



COSCO NEWS

Council of Senior Citizens' Organizations of BC
www.coscobc.ca

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THE WAY AHEAD EDITORIAL

During the first six months of this year, COSCO was very much engaged in the campaign to bring balance to the Premier's CONVERSATION ON HEALTH. We succeeded splendidly. Not only was our flyer well received, but the tone of the conversation switched to "how can we improve public healthcare?" In addition, we succeeded in recruiting a good number of activists into the COSCO ranks.

At the same time, the Executive has been busy securing resources for our HEALTH LITERACY project which is part of our continuing campaign to maintain the health, well being and independence of seniors for as long as humanly possible. We have secured grants from the Canadian Council on Learning, Vancouver Coastal Health and the Federal Governments New Horizon Project. In addition to all of this, we are working with the academic community of Simon Fraser University to assure the quality of our Health Literacy project.

We are currently working on the completion of training materials (modules) for Fall Prevention, Safe Use of Medication, Healthful Eating, Home Safety for Seniors, Elder Abuse Prevention and Chronic Diseases. We have scheduled training sessions for October and November for trainers who will then hold training sessions for other resource people. These resource people will be able to deliver two hour workshops to interested seniors groups anywhere in British Columbia. We are still looking for volunteers who would be willing to be trained as resource people for delivering these training modules.

COSCO is planning a major conference for the New Year on HEALTH PROMOTION and SICKNESS AND ACCIDENT PREVENTION. This conference is designed to create greater awareness of the importance of health literacy among seniors.

COSCO is very concerned at the absence of a strong national seniors' organization. COSCO delegates to the last National Pensioners and Senior Citizens' Federation (NPSCF) Convention were so disappointed with the lack of action, direction and effectiveness of NPSCF that we let our membership lapse. Presently we are exploring affiliation to the Canadian Pensioners Concerned (CPC). To that end, the Executive has delegated COSCO directors to attend the annual meeting of the CPC. A merger between the NPSCF and the CPC could be the foundation of a strong national seniors' organization, something COSCO delegates fought for unsuccessfully at the last NPSCF convention. Some COSCO affiliates will be sending delegates

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CITIZENS' ORGANIZATIONS
OF BC (COSCO)**

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www.coscobc.ca

**Please check it out for past issues
of the COSCO NEWS,
and senior-related issues.**

editorial cont.

to the NPSCF convention to continue the fight towards accomplishing this objective.

Setting up COSCO Branches in Victoria, Nanaimo, North Island, Kamloops, South Okanagan, North Okanagan, East Kootenay, West Kootenay, Prince George, Peace River and Terrace / Kitimat continues to be a priority for us and the Executive has allocated considerable resources for this. Any help the readers of the COSCO NEWS could provide towards achieving this goal would be greatly appreciated.

As seniors we watch with some trepidation the performance of the Harper Government. Generally speaking the effects of this government's policies on civil society have been very negative. The only reason Harper was able to get away with it was the political situation which two of the three opposition parties have found themselves in. It now appears that a Fall election is very likely. No doubt COSCO will play a role to ensure that Harper and buddies from numerous oil companies land up at the short end of the stick.

That's the WAY AHEAD, and for the Executive and the committees of COSCO, that will be a great deal of work. Any help and advice you can offer is, and will be, greatly appreciated.



World's Best Medical Care?

Published: August 12, 2007
New York Times

Many Americans are under the delusion that we have “the best health care system in the world,” as President Bush sees it, or provide the “best medical care in the world,” as Rudolph Giuliani declared last week. That may be true at many top medical centers. But the disturbing truth is that this country lags well behind other advanced nations in delivering timely and effective care. Michael Moore struck a nerve in his new documentary, “Sicko,” when he extolled the virtues of the government-run health care systems in France, England, Canada and even Cuba while deploring the failures of the largely private insurance system in this country. There is no question that Mr. Moore overstated his case by making foreign systems look almost flawless. But there is a growing body of evidence that, by an array of pertinent yardsticks, the United States is a laggard not a leader in providing good medical care. Seven years ago, the World Health Organization made the first major effort to rank the health systems of 191 nations. France and Italy took the top two spots; the United States was a dismal 37th. More recently, the highly regarded Commonwealth Fund has pioneered in comparing the United States with other advanced nations through surveys of patients and doctors and analysis of other data. Its latest report, issued in May, ranked the United States last or next-to-last compared with five other nations — Australia, Canada, Germany, New Zealand and the United Kingdom — on most measures of performance, including quality of care and access to it. Other comparative studies also



put the United States in a relatively bad light.

All other major industrialized nations provide universal health coverage, and most of them have comprehensive benefit packages with no cost-sharing by the patients. The United States, to its shame, has some 45 million people without health insurance and many more millions who have poor coverage. Although the president has blithely said that these people can always get treatment in an emergency room, many studies have shown that people without insurance postpone treatment until a minor illness becomes worse, harming their own health and imposing greater costs. Citizens abroad often face long waits before they can get to see a specialist or undergo elective surgery.

Americans typically get prompt attention, although Germany does better. The real barriers here are the costs facing low-income people without insurance or with skimpy coverage. But even Americans with above-average incomes find it more difficult than their counterparts abroad to get care on nights or weekends without going to an emergency room, and many report having to wait six days or more for an appointment with their own doctors. The United States ranks dead last on almost all measures of equity because we have the greatest disparity in the quality of care given to richer and poorer citizens. Americans with below-average incomes are much less likely than their counterparts in other industrialized nations to see a doctor when sick, to fill prescriptions or to get

needed tests and follow-up care. We have known for years that America has a high infant mortality rate, so it is no surprise that we rank last among 23 nations by that yardstick. But the problem is much broader. We rank near the bottom in healthy life expectancy at age 60, and 15th among 19 countries in deaths from a wide range of illnesses that would not have been fatal if treated with timely and effective care. The good news is that we have done a better job than other industrialized nations in reducing smoking. The bad news is that our obesity epidemic is the worst in the world. In a comparison with five other countries, the Commonwealth Fund ranked the United States first in providing the “right care” for a given condition as defined by standard clinical guidelines and gave it especially high marks for preventive care, like Pap smears and mammograms to detect early-stage cancers, and blood tests and cholesterol checks for hypertensive patients. But we scored poorly in coordinating the care of chronically ill patients, in protecting the safety of patients, and in meeting their needs and preferences, which drove our overall quality rating down to last place. American doctors and hospitals kill patients through surgical and medical mistakes more often than their counterparts in other industrialized nations. In a comparison of five countries, the United States had the best survival rate for breast cancer, second best for cervical cancer and childhood leukemia, worst for kidney transplants, and almost-worst for liver transplants and colorectal cancer. In an eight-country comparison, the United States ranked last in years of potential life lost to circulatory



diseases, respiratory diseases and diabetes and had the second highest death rate from bronchitis, asthma and emphysema. Although several factors can affect these results, it seems likely that the quality of care delivered was a significant contributor. Despite the declarations of their political leaders, many Americans hold surprisingly negative views of their health care system. Polls in Europe and North America seven to nine years ago found that only 40 percent of Americans were satisfied with the nation’s health care system, placing us 14th out of 17 countries. In recent Commonwealth Fund surveys of five countries, American attitudes stand out as the most negative, with a third of the adults surveyed calling for rebuilding the entire system, compared with only 13 percent who feel that way in Britain and 14 percent in Canada. That may be because Americans face higher out-of-pocket costs than citizens elsewhere, are less apt to have a long-term doctor, less able to see a doctor on the same day when sick, and less apt to get their questions answered or receive clear instructions from a doctor. On the other hand, Gallup polls in recent years have shown that three-quarters of the respondents in the United States, in Canada and in Britain rate their personal care as excellent or good, so it could be hard to motivate these people for the wholesale change sought by the disaffected. Shockingly, despite our vaunted prowess in computers, software and the Internet, much of our health care system is still operating in the dark ages of paper records and handwritten scrawls. American primary care doctors lag years behind doctors in other advanced nations in adopting

electronic medical records or prescribing medications electronically. This makes it harder to coordinate care, spot errors and adhere to standard clinical guidelines. Despite our poor showing in many international comparisons, it is doubtful that many Americans, faced with a life-threatening illness, would rather be treated elsewhere. We tend to think that our very best medical centers are the best in the world. But whether this is a realistic assessment or merely a cultural preference for the home team is difficult to say. Only when better measures of clinical excellence are developed will discerning medical shoppers know for sure who is the best of the best. With health care

emerging as a major issue in the presidential campaign and in Congress, it will be important to get beyond empty boasts that this country has “the best health care system in the world” and turn instead to fixing its very real defects. The main goal should be to reduce the huge number of uninsured, who are a major reason for our poor standing globally. But there is also plenty of room to improve our coordination of care, our use of computerized records, communications between doctors and patients, and dozens of other factors that impair the quality of care. The world’s most powerful economy should be able to provide a health care system that really is the best.

Barlow one of “Good 8”

BERLIN – Maude Barlow, National Chairperson of the Council of Canadians, is featured in the popular German news magazine Stern’s “Guten Achte” or “GoodEight” list, along with Kenyan Nobel Peace Prize winner Wangari Mathai and founder of the Grameen Bank Muhammad Yunus.

On newsstands in early June to coincide with the meeting of G-8 countries taking place in Berlin, the issue features prominent international figures known for their human rights achievements or philanthropic work.

Barlow, a leader in the global movement for social justice, was chosen for her pioneering work to promote the global right to water. The Canadian activist is working to mobilize international support for a UN convention on the right to water from governments and organizations around the world.

She is the best-selling author of 15 books, including the coming *Blue Covenant: The Global Water Crisis and the Right to Water*. She has received honorary doctorates from six universities and in 2005, she was the recipient of the “Right Livelihood Award” by the Swedish Parliament.



www.canadian.org

Hospital Cleanliness

By Rudy Lawrence, President



Almost daily we read in the newspapers, witness on television or hear a talk show tell us of the problems with our health care system. In almost every instance, the focus of the media is on the long waiting lists, lack of hospital beds, more and more user fees etc. While these are important issues to all of us, there is an on-going problem that receives relatively minor media coverage and that is the matter of cleanliness in our hospitals.

Many of us can remember, when growing up, being taught by our mothers the importance of washing our hands before being allowed to sit at the supper table. Remember mother intoning that 'cleanliness is next to godliness?' Was mother just being difficult with us or was there hidden wisdom that cleanliness kept us healthy by preventing the spread of germs? Mother may have been on the right track, because today in many of our hospitals and doctors' offices, we can find containers of anti-septic hand cleaners to use as we enter and leave these institutions. The only problem with the situation today is that mother is not there to remind us and these containers are largely ignored by the general public.

There is a much larger problem however with cleanliness in our hospitals than that of people not washing their hands. The problem that is largely ignored by the media, health experts and politicians is the matter of a lack of proper cleaning. Hospitals should be pristine and should be maintained that way by properly trained staff. The lack of cleanliness in many, if not all, of our hospitals is totally unacceptable

The following is a partial quote from a letter to the editor of a local newspaper on the North Shore regarding housekeeping at Lions Gate Hospital. A recent patient writes: *I am a registered nurse who worked for 50 years in hospitals...last month I spent five days as a patient on a surgical floor in Lions Gate Hospital. The meals left much to be desired. I also found the hospital quite dirty... the morning after my surgery a soiled sheet and gown were still lying on the floor beside my bed...there were soiled tissues and basins lying under my bed for four days. ...a visitor to this floor had brought in a dog on a leash...*

The reality is that the foregoing story is not an isolated one. In the past several years I have had several family members in hospitals and have witnessed first-hand a lack of proper house cleaning. While visiting in the Royal Columbian hospital I was appalled at the large amount of rolled dirty linens lying most of the day in the corridors of the hospital ward where my family member was being kept. What I found while visiting in Lions Gate Hospital was a kitchen off the rehab ward where patients could make tea and coffee in dirty utensils. When I inquired about the possibility of having them cleaned, I was told that no staff had been assigned to clean the kitchen. It would have helped to have had some soap so that patients could have done cleaning up. Quite frankly the kettle, toaster and microwave were almost beyond cleaning and should have been thrown out. Surely, this lack of cleanliness must be contributing to some of the outbreaks of infections that we here about in the media? Surely it is time to raise our voices against the lack of something as basic as keeping our hospitals clean. It is time to write letters to newspapers, contact health authorities and your MLA !

MAKING LIFE EASIER FOR SENIORS *by Sonja Alton*

Many seniors are healthy and able to perform ordinary day-to-day activities without too much trouble; a couple of activities, however, that can be really onerous for seniors are grocery shopping or the effort of going for a trip to a mall or to the downtown core of their city. Many elders would like the freedom of being able to take in activities or go shopping in the various downtown centres.

It can be very tiring grocery shopping, walking around large stores such as COSTCO Wholesale, Safeway, the Canadian Super Store or Save-On Foods. Even though some malls supply wheelchairs for the elderly upon request, as far as I know most grocery and chain stores don't supply wheelchairs or other mobility aids for elderly or disabled shoppers; however, grocery stores in one city I know do.

On a recent visit my husband and I made to Newcastle upon Tyne, a city of about three million people in the north of England, a disabled friend took us to a large grocery store called ASDA. There we saw about a dozen electric scooters, large wire shopping baskets attached, all lined up waiting for use. A number of scooters were already effectively in use, and there was a special check-out open for "scooter users." To be able to access a scooter, a person had to produce either a handi-capped placard or show a care card similar to the gold care card Canadian seniors carry. Apparently, several other large stores in the area also provided this service.

My friend actually owns a scooter, and, until recently, her husband was able to lift the scooter, attach it to a frame on the back of their car and off they would go: now that he is physically not able to lift the scooter, my

friend has an alternative. With a special pass from the City of Newcastle, and for the sum of about \$30.00 a year, my friend is able to 'phone ahead to a particular city department and reserve a scooter to be available at a specific location in the downtown area. She is allowed to reserve the scooter for a three hour period. If she and her husband are arriving by car, a parking spot is also reserved for them.

The city encourages the use of public transportation which is people friendly. For those who need to use it - the majority of the population - public bus transportation in Newcastle is excellent. Shuttle buses routinely cruise residential neighbourhoods, picking up passengers and delivering them to main bus loops where these passengers transfer to larger trolley buses. The majority of buses are wheelchair accessible, so the elderly and the disabled are readily able to get out and about.

A few of these services mentioned above are available to British Columbians; however, it seems to me that all seniors should have access to services like those found in Newcastle, services that allow them independence and the ability to enjoy life as do the younger members and the more physically fit elders in our society.



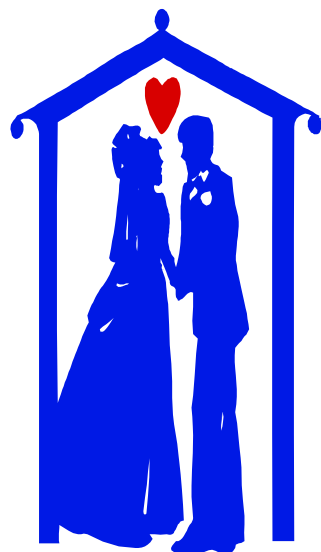
SEXY SENIOR A HEALTHY SENIOR, SURVEY FINDS

Even those aged 75 to 85 surprisingly active

BY MARIA KUBACKI

Can West News Service

Healthy, older adults are enjoying sex well into their 70s and 80s, according to the first



comprehensive survey of sexual behavior among older adults in the U.S., published in a recent issue of the New England Journal of Medicine. Sex among older people is closely linked to overall health, researcher found, and problems in the bedroom may be a warning sign pointing to larger

issues. In other words, a sexy senior is a healthy senior. And while there's lots of research on the sexual health of older men, the new survey also sheds light on the sex lives of older women, who are significantly less likely to report sexual activity than men. Using data from the University of Chicago's National Social Life, Health and Aging Project, the study looked at the sex lives of 3,005 U.S. adults – 1,550 women and 1,455 men – and found that while sexual activity declined with age, even those in the 75 to 85 age bracket are still surprisingly active. Seniors who are sexually active are having sexual relations about as often as younger people; at least two or three times a month. And we're not just talking about missionary position. Among those under 75, about half

engage in oral sex in the previous 12 month. So did about a third of those aged 75-to-85. Seniors were most likely to name vaginal intercourse as primary activity, with about 90 per cent of men and women aged 57 – 64 reporting having done it the previous year. (That dropped to 84 per cent of men and 74 per cent of women in the 75-to-85 age group). However, older women seem to be less likely to have an active sex life. That's partly because more women find themselves alone in old age. Only 40 per cent of women aged 75 to 85 reported having a spouse or other intimate relationship, compared to 78 per cent of men – a consequence of age disparity in relationships. On the average, men have partners who are more than three years younger than they are. And women live longer than men, which means they're more likely to be widowed. But even older women whose partners are still alive may not get satisfaction in the romance department. According to both women and men, the No.1 for not having sex was that the male partner had a physical problem – whether a sexual problem like erectile dysfunction, or an illness such as diabetes, arthritis or heart disease – said lead author Stacy Tessler Lindau of the University of Chicago in an interview with Can West News Service. Overall, half of sexually active seniors reported a sexual problem. Lindau hopes that the study will lead to more openness about sexuality and seniors, especially between doctors and their older patients. "Sexuality in later life has largely been a taboo subject," she said.

Seniors most often victimized by family member, study reports

BY MEAGAN FITZPATRICK ,Can West News Service

OTTAWA – Seniors are less likely to be victims of violence and property crimes than younger Canadians, but when they are victimized, it's often at the hands of a family member, according to a new study released in March. Using results from the 2004 General Social Survey on victimization and police-reported data from the 2005 Uniform Crime Reporting Survey, Statistics Canada determined 10 per cent of seniors were victimized in the year preceding the survey, compared to 31 per cent of those under 65 years of age. The rate of violent victimization among seniors was almost four times lower than the rate for people aged 55 to 64 and almost 20 times lower than the rate for people aged 15 to 24, the study reported. Violent incidents include assault, sexual assault and robbery. Senior citizens and younger victims are both more likely to be victimized by someone they know, but nearly half of all seniors suffer a crime at the hands of a family member, compared to 39 per cent for non-senior victims, the report said. Adult children were the most common perpetrators of family violence against seniors, followed by current or previous spouses. The Statistics Canada study estimated only about half of incidents against seniors were reported. Allison Leaney, who works to prevent elder abuse, believes the incident of crimes against seniors is likely much higher than the numbers indicate because many crimes go unreported, especially ones committed by a family member. "People in some ways feel responsible if they think someone in their family is treating them badly" said Leaney, the executive director of the British Columbia Association of Community Response Networks.

FACTS ABOUT SENIORS' FALLS IN CANADA AND BRITISH COLUMBIA

A fall is defined as 'an unintentional coming to rest on the ground, floor or other lower level, whether or not the faller is injured'.

- 33% of seniors from ages 65-74 fall at least once each year
- 40% of seniors from ages 75-84 fall at least once each year
- 50% of seniors 85 and older fall at least once each year
- \$3 billion is spent each year in Canada on seniors' falls injuries
- In BC over the past four years 42.5% of all seniors hospitalized because of a fall were suffering from a broken hip. The average hospitalization cost of each hip fracture is \$18,508, totalling \$75 million annually for all senior hip fractures.
- Half of those with hip fractures NEVER regain pre-fall functioning
- Seniors aged 65-74 spend an average of 11 days in hospital after a fall, ages 75-84 average 13 days and ages 85+ average 15 days
- 47% of falls that led to hospitalization occurred in or around the home and 21% occurred in residential institutions
- In 2004 in BC 852 seniors (517 women and 335 men) died as a result of having a fall and 10,091 were hospitalized. Total estimated cost was \$151 million
- From highest to lowest, the rate of death from falls per 10,000 seniors in the five regional health authorities is 6.7(Northern), 5.5 (Van. Island) 5.1(Interior), 3.6 (Van. Coastal) 3.3 (Fraser).
- The four greatest risk factors that CANNOT be modified are: older age, female, white, with some chronic disease
- The five greatest risk factors that CAN be modified are: muscle weakness, poor gait and balance, impaired vision, medications, and environmental hazards. Our workshops will make a difference!



Malcolm, Leslie (Mac) Tetlock

March 25, 1920 - July 24, 2007

It is with sincere regret that we announce the passing of former COSCO Director and friend of many, Malcolm (Mac) Tetlock. Mac was a life long Social Democrat whose life was dedicated to the struggle for a just society and a fair shake for everyone. Whenever COSCO held a public forum or street demonstration, Mac was there. His last demonstration was at the Premier's Conversations on Health in downtown Vancouver on July 7, 2007. He will be remembered for his dedication and his many jokes. Our condolences go out to Mac's family and he will be missed by all of us.

*PLEASE FEEL FREE TO
PHOTOCOPY YOUR COSCO NEWS
AND PASS ALONG TO OTHERS
WHO MAY BE INTERESTED*

*Thank you to Kristi Josephson at the
BCRTA office for help in putting
together the COSCO news.*

**MEMBERSHIP APPLICATION
(TO BE MAILED TO THE ADDRESS BELOW)**

I wish to join COSCO as an associate member and I enclose a \$25 membership fee ____
I wish to make a donation to COSCO - please find enclosed cheque for \$ ____

Name _____

Address _____

Postal Code _____ Phone _____ Fax _____

Email address _____

Date _____ Signature _____

**Please make cheque payable to COSCO and send to: Ernie Bayer, Membership Sec.
6079 184 A Street, Surrey, BC. V3S 7P7 (604 576 9734)**

Seniors' Groups or organizations wishing information about joining COSCO should write or phone Ernie Bayer and request a membership package.