Ensuring Healthy Aging for All

Home Care Access for Diverse Senior Populations in the GTA

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EXECUTIVE SUMMARY

Ensuring Healthy Aging for All: Home Care Access for Diverse Senior Populations in the GTA

Publicly-funded home care is provided to people who have health conditions that restrict their daily activities. Home care is an important support for many Ontarians. Our reliance may increase as our population ages, and needs may change. As the baby boomer cohorts enter their senior years, our aging population takes on a different character socially, culturally and ethnically. In the Greater Toronto Area (GTA), immigrant seniors receive less publicly-funded home care and report higher unmet care needs than non-immigrant seniors. The needs for home care among immigrant seniors will continue to grow. The data in this study raises important questions about the future of home care for seniors from diverse ethnocultural groups. Home care must be provided equitably across the region to ensure healthy aging for all. We need a plan now to ensure that we can properly deal with demographic and needs-based changes over time.

Introduction

Improving access to publicly-funded care for all is one of four key objectives listed in *Patients First*, Ontario's action plan for health care.[1] To enhance equitable access to home care, it is crucial to understand the current status of home care utilization for diverse populations. Evidence shows that home care services are inconsistent across Ontario and can be difficult to navigate,[2,3] which can create a greater reliance on informal care systems. Informal caregivers, who provide important support to family members, friends or neighbours, are increasingly experiencing stress and burnout.[4] But, we know very little about who receives home care and what are the current supports they receive to meet their care needs. This report profiles people who receive home care in the GTA to provide a better understanding of the impact of immigration, racialization, and language on home care utilization, and to facilitate the development of policies, programs and services that enhance equitable home care access. It investigates the home care experiences of seniors from immigrant, racialized, and linguistically diverse population groups. The report presents the sources of home care seniors received and how the patterns differ across groups. It describes differences in unmet needs for home care services across diverse senior population groups.

Methods

This study draws on national survey data from the Canadian Community Health Survey (CCHS). The CCHS is a cross-sectional survey administered by Statistics Canada that collects information on health status, health care utilization, and health determinants for the Canadian population. The CCHS covers adults who live in privately occupied dwellings, excluding residents of institutions, full-time members of the Canadian Forces, persons living on reserves and other Aboriginal settlements. The CCHS data are collected annually. The survey includes questions on the use of home care services, the type of services received and needed, and remaining unmet needs for home care. Data on key socio-demographic variables, such as age, sex, household income, geographical location, living arrangements, immigration status, length of time in Canada, country of origin, mother tongue, and racialized identity were also available (racialized persons in this report refer to those who self-identified themselves as non-White).

We combined eight cycles of CCHS data collected between January 2007 and December 2014 to produce a sample of 10,125 people aged 65 and over who were residents of the GTA. Although we pooled multiple cycles of CCHS data, the size of some of our sub-populations was found too small to be reported. Because of small numbers we are unable to comment specifically on LGBT seniors and those who reported having received care from private agencies. Similarly, when looking at country of origin we can only comment authoritatively about the top five countries of origin (Italy, UK, China, India, and Jamaica).

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1 Ministry of Health and Long-term Care 2016. Patients First: Action Plan for Health Care. From: http://health.gov.on.ca/en/ms/ecfa/healthy_change/

2 Donner, G., et al. 2015. Bringing Care Home. Report of the Expert Group on Home and Community Care. From: http://health.gov.on.ca/en/public/programs/ccac/docs/hcc_report.pdf

3 Ministry of Health and Long-term Care 2015. Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario. Discussion Paper.

4 Health Quality Ontario 2016. The Reality of Caring: Distress among the caregivers of home care patients. http://www.hqontario.ca/System-Performance/Specialized-Reports/Caregiver-Distress-Report

Appendix A contains details of our methods, and Appendix B presents detailed data tables describing the results of the CCHS analyses.

Findings

Who Receives Home Care in the GTA

Almost eight (7.7) percent of seniors reported having received home care partially or fully funded by government. Seniors also received home care from non-government sources: 6.7 percent from informal caregivers (including family, friends and neighbours), 1.6 percent from private agencies, and 1 percent from others such as volunteers. One-third of government-funded care receivers also received other sources of home care, mostly from informal caregivers. Family members were the source of informal care on nearly nine out of ten occasions.

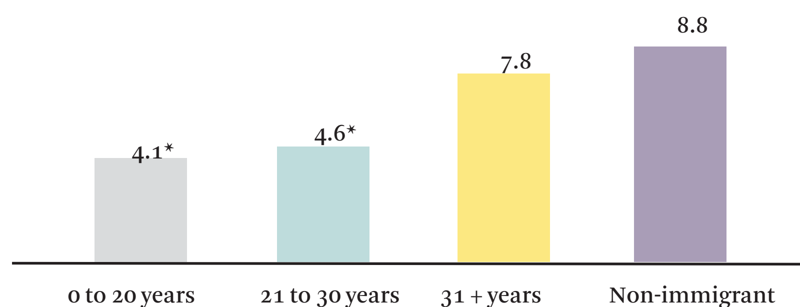
The percentage of seniors receiving home care significantly increased with age (see Appendix B). About 26 percent of people aged 85 or older received government-funded care in the past 12 months, compared with 4 percent of those aged 65 to 74.

In addition to older age, a number of key socio-demographic factors were associated with having received home care: women, those living with low or no income, individuals living alone, and those with chronic conditions were all more likely to receive home care. Higher self-perceived unmet needs for home care was also associated with several key socio-demographic factors (see Table B.1 in Appendix B).

Immigrant seniors were less likely than non-immigrant seniors to receive government-funded home care

Immigrant seniors were less likely than non-immigrant seniors to receive government-funded home care (6.8 percent for immigrant seniors versus 8.8 percent for non-immigrant seniors). Within the immigrant group the rate of receiving government-funded care varied depending on length of time in Canada and country of birth. People who had been in Canada for less than 30 years were significantly less likely to get this type of care (Chart 1).

Chart 1. Percentage of seniors who received government-funded home care in the past year, by immigrant status and length of time in Canada



*Significantly different (p<0.05) from estimate for reference category (non-immigrant)

Source: 2007-2014 Canadian Community Health Survey, population aged 65 years and older, GTA

In the case of country of origin data, while immigrants from Italy and UK showed similar or higher rates of having received government-funded care than the non-immigrant, those from non-European countries reported lower rates than non-immigrant seniors. Only 2.8 percent of immigrants from China reported that they had received government-funded home care, significantly lower than the rate for the non-immigrant group (Table 1).

Of note, racialized seniors were significantly less likely than non-racialized seniors to have received home care from government (Chart 2).

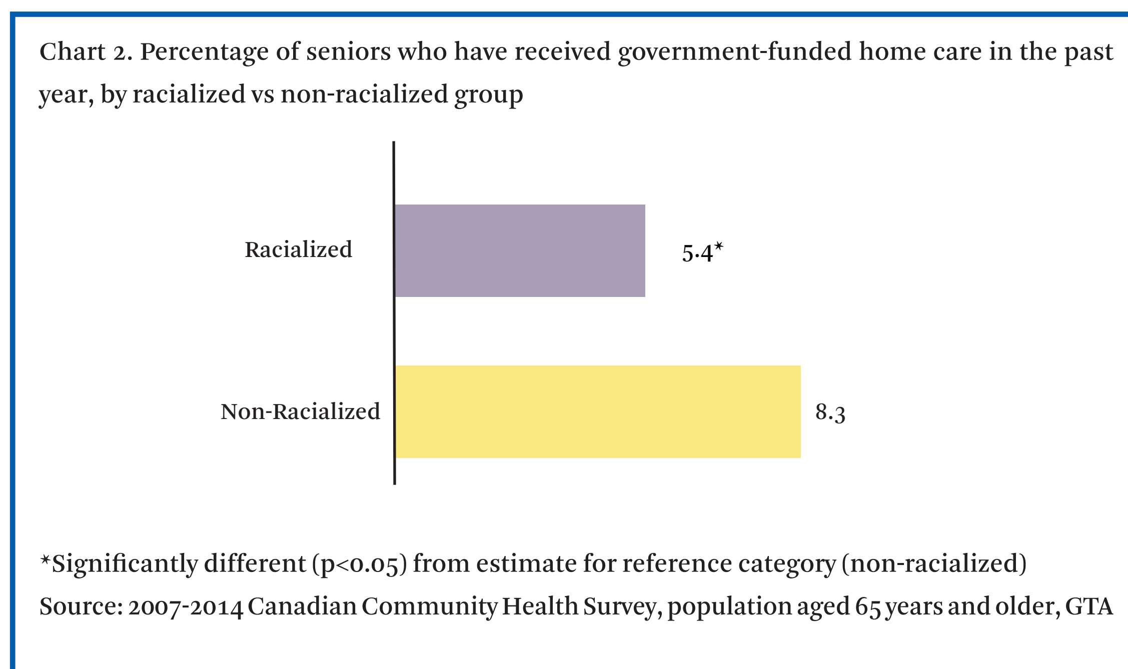
Table 1. Percentage of seniors who have received government-funded home care in the past year, by immigration status and country of birth

Non-immigrant (ref)	Immigrant					
	Total	Italy	UK	India	Jamaica	China
8.8	6.8	10.5	8.8	4.9	4.1	2.8*

*Significantly different ($p<0.05$) from estimate for reference category (non-immigrant)

Source: 2007-2014 Canadian Community Health Survey, population aged 65 years and older, GTA

Chart 2. Percentage of seniors who have received government-funded home care in the past year, by racialized vs non-racialized group



*Significantly different ($p<0.05$) from estimate for reference category (non-racialized)

Source: 2007-2014 Canadian Community Health Survey, population aged 65 years and older, GTA

Immigrant seniors were more likely than non-immigrant seniors to receive home care from informal caregivers

Immigrant seniors received less government-funded care than non-immigrant seniors. But the reverse was found for informal home care. Overall, immigrant seniors as a group reported higher rates of having received informal home care than non-immigrant seniors. Immigrants from Italy reported the highest rate of informal care, and this was significantly higher than the rate for the non-immigrant group. Immigrants from the UK and India reported lower rates than other immigrant groups (Table 2).

Table 2. Percentage of seniors who have received home care from informal caregivers (family, friends, neighbours) in the past year, by immigration status and country of birth

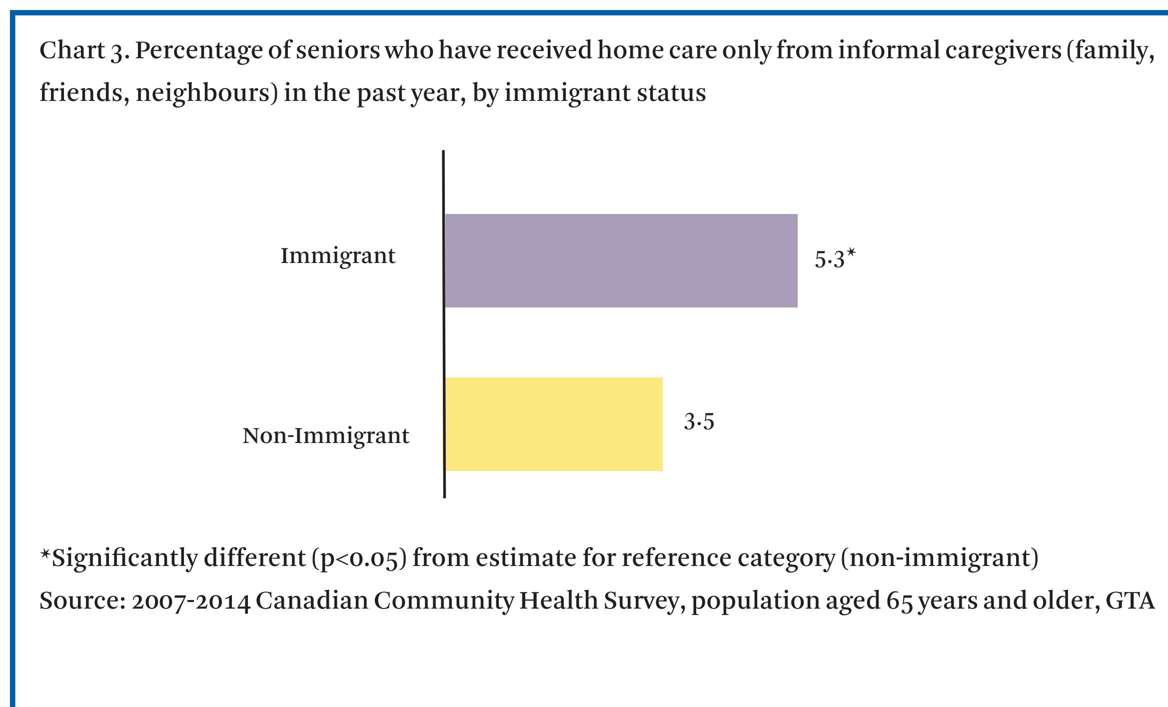
Non-immigrant	Immigrant					
	Total	Italy	China	Jamaica	India	UK
5.4	7.3	11.9*	9.3	6.7	5.3	4.2

*Significantly different (p<0.05) from estimate for reference category (non-immigrant)

Source: 2007-2014 Canadian Community Health Survey, population aged 65 years and older, GTA

Many individuals reported that they had received government-funded home care as well as informal home care. To offer a more comprehensive report of home care recipients and their needs, we analyzed those who only received home care from informal caregivers. Across the GTA, 4.8 percent of seniors identified informal caregivers as their only home care providers. This is 70 percent of the total informal care recipient group. Immigrant seniors as a group reported a significantly higher rate of receiving home care only from informal caregivers than non-immigrant seniors (Chart 3).

Chart 3. Percentage of seniors who have received home care only from informal caregivers (family, friends, neighbours) in the past year, by immigrant status



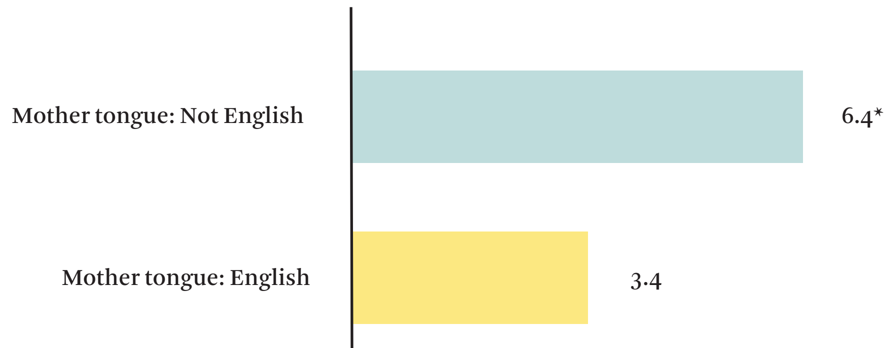
*Significantly different (p<0.05) from estimate for reference category (non-immigrant)

Source: 2007-2014 Canadian Community Health Survey, population aged 65 years and older, GTA

Seniors whose mother tongue was not English were more likely than those whose mother tongue was English to receive home care from informal caregivers

Mother tongue was significantly associated with receiving home care from informal caregivers. Over 8 percent of seniors whose mother tongue was not English received informal home care; significantly higher than the rate for those whose mother tongue was English (5.3 percent). For seniors who received home care only from informal caregivers, those whose mother tongue was not English were nearly twice as likely as those whose mother tongue was English to have received care only from informal caregivers (Chart 4).

Chart 4. Percentage of seniors who have received home care *only* from informal caregivers (family, friends, neighbours) in the past year, by mother tongue



Significantly different (p<0.05) from estimate for reference category (mother tounge: English)
Source: 2007-2014 Canadian Community Health Survey, population aged 65 years and older, GTA

Immigrant seniors as a group had more unmet needs for home care services than non-immigrant seniors

Overall, 5.6 percent of seniors in the GTA reported having at least one unmet need for home care services in the past year. Immigrant seniors as a whole were significantly more likely than non-immigrant seniors to have unmet needs for home care (Chart 5). The prevalence of reporting unmet needs was also strongly associated with the length of time in Canada. Those who had been in Canada for between 11 and 20 years reported the highest rate of unmet care needs (8.6 percent). They were more than twice as likely as non-immigrant seniors to report having unmet needs. Those who had been in Canada for 31 years or longer also reported a significantly higher rate (6.3 percent) than non-immigrant seniors.

Chart 5. Percentage of seniors who reported having self-perceived unmet needs for home care in the past year, by mother tongue

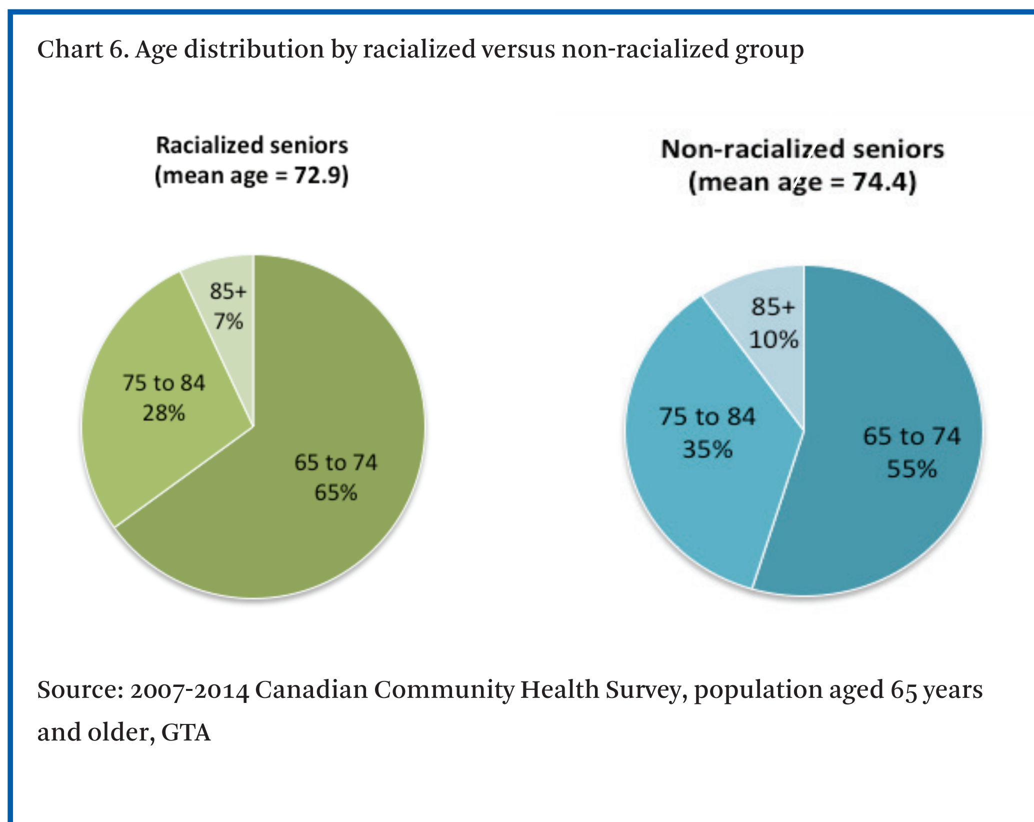
*Significantly different (p<0.05) from estimate for reference category (non-immigrant)
Source: 2007-2014 Canadian Community Health Survey, population aged 65 years and older, GTA

Seniors whose mother tongue was not English were more likely than those whose mother tongue was English to report unmet needs – 6.5 percent versus 4.7 percent. In addition, racialized seniors were more likely than non-racialized seniors to report unmet needs – 6.6 percent versus 5.0 percent – although no significant difference was found.

Are the findings because immigrant and racialized seniors are younger than non-immigrant and non-racialized seniors?

The mean age of our sample was 74.0 years old. Immigrant seniors as a group were slightly younger than the non-immigrant group (the mean age was 73.8 for immigrant seniors and 74.3 for non-immigrant seniors). Within the immigrant group, the age distribution varied significantly by length of time in Canada.[5] Recent immigrants were younger than more established immigrants. Racialized seniors were significantly younger than non-racialized seniors (Chart 6). On the other hand, the two mother tongue groups, English and non-English, were similar in their age distribution (see Table B.3. in Appendix B).

Chart 6. Age distribution by racialized versus non-racialized group



Source: 2007-2014 Canadian Community Health Survey, population aged 65 years and older, GTA

Since older age was strongly associated with a higher prevalence of receiving home care and reporting unmet needs, we examined how different age distributions across sub-population groups might have contributed to the variance in seniors' home care use and unmet needs observed in our sample of seniors

5 The variance in age distribution by country of birth could not be reported due to small sample sizes for a few analytical categories.

aged 65 plus. To understand to what extent age distribution mattered in our sample, we analyzed group differences in receiving government-funded home care and in reporting unmet needs within a selected age category.[6]

In the 75 to 84 age category, immigrants as a whole were more than twice as likely as non-immigrants to report unmet needs for home care services (Table 3). The unmet needs rates for all immigrants and three immigrant sub-groups in the 75 to 84 age category were all higher than the rates for their counterparts in the entire immigrant senior group (aged 65 plus). The rate for non-immigrant seniors in the 75 to 84 age group, however, remained the same as the rate for all non-immigrant seniors. When examining group differences in the same age category, the gap in having unmet needs became larger between racialized and non-racialized senior groups as well as between immigrant and non-immigrant senior groups, compared with the gaps observed in the total senior population.

In this age category, immigrants were as likely as non-immigrants to have received government-funded home care (Table 4). When compared with the rates for all seniors (aged 65 plus), the gap between immigrants and non-immigrants narrowed for this age category. However, the gap among immigrants increased. While all the government-funded home care use rates went up across population sub-groups for the 75 to 84 age category, the mid-term immigrant group reported a lower rate of receiving such home care. Immigrant seniors who had been in Canada for 21 to 30 years were more than three times less likely than those who had been in Canada for 31 years and longer to have received government-funded home care.

Table 3. Percentage of seniors who reported having self-perceived unmet needs for home care in the past year

	Has unmet needs for home care	
	Age 75 to 84	All seniors (65+)
Non-immigrant (ref)	4.1	4.1
All Immigrants	8.4*	6.3*
Recent immigrants	9.1 (0-20 years)[1]	4.9 (0-10 years) 8.6*(11-20 years)
Mid-term immigrants (21-30 years)	7.8	4.4
Long-term immigrants (31+ years)	8.3*	6.3*
Non-racialized (ref)	6.1	5.0
Racialized	9.8	6.6

[1] Two recent immigrant groups were combined for those aged 75 to 84 due to a small number of cases in the 0 to 10 years group.

*Significantly different from estimate for reference category ($p<0.05$)

Source: 2007-2014 Canadian Community Health Survey, population aged 65 years and older, GTA

6 We chose the 75 to 84 age category as we were unable to report data for the 65 to 74 and 85 plus age categories due to small sample sizes for a few analytical categories.

Table 4. Percentage of seniors, aged 75 to 84, who reported having received government-funded home care in the past year

	Has received government-funded home care	
	Age 75 to 84	All seniors (65+)
Non-immigrant (ref)	9.3	8.8
All Immigrants	9.2	6.8
Recent immigrants (0-20 years) [1]	5.8	4.1*
Mid-term immigrants (21-30 years)	3.1*	4.6*
Long-term immigrants (31+ years)	10.9	7.8
Non-racialized (ref)	10.0	8.3
Racialized	7.4	5.4*

[1] Two recent immigrant groups were combined for those aged 75 to 84 due to a small number of cases in the 0 to 10 years group.

*Significantly different (p<0.05) from estimate for reference category

Source: 2007-2014 Canadian Community Health Survey, population aged 65 years and older, GTA

Discussion

Our findings indicate significant differences in receiving government-funded home care between immigrant and non-immigrant seniors in the GTA. Our study does not explain *why* immigrant seniors as a whole and some immigrant groups in particular receive less home care from government. There are a number of possible reasons for our findings. These could include lack of information, linguistic and cultural barriers, or cultural practices.

Our descriptive findings raise serious concerns about existing gaps in accessing formal home care services across diverse senior populations in the GTA. The significantly higher rate of reporting unmet needs for home care among the immigrant groups suggests that immigrant seniors, especially recent and mid-term immigrants, may face additional challenges in accessing home care services to meet their care needs. Having unmet needs for support may lead to negative health consequences such as injuries, higher hospitalization rates, institutionalization and premature death.[7,8] Importantly, the significant difference in the prevalence of having received home care only from informal caregivers between English and non-English mother-tongue groups suggests a potential language barrier to accessing formal home care support in the GTA.

Furthermore, the data on informal care recipients indicate that immigrant seniors rely more heavily than non-immigrant seniors on family caregivers to meet their needs for home care. As noted in previous studies, the true prevalence of those receiving informal home care is likely to be greater since some forms of home care, such as receiving support from a spouse or an adult child which is often perceived as part of daily family life, may have been under-reported.[9] As well, the lack of information provided by the CCHS

7 LaPlante M.P. et al. 2004. Unmet need for personal assistance services. The Journals of Gerontology. 59(2): 98-108.
8 Sands, L.P. et al. 2006. Rates of acute care admissions for frail older people living with met versus unmet activity of daily living needs. Journal of the American Geriatric Society. 54(2): 339-44.
9 Hoover, M. & Rotermann, M. 2012. Seniors' use of and unmet needs for home care, 2009. Health Reports. Statistics Canada.

on the amount of home care received limits our understanding of the intensity of government versus non-government home care utilization. Based on General Social Survey data, researchers estimate that Canadian informal caregivers on average provide seven hours of support to family and friends for every two hours of professional care.[10]

Higher levels of home care use provided by informal caregivers may lead to higher rates of caregiver distress in immigrant groups. Recent reports highlight that family caregivers in Ontario often express difficulties fulfilling family or work responsibilities, financial hardship, some level of stress, and emotional challenges because of their caregiving responsibilities.[11] Another recent study provides strong evidence of language barrier effects on caregiver distress among family caregivers who provide care for government-funded home care clients.[12] Based on the Resident Assessment Instrument – Home Care (RAI-HC) data[13], administered by Community Care Access Centres (CCACs), researchers found that family caregivers of home care clients who reported the need for an interpreter showed significantly higher levels of caregiver distress than those without the need for an interpreter.

Conclusion

The population is aging and the older population is becoming more diverse both ethnically and linguistically across the GTA. The growing diversity in the aging population in the GTA raises important questions about how to best ensure equitable access to publicly-funded services for diverse senior populations. In recent years, the emphasis of health care has shifted from institution to home and community. The Ministry of Health and Long-Term Care (MOHLTC) has committed to investing and strengthening home and community care as a fundamental part of *Patients First*.[14] Adequate access to home care services enables people to stay in their own homes, allowing them to age in place for as long as possible. It also helps people to avoid or delay hospital readmissions, hospitalizations, or moving into a long-term care facility. Equitable access to publicly-funded home care for all seniors across the GTA would have measurable positive impacts on health and health equity.

Our data offer timely and important findings for policy makers and service providers who seek more equitable and effective ways to provide home care services that meet the needs of diverse senior populations. The MOHLTC is moving forward to implement patient-centred health care planning through an extended role of the Local Health Integration Networks (LHINs) and sub-LHINs in delivering home and community

10 Sinha, M. & Bleakney, A. 2014. Receiving care at home. Analytical Paper. Statistics Canada. From: http://www.statcan.gc.ca/pub/89-652-x/89-652-x2014002-eng.pdf

11 The Change Foundation 2016. A Profile of Family Caregivers in Ontario. From: http://www.changefoundation.ca/library/family-caregivers-ontario-report/

12 Chang, B.W. & Hirdes, J.P. 2015. A Cross-Sectional Study to Compare Caregiver Distress Among Korean Canadian, Chinese Canadian, and Other Canadian Home Care Clients. SAGE Open. April-June 2015:1-14. From: http://sgo.sagepub.com/content/spsgo/5/2/2158244015591824.full.pdf

13 In Chang and Hirdes' study, two RAI-HC items were used to define caregiver distress: "A caregiver is unable to continue in caring activities, e.g., decline in the health of the caregiver makes it difficult to continue," and "Primary caregiver expresses feelings of distress, anger, or depression."

14 Ministry of Health and Long-term Care 2015. Patients First: A Roadmap to Strengthen Home and Community Care. From: http://www.health.gov.on.ca/en/public/programs/ccac/roadmap.pdf

care.[15] Population-based planning at the sub-LHIN level will be required as part of these reforms. This structural reform provides an important opportunity for the MOHLTC, LHINs and sub-LHINs to identify the populations that they serve, those with barriers to accessing care, and to accommodate the diverse health and social care needs among senior population groups. Collecting new data on ethnicity, immigrant status, length of residency in Canada, language proficiency, as well as other markers of diversity will help the system better understand and serve clients and identify disparities. Our research highlights the need for the new system to be able to respond to the requirements of diverse senior populations and their family caregivers through enhanced culturally and linguistically appropriate services and expanded caregiver support.

15 Ministry of Health and Long-term Care 2016. Patients First: Reporting Back on the Proposal to Strengthen Patient-Centred Health Care in Ontario. http://www.health.gov.on.ca/en/news/bulletin/2016/docs/patients_first_report_back_20160602.pdf

Appendix A: Detailed Methods

This study draws on national survey data from the CCHS. The CCHS is a cross-sectional survey administered by Statistics Canada that collects information related to health status, health care (including home care) utilization, and health determinants for the Canadian population. The CCHS covers individuals aged 12 or older who live in privately occupied dwellings in all provinces and territories, excluding residents of institutions, full-time members of the Canadian Forces, persons living on reserves and other Aboriginal settlements in the provinces. Since 2007, the CCHS data are collected annually.

To increase our sample size of diverse senior groups, we combined eight cycles of CCHS data collected between January 2007 and December 2014. All the analyses in this report are based on weighted percentages calculated from 10,125 respondents aged 65 or older, who were residents of the GTA (including Toronto, Peel, Halton, York, and Durham). Weighted frequencies and cross-tabulations were used to estimate the percentages of people who reported having received home care and/or having self-identified unmet needs for home care in the GTA. Statistics Canada bootstrap weights were also applied to calculate variance on estimates and on differences between estimates. Results at the $p<0.05$ were considered statistically significant.

Information about receiving home care was derived from questions on home care utilization. The CCHS defines home care services as health care, home maker or other support services received at home that people may receive due to a health problem or condition that affects their daily activities. Respondents were provided with the definition and some examples of home care, such as nursing care, personal care or help with bathing, housework, meal preparation or delivery and respite care. For government-funded care, respondents were asked "Have you received any home care services in the past 12 months, with the cost being entirely or partially covered by government?" For other sources of home care, respondents were asked, "Have you received any other care services in the past 12 months, with the cost not covered by government?" followed by "who provided these home care services?" Information about unmet needs was derived from questions on self-perceived unmet needs for home care services. Respondents were asked, "During the past 12 months, was there ever a time when you felt that you needed home care services but you didn't receive them?"

A number of key socio-demographic variables were identified from a literature review. These include age, sex, living arrangements, primary source of household income, and number of chronic conditions experienced by the individual. Five diversity variables were also added. They were immigrant status, length of time in Canada, birth country (including top five source countries based on our sample), racialized identity, and mother tongue (English or non-English). The majority of racialized persons and those whose mother tongue was not English were identified as immigrants (97 percent and 93 percent, respectively).

In the CCHS 2014, racialized identity was operationalized via the following survey question: "You may belong to one or more racial or cultural groups on the following list. Are you: White? South Asian (e.g. East Indian, Pakistani, Sri Lankan, etc.)? Chinese? Black? Filipino? Latin American? Arab? Southeast Asian (e.g. Vietnamese, Cambodian, Malaysian, Laotian, etc.)? West Asian (e.g. Iranian, Afghan, etc.)? Korean? Japanese? Other-Specify." Racialized persons in this report refer to those who self-identified themselves as non-White on the CCHS.

All the analyses were conducted at the University of Toronto Research Data Centre and all results are presented according to Statistics Canada requirements.

Appendix B: Detailed Tables

B.1: Percentage of seniors who have received home care in past year, by selected characteristics and by source of home care, population aged 65 years and older, GTA, 2007-2014

Home care that are:	Funded by government[1]	Informal care[2] (family, friend, or neighbour)	Informal care only[3]
Age			
65 to 74 (ref)	3.8	4.4	3.6
75 to 84	9.5*	8.1*	5.5
85 or older	26.1*	15.9*	10.0*
Sex			
Men (ref)	6.3	4.8	3.5
Women	8.8*	8.2*	5.8*
Living arrangement			
With others (ref)	6.3	6.5	4.8
Living alone	12.2*	7.1	4.8
Main source of household income			
Other (ref)	7.1	5.9	4.2
Social assistance, OAS/GIS or no income	12.2*	12.2*	7.9
Number of chronic conditions			
None (ref)	2.0	1.8	1.5
1	3.8*	3.4	3.0
2 or more	11.6*	9.6*	6.5*
Immigrant Status			
Non-immigrant (ref)	8.8	5.4	3.5
Immigrant	6.8	7.3	5.3*
Length of Time in Canada			
0 to 10 years	4.1*	7.5	6.9
11 to 20 years	(0-20 years)[4]	7.6	(0-20
21 to 30 years	4.6*	9.8	years)[4]
31+ years	7.8	6.9	8.9
Country of birth			4.4
Italy	10.5	11.9*	
UK	8.8	4.2	N/A[5]
China	2.8*	9.3	
India	4.9	5.3	
Jamaica	4.1	6.7	
Mother tongue			
English (ref)	8.0	5.3	3.4
Non-English	7.1	8.5*	6.4*
Racialized			
Non-racialized (ref)	8.3	6.8	4.6
Racialized	5.4*	6.8	5.4

1 Includes those who received government-funded home care as well as other sources of home care (e.g., care provided by informal caregivers, private agencies, volunteers or others).
2 Includes those who received informal care as well as government-funded care.
3 Excludes those who received informal care as well as government-funded care.
4 Two recent immigrant groups were combined due to a small number of cases in the 0 to 10 years group.
5 As a subset of informal care group, the country of birth data for informal care only group could not be reported due to small counts of difference between the two groups.

*Significantly different from estimate for reference category ($p<0.05$).

Source: 2007-2014 Canadian Community Health Survey, population aged 65 years and older, GTA

B.2: Percentage of seniors who reported unmet needs in past year, by selected characteristics, population aged 65 years and older, GTA, 2007-2014

	Self-perceived unmet needs for home care
Age	
65 to 74 (ref)	3.8
75 to 84	7.0*
85 or older	11.1*
Sex	
Men (ref)	4.0
Women	6.8*
Living arrangements	
With others (ref)	5.0
Living alone	7.1*
Main source of household income	
Other (ref)	5.0
Social assistance, OAS/GIS or no income	7.8
Number of chronic conditions	
None (ref)	1.9
1	2.3
2 or more	8.0*
Immigrant Status	
Non-Immigrant (ref)	4.1
Immigrant	6.3*
Length of Time in Canada	
0 to 10 years	4.9
11 to 20 years	8.6*
21 to 30 years	4.4
31+ years	6.3*
Birth country (Top 5 source country)	
Italy	7.3
UK	2.8
China	4.7
India	5.6
Jamaica	8.0
Mother tongue	
English (ref)	4.7
Non-English	6.5
Racialized	
Non-racialized (ref)	5.0
Racialized	6.6

*Significantly different from estimate for reference category ($p<0.05$)

Source: 2007-2014 Canadian Community Health Survey, population aged 65 years and older, GTA

B.3: Age distribution by selected characteristics and by age category

	Age		
	65 to 74	75 to 84	85 and plus
Immigrant Status			
Non-immigrant (ref)	55.3	35.1	9.5
Immigrant	59.1	32.5	8.4
Length of Time in Canada			
0 to 10 years	70.3	28.9	0.8
11 to 20 years	57.3	35.7	7.0
21 to 30 years	55.6	30.2	14.2
31+ years	59.0	32.6	8.4
Mother tongue			
English (ref)	58.3	32.9	8.8
Non-English	56.7	34.4	8.9
Racialized			
Non-racialized (ref)	54.7	35.6	9.7
Racialized	65.0	28.1	7.0

Source: 2007-2014 Canadian Community Health Survey, population aged 65 years and older, GTA