# PLANNING FOR BRITISH COLUMBIA'S AGING POPULATION: INFORMATION, PARADIGMS, AND STRATEGIES

by

ALAN GLEN CAMPBELL

B. Math. The University of Waterloo, 1970

M.S.W. The University of Toronto, 1976

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Department of Health Care and Epidemiology

The University of British Columbia
2075 Wesbrook Place
Vancouver, Canada
V6T 1W5

Date April 1, 1982

# ABSTRACT

Planners for British Columbia's aging population are beginning to contemplate the difficult problem of ensuring the future adequacy of supportive programs for the elderly in the key areas of health, income, and housing. It now appears that these programs may well be squeezed between increased demand resulting from a rapid rise projected in the number and proportion of older people early in the next century, and lower rates of provincial and national growth foreseen by most economists. This descriptive study draws on available relevant information (much of it included in tables, figures, and appendices) to explore the problem from its origins in previous policy development to the situation at the present time. From this perspective the implications of current demographic, economic, and political/bureaucratic trends for programs for the elderly are assessed in both the national and international contexts.

After a consideration of the roles of philosophy and ideology in social theory, a wide range of social gerontological theories are examined using a sociological scheme which classifies them according to four major paradigms in order to determine their abilities to describe accurately the information presented, and to prescribe useful policy alternatives. It is concluded that a theoretical approach which advocates radical change from a structural perspective is both most valid and most productive as a paradigm for planning for the aging population. A description of the relationship of planning to social change, and a systems analysis of the process of public policy making together introduce a discussion of strategies based upon the selected planning paradigm. Once the approaches used in planning for the elderly in the past are critically reviewed, the outline of a radical structural plan for the aging population is described, and then a strategy for its implementation

over the next two or three decades is presented.

The report concludes with a brief summary, and a number of specific recommendations for action by the appropriate public authorities, including several suggestions for enhancing the capacity for policy and program research in this field. One important recommendation is for the early establishment in British Columbia of an inter-departmental agency on aging to co-ordinate information and planning for the province's elderly.

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# 1. INTRODUCTION

This introductory chapter describes both the focus of the present study, and the nature of its design.

## 1.1 RESEARCH FOCUS

In this section the general problem is outlined, the purpose and context of the study are described, and the research question to be addressed is stated.

### 1.1.1 Problem

Planning for the elderly[1] in British Columbia is presently at a major turning point. The direction taken at this juncture could well determine the shape of policy for the aged, and indeed much of social policy, for decades to come. The problem which public policy-makers are now wrestling with is basically this:

> How can the levels of health-care, income security, housing and other social programs and services of special importance for today's elderly[2] be increased or even maintained when all recent projections indicate both a rapid increase in the proportion of older people, and a slower rate of economic growth?

Those responsible for planning the fiscal, institutional, and human resource requirements involved can take little comfort in the fact that most of the demographic shift is expected to occur after the turn of the century since the lead-times necessary for rational pension and health service planning are substantial. Moreover the current economic recession has demonstrated that even present levels of social programs may not be assured when trade-offs must be made in the political arena.

The anticipated squeeze between escalating demand and declining ability to supply promises to be so intense that policy alternatives thought

radical only a decade ago are now under consideration. The opposing approaches of considerable "re-privatization", and substantial additional socialization of programs for the elderly each have their vocal exponents in British Columbia, a province in which almost every debate seems to be coloured by existing political polarities. This study has been motivated in part by the belief that the best planning decisions are those based on a wide range of data and analysis.

### 1.1.2 Purpose

This study seeks to inform the debate over planning for the elderly by laying out a base of information concerning programs for the aged. Past development, present experience, and future trends relating to services for the elderly in British Columbia are all considered in the context of the Canadian and international situation. This information is analyzed using a variety of social theoretical frameworks in order to arrive at an optimum planning strategy including specific policy recommendations for provincial and federal authorities.

### 1.1.3 Context

Since the elderly, after all, are only a special subset of the general population, their problems must necessarily be considered in the context of the social, economic, and political realities that are modern society. Any attempt to develop a plan for the elderly, then, must come to terms with the complexities of the social policy-making environment, and of the aged themselves as a group. In so doing one must relate empirical material from Demography and Economics to theoretical frameworks developed in Sociology and Social Gerontology, and consider the philosophical and practical issues raised by those in the fields of Public Administration and Planning.

This interdisciplinary approach, while cumbersome and demanding, eventually yields an analysis that can be both comprehensive and powerful.

### 1.1.4 Question

The research question to be addressed in this study, is:

What are the main elements of a plan to ensure the adequacy of health, income security, housing and social service policy for British Columbia's elderly in the early part of the next century?

The elderly will be considered as those aged 65 or over, and the planning horizon will be taken as the year 2031, fifty years from now.

## 1.2 RESEARCH DESIGN

Once the focus of research has been delineated, the way in which the investigation is to proceed must be chosen from a variety of possible research designs. This section discusses the study's methodology, scope, and limitation, and outlines the format of the report as a whole.

### 1.2.1 Methodology

This is a descriptive study that utilizes data from available catalogued documents, as well as information derived from mail enquiries, and personal interviews. There is an urgent need for more original statistical research on the aging population but the paucity of suitable data made it impossible to include such an approach in this study. Suggestions are made for the improvement of existing data to enable such analyses to be made in future.

### 1.2.2 Scope and Limitations

The study surveys the problems of British Columbia's elderly in the context of those in Canada as a whole, and in selected foreign nations to offer useful comparisons. While historical developments are traced throughout this century, the emphasis is on the period after World War II, and, particularly, on the last two decades. This sets the stage for an examination of the current status of programs for the elderly in British Columbia in terms of benefits, utilization, and adequacy. Demographic projections and other trends well into the next century are considered, although the uncertainty of forecasts in general, and of those extending as far as fifty years ahead in particular, constitutes the principal limitation to the study. Notwithstanding this uncertainty, planners must now consider the possible extreme scenarios for the aged far in advance simply because the social, economic, and political implications are so enormous.

### 1.2.3 Format

The completion of this study has involved formulating answers to five basic questions, each of which constitutes a chapter in this report as shown in Table 1.1. The first step involves identifying the problem for study, and posing a related research question. These and other preliminary matters are covered in this introductory chapter. Following the structure implied in the report title, the next three chapters set out an information base for planning for British Columbia's aging population (Chapter 2), evaluate the explanatory power with respect to this material of a number of analytical paradigms (Chapter 3), and, based upon the best of these, formulate a planning strategy intended to ensure the adequacy of programs for the elderly in the years ahead (Chapter 4). The relevant literature is reviewed as part of the analysis in each of the three chap-

TABLE 1.1

THE ORGANIZATION OF THE REPORT

| Chapter | Question to be Addressed |
|---|---|
| 1. Introduction | What is the task? |
| 2. Information | What are the "facts"? |
| 3. Paradigms | How can these best be understood? |
| 4. Strategies | What action does this suggest? |
| 5. Conclusion | What is the plan? |

ters. The final chapter summarizes the conclusions of the study, and makes a number of recommendations for consideration by those responsible for planning for the province's future senior citizens. Lengthy tabular presentations, or those of interest to only a few readers are attached as appendices, while others are included in the text; notes follow the final chapter.

## 2. INFORMATION

This chapter explores the data available for planning taking into account the historical development of programs for the elderly, their current status in the province, future trends affecting them, and the experience of other selected countries. Suggestions are also made for the improvement of existing data sources relating to the aged in British Columbia to permit more empirical research in future.

### 2.1 HISTORICAL DEVELOPMENT OF PROGRAMS FOR THE ELDERLY

This section reviews program development at the federal and provincial levels,[1] after noting the shifting roles played by each level of government over the years, and summarizes briefly the involvement of the municipal and voluntary sectors in service provision.

#### 2.1.1 Federal and Provincial Roles

No account of social program development in Canada can ignore the effects of the differing roles played over the years by the two senior levels of government. There is little doubt that Canada's fathers of Confederation intended to create a strong federal state, with relatively weak provincial bodies.[2] Most important powers (economic, security, and residual) were accorded to the federal government under the *British North America (BNA) Act*, while duties seen as local and minor (education, health, and social services) were assigned to the provinces.[3] Ironically, many provinces now exercise considerable political and economic power by virtue of their control over important natural resources underestimated or unknown in the last century. At the same time the human services, seen as insignificant in 1867, have become easily the largest budget item of all governments today. The inability of most provinces to cope with the

cost of health and welfare programs, especially during the Depression years, helped to expand federal/provincial cost-sharing agreements. In this way the federal government assumed a growing role in the design and operation of many health and social programs.[4]

There has been a shift, then, in the roles played by these two levels of government in Canada in developing the social programs of which those for the elderly form a part. This shift derives partly from the changing economic and social realities alluded to above, and partly from emerging political philosophies at each level. The federal government's early preoccupation with fostering economic growth is now shared by most provinces concerned with developing regional industries. At the same time the senior government has increasingly taken the lead in establishing social programs by intergovernmental agreement across the country (e.g. hospital and medical insurance), although the pioneering role of Saskatchewan has provided a consistent spur to federal efforts in this regard.

The growing influence of the federal government in social program development has had a relatively greater impact on provinces like British Columbia which have fairly steadily followed a conservative utilitarian philosophy in this regard. The liberal welfare state philosophy of the national government has led to the development of programs for the elderly in this province that, arguably might not have occurred otherwise. A case in point to be considered later is the highly successful Long-Term Care Program. In the sections that follow, the development of programs for the aged is considered at both the federal and provincial levels.

### 2.1.2 Federal Program Developments

Developments at the federal level concerning programs for the elderly will be considered below in each of the areas of health, income, and housing.

#### 2.1.2.1 Health

Although the national Liberal Party was on record as committed to health insurance as early as 1919,[5] there was little concrete federal action until the historic 1945 Federal-Provincial Conference on Post-War Reconstruction. Basing its proposals on the innovative Heagerty Report (1943),[6] the senior government offered to pay 60% of the estimated costs of provincial programs of medical, hospital, dental, pharmaceutical, and nursing benefits, in exchange for tax concessions from the provinces. When this was rejected, the federal government unilaterally introduced a National Health Grants Program in 1948 to assist the provinces in extending and improving public health and hospital services. Grants were made available for hospital construction, health surveys, professional training, public health research, general public health, mental health, crippled children, and the control of tuberculosis, cancer, and venereal disease. The stimulus to institutional acute health care provided by these grants, and especially by the *Hospital Insurance and Diagnostic Services (HIDS) Act* of 1957 was to skew health care organization in Canada right up to the present time with important implications for the care of the country's aging population. Under the HIDS Act the federal government agreed to pay half the cost of in-patient and out-patient services provided in active treatment, convalescent, chronic and rehabilitation hospitals in provinces whose schemes conformed to the federal standards of universality, uniformity, and portability. Nursing homes and home

care programs were excluded from coverage under this agreement. By 1961 all provinces had accepted the federal offer and Canada's national hospital insurance program was in place. Following the Hall Commission Report (1964)[7] the federal government passed the *Medical Care Act* in 1966 providing for matching funds for services rendered or directed by physicians under provincial plans that were comprehensive, universal, portable, and under public non-profit administration. As McPhee has pointed out, however, none of these programs was aimed specifically at the aging population since this appears to have been seen as a problem for consideration at some future time.[8] The overall emphasis was clearly on cure, and not care.

Several federal reports in the early 1970's reviewing the organization and effectiveness of health programs drew attention to this imbalance between cure and care, and made recommendations concerning the special health needs of the elderly among others. The *Report of the Task Force on the Costs of Health Care* (1969)[9] suggested that more effort should be made to define the needs of older people, and evaluate programs for them. *The Community Health Centre in Canada* (1972-73)[10] viewed the aged as a group in special need of innovative, problem-oriented approaches to service delivery, and advocated day and home care services. *A New Perspective on the Health of Canadians* (1974)[11] emphasized individual responsibility for health, and mentioned the elderly as one of the groups under-serviced as a result of the system's preoccupation with cure.

At last in 1977 the *Federal-Provincial Fiscal Arrangements and Established Programs Financing (EPFA) Act* ended the former cost-sharing arrangements for health and other services and introduced block-funding in their place. Designed to enhance fiscal accountability and provincial program flexibility the EPFA agreement resulted in the establishment of an Extended Health Care Program under which the federal government would

cover nursing home intermediate care, adult residential care, converted mental hospitals, home care, and ambulatory health care to a specified per capita maximum. This program was specifically aimed at the growing number of elderly people for whom the existing acute-care institutional health system was often inappropriate. However, despite these changes, all was not well with Canada's health system.

Continuing cost pressures on the federal government gave rise to a review of health services by Justice Emmett Hall, *Canada's National-Provincial Health Program for 1980's* (1980),[12] and to the report of the Parliamentary Task Force on Federal-Provincial Fiscal Arrangements, *Fiscal Federalism in Canada* (1981).[13] Both these documents acknowledged the serious challenge to the existing health system posed by an aging population, and recommended the expansion of alternatives to institutional health services under the Extended Health Care Program. The federal budget of November 1981 indicated Ottawa's intention to reduce significally transfers to the provinces under the EPFA Act over the five-year period 1982-87, and provincial protests appear so far to have made little impact on this resolve. Federal leadership in health service development appears to be waning at precisely the time when major restructuring seems necessary if the system is to cope with the increasing number of older people expected in the years ahead.

2.1.2.2 Income

At the beginning of the century trade unionists in Canada were pressing for public pensions like those adopted in Germany (1889), Denmark (1891), New Zealand (1898), Australia (1901, 1908), and Great Britain (1908).[14] Instead, the federal government initiated a system of government annuities in 1908 which, like the private insurance companies' coun-

terparts, induced only a tiny fraction of the population to plan for their own future financial security. Though the notion of public pensions was debated before and after World War I, it was not until 1927 that the federal government passed the *Old Age Pension (OAP) Act*. This Act Provided for federal sharing of the costs of pension payments to needy individuals over the age of 70 in provinces participating in the plan. After the catastrophic events of the 1930's (the Great Depression) and early 1940's (World War 2) there was wide public support in Canada for a range of social welfare programs, and the example of Britain's social reconstruction scheme proposed by Lord Beveridge[15] eventually led the Canadian government also to introduce a comprehensive social security program.

In 1951 the OAP Act was superseded by two pieces of legislation following a constitutional amendment that permitted the federal government to legislate in this area along with the provinces. The *Old Age Security (OAS) Act* provided a universal flat-rate pension at age 70 to those who had lived in Canada for twenty years. In that same year the *Old Age Assistance Act* was passed, providing for federal contributions to means-tested provincial pension programs for individuals between the ages of 65 and 69. The amounts paid under these programs, however, (up to $40 per month in 1951) still left many people in need in their later years.

Although an amendment to the federal *Income Tax Act* in 1957 allowed tax deferrals for contributions paid into Registered Retirement Savings Plans (RRSP's), and institutionalized occupational plans continued to expand, widespread recognition of continuing inadequacies in the pension system led to a series of changes in 1965-66. The Canada and Québec Pension Plans (C/QPP) introduced in 1965 were compulsory contributory schemes aiming to ensure a minimum rate of earnings replacement for those over 65, while allowing considerable scope for private pensions and sa-

vings to extend this further. The C/QPP provided retirement, disability, and survivor's pensions, and a lump-sum death benefit within one social insurance package. Moreover, the federal government announced that the qualifying age for OAS would be lowered by one year annually from 70 in 1966 to 65 by 1970, and in 1966 amended the OAS Act to provide a monthly Guaranteed Income Supplement (GIS) that was means-tested. Finally, the *Canada Assistance Plan (CAP) Act* (1966) empowered the federal government (on provincial application) to pay 50% of provincial and municipal costs of social assistance and social services to persons in need, thereby assisting many of the elderly who remained indigent despite the existing pension programs.

During the 1970's provisions were made for OAS and C/QPP benefits to be escalated according to the increase in the cost of living, but there was again broad agreement that the entire pension system was in need of change if the incomes of older Canadians were to withstand the ravages of apparently chronic inflation. The problems posed to pension funds by inflation, and the rising number of elderly people, prompted a series of federally-sponsored reports in 1979 that explored the various options for reform of the retirement income system.[16] The Department of National Health and Welfare submission to a national conference on pensions in 1981 spelled out Ottawa's objectives for reform as: universality, portability and earlier vesting, indexation, and equity for women.[17] These federal policy goals indicate a commitment to adequate income support for all those over age 65 (universality) through benefits from a variety of pension plans that can follow a worker who changes employers (portability) after a shorter qualifying period of employment (earlier vesting). Adequacy is to be safeguarded through the indexation of pension benefits to the cost-of-living so that payments will keep

pace with inflation. The goal of equity for women in pension income is an important one since in many cases today their lack of regular participation in the labour force, and the general inadequacy of spouses' benefits, combine with the longevity women experience to impoverish them once their husbands die (and their pensions cease). While these objectives are worthy ones, their achievement in the current cold economic climate promises to be a major challenge for policy-makers.

2.1.2.3 Housing

Generally the federal government has viewed the housing needs of the elderly with less concern than those of younger Canadians, and all have been subject to market forces since shelter has been considered not so much part of Canada's social sector as the proper concern of its manufacturing and investment interests. The *Dominion Housing Act* (1935) allowed the government to loan up to 25% of the funds for home construction provided through lending institutions and local authorities. In 1944 the *the National Housing Act* (NHA) used the joint lending technique to address the problems of low-rental accommodation, slum clearance, and rural housing. The Central Mortgage and Housing Corporation (CMHC) was set up a year later to make and administer loans under the NHA, and revisions in 1954 replaced the joint lending scheme with a system of loan insurance for private lenders. The first specific program for the elderly came with 1964 amendments that made funds available to provinces, municipalities and non-profit groups to build senior citizens' housing along with general public housing, and provided loans and subsidies for various forms of group use of new and existing accommodation. A number of changes introduced during the 1970's have focused CMHC programs much more on meeting the housing needs of lower income Canadians through tra-

ditional types of accommodation as well as various innovative alternatives such as housing co-operatives.

### 2.1.3 British Columbia Program Developments

Program developments affecting the elderly at the provincial level will be reviewed in this section in the three areas of health, income, and housing.

#### 2.1.3.1 Health

The main health concerns in British Columbia at the turn of the century were general sanitation and the control of communicable diseases. A provincial public health system was set up by the *Public Health Act* (1893) with a Medical Health Officer and Sanitary Inspectors in each Health District who were to ensure adherence to regulations under the public health code. Hospitals and some homes for the aged where patients could be treated by private physicians were also in existence at the beginning of the century financed by municipalities and voluntary donations.

In 1919 a Legislative Commission that had been appointed to investigate health insurance in the province developed a plan to establish a health care system. Though this was not implemented, ten years later, in response to continuing public interest in such a scheme, the government appointed a Royal Commission on Health Insurance and Maternity Benefits. The Commission's report fared better than its predecessor, and led to the passage of the *Health Insurance Act* of 1936. But, despite wide public support, the opposition of physicians and insurance companies prevented this Act's implementation.[18] Meanwhile one group of the aged received special attention when in 1935 elderly mental patients

were separated from the rest of the patient population at Essondale. As a result of the *Provincial Home for the Aged Act* (1935) these patients were relocated in facilities that later became Valleyview, Dellview, and Skeenaview Hospitals for the aged mentally ill. Beginning in 1943 there was a public medical services plan for old age pension and social assistance recipients but uneven coverage, incomplete municipal participation, and physician discontent with the scheme made a more comprehensive approach necessary. Finally in 1949 the province initiated a Hospital Insurance Program (partly to alleviate chronic hospital deficits)[19] that covered acute care and diagnostic services provided on an in-patient or out-patient basis.

By 1950 there was a recognition among provincial public health officials that the increasing proportion of older people in British Columbia would require a new health strategy in future, but continued heavy demand for child-oriented services precluded the development of special programs for the elderly (except as local or pilot programs) for some time. In 1960 a program covering hospital rehabilitation, chronic treatment, and convalescent care was introduced in the province that interpreted rehabilitation broadly enough to include the re-activation of elderly people, but shortages of space and trained personnel interfered with its efficient operation. The British Columbia Medical Plan was set up in 1965 to provide medical care insurance to individuals of all ages, and was followed by the creation of the Medical Services Commission under the *Medical Services Act* (1967) in compliance with federal health insurance legislation. The extended hospital care program began slowly in 1965 with the redesignation of existing units and the planning of others to provide continuous nursing care and medical supervision to non-ambulatory aged patients. Since by this time the philosophy of treatment for

the elderly mentally ill had changed from custodial care to active treatment and rehabilitation, with the emphasis on returning to the community, local hospital facilities were soon under even greater pressure to provide care for the aged.

A number of Greater Vancouver Regional Hospital District (GVRHD) and provincial reports in the 1970's recommended an increase in bed facilities for the elderly at various care levels, an expansion of home care services, and better co-ordination of health and social services as a whole.[20] Thorough reform of the province's health care system was one of the priorities of the New Democratic government in its term in office from 1972 to 1975. Under the chairmanship of Dr. Richard Foulkes an ambitious review of health services was conducted throughout the province and the findings published in *Health Security for British Columbians* (1973).[21] Advocating major changes in the organization and delivery of health care through regionalization and integration of health and social services, this report would likely have had a tremendous impact on health services to all citizens including seniors if it had been implemented. But when the Social Credit party returned to power in 1975 this report, along with one recommending a provincial dental care plan[22] was shelved indefinitely. However, the greatest impact on health services for older people in the province was made by the introduction in 1978 of the Long-Term Care (LTC) Program of the Ministry of Health.

Attracted by favourable new financing under the federal Extended Health Care Program (part of the agreement embodied in the EPFA Act) the provincial Social Credit government introduced this innovative program a year before the most recent election in British Columbia. Long-Term Care is said to offer the elderly in need of health care a system of supportive services designed to enable them to remain in their own or their

family's homes as long as possible. Health needs are professionally assessed at levels ranging from personal care through intermediate care to extended care. A number of home support services and programs (homemakers, home care nursing, adult day care etc.) may then be utilized or different forms of residential care (family-care homes, group homes, and institutional facilities) arranged as need and availability dictates. The program is universal with means-tested subsidies for homemaker services and adult day care, and is co-ordinated by interdisciplinary assessment staff operating out of the province's many Public Health Units. Now in operation for over four years, the program has proven popular with older people who generally feel it has improved access to high quality health and social services. However Long-Term Care has so far been unable to meet one of its original goals - to reduce the number of acute-care beds occupied by the chronically ill in British Columbia. Beyond this, it now appears likely that continuing pressures for fiscal restraint may well jeopardize the program's ability to provide adequately for the growing number of older people in the years ahead.

The most recent addition to the provincial health system came when the re-elected Social Credit government fulfilled a campaign promise by establishing a Dental Care Plan in 1981. This scheme covered completely the cost of basic dental services and dentures for low-income groups, and half of these expenses for all senior citizens, and children under the age of 15.

2.1.3.2 Income

In the nineteenth century, the maintenance of the elderly in this province was considered the responsibility of their children or relatives, and if these were lacking, the concern of religious or charitable groups,

with public responsibility a situation of last resort. A few homes for the aged were established before the turn of the century by the municipalities of Vancouver and Victoria, and by the province in Kamloops to provide for the isolated, indigent elderly. But other than these few provisions, there was little consideration of special programs for the assistance of older people at the provincial level until after World War 1. British Columbia was the first province to pass legislation under the federal *Old Age Pensions Act* (1927) providing cost-shared monthly pensions to the needy over age 70, and supplemented this increasingly after 1942. *The Social Assistance Act* (1942) empowered the provincial Department of Welfare to make grants to municipalities for financial, residential, and other assistance to those in need including the supplementation of pensions for those requiring special care. The Social Service Division of the Old Age Pension Board completed a number of studies throughout the 1940's on various aspects of life for the aged in British Columbia, interpreting its role as including a responsibility for the welfare of all elderly people, and providing a focal point for information relevant to them.[23] The *Provincial Infirmaries Act* (1948) allowed for the establishment of institutional care facilities for those with chronic illness who did not require hospitalization, and these and other residential settings were licensed and inspected under the *Welfare Institutions Licensing Act* (1948), eventually replaced by the *Community Care Facilities Licensing Act* (1969).

With the passage of the *Old Age Assistance Act* (1951) introducing federally cost-shared universal pensions to those 70 and over, and means-tested assistance for those 65 to 69, pensions became primarily a federal concern, and attention to the problems of the elderly on the part of provincial authorities waned noticeably.[24] In 1957 a Division on Aging

was set up within the Department of Rehabilitation and Social Improvement to administer financial assistance programs, provide a provincial information service, and develop community resources to benefit the aged. Municipal bus passes were issued to all those over age 65, and in 1968 the Senior Citizens' Counsellor program began to operate through the renamed Department of Social Welfare. In 1971 the Department began to encourage the development of senior citizens' day centres through its community grant program, and several centres opened in the next few years. The *Guaranteed Minimum Income Assistance Act* (1972) supplemented the income of those 65 and over from all sources to $200 monthly, to be increased with rises in OAS/GIS, and in 1973 this "Mincome" program was extended to those aged 60 to 64. In 1976 the *Guaranteed Available Income for Need (GAIN) Act* expanded the means test for Mincome (now called GAIN for Seniors) to include assets as well as incomes of elderly applicants. No new income assistance programs for the aged have been introduced in the province since the GAIN program began, although payments are now increased with the cost-of-living along with the federal income programs.

2.1.3.3 Housing

There was little special attention paid to the housing needs of elderly people in British Columbia until well after World War 2, and even then it was not considered as much of a problem as that of assuring an adequate supply of housing for the general population. In 1955, however, the province passed the *British Columbia Elderly Citizens' Housing Aid Act*, one of the earliest of its kind in Canada, allowing provincial contributions of up to one-third of the total cost of new or renovated residential units for the low-income elderly sponsored by regional districts, municipalities, or non-profit societies. Aid to non-profit societies qua-

lified for a 10% forgiveable federal grant, and was therefore preferred over direct public housing projects. Units for the aged built in British Columbia per capita over 65 have risen over the past few decades and are now consistently above the national average, due partly to the rapid expansion of large high-rise facilities in the 1960's and early 1970's.[25] Although a British Columbia Housing Management Commission (BCHMC) had been created in 1967, it was only made responsible for administering the few existing federal/ provincial housing projects until the election of a new government in 1972.

In 1973 the province set up the first Department of Housing in Canada to administer various Acts and funds relating to housing with powers to supervise, acquire, develop, maintain, improve, and dispose of housing in the province. Social housing programs of all kinds were greatly expanded in the years following, and a number of measures approved to ease the burden on elderly tenants and home owners through tax deferrals and exemptions. The BCHMC and the federal government jointly subsidized provincially-owned rental units to ensure that tenants would pay no more than 25% of their income as rent. When the government changed again in 1976 the impetus to public housing programs, including those for the elderly, diminished greatly.[26] A major study of housing problems in the province prepared by Karl Jaffary was shelved,[27] and responsibility for housing was assigned to the Minister for Municipal Affairs as the province gave higher priority to programs encouraging home ownership among moderate income families.[28]

### 2.1.4 Roles of the Municipal and Voluntary Sectors

While the two senior levels of government have historically introduced and funded broad programs for the elderly, such developments were very often preceded by substantial efforts at the local level to fill the perceived service gap through either voluntary or municipal action.

The Panel on Aging of the Community Chest and Council (later United Community Services) of Vancouver was active throughout the 1950's and 1960's in lobbying for increased health and social services to older people in the city. Their focus on the need for a "total concept of care" for the aged, and the expansion of community alternatives to acute hospital care anticipated by over a decade the federal/provincial Long-Term Care Program. The Committee on Aging of the Social Planning and Review Council (SPARC) of British Columbia carried on this concern for services for the aged in the context of the province as a whole. SPARC published a number of guides and reports for senior citizens in the early 1970's,[29] and since 1978 its Long Term Care Committee has published a guide to the LTC Program for potential service users.[30] Some voluntary service agencies have also focused their efforts on the elderly, most notably the Canadian Arthritis and Rheumatism Society (CARS). Older people themselves have become increasingly active in voluntary organizations, and have formed a variety of groups to represent their many interests at various levels. The many Local Old Age Pensioners' Organizations, and Senior Citizens' Associations concern themselves mainly with social affairs, while the Council of Senior Citizens' Organizations of British Columbia makes annual formal presentations to the provincial government, and, through its national counterpart, to the federal government as well.

The municipalities of Vancouver and Victoria were the first to establish homes for the indigent elderly, and their front-line role in the

delivery of public health and welfare programs has made municipal authorities acutely aware of the problems of the aged in an urban setting. Changes in municipal bylaws have made many public buildings more accessible to the frail elderly, and the handicapped, and a number of special provisions and services have made transportation less difficult and expensive for the aged.

## 2.2 CURRENT STATUS OF PROGRAMS FOR THE ELDERLY IN BRITISH COLUMBIA

Having traced the gradual development of health, income, and housing programs for older people at both the federal and provincial levels, it is natural to consider next the actual present situation of those 65 and over in British Columbia today with respect to these public services. In addition to the services outlined below, elderly citizens may also take advantage of a wide range of programs designed for low income adults of any age, or the general public. Benefits available in each of the three basic categories are outlined, their utilization by the elderly reported, and some consideration given to the adequacy of the current programs.

### 2.2.1 Health

Elderly residents of this province are eligible for medical insurance under the Medical Services Plan (MSP), which covers all medically required services rendered by medical practitioners, including osteopathic physicians, in British Columbia, and certain surgical procedures of dental surgeons where necessarily performed in a hospital. Additional benefits under the plan include the following services when rendered in the province:

Chiropractic - payment for up to fifteen visits per year for the

services of a registered chiropractor.

Naturopathic - payment of up to $100 per year for the services of a naturopathic physician.

Orthoptic - payment of up to $50 per year ($100 per family) for orthoptic treatment on the referral of a medical practitioner.

Physiotherapy - payment of up to $125 per year for the services of a registered physiotherapist on the referral of a medical practitioner.

Podiatry - payment of up to $75 per year for the services of a registered podiatrist when rendered within the year unless referred by a medical practitioner.

Optometry - payment for required diagnostic services of registered optometrists to determine the presence of any observed abnormality in the visual system.

Monthly premiums for the MSP as of April 1, 1982 were $15 for single persons and $28 for couples. Permanent residents (at least a year's duration) are eligible for a subsidy of 90% of the full premium rate if their income in 1981 was less than $2,810.

Under the *British Columbia Hospital Insurance Act* elderly people (and all other residents) are also covered for medically authorized in-patient and out-patient hospital care for acute illness or injury, active convalescent, rehabilitative, and extended hospital care. As of April 1, 1982 the daily co-insurance charges for which patients are themselves responsible were $7.50 for in-patient acute care, $10.50 for extended care, and $4 for out-patient care.

The Home Care/Long-Term Care Program offers a universally available service to elderly provincial residents (at least a year's duration) who

can no longer function independently as a result of a health-related problem. The community and residential programs included are:

Home Care - required services at home of qualified nurses as well as physiotherapists, occupational and speech therapists where available, on the referral of a medical practitioner (no direct charge to patients).

Homemaker Services - services as required following LTC assessment including routine housekeeping, laundry, meal planning and preparation, shopping, physician visits, simple home nursing, minor home maintenance (fees geared to income from nil to $8 per hour).

Adult Day Care - where available these centres provide an informal program of social and health services for those who require assistance (fees $1 to $3 daily).

Residential Care Facilities - (excluding acute and extended) residential care as required following LTC assessment as personal care (minimum assistance necessary), or intermediate care (general nursing support necessary) ($11.50 per day).

The Dental Care Plan of British Columbia is available to those 65 and over, as well as children under 15, and those with lower incomes. The program pays 75% of the cost of basic dentisty, dentures and repairs for adults in need, and half these expenses for all children and senior citizens.

The British Columbia Pharmacare Program provides most prescription

drugs free of charge to those over 65 who have resided in the province for at least three months.

### 2.2.2 Income

Under the *Old Age Security (OAS) Act* (1951) persons aged 65 and over may qualify for either the full pension or a partial amount depending on their residence in Canada after reaching age 18. The monthly rate for OAS payments as of January 1982 was $228.73. OAS pensioners with no income or only a limited amount of additional income may, upon application, receive a full or partial supplement, the Guaranteed Income Supplement (GIS). GIS monthly benefits as of January 1982 were $228.63. The spouse of an OAS pensioner may be eligible for full or partial benefits (depending on history of residence in Canada) under a Spouse's Allowance (SPA) program if that spouse is between 60 and 65 years of age and meets OAS residence requirements. The maximum SPA monthly payment as of January 1982 was $404. OAS, GIS, and SPA benefits are adjusted quarterly in accordance with changes in the Consumer Price Index (CPI). See Appendix 1 for details of program conditions for OAS, GIS and SPA.

Under the Canada and Québec Pension Plans (1965) retirement pensions are payable at age 65 based on the pensionable earnings record of the recipient for his contributory period. The maximum retirement benefit, $272.31 per month in 1981, equals 25% of the average adjusted contributory career earnings. C/QPP benefits are increased annually once paid out to fully reflect increases in the CPI. See Appendix 2 for details of program conditions for C/QPP.

British Columbians of the age of 65 or more who are Canadian citizens or landed immigrants with five years' consecutive residence in Canada may qualify for additional benefits under the provincial GAIN program.

The GAIN Seniors' Supplement is an additional payment by the British Columbia government to residents in receipt of OAS/GIS whose income is less than the current GAIN rate to raise their income to this level, $495.24 as of January 1982 for single individuals, and $907.66 for married couples. The GAIN rate is adjusted upward in tandem with the OAS/GIS/SPA on a quarterly basis.

The federal and provincial governments also provide income assistance to those over 65 through the *Income Tax Act* (1972) which in 1981 provides for an age exemption of $1,980, a similar deduction for those blind or bed-ridden, and a maximum deduction of $1,000 from private pension or retirement income. See Appendix 3 for details of these tax programs.

### 2.2.3 Housing

Many non-profit societies in British Columbia operate housing projects offering bachelor and one-bedroom apartments to provincial residents of at least one year's duration who are over the age of 60, with limited income, and capable of caring for themselves and their apartment. Anyone 65 or over, living in their own home may apply to have property taxes payable to the municipality deferred until the property is transferred or sold (unless they exceed the assessed value). They also receive a home-owner grant of $630 in 1981 to be applied against yearly property taxes payable. Under the Shelter Aid for Elderly Renters (SAFER) program persons 65 or over who pay more than 30% of their income for rent may be eligible for direct cash assistance equal to 75% of the amount by which the applicant's rent exceeds 30% of his/her income. The maximum payments under SAFER are $97.50 per month for single persons (for whom the maximum rental allowed is $265 monthly) and $58.12 per month for married individuals (rental maximum is $295 monthly) as of June 1981.

### 2.2.4 Utilization

Utilization statistics for the programs mentioned in the preceding sections give some indication of their acceptance, popularity, and need. The most recent figures are listed for all programs for which data is available in Appendix 4, and highlighted in the remainder of this section.

It is noteworthy that the elderly form about 11% of all MSP subscribers (see Appendix 4.A.1) yet accounted for 18.4% of total plan billings (fee-for-service payments only) in 1979-80.[31] Elderly males formed 26.4% of total male hospital cases in 1980/81, and elderly women comprised 26.0% of total female cases (see Appendix 4.A.2.a). These figures contrast sharply with the percentage of the elderly in the population as a whole in that year, about 10%. Even more dramatic are comparisons of the number of days of acute hospital care used by older men and women - 39.8% and 42.5% of the totals for each sex respectively (see Appendix 4.A.2.a). In fact the average length of stay for those over 70 in 1980/81 in acute care hospitals was 14.7 days, almost double the provincial average of 8.2 days (see Appendix 4.A.2.b). Understandably, the elderly accounted for most extended care hospital cases (82.0%) and days (85.1%) in 1981 (see Appendix 4.A.2.c). Long-Term Care services are used by a small proportion of the aged as a whole (6-8%) but a substantial proportion of the oldest subgroup (20-30% of those over 85) as shown in Appendix 4.A.3, parts (a), (b), and (c). In addition, most utilization rates for LTC services have been rising over the past few years, as Appendix 4.A.3 parts (d) and (e) show, with those for homemaker services increasing more quickly than others (until restrictions on budget growth were announced in June 1981). In the area of pharmaceuticals, the elderly received 22% of all drug prescriptions, and accounted for over 28% of all drug expenditures in 1980.[32] Seniors claiming under the Pharmacare Plan "A" accounted for

63% of all Pharmacare payments despite a utilization rate of less than 11% of the total elderly population (see Appendix 4.A.4.a). In 1979/80 this group received 82% of all cardiovasculars and 53% of all tranquilizers, the two therapeutic classes most heavily utilized under the Pharmacare program (see Appendix 4.A.4.b)

In 1978 about 94% of those 65 and over in British Columbia were receiving some element of OAS/GIS/SPA (see Appendix 4.B.1.a). Of these, 48% received OAS alone, 16% the maximum GIS/SPA as well,and 36% partial GIS/SPA payments (see Appendix 4.B.1.b). The average payment to beneficiaries of CPP retirement pensions in September 1980 was $128.92, calculated from data reported in Appendix 4.B.2.a. In 1977 about 37% of the province's elderly received CPP retirement pensions, up from about 13% in 1971 (see Appendix 4.B.2.b). Almost a quarter (23.4%) of the aged received the GAIN Seniors' Supplement in 1980, down from almost 40% in 1976, although average per capita payments, $381.55 and $384.01 respectively, have varied little over this period (see Appendix 4.B.3). Utilization of the GAIN for Seniors program has been falling steadily in recent years due to the increasing take-up of CPP benefits rendering more elderly people ineligible each year. In 1980 12,500 SAFER recipients, only 4.3% of the province's elderly, applied for rent supplements that averaged $50 per month.[33]

In summary, utilization by the elderly varies with the program areas being considered: from near-total participation (90-100%) in the universal programs of OAS, Pharmacare, and Dental Care, through substantial but minor usage (15-35%) of medical, hospital, and selective income supplementation programs (GIS, SPA, and GAIN), to minor utilization (5-10%) of the Long-Term Care program, and even less participation in housing programs such as SAFER. While this general picture

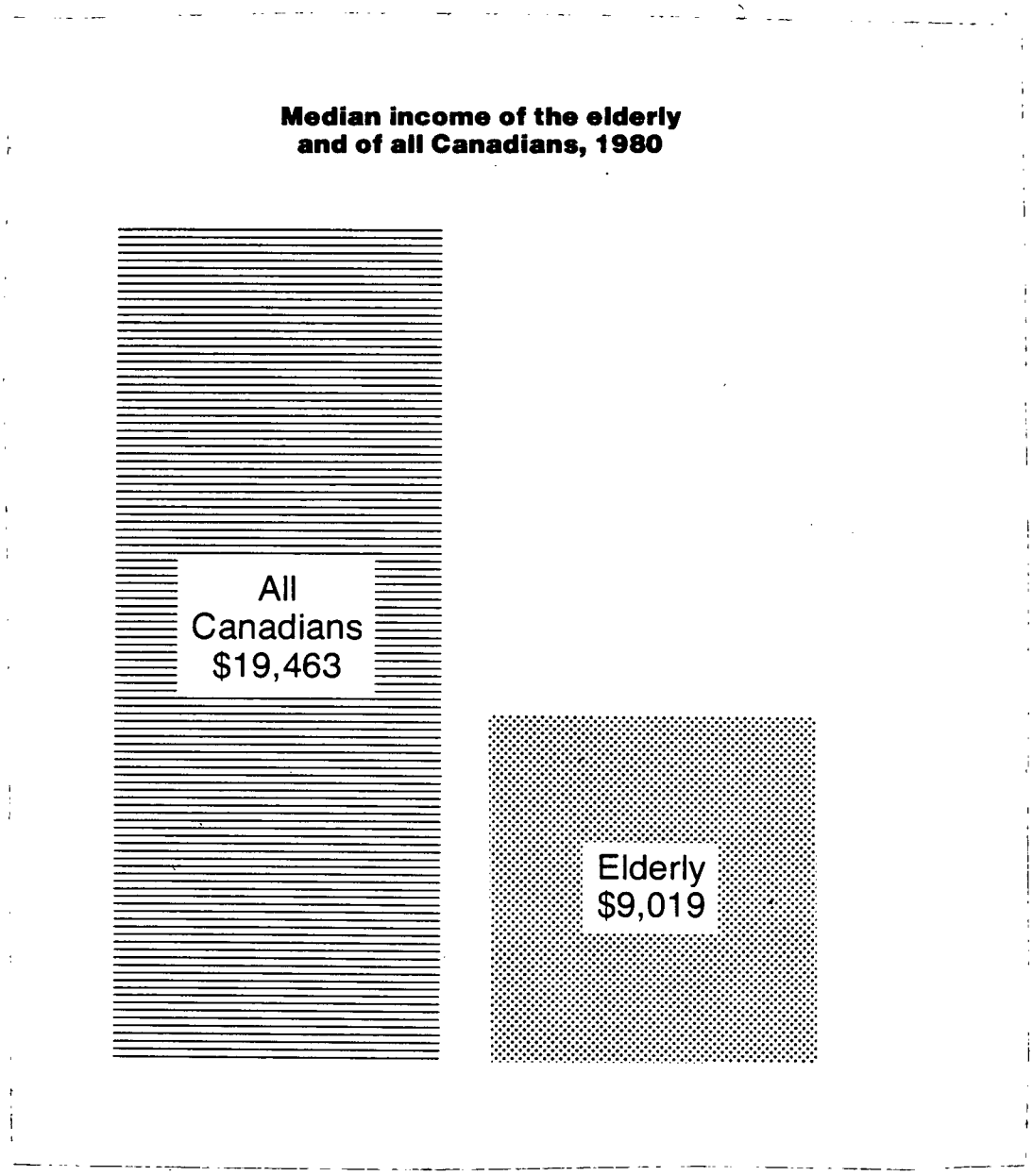
conforms to the traditional rule-of-thumb that most older people (say 85%) do function independently, with relatively few (10%) partially dependent, and very few (5%) fully dependent on others for daily care, these figures do not address the important question of which real needs of the aged still remain unmet despite existing programs.

### 2.2.5 Adequacy

Many are rightly concerned about the adequacy of programs available for elderly people in British Columbia. Concern has been expressed about the level of services in each of the three program areas, and some have pointed out that the need for each is intimately related to the adequacy of the other two. For example, an older person living in sub-standard housing is more likely to become ill, especially without an income adequate for a proper diet and recreational activities. It is generally agreed, however, that the basic element in the program support system for the aged is that of income.

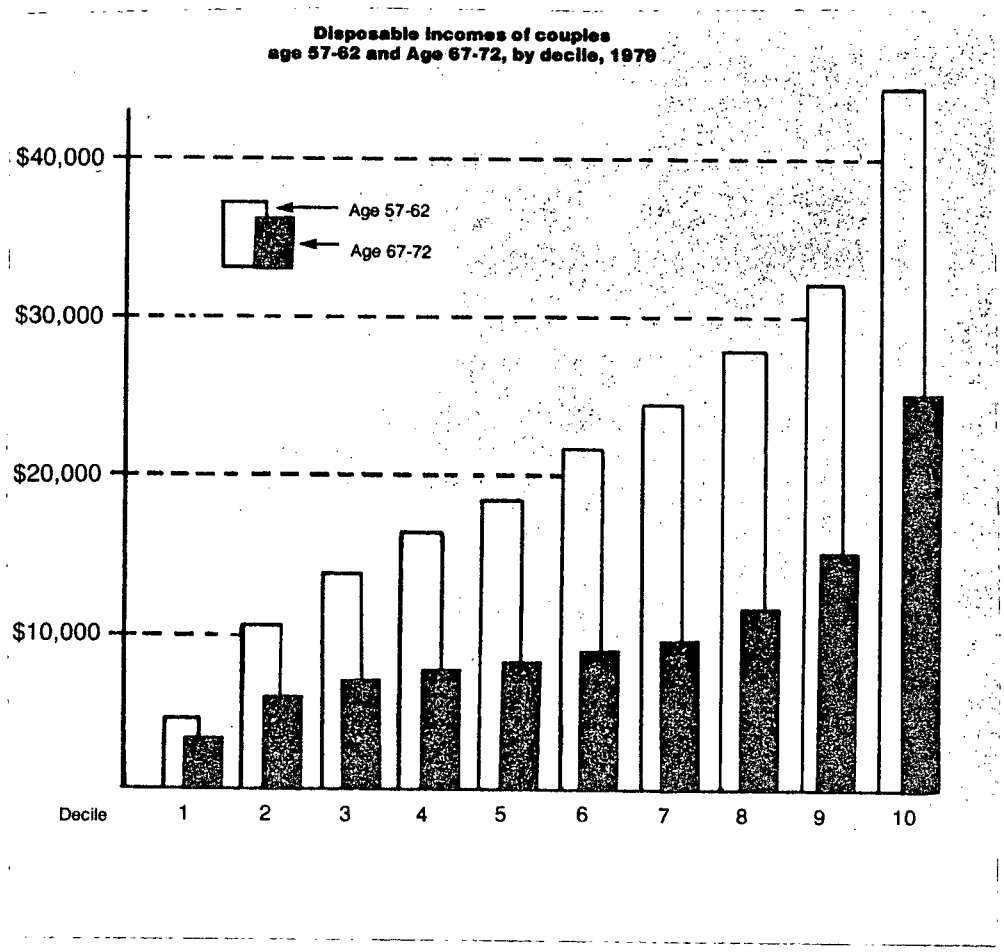
According to recent federal calculations, the incomes of elderly citizens on average are substantially below those of other Canadians (see Figure 2.1), as many suffer a sharp drop in their standard of living after retirement, particularly those in the middle-income range (see Figure 2.2). Almost half the elderly in British Columbia have incomes so low they are eligible for the GIS, although this is true for an even higher proportion in most other provinces (see Figure 2.3), and (as pointed out earlier) almost a quarter of these still receive less than the provincial GAIN guarantees ($5,942.88 per year for single persons, and $10,891.92 for couples in January 1982). Even at these latter income levels, the incomes of single elderly individuals (mainly women) remain below the statistical poverty lines (see Figure

FIGURE 2.1



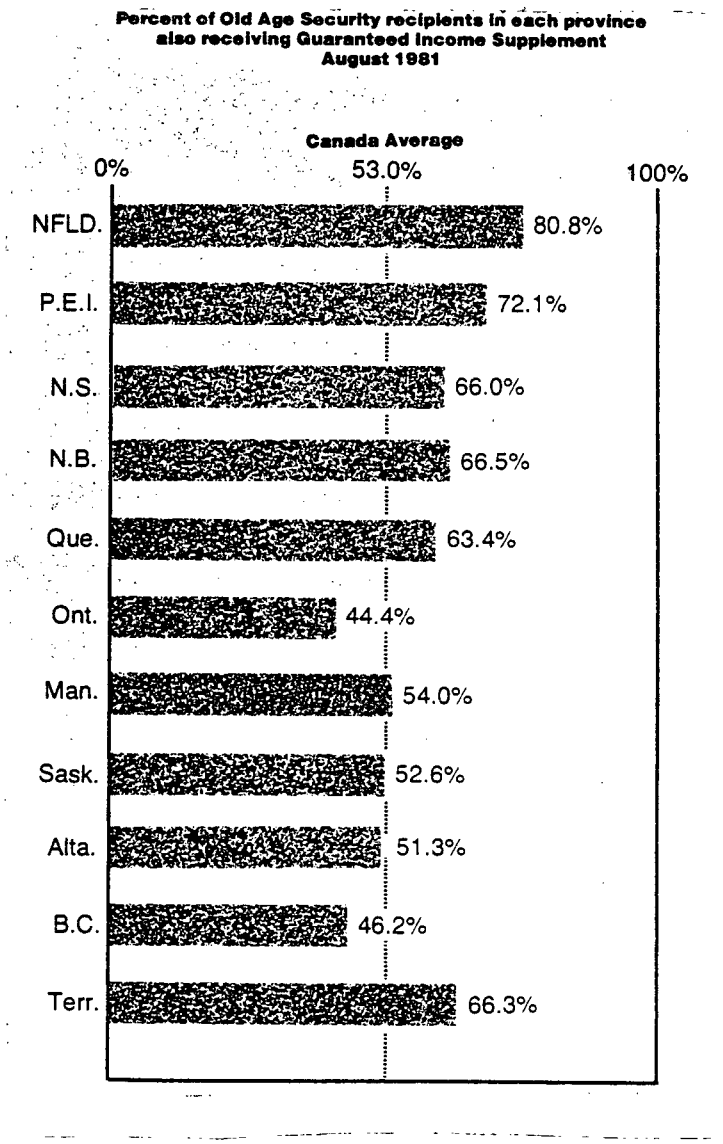

From: Department of National Health and Welfare, *Pensions In Canada* (Ottawa: Health and Welfare Canada, 1981), p. 1. Reproduced by permission of the publisher.

FIGURE 2.2




From: Department of National Health and Welfare, *Pensions in Canada* (Ottawa: Health and Welfare Canada, 1981), p. 2. Reproduced by permission of the publisher.

FIGURE 2.3




From: Department of National Health and Welfare, *Pensions in Canada*. (Ottawa: Health and Welfare Canada, 1981), p. 3. Reproduced by permission of the publisher.

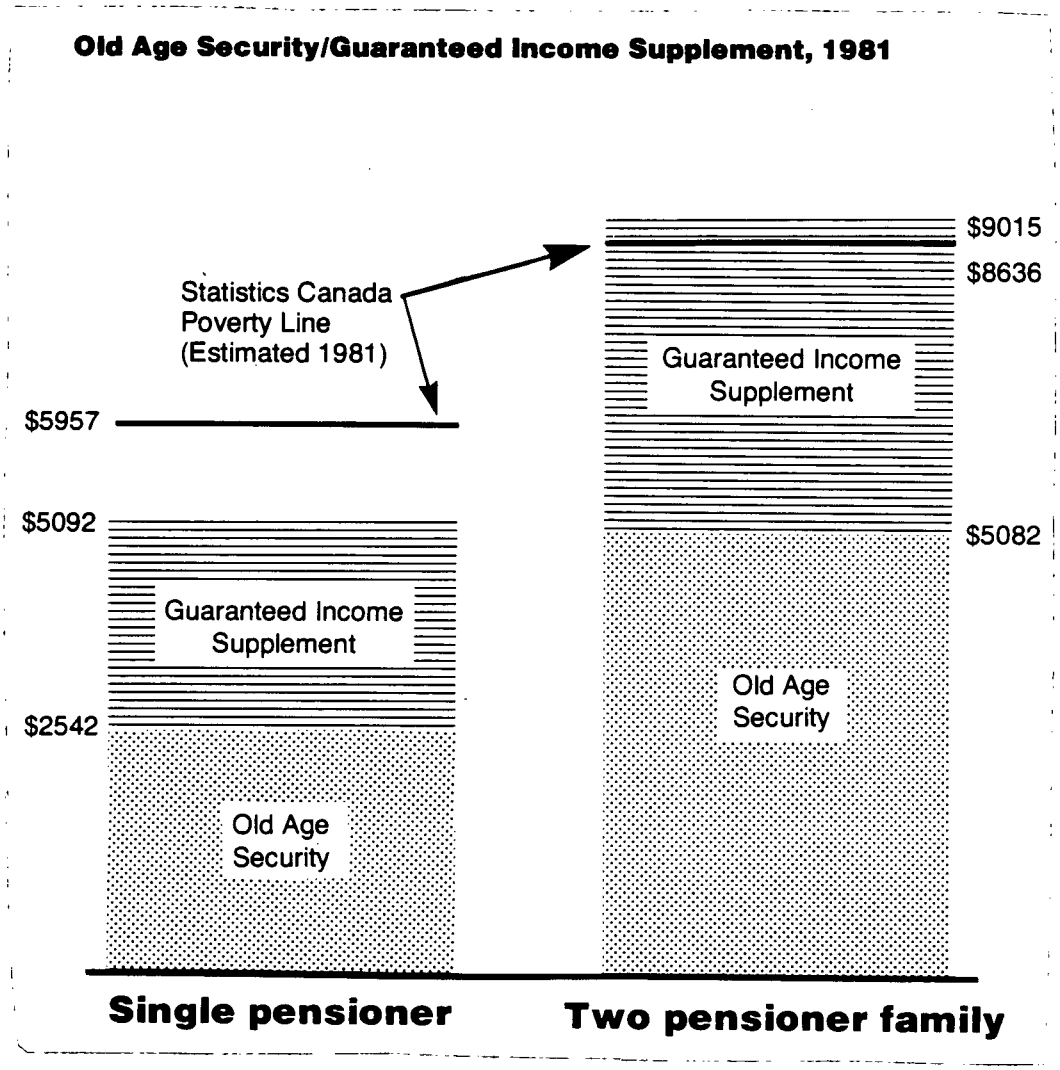
2.4), while those of elderly couples just exceed the lowest poverty line (see Appendix 5). These telling figures surely indicate that the income security system for the aged in British Columbia (and Canada) is currently inadequate by any reasonable standard.

The extraordinary escalation in housing costs in British Columbia in the past few years has resulted in a larger proportion of many people's income going to basic shelter. Although no figures are available, it seems inevitable that a number of older people, affected by this general inflationary increase (through higher taxes, rents etc.) would be forced to spend relatively more on housing than before. The quarterly CPI adjustments to OAS/GIS/SPA and CPP would still fall short of the levels of inflation experienced in this province which have been consistently higher than the national average for some time.

There can be little doubt that the squeeze on older people (and their families) caused by income shortages and rising costs of housing, food, and other basic items has led many whose health has deteriorated to seek residential care under the provincial Long-Term Care program earlier than they might have otherwise. An insufficient number of facility beds under this program has apparently exacerbated the problem of the blocking of acute care beds by long-stay patients which the program was partly designed to alleviate. While this phenomenon is one that is being experienced in many countries,[34] the increasing number of such "bed-blockers" recorded in the province over the past few years has led many to conclude that the problem extends beyond that of inadequate LTC bed supply (although this is part of the story to be sure) to the lack of affordable community alternatives available to the frail elderly today.

This inevitable combining of factors affecting the elderly will be

FIGURE 2.4




From: Department of National Health and Welfare, *Pensions in Canada* (Ottawa: Health and Welfare Canada, 1981), p. 4. Reproduced by permission of the publisher.

considered again in the following section examining the shape of things to come for British Columbia's aging population.

## 2.3 FUTURE TRENDS AFFECTING PROGRAMS FOR THE ELDERLY

In this section the impact of a variety of relevant trends on programs for the elderly in the future are assessed. It is asserted that such forecasts are essential despite the acknowledged difficulties with predictions of this kind.

### 2.3.1. Limitations

It must be emphasized at the outset that since forecasting is necessarily beset by a host of uncertainties, it is prudent to be especially cautious in drawing conclusions from such exercises. It is equally clear that the margin of error in predictions of any kind increases rapidly with the time span involved, and may indeed be so great in some cases that an informed guess would fare as well. Of course planning would be a great deal simpler if such uncertainties did not exist, but their persistence cannot be allowed to discourage the planning enterprise. Indeed it is important to realize that the very acceleration of change that has come to characterize much of modern society makes careful planning all the more imperative if policy-makers are not to find themselves hobbled by outmoded structures in attempting to solve public problems. Thus it is anticipated that planners must increasingly address the structural aspects of their concerns to improve the ability of government (or business) to adapt quickly to new conditions in the turbulence of today's organizational world.

Having made this general qualification, it is important to distinguish the particular limitations imposed on this study by the nature of the task at hand. Projections considered in this section will include those

of an economic and political nature, based upon expected demographic changes. The potential impact of the former trends on programs for the elderly is seen as sufficiently great to justify their inclusion despite relatively larger error margins in forecasting. The basic and most persuasive trends emerge from demographic projections. Although demographers are not exempt from the risks of forecasting mentioned earlier (the extended post-war baby boom itself eluded most forecasters of the day),[35] predictions about the elderly enjoy a distinct advantage. Since those who will be over 65 in the year 2031 are now alive (and in fact over 15), fertility projections can be disregarded in forecasting the *number* of elderly people. Migration is of course a factor subject to considerable fluctuation, but mortality patterns are relatively well known, and advances in health technology can only add to the number of the old. However, if forecasting the number of the elderly is relatively uncomplicated, the same cannot be said of predicting what proportion of the total population they can be expected to form. Fertility rates, once thought to be easily predictable, have surprised demographers again and again - up in the 1950's (not down as expected), down in the 1960's (when rises were forecast) and so on. Since the importance of the aged dependency ratio (the number of those aged 65 and over divided by the number aged 20 to 64) for determining pension funding makes it necessary to engage in fertility predictions, a range of scenarios will be considered. As a rule, the gloomiest picture will be drawn in the hope that policy-makers will plan for this, and use ameliorating developments (if any) to allow more room for other public priorities. It is assumed that major depopulating catastrophes such as global war can never be adequately planned for.

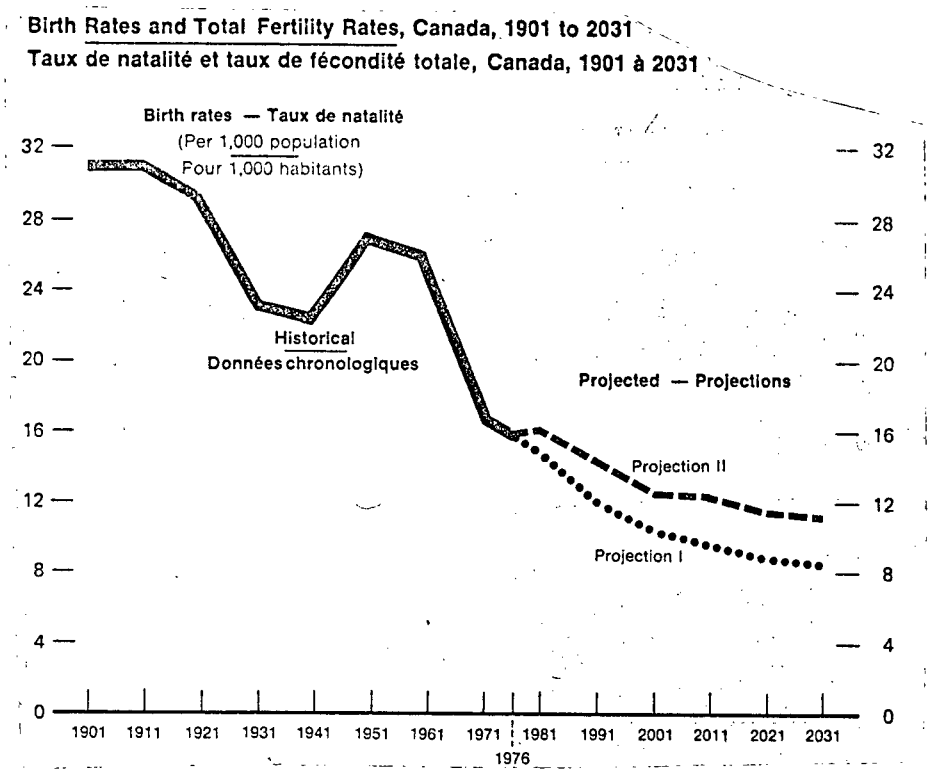
2.3.2. Demographic Trends

The demographic picture presented below will focus both on Canada and British Columbia, although the national situation may receive relatively more emphasis since more work has been done at this level to date.

In 1851 there were only 65,000 Canadians (2.7%) of the total population of 2.4 million who had reached the age of 65. Today almost 10% of Canada's population of about 24 million are elderly, roughly the number in the total population 130 years ago[36]. For British Columbia the historical picture is even more dramatic. From about 1,000 elderly (approximately 3%) in a provincial total of just over 36,000 in 1871, the aged have grown to comprise today almost 11% of the province's total population of about 2.7 million. This increase in the number of the elderly has been a result of general population growth, extended survival through improved health care and living standards, and increased net migration, particularly since World War 2.

But the gradual aging of a gradually increasing population is not the major element in demographic projections of the elderly in Canada. If this were the complete picture the implications for social programs would certainly be serious, and merit careful attention. But a trend that few expected to occur, yet that lasted for over a decade from its early post-war beginnings has radically changed all that[37]. The baby boom in Canada produced more than 400,000 children each year from 1952 to 1965, and created a bulge in the nation's population profile that has been carried along since as the "big generation"[38] ages (see Figure 2.5). This abnormally large birth cohort has combined its influence with other modern societal forces to produce dramatic change in the social institutions and structures through which it has passed. From schools and education in the 1960's, through jobs and the workplace in the 1970's, and now into homes and residential accommodation in the 1980's, this

FIGURE 2.5




From: Canada, Statistics Canada, *Social Security National Programs 1978* (Ottawa: Queen's Printer, 1978), p. 10. Reproduced by permission of the Minister of Supply and Services Canada.

boom generation has revolutionized society through sheer force of numbers. It is this group that poses the greatest challenge to those planning services for the elderly in the years ahead. There can be little doubt that they will test the health services, pension plans, housing developments, and other public programs upon which they will depend in future just as severely as the systems they will have then left behind. This generation also presents planners with a unique opportunity to anticipate social needs since their effects on programs for the elderly will not be felt until about 2011, thirty years from now, and increases in the proportion of those over 65 until then, while sizeable, will be comparatively steady and moderate.

The size and composition of Canada's future population will depend on the rates of fertility, mortality, and immigration that prevail. Because of the uncertainty in predicting future levels of these variables, it is customary for demographic projections to be made on a range of alternative levels, encompassing high, medium, and low estimates for each one. Appendix 6 describes the various levels for each of these variables considered in a recent background study for the Economic Council of Canada[39], and the range of projections produced as a result. The variations in these estimates well illustrate the sensitivity of demographic structure to changes in underlying results that was referred to earlier. For this paper the Statistics Canada Projection Number 3, based on the following assumptions, will be used:

1. low fertility - declining from 1.9 children per woman of childbearing age in 1976 to 1.7 in 1991 and constant thereafter.
2. low life expectancy - rising until 1986 to reach 70.2 years for men and 78.3 years for women, and constant thereafter.
3. medium net immigration - 75,000 persons per year.

This population projection is detailed in Table 2.1, graphed in Figure 2.6,

TABLE 2.1

Canadian Population Projections by Age

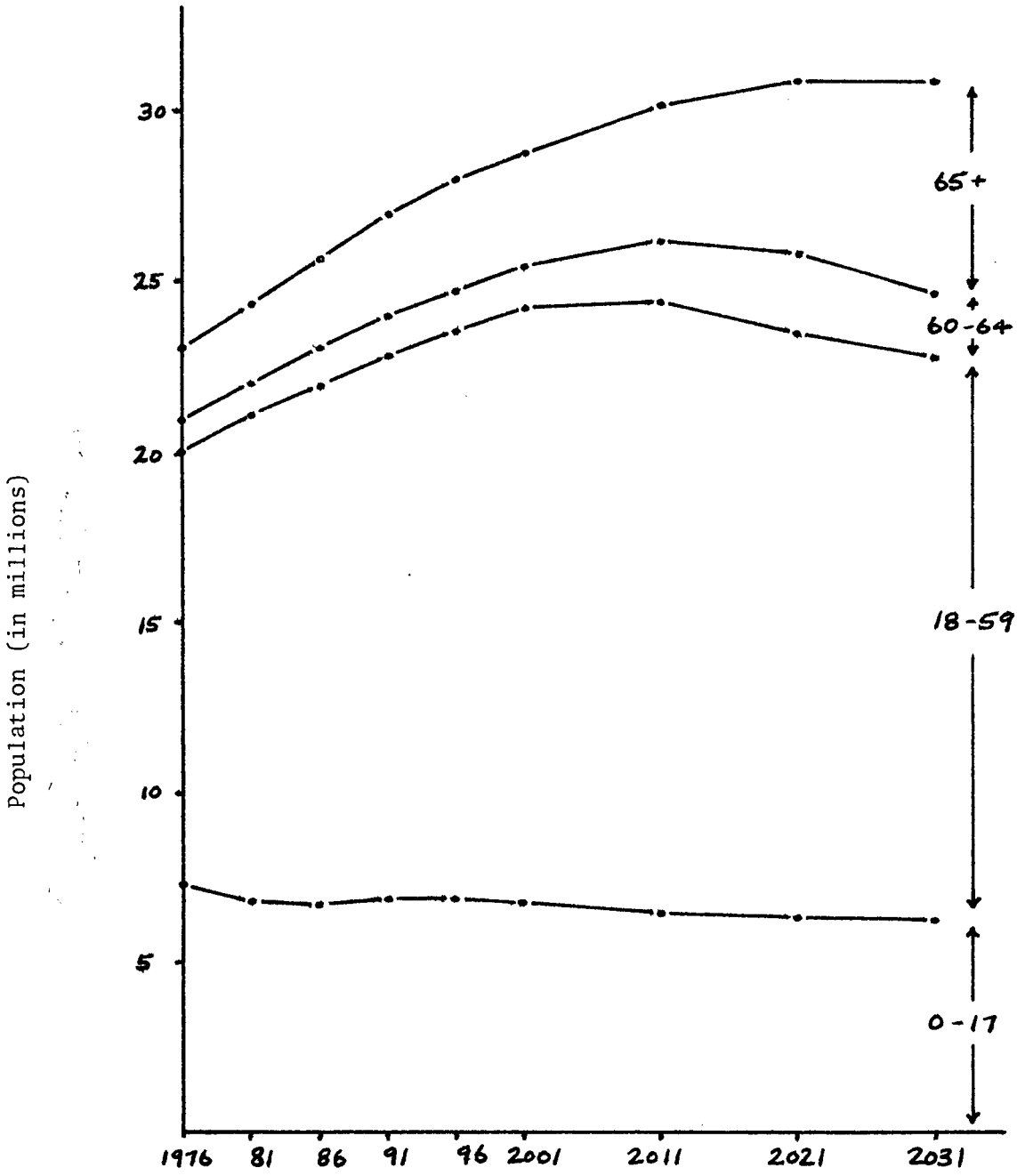
(Statistics Canada Projection No. 3)
(population in thousands)

| Year | Total Population | 0-17 | % | 18-59 | % | 60-64 | % | 65+ | % |
|---|---|---|---|---|---|---|---|---|---|
| 1976 | 22,993 | 7,312 | 31.8 | 12,774 | 55.6 | 905 | 3.9 | 2,002 | 8.7 |
| 1981 | 24,330 | 6,933 | 28.5 | 14,134 | 58.1 | 963 | 4.0 | 2,310 | 9.5 |
| 1986 | 25,713 | 6,833 | 26.6 | 15,159 | 58.9 | 1,110 | 4.3 | 2,615 | 10.2 |
| 1991 | 26,975 | 6,966 | 25.8 | 15,918 | 59.0 | 1,114 | 4.1 | 2,980 | 11.0 |
| 1996 | 27,993 | 6,993 | 25.0 | 16,640 | 59.4 | 1,115 | 4.0 | 3,248 | 11.6 |
| 2001 | 28,794 | 6,805 | 23.6 | 17,401 | 60.4 | 1,165 | 4.0 | 3,425 | 11.9 |
| 2011 | 30,068 | 6,411 | 21.3 | 17,968 | 59.8 | 1,764 | 5.9 | 3,924 | 13.1 |
| 2021 | 30,877 | 6,378 | 20.7 | 17,255 | 55.9 | 2,151 | 7.0 | 5,093 | 16.5 |
| 2031 | 30,935 | 6,162 | 19.9 | 16,715 | 54.0 | 1,817 | 5.9 | 6,240 | 20.2 |

From: B.J. Powell, J.K. Martin,"Economic Implications of an Aging Society in Canada", a paper prepared for the National Symposium on Aging, Ottawa, October 25-27, 1978, p. 6. Reproduced by permission of J.K. Martin.

FIGURE 2.6

CANADIAN POPULATION PROJECTIONS BY AGE




From: Powell and Martin, "Economic Implications", p. 6.

and gives rise to the dependency ratios forecast in Table 2.2 and shown graphically in Figure 2.7. In order to err in the direction of the worst-case scenario, this relatively low-growth projection will be used in the remainder of the paper to consider the impact of various policy changes. The most striking feature of the projection is certainly the dramatic increase in the number (and proportion) of the elderly beginning in about 2011. The slower growth until that time (actually slackening between 1991 and 2001) is also noteworthy, as is the continuous decline in the proportion of those aged 0 to 17 during the entire period.

In British Columbia population projections conform reasonably well with this overall picture. The latest available projection from the Central Statistics Bureau (see Table 2.3 and Figure 2.8) shows clearly the "wave" created by the baby boom as it moves into the higher age groups, and the smaller following "baby-echo" created by the children of those born during the baby boom. As a result of the aging of this dominant cohort, British Columbia too will experience declines in the relative proportion of some of the younger age groups. Dependency ratios are forecast to change as shown in Figure 2.9. The assumptions underlying the Central Statistics Bureau (CSB) projection are explained in Appendix 7.

It is worth noting that the Statistics Canada, Projection Number 3 figures for British Columbia are considerably lower overall than those from the CSB projection (see Table 2.4). While the same patterns are evident (see Figure 2.10), the more conservative growth assumptions used by Statistics Canada produce a less optimistic picture than their CSB counterparts, as can be seen from the somewhat higher elderly dependency ratios forecast (see Table 2.5). This point should be kept in mind when implications for the programs are considered in a later section.

TABLE 2.2

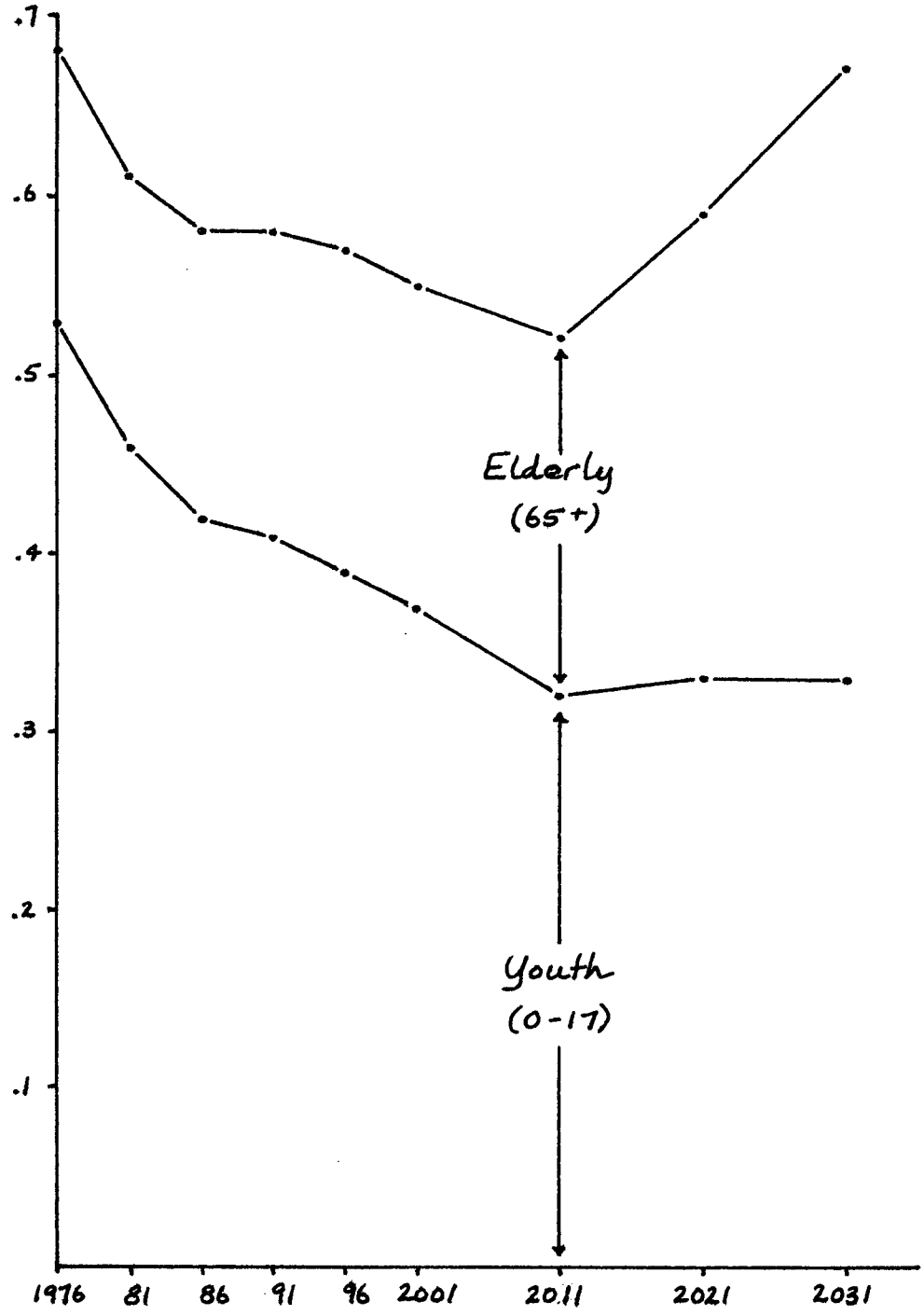
PROJECTED DEPENDENCY RATIOS IN CANADA

| Year | Youth (0-17) Dependency | Elderly (65 ) Dependency | Total |
|---|---|---|---|
| 1976 | .53 | .15 | .68 |
| 1981 | .46 | .15 | .61 |
| 86 | .42 | .16 | .58 |
| 91 | .41 | .17 | .58 |
| 96 | .39 | .18 | .57 |
| 2001 | .37 | .18 | .55 |
| 11 | .32 | .20 | .52 |
| 21 | .33 | .26 | .59 |
| 31 | .33 | .34 | .67 |

From: Powell and Martin, "Economic Implications", p. 6.

FIGURE 2.7

PROJECTED DEPENDENCY RATIOS IN CANADA




From: Powell and Martin, "Economic Implications", p. 6.

TABLE 2.3

*PROJECTED BRITISH COLUMBIA POPULATION BY AGE*
1980-2001 ('000)

| *YEAR* | *AGE GROUP* 0-4 | 5-9 | 10-14 | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65+ | *TOTAL* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1980 | 187.5 | 186.8 | 202.8 | 243.5 | 248.3 | 235.8 | 220.5 | 174.5 | 143.0 | 137.3 | 134.4 | 133.1 | 111.8 | 280.7 | 2640.1 |
| 1981 | 197.4 | 186.6 | 205.1 | 238.0 | 257.7 | 245.5 | 231.8 | 182.5 | 148.8 | 138.2 | 136.5 | 134.1 | 116.1 | 289.6 | 2707.8 |
| 1982 | 206.9 | 190.2 | 205.6 | 232.3 | 265.2 | 254.1 | 235.9 | 197.8 | 155.5 | 139.7 | 138.0 | 133.9 | 121.4 | 298.1 | 2774.5 |
| 1983 | 217.0 | 194.4 | 206.8 | 224.3 | 271.0 | 263.1 | 241.7 | 210.1 | 164.3 | 141.6 | 140.2 | 134.3 | 126.5 | 305.5 | 2840.7 |
| 1984 | 226.7 | 200.7 | 205.5 | 219.2 | 273.6 | 272.6 | 249.3 | 219.8 | 174.0 | 144.8 | 141.0 | 134.7 | 131.4 | 313.2 | 2906.4 |
| 1985 | 235.2 | 208.3 | 204.4 | 218.0 | 271.1 | 282.9 | 257.7 | 231.8 | 182.4 | 149.1 | 141.6 | 136.1 | 132.6 | 324.0 | 2975.2 |
| 1986 | 241.3 | 217.8 | 203.8 | 220.0 | 265.2 | 291.7 | 267.0 | 242.9 | 190.0 | 154.6 | 142.3 | 137.9 | 133.4 | 334.8 | 3042.8 |
| 1987 | 246.6 | 227.1 | 207.2 | 220.4 | 259.3 | 298.7 | 275.3 | 246.7 | 205.0 | 161.1 | 143.6 | 139.3 | 133.1 | 346.0 | 3109.5 |
| 1988 | 251.0 | 237.0 | 211.3 | 221.5 | 251.1 | 304.3 | 284.2 | 252.4 | 217.1 | 169.6 | 145.3 | 141.3 | 133.4 | 356.1 | 3175.6 |
| 1989 | 254.6 | 246.6 | 217.5 | 220.1 | 245.9 | 306.8 | 293.6 | 260.0 | 226.7 | 179.1 | 148.4 | 142.0 | 133.8 | 366.3 | 3241.6 |
| 1990 | 257.5 | 254.8 | 224.8 | 218.8 | 244.4 | 303.9 | 303.5 | 268.2 | 238.4 | 187.2 | 152.5 | 142.4 | 135.0 | 375.7 | 3307.1 |
| 1991 | 259.6 | 260.8 | 234.3 | 218.1 | 246.3 | 297.7 | 312.0 | 277.3 | 249.3 | 194.6 | 157.8 | 143.1 | 136.6 | 384.6 | 3372.2 |
| 1992 | 261.0 | 266.1 | 243.5 | 221.5 | 246.6 | 291.8 | 319.0 | 285.4 | 253.1 | 209.4 | 164.1 | 144.4 | 137.9 | 392.9 | 3436.6 |
| 1993 | 261.8 | 270.5 | 253.4 | 225.5 | 247.7 | 283.6 | 324.5 | 294.3 | 258.7 | 221.3 | 172.4 | 146.0 | 139.8 | 400.7 | 3500.3 |
| 1994 | 262.0 | 274.1 | 263.0 | 231.8 | 246.3 | 278.4 | 327.0 | 303.7 | 266.2 | 230.8 | 181.7 | 149.0 | 140.5 | 408.6 | 3563.1 |
| 1995 | 261.8 | 276.9 | 271.2 | 239.1 | 245.1 | 277.0 | 324.0 | 313.4 | 274.3 | 242.3 | 189.6 | 153.0 | 140.8 | 416.5 | 3625.1 |
| 1996 | 261.3 | 279.1 | 277.2 | 248.5 | 244.4 | 278.8 | 318.0 | 321.9 | 283.4 | 253.0 | 196.9 | 158.1 | 141.5 | 424.4 | 3686.3 |
| 1997 | 260.8 | 280.5 | 282.4 | 257.7 | 247.7 | 279.1 | 312.0 | 328.8 | 291.4 | 256.7 | 211.3 | 164.2 | 142.7 | 431.3 | 3746.8 |
| 1998 | 260.5 | 281.2 | 286.8 | 267.5 | 251.7 | 280.2 | 303.9 | 334.3 | 300.2 | 262.3 | 223.0 | 172.2 | 144.3 | 438.4 | 3806.6 |
| 1999 | 260.5 | 281.4 | 290.4 | 277.1 | 257.9 | 278.9 | 298.7 | 336.8 | 309.5 | 269.7 | 232.3 | 181.1 | 147.2 | 444.4 | 3865.9 |
| 2000 | 261.1 | 281.2 | 293.2 | 285.3 | 265.2 | 277.6 | 297.3 | 333.9 | 319.1 | 277.7 | 243.5 | 188.8 | 150.9 | 450.1 | 3924.9 |
| 2001 | 262.2 | 280.7 | 295.4 | 291.3 | 274.6 | 276.9 | 299.1 | 327.8 | 327.5 | 286.6 | 253.9 | 195.7 | 155.7 | 456.1 | 3983.6 |

From: British Columbia, Ministry of Industry and Small Business Development, Central Statistics Bureau, *British Columbia Population Projection 10/80 1980-2001* (Victoria: Central Statistics Bureau, 1981), Table 2. Reproduced by permission of the publisher.

TABLE 2.4

PROJECTED POPULATION 65 AND OVER, AND TOTAL POPULATION, BRITISH COLUMBIA, 1981-2031

| YEAR | POPULATION 65 AND OVER | TOTAL POPULATION |
|---|---|---|
| | (in thousands) | |
| 1981 | 283.9 | 2,649.7 |
| 1986 | 324.5 | 2,867.9 |
| 1991 | 369.9 | 3,072.9 |
| 1996 | 404.0 | 3,251.3 |
| 2001 | 428.7 | 3,405.4 |
| 2007 | 461.4 | 3,570.6 |
| 2012 | 521.5 | 3,695.3 |
| 2017 | 605.0 | 3,801.6 |
| 2022 | 698.2 | 3,882.5 |
| 2027 | 795.3 | 3,935.2 |
| 2031 | 848.9 | 3,958.4 |

From: Canada, Statistics Canada, *Population Projections for Canada and the Provinces 1976-2001* (Ottawa: Minister of Industry, Trade and Commerce, 1979); and (for 2007-2031) M.B. Ismaily, Demography Division, Social Statistics Field, Statistics Canada, Ottawa in a personal communication 13 January 1982. Projection No. 3 used throughout.

TABLE 2.5

PROJECTED ELDERLY DEPENDENCY RATIOS,

BRITISH COLUMBIA, 1981-2001

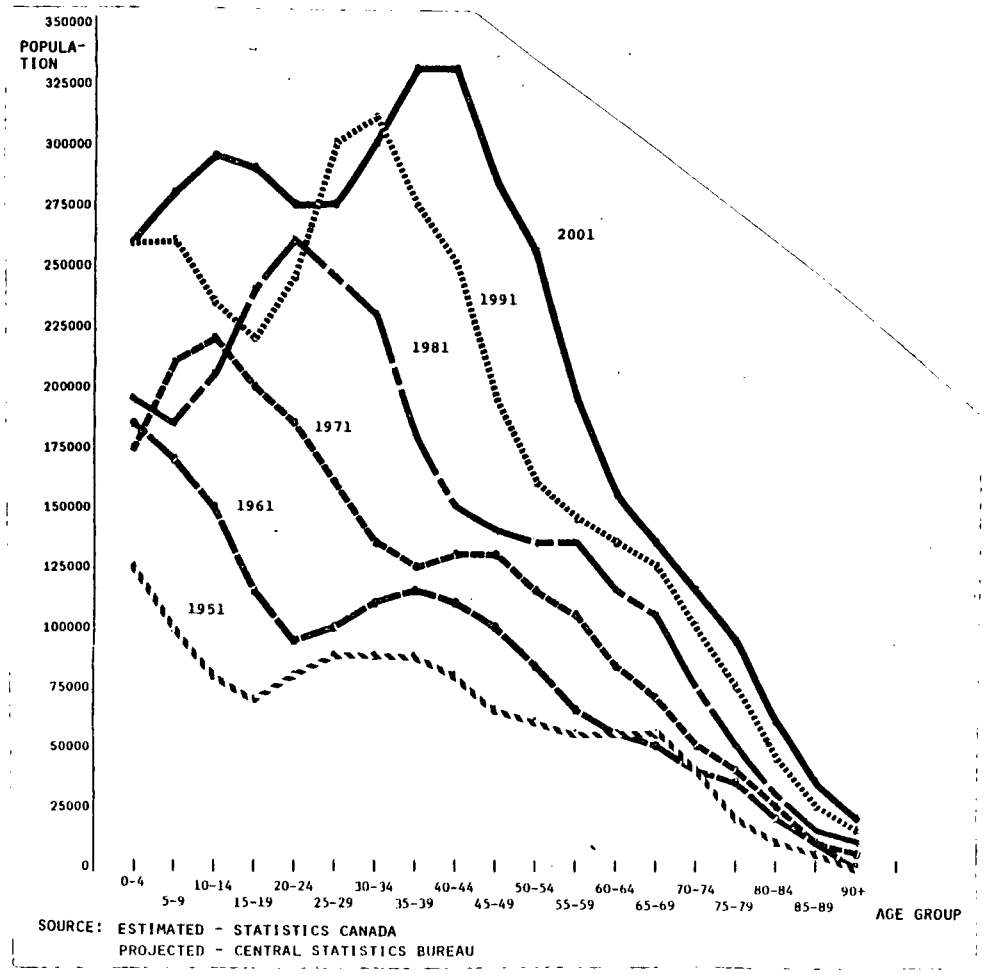
| YEAR | CENTRAL STATISTICS BUREAU PROJECTION 10/80 | STATISTICS CANADA PROJECTION NO. 3 |
|---|---|---|
| 1981 | .16 | .17 |
| 1986 | .16 | .18 |
| 1991 | .17 | .19 |
| 1996 | .17 | .20 |
| 2001 | .17 | .19 |

From: Central Statistics Bureau, *Projection 10/80;* Statistics Canada, *Population Projections.*

FIGURE 2.8

POPULATION AGE DISTRIBUTION FOR BRITISH COLUMBIA

ESTIMATED AND PROJECTED: 1951-2001

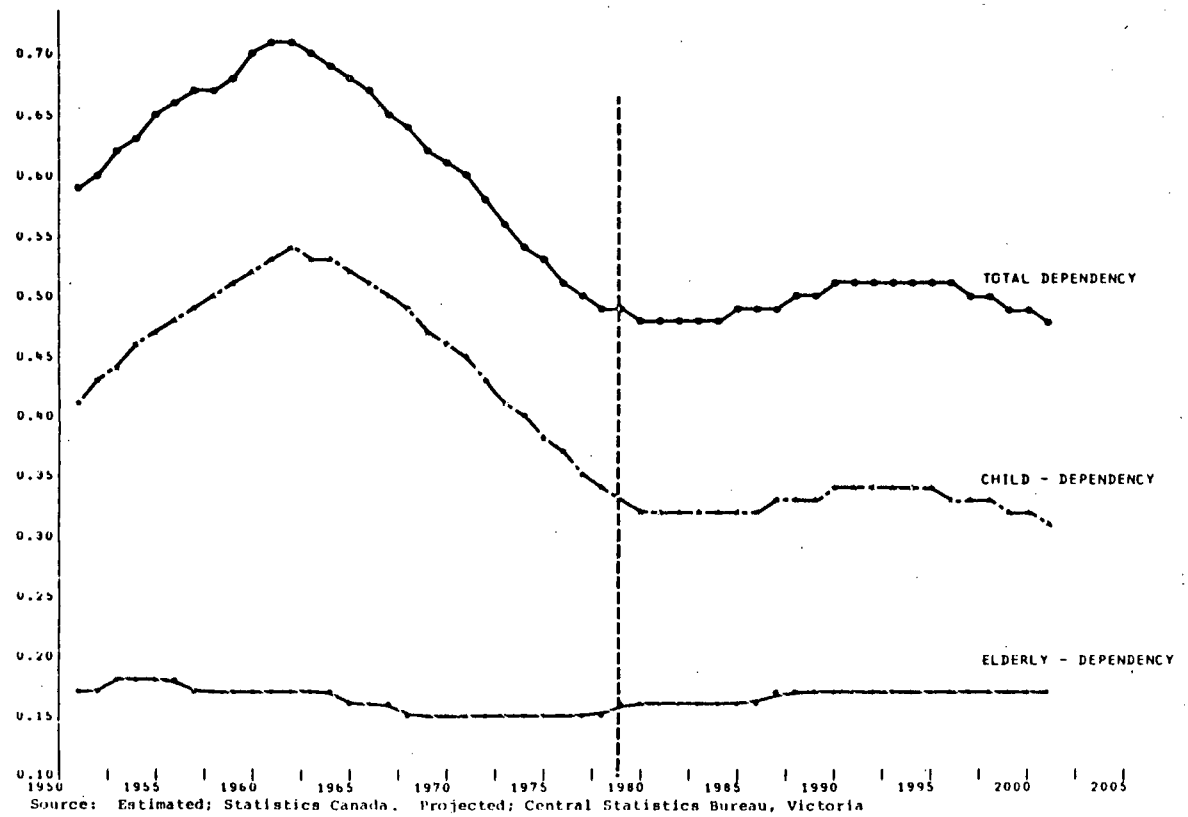



From: British Columbia, Ministry of Industry and Small Business Development, Central Statistics Bureau, *Demographic Impact Summary of British Columbia Population Projection 10/80 1980-2001* (Victoria: Central Statistics Bureau, 1981), p. 2. Reproduced by permission of the publisher.

FIGURE 2.9

COMPARISON OF BRITISH COLUMBIA DEPENDENCY RATIOS

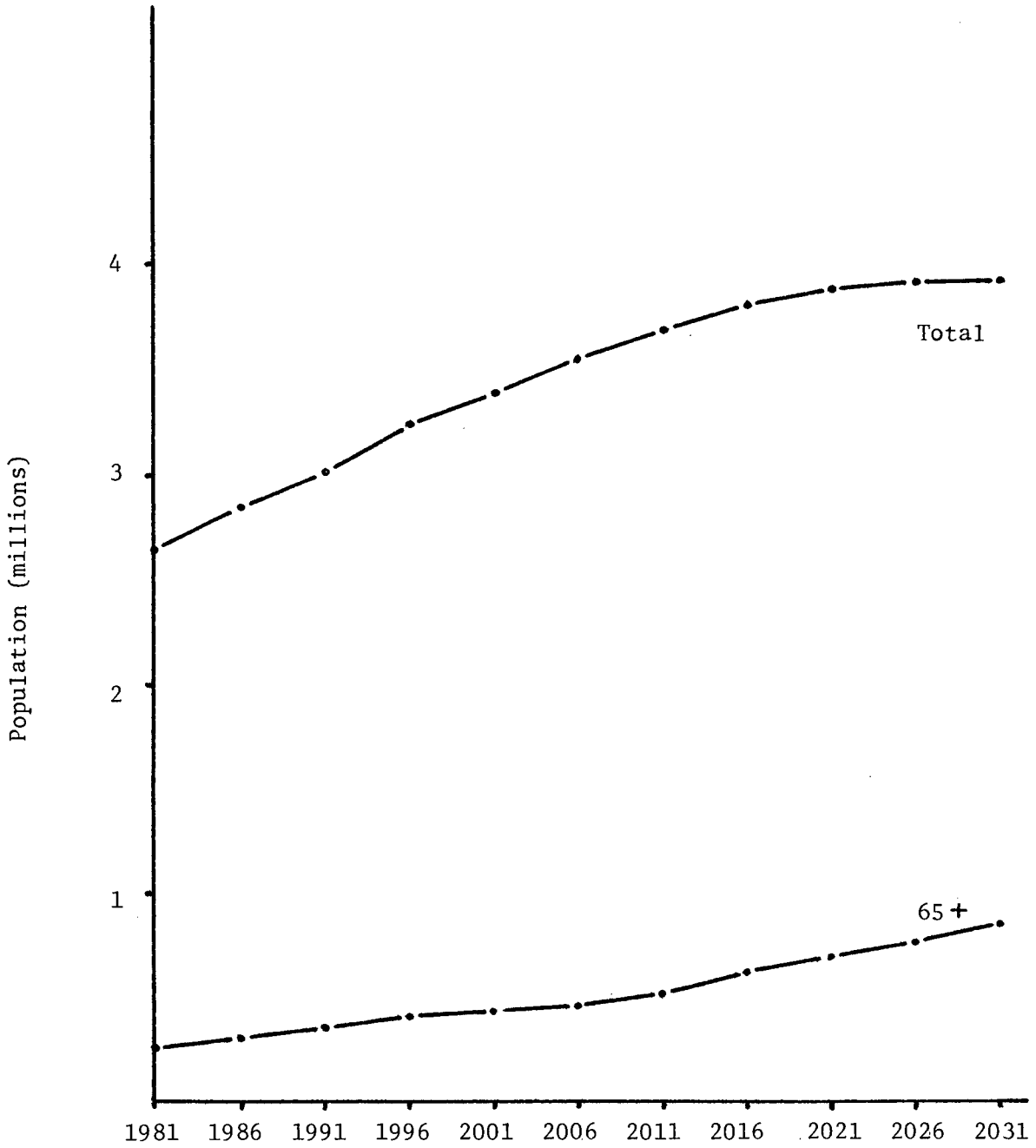
ESTIMATED AND PROJECTED: 1951-2001




From: Central Statistics Bureau, *Demographic Impact Summary*, p. 18. Reproduced by permission of the publisher.

FIGURE 2.10

PROJECTED POPULATION 65 AND OVER, AND TOTAL POPULATION, BRITISH COLUMBIA, 1981-2031




From: Canada, Statistics Canada, *Population Projections for Canada and the Provinces 1976-2001* (Ottawa: Minister of Industry, Trade, and Commerce, 1979); and M.B. Ismaily, Demography Division, Social Statistics Field, Statistics Canada, Ottawa in a personal communication 13 January 1982.

### 2.3.3. Economic Trends

Based on premises similar to those of Statistics Canada Projection Number 3, the Economic Council of Canada's Medium (L-01) demographic projection has been used to produce the labour force forecast shown in Table 2.6 using the assumptions on participation rates described in Table 2.7. Basically this predicts a continuation of current trends in labour force participation such as those for earlier retirement, and increasing rates for women between the ages of 20 and 54. There seems no reason to believe that these trends would not also occur in British Columbia.

Forecasting future growth in productivity and the rate of inflation moves one into the realm of speculation. The technique employed here is to use middle-range predictions over the long term that would tend to worsen the general picture insofar as programs for the elderly are concerned - a sort of moderate worst-case scenario. Consequently a return to the high rates of growth in productivity of the 1950's and 1960's are not foreseen for Canada, and an average increase of about 2% in Gross National Product (GNP) will be used. British Columbia is expected to contribute more to national productivity than most other provinces, with a long-term average 4% yearly increase in Gross Provincial Product (GPP). Likewise, the rate of year-to-year inflation is not expected to return to the low levels of the 1950's and 1960's, and an average rate of 10% is assumed through 1991, dropping thereafter to 5%. Inflation in this province is expected to continue to outpace most of the rest of the country, with rates of 12% and 7% respectively. Generally, then, this admittedly speculative long-range economic forecast calls for continued slow real growth, with high to moderate rates of inflation during the projection period.

TABLE 2.6

ASSUMPTIONS OF LABOUR FORCE PARTICIPATION RATES, BY AGE GROUP AND BY SEX, CANADA, 1981 AND 1991

| | Men | | | Women | | |
|---|---|---|---|---|---|---|
| | 1976 | 1981 | 1991 | 1976 | 1981 | 1991 |
| | Actual | Medium | Medium | Actual | Medium | Medium |
| | (Per cent) | | | | | |
| Age group | | | | | | |
| 15-16 | 33.2 | 30.1 | 30.1 | 27.7 | 24.0 | 24.0 |
| 17-19 | 66.6 | 63.3 | 63.3 | 60.2 | 59.0 | 59.0 |
| 20-24 | 85.2 | 85.2 | 85.2 | 67.3 | 72.0 | 78.0 |
| 25-34 | 95.5 | 95.3 | 95.0 | 53.9 | 60.0 | 68.0 |
| 35-44 | 96.0 | 96.0 | 96.0 | 53.3 | 58.9 | 70.0 |
| 45-54 | 92.5 | 92.0 | 92.0 | 48.3 | 51.1 | 55.1 |
| 55-64 | 76.8 | 74.5 | 70.0 | 32.0 | 32.7 | 34.0 |
| 65-69 | 25.4 | 21.9 | 15.0 | 7.9 | 6.0 | 5.0 |
| 70 and over | 9.7 | 8.5 | 6.0 | 2.1 | 2.0 | 1.4 |

NOTE The participation rates are annual averages based on Statistics Canada *Labour Force Survey* definitions, modified to include the armed forces and residents of the Yukon and Northwest Territories. For years between 1976 and 1981, and between 1981 and 1991, rates are calculated by linear interpolation; for years after 1991, they are assumed constant at their 1991 levels.

SOURCE F. Denton, C. Feaver, and B. Spencer, "The Future Population and Labour Force of Canada: Projections to the Year 2051," a background study prepared for the Economic Council of Canada, 1979.

From: Economic Council of Canada, *One in Three*, p. 128. Reproduced by permission of the author.

TABLE 2.7

PROJECTED LABOUR FORCE, CANADA, 1976 TO 2051

| | Demographic growth projections | | |
|---|---|---|---|
| | Medium (L-01) | High (L-08) | Low (L-09) |
| | (Thousands) | | |
| 1976 | 10,411 | 10,411 | 10,411 |
| 1981 | 11,723 | 11,771 | 11,668 |
| 1986 | 12,803 | 13,040 | 12,559 |
| 1991 | 13,655 | 14,101 | 13,201 |
| 1996 | 14,299 | 15,141 | 13,510 |
| 2001 | 15,099 | 16,771 | 13,689 |
| 2006 | 15,861 | 18,628 | 13,673 |
| 2011 | 16,380 | 20,244 | 13,428 |
| 2016 | 16,610 | 21,589 | 12,922 |
| 2021 | 16,771 | 23,088 | 12,291 |
| 2026 | 16,982 | 25,007 | 11,613 |
| 2031 | 17,296 | 27,347 | 10,960 |
| 2036 | 17,689 | 29,862 | 10,409 |
| 2041 | 18,060 | 32,389 | 9,900 |
| 2046 | 18,331 | 34,908 | 9,383 |
| 2051 | 18,557 | 37,593 | 8,888 |

SOURCE F. Denton, C. Feaver, and B. Spencer, "The Future Population and Labour Force of Canada: Projections to the Year 2051," a background study prepared for the Economic Council of Canada, 1979.

From: Economic Council of Canada, *One in Three*, p. 128. Reproduced by permission of the author.

### 2.3.4 Political/Bureaucratic Trends

It was noted early in this chapter that Canada, originally conceived as a centralized state, has evolved into a highly decentralized one with powerful provincial governments taking a larger and larger role in national policy-making. At the same time, the federal government's increasingly collectivist humanitarian initiatives in the social policy sphere have evoked cautious reaction in British Columbia as a result of the usually conservative utilitarian but always distinctively populist social political approach that holds sway here. As will be elaborated later (see Section 3.1.2), the Canadian government appears to have addressed itself more consistently to the issues of equality in society than has that in this province (where the commitment to planning has been tentative at best as Section 2.1.3 points out). This may be partly due to the provincial government's focus on regional economic development based on the entrepreneurial ethic. This trend of provincial governments having a greater share in shaping national policy has been challenged and partially reversed in the last decade as a result of the interplay of personalities, together with the realities of administration and economics in the political arena.

The recommendations of the federal Glassco Report of 1962[40] to encourage a massive decentralization of authority in the operation of its departments and agencies were followed during that decade by both senior levels of government in Canada. The results in the 1970's were deepening financial deficits on every hand as the many relatively autonomous program managers made similar decisions to increase spending with insufficient regard for the aggregate picture. In British Columbia, where decentralization began later than in most provinces due to Premier W.A.C. Bennett's personal style of administration, the NDP government compress-

ed into three years (1972-75) the liberalization of public administration that had taken a decade in many other jurisdictions. The consequent financial squeeze experienced when the provincial economy entered one of its cyclical downturns in 1975 (reducing resource and other public revenues) has been credited with the downfall of the province's only social democratic administration.[41] Not surprisingly, a number of government studies in the 1970's, most recently the federal Lambert Report (1979)[42] recommended a recentralization of authority in the public sector and considerable strengthening of controlling central agencies to ensure more prudent administration of the public purse. In British Columbia the newly re-elected Social Credit government moved decisively in 1976 to institute structural reforms aimed at upgrading Cabinet's capacity for review of ministerial program requests, and a number of changes since have greatly strengthened the hand of the province's fiscal managers in dealing with public finances. The federal government has also taken steps to increase the power of the Treasury Board and Finance Ministry at the expense of the various line departments in order to slow the rate of federal budgetary deficits. It is also important to acknowledge the role of cyclical economic factors, many of international origin, in precipitating the fiscal squeeze now felt by most Canadian governments, including that in "balanced-budget" British Columbia.

The rapid escalation in energy prices since the Organization of Petroleum Exporting Countries (OPEC) cartel made its presence felt worldwide in 1973-74 has changed the ground rules for international commerce. Intensifying existing inflationary pressures, energy increases have affected all aspects of the Canada economy, and made the ordinary person aware that it is no longer possible to ignore international economic realities even in a country as resource-rich as this. Canadian products

must increasingly compete with those from other developed and developing nations as multilateral trade agreements under the General Agreement on Tariffs and Trade (GATT) restrict the imposition of protective commercial barriers in the interests of expending the world economy. The national and provincial economies in Canada, always dependent on larger foreign markets for much of their revenue, are having to rely ever more heavily on export sales to a variety of trading partners, particularly the U.S.A., the European Economic Community (EEC), and Japan. During the 1970's inflation and low growth strained domestic finances here, and the eventual world-wide recession of 1980-82 has made it difficult for governments everywhere to match high public expectations with diminished public monies. At the federal level there has been a re-ordering of priorities to encourage investment in new industrial ventures, and it is apparent now that social programs may well suffer in the process of reducing the federal deficit. British Columbia, with an economy long dependent on resource revenues tied to export markets, has been hit hard by the slump in sales to its major customers (the U.S.A. and Japan) as a result of recessionary impacts they are feeling, and even the present conservative administration may end the 1982 fiscal year in a deficit position. As might be expected, those difficult times have lead to pressures for more centralized economic management, and bitter confrontations between federal and provincial leaders over revenue-sharing and industrial development. Combined with interactions between the key players in the Canadian polity these economic pressures have accelerated change in the nature of the political system itself.

It cannot be denied that, as Prime Minister for most of the past fifteen years, Pierre Trudeau has exercised considerable influence over the evolving Canadian political/bureaucratic scene. With a special con-

cern for the province of Québec and French speaking people in Canada, Trudeau has attempted to impose his vision of a strong federal government on usually antagonistic provincial premiers in an attempt to consolidate national unity by more visible federal policies and programs. The repatriation of the BNA Act in 1982 with an amending formula and a charter of rights and freedoms is the culmination of the efforts of the various Trudeau administrations since 1968 to renew the Canadian nation in a form that will enhance the country's ability to meet the challenges of the next century. Regardless of whether or not one agrees with M. Trudeau's political philosophy, it is a fact that, despite Québec's objections, the new Canadian Constitution will help the federation grapple with national problems of long-standing while guaranteeing basic elements of the country's make-up. The aspect of the constitutional package that is likely to have the greatest impact on social policy in general, and programs for the elderly in particular, is the section of equality rights (see Appendix 8). This section guarantees equality before and under the law, and the right to the equal protection and benefit of the law without discrimination based on age or mental or physical disability (among other things). When this provision comes into force in 1985 it will provide elderly individuals with legal recourse for unwanted compulsory retirement schemes, inadequate and inequitable public programs, and a host of other grievances as yet unforeseen. In this way the federal initiatives to improve equality rights will inevitably affect the reality of redistribution to the elderly through the enhancement of programs for them administered by CMHC as well as National Health and Welfare, and their provincial counterparts.

These recentralizing trends show no sign of abating at the present time and, given that the contributing influence of economics promises to remain conservative for the foreseeable future, may well lead to fur-

ther retrenchment in the political and bureaucratic spheres. In my opinion this would mean a continued heightening of the federal profile in national social policy, and a levelling of benefits across the provinces, combined with a determined program of fiscal conservatism.

### 2.3.5 Implications for the Programs

The impact of expected demographic changes has been estimated to have the effects on federal program expenditures indicated in Table 2.8.[43] This expenditure projection assumes no changes in current programs, the demographic forecast mentioned earlier (Statistics Canada Projection Number 3), productivity growth of 2% a year, and no radical changes in labour force participation. The projection methodology is described in some detail in Appendix 9. If these assumptions hold, then the increased tax burden implied, according to the authors, is "significant but certainly not revolutionary"[44] since less than 1% will be added to the percent of GNP allocated to the elderly by 2011 (a rise of 15%), and the following two decades will add only an additional 2.5% (a total rise of 67%). Powell and Martin hasten to add, however, that

> if the retirement income system is improved in order to clear up the problems as seen from the individual perspective, then the proportion of GNP going to the elderly population will increase a good deal further.[45]

That significant pension reform is already underway can be seen in the federal proposals outlined in Appendix 10, and for good reason as that submission points out. The elderly in Canada are shown as heavily dependent on public programs for their income, since fewer have private pensions than in most other western industrialized countries, leaving them much worse off than those who do. The private sector has a much poorer record of employee pension plan coverage, and survivor benefits than the public sector, but the real value of non-indexed benefits from

TABLE 2.8

## Projected Expenditures on Current Programs
## Implications of the Changing Age Structure

(1976 $)

| | OAS[1] | GIS[1] | CPP/QPP | CAP | WVA | General Allied Hospital | Other Hospital | Medical | Total | GNP | Total/GNP |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1976 | 3,268 | 1,016 | 584 | 670 | 637 | 1,869 | 422 | 306 | 8,722 | 190,027 | 4.6%[2] |
| 1981 | 3,768 | 1,006 | 1,769 | 853 | 738 | 2,379 | 537 | 389 | 11,434 | 231,554 | 4.9 |
| 1986 | 4,266 | 978 | 2,665 | 1,066 | 757 | 2,974 | 671 | 487 | 13,863 | 275,501 | 5.0 |
| 1991 | 4,862 | 957 | 3,831 | 1,340 | 664 | 3,742 | 844 | 613 | 16,853 | 318,410 | 5.3 |
| 1996 | 5,299 | 992 | 5,020 | 1,614 | 506 | 4,503 | 1,016 | 739 | 19,687 | 366,467 | 5.4 |
| 2001 | 5,590 | 996 | 6,783 | 1,880 | 340 | 5,244 | 1,183 | 863 | 22,373 | 423,086 | 5.3 |
| 2011 | 6,405 | 1,031 | 8,721 | 2,626 | 77 | 7,324 | 1,652 | 1,203 | 29,034 | 548,176 | 5.3 |
| 2021 | 8,310 | 1,209 | 12,946 | 4,153 | 10 | 11,584 | 2,613 | 1,895 | 42,721 | 657,192 | 6.5 |
| 2031 | 10,185 | 1,341 | 17,508 | 6,204 | - | 17,306 | 3,904 | 2,844 | 59,277 | 765,044 | 7.7 |

Note: (1) It must be emphasized that it is assumed that OAS/GIS payments are not escalated in line with average wages and salaries but only with the CPI. Furthermore no cost reduction in health care is assumed although cheaper methods of chronic care are possible.

(2) The total GNP allocated to the aged is 7.2% including earned income and investment.

From: B.J. Powell and J.K. Martin, "Economic Implications of an Aging Society in Canada", a paper prepared for the National Symposium on Aging, Ottawa 25-27, 1978. Reproduced by permission of J.K. Martin.

all plans has been seriously eroded by inflation. The roles of the two sectors in the retirement income field are also being reconsidered as a result of the importance that such vast funds as that of the CPP have acquired in the past decade as ready sources of cheap capital for public development projects. In addition to these pressures for change, Monique Bégin and Judy Erola among others continue to lobby within the federal Liberal Cabinet for new pension programs to benefit the many single elderly women guaranteed only poverty-level incomes at present. So reform of the pension system seems inevitable, probably with dramatic cost implications for the future. While increases in the elderly dependency ratio are expected to be largely offset by decreases in the youth dependency ratio (see Table 2.2 and Figure 2.7), leading some researchers[46] to minimize the problem of the "rentenberg" or "pension mountain",[47] the redirection by governments of large budget sums from, say, education to health care in line with shifting ratios can hardly be expected to proceed without great pressure from those who stand to lose to simply add on the required expenditures. For British Columbia's GAIN for Seniors program the future is one of increasing individual payments to fewer recipients as less elderly people qualify for benefits due to the increasing take-up of CPP benefits. Without further change in the program conditions, it has been estimated that very few will qualify for benefits in 1996.[48] Of course, without increases in retirement income for those in need, it would be expected that the number of the aged currently in receipt of provincial welfare assistance would have increased substantially by that time.

Although the province pays little toward the cost of pension programs, it does foot a large share of the bill for health care services for the elderly. Some have estimated that those over 65 accounted for

34% of the total budgetary expenditures of the Ministry of Health in 1980-81.[49] When one considers the heavy utilization of expensive medical, hospital, and Long-Term Care services by the aged it is easy to understand why this is so. If those over 65 in this province continue to consume health care at current rates, their care may take up over half of the health budget in 2001, *before* the really dramatic rise in their numbers is forecast. The LTC program has made projections of provincial utilization to 2001 based on CSB Population Projection of 10/80, and utilization rates of April 1981. This projection, shown in Tables 2.9 and 2.10, and Figures 2.11 and 2.12, predicts that for those over 65 the number of facility clients will increase by almost 82% by 2001, and the number of homemaker/adult day care clients will rise by about 73%. In each case the most dramatic increases are expected among those 85 and over, with those aged 75 to 84 next. Stone has pointed out that those elderly people over the age of 75 require significantly more health and social services than the "young-old" (65-74), while those over the age of 80 are more in need of personal care programs, including nursing home care.[50] This implies then that increases in health care expenditures in the province over even the next twenty years can be expected to be substantial. But increases in health care costs and utilization to 2001 will pale beside those expected in the following three decades, as the baby boom children finally reach their senior years and make their peak demands on the health care system.

In a study of health care costs for the elderly in Ontario to 2026, Gross and Schwenger found that expenditures on institutional services to the aged would likely double by 2001, and triple by 2026, raising the total institutional budget by 25%, 62%, and 116% by 1986, 2001, and 2026 respectively.[51] They also calculated that physician care costs

TABLE 2.9

PROJECTED NUMBER OF FACILITY CLIENTS OVER AGE 65 BASED ON PROVINCIAL UTILIZATION RATES OF APRIL, 1981 (E.C.U.'S INCLUDED)

| | 1981 | 1986 | 1991 | 1996 | 2001 |
|---|---|---|---|---|---|
| 65-74 | 2,879 | 3,274 | 3,638 | 3,900 | 4,008 |
| 75-84 | 6,215 | 7,491 | 9,127 | 10,339 | 11,505 |
| 85+ | 7,774 | 8,770 | 10,307 | 12,405 | 15,139 |
| 65+ | 16,868 | 19,535 | 23,072 | 26,644 | 30,652 |

Based on utilization rates of 1.6% (65-74), 7.5% (75-84), 29.0% (85+), and 5.8% (65+). Projected numbers of clients derived from population projections of the Central Statistics Bureau, Projection 10/80, 1981.

From: R. Penner, "A Review and Update of Utilization of Long-Term Care Services", Reference Paper 1, prepared for the Ministry of Health, Victoria, B.C., November, 1981, p. 1. (Mimeographed). Reproduced by permission of the author.

TABLE 2.10

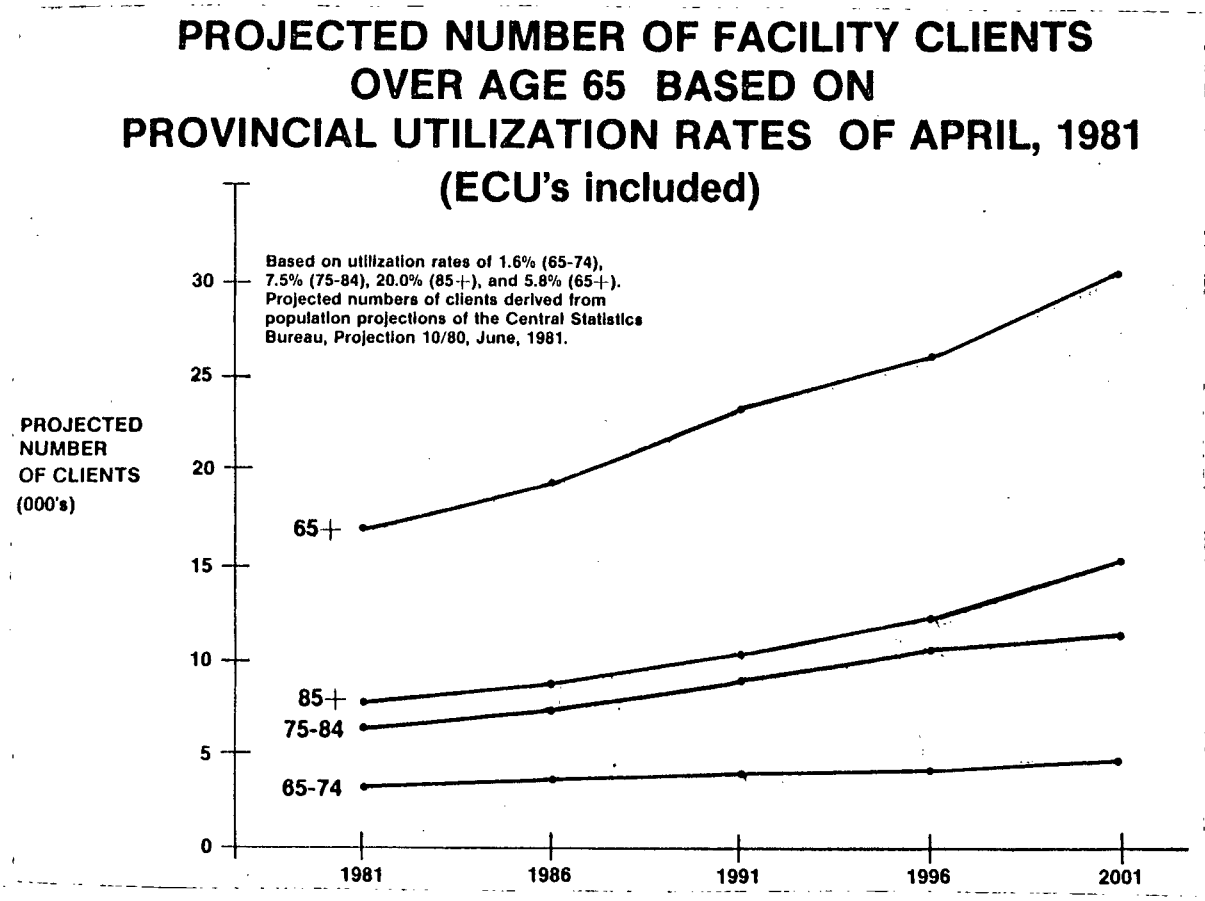
PROJECTED NUMBER OF HOMEMAKER AND ADULT DAY CARE CLIENTS OVER AGE 65 BASED ON PROVINCIAL UTILIZATION RATES OF APRIL, 1981

| | 1981 | 1986 | 1991 | 1996 | 2001 |
|---|---|---|---|---|---|
| 65-74 | 7,199 | 8,186 | 9,095 | 9,750 | 10,019 |
| 75-84 | 10,027 | 12,086 | 14,725 | 16,861 | 18,562 |
| 85+ | 5,201 | 5,867 | 6,895 | 8,298 | 10,128 |
| 65+ | 22,427 | 26,139 | 30,715 | 34,909 | 38,709 |

Based on utilization rates of 4.0% (65-74), 12.1% (75-84), 19.4% (85+), and 7.7% (65+). Projected numbers of clients derived from population projections of the Central Statistics Bureau, Projection 10/80, June, 1981.

From: R. Penner, "Review and Update", Reference Paper 1, p. 1. Reproduced by permission of the author.

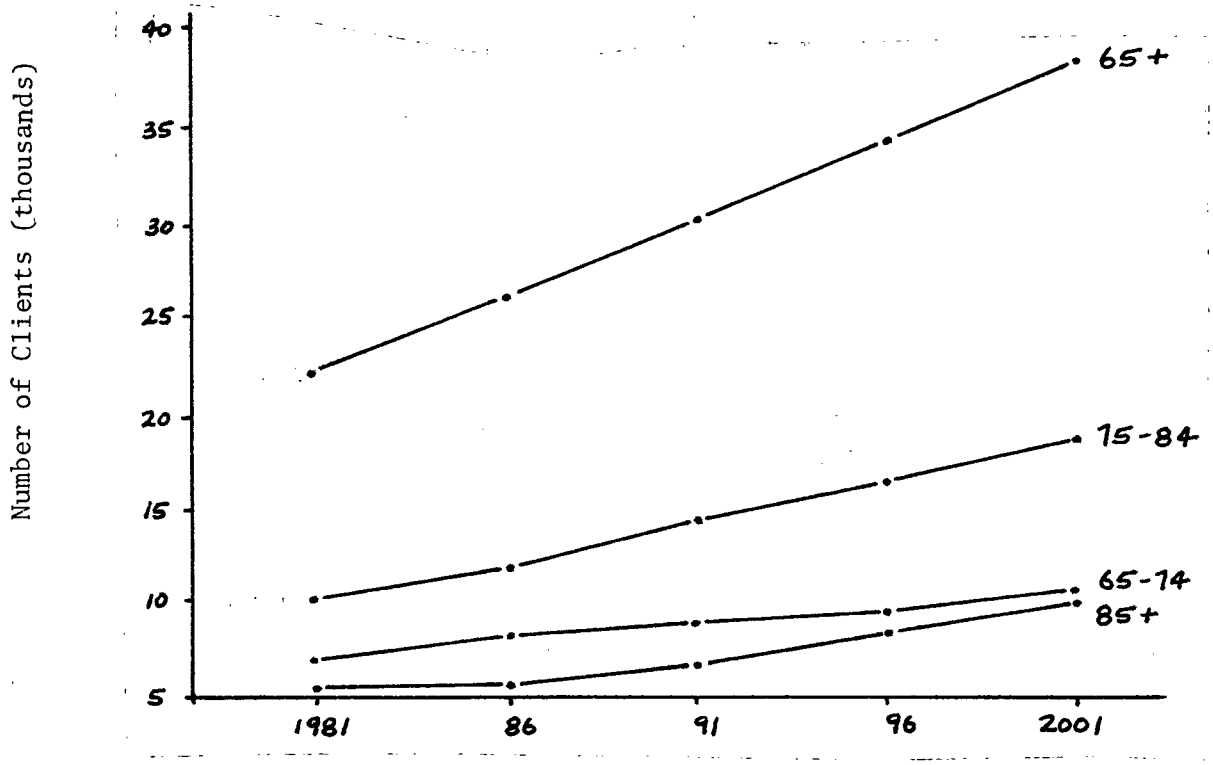
FIGURE 2.11




From: R. Penner, "Review and Update", Reference Paper 1, p. 2. Reproduced by permission of the author.

FIGURE 2.12

PROJECTED NUMBER OF HOMEMAKER AND
ADULT DAY CARE CLIENTS OVER AGE 65
BASED ON PROVINCIAL UTILIZATION RATES
OF APRIL, 1981




From: R. Penner, "Review and Update", Reference Paper 1, p. 3.

for the elderly would increase less dramatically over 1976 values, by 20% in 1986, 77% in 2001, and 192% by 2026, raising the budget for this item by 18%, 39%, and 63% in those years respectively.[52] The experience in British Columbia can be expected to parallel the Ontario projections on the high side, due to its slightly "older" age structure shown in Table 2.11.

It almost goes without saying that the geriatric boom can also be expected to place housing programs for the elderly under great strain, and with such units at a premium today the implications for the future are ominous.

## 2.4 THE INTERNATIONAL CONTEXT

Canada is a middle-old nation[53] compared with those of Europe which have levels of the elderly in their current populations not expected here until the next century (see Table 2.12). There is much to be gained from examining these "elder" nations to find out how they have coped with their aging populations. Other countries are near the same "age" as Canada and face similar demographic prospects in the next several decades. These countries are in the process of planning for their growing elderly population, and can offer valuable insights into the ways in which different polities react to similar social problems. In this section two of Canada's elders (the United Kingdom (U.K.), and the Federal Republic of Germany (FRG)), and two of its peers (the United States (U.S.), and Yugoslavia) are considered.

### 2.4.1 Canada's Elders

The UK and FRG are both in the old-old category of nations mentioned earlier. With a population of about 56 million in 1981, the UK is

TABLE 2.11

THE ELDERLY AS A PERCENT OF TOTAL POPULATION

IN ONTARIO, B.C., AND CANADA: 1986 and 2001

| | 1986 | 2001 |
|---|---|---|
| Ontario | 9.5 | 10.5 |
| B.C. | 11.0 | 11.4 |
| Canada | 9.8 | 10.9 |

From: Gross and Schwenger, *Health Care Costs for the Elderly in Ontario: 1976-2026*, Table 39, p. 66, and B.C. Central Statistics Bureau, *Population Projection 10/80 1980-2001*, Table 2.

TABLE 2.12

PERCENTAGE OF POPULATION AGED 65 YEARS AND OVER,

SELECTED COUNTRIES, 1980

| Country (exact percentage) | Percentage of Population 65 Years and Over |
|---|---|
| East Germany (16.3), Sweden (16.2) | 16 |
| Austria (15.5), West Germany (15.1) | 15 |
| United Kingdom (14.9), Norway (14.6), Denmark (14.3), Belgium (14.1) | 14 |
| Luxembourg (13.9), Switzerland (13.7), France (13.7), Italy (13.5), Hungary (13.4), Greece (13.3) | 13 |
| Czechoslovakia (12.7), Bulgaria (12.0) | 12 |
| Finland (11.7), Netherlands (11.4), United States (11.2) Ireland (11.1) | 11 |
| Spain (10.9), Malta (10.8), Romania (10.4) Uruguay (10.3), Portugal (10.3), Cyprus (10.0), Poland (10.0), USSR (10.0) | 10 |
| Iceland (9.5), Australia (9.3), Barbados (9.2), New Zealand (9.2), Yugoslavia (9.2), Canada (9.0) | 9 |
| Japan (8.8), Argentina (8.6), Israel (8.3) | 8 |

From: United Nations, Department of International Economic and Social Affairs, *Selected Demographic Indicators by Country, 1950-2000: Demographic Estimates and Projections as Assessed in 1980* (New York: United Nations, 1981).

expected to experience a slow rise in its percentage of elderly people from the current level of around 15% to almost 17% by the middle of the next century (see Table 2.13). In the FRG about 15% of its 61 million people were over the age of 65 in 1981. The proportion of the elderly in the FRG has now peaked and will decline slightly before rising again in about 18% in the third decade of the next century (see Table 2.13). Both these countries provide current case-studies in methods for coping with elderly populations not expected here until the 21st century.

2.4.1.1 The United Kingdom

Once the leading capitalist nation with far-flung possessions, the UK since World War 2 especially has been reduced to a minor economic power, struggling to renew its obsolete manufacturing plants, improve productivity, and lower costs. Yet this "prototypical Western liberal democracy"[54] is still viewed as a model welfare state with social philosophy and programs changing little since the inaugurating post-war reforms despite the several shifts in government between the Labour and Conservative parties. Even Mrs. Thatcher's doctrinaire Conservative government has moved slowly to reduce public programs, and has lately encountered stiff opposition from within and without the party. British social policy continues to be marked by the goals of universality, comprehensiveness, and equality as its various programs demonstrates. A unitary state with only two levels of government (central and local) the UK has emphasized direct government administration of services with local authorities funded by central block grants and locally collected "rates" for programs for which they are responsible. A series of laws passed after World War 2 in the UK provide benefits covering health, income security, housing and social services.

TABLE 2.13

PERCENTAGE OF POPULATION AGED 65 AND OVER, SELECTED COUNTRIES, 1950-2050

| YEAR | FRG | UK | US | YUGOSLAVIA | CANADA |
|---|---|---|---|---|---|
| 1950 | 9.4 | 10.7 | 8.1 | 5.7 | 7.7 |
| 1955 | 10.1 | 11.3 | 8.8 | 6.0 | 7.7 |
| 1960 | 10.8 | 11.7 | 9.2 | 6.3 | 7.5 |
| 1965 | 11.9 | 12.0 | 9.5 | 6.7 | 7.7 |
| 1970 | 13.2 | 12.9 | 9.8 | 7.8 | 7.9 |
| 1975 | 14.3 | 13.9 | 10.5 | 8.6 | 8.5 |
| 1980 | 15.1 | 14.9 | 11.2 | 9.2 | 9.0 |
| 1985 | 13.8 | 14.9 | 11.7 | 8.4 | 9.4 |
| 1990 | 14.4 | 15.4 | 12.2 | 9.4 | 10.2 |
| 1995 | 15.0 | 15.3 | 12.4 | 11.1 | 10.7 |
| 2000 | 15.5 | 14.9 | 12.2 | 12.9 | 11.0 |
| 2025 | 18.1 | 15.8 | 15.8 | 18.4 | 16.7 |
| 2050 | 17.9 | 16.9 | | | 17.4 |

From: United States, Department of Health, Education and Welfare, Social Security Administration, *Social Security in a Changing World* (Washington, D.C.: Health, Education, and Welfare, 1979), p. 91; United Nations, Department of International Economic and Social Affairs, *Selected Demographic Indicators by Country, 1950-2000: Demographic Estimates and Projections as Assessed in 1980* (New York: United Nations, 1981).

There are three types of income-maintenance programs available for older people. The basic national insurance scheme provides a cost-of-living indexed flat-rate benefit financed by earnings-related contributions to those retiring at age 65 for men and 60 for women. Another benefit comes from a contributory wage-related plan sponsored by either public or private employers. Finally, a means-tested social assistance supplement guarantees a certain income to all the elderly including cash benefits for reasonable rental costs and allowances for special needs. Almost all older people receive the basic pension, but about a quarter require the supplement since few are covered by occupational plans, and their benefits remain relatively low.

The British National Health Service (NHS) offers health care without charge to all permanent residents, exempts all the elderly from drug user charges, and those receiving pension supplements from similar fees for dental care and prosthetic devices. Health service to the aged is comprehensive, with a stated community focus co-ordinated by general practitioners under a capitation arrangement. Important programs used include home nursing, health visiting, meals-on-wheels, and chiropody (podiatry), although statistics indicate that only a small proportion of the aged are actually served by community care services (see Table 2.14). Although the UK has also emphasized self-help programs for many years, substantial numbers of older people remain in various forms of institutional care (see Table 2.15).

Only a small proportion of British housing is privately rented (13% in 1972) while half is owner-occupied and the remainder rented through local government and housing associations.[55] Buildings are often designed specifically for the elderly, and the poor aged are given higher priority in some cases. Housing and social service de-

TABLE 2.14

SOME ASPECTS OF COMMUNITY-BASED PROVISION, U.K., 1973 and 1976

**Some aspects of community-based provision I Social Services[c]**

| A. Home Help Services | England 1973 | England 1976 |
|---|---|---|
| Total persons over 65 attended | 448,700 | 570,400 |
| Percentage of over 65 population served | | 8.7% |
| **B. Meals Provided** | **England 1973** | **England 1976** |
| Total meals provided at home | 18,147 | 24,346 |
| Total meals provided in luncheon clubs etc. | 10,406 | 16,198 |
| Total persons served with meals in own home | 158,000 | 171,500 |
| Percentage of over 65 population served at home | | 2.6% |

[c]Department of Health and Social Security. Health and personal Social Services Statistics 1977.

**Some aspects of community-based provision II (Health)**

| A. District Nurse Services to people in their own homes | England 1973 | England 1976 | |
|---|---|---|---|
| Total persons over 65 attended[c] | 1,028,100 | 1,294,400 | |
| Percentage of over 65 population served[c] | | 16.7% | |
| Elderly patients as percentage of total workload[f] | | 50% | (approx.) |
| **B. Health Visiting Services** | **England 1973** | **England 1976** | |
| Total persons over 65 attended[c] | 660,100 | 674,200 | |
| Percentage of over 65 population served[c] | | 8.7% | |
| Elderly as percentage of total workload | | 15% | (approx.) |

[f]Department of Health and Social Security. *A Happier Old Age.* 1978.

From: Caroline Godlöve: and Anthony Mann, "Thirty Years of the Welfare State: Current Issues in British Social Policy for the Aged", *Aged Care and Services Review 2* (January 1980), p. 12. Reproduced by permission of the authors.

TABLE 2.15

**A Summary of The Main Forms of Long Term* Institutional Care**

| Persons over 65 accommodated | 1976 - ENGLAND | |
|---|---|---|
| Hospital beds – Geriatric[c] | 51,300 | |
| Hospital beds – Psychiatric[d] | 41,742 | (1975) |
| Local Authority Homes[c] | 99,027 | |
| Private residential Homes[c] | 21,320 | |
| Voluntary residential homes[c] | 23,788 | |
| Private and Voluntary Nursing homes[e] | 20,000 | |
| TOTAL | 257,177 | |
| Over-65 population of England[a] | 6,641,000 | |
| % of over-65 population in all forms of institutional care | 3.9% | |

*Since "long-term care" is not a categorisation used in the collection of official statistics, these figures are necessarily a rough approximation.

[a]Age Concern Research Unit. *Profiles of the Elderly.* Age Concern Publications, 1977.

[c]Department of Health and Social Security. Health and personal Social Services Statistics 1977.

[d]Department of Health and Social Security. In-patient statistics from the mental health enquiry for England 1975.

[e]*Estimate* – from Registered Nursing Homes Association – D.H.S.S. does not collect this data.

From: Godlove and Mann, p. 13. Reproduced by permission of the authors.

partments co-operate to ensure warden services, necessary equipment and adaptations for older residents.

Despite an impressive array of services for the elderly in the UK in the categories mentioned above, and a national focus on the problem of aging in recent years, programs are widely considered inadequate. Many feel that pensions are too low, (especially with continuing inflation) and that health, housing, and social services for the aged are inadequate.

2.4.1.2 The Federal Republic of Germany

Structured much like Canada governmentally, the Federal Republic of Germany (FRG) is a federation of ten states (plus West Berlin) which are in turn composed of self-governing communes. Each level of government has significant powers of taxation and corresponding responsibilities in the social policy field. The federal government may pass permissive legislation in the health and public welfare fields, and grant cash benefits but the states share legislative responsibility and fund in-kind benefits, and the communes administer these services at the local level. German social policy historically developed from a paternalistic base to the present social state model in which the equalization of burdens in the interests of social justice has become the dominant goal. The FRG has made services for the aged, especially in the health field, the major target for its social budget for the last several years. The country's ability to finance growing social programs has been helped by rapid growth following post war reconstruction and modernization that has made the German economy the strongest in Europe. The FRG has also benefitted from the availability of a large number of migrant workers from neighbouring countries

who are ineligible for many social benefits. Only in the past year or two, under the influence of the current world-wide recession, has the FRG fallen prey to the increasing rates of inflation and unemployment that most other nations have experienced for almost a decade. The Social Democratic party which has dominated German politics since World War 2 has consistently avoided direct government provisions of services where possible and protected marketplace incentives, while building a widely-praised social insurance system and a health insurance system that rivals that of the UK.

The FRG maintains a compulsory, fully-indexed[56] social insurance scheme that provides generous pensions on retirement based on a contributory, wage-related plan administered by quasi-public insurance funds, as well as a means-tested social assistance benefit. Most older Germans receive pensions which comprise the bulk of their income, but the small portion (6%) dependent on social assistance is rapidly dominating that program's recipient group.[57] Additional cash benefits and services may also be provided to needy elderly citizens.

Almost the entire population, including all aged people, are insured for medical, dental, hospital, pharmaceutical, and prosthetic services under a large number of independent sickness funds which contract for services required. Needy older people may also receive cash benefits for home-help and home nursing services mostly provided by voluntary agencies funded largely by user fees. Community support services, however, are difficult to obtain in many areas as coverage and manpower remains inadequate. Comprehensive social service centres are being established to co-ordinate the work of local voluntary agencies, which also run social centres for the aged providing personal care, counselling, and leisure activities.

Although the FRG has devoted considerable effort to increasing the supply of housing for the elderly over the past twenty years, it is still considered inadequate. Rent subsidies are provided on a means-tested basis and assistance to the aged in locating, adapting, and maintaining housing is guaranteed by law. About 5% of the elderly are institutionalized (most under public auspices) and the number of beds in such facilities is still thought too few despite an ongoing emphasis on community support services to prolong own-home residence as much as possible. A variety of sheltered housing is planned to be greatly expanded in future, but so far such units have proven too expensive even with rental subsidies, and coverage (about 1%) and availability are very poor.[58]

It is clear that the German emphasis on insurance systems in the income and health fields has paid dividends to the aged in high quality service in these programs, but left the important areas of housing and social services in serious disarray. This contrasts sharply with the British emphasis on the latter areas as part of a generally more collectivist approach to social policy.

### 2.4.2 Canada's Peers

The United States (US) and Yugoslavia are close to Canada's "age" in demographic terms falling into the middle-old and young-old categories respectively. Those aged 65 and over comprised about 11% of the total US population of 226 million in 1981, but this proportion is expected to rise to about 16% by 2025 (see Table 2.13). About 9% of the Yugoslavian population of around 22 million were at least 65 in 1981, with this proportion expected to rise to about 13% by the turn of the century, and pass 18% by 2025 (see Table 2.13). These nations, like Canada, are beginning to plan for the elderly boom to come in the next

century. Their strategies can serve as alternative models for planners in this country to consider.

2.4.2.1 The United States

The US still boasts massive domination of the world economy and, while presently reasserting its traditional free enterprise ethic under President Reagan, its tremendous wealth has permitted the development of a welfare state system, if less well developed than elsewhere, since Roosevelt's New Deal of the 1930's. The US is a very pluralistic and culturally diverse liberal democracy that has evolved into a highly centralized political bureaucracy with federal, state, and local municipal levels of government bound together through constitutionally separated powers. Federal initiative and superior financial means have made that level dominant in social fields over the past few decades with a multiplicity of programs originating from either the executive or legislative branch of government now administered under the gigantic Department of Health, Education, and Welfare. With many social programs funded through federal grants to state agencies and delivered through municipal systems, a lack of nation-wide planning has often led to services that are fragmented and vary widely in quality and availability. The *Older Americans Act* (1965) provided funds for planning and co-ordinating services for the aged at the state level and below, but so far this has not resolved the overall planning problem. This disorganization has resulted from continuing reluctance concerning greater federal intervention, and a general ambivalent attitude toward the role of government in society.[59] In general, as has been noted earlier in the German federal system, the senior government provides cash benefits through permissive legislation while responsibility for services and in-kind benefits are left to the

state and municipal governments.

The federal government administers the standard social security benefits under the Old Age Survivors Disability Insurance (OASDI) program provided for in the *Social Security Act* (1935) and its amendments. This is a contributory retirement benefit to about 90% of the aged beginning at age 65 for men and 62 for women, or at age 72 regardless of employment status. A means-tested supplementary benefit, Supplementary Security Income (SSI), is also available for those not covered by OASDI or receiving only the minimum benefit. Occupational pensions are increasingly available but still represent a minor source of income for the elderly as a group. The public programs have been credited with the drop in poverty rates among the elderly from 35% to 14% between 1959 and 1978, although this rebounded in 1979 to 15%, and continuing high inflation promises to further erode the income status of the aged. Measures currently before the US Congress, if approved, would have the effect of reducing the adequacy of future OASDI payments.[60]

The US has had a universal health insurance program for the elderly, Medicare, since 1965 which pays about half the total medical expenses of the aged. The program is funded by a payroll tax shared by employers and employees, and the revenue from a supplementary voluntary medical insurance program whose premiums are shared between the individual and general federal revenue. Medicare covers acute hospital care and related physician services, but not nursing home care, home care, drugs, dental or optical services. About half the elderly in the US have private health insurance to supplement Medicare, and a joint federal/state program, Medicaid, supplements Medicare for the low-income elderly and provides for their long-term care. With health expenditures in the US still increasing rapidly, a number of cost-containment strategies are

being tested, and home health services are receiving more attention as a lower cost alternative to institutionalization for some of the aged. These economizing efforts notwithstanding, some have predicted a doubling of the federal budget for long-term care in the next five years.[61]

There has been some federal legislation in the US to expand the supply of housing for the aged, but the results to date are very inadequate. The congregate housing that has been developed includes both personal care facilities and specially designed multiple-unit housing and retirement communities. But most elderly people live in ordinary single dwellings or apartments, many of which are considered substandard, and there are long waiting lists for scarce special housing for the aged. These latter units are usually built with little or no co-ordinated planning at the federal or state level.

The American income, health, and housing programs for the aged suffer from a lack of national and state commitment that is perhaps a reflection of the pervasive US ideal of the rugged individualist, and a general distrust of government intervention. Though demographically somewhat older than Canada at present, the country still appears ill-prepared to cope with the huge numbers of elderly people expected in the years ahead.

2.4.2.2 Yugoslavia

Unlike the other countries surveyed so far, Yugoslavia is a socialist state now described as pursuing a course of "market socialism" in in which a multiplicity of diverse interest groups participate in a highly decentralized system of political decision-making.[62] Created after World War 1 and reestablished after World War 2, Yugoslavia is comprised of one republic for each of the five national groups, plus a

"mixed" republic, and two lesser developed provinces attached to the Serbian republic. There is a central (federal), republic, and commune level of government in the country through which policy concerns percolate in an effort to ensure that the nation's cultural and religious groups, as well as other interest groups have a say in most decisions. This participatory process is carefully circumscribed by formal and informal structures at the federal level designed to control foreign policy, security, large-scale industrial development and so on, with the Socialist Alliance and its vanguard, the Communist Party, enjoying formal constitutional rights. Nevertheless the nation has been able to maintain its unity in the face of formidable diversity largely as a result of an effective participatory political system. Despite this, wide variations in social conditions persist between republics and regions within the country. In terms of social policy the Federation and the several republics share responsibility for formulation of standards while implementation and service delivery is left to the communes or their sub-units. An underdeveloped country after World War 2, Yugoslavia has achieved great economic growth since, coupled with rapid industrialization and urbanization. Still it remains a relatively poor rural nation, dependent on other industrialized European countries for the employment of a sizeable part of its labour force as migrant workers. The current recession has led to layoffs of these workers in the FRG and elsewhere, and their return to Yugoslavia has created an instant unemployment crisis.

Yugoslavia has a system of social insurance benefits administered by self-governing associations for invalidity and pensions, organized by the republics, and co-ordinated by national unions. The pensionable age is 65 for men and 60 for women but the varying coverage is very limited and benefits low (though linked to the cost of living). Social

assistance is also available for the needy aged with means-tested cash benefits which are again quite low. In 1972 only 22% of the elderly in Serbia had a regular income from a pension or social assistance.[63] As a result the main source of income support for the aged is still the family, and the principle of relative responsibility remains in Yugoslavian law to compel children to provide for needy parents. Yugoslavia also has numerous tax benefits and exemptions for the low-income elderly.

The country's social insurance system includes cash sickness and maternity benefits administered by health insurance associations organized on a regional basis, and again coordinated by a national union. Serbia provides free medical care for the elderly covering treatment, drugs, and transportation, but benefits vary in the other republics as with most social programs. Long-term care facilities are very inadequate with space for less than 1% of the aged in institutions in Serbia, the most advanced of the republics in this regard. Home care is almost non-existent and congregate housing is extremely limited increasing the demand for institutional care.[64] Community support services are also very scarce, comprised of senior centres, a mobile variant of a homemaker-home-health aid called a "gerontomaid", and local general social work centers with wide latitude but limited means.

Yugoslavia is hampered in its planning for the elderly by economic problems, and great regional disparities. So far the country has been unable to mount adequate programs in any of the categories considered despite wide recognition of their need. Without substantial economic growth it appears likely that existing services will be overwhelmed by the increasing number of older people forecast in the years ahead.

### 2.4.3 Understanding Social Development

Richard Rose has put the extreme case most succintly: "votes count, resources decide".[65] The example of Yugoslavia shows that without a certain level of societal wealth, even the most people-oriented governmental system will be unable to deliver needed social programs for its older people. But, given this minimum prosperity, enjoyed by all the other countries surveyed, the influence of culture, history, and ideology in shaping the particular programs offered to the aged can be substantial.

The wealthiest nation examined, the US, has programs that can charitably be described as unco-ordinated and inadequate, whereas the UK's superior package of income, health, and housing programs are financed out of the smallest GNP in the group aside from Yugoslavia. Though the preponderance of welfare states among the elder European countries suggests strongly that the demographic transition may itself propel a nation toward greater socialization of services for the aged (among others), notable differences already mentioned point to other underlying factors as well. It is sometimes suggested that the lengthier national histories of the UK and FRG (heir to German and Prussian traditions) may have moved their populations to the point of acceptance of collective responsibility for social problems chronologically earlier than younger nations like the US and Canada. Since Germany instituted public pensions in 1889, and the UK in 1908 this theory at first seems plausible, but Australia and New Zealand provide counterexamples (1898 and 1901 respectively), and it seems probable (intuitively) that a search for any single causal element in the development of programs for the elderly is destined to similar failure. In fact a host of influences are most likely responsible for such a complex social process, although many of them might usefully be grouped under the rubric of national ideology.

A good case can be made for the importance of history in the development of a nation's ideology, by considering the impact on several nations of the catastrophic events of the 1930's and 1940's. Certainly Lord Beveridge's social insurance scheme in the UK was an attempt to solidify a sense of national commitment following the sacrifices made by most Britons during the Depression and War years. Hard economic times also made President Roosevelt's New Deal acceptable to US voters, and the FRG's emphasis on equality in social policy may well reflect some national response to the horrors of the Nazi holocaust. In Canada, too, the wartime experience produced widespread support for social programs of all types to guarantee standards of living that everyone had helped to make possible through the war effort.

In seeking to understand the influences underlying national programs for the elderly one can learn from the model of the crime investigator, who attempts to identify suspects with the capacity, motivation, and opportunity to act. A reasonable level of economic prosperity in a country give it the capacity to enact social programs, its peculiar culture and history combine somehow through a national ideology to produce a certain level of motivation, and a set of events (including elections) and personalities lined up in conjunction may create the opportunity to act.

Later in this paper the processes of social change will be considered in more detail as part of an examination of planning strategies.

## 2.5 THE PROBLEM OF DATA

The challenge of coping with the demand for programs for the elderly in British Columbia as the population ages over the next several decades should be obvious from the information presented above. Previous sec-

tions have sketched the outlines of the dilemma by using data collected in different ways at a number of times, and at various levels of analysis. For a general portrayal of the situation as a whole in order to examine theoretical models, and consider planning strategies (the tasks of Chapters 3 and 4 respectively), this sort of data analysis will suffice. For the detailed program planning which it is suggested should soon proceed, however, it most certainly will not do. Careful studies of utilization, cost, and results of programs for the elderly are essential if decision-makers are to plan effectively for an aging population, but these research endeavours are greatly complicated by the inadequacy of existing data on senior citizens in British Columbia. In an effort to address the problem of data this poses, the various primary sources of data on the aged in this province have been tabulated in Appendix 11, and suggestions for improving the quality of this information will be included in the recommendations of the concluding chapter of this report.

# 3. PARADIGMS

The analysis of this chapter links the information presented in the last with strategies for action to be developed in the next. It begins by exploring the philosophical and ideological values that pervade social theory and have their inevitable effects upon social policy making, as demonstrated by the examples of the foreign countries described above. In highlighting important influences underlying social theorizing this first section makes explicit conceptual barriers to be surmounted in the analysis to follow. A method of analyzing competing sociological paradigms is then described, and used to classify a variety of approaches in social gerontology that attempt to explain the experience of elderly people in society today. The resulting theoretical groupings are next evaluated in terms of their ability to describe the information presented in Chapter 2, and to prescribe useful policy alternatives for those responsible for planning for the aging population. This leads to the elaboration of that paradigm seen as most appropriate to the planning task, and sets the stage for the practical strategic considerations of Chapter 4.

## 3.1 VALUES, PHILOSOPHIES, AND IDEOLOGIES

In Section 2.4 a number of differing state responses to the familiar social problems posed by an aging population were described in the context of particular national philosophies and ideologies seen as providing the motivation for policy development. This section examines these important underlying influences more closely to reveal the ways in which they exercise their effects and to sensitize the reader to conceptual barriers in the analysis to follow. It is necessary first to clarify the terms of the discussion by defining what is meant by values, philosophies and ideologies, and how these concepts have been viewed by social theorists.

The development of political and social ideologies in Western democracies is then discussed with reference to the foreign examples cited above, and the situations in Canada and British Columbia are considered. The section concludes with a statement of the ideological obstacles to be overcome in the subsequent analysis.

### 3.1.1 Definitions and Concepts

The following definitions, suggested by Oxford, will be used here:

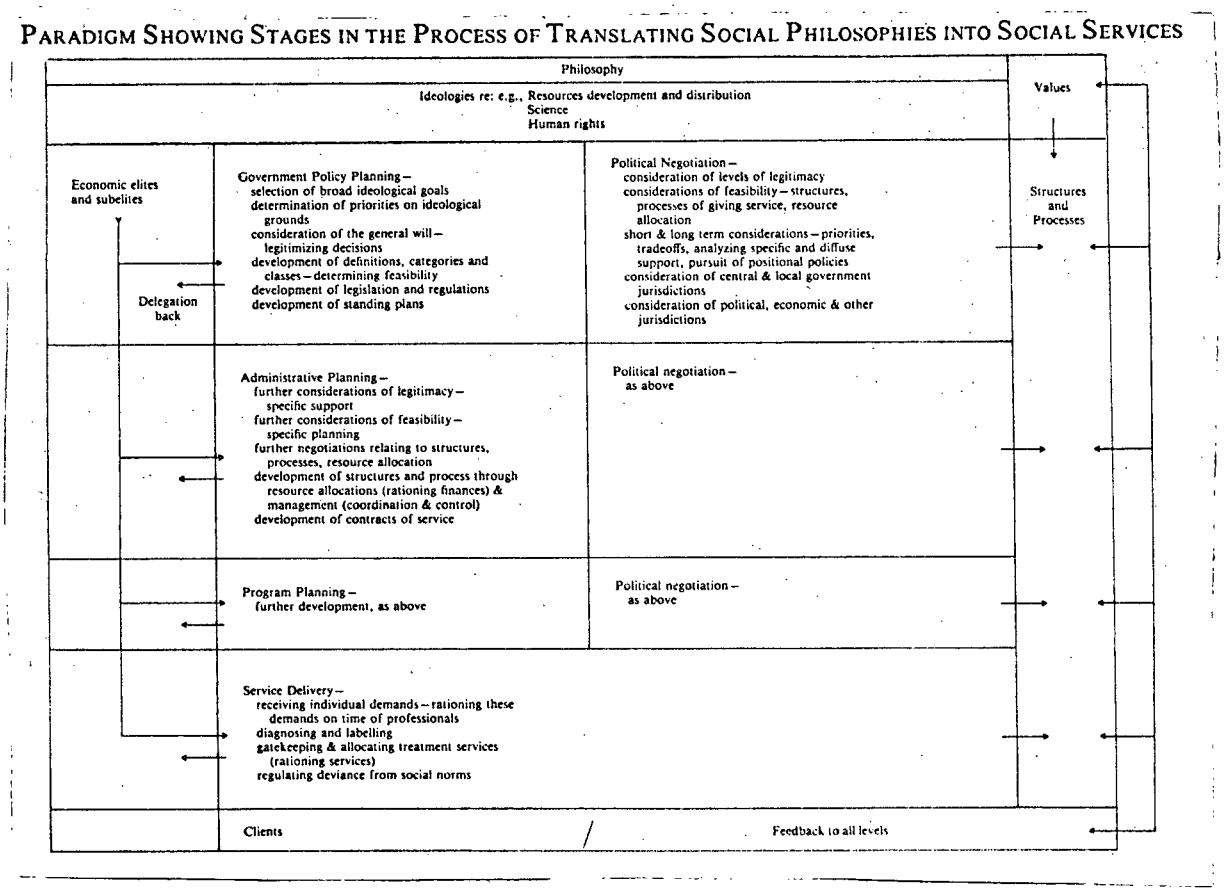
Value: that which is worthy of esteem for its own sake; that which has intrinsic worth

Philosophy: a philosophical system or theory, the system which a person forms for the conduct of life

Ideology: a system of ideas concerning phenomena, especially those of social life[1]

Crichton has pointed out how social philosophies, underpinned by particular values, are translated through various stages into social services, as shown in Figure 3.1.[2] In her view, ideologies are relatively specific ways of implementing broad philosophical goals (e.g. equality, liberty, justice etc.), but both depend on their respective individual and collective valuations by the members of society. For Geertz, ideologies are better explained as part of a continuing effort to correct psycho-sociological disequilibrium in society (the strain theory), than weapons in the struggle for advantage (the interest theory).[3] He also suggests that ideologies are important mechanisms for dealing with cultural strain, by acting as "maps of problematic social reality".[4] Crichton adds that such maps may vary greatly in scope and content, and depend on exposure, intelligence, and motivation for their practical use.[5] She suggests that ideologies act as guides to participants in

FIGURE 3.1




From: Anne Crichton, *Health Policy Making: Fundamental Issues in the United States, Canada, Great Britain, Australia* (Ann Arbor, Mich.: Health Administration Press, 1981), p. 279. Reproduced by permission of the author and publisher.

the unending negotiation process in the political, socio-economic, and cultural spheres in which societal change mainly takes place.[6] While one is accustomed to the idea of ideology as it pertains to the political realm, the notion of related social ideologies is less well understood, perhaps because the beliefs themselves are so commonly accepted. In fact, many social theorists have asserted the possibility of a value-free approach in the study of social organization, though Myrdal and others have since argued strongly against this and in favour of a clear statement of one's own value orientation.[7] Following the latter position, my own bias in approaching social theory will be discussed at the end of this section.

### 3.1.2 Political and Social Ideologies

Crichton has described the evolution in the socio-political order of Western liberal democracies from aristocratic dominance, through laissez-faire capitalism, to modern capitalism, or what is often termed the welfare state.[8] The two strongest influences in the latter shift have been the philosophies of utilitarianism and humanitarianism. Utilitarians (like Jeremy Bentham and John Stuart Mill) persuaded entrepreneurs that social reforms would improve the supply and quality of labour and hence act in their own best interests, whereas humanitarians (like William Booth and B. Seebohm Rowntree) appealed for change on moral or religious grounds alone.

A simple scheme for analyzing the modern political ideological descendants of these philosophies can be constructed by labelling that adhering to the original laissez-faire tenets as conservative, the utilitarian off-spring as liberal, and the humanitarian counterpart as socialist (social democratic). These broad categories can be adequately dis-

tinguished by their resolution of the classic tension between liberty and equality in any society. As Figure 3.2 shows, conservatives are seen as those who believe in liberty above all else, socialists as those valuing equality *of condition*[9] most highly, while liberals attempt to resolve the dilemma by tempering liberty with equality *of opportunity*. Of course, like most simple schemes, this one ignores much of the complex reality that links ideologies and philosophical goals, but it will serve well enough to facilitate the discussion to follow.

Though the utilitarian and humanitarian philosophies appear in different mixtures in the Western democracies, Marchak has pointed out that liberal (utilitarian) ideas are generally dominant, with socialists (humanitarians) in a free society usually providing the counter ideology.[10] In fact, since she wrote, political and social developments in several Western countries have indicated a shift to the conservative right with this political force in some cases overcoming the liberal (US) or socialist (UK) incumbent to assume again a position of ideological dominance.[11] Marchak explains the survival of liberalism by its pragmatic willingness to adopt ideas and policies from the right or left when this appears expedient,[12] and the pendulum swings of liberalism on this continent at least amply attest to that. The conservative, liberal, and socialist political ideologies have each given rise to a social ideology that acts as a map or guide to those involved in negotiating the social order.

Titmuss suggested that three social policy models can be distinguished in Western democratic nations: the residual welfare model, the industrial achievement performance model, and the institutional redistributive model.[13] The strongest connections between the various philosophies, political and social ideologies are illustrated in Table 3.1. This table shows the US as the nation best exemplifying a residual wel-

FIGURE 3.2

DISTINGUISHING FEATURES OF POLITICAL IDEOLOGIES

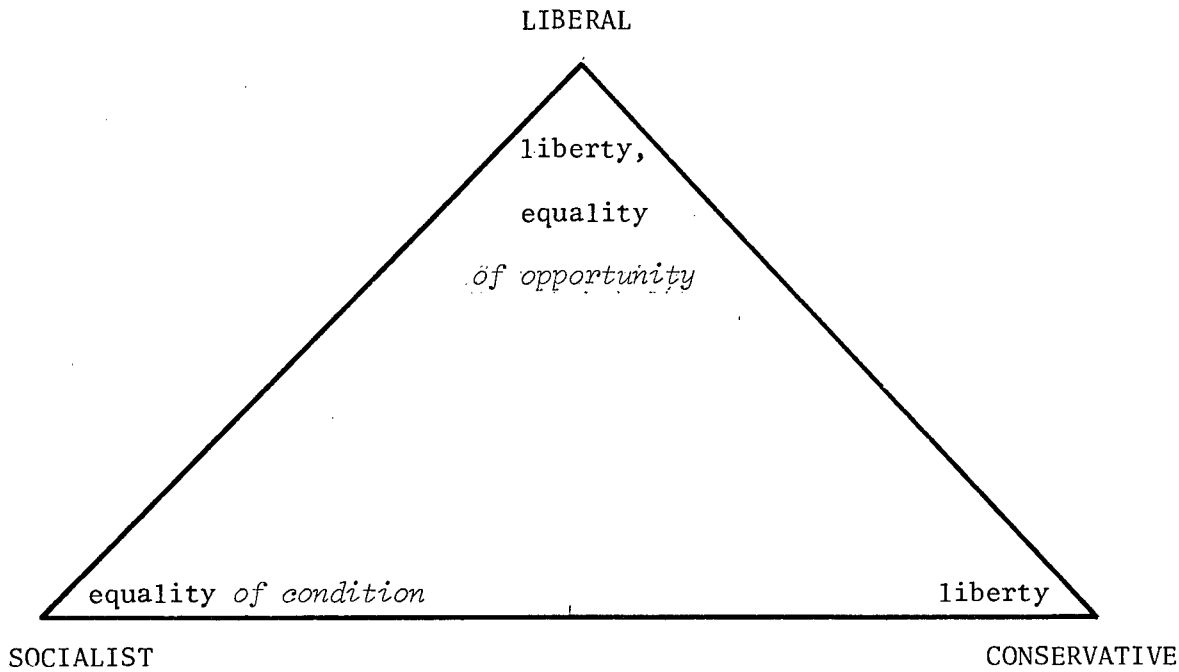


TABLE 3.1

PHILOSOPHY AND IDEOLOGY IN SOCIAL THEORY

| PHILOSOPHIES | IDEOLOGIES | | EXAMPLE |
|---|---|---|---|
| | POLITICAL | SOCIAL | |
| laissez-faire | conservative | residual<br>welfare | US |
| utilitarian | liberal | industrial<br>achievement<br>performance | FRG |
| humanitarian | socialist | institutional<br>redistributive | UK |

fare social ideology corresponding to conservative laissez-faire principles, the FRG's industrial achievement performance model is seen as the social embodiment of its dominant utilitarian liberal ideology, and the institutional redistributive social ideology in the UK is linked to its humanitarian socialist emphasis. This classification is supported by the descriptions of services for the elderly in these countries in Section 2.4 above, and begs the question of how one would classify Canada and British Columbia accordingly.

Canadian social ideology generally follows the achievement model, although some residual and redistributive elements are incorporated in this as well. This wide-ranging social model reflects the breadth of an adaptive liberal ideology in Canada that has dominated for most of this century by artful borrowing of policies from those on its political left and right.[14] In British Columbia the utilitarian liberal ideology has also dominated for many years, withstanding increased challenges from the humanitarian socialists by adopting variants of their policies, and coalescing with elements from the conservative right. With respect to programs for the elderly, both levels of government have opted for the redistributive model in health care (medical and hospital services, Long-Term Care, Pharmacare, and the Dental Care Plan), but retain the residual model for some income programs (GIS/SPA, GAIN), and the redistributive for others (OAS), while attempting to develop further the achievement model through the C/QPP. Housing programs (e.g. SAFER) at both levels have usually been residual in nature.

### 3.1.3 Barriers to Social Analysis

Marchak has put the problem this way:

> If society is judged within its own terms, and those terms arise easily from the kind of social organization it supports, its members do not seek radical solutions to organizational problems. Many, indeed, will not perceive any problem, a tribute to the success of the ideology in appearing to account for events and to realize its own values.[15]

It has been suggested in Chapter 2 that society faces a formidable challenge in planning for its aging population in the years ahead. A serious barrier to analysis of this and other social problems must then be recognized in the comfortable liberal ideology that prevails in this province and the nation as a whole, spawning an uncoordinated social policy whose only consistent redistributive emphasis appears in the health system. Meeting the challenges of an aging society requires considering all alternatives for future programs, including those that deviate from the accepted social ideology. For my own part I shall try to check my own bias toward institutional redistribution which flows from a humanitarian socialist orientation, and consider approaches that originate from all parts of the ideological spectrum. The reader can judge how well this effort succeeds in the analysis to follow.

## 3.2 A META-PARADIGM FOR SOCIAL THEORY

Accepting the definition of a paradigm attributed to Thomas Kuhn as a framework of basic concepts and postulates within which research proceeds,[16] a meta-paradigm (literally, a paradigm of paradigms) can be understood as a way of classifying a number of such frameworks, in this case relating to social theory. The multiplicity and diversity of sociological theories make it imperative to have a method of organizing them along key dimensions to produce a workable number of theoretical groupings with which to proceed. Gibson Burrell and Gareth

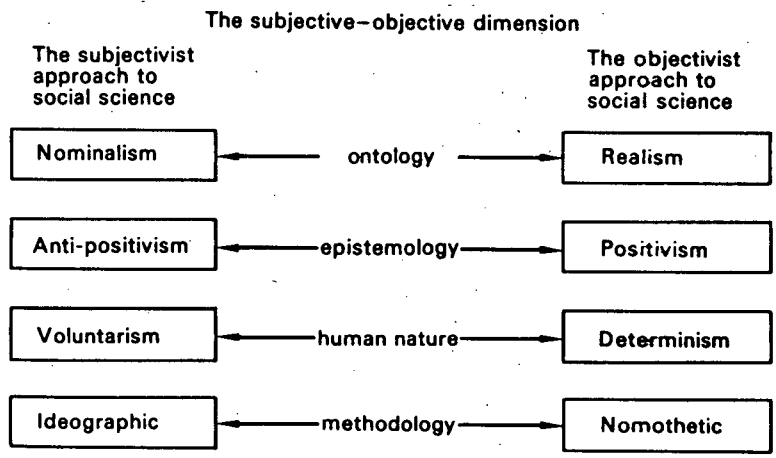
Morgan have developed just such a method, which is described in this section, and applied in the next to bring order to the confusing field of social gerontology.[17] They suggest that social theory can usefully be conceived in terms of four key paradigms based upon different sets of meta-theoretical assumptions about the nature of social science and the nature of society. These assumptions are seen as occupying polar positions along a subjective-objective dimension (relating to social science), and a regulation-radical change dimension (relating to society). The combination of these two dimensions produces a matrix of four key paradigms for the analysis of social theory. Each dimension will be described below before the four sociological paradigms are considered.

### 3.2.1 The Subjective-Objective Dimension

This dimension provides a scheme for analyzing assumptions about the nature of social science that are seen as addressing four basic issues about the nature of the social world and the way in which it may be investigated. Figure 3.3 shows that these four sets of assumptions, addressing the issues of ontology, epistemology, human nature, and methodology can be seen to resolve themselves in the polar positions indicated. Each of these polar sets then defines the subjective and objective extremes of the dimension.

Assumptions of an ontological nature are those "which govern the very essence of the phenomena under investigation".[18] The basic ontological question is whether the 'reality' to be investigated is external or the product of internal cognitive processes. The nominalist position is that the 'external' social world has no 'real' structure and consists only of names, concepts, and labels artificially created

FIGURE 3.3




From: Gibson Burrell and Gareth Morgan, *Sociological Paradigms and Organisational Analysis* (London: Heinemann, 1979), p. 3. Reproduced by permission of the authors.

by the individual to organize and negotiate the external world. In its most extreme form nominalism does not accept the existence of any world outside the realm of individual consciousness. Realism, in contrast, views the social world beyond the individual as composed of hard, tangible, and relatively immutable structures. These social realities exist whether or not they are recognized, perceived, labelled, and described, in the same way as elements of the natural world exist prior to their scientific 'discovery'. For the realist the social world is 'out there', while for the nominalist it is created in the mind of each individual.

A second set of assumptions revolve around the issue of epistemology, the grounds of knowledge. They are concerned with how one can know something, what forms knowledge takes, how (and whether) truth can be separated from falsehood, and how acquired knowledge may be passed on. On this issue the extreme positions are defended by the positivist and his opposite. The positivist tries "to explain and predict what happens in the social world by searching for regulations and causal relationships between its constituent elements."[19] While there are variations within this position, no positivist disputes the notion that knowledge grows over time by the addition of new theories, and the deletion of hypotheses shown to be false. The anti-positivist rejects this quest for patterns and regularity, viewing the social world as basically relative and capable of comprehension only from the point of view of those directly involved in the events under study. While the positivist stresses the observations of social phenomena, his opposite number believes understanding can only come from participation, or being 'on the inside', and generally discards the idea that social scientific knowledge can ever be objective.

Related to these two issues is a third concerning human nature, specifically the relationship between man and his environment. Essential to any social scientific inquiry, the set of assumptions clustered around this question identify the extreme positions of determinism on the one hand, and voluntarism on the other. Determinists view man as conditioned by his environment, responding to influences and situations in a mechanistic fashion, his life's course determined from without. Voluntarists believe that human beings have 'free will', creatively shape their environments rather than the reverse, and are in every sense autonomous and self-controlled. The assumptions of many social scientific theories fall between these two positions, but are usually closer to one extreme or the other.

These three sets of assumptions have important implications for the issue of methodology in social science, some of which have already been mentioned. Differing positions on the questions of ontology, epistemology, and human nature will lead to varying methodological choices. The polar positions on methodology in social science have been termed ideographic and nomothetic.[20] The ideographic method involves proximity to the subject of the inquiry, with the stress on 'first-hand' knowledge gained from subjective reports and direct involvement in the phenomena under study. The nomothetic approach in social science emphasizes systematic research techniques similar to those employed in the natural sciences. Hypotheses are constructed and tested using quantitive data analysis, and standardized research tools such as surveys, questionnaires, and personality tests are employed.

Taken as a group, the extreme positions on each of the above four issues are related to the two great schools of social scientific thought since the eighteenth century, 'sociological positivism' and 'German

idealism'. The first of these defines the objective extreme of this dimension by taking a realist view of ontology, a positivist epistemology, a deterministic orientation toward human nature, and a nomothetic methodological stance. In general, this school of thought approaches the social sciences as if they were natural sciences, employing concepts and approaches derived from the latter. The second tradition is in complete opposition to the first. Essentially it assumes that "the ultimate reality of the universe lies in 'spirit' or 'idea' rather than in the data of sense perception".[21] It is therefore nominalist with respect to ontology, anti-positivist in epistemology, voluntarist regarding human nature, and ideographic in its social scientific methodology. This school rejects the natural science analogy and emphasizes the basic relative nature of social life in defining the subjective extreme of the continuum. While many social theorists today have been schooled in the tradition of sociological positivism, there are indications that German idealism is having an increasing influence in the development of perspectives intermediate between the subjective and objective extremes.

The subjective-objective dimension, then, facilitates the comparison of theoretical viewpoints of the basis of their assumptions about issues central to the nature of social science. It comprises the first dimension of the meta-paradigm for social theory.

### 3.2.2 The Regulation-Radical Change Dimension

This second dimension draws attention to social theoretical assumptions about the nature of society. The debate as to whether society is characterized by order or conflict has been continuing for a very long time, as can be seen from the following view of Thomas Hobbes in 1651:

> Hereby it is manifest that during the time men live without a common power to keep them all in awe, they are in that con-

> dition which is called war; and such a war as is of every man, against every man.[22]

Theorists who focus upon the nature of social order and equilibrium are interested in understanding those societal forces which prevent Hobbes' vision of a war of all against all from becoming a reality. On the other hand, those who concern themselves with the issues of change, conflict, and coercion in social structures see such a 'war' as inevitable without radical social change. The order-conflict debate among social analysts was partially stilled in the middle of this century by those like Coser who argued that social conflict serves a purpose in society, thereby subsuming it as a variable into an overall social order theory.[23] It has also been argued, however, that reports of the death of this debate have been much exaggerated, and the work of Dahrendorf[24] to restore Marxist thought to an influential position in sociological theory has been joined by others who share a radical change outlook. These theorists contend that to try to incorporate conflict within an order perspective is to ignore the very fundamental differences between them, as demonstrated by the fact that extreme situations of conflict such as revolution or war defy any reasonable integrating explanation. Recently some have suggested that a more radical description of the conflict point of view is necessary to prevent misinterpretation and confusion by integrationist order theorists, and it is in line with this approach that Burrell and Morgan offer their modification of the terms of the debate in defining the second analytical dimension of the meta-paradigm.

They suggest that the problematic terms 'order' and 'conflict' be replaced respectively by 'regulation' and 'radical change' to sharpen the distinction they believe exists between the two concepts. Issues that describe the extreme points of view along this continuum are listed in Table 3.2. The term 'sociology of regulation' is used to describe

TABLE 3.2

**The regulation—radical change dimension**

| *The sociology of REGULATION is concerned with:* | *The sociology of RADICAL CHANGE is concerned with:* |
|---|---|
| (a) The status quo | (a) Radical change |
| (b) Social order | (b) Structural conflict |
| (c) Consensus* | (c) Modes of domination |
| (d) Social integration and cohesion | (d) Contradiction |
| (e) Solidarity | (e) Emancipation |
| (f) Need satisfaction† | (f) Deprivation |
| (g) Actuality | (g) Potentiality |

Notes

* By 'consensus' we mean voluntary and 'spontaneous' agreement of opinion.

† The term 'need satisfaction' is used to refer to the focus upon satisfaction of individual or system 'needs'. The sociology of regulation tends to presume that various social characteristics can be explained in relation to these needs. It presumes that it is possible to identify and satisfy human needs within the context of existing social systems, and that society reflects these needs. The concept of 'deprivation', on the other hand, is rooted in the notion that the social 'system' prevents human fulfilment; indeed that 'deprivation' is created as the result of the *status quo*. The social 'system' is not seen as satisfying needs but as eroding the possibilities for human fulfilment. It is rooted in the notion that society has resulted in deprivation rather than in gain.

From: Burrell and Morgan, *Sociological Paradigms*, p. 18. Reproduced by permission of the authors.

attempts to explain the nature of society by referring to its basic order and cohesion. Such theorists see a need for regulation in the social sphere, to maintain consensus, solidarity, and the status quo. The 'sociology of radical change', in contrast, seeks "explanations for the radical change, deep-seated structural conflict, modes of domination, and structural contradiction which its theorists see as characterizing modern society".[25] It is concerned with the potential of society as much as its current state, and perceives a need to liberate man from confining societal structures which presently perpetuate his deprivation. Characterized in these ways the two polar concepts can be seen as basically opposed, and capable of integration only by dilution of their real meanings. The function of social conflict approach is thus viewed as part of the sociology of regulation, even if some distance from its pole. Viewed in this way any social theory can be seen to belong to one side of this spectrum or the other.

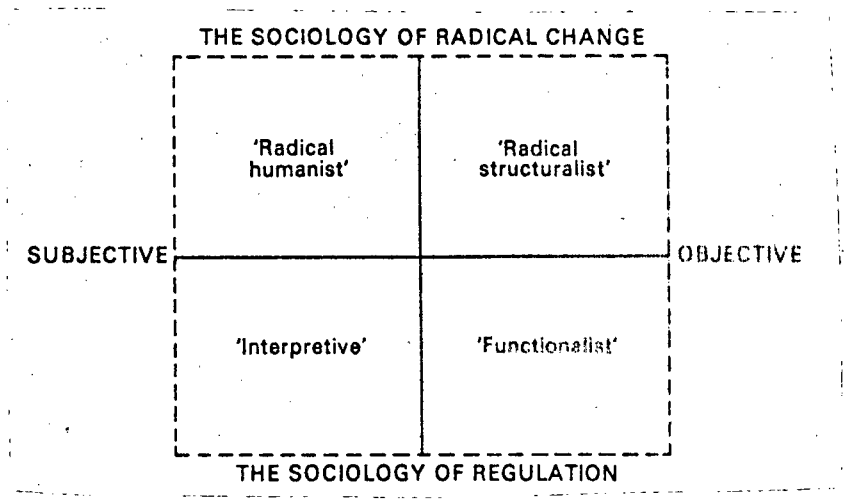
The subjective-objective dimension, together with the regulation-radical change dimension defines four basic sociological paradigms that can be used to classify or map various theoretical approaches.

### 3.2.3 Four Sociological Paradigms

The two dimensions described in the preceding sections can be combined to produce a matrix for the analysis of social theory, comprised of four key paradigms as shown in Figure 3.4. Used in this sense, the term paradigm is intended to indicate a degree of commonality among theoretical viewpoints within each quadrant, but not complete agreement. Theorists located within any one paradigm necessarily share a basic view of the nature of society and of social science, but may well diverge on countless other points. Nevertheless the acceptance of similar meta-theoretical

FIGURE 3.4

FOUR PARADIGMS FOR THE ANALYSIS OF SOCIAL THEORY




From: Burrell and Morgan, *Sociological Paradigms*, p. 22. Reproduced by permission of the authors.

assumptions in each of the four areas both draws together theorists so located, and separates them from those with differing views of social reality. By using the four paradigms to locate various viewpoints one is able to construct a map of social theory that can help to organize the wealth of diverse ideas concerning the social world. It will be used in the next section to negotiate the confusing realm of social gerontology by reducing the many theoretical approaches to these basic four in order to facilitate their evaluation. Here, however, the focus is on understanding the meta-paradigm as it relates to social theory in the broadest sense, and each paradigm will be explored within the context of general sociological theory.

The functionalist paradigm has dominated social theory since the Age of Reason in the seventeeth century. Rooted in a view of society that emphasizes regulation, and an objective approach to social science, this framework has spawned much of what is commonly regarded as modern social research. Functionalists generally accept the set of assumptions referred to earlier as defining the tradition of sociological positivism, characterized by the realist, positivist, determinist, and nomothetic points of view regarding social scientific issues. From this vantage point they seek explanations for the status quo, social order, consensus, social integration, solidarity, need satisfaction, and actuality. The functional approach is often concerned with finding practical solutions to particular social problems,

> is usually firmly committed to a philosophy of social engineering as a basis of social change and emphasizes the importance of understanding order, equilibrium, and stability in society and the way in which these can be maintained.[26]

The foundations of the functionalist approach were laid with the work of such theorists as Auguste Comte, Herbert Spencer, Emile Durkheim, and Vilfredo Pareto, all of whom viewed the social world in much the same

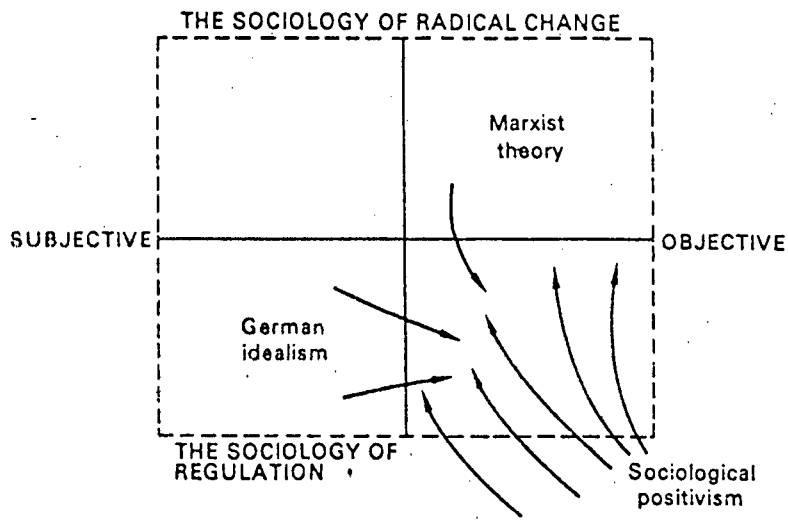
way as its natural counterpart, emphasizing methods of study derived from the latter. In this century, however, the functionalist paradigm has shown the influence of German idealism through the work of Max Weber, Georg Simmel, and George Herbert Mead who rejected the use of mechanical and biological analogies in social science and advocated understanding social phenomena from the point of view of the individuals involved in them. Since the 1940's functionalists have also incorporated some Marxist influences, as discussed earlier in relation to the order-conflict debate, in an attempt to show that the paradigm is able to account for social change. Figure 3.5 shows the ways in which competing intellectual positions have been incorporated into the dominant framework of sociological positivism giving rise to a number of distinctive theoretical perspectives within the functionalist paradigm. Figure 3.6 shows the four paradigms together with the major theoretical schools of which they are composed. For the sake of brevity and simplicity the individual theories will only be listed below, and the reader is referred to Burrell and Morgan's work[27] for detailed explanations. For the functionalist paradigm component theoretical perspectives range from most to least objective as follows:

1. Objectivism - comprising behaviourism and abstracted empiricism
2. Social system theory - including structural functionalism and systems theory
3. Integrative theory - including conflict functionalism, morphogenic systems theory, Blau's theory of exchange and power, and Mertonian theory of social and cultural structure
4. Interactionism and social action theory

It is also worth noting that systems theory, included in this paradigm

FIGURE 3.5

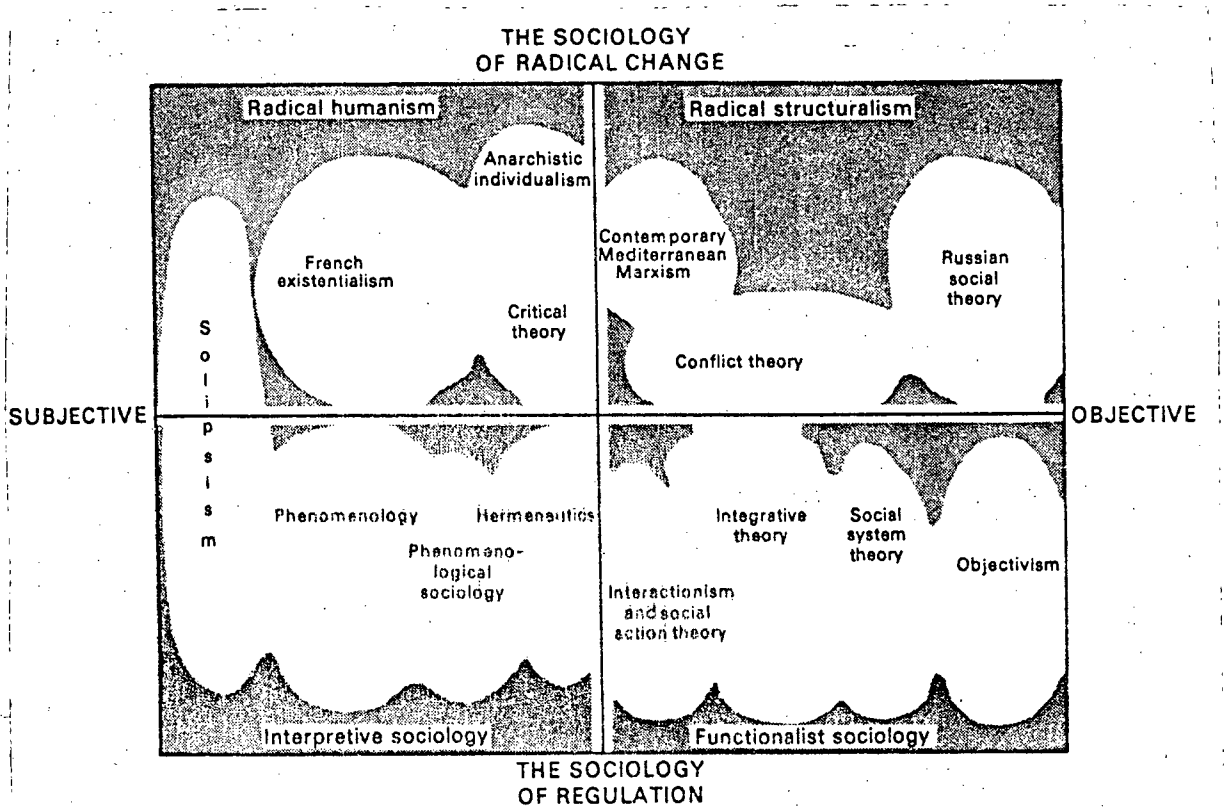
INTELLECTUAL INFLUENCES UPON THE FUNCTIONALIST PARADIGM




From: Burrell and Morgan, *Sociological Paradigms*, p. 27. Reproduced by permission of the authors.

FIGURE 3.6

THE FOUR SOCIOLOGICAL PARADIGMS




From: Burrell and Morgan, *Sociological Paradigms*, p. 29. Reproduced by permission of the authors.

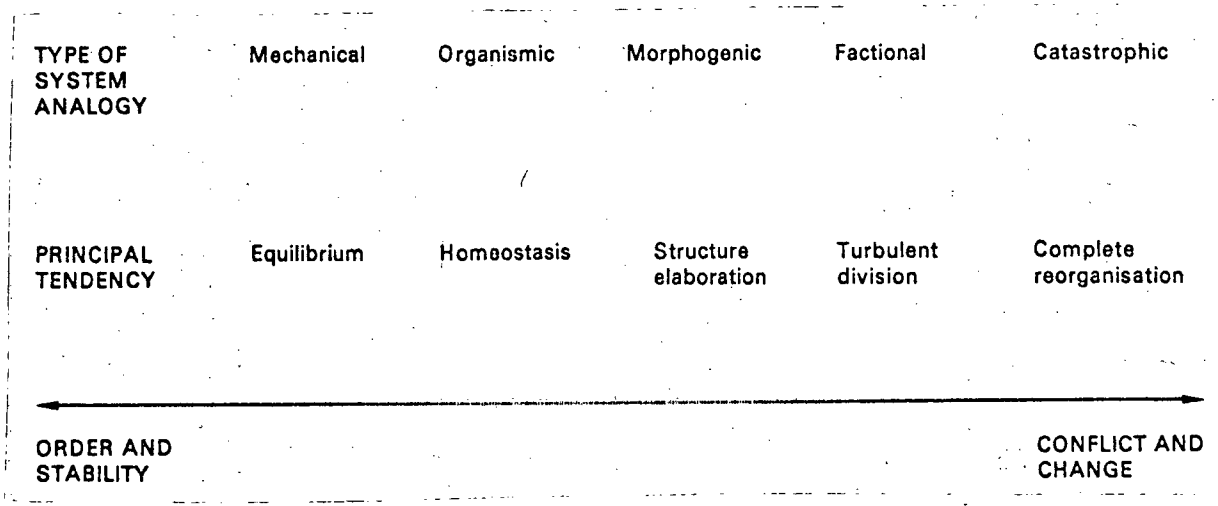
due to its typical use of mechanical, organismic, or morphogenic analogies, is, in principle, not tied to any specific view of the social world beyond that implied by its general positivist orientation. The use of factional or catastrophic analogies within systems theory (representing tendencies toward turbulent division and complete reorganization respectively) would place a systems theoretical approach within the radical structuralist paradigm. The range of models possible within systems theory is shown in Figure 3.7.

The interpretive paradigm is the descendant of the German idealist school of social theory founded by Immanuel Kant that emphasizes the spiritual nature of the social world. Theorists within this paradigm accept the societal view of the sociology of regulation along with functionalists, but approach social science in a basically subjective fashion, tending to hold nominalist, anti-positivist, voluntarist, and ideographic positions. Interpretive sociology considers that social reality is created by those who experience it, and is external to them only insofar as their individual meanings are shared. Theorists adhering to this view are concerned with understanding the essence of social life as an individual process, and though their acceptance of regularity and order places them on the regulation side of the map, they are disinterested in debating this issue as a result of their nominalist orientation. The interpretive paradigm has been explored largely in this century through the work of Wilhelm Dilthey, Max Weber, and Edmund Husserl, and can be seen to include approaches varying from the most to least subjective as follows (see Figure 3.6):

1. Solipsism
2. Phenomenology - including transcendental (or pure phenomenology, and existential phenomenology

FIGURE 3.7

SOME POSSIBLE TYPES OF SYSTEM MODELS




From: Burrell and Morgan, *Sociological Paradigms*, p. 67. Reproduced by permission of the authors.

3. Phenomenological sociology - including ethno-methodology, and phenomenological symbolic inter-actionism

4. Hermeneutics

The radical humanist paradigm shares the subjective orientation of interpretive sociology, but views the nature of society from a radical change perspective. A basic assumption of the radical humanist is that a "wedge of 'alienation' or 'false consciousness'"[28] has been driven in the human mind by normative social philosophies that are reflected in existing social arrangements, preventing people from experiencing complete fulfilment. Derived again from German idealism this paradigm has been influenced by the young Marx, as well as Habermas, Marcuse, Sartre, and a wide variety of contemporary social theorists such as Illich, Castaneda, and Laing. Despite the obvious differences between these thinkers,

> All in their various ways share a common concern for the release of consciousness and experience from domination by various aspects of the ideological super-structure of the social world within which men live out their lives. They seek to change the social world through a change in modes of cognition and consciousness.[29]

Social theories within this paradigm vary from the most to least subjective as follows (see Figure 3.6):

1. Solipsism
2. French existentialism
3. Anarchistic individualism
4. Critical theory-including Lukácsian sociology, Gramsci's sociology, and that of the Frankfurt School

Since radical humanists, along with interpretive sociologists, believe social reality to be an individually-created subjective experience they are only concerned with radical change insofar as human consciousness is involved. Radical structuralists, however, apply the sociology of

radical change to the fabric of society itself.

Theorists within the radical structuralist paradigm share with functionalists an objective view of social science, but believe that the nature of society is better understood from the point of view of radical change than from that of regulation. The main intellectual influence within this paradigm has come from the work of Marx following the "epistemological break"[30] noticed after his involvement in politics and studies of evolution and political economy. While some theorists seek to explain social change by examining society's internal contradictions, and others by analyzing its power structure, all those within this perspective concur that "contemporary society is characterised by fundamental conflicts which generate radical change through political and economic crises",[31] and see such change as liberating man from oppressive social structures. The paradigm is viewed as comprised of the following social theories, from the least to most objective (see Figure 3.6):

1. Contemporary Mediterranean Marxism - including Althusser's sociology and Coletti's sociology
2. Conflict theory - including that of Rex and Dahrendorf
3. Russian social theory - including Bukharin's historical materialism and Kropotkin's anarchistic communism

Whereas functionalism attempts to account for the persistence of existing social formations, radical structuralism takes a fundamental change perspective emphasizing contradiction and crisis. Social change is seen to involve inevitable structural transformations that are catastrophic in nature.

These four sociological paradigms can be used to make sense of the variety of theories that currently comprise social gerontology by redu-

cing them to a few basic groups that can more easily be evaluated for their usefulness in understanding the problems of British Columbia's aging population. The next section uses the meta-paradigm just described to develop a social gerontological map.

## 3.3 MAPPING SOCIAL GERONTOLOGICAL THEORY

As a relatively recent field of social scientific study social gerontology has not yet experienced the consolidation of theoretical viewpoints that simplifies analysis to some extent in the more established disciplines of sociology and psychology. The range and diversity of its many perspectives testifies to the interdisciplinary nature of its origins as well as its continued hybrid development. For the planner seeking to make sense of available information about policy for the elderly (Chapter 2), the problem is to find ways to reduce the many theories to a basic few for practical consideration. This section uses the meta-paradigm outlined above to produce a map of social gerontological theory that will achieve this purpose. The map is presented in Figure 3.8, and described under the headings of each of its four quadrants below.

### 3.3.1 Functionalist Social Gerontology

As was the case in discussing sociological theory, most of the theoretical approaches in social gerontology can be seen to fall within a basic functionalist paradigm. These perspectives share an objective approach to the social scientific enterprise, and a basic commitment to the status quo of society that often focuses on ways in which aging individuals can adapt to social realities. This most popular of the four paradigms has witnessed a continuing debate between exponents of

FIGURE 3.8

A MAP OF SOCIAL GERONTOLOGICAL THEORY

THE SOCIAL GERONTOLOGY OF RADICAL CHANGE

| RADICAL HUMANISM | RADICAL STRUCTURALISM |
| --- | --- |
| minority group theory | generational-conflict theory |
| role theory<br>social reconstruction theory<br>developmental theory | age-stratification theory<br>exchange theory<br>environmental theory<br>activity theory<br>disengagement theory |
| INTERPRETIVE GERONTOLOGY | FUNCTIONALIST GERONTOLOGY |

SUBJECTIVE — OBJECTIVE

THE SOCIAL GERONTOLOGY OF REGULATION

two older perspectives, activity theory and disengagement theory, and an elaboration of more recent social science concepts into environmental theory, exchange theory, and age-stratification theory. Each of these approaches are examined briefly now in turn.

*Activity theory* (also called implicit or continuity theory) emphasizes the stability of the personal coping systems developed by individuals over the course of their lives. In a manner reminiscent of the American rugged individualist ideal the older person, according to this perspective, shifts the focus but maintains a comparable level of activity with retirement and subsequent aging. This is the popular public stereotype of a successful senior citizen: independent, busy, healthy and happy, with continuing activity the key. The emphasis is on developing a number of personal role-options to ease the transition from middle to old age. Lemon, Bengtson, and Peterson have stated the two main propositions of activity theory as follows:

1. Social activity and life satisfaction in old age are positively related
2. The loss of important roles is inversely related to life satisfaction[32]

Using data from a sample of older people moving into a retirement community, these researchers were unable to validate the propositions, casting doubt on the theory itself.[33]

In direct opposition to traditional activity theory, Cumming and Henry developed the first major systematic theory of aging in 1961 called *disengagement theory*.[34] They suggested that a process of disengagement of the individual from society with advancing age is normal and functional when viewed from either perspective. As Rose puts it:

> The society and the individual prepare in advance for the ultimate 'disengagement' of incurable, incapacitating di-

> sease and death by an inevitable, gradual and mutually satisfying process of disengagement from society.[35]

According to this theory, disengagement maintains a necessary balance between the wishes of an individual and society for or against involvement, with society's will prevailing shoud a conflict exist. Taking a somewhat more objective approach to the problem of aging than activity theorists, those using this model also emphasize the need for societal regulation and personal adaptation characteristic of the functionalist school. The subject of much discussion and research over the years, disengagement theory has been attacked on both empirical and conceptual grounds by a variety of scholars. Some have found that continued activity[36] or re-engagement[37] is more satisfying for the older person, while others have criticized the theory's uncritical acceptance of the status quo.[38] As a result of the activity-disengagement controversy a number of other distinct theoretical perspectives have emerged within the functionalist paradigm.

Some analysts have emphasized the pre-eminence of the social environmental context of the aging process in a highly objective view that downgrades the older person's ability to alter his situation except within restrictive social/cultural boundaries. Gubrium[39] has suggested that there are three important elements to *social environmental theory:*

> an emphasis on normative expectations derived from particular contexts, attention to individual capacities for interaction, and a focus on the subjectively evaluated correspondence between ability and what is expected in a particular situation.[40]

These elements should ideally work together to produce satisfaction in the elderly person, but since in fact they proceed at different rates continual adjustment and support is required to maintain a reasonable balance.

*Exchange theory*, primarily associated with Blau,[41] holds that individuals will participate in social interaction only as long as the benefits derived outweigh the cost incurred. These valuations change over time as the aging process occurs and the social network of the elderly shrinks as the result of

> a realignment of their personal relationship brought about by a debasing of the influence that they are able to exercise over their environments.[42]

Lacking socially marketable skills or resources, older people trade their compliance to gain the acceptance and support of others, and cultivate a 'nice' or 'sweet' image in this effort. Postulating a mechanism to explain the adjustment process of the elderly in society, exchange theory lies clearly within the functionalist paradigm.

*Age-stratification theory* views age strata as

> composed of people similar in age or life stage, who tend to share capacities, abilities, and motivations related to age. Age is also a criterion for entering or leaving roles, and for the different rewards and obligations associated with these roles. In short, age is a basis of 'structured social inequality'.[43]

This theory relies on the concept of cohort flow (the aging of successive strata) which is seen as propelling the various age groups through changing social roles depending on their age-related capacities and expectations.[44] Riley and others have emphasized the importance of socialization in ensuring a smooth transition of individuals from one age status to the next,[45] indicating the theory's basic functionalist orientation.

### 3.3.2 Interpretive Social Gerontology

There has been renewed interest in the interpretive paradigm over the past few years as gerontologists have renewed efforts to understand the aging process from the point of view of older people themselves. While partly growing out of reactions against the detachment of functionalism, these subjective perspectives have continued the regulation approach to society that characterizes functionalist theories, but focused on the elderly individual in his adaptation to a changing social reality. As approaches belonging to the interpretive paradigm, developmental theory, social reconstruction theory, and role theory are each described briefly below.

*Developmental theorists* like Erikson,[46] basing their work on psychological and biological research, have viewed the aging process as a series of linked individual life challenges which must be successfully overcome if ego satisfaction is to result. For later life Erikson suggests the challenge is for older people to achieve consummation through realizing ego integrity, or, failing this, to give way to despair. Elaborating Erikson's model, Peck [47] has suggested that

> if adaptation is to be maintained in the years following retirement...new sources of gratification must be elaborated along with an ability to transcend not only bodily functioning but personal skills in order to contribute to the lives of others.[48]

Further extending the developmental scheme, Neugarten and Lowenthal[50] have reported significant sex differences in the developmental tasks faced in later life. Men are forced to adjust to retirement and the loss of income, while women must adapt to their diminishing family obligations. Neugarten has also developed a typology of personality types of older people which describes them as integrated, armored-defended, passive-dependent, or un-integrated,[51] and has concluded

on the basis of subject self-evaluations that these are "most often merely the extensions of middle age coping styles into later years."[52] The developmental theory appears, then, as the classic subjective, regulative social gerontological approach.

*Social reconstruction theory* draws upon labelling theory in community psychiatry which is related to the symbolic interactionist tradition in sociology.[53] The theory acknowledges that the vicious cycle of increasing incompetence known as the social breakdown syndrome can be used to describe the experience of many aging individuals. The breakdown syndrome consists of four main steps which are linked together in a circular fashion:

1. Precondition or susceptibility to psychological breakdown
2. Social labelling as deficient or incompetent
3. Induction into a sick or dependent role and atrophy of previous skills
4. Self-identification as sick or inadequate[54]

The social reconstruction model then describes the breaking of this vicious cycle, and its replacement by a benign one of increasing competence through social system inputs. The main steps linked together in this cycle are:

1. Reduced susceptibility and increased self-confidence
2. Reduced dependence and increased self-reliance
3. Self-labelling as able
4. Build-up and maintenance of coping skills
5. Internalization of self-view as effective

These steps are facilitated by inputs from a supportive social system that help to: liberate the individual from the functionalist ethic and evolve alternate evaluations (at step 1); improve maintenance con-

ditions such as housing, health, nutrition, and transportation (at step 2); encourage internal locus of control and build adaptive problem solving (at step 4).[55] This perspective stresses the importance of individuals' perceptions of themselves and their situations, and is oriented to helping them adapt to societal realities through various social support systems. Social reconstruction theory suggests that some social change is necessary, but may be accommodated within the realm of existing societal arrangements.

*Role theory* in social gerontology considers the career of an individual as he moves through life's various status passages. Hughes puts it this way:

> In a highly and rigidly structured society, a career consists, objectively, of a series of status (*sic*) and clearly defined offices. In a freer one, the individual has more latitude for creating his own position or choosing from a number of existing ones...but unless complete disorder reigns, there will be typical sequences of position, achievement, responsibility, and even of adventure.[56]

But the older person faces a status passage unlike any other (school, marriage, work, etc.) in that there is no exit but death, and this cannot be avoided. The typical effort by individuals changing roles to take control over their status passage is seen as crucial for the elderly who must try to maximize personal control despite the structures of institutions (e.g. old age homes) and diminishing resources of all kinds. This process can often be enhanced through social interaction and the development of community, as Hochschild found in a study of an apartment building,[57] but remains fundamentally a subjective experience by which older people "attempt to control, through symbolic interaction, situations in keeping with biographically meaningful intentions"[58] as they maintain their identity and prepare for death. Role theory, then, continues the interpretive focus on the

subjective experience within the context of a regulative approach to society.

### 3.3.3 Radical Humanism

The radical humanist paradigm includes those approaches to the phenomenon of aging that share the subjective orientation of interpretive theories, but are oriented toward radical change in society as the means of resolving perceived problems. Emphasizing consciousness in general and alienation in particular, radical humanists seek revolutionary change in society through similar change in the individuals of which it is composed. Their aim is to raise the consciousness of all people, and especially that of the elderly, in order to promote a rejection of the stereotype of the aged and a determination to eliminate all restrictive attitudes toward aging. Since this paradigm runs counter to the nature of society as a result of the denial of societal norms upon which it rests, it is not surprising that it should be chosen as a theoretical framework by few social gerontologists. The best example of a radical humanist approach is that of minority group theory.

*Minority group theory* asserts that older people constitute a minority group in society whose members are victims of ageism, the widespread negative stereotyping of the elderly that involves references to their supposed "intellectual decline, conservatism, sexual decline, lack of productivity, and preference for disengagement."[59] Prejudice against the elderly is seen to derive from a number of social, economic and cultural factors that combine to devalue the aged in society on the basis of unsubstantiated normative views of their capacities. Elderly people react to their assigned societal role of 'senior citi-

zen' in a variety of ways that include acceptance, avoidance, and aggression.[60] One of the aggressive responses in recent years has been the emergence of 'senior power' groups, such as the Gray Panther movement in the US, which attempt to organize older people to promote the militant rejection of negative norms as well as the patronizing and inadequate policies to which they give rise. The influence of the women's movement on the growing consciousness of older people has also been considerable. Female activists in the liberation movements of the 1960's have moved into institutional lobby groups (such as the Canadian Advisory Council on the Status of Women) during the past decade and used them to promote a greater awareness of the problems of women, and especially those of elderly women. Since most of the aged *are* women, and many of them lack adequate pension incomes as a result of the inconsistent, low-level employment which family responsiblities and systematic discrimination have forced upon them, the problems of the elderly often highlight important issues of equity for women as a whole. The minority group model suggests that any changes in societal systems affecting the aged must be initiated by older people themselves who recognize their common problems and unite to seek real social equality. The first priority this theory outlines is the raising of the consciousness of elderly people through promotion of the recognition of:

1. The common status conferred by old age
2. The presence of ageism generally and age discrimination in their personal lives
3. Old age as a normal, desirable stage of life[61]

The accomplishment of this primary objective is expected to lead to necessary social and political structural changes throughout society.

### 3.3.4 Radical Structuralism

The radical structuralist paradigm, like its humanist counterpart, includes theoretical perspectives which see the social problems related to aging as symptoms of a deep structural malaise in society that can only be cured through radical change of the system itself. Theorists within this school share the objective view of social reality of functionalists, but see within the total social structural formation contradictory internal forces that are viewed as moving society toward an inevitable crisis that will make possible a necessary transformation of the political, economic, and social order. While conflict theory is exceptional in this respect, most radical structuralist perspectives envision a violent revolutionary transformation that differs sharply from the humanist ideal of a non-violent revolution through consciousness. The emphasis within this paradigm on the need for fundamental system change differentiates it clearly from the most change oriented functionalist theories which accept the current societal framework as normative. The best example of a radical structuralist approach to aging is generational-conflict theory.

*Generational-conflict theory* builds upon the notions discussed under age-stratification theory (see Section 3.3.1), but considers consciousness of stratum position as nascent class consciousness, a necessary prerequisite of revolutionary class action. This theory defines a generation as "a cohort, large proportions of whose members have experienced significant socio-historical changes",[62] such as wars, depressions, and innovations like the birth-control pill. An understanding of the concept of class is found in the action of

> conflicting interest groups, who, because of their relation to property, possession of status, and consciousness of their relative position, exercise power in a historical and dialectical fashion to impose their interests on each other.[63]

The development of a generational consciousness among large numbers of members of a cohort, combined with coinciding class interests is seen as a potent combination for generational-conflict and radical action. The basis for class conflict involving the aged is found in their alienation from labour and the inequality of income status which, with notable exceptions,[64] is the lot of elderly people. Tindale and Marshall point to increasing tension ahead as the baby-boom generation, with its well developed group consciousness, ages and exerts its formidable influence on social and political structures to benefit the elderly at the expense of younger workers, since:

> The bases for conflict lie with the tensions and deprivations of economic and cultural life which in cases of relative scarcity sometimes pit various cohorts of people against each other in generational conflict.[65]

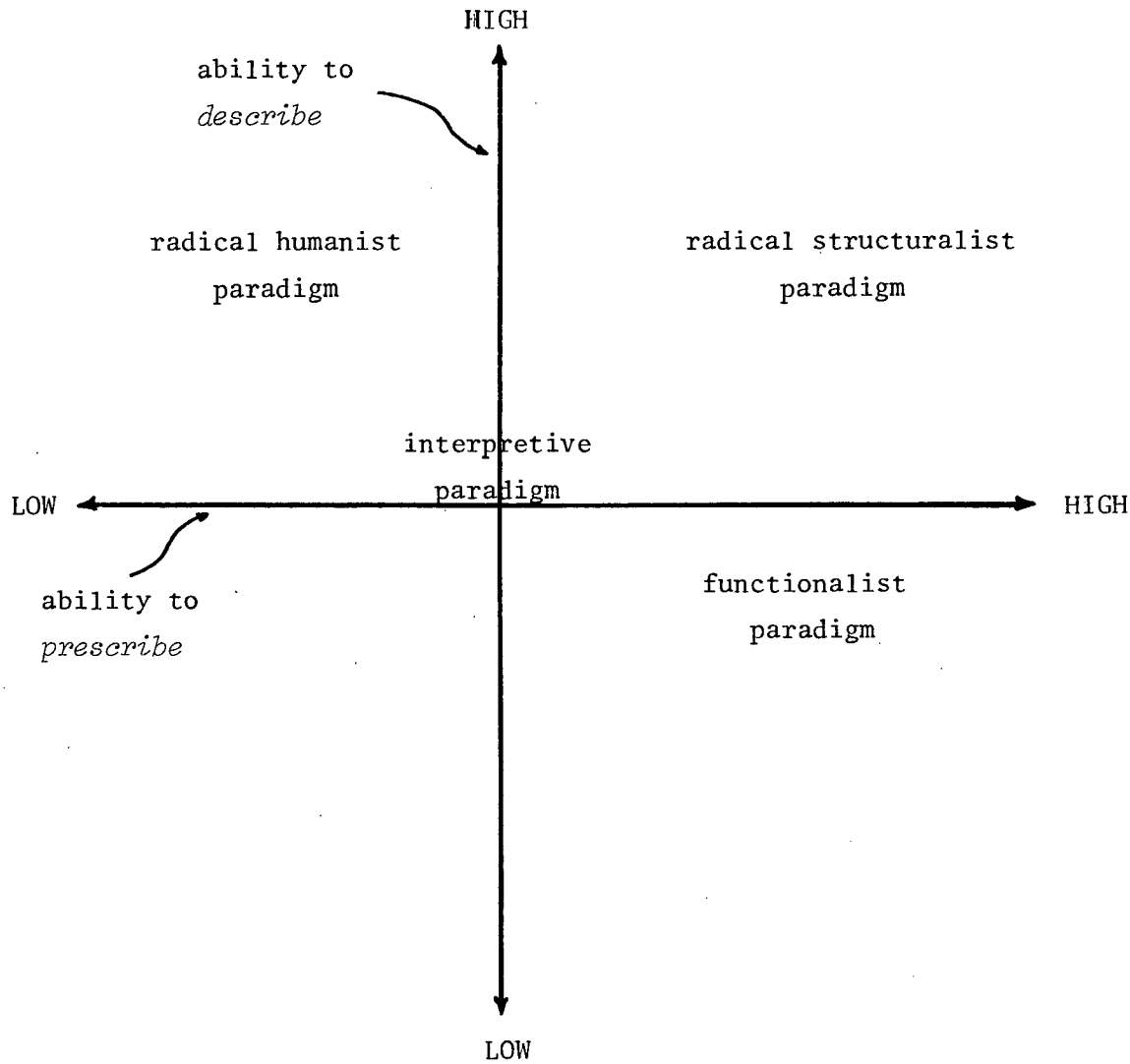
Generational-conflict theory, then, foresees increasing conflict (based on class and generational consciousness) between older and younger citizens that may well reach critical proportions and force far-reaching structural changes in society.

## 3.4 DEVELOPING A PARADIGM FOR PLANNING

The variety of social gerontological theories reviewed in the preceding section according to four basic paradigms can now be analyzed for their ability to describe accurately the situation of the elderly in society, and to prescribe useful planning options for policy makers concerned with the adequacy of future programs for the aged. In this way the paradigms can be plotted on a descriptive-prescriptive ability grid as shown in Figure 3.9. Following this analysis, what are seen as the necessary elements of a paradigm for planning for British Columbia's aging population will be described. The planning paradigm so developed will serve as the theoretical basis for strate-

FIGURE 3.9

SOCIAL GERONTOLOGICAL PARADIGMS BY THEIR ABILITY TO DESCRIBE AND PRESCRIBE



gies to be considered in the next chapter.

### 3.4.1 The Four Paradigms Evaluated

Most of the programs for the elderly in existence now in British Columbia have come about through responses to the needs of the aged implicitly based on functionalist theory. As noted earlier, functionalists are highly problem-oriented, aiming to ease the adjustment of the older person to his perception of social realities. In many respects this approach has served society well, developing an ever increasing number of supportive services that have helped to some extent to mitigate the difficult situation of the elderly in this province. But the basic problems remain despite, and even in some cases as a result of such efforts (e.g. inadequacy of income for the aged and early retirement policies). Marshall and Tindale describe traditional functionalist gerontology as

> a "tinkering trade" engaged in repair work. It focuses on individuals, and on how they might adjust (be adjusted?) to the on-going system. It seldom considers the necessity for serious change in the system itself.[66]

Functionalist theory, then, is high in prescriptive ability, suggesting any number of additional programs to planners for the elderly, but always within the context of the current social structural framework. Radical change is not considered an option. While such conservative approaches may have been workable when the elderly represented a very small proportion of the population, and informal supportive structures (the family, church etc.) remained stable, powerful influences that could be counted on to pick up the slack in program provision, the shape of future British Columbian and Canadian society suggests that these traditional solutions will become less and less relevant over the next twenty to thirty years and beyond. Future pro-

jections describe nothing less than a revolution in the social composition of society, and a simultaneous narrowing of the range of alternatives for public policy as a result of diminishing economic resources. The functionalist paradigm is unable to account for such dramatic changes over a relatively short time-span, and is therefore located on the low side with respect to descriptive ability in Figure 3.9.

The interpretive paradigm is similarly hobbled by its basic acceptance of the status quo, but makes a valuable contribution by focusing on the individual's experience of aging, and his ability to redefine social reality in positive, helpful ways. The subjective aspect of the world of the elderly cannot be ignored in comprehensive prescriptions for the problems of the aged, but at the same time it constitutes only part of the broader social reality of older people. Interpretive theories are located near the midpoint of each of the descriptive and prescriptive ability ranges to indicate that, while they offer useful and valid insights into aging, their utility is diminished by the omission of an objective, structural perspective.

Radical humanism maintains the subjective view but in a radical form that calls for a personal revolution within society. Its insistence on the priority of increased individual consciousness underlines an important precondition for the success of any strategy for social change. The radical change perspective enables this paradigm to describe more fully than its regulative counterparts the past, present, and future situations of elderly people, but humanists are less interested in drawing the implications for corresponding structural change that must follow in a responsible society. As Figure 3.9 shows, this paradigm is therefore considered low in prescriptive ability, but high in descriptive ability.

The radical structuralist paradigm combines a powerful structural analysis of society with a radical perspective better able to account for the complete description of the situation of the elderly presented in Chapter 2. For the period of the historical development of services to the elderly, when the aged comprised a small group with little awareness of their own separate identity, the radical structuralist view suggests that the preconditions for conflict did not exist, and that the proliferation of functional adaptive approaches which emerged during this time was made possible by the lack of a basic challenge to the system itself.

The current period, however, has witnessed a slowly growing 'gray consciousness' that, combined with difficult economic times, has hastened the heightening of tension that is forecast to accompany the dramatic rise in the relative proportion of those over 65 in the period following 2011. This tension has already begun to be felt within governments allocating scarce resources among competing programs that benefit various age groups in society (e.g. health care for the aged versus education for the young). The radical structural paradigm understands this increasing conflict as the build-up of forces of internal contradiction that will lead eventually to a crisis of confrontation, perhaps along class and generational lines, in the next century forcing radical social change. Certainly the baby-boom generation has the necessary features (relative size, consciousness) to fulfill this gloomy scenario when its members reach their senior years. Radical structuralists, then, offer what appears to be a highly accurate description of the situation of the elderly over the entire span of time under consideration. The sources of the inevitable conflict and crisis predicted give rise to powerful prescriptions for

social change. Tensions are seen as derived from basic inequities in society perpetuated by a social, economic, and political order that denigrated the elderly by alienating them from the workplace, and providing usually inadequate levels of needed health, income, and housing programs often in a patronizing way. To defuse conflict, according to this paradigm, radical changes must soon be undertaken. Compulsory retirement, it follows, should be abolished. Adequate income must be guaranteed to all older people so that they can order their own affairs as they choose as much as possible. Health care and housing programs in age-integrated settings must provide adequate service to those unable to live without assistance, in facilities that are at least partly governed by the patients and residents themselves. No possible strategy to accomplish these objectives should be ruled out a priori, regardless of its lack of conventionality, or associated social and political ideologies. The radical structuralist paradigm has a high ability to prescribe future alternatives for older people, although most of these prescriptions will certainly be seen as extremely controversial. It is consequently located in the most favourable quadrant of the grid of Figure 3.9.

### 3.4.2 Elements of a Planned Paradigm

As will be obvious from the foregoing, my own judgement is that the paradigm for planning for British Columbia's aging population should most closely resemble the radical structuralist version just discussed. Its high descriptive and prescriptive abilities make this approach most likely to generate successful strategies for planning, and its radical departure from conventional alternatives appears welcome in view of the apparent chronic inability of traditional approa-

ches to offer genuine solutions to the problems of the aged. With some modifications to be discussed below, then, the radical structuralist paradigm is seen as the best upon which to base future planning efforts.

The most crucial element of this paradigm for planning is the notion that social problems such as those affecting the elderly are the result of deep-seated contradictions in society, reflecting an interaction between personal values and the ideological superstructure, that are evident in basic political and economic institutions and policies. The solution is seen to lie therefore not so much in the adaptation of the individual, as in fundamental reform of the system itself to eliminate these contradictions. Although the paradigm must be capable of an objective structural critique of existing social arrangements, this should be balanced by an appreciation of the subjective experience of aging, and a real "commitment to the 'constituency' of the aged."[67] In particular the framework must emphasize the priority of schemes to increase the awareness of the problems of an aging population, especially among the elderly, and encourage the participation of the aged themselves in the planning process. A revolution in attitudes is indeed required to make needed reforms succeed. Although the paradigm predicts eventual crisis, this is considered avoidable through the elimination of inequities perpetuated by the current system. Anything less than genuine reform, however, amounts to further tinkering and can be expected to deepen the contradictions, hastening a damaging confrontation. The planning paradigm can also be described within a systems theoretical framework that makes use of a catastrophic analogy which represents a tendency toward complete reorganization (as mentioned in

Section 3.2.3). This systems approach lends itself to a consideration of the implications for planning strategies of the various theories of social change with which Chapter 4 is concerned.

# 4. STRATEGIES

In this chapter the results of Chapter 3's analysis of the problems of an aging population outlined in Chapter 2 are used to generate a corresponding strategy for effective planning action. The term strategy is used here to denote a broad approach to policy making, comprised of numerous individual plans, and the specific programs these bring about. The background for this consideration of strategies for planning for the elderly is first described through a review of the theory and practice of social change.

## 4.1 CHANGE THEORY AND PRACTICE

This section examines social change from both an academic and administrative perspective in order to set the stage for the consideration of planning strategies to follow. After a general discussion of planning and change, public policy making is described from a systems perspective.

### 4.1.1 Planning and Change

Smith defines change as "a succession of events which produce over time a modification or replacement of particular patterns or units by other novel ones".[1] He suggests one can usefully distinguish the temporal change sequence of "calendar events, medium term 'processes' and long-term 'trends'",[2] in which individual influence is most noticeable at the micro-analytical level. Comprehensive change studies, then, must take account of the detail of specific happenings, unfolding in days, weeks, or months, sequences and clusters of events that indicate processes occurring on the order of a decade, and the trends to which they give rise over the course of centuries or more. In this way the interplay of societal forces of many kinds proceeding at different rates yields most

readily to analysis. Since philosophical and ideological developments reflecting social trends were discussed in the last chapter (see Section 3.1), the present one will concern itself with events and processes only. This approach still encompasses a wide range of potential social change as a result of the accelerating pace of change that has characterized the twentieth century.

The regulation-radical change dimension of the meta-paradigm described in the last chapter encapsulates a basic dichotomy in the imagery of change. Smith describes the pervasive images of "flow",[3] referring to the smooth, continuous, incremental change process corresponding to the sociology of regulation, and "rupture",[4] denoting the uneven, discontinuous, intrusive mechanisms corresponding to the sociology of radical change. While neither of these approaches is sufficient to explain all social change, it has been argued above that the radical change model is best suited to the task facing those charged with planning for British Columbia's aging population (see Section 3.4). Hall et al[5] have attempted to synthesize the flow and rupture ideas by postulating that the establishment of legitimacy and feasibility, each with sufficient support, are preconditions for issues to bring about policy changes. In their view, the flow model fits the period of build-up of support in each case, but the rupture model more accurately describes the subsequent point of disjunction. Using the terms of this model, it is suggested that planners should now be building support for disjunctive (radical) change in programs for the elderly, as the later discussion of strategies makes clear.

A fundamental distinction in social change theory, deriving from the transitive and intransitive constructions of the verb 'to change', is that between active and passive modes of change. Active change, also called purposive[6] or planned[7] change, is simply that in which people

intervene, while passive (or crescive[8]) change occurs independently of its own accord. Each mode of change has its own characteristic sources, channels, and forms so that

> changes can be differentiated according to whether or not human beings actively intervene in initiating the events, in providing the channels of their impact, and in furnishing novel forms for embodying the changes.[9]

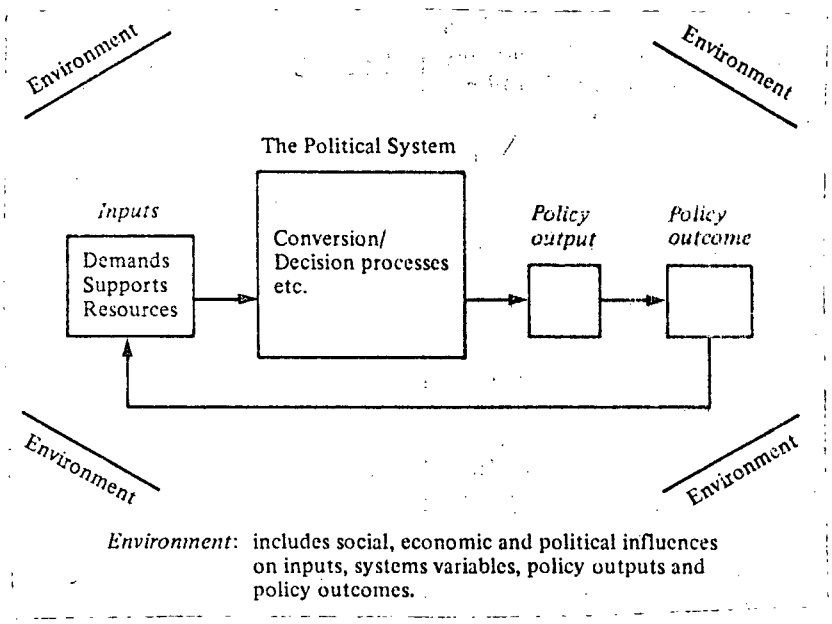
The exploration of strategies here is concerned with active change in which planners may intervene in all these areas to produce changes in public policy concerning the aged. Public policy making is a specialized variant of active social change which finds its source in governmental responses to pressing social problems, uses the political-bureaucratic process as a channel, and takes the eventual form of new policy and program initiatives. The next section explores this policy making process from a systems analytic perspective.

### 4.1.2 Public Policy Making: A Systems Perspective

Dye's definition of public policy as "whatever governments choose to do or not to do"[10] captures the basic notion, but obscures important process elements. While action by governments is certainly involved, the 'choosing' of policy alternatives is a much more complicated phenomenon than the use of that word implies, and requires careful systematic analysis. Early systems models of the policy process followed Easton's input-output approach,[11] showing the conversion as taking place within the 'black box' of the political system (see Figure 4.1). According to this view, shared by Sharkansky, Dye and others,[12] input demands, related support, and resources are transformed into policy outputs, whose impacts feed back to new inputs, all within the context of an interactive environment. Subsequently, some analysts have explored what happens within the 'black box', and have identified variables

FIGURE 4.1

SYSTEMS MODEL OF THE POLICY PROCESS



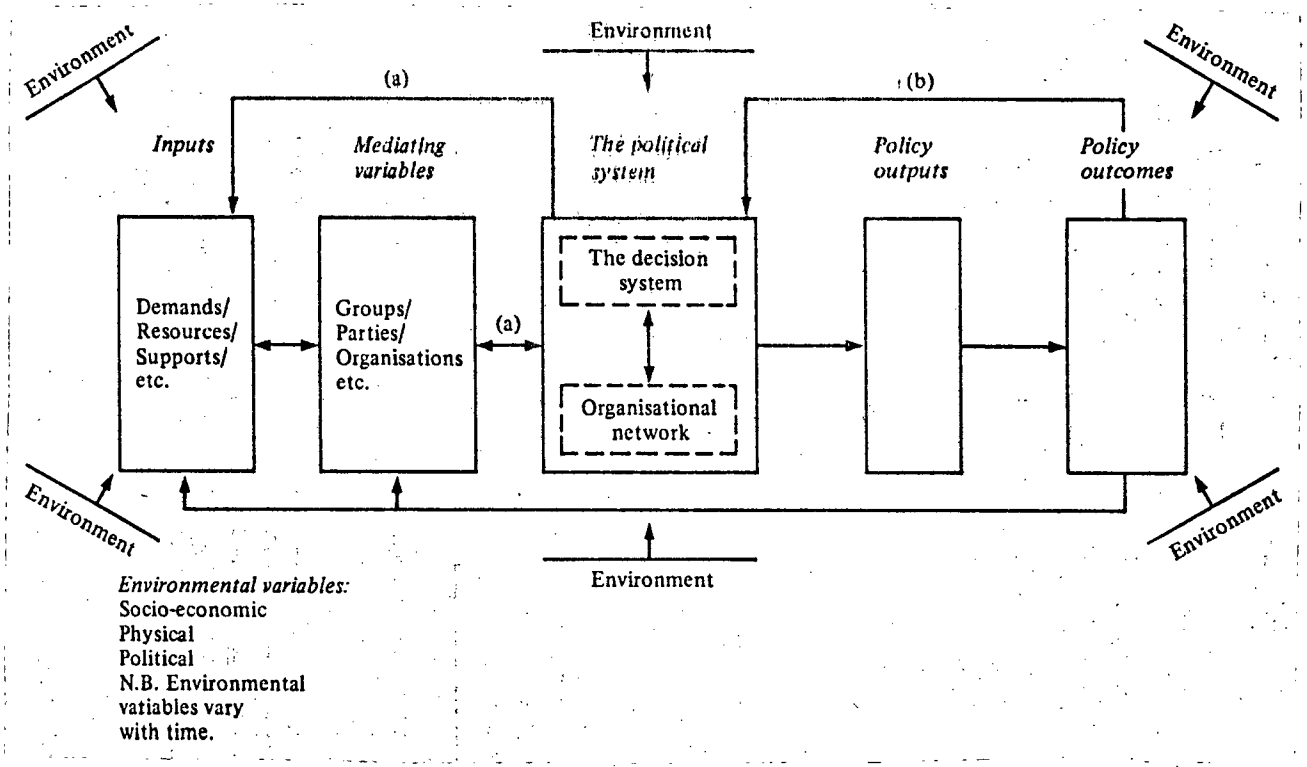

From: W.I. Jenkins, *Policy Analysis: A Political and Organizational Perspective* (London: Martin Robertson, 1978), p. 18. Reproduced by permission of the publisher.

that mediate its inputs. Figure 4.2 shows such an amended systems model depicting the political system as the interaction of decision-making and organizational elements, with groups, parties, and other organizations as mediating variables. Despite the obvious over-simplifications and other short comings of such a systems model, Jenkins argues that it "can serve at least as a useful heuristic map"[13] in the study of policy development. As has been pointed out above, the systems approach can encompass the whole range of views on the nature of society, from regulative to radical change, depending on the type of analogy employed (see Figure 3.7). Given the radical change approach embodied in the selected planning paradigm, the systems analogy appropriate here is either factional or catastrophic (depending on one's optimism about eventual outcomes), stressing the power structure and basic conflicts inherent in the policy making process. One particularly useful model that incorporates these elements with an important focus on underlying values that has been associated with "the new public administration"[14] in the US, and social administration in the UK,[15] is the "public policy flow model" of Simmons et al.[16]

This model, shown in Figure 4.3, attempts to relate values to public policy by identifying actors (significant individuals), groups, and agencies (institutional and administrative), and describing "the critical interactive processes that blend power and value in determining policy choices".[17] The model is distinctive in its appreciation of the "random, multi-channeled nature of policy coalescence"[18] as a variety of influences are seen to result in linkages and/or blockages along the policy trail that may eventually lead to a new public policy. Two important elements of the policy flow model are policy style and policy environment. Policy style refers to that distinctive manner

FIGURE 4.2

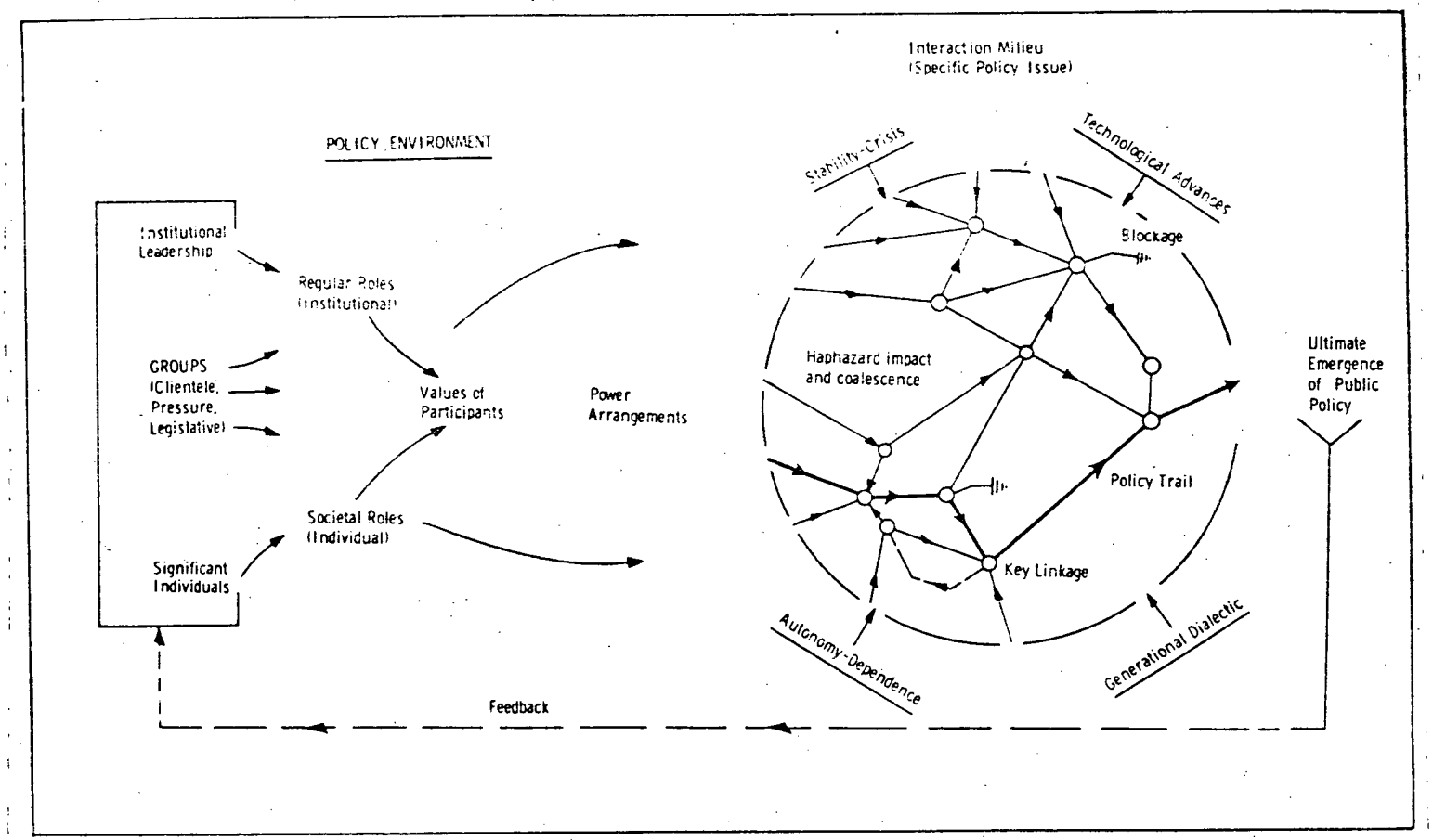
AMENDED SYSTEMS MODEL OF THE POLICY PROCESS




From: Jenkins, *Policy Analysis*, p. 22. Reproduced by permission of the publisher.

FIGURE 4.3

PUBLIC POLICY FLOW MODEL




From: Robert H. Simmons, Bruce W. Davis, Ralph J.K. Chapman, and Daniel D. Sager, "Policy Flow Analysis: A Conceptual Model for Comparative Public Policy Research", *Western Political Quarterly* 27 (Summer 1974): 467. Reproduced by permission of Robert H. Simmons.

which the behaviour of actors and groups involved in the process may acquire over the course of time, and which can be analyzed according to its communication, commitment, leadership, and group dynamics. Important actors often have preferred access to communication networks through connections established in a variety of ways, and will use these to influence policy development. The level of commitment of actors to particular policy choices may affect the decisions taken at different points depending on the role such persons play. Heads of agencies and those in formal leadership roles form a special set of actors who may profoundly affect policy choice through their personal attributes (including charisma) and interpersonal style. Individual perceptions of others' credibility and intention form the basis for formal and informal coalitions whose group dynamics and changing status hierarchies will impinge upon the policy making process.

Two of the most important factors within the policy environment are those of power and resources. Power considerations concern the structure and dynamics of authority within the policy field, and define a continuum along which involved agencies can be located as autonomous from or dependent upon the political system for bureaucratic appointment, tenure, and budgetary supervision. Other aspects of the power configuration are the nature of the affiliations agencies make with related interest groups, the existence and nature of a core professional staff, the financial arrangements for departmental activity, and the historical tradition of agency operations. All of these power arrangements may have substantial impact on the determination of values and thus the emergence of policy. A number of different environmental inputs affect the availability and nature of resources involved in the development of policy. Intersocietal inputs and technological advances

may alter perceptions of the possible, while conflict arising from the generational dialectic (the struggle among the generations) may change wide-spread values and redirect policy. The quantity and quality of technical, physical, and fiscal resources at hand will also have an obvious effect on the ability of actors to shape public policy.

Both power and resources can be affected by the conditions that prevail (or are thought to prevail) in the policy field, ranging from stability to crisis. In the words of Simmons et al.:

> The capacity of a minister, governor, professional staff, or any involved actor to introduce crises into the field may alter significantly the nature of the policy options available. The degree of criticality of crisis, the capacity to generate crisis, the kinds of responses to bring stability, the nature of stability, the integrative or destructive nature of the interaction processes, the success or failure of these integrative or destructive factors, will all have profound effects on policy choices.[19]

The incidence of the modern political-bureaucratic Machiavellianism to which this refers may well be expected to increase in the current era of progressive fiscal restraint. The challenge facing those planning for British Columbia's aging population, then, is to communicate the sense of real and impending crisis that looms over the various programs for the elderly when projected into the next century. No false crisis, this scenario seems reasonably assured (see Section 2.3.5), but there is a danger that its apparent remoteness may lull decision-makers into a false sense of security that will inhibit effective planning action. To prevent the inaction that will indeed lead to a real crisis in twenty or thirty years, strong visionary leadership is required at both the political and bureaucratic levels.

Hartle points out that the role of government extends beyond that of resolving conflicting interests in society "in such a way as to avoid the open use of force: 'the war of all against all', to use

Hobbes' phrase"[20] to that of

> Leadership by which we mean the adoption of policies that are unpopular in prospect but come to be accepted perhaps even with enthusiasm and pride, after they have proven themselves.[21]

Despite the reality of partisan and electoral concerns, Hartle makes a convincing case for the possibility of true political leadership whereby

> the rare politician is able to discern in the discoveries of a few others an insight "just slightly ahead of its time", and through a mixture of persuasion and demonstration bring it to bear on policy decisions before it has been widely recognized by voters[22].

Bureaucratic planners and policy makers play an essential role in this process by developing sound policy alternatives and bringing them to the attention of government political leaders. If support for needed policies can then be gained on a non-partisan basis, as Bainbridge has reported was the case for Long-Term Care in this province in 1975,[23] this is much to be preferred since it eases the process of policy adoption and implementation. The next section considers strategies for planning for an aging population in order to suggest a direction for the development of future policy in this regard.

## 4.2 PLANNING STRATEGIES FOR AN AGING POPULATION

Against the background of change theory and its specialized practice in public policy making, this section reviews conventional planning approaches employed in the past to design programs for the elderly and suggests a shift to a strategy of radical change for the future.

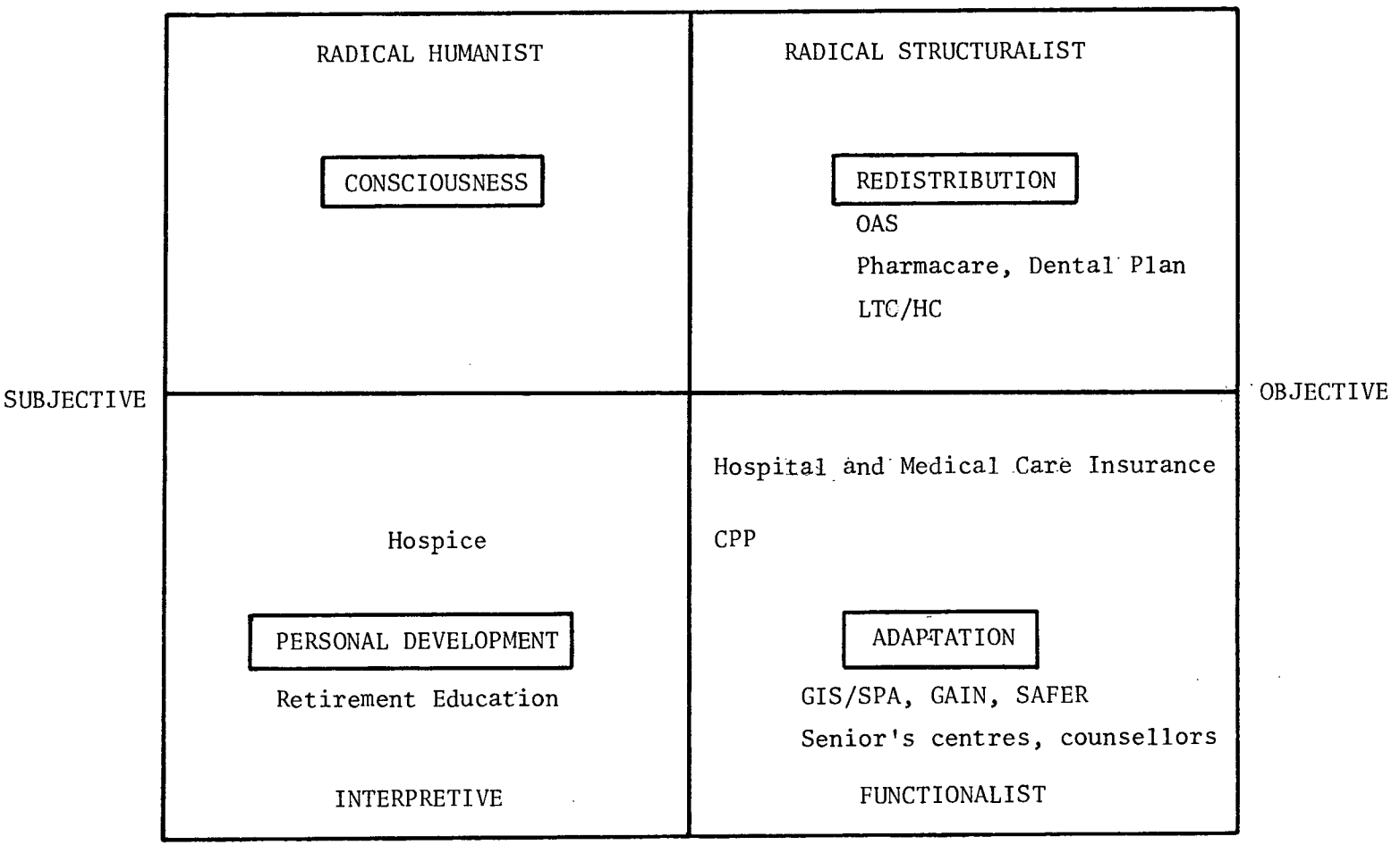
### 4.2.1 Strategies for the Elderly in Retrospect

Planning strategies for the elderly in British Columbia in the past have usually been based implicitly on social gerontological theories that emphasize a regulation orientation to society, and largely on those taking an objective approach to social science which fall into the functionalist paradigm. Functionalist planning strategies have spawned such programs as senior citizens' centres and counsellors, SAFER, GIS/SPA, GAIN, and CPP. Although effecting some redistribution, the older health programs of hospital and medical care insurance are also included in the functionalist group due to their basic adaptive orientation. These strategies are indicated in Figure 4.4 as those of 'adaptation'. Interpretive strategies have taken a subjective regulative approach that can be characterized as stressing 'personal development'. Examples of programs in this category are the hospice programs now getting underway, and various retirement education courses that are offered. A few strategies in the past have arisen from paradigms taking a radical change orientation to society. Those derived from an objective approach to social science that have been termed radical structuralist have brought about the development of programs effecting deliberate transfers of resources in cash or kind to the elderly. Examples of programs arising through such strategies of 'redistribution' are OAS, Pharmacare (Plan A), Dental Care (Plan 3), and Long-Term Care/Home Care for those 65 and over. There are few examples of programs in this province that have come about through radical humanist strategies designed to increase the 'consciousness' of older people, although a few of the more active and radical pensioners' groups may qualify in this regard, as well as some information services set up by seniors such as those funded under the federal New Horizons program

FIGURE 4.4

PLANNING STRATEGIES FOR THE ELDERLY IN RETROSPECT

STRATEGIES OF RADICAL CHANGE




STRATEGIES OF REGULATION

(which provides community grants to qualifying projects by groups of elderly citizens).

As has been discussed in Section 2.3.5, even those programs that can now be considered adequate (and these are few indeed as Section 2.2.5 points out) have little hope of meeting the needs of the swollen ranks of the elderly expected after 2011 without radical changes being effected. It seems an opportune time in 1982 to begin taking steps to ensure that the dramatic program reforms required will indeed be in place when the first group of the baby boom children enter their senior years about thirty years from now. Moreover, the current economic recession has created a climate within the public sector that is more receptive to radical change. In British Columbia the perceived fiscal crisis has certainly changed the availability of power and resources to various government agencies as the policy flow model predicted. Simmons et al. also suggest that

> It may be hypothesized that the access of political actors is greater at times of severe crisis than at times of relative and prolonged stability. In this instance the influence of the professional staff or the expert may be far greater in shaping policy.[24]

If this is so, then the current set of circumstances presents an opportunity for planners for the aging population to lobby for policy changes that are compatible with their longer term goals. The main elements of a plan to accomplish this are described in the next section.

### 4.2.2 The Elements of a Radical Plan

The development of an adequate social policy for the elderly would be greatly facilitated by the integration of the several services in various government departments that presently have some responsibility for health, income, and housing programs for the province's senior citi-

zens. An interdepartmental co-ordinating agency should therefore be established as soon as possible to work toward this end, and to act as the information nexus and monitor for ongoing research and data collection. This agency could eventually become a separate department, if and when this seemed practical, responsible for the provision and monitoring of integrated services through local community service centres which would group programs and personnel now dispersed throughout government. In this way the linkages between the health, income, and housing needs of older people could be more readily identified, and more appropriate services provided as a result. This 'one-stop-shopping' arrangement would also greatly reduce the confusion many elderly people experience when attempting to access needed services. Within this organizational framework, however, each of the three basic program areas must work toward specific policy goals.

The health program area must work closely with other health agents and institutions in the community to ensure continuous, high quality care when needed by an elderly person. As a first step, existing 'blocked beds' in acute care hospitals should be redesignated as long-term care beds (with *no* compensating acute care bed development) to mitigate the current shortage of institutional beds for the elderly, and accelerate the process of redistributing institutional resources from acute to long-term care. These beds should come under the jurisdiction of a Director of Health Care for the Elderly in each region of the province who would sit on the regional hospital's executive committee as well as managing community health care resources for the aged. In addition, a formula based on the changing population age structure should be developed to redirect budget monies to health care for older people (from general health care and education programs) with priority

allocation for home and other community support services. Whenever possible assessments and other health services should be provided by nurses and other ancillary personnel, in the older person's home setting or day hospitals with physicians paid a capitation allowance for medical supervision of a certain number of elderly people. It may also be practical to employ some physicians on salary in the local service centres for those lacking their own private doctors. The young-old (aged 65-74) in general, and other seniors in good health should be encouraged to become involved in assisting those in need in practical ways that stress self-help and disease prevention through the acceptance of personal responsibility for one's health. In addition to further humanizing health services to the elderly, these arrangements might help to put a lid on the alarming escalation in health expenditures that has occurred in the past few decades, driven, as Evans points out, not by extreme shifts in demography, but by the "numbers and types of personnel and gadgetry produced and reimbursed".[25] In turn, this cost-containment should permit resources to be redirected for use in innovative preventive health programs for the growing aging population.

The basic goal for the income program area is the assurance of adequate income to *all* elderly people, especially those who are single, and particularly single women. Although the replacement of mandatory retirement by job competence appraisals is recommended, later retirement does not diminish the need for a major reform of the income support system. The federal and provincial governments must work together to implement a unified retirement income program out of the threadbare patchwork of CPP, OAS, GIS/SPA, and GAIN programs, to include housewives along with those retiring from employment traditionally considered 'productive', and to address the needs of spouses in the neglected 60

to 65 year age range. The income such a scheme would provide should be at least equal to the highest appropriate poverty line (see Appendix 5), and might most efficiently be distributed through a tax credit system that resulted in 'negative income tax' payments to elderly people. While private retirement pension plans with early vesting, portability, and spouse's benefits are to be encouraged, public pension income programs should be viewed as providing a basic income floor for older people, with extra funds required coming from general government revenues. In addition, retirement education courses and transitional employment schemes should be expanded to play a more significant role as status diminution support programs for those anticipating retirement.

The goal for the housing program area is to ensure access to a range of alternatives from independent units in regular housing developments through various types of congregate or sheltered housing (see the description quoted below) for those who can no longer manage in their own homes, but are not in need of resident nursing care. Since congregate housing is such an obvious gap in current housing for the elderly in this province, it is worth quoting here the description of the many forms it may take offered by Kahn and Kamerman:

> Such housing arrangements may be specially planned retirement communities or housing, or multiservice facilities; they may be clusters of detached homes with shared special services and facilities or a multidwelling, high or low-rise apartment house complex, for the aged alone or in part, with similar services and facilities. They are characterized by the presence of a special physical layout and design (wide hallways and elevators and low-level kitchen equipment to permit use by people in wheelchairs ; a buzzer system to ensure constant availability of emergency help); and supportive services (warden or house manager, homemaker-home-health, meals, socialization, and recreation).[26]

Such housing could be constructed by public or private enterprise depending on their relative cost-effectiveness, and made accessible to elderly citizens through special subsidies or shelter allowances which

would reduce the monthly cost to individuals to a specified percentage of their income regardless of the total unit cost. The major building programs for the elderly that must be undertaken in the future could be stimulated by special investment arrangements that reduce or remove taxes on profits in exchange for lowered rates of interest on investment capital (that in turn could lead to lower unit building costs). Another promising alternative would be to encourage the expansion of non-profit housing co-operatives to build and maintain integrated housing developments for seniors.

In each of these program areas it is important to recognize the necessity of social supports for the elderly as bridging mechanisms for the resource supports that have emphasized above. There will always be a need for social support programs, but they perform a crucial role in taking up the slack until resource support programs are made more adequate. The priority of increasing the awareness of older people and others about the problems and prospects of aging through the various information media must also be stressed. Informed awareness is a precondition for intelligent action, and the first step to increasing the self-esteem of many of the aged who now feel unnecessary and impotent. The active participation by elderly people in planning for the aging population is essential to the eventual success of any programs developed. Only seniors themselves can bring to the planning process the sensivity to issues such as integration versus segregation of services, and the special needs of cultural minorities, that will ensure a new public program has a human face and heart. It must also be stressed that public programs themselves cannot hope to meet all the needs of all older people, and that most seniors will continue to require the involvement of families, churches, and a number of other

helping agents in innovative ways (e.g. foster grand-parenting).

The system of supportive programs for the aged just described would go a long way toward effecting the redistribution of resources to the elderly that has been argued here is required to prevent the eventual generational conflict and confrontation that would threaten the very nature of British Columbian society. Since the plan involves genuine redistribution, however, its implementation can be expected to generate determined opposition from groups now benefitting from the status quo who would stand to lose significantly as a result of the changes proposed. It is just as important to develop a strategy for the implementation of such programs as it is to have the plan itself. The final section examines the role of various planning strategies in the development of new policy initiatives, and suggests a timetable for implementation of the plan described here.

### 4.2.3 A Strategy for Implementation

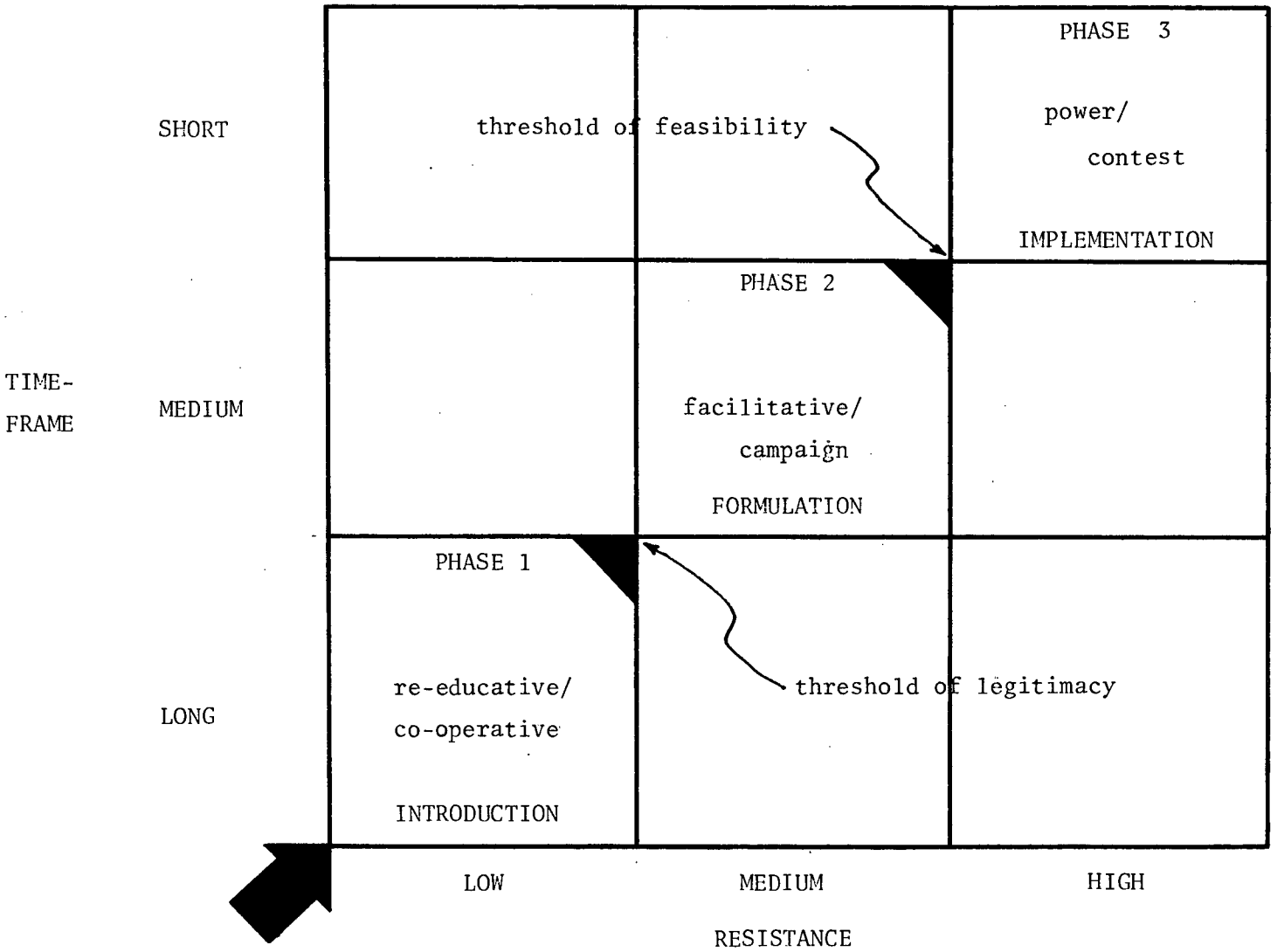
The process of implementing a plan such as that proposed in the last section requires careful strategic consideration. A strategy for implementation must successfully deal with resistance from groups which perceive adverse effects from proposed changes, while developing strong broad-based popular, political, and bureaucratic support. The objective is to enact the plan in such a manner that the entire package is in place by the time the proportion of elderly people in the population begins its dramatic climb early in the next century. It is helpful to identify a sequence of planning strategies involved in policy development and apply this to the plan for British Columbia's aging population in order to develop a workable timetable for implementation.

Warren has divided planning strategies into those of co-operation, campaign or contest reflecting low, medium and high resistance respectively.[27] Other analysts have suggested that strategies may be re-educative, facilitative or persuasive depending upon both the length of time available for pursuit of strategic objectives, and the ease of their accomplishment.[28] In fact a combination of these strategies could be employed at various phases of the development of new public policy for the aged based on the legitimacy-feasibility criteria that Hall et al. have described.[29] As Figure 4.5 shows, during the first (introduction) phase the time-frame is longest and resistance relatively low, allowing re-educative/co-operative approaches to be used. During this phase sufficient support must be garnered from those amenable to change for the new approaches to acquire social legitimacy. The level of resistance offered by dissenters, however, and decreasing time available necessitates a shift to facilitative/campaign strategies in the second (formulation) phase. The additional support evoked through these strategies moves the developing policies to the point of feasibility, and the process shifts to the power/contest strategies of the third and final (implementation) phase during which intense resistance from those most adversely affected must be overcome. At each stage policy support is increased, those remaining as non-supporters pose a more formidable obstacle to policy adoption, and the time available to continue negotiations decreases. In the final analysis, compliance with the new initiative must be assured by the imposition of appropriate binding regulations. It is hoped that the support developed during policy introduction and formulation will make the final implementation phase less contentious.

The radical structural strategy recommended here for the develop-

FIGURE 4.5

THE SEQUENCE OF PLANNING STRATEGIES IN POLICY DEVELOPMENT



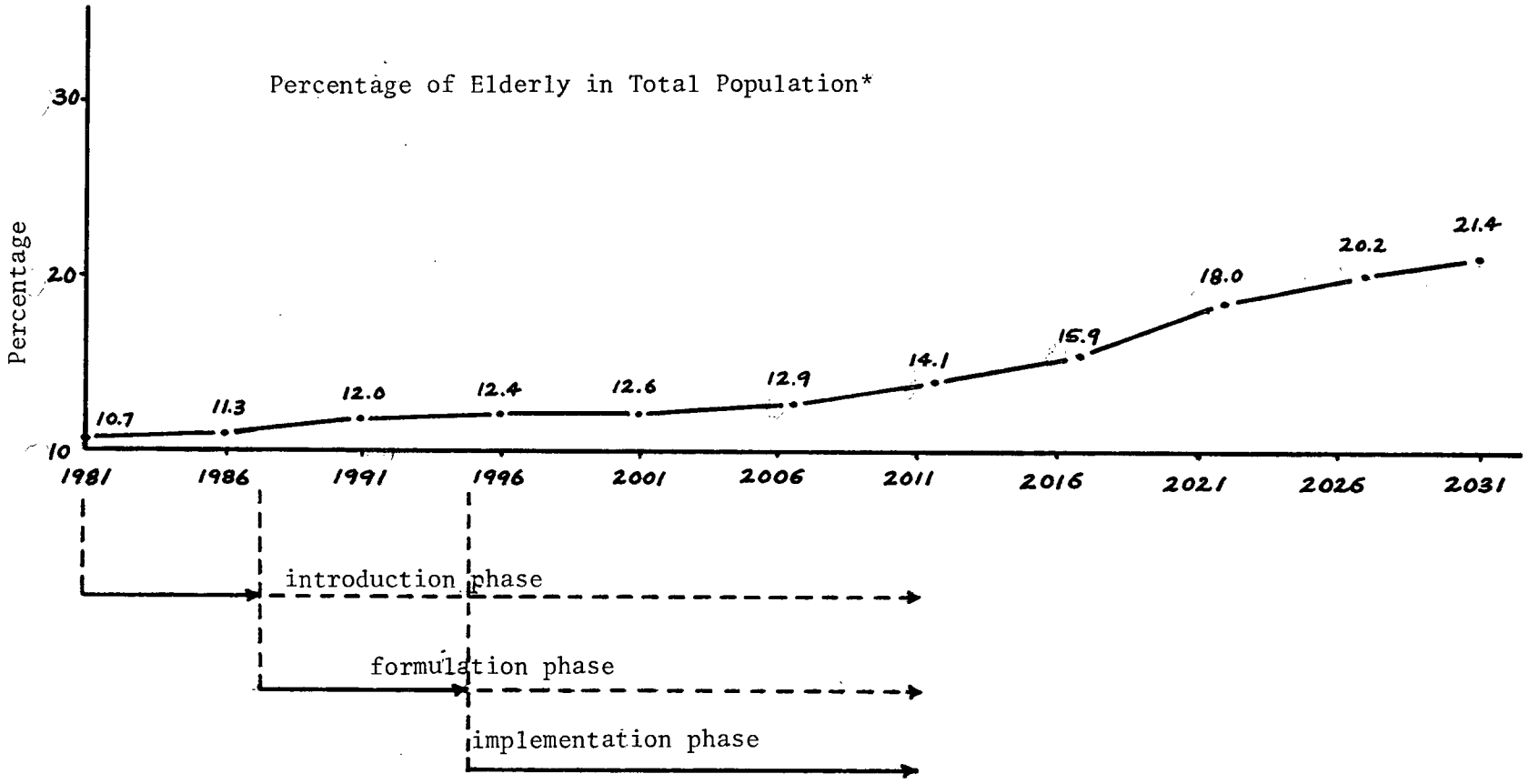
ment of policy for the elderly can be described according to the three-phase model just discussed. During the introduction phase the emphasis would be on developing a data base upon which to build future programs through research into current service utilization and effectiveness, and the projection of future needs on the basis of demographic trends. It is hoped that this paper will contribute to this process by stimulating and encouraging work of this nature in the various relevant agencies. It must be stressed that planning and research should involve the elderly and their representatives as much as possible in order to develop support and consensus, and ensure that ideas advanced have a sound basis in everyday experience. A number of other provinces such as Ontario, Saskatchewan, and Québec[30] are further along than British Columbia, having already completed preliminary reports of this nature. The introduction phase might be accelerated, and certainly the quality of its process improved by the development of a co-ordinating structure within government to act as a focal point for information exchange and planning in the ongoing policy process. It is noteworthy in this regard that Ontario has just appointed a Provincial Co-ordinator for Senior Citizens, in response to a recommendation of the report mentioned above, who is to establish

> a Seniors Secretariat designed to improve information delivery to seniors, to encourage research into issues relating to aging, and to support effective policy co-ordination on aging across ministries.[31]

The timing of planning strategies is shown in conjunction with the increasing proportion of the elderly in British Columbia in Figure 4.6. The first phase of policy development could be well underway in this province by 1987 with enough support generated for the process to cross the threshold of legitimacy (see Figure 4.5) and begin the formulation of specific program options involved in the redistribution of resources

FIGURE 4.6

A STRATEGIC TIMETABLE FOR PLANNING FOR B.C.'S AGING POPULATION*




*Data from Table 2.4

to the elderly in the key health, income, and housing areas that will guarantee the adequacy of these services in the years to come. This formulation phase might continue into the early 1990's, and involve the testing of pilot programs with federal co-operation in various regions of the province. By the mid-1990's enough information on the effectiveness of various program options should be available for province-wide (nation-wide?) policies to be implemented to ensure that the elderly are adequately served in the three basic areas mentioned. The increased support developed during the second phase should enable the policy development process to cross the threshold of feasibility (see Figure 4.5) and enter the final implementation stage. At this point essentially political decisions must be taken to overcome remaining resistance and embark on new program initiatives. These initiatives could still be phased in over the course of a decade or more since the eldest baby-boom children will not reach the age of 65 until about 2011, but it is crucial that action begin by 1996 with full implementation scheduled for 2006. Adherence to this timetable will guarantee the adoption of reforms necessary to avoid the severe social stress that can otherwise be expected to develop as the population ages rapidly in the second and third decades of the twenty-first century. In a positive sense, the implementation of such a plan would assist greatly in "adding life to years"[32] for older people who now enjoy only the sometimes dubious benefits of added years of life.

# 5. CONCLUSION

This chapter draws together the main points of the study as a whole, and lists a number of important recommendations for action by the appropriate authorities.

## 5.1 SUMMARY

Conservative estimates of British Columbia's aging population suggest that the percentage of those 65 and over in the province will almost double over the next fifty years, from about 11% to more than 21% of the total population. Although the most dramatic rise in the proportion of the elderly will take place after 2011 as the baby-boom children reach their senior years, the largest increase *among* the elderly over the next twenty years is forecast to occur in those older sub-groups (75-84, and especially 85 +) which are known to be the heaviest users of costly institutional health care services. At the same time as fixed pensions are being seriously eroded by apparently chronic inflation, rapidly escalating costs of basic commodities like food and housing are making life especially difficult for elderly people living alone, particularly the many women who have not been a regular part of the labour force. The links between an older person's health, income, and housing needs are becoming increasingly obvious amid concern that residential health care settings may face even greater demand as a result of serious inadequacies in other supportive programs. With health, income, and housing programs for the aged hard-pressed to meet current demands, the prospect of intense demographic pressures in the years to come increases the unwelcome possibility of increasing inter-generational conflict unless appropriate reforms are instituted to meet society's obligations to its senior citizens.

The example of 'older' countries like the UK that have had to cope with an aging population despite economic difficulties shows that some success is possible with long-range structural reforms in the social sector even if these are initially at variance with established political and social ideologies. The liberal utilitarian ideology that pervades Canada should not preclude the use of a radical structural approach to the problems posed by an aging population especially since past and future experience appears better explained by this paradigm than by other subjective and conventional alternatives. Such an analysis has clear implications for planning strategies that aim to achieve change through a public policy process conceived of as a comprehensive systems flow model incorporating a factional or catastrophic dynamic. In place of the previous stress on adaptation and personal development in strategies for the elderly, a radical plan to effect genuine redistribution is offered, along with a strategy to ensure its implementation over the next twenty years. The elements of this plan, and the implementation process form the basis for most of the recommendations to follow.

## 5.2 RECOMMENDATIONS

The implications of the aging of British Columbia's population are potentially explosive. It is essential that government begin now to work toward a coherent policy for the elderly that will ensure the adequacy of accessible supportive programs in the future. Unless all politicians accept this task as a high social priority, programs for the aged in this province are likely to continue to be the sometime product of partisan populist appeals, with the familiar result that seniors must negotiate a confused and confusing policy maze only to find that in many cases its eventual provisions fall short of their actual needs. Since

jurisdiction for different program elements is split among various governmental levels, there is an obvious need for co-operative action on the part of federal, provincial, and municipal officials to develop and implement workable proposals for reform. Although action on the recommendations to follow is indicated to proceed from those provincial and federal agencies most closely involved, it is expected that the consultative and co-operative process should extend to other departments of these governments, as well as the various municipalities and regional districts where appropriate. Inevitably, some important areas such as transportation and recreation have been omitted in an effort to focus attention on what are seen as the crucial supportive program areas of health, income, and housing. Finally, the reader should keep in mind that not all older people will need all public programs recommended, so that the plan is not so completely interventionist as it at first may seem to be. In fact, while most (90-100%) of the elderly would indeed benefit from reforms to pension and general health care programs, far fewer (about 50%) would be affected by changes in labour legislation, and only a small minority (5-15%) would likely be involved in housing and Long-Term Care programs. The recommendations listed below indicate steps that, in my judgement, should be taken over the next two decades to meet the challenge of planning for our aging population. In doing so we shall inevitably be planning for ourselves as well.

| POLICY AREA | | RECOMMENDATION | ACTION(provincial/*federal*) |
|---|---|---|---|
| INFORMATION AND PLANNING | 1. | British Columbia should establish an inter-departmental agency on aging at the earliest possible date with initial responsibility for co-ordinating information and planning for the elderly. | Health<br>Human Resources<br>Lands, Parks, and Housing<br>Education<br>Labour<br>Provincial Secretary and Government Services |
| | 2. | Data on the elderly should be upgraded and co-ordinated, and related research at the policy and program level encouraged. (See Appendix 11). | Health<br>Human Resources<br>Lands, Parks, and Housing<br>Finance<br>Universities, Science, and Communications<br>*Health and Welfare*<br>*Central Mortgage and Housing* |
| | 3. | The integration of major public services to elderly people in comprehensive local service delivery centres should be considered. | Health<br>Human Resources<br>Lands, Parks and Housing<br>*Health and Welfare* |
| HEALTH | 4. | To mitigate the current shortage of long-term care beds and begin institutional resource redistribution existing 'blocked beds' in acute care hospitals should be redesignated long-term care with *no* compensating acute bed development. | Health |
| | 5. | A formula reflecting changing demographic realities should be developed for the redirection of budget monies to health care for the elderly from general health and education revenues, with priority allocation for preventive, long-term care, and community support services delivered by ancillary health personnel. | Health<br>Education<br>Finance<br>*Health and Welfare* |

| | | |
|---|---|---|
| | 6. A capitation arrangement for private physicians providing care to the elderly should be considered, with some salaried doctors available in the integrated local service centres. | Health<br>Finance<br>*Health and Welfare* |
| INCOME | 7. Legislation and regulations supporting mandatory retirement at age 65 should be replaced by a system of regular job competence appraisals. | Labour<br>*Manpower, Employment and Immigration* |
| | 8. The Province should work with the federal government to establish a unified retirement income system providing an adequate pension floor for all the aged, including single women and regardless of work history, to replace the many current income support programs for the elderly (CPP, OAS, GIS, SPA, GAIN). | Human Resources<br>Labour<br>Finance<br>*Health and Welfare* |
| | 9. Private employers should be encouraged to establish or expand pension programs for workers with improved provisions for early vesting, portability, and spouse's benefits. | Labour<br>*Health and Welfare* |
| HOUSING | 10. The Province should encourage the construction of a wide range of independent and congregate housing alternatives for the elderly through the public or private sector depending on relative cost-effectiveness in relation to program goals. | Lands, Parks, and Housing<br>Finance<br>Health<br>Human Resources<br>*Central Mortgage and Housing* |
| | 11. Senior citizens should receive housing subsidies to reduce monthly costs to a specified percentage of their income. | Lands, Parks, and Housing<br>Finance |
| | 12. Innovative housing alternatives such as non-profit co-operatives should be encouraged, and programs to assist the independent elderly or the families of those dependent should be expanded. | Lands, Parks, and Housing<br>Finance<br>*Central Mortgage and Housing* |

# NOTES

## CHAPTER 1

1. Throughout the paper the terms 'the elderly', 'the aged', and 'senior citizens', and 'older people' are used interchangeably to refer to those aged 65 or over, primarily to allow some literary variety.

2. While it is far from clear that the needs of elderly people in the future will be similar to those of today's aged, it seems safe to assume that they will continue to require health care, income, and shelter *in some form*.

## CHAPTER 2

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58. Ibid., p. 295.

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# APPENDIX 1

## DETAILS OF PROGRAM CONDITIONS FOR OAS/GIS/SPA

### OLD AGE SECURITY (OAS)

Coverage

Persons aged 65 or over may qualify for either the full pension or a partial amount, depending on their residence in Canada after reaching age 18.

The full pension is payable to everyone who has resided in Canada for a total of 40 years after age 18.

There are also two alternative methods of fulfilling the residence requirements for full pension. These are available only to persons who were 25 years of age or over on July 1, 1977, and resident in Canada on that date or with some prior residence after age 18, and are as follows:

a) residence in Canada for the 10 years immediately prior to approval of the application for pension; or

b) presence in Canada, after reaching age 18 and prior to the 10 years mentioned in (a), for periods equal to three times the length of absences in the 10-year period and, in addition, residence in Canada for at least one year immediately prior to approval of the application.

Persons aged 65 or over who cannot qualify for the full pension may receive a partial pension based on the number of completed years of residence in Canada after the 18th birthday, subject to a minimum of 10 years for payment in Canada and 20 years for payment abroad. A partial monthly pension is calculated at the rate of 1/40th of the full pension for each complete year of residence in Canada after reaching age 18.

In addition to meeting the residence requirements an applicant for full or partial pension must be a Canadian citizen or legally resident in Canada on the day preceding approval of the application; an applicant who is no longer residing in Canada must have been a Canadian citizen or legally resident in Canada on the day before he ceased to reside in Canada.

Once the pension (full or partial) has been approved, it may be paid indefinitely outside of Canada if the pensioner has resided in Canada for at least 20 years after attaining age 18. Otherwise, payment may be made only for the month of departure from Canada and for six additional months, and is then suspended. If the pensioner's absence is a temporary one, payment may be resumed on his return to Canada. If, however, he has ceased to reside in Canada, payment may be resumed only when he again takes up residence.

From: Canada, Department of National Health and Welfare, *Basic Facts on Social Security Programs* (Ottawa: Health and Welfare Canada, 1981), pp. 18-22. Reproduced by permission of the publisher.

## GUARANTEED INCOME SUPPLEMENT (GIS)

OAS pensioners with no income or only a limited amount of income apart from OAS may, upon application, receive a full or partial supplement. Entitlement is normally based on the pensioner's income in the preceding year, calculated in accordance with the Income Tax Act. The maximum GIS is reduced by $1 a month for every $2 a month of other income. In the case of a married couple, each is considered to have one half of their combined income. The GIS is added to the pensioner's OAS cheque. GIS is payable abroad for only 6 months following the month of departure from Canada. In the case of a pensioner residing in Canada who is temporarily absent from the country payment may be resumed when he returns to Canada if the other conditions of eligibility are met. Where a pensioner has ceased to reside in Canada payment may be resumed only when he again takes up residence in Canada.

## SPOUSE'S ALLOWANCE (SPA)

The spouse of an OAS pensioner may be eligible for a Spouse's Allowance if that spouse is between 60 and 65 years of age and meets the OAS residence requirements. The Spouse's Allowance may be full or partial, depending on the spouse's history of residence in Canada. Once the amount based on residence has been established, it is subject to an income test on the basis of the couple's combined yearly income. As of January 1981, the maximum income level under which a Spouse's Allowance may be paid is $10,800. Where there is entitlement only to a partial allowance on the basis of residence, the maximum income level would be lower.

The maximum full monthly allowance is equal in amount to the OAS pension plus maximum GIS at the married rate. A partial allowance is made up of an amount equal to 1/40th of the OAS pension for each year of residence in Canada after age 18 (minimum 10 years) plus maximum GIS at the married rate. The Spouse's Allowance (full or partial) is reduced by $3 for every $4 of the couple's combined monthly income until the OAS equivalent or partial OAS equivalent is eliminated. After that, the GIS equivalent and the GIS of the pensioner are each reduced by $1 for every additional $4 of combined monthly income.

Spouse's Allowance is payable outside of Canada for a period of six months following the month of departure of either the recipient or the pensioner spouse and payment must then be suspended. In the case of a temporary absence, it may be resumed when the Spouse's Allowance recipient and the pensioner spouse return to Canada, provided the other conditions of eligibility are met. Where residence in Canada has ceased, payment of Spouse's Allowance may be resumed only when the couple again takes up residence in Canada.

### Extension of Spouse's Allowance Following Death of Pensioner

Effective November 1979, a spouse who is eligible for a Spouse's Allowance for the month of the pensioner's death retains eligibility for the allowance until age 65, or until remarriage. Entitlement from the month following the pensioner's death is recalculated on the basis of the surviving spouse's income only. The maximum amount is reduced by $3 a month for every $4 of the surviving spouse's monthly income until the OAS equivalent (full or partial) is eliminated; then the GIS equivalent is reduced by $1 for every additional $2 of monthly income. Annual reapplication is required as for GIS and regular Spouse's Allowance.

# APPENDIX 2

## DETAILS OF PROGRAM CONDITIONS FOR CPP/QPP

Benefits

1. Retirement Pension

The retirement pension payable is 25% of average adjusted contributory career earnings. When calculating benefits, there are provisions which allow a person to drop out a certain number of months of low or zero earnings.

2. Disability Pension

This consists of a flat rate portion and an earnings-related portion of 75% of the imputed Retirement Pension. It is payable in the case of a severe and prolonged disability, as a result of which the person is incapable regularly of pursuing any substantially gainful occupation.

3. Disabled Contributor's Child Benefit

This consists of a fixed monthly amount and is payable on behalf of an unmarried child up to the age of 18, or up to the age of 25 in the case of a student. However, in order that he be eligible, the student must attend school without interruption. If schooling is interrupted for reasons beyond his control, the benefits may continue to be paid under certain conditions.

4. Survivor's Pension

This is paid to the surviving spouse of a contributor.

A benefit consisting of a flat rate portion and 37.5% of the contributor's actual or imputed Retirement Pension is payable to:

a) a surviving spouse aged 45 - 64;
b) a surviving spouse under 45 who is disabled or has dependent children.

There is a pro-rated reduction in this benefit when the surviving spouse is between the ages of 35 and 45, is not disabled and has no dependent children. If the spouse is over 65, the benefit is equal to 60% of the contributor's Retirement Pension. This off-setting reduction is made because of the availability of the Old Age Security Pension payable at age 65.

5. Orphan's Benefits

Same as item 3.

6. Death Benefit

This is paid to the estate of the deceased contributor.

It consists of a lump-sum payment equal to 6 months' Retirement Pension up to a maximum of 10% of the YMPE for the year of death.

7. Combined Pension

Refers to a surviving spouse's pension and a retirement or disability pension paid simultaneously to the same person.

N.B. a) Eligibility for benefits other than the Retirement Pension is subject to the contributor having made contributions to the Plan for specified minimum qualifying periods.

b) Applications must be made for all benefits and approved before entitlement to the benefits exists.

From: Canada, Department of National Health and Welfare, *Basic Facts on Social Security Programs* (Ottawa: Health and Welfare Canada, 1981), pp. 6-10. Reproduced by permission of the publisher.

Coverage

Generally speaking, the Plans are an integral part of Canada's social security system, serving as the vehicle whereby millions of members of the Canadian labour force acquire and retain, during their productive years, protection for themselves and their families against loss of income due to retirement, disability or death, regardless of where their employment may take them in Canada, and under certain circumstances, outside Canada.

The Canada Pension Plan (C.P.P.) does not operate in Quebec because this province exercised its constitutional prerogative to establish a similar provincial pension plan to operate in lieu of C.P.P.

Contributions

Employees pay 1.8% of contributory earnings. In 1981, this excludes the first $1 400 of earnings and the maximum earnings on which contributions can be made is $14 700. These contributions are matched by the employer. Self-employed persons contribute 3.6% on the same earnings range. The lower limit is known as the Year's Basic Exemption (YBE), the upper limit is the Year's Maximum Pensionable Earnings (YMPE).

Effective January 1976, and at the beginning of each subsequent year, the YMPE will be increased by 12.5% until it catches up to the average earnings of Canadian workers as represented by the Industrial Composite of weekly wages and salaries published by Statistics Canada. Thereafter, the YMPE will increase annually in line with the Industrial Composite average. The YBE is fixed at 10% of the YMPE.

Division of Pension Credits

Pension credits earned by one or both spouses during their years of marriage may be divided equally between them upon marriage dissolution, that is, upon divorce or legal annulment. The spouses must have cohabited for at least three consecutive years during the marriage, and application must be made within three years of marriage dissolution. This provision applies to marriages dissolved on or after January 1, 1977, for the Quebec Pension Plan (Q.P.P.) and on or after January 1, 1978, for the Canada Pension Plan.

# APPENDIX 3

## DETAILS OF TAX EXEMPTIONS AND DEDUCTIONS

### Age exemption

If you were born before 1917, claim the age exemption of $1,980, regardless of your income. If you did not receive the Old Age Security Pension in 1981, attach a note telling why.

### Pension income deduction

Claim either $1,000 or the total amount received from all of the following, whichever is less:

(a) payments from a pension fund including lump sum payments, whatever your age,

(b) payments from a registered retirement income fund, annuity payments from a registered retirement savings plan or deferred profit sharing plan and the taxable portion of other annuities, if you were born before 1917, and

(c) payments listed in (b), if received due to the death of your spouse, whatever your age.

These amounts do not qualify:

- Old Age Security Pension, Guaranteed Income Supplement and Spouse's Allowance
- Payments from the Canada or Quebec Pension Plan
- Retiring allowances such as severance pay
- Annuity income you choose to report as interest income
- Income-averaging annuity contract payments
- Death benefits
- Pension payments transferred into a registered retirement savings plan, a registered pension plan, or an income-averaging annuity contract, and
- Lump sum withdrawals from a registered retirement savings plan.

### Deduction for blind persons or those confined to a bed or wheelchair

Claim this deduction of $1,980 if you were blind at any time in 1981. You may also claim if you were confined to a bed or wheelchair for a substantial period of time each day for at least 12 consecutive months ending in 1981. Factors such as inability to work, or receiving disability payments are not looked on as reasons for claiming this deduction.

You may not need all of this amount to reduce your taxable income to zero. In this case, your spouse or supporting person may claim the unused part.

Your supporting person is someone who claimed an "equivalent to married" or "child" exemption for you, or would have if your net income had not been over $3,270.

You may not claim this deduction if expenses for an attendant or nursing home were claimed as medical expenses.

### Eligible deductions transferred from spouse

If your spouse has no taxable income, you may claim the unused part of these deductions on your return:

- Age exemption (for persons 65 or over)
- Interest, Dividends and Capital Gains Deduction
- Pension Income Deduction
- Deduction for blind persons or persons confined to a bed or wheelchair
- Education Deduction.

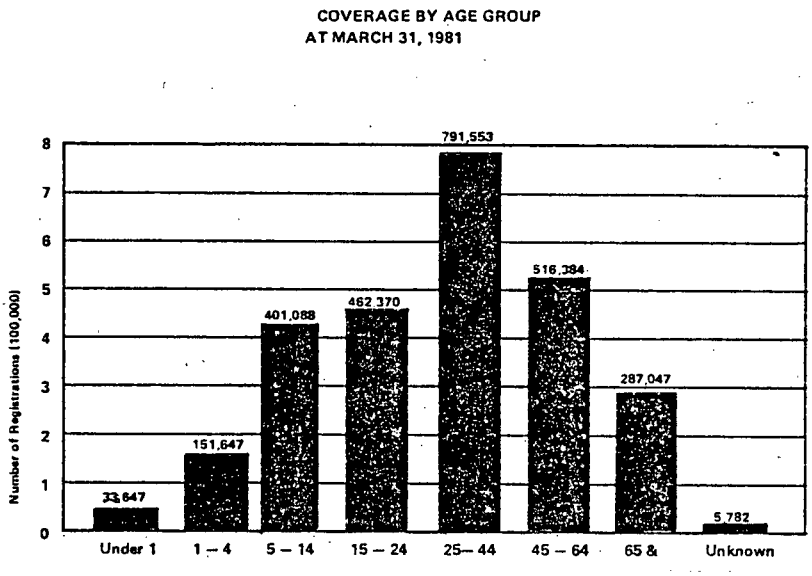
From: Canada, Department of National Revenue, *1981 General Tax Guide - For Residents of British Columbia* (Ottawa: Revenue Canada, 1980), pp. 25, 29-30. Reproduced by permission of the publisher.

# APPENDIX 4

## CURRENT UTILIZATION OF PROGRAMS FOR THE ELDERLY IN B.C.

### A. Health

### 1. Medical Services Plan

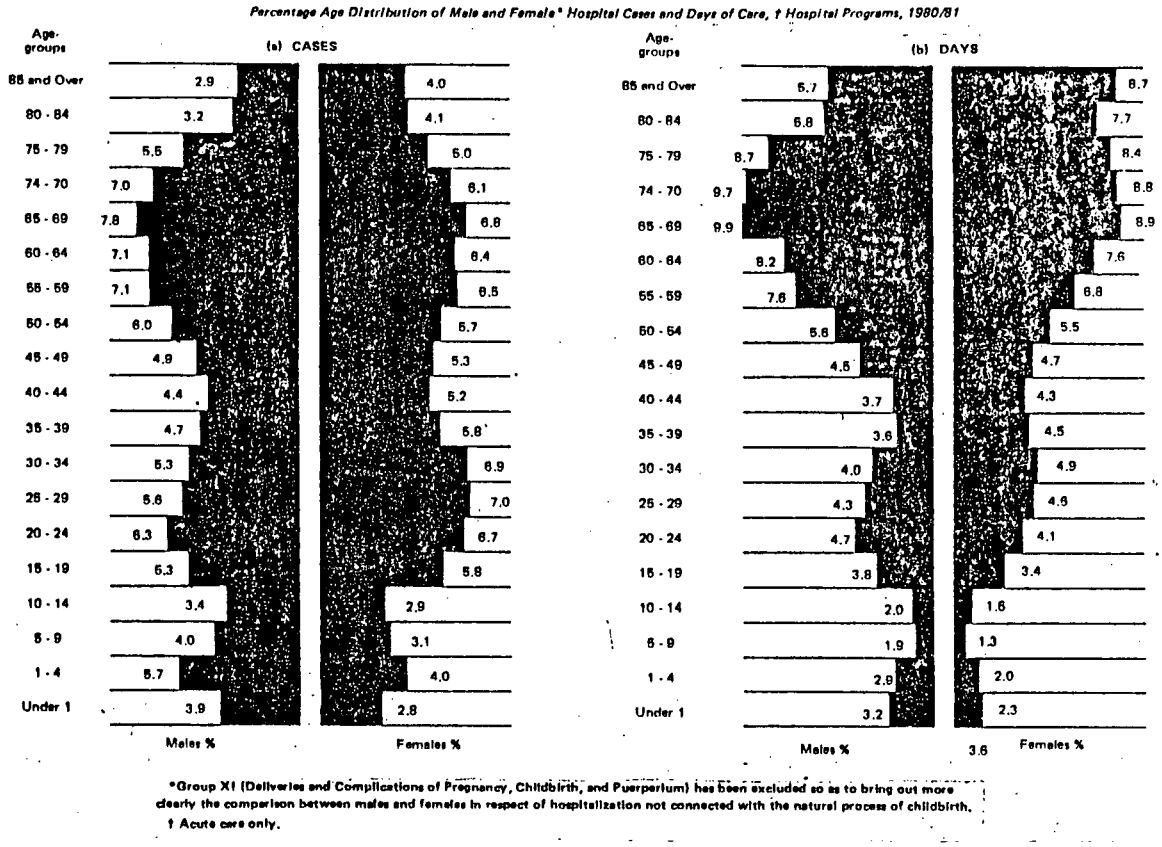



From: British Columbia, Ministry of Health, Victoria, B.C., 1982. (Mimeographed). Reproduced by permission of the publisher.

A. Health (cont.)

2. Hospital Insurance Program

a.




From: British Columbia, Ministry of Health, Victoria, B.C., 1982. (Mimeographed). Reproduced by permission of the publisher.

A. Health (cont.)

2. Hospital Insurance Program (cont.)

b.

AVERAGE LENGTH OF STAY BY AGE GROUP
AND REGIONAL HOSPITAL DISTRICT
APRIL 1, 1980 to MARCH 31, 1981

(in days)

| Regional Hospital District | Under 1 Year | 1-14 Years | 15-44 Years | 45-69 Years | 70+ Years | Total |
|---|---|---|---|---|---|---|
| Alberni-Clayoquot | 6.2 | 4.6 | 6.3 | 9.8 | 14.9 | 7.8 |
| Bulkley-Nechako | 6.9 | 4.8 | 4.9 | 8.3 | 12.9 | 6.3 |
| Capital | 6.8 | 5.4 | 6.5 | 9.8 | 15.7 | 9.7 |
| Cariboo | 8.0 | 4.9 | 5.5 | 8.6 | 12.2 | 6.8 |
| Central Coast | 6.4 | 4.3 | 4.8 | 10.6 | 8.9 | 6.5 |
| Central Fraser Valley | 7.9 | 4.2 | 5.7 | 8.9 | 13.7 | 7.7 |
| Central Kootenay | 4.8 | 3.3 | 5.2 | 8.1 | 12.3 | 7.2 |
| Central Okanagan | 6.9 | 4.0 | 6.4 | 8.9 | 12.5 | 8.3 |
| Columbia-Shuswap | 5.2 | 3.4 | 5.3 | 8.6 | 12.2 | 7.1 |
| Comox-Strathcona | 6.1 | 5.1 | 5.5 | 8.7 | 13.3 | 7.4 |
| Cowichan Valley | 7.7 | 4.4 | 5.8 | 8.6 | 14.0 | 7.8 |
| Dewdney-Alouette | 7.3 | 4.0 | 5.9 | 9.5 | 13.4 | 7.8 |
| East Kootenay | 4.6 | 3.4 | 4.9 | 8.8 | 16.1 | 7.0 |
| Fraser-Cheam | 6.6 | 4.2 | 5.3 | 9.0 | 13.2 | 7.7 |
| Fraser-Fort George | 6.6 | 4.7 | 5.5 | 9.8 | 13.4 | 6.8 |
| Greater Vancouver | 8.4 | 4.8 | 6.1 | 10.3 | 16.1 | 9.1 |
| Kitimat-Stikine | 7.1 | 4.4 | 5.4 | 8.3 | 14.3 | 6.4 |
| Kootenay Boundary | 5.0 | 5.3 | 5.6 | 9.4 | 14.1 | 8.3 |
| Mount Waddington | 9.2 | 4.4 | 4.4 | 9.1 | 13.8 | 5.9 |
| Nanaimo | 6.7 | 4.6 | 5.4 | 8.8 | 11.9 | 7.5 |
| North Okanagan | 5.8 | 3.9 | 6.3 | 8.8 | 14.2 | 8.3 |
| Okanagan-Similkameen | 6.3 | 4.4 | 5.8 | 8.4 | 11.8 | 8.1 |
| Peace River-Liard | 7.1 | 4.2 | 5.2 | 8.0 | 12.7 | 6.2 |
| Powell River | 5.6 | 4.1 | 5.4 | 9.7 | 15.2 | 8.1 |
| Skeena-Queen Charlotte | 7.3 | 4.3 | 4.8 | 10.2 | 16.2 | 6.7 |
| Squamish-Lillooet | 9.5 | 4.9 | 6.3 | 9.4 | 15.0 | 7.8 |
| Stikine | 4.0 | 6.0 | 5.1 | 6.2 | 12.5 | 5.8 |
| Sunshine Coast | 6.1 | 3.7 | 4.9 | 8.7 | 12.0 | 7.5 |
| Thompson-Nicola | 7.5 | 4.3 | 6.7 | 10.2 | 13.9 | 8.2 |
| TOTAL ACUTE | 7.3 | 4.5 | 5.8 | 9.5 | 14.7 | 8.2 |

Does not include Long Term Care in Acute Beds
Includes Acute and Free Standing Rehabilitation.

From: British Columbia, Ministry of Health, Hospital Programs, Hospital Indicators 1980/81 (Victoria: Ministry of Health, 1982), p. 26. Reproduced by permission of the publisher.

A. Health (cont.)

2. Hospital Insurance Program (concl.)

c.

EXTENDED CARE HOSPITAL SEPARATIONS, 1981

| age | # cases | (%) | # days | (%) |
|---|---|---|---|---|
| 0-14 | 64 | (2.0) | 22,404 | (1.4) |
| 15-18 | 35 | (1.1) | 8,898 | (0.5) |
| 19-24 | 40 | (1.2) | 13,468 | (0.8) |
| 25-64 | 445 | (13.8) | 197,130 | (12.1) |
| 65 | 2652 | (82.0) | 1,382,163 | (85.1) |
| total | 3236 | | 1,624,063 | |

From: British Columbia, Ministry of Health, Hospital Programs, Research Division, Victoria, B.C., 1982.

A. Health (cont.)

3. Long-Term Care Program

## UTILIZATION OF LONG-TERM CARE SERVICES BY THE 65 & OVER POPULATION

### ONGOING DATA

Utilization Rate = Percentage of the general population for a given age that is receiving the specified kind of care. Rates are based on population estimates adjusted to the particular month (by interpolating between yearly estimates).

Facility Data include clients in Hospital Programs Extended Care Units (E.C.U.s). About 2,000 cases usually are missing from the E.C.U. data due to artifacts in coding and reporting the information. Therefore utilization is somewhat underestimated, particularly for the 85 and over group which has the greatest portion of E.C.U. clients.

Homemaker Data include Adult Day Care. Home Care is not included in any of the data. Figures reflect the number of persons "currently approved for service", which varies from about 10-15% higher than figures for persons actually receiving service.

From: R. Penner, *A Review and Update of Utilization of Long-Term Care Services*, Reference Paper 7 prepared for the Ministry of Health, Victoria, B.C., November, 1981. Reproduced by permission of the author.

A. Health (cont.)

3. Long-Term Care Program (cont.)

a.

HOMEMAKER UTILIZATION RATES

| | | 1980 | | | 1981 | | |
|---|---|---|---|---|---|---|---|
| | | July 31 | Oct. 31 | Dec. 31 | March 31 | June 30 | Sept. 30 |
| 65 - 74 | B.C. | 3.66 | 3.87 | 3.87 | 4.07 | 4.16 | 3.98 |
| | C.R.D. | 2.27 | 2.20 | 2.30 | 2.37 | 2.41 | 2.37 |
| | VAN | 3.67 | 3.95 | 4.01 | 4.08 | 4.20 | 4.05 |
| | REST | 4.10 | 4.33 | 4.48 | 4.61 | 4.68 | 4.42 |
| 75 - 84 | B.C. | 10.64 | 11.28 | 11.58 | 12.02 | 12.36 | 12.27 |
| | C.R.D. | 7.27 | 7.45 | 7.81 | 8.38 | 8.45 | 8.57 |
| | VAN | 10.01 | 10.81 | 11.03 | 11.45 | 11.93 | 11.90 |
| | REST | 13.14 | 13.74 | 14.11 | 14.47 | 14.72 | 14.42 |
| 85 + | B.C. | 16.44 | 17.39 | 17.78 | 18.65 | 18.73 | 18.05 |
| | C.R.D. | 15.49 | 16.18 | 16.41 | 18.14 | 18.60 | 18.10 |
| | VAN | 14.91 | 16.21 | 16.72 | 17.24 | 17.49 | 16.91 |
| | REST | 19.63 | 20.14 | 20.45 | 21.40 | 20.94 | 20.00 |
| 65 + | B.C. | 6.92 | 7.33 | 7.52 | 7.79 | 7.95 | 7.75 |
| | C.R.D. | 5.42 | 5.53 | 5.72 | 6.15 | 6.26 | 6.22 |
| | VAN | 6.76 | 7.31 | 7.46 | 7.69 | 7.93 | 7.77 |
| | REST | 7.69 | 8.05 | 8.27 | 8.53 | 8.62 | 8.30 |

A. Health (cont.)

3. Long-Term Care Program (cont.)

b.

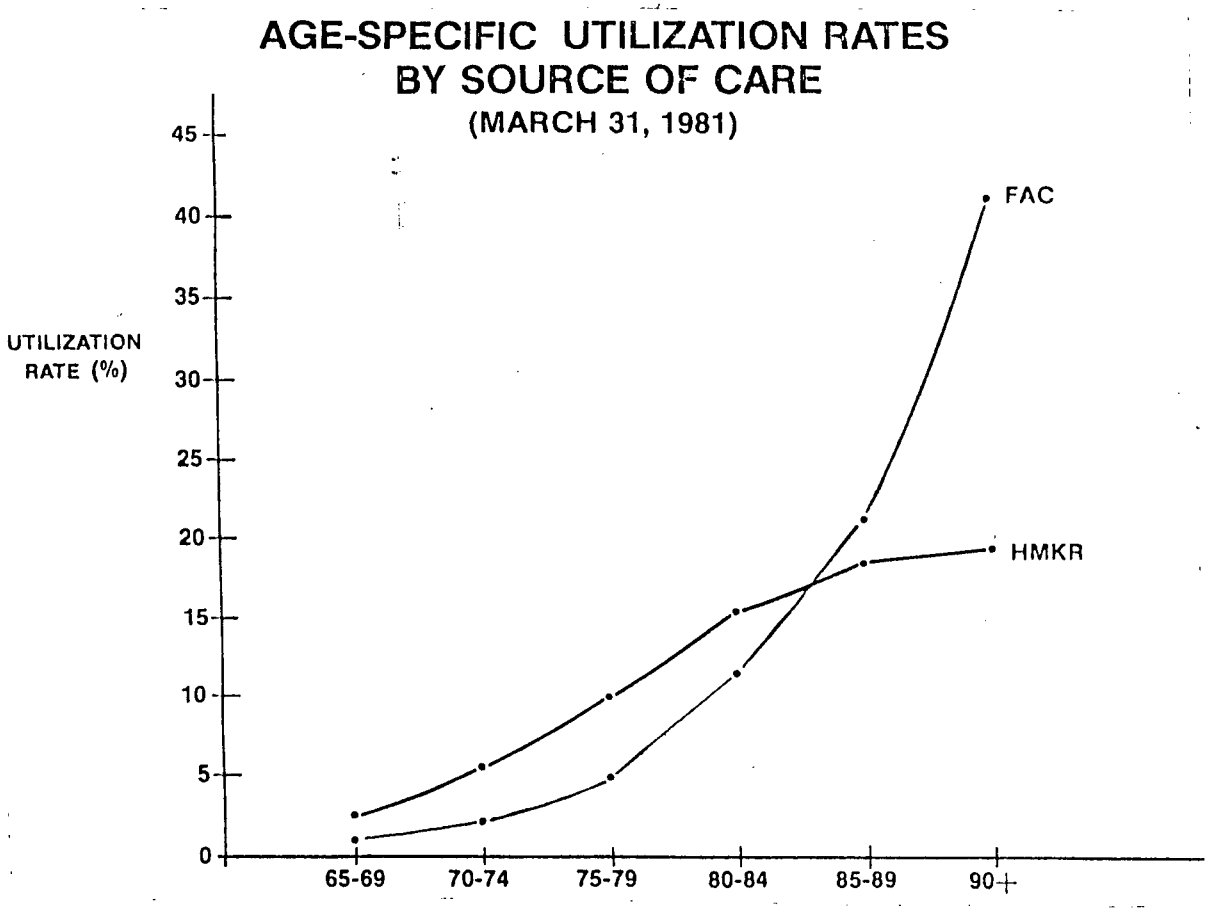
FACILITY UTILIZATION RATES

| | | 1980 | | | 1981 | | |
|---|---|---|---|---|---|---|---|
| | | July 31 | Oct.31 | Dec.31 | March 31 | June 30 | Sept.30 |
| 65 - 74 | B.C. | 1.55 | 1.56 | 1.57 | 1.58 | 1.59 | 1.63 |
| | C.R.D. | 1.24 | 1.23 | 1.24 | 1.28 | 1.25 | 1.34 |
| | VAN | 1.82 | 1.83 | 1.83 | 1.86 | 1.87 | 1.90 |
| | REST | 1.35 | 1.35 | 1.36 | 1.37 | 1.39 | 1.42 |
| 75 - 84 | B.C. | 7.27 | 7.35 | 7.43 | 7.47 | 7.66 | 7.68 |
| | C.R.D. | 5.96 | 5.90 | 6.04 | 6.11 | 6.44 | 6.41 |
| | VAN | 7.68 | 7.81 | 7.87 | 7.83 | 7.94 | 8.01 |
| | REST | 7.28 | 7.34 | 7.44 | 7.56 | 7.80 | 7.80 |
| 85 + | B.C. | 27.13 | 27.54 | 27.50 | 27.87 | 28.56 | 29.44 |
| | C.R.D. | 25.55 | 25.65 | 25.92 | 26.17 | 26.87 | 27.66 |
| | VAN | 26.91 | 27.55 | 27.18 | 27.53 | 28.13 | 29.12 |
| | REST | 28.44 | 28.65 | 29.01 | 29.46 | 30.29 | 31.05 |
| 65 + | B.C. | 5.68 | 5.75 | 5.78 | 5.84 | 5.97 | 6.09 |
| | C.R.D. | 5.61 | 5.61 | 5.68 | 5.77 | 5.95 | 6.10 |
| | VAN | 6.23 | 6.34 | 6.32 | 6.37 | 6.47 | 6.62 |
| | REST | 5.02 | 5.05 | 5.12 | 5.19 | 5.33 | 5.42 |

A. Health (cont.)

3. Long-Term Care Program (cont.)

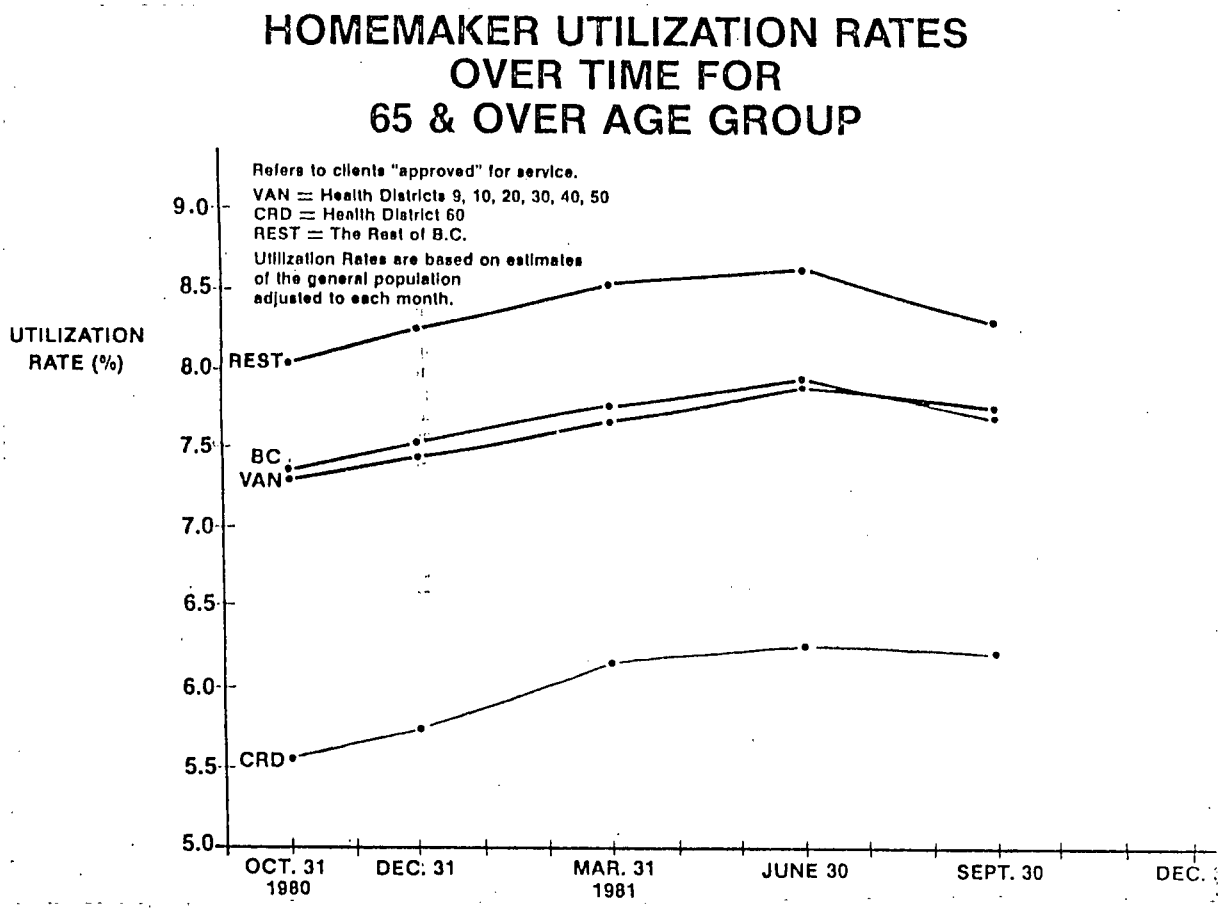
c.



A. Health (cont.)

3. Long-Term Care Program (cont.)

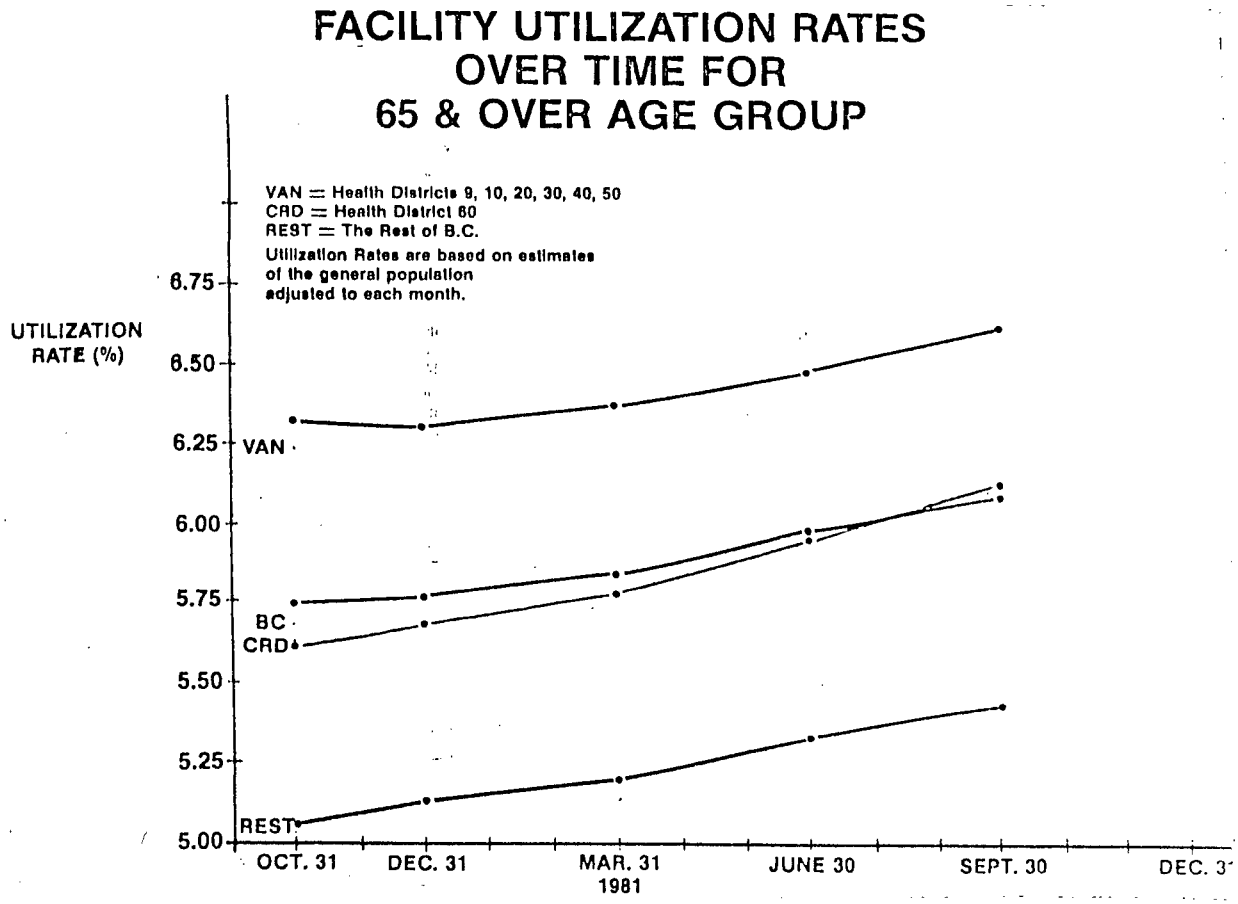
d.



A. Health (cont.)

3. Long-Term Care Program (concl.)

e.



A. Health (cont.)

4. Pharmacare

a.

B. C. PHARMACARE EXPERIENCE

1974-1980

| | FISCAL YEAR | AVERAGE Rx COST | UTILIZATION RATE | ANNUAL COST PER PERSON | TOTAL NO. ELIGIBLE (000's) | TOTAL COST ($000's) |
|---|---|---|---|---|---|---|
| PLAN "A" | 1974/75 | 4.75 | 10.8 | 51.30 | 239 | 12291 |
| | 1975/76 | 5.22 | 12.0 | 62.64 | 255 | 15959 |
| | 1976/77 | 5.90 | 10.9 | 64.35 | 249 | 16025 |
| | 1977/78 | 6.60 | 11.2 | 75.90 | 260 | 19734 |
| | 1978/79 | 7.22 | 10.8 | 77.98 | 270 | 21136 |
| | 1979/80 | 8.41 | 12.2 | 102.98 | 280 | 28836 |
| | 1980/81 | 10.73 | 10.8 | 116.81 | 292 | 34111 |
| PLAN "B" | 1976/77 | 5.90 | 52.0 | 306.80 | 17 | 5215 |
| | 1977/78 | 6.60 | 49.0 | 323.40 | 17 | 5497 |
| | 1978/79 | 6.18 | 37.4 | 231.44 | 17 | 3834 |
| | 1979/80 | 6.79 | 40.0 | 276.19 | 17 | 4695 |
| | 1980/81 | 8.11 | 37.5 | 303.94 | 17 | 5167 |
| PLAN "C" | 1974/75 | 4.75 | 8.2 | 38.95 | 100 | 3895 |
| | 1975/76 | 5.22 | 8.5 | 44.37 | 100 | 4437 |
| | 1976/77 | 5.90 | 9.3 | 55.16 | 100 | 5516 |
| | 1977/78 | 6.60 | 7.4 | 49.32 | 100 | 4932 |
| | 1978/79 | 7.22 | 8.0 | 57.58 | 100 | 5758 |
| | 1979/80 | 8.41 | 7.9 | 66.73 | 100 | 6673 |
| | 1980/81 | 9.06 | 8.9 | 80.38 | 100 | 8038 |
| SUB TOTAL FULLY PAID | 1974/75 | 4.75 | 10.3 | 49.04 | 399 | 16626 |
| | 1975/76 | 5.22 | 11.3 | 59.11 | 355 | 20987 |
| | 1976/77 | 5.90 | 12.8 | 76.10 | 366 | 27856 |
| | 1977/78 | 6.60 | 10.6 | 70.41 | 377 | 26548 |
| | 1978/79 | 6.52 | 12.2 | 79.66 | 387 | 30829 |
| | 1979/80 | 8.10 | 12.4 | 101.20 | 397 | 40204 |
| | 1980/81 | 10.15 | 11.3 | 115.68 | 409 | 47316 |
| PLAN "E" | 1977/78 | 6.60 | 18.9 | 20.00 | *100 | 2000 |
| | 1978/79 | 7.22 | 18.0 | 24.52 | *149 | 3653 |
| | 1979/80 | 8.10 | 17.8 | 35.14 | *175 | 6150 |
| | 1980/81 | 11.90 | 18.6 | 36.47 | *185 | 6785 |

* no. of claimants

From: British Columbia, Ministry of Human Resources, Pharmacare, Vancouver, B.C., 1982. (Mimeographed). Reproduced by permission of P. Tidball, Director.

A. Health (concl.)

4. Pharmacare (concl.)

b.

Percent Utilization by Plan and Therapeutic Class

| | | A | B | C | BY CLASS |
|---|---|---|---|---|---|
| 04 | Antihistamines | 67.0 | 17.0 | 16.0 | 1.1 |
| 08 | Antibiotics | 58.0 | 6.0 | 36.0 | 8.2 |
| 12 | Autonomics | 67.0 | 13.0 | 20.0 | 3.3 |
| 24 | Cardiovasculars | 82.0 | 12.0 | 6.0 | 16.8 |
| 28 | Tranquillizers | 53.0 | 16.0 | 31.0 | 17.1 |
| 40 | Diuretics | 75.0 | 18.0 | 7.0 | 9.7 |
| 48 | Cough Preparations | 76.0 | 1.0 | 23.0 | 1.3 |
| 52 | E.N.T. | 79.0 | 9.0 | 12.0 | 3.5 |
| 56 | G.I. Preparations | 46.0 | 42.0 | 12.0 | 3.0 |
| 68 | Hormones | 70.0 | 10.0 | 20.0 | 6.1 |
| 84 | Skin Preparations | 69.0 | 9.0 | 22.0 | 4.2 |
| 86 | Spasmolytics | 76.0 | 8.0 | 16.0 | 0.3 |
| 88 | Vitamins | 49.0 | 42.0 | 9.0 | 1.5 |
| 92 | Unclassified | 78.0 | 10.0 | 12.0 | 6.6 |
| 93 | Sedatives | 66.0 | 14.0 | 20.0 | 5.9 |
| 94 | Analgesics | 65.0 | 12.0 | 23.0 | 8.9 |
| 99 | Non-Drug | 75.0 | 8.0 | 17.0 | 1.1 |
| | Average % Rx | 67.0 | 14.0 | 19.0 | 100.0 |
| | By Population | 70.0 | 4.0 | 26.0 | |
| | Utilization by plan | 12.2 | 40.0 | 7.9 | 12.4 |

B. Income

1. OAS/GIS/SPA

a.

NUMBER OF OAS/GIS/SPA BENEFICIARIES
BY PROVINCE AND ACCOUNT TYPE
JUNE 1978

| PROVINCE | OAS ONLY | GIS/SPA MAXIMUM | GIS/SPA PARTIAL | TOTAL |
|---|---|---|---|---|
| Nfld. | 7 255 | 19 403 | 15 077 | 41 735 |
| P.E.I. | 3 863 | 4 200 | 6 455 | 14 518 |
| N.S. | 28 774 | 22 857 | 36 260 | 87 891 |
| N.B. | 20 794 | 18 510 | 27 096 | 66 400 |
| Que. | 194 024 | 136 314 | 201 145 | 531 483 |
| Ont. | 406 372 | 95 809 | 261 427 | 763 608 |
| Man. | 46 877 | 19 403 | 46 617 | 112 897 |
| Sask. | 47 225 | 19 204 | 41 873 | 108 302 |
| Alta. | 61 620 | 26 712 | 57 000 | 145 332 |
| B.C. | 119 923 | 40 877 | 90 902 | 251 702 |
| N.W.T. | 257 | 774 | 164 | 1 195 |
| Yukon | 285 | 233 | 127 | 645 |
| TOTAL | 937 269 | 404 296 | 784 143 | 2 125 708 |

From: Canada, Department of National Health and Welfare, *A Profile of OAS/GIS/SPA Beneficiaries for June 1978* (Ottawa: Health and Welfare Canada, pp. 24-26. Reproduced by permission of the publisher.

B. Income (cont.)

1. OAS/GIS/SPA (cont.)

b.

PERCENTAGE DISTRIBUTION
OF OAS/GIS/SPA BENEFICIARIES BY
ACCOUNT TYPE WITHIN EACH PROVINCE
JUNE 1978

| PROVINCE | OAS ONLY (%) | GIS/SPA MAXIMUM (%) | GIS/SPA PARTIAL (%) | TOTAL PERCENTAGE (%) |
|---|---|---|---|---|
| Nfld. | 17.38 | 46.49 | 36.13 | 100.00 |
| P.E.I. | 26.61 | 28.93 | 44.46 | 100.00 |
| N.S. | 32.74 | 26.01 | 41.26 | 100.00 |
| N.B. | 31.32 | 27.88 | 40.81 | 100.00 |
| Que. | 36.51 | 25.65 | 37.85 | 100.00 |
| Ont. | 53.22 | 12.55 | 34.24 | 100.00 |
| Man. | 41.52 | 17.19 | 41.29 | 100.00 |
| Sask. | 43.60 | 17.73 | 38.66 | 100.00 |
| Alta. | 42.40 | 18.38 | 39.22 | 100.00 |
| B.C. | 47.64 | 16.24 | 36.11 | 100.00 |
| N.W.T. | 21.51 | 64.77 | 13.72 | 100.00 |
| Yukon | 44.19 | 36.12 | 19.69 | 100.00 |
| TOTAL | 44.09 | 19.02 | 36.89 | 100.00 |

B. Income (cont.)

2. CPP/QPP

a.

**Contributors and Contributions**

| | CPP (1978) | QPP (1977) |
|---|---|---|
| Contributors | 7 778 929 | 2 658 174 |

Source: CPP Contributors 1978, Health and Welfare Canada.
QPP Statistical Bulletin, October 1980.

| Revenues | CPP 1979/80 | QPP Jan.-March 1979/80 |
|---|---|---|
| | (million dollars) | |
| Contributions | 2 367.5 | 1 002.3 |
| Interest | 1 220.7 | 686.5 |
| Other | 68.3 | 0.8 |
| Total | 3 656.5 | 1 689.6 |

Source: CPP Statistical Bulletin, March 1980.
QPP Annual Report, 1979-80

**Beneficiaries and Benefits**
**For the month of September 1980**

| Type | CPP Beneficiaries | CPP Benefits ($000's) | QPP Beneficiaries | QPP Benefits ($000's) |
|---|---|---|---|---|
| Retirement | 807 823 | 104 142.4 | 232 281 | 30 870.9 |
| Disability | 84 435 | 18 626.7 | 21 725 | 6 994.2 |
| Disabled Contributor's Child Benefit | 35 248 | 2 472.0 | 9 496 | 336.4 |
| Orphans' | 105 730 | 6 399.9 | 44 698 | 1 384.5 |
| Surviving Spouse | 242 022 | 26 746.9 | 92 749 | 15 567.2 |
| Death | 3 562 [3] | 3 551.7 | 1 382 [3] | 1 409.4 |
| Combined Pensions | (37 757) [1] | (6 612.0) | (7 528) [1] | -- [2] |

[1] Recipients of combined pensions are counted for each type of benefit received; thus there is some double-counting.

[2] The actual amount of the components of combined pensions has already been shown in the appropriate columns (i.e., in the Retirement, Disability and Surviving Spouse Pensions columns).

[3] Number of lump sum payments to the estate.

Source: CPP and QPP Statistical Bulletins, September 1980.

From: Canada, Department of National Health and Welfare, *Basic Facts on Social Security Programs* (Ottawa: Health and Welfare Canada. 1981). p. 10. Reproduced by permission of the publisher.

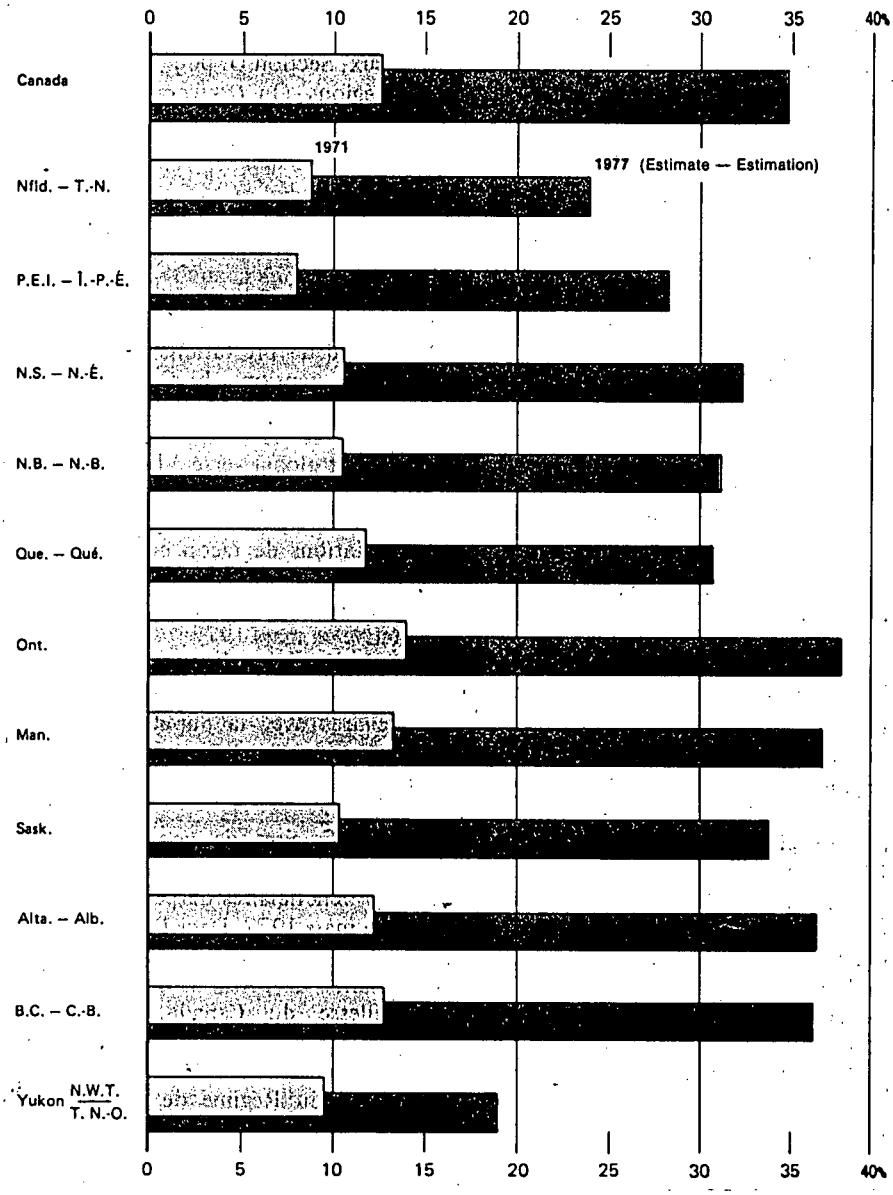
B. Income (cont.)

2. CPP/QPP (concl.)

b.

**Retirement Pensioners of Canada and Quebec Pension Plans as Percentage of Population 65 and Over, Canada and Provinces, 1971 and 1977**

**Bénéficiaires de pensions de retraite des Régimes de pensions du Canada et de rentes du Québec en pourcentage de la population âgée de 65 ans et plus, Canada et provinces, 1971 et 1977**




From: Canada, Statistics Canada, *Societal Security National Programs 1978* (Ottawa: Statistics Canada, 1978), p. 402. Reproduced by permission of the Minister of Supply and Services Canada.

B. Income (concl.)

3. GAIN Seniors Supplement

GAIN SENIORS SUPPLEMENT UTILIZATION

| Year | Recipients as of 31 December | Total Annual Program Cost $ |
|---|---|---|
| 1980 | 67,830 | 25,880,740 |
| 79 | 75,253 | 28,723,195 |
| 78 | 81,996 | 31,877,781 |
| 77 | 92,506 | 35,962,866 |
| 76 | 97,198 | 37,324,860 |

From: British Columbia, Ministry of Human Resources, Annual Report 1980 (Victoria: Queen's Printer, 1981), pp. 41-42.

APPENDIX 5

COMPARISON OF STATISTICS CANADA, CCSD AND SENATE COMMITTEE POVERTY LINES, 1981 ESTIMATES

| Family Size | Statistics Canada range | Statistics Canada mid-range | CCSD | Senate Committee |
|---|---|---|---|---|
| 1 | $ 4,739- 6,521 | $ 5,928 | $ 6,214 | $ 6,960 |
| 2 | 6,877- 9,451 | 8,595 | 10,357 | 11,600 |
| 3 | 8,773-12,059 | 11,295 | 12,429 | 13,920 |
| 4 | 10,429-14,344 | 13,037 | 14,500 | 16,240 |
| 5 | 11,663-16,034 | 14,576 | 16,571 | 18,560 |
| 6 | 12,799-17,602 | 16,001 | 18,643 | 20,880 |
| 7 or more | 14,034-19,300 | 17,544 | 20,714 | 23,200 |

From: Canada, Department of National Health and Welfare, National Council of Welfare, *Measuring Poverty: 1981 Poverty Lines* (Ottawa: National Council of Welfare, 1981), p. 4. Reproduced by permission of the publisher.

APPENDIX 6

# Alternative Population and Labour Force Projections: The Underlying Assumptions

The size and composition of Canada's future population will depend on the rates of fertility, mortality, and immigration. The higher the birth rate, life expectancy, and net immigration, the larger the population will be. Because it is impossible to predict with certainty the future levels of these variables, demographers often base their population and labour force projections on a variety of assumed levels. For each variable, usually three levels are assumed: the high, medium, and low.

This is the procedure followed in the projections that have been prepared for the Council.[1] The demographic and labour participation assumptions used are presented in Table C-1. The levels assumed are based on past experience and/or likely trends. Thus, the high fertility level assumes a return to the high birth rates of the postwar baby boom. The medium level postulates that the birth rates of the early seventies would prevail, while the low level assumes a further decline in birth rates from the present level. As for life expectancy, no drastic changes are expected as the decline in death rates has recently leveled off. Thus, the assumed increases in life expectancy vary from a slight rise in the low projection to a moderate improvement in the high one. In the case of immigration, it is assumed that there would be 140,000 net immigrants annually in the high projection, 80,000 in the medium, and 20,000 in the low.

Some twenty population projections have been prepared on the basis of these assumptions about future fertility and net immigration rates, and life expectancy. Eleven of these, identified as P-01 to P-11, are shown below in Table C-2. The assumptions underlying them are as follows:

P-01: "Medium" projection: medium fertility, medium life expectancy, and medium net immigration.

P-02: High fertility; otherwise the same as P-01.

P-03: Low life expectancy; otherwise the same as P-01.

P-04: High net immigration; otherwise the same as P-01.

P-05: Low fertility; otherwise the same as P-01.

P-06: High life expectancy; otherwise the same as P-01.

P-07: Low net immigration; otherwise the same as P-01.

P-08: "High growth" projection: high fertility, high life expectancy, and high net immigration.

P-09: "Low growth" projection: low fertility, low life expectancy, and low net immigration.

P-10: "Old population" projection: low fertility, high life expectancy, and medium net immigration.

P-11: "Young population" projection: high fertility, low life expectancy, and medium net immigration.

Table C-2 indicates a population of just over 38 million in the year 2031 under the "medium" projection (P-01). Under certain extreme assumptions, the population might reach 63 million in that year as in the "high" projection (P-08), or only 24 million as in the "low" projection (P-09).

Table C-3 shows that the proportion of persons 65 and over in the total population will double under the "medium" projection (P-01), from about 9 per cent to 18 per cent by 2031. On the other hand, it will go to almost 25 per cent under the "low population" projection (P-09). The proportion of old people would rise slightly to 13 per cent under the "high population" projection (P-08).

The labour force participation assumptions (Table C-4) are specified separately for men and

From: Economic Council of Canada, *One In Three: Pensions for Canadians to 2030*, (Ottawa: Queen's Printer, 1979), pp. 125-127. Reproduced by permission of the author.

women, and 1981 and 1991 are chosen as target years in which the assumed changes would be achieved. The 1991 participation rates are similar to the 1981 rates for men under 55, but lower for those 55 and over, to allow for the continuation of the trend towards earlier retirement. For men aged between 25 and 44 the assumed rates are virtually the same as the actual 1976 rates. For other age groups, the assumed changes are rather small. Much larger changes are assumed for women. This is especially true of women aged 20 to 54, for whom higher participation rates are specified in 1981 and with further increases occurring by 1991. For women under 20 and over 65, a slight decline in participation is expected.

Combining each of three alternative levels of labour force participation rates with various population projections produces a large number of labour force projections. Three of these — referred to in this report as high, medium, and low — are shown in Table C-5 (there are twelve more in the background study). The underlying assumptions are the following:

L-01: "Medium" projection: medium fertility, medium life expectancy, medium net immigration, and medium labour force participation rates.

L-08: "High" projection: high fertility, high life expectancy, high net immigration, and medium labour force participation rates.

L-09: "Low" projection: low fertility, low life expectancy, low net immigration, and medium labour force participation rates.

Under the "medium" projection, Canada would have a labour force of just over 17 million by 2031. Over 39 million people would be in the labour force under the "high" projection, but only just under 11 million by that time under the "low" projection.

TABLE C-1

DEMOGRAPHIC ASSUMPTIONS OF ALTERNATIVE POPULATION GROWTH PROJECTIONS, CANADA, 1976 TO 2051

| | Population growth projections | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | High | | | | | Medium | | | | | Low | | | | |
| | | Life expectancy | | Immigration[2] | | | Life expectancy | | Immigration[2] | | | Life expectancy | | Immigration[2] | |
| | Fertility[1] | Men | Women | Gross | Net | Fertility[1] | Men | Women | Gross | Net | Fertility[1] | Men | Women | Gross | Net |
| | | (Years) | | (Thousands) | | | (Years) | | (Thousands) | | | (Years) | | (Thousands) | |
| 1976 | 2,102 | 70.1 | 77.9 | 172 | 131 | 1,923 | 69.8 | 77.4 | 172 | 131 | 1,803 | 69.6 | 76.9 | 172 | 131 |
| 1981 | 2,650 | 70.8 | 79.5 | 171 | 131 | 2,024 | 70.3 | 78.4 | 120 | 80 | 1,607 | 69.8 | 77.4 | 69 | 29 |
| 1986 | 2,979 | 71.5 | 81.3 | 180 | 140 | 2,085 | 70.8 | 79.5 | 120 | 80 | 1,489 | 70.1 | 77.9 | 60 | 20 |
| 1991 | 2,979 | 72.3 | 83.3 | 180 | 140 | 2,085 | 71.3 | 80.7 | 120 | 80 | 1,489 | 70.3 | 78.4 | 60 | 20 |
| 2001 | 2,979 | 72.7 | 84.3 | 180 | 140 | 2,085 | 71.6 | 81.5 | 120 | 80 | 1,489 | 70.5 | 78.9 | 60 | 20 |
| 2011 | 2,979 | 73.0 | 85.3 | 180 | 140 | 2,085 | 71.9 | 82.3 | 120 | 80 | 1,489 | 70.7 | 79.3 | 60 | 20 |
| 2021 | 2,979 | 73.0 | 85.3 | 180 | 140 | 2,085 | 71.9 | 82.3 | 120 | 80 | 1,489 | 70.7 | 79.3 | 60 | 20 |
| 2031 | 2,979 | 73.0 | 85.3 | 180 | 140 | 2,085 | 71.9 | 82.3 | 120 | 80 | 1,489 | 70.7 | 79.3 | 60 | 20 |
| 2041 | 2,979 | 73.0 | 85.3 | 180 | 140 | 2,085 | 71.9 | 82.3 | 120 | 80 | 1,489 | 70.7 | 79.3 | 60 | 20 |
| 2051 | 2,979 | 73.0 | 85.3 | 180 | 140 | 2,085 | 71.9 | 82.3 | 120 | 80 | 1,489 | 70.7 | 79.3 | 60 | 20 |

[1]Total fertility rate per 1,000 women of child-bearing age.

[2]The difference (about 40,000) between gross and net immigration represents emigration.

SOURCE F. Denton, C. Feaver, and B. Spencer, "The Future Population and Labour Force of Canada: Projections to the Year 2051," a background study prepared for the Economic Council of Canada, 1979.

PROJECTED POPULATION, CANADA, 1976 TO 2051

| | Population growth projections | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | P-01 | P-02 | P-03 | P-04 | P-05 | P-06 | P-07 | P-08 | P-09 | P-10 | P-11 |
| | (Thousands) | | | | | | | | | | |
| 1976 | 22,993 | 22,993 | 22,993 | 22,993 | 22,993 | 22,993 | 22,993 | 22,993 | 22,993 | 22,993 | 22,993 |
| 1981 | 24,561 | 24,929 | 24,536 | 24,681 | 24,314 | 24,586 | 24,441 | 25,076 | 24,171 | 24,338 | 24,904 |
| 1986 | 26,351 | 27,624 | 26,278 | 26,810 | 25,499 | 26,426 | 25,892 | 28,181 | 24,982 | 25,572 | 27,546 |
| 1991 | 28,099 | 30,367 | 27,955 | 28,933 | 26,582 | 28,248 | 27,265 | 31,415 | 25,648 | 26,724 | 30,213 |
| 1996 | 29,626 | 32,841 | 29,399 | 30,858 | 27,478 | 29,861 | 28,393 | 34,433 | 26,103 | 27,702 | 32,597 |
| 2001 | 30,966 | 35,222 | 30,655 | 32,616 | 28,169 | 31,288 | 29,317 | 37,389 | 26,341 | 28,473 | 34,884 |
| 2006 | 32,289 | 37,980 | 31,887 | 34,374 | 28,698 | 32,699 | 30,203 | 40,768 | 26,406 | 29,083 | 37,536 |
| 2011 | 33,662 | 41,298 | 33,163 | 36,207 | 29,086 | 34,165 | 31,118 | 44,774 | 26,319 | 29,553 | 40,731 |
| 2016 | 34,992 | 44,892 | 34,394 | 38,019 | 29,314 | 35,588 | 31,966 | 49,121 | 26,071 | 29,859 | 44,192 |
| 2021 | 36,162 | 48,452 | 35,466 | 39,683 | 29,350 | 36,848 | 32,640 | 53,487 | 25,640 | 29,969 | 47,614 |
| 2026 | 37,152 | 52,013 | 36,355 | 41,175 | 29,185 | 37,933 | 33,129 | 57,906 | 25,015 | 29,879 | 51,025 |
| 2031 | 38,014 | 55,848 | 37,109 | 42,541 | 28,819 | 38,896 | 33,487 | 62,661 | 24,204 | 29,592 | 54,690 |
| 2036 | 38,796 | 60,143 | 37,784 | 43,828 | 28,269 | 39,782 | 33,763 | 67,949 | 23,233 | 29,116 | 58,796 |
| 2041 | 39,510 | 64,831 | 38,402 | 45,048 | 27,570 | 40,592 | 33,973 | 73,697 | 22,153 | 28,478 | 63,285 |
| 2046 | 40,156 | 69,753 | 38,970 | 46,195 | 26,778 | 41,312 | 34,116 | 79,735 | 21,027 | 27,719 | 68,006 |
| 2051 | 40,758 | 74,908 | 39,512 | 47,295 | 25,955 | 41,967 | 34,221 | 86,059 | 19,915 | 26,900 | 72,955 |

SOURCE F. Denton, C. Feaver, and B. Spencer, "The Future Population and Labour Force of Canada: Projections to the Year 2051," a background study prepared for the Economic Council of Canada, 1979.

## PROJECTED PERCENTAGES OF POPULATION AGED 65 AND OVER, CANADA, 1976 TO 2051

| | Population growth projections | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | P-01 | P-02 | P-03 | P-04 | P-05 | P-06 | P-07 | P-08 | P-09 | P-10 | P-11 |
| | (Per cent) | | | | | | | | | | |
| 1976 | 8.7 | 8.7 | 8.7 | 8.7 | 8.7 | 8.7 | 8.7 | 8.7 | 8.7 | 8.7 | 8.7 |
| 1981 | 9.4 | 9.3 | 9.4 | 9.4 | 9.5 | 9.5 | 9.4 | 9.3 | 9.5 | 9.6 | 9.2 |
| 1986 | 10.0 | 9.5 | 9.8 | 9.8 | 10.3 | 10.1 | 10.1 | 9.5 | 10.3 | 10.4 | 9.4 |
| 1991 | 10.7 | 9.9 | 10.5 | 10.5 | 11.3 | 11.0 | 10.9 | 9.9 | 11.3 | 11.6 | 9.7 |
| 1996 | 11.2 | 10.1 | 10.9 | 10.9 | 12.1 | 11.6 | 11.6 | 10.2 | 12.1 | 12.5 | 9.8 |
| 2001 | 11.5 | 10.1 | 11.1 | 11.1 | 12.7 | 12.0 | 11.9 | 10.2 | 12.6 | 13.2 | 9.7 |
| 2006 | 11.7 | 9.9 | 11.2 | 11.2 | 13.2 | 12.3 | 12.2 | 10.0 | 13.2 | 13.8 | 9.5 |
| 2011 | 12.4 | 10.1 | 11.8 | 11.9 | 14.4 | 13.1 | 13.1 | 10.2 | 14.5 | 15.2 | 9.6 |
| 2016 | 13.9 | 10.8 | 13.2 | 13.2 | 16.6 | 14.6 | 14.7 | 10.9 | 16.8 | 17.4 | 10.2 |
| 2021 | 15.4 | 11.5 | 14.7 | 14.7 | 19.1 | 16.2 | 16.4 | 11.6 | 19.5 | 20.0 | 10.9 |
| 2026 | 17.2 | 12.3 | 16.4 | 16.4 | 21.9 | 18.0 | 18.2 | 12.4 | 22.4 | 22.9 | 11.6 |
| 2031 | 18.3 | 12.4 | 17.4 | 17.5 | 24.2 | 19.2 | 19.3 | 12.7 | 24.8 | 25.3 | 11.8 |
| 2036 | 18.2 | 11.7 | 17.2 | 17.4 | 25.0 | 19.2 | 19.2 | 12.1 | 25.7 | 26.3 | 11.0 |
| 2041 | 17.5 | 10.7 | 16.5 | 16.9 | 25.2 | 18.6 | 18.4 | 11.2 | 25.8 | 26.6 | 10.0 |
| 2046 | 17.3 | 10.4 | 16.3 | 16.7 | 25.2 | 18.4 | 18.2 | 11.0 | 25.8 | 26.7 | 9.8 |
| 2051 | 17.6 | 10.9 | 16.6 | 17.0 | 25.2 | 18.7 | 18.5 | 11.4 | 25.8 | 26.7 | 10.3 |

SOURCE F. Denton, C. Feaver, and B. Spencer, "The Future Population and Labour Force of Canada: Projections to the Year 2051," a background study prepared for the Economic Council of Canada, 1979.

# APPENDIX 7

## ASSUMPTIONS UNDERLYING BRITISH COLUMBIA POPULATION PROJECTION 10/80

### I. Introduction

British Columbia Population Projection 10/80 provides an informative description of the likely age-sex population structure for the province of British Columbia to the year 2001. The projection results from the application of a Component Cohort-Survival population model to assumptions dealing with fertility, mortality and migration selected by the Bureau as the most likely future course of events for the Province.

As noted above, the methodology underlying Projection 10/80 is a Component Cohort-Survival approach. This method requires separate projections of each of the components of population change, namely fertility, mortality and net migration. With this information, and with a base year age specific estimate of population, a projection for each subsequent year is made by promoting each age group in the preceeding year to the next higher age group, while at the same time taking into account the effects of net-migration, deaths and/or births.

Tables 1 through 4 on the proceeding pages contain the projected age-sex specific populations for British Columbia. This is followed by a brief description of the principal assumptions underlying Projection 10/80. Also available separately is a brief summary of some of the major demographic implications resulting from the projection.

From: Central Statistics Bureau, Population Projection 10/80, pp. i-v.
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## II. Projection Assumptions

To follow is a brief overview of the procedures and assumptions underlying Projection 10/80.

BASE POPULATION:

The base population adopted by the projection was Statistics Canada's preliminary estimated provincial population by sex and single year of age for June 1, 1979.

FERTILITY PROJECTIONS:

The projections of births for the Province are based on the prior projections of three fertility indices.

-Total Fertility Rate (TFR)

This is the sum of the age-specific fertility rates for females aged 15 to 49. The TFR represents the average number of births that would occur to a woman during her reproductive years, and is computed from data at a given point in time. The current Total Fertility Rate for British Columbia is in the neighbourhood of 1.7, down from over 2.25 in 1970 and over 3.5 in 1960.

-Mean and Modal Ages of Fertility

These are summary measures of the mothers' age at the time of birth.

The three indices are combined using Romaniuk's three parameter model to produce a set of age specific fertility rates. These rates in turn are used to compute the total number of projected births (for details of Romaniuk's model see; Technical Report on Population Projections for Canada and the province, Statistics Canada, July 1975, Catalogue 91-516: p. 39-48).

The historical and projected TFR for British Columbia is given in Figure 1. The projected values for the years 1979 through to 2001 result from averaging the high and low fertility assumptions (I and II) used by Statistics Canada (see; Population Projections for Canada and the Province, 1976-2001, Statistics Canada, February 1979, Catalogue 91-520: p. 15-18). The mean and modal ages of fertility are assumed to be constant at the 1976 level of 26.2 and 25 years respectively.

As can be seen in Figure 1 the total fertility rate is assumed to arrest its decline of the 60's and early 70's, and to rise gradually toward a level of 1.82 births per woman by 1991, remaining stable thereafter.

Once projections of the age specific fertility rates are made through the Romaniuk model, projections of total births result from applying these rates to the projected female population aged 15-49.

MORTALITY PROJECTIONS:

The projected number of deaths for British Columbia is based on the 1981 estimated age-sex specific death rates for the province. These projected age-sex specific death rates are converted into life table survival ratios, which are shown in Figure 2.

It is assumed that the life expectancy at birth (a summary of the age-specific death rates) will remain constant at the 1981 level throughout the projection years. This corresponds to an expected life span from birth of 71.13 years for males (1971: 69.85, 1976: 70.01) and 79.12 year for females (1971: 76.69, 1976: 77.50).

MIGRATION PROJECTIONS:

Separate projections were made for British Columbia net interprovincial migration, emmigration and immigration. It should be noted that the migration projections adopted are intended to capture only the general trends expected over the next 20 years, and consequently may not fully reflect any "local" fluctuations that may occur from year to year.

(i) Net interprovincial migration

The historical and projected net movement to/from the Province from/to the rest of Canada is shower in Figure 3. The net inflow of persons to British Columbia from the rest of Canada is expected to decline gradually from the 1979/80 level of almost 40,000 to the historically high level of 27,000 persons annually by 1987/88, remain constant thereafter.

(ii) Immigration

Immigration to British Columbia, as seen in Figure 4, is projected to remain constant at a 1979/80 level of 21,000 persons annually until 1983/84, then increasing to a level of 24,500 thereafter. Because immigration is largely determined by government policy, only general levels over spans of several years have been identified.

(iii) Emmigration

Emmigration has fluctuated within fairly narrow limits over the past decade, with only a slight upwards trend. Emmigration from British Columbia, as seen in Figure 4, is projected to remain constant at a 1979/80 level of 10,500 persons annually until 1985/86, then increasing slightly to 11,000 thereafter.

Age-sex specific migration projections were made by applying the estimated 1978/79 age/sex structure of net interprovincial migrants, immigrants and emmigrants to the projected total net interprovincial migration, immigration and emmigration. The age/sex distributions of migrants assumed throughout the projection years are shown in Figures 6, 7 and 8.

APPENDIX 8

# THE CANADIAN CHARTER OF RIGHTS AND FREEDOMS

For the first time, the basic rights and freedoms of Canadians are entrenched in a Canadian Charter of Rights and Freedoms, which applies to all federal, provincial and territorial authorities.

## Equality Rights

Equality Rights protect citizens from discrimination by governments, particularly on the basis of race, national or ethnic origin, colour, religion, age, sex, or mental or physical disability. This provision does not rule out "affirmative action" programs or activities aimed at improving the situation of disadvantaged individuals or groups. It will come into effect three years after patriation to enable the federal and provincial governments to make any necessary adjustments to their laws.

Under the agreement that broke the constitutional deadlock, both parliament and provincial legislatures retain the power to pass laws that may conflict with the Charter in these areas.

In order to do so, Parliament or a legislature must insert a clause stating specifically that it is passing the law *notwithstanding* the relevant provisions of the Charter of Rights. In other words, when governments propose laws that may limit the rights and freedoms set out in the Charter, they must say clearly that this is what they are doing and accept full responsibility for the political consequences. Furthermore, any federal or provincial law containing this "notwithstanding" or override clause will have to be reviewed and renewed at least every five years or it cannot remain in force.

## Equality Rights for Men and Women

Notwithstanding anything in this Charter, the rights and freedoms referred to in it are guaranteed equally to men and women.

From: Canada, Ministry of Supply and Services, *The Canadian Constitution 1981: Highlights* (Ottawa: Supply and Services, 1981), pp. 2-4. Reproduced by permission of the publisher.

# APPENDIX 9

## ELDERLY PROGRAM EXPENDITURE PROJECTION METHODOLOGY

In this paper the expenditures of several programs for the aged have been projected forward, including: Old Age Security, the Guaranteed Income Supplement, CPP/QPP, War Veterans Allowances/Pensions, Canada Assistance Plan, and Hospital and Medical care. In addition, the population and GNP had to be projected. All expenditures are presented in terms of 1976 dollars.

The methodology follows much along the lines of previous works such as the F. Denton and B. Spencer paper, "Some Government Budget Consequences of Population Change" (Department of Economics, McMaster University, 1974) or L. McDonald's "Changing Population and the Impact on Government Age-Specific Expenditures" (Treasury Board Secretariat, Ottawa, 1977).. Per capita expenditures by age group are adjusted through time and then applied to population projections to develop the cost implications.

Population

In order to illustrate the more serious ramifications of the demographic shift, one of the lower growth standard Statistics Canada population projections was selected (number 3).

GNP

GNP was assumed to be proportional to the number of man hours of employment which was, in turn, assumed to be proportional to the size of the age group 18-64. In addition, it was assumed that real product per man hour would grow at 2% per year. GNP for 1976 acts as the base for the projection.

From: Powell and Martin, "Implications of an Aging Society", pp. 36-39. Reproduced by permission of J.K. Martin.

OAS

Annual expenditure on OAS to 2031 is projected by multiplying the OAS recipient population for each year by the 1976 annual benefit level. The recipient population is obtained by multiplying the total number of persons 65 years and over obtained from projection No. 3 of Statistics Canada by 0.9985.

GIS

Annual expenditure on GIS is projected as follows:

i) the proportion of recipients is assumed to decrease by 1.6% per year until 1991. No decline thereafter.

ii) the average benefit per recipient is assumed to decrease in real terms by 1.4% per year until 1991, and by 1% per year thereafter.

The assumption is that CPP/QPP will have "matured" by 1991 with most of those aged 65 and over receiving some benefits. The assumptions of 1.6%/1.4% decline are based on program data for the period 1973 to 1978.

CPP/QPP

Projections of the proportion of those aged 65 and over receiving retirement benefits and survivor's benefits were obtained from the Department of Insurance. These were applied to the population projection. Annual expenditures were obtained by assigning to each recipient of these two type of benefits 12 times the average benefit of a new recipient in June 1976 escalated by 2% per year.

CAP

CAP expenditure on the aged is projected as follows: 21.7% of total CAP expenditure for 1976 is spent on this group. By dividing this expenditure by the number aged 65 and over, per capita CAP expenditure on elderly persons was obtained. This per capita expenditure is escalated at 2% per year since most costs will be related to wages and salaries.

Details of CAP expenditure on elderly persons in 1976, as obtained from the Treasury Board Secretariat, Planning Branch, are:

| | |
|---|---|
| General Assistance | 1.7% of total CAP |
| Adult Institutional Care | 17.1% of total CAP |
| Health Care | 2.0% of total CAP |
| Welfare Services | 0.9% of total CAP |
| Total | 21.7% of total expenditures |

WVA

Projections of War Veteran's Allowance/Pensions were supplied by the Department of Veteran's Affairs (Reported in the Treasury Board paper "Changing Population and the Impact on Government Age-Specific Expenditures", 1977).

Physicians Services and Hospital Cost Projections

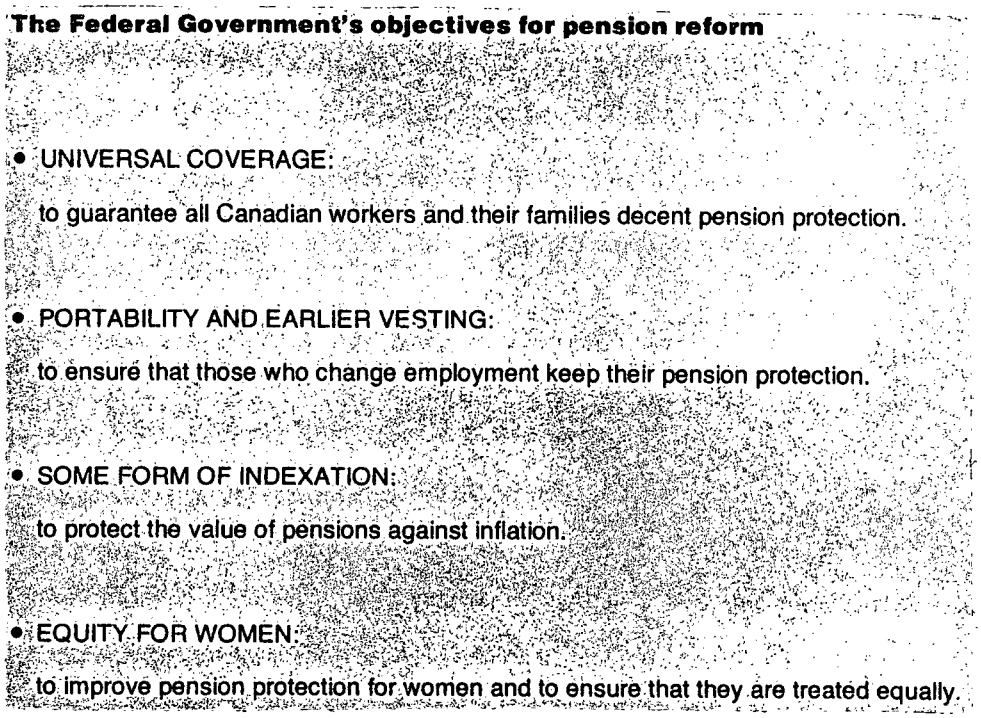
1974 per capita costs of physicians services by age and sex were obtained from the Economic Council of Canada. They were multiplied by 1.21 to obtain the costs

in 1976 prices. These costs were further escalated by 2% per year to reflect the discussed increase in wages and salaries. To obtain total costs of physicians services, the escalated per capita costs were multiplied by the number of elderly persons.

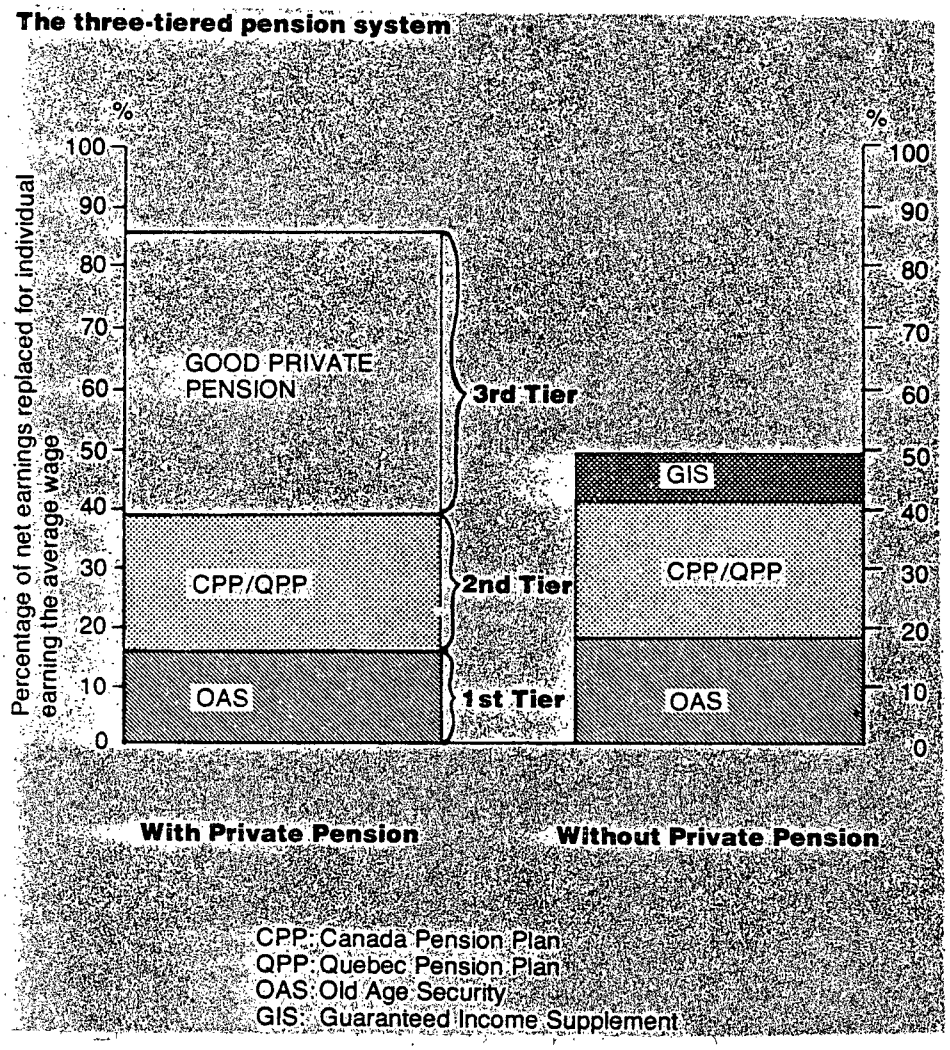
The 1976 costs of hospitals, by type, were estimated by the Health Economics and Statistics Directorate, National Health and Welfare and can be obtained from them. The implied per capita cost was escalated by 2% per year as above, and annual expenditures were obtained by multiplying the per capita expenditures by the number of elderly persons.

APPENDIX 10

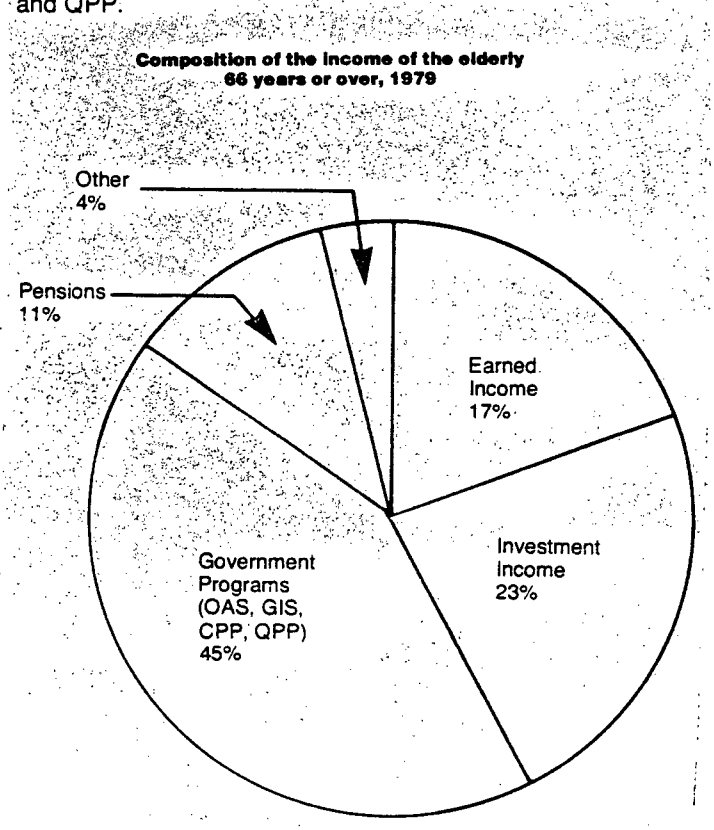
PENSIONS IN CANADA




From: Canada, Department of National Health and Welfare, *Pensions In Canada*, pp. i, ii, 5-11. Reproduced by permission of the publisher.


The three-tiered pension system
Percentage of net earnings replaced for individual earning the average wage
%
100
90
80
70
60
50
40
30
20
10
0
GOOD PRIVATE PENSION
3rd Tier
CPP/QPP
2nd Tier
OAS
1st Tier
GIS
CPP/QPP
OAS
With Private Pension
Without Private Pension
CPP: Canada Pension Plan
QPP: Quebec Pension Plan
OAS: Old Age Security
GIS: Guaranteed Income Supplement

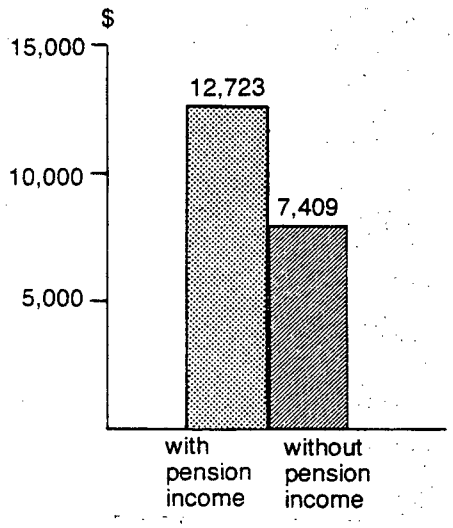
Only about $1 of every $10 of the income of the elderly comes from private pension plans. More than $4 out of every $10 come from public programs — OAS, GIS, CPP and QPP.



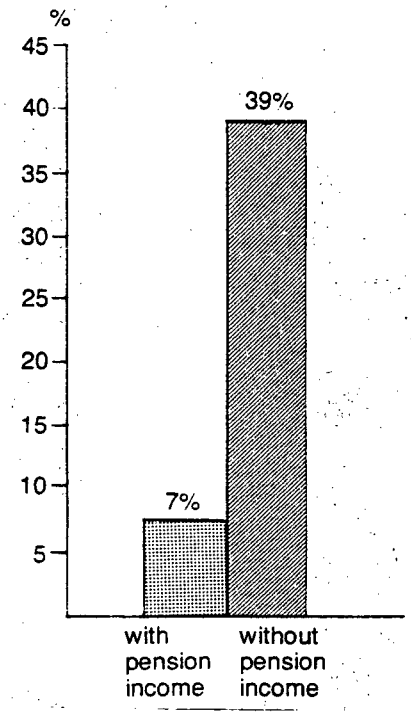

Source: 1980 Survey of Consumer Finances, 1979 Incomes for Census Families

Seven out of 10 persons 66 and over have no private pension, but those who do are far better off

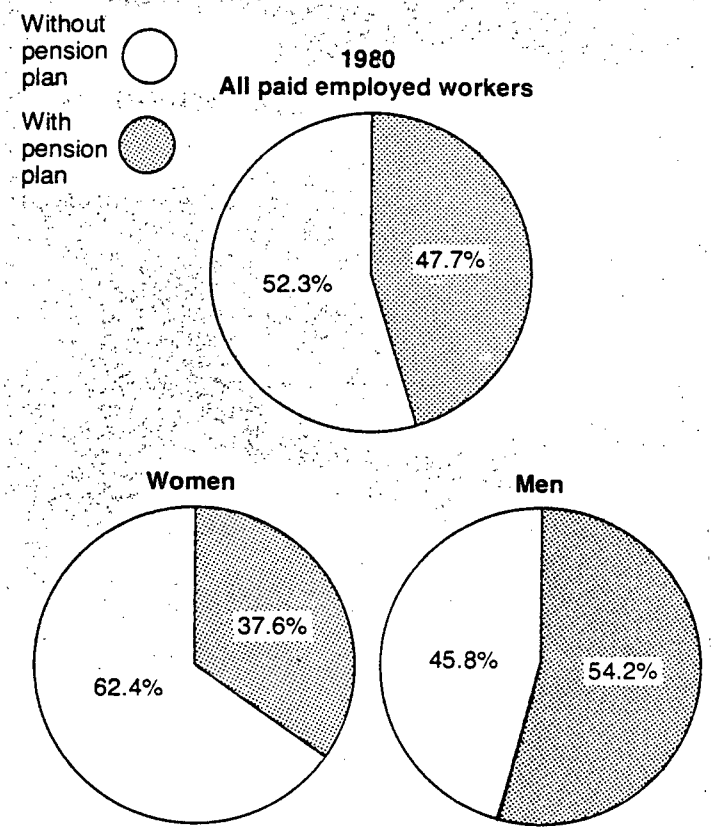
**Average family income of the elderly in 1979**




**Proportion of the elderly below the poverty lines in 1979**

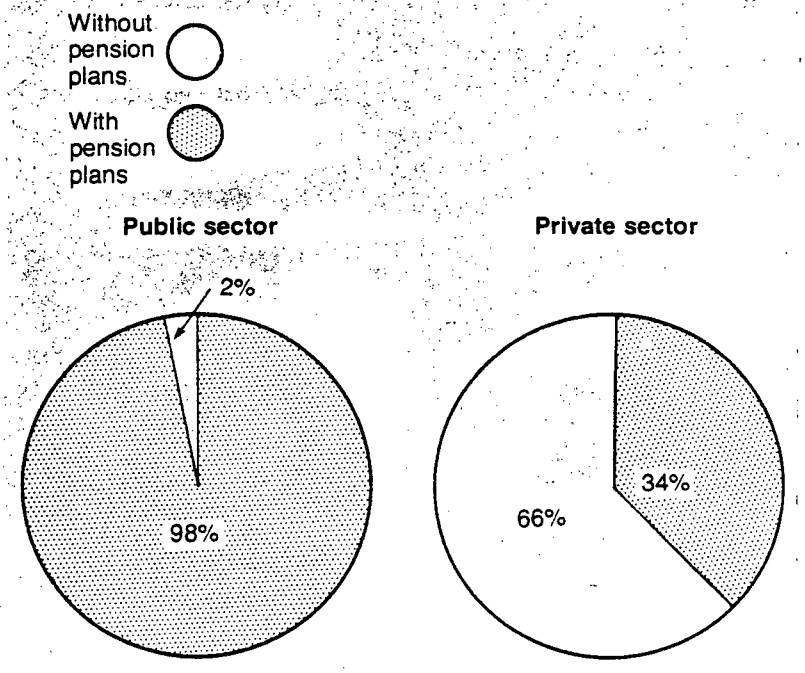


The majority of the work force is not covered by private (employer-sponsored) pension plans. Coverage is particularly poor for women.




Source: Statistics Canada
Pension Plans in Canada, 1980
Publication pending

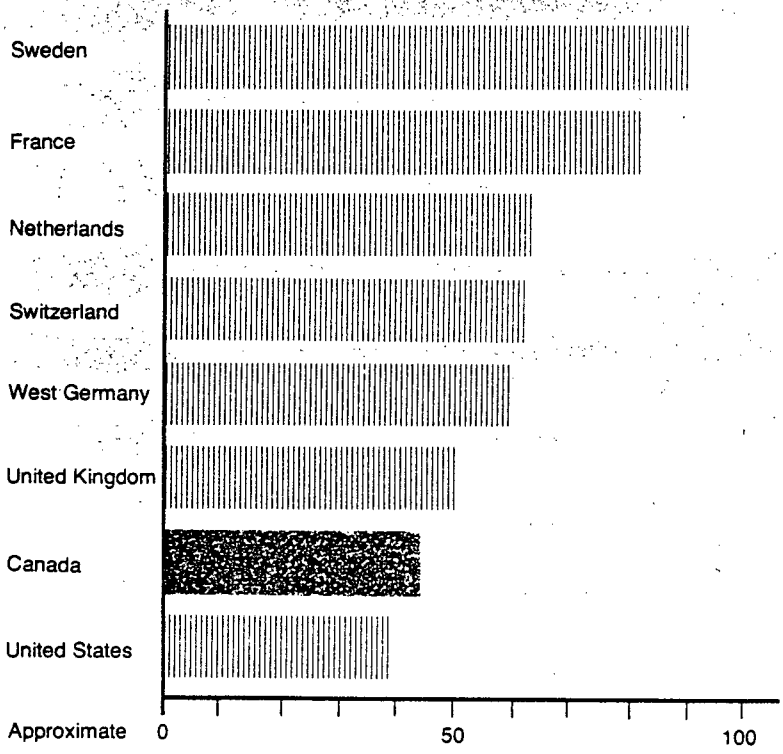
There are major differences in coverage between the public and the private sector. While almost all employees in the public sector belong to pension plans, only about one employee in three in the private sector belongs to such plans.




Source: Statistics Canada
Pension Plans in Canada, 1980
Publication pending

The coverage of the work force in Canada by private pension plans lags behind most other western industrialized countries.

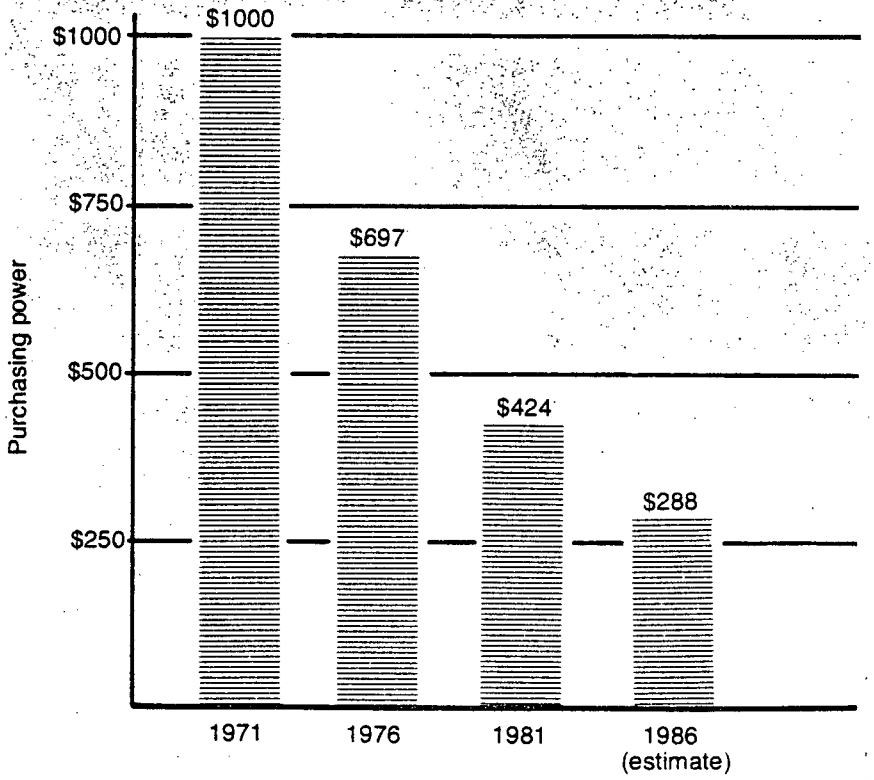
**Proportion of paid workers in Canada and seven other countries covered by employer-sponsored pension plans, 1976**




Source: The Retirement Income System in Canada, Volume 1, Page 41.

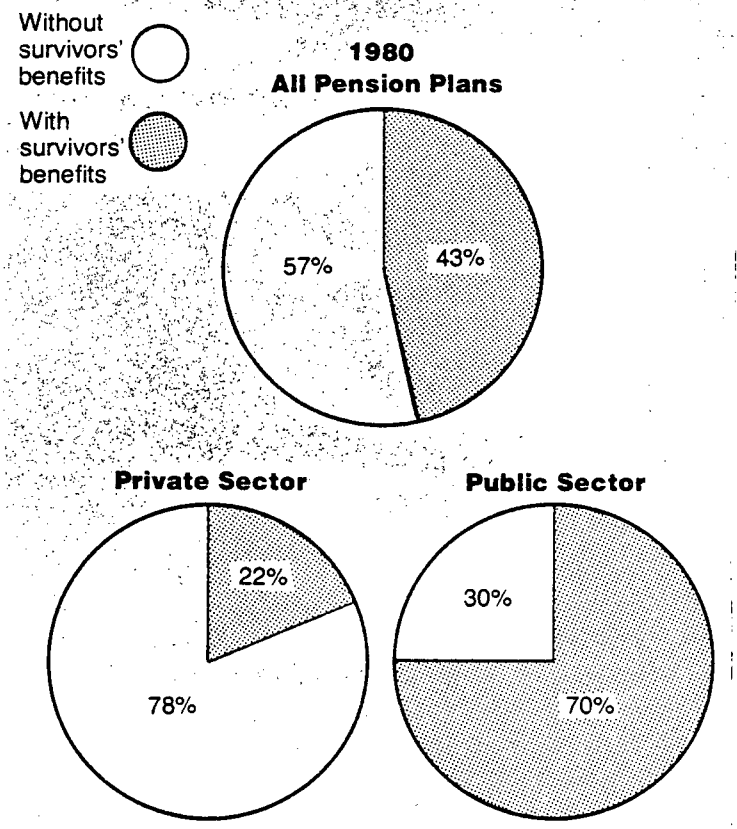
Leaf 213 missed in numbering.

The real value of many employer-sponsored pension plans has been seriously eroded by inflation.




Source: NHW estimates.

More than half of all members of pension plans do not have automatic provisions in their plans for pensions to surviving spouses when the pensioner dies after retirement. This is particularly a problem in the private sector.




Source: Statistics Canada
Pension Plans in Canada 1980
Publication pending

# APPENDIX 11

## DATA ON THE ELDERLY IN BRITISH COLUMBIA

Studies of utilization, cost, and effectiveness of programs for the elderly in British Columbia must soon take place if decision-makers are to plan adequately for the province's aging population. These research efforts continue to be hampered by inadequate, and unco-ordinated data in the key program areas of health, income, and housing. Section A below lists the principal current sources of information, and briefly describes the relevant data reported. Section B indicates some avenues for change to upgrade and co-ordinate data on the province's aging population. All references are to the population of British Columbia aged 65 or over, unless otherwise indicated.

A. CURRENT DATA

| DESCRIPTION | SOURCE | COVERAGE |
|---|---|---|
| I PERSONAL DATA | | |
| 1. Population<br>Numbers, percentages, ratios by sex. | *1966 Census of Canada, Population Age Groups.* (Statistics Canada 92-610) | 1961, 1966 |
| | *1976 Census of Canada, Population: Demographic Characteristics, Five Year Age Groups* (Statistics Canada 92-823) | 1971, 1976 |
| | *Population by Sex and Age, 1921-1971.* (Statistics Canada 91-512). | 1921-1971 |
| | *Population, Revised Annual Estimates of Population, by Sex and Age for Canada and the Provinces, 1971-1976.* (Statistics Canada 91-518). | 1971-1976 |
| | *Population Projections for Canada and the Provinces, 1976-2001.* (Statistics Canada 91-520). | 1976-2001 |
| | *British Columbia Population Projection 10/80 1980-2001.* (B.C. Central Statistics Bureau). | 1980-2001 |
| 2. Health | *General Mortality 1950-1972* (Statistics Canada 84-531). | 1950-1972 |
| Deaths, death rates by sex. | *Vital Statistics, Volume 1, Births and Deaths.* (Statistics Canada 84-204). | Annual |
| | *Vital Statistics, Volume 3, Mortality: Summary List of Causes.* (Statistics Canada 84-206). | Annual |
| Separations, separation rates by sex, ICDA-8 list, average length of stay. | *Hospital Morbidity.* (Statistics Canada 82-206). | Annual |
| Separations, separation rates by sex, Canadian Diagnostic | *Hospital Morbidity, Canadian Diagnostic List.* (Statistics Canada 82-209). | Annual |

| DESCRIPTION | SOURCE | COVERAGE |
|---|---|---|
| List, average length of stay. | | |
| Average length of stay by Regional Hospital District. | *Hospital Indicators.* (B.C. Ministry of Health). | Annual |
| Number of cases, days per 1,000 population by Regional Hospital District. | *Statistics of Hospital Cases Discharged.* (B.C. Ministry of Health). | Annual |
| 3. Income | | |
| Percentages by sex, income groups. | *Income Distributions by Size in Canada.* (Statistics Canada 13-207). | Annual |
| Numbers by sex, level of schooling, 1970 income groups. | *1971 Census of Canada, Income of Individuals.* (Statistics Canada 94-763). | 1971 |
| 4. Housing | | |
| Dwelling characteristics by household head sex, income groups, urban and rural etc. | *Household Facilities by Income and Other Characteristics,* 1972. (Statistics Canada 13-560). | 1972 |
| Dwelling characteristics by sex of household head. | *1971 Census of Canada, Housing, Dwelling Characteristics by Age and Sex of Household Head* (Statistics Canada 93-739). | 1971 |
| II PROGRAM DATA | | |
| 1. Health Programs | | |
| Federal program expenditure and utilization by legislated program areas (e.g. Hospital Insurance and Diagnostic Services, Medical Care, etc. | *Federal Government Finance.* (Statistics Canada 68-211). | Annual |

| DESCRIPTION | SOURCE | COVERAGE |
|---|---|---|
| Provincial program expenditure and utilization by service program areas (e.g. Hospital Programs, Medical Services Plan, Long-Term Care Program, etc.) | *Ministry of Health Annual Report*. (B.C. Ministry of Health). | Annual |
| 2. Income Programs | | |
| CPP utilization and expenditure by program category. | *Canada Pension Plan: Report for the Year Ending March 31.* (Health and Welfare Canada). | Annual |
| OAS/GIS/SPA utilization and expenditure by program category. | *Old Age Security: Report for the Year Ending March 31.* (Health and Welfare Canada). | Annual |
| Provincial program utilization and expenditure by program areas (e.g. GAIN, SAFER, Pharmacare, etc.) | *Ministry of Human Resources Annual Report* (B.C. Ministry of Human Resources). | Annual |
| 3. Housing Programs | | |
| Housing starts, completions, and loans approved by CMHC under legislated programs. | *Canadian Housing Statistics* (Central Mortgage and Housing Corporation). | Annual |
| Provincial program expenditure by region, project, unit. | *Ministry of Lands, Parks, and Housing Annual Report* (B.C. Ministry of Lands, Parks, and Housing). | Annual |

B. FUTURE DATA

To facilitate future research a central bank of data pertaining to the elderly in British Columbia should be set up and maintained by a separate co-ordinating agency. This data bank would hold current information on program utilization and expenditure from all provincial and federal sources, upgraded to show breakdowns at least by elderly age groups (65-74, 75-84, 85+), and cross-tabulated with personal data including population, health, income, and housing status. Central Statistics Bureau population projections should be extended to take in the years of major increase in numbers of the aged through 2031, using a number of different sets of assumptions concerning rates of fertility, mortality, and net migration. It should be possible to develop health service utilization summaries for the elderly as rough indicators of overall morbidity by integrating data currently generated and maintained separately by (principally) the Medical Services Plan, Hospital Programs, the Long-Term Care Program, Pharmacare, and the Dental Care Plan. The Survey of Consumer Finances conducted annually by Statistics Canada should take into account the value of non-money income such as subsidized services, imputed rent, and employer contributions. Finally, the Ministry of Lands, Parks, and Housing data on provincial senior citizen housing should be linked with that maintained on federal projects by the Central Mortgage and Housing Corporation to give a more complete picture of subsidized housing for the aged in British Columbia.

In summary, it is suggested that the province develop a central data capability concerning the elderly that would enable linkage between comprehensive profiles of their status with respect to health, income, and housing and the utilization of and expenditure on public service programs in these areas.

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*pective on the Health of Canadians*. Ottawa: Information Canada, 1974.

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