CANADA - UNITED KINGDOM COLLOQUIUM 2019

AGEING WELL

Policy implications of changing demographics and increasing longevity in UK and Canada

22-24 November 2019

The Møller Centre
University of Cambridge

Ageing Well:

Policy Implications of Changing Demographics and Increasing Longevity in UK and Canada

Rapporteur's Report

Professor Ashwin Kumar

Canada-UK Colloquium, 22-24 November 2019

Møller Centre, Churchill College, Cambridge University

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PREFACE

We have great pleasure in presenting this report by Professor Ashwin Kumar on the Canada-UK Colloquium that was held in St John's College and at the Møller Centre Cambridge from 22-24 November 2019.

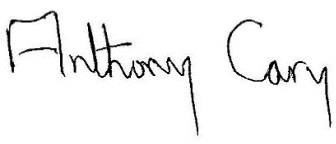
The subject of Ageing was chosen in agreement with the Canadian and UK Governments. The letter of support received from the then British Prime Minister, reproduced here, attests to the importance of the topic to both countries as a focus of policy.

Thanks are due to our respective committee members and advisers for their help and support in preparing this colloquium, and to Lord Filkin for his skilful chairmanship. We would also like to honour the memory of John Wyn Owen, who sadly passed away shortly after the meeting. He was a very good friend to CUKC, and it was entirely due to his energy and initiative that the briefing day was held in St John's College, so beloved by him.

Special thanks are due to our sponsors whose names and logos are on the back cover of this Report. The meeting could not have taken place without their support.

Finally, we are grateful to Ashwin Kumar for taking on the onerous job of reporting on our deliberations. It was a rich and wide-ranging discussion between some of the leading experts in the field. His report is not intended as a full record, but tries to do justice to the ideas and opinions that were expressed; to summarise what struck him as the most interesting points; and to make policy recommendations flowing from them. The recommendations to the two Governments and to their policy advisers are numbered, and contained in text boxes running through the report.

It is perhaps worth adding that the Covid-19 crisis developed in the months following our colloquium. Though it bears heavily on many of the issues that we discussed, our rapporteur has resisted the temptation to refer to it – or, indeed, to draw retrospective conclusions relating to it.



Anthony Cary
Chair, Canada-UK Council (UK)

Mel Cappe
Chair, Canadian Organising Committee

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THE PRIME MINISTER

The longstanding friendship between the UK and Canada means that it is natural for us to seek to work together. As we affirmed during our meeting last November at the G20, Prime Minister Trudeau and I are determined not just to conserve this relationship, but to strengthen it by taking full advantage of the opportunities for our countries to cooperate and learn from each other.

To that end, we have established new official mechanisms to promote regular high-level dialogue and we welcome the role played by industry, civil society, academia and other such informal networks. The annual Colloquium, which explores issues of mutual concern chosen with the support of both Governments, is one important channel for this effort.

This year's Colloquium in Cambridge will be looking at the topic of ageing, one of the Grand Challenges in the UK's Industrial Strategy and relevant to Canada because we share the same challenges – an ageing population, the need to provide dignified, high-quality care and medical support where it is needed, and to fight the scourge of loneliness which afflicts many old people. It is good that we look together at how we can ensure that, within the next two decades, people can enjoy extra years of healthy, independent life. We also need to consider what new challenges and opportunities are being created by the changing demographic structure of our societies, and what public policies will need to be deployed as a result. These are some of the crucial questions facing our countries, and our responses will be better if we work together to look for solutions.

I am delighted this key area of policy has been chosen for the 2019 Colloquium and I offer a warm welcome to all participants.

November 2019

THE CANADA-UK COLLOQUIUM

Overview

The Canada-UK Colloquium (CUKC) was established by the two governments in 1971 as an annual forum to promote in-depth discussion of public policy issues considered critical and timely for both countries. Each year, it brings together some fifty Canadian and British parliamentarians, senior-level public servants, academics, journalists, business leaders and young scholars, to foster practical knowledge-sharing and to encourage constructive collaboration. Meetings take place alternately in Canada and in the UK. Over the past five decades, the CUKC has been regularly endorsed by the Prime Ministers of both countries, as well as being actively supported by the Foreign and Commonwealth Office in the UK and by the Department of Global Affairs in Canada.

Objectives

The objectives of the Canada-UK Colloquium are to:

- Build networks of contact and friendship between Britain and Canada.
- Contribute to the development of public policy in both countries.
- Identify ways in which Britain and Canada can work together in an international context to meet their objectives in specific policy areas.
- Encourage implementation of recommendations from its meetings.
- Involve promising young people to ensure that the benefits of the exchanges are carried forward into the future.

Ageing Well:

Policy Implications of Changing demographics and Increasing Longevity in UK and Canada

Professor Ashwin Kumar

Ashwin Kumar is Professor of Social Policy at Manchester Metropolitan University. He has also worked as Chief Economist of the Joseph Rowntree Foundation, Senior Economic Adviser at the Department for Work and Pensions, as Rail Director of the consumer watchdog Passenger Focus, and as an economic adviser to Gordon Brown.

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1. Introduction

The fact that the age structure of our population is changing is not news. Nor is it new for ageing and changing demographics to be the focus of policy attention. In the UK, there have been several Acts of Parliament which have increased the state pension age to meet the fiscal challenges presented by changing demography. Similarly, in Canada a decision was taken to raise the age for Old Age Security from 65 to 67, though this was subsequently reversed; and there have been recent enhancements to the Canada Pension Plan (CPP) as well as extended eligibility for Guaranteed Income Supplement (GIS).

However, the challenges are not only fiscal. Does increasing longevity mean increased healthy life expectancy, or more years of poor health? Does the changing age structure mean we need to rethink the labour market? How can we turn the discussion from 'affording' more, older people in the population to recognising and capturing their contribution to our society? How does the experience of ageing vary across the population, by gender, income, geography and ethnicity? The answers to these questions have profound consequences for our understanding of ageing and, most pertinently, to the question of how public policy and public services should respond.

Canada and the UK are similar in many respects – for example, in having well-developed public health services – but different in other respects, such as the degree of provincial autonomy in Canada. These similarities and differences give us many opportunities to learn from each other.

2. Canada-UK Colloquium

Over three days, some of the foremost experts on ageing in Canada and the UK met at Cambridge University in the UK to discuss the challenges of ageing well. Participants heard from policy makers, academics, researchers and practitioners. Many of the contributors straddled more than one of these categories, drawing from the highest quality academic research, and experience of having made policy on behalf of national and provincial or local government.

With lively and thought-provoking discussions, participants contributed evidence, reflections and ideas about the challenges that we face. Crucially, they also made a series of recommendations as to how our societies can better meet these challenges.

What was striking from the discussions was the value of bringing together people from a wide range of disciplines to discuss these issues. This underlines the need for cross-disciplinary policymaking on ageing. The challenges and opportunities of ageing are multi-faceted and interact with one another. They need a co-ordinated strategy. Ontario and Wales are good examples of territories within which integrated strategies and accountability have improved the quality of policymaking. Our first recommendation, therefore, is that national and regional governments in the UK and Canada should follow this example.

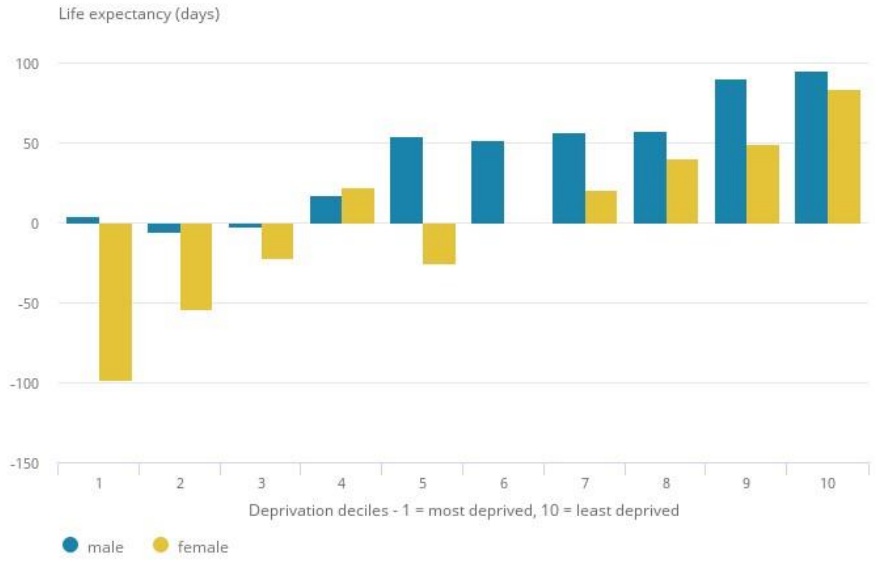
This report sets out the main points made in the discussions, and the recommendations that emerged. The event was held under the Chatham House rule that individual contributors are not identified.

Recommendation	
1	National, provincial and local governments in the UK and Canada should make greater efforts to collaborate on the delivery of services to ageing citizens, developing cross-sectoral strategies where appropriate, so that they are more prepared for the challenges and opportunities of the next few decades.

3. Demographic context

For most of the last 200 years there has been a remarkably steady increase in life expectancy. That is still the long-term trend. However, in the UK, the rate of increase slowed during the early 2010s and the overall curve has been pretty flat in recent years.
But this has not been a uniform story – and inequality is a particularly important factor in the differentiation. In the last three years, life expectancy for women in the most deprived third of the population in England has *fallen*. For men in that tertile, it has marked time. Meanwhile, life expectancy has continued to rise for those in the least deprived groups.

Figure 1 Change in life expectancy in days between 2012/14 and 2015/17, England



Source: Office for National Statistics

It is also important to recognise that the story is not the same in all parts of the country. It is notable that there is very little variation in life expectancy in affluent locations. However, in more deprived locations the picture is different: better-off people can escape the location factors, but outcomes are very poor for people with lower incomes.

There is a compounding effect whereby people on lower incomes living in deprived areas have particularly low life expectancy and a suggestion that it is this phenomenon that has

driven the declining growth in average life expectancy. More targeted policy approaches that addressed geographical and income inequalities and focused where need is greatest might do most to improve the overall picture. There has been a great deal of recent debate about the inter-generational tensions caused by an ageing population, but *intra*-generational inequality (the gap between rich and poor) is in many ways more significant.

A November 2019 report by the Health Foundation, a UK charity committed to better health and healthcare, noted: *"While the difference in life expectancy between the richest and poorest, narrowed in the 2000s, it has widened since 2011. The growing gap in life expectancy between rich and poor is a consequence of improvement in life expectancy stalling for the poorest while it continues to increase for the richest, albeit at a slower rate than before 2011."*

Canada has seen fast growth in its over-65 population. In 2019, more than one in six (17.5%) Canadians was 65 or over. By 2031, it is projected that this proportion will rise to nearly one in four (23%). However, in recent years, overall population growth has been slowing. What is notable is that there has been virtually no natural increase in the population: what growth has occurred has done so mostly due to migration.

As with the UK, inequalities in Canada are important: there is an education gradient in life expectancy. Similarly, the data shows inequality in life expectancy by income. For example, on average, someone born in one of the most affluent areas will outlive someone in the poorest by 8.4 years.

Other forms of inequality are also likely to be linked to life expectancy. It is certainly lower for the indigenous population than for the general population. There are almost certainly differences related to other racial minorities and LGBTQI populations, for example. However, the data is less comprehensive, and it is hard to get an accurate picture of the situation. Given the importance of income and geographical inequalities in life expectancy, we should have a better understanding of whether other forms of inequality are also significant.

Canada has also seen changes in the household structure of the population. Recent years have seen a fast increase in single-person households, particularly in Quebec. Canada has also seen a growth in multi-generational households. The question of household structure is particularly important when it comes to care and support, as well as loneliness. Which sections of the population are most likely to have access to sources of informal support, and which are not?

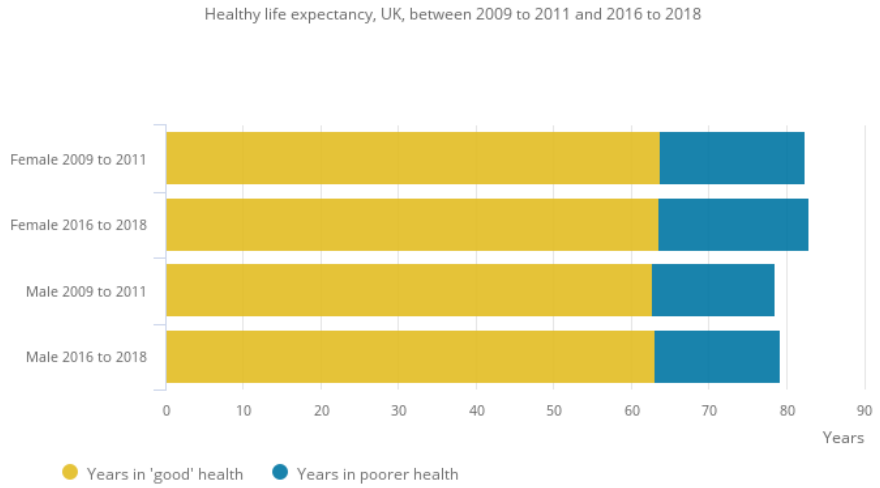
Recommendation

2 Better data is needed on longevity within minority groups, including for example different ethnic groups, different socio-economic groups, and those suffering physical and mental disorders. Standard survey-based measures often have insufficient sample size for any but the most basic insights. National statistical agencies should develop plans to address this deficit.

3.1 Healthy life expectancy

While life expectancy itself provides a high-level indicator of health outcomes, the real goal is to achieve increases in healthy life expectancy. Yet In recent years the overall trend, in Canada as well as the UK, has been that increasing life expectancy has brought smaller increases in healthy life expectancy. Increasing life expectancy, that is, has increased the years of poor health.

Figure 2 Years spent in poorer health has been increasing in the UK



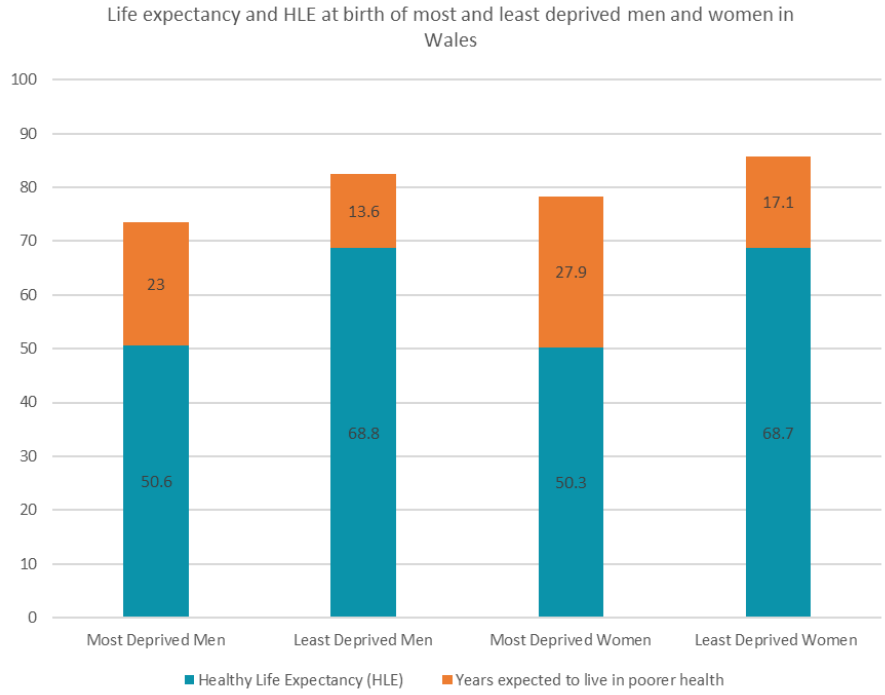
Source: Office for National Statistics

Recent years have also seen the emergence of population-level risks such as obesity and opioids, which is starting to affect the aggregate picture of life expectancy and healthy life expectancy.

As with life expectancy itself, inequalities are stark. Between 2015 and 2017, those in the least deprived areas of England could expect to live around 19 more years in good health than those in the most deprived areas. This has severe consequences for expectations of retirement. Upon reaching 65, those in the least deprived areas can expect over 60% of their remaining life to be healthy, whilst those in the most deprived areas can expect over 60% to be in poor health. And these disparities are getting worse. Between 2012/14 and 2015/17, inequalities in healthy life expectancy *increased* in England.

When it comes to healthy life expectancy, gender inequality is particularly important. Women tend to have higher life expectancy but a relatively long time in poor health. Recent gains in life expectancy have resulted in extended *healthy* life expectancy for men whereas for women, the position has been more equivocal. Thus gains in life expectancy have been positive for men, but less so for women.

Figure 3 Life expectancy and healthy life expectancy at birth in Wales



There is at present poor understanding of why these gender differences occur – particularly those relating to increased years of disability and dependency amongst women. Do these differences arise from cohort effects: the current generation of older women experienced greater degrees of social disadvantage or lower levels of education during younger years, or are there biological differences? For example, women have higher likelihoods of mild impairments: does this arise from differences in bone densities or for other reasons?

Epidemiology and neuroscience have not historically addressed gender adequately. They should, given the clear evidence of inequalities in outcomes. Better research, data and insight in this area would improve the starting point for policymaking. It is therefore important that funders recognise the value of research where there is both the sample size and the analytical focus to explore gender (and other) inequalities more fully.

3.2 Cognitive impairment and dementia

With population ageing, the number of people living with dementia is set to rise sharply in the decades to come. In the UK, there have been cohort studies in place for some years, as well as the English Longitudinal Study of Ageing and Understanding Society. Though these are not focussed on cognitive impairment in particular, they yield useful data in that connection, assisting evidence-based policy. In Canada, the Chronic Disease Surveillance System (CCDSS) collects population-based data on all residents with a valid healthcare insurance number, giving near-universal coverage and a clear annual picture of rates of diagnosed dementia at the national and provincial/territorial levels. Additionally, the Canadian Longitudinal Study on Aging (CLSA) in place since 2011 will generate rich data as the cohort progresses.

Recommendation

3 More research is needed into the drivers of gender differences in life expectancy, disability in the older population and healthy life expectancy.

4. Health risks

The UK government has declared the 'ageing society' a Grand Challenge and has set an ambitious mission *"for everyone to have five extra years of healthy, independent life by 2035 and to narrow the gap between the richest and the poorest"*.

The main drivers of healthy life expectancy are fairly well-established. Four factors which have particular influence are:

- adequate income;
- decent housing;
- good quality work; and
- clean air.

Likewise, there are four behaviours in particular which reduce healthy life expectancy:

- smoking;
- unhealthy diet;
- harmful consumption of alcohol; and
- insufficient physical activity.

It is notable that discussions about poverty, the labour market and housing rarely take into account the known impacts of these policy areas on health. Official forecasts of the fiscal implications of tax and welfare policy may, at a stretch, include the effects of behavioural labour supply responses to policy but almost never include the costs to the healthcare system of the hunger, stress, and poor diet that may be caused. Given that the costs of poor health will eventually be borne by the state through healthcare, it would make sense for more account to be taken of the longer-term health impacts of other policy areas.

When it comes to behaviour, it is well-recognised that prevention strategies – whether smoking bans or promotion of healthy lifestyles – have a big impact on health outcomes. However, health services spend very little on "social prescribing" to reduce ill health. This approach is frequently ignored by political decision-makers. Recent UK policy announcements trumpeting the number of new hospitals planned are a case in point. In the Department of Health and Social Care in England, it is one of the most junior Ministers who is responsible for preventive approaches, combining these duties with responsibility for primary care. In Canada, the annual official publication *National Health Expenditure Trends* makes virtually no mention of expenditure on prevention.

There is overwhelming evidence that healthcare should be about more than health services treating diseases. Spending on health prevention can be extremely effective in preventing

serious diseases, as well as reducing future health costs. It is therefore imperative that prevention is taken seriously.

As the UK's Chief Medical Officer said in October 2019, *"there is a bunch of things that we know work, including stopping smoking, exercising more and so on, which we just need to press "on" on, and the same is true for providing primary and secondary prevention that we know works. There is a bunch of things that are simply not happening, but if they happened to the people most at risk, things would improve really quite fast".*

While the case for greater focus and spending on prevention measures is clear, there is more we could do to improve their effectiveness, especially through better communication of the risks of less healthy activity and the benefits of lifestyle change. Even marginal improvements would make a material difference. This in turn would have a significant effect on the costs of providing healthcare. However, aggregate effects of this kind do not translate easily into widely-understood measures of individual risk, taking personal circumstances into account.

One approach to prevention is to tax unhealthy activities such as the over-consumption of sugar or salt. However, tax-based incentives can introduce or exacerbate inequality if there are socio-economic differences in the prevalence of the activity being taxed. This may reduce public consent for such measures. To stop this happening, whenever such taxation measures are introduced, there should be rebalancing in another part of the tax system (e.g. income tax) such that, in aggregate, taxes that are designed to encourage healthier lifestyles do not become mechanisms for stealth redistribution from poor to rich.

Recommendations

4 Official estimates of the effects of tax and welfare policy should include estimates of the effects of policy on health.

5 Governments should set ambitious targets for increasing the proportion of health spending on *prevention* and commit to annual reports on progress towards meeting such targets.

6 In both UK and Canada a named Minister with cross-sectoral responsibilities should be tasked to ensure that prevention is given the attention it deserves as a focus of government policy.

7 When introducing tax measures to incentivise healthy lifestyles, governments should ensure that, where the burden of taxation is more likely to fall on lower income households, rebalancing measures are put in place elsewhere in the tax system so that there is not a "stealth" redistribution from poor to rich.

5. Healthcare

5.1 Co-morbidities and complexity

People are surviving cancer and heart attacks more often than in the past, but not unscathed. As people live longer we are seeing a growth in the number of people with multiple conditions, or "co-morbidities". As people age, that is, they are exposed to the risk

factors for several chronic diseases which, taken individually, might be thought of as less serious but, combined with others, contribute to reduced functional health.

Figure 4: Age-standardised death rates per 100 000 from cardiovascular disease, all ages, UK and England, Wales, Scotland, Northern Ireland, 1979–2013[1]

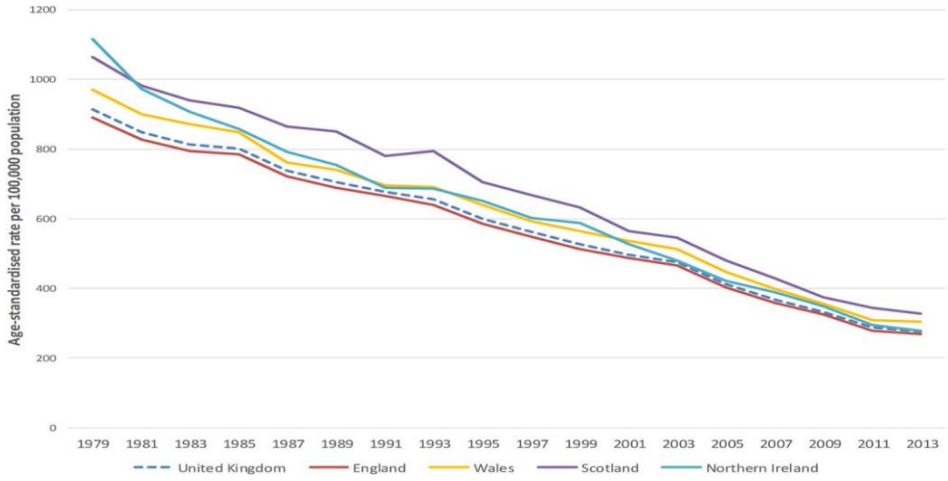
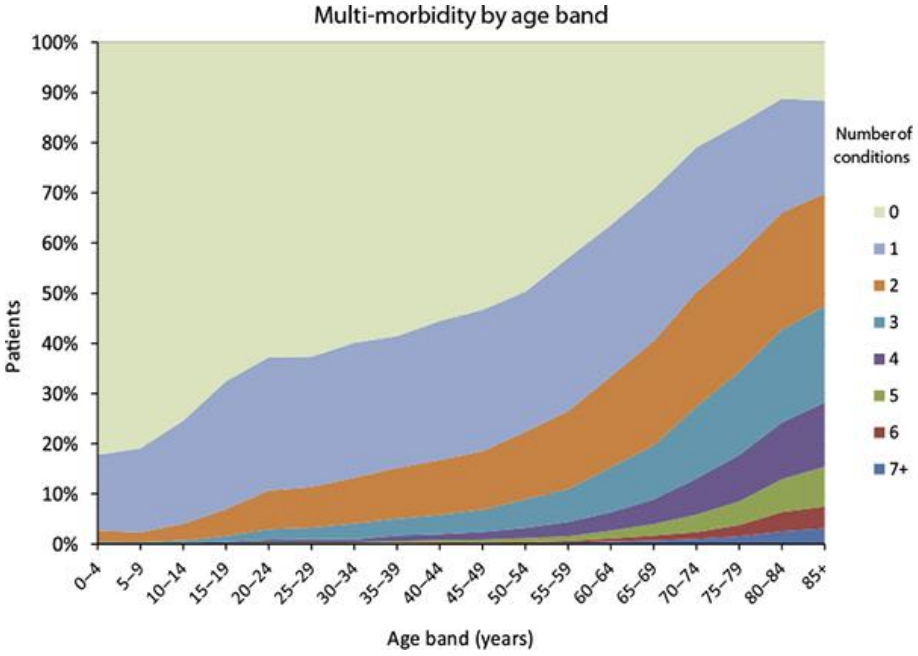


Figure 5 Multi-morbidity by age band

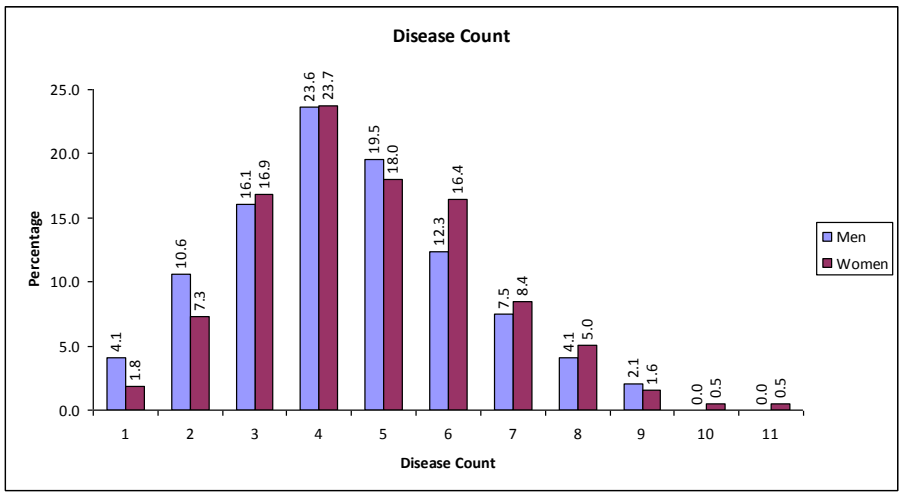


The expectation is that, in the UK, the number of people with four or more of the key morbidities will double from 8 million to 16 million over the next 20 years.

As with healthy life expectancy, there is a gender dimension to multi-morbidity: women tend to suffer from more conditions simultaneously.

[1] Prachi Bhatnagar et al. Heart 2016;102:1945-1952

Figure 6 Disease count by gender



The traditional model of medical care is referral by a general practitioner to a specialist in a particular condition. This fails to take account of the fact that multi-morbidities are the norm for very old people, often including chronic conditions leading to dependency. A single-disease-based healthcare delivery system is not the most effective approach for the older population.

The trend from a workforce point of view is that medicine has become more specialist while patients increasingly straddle disciplines. There are shortages of general practitioners, old-age psychiatrists, and geriatricians – as well as healthcare and support workers in these fields – while trends in patient need suggest these are precisely the professions in greatest demand.

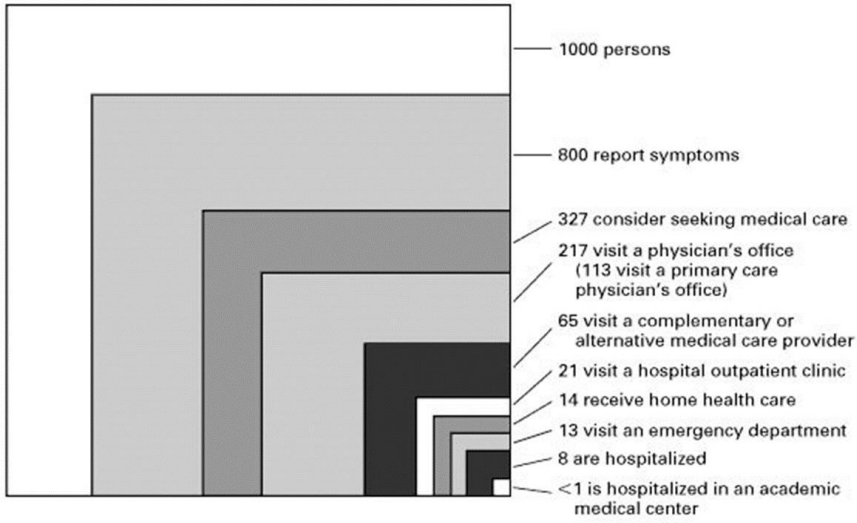
Recommendation

8 Human Resource planners in both countries should work to recruit and retain a greater number of healthcare professionals interested in careers in ageing – geriatricians, geriatric psychiatrists, GPs, nurses – as well as home support workers

5.2 Primary care

This raises the issue of the balance between general practice and hospital care. Not only is hospital care more expensive, but it is typically focussed on specialist treatment of single diseases.

Figure 7 Results of a Reanalysis of the Monthly Prevalence of Illness in the Community and the Roles of Various Sources of Health Care[2]



The evidence that health systems with strong primary care are both effective and efficient suggests that this should be the foundation of a sustainable health system. It allows comprehensive care and a longitudinal approach, both of which contribute to decreased mortality. It is better at bringing in the contribution of multiple professions, and is able to focus better on wellness and prevention, and mental health.

The broader point is that hospitals and highly-medicalised care can be less effective at treating the whole person, not just the disease. Yet there is often a prioritisation of hospital care within health funding and public discussion of health policy. An example of where explicit efforts have been made to redress the balance is the Ontario Seniors Strategy, which has an explicit aim of changing the funding balance between hospital and primary care.

It is important that such strategies are not seen as an excuse for reducing funding but an opportunity to make care more person-centred, more appropriate and responsive to older people's needs. Too often, policy interventions on primary care are responsive rather than proactive, focussed on reducing the costs of hospital admissions rather than on improving working relationships between hospitals and primary care. There can also be a focus on access rather than continuity of care, which is particularly important in the context of complex multi-morbidities.

Interestingly, pilot studies looking at improving primary care sometimes have the effect of increasing admissions because person-centred care can be better at identifying undiagnosed conditions. What such studies have demonstrated is that what matters for effective care is the relationship between carer and patient. Whilst the evidence base is not as strong as it could be, the best option looks to be the development of larger-scale multidisciplinary primary care.

In Canada, these ideas have been brought together under the patient-centred Patient's Medical Home program. This sets out a set of expectations that primary care should be accessible, provide continuity of care, and offer access to a range of professional specialisms, including social and community-based care. Although wider recourse to this model would imply a move away from the

[2] Green LA et al. N Engl J Med 2001;344:2021-2025.

traditional model of small GP practices, we agreed that it was probably the most effective way of meeting the needs of older people, and thought it would make sense in the UK, too.

A less radical intermediary improvement in primary geriatric care in the UK has been achieved by enhancing the role of Senior Nurses at the GP practices. This makes sense for chronic conditions, both in cost terms for the practice and because it is usually easier for patients to obtain an appointment promptly.

While primary care on site is essential, there are many circumstances when virtual, or remote healthcare can help. In remote and rural locations some patients may prefer telephone and/or video call consultations due to mobility issues or costs and availability of transport. Making such services a routine part of the primary care offer will require significant changes in work practices in primary care but providers should start to meet these challenges sooner rather than later.

Recommendations

9 Governments should increase efforts to ensure that more older persons are attached to a multidisciplinary primary care practice based on the Canadian Patient's Medical Home model (https://patientsmedicalhome.ca/), with access to sufficient expertise in ageing and healthcare for older people; access to a wide range of healthcare disciplines, including social and community-based care; and the ability to provide continuity of care

10 Primary care providers should offer virtual care options for patients who want them, including telephone and video call appointments.

11 Hospital practice needs to adapt to the growth of co-morbidity and complexity, not least by ensuring effective working relationships with patients' primary care providers.

5.3. Medical research

Ageing is a multifaceted process studied by basic scientists, public health scientists, social scientists, anthropologists, and policy-makers. But knowledge tends to be locked in silos. For example, we have seen age-for-age reductions in rates of dementia, yet we have limited understanding of social factors that may have influenced this. We need a more multidisciplinary approach.

Many drugs targeted at the elderly have not actually been trialled in those populations. This is an example of a wider problem whereby research into diseases and drugs focusses on otherwise healthy working-age populations. However, as discussed above, the elderly experience high rates of co-morbidity. This may create additional risks where drugs react with one another.

It is therefore important that research into other conditions, such as infectious diseases, should include specific study of elderly populations, and for clinical trials of drugs to include elderly populations. Where this has not happened for drugs already in use, there needs to be surveillance of usage and effectiveness in elderly populations.

Recommendations

12 Create national and international frameworks for multidisciplinary research teams to come together to explore new ways of understanding the causes of diseases.
13 Provide funding for better population-based studies to understand the causes of different types of dementia including better understanding of the effects of communities and social networks on the development and progression of dementia.
14 Ensure that research into the effects of diseases of all kinds includes specific study of elderly populations and those with other conditions (co-morbidities).
15 Include elderly people in the trials of more drugs.
16 Ensure that systems are in place for evaluation of the usage and effectiveness of drugs on elderly populations, and especially of drug interactions, as the number of drugs being taken simultaneously increases with co-morbidity.

5.4 End of life care

"When it comes to death, we are all amateurs" (Philip Roth)

90% of people die slowly and only 10% suddenly. Yet 60% of deaths occur in hospitals and only 8% in hospices. People would be better served if more of them could die at home or in hospices rather than in hospitals. However, in the UK, hospices are charities and only receive 20% of their funding from the NHS.

As a starting point, we need better information on the "quality of dying". It is important to realise that a life-limiting illness has not only a physical dimension but also social, psychological and spiritual dimensions.

Thus palliative care should be thought of as about living rather than dying, and intervention should start at the point of diagnosis of a life-limiting illness, not when acute treatment in required.

In the UK people are encouraged to take out Powers of Attorney, covering both healthcare, including life support preferences, and management of their financial affairs should they become incapacitated. Some care homes encourage the elderly to sign "Do Not Resuscitate" forms at the age of 75 (which may be appropriate in particular cases, but has attracted strong criticism as a general practice).

In Canada, there is greater support for the concept of Advanced Care Planning to encourage the 'difficult conversation' about wishes and preferences at an earlier stage. The Advanced Care Plan can be registered and can be accessed via information on the driving licence in some provinces.

The value in Advanced Care Planning is not just that it helps patients themselves to articulate their wishes and to stay in control of decisions, but also helps family and care providers. If the 'difficult conversation' is left too late, some patients may assume that the conversation is actually about care providers trying to cut costs or even family concerns about inheritances.

End-of-life care decisions should primarily be about the comfort and dignity of patients rather than financial considerations. When it comes to palliative care, it is cheaper for people to die at home than in hospital. There is potentially an overlap between the financial incentive of the provider and the desire of patients to be at home. It is important that, if there are efforts to promote Advanced

Care Planning, money is not, and is not seen to be, the motivator of the process, but that it is about assisting patients, families and doctors to ensure comfort, dignity and the best care for patients.

5.5 Medical assistance in dying

Medical assistance in dying (MAID) became legal in Canada in 2016. 1.5% of Canadians now take advantage of MAID, although there are geographical variations. In British Columbia, it is 3-4% while on Vancouver Island, it is around 7%. Experience in the Netherlands and Denmark suggests that the national figure may settle at around 4%.

Before MAID can be offered, two independent eligibility assessments must be made that various tests have been satisfied. The applicant must:

- be Canadian;
- have capacity to opt for MAID;
- be in an advanced state of irreversible decline;
- be experiencing 'unbearable suffering';
- be at a point when death is reasonably foreseeable.

The provision that death must be reasonably foreseeable has been challenged in the courts on the human rights grounds that it excludes those without a terminal condition. The provision on unbearable suffering is also being challenged. There have also been suggestions that because of the availability of MAID, people should have a guaranteed right to the full range of palliative support (which is by no means equally available across Canada, any more than it is equally available across the UK).

Recommendations

17 The concept of Advanced Care Planning should be more systematically developed and better promoted, especially in the UK – and drawing on Canadian experience.

18 Care providers should help patients undertake Advanced Care Planning (or guide them to other sources of help in this regard) at the time of, or soon after, diagnosis of potentially life-limiting conditions. This gives patients, families and doctors the greatest chance of maximising the dignity and comfort of patients if and when they come to need end-of-life care.

The availability of MAID in Canada increases the case for more general availability of affordable palliative care, so that decisions are driven as far as possible by social, psychological and spiritual considerations rather than chronic medical exigencies. Issues around the availability and funding of palliative care should be a particular focus of policy in both countries.

6. Older people as an asset

Increasing longevity should be a cause for celebration. Yet much of the policy debate relates to problems – particularly fiscal problems – that result from having a greater number of older people. Insufficient attention is paid to opportunities, and particularly the contribution they can make to childcare and volunteering in the community.

Neither the UK nor Canada has been good at capturing the value of this contribution. It has tended to be treated as a residual – what is left over after work and paid-for services – rather than as an essential component of how we support our ageing societies. The UK has tried to address this

through “household satellite accounts” which document the economic value of volunteering and unpaid caring activities.

6.1 Childcare

Grandparents have become an essential part of the modern labour market through their contribution of unpaid childcare. Without this support, many families would find it much harder, if not impossible, to navigate the complexities created by the fact that school hours seldom match working hours.

Discussions about the need for older people to work for longer in order to meet the fiscal challenges of increasing longevity ignore the contribution already being made by many older people to their family’s labour supply. Yet there is little hard evidence on grandparent childcare and factors that might affect its availability. That evidence needs to be collected.

6.2 Volunteering

Within the retired population, there is more than one generation. People aged in their late 80s and early 90s were teenagers during the Second World War while those aged 65 were teenagers in the late 1960s. Not only are their experiences very different, but so are levels of health, mobility and dependency.

For many local charities, seniors – and especially the younger generation of seniors – are a mainstay of volunteering activities. The majority of their volunteers are over 60, and many are over 70. Yet there are large variations in levels of volunteering – with some places and groups of people seeing significantly lower levels of activity.

It is often asserted that volunteering helps to:

- reduce social isolation by providing volunteers with purposeful activities, increasing social connections and self-esteem;
- restore resilience in communities;
- change the relationship between healthcare providers and communities into one of partnership;
- reduce overall healthcare costs (for volunteers as well as for those receiving their services); and
- perhaps also give volunteers better access to, and knowledge of, services which they may themselves require later in life.

Given the potential benefits of volunteering – to society and to the volunteers themselves – both countries need a stronger evidence-base on volunteering and unpaid care, and notably its economic value (recognising, incidentally, that not all volunteering is unpaid. Many voluntary organizations supported by local authorities pay ‘volunteers’ on the same scale as local government officials). The UK has made a start on this work through so-called “household satellite accounts”. In Canada, a recent report[3] estimated that seniors raise more than $4bn every year for charities and other non-profit organizations and generate nearly $11bn in economic value through their volunteer efforts.

It makes sense for the state to support and promote volunteering by seniors where current levels of activity are low. One way may be through “time-banking”, where people volunteer their time and in return receive time credits which they can redeem later in life, should they require the services of

[3] 2019 Revera Report on Aging: Living a Life of Purpose

others. This approach seeks to marry the notion of an individualistic society with a method of building healthy communities with social contact and relationships of reciprocity.

There has been limited assessment of the effectiveness of such schemes. Volunteering deserves to be further studied and promoted on the basis of better evidence.

Recommendations

19 The contribution of seniors – and especially of grandparents to childcare – should be more clearly recognised as an essential part of the functioning of the labour market in today's society. There would be value in more research to document the extent of this contribution.

20 Canada should consider producing "household satellite accounts" similar to those of the UK, which document the economic value of volunteering and unpaid caring activities.

21 Governments at all levels should make more effort to celebrate the contribution of retired volunteers to their communities. Part of this should be the regular publication of statistics on volunteering, such as the UK's Community Life Survey.

22 Local government should provide more information about volunteering opportunities and find other ways to encourage volunteering, particularly through support for people who face barriers to participation.

23 Both countries need to build a better evidence base to prove the effectiveness of different volunteer-led interventions, including "time-banking", which might encourage unpaid contributions to care.

7. Financial security

7.1 Pensioner incomes

40 years ago pensioners in the UK were much more likely to be poor than the working age population. That is no longer the case: average incomes of pensioner households in the UK have increased to the extent that they are now equal to average working age incomes. This reflects generous uprating of the state pension and the fact that new cohorts of pensioners have been retiring with higher amounts of occupational pension. On average, pensioners face lower housing costs than in the past due to higher rates of home ownership. Yet 1 in 6 pensioners still live in poverty.

It is likely that these improvements in pensioner income will not continue, and may reverse, because defined benefit pensions are now very rare in the private sector, and voluntary pension provision is therefore likely to be less generous. Importantly, too, a smaller proportion of the working age population are homeowners, meaning that more pensioners in the future will be renting in the private sector, where costs are higher. It would be helpful if commentary was based on a more granular level than "pensioners" as there is significant diversity of experience: some are comfortably off while others have few assets, small pensions, and struggle with rent payments.

Recommendations

24 Public policy needs to address the fact that recent increases in pensioner incomes in the UK are unlikely to continue due to falling occupational pension income and reduced home ownership. There is likely to be an increase in the number of seniors in privately rented homes without significant pension income or assets.

7.2 UK Pensions

In the past, the state pension system in the UK has been caught between the objectives of providing income replacement for middle and higher earners, and providing a base amount designed to prevent poverty (upon which those with capacity can build their own voluntary private pension saving), doing neither well enough. However, the most recent reforms to the system have made it clear that it is now designed for the latter objective, not the former. Arguably, with a single-tier pension set at a higher level and with a generous calculation for annual increases, it is now better at that objective.

This means there is more onus on individuals who wish to have an income above the base level to provide for themselves. Yet in the context of increasing longevity (and persistently low interest rates), it is harder to save for retirement. The choices facing individuals planning their saving for retirement are to:

- Work for longer;
- Retire later;
- Live on less during retirement;
- Save more while still working.

Longer working lives would at once increase the period in which people can accumulate pensions and savings, and reduce the subsequent period of retirement when these assets have to be drawn upon. Working longer may also have psychological and social benefits. Successive governments have therefore sought to encourage people to work on, for example by making age a protected characteristic under equality legislation; creating a Business Champion for Older Workers; and through the Extending Working Lives programme. The over-60s cohort is the fastest growing component of the labour market, so some progress has been achieved.

Concern was expressed, however, that those enjoying longer working lives tend to be higher-educated people working through choice. People on lower earnings are more likely to want to leave work as soon as they can (whether because of the physical demands of their jobs or the low job satisfaction of shift work, for example). And many of those who would like to remain in employment for financial reasons cannot find good work as they get older.

We need to understand better what older people want from work and how the labour market does or does not deliver this. Are people respected? Do they trust their employer? Do they have some control about their working life? Do workplaces have the flexibility to cater for people with responsibilities as carers? There are plenty of people who would be capable of remaining in work, and might choose to do so, yet go onto disability benefits or retire because their employers do not encourage them to remain in work by offering the flexibilities that might be required.

There is also a question about the real contribution of occupational health services. Do they make a positive contribution to tackling problems such as musculo-skeletal and mental health disorders, or are they too often understood to be a service to which people are sent when their employer is keen to get rid of them?

One area needing more research is the interaction between working longer (or getting state pension later) and increasing morbidity with age.

Recommendations

25 We support continuing labour market reforms to encourage longer working lives, but more research is needed about how this impacts people on lower earnings.

26 Data on the increasing incidence of work-impairing medical conditions with age needs to be updated by researchers; and governments should consider how the results might be socialised.

7.3 Private pensions in Canada

Canadian employer pension plans offer a good deal to savers, because employers have to match employees' contributions. Yet only 38% of workers are covered by such plans, and the median amount of savings for families nearing retirement without such a plan is only $3,000. Too many people on higher incomes in Canada who could afford to make provision for themselves end up not doing so and become reliant on the state.

For people in the lowest marginal tax band, there is also little tax incentive to save for a pension. One reason for this is that there is a patchwork of provincial, income-tested programs for retired people. Combined with national programs, this leads to an effective marginal tax rate on pension savings of over 100%.

One potential solution is the creation of a new savings product with contributions from taxed income, providing investment returns and income drawn in retirement that is exempt from tax. The income from such products would not be taken into account in assessing pension-age means-tested benefits.

To encourage greater take-up by low-income workers, there is a need for products that can be sponsored by employers and organised through payroll systems.

Recommendations

27 There should be adequate modelling and documentation of the overlapping provision of means-tested support for retired people provided by the Canadian federal government and provinces to try to eliminate effective marginal tax rates greater than 100%.

28 Canada should seek to develop employer-sponsored savings products with contributions from taxed income. Investment returns and retirement income would be at once exempt from taxation and excluded from consideration in means-tested systems of support.

7.4 Private pensions in UK

The UK relies heavily on private pensions to supplement the state system. There has been a steady shift to Defined Contribution schemes, not least because occupational Defined Benefit schemes became unaffordable for businesses in a low interest environment.

But not everyone has the same opportunity to provide for their old age. Those working in the public sector tend to receive more generous index-linked pensions than those in the private sector, and the self-employed only have private pensions to the extent that they forego income for that purpose.

In 2012 the Government introduced a new Auto-enrolment Defined Contribution system which has been spectacularly successful in attracting over 10m members. But the contribution rate is too low to provide most people with a decent retirement income.

It is a formidable challenge for citizens to make the best decisions about their finances, and there is inevitably an element of individual risk, given unknown future investment returns, unknown lifespan, and unknown expenditure needs in retirement. Yet if people get these calculations wrong, they may well run out of money and become reliant on the state. There is therefore a case in both countries for more group-defined contribution schemes where annuitisation is pooled across a population to spread longevity risk. Yet the UK reforms of 2015 that gave people more flexibility about when and how to access their defined contribution pension savings *reduced* opportunities for pooling annuitisation risks.

Recommendations

29 The UK Government should seek to implement the findings of the 2017 Auto-Enrolment Review on how to develop the system to produce adequate pensions for the majority.

30 Governments in both countries should consider ways of increasing incentives and support for collective defined contribution arrangements in which annuitisation risks are pooled.

7.5 Pension advice services

Both countries have wrestled with the best way to regulate the quality of advice available to individuals about when and how to take income from private defined contribution pensions – and how to ensure that advice is both correct and genuinely disinterested. Problems in this area are exacerbated by the fact that only those with the large pension pots can afford advice in the first place. Governments offer free online advice services in both countries, but these tools leave much to be desired.

In Canada there is a particular problem about when to take income from the Canadian Pension Plan. Delaying receipt can increase the value of monthly payments by as much as 50%. Yet 95% of people are advised to take their income early, resulting in reduced income.

Recommendations

31 Still more assertive regulatory policing is required to overcome conflicts of interest and bias, and to improve the quality of advice received by people undertaking pension planning.

32 Governments should redouble efforts to provide online (and other) tools offering the simplest possible decision-making process – free at the point of service – to help people navigate complexity in relation to pensions.

8. Other Financial issues

In the UK, the state spends a little over 5% of GDP on pensions, 1% on social care, and just over 7% on publicly-delivered healthcare. These percentages have more than doubled over the past 40 years. Healthcare expenditure has increased by a fifth in real terms during the period since the 2008 recession. Effectively, increases in healthcare expenditure have been funded by cuts to other public services, and notably to defence spending, which was reduced from 5% of GDP in 1980 to 2% in 2000, with the end of the Cold War.

8.1 State pension

State pension expenditure in the UK is expected to rise only by about 2 percentage points of GDP over the next few decades, despite relatively generous indexing that keeps pace with the higher of

average earnings growth and price inflation. This modest growth is to be achieved by planned increases in the state pension age, which is slated to rise to 69 by the 2040s.

With increasing longevity, there is a case for pushing that trend even further. The Office for National Statistics (ONS) has suggested that "old age" should be reckoned to begin at 70. The Centre for Social Justice (CSJ) has even suggested an increase in the state pension age to 75.

But this remains a highly-charged political issue. Lower socio-economic groups live less long than higher ones. In the UK, life expectancy at 65 varies from 12.3 years for the lowest group to 23.5 years for the highest. One consequence is that increases in the state pension age have a regressive effect, as the poorest members of society receive the benefit for less long than the richest, and the implicit redistribution from lower income groups to higher income groups caused by income-related longevity becomes even more pronounced.

Even where state pension systems include a degree of horizontal redistribution through, for example, income-related contributions paying for flat-rate pensions, some of this is counteracted by the fact that people on lower incomes receive their pensions for fewer years.

In consequence, the UK Labour Party has opposed increases to the state pension age, and in Canada Justin Trudeau reversed the previous government's decision to increase the age for Old Age Security from 65 to 67.

If the consensus around funding uprated state pensions through increases in the state pension age is to be restored, it will need to take into account the very different experiences of people who are likely to receive their pension for only a short time compared to those who expect to live for two decades or more after retirement (for many of whom the state pension in any case represents only a small supplement to their income).

Recommendation

33 Better understanding is needed of the redistribution from poor to rich implicit in state pension systems arising from longevity. In June 2019, the UK Minister for Pensions and Financial Inclusion accepted the case for a new cross-party Pensions Commission to chart a way forward on the current fault lines including incentives to save (which are at present greater for higher income individuals). We support the creation of this Commission.

8.2 Social care

In the UK, social care is in a mess. It is provided by local government on a means-tested basis according to national standards. Spending in recent years has fallen because of very large cuts to local government budgets, though social care budgets have been protected to some degree, receiving less than the average cuts.

Means testing and needs-based assessments ensure that state support is restricted to those with little or no wealth, and in the greatest need. Others must draw on personal assets, and many have to use the capital value of their homes to pay for social care. This is not popular, as people want to be able to pass on homes to descendants, but knowledge of the situation is low until people experience it themselves.

Social insurance is the obvious approach to situations of this kind, where large costs are borne by a small minority. Yet significant reform has been ducked by successive governments, because there is little public understanding of the issues, which are easily politicised. In 2017, for example, Theresa

May suffered heavily in the polls for suggesting that people's homes should be included in the means test for eligibility to social care, which was dubbed a "dementia tax". This mirrors the situation in Ontario, where no government wanted to take up the recommendations of a major study on long-term care insurance because they implied an increased tax burden.

In the UK, the 2011 Dilnot Commission report on social care generated a certain consensus that the solution is likely to lie in some variant of saying that people should pay for the first tranche of costs, after which the state will step in. In principle, the additional costs could be funded through general income taxes, a wealth tax, or through taxation specifically designed to be paid by people at older ages. Examples include capital gains tax, housing taxes, inheritance taxes, and taxes on occupational pensions at the point when these are paid out.

People are highly resistant to retrospective taxes. So, although the current tax treatment of pensions is very generous, it is difficult to go back on that expectation. However, in the UK there has been a gradual reduction in the tax advantages of pension saving by higher earners, and by and large this has been accepted.

In the UK, inheritance tax is paid by only 10% of people, yet it remains unpopular ("No taxation without respiration" as one participant put it). It is noteworthy that, though the inheritance tax take has increased over time, this has not reflected a tripling in the value of assets relative to income in the last 30 years. There might be other ways of adjusting the taxation system to raise more from assets.

A final point about the importance of bringing the taxation of assets to the fore relates to the economic situation of the past 10 years. In a very low interest rate environment there is less incentive to save for retirement, and pensioners living off savings income face a real struggle. If this situation were to persist, housing wealth would become an even bigger driver of future wellbeing, with attendant problems of reduced social mobility.

Lack of public understanding seems to lie at the root of obstacles to meeting the fiscal challenge of social care. There is an urgent need to educate people – as Bismarck and Beveridge did in their day – about social insurance as a basis for the Welfare State.

Recommendations

34 Canada and the UK should consider establishing commissions on the balance between taxation of assets and income, as current trends suggest that wealth inequalities will become increasingly significant in the coming years.

35 Both Canada and the UK need to develop better mechanisms for honest, informed debate between politicians, the public, and the media about how to meet the fiscal challenges of an ageing population.

8.3 Unpaid care

The adequacy of state expenditure on social care can only be understood in the context of the contribution made by family members who provide unpaid care. Changes in family structure have huge potential consequences for the supply of unpaid care. If fewer people in future have children, for example, that is likely to increase the costs of state support for social care. Similarly, much unpaid care is provided between couples, and by other members of households.

If the demographic structure of the population were to change – with more people living in multi-generational households, for example, or changes in the proportion of retired people living alone or as couples – this would have an effect on unpaid care. The aggregate fiscal effects of even small changes in the propensity to provide unpaid care are not well understood.

This report has already discussed the merits of longer working lives to sustain healthy household finances. There is evidence, for example, that recent increases in the State Pension Age for women in the UK have increased employment rates within the relevant age groups. One disadvantage of this trend is that it may reduce the supply of people able to provide unpaid care to older relatives.

Section 6 above discussed the extent to which childminding and volunteering by older people has been treated as a residual rather than as an essential component of how we support our ageing societies. The same applies to unpaid care services more generally. This report has already proposed, in Recommendation 22, that Canada might look at UK experience with "household satellite accounts" which document the economic value of volunteering and unpaid caring activities.

Recommendation

36 The role of unpaid care needs to be better understood: its volume, its substitutability (or otherwise) for paid-for care, its relationship to employment, and its relationship to the demographic structure of households

8.4 Healthcare

In the last 25 years, UK health spending has risen from 13% to 19% of public expenditure. The trend is continuing, and the Office for Budget Responsibility estimates that it may reach 27% over the next 25 years. There is little appetite in current discussions for changing delivery mechanisms or funding sources: the big questions have been about how to ration services. This will become increasingly difficult as technological and pharmaceutical advances offer an ever greater choice of interventions.

8.5 Public spending

The UK has seen a one-off change in the wealth of one cohort of pensioners, many of whom have benefitted hugely from economic and social developments in their lifetime, and notably the rise in house prices. This will transmit to future generations through inheritance for some, but not for others. Inheritance will be a larger determinant of wellbeing in retirement in the future.

With fertility below replacement rates, it is likely that fewer people will be entering the workforce in the future, which raises questions about how to sustain the tax base without creating inter-generational tensions. Up to a point, this issue can be internalised within each family. But if this is the entirety of the solution, greater reliance on inheritance will create future problems with social mobility.

To address the needs of an ageing population, public spending will have to rise to pay for increased healthcare, more funding of social care and, potentially, more state support for pensioners without sufficient private pension provision. If another part of state expenditure cannot be reduced, taxes will have to rise. At present this is not being discussed openly. Part of this conversation needs to include a more intelligent discussion about the role of social insurance in funding social care.

9. Technology and digital innovation

There is significant potential for new products and services to help tackle loneliness, promote independent living, improve healthcare and support older people in the workplace.

9.1. Social care

As already observed, the present generation of pensioners has unprecedented spending power. This should drive investment in innovation that would improve productivity in social care, as long as there is clarity about what can be replaced by technology and what cannot.

Much has already been achieved. User-interface design (e.g. text to speech and vice versa) has had beneficial impact for older users, and notably those with disabilities. Advances in self-learning – adapting to real-life usage patterns once deployed – will better enable products/services to meet the needs of older people.

Yet there seem to be obstacles to the development and deployment of technology and digital services to the older generation of seniors.

An important question is the motivation for the deployment of technology: is it to reduce the burden on carers – family or professional – or is to improve the lives of users? Some new services such as remote monitoring of seniors, and communication with them, seem more motivated by providers looking to save costs than the real needs of those they purport to help. There needs also to be greater consideration of the privacy implications of such technologies, particularly if they become a more routine part of social and ('telehealth') medical care.

It will be important to ensure that the people least confident about technology are engaged in the process of designing products and services, and that support is provided to build confidence in using new technology. This applies both to private sector innovation and to the public sector.

It is very difficult to predict the business models and technology that will emerge in the future. Will there, for example, be an 'Uber' of social care? Should more be done to help (mostly younger) tech developers to understand older markets?

We tend not to think of carers as consumers, but they have a strong voice in the adoption of technology, either as the purchasers of technology on behalf of those with care needs, or as direct consumers in their own right. It would help for carers to have a clearer collective voice on many issues – in relation to government policy, but also with regard to the potential for technology to help them in their roles.

9.2 Medical care

Technology is enabling many new medical devices and applications that support health and healthcare. In some cases these are prescribed by physicians. However, there is also a market for products that go direct to consumers.

Both Canada and the UK have also seen the development of online patient groups for the exchange of information and the provision of mutual support. These efforts have often been outside the formal healthcare system, because patients – understandably – have wanted to fill information gaps.

And as noted above there has been an expansion in 'telehealth' services.

Some participants in the meeting raised concerns about the regulation of such products and services, notably as it applies to the accuracy of data, data sharing and privacy. Consumer protection

services, private as well as public, should recognize the particular vulnerability of the elderly to fraud.

9.3 Pensions

Digital technology may help to address some of the problems of unbiased quality information and guidance discussed above – helping young people to make decisions about pension saving, for example, or helping those at the point of retirement to make decisions about what to do with their pension funds.

However, abuse is a real risk. Applications giving unregulated providers direct access to consumers and the potential to set up automated flows of money would bring new risks of financial fraud.

9.4 Transport

Transport technology is a particularly relevant field because mobility plays such an important role in enabling some older people to stay active. Driverless cars are likely to bring a particular benefit to those unable to drive any longer – but there is still a challenge in transferring from wheelchair to car. Up to now, the focus of technological development has been on the driverless function, but in the context of an ageing population thought will also need to be given to the transfer from home to car.

Recommendations

37 Industries should involve older people in product design and seek to reduce barriers to adoption by older people.

38 Regulators should ensure that the marketplace for technological solutions for older people is well protected against abusive and fraudulent products, inaccurate medical information and breaches of privacy.

39 Governments should help build trust in the digital world amongst older populations through active measures to increase knowledge of and confidence in technology

40 Where the market is slow to develop solutions (e.g. for very old people, and people experiencing cognitive decline), governments should consider how to incentivise businesses to develop solutions focussed on these groups, including funding research into potential needs to increase the flow of market knowledge about these groups.

10. Housing

10.1 Importance of home

Home is particularly important for older people: 93% of older Canadians live in their own home (as opposed to care institutions) and, on average, older people spend only about one hour a day outside the home. Housing is both a basic need which everyone must have, and a social determinant of health and wellbeing. In addition to its practical value, it has meaning associated with attachment to place, objects, memories, family and social networks, and community.

Yet too many homes are ill-adapted to their ageing occupants. Damp, draughty and cold homes damage health. By the same token, many homes conceal risks that cause harm. Homes that are not accessible can feel like prisons.

Homes and housing also have an effect on social interaction. Living alone without opportunities to meet people leads to isolation. This can be particularly severe for people living in rural and remote homes. One aspect that contributes to this sense of isolation is the practicality of navigating an icy step at the front door, which is particularly a problem in Canada. The UK has banned the front door step by making flush entry a requirement of new building, although there are many older homes that do not conform to this standard.

Housing also has an effect on personal and public finances. If a home is not suitable and the elderly have to go into residential care, this creates a financial burden on individuals, families and the state. By the same token, it costs health services more when people have to stay in hospital for longer due to having unsuitable housing.

What does the evidence suggest that older people want in a home? In particular:

- Light and Space
  - As we age, less light gets to the back of our retinas.
  - Many older people have an interest in downsizing, but they also want a place to put stuff.
- Accessibility
- Sustainability
  - Net zero homes reduce bills as well as carbon emissions. It is the reduced bills that are the bigger selling point.
  - "Sealed environments" should not be overdone – the circulation of air is still important.
- Shared space and facilities
  - If homes lack spaces in which people can do things together they stifle opportunities for companionship.
- Technology
  - It is cheaper, more practical, and easier to provide support if – where appropriate – older people can be helped to use the same technology as others rather than bespoke applications designed specifically for older people.

10.2 Demand and supply

In both Canada and the UK, three-quarters of over 65s own their own home, but tend to under-occupy it. In the UK, at least, many express a general interest in downsizing, but most never act on it. About one sixth of UK housing is owned by the state. Older people in municipal housing are also more likely to be under-occupying.

The private rented sector in the UK has increased significantly, and now stands at about one fifth of all housing. With home ownership rates declining among people of working age, we can expect more people to retire as renters in the private sector. People in this situation may face increasing hardship in retirement as housing costs rise as a proportion of income (even if Housing Associations and joint ownership schemes help at the margin).

In Canada, 24% of seniors spend more than 30% of their income on housing. To illustrate the problem, the median income of people aged 65 and over is $27,400 but the average rent for a one bedroom apartment is $1,261 per month. There is therefore a growing waiting list for rental housing subsidies (either subsidy or subsidized housing). For example 32% of people on the waiting list in Ontario are aged 65 or over.

In the UK, both major political parties have pledged to build many more homes in the coming years, but there is a question of how much will be tailored for older people. With legal duties on local municipalities to house families with children, the focus is often on family housing. Because of this, the needs of older people are often ignored.

In addition to building more homes, the state can also intervene on regulations relating to sustainability, design, construction and planning. One vehicle for such intervention is through local plans, which set the framework for local planning decisions. It is important that local plans explicitly include provision for older people.

10.3 Ageing in place

One of the aims of policy in recent years in both Canada and the UK has been to improve the options for older people who wish to stay in their own home. There are a number of pillars that are required to deliver this aim. Homes should be designed in a way that is capable of accommodating the changing needs of residents as they age. One example of an attempt to set out what this means is the Lifetime Homes Standard in the UK, which incorporates principles of inclusivity, accessibility and adaptability.

The potential for adaptation is particularly important as most homes are not new. Often, low income seniors may need relatively small amounts of funding to enable them to stay for many years in treasured homes. It can be of help in this process to anticipate these needs and make adaptations gradually whilst at younger ages. There may be value in encouraging people to consider in advance their future housing needs through advanced plans, spreading the cost over a longer time period.

Often, people wish to stay in their own community, but are keen to move to a smaller dwelling without steps. Housing planners should take account of the needs of older people in this way. Enabling older people to move also has the potential to free up larger family homes for others, creating a wider community benefit.

In the UK some local authorities have combined with private sector builders and developers to create sheltered housing for the elderly, grouping individual dwellings around a central hub, with the benefit of a warden and other shared facilities. This model works well, usually on a rental basis.

Not all mortgage lenders have taken account of improved health and longevity. Older mortgage applicants often find themselves refused on grounds of age, even if such discrimination is not formally acknowledged. In the present low interest rate environment, home ownership may be a feasible ambition, even in early retirement. Regulators and politicians should seek to ensure that lenders do not close the door to those in their 50s, 60s or 70s, or discourage them by making loans unreasonably expensive.

Similar considerations apply to insurance – creating difficulties, for example, for older people trying to rent a car. It is not clear that all insurance companies have updated their actuarial tables to reflect better health and greater longevity.

Recommendations

41 Housing policy should explicitly address the needs of older people, not just families with children
42 Local plans in the UK should include provision for housing for older people, including sheltered housing projects, where appropriate.
43 Local government should make standards such as the Lifetime Homes Standard a precondition for permission for building new homes.
44 Funding should be available for older people to make adaptations that will enable them to stay in their own home for longer.
45 There would be value in pilot projects to encourage people to make advanced plans for housing in retirement.
46 Regulators and politicians should seek to ensure that people are still able to acquire mortgages and rent cars – and at reasonable rates – as they get older.

11. Communities

11.1 Age-Friendly Communities

It is of course not just the home that enables people to stay in their community as they get older. Also important are the convenience and accessibility of local shops, whether there are adequate transport facilities, whether a community feels safe and welcoming, and whether there are appropriate services, including libraries, cultural centres and options for adult education. The University of the Third Age plays a valuable role in this context.

The World Health Organisation has developed a framework for Age Friendly Communities and in both Canada and the UK there are networks of municipalities that are working together to share learning and examples of age-friendly practices.

11.2 Diversity

Special attention needs to be paid to an older population that is becoming increasingly diverse. Will the services that have been offered hitherto meet the needs of ethnic and LGBTQ minorities and, in Canada, also indigenous seniors?

There is a need for public authorities to understand the diverse needs and wishes of the population that they serve, and to recognise, as that population changes, that they need to have mechanisms in place for understanding the varying needs of sub-groups of the population.

11.3 Loneliness and isolation

The discussion on health (section 0) highlighted the need to focus on improving care by focusing on the whole person, not just the disease. Part of this is the need to tackle loneliness and isolation. Not only is this right in itself, but it can potentially reduce the need for intensive medical interventions.

There is a lack of consistent data on loneliness. In the UK, there has been some attention on this issue in recent years, but the devolved administrations of the UK each use slightly different approaches to measurement. In Canada, official statistics are limited to the number of people living alone rather than those experiencing loneliness.

11.4 Local services

Local services, social care and primary care are critical to addressing loneliness and isolation. It is particularly important that there are local non-medical services on the ground. Services that could be perceived as non-essential (e.g. cleaning, handyperson services, community wardens) play a vital role in helping reduce isolation. Whether such services are provided through the voluntary sector, or publicly funded, they are a crucial adjunct to medical care.

Handyperson services can be vital in enabling adaptations of the home that allow people to stay in their homes for longer, and permit speedier discharges from hospital. They should therefore be part of the standard framework of services available to older people.

These are issues that can affect people at all levels of income, not just those entitled to state support. While services such as these should be available for free to people on low incomes, they should also be made available to others on a charged-for basis.

11.5 Abuse

Anecdotal feedback from local social care providers suggests that support cases are becoming more complex, and they are seeing more abuse cases. Abuse and safeguarding issues affecting older people have very little visibility. It is important that local governments, police and social care services should have strategies for identifying and tackling abuse, whether it comes from families, members of staff or strangers (or, indeed, from older people themselves abusing carers). This should be an essential requirement of quality standards for local services and inspection regimes.

Recommendations

47 Local governments should, as part of their development of a strategy on ageing, develop proposals to move towards becoming Age Friendly Communities.

48 National statistical agencies should ensure that statistics and microdata on the prevalence of loneliness are published on an annual basis

49 Local authorities, both urban and rural, should ensure that services available to older people include non-medical ones (e.g. cleaning, handyperson services, community wardens) as well as medical care.

50 Local non-medical services such as these should be available for free to people on low incomes but also on a charged-for basis for others.

51 Local governments should ensure that they understand and meet the needs of ethnic and LGBTQ minorities and, in Canada, also indigenous seniors.

52 Local government, police and social care services should have strategies for identifying and tackling abuse of older people, and this should be an essential requirement of quality standards for local services and inspection regimes

12. Conclusion

As is clear from this report, the discussion at the Canada-UK Colloquium was wide-ranging and covered an extraordinary amount of ground. There was a strong desire amongst participants to carry work forward together in the future.

Recommendation

53 The participants of the UK-Canada Colloquium on Ageing Well should form a virtual network – with working groups where appropriate – to deepen the discussions at the Colloquium, to refine these recommendations, to share best practice and to drive policy change in Canada and the UK.

ANNEX

AGEING WELL PROGRAMME

CANADA-UK COLLOQUIUM 2019

MØLLER CENTRE, CHURCHILL COLLEGE, CAMBRIDGE

What are the challenges and opportunities, for Britain and Canada, of demographic shifts towards longer lives and larger populations of older people? What should be the public policy responses?

Chair: The Rt Hon the Lord Filkin (Chair of the House of Lords Select Committee on Public Services and Demographic Change which published "Ready for Ageing?" in 2013).

Friday 22nd November – Briefing Day

St John's College, Cambridge

08.00 BUFFET BREAKFAST

08.45: Depart Møller Centre on foot for the Music Room, St John's College

Case Studies and Presentations

09.10: Introductions
09.15: Tina Woods (Co-founder and CEO Longevity UK) and **Lord Filkin**
Improving healthy life expectancy in England - why and how.

10.00: Professor Carol Brayne, Cambridge Inst of Public Health – Ageing and change in populations: Relationship to Risk Reduction and Prevention

10.45: COFFEE BREAK

11.00: Helena Herklots, Welsh Commissioner for Older People – The Welsh experience
12.00: Dr. Samir Sinha, Provincial Lead Ontario Seniors Strategy – The Ontario Experience

13.00: LUNCH with a welcome to the University of Cambridge from **Professor Eilís Ferran**, Pro-Vice-Chancellor

14.00: Visit to St John's Old Library
15.00: Melanie Wicklen, CEO AgeUK Cambridge
15.30: Anika Krause, LinkAges intergenerational housing project

16.00: Return to Møller Centre on foot

16.30: TEA

18.00: Depart Møller Centre for St John's College by bus
18.30: Evensong at St John's College
19.15: Depart on foot for Darwin College

19.30: Drinks and **DINNER** at the **Old Library, Darwin College**
Speakers: **Professor Jonathan Heeney,** Vice Master, Darwin College
H.E. Mrs. Janice Charette, Canadian High Commissioner
George Freeman MP, Minister of State at the Department of Transport (*in absentia*)

21.30: Return to Møller Centre by bus

Saturday 23rd November

08.15: BREAKFAST

09.00: Introductions

Session 1: Demographics

09.15: UK lead: Professor Sarah Harper (Oxford University)
Canada lead: Dr. Parminder Raina, Lead of the Canada Longitudinal Study on Ageing

Discussion looking ahead 10 - 20 years. Both UK and Canada expect to have larger older populations (both in absolute terms and proportionately), and these populations will tend to live longer lives.

Thematic questions:

- What are the projections in Canada and UK for the number of older people, life expectancy and healthy life expectancy?

- How does this vary socially?
- What are the links to migration?
- What drives well-being in later life, and how does it vary?
- Do UK and Canada face similar trends?
- Is there good awareness of them?
- Are they seen as problems or opportunities?

Session 2: Economics of an Ageing Population

10.15: UK lead: Paul Johnson, Director, Inst of Fiscal Studies
Canada lead: Graham Fox, President, Institute for Research on Public Policy

Larger older populations make more demands on the state for income support, pensions, health care and social care.

Thematic questions:

- How are the governments in Canada and UK responding to predicted increases in aggregate demand?
- Can good state-funded services be afforded?
- Who should pay for what individually, collectively and between the generations?
- Does the balance between personal responsibility and state provision need to change?
- What are the implications for social protection systems, as fewer workers support a growing proportion of retirees?
- Are our societies adequately provisioned?
- Should the role of the Voluntary and Community Sector (VCS) be further developed and even institutionalised?
- How can we best realise the benefits of a larger population of older people – e.g. in terms of labour supply, skills, tax revenue and new business opportunities, not least in the field of design?

11.15: COFFEE BREAK

Session 3: Health Care and Healthy Ageing

11.30: UK lead: Nigel Edwards, Chief Executive, Nuffield Trust
Canada lead: Professor Howard Bergman, Chair of Family Medicine, McGill University

An ageing population poses significant challenges for health and care systems.

Thematic questions:

- Are the issues well exposed and addressed in each country?
- Should the focus shift from treatment of the diseases of old age to targeted interventions to improve the health of younger cohorts - especially for low socio-economic status groups, to reduce post-retirement inequalities?
- What public policies will help to ensure that more people are able to enjoy not just good health in later life, but lives with meaning, purpose and social connection?
- Does 'social prescription' have a part to play?
- What work is in hand to reshape health and care systems for an ageing society?
- Is enough being done to integrate acute care and social care?
- What new technologies will have the greatest impact (positive, but also potentially negative) in achieving these objectives?

12.30: LUNCH

Session 4: Older People - Self-reliant or vulnerable?

13.45: UK lead: Lawrence Churchill – Chairman of the Pensions Policy Institute
Canada lead: Dr Bonnie-Jeanne MacDonald – Director of Financial Security Research, National Institute on Ageing

Many people alive today are likely to live ten years longer than their parents. To generate enough income for a longer life they may need to save more or to work longer. The longer that people remain healthy and stay in the labour market, the greater their potential to save, increasing the likelihood that they will be able to pay for their care and live in a social setting that supports their wellbeing in old age.

Thematic questions:

<u>Pensions</u>

- Across society, are people likely to have enough income to support the needs of a longer life?
- Who is at risk?
- What might governments do to stimulate more savings?
- What is the role of the state, the employer and the individual to ensure adequate personal pensions?
- How is the shift from defined benefit to defined contribution schemes playing out in practice?
- Are individuals being given adequate incentive (and portable pension
- products) to provide for longer lives and careers with fewer 'jobs for life'?
- Are companies under sufficient pressure to protect pension pots?

- With the expectation of longer lives, should the retirement age be adjusted, or even individualised? Was Trudeau right to reverse the policy of his predecessor to increase the retirement age from 65 to 67?

Other issues:

- Do we need greater support for people seeking to remain in work or return to it?
- Does more need to be done to combat workplace or other discrimination on the basis of age? This includes for example access to mortgages and insurance as well as vulnerability to fraud.
- Health and safety implications of work into older age.
- The market in UK has failed to provide insurance against a need for long-term care. Should the state intervene to try to fill this gap?

14.45: TEA

15.00: Breakout Groups

Breakout Group 1: End of Life Care

UK co-chair: Dr Richard Smith, Lancet Commission on the Value of Death
Canada co-chair: Dr Sandy Buchman, President, Canadian Medical Association

Thematic questions:

- How can governments achieve better value for money through a palliative care approach?
- What can Britain learn from Canada's experience of MAID (medical assistance in dying)?
- What is the future for palliative care and hospices? How can the experience of dying in acute hospitals be improved?

Breakout Group 2: Dementia/diabetes/genetic research

UK co-Chair: Professor David Gems, Institute of Healthy Ageing, UCL
Canada co-chair: Professor John Muscedere, Scientific Director of the Canadian Frailty Network (CFN)

Thematic questions:

- Which developments in medicine are likely to have the greatest impact on healthy life expectancy over the next 20 years?
- What are the public policy implications of the latest medical research?

- Will the availability of new treatments (especially 'personalised' medicine) have different implications for the richest and poorest in society?

Breakout Group 3: Safe, accessible, affordable housing

UK co-Chair: The Rt Hon the Lord Best, former head of Joseph Rowntree Housing Trust
Canada co-chair: Dr Suzanne Dupuis- Blanchard, Research Chair in Population Ageing CNFS, University of Monkton

Thematic questions:

- What public policies would drive an improvement in the condition and accessibility of existing housing?
- Should there be action to encourage more 'equity release'?
- Should there be mandatory minimum accessibility standards for all new housing?
- How best to encourage an integrated approach to 'age-friendly communities'? Where are the best examples, and what can we learn from them?

Breakout Group 4: Digital Innovation, especially as a driver of intergenerational initiatives

UK Chair: George MacGinnis, Challenge Director, Healthy Ageing, UK Research and Innovation
Canada Co-Chair: Daniel Fontaine, CEO of the British Columbia Care Providers Association

- How will digital innovation help to empower, support and protect ageing societies?
- Can new technology also help to promote the engagement of youth, and inter-generational approaches? How do young entrepreneurs see the challenges and opportunities?
- Both UK and Canada have legislation against ageism, yet attitudes have been slow to change. Do we sufficiently value qualities of wisdom and experience? Could we harness them more effectively? Does new technology have a role in this?
- The 'internet of things' and the role it can play, for example in social support.

Foyer: Technology Demonstrations

17.00: TEA

18.45: Bus to Trinity Hall College

19.00: DRINKS at Trinity Hall College

19.30: DINNER, Graham Storey Room, Trinity Hall
Speaker: **Dr David Halpern,** Chief Executive, Behavioural Insights Team

21.30: Depart for Møller Centre

Sunday 24th November

08.15: BREAKFAST

Session 5: Report from Break Out Groups

09.00: Report Back from the four breakout groups.

Session 6: Priorities for Action

10.00: **UK lead: Anna Dixon,** Director, Centre for Ageing Better
Canada lead: Mr. Michael Nicin, Director, National Institute on Ageing

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What needs to change, in each country? Who needs to act? How can they be persuaded to do so?

- What are the implications of longer lives and later retirement for the young (and especially those entering employment for the first time)? What of career prospects in middle life?
- Is 'retirement' a concept that has had its day?
- How will longer working lives influence the incidence of multi-generational households (and should childcare by grandparents be rewarded?)
- How can local communities better support an ageing population? (WHO Age Friendly Communities – who is driving this agenda in Canada and UK?)
- Is the private sector best placed to improve the well-being of an older population - and, if so, how can it contribute? What is the right role for government?
- UK's Industrial Strategy for Ageing. Is there a Canadian parallel? Can we learn from one another?

Session 7: Concluding Remarks

11.00: Concluding Remarks by Chairman and Rapporteur

11.30: BRUNCH AND CLOSE

ANNEX

LIST of PARTICIPANTS

Chairman and UK Adviser to the 2019 Colloquium

The Rt Hon the Lord Filkin CBE

Canadian Adviser to the 2019 Colloquium

Dr Samir Sinha MD, DPhil, FRCPC, AGSF

Speakers: Dinner at Darwin College on 22 November

Professor Jonathan Heeney, Vice Master, Darwin College
H.E. Mrs. Janice Charette, Canadian High Commissioner
George Freeman MP, Minister of State at the Department of Transport (*in absentia*)

Speaker: Dinner at Trinity Hall College on 23 November

Dr David Halpern Chief Executive of the Behavioural Insights Team (the 'Nudge Unit') since its inception in 2010. Formerly first Research Director at the Institute for Government, and Chief Analyst at the PM's Strategy Unit (2001-7)

British Participants

Colin Armstrong

Deputy Chief Scientific Adviser at the Foreign and Commonwealth Office (FCO). He is responsible for providing leadership to a network of over 100 officers worldwide to ensure they support the UK's international science and innovation priorities. Colin was awarded an MBE in 2017 for services to emergency response in recognition of his work during the UK's response to the West Africa Ebola Outbreak.

The Rt Hon the Lord Best

Richard Best was CEO National Housing Federation 1973-1988; CEO Joseph Rowntree Foundation 1988-2006; Chair Hanover Housing Association 2008-2016; Chair All Party Parliamentary Group on Housing and Care for Older People 2008

Professor Dame Carol Black

Chair of Ageing Better.

Principal of Newnham College Cambridge and Expert Adviser on Health and Work to NHS England and Public Health England. She chairs the board of Think Ahead, the Government's fast-stream training programme for Mental Health Social Workers and is a member of Rand Europe's Council of Advisers, the Strategy Board for the Defence National Rehabilitation Centre, and the Advisory Board of Step up to Serve. She became Chairman of the British Library in September 2018.

Sam Blyth

Educator and entrepreneur with a foot in both Canada and the UK. Educated at Pembroke College, Cambridge where he is a Fellow Commoner. Philanthropist with a deep interest in Bhutan, issues surrounding longevity and happiness, and building civil institutions in the developing world.

Professor Carol Brayne

Professor of Public Health Medicine and Director of the Cambridge Institute of Public Health in the University of Cambridge. Her main research has been longitudinal studies of older people following changes over time from a public health perspective and with a focus on the brain. She is lead principal investigator in the MRC CFA Studies and other population-based studies. She is a Fellow of the Academy of Medical Sciences, a NIHR Senior Investigator and was awarded a CBE in 2017.

Anthony Cary

British Ambassador to Sweden (2003-6) and High Commissioner to Canada (2007-10). Previous diplomatic postings included Berlin, Kuala Lumpur and Washington DC. Served twice on secondment to the European Commission, latterly as Chris Patten's chef de cabinet. Chairman of the Canada-UK Council. He was awarded a CMG in 1997.

Lawrence Churchill

Lawrence has spent over 40 years in the pensions field, focusing on dignity in later life. His career includes serving as CEO of 3 Insurance groups, and as the founding Chairman of two UK institutions - the Pension Protection Fund and NEST. He currently chairs the Independent Governance Committee at Prudential, Clara Pensions (a DB consolidator) and the PPI.

Dr Anna Dixon

Anna is Ageing Better's Chief Executive, leading its vision of creating a society where everyone enjoys a good later life. She has more than 15 years' experience of working – both in and out of government – at the interface of research, policy and practice to bring about positive change. Throughout her career she has been committed to ensuring the voice and needs of the citizen are at the heart of her work.

Nigel Edwards

Nigel is Chief Executive at the Nuffield Trust, before which he was an expert advisor with KPMG's Global Centre of Excellence for Health and Life Sciences and a Senior Fellow at The King's Fund. As the lead contact for the Nuffield Trust's work for European Observatory on Health Systems and Policies he has advised in developing health systems in Kyrgyzstan, Ukraine, Azerbaijan and Iraq. Nigel is a well-known media commentator, often in the spotlight debating key policy issues.

Professor Eilís Ferran

Pro-Vice-Chancellor for Institutional and International Relations and Professor of Company & Securities Law at the University of Cambridge, and a Professorial Fellow of St Catharine's College, Cambridge. Eilís has written extensively on UK, EU and international financial regulation, company law and corporate finance law. As Pro-Vice-Chancellor she has strategic responsibility for Cambridge University's staff policies and significant international academic partnerships.

The Rt Hon the Lord Filkin

Geoff Filkin is Chair of the Strategic Advisory Board for the All-Party Parliamentary Group for Longevity, developing a National Strategy for Healthy Life Expectancy. He is a former Chair of the Centre for Ageing Better and chaired the House of Lords Select Committee on Ageing. He has worked in many different sectors, as a CEO, Chair, adviser, and government Minister.

Professor David Gems

Professor of Biogerontology at the UCL Institute of Healthy Ageing, where he is Research Director. He has a degree in Biochemistry from Sussex University and a PhD in Genetics from Glasgow University. He established his research group at UCL working on the biology of ageing in 1997 with a Royal Society University Research Fellowship. His research aims to understand the causes of ageing using simple animal models such as the nematode Caenorhabditis elegans.

Professor Sarah Harper

Clore Professor of Gerontology at the University of Oxford, a Fellow at University College, and the Founding Director of the Oxford Institute of Population Ageing. In 2018 she was appointed a CBE for services to demography. Sarah served on the Prime Minister's Council for Science and Technology, which advises on the scientific evidence for strategic policies and frameworks. She served as the Director of the Royal Institution of Great Britain, and is currently a Director of the UK Research Integrity Office and a member of the Board of Health Data Research UK. She chaired the UK government's Foresight Review on Ageing Populations (2014-2016) and the Evaluation Board of the UN Active Ageing Index. She is a Governor of the Pensions Policy Institute, and a Fellow of the Royal Anthropology Institute.

Heléna Herklots

Heléna Herklots CBE is the Older People's Commissioner for Wales, an independent statutory role to protect and promote the rights of older people. Prior to taking up that post in 2018, she was the Chief Executive of the charity Carers UK and has over 30 years' experience in the field of ageing and older people. She is a trustee of the Centre for Ageing Better.

Paul Johnson

Paul has been director of the Institute for Fiscal Studies since 2011. He was previously chief economist at the Department for Education, a director at HM Treasury and deputy head of the Government Economic Service. He is a columnist for The Times, a member of the Climate Change Committee and of the Banking Standards Board. He was appointed CBE in 2018.

Professor Ashwin Kumar

Ashwin is Professor of Social Policy at Manchester Metropolitan University. He has also worked as Chief Economist of the Joseph Rowntree Foundation, Senior Economic Adviser at the Department for Work and Pensions, as Rail Director of the consumer watchdog Passenger Focus, and in the PM's Office, as an economic adviser to Gordon Brown.

Dr Bo Larsen

Bo is one of the UK-Canada Foundation Post-Doctoral Fellows in entrepreneurship and innovation. He is a bioengineer at the Sainsbury Laboratory, Cambridge University, where he is interested in building synthetic biological circuits that can modulate plant developmental processes and agronomic traits via non-natural light stimuli.

George MacGinnis

George leads the UK's £98 million Healthy Ageing Challenge, a research and innovation programme supporting the Ageing Society Grand Challenge. George's background is in health and care innovation with work in the UK, USA, Republic of Ireland and Middle East. He led the user group for the Personal Connected Health Alliance, developing digital standards for consumer health.

Nicolas Maclean

Nicolas' career was in banking and insurance, where he finished as Group Adviser, Asia, for Prudential Corporation and Executive Director of Prudential Corporation Asia. He served as Senior Adviser, China, for Bupa. He was involved in issues of health provision and social care during 15 years as a part-time Political Assistant to Conservative leader Margaret Thatcher and as an elected Councillor of the Royal Borough of Kensington and Chelsea. He initiated Chelsea Conservative Car Helpers, a local precursor of the Dial-a-Ride service for the elderly. He was for many years on the International Committee of the Leonard Cheshire Foundation, Britain's foremost charity for disabled people. He is a member of the Canada-UK Council.

Dr Karol Nowicki-Osuch

Karol is one of the UK-Canada Foundation Post-Doctoral Fellows in entrepreneurship and innovation. He is a Research Associate at the MRC Cancer Unit, seeking to bridge the gap between molecular and clinical biology. He studies early stages of oesophageal cancer, focusing on detection of the disease.

Dr Mike Short

After 30 years in telecommunications with Telefonica, Mike joined the Department for International Trade (DIT) in 2017 as the department's first Chief Scientific Adviser. In 2012 he was awarded a CBE for his services to the mobile industry.

Dr Richard Smith

Richard was once the chair of the British Medical Journal (BMJ) and Chief Executive of the BMJ publishing Group. He is chair of the Lancet Commission on the Value of Death; the UK Health Alliance on Climate Change; the Point of Care Foundation; and Patients Know Best. He blogs regularly for the BMJ.

William Swords

William is an experienced business leader with 30 years of banking expertise gained primarily in London leading Scotiabank's European Corporate Banking business line. A Corporate Director, former Chair of a UK domiciled mid-sized pension fund, past President of the Canada-UK Chamber of Commerce, Chair of the Canada-UK Foundation and a Fellow of the Institute of Directors.

Melanie Wicklen

Melanie is Chief Executive of the local independent charity in Cambridge which forms part of the Age UK Brand Partnership, seeking to provide support to older people and their carers; to prevent poverty; and to tackle isolation through service delivery, addressing matters important to the older population at a local and national level.

Tina Woods

Tina is CEO and Co-founder of Longevity International, which runs the All-Party Parliamentary Group for Longevity focussed on developing a National Strategy to give 5 extra years of healthy life expectancy to British citizens by 2035 while closing the social gap. Tina Woods is also CEO and Founder of Collider Health, a health innovation catalyst working with organisations in both private and public sectors (including NHSX, AHSNs, and UKRI) to accelerate innovation and transform health with sustainable impact at scale.

Canadian Participants

Dr Howard Bergman MD, FCFP, FRCPC, FCAHS

Howard is Assistant Dean, International Affairs in the Faculty of Medicine, McGill University where he is also Professor of Family Medicine, Medicine, and Oncology. He chaired the Canadian Academy of Health Sciences Panel for the Assessment of Evidence and Best Practices for the development of a Canadian Dementia Strategy, at the request of Public Health Agency of Canada. The report was published in January 2019. In 2009, he authored the Quebec Alzheimer Plan.

Dr Sandy Buchman

Sandy is an associate Professor in the Department of Family and Community Medicine at the University of Toronto. He is a palliative care physician providing home-based care as well as providing palliative care to the homeless. He was recently appointed the Freeman Family Chair in Palliative Care at North York General Hospital in Toronto. He was President of the Ontario College of Family Physicians in 2005-2006, President of the College of Family Physicians of Canada in 2011-2012 and is the current President of the Canadian Medical Association. www.cma.ca @DocSandyB

Dr Mel Cappe

Mel is a Professor at the Munk School of Global Affairs and Public Policy, University of Toronto. From 2006-2011, he was the President of the Institute for Research on Public Policy (IRPP). Prior to that, he served four years as the High Commissioner for Canada to the United Kingdom, and worked as the Clerk of the Privy Council, Secretary to the Cabinet and Head of the Public Service in Ottawa. He is an Officer of the Order of Canada.

The Hon.Jean Charest

As a former Deputy Prime Minister of Canada and Premier of Québec, Jean Charest is one of Canada's best-known political figures. The Charest government was perhaps best known for a major initiative for the sustainable development of Northern Québec called "Plan Nord". In the International arena, the Charest government initiated an unprecedented labour mobility agreement between France and Québec, and convinced Canada and the European Union to negotiate a broad economic partnership. Jean is a Partner at McCarthy Tétrault, a leading Canadian law firm.

H.E. Mrs. Janice Charette

Janice Charette assumed her responsibilities as High Commissioner for Canada in the United Kingdom of Great Britain and Northern Ireland and Permanent Representative of Canada to the International Maritime Organization in September 2016. She served previously as Clerk of the Privy Council and Secretary to the Cabinet from October 2014 to January 2016 where she was the principal public service advisor to Canada's Prime Minister and Head of the Public Service. Before this she had been Deputy Clerk of the Privy Council and Associate Secretary to the Cabinet as well as Deputy Minister of Intergovernmental Affairs.

Denise Cole

Appointed as the Deputy Minister of the Ministry for Seniors and Accessibility in the Government of Ontario in July 2019, Denise has been a member of the Ontario Public Service since 201O and has held executive positions in several ministries, including Assistant Deputy Minister, Health Workforce Planning & Regulatory Affairs in the Ministry of Health & Long-Term Care. She has also worked in senior positions within Canada's federal, provincial and municipal levels of government. Denise is a graduate of McMaster University.

Professor Jocelyn Downie SJD, FRSC, FCAHS

Jocelyn is a Research Professor in the Faculties of Law and Medicine at Dalhousie University. She received an honours BA and MA in Philosophy from Queen's University, an MLitt in Philosophy from the University of Cambridge, an LLB from the University of Toronto, and an LLM and doctorate in law from the University of Michigan. She has published numerous books and articles including Dying Justice , winner of the 2005 Abbyann Lynch Medal in Bioethics from the Royal Society of Canada. @jgdownie

Dr Suzanne Dupuis-Blanchard

Suzanne is a Professor at the School of Nursing at the Université de Moncton (New Brunswick) as well as Research Chair in Population Aging and Director of the Centre on Aging. She is the Chairperson of the National Seniors Council and immediate past president of the Canadian Association on Gerontology. Her program of research is on aging in place. @prof_sdb

Daniel Fontaine

Daniel is currently the CEO of the British Columbia Care Providers Association and a past Chair of the Canadian Association for Long-Term Care. He has served on a number of boards including the British Columbia College of Psychologists, SafeCare BC and Douglas College. He is the recipient of the Queen's Jubilee Medal for Public Service. (www.danielfontaine.ca)

Marie-Lison Fougère

Marie-Lison has more than 25 years of experience in the Ontario Public Service where she held senior positions in the Ministry of Education, the Ministry of Training, Colleges, and Universities, and the Ministry for Seniors Affairs and Accessibility. She currently has a dual appointment as Deputy Minister for the Ministry of Long-Term Care and Deputy Minister for the Ministry of Francophone Affairs. She holds a Bachelor's Degree from Dalhousie University, Halifax and a Master's Degree from York University, Toronto. Marie-Lison is fluent in French, English, and German.

Graham Fox

Graham was appointed President and CEO of the Institute for Research on Public Policy in 2011. Prior to coming to the IRPP, he was a strategic policy adviser at the law firm of Fraser Milner Casgrain, a vice-president of the Public Policy Forum and executive director of the KTA Centre for Collaborative Government. A policy entrepreneur, his research interests include parliamentary reform, democratic renewal, citizen engagement and federalism. He was a Loran scholar at Queen's University, and holds a master's degree in political science from the London School of Economics. @foxgw

Isaac Gazendam

Isaac is a second-year law student at the University of Toronto and a Junior Fellow at Massey College, focusing on environmental and human rights law. Isaac's interest in "Ageing Well" stems first from his personal experience witnessing his grandfather's difficult journey with dementia. His interest in urban sustainability includes the question of how to create socially, economically, and environmentally sound and accessible communities fully inclusive of ageing citizens.

Amir Golbang

Amir is a Trade Commissioner at the Canadian High Commission in the UK. He joined the Commercial division in 2011 where he supports Canadian Life Sciences companies with UK market entry and partnerships. Previous to this role, Amir was a business development executive. He is also a Cambridge graduate.

Janet Goulding

As a representative of Employment and Social Development Canada, Janet brings over 25 years of public policy, program, and operational experience to her current role as Assistant Deputy Minister. She is responsible for Income Security and Social Development, leading on social policies and programs that improve outcomes for vulnerable populations and communities who face social and economic challenges. Much of this work is horizontal in nature, cross-cutting ministerial, provincial/territorial and municipal responsibilities.

John Ibbitson

John is co-author, with Darrell Bricker, of *Empty Planet: The Shock of Global Population* Decline. He is Writer at Large at the Globe and Mail, where he has also served as Ottawa bureau chief, Washington bureau chief, and chief political writer. His other books include *Stephen Harper*, his award-winning biography of Canada's 22nd prime minister. @johnibbitson

Dr Janice Keefe

Janice is Professor and Chair of Family Studies and Gerontology, Director of Nova Scotia Centre on Aging at Mount Saint Vincent University in Halifax, and an adjunct professor in medicine at Dalhousie University. Her research areas include family caregiving, home and long-term care, and rural ageing. She recently received a Global Aging Research Network Award for Applied Research and a Canadian Association on Gerontology's Distinguished Member Award.

Dr Bonnie-Jeanne MacDonald FSA

Bonnie-Jeanne is the Director of Financial Security Research at the National Institute on Ageing at Ryerson University, a Fellow of the Society of Actuaries and the resident scholar at Eckler Ltd. @ActuaryOnAgeing

Husayn Marani

Husayn is a third year PhD Student at the Institute of Health Policy, Management and Evaluation and a Junior Fellow at Massey College, University of Toronto. His research interests include ageing policy, social care and caregiver welfare. His doctoral thesis is focused on financial risk protection programs for family caregivers of community-dwelling dependent elderly in Ontario. @husmarani

Liam Greg McCoy

Liam is an MD student and Massey College Junior Fellow at the University of Toronto. He is co-enrolled for an MSc in Health Policy, Management and Evaluation focusing on the disruptive potential of artificial intelligence and data science technologies in healthcare. His additional interests include the ethics and philosophy of medicine and technology, and improving clinical decision-making. @liamgmccoy

Dr John Muscedere MD, FRCPC

John is a Professor of Medicine at Queen's University and an Intensivist at Kingston Health Sciences Center. He is the Scientific Director for the Canadian Frailty Network (CFN) funded by the Government of Canada. CFN is dedicated to improving care for frail elderly Canadians through the generation and mobilisation of new knowledge, and the development of partnerships and training for the next generation of highly qualified personnel. www.cfn-nce.ca

Michael Nicin

Michael is Executive Director of the National Institute on Ageing at Ryerson University. Previously, he served as Chief of Staff and Senior Policy Advisor to the Ontario Minister of Seniors Affairs, leading the design and launch of the $155m provincial seniors strategy - the first government-led seniors strategy in Canada. He also served as the Director of Policy and Strategic Planning for CARP, a 300,000 member-based advocacy organization for older Canadians. www.nia-ryerson.ca, @RyersonNIA

Dr Tina J. Park

Tina is Executive Director of the Canadian Centre for the Responsibility to Protect based at the University of Toronto. She is also a Vice-President of the NATO Association of Canada and a frequent commentator on CBC and CTV. She is an alumna of Trinity College and Massey College, and earned her doctorate at the University of Toronto. She manages the CUKC for the Canadian team. (www.tinapark.ca) @jiwontina

Dr Parminder Raina

Parminder is a professor in the Department of Health Research Methods, Evaluation and Impact at McMaster University, where he specializes in the epidemiology of ageing. He holds the Canada Research Chair in Geroscience and the Raymond and Margaret Labarge Chair in Research and Knowledge Application for Optimal Aging. He is the inaugural Scientific Director of the McMaster Research Institute for Research on Aging and Labarge Centre for Mobility in Aging, and lead investigator of the Canadian Longitudinal Study on Aging. @parminderraina

Anna Romano

Anna is VP of the Health Promotion and Chronic Disease Prevention Branch at the Public Health Agency of Canada. She has over 25 years of experience in providing strategic policy advice and recommendations to decision-makers in ten ministries of the Canadian civil service. Anna holds Economics degrees from the University of Ottawa (Honours) and Carleton University (MA).

Dr Samir Sinha MD, DPhil, FRCPC, AGSF

Samir is Director of Geriatrics at Sinai Health System and the University Health Network in Toronto and an Associate Professor in the Departments of Medicine, Health Policy Management and Evaluation, and Family and Community Medicine at the University of Toronto. He is the inaugural Director of Health Policy Research for the National Institute on Ageing (NIA) at Ryerson University. Samir is both a clinician and an expert in the care of older adults. He has consulted and advised governments and health care organizations around the world and is the architect of the Government of Ontario's Seniors Strategy. He is also a member of Canada's Federal Ministerial Advisory Board on Dementia. @DrSamirSinha

Sonya Thissen

Sonya is the Minister-Counsellor (Political and Public Affairs) at the High Commission of Canada in London, a role she has held since August 2016. She is responsible for two sections: the political section, which oversees domestic political developments, foreign and security policy issues and the Commonwealth, and the public affairs section, which projects an image of Canada in the UK through communications, social media, advocacy, public diplomacy and cultural promotion.

OBSERVERS

Mr Ronald Blanchard

A Coordinator of Nursing Simulation Labs at the Université de Moncton, Ronald is a registered nurse with experience in orthopaedics and oncology with a special interest in technology for learning. He is recognized for developing visionary nursing simulation labs including real-time video auto-evaluation, moulage and much more. He volunteers with local older adult groups and has developed sessions on learning the iPad.

Mrs Michèle Dionne

Michèle earned her degree as a special education teacher at the Université de Sherbrooke. For several years, she worked with children with learning difficulties in Quebec schools. She has been Involved in a number of social causes and community projects, including fundraising campaigns for organizations dedicated to family, the condition of women and development of the arts. She has long been active in the Quebec division of the Canadian Red Cross, where she was Chair of the annual fundraising campaign. She is the author of *Missions*, a collection of her photographs taken during her missions around the world with the Canadian Red Cross.

Professor Jonathan Heeney DVM, DVSc, PhD,ScD, FRCPath

Vice-Master of Darwin College Cambridge, and Professor of Comparative Pathology, Lab of Viral Zoonotics, Department of Veterinary Medicine (Pathology of Viral diseases, "the Virome" and Zoonotic infections)

Major Felix Kesserwan CD, RMC

Felix is an Engineer Officer in the Canadian Armed Forces, providing mobility, counter-mobility, survivability, and general support to Canadian troops around the world. His domains of expertise include Explosive Ordnance Disposal, Counter-IED, Project Management, and Infrastructure. Prior to his current position as Aide-de-Camp to the Commandant of the NATO Defense College in Rome, he served as the ADM(IE) – Real Property Operations Officer for the Province of Quebec.

Mrs Colette Pilon-Bergman, MSc

Colette is a consultant, translator, writer and editor in health and healthcare. She was previously Editor-in-Chief and chief of publications for the *Order of Nurses of Quebec.*

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