

# Canadian Institutes of Health Research– Institute of Aging: Profiles

## Bridging Policy and Research on Aging in Canada: Recognizing an Anniversary, Realizing an Opportunity\*

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This article was inspired by an anniversary and prompted by an exceptional opportunity. At the 2007 annual scientific and educational meeting of the Canadian Association on Gerontology, a plenary symposium recognized the 10th anniversary of a special joint issue of the *Canadian Journal on Aging* and *Canadian Public Policy (CJA/PPP)* on Bridging Policy and Research on Aging in Canada. Symposium presenters included researchers Janice Keefe and Robyn Tamblyn (who had contributed papers in the 1997 volume) (Tamblyn, 1997; Keating, Fast, Connidis, Penning and Keefe, 1997), Anne Martin-Matthews (who had co-edited the volume with the late Ellen M. Gee) and several policy makers, including Margaret Gillis (who at the time was director of the Division of Aging and Seniors at the Public Health Agency of Canada).

The symposium's purpose was to reflect on how the bridge linking research and policy had changed (or not) over the decade, what successes could be considered over the interval, what challenges remain, and to

provide a current "state of the union" of the research-policy interface. In 1997, it was suggested that "policy-makers are recognizing the need for evidence-based decisions, and in the process, reinforcing the power of the paradigm of research as the basis for knowledge" (Gee, 1997, p. v). Have the events of the ensuing decade proven this to be true in terms of the link between research and policy on aging in Canada?

This issue has assumed particular importance again this spring with the release of the Report of the Special Senate Committee on Aging, "Canada's Aging Population: Seizing the Opportunity." The Special Senate Committee on Aging had been appointed in 2006 to examine the implications of an aging society in Canada, in terms of such issues as promoting active living and well-being; housing and transportation needs; financial security and retirement; abuse and neglect; health promotion and prevention; and health care needs, including chronic diseases, medication use, mental health, palliative care, home care, and caregiving.

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While making a wide range of recommendations, the Report specified five primary framework recommendations, relating to active and healthy aging: (a) financial security, (b) aging-in-place and integrated health and social care services, (c) of most relevance to this discussion, the development of a National Integrated Care Initiative, (d) a National Caregiver Strategy, and (e) a National Pharmacare Program. At the time of our writing this article, departments throughout the federal government, and particularly in branches of Health Canada, Human Resources and Skills Development Canada, and in the Canadian Institutes of Health Research are scrutinizing these recommendations and developing responses to them, to be considered by the federal government as it addresses “the appropriate role of the federal government in helping Canadians age well” (Special Senate Committee, 2009, p. vii).

This article brings together the perspectives of researchers who have focused on two of the primary framework policy areas identified in the Report of the Special Senate Committee on Aging: prescription medications (Tamblyn) and caregiving (Keefe), with a policy maker (Gillis) and a scientific director of a key national funding agency for research on aging in Canada (Martin-Matthews), to consider a decade of challenges and opportunities not only specifically in relation to medications and caregiving but also in the wider context of the research–policy interface.

### The Context: Bridges Old and New

In reflecting on the “then” and “now” of the bridge between research and policy on aging in Canada, it is important to acknowledge the context within which the 1997 joint special issue of *CJA/CPA* was developed. It was by no means an isolated venture.

A key impetus was the influence of the Seniors’ Independence Research Program (SIRP) of Health Canada, which existed between 1993 and 1997. SIRP’s mandate was to promote national research initiatives with a balanced emphasis on the social, economic, and health determinants of independence for today’s and tomorrow’s seniors, with the goal of improving the quality of evidence for optimizing social and health policy for seniors. In 1996, SIRP organized a conference, sponsored by Health Canada, on Bridging Policy and Research on Aging in Canada. Two questions guided the conference: (a) Has research made a difference to policy choices on aging issues? and (b) What must be done to better link research and policy for the benefit of Canada’s seniors?

For two days, some 200 researchers and federal, provincial, and non-governmental representatives focused on four tasks: (a) to examine evidence of the relationships between relevant policy research on aging and

decisions; (b) to identify policy issues in the field of aging to which research can and does make contributions; (c) to explore the use of research findings and recommendations in the policy-making process related to aging issues; and (d) to determine what needs to be done to enhance the link between research and policy making in the field of aging. The joint *CJA/CPA* special issue followed a year later.

Much has changed between the “now” of this writing and the “then” of the Seniors’ Independence Research Program. The pivotal role of the National Health Research and Development Program (NHRDP) of Health Canada as a bridge between research and policy on aging in Canada was well acknowledged at the time. The NHRDP, however, was disbanded in 2000 when the Canadian Institutes of Health Research (CIHR) replaced both the Medical Research Council and the NHRDP. CIHR’s mandate therefore now includes not only MRC’s role in funding biomedical and clinical research but also NHRDP’s role in funding research on health services and policy, and on the health of populations. Although the institutes of the CIHR function somewhat differently than did NHRDP in setting strategic priorities for research, the facilitation of the research–policy interface is central to the mission of CIHR: “To excel, according to internationally accepted standards of scientific excellence in the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products and a strengthened Canadian health care system ...” (CIHR). Effective knowledge translation requires a strong bridge between research and policy at all levels, as is well documented in many publications and case studies on the mechanisms fundamental to the process of “knowledge to action” (CIHR, 2008b).

CIHR also includes a strategic research funding mechanism that was unheard of in the days of NHRDP: a national Institute of Aging, whose goal is to advance knowledge in the field of aging to improve older Canadians’ quality of life and health. With CIHR’s investment in research on aging having increased from CAD\$25 million in 2000–2001 to CAD\$136 million in 2007–2008, the “research” side of the bridge has indeed been strengthened, along with continued funding support from the Social Sciences and Humanities Research Council (SSHRC), most notably through four avenues: (a) SSHRC’s Major Collaborative Research Initiatives; (b) provincial health research foundations; (c) several Canada Research Chairs dedicated to the field of aging; and (d) continuing strategic funding from health charities, provincial governments,<sup>1</sup> and federal departments.

But how has the research–policy interface fared? Although a number of specialized “knowledge translation” structures and initiatives have developed to

address issues specific to seniors and aging,<sup>2</sup> a focus on policies involving prescription medications and then on caregiving is illustrative.

### **A Researcher's Perspective on Policies Relating to Prescription Medications**

In the area of prescription medications, there have been important advances in the past decade, based on the evidence, in two key areas that are important for maintaining optimal health in seniors: (a) timely access to affordable medication, and (b) improved mechanisms for optimizing safe and effective utilization.

#### *Timely Access to Affordable Medication*

One of the key premises of the Canada Health Act is to provide equitable access to essential health care for all Canadians. Unfortunately, the Canada Health Act does not effectively address the issue of prescription medication. The premise holds that medications that are provided within hospitals and other health care institutions will be covered as part of equal access to health care. However, prescription medications that are provided to people in the community are not covered by the Canada Health Act. As a result, there is a helter-skelter of drug insurance programs, both private and public, in each Canadian province (Grootendorst, 2002). As health care moved progressively from hospital-based to community-based care for the management of chronic diseases—such as diabetes, heart disease, asthma, chronic obstructive pulmonary disease, and cancer—the inequities and gaps in providing access to prescription medication have become more glaring and problematic. Seniors are particularly vulnerable because they are more likely to be affected by these health problems (Lexchin and Grootendorst, 2004). For many chronic conditions, prescription medications are effective and have been shown to produce at least half of the estimated decline in coronary artery disease mortality in the population over several decades (Ford, Ajani, Croft, Critchley, Labarthe, Kottke et al., 2007; Simpson, Eurich, Majumdar, Padwal, Tsuyuki, Varney et al., 2006).

In response to growing problems of inequity of access to prescription medications, particularly for the seniors population, the federal and provincial governments, supported by researchers and policymakers, crafted the National Pharmaceutical Strategy (NPS) (National Pharmaceutical Strategy, 2006): a comprehensive basket of policies aimed at improving equitable access and appropriate utilization of prescription medications in Canada (Kirby, 2003; NPS, 2006; Romanow, 2002). In particular, catastrophic drug coverage was included as one of the most essential and urgent priorities in the NPS such that no Canadians would be left destitute by

virtue of their out-of-pocket costs for prescription medications for their health. Although the catastrophic drug insurance plan has not yet been implemented, considerable work has been completed, and this is the top priority in the NPS for early implementation. Similar advances to support the seniors population have also been notably present in the United States where the Medicare reform bill instituted, for the first time, drug insurance coverage for seniors (Iglehart, 2001).

Similarly, Canada has provided leadership, through the Patented Medicine Price Review Board, in setting maximum prices for new drugs that are entering the market in Canada, a practice consistent with approaches to the establishment of drug prices in Europe (<http://www.pmprb-cepmb.gc.ca/>). As a result, Canadians have access to more affordable medication in comparison to their counterparts in the United States (Light and Lexchin, 2005). This indeed has produced the interesting paradox of an increasing number of Americans seeking lower-priced drugs in Canada, in addition to the development of the first Canadian Internet pharmacy (Light and Lexchin, 2005).

#### *Improved Safety and Quality of Prescription Medicine Use*

The past decade has seen a considerable preoccupation with the safety of health care delivery as well as with its quality. Numerous studies of hospital-based care have shown that a substantial number of adverse events result from medical care, of which approximately 40-50 per cent are considered to be preventable (Baker et al., 2004; Forster et al., 2004; Forster, Murff, Peterson, Gandhi, & Bates, 2003; Neale, Woloshynowych, & Vincent, 2001; Sanders & Esmail, 2003; Runciman et al., 2000; Wilson et al., 1995; Zhan and Miller, 2003). This situation has created an increasing preoccupation with methods of improving the safety of care delivery and a recognition that system-related factors are important to address in improving the approach to safety in health care institutions (Institute of Medicine, 2000). In particular, there has been increasing support for computerization as a means of reducing preventable errors in treatment, particularly in relation to prescription drug management (Bates & Gawande, 2003). Among the problems are these seven: (a) illegible handwritten prescriptions, (b) incomplete information on current medications, (c) dosing errors in prescribing, (d) ineffective communication between pharmacists and physicians about what drugs are stopped and started, (e) undetected interactions between drugs and diseases, (f) allergies, and (g) inadvertent excessive dosing due to poor documentation. These problems can be readily addressed by computerization of the medication prescribing and delivery process. Indeed, computerized order entry systems have been

shown to reduce the rate of prescribing errors by almost 50 per cent (Bates et al., 1998).

With the aim of improving the safety as well as the efficiency of health care delivery, most countries, including Canada, have established far-reaching policies for introducing computerized health care records. Canada Health Infoway was formed and provided with CAD\$1.2 billion to create an interoperable electronic health record in Canada (<http://www.infoway-inforoute.ca/>). One of the main initiatives in the electronic health record plan for Canada is the implementation of computerized drug management systems. To date, drug repositories that store information on all drugs prescribed and dispensed to all people in a province have been planned or instituted in almost all provinces in Canada. Provided with the repositories is a profile that health professionals who care for patients can access to view all current medications dispensed. In some provinces, such as Newfoundland and Labrador, electronic prescribing is a planned part of their initiative that will be implemented to eliminate handwritten prescriptions and provide the opportunity for systematically checking for doses, drug interactions, and drug allergy and drug disease contra-indications (<http://www.nlchi.nf.ca/>).

Another issue is that drug safety and effectiveness are often tested in young and middle-aged adults who use only a few medications and typically have only one health condition. These results are then applied to the elderly who typically use many medications and often have multiple health problems. Although this issue has not been addressed in Canada's drug licensing requirements, increasingly, both seniors and women are being incorporated into populations in which new drugs are tested. Most importantly, there are initiatives in the United States—and now in Canada—to institute proactive pharmaco-surveillance systems that will allow earlier detection of adverse events occurring with new drugs that enter the market and are used in populations, such as seniors, where they have not been comprehensively tested. In Canada, in an unprecedented collaborative initiative, provincial drug benefits managers, Health Canada drug regulators, and researchers have joined forces to develop a network of centres of excellence across Canada that will be responsible for timely monitoring and reporting of treatment effects and adverse effects concerning new vaccines and drugs that will be increasingly important to the health of seniors. Canada's Drug Safety and Effectiveness Network was established in 2008.

While many challenges remain in improving the access and optimal use of prescription medication, the past decade has been one of considerable progress in improving timely access and safety of prescription medi-

cation for seniors. The Special Senate Committee on Aging recognized that "prescription drugs are an essential part of integrated care for seniors" (Special Senate Committee on Aging, 2009, p. 71). Action on the policy recommendations in their Report will improve on achievements made thus far.

## **A Researcher's Perspective on Policies Relating to Caregiving**

In the past decade of research and policy development on caregiving in Canada, evidence of progress, failure, and potential is noteworthy. On a positive note, progress in the advancement of research and policy partnerships is clearly evident. On a less positive note, Canada has made little progress in an integrated policy approach to addressing caregiver issues. This lack of progress has occurred despite the fact that Canadian researchers are known internationally for the rigour and relevance of our work on caregiving. Transforming caregiving research into action is more elusive and will require what has been called the three P's: Popularity, Partnerships, and Politics (Pitkeathley, 2007).

More than a decade ago, Keating, Fast, Connidis, Penning, and Keefe (1997) discussed the need to make timely connections between researchers and policy makers, to engage both parties by asking the right questions in our research endeavours. This is an area where we have had the greatest success. Both the Social Sciences and Humanities Research Council and the Canadian Institutes of Health Research are committed to supporting quality research on caregiving for an aging and elderly population, and the number of multidisciplinary and multisectoral research teams that have developed to bridge the research-policy divide is ever growing: among them, the Hidden Costs/Invisible Contributions research team based at the University of Alberta (<http://www.ales.ualberta.ca/hecol/hcic/>); the SEDAP: Social and Economic Dimensions of an Aging Population research program based at McMaster University (<http://socserv.mcmaster.ca/sedap/>); the National Initiative for Care of the Elderly (a Network of Centres of Excellence), based at the University of Toronto (<http://www.nicenet.ca/>); and the Population, Work, and Family Policy Research Collaborations (PWFC), which is a joint initiative of the federal government and the academic research community ([http://www.policyresearch.gc.ca/page.asp?pagenm = PWFC\\_index](http://www.policyresearch.gc.ca/page.asp?pagenm = PWFC_index)).

With these initiatives has come a proliferation of meetings that bring together policy makers and researchers in the area of caregiving. Researchers and policy makers have also participated in numerous conferences, think tanks, and workshops to discuss caregiving issues,

including these six: (a) a National Home Care Program (and the role of caregivers), (b) the role of men in caregiving, (c) economic security of caregivers, (d) respite care, (e) financial support for caregivers, and (f) work and caregiving. This plethora of meetings underscores an unfortunate truism of our approach to policy development around caregiving in Canada: “We are all talk and limited action.”

Jurisdictional issues that intersect the caregiving policy domains represent a significant challenge. Policies related to the delivery of health and social services are located solidly in the realm of provincial/territorial jurisdiction, whereas policy domains of income security and labour are shared across federal and provincial/territorial lines. Consequently, despite ongoing efforts, researchers, policy makers, advocates, and politicians strive but fail to reach consensus on the best direction for policy. In the past decade, several federal policy initiatives in relation to caregiving were launched that involved taxation and employment insurance. The limited scope and entitlements of these policies demonstrated that governments have truly failed to see caregivers as partners in the delivery of services or in a comprehensive approach to the development of policy to support them.

Limited progress has been made in extending this successful research–policy partnership to improving the circumstances of front-line caregivers and viewing caregivers as equal partners with their own unmet needs (in addition to those of their elderly care receivers). In all provinces and territories, governments venerate “community care” policy, designed to support the person in need in the community. Such policies are built on the assumption that family and friend caregivers are available to provide most of the care that elderly people require to enable them to live in the community.

### *The Development of Policy Initiatives*

At the national level in Canada, two types of policies have been developed—one that links to the taxation system and the other to the Employment Insurance Program. Within the taxation system, five credits and deductions exist at the federal level that caregivers can access: (a) the Caregiver Tax Credit, (b) the Infirm Dependent Tax Credit, (c) the Transfer of a Personal Credit, (d) the Disability Tax Credit Transferred from a Dependent, and (e) the Medical Expenses Tax Credit. An applicant cannot claim more than one of these credits or deductions in the same year. Since the publication of Keating et al.’s (1997) review of bridging research and policy in eldercare, the Caregiver Tax Credit was added in 1997 to allow a non-refundable tax credit a maximum of CAD\$640 for 2008. This credit is intended for co-residing caregivers of an adult dependent or elderly

relatives meeting relationship and income criteria.<sup>3</sup> This credit is “non-refunded”, which means that while the benefit can be deducted from taxes owing, one must therefore be paying taxes in order to receive the benefit.

The Compassionate Care Benefit (CCB) was introduced in January 2004 as part of the benefits available under Canada’s Employment Insurance Program. The CCB allows eligible employees to take up to eight weeks, including an unpaid two-week waiting period, from their workplace to care for a dying family member at up to 55 per cent of income capped at CAD\$425 per week in 2008. The definition of family was expanded from immediate family to include a broader range of relationships including caring for someone who considers you “like a family member” (Service Canada, 2009).

These policies are positive first steps. However, a recent international review of 10 countries demonstrates how far Canada is lagging behind others in this area. Since 1996, Australia has implemented the National Respite Care Program, with a universal carer allowance and a means-tested carer payment that financially support carers. Germany’s Long Term Care Insurance allows the payment of family members providing care to an elderly relative. The United Kingdom has a financial support program and has legislated the right for caregivers to be assessed for this support (Keefe & Rajnovich, 2007).

How are these countries different from Canada? How is it that they have developed policies that we have not? For one, services in each are delivered at the national level, while Canada requires provincial and territorial governments to agree with any proposed federal initiative. Federal, provincial, and territorial relations affect our ability to move on critical issues such as caregiving. The policy domains chosen by the federal government are deliberate—they are ones most readily accessible under federal jurisdiction. However, researchers have questioned the use of taxation and employment insurance to solve caregiving challenges. For example, the purpose of the Employment Insurance (EI) policies is to support an active labour force, and to prevent unemployment. EI is not designed to support caregivers specifically (Keefe, 2007). Incremental policy strategies are common in Canada. While including caregiver policy within existing policy instruments such as EI serves an immediate purpose, one must not lose sight of the many caregivers who cannot access such policies because either they are not currently employed or the care is not palliative.

What Canada lacks is a strategic direction for caregiver policy. Our Commonwealth sisters, the United Kingdom, Australia, and, most recently, New Zealand, have

each developed a carer strategy. The Canadian Caregiver Coalition has outlined a national caregiver framework, but it does not represent a public policy vision from the Government of Canada. The appointment of a Minister of State for Families and Caregivers in 2004 did appear to be the requisite catalyst for change. Again, numerous meetings and consultations were held. Minister Ianno traveled the country, meeting caregivers, their organizations, and interest groups; he convened experts and held regional discussion groups. In 2005, a National Conference on Caregiving was held, attracting more than 150 participants from a wide range of constituents. Again, more talk, no action.

Where does this leave Canada today? We need to coalesce the energy, the evidence, and the political will to move the agenda forward. We need to learn from the experiences of such drivers of policy as Baroness Jill Pitkeathley (2007), in focusing on the three P's of Partnerships, Popularity, and Politics in order to place caregivers on the agenda and achieve some gains in terms of policy developments.

As a community of researchers, policy makers and organizations, we have some basic elements of two of these P's in place. Partnerships between researchers, policy makers, and caregiver organizations have been developed. In 2000, the Canadian Coalition of Caregivers was founded. Provincial organizations to support recognition of caregivers and advocate for their needs now operate in six provinces. But politically the caregiving agenda in Canada does not appear to be moving forward. We have lost a collectivist vision in our current political arena where the emphasis is on the individualist notion of personal income tax, rather than the direction of services and programs, to support those in need. Moreover, we lack fundamental partnerships among provincial and territorial jurisdictions responsible for delivering policy, and with the federal government to provide resources to support caregiver policy and programs.

As the Final Report of the Special Senate Committee on Aging notes, there is solid evidence to support the need for and the development of policies to support caregivers. We have the policy makers engaged, and recognition of caregivers' needs is growing. With the support of the Special Senate Committee on Aging and its well-informed recommendations for amendments to the Employment Insurance Act to enhance benefits for caregivers, for a drop-out provision for caregivers in the Canadian Pension Plan, and for a National Caregiver Strategy as part of a larger federal care initiative (2009, pp. 127–129), we have the opportunity to work to advance the development of an integrated support policy for Canadian caregivers. They deserve no less.

## A Policy Maker's Perspective on the Research–Policy Interface

The mission of the Public Health Agency of Canada (PHAC) is to promote and protect the health of Canadians through leadership, partnership, innovation, and action in public health. More than 30 years ago (since the Lalonde Report of 1974), it was recognized that there is a federal role in public health to promote overall health, including efforts against both infectious and chronic diseases. Because public health is shared, the most effective initiatives are those in which the federal government works in collaboration with provinces and territories as well as with non-governmental organizations.

The Division of Aging and Seniors has four priority policy areas: (a) emergency preparedness, (b) injury prevention, (c) mental health, and (d) healthy aging.

Healthy aging is defined as “a lifelong process of optimizing opportunities for improving and preserving health and physical, social and mental wellness, independence, quality of life and enhancing successful life-course transitions” (Health Canada, 2002, p. 5).

Along with mutual aid and self-care, supportive environments are central to healthy aging. Supportive environments refer to creating policies, services, programs, and surroundings that enable healthy aging in the settings where older Canadians live, work, learn, recreate, and worship. Federal, provincial, and territorial officials believe that governments can have the most strategic impact by fostering supportive environments.

Two research projects in which PHAC has heavily committed illustrate this belief: (a) the World Health Organization (WHO) Age Friendly Cities (AFC) project, and (b) the Age Friendly Rural/Remote Communities Initiative (AFRRCI). The WHO Age Friendly Cities project involved 33 cities in 22 countries, with four participating Canadian cities. Researchers, community representatives, and government collaborated in conducting research in each city—including seniors and caregivers, local merchants, service providers, and community officials to assess which features of the physical and social environments are or are not age-friendly and to elicit suggestions as to what makes communities age-friendly.

The Age Friendly Rural/Remote project involved 10 small communities in eight provinces and followed a methodology similar to the WHO-AFC project.

With both projects endorsed by the federal, provincial, and territorial Ministers Responsible for Seniors, an *Age Friendly Cities Guide* ([http://www.who.int/ageing/publications/Global\\_age\\_friendly\\_cities\\_Guide\\_English.pdf](http://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf)) and an *Age Friendly Rural/Remote Communities*

*Guide* ([http://www.phac-aspc.gc.ca/seniors-aines/pubs/age\\_friendly\\_rural/index\\_e.htm](http://www.phac-aspc.gc.ca/seniors-aines/pubs/age_friendly_rural/index_e.htm)) have now been produced. These evidence-based tools are policy development guides to assist interested jurisdictions in identifying barriers as well as possible solutions, best practices, and actions needed to move forward on healthy aging in their communities.

The implementation of these tools can involve various levels of government—the private sector as well as community organizations—in the assessment, planning, and follow-up actions. Already the provinces of British Columbia and Manitoba are putting implementation plans in place.

The knowledge gained through partnerships, innovative approaches, testing and evaluating, sharing the results—including the identification of best practices—has the potential to build a strong knowledge base that will support moving healthy aging “policy” forward, resulting in changes that will have lasting positive impacts on people’s lives.

This policy work, however, is not without its challenges. We all know that public-health issues are complex. To effect real change, policy requires a systematic and comprehensive approach. It is also impossible to move forward alone. We have learned that quick fixes will not work in terms of sustainability, especially now, in our ever changing and oftentimes unpredictable world.

Using innovative approaches that are inter-sectoral in design and include a strong research and evaluation component is essential to the evidence needed for policy development, a solid foundation on which to move healthy aging forward. Knowledge translation and dissemination are keys: sharing learning, identifying best practices across and within Canada as well as internationally, will strengthen and broaden our scope in influencing advancements in public health domestically and abroad.

### Other Opportunities for the Research–Policy Interface

Time will tell how the Report of the Special Senate Committee on Aging influences the research–policy agenda on aging in Canada. Certainly, the research, policy, and practice/professional communities, and representatives of seniors organizations, health charities, and advocacy groups nationwide had considerable input to the Committee’s deliberations, and many if not most of the recommendations are ones that have been advocated in one form or another for some time. For the CIHR Institute of Aging, key recommendations of the Report will help to inform strategic research initiatives in months and years to come. But we recognize that fundamental to the process of moving research to

action in aging is the communication of research results in order for the research to have impact.

In addition, structures and processes must be in place to facilitate the flow of two-way traffic across the bridge linking (or, oftentimes, symbolically separating) research and policy in aging (Martin-Matthews, 2009). These may be funding mechanisms that require the involvement of policy-maker partners, at the very outset of project initiation, through to research tools that enable longer-term intervention research geared to issues of sustainability, to mechanisms for generating necessary awareness of policy-relevant issues.

For aging research, the release of the Special Senate Committee Report comes at an especially opportune time in our history. In the fall of 2008, Canada’s Science and Technology Innovation Council (STIC) identified “health in an aging population” as an issue of strategic importance to Canada (<http://www.ic.gc.ca/eic/site/ic1.nsf/eng/04160.html>). Already this is influencing funding initiatives and strategic priorities at the federal level. In addition, the recent launch of the long-planned Canadian Longitudinal Study on Aging (CLSA) (the focus of an issue of the *CJA/RCV* later in 2009) represents a milestone in the development of a research platform in aging for Canada (Martin-Matthews & Mealing, 2009). But if we are to build strong partnerships among the research community and federal and provincial governments, health charities, and private sector partners in the building of the CLSA, it will be critically important that researchers are informed about, and able to respond to, the key pressing questions and issues that sector stakeholders and policy makers face with respect to population aging.

We know this task is complex, multifaceted, and challenging. In both recognizing an anniversary and realizing the opportunity of current national policy-relevant initiatives in aging, this article is intended as a further step in continuing the dialogue on bridging research and policy in aging.

### Notes

- 1 Some provincial governments support innovative work at the research–policy interface. For example, in British Columbia, the Alzheimer Drug Therapy Initiative is intended to generate and evaluate information on the safety, effectiveness, and appropriate use of specific drugs in the treatment of Alzheimer’s disease to inform future government policy on coverage of these medications.
- 2 These strategic “KT” initiatives include the Alzheimer’s Knowledge Exchange (<https://www.ehealthontario.ca/portal/server.pt?open=512&objID=704&PageID=0&mode=2>), the Senior’s Health Research Transfer Network in Ontario (<https://www.ehealthontario.ca/portal/server.pt?open=512&objID=705&PageID=0&cached=true&mode=2%26userID=11862>); and the Canadian Dementia Knowledge

Translation Network (<http://communications.medicine.dal.ca/newsroom/cdktn.htm>). For a recent commentary on structures and processes to enhance research to action on aging in Canada, please see Martin-Matthews, 2009.

- 3 The dependent adult or elderly relative must be the caregiver's spouse or common-law partner's sibling, niece, nephew, aunt, uncle, parent or grandparent. Care receivers must be dependent on the applicant due to mental or physical disability or be the parent or grandparent of the applicant, his or her spouse or common-law partner, aged 65 or older. A dependent's net income of \$14,336 or less will be eligible for the full claim – those between \$18,534 and \$14,336 can apply for a partial claim (Canada Revenue Agency, 2009).

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