan

Retired employees of the University of New Brunswick and their spouses over age 65 are to receive a 15-month vacation from health plan premiums. The premium holiday takes effect on January 1, 2007, and will be financed from previous years'' surpluses.

UNB retirees may retain health benefits by paying 100 per cent of the required premiums. However, their eligibility for prescription drug coverage ends at age 65, when premiums are adjusted to reflect the reduced coverage.

In 2005 the UNB Retired Employees Association asked the University to consider extending drug coverage beyond age 65. The University declined to do so, but a joint committee appointed by UNBREA and the University to explore this question discovered that the premium reduction made when drug coverage ended had been too small.

As a result of the UNBREA initiative, ongoing premiums for non-drug benefits have been reduced by nearly 40 per cent, and the 15-month premium holiday implemented to return the surplus accumulated in previous years. The holiday represents total premium savings of $490 for a single retiree and $1,042 for one with family coverage.

Full details of premium holiday are contained in the Fall 2006 edition of the UNBREA newsletter, available at http://www.unb.ca/retirees/documents/2006Fall.pdf

Survey Asks Retirees About Links They Want With University

In 2005 the President of the University of New Brunswick appointed a committee to recommend ways to strengthen relationships between the University and its retired employees.

The committee consists of four members appointed by the University and four appointed by the Retired Employees Association. As a starting point, the committee decided to carry out a survey of all 700 retired employees for whom a mailing address was available. The detailed questionnaire asked retirees to identify the kinds of UNB services they have continued to use and to provide to the University since retiring, and the kinds of new linkages they would like to see develop in the years ahead. About 50 per cent of the retirees completed the questionnaire.

To compare the actual experience of retirees with the aspirations of current long-service employees now approaching retirement, the committee sent a similar questionnaire to154 employees who had taken part in a recent pre-retirement information session. Again the response rate was about 50 per cent.

The committee intends to use the survey results as background information for the development of its own recommendations to the University.

Both a four-page summary of the survey results, and the complete survey report, can be accessed at
http://www.unb.ca/hr
http://www.unb.ca/hr/documents/FinalReportInternetVersion.pdf

Friends and Neighbours

AROHE's 3rd International Meeting A Great Success
by Peter Russell and Howard Fink

On October 13 to 15, about a hundred retired staff and faculty representing just under 60 institutions of higher learning gathered in Tempe Arizona for the Association of Retiree Association of Higher Education's (AROHE) third biennial conference. From its beginning six years ago AROHE has aimed to be an international organization of university and college retiree organizations. The international component of this year's meeting consisted of a small Canadian contingent, Doug Creelman, the President of RALUT, the University of Toronto's retiree association, and ourselves, the present and past presidents of CURAC. For we three Canadians, the conference was a most instructive and stimulating experience. We hope that our report of the 2006 meeting will stimulate many more Canadian colleagues to attend the 2008 AROHE meeting.

The program combined lectures and panels on both the theoretical and practical aspects of the conference theme: *Building On Experience For An Innovative Future*. The Paul Hadley Honorary Address, named after AROHE's founding President, was given by Gene Cohen, Director of the Centre on Aging at George Washington University. Dr. Cohen brilliantly illuminated the latest findings in the health and social sciences on the distinctive strengths of the Mature Mind. Cohen's lecture and several other panels gave us new insights into the combination of knowledge and

experience that produces the "pragmatic creativity" that marks the post-retirement activities of so many retirees.

Panels on developing retiree centres and securing the support of university administrations for retiree organizations gave us new ideas about how to engage the "pragmatic creativity" of retirees in the life of our campuses.

Our American colleagues expressed interest in knowing more about what university and college retirees are doing in Canada. Out of this came a decision of AROHE's Board of Directors to have their 2007 Board meeting next May in Windsor so that they can participate in CURAC's annual conference. Of course we were delighted with this decision. The attendance of leaders of the US college and university retiree movement is bound to enrich our meeting.

A Final Word from the Editor

Please let us know what you think of this inaugural issue of the CURAC Newsletter and consider getting involved in the production of subsequent issues. The objective is to provide a forum for the exchange of information among member associations of CURAC and to establish a conduit through which the concerns and interests of member associations can be transmitted to the CURAC Board. To succeed we obviously need your participation. There is no "CURAC Central", no paid staff. This newsletter is produced entirely by volunteers who provide whatever "reporting", "production", and "circulation" is needed. While all three functions are important and need your active support, the latter is particularly critical because, in the absence of funding, what we produce will only reach a broad readership if the material we have generated here gets out into local association newsletters and other channels of communication, both electronic and paper-based. Please accept our invitation to copy, extract, or redistribute any of the content in whole or in part as you see fit. Your comments, suggestions, and material for future issues should be sent by email to *curac@curac.ca* or by post to CURAC, Suite 997, 7-B Pleasant Boulevard, Toronto, ON M4T 1K2. If you would like a copy of any article in some other format (Word, plain text, RTF, HTML) just let us know. Copies of the Newsletter will be available for download from the CURAC website at <www.curac.ca>.