HEALTH CARE OR HEALTH:
THE DEVELOPMENT OF THE ELEMENTS OF A PLAN
TO ADDRESS THE HEALTH NEEDS OF THE ELDERLY
IN BRITISH COLUMBIA
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ABSTRACT

This is an attempt at the development of the elements of a plan to address the health needs of the elderly in British Columbia, which could be directed to the minister of health of the Province.

It begins with a review of provisions and legislation affecting this age group at the federal and Provincial level, and concludes that as services other than medical ones contribute to health, there is an undue emphasis on acute medical and institutional care, and a comparative inadequacy of those preventive and supportive community and social services which might meet many needs more appropriately and more economically.

Most of the problems seem to stem from lack of any coherent policy with regard to the elderly - perhaps because it is only recently that they have been identified as a category, and partly because society's attitude to them is so ambivalent. It is suggested that the elderly do not require separate services but they do require a special policy.

Most of the inappropriate aspects of the present delivery of health services affect all age groups and the elderly will only be able to benefit from recommended changes if they are made to the system as a whole.

However, because of the increasing numbers of elderly in the population and their disproportionate consumption of medical services, and because of the evidence that many of their needs are being met inappropriately and
uneconomically, it seems particularly desirable to make alternative services available to this age group. And because of their disadvantaged position with regard to income, family, friends and other social contacts, and energy compared with other age groups, it is recommended that a policy of positive discrimination be adopted towards this age group in the provision of preventive, community and social services.

Various recommendations are made for elements which should be considered for inclusion in a plan, the main one being that it must be made in very close co-operation with the Department of Human Resources and with input to and/or from other relevant departments.
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INTRODUCTION

In the present century, any country which has managed by public health measures, sanitation, higher standards of living and advances in medicine, to lower its infant mortality rate and the incidence of communicable disease, to cure the formerly incurable, and to keep alive the impaired and chronically ill, has been faced with an increasing proportion of elderly people in its population.

These same countries with their highly developed systems of medical care, financed and administered to different degrees by various levels of government, are also faced with the situation whereby an ever-increasing proportion of the G.N.P. either is devoted to health services, or would be if steps were not taken to change this trend.

Both of these phenomena can be observed in Canada, in the country as a whole and in each of the provinces, not least in British Columbia.

At a time when there is much talk of necessary changes in the health care system, it seems appropriate to look at the elderly population, which is one of the important consumer groups of health services, and to consider what are the particular needs of this group for maintenance of their health, and how these needs can best be met. It was decided to undertake this task from the point of view of a consultant required to make recommendations to the B.C. Minister of Health, using secondary data only, since the writer has neither the time nor the resources to obtain new data.

The process would begin with a study of the history of the B.C. health services, welfare services, voluntary services, and housing and income security provisions, to find out at which point, if at all, the
elderly were identified as a special category, and what services and programmes were provided for them and also to identify general services which would include the elderly among their clientele. The relevant federal and provincial reports and legislation would also be studied, and the nature of their recommendations considered. It should then be possible to trace the trends and hopefully, the causes of the trends which have led to the present situation.

If we can arrive at some understanding of the nature and needs of the older population now and in the near future, and compare these with the services now being provided and likely to be provided in the coming years if present trends continue, we shall be able to assess the appropriateness of the present arrangements.

If there are elements in the present system which appear inappropriate in the light of the apparent needs, then the planner will have to attempt to find the reasons for this discordance, and to make recommendations which would result in a more appropriate provision of services in the future.¹

¹By 'appropriate' we mean the most efficient and economical form of care compatible with the overall needs of the individual, and the use of a service in a way which is compatible with its objectives.
CHAPTER I

A HISTORICAL OVERVIEW OF SERVICES FOR THE ELDERLY IN BRITISH COLUMBIA

In this chapter we look at some of the formal provisions made for the elderly in Canada up to the present time. By 'formal' we mean provided by government or other organizations as distinct from family and friends. From this material we shall attempt in a later chapter to derive some of the reasons for the way in which services are now made available to the elderly, and for their relative importance.

In looking at services provided in the past for the elderly we chose to look at health services and at those other services-social or welfare services, income security, housing, and services provided by voluntary agencies-which could or do act as supports or alternatives to health services.

In most cases we followed the history by looking at the annual reports of the various departments, such other reports as are available, and to other books and articles which are cited. We have tried to pull out the developments within each service which affected the elderly-because they were provided for the elderly, because they were provided for the population at large including the elderly, or because they represent a need for resources which could not therefore be devoted to the elderly.

When considering some of the formal provisions made by society for the elderly, we have followed the different services separately because this is how they are provided, financed and reported on. To try to provide a chronological account of all the services together would not
greatly add to our understanding and might even be misleading, suggesting interaction, interdependency or even co-operation and co-ordination and there is no evidence that any of the services studied had much regard for what was happening in other sectors, as they made their decisions or allowed developments to take place in their own field.

This chapter also contains a very selective summary of only the legislation and reports which refer to the elderly or to provisions which could or do affect the elderly. This means that some legislation in the field has been omitted altogether, that what we have highlighted is not necessarily what are normally considered the most significant aspects of the documents in question; and we have not always repeated recommendations which have already been made several times.

1. **HEALTH SERVICES**

   (a) **Public Health Services**

   An outbreak of smallpox in British Columbia led to the appointment of the first Provincial Health Officer in 1892. In the following year, the first Public Health Act was passed providing for the establishment of a Provincial Board of Health and for the division of the Province into Health Districts with local boards of health who were to appoint Medical Health Officers and Sanitary Inspectors.

   The main concerns of the Board in the early years were general sanitation, the prevention or arrest of communicable diseases and (by 1924) "the social analysis of disease, personal hygiene and education." New concerns brought amendments to the public health code—regarding the control of tuberculosis (1901), sanitary inspection and regulation (1904), inspection
of foods (1906), medical examination of school children (1910) etc.

It is not surprising if little attention was devoted to the elderly in the first 55 years of operation of Public Health Services. In 1895, it was reckoned that one third of deaths and sickness resulted from lack of efficient sanitation and one third of deaths in many places were of children under 5. In 1911, deaths from reportable disease (measles, etc.) amounted to 58.9 per 100,000. In 1914, measles in young children was still commonly fatal. In 1919, almost 10 per cent of deaths were in the age group under 10 years, and 53 per cent were of people between the ages of 20 and 50. In 1922, 12 per cent of hospital patients and 25 per cent of asylum patients were victims of venereal disease. In 1930, the death rate from tuberculosis was highest in the age group 20-29. By 1933, the rate of 76.5 per 100,000 was higher than that of any other province except Quebec and the Maritimes; in 1940, it was still 72.7. And in 1941, the maternal death rate was 2.7 per 1000 live births. In circumstances like these people who survived to old age, far from requiring special services, might be considered very lucky indeed. There was every incentive too for the public health authorities to take action against the striking problems which existed because measurable results showed that the action was worthwhile. By 1926, when the Infant Mortality Rate for Canada was 88.1, it was 50.4 in B.C. The venereal disease rate was halved between 1922 and 1926 and by 1946 was the lowest in Canada. Deaths from reportable diseases fell from 58.9 per 100,000 in 1911, to 7.4 in 1933, and the maternal death rate from 2.7 per 1000 live births in 1941 to 0.6 in 1952. By 1950, over 70 per cent of deaths were occurring at ages
over 60. Some problems showed themselves to require constant vigilance. The number of cases of venereal disease, tuberculosis and diphtheria found all rose between 1945 and 1946, for example. And in 1952, there was polio. (Presently, gonorrhea, diphtheria and rubella are on the increase again.)

Up to 1950 there was the occasional reference to the increasing death rates in the older age groups—to explain the overall increase in the death rate. In 1950, we have the first hint of a different sort of awareness. "An important feature of the population of this Province is the increasing proportion of persons in the older age groups. This fact is of considerable importance to the public health administrator in as much as the health problems of the aged are materially different than those in the younger age groups."

The Survey of Health Services and Facilities in B.C. (1952) carried out on a federal health survey grant, made no major recommendations regarding the elderly. The Public Health Nursing Division was described as so busy in the fields of maternal and child health and control of communicable diseases that it had not been able to expand into the fields of care of the chronically ill, home nursing and rehabilitation. A pilot study of home care and home nursing for the chronically ill was proposed. It was further recommended that efforts be continued to provide special facilities for the care of senile psychotic patients separate from mental patients requiring more active treatment measures, and that closer co-operation be developed between general hospitals, the British Columbia Hospital Insurance Service (BCHIS) and the Health Branch.

The 1952 Health Branch Report noted that whilst the population of
B.C. had increased by 42 per cent between the censuses of 1941 and 1951, the population over 60 had increased by 64 per cent, and B.C. had a greater proportion of over 60s (16 per cent) than Canada as a whole (11 per cent). "The figures highlight not only the necessity of increased facilities for health care and preventive measures, but also give some indication of the changing emphasis which public health programmes must envision." By that year, when complete Provincial coverage by health units was in sight, it was stated that this would permit the development of additional services which would include mental hygiene, bedside nursing and geriatrics. However, in 1960 the first complete statistical analysis of the work of the 496 public health nurses and 61 Victorian Order Nurses (VON) employed in the Provincial service showed that 79 per cent of patients receiving visits were indeed over 60 years of age, but all the nursing care home visits constituted only 2 per cent of the total number of services rendered which included mainly immunizations and school and pre-school services.

A Community Housekeeper Service commenced in Kelowna in 1946 to permit early discharge from hospital or to make admission unnecessary, and the home care programme eventually became a basic part of the nursing activities in the health units. By 1966, the majority of patients in the home care programme were aged over 60 years of age.

The 1966 Annual Report is the first one to refer specifically to 'the elderly' as a distinct category and to geriatric care which was considered to involve health supervision of the elderly at home, in private nursing homes and in personal care institutions. The need for activation
programmes in the latter two types of residence was noted. A few units were making plans for health counselling and screening of persons over 65 years of age.

By 1971, 56 per cent of the general health supervision visits and almost 70 per cent of home care visits were made to patients over the age of 65 years. This implied quite an adjustment in the approach of the public health nurse from the day when prevention of disease and education were almost her only concerns, and school children and their parents her only target, through the forties and fifties when she widened her focus (though in the 50s, the VON still had to go to give injections to tuberculosis patients in the same homes which public health nurses were visiting with an educational purpose). However, it seems that (1) for a variety of reasons, the nature of community health problems changed, (2) as local communities were paying for the service, they could call the tune, and their tune changed, (3) once the home nursing began and was provided by public health nurses in areas where there was no one else, the demand for it grew from referring doctors and the community, and it was by coincidence that the majority of people referred were elderly. By 1968, the newer orientation was made quite explicit—direct professional nursing services along with promotion of community health services were the two general categories of public health nursing activities.

In view of this new trend, it is not surprising that the next report published in the Province was on the subject of home care. The Report of the Standing Committee on Social Welfare and Education (1973), on Home Care in the Province recommended the expansion of home care
programmes, the provision by government of intermediate care, equity in the coverage of all levels of care, including home care, an incentive for training of health care students willing to work in underserviced areas of the Province and the co-ordination of social and health services on a local, regional and Provincial basis.

Greater Vancouver and Greater Victoria run Health Departments separate from, though in co-operation with the Provincial Department. These cities have benefitted from the activities of the VON which was first established in Victoria in 1910. Probably because the latter were more concerned with bedside nursing, there is reference to the needs of the elderly at an earlier date in areas where the VON are involved. In the early days they were mainly needed for home surgery and deliveries, but by 1953, almost one third of VON visits in Victoria were to people over 70 years of age; and by 1956, two thirds were to people aged 65 and over. There is frequent reference to the fact that the elderly prefer to be cared for in their own homes and that nursing visits often make this possible.

By 1954, the Senior Medical Health Officer (MHO) in Vancouver was noting a need for expanded services for "citizens in the upper age brackets". A weekly screening clinic '60 and up Centre' to serve elderly citizens which opened in November 1966 was booked for six months ahead by the end of its first day of opening. In 1967, the service, which employed doctors, nurses, social workers and nutritionists was provided in all five health units, but the clinics were allowed to 'peter out' after 1972. The main explanations advanced for this were that when the medical plan premium
for the elderly was reduced from five dollars to fifty cents per month, people could now afford access to a family physician; the small number of people seen by a doctor in one morning made the service "an expensive way of doing public health;" and in some units, elderly people apparently came for a second opinion after visiting their own doctors.

(b) Hospital Services

Hospitals existed before public health services in B.C. The first edition of the Vancouver General Hospital (VGH), 1888 (10 beds for men only, toward which the City Council paid two thousand dollars) became an Old People's Home in 1906 when the newer VGH opened. St. Luke's Home too, begun in 1888 as a hospital taking mainly maternity and typhoid cases, was rebuilt in 1925 as a Home for the Aged [Nelson, 1934 p. 5]. So there was at that time acceptance of public responsibility for at least some aged. Also, from as early as 1886, the Province was making grants to hospitals which made special claims for help mainly to pay for indigent patients [Cassidy, 1945].

The Provincial Infirmary was established in 1937 to care for the chronically ill. Advanced age does not seem to have been the most striking feature of the chronically ill group in those days. And though blocking of acute beds is frequently complained of by hospital administrators and the Provincial Advisor on Hospital Services, it is by "social problem cases" not elderly people. In fact, age of hospital patients in general does not seem to have been of particular interest because, until 1948 at least, the Annual Reports on Hospital Statistics deal almost entirely with costs and staffing.
Hospitals seem to have been considered important in B.C. even before the days of hospital insurance. As early as 1929, the VGH had 1400 beds. By 1934 there were 104 hospitals in the Province. In 1936, the B.C. hospitalization rate of 1515 patient days per 1000 population was 50 per cent higher than the average rate in the five provinces of Alberta, Saskatchewan, Manitoba, Ontario and Quebec. [Cassidy, 1936]. At that time the hospital, built largely from voluntary funds, was a source of community pride; there was no co-ordination of planning or building; and municipalities and the Province each paid (with a reduction of forty-five cents for 1933 only) seventy cents per day for their residents. In theory to pay for the cost of indigents, this actually met 40 per cent to 50 per cent of total operating costs in the 30s [Ibid. p. 1] already permitting a certain irresponsibility with regard to deficits. The Hospital Act (1948-c152) first legislated for the licensing of hospitals.

In spite of various forms of voluntary insurance against medical and/or hospital costs which became available in the 30s, hospitals could still not obtain enough revenue in the 40s to finance their operations and in 1949, B.C. became the second province to introduce a province-wide hospitalization programme, financed originally by a premium system, later by co-insurance and general revenues. This plan covered the aged, infirm and chronically ill who had sometimes been refused coverage by a voluntary plan [Taylor, 1956 p. 71].

The Hospital Insurance Act (1948-c151) laid down that insurance was to cover treatment of acute illness, active treatment for chronic illness and disability and outpatient treatment and diagnostic services. From
1952, the per diem charge for acute care was to be one dollar.

From 1949 on, the BCHIS produced an annual report showing among other things, the percentage of discharges and patient days for different age groups.

From 1952, the Provincial Social Assistance Medical Care Programme met costs for indigents. At that time, of 63678 beneficiaries, 43618 were in receipt of old age benefits [Taylor, 1954, p. 752]. This programme is said to have resulted in a second class system of medicine and also one which could jeopardize the livelihood of any doctor who had a high percentage of indigents among his case-load because payment was pro-rated out of a fixed pool, at a rate which was much lower than the regular fee. (It could be as low as 45 per cent.)

'A Hospital Plan and a Professional Education Programme for the Province of B.C.' (1949) was the survey of hospital needs which was required of any province before receipt of a federal grant for hospital reconstruction. J.A. Hamilton and Associates presented a 20 year programme and proposed four types of units for acute care—community clinic and health centres, community hospitals, regional hospitals and teaching hospitals.

The report emphasized the importance of hospitals. "The modern hospital of tomorrow emerges from its isolated role to form the frontier for medical care and the axis about which the entire integrated system of health agencies revolve" and also mentioned that the increasing proportion of the population in the older ages "in which illnesses occur with greater frequency" would be one of the factors leading to greater demand for hospital care.
Hospitals for special groups were to be avoided. Outpatient and community services were seen as important. And professional education in the field of geriatrics for physicians, social workers, nurses, dietitians and rehabilitation workers was specifically advocated.

The introduction of the Federal hospital construction grants in 1949 provided such an inducement to hospital construction, that the operating costs of the new hospitals became insupportable at the provincial level and eventually had to be cost-shared by the Federal Government under the Hospital Insurance and Diagnostic Services Act (1957).

The Department of Health Services and Hospital Insurance Act (1959-c38) separated the Health Ministry out from the Ministry of Health and Welfare.

In 1960, a coverage programme for rehabilitation, chronic treatment and convalescent care was introduced in the Province.

A broad interpretation is placed on 'rehabilitation' and it applies to all age groups. A patient of 75 who can be improved sufficiently to enable him to return to his home, even for a few months, is considered to be a rehabilitation patient just as much as a youth of 19 . . .

Even at the inception of the programme, scarcity of trained staff and hospital space were expected to prevent early implementation of the plan in many hospitals. A 1961 amendment to the Hospital Act laid down that a 'hospital' does not include anyone receiving personal (non-skilled in nursing) or occasional skilled care.

The extended hospital care programme was started in 1965 when some existing units were designated as suitable (c. 1020 beds) and others were planned. To be medically eligible for coverage, patients must require
skilled nursing service available twenty-four hours a day and continuing medical supervision—and be unable to walk or use a wheelchair without assistance. About 60 per cent of patients presently in nursing home type facilities were expected to be eligible. In spite of the shortage of personnel, it was \textit{hoped} that each unit would engage the consultative service of a physiotherapist and/or occupational therapist, to advise on maintenance of function in elderly patients, and that diversional interests and activity programmes would "slow up the aging process and ... make life more enjoyable for such patients ..."² From the beginning, the charge of one dollar per day for the extended care hospital (the same as for the acute hospital) was anomalous in that there was no incentive for occupants of extended care beds to progress to the stage of requiring intermediate or personal care which was much more expensive to the patient. The patient charge for extended care was raised to four dollars per day in 1976.

\textbf{The B.C. Regional Hospital Districts Act (1967-c5)} provided for the division of the province into twenty-nine large districts, to enable regional planning, development and financing of hospital projects to be carried out under a revised formula according to which the Provincial government would give increased assistance toward capital costs. The districts were to have the same boundaries and boards as the regional districts incorporated under the Municipal Act (1965). Since that time, the Greater Vancouver Regional Hospital District has produced various reports which refer directly or indirectly to the elderly.

\textbf{The Patterns of Care Report (1969)}, setting planning and
construction priorities for hospitals, saw hospital plans as the first step only in a recommended regional health plan. Levels of care were described. It was recommended that extended care hospitals be built close to acute care facilities to assure professional interest and supervision. (GVRHD 1969)**

The NDP government which took up office in late 1972 published a 'Classification of Types of Health Care' defining 5 types of care which might be provided in public or private institutions, purchased a few private hospitals, authorized more extended care beds, set up a Central Registry in Victoria for extended care applications, opened three intermediate care facilities, and made out-patient physiotherapy an 'authorized benefit' at one dollar per visit. It was noted that as the number of extended care beds increased, the number of patient separations, the number of patient days, and the average length of stay in acute hospitals all declined.

In the three years following, the GVRHD produced four more reports on the various levels of care.

The Extended Care Report (1973) described the extended care programme to date and the location of extended care patients. It was estimated that 755 more beds would be required by 1976 to meet needs (estimated by BCHIS at twenty beds per 1000 population over sixty-five years). There were various recommendations on the size of units and the facilities required for treatment but no comments on quality of care.

The Intermediate Care Report (1974) estimated a need for 3500 intermediate care beds which would grow to 4000 by 1981. Various recommendations were made for the care of patients including a potential **In the bibliography, GVRHD is listed as Greater Vancouver Regional Hospital District.
role for the nurse-practitioner.

The Geriatric Report (1975) showed that personnel in acute hospitals did not feel that special facilities were necessary for the elderly patients as all patients were and should be treated, not according to age, but according to physical status. However, concern was expressed about lack of activation of long-stay elderly people in the acute setting and about the lack of adequate discharge planning and community facilities for after-care.

The Home Care Report (1975), recommending an expanded and more flexible use of the service, was the last of the GVRHD reports referred to.

Health Security for British Columbians (Foulkes 1974), the report of R.G.Foulkes to the B.C. Minister of Health, after a year-long study of the Provincial health services, suggested a new health system with community human resource and health centres at the local level, regionalization of health service provision and eventual joining of the Department of Health and the Department of Human Resources in a Department of Social Affairs. This was to overcome inefficiencies, lack of co-ordination, neglect of some groups, lack of participation of recipients and providers of service in decision-making, overuse of hospitals, etc. 'Total health care' should replace an emphasis on medical care, the former to include more preventive, community-based and social services.

The aged were mentioned as a group with special problems. Health services for the elderly were often so dispersed and various that they were not easily accessible. However, health services for the elderly should not be separate from those available to the general public. Health care programmes for the aged have the same requirements as others
discussed in the study. They must be integrated for personal and institutional care. Everything recorded regarding emergency treatment and transportation, nutritional services, rehabilitation programmes, housing, home care, etc. was to apply to the elderly as to any other group of citizens. Community human resource and health centres might provide the answer to many of the problems of the elderly. It was suggested that it might be desirable to have a bureau within the Department of Human Resources to promote programmes for everyone aged 65 and over and indeed between fifty and sixty-five also.

Partly as a result of this study, the Department of Health Act was amended to allow for a complete re-organization of the Department whereby the former four branches—Public Health, Mental Health, Hospital Insurance and Medical Services were consolidated into two main branches—a Medical and Hospital Programmes Branch and a Community Health Programmes Branch.

The Medical Centre of British Columbia Act (1973 c124) provided for the setting up of a corporation to establish and operate a provincial medical and health sciences centre, to establish and operate hospitals, and to oversee training and research in the field of health.

When the British Columbia Medical Centre was evolving plans for the future provision of medical care, it set up a variety of task forces including the Geriatric Task Force (Chairman Dr. Brock Fahrni) which submitted two briefs—in February 1974 and July 1975.

Particular emphasis is laid in the briefs on geriatric services required by the 95 per cent of the over-65 population who live outside
institutions. It was established that about one third of elderly people in the community could benefit from some sort of service but most of the needs (Most estimates say about two thirds) are non-medical, at least to begin with. Even health needs are mostly those which can be treated by allied health professionals. Early identification of needs, a preventive approach, integration of social welfare services, availability of education and counselling services, use of para-professionals to assess, treat, and refer, and localized provision of service, were all seen as necessary elements of a geriatric programme. There were also some recommendations relating to institutional care, education and research.

The second brief introduced the idea of regional geriatric service areas, hospital-based initially, in the community later, possibly in association with existing community service areas. The medical care system could not and should not deal with all the problems of the elderly. Even assessment, it was felt, could be left to satisfactorily trained allied health professionals. The family physician's role is seen as diagnosis and treatment of medical and surgical illness, working closely with, and acting as consultant to, allied health professional staff, arranging adequate community resources for patients, helping to staff geriatric ambulant and residential care programmes. Geriatric consultants would assist family physicians, promote programme development and take part in education and research.

(c) Mental Health Services

No separate mental hospital provision was made for the elderly till 1935 when the Provincial Home for the Aged Act was passed and some cottages
adjacent to the Boys' Industrial School at Port Coquitlam were given over to the use of aged mental patients. In the following years, when over 20 per cent of admissions to Essondale were aged sixty-five and over it was proposed that the "aged and decadent" should be housed in a separate building as they interfered with proper classification of patients and were not appropriately accommodated with "those actively disturbed".

New 100-bed units for the elderly were added to the Port Coquitlam complex in 1946, 1947 and 1952 and one at Essondale in 1948. Vernon and Terrace Military Hospitals were purchased by the government and opened as Homes for the Aged (for ambulant senile patients) in 1948 and 1950. [Mental Health Branch 1972].

On April 1st 1950, various mental health activities were amalgamated into the Provincial Mental Health Services. The Geriatrics Division—one of five—included the three units of Homes for the Aged and dealt with "the aging group suffering from degenerative diseases". Transfer at age 65 to Homes for the Aged was expected to relieve the overcrowding at Riverview. It was recommended that further building should be for the elderly and mental defectives "whose outlook for recovery or improvement is poor", and that in future the three groups—psychotic, mentally defective and senile—should be clearly delineated and admitted directly to their respective institutions. Special accommodation of the elderly was supposed to enable a more active treatment programme and higher discharge rate for younger patients.

From 1958 there is more talk of rehabilitation to the community (The Boarding Home Programme began in 1959, also the year in which the
Mental Health Services were placed under the Department of Health Services and Hospital Insurance. From 1960, Homes for the Aged, renamed Valleyview, Dellview and Skeenaview were operated under the Mental Hospitals Act, having been designated public mental hospitals under a 1958 amendment to the 1948 Mental Hospitals Act. Some nurses were sent on courses in geriatric nursing, and an occupational therapy department was set up at Valleyview.

From this point on, there seems to have been a change in philosophy with regard to treatment of the aged mentally ill. Instead of custodial care only, Valleyview provided an active treatment and rehabilitation programme and the emphasis was on return to the community—to self care, family care, nursing home care and boarding home care. The Mental Health Act (1964 c29) established Valleyview Hospital as a Mental Health facility for the care and treatment of aged persons (in practice, persons aged seventy and over) suffering from psychiatric illness associated with aging. In 1966, 254 patients died at Valleyview, 181 returned to the community and there were 748 in residence (254 males, 494 females) in March 1967. Some patients of previous years had returned because of social and financial problems, and the social workers arranged 104 alternatives to admission. In late 1967 there were 176 persons in hospital who could have been discharged, given other types of institutional care.

In 1969 consideration was being given by the Mental Health Branch to specialized extended care facilities in association with general hospitals, on a regional basis, for severely handicapped retarded and for psychogeriatric patients, but these have not been developed.

In 1974, the last year of the Mental Health Branch as a separate
entity, the operation of Skeenaview Hospital in Terrace was transferred to a local voluntary society.

Community Services

By the end of the 60s there were over 2600 beds licensed for personal or intermediate care in the boarding home programme in Vancouver and the Lower Mainland. Mental Health Centres, also set up for the provision of community care, numbered thirty-one by 1974. In 1967; the Province was divided into eight mental health planning regions. Integrated services for the aged mentally ill were one of the areas supposed to be specially emphasized in the new programme. Probably largely as a result of the new emphasis the number of geriatric in-patients in mental institutions had fallen from 2127 in 1966 to 987 in 1974.

The Greater Vancouver Regional District has administered its own community care programme based on the 'Plan for Vancouver' proposed by Dr. John Cumming in 1972. Although treated as a blueprint, Dr. Cumming's proposals were apparently intended to be no more than a position paper for discussion and did not therefore go into any detail on services required for the elderly (or children) although the need for a psycho-geriatric centre was mentioned.

(d) Medical Services

Dr. John Sebastian Helmcken, the first physician to practice his profession in B.C. came to the Pacific Coast in the service of the Hudson's Bay Company in 1850 and by 1866 there were twenty-four doctors in the territories. For many years individuals were responsible for obtaining
their own medical care though even before 1886 grants were being given to some resident physicians in outlying districts to compensate them for serving the poor and in the 30s, medical services were provided by government to recipients of unemployment relief. Insurance schemes developed in the 40s, and from 1943 there was a government-administered medical services plan (in the Social Welfare Branch) for recipients of old age pensions and social assistance. As well as medical and hospital services, it covered optical and limited dental services, prescriptions and transportation, and was financed 80 per cent by the province, 20 per cent by municipalities (Specialist services were to be financed 100 per cent by municipalities). In 1946 however, such difficulties were noted as unwillingness of many physicians to serve under the plan, gaps in the programme, particularly in relation to special services, lack of uniformity among municipalities, (There was variation in the provision, for example, of spectacles, dental services and surgical appliances, and eight municipalities did not participate at all until 1948), problems about serving old persons in isolated places, and the inability of the aged group to grasp written instructions.

The Medical Act (1948 c206) defines the practice of medicine in wide terms and makes it illegal for any person not registered to practise medicine, surgery or midwifery.

The Dental Technicians Act (1958 c13) finally made legal the setting up of dental laboratories where registered dental technicians could make dentures from impressions received from dentists, and where registered dental mechanics could also carry out intra-oral procedures
if a certificate of oral health was obtained from a dental surgeon. More people were thus able to afford dentures and no longer required to have recourse to 'back street' operators.

In 1965, the Province set up the B.C. Medical Plan to provide medical care insurance to individuals regardless of age or physical condition.

The Medical Grant Act (1965 c25) provided for the Minister of Health to pay 90 per cent of the medical insurance premiums of anyone not liable to pay income tax in the previous year, 50 per cent where taxable income did not exceed $1000.

The Medical Services Act (1967 c24) set up the Medical Services Commission to bring medical care insurance in B.C. under the national scheme laid down in the Federal Medical Care Act (1966). When the federal Act became effective in 1968, B.C. immediately entered the plan. Services covered were physician services, a limited range of oral surgery in hospitals, refractions by optometrists, some orthopaedic services, limited physiotherapy (up to fifty dollars per person) special nursing (only on the recommendation of a physician and only up to forty dollars per person per year) Chiropractic and naturopathy (up to one hundred dollars per person aged sixty-five and over). Among services not covered was travelling, except for emergency cases. The Pharmacare programme introduced in 1974 is administered by the Department of Human Resources.

2. WELFARE

In the early years of the century elderly people who could not
be independent were treated like anyone else who applied for relief (Matters 1973 p.45) though Victoria and Vancouver did establish old people's homes, the Provincial Home for the Aged and Infirm was opened at Kamloops in 1983 with 150 places (Cassidy, 1945) and B.C. was the first province to pass legislation (in 1927) to establish old age pensions in accordance with the federal Old Age Pensions Act - up to twenty dollars per month to needy persons aged over 70 of which the federal government contributed 50 per cent (75 per cent after 1931).

In the 30s, unemployment was a major problem and most established social service programmes were drastically curtailed in favour of unemployment relief. (Cassidy, 1934). At the outbreak of World War II, at least a third of Canadians - of all ages - were probably too poor to afford adequate diets. However, after 1942, the Province supplemented the standard monthly old age pension by five dollars, and by ten dollars after 1947. In 1943, old age pensions were transferred from the Workmen's Compensation Board to the Provincial Secretary's Department where three department officials formed an administrative board. The Social Assistance Act (1948 R.S. c310) allowed the Provincial Government through its Department of Welfare to grant funds to municipalities to provide financial assistance, residential care and "generally any form of aid necessary to relieve destitution and suffering". This included supplementation to pensions where special care was required.

In 1946, the Provincial Department of Health and Welfare was created with a Deputy Minister of Health and a Deputy Minister of Welfare who was in charge of the Social Welfare Branch. The Annual Reports of
this Department, published from 1946 to 1957 suggest far more awareness of the needs of the elderly than do the Health Branch Reports of the same period. Of course there was a specific board administering a specific benefit to this age group but even so, the government did not have to provide services along with pensions, nor were the Board of the Social Service Division obliged to show so much concern for the elderly.

Fieldworkers were trained social workers who considered emotional needs and social factors whilst investigating the financial needs of the elderly and even clerical staff were given social information to improve their ability to deal with elderly people.

The Old Age Pension Branch also administered from 1943 a plan for medical care for the elderly and reports show an awareness of the link between health and social factors, and indeed put forward some ideas which are only now being 'rediscovered' and taken seriously—that medical science has been concerned largely with disease of the earlier years of life whereas the disability of the elderly may be partly attributable to poor housing and insufficient nourishment; a concern with health may suggest lack of other interests; while it is hoped that the development of adequate programmes by governments and communities will decrease, or at least delay, admissions to public institutions, nevertheless, there can be no sense of security for pensioners or those who care for them if care facilities are not available when required [1946-47].

One is constantly surprised too by the broad view that the Old Pensions Board took of their remit.
The problem of the physical health of our pensioners has been recognized. That of their mental health, so closely related, is a much more insidious one which involves an understanding of the aging process as a whole. Of progress in this part of our work, we have little of significance to report.

Reduced to their simplest terms, old folks' needs are found to be much the same as those of younger people. They are summed up in the term "social security"—if one looks at it in its broadest sense as the assurance that one may continue in the accepted way of life and amidst surroundings such as those to which he has been accustomed. For most of us this "way of life" includes affection, friendly intercourse, interests and activities that make reasonable demands upon abilities and skills, quickly lost when allowed to fall into disuse.

What means have we of helping the old prospector preserve, in some degree, his sense of freedom and self-sufficiency?

What satisfactions are to be found for the older woman whose every thought and action during the past forty years has been dictated by the needs of a family, no longer seemingly having any need of her services—even as a grandmother!

To the man forced out of employment, what substitute is there for work—in his world the symbol of worth-while living and achievement?

These are the questions with which our case-workers are constantly faced. They cannot, of course, be expected to provide all the answers. We need, in brief, community programmes of leisure-time interests and activities. In the large centre of Vancouver there has been a small beginning. [Report of Social Welfare Branch 1947–48 pp. 62,63].

Enforced retirement is deplored as a "tragedy" for both the old person and the community. Together with the incentive not to work because of forfeiting a pension, this could soon face society with an "overwhelming responsibility in caring for this large inactive group". When working they help to bear the costs of social services. The increasing number of elderly require "our best thinking and planning". In the not distant future the problem may have to be faced of 40 per cent of the people having
to support 60 per cent if present trends continue [1950]. There is also
the fear expressed that as a result of assuming financial responsibility
for the old people, governments are going to be expected by younger
relatives to assume total responsibility. As this is good from "neither
a psychological nor an economical point of view", frequent contacts and
renderings of incidental services are recommended as a way of encouraging
and strengthening family ties [1949]. On the other hand it is recog-
nized that alternative plans are essential if family life is threatened
as when the burden of caring for a sick old person becomes too great
[1950].

Various studies were made in the 40s—of the effect of income on
persons, on the length of life of pensioners, marital status, accommoda-
tion, etc. The Board explained the reasons for its analytical approach
in 1950.

The Social Service Division of the Old-age Pension Board at
present seems to offer the only focal point for bringing together
and examining information in relation to the many phases of the
social situation and needs of the increasingly large numbers of
old people in the Province. Contacts with the "70 and up" group
in the past seven years have been far reaching and enlightening,
particularly since the "Old-age Pensions Act" and regulations
have called for an over-all coverage in this category, including
well-adjusted old folk, living relatively comfortably, as well
as those suffering from the numerous disadvantages and problems
to which older people are subject. One fact that emerges clearly
is that whatever the older age-group included in our security
programme, sound planning in this as in other areas of social
service, must be preventive in outlook rather than designed to
meet only the immediate situation.

Of our total population in British Columbia, 15.5 per cent, or
173,672 persons, are now over 60 years of age. What we have
learned in pioneer efforts with old-age pensioners should surely
be carried over into our association with this wider group. We
do not plan programmes for 5-year-olds. Rather, we develop
"child welfare" services. In the same way, social workers cannot
think only in terms of "pensioners," but of what will make for the good life for all our older citizens. Hence it is not unfitting that this section of the report of the administration of old-age pensions, while primarily concerned with a particular category, does have in certain respects a somewhat wider application than may seem to come strictly within its province.

Each yearly report shows a startling increase in the moneys expended in the payment of old-age pensions. A total of all Provincial Government expenditures for the benefit of pensioners would include costs of medical care and of other social services along with payments for pension and would show a much higher figure.

Annual reports are understood to give an account of stewardship. To this end we may well ask ourselves whether these funds have been expended in the way that ensures maximum benefit to the pensioners. Since social work accepts the premise that it matters greatly how things are done, we cannot be satisfied with providing what is understood to be merely a floor of protection. In order to make the allowance more effective, it is necessary to supplement with certain other services. From our experience we venture to suggest which of these may be considered most essential, i.e. casework, medical care, accommodation, housekeeping services, leisure-time activities, employment [Annual Report 1949050 pp. 61,62].

The Board actually functioned to some extent as an accommodation and employment bureau receiving offers as well as demands.

The Provincial Infirmaries Act, (1948 c272) enabled the Lieutenant Governor in Council to establish and maintain institutions for the care and maintenance of persons who, being chronic or convalescent patients afflicted with some bodily disease or disability, did not require or were not likely to benefit from care or treatment in a general hospital, but nevertheless required institutional care. The Provincial Home for Incurables, renamed Provincial Infirmary, Marpole, was to be under the Minister of Social Welfare, with payment for residents being made by their municipalities. (In 1961 it was transferred to the Ministry of Health Services and Hospital Insurance.)
The Welfare Institutions Licensing Act (1948 R.S. c363) set up a Welfare Institutions Board to license and inspect various residential establishments, one category of which was "a refuge etc. for old people unemployable on account of age". A 1961 amendment added "and who need attention or care". This Act was superseded by the Community Care Facilities Licensing Act (1969 c4) (and amendments) now administered by the Ministry of Health.

By 1950 there were five housing projects specifically for the elderly in the Province, the number of boarding homes was increased—but lack of privacy and lack of stimulation were already noted as problems by the Old Age Pensions Board. Two municipalities were experimenting with foster homes. It was even stated (1949-50) that "From several years' observation it had been noted that if placement is made when older persons first need boarding-home care, they usually escape the diseases which attack old age and remain active until death".

The difference in the tenor and presentation of Board reports from 1952 is quite striking, and coincides with the implementation in January 1952 of the Old Age Assistance Act (1951 c2) which introduced universal old age security payments (cost shared with the federal government) to people aged 70 and over, old age assistance (means tested and cost-shared) for persons aged 65-70. So pensions for people aged 70 and over were no longer a provincial concern. And throughout the 50s, there were rarely more than 7000 recipients of old age assistance, whereas on March 31st 1951, there had been 31,983 recipients of old age pensions. For some reasons, the new recipients did not receive the same consideration—maybe
because applicants under 70 were the exception rather than the rule. Reports were now written up by region, and the only reference to the elderly is to the number and costs of their assistance benefits, and to increased longevity. With responsibility for financial needs removed, there is no longer interest in their other needs.

The Department of Social Welfare Act, (1959 c76), set up a separate department (formerly part of the Department of Health and Welfare) to have charge of all matters relating to social and public welfare and social assistance. The title was later changed to the Department of Rehabilitation and Social Improvement.

On April 1, 1967 the Division on Aging was created "to develop services and resources to elderly people".

In addition to administering old age assistance and supplementary social allowances, the new authority anticipated becoming involved in a number of other activities, viz.

(a) The development of community resources designed to directly assist and encourage the recreational, educational, physical, and emotional well-being of the aged.

(b) An information, referral, and consultative service on a Province-wide basis.

(c) Planning, initiating, and administering such programmes and projects, experimentations, or demonstrations concerning the aged as it is deemed necessary or desirable and fiscally possible.

The issuing of bus passes to all persons aged 65 and over was seen to be the start of a trend whereby the Division would in future be involved with not only those elderly who were economically disadvantaged.

In 1968 Senior Citizen Counsellors began to operate and a Drop-in
Centre was opened in Vancouver. In 1969, a couple of hearing assessment clinics were arranged in Abbotsford and Port Alberni, a Pioneer and Elderly Citizens' Week was promoted and the Community Care Facilities Licensing Act replaced the Welfare Institutions Licensing Act. The number of places in homes was always increasing and a need was being expressed for 'intermediate care'.

In 1971 the staff were said to be increasingly involved with service-oriented programs—"a reflection of the current public emphasis upon the physical, social and psychological needs of older persons". However, apart from maintaining contact with a variety of organizations concerned with the elderly, the Senior Citizens' Counsellor programme, and bus passes were the only programmes provided by the department. The responsibility for administering the Community Care Facilities Licensing Act (1969) was transferred in 1971 to the Health Branch.

The New Democratic Party took up office in late 1972, and renamed the Department the Department of Human Resources. The activities of the Department are reported as services for different groups, and one of these groups is the elderly.

One of the most important innovations of the NDP Government was Mincome. Because B.C. had from 1942 paid a supplement to persons who satisfied a very stringent needs test, pensioners in B.C. were slightly more favourably treated than those of any other province. Partly as a result of the efforts of the Provincial pensioners' organizations, pensions had become an important issue in the 1972 provincial election campaign, and almost immediately after the election, the new NDP government produced its
Mincome plan with the Guaranteed Minimum Income Assistance Act (1972 c3). Beginning in December 1972, the province guaranteed a minimum income of two hundred dollars a month to people sixty-five and over by legislation providing for a supplement equal to the difference between two hundred dollars and the recipient's income from all sources (including the universal pension and GIS) where that income was less that two hundred dollars. In addition to the significant increase in the maximum provincial supplement produced by this change, the number eligible for full or partial supplementation increased from about 18,000 to over 100,000. In line with an increase in the combined universal pension and maximum GIS that came into effect on October 1, 1973, the Mincome guarantee was increased to $209.14 effective on the same date. It was also extended to those between sixty and sixty-five.

When the Department of Human Resources and the Department of Health Services sponsored a conference on the needs of senior citizens in 1972, the seniors strongly advocated decentralization of services. Their main areas of concern were transportation, the cost of drugs, prostheses and other special equipment, meals on wheels, homemaker services and recreational needs. (In 1975, approximately 25 per cent of the users of the Department's Homemaker Service were aged over sixty years of age).

The Pharmacare programme introduced on the 1st of January 1974 provides free prescription drugs for provincial residents aged sixty-five and over, 30 per cent of whom suffer from one or more chronic diseases. Also, that year just over one million dollars were paid out in community grants for senior citizens mainly for hospitalization, home
aid and visitations. And the Human Resources Facilities Development Act (1974 c39) enabled the Minister of Human Resources to pay grants from the Consolidated Revenue Fund to provide, inter alia, centres for senior citizens. The Community Resources Board Act (1974 c18) was passed and already five human resource and health centres were being set up, thirty-one groups received grants to set up or develop resources boards outside Vancouver and four boards were elected in Vancouver. Though these boards of elected citizens were to be responsible for the delivery of social services on an area basis to all age groups, there was little evidence that services to the elderly would be accorded any priority.

The last legislation passed in B.C. which deals with welfare was the Guaranteed Available Income for Need Act (1976 c19), announced in May, 1976, which requires an assets test as well as an income test to determine eligibility for Mincome.

3. VOLUNTARY SERVICES

Voluntary or charitable organizations have never enjoyed quite the same support and prestige in the west as they did in the older provinces though some voluntary services did spring up to help to meet many unfilled needs.

Between 1910 and 1920, most voluntary efforts in the community were on behalf of the unemployed. Homes built by charitable bodies tended to be for orphans, invalids or 'wayward' girls (Matters, 1973).

In the early days of the Province, some national organizations in the health field already existed - the Canadian Branch of the Red Cross, the VON which opened its first branch in Vancouver, later the CNIB, etc.
Most of these organizations were set up to deal with problems as they were brought to public notice. In the late 30s, as Canada was recovering from the Depression, more national societies sprang up, mostly associated with specific diseases and most of these eventually had B.C. branches. Those dealing with cancer, rheumatism, heart disease, diabetes etc. might include numbers of elderly in their target population, but more often, it was the diseases which attacked younger age groups which aroused more public concern and not a single organization was set up for the benefit of the elderly as a group.

By 1927 there were local organizations as well—the Women's Institutes, the Rotary Clubs, the Kiwanis and church organizations—often interested mainly in children but also in health problems and services.

Planning Agencies

The main organization which has shown concern for the interests of the elderly has been the U.C.S. with its Committee on Aging, later to become the Committee on Aging of SPARC of B.C.

In 1930 the Council of Social Agencies was set up and in 1931, the Welfare Federation—the former to be a planning body to work toward the integration of agency programmes with government sponsored services, the latter to institute central financing (In 1946, they combined to form the Community Chest and Council of Greater Vancouver). [Jackson, 1960]. At first, the main interests were children, the destitute, public health—and later, the war effort. However, in 1944, a Committee on Aged was planning a training programme for friendly visitors to the aged, and there was discussion of a nursing service for older people. In 1946 a
sub-committee produced a comprehensive survey on the Situation of the Aged in Vancouver. By 1951 the Committee on the Welfare of the Aged had become a Division with numerous sub-committees dealing with every aspect of aging and the welfare of the aged. The aims of the organization were 'To ensure the development of social services in a manner that enables them to respond effectively and with justice to the needs of the people; and to provide for access to the opportunities afforded by society to those persons unable to obtain it for themselves'—and it seems that by 1951, the elderly were recognized as one of the groups of people in need of help.

It was the Community Chest and Council of Greater Vancouver along with the Extension Department of UBC which held the first and second B.C. conferences on the needs and problems of the aging in 1957 and 1960. In 1958 a Priorities Study Committee composed of 24 members from a variety of backgrounds rated the relative value to the community of 79 services. Old age assistance was ranked sixth, long term medical care tenth, home nursing twenty-sixth, homes for the aged twenty-ninth, and housekeeping services thirty-first. This was before the days of medicare and on the whole general medical services and services for children were accorded higher priority than those for the aged. The Priorities Establishing Committee which produced a report based on the priority ratings [Community Chest and Councils, 1965] recognized a growing need for services for older people in Vancouver and for properly qualified staff to run them, but considered that 'increased longevity and the problems associated with advanced age required government funds
in providing services for senior citizens'. (In 1966 the Community Chest and Councils took the name of United Community Services). A study of care and shelter facilities authorized by the Planning Committee in 1967 ascribed most of the problems in this area to the lack of a 'total concept of care' embracing prevention, shelter and intensive medical care, this led to various administrative and organizational anomalies and absence or misuse of resources [Bell (1) 1968]. 'A Total Concept of Care' [Bell (2) 1968] was a "critical examination of health resources from acute hospital to home nursing care". The recommendations, particularly applicable to the elderly, were that planning responsibilities of regional hospital boards should be expanded to include all levels of care requiring nursing supervision, that multi-level care facilities and home care should be encouraged, and that intermediate care should be covered by insurance. It criticized the failure of the Province to provide adequate community services or care and shelter facilities as a follow-up or alternative to the acute hospital. UCS is committed to optimal allocation of the funds collected by the United Way. This commitment has necessitated over the years continuous researching of needs and formulation of policy. It was probably the first organization in this part of the country to recognize, study and publicize the needs of an increasingly elderly population.

UCS however, confines its activities to the Vancouver area. In 1966, several committees which wished to maintain a province-wide focus formed the Voluntary Association for Health and Welfare (now the Social Planning and Review Council of B.C.) SPARC undertakes various research
projects and acts as a consultative body in the areas of communication, planning and advocating. The Panel on Aging of UCS became the Committee on Aging of SPARC which might now be said to play the leading role in the Province (certainly in the voluntary sector) in identifying and making known the needs of the elderly, and which also co-operates with other local and national organizations working for the interests of the elderly. A major publication was 'Community Care for Seniors' (1972), the first systematized description of services for the elderly and analysis of needs in the Province at all levels of institutional and community care, including a profile of services available in each regional district. In its conclusions, the committee noted particularly the inter-relatedness of all provisions and services for the elderly and the increasing involvement of the elderly themselves in matters which affected them. It was recommended that much higher priority should be accorded to the needs of the elderly, that they required an "integrated, humane, comprehensive and accessible, community-oriented and research-based" system of care. The spectrum of care would include services for the 85 per cent of the elderly who are independent, the 10 per cent partially dependent and the 5 per cent dependent.

In 1972 and 1975, SPARC produced a Senior Citizens' Guide to Services in B.C. Standing Committees on Health, Housing, and the Panel on Handicapped make recommendations, aimed largely at government, on issues such as transportation, which are also of concern to the elderly.

Service Agencies

The two main voluntary organizations which provide service to the
elderly are the Canadian Arthritis and Rheumatism Society and the Victorian Order of Nurses. CARS was incorporated in March 1948 and the B.C. Division was organized in June of the same year. From three physiotherapists and an office, it has now expanded to the stage where it operates a large treatment centre in Vancouver (opened in 1969), a sheltered workshop (opened in 1964), a small residence (opened in 1965) and three vans which provide travelling clinics. About five hundred in-patients and over 5,000 out-patients are treated each year. Of these, about 32 per cent are aged over 65.

The VON was established in Vancouver in 1897. By 1910 there were five nurses who treated the most needy cases which were most often families with young children. By the end of the first World War, the Order was being paid by the Vancouver Health Department to be responsible for all children under school age, and later all T.B. patients. However, over the years, more and more of the patients referred for care in the home have been elderly - 50 per cent by 1958 were aged sixty-five or over. (By then there were branches in eight municipalities as well as Vancouver). In 1960, almost 110,000 visits per annum were being made to provide nursing care to each of the age groups 75-79, 80-84 and 85+. Another 14,000 visits were made for health instruction. 3 per cent of patients were 'on the books' for over three years. The VON also took on some visiting physiotherapy and occupational therapy, and to a small extent, meals on wheels. In June 1972, the B.C. Government took over financing of the service. Then in 1975 it said that it could no longer fund the service and that it would provide alternative home nursing
through the Health Department. Although technically a voluntary service, the VON has been so important in the home care field that it could almost be considered a statutory service. Over the years it was a service which was always included in the Provincial Health Reports and the impression one has is that these nurses showed understanding of and compassion for the elderly at a time when public health nurses were trying to keep clear of both that age group, and practical involvement—almost as if the public health nurses were the instrumentalists whose task was to protect the public health whilst the VON had a more expressive role, and provided the caring.

Self-help and Community Services

Another type of volunteerism is that whereby the elderly form groups with the intention of improving their situation.

One writer believes that "although the aged have important interests in common, it took the shared experience of being pension recipients to create a perception of common interest sufficient to provide a basis for organization" [Bryden, 1974, p. 194]. The Old Age Pensioners' organization of B.C. was formed in 1932 to protest the rigid administration of the means test. A rival organization with similar purposes, the Senior Citizens' Association of British Columbia was established a few years later. In 1958 the Federated Legislative Council was set up to co-ordinate all pensioners' organizations in the Province. Now the various Senior Citizens' Associations and Old Age Pensioners' Organizations (250 local branches with about 50,000 members) seem to organize mainly social gatherings whilst the FLC presents an
annual brief to the Provincial Government, and as a member of the National Pensioners' Association of Canada, to the Federal Government.

Community Groups for older people were slow to develop outside Vancouver and Victoria but now exist in most centres of population. Some organizations are organized quite professionally and recognized for their importance to the community. The Silver Threads Association of Victoria would come into this category and there are many more—providing social activities, day care etc. all over the Province. This type of organization tends to receive provincial government subsidy. Other organizations are entirely voluntary or may be funded temporarily, fading away as the funds do. At one time or another, most of the services that an elderly person might want, have been provided by someone, somewhere, but not in any comprehensive way.

Volunteers

Individual volunteers (including elderly persons) may be found in all sorts of settings. The Voluntary Action Resource Centre, a department of the Volunteer Bureau of Greater Vancouver, maintains a library on volunteers and voluntary activities and organizations, and provides advice on the supervision, recruitment and training of volunteers.

4. HOUSING

It is not easy to obtain information on housing for the elderly in B.C. because, before the Department of Housing was established in 1973, B.C. had no Provincial Housing Corporation, the Province's housing programs were administered by various departments (Finance, Provincial
Secretary, Municipal Affairs) and do not seem to have been accorded a high priority. For housing the elderly, B.C. has favoured non-profit corporation housing over public because the former qualified for a 10 per cent forgivable federal grant. The B.C. Elderly Citizens' Housing Aid Act (1955 c19) allowed the Province to make a maximum of one-third contribution towards the project cost of construction or reconstruction of dwelling units, boarding homes, or special care homes for elderly citizens of low income to a regional district, municipality or non-profit society. Originally a 10 per cent matching contribution by a non-profit corporation was required but since 1974 this has been discounted against the 10 per cent figures available under the NHA amendments.

Between 1946 and 1970, 5346 dwelling units and 1747 hostel beds were built in B.C. 68.4 per cent under S 15-1 (non-profit), 31.6 per cent under S 40 (public). Between 1971 and 1973, 3315 dwelling units and 2351 hostel beds were built, 90.1 per cent under S 15-1, 9.9 per cent under S 40. Between 1946 and 1970, B.C. received 1.5 hostel bed approvals per 1000 elderly persons for CMHC loans (The Canadian average was 12). By 1973, it had 18.9 hostel places approved per 1000 elderly persons, (The Canadian average was 14.9). In 1970, B.C. had 26.1 dwelling units per 1000 over 65 (The Canadian average was 15.7) and in 1973, 40.0 (Canadian average was 30.3). (The Saskatchewan Housing Corporation would like to be able to house 15 per cent of the elderly. The Senate Committee estimated a projected need to house 21 per cent of the elderly).

By the late 60s, the trend towards building large highrise
facilities for the elderly was under way, a programme that was slowed down in 1969 because of the downward economic trend. Thereafter, up to 1972, there was a sudden boom during which housing units almost trebled.

In 1969, a new area of need was being defined, described by many doctors, social workers, operators and private individuals as 'intermediate care'.

The NDP government which was elected to office in November 1972 identified the elderly as a group requiring special consideration. It immediately increased the amount allocated for senior citizen accommodation in 1974 to ten million dollars for self-contained and hostel accommodation and two million for personal and intermediate-care facilities.

The Department of Housing Act (1973 c110) set up the first Department of Housing in Canada to administer various acts and funds relating to housing and with powers to supervise, acquire, develop, maintain, improve and dispose of housing in the Province. In the first year of its operation, the Department launched a programme of building 21,412 units of social housing, including 1804 provincial senior citizens' units, 4,607 non-profit senior citizens' units and 1239 special care beds. [B.C. Department of Housing, 1975 p. 5]. Under B.C. Housing Management Commission, the Province also undertook a major new programme to build and operate provincially-owned rental units for various income groups, with ample social and recreational facilities, and with rent supplements for those who need assistance. After months
of negotiations, the federal government agreed, because the costs of building had risen so much, to new legislation whereby no one in non-profit or public housing pays more than 25 per cent of income as rent. The Federal government pays 50 per cent of the subsidy. This led to a large increase in the demand for this type of accommodation.

Provincial expenditure for senior citizens' housing rose from a hundred thousand dollars in 1956 to eight hundred thousand dollars in 1965, one million in 1967, almost four million in 1972, and an estimated twelve million in 1974. The 12.5 per cent operating subsidy previously required of municipalities was abolished in 1974. The Municipal Act was amended in 1974 to remove the obligatory municipal tax exemptions for new non-profit developments for seniors. Provincial Home Owner Grants were increased in 1973 to $250 for resident home-owners aged 65 or over. Renters were to receive eighty dollars. (54684 renter grants were approved in 1974). Another measure was the passing of the Real Property Tax Deferment Act (1974 c78), which allows elderly home-owners to defer the payment of taxes on the property they occupy till their death and/or the sale of the property.
One might say that it was almost insidiously that the elderly worked their way into public health programs. On the other hand, it is only recently that care of the elderly has had much significance compared with the other targets of the concern of public health authorities, and let it be said that they did eventually respond to that need. The health unit might seem a good base for an expanded and co-ordinated system of services; yet the public health (legitimate) emphasis on prevention may not be any more likely to respond to the elderly's need for care than the acute care system's emphasis on cure.

The emphasis on acute care, especially hospital care, which has only recently been recognized as problematic, obviously has early origins and a variety of contributing factors. Valleyview, the only hospital which restricts its intake to persons seventy and over, also seems to be the only long-term facility which takes an optimistic view of the potential of the elderly for rehabilitation to the community.

Sometimes the elderly have benefitted from provisions made for indigents. In fact as far as welfare services go, that is still true to this day.

Particularly striking is the way in which medical services have expanded and developed compared with any of the other services, though of course this affects all age groups. And it is also striking that community services have been so slow to develop though recommendations that they should have been emanating from one source or another for the last twenty years at least.
NOTES

Almost all the information in this section is obtained from the Annual Reports of the services from 1895 to the present date. Unless otherwise specified, the information is found in the Annual Report of the year in question.


CHAPTER II

OVERVIEW OF DEVELOPMENTS RELATING TO THE ELDERLY

AT THE NATIONAL LEVEL

1. HEALTH

Many of the developments described in the preceding chapter were made possible by federal legislation. This was usually permissive or enabling as far as the provinces were concerned, and the latter more often than not, passed corresponding legislation to take advantage of federal cost-sharing. A brief summary follows of the legislation relevant to our field of study. It will concentrate on those aspects which apply, or could apply, to the elderly, or which may be relevant to planning for the elderly. Also included will be résumés of a few of the major reports which preceded the more significant pieces of legislation. Again what will be highlighted will be references to the elderly, or to situations or services which do or could affect them. Finally, income security, outside Quebec tends to be largely a federal concern.

The B.N.A. Act (1867 30 & 31 Victoria c3 U.K. Statutes), Section 92 has been interpreted to mean that provincial governments have responsibility for general health and welfare matters. Section 91 accords to the Federal parliament the exclusive right to raise money by any mode or system of taxation, though the provinces have exclusive right to direct taxation within the provinces for provincial purposes.

The Report of the Committee on Health Insurance (1943) [Heagerty
Report] was presented along with the Marsh Report to the Committee on Post-War Reconstruction. It proposed an insurance scheme which would cover a full range of medical benefits—including pharmaceutical and visiting nurse. Although it was recognized that the population was aging, the main deficiencies stressed to the Committee were in control of communicable diseases and of diseases of middle age. So its recommendation was that concentration should still be on eliminating deaths in the younger age groups.

Department of National Health and Welfare Act (1944 c22) accorded to the Minister control over all matters relating to the promotion or preservation of the health, social security and social welfare of the people of Canada but not over any health authority operating under provincial laws.

The National Health Grants Programme (1948) was instituted to assist the provinces in extending and improving public health and hospital services. The first grants were for hospital construction, health surveys, professional training, public health research, general public health, mental health, tuberculosis control, cancer control, venereal disease control, and crippled children. A Medical Rehabilitation Grant was introduced in 1953.

Illness and Health Care in Canada (1951) contained the results of the first nationwide study of illness in Canada. The twelve-month Canadian Sickness Survey, begun in 1950, showed that with almost 80% of the population ill at some point in the year there were not more ill people in the over sixty-five group, but that those elderly who were ill, were more ill
and for more of the time. Of the 3 per cent of the population who were severely or totally disabled, 40 per cent were aged over sixty-five. The elderly received health care at about the same rate as any other age group, though less, in proportion to disability. They received twice the number of home calls by doctors and their hospital stays tended to be longer. Among the more important findings of the survey were that in every age group, the lower income groups had higher levels of disability and that poverty was more likely than old age to be associated with inadequate health care.

Hospital Insurance and Diagnostic Services Act (1957 c28). Under this act, the federal government would reimburse approximately 50 per cent of the cost of hospital care and diagnostic services provided by any province, on condition that the provincial scheme provided comprehensive coverage of in-patient care, universal coverage on uniform terms and conditions, and portability. 'Hospital' was to mean a facility providing in-patient or out-patient services and did not include a tuberculosis hospital, a hospital for the mentally ill, a nursing home, a home for the aged, an infirmary or other institution the purpose of which is the provision of custodial care.

The Vocational Rehabilitation of the Disabled Act (1961 c26) provides for cost-sharing between the federal and provincial governments for the coordination and provision of services to physically and/or mentally disabled persons, training of personnel, research and publicity. A vocational rehabilitation programme may include assessment and counselling services for disabled persons and "services and processes of restoration, hiring,
employment or placement to dispense with the necessity for institutional care or the necessity for the regular home services of an attendant".

The Report of the Royal Commission on Health Services (1964) [Hall Commission] contained the first detailed overview of the health of Canadians and of the health services available to them, and recommended a comprehensive, universal Health Services Plan for the Canadian people. The main justification for this public expenditure was in terms of investment in human resources and contribution to productivity. The health needs of the aged seems to have been seen as something to be considered in the future. "With improvement in life expectancy, a significantly greater number of the population will be over sixty-five, and we will be faced with meeting the health needs of the aged" [Volume I, p. 113]. Thousands of Canadians (57,691 in 1960) were still dying under the age of sixty-five, and it was felt that the needs of the mentally ill and retarded and crippled children should receive much higher priority than those of the aged and infirm. What the committee recommended for the elderly applied more to their care in the community-homes, foster homes, and domiciliary services, particularly home care. It was recommended that rehabilitation services should be extended to any disabled persons, not only those who could be restored to productivity. And it was pointed out that to make medical care outside the hospital setting effective, ancillary services were needed, with insurance coverage of dental care, drugs and protheses and the upgrading of general practice.

Administrative recommendations included one that the federal government should set general standards and guidelines and provide fiscal
assistance but leave each province to establish and operate its own programme. Others were for participation of consumers and producers in the decision-making process, in the setting of goals and objectives and the formulation of proposals for meeting human needs.

The Prosthetic Services Act (P.C. 1965-218) allows the Department of National Health and Welfare to enter into agreement with provincial governments to extend prosthetic services to non-veterans according to conditions determined by provincial health departments.

The Medical Care Act (1966 c64 S1) provides for the federal government to pay approximately half the cost of insured services in a province where the medical care plan is comprehensive, universal, portable and operated on a non-profit basis, covering all medically required services provided by physicians and a limited number provided in hospital by dental surgeons. A restricted volume of services provided by such practitioners as chiropractors, podiatrists, osteopaths, and naturopaths may also be insured.

The Task Force Reports on the Cost of Health Services in Canada (1970) were prepared for a Committee set up by the Health Ministers who were concerned at the rapidly rising expenditure on medical care and even more so on hospital care. The task forces inquired into utilization, operational efficiency, salaries and wages, beds and facilities, methods of delivery of medical care, price of medical care, and cost of public health services.

It was found that 95 per cent of all health expenditure was being devoted to the operational and curative aspects of health—only 5 per cent
to education, training and research. A substantial increase in the public health (preventive) component was recommended. There were many references to abuse of hospitals and recommendations for services and organizational changes which would replace or relieve hospital beds, health centres, a progressive patient care programme covering all levels of care, careful discharge planning, more hospital day care and out-patient services, hostels, transportation, more community services, and more flexible use of personnel. For planning and research, there should be regionalization of all health services.

With regard specifically to the elderly, it was recommended that greater emphasis be placed on defining the needs of elderly and other disadvantaged groups and on evaluating the programmes now directed at these groups in order to achieve a judicious allocation of resources in relation to anticipated results.

The Community Health Centre in Canada (1972) was a study of this alternative method for the delivery of health care, being considered because it was realised that health insurance has nothing to do with guaranteeing efficient or effective organization and distribution of services. Community health centres were seen as one solution to the problem of increasing costs and also as permitting more 'people-centred' and 'problem-centred' approaches to health. It was recommended that several of these should be developed but that there should be a concurrent reorganization and integration of all health services.

The Report made several references to the aged—this was one of the groups whose health and social problems were hard to separate, whose
special needs were not presently taken adequate account of, and for whom services should be offered in imaginative and problem-centred ways. Day care and home care were again advocated.

Health Care in Canada: a Commentary (1973) was the report of a study group under Dr. H. Rocke Robertson appointed by the Health Services Committee of the Science Council of Canada to examine the "overall level, adequacy and appropriateness of research related to the development of a comprehensive and co-ordinated system of health care".

The Report pointed to lack of co-ordination, accessibility, continuity of care, efficiency, etc. It recommended research to identify and develop ways of obtaining data which would increase the capacity for measuring the quality of health care, and into means of determining how the 'system' of health care is working. Although the Report confined itself more or less to the health care system as now defined, it did however recognize that "If a better way of life is the only ultimate solution to the problem of health, so far we have only seen the first glimmer of recognition of the sorts of things that might be done or tried to achieve it".

Science for Health Services (1974) was a report of the Science Council of Canada which considered "how science and technology can help in the search for solutions to the problem of improving the delivery of health care as a socially supported service". It noted a consensus that the reform of the health care system has to be guided by a comprehensive definition of health, encompassing not only its physical, but also its social and emotional aspects. "This broad concept of health has led to a
recognition of the need to integrate health care and social welfare to a degree as yet not well determined." Much more emphasis should be given to the protection of health as compared with the care of the sick. The means for maintenance and promotion of health must be greatly increased. (The most effective short-term measures could be found in improved organization and management of health care services); there should be greater involvement of local communities in the definition of requirements and in planning and management of local facilities, and there is a need to expand the extent of publicly financed health care.

A New Perspective on the Health of Canadians (1974) appeared when the annual rate of cost escalation for health services was between 12 per cent and 16 per cent. Since self-imposed risks and the environment are the principal or important underlying factors in each of the major causes of death in Canada between one year and age seventy, it is claimed that what are required to improve the health of Canadians and reduce death rates, are improvements in the environment, reductions in self-imposed risks and a greater knowledge of human biology. The Government of Canada has decided to give as much attention to these three elements as it has to the financing of the health care organization (To date 95 per cent of health expenditures had been directed at curing existing illness).

The Working Paper also mentions some groups who have gone beyond risk to actual illness but who are often neglected as they do not readily lend themselves to cure. Examples are the disabled, the chronically ill, the retarded, the mentally ill and the aged. For the needs of these groups to be met 'care' will have to be raised to the same level of
importance as 'cure'.

There is need for training of more health personnel to work with the elderly, for consideration of more use of nurses instead of physicians in chronic care, and for de-emphasis of acute hospital beds in favour of extended care beds.

The paper concludes with two broad objectives to be pursued by the Government of Canada—reduction of hazards for populations at risk and improvement of accessibility to health care of those whose present access is unsatisfactory. Five strategies are proposed in pursuit of these objectives, which in turn give rise to 74 possible courses of action. Of these only a small number—including retirement counselling and programmes to make life more interesting—apply specifically to the elderly. Since the health field concept was based on work done on 'life years lost' calculations—that is years lost up to age seventy, it is not surprising if the needs of the older group do not come through as an integral part of the overall scheme.

2. INCOME SECURITY

Among provisions for the elderly, income maintenance has always been the biggest issue in political terms. Outside Quebec income security for the elderly is now accepted as a federal rather than a provincial responsibility.

From 1905 trade unions had been pressing for a pension scheme in Canada.

The 1919 Report of the Royal Commission to Investigate Industrial
Conditions in Canada recommended a compulsory social insurance system covering old age, unemployment, sickness and invalidity. Though not implemented, these proposals began to enter into political debate in Canada. But it was 1927 before the first Old Age Pension Act (1927 c35) was passed. What was provided was not the insurance scheme promised by the Liberal government (The provinces were unwilling to co-operate in this and the Department of Justice said it would be unconstitutional) but means-tested non-contributory pensions of $240 per annum to persons whose total annual income including the pension did not exceed $365, for people seventy years and over, accorded by the provinces and cost-shared by the federal government, 50 per cent till 1931, 75 per cent thereafter. Adult children were considered to have some responsibility for maintenance of elderly parents, and the provinces could make recoveries from estates.

The B.C. Liberal government took immediate advantage of the federal legislation, believing that the party's fate depended on this. [Bryden, 1974, p. 73].

By the late 1920s, poverty among the elderly was being recognized as a social problem which was reaching serious proportions in Canada. Many of the immigrants who had come here at a mature age during the early days of the wheat boom were reaching old age without having been able to lay aside provisions for it and many aging parents had lost their potential source of support in the war. So when the Conservatives took up office in 1930, they recognized public approval of the scheme and increased the federal contribution to three quarters. From 1935 when the Federal Department of Labour ceded administration to the Department of
Finance, there was much more concern with economy. Means tests and annual investigations were made more thorough; it was made explicit that contributions which children could reasonably be expected to make were to be counted as income whether they were made or not; and the power to make recoveries from estates was made more effective.

The Royal Commission Report on Dominion-Provincial Relations (1940) (Rowell-Sirois Report) pointed out that the problems being experienced in the 20s and 30s were due not only to the Depression, but also to the increasing proportion of elderly in the population, the increased specialization of the economy, leading to decreased local and family self-sufficiency, and the growth of cities . . . all normal features of a maturing economy. It was suggested in fact that the depression had simply intensified and brought to a head a situation which was developing in any case, so that a more comprehensive and constructive approach was necessary instead of the current ad hoc type of arrangement.

The Report of the House of Commons Advisory Committee on Post-War Reconstruction (1943) (The Marsh Report) recommended a two-fold classification of income security risks: universal risks such as medical care and pensions; and employment risks-unemployment, disability, etc. A comprehensive set of income security proposals designed to guarantee national minimum standards was proposed.

After World War II, the comprehensive national scheme of social insurance recommended by Marsh stood little chance of being implemented as long as federal-provincial problems were so over-riding, but in 1950
the provinces did agree to the financing by the federal government of a universal flat-rate non-contributory pension to everyone seventy years and over, (This was the age proposed by the business organizations; the labour centrals opted for sixty-five) with cost-shared supplements to people aged 65-69. The Old Age Security Act (1951 c38) was passed in 1951 providing for a universal pension of forty dollars per month to people who had resided in Canada for twenty years and had no children to support them. The pensions were financed by an old age security tax of 3 per cent on the sale price of goods taxable under the Excise Tax Act, a 4 per cent tax on individual taxable income or $240, whichever was less, and a 3 per cent corporation tax. The Old Age Assistance Act (1951 c51) enabled the federal government to pay 50 per cent of pensions up to a limit of forty dollars per month accorded by any province to a person aged sixty-five or over, whose total income would not be more than $720 per annum (twelve hundred dollars for a couple).

In 1951 also, a constitutional amendment gave the Parliament of Canada concurrent jurisdiction with the provinces to make laws in relation to old age pensions.

The Unemployment Assistance Act (1956 c26) defined the "unemployed" as "persons who are in need". Payments which were shared by the federal government were not to cover medical, hospital, nursing, dental or optical care but could cover supplements to old age assistance payments to persons in "homes for special care" which included homes for the aged, nursing homes and hostel facilities provided for the aged within housing projects constructed under the 1956 National Housing Act. (This has been superseded by the Canada Assistance Plan.)
Till well into the 60s, little more was accomplished or even attempted to extend the coverage of universal social security benefits though rates were increased occasionally. The fact that the elderly were the first people covered (with children coming next) was probably not attributable to a policy of positive discrimination in their favour. Federal-provincial rivalries, a belief in self-reliance, and in the 50s, industrial expansion, economic growth and a fairly high level of employment, made state-sponsored social security provisions appear unobtainable, undesirable or unnecessary. However, children and the elderly were least able to provide for themselves. So it may be that provision for these groups was seen as an alternative to be chosen over universal social security coverage. However, the Liberal government which came into power in 1963, had promised at election time to introduce a national contributory plan of wage-related pensions, and after working through the objections of private insurance companies, of Ontario which had its own proposals for a plan, and Quebec which objected on grounds of unconstitutionality, the more comprehensive coverage came with the Canada Pension Plan (1965 c51 S1) and the Canada Assistance Plan (1966 c45 S1).

The Canada Pension Plan (CPP) is a contributory insurance plan which entitles eligible beneficiaries to earnings-related retirement, disability and survivor pensions. The retirement pension was intended to be 25 per cent of average adjusted life-time pensionable earnings.

The Canada Assistance Plan (1966 c45 S1) is "an Act to authorize the making of contributions by Canada toward the cost of programmes for the provision of assistance and welfare services to and in respect of
persons in need". The Plan (CAP) authorizes the federal government to assume 50 per cent of the costs of providing assistance to persons in need and of improving or extending welfare services. It covers those costs previously shared under the Unemployment Assistance Act, including payments to employable and unemployable persons in need, costs of maintenance of needy persons in homes for special care, such as nursing homes for the aged, and costs of supplementary assistance to needy recipients of old age security pensions, blind persons' allowances, disabled persons' allowances and unemployment insurance benefits. It also extends federal sharing to: health care services to needy persons, e.g. prescription drugs, dental services, eye glasses, nursing services, etc., and the extension of welfare services designed to prevent and remove the causes of poverty and to assist persons receiving assistance to achieve the greatest possible degree of self-support. Welfare services include among others, rehabilitation services, counselling, homemaker, daycare and similar services.

Need is determined by a means test which takes into account the person's budgetary requirements and his income and resources. The determination of need and conditions of eligibility are set by the provinces. Maximum amounts are not set in the federal legislation. Between 1966 and 1970, the pensionable age was progressively lowered from seventy to sixty-five years. The government had intended that the CAP would cover the needs of indigent old people but the opposition parties pressed instead for more generous old age pensions, the report of the Senate Special Committee on Aging showed that 70 per cent of women and 40 per cent of men over seventy possessed no other income than the old age pension, and there was such
widespread support for additional help for the elderly that the government did not have much choice than to introduce the Guaranteed Income Supplement (GIS) paid from January 1967, still income-tested, but by a new periodic submission of income statements. Some people wished old age pensions to be abolished when the CPP was introduced but they were retained for various reasons. The CPP payments would be inadequate for a long time, old age pension payments were taxable, so some of the outlay was recoverable, many people were counting on receiving old age pensions, and because they had been financed for over twenty years, in part by a surcharge on personal income tax, people felt entitled to them.

The Special Senate Committee on Poverty while not dwelling to any great extent on the elderly, did point out that 27 per cent of all low-income family heads were sixty-five years of age or older and that the old age pension was inadequate. They recommended that the Guaranteed Annual Income they proposed, should apply to the elderly as well as to people of other ages.

The "first guiding principle" defined in the Working Paper on Social Security in Canada (1973), was that "the social security system must assure the people who cannot work—the aged, the blind, and the disabled, a compassionate and equitable guaranteed income".

In April 1973, old age pensions were increased to a hundred dollars per month—to be escalated in future in accordance with a cost of living increase.

On April 5, 1974 M. Lalonde introduced in Parliament, a bill to amend the Canada Pension Plan so that the year's maximum pensionable earnings
earnings would be increased by 12.5 per cent per year until the sum caught up to average earnings of Canadian workers. This would enable monthly retirement benefits to be raised to $350 per month by 1985. Other recent suggestions have been that the retirement age under the CPP should be reduced to sixty, and that housewives should be included in the plan.

In November 1974, a bill received royal assent in the senate which provided for widowers to receive pensions in the same way as widows. (Previously the widower had to be disabled and have been wholly dependent on his wife). From January 1, 1975, female and male contributors and beneficiaries have enjoyed equal status. The earnings test for contributors between the ages of sixty-five and seventy was also eliminated.

In June 1975, a bill was introduced which would allow the spouses of old age pensioners to receive means-tested pensions between the ages of sixty and sixty-five. This was expected to apply to about 85,000 spouses.

The Mincome scheme administered by the B.C. Department of Human Resources supplemented the Old Age Security Pension and Guaranteed Income Supplement for those with no other income. In 1973 and 74, this applied to about 97,000 persons aged sixty-five and over and 13,000 in 1973, 23,000 in 1974, aged between sixty and sixty-four. It has been replaced by GAIN (Guaranteed Available Income for Need) which introduces an assets test.

The legislation introducing the New Horizons programme was passed in 1972. This programme is for retired Canadians who wish to plan projects for their leisure time. Funds are granted to groups of at least ten volunteers, the majority of whom must be aged sixty-five or over.
3. HOUSING

As far as housing is concerned, the position in earlier years seems to have been much as with other services, i.e. the housing of the elderly may have left much to be desired but as the same could be said of the younger age groups also, there was no special concern for the needs of the elderly, the less so since housing has been, and still is, viewed as a market commodity rather than as a social service in Canada. (The first Housing Act probably had as its main objective the stimulation of employment through construction.)

The Dominion Housing Act (1935) was the first housing legislation in Canada. Like the first National Housing Act, (1938 c49) it permitted the government to make joint loans for house building with lending institutions and local authorities on a 25/75 per cent basis. In spite of this, there was great concern in Canada in the early 40s about the shortage and dilapidation of houses in both urban and rural areas, (the result of failure of the building industry to replace obsolete structures or provide for a growing urban population in the 30s) and several provincial reports as well as the Seventh Census of Canada document this situation. Since that time, both Federal and provincial governments have made more provisions to aid home-buyers, as well as elderly low-income renters.

The National Housing Act (1944 c46) continued the joint lending technique but it began also to deal with more specific needs such as low-rental housing, slum clearance and rural housing. After the war, however, the legislation for the provision of public housing was used mostly to meet the housing needs of young families. At the time of the Senate
Committee on Aging, only 1,300 rental units had been built in Canada, and of these only 167 were for old people.

The **Central Mortgage and Housing Corporation Act** (1945 c15) set up a Crown agency responsible to government through the Minister of State for Urban Affairs to carry out federal housing legislation and to make loans from money advanced out of the Consolidated Revenue Fund.

The **National Housing Act** (1954 c23) substituted a system of loan insurance for the earlier joint-loan technique to private entrepreneurs. Various other amendments have since been made. Amendments made in 1964 allowed for aid to provinces, municipalities and non-profit organizations to build senior citizen housing projects (as well as public housing) and also made loans and subsidies available for hostels and other forms of group living accommodation, not only for new construction, but also for acquisition and conversion of existing housing.

In recent years there has been a considerable shift in emphasis in the legislation administered by the Central Mortgage and Housing Corporation from primary concern with making or guaranteeing loans, to an emphasis on a number of socially oriented housing programmes to meet the needs of low and moderate-income persons. In 1972, 85 per cent of the federal housing budget was directed to this aspect of the programmes [Minister of National Health and Welfare, 1974]. 1973 amendments included provisions to enable low-income families and cooperatives to buy homes. Increased assistance was made available to voluntary groups such as church groups and service clubs who wished to provide housing for low-income persons, particularly the elderly and other disadvantaged people.
S44(1)B (a new amendment in 1974) indicates that if a province is willing to designate a non-profit project as a public one, the project or units within the project are eligible for cost-sharing of the operating deficits.

In 1975, legislation was passed giving CMHC authority to lease land at favourable interest rates to any organization wishing to undertake a low-rental housing project.

4. NATIONAL REPORTS

Two major reports on the elderly which deal with a whole range of services were the Report of the Special Senate Committee and the Proceedings of the Canadian Conference on Aging held by the Canadian Council on Social Development in 1966.

The Report of the Special Senate Committee on Aging (1966)

The Committee described their study (p.v) as "the first attempt to examine the problems of aged Canadians as a whole on a national scale though the problems of the aged and aging have been receiving attention in recent years in many parts of the world. There is ample evidence in Canada of public interest in the subject and many organizations and individuals are involved in trying to improve the lot of aging citizens".

The Committee was appointed "to examine the problems involved in the promotion of the aged and aging person, in order to ensure that in addition to the provision of a sufficient income, there are also developed adequate services and facilities of a positive and preventive kind so that older persons may continue to live healthy and useful lives as members of
the Canadian community, and the need for the maximum co-operation of all levels of government in the promotion thereof".

The Committee dealt with income, employment, health, housing and community services.

Because aging is a normal and natural phenomenon, the committee deliberately rejected the idea of defining services for old people as "welfare services". It was pointed out that a policy for old people must fit in with the social and economic goals of the wider society, but that the elderly are more vulnerable to change and more defenceless. Constructive planning for old people cannot proceed on an ad hoc basis but must rest on an analysis and understanding of the total situation. They need continuity, and freedom of choice when continuity has to be broken, they need recognition of their individuality, and they treasure independence. Various recommendations were made for health care including community facilities, (clinics, outpatient departments of hospitals, etc.) to which sick elderly people could go or be brought for on-the-spot assessment, treatment, counselling, etc., extension of services (including nursing homes) covered by medicare. The need for team-work among the three levels of government was emphasized. Departments of Health and Departments of Welfare should have special branches concerned with older people and should liaise. There should be a special division also in the Department of National Health and Welfare.

Needs for education, planning and research were pointed out. There were a number of recommendations regarding income, employment, housing and social services, and for a National Commission on Aging to
keep under review the needs and problems of older people and to develop recommendations on policy and programmes for dealing with them, etc. A body should also be established in each municipality to plan and coordinate programmes for the elderly.

The Proceedings of the Canadian Conference on Aging (CCSD, 1966) covered much the same area as the Senate Committee.

In his opening remarks, Hon. Allan J. MacEachen, Minister of National Health and Welfare, described the care of the aged as "probably without question the most difficult problem of our times in all civilized countries. The problem is becoming more urgent because of the increasing number of people living into the later years. The placing of more emphasis upon older people in our community is becoming a permanent feature of our population structure".

Rev. André Guillemette further set the stage by pointing out that "... the existence of mass societies with large numbers of persons who spend as much time in retirement as they do in childhood is a new phenomenon. To date no adequate social theory has been developed to find a function for the aged ... Our first concern and our first action should therefore be: to restore the position of the elderly in our culture and society in the interest of the elderly, of course, and in the interest of our entire society. Consideration must be given to defining the value of the elderly person's experience and wisdom. This redefinition is imperative at the family level, i.e. extra familial social relations, and in the world of work, business and employment. Consequently we must revive our concept of old age, we must rethink the roles and functions of old age" (p. 53). M. Guillemette pointed to the huge gap between medical
research and social research on the problems of the elderly. "The advances in medicine are partly responsible for the social problems which affect the elderly, since the social structures have not evolved and our social attitudes have not changed to keep pace with the growing numbers of old people in our society and with the technological revolution through which we are passing". (p. 60) Again various recommendations with regard to services and organizations were made, many similar to those of the Senate Committee.

The CELDIC report, One Million Children, published in 1970 by the Commission on Emotional and Learning Disorders in Children made recommendations about the nature and organization of services for the children concerned, of which many might equally well apply to the elderly in a community, e.g. community service centres in each area with a population of 25,000 to 50,000; boards who would promote and plan the establishment of a comprehensive and co-ordinated network of personal care services, devolution of service responsibility to local level, that priorities be decided by local needs rather than by the funding provisions of governments. There were also recommendations that each provincial government should establish a cabinet committee with a designated chairman responsible for the co-ordination of the personal care services and an advisory council to the cabinet on personal care services (composed of representatives of consumers, providers and administrators of services). There was regret at the prejudice against planning which had prevailed at least up to World War II, and a recommendation that "the Government of Canada undertake such measures as are necessary to ensure that citizens in all regions of Canada
have available to them those personal care services which are required to assist them towards maximum development of their potentials as persons and as citizens of this nation".

What is most interesting about the federal legislation is that it enables one to trace the origins of many of the problems, as well as the merits, of today's services. As far as the reports are concerned, usually what is more striking is how often recommendations have been ignored though they have been reiterated many times over the years. Now that the federal government has declared an end to its open commitment to cost-share health services recommendations for less emphasis on acute and medical care, and more on community and social services may at last be heeded. Even now that the increasing size of the elderly population is recognized by everyone, reports from the health field still seem to give low priority to the needs of the elderly.
CHAPTER III

PRESENT SITUATION

In Chapter II we followed the historical development of various services which can affect the health and well-being of the elderly. In this chapter we look at the present situation. We have divided health services into institutional services and community health services, still keeping mental health services separate because for the elderly, they are still mainly provided separately. Then having looked at social services (including voluntary services), income security and housing, we look briefly at the financing of services and at some of the structures within which they are provided. Finally we review some of the characteristics of the present arrangements.

PRESENT SITUATION - DESCRIPTION

1. HEALTH SERVICES - INSTITUTIONAL

Since September 1973, health care in British Columbia has been classified into five types similar to those proposed by a national working party for use throughout Canada, and intended to cover the whole range of health care requirements from Type I-personal care (for persons whose physical disabilities are such that their primary need is for room and board, limited lay supervision, assistance with some of the activities of daily living and a planned programme of social and recreational activities), through intermediate care (where daily professional nursing is also required), extended care (requiring skilled twenty-four-hour a day nursing services and continuing medical supervision), activation, and Type V, acute
care. **Hospital Insurance** covers accommodation, meals, necessary nursing services, diagnostic procedures, pharmaceuticals, the use of operating rooms, anaesthetic facilities and radiotherapy, and physiotherapy if available, in general and public allied, rehabilitation and extended care hospitals. Outpatient services covered include emergency services, minor surgical procedures, day care surgical services, outpatient cancer therapy, psychiatric day care and night care and some outpatient services, day care rehabilitation services, physiotherapy services and diabetic day care. The authorized charges were raised in 1976 from one dollar to four dollars per day for standard ward acute and extended care. Charges for other services are two dollars and one dollar per visit.

There are ninety-five **acute hospitals** in British Columbia, and 11,429 'general' beds. Most acute hospital personnel believe that treatment of adults in the acute hospital should be geared to the patient's medical needs and not to his/her age, though the latter may affect the nature and extent of the needs. [GVRHD 1975 (2)]. Hospital admission rates are higher and length of stay longer for the elderly patient mainly because the commonest conditions treated in this age group tend to be long term.

**Activation and Rehabilitation** is the 'type of care required by persons of any age with physical disabilities of a kind that require a planned intensive programme of rehabilitation to improve or restore function as it relates to mobility, the activities of daily living and vocational capacity'. There are three **rehabilitation centres** in B.C.—the G.F. Strong and the Holy Family Rehabilitation Centres in Vancouver
(100 and 80 beds) and the Gorge Rehabilitation Centre in Victoria (99 beds). There are also nine rehabilitation units in other hospitals with a total of 193 beds. New units in the planning or construction stage will provide an additional 120 beds. The Workers Compensation Board of B.C. also has rehabilitation facilities in Vancouver.

The G.F. Strong serves the whole province, gives priority to the severely disabled, and rarely admits elderly patients. Holy Family Hospital on the other hand, in 1975, admitted 256 patients aged sixty and over and sixty-seven only under age sixty. Over 90 per cent had a diagnosis of c.v.a., fractures, or arthritis. In this hospital a 'programmer' prepares an individual program for every patient each week which includes group and individual therapy, occupational therapy, speech therapy if necessary, etc. There is progressive nursing care with the final stage including overnight visits home and all professional staff take part in planning and discharge conferences. In 1974, the average length of stay was 56.5 days. 68.8 per cent of patients were discharged home, 12.9 per cent to Boarding Homes, 10.2 per cent to acute care and only 7.1 per cent to extended care. The waiting-time for admission usually ranges from four to eight weeks.

In a study of acute hospitals in the GVRH D carried out in 1975, [GVRHD, 1975 (2)], it was found that even in the few hospitals where there were rehabilitation units or areas these were usually considered inadequate in size and facilities. Less than half the patients treated, on average, were aged over sixty-five. Most hospitals would have appreciated having more rehabilitation beds available to them because it was felt that the treatment provided to the elderly by the acute hospital would be
consolidated by a period of rehabilitation before returning home. Home care was not usually considered adequate as a substitute because it does not include education or training for independence.

The line between rehabilitation and activation may not be too clear though the latter seems to be less energetic and applied more to treatment of elderly patients, particularly stroke patients. There are less than a hundred beds designated activation beds in the Province.

There were 3,538 extended care beds in fifty-two facilities in B.C. in 1975 mostly attached to general hospitals, though seven were free-standing and managed by non-profit boards. The average size was seventy beds. The provincial formula is twenty beds per 1,000 population over age sixty-five. To be eligible for admission, a person must be unable to get in and out of bed or use a wheelchair unassisted, or must require regular and continuing medical supervision and professional nursing care beyond that available in Intermediate Care facilities. Names of eligible applicants are kept on a Central Registry in Victoria until a vacancy occurs, and after admission patients are assessed at quarterly intervals as to their continuing eligibility.

Of 3,003 patients in extended care in 1974, 1,960 were female 1,043 male, 577 were single, 883 married, (married and single were almost equally divided by sex) but of 1,518 widowed, divorced or separated, 1,221 were female, and 297 male. The chief profile was the older widowed female. By age, 23 per cent were under sixty-five years of age, 7 per cent were 65-69, 9 per cent 70-74, 14 per cent 75-79, 18 per cent 80-84, 17 per cent 85-89, and 17 per cent 90-99. A 1972 study (Foulkes 1973) has shown that the most
common diagnoses were c.v. disease and ischemic heart disease, followed by arterio-sclerosis, other non-psychotic mental disorders, fracture of the femur, paralysis agitans, and diabetes mellitus. Almost half of the patients had stayed beyond six months, and another quarter beyond a year.

The GVRHD 1973 study found that in their region, 44 per cent of extended care patients had been admitted from acute hospitals, 37 per cent from other care facilities and 14.3 per cent from home. Of discharges, 71 per cent had died, 7.4 per cent went to acute hospitals, 9.4 per cent went home, and the others to equivalent or lower levels of care. A study of the characteristics of 3,209 1974 patients showed that 88 per cent were receiving oral medications and 45 per cent regular bedtime sedations, 33 per cent required attention for bowel or bladder problems, 59 per cent could not walk, 39 per cent could walk with assistance and 2 per cent independently. 21 per cent were aphasic, 5 per cent had severely impaired vision, 24 per cent were confused and disoriented and 6 per cent were disruptive, noisy or with unacceptable behaviour.

Intermediate Care Beds are a fairly recent innovation in B.C. which now has 820 in Vancouver, Burnaby, Victoria, Kamloops, Penticton and Nanaimo. Again, applicants are registered in the Central Registry in Victoria. There is a 3-4 months waiting time for Vancouver, less for Burnaby. Residents pay ten dollars per day which is subsidized by the Department of Human Resources for those (50 per cent) who are unable to pay the full cost. The actual cost to the government is at least twice the amount charged, and this also is paid for by the Department of Human Resources. In 1974, an Intermediate Care Study Committee recommended
that in the GVRD alone, four thousand such places should be provided by 1981, though some of these could be provided by the modification of existing private facilities. The Province estimates a need by 3 per cent to 4 per cent of persons over sixty-five for intermediate and personal care.

The number of Private Hospitals has decreased steadily over the past ten years presumably because of the provision of extended care hospitals so that in 1974 there were fifty-three hospitals and 2,541 beds, mostly located in Vancouver and Victoria. Private Hospitals are licensed under the Private Hospitals Licensing Act and are required to provide twenty-four-hour skilled nursing care. They are supposed to provide type II care, but to an unknown extent also provide for levels I and III. Five year old data give a 2:1 female to male ratio, an average age of eighty-seven for females and eighty for males, and an average length of stay of six months. About half the patients are 'welfare' patients who are evaluated in local DHR offices, and must have assets no greater than fifteen hundred dollars if single, and twenty-five hundred dollars if a married couple. Charges may be as high as nine hundred dollars per month. In spite of this, some owners find that as long as government pays only $525 per month for welfare patients, they can no longer operate except at a loss, and are closing down (Vancouver Province 'Hospital Owner regrets he had to close down', July 17, 1976)

In 1975 there were about 485 Personal Care Homes in the Province licensed by the Community Care Facilities Licensing Board. 75 per cent of these facilities containing 55 per cent of the known beds, are privately owned. Most of the remainder are owned by voluntary organizations. The
average size is 25.9 beds though sixteen have over one hundred beds. Of the 12,000 residents, about half are subsidized by the provincial government, under a cost-sharing agreement with Ottawa. Department of Human Resource expenditures to assist persons in boarding and rest homes and private hospitals more than doubled in 1975 as the number of persons assisted more than doubled.

In July 1975, the president of the B.C. Rest Homes Association claimed that rising costs and low revenue (even at $400 to $600 per month) were forcing private operators out of business, and claimed that in the previous twelve months, twenty out of eighty private homes in Victoria had closed. Residents unable to pay the costs could be subsidized by the government by $250-$400 per month in addition to a twenty-five dollar per month comforts allowance and a twice yearly clothing allowance (for those whose assets do not exceed $500). Mr. Hanrahan wanted a government subsidy of eight dollars per day for all residents.3

The Minister of Health had stated in the 1973 Classification of Types of Health Care that the provision of several types of health care in one facility or under the auspices of one agency would be encouraged. Examples of this are the Penticton and District Retirement Complex which provides a six-storey apartment unit for 156 residents aged sixty-five and over, adjoining a 9,000 square foot recreation centre which in turn is linked to a Care Home with ninety-seven intermediate care beds. In Vancouver, Seton Villa provides self-contained suites, board residence and personal care. Then in February 1976, the first intermediate care (79 beds) and personal care (23 beds) unit to be associated with and operated
by an acute hospital was opened in Nanaimo.

2. HEALTH SERVICES - COMMUNITY SERVICES

Community services for the elderly may be provided by independent practitioners, the Health Department, the Department of Human Resources, voluntary agencies funded to varying degrees by either or both of these, and other sources also.

The Medical Services Plan of British Columbia provides services upon uniform terms and conditions for all residents of the Province who choose to pay the premium (now $7.50 per single adult per month, $3.75 for people with taxable income below $1,000). The Plan provides insurance coverage for all medically required services rendered by medical practitioners and for optometric assessment. Chiropractic is available up to a cost of seventy-five dollars per year for people under sixty-five, one hundred dollars for those over sixty-five. Naturopathic services, podiatry and orthoptic services, physiotherapy, provided outside the hospital are available up to fifty dollars per patient per year, special nursing up to forty dollars.

Covered now also are services rendered at outposts approved by the Commission within the Province of B.C., where the services of a medical practitioner are not regularly available, by nurses employed by the Canadian Red Cross Society—to be paid at the rate of two dollars per office service, and four dollars per house visit, where such services of the Red Cross nurse are rendered under the instructions of a medical practitioner or consist of treatment for minor injuries and infections.

Elderly persons have the same right to services as other members of
the Provincial medical insurance plan. Since statistics are not kept according to age, it is not possible to obtain figures on the number and nature of services provided by family doctors to ambulant elderly patients. Nor is there any documentation of how often elderly patients who present with medical problems in fact require a different form of attention or intervention.

There is a free prescription drug programme for residents over sixty-five. More prescriptions are now filled for elderly persons than before introduction of Pharmacare.

The Department of Human Resources provides transportation for low income persons in need so that they may go to clinics, hospitals, rehabilitation centres and nursing homes. Over 60 per cent of users of the emergency transportation service are elderly and the emergencies are mostly of a medical nature. The Department may also pay for medical services, supplies and equipment not covered by medical insurance. Special Needs Committees assess the needs of people who are not already in receipt of social assistance.

Public Health Services-Nineteen Public Health Units in B.C., (just over one hundred public health offices) provide a variety of preventive and treatment services. The services most used by the elderly are home care and visiting nursing, physiotherapy, consultation and support to community groups, assistance to community support services, e.g. home-makers, meals-on-wheels, and visiting. The units also provide liaison with hospitals in planning home care, provision of special clinics-"over-60", hearing, podiatry, nutrition, screening-and counselling about
general health issues, etc. A few units provide speech therapy to stroke
patients. Health Department staff inspect Community Care Facilities to
determine their eligibility for licence and nurses from some units visit
personal care homes to offer supervision and consultation.

There are eight health units in Metro Vancouver. Nurses have
some dealings with the elderly but there is no one concentrating on the
elderly as such. Each office except Burrard has a co-ordinator of volun-
teers who visit the elderly—a service financed by Human Resources.

A doctor and a nurse from the Vancouver East Unit take part in two
Well-Being Centres for Seniors, each held once a month in Columbus Towers
and Lions' Manor. Staffed mainly by volunteers, the programmes are mostly
recreational and educational, but people 'who don't want to bother' their
family doctor may approach the Health Unit doctor, and may also be per-
suaded that they should consult their family doctor.

Home Care—B.C. may have the most advanced Home Care Programme in
Canada with services available to about 90 per cent to 95 per cent of the
population. The programme is administered by the Health Units and visits
are made, on the request of a physician, by regular line public health
nurses who also call on R.N.s, physiotherapists, orderlies, visiting
homemakers, meals-on-wheels personnel, visiting volunteers, occupational
and recreational workers. Till 1976, in Vancouver and Victoria, and a few
other areas, the Home Care services were available through the V.O.N. and
more of the costs of services were charged to the patients. The B.C.
Medical Services Plan paid the V.O.N. two dollars per visit.

In 1973, 67.1 per cent of people receiving home care services were
aged sixty-five and over (excluding the V.O.N. areas in Vancouver, Victoria and Surrey, and special projects). And the number of new admissions in that age group rose from 2,525 in 1969 to 3,928 in 1974. The figures vary markedly from one district to another, depending to a large extent on the size of the elderly population in the area.

Special Home Care Projects in nineteen areas (i.e. almost all major population areas) provided care to patients discharged early from acute hospitals, and to a very few patients instead of admission. They were financed completely by the Provincial Government, and all services required, i.e. nursing, physiotherapy, homemaker, meals-on-wheels, medication, supplies, social worker, orderly, transportation, laboratory, dietitian, etc. are provided without charge to the patient. In B.C. in 1974, 2,501 patients (31.4 per cent) discharged from the Special Programme were aged sixty-five years or over. In 1976, the traditional and special programmes were amalgamated and all services are now provided completely without charge to the patient if they are provided as hospital replacement. Otherwise, only nursing and physiotherapy are free and there is no time limit on nursing.

In the age group 60+, 25 per cent of home care is hospital replacement and 75 per cent support.

A study of Home Care undertaken by the GVRHD in 1975 recommended more admissions from the community to the programme, more use of it for long term and terminally ill patients and more education of hospital staff and patients regarding the programme.

V.O.N.—Until 1976, the V.O.N., funded since 1974 by the provincial
Department of Health, provided home nursing and physiotherapy and in some areas administered homemakers, meals-on-wheels, and home aides in Greater Vancouver, Surrey and Victoria. In addition, in some areas, V.O.N. physiotherapists would pay predischarge visits to assess a patient's home, and would instruct relatives on how to care for patients. When BCMP coverage (forty dollars per annum for nursing, fifty dollars for physiotherapy) was exhausted, people were charged according to means, with the Department of Human Resources paying for low-income persons. The present government decided that these services should be taken over by public health units to avoid duplication of services and this take-over was completed in October 1976, when the services of the Vancouver Branch were taken over.

Homemakers—Several non-profit societies in the Province hire and train homemakers. The Department of Human Resources makes annual grants to these societies to help defray costs. Services may be provided for from four hours once a week up to twenty-four hours a day in a crisis. Fees charged to low-income families or patients on hospital replacement home care, are paid by the Department.

An April 1974 survey showed that in the several non-profit agencies which provided the provincial homemaker service, there were 1,345 homemakers (some on a part-time basis), over eighty home-aides and seventy-five supervisors. The usual payment was the minimum wage of $2.50 per hour. Care for the elderly and the chronically ill were the types most commonly required. It was thought that the lack of middle income consumers suggested, not the absence of need for services but deterrence by the cost.
[Rosettis, 1974]. A survey done in Vancouver in February 1974 by the Department of Health Care and Aging found that of the 206 cases helped, eighty-six were aged eighty and over, and fifty-six between sixty-five and seventy-nine. In the course of the GVRHD Geriatrics study it was claimed that demand for this service far exceeded supply. Also, a rather rigid division of function was regretted—until recently a homemaker had not been allowed to get a patient out of bed. In 1975 in the Province as a whole, services expanded considerably and costs of $6.5 million were almost double the 1974 expenditures. 58 per cent of services were to the elderly. (GVRHD 1975 (2)).

Meals-on-wheels—These are provided in most centres of population (forty-two altogether), administered by health units, V.O.N. or voluntary organizations, and staffed by volunteers. Meals in most units are provided entirely to the elderly. Some groups receive grants from the Department of Human Resources to offset the administrative costs or to partially subsidize the cost of the meals.

Health Clinics—A few communities have organized locally controlled health clinics with financial assistance from the Provincial Health Department. The only one which seems to have a large number of elderly people among its clients is the Downtown Community Health Society in Vancouver. Funded originally by the community and a National Health grant, now by the Provincial Government, and staffed by twenty-five professionals or paraprofessionals and thirty-nine volunteers, it runs a medical and dental clinic, a home care programme serving isolated and lonely aged and handicapped, providing nursing care, social companionship and other
assistance. It has a mid-day soup programme and also offers recreational services. The facilities are used mainly by male residents of the Skid Row area, 60 per cent of whom are elderly (and 25-30 per cent of whom are chronic alcoholics).

**Community Human Resource and Health Centres**—The Queen Charlotte Islands was one of the first parts of the Province to apply for a CHRHC with the original initiative coming from the Hospital Board. Others are at James Bay, Victoria, Grand Forks-Boundary, Houston and Granisle. They tend to be seen as offering the best solution for provision of services in remote areas with scattered populations, problems in attracting professional staff, etc. However, because these areas may also consist largely of recently established company towns or Indian settlements, the percentage of elderly in them tends to be small. (3 per cent over sixty-five in the Queen Charlottes) and special services for the elderly are almost nonexistent (and unnecessary). The James Bay Centre is the exception with 40 per cent of the population of the area over the age of sixty. The lunch hour is set aside each day as a time when appointments in the health component can be made by elderly people wishing to come at a quiet period. Home visits by a doctor and nurse may also be booked daily between nine and noon. Health education classes are held, a public health nurse attends a New Horizons Group to discuss individual problems, check blood pressures, etc. The provincial government has a vision care programme in the Queen Charlottes—one ophthalmologist, one optometrist and one dispensing optician go up three times a year for three days.

**Voluntary Agencies**—The B.C. Division of CARS runs the Arthritis
Centre in Vancouver where a staff of rheumatologists, therapists, nurses and social workers provide outpatient rehabilitative treatment to patients of whom the majority suffer from arthritis. This was declared a non-bedded hospital for funding by BCHIS in November 1972. There are also therapists located at five other stations in the Greater Vancouver Area, and three travelling vans provide service in many other areas of the Province. CARS has thirty-six beds in three Vancouver hospitals. Rufus Gibbs Lodge is a residence for out of town patients attending the Centre. Carscraft is a sheltered workshop and sales outlet. Club 985 is a social club. Funding is provided approximately 40 per cent by government grants, 32 per cent from voluntary contributions, including United Appeals and 28 per cent from treatment fees including those from medical plans. Of 277 patients treated in the thirty-six beds in 1975, ninety-two were aged over sixty. And over 60 per cent of physiotherapy time and over 50 per cent of occupational therapy and nursing time were devoted to patients in the same age group.

Other voluntary agencies which may provide services to the elderly include the Red Cross which supplies on free loan, sickroom equipment including hospital beds and wheelchairs.

The Crisis Intervention and Suicide Prevention Centre of Greater Vancouver administers a Telephone Tree for Seniors - a regular call from a senior to a senior to combat loneliness.

(Voluntary agencies providing 'social' services will be included in a later section though the division is a very artificial one.)
3. **MENTAL HEALTH**

**Institutional Care**—Psychiatric patients under age seventy are admitted to Riverview Hospital, and the chronically ill who cannot be discharged remain at Riverview, so that over a quarter of the approximately 1,200 Riverview patients are aged sixty-five and over. Organic brain syndrome patients are accepted for care in a special unit in which turnover is low. In fact as younger people seek help from general hospitals and community teams, the Riverview population tends to be older, and to have more physical infirmities.

**Valleyview Hospital** is more or less the only psychiatric facility for in-patient treatment of the elderly in British Columbia, accommodating about 650 patients at any one time nowadays, all aged at least seventy, and with an average of 75 per cent confused and a ratio of two females to one male. Of approximately 4,000 admissions per year, about 5 per cent to 10 per cent are admitted for psychiatric treatment, (Few doctors think of this as a possibility) and most are admitted for custodial care because of mental disorders causing behaviour which is not socially tolerable. A pre-admission screening programme was started seven to eight years ago, 15 per cent to 25 per cent of people seen are rejected as not requiring hospitalization and the social worker is able to make alternative arrangements. Nor is admission seen as "terminal disposal". Many patients respond to treatment. Each year discharges are equal to just under half the number of admissions (Deaths are equal to over half), and of the 1974 discharges, thirty-one returned to spouse or private care, seventy-two to boarding homes, forty-one to nursing homes, and twenty-seven to extended care.
Skeenaview in Terrace and Dellview in Vernon, formerly designated as mental health facilities, are now care facilities only, under the Department of Human Resources. Skeenaview, for men only, has been operated since 1974 by a local society, in an area where it has proved impossible to develop boarding homes. Many of the approximately two hundred men now at Skeenaview were people without relatives, transferred from Riverview where they had been long-term patients institutionalized and many bedridden. In Terrace emphasis was placed on increasing ambulation so that today all patients are ambulatory, wear outdoor clothes and lead comparatively full and active lives. However the buildings are apparently old, dilapidated army huts which the Board has been told can be replaced provided that in exchange they reduce physiotherapy, the core of their ambulatory programme. Dellview, in Vernon, with about 180 beds occupied mainly by local people, offers no active treatment, though it does discharge a few patients to community care.

Community Services-B.C. is divided into eight mental health planning regions each of which includes several school districts and all or part of at least two health units. There are thirty Mental Health Centres operating in the Province and nine Community Care teams operating under the Greater Vancouver Mental Health Services project. The Mental Health Centres are intended to provide preventive, treatment and rehabilitative services. However, it is generally agreed that almost nothing is done for the elderly in these centres. A two to three year survey of mental health centres in the Lower Mainland showed that less than 1 per cent of their patients were aged over sixty-five. Doctors do not refer and elderly people are rarely
anxious to seek help with mental illness. In Greater Vancouver approximately 15 per cent (285) of the caseload of community care teams are aged sixty-five and over. This means that these patients are included in groups if there are any, not that they are receiving individual treatment.

The Boarding Home Program was begun in 1959 and by October 6, 1975, there were 1,866 patients in three hundred homes in every region of the Province (some homes of course have as few as two patients) — discharged patients who still require some care or rehabilitation or have nowhere else to go, and temporary residents who are normally looked after by relatives. Administration has been shared by the Health Branch and the Department of Human Resources. Homes taking three or more residents must be registered. Exact numbers by age are not available but it appears that a large percentage of people in the Boarding Home Programme are aged sixty-five years and over.

4. SOCIAL SERVICES

Department of Human Resources - The Department of Human Resources provides few direct services and those which are provided are mostly available only to people who are in receipt of allowances from the Department. In the case of the elderly this means people in receipt of Mincome allowance.

Senior Citizens Counsellor Service was begun in 1968 to provide a counselling and information service to senior citizens by counsellors who are themselves senior citizens. In 1975 there were 160 senior citizen counsellors in the Province. They undertake all kinds of service from giving advice and filling in forms, to assisting in the development of
activity centres, visiting, providing transportation etc. In 1975, 66,750 persons were served. Counsellors may be reimbursed for expenses up to sixty dollars per month.

Available to senior citizens who are in receipt of G.I.S. or Mincome are the Courtesy cards which cost five dollars for six months and which allow them to travel free on B.C. Hydro metro services and at reduced rates on suburban services vehicles on the Lower Mainland. On production of their pharmacare cards, any senior citizen may make a thirty-five cent journey for fifteen cents.

In local resource board offices, arrangements may be made for elderly low-income persons to receive homemaking help, counselling, referral to other social agencies, help with special medical expenses, etc.

The Department subsidizes personal care, intermediate care and private hospital care. Requests to the local Human Resources offices for referral of patients to care facilities are made by relatives, friends, doctors, etc. and local departmental staff are responsible for reviewing each application and making placement in the most appropriate facility.

The Special Care Adults Division of the Department was created in May 1974 and is responsible for personal and intermediate care residential facilities and community facilities for adults including the elderly and disabled. The emphasis of the division is on finding alternatives to institutional care.

The Department of Human Resources also makes community grants to senior citizens' centres and projects (to a total of $415,142 in 1975).

Vancouver now has fifteen Community Resource Board offices. The
Vancouver Resource Board has agreed that counselling services will be provided for all elderly persons and most offices now will provide a service to seniors—but seniors may not know this. In most areas in Vancouver and the surrounding municipalities, specialized caseloads are developing. Boards decide on the allocation of Community Grants. The Advisory Committees have a duty inter alia to assess needs and priorities for social services in the local communities and to encourage integration and co-ordination of services. As well as dealing with GAINS and bus passes, the Services for Seniors Section located at 411 Dunsmuir provides a restaurant and a social centre where many old people come, some travelling quite a distance and some spending their whole day there five days a week. The Centre is also seen as somewhere where the elderly and their friends or relatives may turn for advice or information and they receive enquiries from out of town as well as from local people.

Voluntary Services—As opposed to the financing of services, most of the providing of services to elderly persons is done by voluntary organizations or by individual volunteers.

Voluntary services or service may take several forms. There are voluntary bodies which are heavily subsidized by public funds and which provide statutory or at least necessary or desirable services. There are other voluntary bodies such as SPARC of B.C. which may act as advocates, to measure and create awareness of the needs of groups such as the elderly and recommend and even press for measures to meet them. Like the V.O.N., the staff of such organizations may be salaried professionals. Some volunteer organizations, such as the Lower Mainland Stroke Association, some
clubs for seniors, even transportation services, may be run by unpaid volunteers. Then some individuals serve voluntarily—from the members of hospital boards (Technically, a hospital is run by a voluntary society) to 'friendly visitors'. And some volunteers prefer the more impersonal task of raising funds to purchase service or facilities. (An example of this would be the Intermediate Care and Personal Care Facility opened in Nanaimo on March 1, 1976, a project conceived and financed to a large extent by the local Kiwanis Club). Women Auxiliaries in hospitals often raise funds for special projects in addition to providing services. Some hospitals are now employing Directors of Volunteers—a different group from the auxiliaries. In the community, volunteers work for a variety of senior citizen organizations.

Facilities have been developed recently to which seniors may go or be taken for socialization and/or treatment as well as to relieve family members for short periods. Senior Activity or Drop-in Centres, often developed by senior citizen groups, provide diversion and an opportunity to remain active. Adult Day-Care Centres provide opportunities for socialization, rehabilitation or protective care. They provide a change of environment for the elderly and relieve pressure on families. These are found mainly in the Lower Mainland. Examples are Cross Reach in Vancouver which provides various recreational activities and lunch three days a week to people (twenty-two on average) who live in their own homes and who are provided with transportation to the Centre. One day is set aside for more planned group activities offered mainly to people living in homes or private hospitals, and another for visiting the home bound. Over
the years, Cross Reach has received funding from federal, provincial and municipal governments, United Way and churches. Silver Harbour Manor in North Vancouver with six staff and four hundred volunteers (all seniors) has almost 2,000 members. Confederation House, North Burnaby provides recreation and minor services for old people—about seventy-two people per day from nursing homes and rest homes. Edmonds House in Burnaby has two full time staff, ten part time instructors (trained to teach painting, pottery, French, etc.) and over 1,200 members. Forty people use the centre seven days a week, and 150 five days a week. People from rest homes are brought in once a week. Neighbourhood Services Service Units at Cedar Cottage and Gordon House provide day care, and two more centres are preparing programmes. All seven units offer social and recreational facilities and counselling. The Parks Board finances a Day Care Programme started five years ago at the Mount Pleasant Community Centre in Vancouver, held every Wednesday for referred patients who are discharged from the VGH and Holy Family hospitals. Five years ago there was a hope in the Parks Board of one in every Community Centre, but this has not materialized.

Other organizations provide other services.

The Senior Citizens' Service Bureau of New Westminster provides transportation, home visits with various tasks undertaken, information centre, day-care-drop-in (to allow people who are usually looking after an elderly person to keep appointments, shop, etc.) and a home help service whereby crews from Woodlands School help with gardening, window-washing, etc. In Surrey, the Community Resource Centre provides information services (35 per cent of the clients are the elderly) and transportation to
medical facilities (58 per cent of these services go to the elderly).
In West Vancouver, 'Seniors Helping Seniors' is a group of services
organized to help seniors with the help of a New Horizons Grant. Various
organizations will do shopping, and several provide transportation. These
were often funded by L.I.P. grants, though the Provincial Government in
1975 allocated community grants amounting to $661,878 to eighteen trans­
portation programmes for handicapped senior citizens.

Individual volunteers may be found in hospitals, in the Volunteers
in Nursing and Boarding Homes Programme run by Vancouver City Department
of Health or the Provincial programme 'Auxiliary Workers for Public Health
Nursing Programmes' (In 1972 volunteers donated 10,930 hours of their time
to the health services and provided 10,494 services to individuals.).
Organizations like the Kinsmen, the Rotarians, the Lions, the Kiwanis, may
choose to take on the financing of large scale operations-bowling clubs,
housing, [Moore et al, 1975].

Senior Citizens' Organizations comprise over twenty groups or
societies. The Federated Legislative Council of Elderly Citizens Associa­
tions of B.C. is the umbrella group which has representatives from each
organization. The OAP's Organization of B.C. has provincial membership of
approximately 17,500 in 118 branches and the Senior Citizens' Association
of B.C. has approximately 10,000 members in seventy branches throughout
B.C. The aim of these associations is to aid in the improvement of the
quality of life of the elderly. They have social and recreational
activities and also provide a vehicle for senior citizens to gain access
to government and to make their views and needs known to the public. At
present, the FLC is becoming interested in pre-retirement. They are also concerned about middle-income people. They seem to be able to identify various needs and complaints of elderly people but there is not a lot of evidence that they have achieved many improvements.

**Leisure and Recreation**—Most municipal recreation departments (in Vancouver, the Board of Parks and Recreation) run community centres offering recreational and social programmes for seniors. Various colleges and the universities provide special courses for senior citizens or make special financial concessions to those who take the regular courses. At the six week Summer Programme at UBC, no fees are charged to persons over sixty-five years of age, free accommodation is provided on campus for persons from out of town, regular undergraduate and special interest courses are available—exams, essays and registration for credit are optional.

Under the New Horizons programme, groups of ten or more retired people who undertake activities for the benefit of themselves and others in the community can apply for federal grants for eighteen months. Many grants seem to have gone to existing organizations for and of old people rather than to bring out isolated old people [Hepworth, 1975, p. 73]. Grants tend to be given as seed money to projects which can later become self-sufficient. The money is not available for salaries or capital construction. To date, since 1972, eighty thousand people have been involved in eight hundred projects in the Province. In 1975, B.C. received $1.3 million.

**Age of Options** is a T.V. information programme for seniors broadcast on Channel 10. Originally a project of Simon Fraser University, it
is now produced by seniors who have obtained a New Horizons grant.

Finally, there are voluntary organizations which give neither funds (Indeed they are fund seekers) nor individual services, but provide an important advocacy role. SPARC of B.C. with wide provincial representation in its board membership is very active in identifying the needs of various groups including the elderly, and in making these needs known to government. It arranges conferences and seminars, conducts surveys, publishes results and advises and activates communities and individuals to recognize and plan to solve their own problems.

The Vancouver Action Resource Centre, a department of the Volunteer Bureau of Greater Vancouver has been operating under a community grant from the Department of Human Resources to provide a province-wide clearing house of information related to voluntary action and to provide consultation and training for volunteer groups.

5. INCOME SECURITY

The present situation with regard to income security is that all Canadians aged sixty-five or over who meet the residency requirements (ten years in Canada) are eligible to receive old age security payments of $137 per month (July 1976) indexed quarterly to the cost of living and regardless of other income or assets. Spouses aged sixty to sixty-five receive an income tested pension. The Canada Pension Plan pays pensions to contributors and survivors. The full retirement pension is 25 per cent of a contributor's averaged adjusted pensionable earnings. (The ceiling was $8,300 in 1976.) Maximum pension was $154.86. A survivor receives 60 per cent of the spouse's pension (maximum $99.51). There is a lump sum death
benefit (maximum $830.00). Contributions are 1.8 per cent of the earnings up to a maximum of $135 per annum by both employer and employee. Income Supplement (maximum ninety-six dollars per month for a single person, eighty-five dollars per month for a married person) is paid to anyone whose income amounts to less than $233 per month ($445 for a couple). Mincome is a B.C. programme available to people over sixty who have resided in B.C. for at least five years, which brings income up to the minimum of $272.07 per single person (i.e. net $49.65). Of the 241,000 senior citizens in the Province in 1975, over 50 per cent had no taxable income. In 1974, when the over-sixty-five population numbered 230,000, 97,000 over sixty-five (42 per cent) and 19,000 aged sixty to sixty-four were in receipt of Mincome. The GAIN programme incorporates an assets test. The government encourages participation in Registered Pension Plans by offering income tax exemptions on contributions up to a maximum of $2,500 per year. Deferred tax relief is available on up to a total of $4,000 per year (maximum is 20 per cent of income) for Registered Pension Plans and Registered Retirement Savings Plan contributions.

6. **HOUSING**

At the time of the 1971 census, of B.C. residents aged sixty-five and over, 92 per cent of rural dwellers and 69 per cent of urban dwellers were home-owners (73.1 per cent altogether). It is fairly uncommon for persons over the age of sixty-five to enter the housing market as buyers and when they do it is normally to sell one house in order to buy more manageable accommodation.

On the other hand, the elderly do move as renters into accommodation
built by government, non-profit organizations or of course regular commercial developers. Few entrepreneurs build housing specially for the elderly. In 1973 only 7 per cent of CMHC loan approvals for housing the elderly went to entrepreneurs [Yudelman, 1974, p. 75] and it is now a much smaller proportion. As well as self-contained units, boarding homes, personal care units and intermediate care units may all be eligible for government aid. S-15(1) of the National Housing Act provides funds directly to non-profit organizations and allows up to a 100 per cent low cost loan (8 per cent amortized over fifty years) with a 10 per cent forgiveness. CMHC does not impose income limitations in projects sponsored by non-profit organizations which cater to special disadvantaged groups such as the elderly whose housing choices in the market are very limited. In B.C. the provincial government allows grants of 33 per cent for self-contained, 35 per cent for hostel places and facilities providing special care. The B.C. Housing Department will purchase the site temporarily, if necessary. Some non-profit organizations continue to manage developments they have built; others hand them over to the B.C. Housing Management Commission. S-40 allows the CMHC to enter into partnership with the Province to directly provide the housing, with a 75 per cent contribution from CMHC, 25 per cent from the Province.

Under S-43, the Corporation lends funds to the Provincial housing bodies who direct the construction of the housing—up to 90 per cent of the capital cost of the project. S-40 and S-43 are public housing, normally with rent geared to income so that no elderly person spends more than 25 per cent of income on rent. CMHC provides 75 per cent of operating deficits
under S-40 and 50 per cent under S-43. Developments (over 7,000 units) are managed by the B.C. Housing Management Commission who use a point system. Needy applicants with at least twelve months' residence in B.C. are given priority and rent is geared to income.

Non-government groups may apply for a grant of up to $10,000 to get a project under way. Loans are available to individuals to buy mobile homes and for home conversions. CMHC may also construct and administer housing on its own account.

There has been more senior citizen housing built in B.C. relative to the population than in any other province. Over 19,000 units had been built with government assistance by the end of 1975. Of those built since 1957, 9,131 were community sponsored and 3,872 government sponsored.

The Provincial grant for the last three years has been about twelve million dollars = ten million dollars for self-contained units and two million dollars for care places.

Many municipalities make specific lands available at nominal taxes or on easy purchase terms for non-profit old person housing and they may refrain from charging property taxes. (Tax exemption was obligatory before 1974.) This can make a difference of twenty dollars to thirty dollars per suite per month.

The Greater Vancouver Housing Department acts as agent for senior government and works with non-profit groups, citizen groups and municipal housing committees. For elderly persons, the Department has tended to build large high-rises which incorporate communal facilities for socialization and recreation. They have also built hostel accommodation for elderly
men in down-town east side Vancouver. By the end of 1975, over 15,000 of the housing units for seniors were in the GVRD. The percentage of low-income households served varied from a low of 8.8 per cent in Delta to a high of 108.4 per cent in Port Coquitlam. [Bairstow, Mercer, 1976, Table I.] In the regional district, it is estimated that about 27,000 elderly low-income households are housed in the private housing market and many experiencing very high housing costs in relation to their incomes. [Bairstow, Mercer, 1976, p. 3.]

Vancouver has now accepted the "fair share" concept first proposed by the Senior Citizens Housing Liaison Committee and has set senior citizen housing targets for local planning areas which will help to rationalize funding decisions. It is hoped by the developers of the concept that it may be accepted also by other municipalities.

Other provisions which benefit elderly renters are the Renters' Tax Credit Programme under which all renters over sixty-five are eligible for a Renters' Tax Credit of eighty dollars. From 1976, depending on income, this could be up to one hundred dollars. The grant to resident homeowners is $250 plus sixty dollars to eighty dollars school tax removal grant. Finally, under the Real Property Tax Deferment Act, anyone over sixty-five can defer taxes payable to a municipality until the property is sold, transferred or left vacant for over ten years.

7. FINANCING

The services which we have described are financed by various levels of government and by voluntary funds.

Each regional hospital district is able to pass money by-laws
authorizing debentures to be issued covering the total cost of one or more hospital projects. (This includes general, rehabilitation, and extended care hospitals.) The Provincial Government pays its share of the amortization costs each year through the Hospital Insurance Service, and each district raises the remainder by taxation. Operating costs in B.C. are met from general provincial revenues and utilization charges. Approximately 50 per cent of agreed costs are reimbursed by the federal government.

Local health services are financed by provincial and municipal governments. The per capita cost of services is now about ten dollars per annum. Municipalities contribute thirty cents (forty cents if there is a home care service) per head. In Greater Vancouver, services operated by the Metropolitan Board are funded 100 per cent by the Province. For services provided by local health departments, funding is approximately 50 per cent local and 50 per cent provincial. In the Capital Region, funding is 70 per cent provincial and 30 per cent local.

Mincome and payment for care in nursing homes and private hospitals and services provided by the Department of Human Resources to people 'in need of assistance' are 50 per cent cost-shared by the federal government. Services and allowances provided to persons other than those technically in need have to be financed entirely by the Provincial Government—e.g. Pharma-care. (To be 'in need' elderly persons must have assets of no more than $1,500, if single, $2,500 for a couple, and income no higher than the O.A.P. + G.I.S.)

In the case of home care, nursing is financed by Health Department,
home maker service by the Department of Human Resources.

In the building of housing and homes for the elderly, CMHC, the Province, regional districts, municipalities and private organizations may all be contributing funds. CMHC and the Provincial Department of Housing subsidize rents. And the Department of Human Resources pays all or part of the fees for nursing homes, intermediate, or personal care for persons who cannot meet the costs themselves.

When it comes to income security, old age security and the G.I.S. are financed through sales, corporation and personal income taxes. The Canada Pension Plan is entirely self-supporting so far in that all benefits and costs are financed by contributions and interest earned from the investment of funds.

In the fiscal year 1975-76, the Department of Human Resources spent $106.2 million on Mincome, $20.4 million on Pharmacare, $4.3 million on housekeeper and homemaker services, and $20.8 million on Adult Care. The $8,810,410 contribution to the cost of keeping 2,600 persons per month in private hospitals and $18,417,750 paid towards the upkeep of 13,000 persons per month in intermediate care presumably includes comfort allowance. Community grants, for which priority is given to projects which show a heavy demand from the public and high community support and use of volunteers amounted to $8.25 million altogether. Of this, $661,878 was allocated to eighteen projects throughout B.C. to provide transportation for handicapped persons and seniors. Another $415,142 went to senior citizen centres—nine in Vancouver, one in North Vancouver, one on the North Shore, one in Victoria and one in Penticton. The City of Vancouver also
dispenses some funds. For example, it gave a grant-in-aid of $127,000 to the Neighbourhood Services Association for 1977 (for services to all age groups). Compared with government funds, voluntary funds form a minor part of financing but may nevertheless provide some very useful services. An organization just beginning to take an interest in the needs of the elderly is the Vancouver Foundation.

The Vancouver Foundation was incorporated in 1950, by Provincial Statute to provide funds for various charitable purposes. In 1974, with capital funds of $40,000,000 it ranked among the first ten Community Foundations in North America. It administered 106 funds and had committees on Cultural Activities, Youth Activities, Education, Child Welfare, and Medical Research Services.

Up till recently, none of its grants has been specifically for the elderly, though there were some to CARS, VON etc. However, in 1976 the Board became aware that the needs of the elderly were among the most often reported, and that they should develop their input in this area; and have for example, made $250,000 available for development of a care facility for the elderly.

Charitable funds are solicited directly by or donated directly to a variety of voluntary organizations. Many organizations however, have delegated fund-raising to the United Way. UCS in 1972 increased their support for Day Care for Older Persons, for Counselling, including of aged persons, of group work services with seniors. Day care support was increased again in 1973 and 1974. In 1975, it allocated $2,739,093 altogether. Of this, $10,000 went to the Adult Day Care Centre on the
North Shore (whose total budgeted revenue was $58,109), $147,500 to the B.C. Division of CARS (total revenue—$1,478,315), $290,000 to Neighbourhood Services Association of Greater Vancouver which has some small programmes for seniors (total budget—$462,250), $33,500 to the VON Richmond-Vancouver (total budget $277,160) and $24,200 to SPARC of B.C. (total budget $205,364). Services for the elderly do not have high priority for 1977. UCS does not fund activities which it considers to be the responsibility of government.

8. ADMINISTRATIVE STRUCTURES

Ministry

Figure 1 shows the present organization of the Health Ministry. The programme consultant in Geriatrics is a member of the 'Departmental Planning and Support Services Group'.

Regional Hospital Districts

The Municipal Act, 1965, provided for the establishment of regional districts in B.C. and by the end of 1968, twenty-eight regional districts had been established. Regions administer services, some statutorily, some on an elective basis, which are considered to be provided more satisfactorily at regional rather than municipal level. Regional Boards are composed of Directors appointed by and from their elected councils in the case of incorporated municipalities, and by direct election from non-municipal areas. Following the Regional Hospital Districts Act, 1967, these Regional Districts also became the Regional Hospital Districts, and the Regional Boards, the Regional Hospital District Boards, who are responsible for regional planning and development of hospital projects, and for obtaining the
necessary funds. Advisory Committees are also set up under the Regional Hospital Districts Act and each Regional Hospital District Board decides on the composition of its advisory board. Often the vice-chairman of the Regional Board is chairman of the Regional Hospital Board. At least 50 per cent of the membership must be non-medical.

The vast majority of Canadian hospitals are still in theory at least 'voluntary organizations' whose affairs are conducted and managed by Hospital Boards elected from the hospital societies.

Health Units are administered by Union Boards of Health composed of publicly elected persons seconded from other bodies such as school boards, member municipalities and regional districts. Each Unit has a Medical Health Officer and may have several assistant directors as well as a nursing supervisor, health inspectors and sundry other professional and non-professional employees. Outside Vancouver and Victoria, staff numbers range from fourteen to fifty-four.

A structure introduced in 1974 was the Community Human Resource and Health Centre. This mechanism for providing health and social services together was advocated in the Foulkes Report but the idea was not received with much enthusiasm, especially by the medical profession, and the Government did not press it, but did set up a Community Human Resources and Health Centre Development Group to help with the development of centres where there was local demand. A CHRHC as envisioned by the Provincial Government was "an organization for the provision of locally planned, controlled and operated health and social services programmes functioning within provincial standards". [Development Group, 1974, p. 2.] The
organization would operate out of one or more facilities but would have a 'one door' approach to the provision of services so that unnecessary referrals between agencies could be reduced and artificial barriers between services eliminated.

PRESENT SITUATION - REVIEW

1. HEALTH SERVICES

Elderly persons in Canada, and B.C. have the same entitlement to health services as persons of any other age, and as far as acute medical care is concerned, if measured by the conventionally accepted health indicators, the care received in B.C. compares favourably with other Canadian provinces and with other countries.

For a start, the life expectancy at birth for males in B.C. is 69.3, which is the same as the Canadian average and makes B.C. rate the fourth in Canada. For females it is 76.7, marginally above the Canadian average and sixth in Canada. [Romeder, McWhinnie, 1974.]

B.C. had six hospital beds per 1,000 in 1974 when the Canadian average was 5.3. In 1973 it had 5.1 short term beds (the Canadian average was 5.4) and 1.7 long term beds per 1,000 (the Canadian average was 1.4). It had more 'rehabilitation, readaptation, convalescent' beds than any other province except Quebec—i.e. 701 out of a Canadian total of 2,712.

In 1971, the average number of days of hospitalization per person was 1.9 in Canada, 1.8 in B.C. For persons aged over sixty-five, it was 8.3 in Canada, 6.7 in B.C. And the charge of four dollars per day should not cause great hardship.
It can be seen from Table I, (1975), that average days of stay, and patient separation and length of stay rates all increase markedly in the older age groups. This is also true of all the regional districts in B.C. except seven where the rates of hospital cases are higher under 1 year and one (Stikine) where two other age groups had longer average length of stay.5

According to the mental health statistics, B.C. at 2.6 per 1,000, has the third highest rate of mental hospital beds in Canada, and the rate of mental hospital first admissions, 877 per 100,000 of population aged sixty and over, was also the third highest in Canada.6 However, there is also now a reasonably high discharge rate, and Social Workers can arrange alternatives to admission.

In 1970, B.C. had 18.9 hostel places approved, per 1,000 population over 65. The Canadian average was 14.9 [Yudelman, 1974].

Since at least 1968, B.C. has consistently had the lowest ratio of population to active physicians being 533:1 in 1975 [Division of Health Services Research and Development, 1976] and the per capita costs of insured services ($71.59) was the highest in Canada in 1975 when the Canadian average was $65.14.

It is difficult to obtain data in Canada on utilization of medical services by age, and figures are not available for B.C. In 1961, (before the introduction of Medicare) 17 per cent of physicians' services were delivered to patients sixty-five and over. (Kohn 1965 p. 301.) Figures from Ontario [Clute 1963] Quebec [Clark, Collishaw, 1975 p. 19] and Saskatchewan8 show that persons aged sixty-five and over consume medical
services, home visits by doctors, hospital visits by family doctors and other services such as chiropractic, at a rate which is considerably above that of persons aged under sixty-five. (Of course they also had the highest rate of disabling and non-disabling illness in 1951, when this was last assessed.)

We do know that in 1974, the elderly, accounting for less than 10 per cent of the population, received 22 per cent of all prescriptions and accounted for 28 per cent of all drug expenditures.

In 1975, B.C. had above the Canadian average rate per population of dietitians, chiropractors, O.T.s and podiatrists. Of sixteen types of health personnel studied for Rollcall (Division of Health Services Research and Development, 1976), all increased in metropolitan areas between 1974 and 1975, except for food supervisors, and in non-metropolitan areas, except for public health inspectors and dental laboratory technicians. Apart from podiatrists, O.T.s and dietitians, health care personnel were fairly well dispersed throughout the Province, though taking twenty-five types of health personnel, Stiking was "underdeveloped" for twenty-one, Ocean Falls for eighteen, and Mount Waddington for sixteen.

In the nursing care programme in 1973 (excluding special home care projects) patients aged sixty-five and over received 65.9 per cent of visits. They made up 31.4 per cent of patients discharged from special home care programmes in the Province. They received 58 per cent of the homemaker services subsidized by the Department of Human Resources. They were more or less the only recipients of meals-on-wheels. And at CARS, they received 60 per cent of physiotherapy time and 50 per cent of O.T.
time.

However, such statistics say little about the quality and appropriateness of care and most are measures of input rather than output.

There are many ways in which the acute hospital with its rapid tempo and emphasis on recovery and cure does not suit the slower pace of the elderly and their tendency to suffer from chronic and long-term illnesses. There is little provision for activation; some hospitals don't have O.T.s or speech therapists on staff; so that some elderly persons obliged to occupy an acute bed for several months while waiting for alternative accommodation, may actually deteriorate. Convalescent areas are not favoured in B.C. even though hospital staff tend to believe that many older people who take longer than young people to recover from an operation, could benefit from a convalescent period to 'catch their wind'.

A few personal care homes provide convalescent care for as little as thirteen dollars a day, but the Government will not pay for private hospital care if the person's home (an asset) is temporarily empty.

It is generally believed that many more elderly patients could benefit from rehabilitation if it were available. (The Royal Commission on Health Services recommended 0.5 beds per 1,000 population.) Even for Holy Family Hospital which offers a well thought-out programme, there is nevertheless a four to eight week waiting time during which the older person occupies an acute bed or waits at home—in both cases probably without activation.

Whilst the Province may now have the 'recommended' number of extended care beds (though how does one judge this if waiting time for
some hospitals can still be over a year?) acute hospital beds may still be occupied for many months by patients on the waiting lists with the alternative being a private hospital bed. People who are in their own homes while waiting for admission are not visited till their names come to the top of the list, which in West End Vancouver may be eighteen months, and it may be only at this point that they learn that for some reason they are ineligible. Few extended care hospitals, if any, have the recommended quota of one therapist for every seventy-five patients and patients do not seem to be expected to improve to a point where they could perhaps be discharged. The criteria for admission are so stringent as to exclude some persons who may need nursing care only so that there is a group, falling between extended and intermediate care, which is not really provided for—-that is, if one is to continue to allocate people to the different levels entirely according to their medical status as the current classification dictates.

Provision of intermediate care is also generally considered inadequate. And there are few examples of multi-level facilities though these seem to be appreciated by the elderly.

There are marked anomalies between the charge to the patient of different levels of care—from four dollars per day in the acute and extended care hospital to ten dollars per day in intermediate care, up to $600 per month in a personal care home and $900 in a private nursing home.

And facilities are unevenly distributed. Four Regional districts for example—Sunshine Coast, Mount Waddington, Ocean Falls, Kitimat-Stikine have no community care facilities at all, and 3 more have only one facility. Surrey is said to be low in private hospital and extended care beds but
well provided with intermediate level care with plenty of good local
guest houses and rest homes, and good community facilities for old
people. In Whiterock, there is no private nursing home so that anyone
admitted to a nursing home may be separated from a spouse in an area
where transportation is a problem also. Although the average length of
stay in the facilities which do exist in B.C., is six months, many lack
any arrangements for therapy, recreation, or volunteer activity. Licens­
ing standards refer only to physical requirements and there is no real
way of supervising the quality of care in these institutions.

Foulkes [1973 Tome V p. 116] refers to a survey of private
hospitals in B.C. carried out by BCHIS which showed that "the standards
of administration, bedside records, etc. are very much lower than those
encountered in the general hospitals of the province". A study done in
Kelowna found that 63.3 per cent of patients in private hospitals and
boarding homes had no hobbies—not even reading, and 25 per cent did not
interact with any other residents. It was questioned if the high use of
medications meant that psychotropic drugs were taking the place of
occupational and diversionary therapy. (Kelowna Medical Society and South
Okanagan Union Board of Health 1973.)

It is not only the privately-owned institutions which are low in
provision for recreation. Dogwood Lodge (152 residents) has one OT and a
Recreational Director, no activity aides (Government funding was refused)
and eight attendants, part of whose time is spent on 'activity'. At
Burnaby there is no O.T. or Recreational Therapist.

Staff of several acute hospitals complain about difficulty in
'placing' psychiatric patients aged between sixty-five and seventy, particularly if they are suffering from organic brain syndrome or symptoms resulting from alcoholism or other long term conditions. Very little of the mental health services provided in the community go to the elderly.

In fact very few community health services of any kind are available to the elderly—clinics, outpatient treatment, etc. Even when services exist, they may not be available or accessible in certain places or at certain times. In Vancouver in 1969 for example, 45.6 per cent of Vancouver physicians were in Fairview and 18.4 per cent in the Central Business District [Morgan, Mansfield, 1969].

Probably the community service which is most lacking and which could make one of the biggest contributions to allowing the elderly to gain access to services and to function more independently, is suitable transportation.

Items like eye glasses, dentures, artificial limbs, braces, etc. all have to be paid for by elderly persons unless they are in receipt of Mincome.

The structure and financing of the health care system is not conducive to preventive care. If it is practised anywhere it is in health units—yet in 1974 there were only seventeen physicians and 377 nurses employed in health units in B.C. When nurses have been employed full time, or part time in Senior citizens housing developments, they are kept fully employed and also divert some people from doctors and hospitals but there are few such positions in the Province.

Whilst we noted an above average supply of physicians in B.C. (and this is true even of Medical Health Officers) the Province has a below average supply of physiotherapists (almost half the national average),
L.P.N.s and R.N.s—all personnel who are important in caring for the elderly. There is almost a complete absence of geriatricians and psycho-geriatricians.

2. SOCIAL SERVICES

There are almost no personal social services provided by government for the elderly, except to those who technically qualify as being 'in need'. Self-help voluntary organizations for the elderly tend to be more like clubs. Their funds are derived from membership fees and not from public support on the whole. As clubs, offering social and recreational activities, they obviously perform a valuable function for people who enjoy this sort of involvement (a minority of the elderly, that is). The Federated Legislative Council in B.C. has obtained a few concessions for the elderly, e.g. agreement for people to go directly to a denturist instead of a dentist, an arrangement with a Victoria hearing-aid supplier for modestly priced aids. They may point out arrangements which are unsuitable for the elderly, e.g. the locations of some senior citizen housing—but this is reaction to faits accomplis. They do not seem to be consulted at the planning stage of services. Also, though they have access to the provincial government, and as a member of the National Pensioners' Association of Canada, can have the ear of Marc Lalonde once a year, this smacks of tokenism. There is no evidence that these pensioners' organizations achieve changes in legislation or policy and in fact they themselves seem to consider it an achievement just to receive an audience. In other words, they do not seem to have any real power as political pressure groups. Unlike their counterparts in the U.S. they are quite unmilitant. In fact, the FLC prefers to maintain an a-
political stance. Though strong in number of votes, they feel that they have "no way of demanding". Some elderly people, and often this means the white collar types who hold executive office in these organizations, are very hard on their contemporaries. And of course that generation tends to be very much in favour of independence; so they may not always be the most convinced advocates of improved treatment of the elderly.

Most voluntary organizations concerned with the elderly in B.C. are providers of service or of funds for obtaining service. Organizations like the Kinsmen, Rotarians, etc. are at the mercy of charitable giving but on the other hand, as they have no fixed commitments, can tailor their activities to fit their resources. Organizations which have programmes, from CARS to a four-person transportation organization are much more in need of a guarantee of regular funding; yet they don't have this, either with regard to charitable giving or even in the form of government grants which have to be applied for anew every year.

3. **INCOME**

In both 1961 and 1971 B.C. after Ontario had the lowest population of poor elderly in Canada. [Bairstow, 1973 pp. 61 and 78.] But the number of elderly with annual incomes below $2,000 has scarcely changed in Vancouver, Victoria and New Westminster between 1961 and 1971 (about 50,000 in both years) although $2,000 was worth much less in 1971, and was well below the unofficial Statistics Canada low-income cut-off in both years.

In 1973, 51 per cent of the retired in B.C. were eligible for Guaranteed Income Supplement. (In other words, they had no income other than the old age pension.) The present GAINS allowance does bring people
above the poverty line. The maximum sum to which a single elderly person is entitled is now $272.07 per month. However, it is still only enough for basic needs—and indeed, a single person would find it hard to pay an unsubsidized rent out of GAINS. Rent increases (even at or below the statutory maximum of 10.6 per cent) are the most common cause for which elderly persons appeal to the B.C. rentalsman.

Increased prices generally are the main source of the complaints brought by the elderly to the federal Department of Consumer and Corporate Affairs.

A 1975 study showed that when Mincome was $243, the average single elderly homeowner spent $236 per month on housing, food and utilities and overall expenditure was 119.9 per cent of income; single renters spent 99.5 per cent of income. Couples did better because they shared the rent. [Bairstow 1976.] (Pensions are at least indexed to the cost of living. Private pension plans do not carry this guarantee.)

Of the people surveyed for the report Housing Needs and Expenditure Patterns of the Low-income Elderly in B.C., 1976; 45 per cent were not satisfied with their monthly income. The most repeated figure for desired monthly income seemed to be $600 for a couple and at least $300 for a single person ($350 in the Okanagan and Northern B.C.). (Bairstow 1976)

4. HOUSING

Costs seem to be the main problem actually with regard to the housing of the elderly. 77 per cent of persons on the B.C. Housing Management Commission's waiting list are on the list because their present housing costs are too high in relation to income (i.e. over 25 per cent to
30 per cent of income). The average homeowner couple in 1975 were spending $172 (35 per cent of combined income) on shelter (principle, interest, taxes and repairs), the average single person spent $115 (45 per cent). For renters the proportion of income spent thus was 25.7 per cent for couples, and 38.6 per cent for single persons [Bairstow, 1976]. 87 per cent of the respondents in the Bairstow study were satisfied with their housing; many of the dissatisfied were in accommodation that was too large. Many of the homeowners who were living alone were on a waiting list for senior citizen housing in smaller units because they could not afford to keep up their own homes. (The importance of finance should not be allowed to obscure the fact that elderly persons of all income groups require convenient accommodation). About 25 per cent of persons appealing to the Rent Review Commission are aged sixty-five and over and most of them are complaining about rent increases below the permitted maximum of 10.6 per cent because they say that their pensions just won't cover them.

Compared with other provinces, B.C. has a good record in the provision of housing for the elderly (forty dwelling units per 1,000 over sixty-five in 1973) but the public housing is all in metropolitan areas and the total provision falls far short of the demand. In fact, there is little evidence that housing is a high priority with the B.C. government. In 1975, the Provincial budget for special care senior housing was so low that in the whole of B.C. only two 125-bed projects in the north were funded. Also, seniors are competing with low-income families for grant money. There are over 20,000 units for seniors in B.C. now. Over 100,000 renters in B.C. are over sixty; 60,000 of these are poor. There are another 37,000 'poor'
homeowners [Bairstow, 1976]. But there is no policy as to the percentage for whom the government should attempt to build—complete uncertainty as to what the target should be. To date, funding to non-profit groups has been reactive so that complexes have been built without regard to location. It is thought for example that the Burnaby community may now be oversupplied by 1,000 places. Applications for funds from non-profit societies far exceed government budgets but to date it is difficult to find any rationale in the way in which decisions were made.

One effort at rationalization in the Province has been the Senior Citizens' Housing Liaison Committee organized by the Centre for Continuing Education at UBC and the CMHC. The group which consisted of individuals representative of different levels of government concerned with housing for older people, and other interested citizens, undertook a project 'Housing for Older People', has produced an "Information Kit" for people wishing to sponsor a project, and is now working with the administrators of non-profit care facilities who are forming an organization. They recently developed the 'fair shares' concept for housing—a means for calculating and comparing the need for senior citizen housing in various municipalities and they are hoping that housing authorities will implement the concept. Recent re-organizational changes in the CMHC, giving more responsibility and resources to field offices, may mean that they are better able to identify and respond to the needs of local areas.

At both federal and provincial levels there is a lack of any comprehensive planning system for senior citizens' accommodation which provides a range of different accommodation types and care levels to meet
varying needs and to allow for some sort of choice.

No one incidentally has to date set up an office or a network of offices where individuals seeking a change of accommodation may go for information, counselling and/or referral.

Summarizing the workshop discussions at the conference of 'Quality of Living in Housing for the Elderly' sponsored by SPARC of B.C. and the Canadian Council on Social Development on October 4, 5, 1974, Jeffrey Paterson, Director of the Housing Programme at the CCSD concluded [SPARC, 1974] that the housing of the elderly was the responsibility of the provincial government which "should prepare comprehensive plans for the accommodation and care of their senior citizens which embrace a range of housing options in a continuum of supportive services, -this to be done in co-operation with the CMHC and DNH&W, provincial departments of health and social services, municipal affairs, labour, citizenship, housing corporations and municipal governments, public and voluntary health and social security and recreation agencies and citizen groups of all types'.

When considering housing for the elderly in Vancouver one should probably give separate attention to the Skid Row area. A study of the area in 1965 by the City of Vancouver Planning Department found that there were about 1,500 men over the age of sixty-five living there, some of whom were sick and disabled. There were already several missions and hostels under voluntary auspices in the area. Since then, the City has built two hostels - Strathcona Lodge and Antoinette Lodge, and a third is planned. However, it appears that many people are still living in hotels and rooming houses which do not meet city by-law standards and are liable to be closed
but which are not eligible for improvement grants or loans because the owners are not non-profit corporations.

At present neither the quantity nor the nature of housing offered seems to match the demand. Waiting lists have already been mentioned. With regard to the type of service provided, it was found that in B.C. in 1972 only 4 per cent of all projects had nurses on staff (19 per cent in Canada). [Audain, 1973.] Few residences provide any sort of health services though doctors and nurses may come in. Many projects are built far from community facilities and services—wherever land is available or is cheap. Some municipalities discourage building of housing for seniors because concentrations of elderly people lead to increased costs for social and health services.

There may be a complete lack of social facilities. Managers and sponsors do not usually see the social well-being of residents as their concern, especially in developments offering self-contained accommodation, and it is stated [Audain, 1973] that in a typical development about 20 per cent of the residents are still leading isolated lives and feeling lonely. Only 14 per cent of occupants of self-contained housing receive friendly visitor visits.

Several studies have in fact come to the conclusion that housing dissatisfaction is primarily a manifestation of an income problem [Bairstow, 1974, 1976; Rosow 1967] and that special housing is not necessary.

Many elderly persons would prefer government subsidy of rent in private accommodation over government-built apartments [Yudelman 1974]. No province in Canada has a fully fledged 'in situ' rent supplement scheme. It is considered to be administratively complicated and to end up by
benefitting landlords. B.C. is the only province with a rent control programme operating.

So far no study appears to have been carried out of the cost differentials between different types of accommodation and social facility and service arrangements.

Bairstow compared the economics for B.C. of government building and shelter allowances. To build 1,750 senior citizen units in B.C. would cost federal and provincial governments approximately forty million dollars. If the average subsidy were to be $150 per unit per month, another $2.6 million would be required. To build units for everyone on the present waiting list whose rents are too high, would cost over $100 million (which might be better spent on multi-level facilities). Whereas if one took the elderly single persons with monthly accommodation costs of ninety-five dollars and subsidized them by the extent that that is in excess of 25 per cent of their income, it would cost $420 per person per annum, at most $1.9 million for everyone on the waiting list whose rents are too high. This sort of solution is not one that to date had been considered by government at any level, until the B.C. announcement in March 1977. (See page 260).

5. PERSONNEL

In spite of the large amount of health resources now devoted to the elderly medical personnel may not be especially interested in caring for the elderly or be fitted to do so. Physicians appear to be more interested in life preservation than in promotion of health or quality of life. Of Canadian medical school graduates between 1959 and 1967, only 30 per cent were in general practice providing primary medical care by 1972. [Greenhill
In a study of 86 general practitioners in Ontario and Nova Scotia in the early 60s, it was found that only one out of eighty-six said that geriatrics was of special interest. [Clute 1963.] It is significant that despite the financial advantage under the fee for service system, of seeing several patients in the same location, it is still said to be difficult to get doctors to visit their patients in the extended care hospitals.

BCMA has no section of geriatrics among its twenty-two sections, nor a geriatric committee among its sixteen Health Planning Council Committees and has carried out no studies of the elderly though the Committee on Chronic Care and Rehabilitation would of course include some provisions for some elderly in its field of interest.

Nurses also seem to see their work as contributing to the cure or management of acute disease. One writer believes that the nursing function has become so technical and impersonal that the nurse in extended care observes psycho-social care as a non-nursing function, resents the involvement and busies herself with mechanical duties because she lacks confidence and knowledge in a people-oriented environment. [McIver, 1973.]

In 1966, all public health nurses in the G.V.A* were given the opportunity to attend in-service training on the aging. Apparently it is nurses in their thirties and forties who are the most willing to work with the elderly. Younger ones are more likely to wish to work with young people. Those who are approaching retirement themselves may already be caring for elderly relatives at home, and also prefer not to be faced with a situation which they may soon be in themselves.

There is no actual shortage of doctors or nurses. When it comes to

* Greater Vancouver Area
therapists who do see a role for themselves in the care of the elderly and are particularly valuable in rehabilitation, or maintenance of persons independently in the community there is a real dearth. Even of those who are employed in the Province, 40 per cent are trained outside Canada. At any one time there are about thirty vacancies advertised in the Province—not to mention the posts there would be if the optimal amount of therapy were to be available in the community and in institutions. UBC has an intake of forty students per year for the four year combined O.T.-P.T. course, and cannot obtain permission to increase this number.

With Social Workers there is a different sort of problem. Social Workers in hospitals take it for granted that more than half their time will be spent on making discharge arrangements for the elderly. Department of Human Resources Social Workers in the community are used to elderly persons in their case load and may see them as more 'deserving' than other categories of persons who receive benefits. However, social workers too have an individualized 'pick up the bits' approach. In a study of all 1971 and 1972 graduates of Canadian Schools of Social Work, Community College Social Services Courses and CEGEPS, it was found that more than 91 per cent were practising in the area of casework or groupwork whereas only 5 per cent were practising in planning, policy and administrative roles only. The writer noted that "the commitment of social services education . . . continues to be overwhelmingly in the direction of remedial and substitutive social services rather than toward social action and social provision'. [Crane, 1974.] Yet social workers could be among those people who point to and help to implement a new orientation for the care of the aged.
Teamwork and interchangeability of personnel are often mentioned as necessary elements of any system of health care for the elderly. Nurses are well aware of how much more responsibility they could be taking—and are taking in the north for example, where there aren't doctors. But as nurses are registered, not licensed, and as the federal government cost-shares the cost of care by a physician only, it is difficult under the present system to allow nurses to become involved in diagnosis and treatment as nurse practitioners. The director of Rehabilitation Medicine at UBC considers that with the sort of training they receive nowadays, therapists and social workers employed in the community, could also be primary diagnosticians in the care of the elderly. Doctors do not take easily to the idea of teamwork either (vide the hostile reaction to the Hastings Report). This might require a less hierarchical view of health professionals. In fact the status of care of the elderly may not improve until the hierarchical view of 'levels' of care changes also. The elderly cannot be best served either where there is rigid adherence to function, or rigid demand for formal qualifications for jobs which do not really require them.

Education—The orientation of health professionals is no doubt heavily influenced by their education. Medical education for example tends to emphasize details of unusual diseases but make no mention of the social system. It is generally believed that education would also bring about more understanding of the elderly and their needs, and therefore more interest in working with them. At present in B.C. there is little on the elderly in the undergraduate medical course, senior residents in the family practice programmes spend one month in a geriatrics residency at Shaughnessy,
nurses are considered to obtain experience of geriatric care in various clinical settings, social workers have education specific to geriatrics/gerontology in their Human Behaviour and Social Environment sequence. People who are concerned about the care of the elderly consider that the geriatrics component in the education of all health and social care personnel could profitably be increased. This would undoubtedly bring better understanding of the elderly. And people who are to work mainly in the community would also need training for that medium. Whether personal attitudes to aging and the aged can be changed by education is, in the opinion of the writer, a moot point, or at best one that has still to be demonstrated. The formal education system may have little effect against the attitudes which pervade the whole of society.

6. LACK OF CO-ORDINATION, PLANNING

In the health field there is no body with the responsibility for looking at all levels of care, including home care, together, and deciding which one is most appropriate for any particular individual. Some people believe that in Britain the family doctor is best placed to mobilize and co-ordinate health and welfare services in the interests of any one individual [British Medical Association Standing Medical Advisory Committee, 1963] but the fee for service option makes this even less feasible in Canada than in Britain and anyway at present there are fewer welfare services to mobilize.

Nor is there one body responsible for deciding on the amount and location of the different services seen in a co-ordinated way. The present system is self-perpetuating and not conducive to the search for new solutions. For example the need for more acute hospital beds is deduced
from hospital utilization. It is not the responsibility of the hospital service to consider alternatives to acute hospital care. An example of a service where a fair amount of co-ordination and integration is achieved is the mental health field where there is more integration between the hospital and community services than is the case with the physically ill.

The consultant in geriatrics appointed to the Ministry of Health in 1975 acts in an advisory capacity. It is the Deputy Ministers who are in charge of the allocation of funds to the different services and categories.

There are not many fields where the Department of Human Resources has enough direction or autonomy to do much planning on its own. So many services depend on cost-sharing agreements and on the technical state of 'need'. In the matter of accommodation it cannot decide what facilities can be built but is only involved in operating costs. One example of priority setting at the local level is with community grants. Societies submit applications through local offices of the Department of Human Resources. Submissions are considered by the local office and Community Resource Board if there is one, before being forwarded to the Regional Director, so as to avoid duplication and fragmentation and to assure that they fall within departmental priority guidelines. The Regional Director reviews them again and sends them on to the Community Programs Division in Victoria. In this way, the non-statutory services required are determined by the people most knowledgeable about the unique needs of a community and region.

There is a tendency for private agencies to provide services in an arbitrary and unsupervised fashion with little public accountability. The sort of evaluation done by UCS can be applied only to its member agencies. Government funding of voluntary agencies (like housing) appears to be reactive
rather than according to defined policy. If North Shore Vancouver can organize several facilities for the elderly which apply for funding, they will all be considered, whereas other areas may not have the necessary skills to make the original request.

There is no formal mechanism either for co-operation between different departments or ministries or for any overall planning which encompasses more than one of these. In Vancouver, the Welfare Department was originally responsible for chronic care, from 1936 public health nurses were employed by the Department to look after the boarding home programme, and there were two doctors and two nurses employed in the Medical Section. Later when the Medical Section became the Department of Health Care and Aging, it was staffed by social workers and seconded nurses. Since the provincial takeover of the Department of Human Resources, the boundaries of health and welfare areas are no longer co-terminous in Vancouver and the 'health care teams' which dealt with a variety of needs, no longer exist. Nowadays even home helps who may recognize various needs or potential needs would not know who if anyone could deal with them. There are not many centres like the Marpole Centre in Vancouver where the Day Centre is housed in the same building as the Resources Board office, and homemaker and meal-on-wheels service.

Even the departments involved in planning, licensing, operating and financing care facilities do not have joint committees so that areas of responsibility may not be clearly established nor common aims clarified. And of course present financing arrangements provide no incentive for one department (e.g. Human Resources) to direct more funds to services which will
contribute to economies in another department (e.g. Health).

7. **EVALUATION**

In Canada and B.C. it is possible to obtain detailed and accurate vital statistics on births and deaths, the causes of death and the age and sex and location at time of death. Similarly, statistics are available on the number of people in hospital and the nature of the conditions treated. (Statistics on morbidity are not available later than the 1951 survey and even the B.C. Handicapped Register is quite unreliable on numbers of adult handicapped.) *'A New Perspective on the Health of Canadians’ (p. 26)* cites three overall indicators of the level of health services—the ratio of various health professionals to the total population, the ratio of treatment facilities to the population, and the extent of prepaid coverage. Looking at these figures, Canada is seen to be 'among the world leaders for health care services'. [Lalonde, 1974]

But measures of mortality and morbidity say nothing on the quality of life and are probably no longer really appropriate in a developed country as indices of health care. To measure personnel is to concentrate on inputs. We have no way of measuring the effects of these inputs—or the efforts of different types of personnel (or when we do have methods, because there has been some differential cost-benefit analysis, we don't take advantage of them). The amount of technical equipment or precision of methods used is also often considered a measure of quality. Thought is rarely given to accessibility or efficiency of distribution as indicators. In any case whose objectives should one be meeting—that of the health care provider who believes in high technical quality of care—or that of the
elderly patient who may have different priorities? Standards of care too, may be measures of the service provided. We have no measures of the service received.

The question of evaluation is important for several reasons. We may have to rethink what we should be evaluating. Evaluation should be against standards or priorities, but whose standards and priorities? Having decided what is important we have to consider how we can evaluate. And finally, how you evaluate, how you collect statistics, influences the services provided and the way in which staff and administrators think. If a short average length of stay seems a recommendation, they will get short stays, if low mortality rates are important, they will fight to keep alive people who are fighting to be allowed to die. And if the number of intermediate care beds you provide is going to satisfy the demands of all sorts of professionals and other experts, who is going to put their money into home care?

In this chapter we have looked at what is presently being provided to meet the health and allied needs of the elderly. The provisions have developed over the years sometimes in response to the perceived or expressed needs of the elderly, but more often coincidentally. The elderly population for whom the services have been provided has changed over the years also—not only in numbers but in response to a whole complex of economic, technological, sociological and psychological factors. In the next chapter we shall attempt to arrive at some understanding of the nature of the elderly population for whom we are providing services in this day and age.
From there we shall attempt to identify the needs of the present generation(s) of elderly with a view to considering later how well the present arrangements meet those needs.
NOTES

1 'See the British Columbia Classification of Types of Health Care, B.C. Department of Health, September 1973.

2 Twenty beds in Surrey Memorial Hospital, thirty-one at the Royal Columbian, sixteen used as rehabilitation beds in St. Paul's. Since then, ward C8-9 of the Heather Pavilion, V.G.H. has been set aside as a Rehabilitation Unit.

3 Vancouver Province, July 12, 1975 p. 13.


10 In the U.S., a national organization, the Grey Panthers, has been formed to combat age discrimination.

11 Interview with Mr. Frank Way, president of F.L.C. on 3rd May, 1976.
### TABLE I

**HOSPITALIZATION BY SEX AND AGE FOR ALL PERSONS HOSPITALIZED IN B.C., 1975**

<table>
<thead>
<tr>
<th>Age</th>
<th>Population (percentage distribution)</th>
<th>Average days stay</th>
<th>Separations during year</th>
<th>Patient days since admission</th>
<th>Population (percentage distribution)</th>
<th>Average days stay</th>
<th>Separations during year</th>
<th>Patient days since admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>-excluding newborn</td>
<td>100.0</td>
<td>9.6</td>
<td>140.2</td>
<td>1,346.1</td>
<td>100.0</td>
<td>8.4</td>
<td>187.4</td>
<td>1,574.2</td>
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<tr>
<td>-including newborn</td>
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<td>9.3</td>
<td>155.2</td>
<td>1,435.9</td>
<td>8.2</td>
<td>201.9</td>
<td>1,658.4</td>
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<tr>
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<td>4.8</td>
<td>11.0</td>
<td>182.1</td>
<td>1,999.2</td>
</tr>
<tr>
<td>60 - 64</td>
<td>4.0</td>
<td>11.5</td>
<td>250.7</td>
<td>2,883.3</td>
<td>4.4</td>
<td>11.9</td>
<td>200.8</td>
<td>2,397.8</td>
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<tr>
<td>65 - 69</td>
<td>3.1</td>
<td>13.2</td>
<td>295.1</td>
<td>3,884.7</td>
<td>3.3</td>
<td>13.1</td>
<td>232.1</td>
<td>3,046.5</td>
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<tr>
<td>70 - 74</td>
<td>2.3</td>
<td>14.0</td>
<td>353.3</td>
<td>4,956.0</td>
<td>2.5</td>
<td>14.3</td>
<td>262.4</td>
<td>3,754.2</td>
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<tr>
<td>75 - 79</td>
<td>1.4</td>
<td>15.0</td>
<td>430.3</td>
<td>6,478.2</td>
<td>2.0</td>
<td>16.5</td>
<td>298.4</td>
<td>4,916.4</td>
</tr>
<tr>
<td>80 - 84</td>
<td>0.9</td>
<td>16.7</td>
<td>492.5</td>
<td>8,205.1</td>
<td>1.4</td>
<td>18.9</td>
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<td>6,533.8</td>
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<td>85+</td>
<td>0.7</td>
<td>18.7</td>
<td>570.1</td>
<td>10,663.2</td>
<td>1.2</td>
<td>20.4</td>
<td>368.2</td>
<td>7,496.8</td>
</tr>
</tbody>
</table>

Source: Research Division, Hospital Programmes, Department of Health, Victoria, Statistics of Hospital Cases Discharged during 1975, B.C., Table 2, pp 14, 15, 16, 17
CHAPTER IV

THE ELDERLY POPULATION

Everyone who writes about the elderly agrees that there is no one age at which everyone becomes "elderly" and neither do different aspects or systems of one person begin to slow down or deteriorate at the same time or the same rate. However, for the purposes of study, most people end up by choosing the age of sixty-five as the one at which old age is considered to begin and we follow that custom. It is the official retirement age for pension purposes and a cut-off point of many statistics. We use it, recognizing that chronological age may be a poor indication of the need of service for the elderly.

Aging Populations - Selected Countries and Canada

At the second B.C. Conference on Aging, Ralph Goldman presented a table which shows how average length of life has increased over the ages. (Table II)

This means that life expectancy at birth has also risen. The Economic Council of Canada included in its 11th Annual Review, tables showing comparative recent figures for some selected countries, (Table III A) and comparative figures for Canada and the provinces from 1931 to 1971. (Table III B)

The increase in life expectancy can be attributed to such factors as lowered infant mortality rates, control of infectious diseases and other environmental hazards, advances in medicine, improved access to medical care,
higher living standards (nutrition, housing) etc.

This increase in longevity has meant that in the countries where it has taken place, there has been eventually also an increase in the numbers and proportion of elderly (people aged sixty-five and over) in the population. In Britain the proportion of old people more than doubled between 1901 and 1961. [Sumner and Smith, 1969, p. 31.] Between 1960 and 1970, the proportion rose from over 12 per cent to over 13 per cent in Sweden and France, from over 11 per cent to over 12 per cent in England and Wales, over 10 per cent to over 12 per cent in Norway and Denmark and from 9.3 per cent to 9.87 per cent in the U.S. [UN, 1963, 1972.]

Comparative figures for some selected countries are given in Table IV. Canada's lower percentage in the past has resulted largely from higher birth and immigration rates than those of countries with more settled populations, but its percentage is increasing also now, and a falling birth rate accentuates the proportional increase in the number of elderly. (Table V) There has been a substantial increase even since the last census. (In 1901, the proportion was 5 per cent.)

The population projected for 1986 is shown in Table VI. At that time, the number of people aged sixty-five and over is expected to be almost 50 per cent higher than the 1971 figure, and to represent 9.8 per cent of the population.

Statistics Canada projects for later years, an elderly population which continues to increase but at a slower rate after 1986 (Table VII).

It is frequently pointed out that if the present low fertility rates continue, in future years, a decreasing proportion of working people
and tax payers will have to care for and support increasing numbers of elderly. As the proportion of the population aged nineteen years or less is expected to decrease even more, the total dependency rate (proportion of people aged nineteen years or less and sixty-five or more, compared with the proportion aged twenty to sixty-four) should fall. (Table VII.)

Whilst a precise calculation would be difficult if not impossible, the increase in the aged dependency rate should be at least partly compensated for by the decrease in the other—though numbers are not complete measures of dependency needs which may be greater as the number of very aged increases.

The Elderly Population of B.C.—Numbers and Location—From Table IX, it can be seen that people aged sixty-five and over form a higher proportion of the population in B.C. than the Canadian average, but that the B.C. figure is expected to equal the Canadian average in 1986. In 1971, the Province had 10.1 per cent of the Canadian population, 11.8 per cent of the population over sixty-five. [Audain, 1973 p. 38.]

For four selected years, Table X gives a breakdown into five year age groups from fifty years onwards, so as to include the cohorts who will proceed to become the elderly in five, ten and fifteen years. Figure 2 and Table XI show the total population breakdown. From Table X, it can be deduced that over time, it is in the oldest age group that the largest proportional increases will occur. (Table XII.) Also the discrepancies in the survival rates of men and women can be seen to be expected to increase, both with age, and over time. Even though by 1985, and in 1990 up to the age of sixty, males are expected to outnumber females the proportion is
reversed for those over sixty. There will be more than twice as many females as males over eighty-five by 1985, and the proportion of women in all the age groups over sixty is higher by 1980.

B.C. Research also provides a breakdown in five year age groups up to age 70+ annually from 1974 to 1981 and from 1986 to 1991, for each regional district in the Province. [B.C. Research, 1974.]

Figures 3 and 4 are derived from some of these data.

The main concentrations of the elderly are expected to be in the southern rim of the Province and the lower quarter of Vancouver Island. Table XII shows the proportion of population aged sixty-five and over in some municipalities in 1961 and 1971.

Victoria and Vancouver are unique in Canada, in that net in-migration ratios for age groups sixty-five to 75+ are higher than 10 per cent (or were up until 1969 at least), the majority coming from the Prairies. [Capital Region Planning Board of B.C., 1969.]

In the Livable Region 1976/1986, the GVRD has produced forecasts by age group to 2001 and trends and targets by municipality to 1986. [GVRD Planning Department, 1975.] Population pyramids vary considerably from one municipality to another (Figure 5.)

It is also possible to have the 1971 population in five year groups up to age twenty-four, ten year groups up to age sixty-four, the number aged sixty-five to sixty-nine and seventy over in 200 census tracts. This means that one can have highly localized figures regarding the distribution of the elderly—though it is doubtful if such figures are completely valid for long [Priest, 1970].
CHARACTERISTICS OF THE ELDERLY POPULATION

We propose now to consider some characteristics of the elderly population—in Canada and more particularly in B.C.

Sex and Marital Status—Up to and including the 1951 census, in Canada the total population and the population aged sixty-five and over, had a slightly higher proportion of males. This was still true in 1961 in B.C. By 1973, there was a slight preponderance of females in the total population of the country and the Province, and a considerable preponderance in the age sixty-five and over group, which increased with age. Because more women survive into the older age groups and because, as census data testify, most men marry women in the next lower five year age group, more older women than men are likely to have lost a spouse. By age seventy, widows outnumber married women.1

Table XIII shows the population sixty and over, by five year age groups, sex and marital status for British Columbia in 1971.

Accommodation—In 1971, of the sixty-five and over population in B.C., 81.7 per cent lived in urban areas, 18.3 per cent in rural. 92 per cent of these rural dwellers and 69 per cent of the urban dwellers owned their homes. [Statistics Canada, 1972.]

In a study of the housing needs of the elderly in B.C. it was found that 30 per cent were married and the rest alone [Bairstow, 1976]. 40 per cent were home owners, 60 per cent renters (The proportion of owners was much higher in rural areas which offer little or no rented accommodation.) 52 per cent of owners were married, though in Victoria 67 per cent of owners lived alone. 46 per cent in B.C., 59 per cent in Vancouver and 57 per cent in
Victoria lived alone. 29 per cent in B.C. lived with a spouse (more in rural areas, less in the cities) 13.5 per cent lived with a child (25.4 per cent - the highest rate in metro Vancouver). In B.C. 52 per cent lived in single family homes, 30 per cent in apartments, 10 per cent in hostel units or care homes. 35 per cent were one-bedroom, 33 per cent two-bedroom, 16 per cent three-bedroom and 16 per cent bachelor apartments. All the evidence suggests that most elderly people prefer to live as long as possible in their own homes - near but not with their families, if possible.

More elderly women than men live alone, and more women than men move in with adult children.\(^2\)

The 1971 census returns show that of family heads over sixty-five, not maintaining their own households, in British Columbia, almost 87 per cent of women and 69 per cent of men were living with relatives, confirming, as so many writers have maintained that for younger adults to care for their elderly relatives is not a thing of the past.\(^3\) Another result of the age/sex distribution is that men who have outlived their wives and are now alone may be very old. 42 per cent of this category were aged over eighty in Victoria in 1969 and most were over seventy-five. [Capital Region Planning Board of B.C. 1969, p. 28.]

Employment—Though the official retirement age and the age of eligibility for old age pension, Canada Pension Plan etc. is sixty-five, some people continue to work after that age, or at least to register for employment, less now than formerly for men, more for women. The average age at application for the Canada Pension Plan in 1973 was sixty-seven [SPARC, 1974]. Employment rates for males of all ages declined from 85 per cent to
78.8 per cent in Canada between 1950 and 1963, the biggest decrease being in the 65+ group—from 40.4 per cent to 26.3 per cent. (The only other decrease was in the fourteen to twenty-four group.) Among women, the total rate rose from 23.2 per cent to 29.6 per cent, rising in all groups except under nineteens, and rising in the 65+ group from 4.2 per cent to 5.8 per cent. [Martin, 1970, p. 84] By 1974, the unemployment rate among people 65+ was 5.4 per cent and the participation rates were 17.8 per cent for males and 4.2 per cent for females. In B.C. the participation rates in 1971 and 1974 were 8.8 per cent and 7 per cent respectively, and the unemployment rates were 7 per cent and 7.3 per cent. The participation rate was the lowest in Canada, though Quebec and the Atlantic Provinces have higher unemployment rates [Brown, 1975, pp. 29,30].

Income—Table XIV shows the relative deprivation with regard to income, of those aged 65+. In real terms, their buying power has not increased. Elderly median income had risen in ten years from 35 per cent of total median to 44 per cent. The number of elderly people with incomes below $2,000 scarcely changed between 1961 and 1971, in Canada or in B.C. (where the number of people involved dropped from just over 125,000 to almost 119,000 (57.9 per cent)) [Bairstow, 1976, p. 62]. The municipalities of New Westminster and Victoria have some of the lowest proportions of elderly with incomes below $2,000 in Canada (reflecting the elderly retirees). In Vancouver, on the other hand, 39,300 (68.4 per cent) had incomes below $2,000 [Bairstow, 1976, pp. 76,77].

As further evidence of the number of people with minimal incomes, in 1972, of 206,455 OAS pensioners in B.C., 100,460 (48.7 per cent) had no Guaranteed Income Supplement, 57,792 (28 per cent) had partial G.I.S. and
48,203 (23.3 per cent) had full GIS [DHH&W 1972].

In 1974, of 230,000 "Seniors", 97,000 (42 per cent) were in receipt of Mincome. [SPARC 1974 p. 1.]

What we have then is a group of people, the majority of whom are fit and active who are mostly obliged to retire from the work force at age sixty-five, which many find demoralizing and for whom one of the main problems is inadequate income, particularly to meet market rents.

We know that this group is an important consumer of health services, which are the most expensive of the government-financed services which they receive. And we know that this group is going to increase in size, especially the oldest part of the group who (those over age seventy-five), make the heaviest demand on services, at the same time as there is a decline in the proportion of people comprising the work force who generate the taxes which finance the various services. If 1971 patterns of hospitalization for example were to continue, and if the distribution of diseases in the population remained unchanged, in 2001, the group aged sixty-five and over would utilize 53 per cent of all patient days, and in 2031, 72.4 per cent [Rombout, 1975].

If the discrepancies in the survival rates of older men and women increase as anticipated, there will be more widows in the population i.e. people without the immediate support of a spouse, and also more people who wish to remain in the community since women on their own are less liable than men to give up their own home, and when they do are more likely than men to move in with children rather than into institutions.
We also know that if necessary we can obtain predictions about future population sizes by age group for quite small areas if a plan necessitates a localized approach.

We now propose to look at what appear to be the needs of the elderly at this time with a view to considering whether the services provided meet these needs in the most appropriate (including economical) way, and what the implications are now and for the future if they do not.
NOTES

1 Statistics Canada 1971 Census Book 2-2 pp. 61-65.

2 21 per cent women and 11 per cent men over seventy-five according to Health and Welfare Canada Staff Papers. Long Range Health Planning, May 1975, p. 9.

### TABLE II

Average Length of Life

<table>
<thead>
<tr>
<th>Period</th>
<th>Length of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Iron &amp; Bronze Age, Greece</td>
<td>18 years</td>
</tr>
<tr>
<td>2000 years ago, Rome</td>
<td>22 years</td>
</tr>
<tr>
<td>Middle Ages, England</td>
<td>35 years</td>
</tr>
<tr>
<td>1687-1691, Breslau</td>
<td>33.5 years</td>
</tr>
<tr>
<td>Before 1789, Mass &amp; N.H.</td>
<td>35.5 years</td>
</tr>
<tr>
<td>1838-1854, England &amp; Wales</td>
<td>40.9 years</td>
</tr>
<tr>
<td>1900-1902, United States</td>
<td>49.2 years</td>
</tr>
<tr>
<td>1945, United States</td>
<td>65.8 years</td>
</tr>
<tr>
<td>1957, United States</td>
<td>69.3 years</td>
</tr>
</tbody>
</table>

(Data from Metropolitan Life Insurance Company)

### TABLE III A

Life Expectancy at Birth in Selected Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Year (or Range)</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweden</td>
<td>1967</td>
<td>71.9</td>
<td>76.5</td>
</tr>
<tr>
<td>Norway</td>
<td>1966-70</td>
<td>71.1</td>
<td>76.8</td>
</tr>
<tr>
<td>Iceland</td>
<td>1961-65</td>
<td>70.8</td>
<td>76.2</td>
</tr>
<tr>
<td>Netherlands</td>
<td>1970</td>
<td>70.7</td>
<td>76.5</td>
</tr>
<tr>
<td>Denmark</td>
<td>1969-70</td>
<td>70.8</td>
<td>75.7</td>
</tr>
<tr>
<td>Switzerland</td>
<td>1958-63</td>
<td>68.7</td>
<td>74.1</td>
</tr>
<tr>
<td></td>
<td>1971</td>
<td>69.3</td>
<td>76.4</td>
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<tr>
<td>Canada</td>
<td>1966-70</td>
<td>68.8</td>
<td>75.2</td>
</tr>
<tr>
<td></td>
<td>1971</td>
<td>69.3</td>
<td>76.4</td>
</tr>
<tr>
<td>France</td>
<td>1970</td>
<td>68.6</td>
<td>76.1</td>
</tr>
<tr>
<td>Japan</td>
<td>1968</td>
<td>69.1</td>
<td>74.3</td>
</tr>
<tr>
<td>England and Wales</td>
<td>1968-70</td>
<td>68.6</td>
<td>74.9</td>
</tr>
<tr>
<td>Australia</td>
<td>1960-62</td>
<td>67.9</td>
<td>74.2</td>
</tr>
<tr>
<td>United States</td>
<td>1971</td>
<td>67.4</td>
<td>74.9</td>
</tr>
<tr>
<td>Federal Republic of Germany</td>
<td>1968-70</td>
<td>67.2</td>
<td>73.4</td>
</tr>
</tbody>
</table>

1 Accidental and violent deaths are included; data are for the most recent years available.


Source: Economic Targets and Social Indicators, Eleventh Annual Review E.C.C. 1974 Table 4 - 10, p82.
### TABLE III B

<table>
<thead>
<tr>
<th>Region</th>
<th>Atlantic Region¹</th>
<th>Prairie Region²</th>
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<td>Canada</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Newfound-land</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prince Edward Island</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nova Scotia</td>
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<tr>
<td></td>
<td>New Brunswick</td>
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</tr>
<tr>
<td></td>
<td>Quebec</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ontario</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manitoba</td>
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</tr>
<tr>
<td></td>
<td>Saskatchewan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alberta</td>
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</tr>
<tr>
<td></td>
<td>British Columbia</td>
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</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Males</th>
<th>Females</th>
<th>Males</th>
<th>Females</th>
<th>Males</th>
<th>Females</th>
<th>Males</th>
<th>Females</th>
<th>Males</th>
<th>Females</th>
<th>Males</th>
<th>Females</th>
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<th>Males</th>
<th>Females</th>
<th>Males</th>
<th>Females</th>
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</thead>
<tbody>
<tr>
<td>1931</td>
<td>61.8(1.8)</td>
<td>62.0(1.8)</td>
<td>57.8(1.6)</td>
<td>63.2(1.9)</td>
<td>65.1(1.6)</td>
<td>64.5(2.4)</td>
<td>66.1(0.4)</td>
<td>66.1(0.8)</td>
<td>67.1(1.7)</td>
<td>66.1(0.4)</td>
<td>67.7(2.7)</td>
<td>66.1(0.4)</td>
<td>67.7(2.7)</td>
<td>66.1(0.4)</td>
<td>67.7(2.7)</td>
<td>66.1(0.4)</td>
<td>67.7(2.7)</td>
<td></td>
</tr>
<tr>
<td>1951</td>
<td>63.2(1.7)</td>
<td>63.5(1.7)</td>
<td>66.2(1.5)</td>
<td>67.3(1.6)</td>
<td>70.1(1.7)</td>
<td>69.3(2.0)</td>
<td>72.9(0.6)</td>
<td>73.3(2.9)</td>
<td>71.1(1.8)</td>
<td>70.5(2.4)</td>
<td>74.9(0.7)</td>
<td>74.7(0.4)</td>
<td>71.1(1.8)</td>
<td>70.5(2.4)</td>
<td>74.9(0.7)</td>
<td>74.7(0.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1961</td>
<td>69.3(1.5)</td>
<td>69.9(2.0)</td>
<td>68.0(1.9)</td>
<td>69.7(1.9)</td>
<td>71.6(1.8)</td>
<td>71.3(2.4)</td>
<td>71.6(1.8)</td>
<td>71.3(2.4)</td>
<td>71.6(1.8)</td>
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<td>71.6(1.8)</td>
<td>71.3(2.4)</td>
<td>71.6(1.8)</td>
<td>71.3(2.4)</td>
<td>71.6(1.8)</td>
<td>71.3(2.4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ The figures in parentheses represent the effect of accidental and violent deaths on life expectancy at birth. Subtracting the figures in parentheses from the figures in their left gives life expectancy at birth, taking all causes of death into account—i.e., the life expectancy figures usually presented.
² Figures for 1931 to 1961 are averages of all the provinces in the region.


### TABLE IV

<table>
<thead>
<tr>
<th>Country</th>
<th>Total Population</th>
<th>Population Aged Over 65</th>
<th>Percentage Aged Over 65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweden (1970)</td>
<td>8,076,903</td>
<td>1,109,327</td>
<td>13.73</td>
</tr>
<tr>
<td>France (1968)</td>
<td>49,654,556</td>
<td>6,662,484</td>
<td>13.41</td>
</tr>
<tr>
<td>Norway (1970)</td>
<td>3,888,305</td>
<td>503,322</td>
<td>12.94</td>
</tr>
<tr>
<td>Denmark (1969)</td>
<td>4,890,687</td>
<td>590,575</td>
<td>12.07</td>
</tr>
<tr>
<td>Netherlands (1970)</td>
<td>13,038,526</td>
<td>1,325,361</td>
<td>10.16</td>
</tr>
<tr>
<td>United States (1970)</td>
<td>203,211,926</td>
<td>20,065,502</td>
<td>9.87</td>
</tr>
<tr>
<td>New Zealand (1969)</td>
<td>2,808,590</td>
<td>236,650</td>
<td>8.42</td>
</tr>
<tr>
<td>Australia (1970)</td>
<td>12,551,707</td>
<td>1,047,778</td>
<td>8.34</td>
</tr>
<tr>
<td>Canada (1971)</td>
<td>21,568,315</td>
<td>1,744,405</td>
<td>8.10</td>
</tr>
</tbody>
</table>

### TABLE V

<table>
<thead>
<tr>
<th>Year</th>
<th>Persons 65 and over</th>
<th>Percentage 65 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td>1,086,400</td>
<td>7.7</td>
</tr>
<tr>
<td>1971</td>
<td>1,744,410</td>
<td>8.1</td>
</tr>
<tr>
<td>1973 (estimated)</td>
<td>1,834,200</td>
<td>8.3</td>
</tr>
</tbody>
</table>

Source: Statistics Canada

### TABLE VI

**Absolute and Relative Increases in the Size of Specified Age Groups, Canada, 1956 - 1971 and 1971 - 1986**

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number</th>
<th>Per cent change from 1956 to 1971</th>
<th>Number</th>
<th>Per cent change from 1971 to 1986</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19 years</td>
<td>6,383</td>
<td>8,495</td>
<td>7,430</td>
<td>9,432</td>
</tr>
<tr>
<td>20-44</td>
<td>4,018</td>
<td>6,028</td>
<td>5,053</td>
<td>5,053</td>
</tr>
<tr>
<td>45-64</td>
<td>2,766</td>
<td>4,023</td>
<td>4,723</td>
<td>4,793</td>
</tr>
<tr>
<td>65+</td>
<td>1,244</td>
<td>1,745</td>
<td>2,566</td>
<td>2,566</td>
</tr>
<tr>
<td>Total</td>
<td>16,051</td>
<td>21,588</td>
<td>23,383</td>
<td>27,811</td>
</tr>
</tbody>
</table>

### TABLE VII

<table>
<thead>
<tr>
<th>Year</th>
<th>Population 65+</th>
<th>% of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>2.6 million</td>
<td>9.8</td>
</tr>
<tr>
<td>1990</td>
<td>3.0 million</td>
<td>11.4</td>
</tr>
<tr>
<td>2001</td>
<td>3.3 million</td>
<td>11.6</td>
</tr>
</tbody>
</table>

Source: Statistics Canada
TABLE VIII

CANADIAN DEPENDENCY RATIOS (1)

<table>
<thead>
<tr>
<th>Year</th>
<th>Child Dependency Ratio</th>
<th>Aged Dependency Ratio</th>
<th>Aged-to- Child Ratio</th>
<th>Total Dependency Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961 (c)</td>
<td>0.83</td>
<td>0.15</td>
<td>0.18</td>
<td>0.93</td>
</tr>
<tr>
<td>1971 (c)</td>
<td>0.75</td>
<td>0.15</td>
<td>0.21</td>
<td>0.90</td>
</tr>
<tr>
<td>1981 (d)</td>
<td>0.61</td>
<td>0.16</td>
<td>0.26</td>
<td>0.77</td>
</tr>
<tr>
<td>1991</td>
<td>0.63</td>
<td>0.18</td>
<td>0.28</td>
<td>0.81</td>
</tr>
<tr>
<td>2001</td>
<td>0.62</td>
<td>0.18</td>
<td>0.28</td>
<td>0.80</td>
</tr>
</tbody>
</table>


(a) Child - Age 0 - 19
(b) Aged - Age 65 and over
(c) 1961, 1971 - calculated from Census data

CANADIAN DEPENDENCY RATIOS (2)

<table>
<thead>
<tr>
<th>Year</th>
<th>Child Dependency Ratio</th>
<th>Aged Dependency Ratio</th>
<th>Aged-to- Child Ratio</th>
<th>Total Dependency Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961 (c)</td>
<td>0.83</td>
<td>0.15</td>
<td>0.18</td>
<td>0.98</td>
</tr>
<tr>
<td>1971 (c)</td>
<td>0.75</td>
<td>0.15</td>
<td>0.21</td>
<td>0.90</td>
</tr>
<tr>
<td>1981 (d)</td>
<td>0.55</td>
<td>0.16</td>
<td>0.30</td>
<td>0.71</td>
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<tr>
<td>1991</td>
<td>0.47</td>
<td>0.18</td>
<td>0.39</td>
<td>0.65</td>
</tr>
<tr>
<td>2001</td>
<td>0.43</td>
<td>0.19</td>
<td>0.44</td>
<td>0.63</td>
</tr>
</tbody>
</table>


(a) Child - Age 0 - 19
(b) Aged - Age 65 and over
(c) 1961, 1971 - calculated from Census data

Source: How Much Choice, C.C.S.D. p 8
# TABLE IX

**POPULATION 65+ AS PERCENTAGE OF TOTAL POPULATION**

**BY PROVINCE**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1971</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>1,744,410</td>
<td>205,010</td>
<td>118,745</td>
<td>94,805</td>
<td>95,555</td>
<td>644,410</td>
<td>413,015</td>
<td>54,705</td>
<td>72,470</td>
<td>12,345</td>
<td>32,075</td>
</tr>
<tr>
<td>% of Total Population</td>
<td>8.1</td>
<td>9.4</td>
<td>7.3</td>
<td>10.2</td>
<td>9.7</td>
<td>8.4</td>
<td>6.8</td>
<td>8.6</td>
<td>9.2</td>
<td>11.1</td>
<td>6.1</td>
</tr>
<tr>
<td><strong>1973 (est)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>1,834,200</td>
<td>216,600</td>
<td>125,500</td>
<td>98,100</td>
<td>99,500</td>
<td>675,900</td>
<td>439,600</td>
<td>56,700</td>
<td>74,900</td>
<td>12,800</td>
<td>33,400</td>
</tr>
<tr>
<td>% of Total Population</td>
<td>8.3</td>
<td>9.4</td>
<td>7.5</td>
<td>10.8</td>
<td>10.0</td>
<td>8.5</td>
<td>7.2</td>
<td>8.7</td>
<td>9.3</td>
<td>11.1</td>
<td>6.2</td>
</tr>
<tr>
<td><strong>1986</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Projected)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Total Population</td>
<td>9.8</td>
<td>9.8</td>
<td>8.7</td>
<td>15.0</td>
<td>12.2</td>
<td>9.5</td>
<td>9.6</td>
<td>10.3</td>
<td>11.3</td>
<td>11.4</td>
<td>7.8</td>
</tr>
</tbody>
</table>

**Source:** Statistics Canada

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>50-54</td>
<td>M 64.8</td>
<td>69.9</td>
<td>76.0</td>
<td>84.6</td>
</tr>
<tr>
<td></td>
<td>F 66.7</td>
<td>66.7</td>
<td>69.4</td>
<td>79.1</td>
</tr>
<tr>
<td>55-59</td>
<td>M 54.5</td>
<td>61.7</td>
<td>68.4</td>
<td>74.2</td>
</tr>
<tr>
<td></td>
<td>F 59.5</td>
<td>66.2</td>
<td>67.3</td>
<td>70.0</td>
</tr>
<tr>
<td>60-64</td>
<td>M 49.8</td>
<td>50.9</td>
<td>58.3</td>
<td>64.5</td>
</tr>
<tr>
<td></td>
<td>F 53.9</td>
<td>58.1</td>
<td>65.8</td>
<td>66.9</td>
</tr>
<tr>
<td>65-69</td>
<td>M 38.3</td>
<td>44.1</td>
<td>46.1</td>
<td>52.7</td>
</tr>
<tr>
<td></td>
<td>F 41.4</td>
<td>50.3</td>
<td>56.2</td>
<td>63.6</td>
</tr>
<tr>
<td>70-74</td>
<td>M 29.3</td>
<td>31.7</td>
<td>37.4</td>
<td>39.0</td>
</tr>
<tr>
<td></td>
<td>F 31.8</td>
<td>36.9</td>
<td>46.9</td>
<td>52.5</td>
</tr>
<tr>
<td>75-79</td>
<td>M 18.1</td>
<td>21.6</td>
<td>24.1</td>
<td>28.4</td>
</tr>
<tr>
<td></td>
<td>F 23.9</td>
<td>26.9</td>
<td>32.6</td>
<td>41.5</td>
</tr>
<tr>
<td>80-84</td>
<td>M 11.0</td>
<td>11.4</td>
<td>14.0</td>
<td>15.7</td>
</tr>
<tr>
<td></td>
<td>F 16.5</td>
<td>17.9</td>
<td>20.9</td>
<td>25.5</td>
</tr>
<tr>
<td>85-89</td>
<td>M 6.2</td>
<td>5.6</td>
<td>5.9</td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td>F 9.2</td>
<td>10.0</td>
<td>11.6</td>
<td>14.0</td>
</tr>
<tr>
<td>90+</td>
<td>M 2.9</td>
<td>3.1</td>
<td>3.0</td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td>F 4.1</td>
<td>4.7</td>
<td>6.2</td>
<td>8.1</td>
</tr>
<tr>
<td>TOTALS</td>
<td>M 1270.4</td>
<td>1437.8</td>
<td>1667.4</td>
<td>1898.2</td>
</tr>
<tr>
<td></td>
<td>F 1242.3</td>
<td>1400.5</td>
<td>1620.4</td>
<td>1843.4</td>
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<tr>
<td>TOTAL</td>
<td>2512.6</td>
<td>2838.3</td>
<td>3287.8</td>
<td>3741.6</td>
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</tbody>
</table>

## TABLE XI

<table>
<thead>
<tr>
<th>AGE</th>
<th>HISTORICAL YEARS</th>
<th>FORECAST YEARS</th>
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</thead>
<tbody>
<tr>
<td>0-4</td>
<td>36490</td>
<td>23267</td>
</tr>
<tr>
<td>5-9</td>
<td>186793</td>
<td>189777</td>
</tr>
<tr>
<td>10-14</td>
<td>150662</td>
<td>102421</td>
</tr>
<tr>
<td>15-19</td>
<td>112656</td>
<td>150466</td>
</tr>
<tr>
<td>20-24</td>
<td>95228</td>
<td>129741</td>
</tr>
<tr>
<td>25-29</td>
<td>101057</td>
<td>116817</td>
</tr>
<tr>
<td>30-34</td>
<td>112216</td>
<td>112060</td>
</tr>
<tr>
<td>35-39</td>
<td>113754</td>
<td>122112</td>
</tr>
<tr>
<td>40-44</td>
<td>110055</td>
<td>120279</td>
</tr>
<tr>
<td>45-49</td>
<td>98663</td>
<td>112363</td>
</tr>
<tr>
<td>50-54</td>
<td>86127</td>
<td>103669</td>
</tr>
<tr>
<td>55-59</td>
<td>67367</td>
<td>61700</td>
</tr>
<tr>
<td>60-64</td>
<td>56491</td>
<td>67611</td>
</tr>
<tr>
<td>65-69</td>
<td>50757</td>
<td>55457</td>
</tr>
<tr>
<td>70-</td>
<td>114851</td>
<td>121773</td>
</tr>
</tbody>
</table>

| TOTAL | 1629070 | 1877809 | 2184233 | 2351610 | 2409514 | 2549229 | 2540220 | 2610350 | 2687970 | 2763933 | 2940294 | 3201826 | 3536003 | 3819413 |

**Sex**

- Male: 50.6
- Female: 50.4
- Total: 50.4

Source: British Columbia Population Projections, B.C. Research, 1974, p 9
### TABLE XII

Proportional Percentage Increase in Population Aged 65 and Over

<table>
<thead>
<tr>
<th>Age</th>
<th>Numbers to nearest 1000</th>
<th>Proportional Percentage Increase to:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>79,700</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>70-74</td>
<td>61,100</td>
<td>28</td>
<td>10</td>
</tr>
<tr>
<td>75-79</td>
<td>42,000</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>80-84</td>
<td>27,500</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>85-89</td>
<td>15,400</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>90+</td>
<td>5,000</td>
<td>0</td>
<td>29</td>
</tr>
</tbody>
</table>

### TABLE XIII

In 1961 and 1971, the proportion of the population aged 65 and over in some MUNICIPALITIES

<table>
<thead>
<tr>
<th>MUNICIPALITY</th>
<th>1961</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vancouver</td>
<td>13.8</td>
<td>13.5</td>
</tr>
<tr>
<td>Victoria</td>
<td>20.9</td>
<td>22.9</td>
</tr>
<tr>
<td>Burnaby</td>
<td>8.6</td>
<td>7.9</td>
</tr>
<tr>
<td>Surrey</td>
<td>8.7</td>
<td>7.9</td>
</tr>
<tr>
<td>Saanich</td>
<td>12.0</td>
<td>10.2</td>
</tr>
<tr>
<td>New Westminster</td>
<td>11.2</td>
<td>12.9</td>
</tr>
<tr>
<td>Richmond</td>
<td>4.9</td>
<td>5.2</td>
</tr>
<tr>
<td>North Vancouver</td>
<td>5.6</td>
<td>4.1</td>
</tr>
<tr>
<td>Prince George</td>
<td>3.6</td>
<td>3.0</td>
</tr>
</tbody>
</table>

Source: Dale Bairstow 'Demographic and Economic Aspects of Housing Canada's Elderly' Policy Planning Division CMHC, Ottawa, 1973, p 39
### TABLE XIV

Sex and Marital Status, British Columbia, 1971

<table>
<thead>
<tr>
<th></th>
<th>60-64</th>
<th>65-69</th>
<th>70-74</th>
<th>75-79</th>
<th>80-84</th>
<th>85-89</th>
<th>90+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>6,140</td>
<td>5,655</td>
<td>4,350</td>
<td>3,240</td>
<td>2,410</td>
<td>1,425</td>
<td>615</td>
</tr>
<tr>
<td>M</td>
<td>3,445</td>
<td>3,385</td>
<td>2,615</td>
<td>1,765</td>
<td>1,385</td>
<td>755</td>
<td>305</td>
</tr>
<tr>
<td>F</td>
<td>2,695</td>
<td>2,270</td>
<td>1,735</td>
<td>1,475</td>
<td>1,020</td>
<td>670</td>
<td>310</td>
</tr>
<tr>
<td>Married</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>T</td>
<td>65,225</td>
<td>44,720</td>
<td>30,380</td>
<td>19,210</td>
<td>11,000</td>
<td>4,445</td>
<td>1,190</td>
</tr>
<tr>
<td>M</td>
<td>35,595</td>
<td>27,725</td>
<td>18,845</td>
<td>11,905</td>
<td>7,455</td>
<td>3,170</td>
<td>875</td>
</tr>
<tr>
<td>F</td>
<td>29,630</td>
<td>19,995</td>
<td>12,535</td>
<td>7,305</td>
<td>3,550</td>
<td>1,275</td>
<td>320</td>
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<tr>
<td>T</td>
<td>10,610</td>
<td>13,205</td>
<td>15,200</td>
<td>15,620</td>
<td>13,650</td>
<td>8,560</td>
<td>3,500</td>
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<td>2,230</td>
<td>2,550</td>
<td>2,975</td>
<td>3,185</td>
<td>2,420</td>
<td>1,075</td>
</tr>
<tr>
<td>F</td>
<td>8,935</td>
<td>10,975</td>
<td>12,655</td>
<td>12,460</td>
<td>10,465</td>
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<td>Divorced</td>
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<tr>
<td>T</td>
<td>2,645</td>
<td>1,655</td>
<td>985</td>
<td>530</td>
<td>305</td>
<td>115</td>
<td>45</td>
</tr>
<tr>
<td>M</td>
<td>1,270</td>
<td>855</td>
<td>560</td>
<td>270</td>
<td>170</td>
<td>55</td>
<td>25</td>
</tr>
<tr>
<td>F</td>
<td>1,375</td>
<td>795</td>
<td>430</td>
<td>255</td>
<td>130</td>
<td>60</td>
<td>20</td>
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</table>

Source: Census 1971 book 1:2

### TABLE XV

National Income Distribution of all Individuals and of the Elderly


<table>
<thead>
<tr>
<th>INCOME GROUPS</th>
<th>1961</th>
<th>1965</th>
<th>1967</th>
<th>1971</th>
</tr>
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<tr>
<td></td>
<td>TOTAL 65+</td>
<td>TOTAL 65+</td>
<td>TOTAL 65+</td>
<td>TOTAL 65+</td>
</tr>
<tr>
<td>0-1,999</td>
<td>39.3 77.9</td>
<td>37.2 73.0</td>
<td>32.9 68.4</td>
<td>32.0 60.8</td>
</tr>
<tr>
<td>2-3,999</td>
<td>30.9 14.6</td>
<td>24.7 18.0</td>
<td>21.5 18.9</td>
<td>16.6 21.0</td>
</tr>
<tr>
<td>4-5,999</td>
<td>18.6 --</td>
<td>-- 5.5</td>
<td>20.7 7.4</td>
<td>14.9 8.5</td>
</tr>
<tr>
<td>6,000+</td>
<td>10.3 --</td>
<td>-- 3.5</td>
<td>24.8 5.2</td>
<td>35.5 9.8</td>
</tr>
</tbody>
</table>

| MEDIAN INCOME | 2,615 926 | 3,052 1,084 | 3,606 1,398 | 4,186 1,840 |

Source: Based on special tabulations from Statistics Canada (Dale Bairstow: Demographic and Economic Aspects of Housing Canada's Elderly, p 53)
FIGURE 2
BRITISH COLUMBIA POPULATION PROJECTIONS
1974 - 1996

- ACTUAL POPULATION
- PROJECTED POPULATION

POULATION, millions

YEAR
B.C. Regional Districts
Numbers of people aged 65 and over in 1976 (upper figure) and 1980 (lower figure)
B.C. Regional Districts

Percentage of people aged 65 and over in 1976 (upper figure) and 1980 (lower figure)

REGIONAL DISTRICTS

No.  Name
1.  Alberni-Clayoquot
2.  Bulkley-Nechako
3.  Capilano (Victoria area)
4.  Coast
5.  Central Fraser Valley
6.  Central Kootenay
7.  Central Okanagan
8.  Columbia-Shuswap
9.  Comox-Smelt inlet
10. Comox Valley
11. Delta-North
12. East Kootenay
13. Fraser-Fraser
14. Fraser-North George
15. Greater Vancouver
16. Kootenay-Salmo
17. Kenten Boundary
18. Mount Washington
19. Nootka
20. North Okanagan
21. Queen Charlotte
22. Quesnel-Williams Lake
23. Peace River-Liard
24. Peace River
25. Queen Charlotte
26. Squamish-Lillooet
27. Sitka
28. Smithers-Coast
29. Thompson-Nicola
30. Williams Lake-Salmo

FIGURE 4
Source: Social Trends in Greater Vancouver, Michele Lioy, Social Policy and Research Department, United Way of Greater Vancouver, 1975, appendices.
CHAPTER V

THE ELDERLY POPULATION - NEEDS

Social services (in which we would include health and social services), are usually defined as interventions outside the market system (Titmuss, 1968) and usually considered to respond to human needs (Thayer, 1973). This may be why potential planners of services for the elderly, or those who try to influence planners or decision-makers, often attempt to identify and measure needs. There may be at least two rationales behind this behaviour. One is that one should identify needs because needs should be met. The other is that as it is perceived needs which generate demand, one must be able to predict the former in order to decide how to deal with the latter.

Types of Need

At least four kinds of need may be described. Normative need is what the expert or professional defines as need in any given situation, as measured against some desirable standard. This definition of need will vary according to the different standards set by experts, which again may depend on their personal values, their view of the importance of the need, and their views on the solubility of the problem. Comparative need measures need by comparing the services received by one individual, group or area with those received by another (which still does not imply an optimal level). Felt need is want. It depends to some extent on a person's expectations and is not normally experienced unless a solution is known to be possible. If the person's expectations do not coincide with
the normative standards of the expert, the expert may deny that a need exists. Finally, expressed need is the economist's 'demand' which is felt need translated into action and which again may not coincide with normative need as described by experts.

All of these definitions of need may be found singly or together, in the various studies, surveys and reports on the health and social status and requirements of the elderly.

Assessment of normative need may involve interviewing individual patients. In the Health Care of Aged Study [University of Rochester, 1968] a random sample of the elderly population was interviewed by teams composed of physicians and public health nurses using a questionnaire which was adjusted until a set of questions was found which brought the conclusions of nurses, on needs, into line with the assessments of a group of physicians. The final questionnaire required subjective and objective responses regarding health, by the patient, subjective and objective observations by the interviewer and the latter's assessment of the patient's need for services of institutional care. Later, eight classifications of physical status and five of mental status were differentiated. This sort of approach presumes that the appropriate service depends on the physical, even medical status of the person concerned and it neglects various social factors which might affect the need, and psychological factors which might affect the solution.

Studies of normative need involving medical examinations of sample populations by doctors usually bring to light various unreported health problems (Williamson, 1964) or even patients with unreported conditions
who would have liked a visit from a general practitioner [Cartwright, 1967].

For the GVRD Extended and Intermediate Care Reports individual patients (or their records) were studied but this was done by researchers and staff members. These two studies differed from the earlier ones mentioned in that they were not open-ended. They were looking only at the suitability of patients for specific levels of institutional care.

Sometimes data are based on interviews with professionals (e.g. the GVRHD Geriatrics Report, (1975 (2)) and Sumner and Smith's 1969 study.

Sometimes people take it for granted that without any special research their expertise or experience permits them to make judgments and or pronouncements. It may be the expertise of familiarity (e.g. the Health and Human Resources Council of the Queen Charlotte Islands who know the area) or experience (e.g. the BCMA 1968 Annual Report which notes various needs of the elderly, the 1976 Report of a Working Party of the British Medical Association on Services for the Elderly).

The writers of the last report even take upon themselves to propose the overall approach which should be taken in the care of the elderly [BMA 1976].

Perhaps the epitome of contribution by experts is produced when a committee with a variety of expertises collaborate in discerning the needs of one particular group and in making recommendations as was the case when the Geriatric Task Force prepared and submitted their brief to BCMC.

Comparative need is sometimes deduced by comparing the services received by different groups or the status of different groups, the latter being considered to imply certain needs. Two researchers in Britain deduced
the need for domestic help of poor disabled people who had no help by measuring the amount of help being purchased by better-off equally disabled persons. (Townsend, Wedderburn, 1965.) Sometimes it requires quite a lot of imagination, as in this case, to work out methods for measuring comparative needs. At other times, people rely entirely on printed figures, i.e. the numbers or rates of service provided by different provinces are noted. Sometimes there is an assumption that more (of hospital beds for example) means better though no basis is offered for this assumption.

Perceived need may be met or unmet, but is need as seen by the person experiencing it. Probably the most important study in Canada of the perceived needs of the elderly is the ten-volume Aging in Manitoba (Manitoba Department of Health and Social Development, 1973) based on research undertaken in order to provide a comprehensive knowledge base on the needs and resources of Manitoba, necessary to meet the need being felt for long-range planning of services for the elderly.

Eighteen areas of need identified from an extensive review of the literature relative to needs and of community based surveys and studies of the elderly, were reduced after various forms of pre-testing, to nine discrete need areas, psycho-social; shelter; household maintenance, food and clothing; language; religion-ethnic-cultural; physical health and functioning; mental health and functioning; economic; proximity to family/friends, familiar community; and family/friends available resources—each with five scales of need.

Since it was believed that the needs of the elderly were best revealed by the elderly themselves, 4,805 persons over age sixty-five (3558
from the general community and 1247 residents in facilities) were selected according to careful sampling techniques and interviewed according to a standard questionnaire by fifty trained students between June and mid-September, 1971. The questionnaires which took approximately one hour to complete, asked respondents for factual information and wishes regarding the nine "need areas". They also asked for the interviewer's assessment of the respondent's attitude, state of mind, and comprehension of questions.

For 680 potential resources identified in the community (305 residential, 375 non-residential) data were collected from central sources, by mailed questionnaires and by interviews with staff of the facilities regarding the population served, the services and facilities provided, types of staff, costs, and their judgment of the degree of unmet need experienced by the elderly.

Other data used were Dominion Bureau of Statistics and Manitoba Health Services Commission past and projected population distributions and community information data derived from several sources, especially the Department of Industry and Commerce.

From the data from the elderly person interviews and the resources available, matched profiles were prepared for each geographic area (village and towns as well as regions) to be used along with demographic data and cost analysis to establish priorities, alternatives and innovations for long and short term planning and for subjective assessment of health functional status and life satisfaction.

Snider's study (Snider, 1973) attempted to provide systematic information regarding the health and related needs of non-institutionalized
senior citizens in Edmonton. 428 families (500 would have been 10 per cent systematic sample) represented by a person aged sixty-five or more were interviewed by trained interviewers using a questionnaire which included closed and open ended questions on demographic details, health status, use of agencies, morale, anxiety, attitudes to old age, activities and employment. Health was measured by self-reported health status, specific illness and medical care histories, and functional health scores. Forty health and related agencies were also contacted about the services which they provided.

An example of a study of needs on a different scale was that carried out by the Cedar Cottage Neighbourhood Services in Vancouver in 1972. Responses to a pamphlet entitled 'Can we Help?' showed that in spite of the many existing services in that community, there still existed many unmet needs, particularly for an individualized type of service—which the organization proceeded to provide.

It is not usual for a special study to be undertaken to measure expressed need or demand as this is usually equated with utilization and these figures are available as long as statistics are kept.

The planner who tries to predict demand is really trying to meet his own needs as a planner—for information—so as to forestall any apparent dearth or superabundant provision of services and facilities which might embarrass future politicians and civil servants or inconvenience personnel or citizens. The simplest method then used to predict future needs (of the system, not the consumer) is to look at present utilization, of hospital beds for example, per thousand of population, and extrapolate
future needs from population projections. To be able to respond to demands for sophisticated population projections, Statistics Canada is continuously engaged in projections-oriented research and development of the data base and technical capabilities. The Research Division, B.C. Hospital Programs publishes an annual report of hospital statistics in the Province which gives information on diagnosis, length of stay, etc. by age group.

More sophisticated estimates of this type of demand (based on utilization) take into account the number of bed days by age group and by diagnosis. In Britain and some parts of the U.S., the 'critical bed number' is based on present hospital admissions plus waiting list additions, times average length of stay. To derive the 'correct number' two standard deviations are added to allow for fluctuations in demand.

International differences in Utilization can demonstrate the effects of different delivery systems, economic factors, psychological and social attitudes and structures though there are still some differences which current information does not explain. (Shanas, 1968 and Kohn and White, 1976.)

Some people would add another category known as unexpressed demand, that is need that is felt but not translated into demand because the solutions are not known or not available or acceptable to the person who feels the need. The Senior Citizen Housing Study carried out in B.C. [Gutman, 1975] might be considered to fall into this category, because it was designed "to determine the expectations and housing preferences of senior citizens" i.e. it looked at something rather wider than their imminent housing change. Interviews following a standard questionnaire were
conducted with 146 applicants for a nineteen-storey high-rise building offering four levels of care, fifty applicants for accommodation in two fourteen-storey blocks of self-contained suites in a retirement housing complex, and a control group of fifty persons living in their own homes and not on any housing waiting list. Applicants were interviewed one to four months prior to moving and twelve to eighteen months after moving in.

Some studies seek out more than one type of need. The Special Senate Committee on Aging solicited and/or received evidence from federal government departments, provinces, various citizen organizations representing health and welfare, religion, education, business, labour, and the elderly themselves. The Aged and Long Term Illness Survey Committee in Saskatchewan (1963) obtained information on existing programmes from administrators and other providers of service, received eight briefs from organizations, studied programmes, services, and research in other countries, consulted international experts, surveyed samples of employers, of institutionalized patients aged sixty-five and over and 1,000 other self selected aged persons. The Community Care for Seniors Study [SPARC, 1972] reviewed other projects and studies, visited 24 regional districts to obtain first-hand impressions of a community, its resources, its ability to plan, held hearings, contacted senior citizen organizations, solicited information from various groups. 1,800 questionnaires (819 returned) were sent to staff of various statutory and voluntary agencies, asking what they saw as the major gaps and most pressing needs in their communities. 450 questionnaires were sent to Senior Citizen Counsellors to be filled in by 'clients'
(185 were processed). A small survey was undertaken of private physicians in Vancouver to assess availability and use of community services, and another of homemakers in the Province.

Some studies do not even attempt to be scientific, or to do original research. 'Pour une Politique de la Vieillesse' [Martin, 1970], Appendix 17 of the Castonguay Report, derived the needs of the elderly from the Special Senate Committee Final Report and briefs, the Proceedings of the 1961 White House Conference on Aging, and the writings of Peter Townsend. 'Target for Senior Citizens' [Don Mills Federation of Labour 1973] was based on eighteen hearings held across Ontario. For 'The Health Needs of the Independent Elderly' [SPARC 1976] the SPARC social planner arranged workshops in the four communities studied and accepted whomever turned up. 'Housing the Elderly' [CCSD$ 1976] is the result of regional seminars and workshops.

The concept of need is basic to a technique developed by the UCS of Greater Vancouver over the last four years with Welfare Grant funding. Over the years, the United Way shifted from an agency to a service or programme orientation for budgetting, based on established service priorities. The latest development is an attempt to budget according to community problems and needs. LOGAN (listing of overall goals and needs) identifies six basic goals of Canadian Society, eighteen sub-goals or conditions to be achieved, and fifty-two specific individual and community need conditions that must be met for the subgoals and eventually the major goals to be realized. These were developed by a committee of United Way volunteers, mainly from the business community, and based on the United Way of America.

* Canadian Council on Social Development
Service Identification System. The six goals are Economic Opportunity and Income Protection, Provision of Basic Material Needs, Assurance of Optimal Environmental Conditions, (3) Optimal Physical and Mental Health, Adequate Knowledge and Skills, Optimal Personal and Social Development, Adequately Organized Social Means. Sub-goals of (3) for example are:

(1) Creation, Preservation, Maintenance of Good Health
(2) Habilitation and Rehabilitation of Mentally and Physically Handicapped
(3) Care and Treatment of Ill-health.

Needs are

3.1.1. Optimal Biological/Organic Make-up of the Body
3.1.2. Community (Environmental) Conditions Conducive to Good Health
3.1.3. Develop and Maintain Life Style Conducive to Good Health
3.2.1. Reduce Handicapping Effects of Disability by Personal Adaptation and Adjustment
3.2.2. Reduce Handicapping Effect of Disabilities by Changing Environmental Conditions.
3.3.1. Care and Treatment of the Ambulatory
3.3.2. Bed Related Care and Treatment
3.3.3. Emergency Medical Care and Treatment

Agencies applying for funding are assessed as to whether they meet the needs elaborated. UCS considers that basing priorities on funding guidelines or agencies tends to maintain the existing system; priorities based on services or programmes act to reinforce present strategies and ways of doing things; problem or need based priorities tend to identify problem and need situations and give agencies and communities freedom to innovate and experiment with alternative approaches and delivery systems. This could probably be applied also to health planning [Jaques, 1976].

To make recommendations based on 'major obstacles to maintaining the health of the elderly' does not always wait on the identification of needs. The Working Group on the Study of Health Services for the Elderly 1976 to the Advisory Committee on Community Health, Department of Health and Welfare
(Working Group] chose to identify sixteen 'problem areas' (Appendix A), on which they based their recommendations. These problem areas were enunciated after a study of current geriatric and gerontological literature, a look at the current situation of elderly Canadians, analysis of the recommendations of other committees and working groups, a review of Canadian research on aging and the aged, visits to various health and welfare delivery projects, and input from the elderly themselves. The group does not mention needs in its overall objectives which is "to make recommendations for ways of protecting, promoting and maintaining the health of the elderly population of Canada".

Some studies aim at providing information on which the development of services can be based. The Nutrition Canada B.C. Survey identified the elderly as the group most vulnerable to nutrient deficiencies. [Bureau of Nutritional Services 1975]. The 1963 Saskatchewan Study aimed at gathering facts about people and resources "so as to sketch a broad framework" for the development of needed services. [Aged and Long Term Illness Survey Committee, 1963]. The Major comparative study of elderly people in three industrial societies [Shanas et al 1968] wished to provide "fundamental information about the life of old people in the three countries" to provide inter alia, a basis for social policy. The findings were based on structured interviews with stratified multi-stage probability samples of about 2,500 elderly people in private households in each of Denmark, Britain and the U.S.

The recent massive international study of Health Care [Kohn and White, 1976] is not trying to discover needs as all the other studies were, in order to try to meet them, but rather it assumes (p.99) that perception of morbidity is a measure of need and therefore a major determinant of
potential demand and use. Because it is the task of decision-makers to balance available resources with perceived and expressed needs (p. 352), it will be useful for them to have information on the dynamics of the health care system, including the various factors which contribute to a perceived need for medical care. The information on which this highly analytical report was based, was obtained from 47,648 individuals in households in twelve areas, seven countries, selected by standard internationally accepted sampling plans. The final questionnaire administered by specially selected and trained interviewers (307 items for a responding adult; 236 for a child) covered psychological and demographic characteristics, levels of ill-health, perceived morbidity, use of health services, etc.

Characteristics of Need

Several characteristics of need should be noted. Different 'authorities' may have different opinions about need. Obvious examples are the question as to whether long term care facilities should all be attached to acute hospitals, the value of screening, and of regular health examinations—even whether old people prefer to be segregated. (If old people were seen as individuals instead of a group, this latter would not be a problem—or even a question). There is a common tendency to define needs according to the available services and structures which often serve the convenience of the providers more than the needs of recipients of care.

Some people—providers of care specially—more or less equate need state with their solution because of an occupational bias or lack of awareness.
of alternatives.

Needs may also conflict—especially as seen by different agents—as in home care.

In other words, there is not such a thing as uncontestable objective need. This applies even to medical care because there can be a lack of consensus among physicians in some cases as to the type of procedures necessary (e.g. with regard to tonsillectomies, hysterectomies, the timing of efforts to correct deformities).

However, there are some needs on which only doctors are qualified to make decisions, mainly because they are the only people capable of performing the necessary procedures, and the only people who know the prognosis, the natural history and that certain results are possible.

Needs as seen by experts and self-perceived needs do not differ markedly if the experts and the persons concerned share the same goals for the latter and if the experts have experience with the latter. However, studies of self-perceived need do cast doubt on some previously held ideas such as that old people like to live with their children, that children nowadays neglect elderly parents, that relatives are more significant than friends, that old people do not wish to be housed near contemporaries, that most old people are frail and ill, etc. [Townsend, 1957, Shanas 1968, Audain 1973 etc. Riley 1968]. Staff may rate needs higher than elderly persons and tend to extrapolate the needs of the frail elderly to all elderly. [Manitoba Department of Health and Social Development, 1973.]

Needs vary from place to place and time to time. Ultimately it is the needs of each local area which must be assessed because these will vary
according to different economic status, state of agedness, as well as various socio-cultural factors. For example, because the old-timers in the Queen Charlottes are part of a small community and respected for their still relevant experience in logging and fishing, and because respect for the elderly is traditional among the Haidas, 'As a group, senior citizens on the Islands do not always share many of the problems of their contemporaries in the cities' [Q.C. Islands Regional Health and Human Resources Council, 1974]. Community Care for Seniors looked at each regional district. The Saskatchewan Report assessed needs for nursing home care and sheltered accommodation in sixteen health regions and the Manitoba Report also took the local area view. The UCS, already referred to, is now proceeding to produce local need profiles. To obtain local information, it modified the Geographically Referenced Data Storage and Retrieval System (GRDSR), commonly known as Geocoding, developed by Statistics Canada which can tabulate census information for any 'standard area' and 'user specified' areas such as planning districts, traffic zones, neighbourhood areas, school districts, etc. For GVRD data, the PPBS Address Conversion, Plotting and Statistics System has been set up at UBC for public use.

Needs change also as new solutions, medical and other, emerge, and as social conditions alter—even as the demographic pattern of the over sixty-fives changes. There may be certain times when people are specially vulnerable such as after bereavement, or particularly in need of support services i.e. immediately after discharge from the acute hospital [Marshall, French and Macpherson, 1976].

Need occurs and should be assessed at a variety of levels from the
total population to the individual. Different disciplines have to be resorted to for guidance on the needs at different levels - epidemiology, economics, sociology, administration and psychology, - and some will be far more important than others at any particular level. (For example, sociology and psychology are probably the most valuable disciplines for the study of the needs of institutionalized old people.

A limitation of the value of global figures was shown in the Health Care of Aged Study [University of Rochester, 1968]. According to the criteria used to study an institutionalized population, 46 per cent were considered misplaced, including 93 per cent of psychiatric in-patients. Yet the overall allocation of places for the physically impaired was not much different from the prevailing allocation because under and over placement of patients cancelled each other out.

Needs may be conditional. It seems possible that the elderly prefer to be with their contemporaries in housing but not in hospital. They vary greatly before and after seventy-five years of age.

Needs are often interdependent or substitutable e.g. different types and levels of accommodation and community services. The 1962 Hospital Plan for England and Wales was expressly intended to "complementary to the expected development of the services for prevention and for care in the community". [Ministry of Health 1962]. The 1963 recommendations for places to be provided in local authority homes were calculated for "when domestic and hospital services would be adequate" [Committee on Community Care 1963]. In some areas in England, welfare officers and hospitals cooperate in planning the overall accommodation needed. [Committee on Local Authority and Allied Personal Social Services 1968, p.115].
The Seebohm Report on Local Authority Health and Welfare Services noted that these services were bound to be over-extended unless the right kinds of accommodation were provided in adequate amounts, in the right proportions and in the right places. [Committee on Local Authority and Allied Personal Social Services, 1968]. Conversely, the 1973 CCSD study on housing for the elderly [Audain 1973] found that to study housing needs meaningfully it also had to look at needs related to health, social services, recreation and community contact.

In Alberta, satisfying one need led to recognition of another. A year after an active treatment hospitalization program was initiated in 1958, it was found that 10 per cent to 15 per cent of acute bed days were taken up by long-term patients - up to 25 per cent in some rural areas. So the Auxiliary Hospital Act was passed in 1962, and by 1972, two rehabilitation hospitals and twenty-nine auxiliary hospitals were providing 2,965 beds (1.8 per 1,000). Finally the Nursing Homes Act was passed in 1964 to fill the gap which had become apparent between the auxiliary hospital level and the senior citizen homes programme.

A similar phenomenon occurs when provision of a new service to meet some recognized need calls forth all sorts of latent demand. [Committee on the Economic and Financial Problems of the Provision for Old Age, 1954]

Needs are relative to aims and results. If you aim to keep the elderly out of institutions, you provide more community services. The lady with a pain whose aim is to be rid of it, may think that she needs an operation. The doctor who knows that an operation will not remove the cause of the pain, will not believe that she needs an operation. It is inappropriate to attempt to meet a need with a service which cannot produce the required or desired result.
Also the individual citizen will go for the solution that is most visible or easily obtainable though it is not always most appropriate.

Finally there is a tendency to confuse needs, and ways of meeting needs. A medical diagnosis does not automatically imply a certain treatment, even less the need for a certain form of institutional care. Similarly the definition of any other sort of need is not the definition of a solution. Basically needs are for results not for services. There is still room for alternatives or choices as to how and by whom the needs will be met and a need for the development of techniques for evaluating methods of meeting need.

Sometimes need is based on diagnosis plus previous utilization for the diagnosis. But maybe the utilization pattern should be changed. Is a home-help a need or a solution? Automatic supply of the solution may prevent elucidation of the real need. Before supplying health and welfare solutions, one should perhaps look at needs for housing and income to see if in fact the health and welfare services are not being expected to patch up the holes in the other services (Sumner, Smith 1969 p. 362).

Automatic presumption of a solution may also lead to inappropriate use of a service i.e. you put an elderly person in an acute hospital and then complain that the hospital is so intent on cure that it fails to give this person care. It might be more appropriate to decide that as the valid objective of the acute hospital is to cure, this person is misplaced. He/she does not need an acute hospital bed.

We are most likely to find the appropriate solution if we study how the need arose in the first place i.e. why a person can no longer manage without help.
And finally of course, there has to be a decision as to what needs the government and voluntary agencies should meet.

**NEEDS FOR SERVICES**

It is generally estimated that at least 85 per cent of people aged sixty-five and over are independent, that about 10 per cent require some form of health and/or social services in order to remain in the community, and that the remaining 5 per cent require major supportive care, i.e. congregate or twenty-four hour supervision. [Nuffield Foundation 1947, Aged and Long Term Illness Committee 1963, Special Senate Committee 1966, Shanas 1968, McDonnell 1972, BCMC Task Force on Geriatrics 1974, etc.]

Recommendations have been made with regard to the elderly in acute hospitals [GVRHD 1975 (2)] and for the treatment of the elderly in various types of institutions. [World Federation of Occupational Therapists 1964, Aged and Long Term Illness Committee 1962, 1963, Special Senate Committee 1966, BCMA 1968 Annual Report, Bell 1968, SPARC 1972, GVRHD 1973, 1974, BCMC Task Force on Geriatrics 1974, Working Group 1976, etc.]. The main recommendations for the care of these patients are for more assessment units, more activation and rehabilitation, more discharge planning and follow-up, more multi-level accommodation, more flexibility in the use of staff, more attention to aspects other than the medical needs of patients and more aware of psychological needs. It is often recommended that home care should be delivered in institutions and that various services should be made available to private individuals who care for persons who would otherwise have to be institutionalized. Alternatively students of sheltered residential accommodation recommend
that medical attention be more readily available [Audain 1972, Gutman 1975].

When health needs in terms of medical needs are considered for persons in the community, the need for a gradation of provisions is again pointed to, with a more flexible blending of levels e.g. nurses and sick bays in senior citizen accommodation, clinics and outpatient departments for assessment, treatment and rehabilitation, day hospitals and halfway houses, more services provided by nurses instead of doctors, more use of volunteers, day centres – for the mentally ill too and therapy for the latter. Numerous studies point to the importance of good health for life satisfaction in old age, but a significant finding of most studies, whether of health needs or of needs in general is that what are commonly known as health services (and which in fact are medical services) are not the most needed services. Indeed when they are needed, medical services are more likely to be received than any other types of service. [BCMC Task Force Committee on Geriatrics, 1974, etc]. In the Saskatchewan Information and Opinion Survey, 1962 [Aged and Long Term Illness Survey Committee, 1962], 87.4 per cent of respondents identified problems. Of these, 94.2 per cent identified economic problems, and 45.3 per cent health and welfare ones. (That was before CPP and CAP but also before Medicare.)

In Snider's study (1973), physical health problems were mentioned as problems of aging by 25 per cent but when it came to choosing the most important things which could be done for old people, 22 per cent made recommendations on finance, 16.1 per cent on activity and relief of boredom, 15.2 per cent on housing and only 6.8 per cent gave recommendations on
health, first priority.

Every study of the needs of the elderly which has been done in this country points to the unmet need for adequate community services to supply the approximately 10 per cent who require them if they are to avoid institutionalization and to prevent the 85 per cent who are independent from deteriorating as long as this can be avoided. [also Shanas 1968, re other countries.]

Even the 10 per cent who do need some individually provided health or social services to remain in the community may still not require primarily medical services and certainly not the most highly technical medical services. Community Care for Seniors lists telephone reassurance services, crisis lines and/or emergency numbers, various transportation services. (Other sources recommend escorts with or without transportation), and visiting counselling, meals-on-wheels, home-making, home maintenance, relocation services and nightitters. Health aids noted as necessary are home nursing and physiotherapy, adaptation of homes, appliances, equipment, drugs, dental and podiatry services, activity and day centres and mental health community care services. (In Beyond Shelter (p. 316) it was noted that 19 per cent of the sample group studied had a cane, crutch, brace or artificial limb.)

For the other 85 per cent Community Care for Seniors recommended counselling services for individuals and families, access to health centres, physicians, screening clinics as appropriate, low rental and specially designed housing; adjustment of incomes according to cost of living, financial aid for extra-ordinary health and social needs, nutritional
counselling, more suitable and cheaper transportation, social, recreational and educational facilities, drop-in and information centres and/or multi-service 'Senior Centres', provision of resource information and a referral system, more flexible and accessible library facilities, opportunities for continued involvement in and contribution to the community as resource people, volunteers, etc. (Most of these recommendations come up again and again in the literature.) The Aging in Manitoba study found that availability of resources was the lowest mean unmet need, shelter came second, mental health services third. In the areas in B.C. where community human resource and health centres have been set up, the needs noted for the elderly are legal advice and a drop-in centre (in Houston), drop-in centres in Grand Forks, friendly visitors, readers, visiting hairdressers in Greenwood where the elderly have appreciated talks on protecting their homes from vandalism, on pensions, and on funerals.

When, in 1976, SPARC undertook a study of the Health Needs of the Independent Elderly (SPARC, 1976), the major need in every area, which it was felt should be met by the Provincial government was for intermediate care (which in fact is social rather than medical care and may only be demanded because of the lack of alternative sources of care in the community), and much further down the list came temporary placements in extended and intermediate care. But the other services for which the greatest need was felt were publicly funded transportation using accessible vehicles, for rural and semi-rural areas, extended, expanded and less expensive home care services (see also the GVRHD Home Care Report, 1975) expensive prostheses, orthoses and special devices, and geriatric day
centres. Voluntary organizations and local governments were asked to look to the co-ordination of transportation under various auspices, information service, emergency phone number, telephone tree, commercial outlets for dissemination of information, low cost housing near services innovative services in the home e.g. podiatry, meals-on-wheels, hair-dressing, voluntary visiting and recreation for the homebound. Various writers mention the need for pre-retirement courses and for the opportunity for education. Finally the elderly suffer along with the handicapped from a general environment (and communication and transportation systems) which does not take account of a slow or unsteady walking pace, for example. Elderly people themselves are more inclined to ask for the means to help themselves rather than for direct service. For example, the Don Mills Ontario Federation of Labour 1973 Task Force on Senior Citizens based on eighteen hearings held across Ontario, found that the main needs were for more income, extension of coverage of health expenditures, more housing which the elderly can afford, transportation, and community and information centres and retirement counselling. The Saskatchewan Senior Citizens' Commission (1974) found on interviewing 3,309 elderly persons that the main needs expressed were for finance, housing and transportation and for 'the development of mechanisms for the more efficient planning, co-ordination and delivery of services, and methods whereby community organizations and individuals can participate in assessing needs and planning services to meet them on a continuing basis.'

In B.C., senior citizen counsellors have had the opportunity to express the needs of the elderly at conferences sponsored by the Department
At these meetings, senior citizens stressed that co-ordination and integration of services must begin at the local delivery level, and local services such as housekeeper/homemaker services, meals-on-wheels, and information services must be made available in cooperation with local Human Resources offices. Transportation, the cost of drugs, the cost of prostheses and other special equipment, meals-on-wheels, homemaker services, and recreational needs, were some of the items of concern raised by participants.

(Services for People, B.C. Dept. of Human Resources, Annual Report 1973, Victoria, 1974, p. 59)

A 1976 survey of transportation needs in Chilliwack where 12.75 per cent of the population is elderly, showed that 4 per cent are homebound because of lack of suitable transportation. 16 per cent get out with difficulty and 3 per cent use the present public transportation system. About 90 per cent of respondents would have liked accessible buses. A voluntary organization which will transport patients for medical visits at a cost of $4.25 per trip has an average of sixty-five calls per month.4

Inherent in these needs or sometimes mentioned separately are (1) personnel needs—for doctors or someone to undertake co-ordination and referral, for professionals to have more training in the needs of the elderly, for licensing of more health care providers, a more generous supply of rehabilitation and other home care personnel to provide services in various accommodations, and (2) organizational needs—more emphasis on prevention, precautions to ensure that services are accessible (geographically, psychologically, financially) and known about and co-ordinated. This usually requires decentralization, outreach, and modification to local needs and utilization patterns.
The studies which we have looked at were done in various parts of Canada including B.C. and over about twenty years. In that time needs have changed as provisions have changed and as economic conditions have fluctuated. There is no way of measuring exactly what the priority needs are at any time but as far as one can gather from the elderly themselves and from those who deal with them, the two needs which are causing most urgent concern in B.C. at this time are for moderately priced accommodation and for transportation specially adapted to the needs of the frail and/or handicapped.

2. PSYCHOLOGICAL NEEDS

As the elderly become more numerous, their characteristics and needs are receiving ever-increasing attention from psychologists. The results of psychological studies are rarely quoted and more rarely used by planners and administrators, however. To many health planners aging seems to appear as purely biological rather than as a bio-psycho-social process. Yet it is only if we understand the needs of the elderly that we can help them to continue to meet their own needs, that we can help to meet the needs of those who are no longer able to help themselves, and that we will be able to present services in ways which will make them acceptable to a very heterogeneous population.

What most psychologists agree on is that the individual differences between most people over 65, including personality and morale, are greater than in any other age range. One most also remember that the over-sixty-five population nowadays stretches over an age range of more than thirty-five years which in itself implies wide variations in status and needs. On
the other hand, it is generally agreed also that the elderly have the same psychological needs as people of any other age, Maslow's scale of five basic human needs (physiological needs, need for security, need to belong and be loved, need for self-esteem, need for self-actualization) [Maslow, 1959, pp. 35-38] is frequently pointed to as a model to be followed when trying to meet the needs of the elderly. However, there may be more threats to the meeting of these needs in old age-involved in retirement, loss of mobility, maybe loss of spouse, etc.

The 1976 CCSD study, 'Housing the Elderly' identified the same sort of needs—for status, security and independence. The study concludes that the elderly can maintain their status by participating in the decisions that affect their living conditions, they can feel secure if they have a choice of housing and they can remain independent if adequate income, services and accommodation are available to them.

The earlier CCSD study [Audain 1973] showed that residents of sheltered accommodation appreciated the lower rent, security, services available and companionship. The study also concluded (p. 403) that for most residents of senior citizen housing, the development represented their world and that it was therefore expected to provide them with "most of the social, physical, mental, emotional, and to some extent spiritual, stimulation that life has to offer".

If we look at some of the individual needs felt by many elderly people in whatever setting a feeling frequently complained of is loneliness. [Aged and Long Term Illness Survey Committee, Saskatchewan 1962 (1), Special Senate Committee on Aging 1966, Snider 1973, Gutman 1975,
Havens and Thompson 1975]. Over 60 per cent of respondents in the Aging in Manitoba Study experienced extreme isolation. Loneliness may be literally 'aloneness', it may be lack of availability of 'important' people such as friends or relatives. It may be "desolation" following loss of a loved one [Shanas 1968]. Abraham Kaplan defines loneliness as the experience of being denied an identity, or frustration of the need for interpersonal relationships. Loneliness ranks high among the common causes of depression and suicide among the elderly. [Bancroft, 1971.] Loneliness may be a reason for seeking the help of the family doctor—or some other form of medical care [Freeman, 1969]. Low health status is commonly associated with feelings of loneliness in the community. And among patients it may lead to demanding behaviour, unfounded physical complaints, etc.

For the satisfaction of elderly persons therefore, and for those who care for them, as well as perhaps to prevent some overuse of health services, thought should be given to the alleviation of loneliness in the community and in institutions, in any plan for the health care of the elderly. At its simplest this would require only arrangements for friendly visiting—frequently advocated by the elderly themselves, and also enough facilities for people to be cared for in their own locality when they may continue to interact with family, friends, and the familiar community. It is important also that staff should be trained to recognize loneliness in elderly persons. [Brennan, 1975]

Elderly people also need to be involved. They need social interaction and stimulation if they are to remain alert, they need access to the usual community facilities—shops, doctors, transportation, church, clubs.
(Shopping is a very important social activity for elderly people who are fit enough to get to shops). This is all the more important in that most of them have lost many of the social contacts provided by employment. (Havighurst, Friedman, 1954, Elkin 1964, Clark 1968, Special Senate Committee 1966, Weinstock and Bennett 1971, SPARC 1972, Working Group 1975).

Elderly people with hobbies tend to be people who have had these interests in earlier years (Hepworth 1975). Other people seem not necessarily to choose group activities, or highly organized ones. A popular activity for those for whom it is possible, is visiting friends or relatives, i.e. seeking out compatible company. The facilitation of the coming together of compatible people in institutions would probably be much more appreciated than the almost routine provision of facilities for bowling in corridors. It is hard to understand why the elderly should be expected to develop an interest in a sport which appeals to so few people of younger years.

Actually, elderly people want their activity to be meaningful. Many would like to contribute to the community, to be of service to others. Often people in institutions would be delighted to be able to work (Kraus, 1976) - in the kitchens or the gardens, etc., but this seems to be almost unheard of - too dangerous, too time-consuming, the staff gardener feels that gardens that are less than perfect discredit him, etc. They need some variety of role. The only role open to the institutional resident is that of 'patient'. Kastembaum (1972) reports on an experiment in a geriatric hospital where wine-drinking sessions were introduced daily
at 3:00 p.m. in the day rooms for patients and any staff who cared to attend. For the first time the patients spontaneously formed groups, began to function as members of a 'club' and their behaviour became much more positive, varied and communicative.

The elderly need to feel secure [Audain 1972, Working Group, 1975.] Most of us feel relatively safe for most of our lives. In youth we are protected by parents, in middle age we can rely on our skills, our capacity to earn, maybe a spouse. In old age people may continue to feel safe if there are children at hand, or friends, or a social worker or doctor to whom they know they can turn. If they know of no-one, they feel insecure and abandoned. Often it is enough to know that help is available for times of illness or stress. Cosin found in Oxford that requests for admission to his continuing care program for geriatrics diminished as people were reassured of the possibility of rapid readmission for new medical or social crises.

It is frequently pointed out that successful aging requires continuity [Neugarten, 1964, Atchley, 1971, Kuypers 1973, Rosow, 1972, Seguin, 1973], not to be suddenly removed from what is familiar [Havinghurst, 1963, Special Senate Committee, 1966, SPARC 1972]. This seems to be the main reason for the popularity of multi-level care accommodation. Security too depends on the attitudes of staff who are working with the elderly. If they are not understanding and compassionate, the elderly cannot be but fearful or untrusting. Finally some people, to feel secure, may need paternalistic treatment. Some people have been by nature dependent all their lives and whilst the problem to date has often been that far too many elderly people were treated in paternalistic ways, even in trying to
counteract this, one should perhaps still leave room for 'protecting' the minority who want this.

Most elderly people of the present day do wish to be independent and self-directing for as long as possible—to set their own goals, make their own plans—to remain in control of their own lives. [Special Senate Committee 1966, Clark 1968, Riley and Foner 1968, Palmore and Luikart 1972, SPARC 1972, Lawton 1974.] This need—most people would say this right—is very frequently denied the elderly by even the most well-meaning friends, care personnel and staff of institutions who believe they know best what the elderly person needs. At worst, the elderly have to fit in with staff needs. (In fact the only needs which sane individuals cannot assess for themselves are strictly medical ones.)

To allow people to control their lives is to recognize their dignity. [Special Senate Committee 1966, SPARC 1972.] Dignity and privacy are also important to the elderly and again often denied them especially in institutions. [Audain 1972, Gutman 1975.]

We are not saying that any of these needs are specific to the elderly or that these are their only needs but these have to be stressed particularly because they do not always seem to be taken sufficiently into account when plans and provisions are being considered for them.

Finally, any plan contains incentives, encouragement, direction. The planner has to decide how far he must decide on the goals; what, if any, incentives can be built in without depriving the individual of the right to self-determination; and how the common interest is to be balanced against that of the individual when or if they are in conflict.
3. **GROUPS WITH SIMILAR NEEDS**

Many of the needs or problems of the elderly are shared with other groups—the unemployed, the childless, the disabled, the chronically ill, children, especially those with emotional and learning disorders, and the mentally ill. And of course personal and family stress and crisis may occur at any age.

Some elderly would benefit from programs to prevent and alleviate social isolation but so would many divorces, many middle-aged unmarrieds, widow(er)s of any age, young people who do not wish to become part of the 'system', and even those in the system who, in today's world are prey to various externalities which reduce their control over the attainment of their goals and put in doubt the wisdom of clearly defined expectations.

Sudden leisure (retirement) may be a problem of old age, but increasing leisure and the need for preparation for its use, applies to all age groups.

The decline in labour force participation begins at age forty-five. Unemployment may bring insecurity and unhappiness. It has psychological as well as material implications and these may be greater for people below retirement age who do not have society's sanction for their idle state. The CMA brief to the Senate Committee on Aging recommended community workshops. Would these be needed only or even most by the elderly?

The childless elderly are almost a separate category. But at any age, the lifestyles of parents and childless persons differ considerably.

Many of the needs of the handicapped coincide with those of the elderly—needs for better transportation, housing, access to recreation and buildings.
There has not been a survey of chronic illness in Canada but in the CMA brief to the Senate Committee on Aging it was estimated that 50 per cent of patients with chronic illness were aged under forty-five. They may all need counselling on management of their illness, adaptation of their physical environment and social arrangements, may all need various aids and services.

The writers of the CELDIC Report* (esp. pp. 11, 299) emphasized the need for more co-ordination and co-operation between different departments, services and professionals. And whilst they confined their detailed consideration to the needs of children only, they did recommend (p. 306) "that service programs for children be developed at the local level as integral components of agencies serving the needs of all age levels in the community", co-ordinated by a community board and integrated by a community services centre.

The organizational and operational principles to which the B.C. CELDIC Committee was committed (pp. 2,3) could also be profitably applied to services for the elderly. These principles included integration of separate government and private agencies at the local level, community responsibility for control of funding, planning, operating and developing services; voluntary citizen and professional participation, variations in service organizations and community based facilities, guaranteeing that the individual can be cared for in or close by his own community; an accent on prevention and early intervention; continuity of care, and increased use of volunteers and paraprofessionals. [SPARC 1973 (2)]

Justice Councils, initiated in May 1974 in B.C. are another mechanism.

*Committee on Emotional and Learning Disorders in Children
set up to facilitate citizen participation, decentralization, communication, co-ordination, cross-system planning and innovation [Lajeunesse, 1976].

D.B. Coates has outlined a model of levels of care for the mentally disturbed which is descriptive—at least of the better situations. It could be applied normatively to the elderly also. Features which might profitably be copied would be the gradual gradation upwards i.e. it does not require an acute episode in order that an intermediate need be recognised and met; total care is at the apex of a triangle, not at the end point of a line which slopes in one direction (i.e. the need for total care is seldom permanent or irreversible); emergence from the system is gradual also and various workers who were in on the treatment and diagnosis stage have to be re-involved. (The elderly particularly lack a connecting link into the service system and out of it.) Finally intimates or casefinders may be able to offer or find satisfactory solutions without referral to a higher level of care.

The Greater Vancouver Community Mental Health Project is developing local area community care teams of a psychiatrist, senior mental health workers (social workers, nurses or psychologists), several mental health workers, an occupational therapist and secretarial staff to try to treat patients in the community instead of in hospital.

The BCMC Geriatrics Task Force, 1975 pointed to the provincial pattern established by CARS in respect to their arthritis program as having many characteristics applicable to geriatrics, i.e. the stress on preventative extra-institutional aspects of care, working with family practitioners
and lay organizations in districts, employment of allied health professionals, provision of well-trained consultants, centralized records and statistics, co-ordination of volunteer and community effort, recognized provincial base.

There are ways then, in which some elderly may be more suitably identified with a category other than one of age. On the other hand other categories may be quite inappropriate. For example, the various provisions such as special clinics which serve young 'deviants' may be quite inappropriate for the elderly residents of Skid Row, just as neighbourhood information centres staffed entirely by young persons in unconventional garb may scare off older people however non-conforming or in need of information they may be.

All this highlights one of the problems which the planner must face-just how far if at all should special provisions be made for the elderly. The Foulkes Report [Foulkes 1973] saw no need for a separate system to deal with the health needs of the elderly. The Special Senate Committee (1966) pointed out (p.4) that "older people can often satisfy many of their needs and interests through existing or emerging community arrangements, or could do so if the opportunity were as readily available to them as to other age groups in areas like education and community recreation, for example" and (intro) that "to segregate on the basis of age is degrading". In a way, to make special provision for the elderly is to say that they are not an integral part of the mesh that is society and which is spontaneous. We don't think out what the status of spouse, children, cousins, is, or should be, or feel any need to separate off their needs.
Most people would probably agree that no publicly provided services available to anyone else should be refused to the elderly.

What has to be decided is whether all the elderly need is a watchdog whilst various services are left to deal inter alia with the problems of the elderly. In Quebec, provision for the elderly, as for persons of all ages, is divided not even according to service, but by function-planning, programming, etc. The danger in universal services or functions is that statutory services may be carried out at the expense of non-statutory ones and with overall planning and programming too, there is still a decision to be made as to how recipients of service are to be categorized.

4. NEEDS OF THE SYSTEM

Other needs which are reported or can be derived, may be called the needs of the system.

At present there is no organized framework for the delivery of primary health or social care to ambulatory patients or other members of the community of whom many are elderly, and there is need for some well recognized entry point to the system which is accessible and available and preferably where several services may be obtained in one location. Coordination of the various health and social services at local level and co-ordination of planning at regional level would seem to be the best way of meeting the needs of the elderly and co-ordination of the various 'levels' of care might ensure more continuity, whilst avoiding over-lapping, duplication and overuse of the more highly skilled facilities and personnel. Most of the reports we have mentioned recommend some sort of body at national, provincial and (sometimes) local level to stimulate, co-ordinate and integrate
programmes for the aged.

There is need for teamwork in the care of the elderly, and for more services now provided by physicians to be delivered by less highly trained professionals, particularly nurses. (Lalonde points out that at the Kaiser Permanente Foundation in Oakland, California where nursing personnel carry out procedures and provide counselling in the chronic care clinics, four nurses in collaboration with one M.D. can deliver as much care as four M.D.s and at a much lower cost. [Lalonde 1974 p. 60]) The chairman of the Task Force on Geriatrics to the BCMC believes that a variety of health professionals could be trained to carry out an adequate clinical evaluation. [Fahrni 1974]

Personnel need to be educated to accept that there are other objectives than cure in the care of the elderly, but that the elderly also want to be as independent as possible. Administrators need to learn that education rather than regulation will improve attitudes to the elderly and therefore the quality of their treatment. And the population needs to be educated to live lives which may prevent some of the ailments which presently accompany old age and also to recognize that doctors cannot 'cure' old age, or loneliness, and that solutions should not be sought from the health care system.

A need is usually expressed for research. In earlier years, this tended to be research on 'the needs of the elderly'. Now there is more often reference to research into what factors contribute to dependency states and to demand for medical care, or the solutions to certain needs, or the use and outcome of services.
There are problems of resource allocation between the different services for the elderly and between them and those for other age groups— if these should be separated. At least there should be some means of guaranteeing that in a time of economies and cutbacks the elderly do not suffer disproportionately just because of the nature of their needs.

It will have to be decided if the main need is merely for some mechanism like the Council on Aging for Ottawa-Carleton which seeks to identify and publicize the needs of the elderly in the community and to mobilize and co-ordinate the resources to meet them.

5. SOCIAL NEEDS

Other needs which have to be met are economic needs because unwillingness to support the burden of any further rise in the rate of escalation in health services costs is what has begun the recent rethinking about provision for health care. And of course the plan will have to be politically viable which means in accordance with the overall aims of the government and acceptable to the public, as taxpayers, and producers and consumers of services.

Conclusion

In view of the difficulty of defining health [Kohn 1965, Robertson 1973, Economic Council of Canada, 1974 p. 89] it is not surprising to find the opinion that "any characterization of the dimensions, quantitative and qualitative of requirements for health services is arbitrarily defined, at least within the limits of the present scientific ignorance". [Kissick, 1968.]
We do know that at the present time in Canada there is a move to contain the very rapid increase in health expenditure and it would be desirable to make economies on services which are now perhaps superfluous in quality or in sophistication.

One of the groups which may be 'overusing' services is the elderly, in the sense that they may be using medical services when medical services can effect little change in their physical status and when other types of service might effect the improvement in their social adjustment which is the most they can hope for and may even be what they are really seeking.

The major 1976 International Study of health care [Kohn and White 1976] showed that whereas perceived morbidity was the most important variable predisposing to the use of health services in the twelve areas studied, the strongest predictor of use was perceived availability of care i.e. health services organization and resource allocation. It was furthermore put forward that the differences in use between areas was more likely explained by societal values and the organization of health services than by individual perception of health and health needs, and that in equating needs for and use of services, resources and systems factors may be more amenable to societal manipulations than variables which measure perceived morbidity and attitudes.

We think that it is abundantly clear from the various reports and studies on the needs of the elderly as perceived by themselves and other people, that one way in which the need for and use of health services by them may be equated is by diverting some of the resources now devoted to health services into a variety of community social services.
This would probably be cheaper. It would probably meet more exactly the perceived needs of the elderly, who, we suspect, turn to the health care system at present for the sort of help which the social system is failing to provide.

If they want love, attention, security, but cannot be transported to a social club or have a friendly visitor, then they may seek what they want in a home for the aged or the emergency department of a hospital. Evidence of the reverse trend was given in the Saskatchewan Report.

Over the years several studies have been done of persons attending day centres. They have disclosed that a reduction in clinic visits occurred from the time oldsters became members of day centres. In the city of New York, a study done in the day centres showed the reduction to be 50 to 70 per cent. The extent of an individual's involvement in the activities of the day centre closely paralleled the reduction in his clinic visits. Pre-occupation with illness, use of the doctor's waiting room to find needed companionship, the attention sought from clinic personnel all became less important to the old person. Those requiring health care sometimes needed to be prompted to attend clinics for they became so absorbed in the life of the centre they forgot medical appointments. It therefore appears that when old people become active participants in organized activities there is less tendency for them to show excessive concern about their health.

[Aged and Long Term Illness Survey Committee, 1962, p. 132]

Weinstock (1974) reports on a programme initiated for geriatric out-patients of a metro hospital to offer opportunity for older people to interact with a group of their peers to modify their social behaviour. It was realised that at least some of the older patients were attending the clinic in a search for social interaction. "These patients in part play the 'sick role' which is then reinforced by the sympathetic treatment of staff. But if they are given substitute socially interactive opportunities and receive negative reactions to constant physical complaints, their need to be sick might diminish along with the 'need' to attend the clinic..." In fact
Weinstock's group made considerable progress in solving their own problems on their own and with the help of other members.

When old people are asked what they most feel the lack of, they do not say hospital beds. They say income (which represents freedom), transportation, community services which enable people to remain in their own homes, etc. They make good use of senior citizen counsellors, self-help programs, nurses in senior citizen housing. To screening clinics they bring as many social as health problems. Various studies show that old people prefer to live independently as long as possible.

There is little reason to suppose that many people would demand the more expensive forms of health care (usually institutional), if they could function in the community. It is sometimes objected that even if the elderly do not make excessive demands on the system, their relatives will. It is true that elderly people living near or with relatives seem to have a higher utilization of health services than those living alone [Adams and Sindell, 1969, Cartwright 1967], but they also manage to remain in the community for longer [Shanas 1968, Adams and Sindell 1968].

As we have already suggested, a switch of resources from the health to the social service system might be more effective for keeping elderly people independent and in the community for longer and more appropriate to their needs considering the sort of outcomes one can anticipate from the respective services. So not only would manipulation of 'the system' be enough. The result might actually coincide with the perceived needs of the elderly themselves, with regard to which they often seem to be more realistic than health professionals in recognizing the inevitability of some chronic
disease and physical discomfort. [WHO 1959, p. 8, Shanas 1968, Linn 1975!]

It is increasingly recognized that in developed countries with good public health facilities, the need to be healthy is no longer a need for mere medical care.

A person's level of health is related to many things; an adequate income for himself and his family, job satisfaction and job security, adequate housing, feelings of self worth and competence, a sound physiological system that has been nourished and cared for since conception, adequate intellectual and educational stimulation, access to quality medical and dental care, satisfactory marital and family relationships, opportunity for recreational and other leisure pursuits, plus the feeling of having some control over his own destiny. [Foulkes 1972, Tome II p. 43.]

The health concerns of a society have become part of the general social service concerns of that society and health becomes part of the concern for the public welfare or well-being. Evaluation of the impact and interaction of all social services can lead to more sophisticated decision-making and resource allocation, and to the formulation of policy questions which are more specific and are concerned with long-term effects. [Kohn and White 1976, p. 396.]

and finally,

The Working Group believes that health goals can be achieved by non-health types of projects and that social services are as important as health services in maintaining the health of the elderly. [Working Group on the Study of Health Services for the Elderly 1976.]
NOTES

1 Population Projections for Canada and the Provinces 1972-2001
Cat. 91-514, occasional 1974, gave the first official Stats Canada
population projections by age and sex for Canada and each province and
each year from 1972-2001. The four alternative sets of projections which
allow for differences in mortality and migration rates are to be revised
at three year intervals.

2 The Reports of the 1st and 2nd B.C. Conferences on the Needs and
Problems of the Aged, 1957 and 1960, the Aged and Long Term Illness
Survey Committee Report, Saskatchewan, 1963, Health Care in Nova Scotia, 1963,
Special Senate Committee April 1966, the Canadian Welfare Council Reports,
Social Policies for Canada, 1969, and Information and Referral Services for
the Aged 1970, Aging in Manitoba, 1970, the Report of the Commission of
Inquiry on Health and Social Welfare, Quebec, 1970, Health Security for
British Columbians, 1974, etc. etc.

3 Personal communication from Mrs. Keller.

4 Information provided by member of Transportation Committee of
SPARC of B.C.

5 This is reproduced in Equality as an Organizing Concept in Health
Care in Canada by Anne Crichton, (National Welfare Grant 2559-26-7) mimeo,

6 Proceedings of Senate Special Committee on Aging, 1964, Vol. 20,
Nov. 5.
CHAPTER VI

INAPPROPRIATE ASPECTS OF PRESENT PROVISIONS

There is a certain amount of disagreement among experts as to the attributes of the elderly. Do they withdraw from life activities (Bromley 1966) and disengage psychologically too (Cumming, Henry 1961) or do they enjoy the best years of their lives? (Maas, Kuypers 1974). Much of the discrepancy may be accounted for by the fact that in studying 'the elderly', people may be looking at an age range from sixty to one hundred, and this will obviously include a whole range of attributes also. The date of the research may also be significant as each cohort of elderly seems to push forward somewhat the limits of what they can do, do, do, and expect to do.

We do know that on the whole, the elderly have the same social and psychological needs as any other age group though there may be more frustrations in the way of attaining them. Most old people wish to be independent, self-directing, goal-oriented and involved as long as possible, and this normally means being part of the community and as far as possible in their own homes.

To remain in the community and reasonably independent, they require adequate income, adequate accommodation and varying amounts of support services. And for them to be independent and to obtain satisfaction from life, good health is an important, if not the most important contributing factor. However, as we have already seen, medical services are only one of the services which contribute to health;
medical services on the whole are effective only in treating (some) active illness and in fact only a small percentage of the elderly population requires medical and/or nursing care at any time. (5 per cent is the usual estimate). Yet over the last twenty years, these people in common with the rest of the population, have been offered a 'health care system' in which the major emphasis has been on treatment of sickness, on hospitals, on diagnosis and cure, and on acute care. Much more attention and resources have been devoted to institutional care than to community services. And there has been a 'medicalization' of needs and of services which might have been more appropriately viewed and dealt with in a different way.

EMPHASIS ON HOSPITALS AND ACUTE CARE

We shall look later at the factors which encouraged the building of hospitals in Canada, and then the increase in the use and cost of medical care. How costs have escalated is shown in Table XVI for Canada and Table XVII for B.C. Even before the introduction of medicare, provincial expenditure on health services rose more than eight times in current dollars between 1947 and 1963 i.e. from 12 per cent to 22 per cent of total provincial expenditure per annum (Hanson 1964), but as total government expenditure on health services was still only 3 per cent of G.N.E., no concern was expressed about costs at that time. Indeed when Medicare was being considered, it was anticipated that total government spending would eventually rise to 5½ per cent, but "Canadians can afford a high standard of health services, available to all, and the funds required can be made available largely from additional
growth. The challenge facing the Canadian people is to devise the appropriate policies and measures needed to translate the objective of comprehensive health services for all into reality" [Hanson 1964, p. 123]. However the further increases in costs—from $3.7 billion in 1967 to a projected $6.2 billion in 1972—after the passing of the Medical Care Act (1966) led to the setting up of the Committee on the Cost of Health Services in 1969 to find ways to restrain the growth of cost increases. In 1969 the cost of health services, at 5.5 per cent of G.N.P. was still disturbing [Robertson, 1973, p. 108]. In 1974 when the figure was 7 per cent, the federal government finally decided to take a firm stand. At present the national costs of health care in Canada are among the highest in the world.

This importance accorded to medical services, especially acute hospital care, has had various repercussions which have affected the elderly (and most of which have affected other age groups also).

First of all, the benefits of advances in medicine and technology have meant that the elderly can be successfully treated for conditions that would once have been disabling or fatal. When sickness strikes there are excellent facilities available. However staff consider that the tempo of acute hospitals is not always suited to the elderly patient [GVRHD, 1975(2)], they probably take longer to recover so that staff may become impatient or uninterested, and discharge planning, which is very important for very many elderly people may be entirely neglected. If they occupy an acute bed for long whilst waiting for a long-term bed, lack of activation may actually hasten their deterioration.
Some acute hospitals do not even have occupational therapists or speech therapists on staff.

In spite of this, elderly patients may be occupying acute beds unnecessarily whilst waiting for an extended or intermediate care bed. In the summer of 1975, the waiting times for the extended care units at Lions Gate, St. Pauls and St. Vincent Hospitals in Greater Vancouver ranged from a year to eighteen months. Sometimes patients have to wait so long for extended care beds that they improve to intermediate care level. This requires re-assessment and transfer to another waiting list. On the contrary, a long wait for a rehabilitation place often allows the elderly patient to deteriorate. Some hospital administrators and social workers readily admit that they take a "very firm hand" in order to free up beds occupied by extended care patients, mainly by saying that the alternatives are a private nursing home locally or an extended care bed in a remote part of the province.

Increasing the number of extended care beds has not to date lessened the waiting time—perhaps because extended care patients are living longer, perhaps because an increase in bed numbers has made entrance requirements less strict (unofficially any way). On the other hand some people believe that already we are preparing to over-provide with extended care beds. It is pretty incontrovertible that no matter how many beds are provided, they will be filled (except perhaps in certain geographic locations). The present apparent shortage of extended care beds might well be alleviated if more community services were made
available which would allow actual or potential extended care patients to return to the community.

Mental Health Services

In psychiatric units of general hospitals very few elderly patients are accepted. Various reasons are given for this—most are 'geared' to treating young acute, the programme is designed to change attitudes and the old are slow to change, trying to motivate the old is difficult, noisy young people may annoy them, shortage of boarding homes and intermediate care facilities in some areas may make placement difficult. This despite the fact that reactive depressions and other psychiatric illnesses in the elderly have been shown to respond to treatment, [Campbell, 1974] (In fact, disturbed brain function is often the result of organic processes which are reversible) and it is also coming to be accepted that the stereotype of the elderly as slow to change may not be as accurate as has been believed. A psychologist appears to be used to considerable advantage in the Sunnybrook Medical Centre in Toronto extended care department (average age over 75 years)—for individual, couple, family group therapy and for staff consultation. [Shedletsky 1976] Staff of some acute hospitals claim that it is difficult or impossible to arrange admission to Riverview of patients aged under seventy with brain syndromes or symptoms resulting from alcoholism which makes them unmanageable in the community, and of other long-term patients still in need of treatment. The lack of facilities for dealing with patients between the ages of sixty-five or even sixty, and seventy
is deplored by many, and can be a burden on the acute general hospital which may be left with them.

The Greater Vancouver Mental Health Service has no input into programmes in homes for the elderly. It is felt by many that this population could benefit from advice such as the inadvisability of segregating the sexes, etc. but the service has been specifically told by government that this is not included in their remit. (It is in the mandate of other Mental Health Centers in B.C. though it is not provided.)

What the Vancouver service provides in fact is individual treatment for the severely disturbed. There is no consultation to families of elderly persons (as in the U.S. Mental Health Services) and no consultation and preparation for retirement. The Broadway Clinic for ex-Riverview patients does run a weekly Seniors Group for people who have difficulty in socializing and coping with excessive leisure time.

One of the factors contributing to the inadequacy of facilities for the elderly psychiatric patient is the lack of qualified staff. So far B.C. has tended to import doctors for psychiatric work in institutions. Psychogeriatrics is apparently uninteresting to most doctors and it appears that little effort has been made to make it an interesting or challenging field in this Province.

Rehabilitation

The concentration on acute care and on patients with potential for rapid or dramatic improvement has other implications too for the elderly. There is a tendency for personnel to behave as if only the acutely ill can respond to therapy. To attempt to improve the function
of the impaired patient, especially the elderly one is too often seen as a waste of time. This attitude often spills over to the extended care hospital where activation of long term patients is not a high priority. In fact, chronically ill patients are often consigned to a long term facility without adequate assessment of their potential for rehabilitation.

The inadequacy of rehabilitation facilities in B.C., especially outside Victoria and Vancouver, has been documented [Foulkes, 1974 Tome IV]. The Royal Commission on Health Services [Hall 1964, Vol. I, pp.633-35] found that rehabilitation services were on the whole insufficient in Canada and usually directed by orthopaedists or podiatrists. It noted that rehabilitation is not a specific type of service but an objective underlying a great variety of services, and means more than most medical restoration. "Rehabilitation services for those above retirement age might restore them from helplessness and dependency to self-care and a considerable degree of independence". (The Commission recommended 0.5 beds per 1000 of population for rehabilitation/activation). The Special Senate Committee on Aging (1966) also had recommended that in all institutional facilities, a positive attitude be adopted toward the possibility of rehabilitating elderly people. (At least one advantage of acute hospital treatment is that patients are expected to recover).

That time spent on rehabilitation of the elderly is not wasted is shown wherever such facilities are provided.² [Cosin, 1973, Statistical Reports of Holy Family Activities Centre]. As there is scant provision of, or belief in, the need for convalescent care either, after
the acute phase of illness, the acute hospital does not appear to be suited to the needs of the elderly.

Whilst we recognize that many criticisms have been made of the geriatric hospital, we have nevertheless been impressed by those organized by Dr. Ferguson Anderson in the City of Glasgow in Scotland. The city is divided into five sectors, each with a population of about a quarter of a million, with a geriatric unit in each, attached to a major general hospital. A 1972 study showed that of patients referred from home or by the acute facility, two-thirds were accepted for a program of full medical and social investigation and rehabilitation. [Isaacs et al, 1972]

There were four criteria for admission to the Geriatric Unit—therapeutic optimism (one-third) (discharge likely within three months), medical emergency (one-half), basic care (one-quarter) (patient lacked food, warmth, cleanliness or safety as a result of illness) and relief of strain (one-third) (if helper was suffering undue physical or mental exhaustion). (N.B. Geriatric care was not an automatic alternative to the acute hospital after a certain age.) When four groups of elderly people drawn from geriatric patients, general medical patients, a random group and a matched group of non-patients were studied, the geriatric patients were found to be older, more likely to be single or widowed, to live alone and to be socially deprived. There was among them a much higher incidence of falls, inability to walk, incontinence and mental abnormality—dementia or confusion (about 50 per cent) and of a longer period of care at home (25 per cent over a year) before admission. For geriatric patients
the average stay was six months. Most medical patients who survived were discharged rapidly; of the geriatrics, one-third went home after one to three months, one-third died within three months and one-third were transferred to long stay wards. 51 per cent of geriatric patients were incontinent. Of these 15 per cent went home continent, but on the whole patients with mental abnormality and/or incontinence were unlikely to be discharged home. The majority of patients transferred from general medical and surgical wards failed to improve after full investigation and treatment and while some responded favourably to intensive rehabilitation, a large proportion became long-stay patients.

It is not clear where such a group would be found in Canada—probably dispersed between acute care, intermediate care and extended care. What does seem likely is that in the last two locations at least they would never have such a good chance of rehabilitation as they would in a Geriatric Unit. In fact in spite of the reported dislike of the elderly of being segregated in an institution specially for their age group, they might well receive more optimistically active treatment in the Geriatric Hospital (especially one attached to an acute hospital) than in institutions categorized according to the patients' physical status, where the possible modification of that status may not even be considered.

Relative Neglect of Preventive and Community Services

The bias in favour of hospital and acute care is evident in the amount of financing devoted to various parts of the health care system (Table XVIII). The hospital is also patently the focus of care.

45 per cent of physicians in B.C. were functioning as specialists
in 1975 [Division of Health Services Research and Development, U.B.C., 1976]. Shanas et al (1968) found 21 per cent in England and Wales, and 30 per cent in Denmark. Also, of 12,347 R.N.s practising in B.C. in 1975, there were only 1188 in community services (public health, occupational health, home care, community health), 239 in physicians' offices, eighty-nine in nursing homes and 9544 in hospitals. [Division of Health Services Research and Development, U.B.C., 1976]. (Yet Castonguay reported that 80 per cent to 90 per cent of demand involves only the primary care level) [Government of Quebec, 1970, Vol. IV, Tome II p.32].

This means that there is a comparative neglect to provide preventive services, such as screening, counselling, education, which might prevent more serious illness in all age groups but may be particularly effective with the elderly.

Community services are also relatively undeveloped.

Any system of care for the elderly which is to keep them out of institutions requires a comprehensive, co-ordinated system of community services - nurses, clinics, physiotherpay, home-makers, night-sitters, O.T. (So far the B.C. Government refuses to pay for O.T. services in the home), and, attached to institutions if necessary, out-patient care, day hospitals. There is nothing in B.C. equivalent for example to the four Oxford Day Hospitals with multi-disciplinary facilities for three hundred patients having five hundred attendances each five day week, which provide continuing physiotherapy, O.T., and speech therapy to patients who have had their cardio-respiratory or mild cerebro-vascular episodes treated at home by the primary care physician. [Cosin, 1973].
Transportation would make services accessible and therefore available to the elderly who would perhaps use services earlier and so avoid unnecessary deterioration, use appropriate services instead of the only accessible ones (e.g. physician's office by car instead of emergency department by ambulance) and be able to take an active part in community life so that they would probably present fewer health problems in any case, and finally, it would postpone or remove the need for institutionalization. Items like eye glasses, dentures, hearing aids, braces and artificial limbs all have to be paid for by elderly persons; yet these too are important as aids to independent functioning. As a matter of fact, in the case of prostheses, orthoses and special devices, it is estimated that only five per cent of patients pay for their own services but as there are twenty-seven agencies, public and private, providing financing, the "shopping around" required is time-consuming for social workers—and impossible for most patients. [SPARC 1973]

HOME CARE

From the inception of the National Health Programme, grants were made available to assist newly established home care programmes, but as the initiative had to come from the local areas concerned, and experimentation was encouraged, there was no systematic organization developed. Estimates of the savings effected by home care plans vary. However, it is quite clear that unless there is an accompanying reduction in hospital beds, hospital costs will in fact go up. If the objective is to economize, it will fail if elderly people are kept out of acute beds by provision of care, but the beds are then occupied by younger people.
There are various difficulties. Some administrators in hospitals with short waiting lists fear empty beds. It is easier for doctors to visit patients in hospital, and it may be cheaper for patients to be in hospital. (From the point of view of the financing agency, even thirty-five dollars to fifty-five dollars per day for a twenty-four hour homemaker service is cheaper than the acute hospital per diem.) The main advantage of home care for the elderly appears to be that it could help to keep them out of institutions. In Sweden where homehelpers are available to 4.7 per cent of people over sixty-five, 5 per cent are in homes for the aged. In Denmark, the Netherlands and Finland, corresponding figures are 2.3 per cent and 6 per cent, 0.6 per cent and 8.2 per cent, 0.5 per cent and 10 per cent [Brickner et al, 1975]. The Chelsea-Village Programme in Manhattan was started in January 1973 to meet the health-associated needs of the homebound, isolated elderly with the doctors, nurses and social workers of St. Vincent's Hospital, plus a co-ordinator and a driver. In the first sixteen months of operation, they had two hundred referrals. It is reckoned that without the program, seventy would have been institutionalized. Sixteen actually improved to being no longer homebound. That home care services could be expanded in B.C. is evidenced apart from anything else by the widely differing use of the service at present from one area to another [GVRHD 1975(1) p7]. If it is to be expanded there would have to be a big increase in the number of homemakers and probably also the incorporation of some skills not so far included, such as recreational therapy, OT and volunteers. An expanded Home Care Service would have to be a more highly organized operation than it is at present and not
arranged through a hospital based liaison person. A decision would have
to be made as to who is to be responsible for deciding on the type and
length of services required, and what is to be the mechanism for co­
ordinating the various services. A good model might be the Office of
Continuing Care established in 1974 in the Community Services Division of
the Manitoba Department of Health and Social Development. [Shapiro 1976]

Shanas found (1968 p.112) that elderly persons without a spouse,
children or other relatives were more likely to be in institutions. And
lack of community services may also force people to apply for institutional
care. [Kraus, 1976] Indeed, with many people the first public intervention
may come only when they need or apply for institutional care.

Even where there are clear medical problems, community care may
still be all that is required.

In Britain it was realized some years ago that it was time to call
a halt to the growth of acute care services. There has followed an effort
to provide more care in the community, particularly for the elderly, and
there is no evidence that the change has had an adverse effect on the
health of the elderly.

MEDICALIZATION OF NEED

There was not always this concentration on health and medical care.
When the Old Age Pension Board, on conducting a survey in 1946 of its over­
seventy year old clients, found that 25 per cent claimed to be healthy, 46
per cent complained of general debility related to one or another particular
ailment, and 20 per cent were so ill as to be incapacitated, the Board
stated that this might suggest a preoccupation with health! They also
suggested however that it could be the result of inability to afford medical care at a younger age, poor housing, insufficient nourishment or lack of other interests.

Nowadays, not only may some people be unnecessarily located in the acute hospital, (A survey of all 2710 patients in Nova Scotia hospitals in 1972 showed that 30 per cent of patients, 40 per cent of those aged over ninety, could have been maintained in the community). [Nova Scotia Council of Health, 1972]; not only has responsibility for chronic care and community care facilities in B.C. been transferred from Welfare to Health; but there has also been a tendency to treat the social needs of the elderly as medical problems.

When health was defined by the W.H.O. as complete physical, mental and social well-being and not merely the absence of disease or infirmity, it was most certainly not referring to medical status. The purpose was presumably to encourage people to take a broad view of health and therefore the factors which contributed to it. In practice, the result tends to have been, on this continent at least, for the medical system to absorb aspects of human living which are neither medical nor problematic but rather normal human needs, when in fact it is now accepted that various environmental and life-style factors may have more effect on health than medical services.

This medicalization of needs is found particularly with regard to the elderly. Shanas says, "The variation among the elderly in their physical health and in their degree of impairment is enormous. One can speculate why old age has come to be synonymous with sickness. It can be argued that we only notice old people when they are ill and enfeebled" -or
because so many studies of the aged are of the sick and institutionalized. [Shanas et al., 1968]. The Saskatchewan Aged and Long Term Illness Survey Committee wrote:

In the past the traditional or mainly medical approach has been used in dealing with these old people. Old age has also been frequently and fallaciously equated with long-term illness. To no small extent the problems of old age are social problems. It is a mistake to confuse these with the mental and physical disabilities of old age and call them medical problems. Such mistakes have resulted in old people being placed or retained in hospitals; yet in many cases the need of those oldsters is for social help rather than solely medical help. A more accurate assessment of the social and medical needs of elderly people might reveal that it is unnecessary to continue to provide so many beds for institutional care, and that there are alternative ways to care for aged persons.

(Province of Saskatchewan Aged and Long Term Illness Committee 1963, p. 129)

One reason for this distorted emphasis is that health services are seen as respectable; social services in Canada, are stigmatized, residual. Also, doctors are powerful, social workers are not, and the health paraprofessionals are numerous and well organized.

Elderly patients seek the medical solution because it is free, available, and visible-counselling services for example, which may be what they really need-are not so available or visible. When twenty problems common to the over sixty-five cohort were listed and people in Edmonton asked to whom they would refer an elderly person with the problem, it was found that the medical profession was used as the first line source of assistance with a variety of problems [Snider, 1973]. (Apart from the overuse of the doctor involved, one must also remember from other studies, how little the average doctor knows of, or refers to, other community
services.)

The result of this orientation is that the present nature and quality of provisions are pressurizing elderly people into the sick role. This can have several unfortunate consequences.

Various studies have shown that self-estimates of health are highly correlated with life satisfaction of the elderly. In fact some authors consider that it is morale rather than health that is measured by self health appraisals. At any rate it appears that the elderly function according to how they feel rather than according to an objective expert opinion of their health status. They often report their health as reasonable 'for their age', and may be more realistic than professionals as to what they can aspire to. Various reports have recommended screening clinics for the elderly. Recently there has been more scepticism about their value [Kastner, 1976]. It is worth noting that as often as not it is with non-medical problems that the elderly present at screening clinics. But the continuous reinforcement of the idea that they need medical care may change their perception of need in exactly the opposite direction from what we might wish.

Without realizing it, this may be a way of doing to old people what modern society is accused of doing to the 'mentally ill' [Szasz 1970]. We lump all their needs and problems under the rubric of old age, and proceed to leave them alone or offer total care and separation from society. So we 'demoralize and de-politicize' social problems.

And finally, once a person is labelled as a 'patient' with medical needs, essential non-medical support from family, friends and community
may not be offered [Geriatric Task Force, 1974].

It is fairly natural that doctors should be medically oriented. In the SPARC study of fifty Vancouver physicians [SPARC 1972], 98 per cent had used the VON, 84 per cent City Social Services and 76 per cent Home-makers and Meals on Wheels; but all other community services had been used by between 0 and 48 per cent. When asked what resources they would like to see developed, 96 per cent wanted more intermediate and extended care beds, and the preference among the community services was for those with a medical rather than a social emphasis. So there is little chance the emphasis of the system will be changed by doctors and really no reason why it should be them. It would seem that this task must be undertaken by planners at various levels of government who have a broad view of needs which can be met by a variety of services and disciplines, or merely by providing the means or mechanism for self-help. The 1976 international study [Kohn, White 1976] shows that 'high levels of distributional responsibility' is one of three factors which tend to approach balances between need, resources and use of services (p. 395).

INSTITUTIONS

The Canadian and B.C. approach to health care has tended to be institution-oriented, quite apart from hospital-oriented, compared to many countries with fairly similar populations. The rate of admission to nursing homes or extended care is about double the European rate [Skelton, 1976].

Various studies point to better personal and social adjustment and general satisfaction among people living in the community over those in
institutions [Zay, 1965, Riley and Foner, 1968, Abdo et al 1973, Thompson and Haven, 1974, Brennan 1975]. Institutions may have positive and negative effects [Anderson 1964, Lieberman, Prock and Tobin, 1968, Weinstock, 1974] but the positive effects are mainly temporary and found in people coming from a very deprived situation. Various other studies show the debilitating and deteriorative aspects of the institutionalization of the aged [Lieberman and Lakin, 1963, Robb, 1967; Townsend 1971, Brody 1973 Brody 1976]. It has been shown how people exposed to uncontrollable events learn that responding is futile, lose all incentive and motivation, and frightened by their lack of control, sink into depression [Seligman 1975]. For many people 'placement' has overtones of death. At its worst, institutionalization leads to dependence, depersonalization, low self-esteem, lack of occupation or fruitful use of time, geographic and social distance from family and friends, routinization, loneliness, lack of privacy and reduced freedom, desexualization and infantilization, crowded conditions, and negative disrespectful or belittling staff attitudes—leading to unhappiness, submissiveness, anxiety, negative self-image and general poor adjustment.

Psychological insights could be used very profitably in institutions. One speaker on extended care has pointed to a NASA study showing the effects of human crowding, particularly in restricted isolated monotony and the greater hostility generated when two people are confined; to Vance Packard's *Nation of Strangers* which portrays the deteriorating effects of rootlessness—how a person moved from place to place finally loses his identity; to insights provided by Skinner and others on the effects of
territoriality. (If people are going to isolate themselves rather than share, then community facilities and functions are called for); and on the need for some personal possessions in order to maintain an identity; to the effects of segregation of the sexes, lack of sensory stimulation, exercise, etc. [McIver, 1973].

The average length of stay in these facilities in B.C. is six months; yet many lack any arrangement for therapy, recreation, or volunteer activity. Of course, activity per se may have no value for some old people who take very badly to being suddenly removed from running a home, tending a garden, etc. and who are not interested in an occupation which is not meaningful or purposeful.

Licensing standards refer only to physical requirements—fire hazards, floor area, handling of food. There is no guarantee of quality of treatment. The regulations have not been revised since 1962 though new ones have been promised for some time, and regulations on training, experience or qualifications required of operators, have never been written. There is no real way of supervising the quality of care in these institutions where physical needs still take precedence over psychological ones.

Many homes refuse to take 'welfare' patients because the Department of Human Resources pays less than the economic charge. (The regulation that operators of homes must accept welfare patients for one third of their places has not been enforced.) So waiting times for an intermediate care bed may be from three to five months, for such patients. Some homes put welfare patients in a separate wing. Others refuse to keep
on patients whose financial resources are exhausted. Incidentally, the resources of a spouse remaining at home have also to be reduced to $1500 before government steps in. A few personal care homes provide convalescent care for as little as thirteen dollars a day, but the government will not pay for private hospital care if the person's home, an asset, is temporarily empty.

Some homes cannot handle tray service, won't take back people waiting for intermediate or extended care, refuse people with infections, might not even handle 'flu. Yet because they have a nurse on staff, community services will not go in.

Staff is often criticized. Foreign or other nurses not eligible for B.C. registration may be employed. Other staff, usually paid minimum wages, are largely untrained. There are no clearly established standards or guidelines. Doctors are said not to be interested in visiting their patients in institutions, and have been known to prescribe for patients they haven't seen.

As a matter of fact it is probably confusing for staff as well as patients to provide long-term care, essentially a LIVING arrangement, on a medical model—especially when the doctor refuses to show up (maybe justifiably) and no-one seems to get cured.

The amount and nature of inadequacy of facilities vary from area to area. Five regional hospital districts have no community care facilities. Surrey is said to be low on private hospital and extended care beds but to be well provided with intermediate level care with plenty of good local guest houses and rest homes and good community facilities for older people—though there is no outreach. In White Rock there is no
private nursing home so that anyone admitted to a nursing home may be
separated from a spouse—in a situation where transportation is difficult
also. Since most facilities have been established by people seeking
private profit, the location, size and type of care provided is unre­
lated to need. And what is provided may be geared to keeping relatives
rather than patients happy.

Finally the lack of choice of facilities creates problems. At
present the B.C. Classification of Types of Health Care classifies
people entirely according to their physical status [B.C. Department of
Health 1973] and they are then obliged to enter a facility which
provides that level of care. Because there is so little choice and
because few facilities provide more than one level, little regard can be
paid to the individuals' psychological, social or spiritual needs or
attributes. These may vary considerably between people with the same
physical status. Then as their levels of physical or medical or nursing
needs change, patients are usually moved, with consequent loss of social,
emotional and environmental continuity and complete disregard to any
other needs. There is nothing in B.C. like the Assessment and Place­
ment Service for Ottawa-Carleton which aims at assessing physical,
psychological and social needs as well as health needs when arranging the
placement of patients [Fraser, 1976].

SOCIAL SERVICES

As we have seen in the previous chapter, it is generally agreed
nowadays that many services other than medical services contribute to
health. Indeed in Canada, social services have been defined as "The services provided by the State to individuals and families, or paid for by the State on their behalf to ensure their health and social welfare", including public health services, curative health services and social welfare services [Trudeau, 1969, pp. 12, 14].

Yet the social services are not highly developed in Canada. In a study of twenty-two countries at a comparable state of development, Canada ranked sixteenth for its expenditure on social security in 1966 [Wilensky 1975] and still in 1971, a very different level from its health expenditure ranking. Its comparable attitudes are illustrated by official documents-'The achievement of the highest possible health standards for all our people . . . [Hall, 1964] and 'the provision of assistance and welfare services to and in respect of persons in need' [Canada Assistance Plan, 1966]

When the Division of Aging was created in the B.C. Department of Welfare in 1967, we saw that it was to undertake, in addition to the payment of pensions a) the development of community resources designed to directly assist and encourage the recreational, educational, physical and emotional well-being of the aged; b) an information, referral and consultative service on a Province-wide basis; and c) planning, initiating and administering such programs and projects, experimentations or demonstrations concerning the aged as is deemed necessary or desirable and fiscally possible. We have seen too how little of this was put into effect.

When the social services are studied or described in Canada, it is usually with regard to the needs of the poor. The main statutory social
services have been developed around the social assistance programme and are administered by provincial and municipal governments. Expansion of these services was one of the major objectives of the Canada Assistance Plan, but as the federal government is willing to cost-share only services provided for people 'in need' (translated as 'eligible for social assistance'), the provinces have mostly made their services available to this category only, and usually, in fact only to welfare recipients who may thus be rendered more 'employable'.

The Special Senate Committee on Poverty said in 1971:

As we have seen, services for the poor alone tend to be poor services. Discrimination in provision of services has been one of the main failures of our system. All people experience a variety of problems at various points in the life cycle, for which help is needed. It is a normal and universal phenomenon. The increased pace of life and change, and the increased demands that we make of ourselves and others, only add to the frequency and intensity of needs. Our goal over the next decade should be to have readily accessible services available to all who need them, and at as high a standard as we can possibly obtain.

(Final Report p. 98)

It is not only welfare recipients who have personal and social problems (in which after all, lack of money may be a minor or non-existent factor) and in today's society, social needs or needs for services of various kinds are not problems, and not indications of 'personal inadequacy' but more or less inherent in the social structure. To see social welfare as coming into play only after family, market, the economic system have proved inadequate, is to take what Wilensky and Lebeaux call the residual view of welfare [Wilensky and Lebeaux 1975]. The institutional view on the other hand sees welfare services as normal, integral functions
of modern industrial society. This is Kahn's view.

For Kahn, the tasks of social services are:

1. To strengthen and repair family and individual functioning with reference to ongoing roles.

2. To provide new institutional outlets for socialization, development and assistance, roles that once were—but are no longer—discharged by the nuclear or extended family.

3. To develop institutional forms, for new activities, essential to individuals, families, and groups in the complex urban society even though unknown in a simple society.

[Kahn 1973 p. 16]

Shanas et al showed in 1968 that "(health and social) services do not undermine self-help because they are concentrated overwhelmingly among those who have neither the capacities nor the resources to undertake the relevant functions alone. Nor, broadly, do the services conflict with the interest of the family as a social institution because either they tend to reach people who lack a family or whose family resources are slender or they provide specialized services the family is not equipped or qualified to undertake": (p. 129)

Old people, regardless of their financial status, may need many of the services which are presently available only to recipients of welfare-services to improve the quality of their life, to alleviate loneliness, to enable them to remain longer participating members of their community. Yet there is no department at the federal or provincial level responsible for co-ordinating services for the elderly. A recent international study notes that in all countries there is increasing recognition of the need for community (non-medical) services for the aged—and other groups. "With a few exceptions, these are no longer 'poor law' programs. Tending toward
universalism, these are expected to be dignified, accessible, effective, good enough for all citizens" [Kahn, Kamerman, 1975, p.7].

In Canada, and B.C., many community social services are provided for the elderly by voluntary agencies. There is nothing wrong with this, but if voluntary agencies are performing a routine service function they cannot act as well as innovators or instruments of change which is usually considered to be valuable and necessary roles for them to fill.

INCOME AND HOUSING

Adequate income and suitable housing are other items which the elderly need to be able to function independently. The guaranteed minimum income received at the moment (and over half of the elderly are at that level), is barely enough to cover essentials, especially for a single person. The biggest expense for most people is for accommodation and we have seen how many people are on the waiting list for public housing, mainly because their present accommodation is too expensive. Sheltered housing does not always provide personnel who ensure the security that many residents are seeking [Audain, 1973].

It is important that health planners should be aware of provisions in the other social service sectors because medical care may be chosen inappropriately over social services if the latter are non-existent or unattractive. To give only one example, it was thought, that the introduction of Mincome in B.C. (allowing more people to afford to live in the community) reduced the rate of increase in people being admitted to boarding and rest homes [B.C. Dept. of Human Resources, 1974].
PROBLEMS OF DELIVERY AND ORGANIZATION

There is inappropriateness also in the way in which services are delivered or organized.

Need for Flexibility

If we are to get away from the medicalization-institutionalization pattern, and if we are to improve the quality of life for the elderly who do require medical or institutional care, there will have to be much more flexibility in the system—in the functions of institutions, services and personnel.

We need day care centres, attached to hospitals or not, hospitals that provide day care, night care, outpatient services, swing beds. The new UBC extended care hospital has been considering day, night care, but so far the government has not agreed to finance it.

According to the BCHIS 1974 Annual Report, the Division had formulated policies for experimental discharge and short-term admissions under the extended care programme, but little advantage seems to have been taken of these possibilities. We could have dining and recreation areas in residential establishments which also serve the community, more community services which outreach to residents of institutions.

Patients' doctors can order therapy in a nursing home, and some nursing homes have asked for a half day of services per week. But there is no home care in hostels or homes for the aged.

The Select Standing Committee on Social Welfare and Education found in 1973 that there were private homes available for home care in some areas but licensing requirements are the same as those for a residence for three hundred people and to conform to the building and safety
codes would be prohibitively expensive.

We need multi-level care combining two or more levels of independent living, intermediate and extended care so that some continuity is assured in the living experience of the elderly. There is nothing in B.C. like the Baycrest Centre of Geriatric Care in Toronto which is a Home for the Aged with eighty-six special care beds, one hundred and fifty intermediate care and eighty-nine nursing care. Patients are admitted only if the admissions committee are convinced that they can no longer function with only community service support. Baycrest Hospital provides one hundred and fifty-four chronic and rehabilitation beds. Baycrest Day Care Service can accommodate three hundred participants per week on two or more days, and all applicants to the home must take part. Baycrest Residence, half a mile from the others, houses two hundred and thirty-seven persons. It has dining rooms, social and public facilities which serve the surrounding community also, and a nursing station manned twenty-four hours per day. At Deer Lodge Hospital in Winnipeg, geriatrics programs include clinical geriatrics, restorative geriatrics, extended care, domiciliary care, home care, day care and ambulatory care. In the thirty-bed restorative unit, where patients may spend from two days to two years, an assessment team assesses the patients' clinical, social, physical and mental assets and liabilities and prepares a plan of action which is reviewed right up to discharge. One hundred and thirty patients attend the Day Hospital—usually twice a week—for recreation, nursing and check on medications. Patients from the restorative unit lunch with the Day Hospital patients and may share their
activities. Home Care goes along with the Day Hospital and may precede or replace acute hospital admissions. There is also a Regular Intermittent Readmission Program of one to two weeks in hospital followed by six to eight weeks at home [GVRHD 1975(2) Appendices F.G].

Because needs for health care are on-going features of community life, long-term plans are essential. It should be possible to know which needs are most susceptible to short-term change and to allow for flexibility and lack of rigid structures in these areas. An example of flexibility is the Olive Devaud Home in Coast Garibaldi. Set up as a boarding home for its forty residents, it became an intermediate care facility as the health of its residents declined and they had nowhere else to go [Harmon, 1973]. The Home for the Jewish Aged in Philadelphia was set up originally for non-impaired elderly. As staff became aware of changing needs and carried out studies to confirm their observations, what began as a hundred and fifty-bed home 'for well aged', has become a multi-service agency sheltering one thousand and fifty old people in various levels of care and delivering services to community dwellers as well [Liebowitz, Brody, 1970].

Perhaps more than anything we need more flexible personnel. The more successful extended care units already use their staff interchangeably (e.g. Banfield, Louis Brier). In the community the B.C. Medical Services Plan covers only services rendered by medical practitioners so that if doctors hire assistants of another profession they cannot claim for their salaries, and it is only medical costs that the federal government cost-shares. Various reports have pointed out that a large percentage of
services are provided by personnel who are more highly trained than is necessary. Legislation making doctors alone responsible for any 'medical act' which is fairly narrowly defined does not allow for the independent nurse-practitioner. Yet it is well recognized that where public health nurses have functioned as primary care providers for the elderly (e.g. in high rises) calls on doctors and hospitals have been reduced and morale has been in general higher.

On the other hand, there is no evidence that doctors are sincerely interested in providing the sort of attention that the elderly need. And the fee-for-service system which pays for medical acts, diagnostic tests and consultation does not encourage arranging home care, explaining needs, guaranteeing comprehensive care, attention to social needs, communication with others, participation in teamwork, which are all necessary components of the 'health care' of the elderly persons.

Lack of Planning and Co-ordination

As we have already seen there is a lack of planning and co-ordination in the delivery of services to the elderly. There is no person paid for such co-ordination. Even when health care personnel have the opportunity to become aware of unmet needs (e.g. the staff of hospital Emergency Departments), there may be no mechanism for reporting them, and no-one to report them to.

Financing

There are marked anomalies between the financing of different levels of care. For example, in March of this year, the provincial
government was paying $124 a day for an acute bed, but at $18.99 per day for welfare patients in private hospitals was forcing some of the latter to operate at a loss or close down (operating costs in Grandview were $22.50 per day) Partly, the anomalous financial differentiation between different levels of care is explained by the legislation which restricts federal cost-sharing to hospital beds so that convalescent and nursing home beds are not included.

There is a tendency for private agencies to provide services in arbitrary and unsupervised fashion with little public accountability. There would appear to be a need for some sort of evaluation of effort. The UCS performs this function to some extent but can affect only its member organizations.

Financing methods do not permit consideration of the total system of service delivery, including hospital and community services, no way of measuring trade-offs between different levels of care or services and little incentive for one department to take measures which will effect economies in another department.

Participation

Elderly people are the ones with the most experience as consumers of the services which they use and could contribute a great deal as advisors or consultants to planners and administrators in the private and public sectors, as individuals or as associations; yet they are rarely used. Maybe this is one reason why the people who have made the choices and the decisions have produced an end-result which is inappropriate in the ways
which we have described and at the same time fails to meet the wishes and needs of the elderly. In other words there has been a seeking of an end-result, even an attempt at providing an end-result when what is really required is provision of the means whereby elderly persons can achieve, or fail to achieve, their own end-result.

**PSYCHOLOGICAL NEEDS**

Services for the elderly seem always to be aimed at physiological needs first, and often only. Yet psychological needs may often be in conflict with physiological and physical needs and many people would prefer to forego some of the services which meet the latter in return for some consideration of the former i.e. a 'home' chosen because other residents are compatible rather than for its glittering cleanliness, staying in familiar surroundings with less than optimal medical care rather than admission to hospital, etc. Once in hospital, 'good treatment' may depend less on exotic procedures than on staff attitudes.

We do not propose to dwell further on psychological needs. We merely need to point out that the provisions which we presently make for the elderly, particularly institutional care, and the way in which we deliver services, appear to take little account of the psychological needs which we noted in the preceding chapter.

**CONCLUSION**

It would be unrealistic to deny that failing health usually accompanies old age and that death is more often preceded by chronic deterioration than by a quick acute illness. Even so, it would enable people to live more normally and independently if they were able to function for as long as possible in their own homes, with institutions as an alternative,
and not vice versa, if care were raised to the level of cure, but supported self-care was seen as even more desirable.

If we are to believe the conclusions of an economist who has studied the whole question very extensively, there is little hope that in future more health resources will be allocated to the elderly [Anderson 1973]. And it appears that in Canada overall health costs are not to be allowed to develop uncurbed in future. However, curing disease is not the same thing as promoting health and well-being. If health is seen, as it once was, as successful adaptation to one's situation or overall environment [Dubos 1959, p. 103], we can help the elderly achieve this by different types of service and different methods of delivery from what we now offer them. And we may end up with a system which is more efficient, more effective, more humane, and into the bargain, less costly.
NOTES


2 The Medical Brief to the BCMC Geriatric Task Force, 1974, states that the use of intensive training areas such as Rehabilitation/Activation wards for disabled geriatric patients results in the return of about 70 per cent to their home setting.

3 Various studies on this subject are summarized in Studies in Relating the Physical, mental and social Dysfunction of the Chronically Ill Aged, Margaret W. Linn, Conference on Long Term Care, Tucson, Arizona 12-16 May, 1975.


5 Information provided by Social Worker at Surrey Memorial Hospital.
TABLE XVI  EXPENDITURE ON PERSONAL HEALTH CARE, CANADA, 1960 - 1971

PERCENTAGE OF GROSS NATIONAL PRODUCT AT MARKET PRICES

<table>
<thead>
<tr>
<th>YEAR</th>
<th>GENERAL AND ALLIED SPECIAL</th>
<th>MENTAL</th>
<th>TUBERCULOSIS</th>
<th>GOVERNMENT OF CANADA</th>
<th>ALL HOSPITALS</th>
<th>PHYSICIANS' SERVICES</th>
<th>DENTISTS' SERVICES</th>
<th>PRESCRIBED DRUGS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>1.67</td>
<td>0.32</td>
<td>0.07</td>
<td>0.14</td>
<td>2.20</td>
<td>0.93</td>
<td>0.25</td>
<td>0.35</td>
<td>3.70</td>
</tr>
<tr>
<td>1961</td>
<td>1.82</td>
<td>0.34</td>
<td>0.07</td>
<td>0.16</td>
<td>2.39</td>
<td>0.98</td>
<td>0.29</td>
<td>0.34</td>
<td>4.01</td>
</tr>
<tr>
<td>1962</td>
<td>1.89</td>
<td>0.34</td>
<td>0.06</td>
<td>0.16</td>
<td>2.46</td>
<td>0.95</td>
<td>0.28</td>
<td>0.34</td>
<td>4.02</td>
</tr>
<tr>
<td>1963</td>
<td>1.93</td>
<td>0.35</td>
<td>0.06</td>
<td>0.16</td>
<td>2.56</td>
<td>0.99</td>
<td>0.30</td>
<td>0.35</td>
<td>4.13</td>
</tr>
<tr>
<td>1964</td>
<td>2.02</td>
<td>0.36</td>
<td>0.05</td>
<td>0.15</td>
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<td>0.99</td>
<td>0.29</td>
<td>0.36</td>
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<tr>
<td>1965</td>
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<td>0.33</td>
<td>0.05</td>
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<td>0.29</td>
<td>0.33</td>
<td>4.30</td>
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<tr>
<td>1966</td>
<td>2.13</td>
<td>0.39</td>
<td>0.04</td>
<td>0.13</td>
<td>2.70</td>
<td>0.98</td>
<td>0.29</td>
<td>0.33</td>
<td>4.34</td>
</tr>
<tr>
<td>1967</td>
<td>2.29</td>
<td>0.43</td>
<td>0.04</td>
<td>0.13</td>
<td>2.89</td>
<td>1.03</td>
<td>0.23</td>
<td>0.40</td>
<td>4.60</td>
</tr>
<tr>
<td>1968</td>
<td>2.47</td>
<td>0.43</td>
<td>0.04</td>
<td>0.12</td>
<td>3.06</td>
<td>1.09</td>
<td>0.29</td>
<td>0.41</td>
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</tr>
<tr>
<td>1969</td>
<td>2.54</td>
<td>0.45</td>
<td>0.03</td>
<td>0.11</td>
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<td>1.13</td>
<td>0.30</td>
<td>0.40</td>
<td>4.97</td>
</tr>
<tr>
<td>1970</td>
<td>2.69</td>
<td>0.49</td>
<td>0.03</td>
<td>0.11</td>
<td>3.31</td>
<td>1.20</td>
<td>0.31</td>
<td>0.42</td>
<td>5.24</td>
</tr>
<tr>
<td>1971</td>
<td>2.79</td>
<td>0.47</td>
<td>0.02</td>
<td>0.11</td>
<td>3.39</td>
<td>1.33</td>
<td>0.32</td>
<td>0.45</td>
<td>5.55</td>
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</table>

TABLE XVII EXPENDITURE ON PERSONAL HEALTH CARE, BRITISH COLUMBIA, 1960 - 1971

IN THOUSANDS OF DOLLARS

<table>
<thead>
<tr>
<th>YEAR</th>
<th>GENERAL AND ALLIED SPECIAL</th>
<th>MENTAL</th>
<th>TUBERCULOSIS</th>
<th>GOVERNMENT OF CANADA</th>
<th>ALL HOSPITALS</th>
<th>PHYSICIANS' SERVICES</th>
<th>DENTISTS' SERVICES</th>
<th>PRESCRIBED DRUGS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>59,445</td>
<td>15,572</td>
<td>2,017</td>
<td>9,530</td>
<td>86,584</td>
<td>45,354</td>
<td>14,951</td>
<td>12,219</td>
<td>159,108</td>
</tr>
<tr>
<td>1961</td>
<td>64,124</td>
<td>16,518</td>
<td>1,893</td>
<td>10,849</td>
<td>93,384</td>
<td>47,069</td>
<td>16,069</td>
<td>12,242</td>
<td>168,704</td>
</tr>
<tr>
<td>1962</td>
<td>68,528</td>
<td>17,035</td>
<td>1,905</td>
<td>11,522</td>
<td>98,890</td>
<td>48,412</td>
<td>16,303</td>
<td>12,197</td>
<td>175,802</td>
</tr>
<tr>
<td>1963</td>
<td>73,607</td>
<td>17,808</td>
<td>1,825</td>
<td>12,068</td>
<td>105,308</td>
<td>50,077</td>
<td>19,048</td>
<td>13,616</td>
<td>188,049</td>
</tr>
<tr>
<td>1964</td>
<td>78,776</td>
<td>19,655</td>
<td>1,428</td>
<td>12,657</td>
<td>112,516</td>
<td>57,027</td>
<td>19,354</td>
<td>14,315</td>
<td>203,212</td>
</tr>
<tr>
<td>1965</td>
<td>87,179</td>
<td>21,166</td>
<td>1,190</td>
<td>13,322</td>
<td>122,857</td>
<td>61,372</td>
<td>21,033</td>
<td>16,418</td>
<td>221,680</td>
</tr>
<tr>
<td>1966</td>
<td>102,296</td>
<td>21,034</td>
<td>1,031</td>
<td>14,322</td>
<td>138,683</td>
<td>71,681</td>
<td>23,255</td>
<td>18,892</td>
<td>252,511</td>
</tr>
<tr>
<td>1967</td>
<td>120,019</td>
<td>25,763</td>
<td>1,182</td>
<td>14,545</td>
<td>161,509</td>
<td>79,156</td>
<td>25,493</td>
<td>26,945</td>
<td>293,103</td>
</tr>
<tr>
<td>1968</td>
<td>144,928</td>
<td>28,185</td>
<td>1,317</td>
<td>15,346</td>
<td>189,776</td>
<td>91,174</td>
<td>28,580</td>
<td>25,607</td>
<td>335,137</td>
</tr>
<tr>
<td>1970</td>
<td>192,010</td>
<td>39,100</td>
<td>1,665</td>
<td>16,525</td>
<td>249,300</td>
<td>123,961</td>
<td>30,143</td>
<td>29,896</td>
<td>441,320</td>
</tr>
<tr>
<td>1971</td>
<td>220,995</td>
<td>37,280</td>
<td>2,017</td>
<td>18,387</td>
<td>278,679</td>
<td>135,961</td>
<td>43,892</td>
<td>36,769</td>
<td>495,121</td>
</tr>
</tbody>
</table>

Source: Expenditure on Personal Health Care in Canada, 1960-71, Health and Welfare, Canada. Table 15
TABLE XVIII

Table II.2—Estimated National Health Expenditures, Canada: Distribution by Category of Expenditure (Percentage of Total)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Care</td>
<td>45.3</td>
<td>45.9</td>
<td>46.9</td>
<td>47.9</td>
<td>48.6</td>
<td>48.8</td>
<td>47.7</td>
</tr>
<tr>
<td>Nursing-home Care</td>
<td>2.5</td>
<td>2.5</td>
<td>2.6</td>
<td>2.6</td>
<td>2.7</td>
<td>2.8</td>
<td>2.3</td>
</tr>
<tr>
<td>Total Institutional Care</td>
<td>47.9</td>
<td>48.4</td>
<td>49.6</td>
<td>59.5</td>
<td>51.3</td>
<td>51.7</td>
<td>50.5</td>
</tr>
<tr>
<td>Physicians' Services</td>
<td>16.9</td>
<td>16.6</td>
<td>16.8</td>
<td>17.0</td>
<td>17.5</td>
<td>17.8</td>
<td>18.7</td>
</tr>
<tr>
<td>Dentists' Services</td>
<td>5.0</td>
<td>4.8</td>
<td>4.6</td>
<td>4.6</td>
<td>4.7</td>
<td>4.5</td>
<td>4.3</td>
</tr>
<tr>
<td>Other Professional Services</td>
<td>2.3</td>
<td>2.0</td>
<td>2.0</td>
<td>2.0</td>
<td>2.0</td>
<td>2.0</td>
<td>1.8</td>
</tr>
<tr>
<td>Total Professional Services</td>
<td>14.7</td>
<td>13.5</td>
<td>13.4</td>
<td>13.4</td>
<td>13.4</td>
<td>13.0</td>
<td>13.2</td>
</tr>
<tr>
<td>Drugs and Appliances</td>
<td>14.2</td>
<td>13.8</td>
<td>13.7</td>
<td>13.4</td>
<td>12.9</td>
<td>13.0</td>
<td>13.2</td>
</tr>
<tr>
<td>Total Personal Health Care</td>
<td>86.2</td>
<td>85.7</td>
<td>86.7</td>
<td>87.5</td>
<td>88.4</td>
<td>89.0</td>
<td>88.8</td>
</tr>
<tr>
<td>Cost of Prepayment &amp; Administration</td>
<td>2.2</td>
<td>2.0</td>
<td>1.5</td>
<td>1.7</td>
<td>1.3</td>
<td>1.5</td>
<td>1.8</td>
</tr>
<tr>
<td>Government Public Health Activities</td>
<td>3.6</td>
<td>3.9</td>
<td>3.6</td>
<td>3.6</td>
<td>3.1</td>
<td>3.3</td>
<td>3.1</td>
</tr>
<tr>
<td>Voluntary Health Organizations</td>
<td>0.4</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>Research</td>
<td>0.8</td>
<td>0.9</td>
<td>1.0</td>
<td>1.0</td>
<td>1.1</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Medical Facility Construction</td>
<td>6.8</td>
<td>7.2</td>
<td>6.9</td>
<td>6.4</td>
<td>5.5</td>
<td>5.0</td>
<td>5.1</td>
</tr>
<tr>
<td>Total Other Health Expenditures</td>
<td>13.8</td>
<td>14.3</td>
<td>13.3</td>
<td>12.5</td>
<td>11.6</td>
<td>11.0</td>
<td>11.2</td>
</tr>
<tr>
<td>Total National Health Expenditures</td>
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<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Includes general and allied special hospitals, mental hospitals, tuberculosis sanatoria, and federal hospitals.

**Includes chiropractors, naturopaths, osteopaths, podiatrists, physiotherapists, and private duty and Victorian Order nurses.

**Expenditures relating to professionals employed in various institutions are included in institutional care.

*Includes prescribed and non-prescribed drugs, eyeglasses from optometrists and from opticians, hearing aids and parts, and other prostheses.


CHAPTER VII

PROGRAMMING WITHOUT A POLICY

At the beginning of this exercise to develop the elements of a plan to address the health needs of the elderly in British Columbia, we set ourselves to look for trends in the past development of the services which might help us when recommending the course which should be taken in the future. In fact, past trends have not been as clear-cut as we had hoped.

What we have found is that the main trends which have affected the elderly (e.g. the growing importance of medical care) affect all age groups. Many social attitudes which affect the elderly (e.g. the lower status of 'non-productive' members of society) affect other groups also (the disabled, the unemployed). Sometimes factors which might appear to be in the interests of the elderly (i.e. no discrimination with regard to eligibility for medical care) in fact fail to take into account that they may have some different needs. And finally, there could not be special provisions for the elderly as a 'category' until they were recognized as a category. This assignation of a special status to the elderly has taken place at different times in the various services, and in some, has not happened at all.

SYSTEM TRENDS OR FEATURES WHICH AFFECT ALL AGE GROUPS

The major trends in the development of health services apply to the population as a whole.

From the early days of the province of British Columbia, great
importance was attached to hospitals. Even when communities had to finance the building of their own hospitals they were built because they were a source of prestige and community pride as well as of services and employment. Hospital construction grants gave impetus to the trend, with building being seen also as an economic measure. Because even by 1948, hospitals could not obtain enough revenue to finance their operations, B.C. passed the Hospital Insurance Act (covering, on payment of a premium initially, treatment of acute illness, active treatment of chronic illness, outpatient treatment and diagnostic services, and including the elderly and infirm), long before the federal government passed cost-sharing legislation in 1957, which still applied to acute hospital care only.

That the benefits of new technological developments which can be provided only in hospital may be demanded by physicians and the public in their own locality, that hospitals may still be allocated to bestow political favours in certain communities, and that local communities still partly 'call the tune' without having responsibility for finding the necessary funds, have all contributed to the generous provision of hospitals. With the highly skilled services and complex equipment they provide in one location, the opportunity they offer for associating with colleagues and for seeing several patients in one visit, hospitals are also attractive places for doctors to do business in. And present methods of financing encourage hospitals to keep their beds full.

These factors, together with the fact that hospital insurance came before medical insurance all contributed to an emphasis on the acute hospital which has made the Canadian and B.C. provision of acute hospital
beds high by international standards though B.C. is below the Canadian average for acute beds. The elderly have been as entitled as any other age group to acute hospital care and as we have seen, have consumed an amount of it disproportionate to their numbers in the population.

Because of the nature of their needs, the elderly have been more affected than younger people by the failure to fund or cost share chronic and custodial care at the same time as acute hospital care.

Extended care beds are occupied mainly by the elderly but when they were originally cost-shared it was probably more to enable the freeing up of acute beds than with the special need of the elderly in mind.

The elderly are not the only group to have experienced the inadequacies of rehabilitation services (in amount and co-ordination), or the shortage of community services as compared with institutional ones.

We have seen (chaps. 1 and 2), that most federal and provincial reports over the years have recommended the provision and funding of various alternatives to the acute hospital, the provision of a complete range of services, and new patterns of delivery, but so far these recommendations have never been implemented in any serious way. The main problems appear to be lack of provincial consensus (as in 1945) and the resistance of the medical profession to any restructuring which might threaten their autonomy and their exclusive authority. (Incidentally the chances of overcoming this resistance do not seem too high [Mechanic, 1974].)

Even services of which the elderly are now heavy users were not set up originally with them in mind. Home care was started for young
mothers, public health nursing and home visiting, for young children; but these services were flexible enough to meet changing demand and the demand eventually came from people who happened to be old.

There have been a very few services provided specially for the elderly in the health field. Some public health units, mainly in Vancouver, began to provide special clinics just before Medicare was introduced, and mental hospitals for the elderly are separate institutions. But on the whole, there are no special services for the elderly in public health units, and pretty well no services for the elderly in mental health units throughout the Province; no special services in acute hospitals or in the system of ambulatory medical care.

The elderly have been eligible for some services under the category of 'indigent'. e.g. the medical services plan administered from 1943 by the Welfare Branch (Over two-thirds of the beneficiaries were elderly), the payment of hospital insurance premiums from 1952, and of medicare premiums since 1965 though the elderly may have been the principal target group. (It is worth noting that the Social Assistance Medical Care Scheme gave rise to a 'second class system of medicine', payment of medicare premiums could not. One might also note that many of the features criticized in the Medicare system in the U.S. are attributable to the fact that it is provided for the elderly as a category.) At present the Department of Human Resources pays for transportation, medical services and supplies and equipment not covered by medicare for recipients of GAINS.

For other services, the elderly have been bracketed with the handicapped e.g. community grants for projects providing
transportation, and indeed GAINS itself.

There is no universal right of 'citizens' including the elderly, to welfare services as there is to medical services.

The elderly are affected as are all consumers of services by the lack of co-ordination of various services, especially health, welfare and housing at any level, and by the facts that regional health districts, health unit areas, resource board areas do not coincide, and that funding of various community services (and therefore their continuance) is not guaranteed from year to year.

SERVICES FOR THE ELDERLY

In contrast to the physical health care system, the mental health care system has separated out the elderly. In the community and acute hospital services, there is no definite policy of excluding the elderly but the programs offered are usually said by staff not to be suitable for the elderly. In the mental institutions there has been a deliberate decision to segregate the elderly. Originally the purpose of this was to separate the 'aged and decadent' 'senile' who were not expected to recover, from the younger psychotic who were supposed to respond to treatment. In practice it seems that those patients who have benefitted from the active treatment and rehabilitation programme at Valleyview have probably fared better than they would have done if mixed in with other age groups in a large institution. Valleyview staff have also viewed community care as the goal for as many patients as possible. Terrace and Dellview are mainly care situations.

The Pharmacare programme was set up for the specific benefit of
the elderly, and they alone are eligible for subsidized bus fares.

The two services where special provision has been quite definitely made for the elderly as a category are income maintenance and housing. Before public provision of any other sort of service was considered, it was recognized that everyone needed money and shelter.

Income maintenance has always been an important issue in political terms, and income is what the elderly themselves always ask for. The first old age pensions were probably enacted mainly in response to trade union pressure and to the recognition of the genuine poverty which many elderly people were experiencing, and to which the population as a whole was sympathetic, although fears were expressed in the senate that pensions would undermine thrift and family responsibility. B.C. was the first province to take advantage of the federal legislation which would differentiate between the old and the 'destitute' and it also paid supplements to the old and the blind from 1942. The first old age pensions were administered federally by the Department of Labour, and in B.C. by the W.C.B. The old age pensions and assistance granted in 1951 may have been a substitute (along with children's allowances), for a universal social security scheme.

At the Canadian Pension Conference held in Toronto in 1964 to hear various views on the proposed Canada Pension Plan, doubts were expressed about the effect on men's happiness of 'elaborate provisions for security' [Canadian Pension Conference, 1964]. Indeed old age insurance (as the CPP was) was introduced late in Canada compared with most countries, and has never been a very important part of the income of the elderly though it is becoming more so now. (The private insurance market has always
opposed it.) The G.I.S. had to be added in response to the disclosures of the Special Senate Committee on Aging about the number of elderly people living in poverty. When the 1970 White Paper on Income Security, which would have concentrated benefits on certain needy groups was thrown out of the House of Commons, mainly because of middle-class opposition, [McPhee, 1976, chap. II] its provisions with regard to the elderly were coincidentally included.

It is not in the Canadian tradition to provide unearned income support benefits easily or generously. However, old age assistance rates from their inception have always been slightly higher than the general assistance rates. And the old age pension plus guaranteed income supplement is also somewhat higher these days. So it does seem to be accepted that the elderly have more right to state support than younger 'non-producing' members of the community. Also, since 1951, old age pensions have, theoretically at least, been financed by various taxes which gives recipients some feeling of entitlement, and as we have already said, the CPP is self-financing.

Who distributes these various monies is a federal government decision, with the federal government retaining the power to redistribute income and the provinces being left to 'support the incomes of those who are in need' [Trudeau, 1969 (2)].

Looking at accommodation, we find that from the early days of the Province, there was some provision of homes for old people. One of the first institutions built from public funds in B.C., and certainly the largest up to that time, was the Provincial Home for the Aged and Infirm.
(150 places), opened in Kamloops in 1893 - but residents were probably a particular type - the bachelor pioneer, and residents were more likely seen as individuals than as a 'group'. In 1935, the Provincial Home for the Aged Act was passed and the Provincial Infirmary for the Chronically Ill was established in 1937.

As early as 1947, the B.C. government announced substantial financial assistance for municipalities or groups to establish homes for the elderly. (This was at a time when the old age pensions board was describing a serious lack of accommodation for this age group.) The B.C. Elderly Citizens' Housing Aid Act (1955) also preceded the first (1964) federal legislation making provision specifically for the elderly. Since then, there have been rent supplementation for elderly persons in public housing, the Real Property Tax Deferment Act, The Renters' Tax Credit Program, and now (March 1977) the announcement of the Social Assistance for Elderly Renters Programme.

LACK OF POLICY

What emerges from studying the services which are provided for the elderly or include the elderly among their consumers, is the lack of any coherent policy with regard to the elderly as a group - at the federal or the Provincial level.

There has been an attempt at a policy on health in Canada. (e.g. the Health Charter for Canadians of the Hall Commission, 1954, Lalonde 1974, etc.) The Quebec Ministry of Social Affairs has enunciated a policy with regard to old people [ Ministere des Affaires Sociales, 1975]. The 1st and 2nd B.C. Conferences on Aging expressed the need for a policy, as did the Special
Senate Committee on Aging and the Canadian Conference on Aging in 1966—as in fact, does any group which looks at the overall needs of the elderly. Maybe that is why the body in B.C. which got nearest to formulating an overall policy was the Old Age Pensions Board which functioned from 1943 to 1952, and which was part of a Department of Health and Welfare. In addition to economic security (the main concern of the Board), it stated that other securities were essential to 'the good life'. It therefore listed the measures it proposed to take to attempt to bring these other securities within the reach of the elderly—including provision of various services and a concern with housing and with health, which they saw as affected by housing, nourishment and income as well as medical care (1946-47). In 1949-50 when they realised that they were the only focal point for bringing together and examining information about the elderly in B.C., they pointed out that we should be thinking of what would make the good life 'for all our older citizens—not only 'pensioners' '. It is also evidence of their conception of a policy that at a stage when their workers were 'taxed beyond capacity', they set targets in order to use their resources most efficiently and with regard to the needs of competing groups.

On the whole however, we can find no evidence of a Federal or Provincial policy. Even 'A New Perspective' fails to convince that it has a policy with regard to the elderly, and even the 1972 N.D.P. government which identified the elderly as a group requiring special consideration, did little more really than provide more of the same.

By 'policy', we understand 'any set of values, opinions and
actions which moves decision-making . . . in certain directions' [Anderson, 1966]. With regard to the elderly in Canada at this time, it seems that there has been a failure to clarify values or even to reach a consensus on norms.

One writer provides a very useful framework for understanding this type of situation [Jantsch, 1970]. In an analysis of 'rational creative action', he describes three levels of functional relations between a plan and the environment. These are:

1. Policymaking functions which result in normative planning and are directed toward the search and establishment of new norms that will help define those values which will be more consonant with the problematic environment.

2. Goalsetting functions which result in strategic plans which will achieve such objectives of the normative plan as can be reduced to feasible and attainable goals.

3. Administrative functions which lead to operational planning wherein strategies to be implemented are ordered according to various constraints.

At each level there are four processes which take place. Forecasting and planning are linked by relevance; planning provides information for decision-making; decision-making provides the organization for action, and rational creative action deals with the creation of institutions, instrumentalities and operations (depending on which of the three levels is involved.) Policy-making is the guiding function of the entire action process. (This is depicted schematically in Figure VI) This analysis also shows that unless the underlying values and norms of any policy are
stated and analyzed, and unless policymaking emanates from this level, other values and norms will be implemented by default. For example if all the action is at the operational level, current structures, modes of operation and norms are reinforced in bureaucratic type action; if most of the action originates at the strategic level, there is technocratic type behaviour which will probably mean the indiscriminate (non-normative) creation of new structures and instrumentalities (Figure VII).

**EFFECTS OF LACK OF POLICY**

We can now see why lack of a policy can lead to the incoherent and potentially inappropriate provision of services, and how it can account for these aspects of the provision of services for the elderly. The implementation of the Canada Assistance Plan, and the ad hoc measures in the field of housing in the last few years are only two examples out of many bureaucratic decisions where there was no looking beyond the tactical level. There are examples too, of situations where attempts have been made to improve efficiency, but outcomes cannot be measured or the means of achieving them understood. We think of such things as the rigid application of the classification of levels of care, the strict rules for the physical standards of community care facilities, the increase of the home care budget from $1 million to $8 million in two years after the Select Standing Committee on Social Welfare and Education recommended that there should be more home care.

Some actions have been technocratic in the sense that means to ends were known but the ends were not analyzed or sometimes even understood. This would explain the expansion of the acute medical care system,
why it is seen as more important to free an acute bed immediately than
to make long-term discharge plans, why on the other hand it is important
to keep beds full. Some institutions and instrumentalities are so firmly
entrenched that change is impossible unless the values and norms which
buttress them are undermined. This could apply to the institutions of
medicine and free enterprise, the instrumentalities of hospitals and
other institutions, of separate health and welfare departments and corres-
ponding 'departmental' solutions.

In fact we can see that very many aspects of the delivery of health
care to the elderly in B.C. accord with the sorts of situation described
by Jantsch as degeneration of an 'rational creative action'.

If one does not 'get back to basics' or have some alternate values
or at least norms to which to refer, one ends up with various anomalous
situations and various problematic situations which it is hard to resolve.
When the federal administration of old age pensions was transferred
originally from the Department of Labour to the Department of Finance, what
was the rationale behind the more stringent testing of eligibility? What
were the implications of turning several hundred residents of Provincial
Homes for the Aged into committed inmates of mental hospitals by the 1958
amendment to the Mental Health Act? We financed hospitals for the sick
and residential care for 'those in need' but failed to provide a 'programme'
to bridge the gap. In fact the whole fragmentation of legislation and
provision of services can be traced to the lack of a unifying policy. When
the government reduces its grant to CARS, does it see this as depriving a
large number of elderly women of treatment for their rheumatoid arthritis-
or as so many dollars saved or allocated to services which now have more priority? When it finances a kidney dialysis programme, does it mean to keep people aged over 70 alive? [Crichton, 1974 p. V-44] New Horizons is the first programme outside income maintenance provided directly by the federal government for the elderly. Has it reached its target populations, and if not, why not? The N.D.P. government started buying private hospitals. The present government is continuing the trend. Why? What is the underlying policy?

**REASONS FOR LACK OF POLICY**

There are two factors in Canada which seem to take precedence over any other 'policy'. One is the over-riding importance accorded to economic considerations. In Canadian government statements, economic goals are always put ahead of social goals and social welfare expenditures described as 'a burden'. [McPhee, 1976 pp. VII-14 to 17] This of course affects all age groups but may especially affect the 'non-productive' elderly. For example, the rehabilitation facilities provided in the community by the Aid to Handicapped Division under the VRDP Act\* according to which the Department of Labour cost-shares services for those who can be helped to pursue regularly 'a substantially gainful occupation', are not provided for the elderly who might be helped to live independently or to live outside an institution. On a wider scale, the whole question of redistribution of income is involved. The Senate Committee on Aging felt it necessary to point out (p. 79) that 'It should be remembered that the very objective of economic endeavour is to achieve a maximum of well-being for people and that considerations of economic investment must not be the only ones taken into

* Vocational Rehabilitation of Disabled Persons.
The other important factor mitigating against the implementation of federal or provincial 'policies' in Canada is the federal system of government. The federal government is often obliged to yield on policies for the sake of keeping the federal system together'. [Doern and Aucoin, 1971] Provincial governments, if they need federal funding to proceed, have to wait on federal initiation of programmes, and federal priorities or policies do not necessarily accord with provincial ones. B.C. has always taken advantage immediately of federal health and welfare legislation and indeed has anticipated some, but mincome and pharmacare (the first now changed and the second about to be so) are the only programmes in favour of the elderly which have been carried on in recent years without federal subsidization. In other words fiscal policy may have more effect than conceptions of need on the services provided at the provincial level, and constitutional considerations may take priority over other policies at the federal level.

Apart from these considerations, we think that there are two reasons why, to date there has not been a clear policy regarding the treatment of the elderly in this country and province. One is that it is not all that long since the elderly were recognized as a category. The other is uncertainty as to the role and status of the elderly in today's society.

Lack of Categorization of Elderly

Before the end of the second world war, few studies had been carried out in industrial societies of the aged and the aging process. Though the number of people aged 65 and over in Britain increased between
1900 and the mid 1940s from under two million to five million, little in-
formation was published on the aged, and it was not until 1948 that "the first 
really perceptive account of the social problems of the elderly" was 
produced [Townsend, 1966]. In the U.S., growing public awareness and govern-
ment involvement culminated in the 1961 White House Conference on Aging. 
Nevertheless, pensions for the elderly were legislated much earlier than 
that in both countries, showing that there was an awareness of them as a 
group with special needs.

In Canada, the Old Age Assistance Act, the first major federal-provincial 
cost-shared programme, was introduced in 1927. Till the 1920s any aid to the 
elderly was accorded by charitable organizations and by whatever municipal 
offices existed to provide relief to destitute persons of any age. And even 
after the passing of the Old Age Assistance Act, there does not seem to have 
been any special awareness of the elderly as a 'category'. In 'Public 
Welfare Administration in Canada', published in 1930, apart from the briefest 
of references to old age pensions, the author makes no mention of the 
elderly. [Strong, 1930]. In 1963, when the Special Senate Committee on 
Aging was taking evidence, there had been almost no research in Canada in 
the field of aging apart from purely medical research,¹ and by 1964, the 
Dominion Burear of Statistics had only just been persuaded to collect 
statistics in such a way as to provide information on the elderly. [Canadian 
Pension Conference, 1964, p.23]

However, the number of articles on gerontology and geriatrics 
published in 1964 was eight times greater than the average number of articles 
published annually from 1928 to 1963. "The year 1964, therefore, can
be considered the year the issue of aging 'came of age' in Canada'.
[Environics Research Group, 1973] In the evidence to the Special Senate Committee it was also pointed out that "We are experiencing a groundswell of concern for the aging in our society . . . -older people are more vulnerable to change than other social groups, more liable to be discarded in the ruthless march toward 'progress'".  

Up till that time, the problems of the poor had been more striking than the problems of the elderly. Too, the elderly were seen as individuals who happened to be aged. (The Hall Report of 1961 does not even mention 'the old' as a special category.) It was not taken for granted that the elderly were entitled to 'leisure'. In the 50s they were mostly working like anyone else unless they were ill, so that the only ones who were dependent financially were dependent physically and thus eligible for special treatment. Otherwise, they were subjected to the same norms as everyone else. For example in 1958, the Canadian Welfare Council did not recommend a lowering of the age limit for old age pensions to sixty-five because it would encourage the able-bodied to retire and employers to retire them. [Canadian Welfare Council, 1958]

However, in the 50s the percentage of elderly in the population was over 7 per cent and reached the million mark for the first time, and from the early 60s there was increased interest in the special needs of the elderly. The Saskatchewan government published its important report, the Canadian Welfare Council was exploring needs and preparing the 1966 national conference. There was a growing range of experimentation in the provision of services, particularly by private agencies. The evidence
presented to the Special Senate Committee revealed much more deprivation than had been realized. And finally there were the negotiations about, and eventual implementation of, the Canada Pension Plan. And that, plus the fact that by 1970 the age of eligibility for the old age pension had dropped to 65, probably did more than anything else to create a special category of 'elderly persons' in Canada. From then on, one was 'old' at sixty-five. Not only could one be legitimately retired then, it rapidly came to be the exception to be allowed to work beyond that age. This deprivation of the right to contribute as a member of the work force, and consequent sudden large drop in income immediately sets aside this now large group from the mainstream of Canadian life.

In B.C. we see a similar pattern. In real numbers there were not four and a half thousand people aged sixty-five and over in 1901 (The total population was 178,657). In 1921 there were only eighteen thousand, but sixty-eight thousand by 1941, 126 thousand by 1951, and 165 thousand by 1961. In 1950, there was the first mention in Health Branch Reports of the increasing numbers of elderly in the population. By 1954, the Vancouver Senior MHO was noting a need for expanded services for 'citizens in the upper age brackets' but it was 1966 before the elderly were first mentioned as 'a group'.

In a less affluent age, the elderly on low incomes would not be so exceptional either. In 1949, the Old Age Pension Board notes that 'pensioners include well-adjusted old folk, living relatively comfortably ...'. There was no rush to enter the category of 'pensioner' in 1951 when means-tested assistance became available at age sixty-five. (Only 23 per cent of
persons over that age applied.) Pensioners themselves did form associations to fight for better pension conditions but otherwise did not seem to see themselves as a group.

The First B.C. Conference on the Needs and Problems of the Aging (1957) was the first provincial conference on aging—appropriately because B.C. had a higher percentage of people over sixty-five years of age than any other Canadian province at that time. The Conference was considered necessary because the increasing number of old people over sixty-five, their increasing dependence on their own resources, and the increasing cost of living had developed into a situation which was "a challenge for each community and for governments at all levels". In fact, "No thinking person would now dispute that old age is one of the most formidable problems of our time . . . second in importance only to the problem of world peace". [Community Chest and Councils, 1956]

Uncertainty about the Role and Status of the Elderly

From the foregoing it appears that the emergence of the elderly as a group has been accompanied by a growing uncertainty as to their role and status. As long as the elderly are seen as individuals, they have a role as individuals. In traditional societies, even as a category there is an etiquette for their treatment ranging from the role of 'venerated elder' at one extreme to the status of 'disposable by neglect' at the other. But such rapid change as has taken place in this century in the Western world upsets the social order and requires re-consideration of roles and reallocation of status. So far on this continent, social structures have not evolved nor attitudes changed to accommodate to the increased elderly
population and rapid technological change.

On the one hand, one of the results of technological change is the requirement for less manpower in the work force and the now almost enforced retirement of employees at the age of sixty-five, which deprives them of their feeling of worth, [Miller 1968] their status as contributing members of society, [Rose 1968 and various testimonies to the Senate Committee on Aging] and of their income. And then, because people's value to society tends to be judged by that very contribution which the elderly are prevented from making, there is considerable ambivalence regarding the share of the social weal which should be allocated to them. Are they dependent people requiring help, people who after a lifetime of labour deserve a reward, or simply, 'problems' to the social and economic order? (A perusal of various reports and other writings on the elderly shows that up to the time when the elderly emerged as a recognized category (i.e. in the middle sixties) what people were concerned about were the needs or problems of the elderly and how these should be dealt with by society. More recently the tendency has been to talk more in terms of the problem which the elderly present to society).

Other changes have affected the relationship of elderly persons with their families. It seems likely that multi-generational families living under one roof were not as common in the past as is often supposed [Goode, 1963]. And when they did live together, it may have been in the aged person's house, the aged person may not have been all that aged (When articles in the Toronto newspapers of 100 years ago talk of old people, the people are aged fifty-five years), and he/she was probably
pretty fit and able to contribute—or he would have been dead. Nor is there any evidence that where there was three-generation co-habitation, it was harmonious or from choice. (Novelists are probably as illuminating on this as are the sociologists.) It is also clear that in the present era, a high proportion of elderly North Americans do live near their relatives. (About 62 per cent of the 2,567 old people studied by Shanas in 1968 had a son or daughter living within walking distance.) (See also Audain, 1972, Manitoba Dept. of Health, 1973).

That the elderly are no longer 'integrated' into the families of their children is explained by smaller houses, employment for both spouses, lack of sense of duty on the part of unmarried women. But old people are also more 'emancipated' than they once were. They may be healthy, alert, strong characters with full lives of their own. The elderly mother may be no more willing nowadays to take second place in the kitchen than the young wife is, and there are more community activities to be involved in. Only 40 per cent in the Beyond Shelter study said that it was important to them to live close to their children. The rest preferred a neighbour and access to services. And very few nowadays would choose to live with their children. [Townsend 1957, Zay 1966, Shanas 1969].

In a study undertaken by the Coast Garibaldi Health Unit, it was found that 60 per cent of elderly persons were not willing to move in with their family even if it were necessary, and even though 50 per cent of the families had offered [Harmon 1973]. Like most of us, the elderly show what they really want by their behaviour. And between 1951 and 1961, after the introduction of old age pensions, there was an obvious drop in
the number of elderly, even widowed ones, who lived with their children. Sometimes it is the young people who cannot accept the new styles. They feel guilty about not sheltering their parents or fear for their safety if they insist on coping alone.

Other factors affect our treatment of the elderly. If they are reminders of aging and death, in a society which tries to shut out the awareness of aging and death, then we may wish to shut them out. If we are less tolerant of deviance or if there is more of it, we may label 'senility' a disease and remove the senile from the public view. In fact, is institutional care the easy way out, particularly when community resources are scarce, or a technique for relieving the elderly of all their worries (Government of Quebec, Vol. IV Tome I part 4, pp. 87-90) or a way of protecting those 'lacking the full physical equipment' from the action-achievement-success orientation of American society (Kutner 1964)—or a way of protecting society?

NEED FOR A POLICY

In the first part of this chapter we came to the conclusion that the lack of a basic policy to refer to was the main explanation for many of the problems which we have identified in the present provision of services for the elderly. And we have tried to discover some of the reasons for this. We now proceed to explain why it is particularly important at this time to develop a policy as a basis for the future planning and development of services for the elderly. We see four main reasons for this:

1) We are presently suffering from the results of former lack of policy
whereby inappropriate provisions have been allowed to develop and expand
and services have been provided in a way that is not in the best interests
of the elderly even though appropriate ones might have been cheaper
2) The changed and changing nature of the elderly population requires new
approaches
3) The size of the elderly population requires new approaches
4) Successful, comprehensive planning must be based on a conscious,
coherent policy.

1) We have already described a variety of problems which stem
from the lack of policy in the past. We would add that other results are:
lack of information about the elderly, their needs and use of services,
about outcomes of service, etc. because there has not been grappling with
policy issues which would give rise to a series of questions; and lack of
personnel trained in geriatrics and gerontology because of the failure to
delineate this as a special and relevant 'field'.

2) The changed nature of the elderly population, e.g. the majority
financially dependent though physically healthy, a large group and yet in
some ways on the fringe of the on-going life of the community, makes them
worthy of special consideration. There is evidence that the elderly have a
negative view of society's attitude to them [Signori, Kozak 1976, etc.].
And indeed they are often seen as a homogeneous group with a negative image,
having medical economic, social and personal problems with which assistance
is needed. The unjustified stereotyping of them as inflexible, conservative,
declining intellectually, plus their forced exclusion from the work force,
both serve to act against their integration into society and contribute to
boredom, loneliness and unhappiness. In later old age, declining health and death of peers aggravate the situation. We consider it unrealistic to believe that the social services (or indeed any agent, deliberately) can 'define a new role' for the elderly in our society but it would at least be appropriate to ensure that measures taken do not increase alienation, particularly in view of the tendency noted, to label and set aside. We must also consider whether, as Kahn recommended society should 'guarantee and institutionalize the means to assure that essential old functions are discharged in new ways and that new functions are recognized as legitimate responses to new circumstances'. Elderly people may have many reasons for adopting the sick role. [Tibbitts, 1970]

The aged individual, occupationless and with no traditionally assured place in the families established by his daughters or sons, through illness may once again become an integral member of a meaningful social group, cared for either by his grown children or by a medical community of some sort. [Parsons, Fox, 1960]

We may have to think of ways other than illness behaviour to institutionalize. To take a very topical example, in the health field, now that concerns such as environmental pollution and participation programs are demanding a new and bigger share of public health resources, and as health is being seen more and more as a matter of person responsibility with the accent on prevention, where are the elderly going to fit in in all this, what share of resources is going to be allocated to people whose problems are often past the preventable stage? And perhaps, above all, what can take the place of employment as a source of life satisfaction and thus of 'health'.

3) We are long past the day when people became eligible for the
old age pension only after they were well beyond the age of life expectancy at birth. Now the elderly are an important part of the population, not a few rare individuals. Aging is a normal fact of life, and it is not until well into old age that it is usual for the elderly to require a lot of medical care. False ideas about old age and stereotyped notions about the elderly require to be contradicted because they are resulting in inappropriate behaviour by the elderly and inappropriate attitudes to the elderly by other people e.g. the idea that old age is a medical condition. From the point of view of the planner however, it has to be borne in mind that the debility of old age is more likely to be postponed than prevented. There are going to be more old people, and more old, old people; so it is important to decide how to provide adequate support as economically as possible.

As Dubos points out (1959), the political philosophy of a population made up largely of young and adult men eager for economic expansion is bound to differ from that of a community consisting in large part of older individuals concerned with problems of retirement, and as the percentage of individuals past the wage-earning age becomes larger, there is increasing demand for social security and for a planned economy to provide for old age. A study of the social security systems of 60 countries concluded that social security spending was strongly correlated with age of population (percentage of old people), age of system, and per capita GNP, in that order. Type of political system contributed little to the type of social security effort. When twenty-two industrialized countries were ranked for social security spending as a percentage of G.N.P., Canada
was sixteenth (Wilensky 1975). It was still in about the same position in 1971 when it was fourth in the world list of affluent countries. As its elderly population increases proportionately, it may have to increase this percentage. Whether or not it moves from this position, the exponential increase in the numbers and proportion of the population over the age of sixty-five will in future place an unprecedented burden on the tax-paying population. (In 1952 when the British government saw a similar situation ten years ahead, it immediately raised national insurance contributions.) For hospitalization alone, if past trends remained the same they should require 42.5 per cent of the overall increased number of hospital days by the year 2001, which would represent an enormous cost (a very good reason for considering what are the alternatives). There has to be a policy then on the amount of the overall resources to be devoted to the elderly, how much of it is to be by way of enforced savings by the elderly themselves (i.e. insurance), and within the resources devoted to the elderly, what will be the optimal allocation to different service sectors.

4) We need a policy with regard to the elderly just because planning for them will have to fit in with the social and economic goals of the wider society. At the same time, without an embracing policy, they may be accommodated but they will not be integrated into society. (The same could also be said, of course, of the mentally handicapped and the disabled.)

An important reason for any organization having a policy at any time is for the reconciliation (as far as possible) of conflicting goals;
to provide a framework within which various components (departments) may function as a system, and to offer ends to which the totality of services and specific actions can be directed. We need a policy according to which we can delineate other policies. (For example people talk freely about community care. We still have to spell out more clearly the intention of community care, not to mention the costs.) When there is one programme financed by various bodies, one body financing various programmes, or different bodies financing various programmes, only an overall policy can effect the necessary co-ordination. We need a policy within which to understand the actual nature of some problems. For example, the lack of a 'place' for people under seventy suffering from organic brain syndrome. We know what the problem is for the patient and relatives. But what is the real problem as far as the system is concerned?

We need a policy in order to know where and how the voluntary sector can fit in so as to make the maximum contribution possible. Adequate care for the elderly in the future will be impossible without a large volunteer input. And this should be used as effectively as possible.

We need a policy as a rationale if we want to cut back on some programmes which presently have in-built spiralling costs (and vested interests). We need a policy to decide whether and then how, to alter people's perception of their health needs. The outcomes we want to achieve may not be easily measurable in numbers, or may be so expensive to evaluate that it would be better to spend money on services. It is not always possible to measure precise costs or trade-offs for one age group. So we may need a policy which accepts that trends are as much as we can measure.
But at least we can justify our lack of precision in the knowledge that there are sound reasons for it.

We need a policy because to evolve a policy requires thought and brings realization of all the things we do not know, need to know, and should try to discover.

We need a policy because we are planning for change, and fundamental change does not take place at the strategic or operational level. We need a policy finally, because without one, the status and treatment of the elderly will be decided by default, and it is unlikely that this would be to the benefit of either the elderly or of society.
NOTES


FIGURE VI

Fig. 3. Structured rationalization of creative action. (Dotted arrows indicate feedback.)

Source: Jantsch, Erich, 'From Forecasting and Planning to Policy Sciences, p.36
(a) "Bureaucratic" Type. Action here is neither rational nor creative. The result is the rigidification of current structures, activities, and modes of operation.

(b) "Technocratic" Type. The result is the indiscriminate (nonnormative) creation of new structures and instrumentalties: "Can" implies "ought," as evidenced by "the triumph of technology" (Ozbekhan).

(c) "Futurocratic" Type. The result is the futile attempt of "system-immanent" change through measures at the operational, or at most, strategic level only.

Fig. 4: Types of degeneration of the process of rational creative action.

Source: Jantsch, Erich, 'From Forecasting and Planning to Policy Sciences, p. 40
CHAPTER VIII

ELEMENTS OF A PLAN

At the present time in Canada, there is an expressed intention to contain the escalation in the cost of providing health care, which is understood to mean medical and hospital care. However, if the aim of health care is the preservation and improvement of health and the prevention of disease, health care concerns are only a part of the concern for general well-being in a society, health services are only one part of social services, and indeed only one of several services which contribute to health; not only are income, housing, and various community services also involved but they are also inter-related and often substitutable; indeed problems in social functioning are often what motivate people to present to a doctor [Balint 1957]. So ideally, the impact and interaction of all the relevant services would have to be evaluated if resource allocation and decision-making were to be optimized - for any age group.

Our research suggests that consumption of medical and hospital care could be reduced without prejudice to the health of the people, if more preventive, community and social services were developed as alternatives to the medical care which is now so readily available to most people, and if professionals and the public were educated to realise that needs which are now perceived as needs for medical care may in fact be needs for other kinds of service.

If the policy eventually accepted with regard to all age groups was to be to ensure availability for each individual of the most appropriate services (as defined in page xi) we would anticipate for example that in the long run, regional hospital districts (or some analogous unit) would have to
become health districts (maybe distributing block grants between medical and social services), something like community human resource and health centres would have to be more commonly provided, the acute hospital bed rate would be reduced, and there would be a redistribution of tasks among different types of health care personnel. Since the elderly are eligible for health services in the same way as anyone else, they would of course share in the effects of any such changes. On the other hand, no matter how desirable such changes may be for the well-being of older people, it is unlikely that they could take place for that age group alone; so the elderly will have to wait on decisions which will apply to all age groups.

**HEALTH POLICY FOR THE ELDERLY**

However, we did set out to develop the elements of a plan to address the health needs of the elderly in B.C. and to make recommendations to the Minister of Health of the Province. And whilst we do not envisage a separate health system for this age group in terms of provisions, we do consider that there is a need for a special policy with regard to the elderly and for a system which is conceptualized and planned separately.

A policy with regard to the elderly is necessary because of their increasing numbers, (If present low birth rates were to continue, the eight million senior citizens living in Canada in 2031 would constitute twenty per cent of the population), and because of their disproportionate consumption (according to size of population) of the more expensive forms of medical care, particularly the hospital. We need a plan both to improve on the inappropriate aspects of the present system and to meet future needs in more appropriate ways.

We have seen that in our society the elderly have none of the attributes which earn them value in different societies. Nor do they rate
high when judged according to social values which prize achievement, progress, independence, etc. On the other hand, it is unlikely that society would endorse any deliberate discrimination against them at this time.

In the provision of health services to date, they have not been discriminated against, though not enough attention has been paid to their psychological needs in those areas where they have special needs.

The only major area where the elderly are at a disadvantage is the economic one.

Because the elderly do consume such a large proportion of health services, it is particularly important to try to effect the substitution of other types of service for unnecessary medical care. Because at the moment they have less access to alternative services than people of other age groups (though other minority groups such as the handicapped may be equally disadvantaged), and because it is traditionally more common to institutionalize this age group instead of providing community services, we feel that at the present time, a policy of positive discrimination is necessary with regard to the provision for the elderly of those preventive and supportive community and social services which may be substitutes for acute medical care or preclude the need for it. Apart from the fact that services may not exist, their availability to the elderly is prejudiced compared with people of other age groups, by lack of funds to purchase them, lack of family, relatives, friends, to provide or arrange them, and usually less of the physical, mental and emotional energy necessary for finding the way round the system.

The Ministry of Health is only one of the ministries involved in the provision of relevant services. We would like to commend, for example, the rental aid program for seniors announced by the Minister of Housing (March 1977), particularly since it is accompanied by a seven per cent ceiling on
annual rent increases. We would like to commend to the Minister of Education, the March 1977 recommendation of the Provincial committee on continuing and community education for a great increase in the priority given to adult education, with particular consideration being given to the elderly. We would like to make recommendations to the Parks Board, to the Transportation Minister, etc. We would like to recommend that the federal government consider enforcing much more massive redistribution of income over the lifetime of individuals if so many more are to be living beyond retirement age and for so much longer.

Since matters such as these are relevant to the Minister of Health, yet not within his sphere of authority, there is obviously a need for a mechanism by which he can have some input to such decisions.

We do not mention the Ministry of Human Resources at this point because we consider that it is quite impossible to plan for the health needs of the elderly without directing our recommendations at least as much to the Minister of Human Resources as to the Minister of Health.

Health Ministry policy with regard to the elderly should be made known to all ministries which will be providing services which affect the elderly so that as far as possible they can direct their efforts to the same ends. Ideally all departments serving the elderly would adopt a common policy with regard to this age group.

**PLANNING FOR THE ELDERLY**

**Some Assumptions**

Our analysis of the present situation leads us to believe that a plan for the health care of the elderly should be predicated on certain assumptions. These are:

a) a systems approach to services for the elderly,
b) centralized planning, decentralized provision of services,
c) participation at all levels of all the parties involved - civil servants and providers and consumers of care,
d) an initiative rather than a reactive approach to volunteer efforts,
e) maximum encouragement and utilization of volunteer efforts,
f) the concept of a continuum of care,
g) accessibility of services,
h) more attention to psychological needs.

a) **Systems Approach**

It seems that there is a need for a separate system to consider the needs of the elderly - unless they are one day defined and met well enough to be integrated back into the universally provided services (much as pediatrics was). Some sort of organizational framework is required to co-ordinate at all levels the activities concerned with the care of the aged, within the Health Ministry, and within the whole of the community served by a variety of services. A systems approach would provide this sort of framework and would ensure the existence of a common purpose, mutually optimizing relationships, and specialization. [Science Council of Canada, 1974, p.30 ff]

To treat first of all the 'health services for the elderly' part of the Health Department as a conceptually separate component or subsystem would mean that once it was fully implemented there would be a built-in on-going evaluation (feedback) and correction mechanism. If it were difficult or impractical to measure goal attainment in an on-going way, one could measure effectiveness by asking how close the allocation of resources approached an optimum distribution [Etzioni 1960].

A systems view of health services is particularly appropriate in that we would see the changes presently proposed as an interactive process rather
than a linear progression, and because the systems approach recognizes the importance of environmental conditions and constraints and the need to relate to other systems which may be relevant though outwith control and also changing. (It may also enable a more realistic assessment of where a problem lies and if anything can be done about it).

The systems approach may be even more useful at the macro level if from the departments concerned with human resources, education, health, housing, recreation and income security, subsystems concerned with services for the elderly were to come together to form another subsystem. This is important because of the substitutability of the services provided by the various departments (e.g. housing and services instead of intermediate care), the requirement for close cooperation (to provide a continuum of care), or the dependency of one department on the actions of another. (The training of more doctors by an Education Department policy may act against the intentions of the Health Department). At least linkages are necessary so that each department can have input into the relevant programmes of the others.

As we have already suggested, we do not consider that there can be discrete health and human resource systems for the elderly. The emphasis on community care will make co-operation between these two departments more important than ever. There will be a particular need to establish areas of responsibility and levels of authority. In the field of community care, it appears that there may be opting out of responsibilities where there is

A) ambiguity about the division of responsibility for planning, policy making and administrative and executive action,

B) ambiguity about who initiates action at the level of the individual and who sees that action is actually taken,

C) ambiguity about who sees that a series of actions are appropriately coordinated at the right time and in the right sequence. 

[Fitmuss1968 p.99]
It appears that the organizations which react most effectively to changes are at once more differentiated and more integrated [Lawrence and Lorsch 1973], that in order to effect change in systems the most successful innovative subsystems are composed of members of the various on-going sub-systems, and that these are centred at the operating level where decisions can be effectively reached and implemented. [Lynton 1969]. We would therefore recommend permanent linkages with all the departments we have mentioned and a very close relationship with the Department of Human Resources.

The main problem we see in this latter area is the extreme difficulty of separating out expenditures on the elderly in these two departments and the difficulty of proving trade-offs. One would of course anticipate a greater expenditure by the Department of Human Resources and less by the Health Ministry, but if Health expenditure is not reduced i.e. if the services left 'unused' by the elderly are used by people of other age groups, there will be no overall savings and indeed discrimination against the elderly. It is to be hoped that the new system of block grants for health services and the proposed changes in the Canada Assistance Plan will change the emphasis of former built-in incentives.

b) Centralised Planning, Decentralized Provision of Services and Assessment of Need

Whilst we feel that a provincial body is best placed to decide on the overall needs and deployment of resources, we nevertheless feel that assessment of the needs of the elderly and the delivery of most services should take place locally.

The needs of the elderly vary substantially in different areas of B.C. according to the size and nature of the population and also according to the nature of the area. One has only to compare census tract 6 in Victoria
where forty-three per cent of the population is retired, with Skid Row in Vancouver where the majority over 65 are single men, many of Asiatic origin, and the Queen Charlottes where the elderly are comparatively free of the problems experienced by their contemporaries in the city. In Vancouver and its environs also, clusters of elderly people change or disappear fairly rapidly. [Priest 1970]. We therefore feel that to start with at least, needs should be assessed locally, though as the new system becomes established it may be possible, given certain characteristics of an area and its population, to assess how many home helps it will require, etc. We also believe that the nature and quantity of services provided in the first place should be responsive to the expressed needs and feedback or take-up from local communities.

To consider needs on a local area basis would allow for experimentation with different patterns of delivery. For example, the West End Community Health Services Society in 1974 proposed a Mobile Geriatric Service for the West End of Vancouver. It would only be a metropolitan area which would have the sort of population which could support such a service.

Who is to assess local need and indeed who is to provide services, and how they are to be paid for, will have to be worked out. A most important need in every locality will be for some agency or person to assess individual needs and co-ordinate delivery of care.

There is a fair amount of experience now in Canada (e.g. in Quebec and Ontario) and in B.C. (local area councils, community human resource and health centres, Victoria integrated family services, social planning councils) of local and co-ordinated provision of service - as well as local health units.

c) Participation
We see participation by care personnel and the public, particularly the elderly, as essential at all levels from local assessment of need to policy-making. When it comes to representation of the elderly themselves, we feel that the mechanism for choosing representatives should be decided on only after very careful thought and different methods should probably be experimented with. The people who offer themselves are rarely typical. We find that office-bearers of organizations are not always very able to put forward the point of view of 'the elderly' - naturally enough, because many people don't know what 'the elderly' means. (Guaranteeing the 'representativeness' of representatives is of course an unsolved problem in all sorts of spheres). However, when it comes to an organization to represent the needs of the elderly vis à vis government, we would prefer to see this done by the health subsystem and the multi-ministry subsystem which we have already mentioned. In those provinces which have Councils on Aging etc., of a mainly voluntary nature, they do not appear to be seen enough as an integral part of the system which is involved in on-going planning. And instead of having a role in questioning present structures, they seem to be merely another variable, though an important one. We would recommend however, that any major provincial agency might be represented on a government committee. (Hopefully also, the Government will benefit from input from the Gerontology Association of British Columbia, formed early in 1977.

d) Volunteers

The elderly will never receive all the services they need without an enormous input of volunteer help. Already there is a large amount of volunteer effort in these areas - including that by elderly people themselves, but we are sure that it should and could be increased. Since in our society it may be quite difficult for people to find a 'way in' to helping, mechanc-
isms should be devised to aid them. There is probably room for some sort of Help the Elderly campaign to give people an 'excuse' for volunteering aid if they are nervous about making unsolicited offers. Yet it seems quite ridiculous that people in the SPARC survey of the independent elderly [SPARC 1976] expressed a need to have clothes taken to the cleaners when probably almost everyone in their block passed by the cleaners nearly every day. This sort of service too can only be arranged locally. Needs could be publicized in churches for example. Some funds devoted to the encouragement of volunteers would probably be well spent. We would also encourage a massive increase of the Senior Citizen Counsellor Scheme, with no increase in the expense allowance.

e) **Initiative Approach to Voluntary Agencies**

With regard to voluntary agencies we would like to see a less reactive approach. A more appropriate allocation of funds would be ensured if government decided what services were needed in various areas, and then solicited offers to supply them, as U.C.S. does. [Patillo, Fitzpatrick and Jaques 1976]

Finally when an agency such as SPARC of B.C. can muster up as much expertise and information as it did to produce for example its report on 'Public Transportation and the Elderly or Handicapped Citizen' (1976), we feel that such a report should be considered as seriously as if it had come from within the Department itself.

f) **Continuum of Care**

At the moment there is no co-ordination of the different levels of care available, no mechanism to ensure a 'flow' which takes into account all the available possibilities and directs the patient towards the best one. Such a flow would encompass the whole range from home care (maybe
even surveillance of 'at risk' elderly), through various kinds of residential accommodation to extended and acute hospital care with potential for movement in any direction.

This would make possible planning of a more coherent and appropriate spectrum of services. (In New Zealand, national guidelines on the accommodation and services necessary for people aged 65 and over cover everything from hospitals and day care to equipment loan and laundry service. [Wellington Department of Health, 1976.]

In this country, the Assessment and Placement Service of the Hamilton District Health Council was set up in 1971 and experiments have been or are taking place in several provinces [Shapiro 1976, Fraser 1976]. And there has been some study of suitable mechanisms [Sutherland 1976 and various papers in Murnaghan, Ed.]

This approach requires close co-operation between the Health Department and the Department of Human Resources, a commonly accepted assessment technique and one or more assessment agencies. It also requires an inventory of all possible sources of help.

It should have as one of its aims that the number of transfers for a patient is kept to a minimum which would suggest the integration of the maximum possible number of levels of care.

In assessment, medical needs should be structured into a matrix of multidimensional needs and people should be offered a choice and the possibility of moving around till they find the facility or part of a complex which is most congenial. We are told too that to house together patients needing different levels of nursing care need not be more expensive than to segregate the levels.

We would like also to recommend consideration of:
licensed private homes for home care which assess the family rather than the building,

ambulatory geriatric assessment units,

geriatric units in hospitals for assessment and rehabilitation after acute ward treatment,

medical hospitals without the expensive equipment and facilities which many patients do not require,

adaptable buildings for community care facilities and the possibility of sometimes housing cohorts of elderly with adjustment of the services provided as their needs change i.e. changing the level of the care provided by a facility instead of moving individuals to other facilities with different levels of care.

**g) Accessibility and Co-ordination of Services**

Services, to be useful, have to be accessible; yet lack of accessibility is frequently complained of. So that persons in need obtain appropriate services, there will have to be some mechanism for attempting to detect unreported needs, medical and social, some well recognized point of entry into the system, and a means for assessing need, co-ordinating services, and referring. Apart from the direct benefit to elderly persons, it is urgently needed as an agency to which doctors and other people in the community and hospitals can direct people for advice and aid.

**h) More Attention to Psychological Needs**

We have seen that the only criticisms levelled against the medical system for treatment of the elderly, related to psychological needs. There were criticisms of the attitudes of personnel, the tempo of the acute hospital, the many ways in which long-term institutions are not geared to the needs of the elderly. To cater to the psychological needs of patients in institutions would not be to give them preferential treatment; it would merely be to recognize that some of their needs are different from those of other age groups - not different basically but because they have less means - social, physical, economic - for meeting them. It has to be decided
then whether there is to be a deliberate policy of not discriminating against the elderly in those institutions of which they are the major users (various types of long term care). As far as community or social services are concerned, the services can be effective only if their nature and the way in which they are provided meet the needs of the elderly. This immediately implies variation and choice, outreach, facilitation of self-help, and maybe an ombudsman or advocacy service.

We must recognize however, that there are some things that no ministry can effect. It is difficult if not impossible for example, to change those social values which evolve as the result of a multitude of factors and from which emanate the attitudes of society to the aged. We even doubt if there is any point in trying to find new roles for the elderly. They will probably have to do that for themselves - but the rest of society will have to allow them to do it. Again, there are many recommendations for abolition of 'enforced retirement'. If the sort of unemployment rates we have at the moment are likely to continue, it might be only fair for older people to step aside and give others a chance. But then we mustn't penalize them by reducing their income so drastically and labelling them 'dependent non-producers'.

THE Planning Process

Once a policy is agreed upon, planning requires definition of goals, consideration of alternative ways of reaching goals, choice of means, setting of objectives, consideration of implementation, evaluation of results, adjustment of objectives, sometimes adjustment of goals or change in policy resulting from changing environmental conditions - economic, demographic, technological, etc.

1) Goal Setting. The first goal must be to decide on and set up the struct-
ures necessary for close co-operation with the Department of Human Resources and linkages also with the Departments of Housing, Recreation, Education, and any other departments which may be considered relevant. There should also be some input from people with experience of the services either as providers or recipients of care and from informed lay people, who can bring a different perspective, and are not committed to divisional or departmental boundaries. The options appear to be:

a) a joint committee formed of members from the Departments of Health and Human Resources and representation of the public, with input (appointment of one member) to committees of other Departments whose planning decisions might affect the elderly.

b) a joint committee formed of members from the Department of Health and Human Resources and representation of the public with other members appointed one each by the various other departments which provide services to the elderly.

c) a joint governmental committee on services for the elderly formed with members from all relevant departments.

d) a committee formed outwith government.

We would see the first option as the most suitable and the most likely to be supported and successful. It is unlikely that departments other than Health and Human Resources will feel involved enough with the special needs of the elderly to be willing to devote time to regular attendance at committee meetings. A committee formed completely of non-government persons would not afford the close association which we consider necessary between decision-making and implementation. And the first option would allow for co-option of people with relevant expertise or experience, or the request for the attendance of someone from another department for consideration of
matters which were within his/her sphere of influence or expertise. It might be desirable to appoint a committee as described in (c) as well as the one described in (a), and this option is not limited by attempting (a) first.

It would then be for this committee to define goals, which would have to be seen in the context of other goals of the respective departments and for other categories in the population and which will depend also on what (substitutable) services other departments are likely to provide. If goals set for the elderly are always seen in the context of overall priority-setting, they are less likely to be changed arbitrarily. Some sort of order of priorities and allocation of resources will of course have to be decided upon but we would recommend that this would not be too firm since as we have stated, we feel that long-term decisions on priorities and quantities of service should wait upon feedback from local areas.

A clear statement and broad understanding of the Ministry's Goals and Objectives is required so that people involved in the system can see their contribution as part of the whole and understand the contribution of other people.

Setting of goals should be a continuing process at all levels.

2) Choice of Strategies or Objectives.

The choice of strategies should depend on the supposed or proven effectiveness of each option and on overall savings and costs.

At the moment we do not know how much acute care is 'superfluous'. And this may be immeasurable. It is also much too early at this stage to know how much of acute, medical, or institutional care can be replaced by preventive, community, para-professional care. In the early stages, therefore, we think that we can only make decisions as to inputs of resources into the respective areas, rather than decide on an output to be
aimed at. It will be some time in any case before the different provisions of the health system and education will affect perception of need enough to make marked differences in utilization.

What would be being done at first would be what we have criticized the present system for doing - guaranteeing inputs (medical care) and taking output (health) on faith, but by experimenting, and providing a range of options so that the elderly themselves are allowed to some extent to define future strategies, we would hope eventually to be able to develop some guidelines given certain age groupings, with certain characteristics, in certain localities.

It is essential that structures be devised or used which ensure maximum accessibility of the services which are provided. To provide services is useless unless these services can be reached by the elderly, who must be able to afford them and find them psychologically acceptable.

Strategies will have to include education of both providers and consumers of service.

As it is well-nigh impossible to separate out the cost of health services for the elderly, it will be very difficult to measure what savings, if any, are affected by a switch of demand from health to social services. In fact until changes are made in the delivery of health care to all age groups, there may be no economy because people of other age groups would possibly take up the capacity (of hospital beds, etc) left unused by the elderly.

3) Tactics

Decisions have then to be made about the variables to be provided or changed at the operational level, i.e. the inputs required to implement the chosen strategies. (Of course the tactics available will usually have been taken into account in the choice of strategies).
Examples of tactics might be:

Some screening mechanism which is outreach and not necessarily patient-initiated so that it may preclude the tendency to consult the doctor unnecessarily,

some home calls by paraprofessionals instead of doctors,

involvement of residents of institutions in activities of the neighbourhood.

At this level it is worth remembering:

that provision of services does not have to mean provision of services free,

that one should sometimes start by looking at functions rather than personnel, at need rather than service, and at services rather than site of delivery. In other words there should be flexibility as to who performs a task, as to where a service is delivered (i.e. services based in a residential facility might be delivered in the community and vice versa, hospital equipment may be lent for use in the home), or even if it is delivered as contrasted with the patient travelling (e.g. lunch clubs instead of meals on wheels),

that it may be more appropriate to subsidize the regular service than to provide a segregated one e.g. housing,

that if paraprofessionals are trained and experienced in institutional work, they may need extra training for the different nature of demands and requirements of community.

4. Implementation

The priorities for implementation will have to be worked out in collaboration with all the people involved (civil servants, health professionals, the public), and depending on when the necessary personnel can be available.

There should be education of providers of care in the new goals of the system and an effort to encourage application of its 'spirit'.

It would be well to try to judge which people might resist the new arrangements, and take anticipatory action.

Although some people have said that there would be no resistance from doctors because they are not interested in old people as patients, nevertheless, since they see medical care at least, as their responsibility, they may well object to increased responsibility being given to paraprof-
essionals unless they can be reassured that the latter are capable of offering adequate care. Doctors would therefore have to be persuaded to co-operate in changes. We would add that studies that have been done on the use of paraprofessionals suggest that objectives are met better if the health practitioner (nurse) refers up from specified delegated groups rather than if the doctor refers down, and Kohn and White concluded that to merely increase the number of paraprofessionals has little effect on the extent to which they can supplement or substitute for the physician. Success requires the delegation of responsibility, authority for decision-making and risk-taking and organizational and institutional arrangements in which both selected health care personnel and physicians work. There has to be prior setting of policies with respect to staffing patterns, financial relations and deployment.

6) **Evaluation**

Evaluation should be on-going once the new system is in operation but it may be some time before any realistic appraisal of its effects and weaknesses are apparent.

7) **Research**

While we consider that there is enough empirical evidence to start immediately to implement a new policy for the health care of the elderly, nevertheless there are many areas in which research or further research is required.

There is a need for research into the origins of various needs and the characteristics of those in need. How does one reach those with unmet needs? How does one evaluate various methods for meeting needs? For some goals, there is a need for identification of indicators which can be measured. There is a need for measures of psycho-social status as well as functional
status. There is a need for research into what sort of geriatric component should be added to present training schemes, and how it should be added, what sort of education, if any, might change general attitudes to the elderly, what would be the most effective way of educating the elderly, about nutrition, exercise, etc.

There is much talk nowadays of the requirement for quality of care. Some people consider that the most important factors in quality care of the elderly are kindliness and ability to communicate (McLachlan, 1976). How do you guarantee and then evaluate that?

There is need for local research, for research into the best conditions for institutions e.g. how do you guarantee on-going stimulation. (It appears that some system of 'milestones' may help this).

There is a need to initiate research, not to accept whatever happens to be done. Members of the system should be alert to the need for research and persuaded to use its useful results.

**EPILOGUE**

We have based our recommendations mainly on the premise that it is desirable to provide health services for the elderly as economically and therefore as appropriately as possible. It is only be coincidence that services provided in this way will often be what the elderly themselves desire.

A truly humane society would have required other criteria.
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Problem Areas Identified

Question - In your opinion what are the specific problems in maintaining the health of the elderly population of Canada?

1. Lack of well-organized, coordinated and integrated health and social services.
2. Financial barriers to obtaining the essential health and social services by the elderly.
3. Unawareness by the elderly and public of the services and help available due to lack of appropriate information services.
4. Inadequacy of preventive services e.g. screening, counselling, education.
5. Lack of preparation for healthful living in old age.
6. Inaccessibility of services and lack of outreach programs.
7. Lack of education and training of all categories of health personnel in the fields of geriatrics and gerontology.
8. Absence of data base and information systems.
9. Lack of alternatives to meet a variety of individual needs and choices of life style.
10. Lack of identification of the elderly population at risk.
11. The attitude of society, of the elderly and of the providers of services for the elderly to ageing.
12. Lack of understanding on the part of the population as a whole regarding the needs and care of the elderly.
13. Very limited input by senior citizens into program design, content, organization and implementation.
14. Lack of knowledge re the ageing process and the sociology of the elderly.
15. Factors (economic, change, etc.) which mitigate against mental health and physical health of the elderly.
16. Isolation from the mainstream of life, and boredom leading to loneliness.