CURAC 2017 Conference Report

The fifteenth annual conference of the Colleges and Universities Retiree Associations of Canada took place at Carleton University from May 24 to 26. York was well represented as, in addition to myself, John Lennox and Charmaine Courtis attended for YURA and Fred Fletcher attended both as ARFL's Alternate Voting Delegate and as a CURAC Board member.

Following the opening reception on May 24, panels convened on Thursday, May 25 with morning roundtables on (i) best practices in retiree associations and (ii) major conference themes (economy, health and higher education). Reports on the roundtables will appear in due course on the CURAC website, but I can give you some flavour of one roundtable I attended on best practices.

Our best practices group discussed three general themes: how to get and keep members; how to ensure recognition and support from active employees and of the College or University that had been our employer; and how to engage with the community outside our associations.

It was agreed that associations should endeavour to get agreement from retirees to join at the point of retirement. Communication with new retirees could be facilitated if (a) institution would agree to provide their retiree associations with the names and contact information of retirees and (b) if all retirees were permitted to retain their College or University e-mail address after retirement. A model suggested for ensuring membership was the collection of a small amount from each active employee (e.g. as part of union dues) that then would guarantee those employees subsequent membership in the retiree association without fee. Another encouragement was the provision of free membership in the first year. Small associations expressed concern about finances however, making free membership a less attractive option. One association noted that their dues were deducted from monthly pension payments, but many others doubted that would be possible in their institutions.

Means suggested to increase interest in membership included luncheons, guest speakers, concert and play outings (on campus or off), and the willingness tio provide transportation to members with mobility issues.

Some observed there was a challenge in getting active employees to have an interest in retiree benefits, which their union/association would have to negotiate. A campaign to provide information to current employees about the benefit changes (if any) they would experience at retirement was thought desirable, though effectiveness was hard to assure. A close link between the retiree association and the bargaining agent of current employees was considered valuable, but there was the risk of weakening the employer's commitment to support for the retiree organization. It could be the case that organization support would become another retiree benefit to be negotiated, rather than a willing commitment to emeriti. One desired support not always provided was free space on campus for a retiree organization office.

Getting our former employers to recognize our continued value to the College or University required providing reminders of continuing contributions to scholarship and teaching (where relevant), as well as donations to scholarship funds and other institutional priorities. As well, offers to mentor new faculty and graduate students could prove

valuable, as well as supportive participation in institutional events like graduation ceremonies.

Suggestions for community outreach included building bridges with organizations representing students who might benefit from faculty advice. "Senior Colleges" or other programmes offering mini-courses or lectures to the general public could help develop support for retiree organizations, both inside and outside the College or University. Advocacy was considered, but many looked to CURAC's lead in that area. Finally it was suggested we could do more, in most cases, to connect with other College and University retiree organizations in our local communities, for joint activities and support, between CURAC conferences.

In the first afternoon session on May 25, Dr. Daniel Lee from Carleton's business school presented on *Trump and the Canadian Economy*. He noted that the common narrative of pundits and politicians after the November 8 election was that President Trump was irrational and unpredictable. Dr. Lee took issue with that presumption and warned that we would be unwise to ignore the fact that Trump was not alone among US political actors in proposing tax reductions, deregulation and trade renegotiation. Moreover he made the case that many of these proposals could be expected, given conditions in the US economy. And he was quick to note that all of these actions could have considerable consequence for Canada.

He noted that half the US trade deficit was with six countries, including Canada, and that concern with dairy and lumber industries in particular was not limited to President Trump and had pre-existed his election. He pointed to US economic conditions that he said helped account for Trump's appeal: the fact that median income in the US was flat, that wage growth was in decline, that wages are declining as a proportion of consumption, that labour participation was down, that GDP growth had declined between 1948 and 2016, that manufacturing employment had declined from 1947 to 2015, that productivity has been declining since the 1960s, and that the middle class, which had grown from 1913 to 1980, had been in decline since that point. Nevertheless he argued that income inequality had been less significant in dividing voters for and against Trump than education and age. Trump's principal economic proposals included renegotiating NAFTA, withdrawing from the Tarns-Pacific Partnership trade deal, detecting and opposing unfair foreign trade , lifting regulations on the energy industry (including approval of the Keystone XL pipeline), and lowering taxes and regulations across the board.

Trade issues that promised to be problematic for Canada included agricultural supply management, grain exports to Canada, wine and beer exports, aerospace, and government procurement rules. Ss well, there were concerns around intellectual property, telecommunications, Canadian content rules, and restrictions on foreign investment. All of these areas had been matters of concern and negotiation between Canada and the US before Trump's election.

Other issues that should concern Canadians were proposals to lower the corporate tax rate in the US from 35% to 15%, efforts to bring back overseas earnings at a special 10% tax rate, and the deregulation of energy, banking, pharmaceuticals, health care and the environment. Canadian industry (and governments, workers and consumers) would need to find ways of adjusting to these shocks, and given the fact that support beyond the White

House existed for US action in all these areas, it would be naïve and dangerous to presume we could simply wait and hope for Trump's defeat in 2020.

Depression engendered by this presentation was lifted slightly by the address at our Thursday evening banquet by Professor Matthew Bellamy of Carleton University on the development of the Canadian beer industry – *How Labatt and its Allies Brewed Up a Nation of Beer Drinkers.*

The morning session on Friday, May 26 featured Dr. Jeff Turnbull, Chief of Staff at the Ottawa Hospital, who spoke about *Health and Health Equity: Our Collective Responsibility.* His focus was the challenges to the health system in providing care for vulnerable populations – the homeless, frail elderly and indigenous peoples.

He spoke of financial and value pressures on the overall system. Canada spends just under $7000 per capita on health – 6th in the OECD – and while the US has the highest costs and the poorest outcomes, we do not compare favourably with other western countries. While 70% of our spending is public, 30% is not, and we are in the top one third in expenditures but in the middle to lower third in quality – safety, access and patient engagement. In particular, some 10% of the working poor are unable to pay for their medications, while 16% of all health expenditures in Canada are for pharmaceuticals.

Pressures on the financial health and quality of the system come from an aging population, levels of chronic disease, levels of utilization, fiscal restraint, classic federalism, and rising social inequality. For the poor especially the system is not effective. Why is health inequity such a challenge? The GINI index of inequality in Canada is 0.32 and growing faster than in the US. Health costs are rising as a proportion of provincial budgets, and the consequence is that there are fewer dollars for other services. That in turn leads to growing social inequality. Money going to acute care, he said, is in effect making us sicker, because while 50% of our health condition can be attributed to our genes and 25% to our care, the remaining 25% is attributable to social factors such as gender, housing, and education.

Obstacles to better health care for vulnerable populations include transportation problems, stigmas of class and lifestyle, poor education, judgmental health care providers, and problems getting medications effectively to the vulnerable. In addition we must address the different concept of health sometimes found in poor communities – a short time frame, sometimes a focus on addiction, and a kind of fatalism about outcomes.

Our collective responsibility to address care for the vulnerable, Dr. Turnbull asserted, should lead us to consider new models of care. We have to define the nature and extent of community, address barriers to care, and develop a system of shelter-based programmes in place of a hospital-centred system. Funding for shelter-based care is hard to come by, he observed, and global funding for such care often requires a team of different professionals, and provincial support of a fee-for-service system requires a health card, which not all vulnerable persons have. It also requires facilities to house, as well as treat, patients. Once one develops a shelter-based, team-delivered model of care, it is then a challenge to scale up such a program to serve a wider population. Ultimately however, Dr. Turnbull suggested, such a wider programme is essential if health equity is to be achieved.

Friday morning's second session continued the health theme with a focus on successful aging. It featured presentations by Dr. William Dalziel, from the Regional Geriatric Program

of Eastern Ontario and Associate Professor at the University of Ottawa, and Dr. Yoni Freedhof, Medical Director of the Bariatric Medical Institute.

Dr. Dalziel described healthy aging as a "shared responsibility" of individuals, medical personnel and institutions, and governments. He asserted there had been government dereliction in elder care. Healthy aging, he pointed out, is normally defined in terms of freedom from chronic disease, disability or dependency; good cognition; and abundant quantity and quality of life. However recognizing some variance in exposure to disease and disability, he offered a broader definition: dealing optimally with the hand you are dealt.

Increasing life expectancy and increasing numbers of centenarians makes it necessary for us to re-think health care for seniors. If people are living longer, he said, let's make it healthier. Some 70% of 80 year-olds are functionally independent, so we know healthy aging is possible. Seniors who visited hospital last year had 0 to 1 previous visits in the past 10 years. On the other hand we know there are some with serious problems: 10% of the most complex needs patients use 60% of total health care costs. Health care providers must therefore recognize the heterogeneity of the senior population they serve.

About 1/3 of the symptoms presented by aging patients, Dr. Dalziel suggested, could be attributed to deconditioning. Health promotion to maintain good condition should therefore be a priority. He pointed to tobacco cessation, good nutrition, proper levels of calcium for bone health, sun exposure (or supplements of 1000 to 2000 IU) for vitamin D, exercise, and vaccinations for herpes, pneumonia, and tetanus as elements of attention to good condition. With regard to exercise, he pointed out that one hour of walking per week had been found to reduce dementia risk by 30%.

With some 15% of seniors deemed "frail" using 30% of health care dollars, he argued for opportunities to "unfrail" by better primary care, primary prevention of illness and better attention to geriatric complaints. He urged people to expect their primary care physicians, in conducting an examination, to listen first to the patient's presentation of their chief complaint, to take a comprehensive medical history and to get information on all medications the patient was taking. Thus could begin a focus on preventive care and maintaining conditions for healthy aging.

Dr. Freedhof continued the focus on means to preserve health and good physical condition in aging with particular attention to nutrition, good quality sleep, exercise and social connections. In regard to nutrition, he observed that good information was hard to come by. Headlines tend to focus on single foods, rather than a full diet, and actual outcomes are not well reported. In particular dietary supplements are not well regulated, and assertions of their efficacy are not always supported by evidence. Chronic non-communicable disease and obesity are on the rise, and excessive weight is not primarily a matter of will power, he suggested, but largely a result of poor information and changing ideas of what constitutes "normal" food.

What can be done to address these impediments to healthy aging? Like Dr. Dalziel, Dr. Freedhof began with tobacco cessation and exercise, but he added moderation in alcohol intake to the list: "indulge only enough to make you happy." He also cited the benefits of regular sleep – facilitated by a cool, dark room, avoidance of electronic devices (with blue light) before sleeping, and no noise (except perhaps "white" non-distracting noise). He pointed to the "stop" warning symptoms of sleep apnea – Snoring, Tiredness, Observed

interruptions of breathing and high blood Pressure – and suggested that anyone with three of four "bang" risk factors should be referred for sleep testing. The risk factors were Body Mass Index greater than 35, Age greater than 50, Neck circumference over 40 cm., and Gender male. With regard to nutrition, he urged people to learn to cook, lessening their dependence on prepared foods. He also cited friendship and regular socializing as important to maintain a healthy disposition.

Dr. Freedhof then turned to the responsibility of health care providers to attend more effectively to the needs of an aging population. The first step, he suggested, is to identify cases – to recognize dementia, depression, chronic pain, falls, osteoporosis, high blood pressure and incontinence – and to provide an effective response. Such a response meant mobilizing resources in hospitals, identifying the potential for rehabilitation, optimizing the patient's environment and providing support for caregivers.

Dementia, he observed, is becoming the disease of the 21st Century. The risk of dementia before age 65 is roughly 2%, but the risk doubles every five years thereafter, so that at age 85, the risk is nearly one third and by age 90 is over 60%. What should we do to avoid dementia? Dr. Freedhof urged treatment of vascular issues, exercise, continued learning and social activity. He warned against head injury ("wear a helmet') and tobacco use, and he asserted the value of marriage, a Mediterranean diet, and a positive attitude.

As far as the medical system is concerned, he argued the need for a focus on the aged as major clients, better community services, better coordination of treatment and better integration of patient information. Finally he recommended training for health care providers to have everyone make geriatrics their business.

Over lunch we heard a presentation from Dr. Rebecca Trueman of Algonquin College on the joint Algonquin-Carleton Bachelor of Information Technology. She pointed to the enormous growth of on-line users and the growing demand for specialists who could combine theory and practice. The programme had four streams – network technologies, interactive media design, photonic and laser technology, and information resource management. The programme enrolls some 500 to 1000 students yearly in co-op learning. More information can be obtained from Carleton or Algonquin.

Finally the afternoon session addressed older adult education with presentations from Professor Ross Finnie of Carleton's Graduate School of Public and International Affairs and Dr. Tim Pychyl of Carleton's Psychology department. Dr. Finnie outlined his research on tracking post-graduate employment earnings of undergraduates using tax data. While many of his findings were interesting, follow-up questions centred on the absence of data in several areas of interest. For example, his study was limited to those who sought employment immediately after graduation and left out those whon went on to graduate or professional training. Dr. Pychyl spoke about Carleton's Learning in Retirement programme, providing short courses and lectures for seniors in the community. My own learning in retirement was curtailed at that point by my fatigue after two full days of sessions, so with apologies I must invite those of you who want further information on the subjet to contact Dr. Pychyl at Carleton's Centre for Initiatives in Education.