POPULATION AGING:
AN OVERVIEW OF THE PAST THIRTY YEARS

REVIEW OF THE LITERATURE

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SUMMARY

In Canada as in most industrialized societies during the postwar period, the establishment of the welfare state was primarily marked by the launching of a range of social programs to improve the living conditions of the elderly. The aim of the measures introduced at that time was to respond to an urgent situation of material poverty, poor health and social isolation. However, these major developments thus sanctioned the institutionalization of aging by leading governments in industrialized nations to set the retirement age, i.e. the age of entitlement to old age benefits, at 60 or 65 years of age, thus engendering an administrative approach based on a formal association between entry into old age and this chronologically fixed age.

But the financial, health and social situation of the elderly has changed significantly over the past 30 years. Today, people no longer age in the same way as before.

In that chronological age has remained the foundation of old age policies, and in light of the changes occurring in the past 30 years, one can justifiably question the viability of such policies and their ability to appropriately meet the new needs of the elderly. To what extent does the resultant representation of the elderly as a vulnerable group still match the situation of people in their sixties today? Are the age thresholds set in the early 1960s still valid? To what degree do they reflect the economic and social realities of old age today?

The ***review of the literature*** *offered in this study attempts to document this set of issues. Its main focus is Canada, but it includes, wherever possible, information and references from other countries. While considering the demographic, economic and sociological aspects of aging, this review of the literature emphasizes the fact that aging is not a homogeneous process, but rather varies according to gender, income, education and the extent of integration into family, community and social networks.*

The first part of this study sets out the various analytical models of aging prevailing in the past 30 years. It especially focuses on the so-called "Third Age" approach emerging in the 1970s. This approach highlights changes in the reality of aging since the development of major social welfare systems for the elderly, especially the shift from a view of this population characterized by poverty and dependence to a vision centred on autonomy and initiative in markedly more favourable economic conditions.

The second part of the study concerns the economic situation of the elderly which has indeed significantly improved over the past 30 years. This improvement is shown by the growth in the elderly's average income and the decline in the proportion of those with incomes below the low income cut-off, both for seniors in families and unattached individuals. Today, more than before, many elderly can count on income sources other than Old Age Security (OAS) and the Guaranteed Income Supplement (GIS). These include benefits from the Canada and Quebec Pension Plans (C/QPP), private pension plans and investment income. But transfer payments remain the primary income source for most seniors, especially unattached women. In terms of available financial and economic resources, the elderly are not a homogeneous group. They exhibit disparities according to gender and income category. Whereas the majority (approximately 60%) have incomes under $15,000, 4.8% receive an annual income of over $50,000, and 1% enjoy an annual income of over $100,000.

We also know that the risk of poverty is far greater for women than for men, and for unattached individuals than for those living as couples or in families. Not only do a higher percentage of men receive private pensions than women, but the average proportion of their income deriving from these pensions is also higher. The majority of elderly women are generally dependent on government transfer payments. Some studies have shown that these disparities are tied to the processes of differentiation people undergo during their working lives. It is the opportunities or constraints encountered specifically on the labour market that determine the quality of life at retirement and the level of dependence on government transfer payments. An in-depth analysis of the incidence of poverty at retirement and inequalities among the elderly is thus inevitably linked to their working lives, since employment income is apparently the primary factor in one's ability to save for retirement and become economically independent and autonomous.

The third part of the study highlights the fact that today's seniors enjoy better health than their predecessors. The majority assess their health positively. This high level of physical and psychological well-being is however dependent on effective social integration and a relative absence of chronic disease. We continue to see a decline in the prevalence of infectious illnesses, whereas degenerative disorders such as Alzheimer's disease and various forms of cancer remain constant threats to the elderly's autonomy. On the other hand, while coronary heart disease is still the leading cause of death and hospitalization in seniors, its prevalence has decreased considerably in recent years. Another finding points to a significant relationship among gender, income category, illness patterns and state of health. Although their life expectancy is longer, women suffer far more health problems and far more chronic illnesses than men.

In the area of social bonds and intergenerational relations, we see in the fourth section that despite the profound changes occurring in family structures, family ties have not diminished. Analysis of the development of intergenerational relationships shows the family to be a sphere for the structuring of various forms of solidarity. Families not only assume responsibility for dependent seniors but also provide the majority of the care they receive. However, if intergenerational relationships are characterized by exchange and solidarity, they vary according to class, gender and marital status. With limited economic resources and a sometimes precarious state of health, low-income elderly, especially unattached women, are generally less autonomous than middle-class seniors. Middle-aged women also play a central role in intergenerational family solidarity. With their involvement in home care, the work force and household tasks, they risk becoming overburdened by work, affecting them both physically and emotionally.

The fifth part of the study stresses the importance of social policies taking greater account of the changes highlighted if they wish to continue to meet the real needs of an aging population. In the area of economic resources, and in line with the goal of equity, transfer payments must be increasingly aimed at individuals with low or non-existent employment or investment income, and, as a preventive measure for tomorrow's elderly, government policies must necessarily target the causes of poverty and dependence at retirement, i.e. segmentation of the labour market, the occupational "ghettoization" of women, unequal access to employment, and pay disparities.

On the level of social services and care, the reorientation of social policies toward reducing institutionalization and developing home help services must be accompanied by adequate financial and professional assistance for families and especially women, who assume the largest portion of the work of caregiving. Two parallel approaches to care, a family approach based on the notions of duty and reciprocity, and an institutional approach centring on the notions of equity and universality, must inevitably interact and interlink. This is one of the major issues involved in the development of services and policies for the elderly.

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CONTENTS

INTRODUCTION

In Canada as in most industrialized societies during the postwar period, the establishment of the welfare state was primarily marked by the launching of a range of social programs to improve the living conditions of the elderly. The aim of the measures introduced at that time was to respond to an urgent situation of material poverty, poor health and social isolation. However, these major developments thus sanctioned the institutionalization of aging by leading governments in industrialized nations to set the retirement age, i.e. the age of entitlement to old age benefits, at 60 or 65 years of age, thus engendering an administrative approach based on a formal association between entry into old age and this chronologically fixed age.

The overriding vision in the setting of these age thresholds derived from the traditional view of aging which tends to associate old age with physical decrepitude, dependence, a decline in the body and a poor state of health. Developed on the basis of this diagnosis of failure, loss and maladjustment, the apparatus of institutional caring for the aged sanctioned the retirement of elderly citizens from social and economic activity. The negative stereotypes closely tied to the idea of becoming "old" at age 60 or 65 led to a policy of integration being implemented in the 1980s, focussing on the elderly's level of income and aimed at encouraging their independence as long as possible. In that chronological age has remained the foundation of old age policies, and in light of the changes occurring in the past 30 years, one can justifiably question the viability of such policies and their ability to appropriately meet the new needs of the elderly. To what extent does the resultant representation of the elderly as a vulnerable group still match the situation of people in their sixties today? Are the age thresholds set in the early 1960s still valid? To what degree do they reflect the economic and social realities of old age today?

These various types of questions that are at the very core of the process of reorientation of the welfare state are the subject of major debate. For example, Bourdelais (1993, 1994) suggests that, contrary to demographic aging which tends to freeze the human and social realities of age at a given point in time, old age has changed. Given the improvement in seniors' state of health and economic situation, there is a dramatic difference between the reality of age and the notion of population aging

based on a set threshold of entry into old age. The "new elderly" are not only in "better physical and mental shape", but they also have economic and social assets that give them a central position in today's society (id., 1994).

Old age policies often fail to reflect the sociological changes that have especially marked the past 30 years; they are in fact based on an unchanging threshold of entry into old age which does not encourage the distinction between biological aging and actual aging. Attempting to define the current process of aging thus requires a dual distancing: first, with regard to ways of thinking based on large statistical categories, and then with regard to prevailing notions of age-induced dysfunction, dependence and deteriorated status.

If this viewpoint underlies this **review of the literature** whose main focus is Canada[1], we however intend to add an important nuance. For while seeking to consider the demographic, economic and sociological aspects of aging, we take into account the fact that aging is not a uniform process. It varies according to gender, income, education and the degree of integration into family, community and social networks. From this perspective, we attempted to provide a review of the literature enabling us to pinpoint the main features in the evolution of aging over the past three decades.

We then encountered a *major problem*. In contrast to prospective studies, the number of *retrospective* studies proved extremely limited, not to say virtually non-existent. Given this lack of material, which obviously deserves to be remedied, we had to make do with a rather unspecialized and sparse body of literature. This has thus led to a *relative heterogeneity of sources*. The key point that emerged from this approach in our **review of the literature** was the interest of a retrospective examination of aging in industrialized societies to enable us to place into perspective, and thus better understand, the social problems we face today.

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1 We also include references from other countries whenever information is available.

This review is structured around three major themes: the elderly's income, health situation and integration into social and family relational networks. Based on the finding that seniors today are very different from their predecessors, we present in the first part of our study various analytical approaches brought to bear on the key issues of aging. This shows how the perception of old age has changed over time, and how an approach such as that of the "Third Age" emerged in the early 1970s out of a series of favourable conditions. Through our discussion, we are able to outline the premisses of a differential approach to aging. The second section involves changes in the elderly's economic and financial resources over the past 30 years. With various income sources, the primary ones being government transfer payments, private insurance plans and investment income, seniors are enjoying a higher standard of living than before. The third section looks at health issues, and the fourth focusses on transformations in family structures, which have become multigenerational. These transformations, combined with a longer life expectancy, improved economic situation and better health, are fostering new types of relationships, exchanges and solidarity in families. Finally, the last section offers a brief reflection on the role and contribution of social policies on aging in a context of profound economic, social and cultural changes in the realities they target.

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SECTION 1

ANALYTICAL APPROACHES TO AGING

1.1 The chronological aging model

Population aging is often approached in terms of demographic growth of the age group reaching 65 years of age, i.e. retirement age. This quantitative approach to aging is generally linked to the concerns of public authorities who view the elderly as a burden imperilling the future of social programs and the State's ability to adequately fund them (see OCDE, 1994a). Stemming from this viewpoint, which turns chronological age into an indicator of dependence, is an objectivizing approach more attuned to statistical needs than to expressing the current realities of old age. Its practical utility for institutional administration simultaneously leads to an oversimplification of the day-to-day realities of the elderly (Desjardins and Légaré, 1984).

For its part, the cognitive approach adopted by social gerontology primarily focusses on problems of maladjustment, and sometimes even the survival, of the elderly. The studies conducted frequently involve aspects such as illness, social isolation and material poverty. Seniors are generally seen as a category living in precarious socioeconomic conditions, with housing and nutrition problems, and severe physical and mental deficiencies that make them totally or partially dependent. Not only is their daily life described in terms of decline, limitation and loss (see Lesemann and Martin, 1993), but this "discourse of misery" and "these images of poverty" also result in stereotypes portraying the elderly as poor, isolated and incompetent. Spawned by the ideology of dependence, these stereotypes are based on the notion of loss: diminished cognitive ability, decreased functional physical capacity, and inability to care for oneself or appropriately fulfil social roles. Such a representation of the elderly thus sets up a natural link between aging, poverty, illness and physiological decline. In both Canada and the United States, it explains the development over the past 30 years of a tendency to medicalize old age (Fry, 1996), a tendency that not only reinforces these same negative stereotypes linked to chronological age but also justifies the exclusion of seniors from various spheres of activity (Estes and Binney, 1989).

1.2 The social aging model

In contrast to the two preceding approaches, some authors seek to de-emphasize chronological age by presenting aging as a process that is at once biological, psychological and social (see Lesemann and Martin, 1993; Lemieux, 1986). Others tend to see aging as a social problem constructed by groups with at times divergent interests (Myles, 1989; Myles and Teichroev, 1989), attempting to either increase care and services for the elderly or justify cutbacks in social spending. Social aging thus becomes "the product of power struggles between generations and society, ... age groups ... and social classes. And this whole series of power struggles congeals, as it were, into policies, decisions and institutions" (Guillemard, 1989: 11). Maheu and David (1989: 19) also feel that "aging is not merely a stage of natural physiological decline we must all face. The personal hardships experienced at this stage of life are also in large part caused by social, political and economic decisions over which the elderly have little control." For his part, Belgian author Claude Javeau (1994) describes aging as a set of social, economic, political and cultural issues. The issues for an aging society consist as much in knowing how to meet the social costs generated by the rising number of elderly as in finding ways to ensure an active role for the growing portion of the population that has retained its full physical and mental capacities, and yet been rendered inactive by the institutionalization of mandatory retirement.

"Invented" at the very beginning of industrialization (Guillemard, 1989), the notion of "older workers" responds to a dual concern on the part of employers. It enables them first to rationalize work and then to manage the work force by excluding individuals who by reason of their age are presumably able to work less quickly. Such practices are legitimized by the implementation of mandatory retirement, which Kohli (1989: 92) describes as "a social construction directly linked to basic aspects of contemporary capitalist societies". This relatively recent idea, the institutionalization of which coincides with the shift from an agrarian and familial economy to an industrial economy (Kohli, 1989), nevertheless owes its current form to the public policies of modern societies (Myles, 1989).

The contradictions between the discussion on the right to retire and the structural aims underlying forced retirement are more obvious in the model of early retirement[2], which leads to the exclusion from employment of people who are not only still of working age but also still able to work. Because they form part of an aging work force, these workers are seen as showing little flexibility, resistance to technological change, inability to function competitively and a lower productivity level than their younger counterparts. Under the pretext of opening up more jobs for young people, most States foster the development of a policy to manage the work force through various kinds of "institutional arrangements" to help provide laid-off workers with an income before they are eligible for their retirement pension (Guillemard, 1989). In the case of both retirement and early retirement, age, like race and gender, is thus established as a criterion of social categorization and segregation (Arber and Ginn, 1991). For older workers are excluded from the job market not on the basis of their health or ability to work, but rather on the basis of a set of stereotypes specifically tied to chronological age.

In its report tabled two years after it was set up in 1977, the Senate Committee tasked with studying the problem of retirement arrived at similar conclusions. It maintained that mandatory retirement based solely on age was discriminatory and constituted a human rights violation. It recommended that retirement be made optional by leaving the decision to retire up to the individual, while respecting certain basic standards with regard to competence and physical condition. The Committee also recommended that the entire human rights legislation be revised to eliminate any loophole allowing for discrimination on the basis of age (Canada, 1979). But such an approach has only been undertaken in the United States, which in 1986 adopted legislation prohibiting age-based job discrimination and recommending that the notion of "functional age" replace that of chronological age[3]. Fry (1996: 118)

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2 This issue, which has developed with labour market restructuring and companies' growing use of technology, is widely documented in both Europe and North America. Some of the leading authors in this field are H. David, A.-M. Guillemard, M. Kohli, J. Myles, V. Marshall, M. Rein and J. Quadagno. Aging in the workplace now begins earlier on in life, especially affecting workers aged 55 and over.

3 Fry (1996) maintains that the meanings attached to age are strongly correlated with the type of society in which the individual develops. In societies where subsistence conditions are precarious and resources limited, the tendency to foster egalitarian social relations overshadows the reality of age. On the other hand, in circumstances where it is possible to amass material resources, age becomes a mechanism of social and political control, a tool that helps not only to manage populations but also to control their access to resources and knowledge. The research conducted by Jacques St-Onge (1990) on four Native *Nations* in Québec indicates that even today, chronological age does not represent an aspect of aging for Native

maintains that: “Age is a dimension of social life used to manipulate and make decisions about people. As such, age is a problem in social organization.”

Such reflections enable us to assert that the concept of aging transcends the bio-psychological reality it ordinarily helps to describe. Deriving from certain values that affect how we view our relationship to work and society, it can be used to justify the application of certain strategic choices, while simultaneously attesting to the strength of the means of inclusion and exclusion set up in the context of this society.

1.3 The Third Age approach

Recent studies, whether Canadian, American, British or French, stress the unprecedented nature of the current process of aging (Bourdelais, 1994; Lemieux, 1990; Conseil économique et social, 1993). *Today, people no longer age in the same way as before.*

This statement, which underlies the optimistic vision of Bourdelais (1993), fundamentally contradicts the picture of precariousness, poverty and isolation that typified the media image of the elderly in the 1970s. In his text entitled *L’âge de la vieillesse*, this author in fact attempts to deconstruct the traditional discourse on old age and the negative social representations it had spawned. Using a historical and cultural perspective, he observes that the reality of old age has changed and that today’s seniors have little in common with elderly in the period between the World Wars, and even less with old people in the last century. Not only are they in better physical and mental condition, but their economic situation has also significantly improved (Bourdelais, 1993). With good health and a longer life expectancy, their lifestyle, their real position in society and their role in the succession of generations have changed markedly. This new discourse generally challenges the hypothesis that population aging will produce major social and economic problems. The author defends the idea that the place of the elderly in today’s society is a central and active one. Not only are they sustaining an

Peoples. Their description of “old people” is mainly based on the conjunction of two factors: the person has to be losing his or her physical abilities, and thus autonomy, and has retired from community activities.

entire sector of the economy, but people in their sixties[4] today are far from being an "old and tired" group. On the contrary, they represent an intermediary generation functioning at the centre of a family life where the different generations overlap (id.). In these circumstances, the fact that the threshold of entry into old age has not altered does not take into account either the profound transformations the process of aging has undergone or the changing realities of old age. Social policies that continue to focus on problems of loss among the elderly appear outmoded and inappropriate to meet the new needs of this population.

However, the model that best expresses this shift in our perception of the elderly remains that of the "Third Age". Emerging in France in the early 1970s, this model developed as seniors' resources improved (Conseil économique et social, 1993). Focusing on consumer practices and the values of the leisure society, it encompasses work, leisure, social and economic aspects. Through their involvement in volunteer work, some seniors are attempting not only to redefine the social roles of retirees but also to continue to practise their citizenship. In France, for example, they participate in the social, economic, educational and cultural spheres. They are helping other seniors with incapacitating illnesses as well as playing an active role in combatting unemployment and the exclusion of young people (id.). For these seniors, being a volunteer means far more than performing unpaid work. It is in fact a question of making themselves socially useful in continuing to fulfil their obligations toward society. They are demonstrating a "social utility" (id.) that not only forces us to reconsider age-related stereotypes but also questions the passivity generally attributed to the elderly. However, if this innovative model, "essentially oriented toward the search for personal satisfaction" (id.: 17) marks the transition from inactive to active retirement, it primarily involves relatively well-off, educated individuals.

The useful and even essential role seniors are playing in the effective functioning of society is also being underscored in Canada (Canada, 1990). In a document intended to negate clichés, unwarranted assertions and preconceived ideas about the elderly, the Minister of State for Seniors maintains that

4 It should be noted that in France, retirement age is set at age 60.

the elderly are not "a burden". With over 15% active in volunteer work, they are instead involved and productive individuals who are attempting to meet social needs in ways ranging from helping other dependent seniors to helping to integrate new immigrants (id.). Through this approach of sharing "a lifetime of experience and knowledge", they are helping to strengthen the social fabric. The conclusions of the work entitled *La Part des aînés* (Grand'Maison and Lefebvre, 1994) confirm this vision of aging. To describe the elderly's contribution, which they term invaluable in the current historical context, the authors stress the role seniors play in the daily transmission of values and the qualities of self-transcendence, as well as their historical experience in "coping with crisis" (Grand'Maison, 1994). They maintain that the elderly promote the renewal of intergenerational solidarity and, through the consideration of memory, foster a dynamic of integration, historical awareness and sustainable development (id.: 15).

It is this memory that has always enabled Native old people, designated as "Elders", to perform both a symbolic and functional role for members of their community. Viewing advanced age as the reward for an exemplary life, the community accords them a respect based on their acquired experience, past achievements and knowledge of tradition. Some are even seen as "sages", i.e. guardians of the essential values of tradition. Such a status invests the latter with supernatural power, which explains their influence over younger generations. Elders often passed on to younger generations the required know-how for survival as well as traditional knowledge (St-Onge, 1990; Labillois, 1994), in providing both physical care and the teaching of traditional language, history and ancestral customs (Mussell, 1994). Although the advent of the modern age in Native communities has altered the status of Native seniors, often turning "Elders" into mere "elderly" (Labillois, 1994), they continue to make a significant contribution in developing the skills of younger generations and transmitting cultural realities, sacred traditions and secrets (National Indian Council on Aging, 1980; Vanderburgh, 1982).

The study conducted in Great Britain by the *Carnegie Inquiry into the Third Age* (1993) expresses an awareness of the changing realities of old age. Structured around the need to better theorize and conceptualize the "Third Age", it is an attempt to offer a new, more positive terminology. Its concrete recommendations include changing social policy orientations to enable seniors in good physical and

mental health to carry on a normal life and perform roles that allow them to continue to fulfil themselves personally and socially (*Carnegie Inquiry into the Third Age*, 1993). Barthe, Clément and Drulhe (1990) also feel that the "Third Age" model repositions seniors at the heart of the modern age, characterized by the search for personal autonomy, a consumer culture and growth in purchasing power. Since development of the Third Age model coincided with a period of improved material, financial and physical living conditions for seniors, it is tied to a vision of the elderly defining them as consumers.

But the new division of the life course into four stages as proposed by the *Carnegie Foundation* study raises practical and ethical questions. Given that this perspective correlatedly gives rise to a "Fourth Age" (75 years or older) more closely associated with dependence, decrepitude and death, one can ask to what extent the Third Age approach is not merely reproducing the statistical logic it is at first sight attempting to deconstruct. Are not its advocates primarily seeking to push back the effects of age-based marginalization to the end rather than the beginning of retirement? Does not the "Third Age" approach chiefly represent an attempt to postpone for a few years the application of these still negative stereotypes? Finally, is not its recommended re-enhancement of this category of seniors occurring at the expense of those viewed as the most elderly and vulnerable in our society? We cannot answer all these questions here. But we have to acknowledge that despite their legitimacy, these questions in no way challenge the operational value of the notion of "Third Age". The latter is helping us clearly differentiate retirement, senility and disability. It is moving us away from ageist attitudes, and helping us see seniors as social actors with additional roles to play. It is easing the transition from an ideology of dependence and bio-psychological deterioration to the now dominant ideology of autonomy and independence. And it is in this same trend of ideological change that Desjardins and Légaré (1984) suggest that we measure age not in terms of the years gone by but rather the years one still has to live.

1.4 The political model of "gray power"

The new perception of old age is rooted in the ability of seniors themselves to organize and mobilize to defend their rights and interests (Binstock and Day, 1996; Ginn, 1993; Pratt, 1993). Over the past few decades in Canada, the United States and Britain, there has been a proliferation of pressure groups of the elderly[5], whose main goal is to safeguard their gains while seeking to create new opportunities (Binstock and Day, 1996; Ginn, 1993; Pratt, 1993; Walker, 1983). It is important to stress that the development of these groups has been more reactive than proactive. According to several authors (Pratt, 1993; Walker, 1983; Binstock and Day, 1996), these groups have not contributed to either the launching of major government programs for seniors or the establishment of universal retirement pensions. They have instead emerged as a democratic response to the process of erosion of what Myles (1989) calls the welfare state for the elderly, and to the State's desire to curb social spending to cope with budget deficits (Binstock and Day, 1996). And yet, given their demographic importance, seniors have gained the ability to influence public policies (Walker, 1983) and position themselves as a political force preventing various governments from cutting retirement pensions as they would have liked (Pratt, 1993).

The social safety net that the setting up of these pressure groups helped to preserve is not however benefiting all seniors equally. Binstock and Day (1996) note that in the United States, despite their political importance, these groups are not very sensitive to the needs of the most disadvantaged elderly. The same observations apply in Britain, where Ginn (1993) stresses that even if women are increasingly involved in seniors' organizations, they inevitably remain blind

[5] According to figures provided by Binstock and Day (1996), there are over a hundred national organizations in the United States, with branches and affiliations in nearly every state. Total membership in these organizations is estimated in the tens of millions.

to structural inequalities linked to gender, class and race. People in these groups identify more with the interests of their class than those of their age group.

1.5 The differential aging model

These last comments reinforce our critical outlook on the thesis of a transformation of old age. We in fact know that aging is not a uniform process for everyone, and that the elderly are not a homogeneous group. Various aspects prevent seniors from all aging in the same way. These may include factors such as gender (Arber and Ginn, 1991, 1993; Statistics Canada, 1990), ethnicity and/or social origin (Markides and Black, 1996). Structural and social factors are largely tied to the labour market and macroeconomic structures. Other factors are socio-occupational status, the types of organizations individuals were involved in during their working lives, and the diversity of their occupational paths (McDonald and Warner, 1987). People in the core sector of the economy, whether men or women, end up better off. At retirement, they are more likely to have a private pension plan and income sources other than government transfer payments (McDonald and Warner, 1987). On the other hand, it is unlikely that people employed in the peripheral sector who also experience a broken work history or interrupted professional career will have enough fringe benefits or resources to enjoy their "leisure years". Moreover, people encountering difficult working conditions requiring intense physical effort age more quickly than those enjoying better conditions (Maheu and David, 1989).

A comparative study involving Britain and the United States (Arber and Ginn, 1991) shows a continuity between one's working life and retirement life. People with significant material resources have more chance of being healthy (Arber and Ginn, 1991); they and their family members are better able to see to the quality of their care and negotiate support services (Arber and Ginn, 1993). In that we know that living conditions prior to retirement are deciding factors in the post-retirement period (Guillemard, 1989; Maheu and David, 1989; Marshall and McPherson, 1994), women are generally worse off than men (Gee and Kimball, 1987; Gee and McDaniel, 1991). The same is true for the working class compared to the middle class, and for unattached individuals compared to people living as couples (Arber and Ginn, 1993). Old age in no way levels out the inequalities built up over one's

working life, whether class-, gender- or race-related. On the contrary, including prior working conditions in an analysis of population aging places the latter in a dynamic that turns it into a universal referent, the scope and significance of which depend on the impacts--both positive and negative--of individual life paths. The situation of the elderly must be approached by considering three types of resources: material and financial resources, physical resources (physical abilities and functional skills), and the degree of accessibility of health care and social support services (Arber and Ginn, 1991).

If aging can be seen as an overall social phenomenon affecting all major institutions in our societies, it can only be understood through a multidimensional analysis highlighting its demographic, socioeconomic, socio-health and socio-familial aspects. To this end, we suggest that old age is a multifacetted experience that is structured according to available material and financial resources, quality of health, and degree of integration into social and family networks. Profiles of the elderly and their existential realities vary according to the categories to which they belong[6]. This differential analytical approach enables us to move away from ageism, which tends to deprive seniors of their individuality and foster assumptions about the homogeneous nature of their age group. This approach instead helps to present population aging as a diverse process where individual and social factors interact. From this perspective, without being linked to objective and subjective living conditions, age cannot be viewed as an adequate gauge of individual functional capacity.

[6] By "categories to which they belong", we mean social class, gender, ethnicity, socio-occupational status and related factors.

CANADA'S ELDERLY POPULATION

Canada's elderly population has grown significantly over the past three decades. The percentage of persons aged 65 or older climbed from 7.6% in 1961 to 8.1% in 1971, 9.7% in 1981, and 11.6% in 1991. This difference of 4 percentage points expresses a dual reality. On the one hand, it shows a sizeable increase in the number of seniors: this population, estimated at 1.4 million in 1961, rose to 3.2 million in 1991. It also indicates that the population aged 65 or older is experiencing a far more rapid growth rate than the general population, respectively 128% compared to 50%. However, despite this sharp increase, the proportion of seniors in Canada remains low compared to some European countries such as Sweden (18%), Norway (16%), West Germany, Denmark and Britain (15%). The proportion of seniors in the United States was 12% in 1991.

In 1991, 60% of Canada's elderly population was aged 65 to 74, and 58% of them were women. There were 723 men aged 65 or older for every 1,000 women in the same age group, a difference that increased as age levels rose. In 1991, women accounted for 70% of seniors aged 85 or older, with a proportion of 423 men for every 1,000 women in this age bracket, due to the gender-based variance in mortality rates. From 1985 to 1991, mortality rates for men aged 65 to 74 were twice as high as for women of the same age (Statistics Canada, 1994).

Table 1, however, shows that all Canadian provinces are not undergoing the same rate of growth in population aging. In 1986, Prince Edward Island and Saskatchewan, whose proportion of seniors had reached 12.7%, were the provinces with the highest percentage of Canada's elderly. They were followed by Manitoba (12.6%) and British Columbia (12.1%). Québec ranked eighth with a percentage of 10.0%. But according to 1991 census data, not only did the proportion of seniors significantly rise, but the 1986 pattern was also substantially transformed. Prince Edward Island, with a percentage of 13.2%, fell to third place, behind Saskatchewan (14.1%) and Manitoba (13.4%). While Québec still ranked eighth, its percentage of seniors increased from 10.0% to 11.2%. With a 9.1% percentage of elderly, Alberta remained Canada's youngest province, after the Yukon (4.0%) and Northwest Territories (2.8%). In 1991, 75% of all those 65 or older lived in Ontario, Québec and British Columbia.

Based on 1991 census figures, Statistics Canada (1994) established that the majority of Canada's seniors (2.9 million) lived in private elderly households, i.e. households including at least one elderly person. Only 4% of men 65 or older and 8% of women of the same age were in special care institutions. In 1991, elderly women accounted for 72% of all seniors living in institutions.

SECTION 2

INCOME

Due to the complementarity of public and private income sources, the financial and economic situation of Canada's elderly has markedly improved from 1971 to the present. The economic realities of aging vary according to gender, income category, education and type of family unit.

2.1 Primary income sources of persons aged 65 or older and changes in such income sources over time

Public income sources for persons aged 65 or older include several components. First, Old Age Security (OAS). Established in 1952, this program set up a universally-targeted public pension scheme intended to guarantee a fixed minimum income for all retired seniors, that is, people having reached a set age who were no longer employed. Over the years, there have been substantial changes to old age security legislation. Starting in 1966, the age of eligibility for the OAS was gradually reduced from 70 to 65. In 1973, in response to the precarious economic situation affecting the elderly, the federal government tied the amount of benefits to the consumer price index. In 1983, indexing reached a ceiling of 6% of the total amount. In 1985, a process of full deindexation was launched, but thwarted as seniors mobilized to oppose it. In 1989, however, the federal government was able to recover, through taxation, part or all of the benefits received by persons with incomes over $50,000, so that since 1994, the basic benefit amount is only retained in full by beneficiaries with annual net incomes of $53,215 or less. Persons with income over this threshold are required to repay OAS at the rate of 15% of their net income above this threshold. Seniors with annual incomes of $84,195 or more repay the total benefit amount.

To remedy the precarious economic situation of the elderly, two other programs were added to OAS: the Guaranteed Income Supplement (GIS) and Spouse's Allowance (SA). The GIS, established in 1967, is intended to supplement the income of all seniors with no income source other than OAS. Implemented in 1975, the SA is provided to spouses of OAS recipients and to low-income widows

and widowers aged 60 to 64. Benefits from both these programs are also indexed to the consumer price index. However, while complementing OAS, these programs differ in their non-universal or selective nature. Designed to compensate for low income, they provide benefits in amounts varying according to individual socioeconomic characteristics.

The aim of the latest federal reform proposal is to set up a single system as of 2001, called *The Seniors Benefit*, combining OAS and GIS allowances. This proposal, outlined in the 1996 federal budget speech, provides for a gradual reduction of benefits based on income level until they are entirely eliminated for unattached individuals with incomes over $52,000 and couples with incomes over $78,000. On the other hand, unattached persons or couples with combined incomes of $40,000 or less will receive the same or higher benefits than those they are entitled to at present (Canada, 1996b). For unattached persons or couples with incomes between $40,000 and $45,000, benefit amounts will depend on their exact tax situation under the current system. Moreover, the new rules grant persons aged 60 or older on December 31, 1995 the choice of being treated under either the current or the new system.

This transformation in the old age security system marks a major turning point in the political and social philosophy that has prevailed to date in establishing the public pension system. The federal government believes that it is reasonable to sacrifice universality in order to foster equity, solidarity and individual accountability. By targeting benefits solely to persons with low or moderate income, it expects to ensure the viability of the public retirement system and curb the long-term growth of pensions, which are funded through general government revenues (Canada, 1996b), while setting up a more equitable retirement system.

Added to OAS, for any individual with prior employment, are benefits from the Canada Pension Plan (CPP), or its Québec equivalent, the Québec Pension Plan (QPP). Participation in these plans is compulsory for all workers aged 18 to 70. Contributions are proportional to income and are shared

equally between the employee and employer. The C/QPP guarantees a reduced benefit to the surviving spouse upon the death of the beneficiary.

Private pension plans, most of which are employer-sponsored, include registered pension plans (RPPs)[7] and deferred profit sharing plans (DPSPs). However, unlike the C/QPP, some private pension plans do not provide for benefits to the contributor's spouse upon the death of the principal beneficiary. They also rarely include provision for indexing to the consumer price index.

Finally, some seniors have investment income or registered retirement savings plans (RRSPs) to which they had contributed during their working lives.

2.2 Changes in seniors' economic situation over the past few decades

In the late 1970s, the precarious economic situation of the elderly was a source of concern for public opinion and politicians alike. This concern was echoed in the Québec press of that period. In its report entitled *Retirement Without Tears* (1979), the Senate Special Committee established in 1977 maintained that benefits from both the public and private systems were inadequate[8] to enable the elderly to escape poverty. The Committee stated that since inflation continued to threaten retirees on a fixed income, non-indexing of retirement pensions paid by private funds represented a serious handicap in inflationary times (Canada, 1979).

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7 RPP benefits are only paid to retirees having worked a sufficient number of years to accumulate retirement benefit entitlement. In 1993, public sector employees represented only a quarter of the paid work force but almost half of RPP contributors.

8 In 1979, combined monthly federal and provincial benefits ranged from $300 to $400 for unattached persons, and from $600 to $700 for married couples. Based on Statistics Canada figures, the Committee underscored that 48% of unattached elderly women were poor, and had yearly incomes under $3,000.

Today, however, it is generally agreed that the economic picture for seniors has improved considerably. As indicated in Chart 1, in 1969, 41.6% of families headed by an elderly person were poor. This proportion dropped to 19.2% in 1980, 10.1% in 1989, and 7.1% in 1994.

In the late 1970s and early 1980s, several of Québec's leading written media sounded a cry of alarm regarding the precarious situation of the elderly. In *Le Commerce* of April 1977, Gaude stressed that inflation was having a disastrous economic impact on seniors. Given their fixed incomes, largely derived from retirement pensions, their purchasing power was declining as inflation rose. *Le Québec Industriel* reiterated this same theme in 1979, maintaining that inflation was not only eroding the real value of retirement pensions but also undermining seniors' purchasing power. In 1979, Patricia Poirier published an article in *Le Devoir* noting that despite the existence of social old age policies, over 1.1 million Canadian seniors were living in poverty. The situation was worse for women than for men (Poirier, 1979). A year later, *La Presse* described retirement as "a serious economic situation that must be remedied"; 63% of Quebec's elderly with public pensions as their main income source were living below the poverty line. In 1982, *Le Soleil* estimated that 62% of Quebec seniors lived below or near the poverty level. In 1984, an article in *Le Devoir* underscored that Quebec topped the list in statistics on poverty among the elderly. Seventy percent of seniors were living below the poverty level, compared to 50% for New Brunswick.

Over the last decade, the percentage of low-income seniors, in fact, declined by nearly half: from 34% in 1980 to 19.3% in 1989. From 1980 to 1993, the proportion of low-income elderly women fell from 72% to 56%. A study by Oja and Love (1988) showed that from 1971 to 1985, the elderly's average income rose more rapidly than that of all other population groups, jumping from $2,876 to $12,829[9].

Seen among both men and women, this growth nonetheless conceals major differences between the sexes. In 1980, the average reported income was $11,500 for elderly men and $7,000 for elderly women. According to Norland's study (1994), the average income for all men aged 65 or older was $24,500 in 1991, compared to an average of only $15,300 for women of the same age[10].

9 Expressed in constant 1971 dollars, this increase is equivalent to $4,234.

10 It is important to stress here that despite this increase, the elderly's average income was still below that of the general population. Elderly men's income was 19% lower than in the overall male population, whereas elderly women's was 13% lower than that of the female population, whose total average income was already considered low.

Average income also varies according to age group. In 1991, the figure was $27,500 for men aged 65 to 69, $22,100 for those aged 75 to 79, and $18,700 for men 85 and over. But these variations by age group do not appear very significant for women. Women aged 65 to 69 had an average income of $14,800, compared to $15,600 for those aged 75 to 79 and $15,300 for women 85 and over. Norland establishes a correlation between the low variability of elderly women's income according to age group and the fact that these women are far more dependent on government transfer payments than men.

As shown in Table 2, the gaps between men and women have remained throughout this period. From 1980 to 1994, for unattached individuals, men's average income grew from $18,617 to $23,782, while women's rose from $14,854 to $17,106. However, from 1990 to 1994, whereas unattached men saw a $2,033 increase in average income, the amount for unattached women fell by $985. Statistics Canada (1994) presents certain data, in constant 1994 dollars, noting the change of families headed by a person aged 65 or over for the period 1980-1994. The average income of economic families headed by an elderly person rose from $37,521 to $40,183, while that of unattached individuals increased from $15,891 to $18,780.

The 1994 Statistics Canada data thus show a marked decline in the proportion of low-income elderly, but this decline varies according to gender and type of family unit. From 1980 to 1994, the percentage of low-income elderly living in families decreased from 17.8% to 6.1%, whereas the proportion of low-income unattached elderly fell from 68.6% to 47.6%. The percentage of low-income men was down from 26.6% to 10.7%, while the figure for low-income women dropped from 39.8% to 25.8%. Whereas seniors accounted for 19.2% of all low-income individuals in 1980, they represented only 12.8% of the 1994 total despite their strong demographic growth. This decrease is, however, far more pronounced for elderly persons in families than for unattached persons (Table 3). The average income deficiency--i.e. the amount by which income was below the official poverty level--also declined, both for seniors living in families and for the unattached elderly. Table 4 shows that the drop is greater for the unattached elderly and men.

Although there has clearly been a positive change in the economic situation of the elderly during the period examined, Tables 5 and 6 also show that seniors' average income is still substantially below that of the population as a whole. Norland (1994) explains this dual reality by highlighting differences in educational levels and labour force participation rates. For this author, there is no doubt that a rising educational level among younger cohorts of elderly[11] is a decisive factor in their improved economic situation. He even says that: "This suggests that as Canada's future seniors have higher educational levels than they have currently, the gap between their income and the income of the total population will likely decrease, and their dependence on government will likely lessen". (Norland, 1994: 40). On the other hand, their absence from the labour force means a loss of income for the elderly. Their level of labour force participation is inordinately low compared to the general population[12]. Data from the 1971, 1981 and 1991 censuses confirm the latter trend, which is likely to negatively affect the elderly's average income. And yet other analysts attribute gains in seniors' economic situation to increased labour force participation by women (Statistics Canada, 1996), the beneficial effects of government transfers, and wider access to private pension plan benefits (Oja and Love, 1988).

2.3 The importance of the elderly's primary income sources

If government transfer payments represent the leading source of income for the elderly, age and gender remain significant indicators for assessing changes in these payments and their importance in the composition of seniors' total income. From 1971 to 1994, the number of OAS recipients showed a marked increase, linked to the process of accelerated demographic aging. The total literally doubled, skyrocketing from 1.7 million to 3.4 million. The number of GIS recipients rose from 932,000 in 1971 to 1.3 million in the mid-1980s, after which it remained stable for a number of years. If in 1971, 74% of women aged 65 or older and 59% of men in the same age group derived their

[11] While 76% of seniors 85 or older had not obtained a diploma, the percentages were 70% for persons aged 75 to 79 and 63% for those aged 65 to 69.

[12] In 1991, labour force participation rates were 14.4% for elderly men and 5.6% for elderly women. The corresponding rates for the overall adult population were 76.4% for men and 59.9% for women.

income from Old Age Security and Guaranteed Income Supplement benefits (Chart 2), OAS and GIS benefits respectively comprised 61% and 29% of the total income of elderly women and men in 1971. The relative proportions were 45% and 26% in 1985, and 42% and 24% in 1993 (Oderkirk, 1996a). After increasing in the early 1970s, OAS benefits have remained stable at amounts between $370 and $387 (in 1994 dollars). However, the rising trend in the maximum GIS benefit was maintained, up from $203 to $337 between 1971 and 1980, and $460 in 1994 (still in 1994 dollars) (id.).

Based on data from the *Survey on Consumer Finances* published in 1972 and 1990, Chawin (1991) stresses that transfer payments play a key role in protecting the welfare of unattached elderly persons and families with a head aged 65 or older. In 1971, transfer payments represented the sole income source for 40% of the unattached elderly and 16% of families with a head aged 65 or over. Eighteen years later, these percentages had fallen to 31% and 10% respectively. In 1971, people 65 or older accounted for 77% of all transfer payments to unattached persons; in 1989, this proportion dropped 8 points to 69%. The survey also shows that in 1993, 59% of low-income unattached persons and families collecting OAS benefits had an income equivalent to at least 80% of the low income cut-off (id.). In 1994, the maximum OAS benefit was $387. Combined with GIS, it provided an amount of $847 for unattached individuals and $1,374 for couples. Unattached persons with annual incomes equivalent or equal to $11,064 and couples with incomes of $14,448 were not eligible for GIS.

Gender and age remain important indicators in assessing changes in government transfer payments and their significance for seniors. In 1994, the number of female OAS recipients was proportional to their demographic importance in the elderly population; they represented a total of 58%; however, they accounted for 65% of GIS beneficiaries. The proportion of female OAS and GIS recipients varies according to age bracket. The percentage in the first group rises from 53% for those aged 65-69 to 75% for women aged 90 or older. The proportion in the second group increases from 57% for women aged 65-69 to 63% for those aged 70-74, and 78% for women aged 90 or older. In 1993, 42% of elderly women's total income derived from OAS and GIS, compared to 24% for men (id.).

These variations over time should be related to developments in the C/QPP since its inception in 1966. Benefits paid by these plans accounted for only 2% of the elderly's total income in 1971. This proportion, however, grew over the years to 11% in 1983, 13% in 1985 and 17% in 1993 (Chart 3). Once again, the situation of men differs from that of women. In 1985, 85% of men and 40% of women aged 65 to 74 collected C/QPP benefits. A difference of $1,470 is seen in the average maximum annual benefits paid to men and women, i.e. $4,770 compared to $3,300. The maximum monthly benefit rose from $218.06 to $727.08 between 1979 and 1996, for an annual total of $8,728.

The number of persons entitled to C/QPP benefits has continued to increase since the plan's implementation. This number grew from 241,000 persons in 1971 to 1.6 million in 1986 and 2.9 million in 1994. In 1996, over 3.3 million Canadians and Québecers received C/QPP benefits (Canada, 1996a). Whereas less than 75% of seniors were entitled to C/QPP benefits in 1983, over 82% collected such benefits in 1993. In 1994, 61% of seniors of retirement age were eligible for the plan, compared to 44% in 1980 and under 20% in 1970. From 1983 to 1993, the proportion of women contributing to the C/QPP rose from 41% to 45%. Although the differential between the sexes--in terms of accessibility and number of persons entitled to benefits--remained extensive, it did however decrease during this period. In 1977, the percentage of men receiving C/QPP benefits was twice the proportion for women. In 1988, 79% of men aged 75 or older drew benefits, compared to 47.8% of women of the same age. In 1993, 92% of men received C/QPP benefits compared to 73% of women. The gap between the sexes in fact narrowed by 19 points from 1983 to 1993. Like the number of recipients, the average monthly benefits offered by these public pension plans continue to rise (Oderkirk, 1996b). For the CPP, the amount increased from $104 in 1971 to $254 in 1981 and $376 in 1994. The QPP amount showed a similar trend, up from $113 in 1971 to $260 in 1981 and $348 in 1994.

The fact that, with this development, the C/QPP became a source of income for a growing number of seniors also helped to substantially reduce the need to draw upon the GIS. The impacts involved are direct and significant since both the proportion of seniors receiving full GIS benefits and the proportion receiving partial benefits declined in 1993. From 1983 to 1993, the percentage of seniors

receiving both OAS and GIS fell from 50% to 40%. Despite the role that women's participation in the paid work force may have played in this decline, which can be seen as a sign that seniors' income is becoming more adequate, elderly women's economic situation remains far more precarious than that of men. In 1990, the full amount of the GIS benefit was paid to 18% of women aged 85 to 89 and 26% of women aged 90 or older. In 1993, OAS represented 23% of women's total income, compared to 15% of men's. In 1994, OAS was the sole income source for over 50% of women aged 65 or older. Whereas these women accounted for 61% of persons receiving both OAS and GIS benefits in 1981, this percentage rose to 65% in 1994. One can thus say that the economic situation of elderly women is still precarious.

The percentage of seniors with private pension plans also increased from 20% in 1971 to 33.2% in 1985. During the same period, the number of persons without private pension plan benefits or investment income dropped from 49.2% to 33.7%. The group with the highest average income, i.e. able to combine government transfer payments, investment income and private pensions, grew from 13.5% to 23.0% between 1971 and 1985. In 1988, a significant rise in these percentages was noted among men aged 65 to 69 and those aged 70 to 74. In the first group the proportion was up from 38.5% in 1977 to 57.4% in 1988. During the same period, this proportion also jumped 20 points for the second group, from 33.2% to 53.3%. In 1988, the percentage of women aged 65 to 69 receiving private pension plan benefits was only 26.7% (Oja and Love, 1988).

In 1991, private pension plan benefits ranked third in the composition of the elderly's income. They provided an average income of $3,200 for seniors, representing 17% of their total income. The importance of this type of income varies according to age group and gender. Whereas in 1991, average annual private pension plan benefits amounted to $5,200 for men, or 21% of their total income, this figure was only $1,740 for women, or 11% of their total income. Moreover, the percentage of men aged 75 or older receiving a private retirement pension was twice as high as for women in the same age group, i.e. 46.9% and 21.5% respectively. The share of income from private pension plans in fact represented the second largest income source for elderly men, but only the third

for women. Such gaps can only be explained in reference to prior work histories (Norland, 1994), i.e. in reference to internal labour market dynamics and differences in occupational activity and income.

Investment income is the second largest income source for all seniors. The importance of investment income in the composition of the elderly's total income also varies according to gender. It is the second leading income source for women, but only the third for men. From 1971 to 1985, the share of income generated by investments rose from 20% to 24.3%. If over 25% of the total income of women aged 65 or older during the same period derived from investment income, nearly 62% of unattached elderly women reported such income. Chart 4 shows how the proportion of taxfilers with investment income increases with age. In 1990, 81% of persons aged 75 or older reported investment income. With a median investment income of $4,450, they outstripped all other age groups. Whereas in 1990, taxfilers aged 65 and over represented only 9% of taxpayers reporting investment income, they received 20% of the total amount of this income. However, from 1983 to 1993, the percentage of seniors with investment income decreased from 88% to 70%. The share of income generated by investments thus fell from 27% to 23% between 1983 and 1993.

Although the number of employed persons aged 65 or older has dramatically declined since 1971 (Table 7), employment is still one of the main income sources for seniors. During the 1981 census, over 25% of men aged 65 or older and roughly 10% of women in the same age group were still part of the work force. From 1981 to 1991, labour force participation among persons aged 65 to 69 fell from 22% to 17% for men and from 8% to 7% for women. The percentage of men aged 65 or older in the work force dropped from 48% to 29% from 1971 to 1991. Labour force participation among the elderly shows a decline with age. In 1991, labour force participation among men decreased from 15% at age 70 to 10% for those aged 75-79 and 7% at age 80 (Norland, 1994). The same phenomenon was found among women, whose participation in the work force dwindled from 14% for those aged 65-69 to 6% for the 70-74 age group and 3% for women 75 or older. Due to these trends, the importance of employment income decreased significantly from 1971 to 1986 in the composition of seniors' total income, falling from 22% to 10%.

2.4 Unequal growth in income

In terms of financial resources, as we have seen throughout this section, seniors are not a homogeneous group defined by age alone. Their socioeconomic status varies based on a range of factors such as gender, marital status and occupational activity. In 1985, the average income of seniors in the top income group ($21,048) was nearly three times that of elderly in the lowest income group ($7,474) (Oja and Love, 1988). Those without private pensions or investment income, mostly women and unattached individuals, not only have the lowest average income level but are also far more dependent on government transfer payments. In 1991, while the majority of seniors (58.7%) had incomes under $15,000, 4.8% enjoyed incomes over $50,000 and 0.9% had incomes in excess of $100,000 (Table 8).

These disparities in income distribution among the elderly initially seem to stem from the realities of a segmented labour market that enables only some individuals to save for retirement. A Statistics Canada study (1996) shows that from 1991 to 1993, only 20% of persons with annual incomes under $10,000 contributed, for purposes of their retirement, to RPPs or RRSPs. This percentage rises to 56% for workers earning between $10,000 and $19,999, and to 90% for those earning $30,000 to $39,999. The percentage is nearly 100% for those earning over $40,000. In 1993, persons in the latter group accounted for two thirds of the amount saved in RRSPs and RPPs, while representing less than a quarter of individuals reporting such savings. Statistics Canada (1996) also shows that the proportion of women who put money aside for their retirement at least once in the past three years (53%) is substantially lower than the percentage for men (66%). The data presented by Frenken and Maser (1992) tend to confirm findings of a positive relationship among the ability to save for retirement, the fact of being male, and belonging to a high income category. A study by these authors indicates that more full-time (53%) and unionized (over 75%) workers participate in RPPs than part-time (24%) and non-unionized (30%) workers. In 1989, the participation rate was 82% for workers with employment incomes from $40,000 to $59,999, and 73% for those earning $60,000 or more.

Only 27% of workers with incomes under $20,000--62% of whom are women--participated in such plans. Overall, more men (54%) than women (42%) contribute to RPPs[13], a difference that Frenken and Maser (1992) explain by noting the overrepresentation of women among part-time workers and their overconcentration in the service sector of the economy, where jobs are uncertain, low-paid and unstable.

These general data on workers as a whole become relevant to our study when linked to the distribution and composition of the elderly's income. For example, in 1993 (still according to Statistics Canada (1996) figures), a high proportion of taxfilers aged 65 or older with total incomes under $20,000 were largely dependent on OAS, GIS and the C/QPP, from which they derived 75% of their income. RPP benefits comprised the major portion of the income of seniors with incomes in the $30,000-$59,999 range. Only 5% of the income of those with annual incomes of $60,000 or more derived from government programs; the C/QPP represented the largest share of this 5%.

The findings in Canada also apply to other countries. For example, similar trends were seen in both Britain and the United States. Falkingham and Johnson (1992) note that from 1970 to 1980 in England, incomes of seniors rose more than workers' incomes. But all elderly did not experience such gains equally. While receiving sizeable employment pensions from social insurance schemes, a minority of seniors can count on savings and investment income, whereas a large proportion remain dependent on public benefits. This duality means that elderly females are more likely to live in poverty than elderly males (Arber and Ginn, 1991). In addition to the sexual division of labour and pervasive job discrimination, the non-continuous nature of women's work careers significantly reduces the number of years of contributions enabling them to receive adequate benefits from private pension schemes. Moreover, the rules governing eligibility for public pensions are only designed on the basis of employment and remuneration profiles of middle-class men (Arber and Ginn, 1991).

[13] The percentages of men and women participating in RPPs vary in the public and private sectors. Whereas in 1989, the participation rate was 81% for men and 66% for women working in the public sector, the corresponding rates for the private sector were only 47% and 30% (Frenken and Maser, 1992).

In the United States, the elderly's economic situation is also seen to have improved in recent years due to social security and private pension systems (Crown, 1989; Kilty, 1990). Kart et al. (1989) report that 50% of seniors and 40% of households headed by an elderly person can be viewed as belonging to the privileged class. These groups have numerous income sources providing them with an average income of over twice the official poverty level. According to the latest census, only 7.6% of elderly families and 26.9% of unattached elderly persons live below this level. And yet, as in Canada and Britain, Hardy and Hazelrigg (1993) note the existence of a process of feminization of poverty among the elderly. Based on data supplied by Laing (1990), the average social security benefits in 1988 were $655 for men and $426 for women. Moreover, 40% of women and less than 10% of men receive benefits of under $350. Given these findings, Crystal and Shea (1990) affirm that social security programs generate more inequalities than the labour market and reinforce those built up during one's working life. Using a distribution by quintile, these authors note that the most disadvantaged 20% of the elderly population--mainly comprised of elderly women, ethnic minorities and the physically disabled--receive only 5.5% of the resources allocated, whereas the most privileged 20% alone consume 46% of the total allocations. Finally, in very old age, the economic vulnerability of some categories of women seems to have increased rather than decreased (Holden and Smeeding, 1990). This vulnerability stems from a series of factors including race, class, prior work history and gender. Low hourly wage rates and the poor-quality jobs held by women during their prior working lives account for the fact that a large portion of women reach the threshold of old age without having been able to contribute to pension plans, so that the public benefits that comprise their sole source of income are not enough to keep them above the poverty line.

Back in Canada, we can refer to Statistics Canada's Ageing and Independence Survey (1991) and the related analyses conducted by L. McDonald (1994) to highlight again the factors of gender, marital status and occupational activity in influencing retirement behaviour. For men, the variables associated with early retirement appear to include being married, having a high level of occupational prestige, a high level of education, a job in the core sector of the economy, a job-related pension, owning a home, and having an adequate retirement income. Men's later retirement is associated with lack of a job-related pension, mandatory retirement provisions, unemployment rates, and small household

size. The associated variables are the same for women, except that women's early retirement is also linked to being married with children, providing care to family members, or having a chronic health problem. Women's late retirement is also associated with not being married, a lower educational level, and a poor financial situation.

SECTION 3

HEALTH

Seniors are in better health today than they were a quarter of a century ago. Changes in their health vary according to gender, income category and marital status. This section looks at patterns of illness, prevalence of morbidity and causes of death and hospitalization.

3.1 Two approaches to health issues among the elderly

There are two main models regarding the elderly population's medical and health care needs. The first, that of the compression of morbidity, maintains that technological and medical advances have been able to postpone the symptoms of chronic disease to the very end of life (Fries, 1983). According to this approach, as life expectancy increases, health problems will be limited to the final years of life. Controlling the rate of progression of chronic illnesses will greatly reduce the risk of disability. Since disabilities and quality of life deterioration among the very old are more closely tied to the eventuality of death than to chronic disease itself, medical and health care needs will tend to decrease rather than increase (Fries, 1980). However, Kramer (1981) and Gruemberg (1977) claim that the prevalence of chronic disease and long-term disabilities, on the contrary, is growing as the elderly's life expectancy lengthens. This phenomenon does not involve either a decrease in the progression of chronic illnesses or a decline in their incidence rate. It simply means that the fatal effects of these illnesses are now being controlled and that the elderly are suffering them longer (Schneider and Brody, 1983). Since there is little evidence that chronic disease is limited to the final stage of life (Manton, 1982), we should expect to see a greater demand for health care and an expansion of services. Based on certain Canadian and American studies, Simmons-Tropea and Osborn (1987) also find that, although the effects of fatal illnesses such as cardiovascular disease are now being controlled, the situation is entirely otherwise for non-fatal illnesses likely to result in handicaps and disability. In general, other than heart disease, stroke and diabetes, the illnesses that end life are not necessarily those that affect its quality. Northcott (1992) adds that seniors today are more likely

to die from a chronic and degenerative disease than an infectious illness. Death is most often caused by cancer, heart disease or stroke.

3.2 Changes in patterns of illness and causes of mortality and morbidity in seniors[14]

Over the last few decades, the patterns of illness affecting seniors have changed. The elderly are suffering fewer strokes and more chronic and degenerative illnesses. These illnesses, whose progression is always linked to a slow but gradual destruction of cognitive and functional capacity, often lead to loss of autonomy, dependence, and increased demand for health care and services (Québec, 1991). A 1987 Santé Québec study identified arthritis, rheumatism, hypertension and mental disorders as the most common health problems among the elderly (Émond, 1988). At the Canadian level, similar trends have been noted by Baker (1988) and the National Advisory Council on Aging (NACA). In fact, in a series of "Aging Vignettes", NACA (1993) showed that in 1985, 55% of Canadian seniors suffered from arthritis and rheumatism, with 39% experiencing hypertension and 24%, respiratory problems.

A study by Stokes and Lindsay (1996) offers a fairly complete picture of changing trends in major causes of death and hospitalization in Canadian seniors over the past few decades. The authors underscore that the average decline in the death rate varied from 0.5% to 2% annually over the last 30 years. From 1984 to 1993, coronary heart disease was the leading cause of death for both sexes, followed by lung cancer whose prevalence increased 237% from 1964 to 1993. Stroke was the third leading cause, and chronic bronchitis, emphysema and asthma ranked fourth. From 1964 to 1993, the death rate due to the latter three illnesses rose 225% for men and 444% for women. However, colorectal cancer, on the increase since 1964, showed a decline as of 1983, with an annual average of 1% for men and between 1% and 2% for women. The prevalence of

[14] The data presented in this section are derived from the article "Major Causes of Death and Hospitalization in Seniors" by J. Stokes and J. Lindsay, *Chronic Diseases in Canada*, 17, 2, (1996): 63-73, and the articles "Mortalité et morbidité dans la population âgée du Canada: Rétrospective" by Kathryn Wilkins, S. Morris and R. Lane (1988) and "L'ostéoporose dans une population vieillissante" by Nancy Kreiger (1988).

breast cancer, the fifth leading cause of death for women, has not changed in the past three decades. This stability, found in the causes of both death and hospitalization, in part is due to early detection programs, which have benefited most greatly women aged 50 to 69.

From 1983 to 1992, coronary heart disease remained the leading cause of hospitalization for both sexes. The proportion of senior men affected by this illness is over one and a half times greater than the percentage of senior women affected (see Tables 9 to 10.1). Other major causes of hospitalization for senior men, by order of importance, are stroke, symptoms referable to systems, chronic bronchitis, emphysema, asthma, pneumonia and lung cancer. Women more frequently experience accidental falls, fractures of the femur, intestinal illnesses and diabetes. The third-ranking cause of hospitalization for both sexes, symptoms referable to systems increased 5% from 1973 to 1983, before showing a persistent decline up to 1992.

Despite its continuing to rank first among causes of death and hospitalization, coronary heart disease showed a 30% decline for men and a 35% decrease for women from 1971 to 1986 (Wilkins, Morris and Lane, 1988). This decline is chiefly linked to technological advances and improved quality of life and environmental conditions. During the same period, the *age-standardized mortality rates* (ASMRs) due to stroke--the second leading cause of death for women aged 65 or older, and the third for men of the same age--also indicated a 43% decline for both sexes. Wilkins (1995) underscores that from 1950 to 1993, death rates due to circulatory system illnesses dropped 64% for women and 52% for men.

Other ASMRs, however, were marked by significant increases. From 1971 to 1986, the ASMRs for lung cancer rose 46% for men and 20% for women. The ASMRs for chronic respiratory illnesses such as bronchitis, emphysema and asthma also showed comparable increases. In 1986, lung cancer and chronic respiratory illnesses caused 10% of all deaths of persons aged 65 or older in Canada (Wilkins et al., 1988). The importance of chronic respiratory illnesses as a cause of death also grows with age. From 1969 to 1986, the mortality rate due to these illnesses for persons aged 85 or older was nearly

three times that for individuals aged 65 to 74 (Wilkins et al., 1988). Tobacco use is apparently responsible for 80% of the incidence of lung cancer in men and 40% of the incidence in women.

A large proportion of seniors also suffer from osteoporosis. In North America, this disease, which causes deterioration of the elderly's bone structure, leading to fractures of the wrist, spine and hip especially (Kreiger, 1988), affects 25% of menopausal and post-menopausal women. In 1981, there were 18,000 cases of hip fracture in Canada, resulting in $166.6 million in health system costs. In 1989-1990, this figure increased to 25,000, generating costs of $400 million. Hip fractures due to osteoporosis are a cause of death in 12% to 20% of cases; 75% of survivors do not regain their prior functional capacity. In the first year of the illness, hip fractures due to osteoporosis cause the death of 20% of women and 34% of men.

More senior women than men are affected by osteoporosis. In 1982-1983, 66% of cases of hospitalization recorded in Canada for causes related to osteoporotic fractures involved women. From 1979 to 1983, hip fractures ranked from twelfth to twentieth among all causes of hospitalization, and were fifth or sixth for elderly women. The incidence of osteoporosis varies according to gender, age, race and endogenous hormonal status (Kreiger, 1988). In 1986, 93% of men and 98% of women suffering a hip fracture were at least 70 years of age. Based on hospital discharge statistics, Kreiger (1988) places the incidence rates in Canada at 8 per 1,000 for elderly men and 18 per 1,000 for elderly women. She notes that data from the *U.S. National Hospital Discharge Survey* show similar rates in the United States, i.e. 7.4 per 1,000 for Caucasian males aged 80 to 85 and 17.3 per 1,000 for senior women with the same characteristics.

A study by two French authors, Dargent-Molina and Bréart (1995), also highlights the role of osteoporosis in accidental falls, which Wilkins (1995) terms the most common "external" cause of death for Canadian seniors, especially women. This study, which reviews findings from several studies in the United States, Britain, New Zealand and Sweden, claims that roughly a third of the elderly population falls at least once a year, and that the proportion of women experiencing falls is twice as

high as for men. The percentage of falls leading to fractures can be estimated at 5%. Another 5% to 10% result in serious traumatisms caused by wounds, sprains or hip fractures. The authors believe that the causes of such falls are many and varied. They result from "the combined effect of aging, various pathologies affecting the balance, the taking of certain drugs and environmental and behavioural factors" (Dargent-Molina and Bréart, 1995: 76).

3.3 Mental health problems in seniors

Two major mental health problems for seniors are depression and suicide. The suicide rate, higher for elderly men than elderly women, has been continually rising since 1978. From 1977 to 1986, the suicide rate for Canadian seniors increased from 10% to 13% of all cases of suicide. In 1993, the rate for men aged 65 or older was 24 deaths per 100,000 men (Wilkins, 1995). A group of experts examining the problem in Québec pinpointed several explanatory factors, the main ones being widowhood or widowerhood, living alone, social isolation, physical illness, alcoholism, and feelings of rejection (Québec, 1991).

Alzheimer's disease including presenile dementia is currently the tenth leading cause of death in Canada (Huang and Lindsay, 1996). This illness is the most common cause of dementia in North America and Europe, accounting for 50% to 60% of all cases of dementia found in seniors (Ebly, Parhad, Hogan and Fung, 1994). In 1988, Hill noted that it was difficult to arrive at a specific diagnosis of Alzheimer's disease. Indeed, major epidemiological studies focusing on dementia in general were unable to accurately estimate the prevalence of this disease or the number of deaths it caused (Hill, 1988). Based on the convergence of two American and two Scandinavian studies centring on a small number of individuals and using different design criteria, the author placed the incidence rate for Alzheimer's disease at approximately 1 in 1,000 at age 60 and 1 in 10 at age 95. Referring to other American studies[15], he also maintained that, at five to eight years, the average life

[15] These are two longitudinal studies, one conducted in Minnesota and the other in Baltimore. In the first, the duration of survival of affected individuals was compared to that of the general population. In the second, a comparison was made between persons in the same cohorts.

expectancy for seniors with Alzheimer's disease was greater than that of institutionalized dementia patients. Their mortality rate differed very little from that of unaffected persons in the same age cohort. But knowledge on Alzheimer's disease and the ability to diagnose it have since advanced. The "NINCDS-ADRDA" diagnostic criteria are now almost universally employed, offering a more than 85% degree of reliability in diagnosing the various forms of dementia.

Partial results from the national study on the prevalence of dementia and Alzheimer's disease conducted by the *Canadian Study of Health and Aging* (CSHA) shed light on the consequences of Alzheimer's disease and dementia in general. According to the CSHA (1994), the various forms of dementia are among the most distressing and demanding of illnesses, involving risks for both the elderly persons affected and their caregivers. In addition to its many social, medical and economic implications, dementia is a major cause of illness and death in seniors aged 85 or older (Ebly et al., 1994). The results[16] of this study assess the proportion of Canadians aged 65 and over suffering from various forms of dementia at 8%, representing a total of 252,600 seniors. Twice as many women as men are affected, reaching a ratio of 2.9 women for every man in the oldest age group. The rate for dementia in general ranges from 2.4% for persons aged 65 to 74 to 34.5% for those aged 85 or older.

Alzheimer's disease afflicts 5.1% of Canada's elderly population. It represents 64% of all cases of dementia encountered, and 75.3% of cases are diagnosed in persons aged 85 or older. Its prevalence varies from 1.0% for seniors aged 65 to 74 to 26.0% for persons 85 or over. Its incidence far outstrips the next leading form of dementia, vascular dementia, which affects 1.5% of all seniors, with a prevalence ranging from 0.6% for groups aged 65-74 to 4.8% for those over 85. Vascular dementia accounts for 19% of all cases of dementia encountered, and shows a balanced ratio between the sexes. In general, some of the leading risk factors for Alzheimer's disease are age, family history and cranial traumas. New findings indicate that continued exposure to glues, pesticides and fertilizers

[16] These results appear to be authoritative in this field. In an article published in the *Canadian Journal of Psychiatry*, Rockwood and Stadnyk (1994) maintain that this longitudinal study, involving a large sample of seniors living in both the community and institutions, offers the best estimates on dementia in general and Alzheimer's disease in particular.

represents another probable risk factor. Finally, a correlation has been found between susceptibility to this illness and a low educational level (CSHA, 1994).

As seen in Table 11, the prevalence of dementia increases with age. However, there is a lack of consensus as to its progression rate. Several authors find that after age 65, the prevalence of dementia doubles every five years within a given cohort, and that after age 84, the increase does not appear to be statistically significant. Ebly et al. (1994) disagree with this finding. They maintain that, on the contrary, dementia continues to increase with age. The rate of 28.5% found among the 85 and over age group is twice that of the 75-84 age cohort. While the proportion of afflicted persons aged 84 to 89 is 23%, the percentage rises to 40% for those aged 90-94, and 58% for persons 95 or older. The exponential model used by Jorm et al. (1987: 472) in their meta-analysis shows that up to about age 95, the prevalence of dementia doubles roughly every five years. These authors, however, acknowledge that the problem is complex. Not only does the progression rate vary according to the type of dementia studied, but prevalence findings can also be influenced by a number of factors, including the research model used, the sample composition, the way dementia is defined, and the measurement tools employed.

3.4 Assessing the current state of health of the elderly

Seniors today enjoy better health than earlier generations. Their life expectancy is longer than ever before: at age 65, a man has an average life expectancy of 15.4 years and a woman, 19.6 years (Norland, 1994). From 1951 to the present, these life expectancies increased 2.1 and 4.6 years respectively. The death rate due to cardiovascular disease declined by 50% from 1951 to 1981, and the death rate due to flu, bronchitis and pneumonia decreased 70% for men and 90% for women.

In subjectively assessing their state of health, 68.9% of Québec seniors say that they are in “good” or “very good” physical and mental health (Santé Québec, 1987). In connection with their good health, they claim to enjoy a high degree of well-being and personal satisfaction. According to data

from the 1991 General Social Survey (GSS), the percentage is even higher at the Canadian level (see Norland, 1994). A 72% majority of Canadians aged 65 and over rated their health as "excellent", "very good" or "good". Only 28% viewed it as average or poor. The level of personal and social satisfaction was 94%. While 46% of seniors were affected by some type of incapacity, only 20% of the elderly appeared to need help in their daily activities due to functional disabilities.

The literature examined, however, suggests that income category, gender and health are closely linked since low-income seniors have more physical and mental health problems than well-off individuals (Hirdes et al., 1986), and women experience more of these problems than men (Gee and Kimball, 1987; Verbrugge, 1989). Poor, non-Caucasian and less-educated individuals are more likely to suffer ill health than those with significant economic and educational resources (Baker, 1988). The former live shorter lives and experience more cardiovascular disease, diabetes, cancer and hypertension (Feinstein, 1993). The proportion of elderly men in the top income group who assess their health as good is 20% higher than in the group of unskilled workers. Even at age 80, women in the top income category are more likely to enjoy better health than semi-skilled or unskilled 70-year-old women (Arber and Ginn, 1991).

Herzog, House and Morgan (1991) note the impact of prior working conditions on seniors' health. On the one hand, professionals of both sexes, who are able to choose their field of work, enjoy better health at retirement. On the other hand, mortality rates at retirement for "blue collar" and unskilled workers are higher than rates for the group of professionals. A study conducted in Ontario by Roberge, Berthelot and Wolfson (1995) confirms these findings in establishing a positive link among health, longevity and socioeconomic status. Income category, educational level and occupation affect health both objectively and in the way it is subjectively viewed. These aspects not only determine the prevalence of health problems and types of disability, but also influence seniors' perceptions of themselves. Frideres' study (1994) links Natives' precarious state of health and lower life expectancy to their marginal position in Canadian society, low educational level and very high levels of unemployment and poverty.

American authors also find a causal relationship between precarious socioeconomic status and poor health at retirement, which they especially note among seniors belonging to Black, Hispanic and Native minorities in the United States (Markides and Black, 1996; Yee and Weaver, 1994). These ethnic seniors have a reduced life expectancy. They experience far more hypertension, diabetes, hepatitis, cardiac arrest, and accidents. Poor, Black and female elderly have higher durations and rates of functional disability and dependence than those of their White contemporaries, even when the latter are older (Belgrave and Bradsher, 1994; Yee and Weaver, 1994). The latter two authors leave no doubt as to the link among belonging to a given social class, socioeconomic factors, and prevalence of certain types of illness. They maintain that the frequency of cancer in seniors increases in higher social strata, whereas stroke is most often found among individuals in lower social strata.

The prevalence of illness also varies by gender. The most common illnesses among women of all ages are heart disease, osteoporosis and throat cancer. Twice as many women suffer from depression and Alzheimer's disease as men, who however show a higher frequency of heart disease, asthma and bronchitis. Whereas less fatal illnesses such as arthritis, rheumatism, hypertension and mental problems are more often seen in women, men experience more severe handicaps, emphysema and virulent forms of cancer. Heart disease is the leading cause of death for both sexes. The frequency of health problems and disability is also higher for women than men. Verbrugge (1989) finds that women, although they live much longer, suffer far more incapacitating chronic illnesses. However, the indicators of gender and socioeconomic status, which researchers attempt to separate in studying seniors' health, very often overlap in practice, given the fact that women represent the majority of persons living below the poverty level. According to Arber and Ginn (1991), these women are poor not because they are old, but because they are the victims of structural inequalities linked to the fact of being women. Faced with discrimination in the labour market during their working lives, they have been unable to accumulate adequate material and financial resources to allow them to enjoy good health at retirement, to have equal access to specialized health care and services, or even to create personal spaces of sociability and well-being (Arber and Ginn, 1991).

SECTION 4

INTERGENERATIONAL RELATIONSHIPS

Demographic aging, longer life expectancies, declining birth rates, changes in family structures, and State intervention in the development of a social safety net are profoundly altering relationships among age groups and helping to create new configurations in family structures (Attias-Donfut, 1995; Bourdelais, 1993, 1994; Bengtson and Giarusso, 1995).

4.1 Types of intergenerational relationships and the middle generations

Today, more than before, there can be four and even five generations in a single family. These changes in family structures are engendering different types of relationships and interactions among generations and new ways of expressing intrafamilial solidarity revolving around a wide variety of help and services (Buisson and Bloch, 1992), of which "the flows are differentially directed according to the individuals they benefit" (Conseil économique et social, 1993). These exchanges can be instrumental, functional, practical, emotional, affective and associational (Rosenthal, 1987). They may take the form of financial assistance, practical help with daily chores, child care, or care for dependent elderly parents. They may also involve help in housing, helping young couples set up, personal care and services, or providing a reassuring presence in times of crisis. In other words, these relationships of mutual aid, on which intergenerational relationships are structured, encompass both material and symbolic values. They foster the interaction of various forms of solidarity so that the family appears as a "micro-society", an organization where descendents and ascendents assume responsibilities and perform specific tasks to give meaning and significance to their place in the family line (Bengtson and Giarusso, 1995).

The international studies examined stress the part that people in their fifties play in developing and restructuring intrafamilial solidarity (Attias-Donfut, 1995; Schaber, 1995). Their central role in the

new family structures suggests that the flow of exchanges involving individuals can only be assessed in relation to the individual's place in the family life cycle and position among coexisting generations (Attias-Donfut, 1995). This comment is even more relevant in that generations are "social constructions, actually situated within a continuum where changes are gradual and the thresholds impossible to determine" (id.: 44). Aside from the varied disciplinary analyses they inspire in theory, generational identities are altered in practice as the individual's position in the family cycle changes. Schaber's comparative study (1995) on Luxembourg and the United States also highlights this dynamic and structured aspect of intergenerational relationships. Schaber maintains that help provided by the different generations changes over time and that the nature of the contribution to intrafamilial solidarity depends on the life stage in which the generations are situated. If adults provide more support in the beginning, the help changes in focus and direction when the adults in turn grow old or very old.

Although different in design, these two studies[17] arrive at a number of similar conclusions. First, in three-generation families, members of the middle generation are the major providers of services; the young, called upon more for emotional support when needed, benefit more than the elderly, who nevertheless receive a higher than average level of help. Secondly, both studies find that monetary exchanges generally follow a path descending from older to middle generations, from middle to younger and from oldest to youngest, with the opposite order representing the exception. Both studies also show that aside from money and time (services), cohabitation among generations is an important element in intergenerational or intrafamilial solidarity, enabling, for example, young people living with their elderly parents in Luxembourg to realize savings of up to 75% of their expenses for housing, living and food, not to mention child care and housework. The work of French researcher Attias-Donfut is also original in attempting to integrate intergenerational relationships into a temporal and historical dynamic by looking back to the 1960s and 1970s to explain the current orientations of intrafamilial solidarity and the flow of exchanges it is structured around (Attias-Donfut, 1995). This

[17] The study conducted by Attias-Donfut is designed on the basis of a random sample drawn from 1990 French census data, whereas Schaber's study is comparative, using data from an American panel (*Panel Study of Income Dynamics, PSID*) and a Luxembourg panel (*Vivre au Luxembourg*). Income dynamics is a focus in the second study.

turning point marked by discontinuity in the succession of generations is characterized by two major historical reference points. First, the still young middle generations had developed new family models prompting them to be harder on their parents than their children. And second, the massive intervention of the welfare state in development of the social safety net spawned what the author herself terms "the generation of public solidarity".

Viewed from another angle, this historical dimension is the analytical basis of a longitudinal study[18] conducted in the United States by Bengtson and Giarusso (1995). Since the main focus was continuity and change in relationships within a given family, the authors developed a temporal analysis showing that after 20 years, and despite the maturing of the middle generation and aging of their parents, the way the different generations perceive emotional solidarity changes very little. In 1991 as in 1971, parents invest more than their children in the parent-child relationship; the former place considerable emphasis on emotional solidarity and experience it more intensely. Thus, despite profound changes in family structures and the development of public social welfare systems, parent-child bonds retain all their strength and meaning over time. Affective intergenerational family solidarity is still valued and remains an important priority in society today (Bengtson and Giarusso, 1995: 95).

4.2 The family as a special sphere of intergenerational relationships

The myth of abandonment of the elderly by younger members of their family cannot withstand the empirical evidence presented in the literature (Rosenthal, 1982, 1987; Bengtson and Harrotan, 1994). Despite the structural transformations it is undergoing, the family is still a source of interaction and support for a large proportion of the Canadian population (Connidis, 1989). It provides a high quality of help to its oldest members and offers them emotional, social and practical support. By comparing data from Statistics Canada's 1985 and 1990 General Social Survey and the national Ageing and

[18] This study, conducted by the University of Southern California, involved 300 families. It lasted from 1971 to 1991, during which period the respondents were interviewed four times.

Independence Survey of 1991, Chappell and Prince (1994) note that the vast majority of Canadian seniors have a nuclear family (a spouse and/or a child) and belong to a large social network. They are thus not socially isolated. They receive support from their informal network throughout their old age, and this support is not declining.

In a study conducted by Connidis (1989) in Hamilton, Ontario, the majority of the elderly stated that they were in contact with a child they could turn to when needed, but that a spouse, especially a female spouse, represented their most important resource. In most cases, the supportive child apparently lived quite near the elderly person interviewed. The French study by Attias-Donfut (1995) reached similar conclusions on the importance of spatial proximity in structuring intergenerational relationships. It showed that 49% of the elderly parents interviewed lived less than a kilometre away from one of their children and that 90% were less than 50 kilometres away.

The findings of Garant and Bolduc (1990), in the context of their review of the literature[19] on caring for the dependent elderly and the contribution of formal and informal services, also confirm that the family is still the major source of help for seniors losing their autonomy. The family is not only there for them, but also provides the needed care in a proportion of up to 80%, depending on the country examined (Brody, 1985). Other Canadian and American studies (Day, 1993; Chappell, 1989; Gerald, 1993; Lesemann and Martin, 1993; Monk and Cox, 1993) have shown similar rates. This support, targeting both material and emotional needs, continues even when institutionalization proves unavoidable (Hagestad, 1995; Paquet, 1990, 1996). The family is not simply an alternative to institutional care, but is in the process of taking over from the State in a context of limited resources (Maheu and Guberman, 1992). According to Gerald (1993), the help it provides is more than important; it is central.

Lesemann and Martin (1992, 1993) deepen this analysis by interrelating the instrumental aspect of caring for the elderly and the meanings assigned to the family as a sphere of mutual aid, solidarity and

19 This review of the literature centred primarily on Quebec, Canadian and American literature.

structuring of identity. Because the family functions according to its rules of symbolic and material exchange and its domestic practices which nurture emotional relationships, the care it provides in the context of family life is more intense than the functional and indeed utilitarian approach of formal services. In reality, based on "social relationships, exchange, gifts and symbolic debts", family support tends to "prevent or delay the use of sheltered accommodation, and offsets and fills gaps in the public service system. It in fact regulates this system by adapting to budgetary and organizational constraints, thus enhancing institutional efficiency" (Lesemann and Martin, 1993: 266). This centrality of the domestic sphere in daily care for the dependent elderly (Strauss and Corbin, 1988) is rooted both in the psychological bonds uniting the members of a given family and the social norms that make them accountable, and indeed blame them, if they refuse to fulfil their obligation toward their elderly parents (Garant and Bolduc, 1990). Rosenthal and Gladstone (1994) also stress the ascendent nature of intergenerational relationships. Children help their dependent elderly parents, whatever their feelings toward the latter. Society places so much importance on helping one's own parents that children dare not shirk this duty without running the risk of being socially sanctioned. This thesis of social sanction is reinforced by American authors Wagner and Hunt (1994) who, in a study on a workplace eldercare program, tend to link the failure of this program to the values and meanings the members attach to caregiving[20].

Parent-child support is generally effected within a relationship of exchange (Dowd, 1980, cited by Connidis, 1989) based on the fundamental norms of the principle of reciprocity (Bengtson and Roberts, 1991). Some types of exchange follow an ascendent order and others a descendent pattern. For example, seniors and adults provide more financial assistance to younger generations than they receive. On the other hand, children supply more practical help, including personal care and services, home repairs and performance of daily household chores (Rosenthal, 1987). Although the elderly sometimes use the financial assistance they provide to increase their position of power over their children, their health care needs often place them in a position of relative weakness (Connidis, 1989).

[20] According to the authors, the majority of employees in this company refused to participate in this program set up in their workplace because they felt that caregiving involved a dual aspect, i.e. instrumental help combined with affective and emotional support.

This interplay of interdependence and multifacetted solidarity, which underlies the familial social bond, is thus essential to the realization of various aspects of intergenerational relations.

4.3 Intergenerational relationships, social class and the role of women

The nature and orientation of intergenerational solidarity, however, vary according to a certain number of factors such as social class, gender and type of family unit. For example, working-class parents receive more help from their children than middle-class parents. Whereas exchanges in working-class families primarily involve services, middle-class families tend to offer help in the form of money and gifts. Elderly working-class women are more likely to live with their children, in exchange for services they provide. Elderly middle-class women keep in touch with their grandchildren more by phoning and letter-writing. Reciprocity in services is common for the working class, whereas occasional exchanges directed from older to younger family members are typical of the middle class.

Middle-aged women are central to intergenerational relationships. They meet a variety of demands, first in providing instrumental services and in acting as liaisons between members of the family line and second, as sources of emotional and moral support for members of the extended family. Sometimes having to combine paid work, family life and care for a dependent loved one, they are active on all three fronts; this often necessitates a complex organization of daily life and causes difficult living conditions (see Maheu and Guberman, 1992; Martin Matthews and Rosenthal, 1993; Martin Matthews and Campbell, 1995). This combination also induces a spatial and temporal reorganization that profoundly alters forms of social interaction in the nuclear family (Facchini, 1992). Due to this complexity and the fragmentation and number of tasks they perform, some authors thus refer to a "generational squeeze", and term them "women in the middle" or the "sandwich generation" (see Rosenthal, 1987). Bourdelais (1994) speaks of a "pivotal generation in family life" to generally describe the central and active role young retirees in their sixties play in society today. However, Connidis (1994) views this approach to the problem of middle-aged women being overburdened by

work as somewhat exaggerated. She claims that given the improvement in seniors' general health, the percentage of women combining paid work and care for the elderly must be relatively low. The actual possibility of being caught in the middle is therefore limited.

Nevertheless, no matter how the role of women caregivers is evaluated in structuring intergenerational relationships through care for the dependent elderly, their contribution is fundamental. Not only are they more involved than men in caring for elderly parents, but daughters also supply the needed help three times out of four (Renaut and Rozenkier, 1995). Sons only help 29% of elderly parents. The dominant role of women is especially obvious in families of mixed composition, where daughters provide 64% of the care for dependent elderly parents (id.).

Hagestad (1995) corroborates these findings. In her study on the health of the very old in Norway, the author underscores that while help and care are supplied by a daughter in half the cases and by a daughter-in-law in a third, only in a tenth of all cases are they provided by a son. In multigenerational structures, women are still the ones most often involved in negotiations to obtain public help, and in effectively coordinating institutional public help and private family help to keep the dependent person in his or her usual living environment. Whereas men's contribution seems mainly limited to material, economic and financial assistance, women's responsibilities range from satisfying material and concrete needs to ensuring psychological well-being (Jutras and Renaud, 1987).

Several authors have advanced different viewpoints to explain this social "sexualization" of caregiving which, according to Hagestad, is reproduced, maintained and encouraged by the various social policy systems. The review of the literature by Jutras and Renaud (1987), for example, seems to highlight the fact that historically, women did not work outside the home and were thus allotted the responsibility of looking after the family's health. Lesemann and Martin (1993) add that after the transformations occurring in traditional roles, caregiving represents one of the most reliable indicators of current societal dynamics. If it fosters the interplay of emotional relationships involving both the

"spirit of selfless love" and the bonds of obligation that mark family ties and exchanges, caregiving is also a material demonstration of unequal gender relationships. Facchini (1992) concludes that it is the dominant cultural system that assigns women the exclusive responsibility for caregiving.

SECTION 5

IMPLICATIONS FOR SOCIAL POLICIES

This review of the literature has attempted to document changes in the process of aging over the past few decades. Social policies are not unaware of these, but will undoubtedly have to take greater account of such changes if they wish to continue to meet the real needs of the elderly population.

In 1970, Canada's federal government and provinces began to significantly improve their pension systems and social and health care services. Government transfer payments have markedly contributed to the welfare of the elderly by offering them relative financial security. Although these government interventions increased their dependence on the State (Walker, 1983), the new generations of seniors have experienced better living conditions than earlier generations. The economic situation of the elderly has continued to improve. However, profound income inequality still exists (Myles, 1989). It is important that gaps in the social safety net targeted to seniors be narrowed in an effort to reduce such inequality. From this perspective, it is a question of determining to what extent programs with benefits based on chronological age are still justifiable and effective (Neysmith, 1987). In a context of acute economic crisis, to what extent can they still meet the needs of an elderly population whose numbers and life expectancy continue to rise? As Bourdelais notes, at age 60 or 65, today's seniors are not necessarily old or tired. In these circumstances, retirement tied to a specific age seems to relegate to the sidelines people who are to work and still able to contribute to the welfare of society.

Although many elderly still face difficult economic situations, a large proportion of seniors have a satisfactory annual income. We must therefore ask how the universal redistribution mechanisms social policies have represented to date can reach their social objectives, especially if they remain specifically centred on the notion of age. In that we know that seniors' socioeconomic situations vary according to a series of factors, a differential approach to financial support for the aging process must be developed, since the equity advocated by social policies cannot be achieved, especially in the case of

women, without considering aspects such as life paths, work histories and the accessibility of public and private pension systems. It has been shown that government OAS, GIS and SA programs will continue to represent a crucial income source for persons who have been unable to save or work long enough to be entitled to benefits through contributions to the C/QPP or RPPs. From this viewpoint, the goal of improving the economic situation of tomorrow's elderly is indissociable from the need to combat the causes of poverty and dependence at retirement, i.e. segmentation of the labour market, the occupational "ghettoization" of women, unequal access to employment, and pay disparities.

It is true that social old age policies have in part adapted to the changing realities of aging. Since its inception in 1952, the retirement system has continually evolved to better respond to many new realities, moving from allocation of fixed benefits to seniors to implementation of the GIS in 1966, the spouse's allowance in 1975, indexing in 1974 and, in 1989, total or partial repayment of benefits through taxation. The proposal, as of July 1996, to pay partial benefits to seniors with annual incomes over $53,215 and even eliminate benefits for those with incomes over $84,195 also represents a fundamental shift, in that the old age security system is abandoning its universality in favour of a selective policy. The government has made a choice between programs centred on age and those based on income and need.

The elderly's health has also improved over the past three decades, undoubtedly due to the series of health and preventive measures and those aimed at altering harmful behaviours which have stemmed from public health initiatives, but also due to access to health care made possible by the setting up of a universal health care system. We know nevertheless that various cultural and social barriers continue to restrict some categories of the aging population from access to healthy behaviours and adequate care. This review of the literature has shown that the majority of seniors assess their physical and mental health positively and objectively enjoy good health. Beyond this, several studies suggest that exorbitant health system costs have far more to do with the overmedication and overmedicalization of old age than with demographic aging as such. However, we must recognize once again that health varies according to gender and income.

In the area of social services and care, social policies have also prompted a significant shift toward family and community resources by beginning, in the late 1970s, to limit institutionalization of the elderly and simultaneously encourage the development of home help services (Chappell and Prince, 1994). This shift has resulted both from governments' determination to cut service and care costs and from the elderly's desire to continue to participate in social activity by maintaining their independence as long as possible. Home help has thus become the spearhead of a new health and social services policy aimed at linking economic and fiscal imperatives to seniors' needs for autonomy and independence. Involving a reorientation of services toward the local and community levels, typified in principle by relationships of self-help and solidarity (Lesemann and Nahmiash, 1993; Chappell and Prince, 1994), home help is part of a new philosophy that highlights the social aspect of health while prioritizing prevention. Emphasis is thus placed on environmental factors such as social isolation, poverty, precarious housing conditions and financial insecurity. With the goals of social reintegration, independence, autonomy and respect for private life, various types of informal and community support are made available to the elderly; "the services have a coordinating role, are complementary to family resources and mobilize resources available in the community" (Lesemann and Nahmiash, 1993: 84). This policy shift toward provision of support for family resources has helped to fuel a debate on the hypothetical substitution effect produced by this availability of services, whereby public services are said to supersede family help. Studies on this issue concur that services provided to families in no way lead to caregivers relinquishing their caregiving responsibilities (Chappell, 1989).

A great many authors throughout the industrialized world have stressed the increased role of women in home care and caregiving. Studies in Canada (Guberman, Maheu and Maillé, 1991; Chappell, 1992; Lesemann and Nahmiash, 1993; Martin Matthews and Rosenthal, 1993; Chappell and Prince, 1994; Martin Matthews and Campbell, 1995) have, among many others, underscored the diversity and complexity of tasks and the social isolation experienced by women, aside from the demanding nature and very unequal gender distribution of the work of caregiving. Research by Gerald (1993) and Paquet (1990, 1996) also shows that the excessive workload involved in home care negatively affects not only the caregiver's personal life, but also the quality of seniors' care. The most well-known consequences are stress and fatigue caused by lack of rest or vacation time, lack of socialization, and

physical abuse of the elderly. This exacting work is even more difficult in that it requires a harmonization of multiple tasks (Guberman and Maheu, 1994; Facchini, 1992). The burden is even heavier when the primary caregiver lives with the dependent person and does not work outside the home (Jutras, Veilleux and Renaud, 1989). These caregivers must not only coordinate and organize the care, but also orchestrate formal and informal, and community and institutional, resources.

Caregivers' hardships do not only stem from the complexity and extent of their tasks. Inadequate resource allocation, lack of available services and the precarity of public support for informal caregivers also add to the burden (Roy et al., 1990) and undermine the partnership between family and State (Paquet, 1996). Although countries such as Sweden and Britain have adopted the principle of remuneration for caregivers to remedy this high-risk situation, a comparative study[21] commissioned by the British social security system (Glendenning and McLaughlin, 1993) nonetheless warns against the temptation of using this compensation system to recruit carers rather than seeing it as a means to help caregivers provide care longer and thus delay institutionalization. Without denying the effectiveness of the financial compensation approach and the need to allocate more resources to caregivers, Gerald (1993) views these measures as inadequate, since they fail to target the most critical aspect of home care: the physical and emotional exhaustion experienced by caregivers. Paquet is in full agreement and underlines the need for a preventive policy aimed not only at the elderly but their caregivers as well (Paquet, 1996: 49). The concept of payment for care is also being debated and tested in Canada (Canada, 1982; Chappell, 1989), particularly in Nova Scotia (Keefe, n.d.) and Québec (Bolduc, 1993a 1993b, the United States (Linsk et al., 1988; Keigher and Murphy, 1992; Stone and Keigher, 1994), Britain (Johnson, 1987) and Sweden (Sundstrom, 1986; Johansson and Thorslund, 1993) where there is a strong trend toward "professionalizing" caregivers. It has also been the focus of an extensive comparative study in Europe under the aegis of the European Center for Social Research in Vienna (1995).

[21] This study mandated by *United Kingdom Social Security* involved six European countries: Ireland, Italy, France, Germany, Finland and Sweden. The research project had a triple objective: 1) to systematize the various measures, 2) to document the types of measures introduced and the proposed services, and 3) to analyze the causes leading to the introduction of these measures, as well as their impacts.

The way Canada's health and social services system is organized has a major impact on the funding of home help services, which are not targeted by national financial assistance measures. The system has historically been dominated, and remains largely so today, by the medical profession and a hospital-centred approach focusing on emergency and acute care. Support for caregivers falls within the realm of community care and varies from province to province. Unless there is a major reorientation of health care based on the needs of an aging population, and a change in the professional culture of physicians who remain the "gatekeepers to health care", vigorous home help policies cannot be developed (Chappell, 1989; Lesemann and Nahmiash, 1993).

These issues lie at the heart of important discussion on the role of social policies in home help for dependent seniors and open up interesting perspectives on interrelations among the phenomena of aging, the crisis in public finances, the impact of professional cultures, employment, and re-enhancement of the roles of the family and the domestic sphere.

It is thus no longer enough today to acknowledge the family as a formal partner. Social polices must grant the latter a real status based on a recognition of needs that are not statistically standardized, but assessed from a socio-anthropological viewpoint. We can only revitalize intergenerational solidarity and the task of care by fostering a necessary interlinking of two parallel but inevitably coexisting approaches (Paquet, 1996): a family approach based on the notions of duty, gifts, emotion, reciprocity and solidarity, and an institutional approach centering on the notions of equity and universality. A better linking of community and family solidarity to availability of institutional support is crucial to current thinking in social policies for the elderly.

CONCLUSION

Over the past 30 years, broad changes in demographic population aging have challenged social policy and social transfer systems, their viability, as well as their ability to meet new needs spawned by an ever-faster growing process. First, the indicators of aging--economic vulnerability, social isolation, physical decline and cognitive loss--which largely influenced the development of these systems and led to the institutionalization of mandatory retirement, have all changed. The myth of misery that had long served to characterize earlier generations and justify their exclusion from various spheres of social activity has become obsolete. It no longer fits seniors today, most of whom, thanks to an effective meshing of public and private resources, enjoy a markedly better economic situation, improved health and longer life expectancy. Moreover, the social impacts of their social involvement and organizational abilities are sparking a positive change in seniors' role and image, both on the level of society and the community and in the area of family structures, which have become increasingly multigenerational.

This review of the literature calls into question the idea that today's elderly have been abandoned by younger members of their families. On the contrary, it would appear that despite the development of public and institutional care networks, families continue to care for dependent seniors in a proportion of some 80% to 90%. Middle-aged women play a key role in this process. The family thus remains one of the main spheres where the different generations meet, confront one another and are shaped by their continual interaction (Attias-Donfut, 1995b: 41). The family represents one of the "circuits", if not the primary circuit through which intergenerational solidarity is structured, based on a range of gifts and exchanges (goods, time, services, money) which circulate in both a descendent and ascendent pattern.

Finally, it is vital to stress that the transformations in aging do not have the same meaning for all seniors. The latter are far from a homogeneous group defined by the sole criterion of chronological

age. The daily reality of each senior is instead dependent on a number of factors including gender, educational level, degree of integration into family and community networks, prior work history, and income. It is in fact in this perspective that the relevance of the historical and comparative approach emphasized in this review of the literature is validated. It has enabled us to: understand aging and its transformations through several of its many facets; show the structured aspect of this process; highlight various groups of actors involved in the structuring of aging and orientation of the changes it has undergone; anchor issues in the study of aging in concrete, daily reality; and grasp the historical nature of the power struggles and inter- and intrasocietal differences that are helping to give shape, meaning and significance to the process of demographic aging.

REFERENCES

ARBER, Sara and Jay GINN (1993). "Class, Caring and Life Course." In Sara ARBER and Maria EVANDROU (eds.), *Ageing, Independence and the Life Course* (pp. 149-168). London: Jessica Kingsley Publishers.

ARBER, Sara and Jay GINN (1991). *Gender and Later Life: A Sociological Analysis of Resources and Constraints*. London and Newbury Park, CA: Sage Publications.

ATTIAS-DONFUT, Claudine (1995a). "Transferts publics et transferts privés entre générations." In Claudine ATTIAS-DONFUT (ed.), *Les solidarités entre générations: vieillesse, famille, État* (pp. 5-24). Paris: Nathan (coll. "Essais et Recherches").

ATTIAS-DONFUT, Claudine (1995b). "Le double circuit des transmissions." In Claudine ATTIAS-DONFUT (ed.), *Les solidarités entre générations: vieillesse, famille, État* (pp. 41-82). Paris: Nathan (coll. " Essais et Recherches").

ATTIAS-DONFUT, Claudine (ed.) (1995c). *Les solidarités entre générations: vieillesse, famille, État*. Paris: Nathan.

BAKER, Maureen (1988). *Aging in Canadian Society: A Survey*. McGraw-Hill Ryerson Limited, Library of Parliament, ISBN 0-07-549173-7.

BARTHE, J.F., S. CLÉMENT and M. DRULHE (1990). "Vieillesse ou vieillissement? Les processus d'organisation des modes de vie chez les personnes âgées," *Revue internationale d'action communautaire (RIAC)*, 23/63: 35-46.

BÉLAND, François (1982). *La famille et les adultes âgés de 65 ans et plus: un mode de cohabitation et les situations d'aide*. Québec: Ministère des Affaires sociales.

BELGRAVE, Linda and Julia E. BRADSHER (1994). "Health as a Factor in Institutionalization: Disparities between African Americans and Whites," *Research on Aging*, 16 (2): 115-141.

BENGTSON, Vern and Roseann GIARUSSO (1995). "Effets à long terme du lien filial: Une enquête longitudinale de l'Université de Californie du Sud." In Claudine ATTIAS-DONFUT (ed.), *Les solidarités entre générations: vieillesse, famille, État* (pp. 83-96). Paris: Nathan (coll. "Essais et Recherches").

BENGTSON, Vern L., Waner SCHAIE and Linda M. BURTON (1995). *Adult Intergenerational Relations: Effects of Societal Change*. New York: Springer Publishing Company.

BENGTSON, Vern L. and Robert A. HARROTAN (eds.) (1994a). *Intergenerational Linkages: Hidden Connections in American Society*. New York: Springer Publishing Company.

BENGTSON, Vern L. and Robert A. HARROTAN (eds.) (1994b). "Generational Linkages and Public Policy." In Vern L. BENGTSON and Robert A. HARROTAN (eds.), *Intergenerational Linkages: Hidden Connections in American Society* (pp. 210-233). New York: Springer Publishing Company.

BENGTSON, Vern L., G. MARTI and R.E.L. ROBERTS (1991). "Age-Group Relationships: Generational Equity and Inequity." In K. PILLEMER and McCARTNEY (eds.*), Parent-Child Relations Throughout Life* (pp. 253-278). Hillsdale: Lawrence Erlbaum Associates.

BENGSTON, VERN L. (1983). *Adapting to Family Role and the Negotiation of Change for the Aged*. Ottawa: National Advisory Council on Aging (Writing in Gerontology Series).

BINSTOCK, Robert H. and Christine L. DAY (1996). "Aging and Politics." In Robert H. BINSTOCK and Linda K. GEORGE (eds.), *Handbook of Aging and the Social Sciences* (pp. 362-387). Academic Press.

BOLDUC, M. (1993a). *Proposition d'un devis préliminaire d'une étude portant sur la formule de "l'allocation directe*." Working paper, 8 p.

BOLDUC, M. (1993b). *Le financement personnalisé: résumé de l'expérience québécoise*. Québec: Ministère de la Santé et des Services sociaux, Direction générale de la planification et de l'évaluation, 9 p.

BOURDELAIS, Patrice (1994). "Le vieillissement de la population: question d'actualité ou notion obsolète," *Débat*, 82, November-December.

BOURDELAIS, Patrice (1993). *L'âge de la vieillesse: Histoire du vieillissement*. Paris: Odile Jacob.

BRODY, E.M. (1985). "Parent Care as Normative Family Stress," *The Gerontologist*, 25: 19-29.

BRODY, E.M. (1981). "Women in the Middle and Family Help to Old People," *The Gerontologist*, 33.

BRODY, J.A. and O. COHEN (1989). "Epidemiologic Aspects of Alzheimer's Disease," *Journal of Aging and Health*, 1 (2), May.

BUISSON, Monique and Françoise BLOCH (1992). "Prendre soin de ses petits-enfants, c'est donner, recevoir et rendre," *Revue internationale d'action communautaire (RIAC)*, 28/68: 15-19.

BUREAU DE LA STATISTIQUE DU QUÉBEC (1986). *Les personnes âgées au Québec*. Québec: Les Publications du Québec.

CANADA (1996a). *An Information Paper for Consultations on the Canada Pension Plan.* Ottawa: Department of Finance.

CANADA (1996b). *The Seniors Benefit: Securing the Future.* Ottawa.

CANADA (1990). *Mise au point: Les aîné(e)s au Canada, une vie active et engagée.* Ottawa: Ministre d'État pour le Troisième Âge.

CANADA (1989). *Les personnes âgées au Canada*. Statistics Canada, Cat. No. 11-519 F.

CANADA (1986). *Longévité et tables de mortalité chronologiques*. Ottawa: Supply and Services Canada, Cat. No. 89-506.

CANADA (1982). *Canadian Governmental Report on Aging.* Ottawa: Supply and Services Canada.

CANADA (1979). *La retraite: politiques, pensions, propositions. Points saillants du Rapport du Comité spécial du Sénat sur les politiques relatives* à *l'âge de la retraite intitulé "Retraite sans douleur."* Ottawa: Approvisionnements et Services Canada.

THE CANADIAN STUDY OF HEALTH AND AGING (1994). "The Canadian Study of Health and Aging: Risk Factors for Alzheimer's Disease in Canada," *Neurology*, 44: 2073-2080.

CANADIAN STUDY OF HEALTH AND AGING WORKING GROUP (1994). "Canadian Study of Health and Aging: Study Methods and Prevalence of Dementia," *Canadian Medical Association Journal*, 150 (6): 899-913.

CARNEGIE INQUIRY INTO THE THIRD AGE (1993). *Life, Work and Livelihood in the Third Age, Final Report of the Inquiry*. Carnegie United Kingdom Trust, Dunfermline, Fife.

CHAPPELL, Neena L. (1992). *Social Support and Aging*. Toronto: Butterworths.

CHAPPELL, Neena L. (1989). *Formal Programs for Informal Caregivers to Elders*. Winnipeg: University of Manitoba, Centre on Aging.

CHAPPELL, Neena L. and M.J. PRINCE (1994). *Social Support Among Today's Seniors*. Final Report, Victoria, B.C.:University of Victoria, Centre on Aging.

CHAWIN, K. Raj (1991). "Dépendance à l'égard des paiements de transferts, de 1971-1989," *Perspectives*.

CONNIDIS, Arnet Ingrid (1994). "Growing Up and Old Together: Some Observations on Families in Later Life." In Victor MARSHALL and Barry McPHERSON (eds.), *Aging: Canadian Perspectives*, (pp. 195-205). Broadview Press/Journal of Canadian Studies.

CONNIDIS, Arnet Ingrid (1989). *Family Ties and Aging*. Toronto and Vancouver: Butterworths.

CONNIDIS, Arnet Ingrid (1986). "The Relationship of Work History to Self-Definition of Employment Status among Older Women," *Work and Occupations*, 13 (3), August: 348-358.

CONNIDIS, Arnet Ingrid (1985). "The Service Needs of Older People: Implications for Public Policy," *Canadian Journal on Aging/La Revue canadienne du vieillissement*, 4 (1), March: 3-10.

CONNIDIS, Arnet Ingrid and Julie-Ann McMULLIN (1992). "Getting Out of the House: The Effect of Childlessness on Social Participation and Companionship in Later Life," *Canadian Journal on Aging/La Revue canadienne du vieillissement*, 11 (4), Winter: 370-386.

CONNIDIS, Arnet Ingrid and Judith REMPEL (1983). "The Living Arrangement of Older Residents: The Role of Gender, Marital Status, Age, and Family Size," *Canadian Journal on Aging/La Revue canadienne du vieillissement*, 2 (3): 91-105.

CONSEIL ÉCONOMIQUE ET SOCIAL (1993). "Les activités d'utilité sociale des retraités et des personnes âgées: Rapport du conseil économique et social," *Gérontologie*, 4: 17-23.

COOPMANS, Marianne, Anne HARROP and Marijke HERMANS-HUISKES (1989). *La situation sociale et économique des femmes âgées en Europe: Rapport de synthèse de deux études*. Luxembourg: Commission des communautés européennes.

CORIN, E. (1984). "Manières de vivre, manières de dire: réseau social et sociabilité des personnes âgées au Québec," *Troisième âge et culture*. Québec: Institut québécois de recherche sur la culture (coll. "Questions de culture").

CORIN, Ellen (1982). "De la structure à la signification des réseaux sociaux de personnes âgées dans la région de Québec," *Cahiers de l'ACFAS*, 11. Québec: Université Laval, pp. 147-191.

CORIN, E., J. TREMBLAY, T. SHERRIF and L. BERGERON (1984). "Entre les services professionnels et les réseaux sociaux, les stratégies d'existence des personnes âgées," *Sociologie et Sociétés*, 16 (2): 89-104.

CROWN, William H. (1989). "Trends in the Economic Status of the Aged, and the Implications for State Policy," *Journal of Aging and Social Policy*, 1 (3-4): 89-128.

CROWN, William H. et al. (1993). "Networth and the Economic Diversity of the Elderly," *Journal of Aging and Social Policy*, 5 (4): 99-118.

CRYSTAL, S. and D. SHEA (1990). "Cumulative Advantage, Cumulative Disadvantage, and Inequality among Older People," *The Gerontologist*, 30 (4), August: 437-443.

DARGENT-MOLINA, P. and G. BRÉART (1995). "Épidémiologie des chutes et des traumatismes liés aux chutes chez les personnes âgées," *Revue d'épidémiologie et de santé publique*, 43: 72-83.

DAVID, Hélène and Michel BIGAOUETTE (1986). "Le poids de l'inaptitude au travail dans les prises de retraite d'une grande municipalité," *Sociologie et Sociétés*, 18 (2), October: 47-60.

DAVIDSON, J.L. (1979). "Elder Abuse." In M.R. BLOCK and J.D. SINNOTT (eds.), *The Battered Elder Syndrome: An Exploratory Study*. University of Maryland: Center on Aging.

DAY, Peter (1993). *Perspectives on Later Life*. London: Whiting and Birch.

DEATON, R.L. (1989). *The Political Economy of Pensions: Power, Politics and Social Change in Canada, Britain, and the United States*. Vancouver: University of British Columbia.

DÉCARIE, Suzanne (1994). "Coincées entre deux générations, les femmes sandwich!" *Coup de pouce*, 11 (1), March: 88-97.

DENTON, Frank, Christine FEAVER and Byron SPENCER (1986). "Prospective Aging of the Population and Its Implications for the Labour Force and Government Expenditures," *Canadian Journal on Aging/ La Revue canadienne du vieillissement*, 5 (2), Summer: 75-98.

DENTON, Frank and Byron SPENCER (1978). "On the Prospect of a Labour Shortage," *Canadian Public Policy/Analyse de politiques*, 4 (1), Winter: 101-118.

DESJARDINS, Bertrand and Jean DUMAS (1993). *Vieillissement de la population et personnes âgées: la conjoncture démographique*. Ottawa: Statistique Canada, Division de la démographie.

DESJARDINS, Bertrand and Jacques LÉGARÉ (1984). "Le seuil de la vieillesse: quelques réflexions de démographes," *Sociologie et Sociétés*, 16 (2), October: 37-48.

LE DEVOIR (1984). "La pauvreté chez les personnes âgées: le Québec vient en tête," *Le Devoir*, February 11, p. 10, col. 1, art. 3.

DULUDE, Louise (1985). *Vieillir au féminin 2*. Ottawa: [Status of Women Canada].

EBLY, E., I.M. PARHAD, D.B. HOGAN and T.S. FUNG (1994). "Prevalence and Type of Dementia in the Very Old: Results from the Canadian Study of Health and Aging," *Neurology*, 44: 1593-1600.

ÉMOND, Aline (1988). *Et la santé, ça va: rapport de l'enquête Santé Québec 1987*. Publications du Québec.

ESTES, C.L. and L.A. BINNEY (1989). "The Bio-Medicalization of Aging," *The Gerontologist*, 29: 587-596.

FACCHINI, Carla (1992). "Devenir une mère pour sa mère," *Revue internationale d'action communautaire (RIAC)*, 28/68: 63-69.

FALKINGHAM, Jane and Paul JOHNSON (1992). "Income and the Elderly," *Review in Clinical Gerontology*, 2 (4), November: 343-351.

FEINSTEIN, J.S. (1993). "The Relation between Socioeconomic Status and Health," *Milbank Quarterly*, 71: 279-322.

FOOT, David and Rosemary VENNE (1990). "Population, Pyramids and Promotional Prospects," *Canadian Public Policy/Analyse de politiques*, 16 (4), December: 387-398.

FRENKEN, Hubert and Karen MASER (1992). "Le régime de pensions d'employeur – qui y participe?" *Perspectives*, 4 (4), hiver, Statistique Canada, Cat. No. 75-001F, pp. 30-38.

FRIDERES, James (1994). "The Future of Our Past". In National Advisory Council on Aging (ed.), *Aboriginal Seniors Issues* (Writings in Gerontology Series (15)), Ottawa.

FRIES, James (1983). "The Compression of Morbidity," *Milbank Quarterly*, 61 (3): 397-419.

FRIES, James (1980). "Aging, Natural Death and the Compression of Morbidity," *New England Journal of Medicine*, 303: 130-135.

FRY, Christine L. (1996). "Age, Aging, and Culture." In Robert H. BINSTOCK and Linda K. GEORGE (eds.), *Handbook of Aging and the Social Sciences* (pp. 117-136). Academic Press.

GARANT, Louise and Mario BOLDUC (1990). *L'aide aux personnes âgées: mythes et réalités*. Québec: Ministère de la Santé et des Services sociaux, Direction de l'évaluation.

GAUDE, M. (1977). "Les pensions à l'index," *Commerce*, 79, April: 46-48.

GAULLIER, Xavier (1992). "Le risque vieillesse, impossible paradigme," *Sociétés contemporaines*, 10, June: 23-45.

GAULLIER, Xavier (1989). "Quel avenir pour les salariés âgés?" *Futuribles*, 136, October: 45-62.

GAULLIER, Xavier (1982). "Economic Crisis and Old Age: Old Age Policies in France," *Ageing and Society*, 2 (2), July: 165-182.

GEE, Ellen (1990). "Demographic Change and Intergenerational Relations in Canadian Families: Findings and Social Policy Implications," *Canadian Public Policy/Analyse de politiques*, 16 (2), June: 191-199.

GEE, Ellen and Susan McDANIEL (1991). "Pension Politics and Challenges: Retirement Policy Implications," *Canadian Public Policy/Analyse de politiques*, 17 (4), December: 456-472.

GEE, Ellen M. and Meredith M. KIMBALL (1987). *Women and Aging*. Toronto and Vancouver: Butterworths.

GERALD, L.B. (1993). "Paid Family Caregiving: A Review of Progress and Policies," *Journal of Aging and Social Policy*, 5 (1/2): 73-89.

GIBSON, Rose and Cheryl BURNS (1991). "The Health, Labor Force and Retirement Experiences of Aging Minorities," *Generations*, 15 (4), Fall-Winter: 31-35.

GINN, Jay (1993). "Grey Power: Age-Based Organisations' Response to Structured Inequalities," *Critical Social Policy*, 13 (2): 23-47.

GLADSTONE, James W. (1989). "Grandmother-Grandchild Contact: The Mediating Influence of the Middle Generation Following Marriage, Breakdown and Remarriage," *Canadian Journal on Aging/La Revue canadienne du vieillissement*, 8 (4).

GLENDENNING, Caroline and Eithne McLAUGHLIN (1993). *Paying for Care: Lessons from Europe*. London: Her Majesty's Stationery Office.

GRAND'MAISON, Jacques (1994). "Un nouveau pacte intergénérationnel." In Jacques Grand'Maison and Solange LEFEBVRE (eds.), *La part des aînés* (pp. 335-356). Fides.

GRANGER, Denise (1991). *Revue de littérature sur les modèles et les stratégies des prestations des services communautaires offerts aux personnes âgées en perte d'autonomie fonctionnelle et mentale et* à *leurs aidants naturels*. Montréal: Faculté des sciences infirmières, Université de Montréal.

GRUEMBERG, E.M. (1977). "The Failure of Success," *Milbank Quarterly/ Health and Society*, 55: 3-24.

GUBERMAN, Nancy and Pierre MAHEU (1994). "Au-delà des soins, un travail de conciliation," *Service social*, 43 (1): 87-104.

GUBERMAN, Nancy and Pierre MAHEU (1994). "Au-delà des soins, un travail de conciliation," *Service social*, 43 (1): 87-104.

GUBERMAN, Nancy, P. MAHEU and C. MAILLE (1991). *Et si l'amour ne suffisait pas: femmes, familles et adultes dépendants*. Montréal: Remue-ménage.

GUILLEMARD, Anne-Marie (1995). "Emploi, protection sociale et cycle de vie: Résultats d'une comparaison internationale des dispositifs de sortie anticipée d'activité." In Anne-Marie GUILLEMARD, Jacques LÉGARÉ and Pierre ANSART (eds.), *Entre travail, retraite et vieillesse: Le grand écart* (pp. 43-67). Paris: L'Harmattan.

GUILLEMARD, Anne-Marie (1994). "Attitudes et opinions des entreprises à l'égard des salariés âgés et du vieillissement de la main-d'oeuvre," *Gérontologie et Société*, 70, October: 154-169.

GUILLEMARD, Anne-Marie (1989). "Être vieux ou vieille, une question de jugement social," *Actes du colloque sur le vieillissement au travail, une question de jugement*, Montréal, pp. 11-13.

GUILLEMARD, Anne-Marie and Martin REIN (1993). "Comparative Patterns in Retirement: Recent Trends in Developed Societies," *Annual Review of Sociology*, 19: 469-503.

GUILLEMARD, Anne-Marie and Hermann Van GUNSTEREN (1991). "Pathways and their Prospects: A Comparative Interpretation of the Meaning of Early Exit." In Martin KOHLI et al. (eds.), *Time for Retirement: Comparative Studies on Early Exit from the Labor Force*. Cambridge University Press.

HAGESTAD, Gunhild (1995). "La négociation de l'aide: jeux croisés entre familles, sexes et politiques sociales." In Claudine ATTIAS-DONFUT (ed.), *Les solidarités entre générations: vieillesse, famille, État* (pp. 157-168). Paris: Nathan (coll. "Essais et Recherches").

HARDY, Melissa and Lawrence E. HAZELRIGG (1993). "The Gender of Poverty in an Aging Population," *Research on Aging*, 15 (3), September: 243-278.

HAREVEN, Tamara K. (1994). "Aging and Generational Relations: A Historical and Life Course Perspective", *Annual Review of Sociology*, 20: 437-461.

HILL, Gerry (1988). "Maladie d'Alzheimer," *Maladies chroniques au Canada*, 9 (5): September: 93-94.

HIRDES, John P. et al. (1986). "The Association Between Self-reported Income and Perceived Health Based on the Ontario Longitudinal Study of Aging," *Canadian Journal on Aging/Revue canadienne du vieillissement*, 5 (3): 189-204.

HOLDEN, K.C. and T.M. SMEEDING (1990). "The Poor, the Rich, and the Insecure Caught In-Between," *Milbank Quarterly*, 68 (2): 191-219.

HOUSE, James et al. (1990). "Age, Socioeconomic Status, and Health," *Milbank Quarterly*, 68 (3): 383-411.

JACOBS, Klaus, Martin KOHLI and Martin REIN (1991). "Testing the Industry Mix of Early Exit." In Martin KOHLI et al. (eds.), *Time for Retirement: Comparative Studies on Early Exit from the Labor Force* (pp. 67-96). Cambridge University Press.

JAVEAU, Claude (1994). "Les enjeux d'une société vieillissante," *Gérontologie (3):* 17-22.

JOHANSSON, Lennarth and Mats THORSLUND (1993). "Importance et limites des ressources formelles." In F. LESEMANN and C. MARTIN (eds.), *Les personnes âgées: dépendance, soins et solidarités familiales: Comparaisons internationales* (pp. 115-215). Paris: La Documentation française.

JOHNSON, Norman (1987). *The Welfare State in Transition*. Brighton: Wheatsheaf Books.

JORM et al. (1987). "The Prevalence of Dementia: Quantitative Integration of the Litterature," *Acta Psychiatrica Scandinavica*, 176: 465-479.

JUTRAS, Sylvie, France VEILLEUX and Marc RENAUD (1989). *Des partenaires méconnus: les aidants des personnes âgées en perte d'autonomie*. Montréal: Université de Montréal.

JUTRAS, Sylvie and Marc RENAUD (1987). *Personnes âgées et aidants naturels. Éléments pour une réflexion sur la prévention dans le plan d'ensemble "La santé pour tous"*. Ottawa: Santé et Bien-être social Canada.

KART, C.S. et al. (1989). "Comparing the Economically Disadvantaged and the Pension Elite: 1980 Census Politics," *The Gerontologist,* 29 (6), December: 745-749.

KEEFE, J. (n.d.). *Shared Care: The Organization of Home Care and Family Caregiving*. Halifax: Centre on Aging, Mount Saint Vincent University.

KEIGHER, S.M. and C. MURPHY (1992). "A Consumer View of Family Care Compensation Programs for the Elderly," *Social Service Review*, 66 (2).

KILTY, K.M. (1990). "Social Security, Private Resources, and the Economic Security of Older Americans," *Journal of Aging Studies*, 4 (1), Spring: 97-109.

KOHLI, Martin (1989). "Réorganiser le processus de retraite: les entreprises, les syndicats et l'État," *Actes du colloque sur le vieillissement au travail, une question de jugement*, Montréal, pp. 92-97.

KOHLI, Martin and Martin REIN (1991). "The Changing Balance of Work and Retirement." In Martin KOHLI et al. (eds.), *Time for Retirement: Comparative Studies on Early Exit from the Labor Force* (pp. 1-35). Cambridge University Press.

KOHLI, Martin et al. (1991). *Time for Retirement: Comparative Studies on Early Exit from the Labor Force*. Cambridge University Press, pp. 67-96.

KRAMER, M. (1981). *The Increasing Prevalence of Mental Disorders: Implications for the Future.* Paper presented at the National Conference on the Elderly Desinstitutionalized Patient in the Community, Arlington, Virginia.

KREIGER, Nancy (1988). "L'ostéoporose dans une population vieillissante," *Chronic Diseases in Canada*, 9 (5): 91-93.

KULIS, Stephen (1992). "Social Class and the Locus of Reciprocity in Relationships with Adult Children," *Journal of Family Issues*, 13 (4): 482-504.

LABILLOIS, Margaret (1994). "Aboriginal Housing: A Personal Perspective". In National Advisory Council on Aging (ed.), (Writings in Gerontology Series (15)). Ottawa.

LAING, B.A. (1990) . "Women Beneficiaries Age 62 or Older, 1960-1988," *Social Security Bulletin*, 53 (7), July: 2-12.

LEMIEUX, R. (1990). "Vieillir: une question de sens?" *Revue internationale d'action communautaire (RIAC)*, 23/63: 25-33.

LESEMANN, Frédéric (1990). "Pauvreté et classes d'âge: les ménages plus âgés améliorent nettement leur situation relative," *Le Devoir*, May 1: 7.

LESEMANN, Frédéric and Claude MARTIN (1993). *Les personnes âgées: dépendance, soins et solidarités familiales: Comparaisons internationales*. Paris: La Documentation française.

LESEMANN, Frédéric and Daphne NAHMIASH (1993). "Canada: Logiques hospitalières et pratiques familiales de soins au Québec." In F. LESEMANN and C. MARTIN (eds.), *Les personnes âgées: dépendance, soins et solidarités familiales: Comparaisons internationales* (pp. 155-170). Paris: La Documentation française.

LESEMANN, Frédéric and Claude MARTIN (1992). "Prendre soin: liens sociaux et médiations institutionnelles," *Revue internationale d'action communautaire (RIAC)*, 28/68.

LINSK, N.L., S.M. KEIGHER and S.E. OSTERBUSCH (1988). "States' Policies Regarding Paid Family Caregiving," *The Gerontologist*, 28: 204-212.

MAHEU, Pierre and Nancy GUBERMAN (1992). "Familles, personnes adultes dépendantes et aide 'naturelle': entre le mythe et la réalité," *Revue internationale d'action communautaire (RIAC)*, 28/68: 51-62.

MAHEU, Louis and Hélène DAVID (1989). "Pourquoi se préoccuper du vieillissement au travail," *Actes du colloque sur le vieillissement au travail, une question de jugement*, Montréal, pp. 9-10.

MANCINI, Jay A. (1992). "Intergenerational Relationships," *Journal of Family Issues*, 13 (4): 429-431.

MANTON, K.G. (1982). "Changing Concepts of Mortality and Morbidity in the Elderly Population," *Milbank Quarterly*, 60: 183-244.

MARCIL-GRATTON, Nicole and Jacques LÉGARÉ (1987). "Vieillesse d'aujourd'hui et de demain: un même âge, une autre réalité," *Futuribles*, 110, May: 3-21.

MARKIDES, Kyriakos and Sandra BLACK (1996). "Race, Ethnicity, and Aging: The Impact of Inequality." In Robert H. BINSTOCK and Linda K. GEORGE (eds.), *Handbook of Aging and the Social Sciences* (pp. 153-170). Academic Press.

MARSHALL, Victor and Barry McPHERSON (eds.) (1994). *Aging: Canadian Perspectives*. Broadview Press/Journal of Canadian Studies.

MARSHALL, Victor, Carolyn ROSENTHAL and Joanne DACIUK (1987). "Older Parents' Expectation for Filial Support," *Social Justice Research*, 1 (4), December: 405-424.

MARTEL, Laurent (1994). *Passage de la vie active à la vie de retraite, vers une plus grande autonomie des personnes âgées? Synthèse des travaux existants*. Montréal: Département de démographie, Université de Montréal.

MARTIN MATTHEWS, Ann and L.D. CAMPBELL (1995)."Gender Roles, Employment and Informal Care." In S. ARBER and J. GINN (eds.), *Connecting Gender and Ageing: Sociological Approaches to Gender Relations in Later Life*. London: Open University Press.

MARTIN MATTHEWS, Ann and C.J. ROSENTHAL (1993). "Balancing Work and Family in an Aging Society: The Canadian Experience." In G.L. MADDOX amd M.P. LAWTON (eds.), *Annual Review of Gerontology and Geriatrics: Focus on Kinship, Aging and Social Change*. New York: Springer Publishing Company.

MASSÉ, Jacqueline and Marie-Marthe T. BRAULT (1984). "Sociétés, vieillissement et stratification des âges," *Sociologie et Sociétés*, 16 (2): 3-14.

McDANIEL, Susan (1993). "Soutien affectif et contacts familiaux chez les Canadiens âgés," *Tendances sociales canadiennes*, 28: 30-33.

McDONALD, Lynn (1994). *Transitions into Retirement*. Toronto: University of Toronto, Faculty of Social Work (ronéo).

McDONALD, Lynn (1989). "Les travailleuses et travailleurs âgés et l'économie duale," *Actes du colloque sur le vieillissement au travail, une question de jugement*, Montréal, pp. 55-62.

McDONALD, Lynn and Richard A. WARNER (1987). "Retirement in a Dual Economy: The Canadian Case." In Victor W. MARSHALL (ed.), *Aging in Canada: Social Perspectives* (2nd ed., pp. 245-261). Fitzhenry & Whiteside.

MONK, Abraham and Carole COX (1993). "États-Unis: Un système fragmenté: professionnalisme et contribution." In F. LESEMANN and C. MARTIN (eds.), *Les personnes âgées: dépendance, soins et solidarités familiales: Comparaisons internationales* (pp. 171-195). Paris: La Documentation française.

MUSSELL, W.J. (1994). "First Nations Elders as Resource Persons". In National Advisory Council on Aging (ed.), (Writings in Gerontology Series (15)). Ottawa.

MYLES, John (1989). *Old Age in the Welfare State: The Political Economy of Public Pensions*. Lawrence, KS: University of Kansas Press.

MYLES, John and Les TEICHROEV (1989). "Une politique dualiste: la politique de la vieillesse au Canada," *Actes du colloque sur le vieillissement au travail, une question de jugement*, Montréal, pp. 14-24.

NATIONAL ADVISORY COUNCIL ON AGING (1993). *Aging Vignettes n^{o} 6*. Ottawa: the Council.

NATIONAL ADVISORY COUNCIL ON AGING (1991). *The Economic Situation of Canada's Seniors: A précis*. Ottawa: the Council.

NATIONAL ADVISORY COUNCIL ON AGING (1989). *Understanding Seniors' Independence*. Ottawa: the Council.

National Advisory Council on Aging (1984). *Coping and Helping with Alzheimer's Disease*. Ottawa: the Council.

NATIONAL INDIAN COUNCIL ON AGING (1980). *May the Circle Be Unbroken: A New Decade. Final Report on the Third National Indian Conference on Aging.* Albuquerque, New Mexico.

NELSON, Martha (1993). "Race, Gender and the Effect of Social Support on the Use of Health Services by Elderly Individuals," *International Journal of Aging and Human Development*, 37 (3): 227-246.

NEYSMITH, Sheila (1987). "Social Policy Implications of an Aging Society." In Victor MARSHALL (ed.), *Aging in Canada. Social Perspectives* (2nd ed., pp. 586-597). Fitzhenry &Whiteside.

NEYSMITH, Sheila (1982). "Aging in Canada: The Making of a Social Problem," *Question de développement social*, 6 (1): 27-40.

NG, Edward (1992). “Les enfants et les personnes âgées: le partage des ressources de l’État,” *Canadian Social Trends*, Statistics Canada, summer.

NORLAND, J.A. (1994). *Profil des personnes âgées au Canada*. Statistique Canada, Cat. No. 96-312F.

NORTHCOTT, Herbert (1992). *Aging in Alberta: Rhetoric and Reality*. Alberta: Detselig Enterprises Ltd., ISBN 1-55059-049-9.

NOVAK, Mark (1988). *Aging and Society: A Canadian Perspective*. Scarborough, Ontario: Nelson Canada.

ODERKIRK, Julian (1996a). “Programmes gouvernementaux de sécurité du revenu à l’intention des personnes âgées: Sécurité de la vieillesse,” *Canadian Social Trends*, 40, spring, pp. 3-8.

ODERKIRK, Julian (1996b). “Programmes gouvernementaux de sécurité du revenu à l’intention des personnes âgées: Régime de pensions du Canada (RPC) et Régime de rentes du Québec (RRQ),” *Tendances sociales canadiennes*, 40, spring, pp. 9-17.

OJA, G. and R. LOVE (1988). *Pensions and Incomes of the Elderly in Canada, 1971-1985*. Statistics Canada, Cat. No. 13-588, June.

ONTARIO ADVISORY COUNCIL ON THE STATUS OF WOMEN (1981). *Women and Aging*. Toronto: the Council.

ONTARIO WELFARE COUNCIL (n.d.). *Pensions and Alternatives: Here are the Facts*. Toronto: Government of Ontario.

ORGANISATION DE COOPÉRATION ET DE DÉVELOPPEMENT ÉCONOMIQUE (1994a). “Les nouvelles orientations de la politique sociale”, *Études de politiques sociales*, 12, Paris: OCDE.

ORGANISATION DE COOPÉRATION ET DE DÉVELOPPEMENT ÉCONOMIQUE (1994b). “Protéger les personnes âgées dépendantes,” *Études de politiques sociales*, 14, Paris: OCDE.

ORGANISATION DE COOPÉRATION ET DE DÉVELOPPEMENT ÉCONOMIQUE (1988). *Le vieillissement démographique: conséquences pour les politiques sociales*. Paris: OCDE.

PAQUET, Mario (1996) (forthcoming). “La prévention auprès des personnes-soutien de personnes âgées dépendantes,” *Canadian Social Work Review*.

PAQUET, Mario (1990). “Les conséquences de la prise en charge d’une personne âgée en perte d’autonomie: une recherche exploratoire,” *Intervention*, 85, March: 101-109.

PHILLIPSON, Chris (1989). “Towards a Sociology of Retirement,” *Reviewing Sociology* (New Series), 6 (2): 3-10.

POIRIER, Patricia (1979). “Venir en aide aux personnes âgées sans qu’il en coûte un cent: un rapport du Sénat,” *Le Devoir*, December 20, p. 4, col. 4, art. 1.

PRATT, Henry J. (1993). *Gray Agenda: Interest Groups and Public Pensions in Canada, Britain, and the United States*. Ann Arbor: University of Michigan Press.

LA PRESSE (1980). “La retraite. Un drame économique qui mérite des redressements,” *La Presse*, April 14, D1, col. 2, art. 1.

QUÉBEC (1995). *Le Québec Statistique* (60th ed.). Bureau de la Statistique du Québec: Les Publications du Québec, ISBN 2-551-16086.

QUÉBEC (1991). *Vers un nouvel équilibre des âges: Rapport du groupe d’experts sur les personnes âgées*. Québec: Ministère de la Santé et des Services sociaux.

RENAUT, Sylvie and Alain ROZENKIER (1995). “Les familles à l’épreuve de la dépendance.” In Claudine ATTIAS-DONFUT (ed.), *Les solidarités entre générations: vieillesse, famille, État* (pp. 181-208). Paris: Nathan (coll. “Essais et Recherches”).

ROBERGE, Roger, Jean-Marie BERTHELOT and Michael WOLFSON (1995). “Indice de l’état de santé: mesurer les écarts dans l’état de santé en Ontario, selon la situation socio-économique,” *Rapports sur la santé*, 7 (2), Statistique Canada, Cat. No. 82-003.

ROCKWOOD, Kenneth and Karen STADNYK (1994). “The Prevalence of Dementia in the Elderly: A Review,” *Canadian Journal of Psychiatry*, 30: 253-257.

ROSENTHAL, Carolyn (1987). “Aging and Intergenerational Relations in Canada.” In Victor MARSHALL (ed.), *Aging in Canada: Social Perspectives* (2nd ed., pp. 311-342), Fitzhenry & Whiteside.

ROSENTHAL, Carolyn (1986). “The Differentiation of Multigenerational Households,” *Canadian Journal on Aging/La Revue canadienne du vieillissement*, 5 (1): 27-42.

ROSENTHAL, Carolyn (1982). "Family Responsibilities and Concerns: A Perspective on the Lives of Middle-Aged Women," *Documentation sur la recherche féministe*, 4 (3): 211-212.

ROSENTHAL, Carolyn and James GLADSTONE (1994). "Family Relations and Support in Later Life." In Victor MARSHALL and Barry McPHERSON (eds.), *Aging: Canadian Perspectives* (pp. 158-174), Broadview Press/Journal of Canadian Studies.

ROSENTHAL, Carolyn, Sara MATHEWS and Victor MARSHALL (1989). "Is Parent Care Normative? The Experience of a Sample of Middle-Aged Women," *Research on Aging*, 11 (2): 244-260.

ROY, Jacques (1994a). "Les personnes âgées: dépendance, soins et solidarités familiales: Comparaisons internationales," *Service social*, 43 (1): 154-158.

ROY, Jacques (1994b). "L'histoire du maintien à domicile ou les nouveaux apôtres de l'État," *Service social*, 43 (1): 7-32.

ROY, Jacques, R. LÉPINE and L. ROBERT (1990). *État et famille: des politiques sociales en mutation. Document de réflexion soumis au Conseil de la famille*. Québec: Centre de recherche sur les services communautaires, Université Laval.

SCHABER, Gaston (1995). "Don de temps, don d'argent, don d'espace: Les flux intergénérationnels aux États-Unis et au Luxembourg." In Claudine ATTIAS-DONFUT (ed.), *Les solidarités entre générations: vieillesse, famille, État* (pp. 97-113). Paris: Nathan (coll. "Essais et Recherches").

SCHNEIDER, E.L. and J.A. BRODY (1983). "Aging, Natural Death and the Compression of Morbidity: Another View," *New England Journal of Medicine*, 309: 854-856.

SIMMONS-TROPEA, Daryl and Richard OSBORN (1987). "Disease, Survival and Death: The Health Status of Canada's Elderly." In Victor W. MARSHALL (ed.), *Aging in Canada: Social Perspectives* (2nd ed., pp. 399-423), Fitzhenry & Whiteside.

SIROONIAN, Jason (1993). "Le revenu de placements des Canadiens," *Perspectives*, Statistique Canada, Cat. No. 75-001F, summer, pp. 59-65.

LE SOLEIL (1982). "Des revenus trop bas," August 17, sec. A, p. 5, col. 3, art. 2.

ST-ONGE, Jacques (1990). *Personnes âgées amérindiennes et modernisation.* Groupe de recherche et d'intervention régionale (GRIR), Université du Québec à Chicoutimi.

STATISTICS CANADA (1996). Canada's Retirement Income Programs: A Statistical Overview. Cat. No. 74-507-XPB.

STATISTICS CANADA (1994). *Income Distributions by Size in Canada, 1994*. Cat. No. 13-207.

STATISTICS CANADA (1990). *A Portrait of Seniors in Canada: Target Group Project*. Cat. No. 89-519.

STOKES, Julie and Joan LINDSAY (1996). "Major Causes of Death and Hospitalization in Seniors," *Chronic Diseases in Canada*. (typewritten version)

STONE, Leroy and Hubert FRENKEN (1986). *Les personnes âgées au Canada. Recensement de 1986. Le Canada* à *l'étude*. Ottawa: Statistique Canada, Division des études démographiques.

STONE, Leroy and Susan FLETCHER (1980). *A Profile of Canada's Older Population*. Montréal: Institute for Research on Public Policy.

STONE, R. and S. KEIGHER (1994). "Toward an Equitable, Universal Caregiver Policy: The Potential of Financial Supports for Family Caregivers," *Journal of Aging and Social Policy*, 6 (1/2): 57-75.

STRAUSS, A. and J.M. CORBIN (1988). *Shaping a New Health Care System*. San Francisco: Jossey-Bass Inc. Publishers.

SUNDSTROM, G. (1986). "Family and State: Recent Trends in the Care of the Aged in Sweden," *Aging and Society*, 6: 169-196.

TENNSTEDT, Sharon, Sybil CRAWFORD and John McKINLAY (1993). "Is Family Care on the Decline? A Longitudinal Investigation of the Substitution of Formal Long-Term Care Services for Informal Care," *Milbank Quarterly*, 71 (4): 601-624.

TROYANSKI, David (1994). "The New Age of Old Age," *Ageing and Society*, 14 (3), September: 429-436.

VANDERBURGH, Rosamon (1982). "When Legends Fall Silent Our Ways are Lost: Some Dimensions of the Study of Aging among Native Canadians," *Culture*, II (1): 21-28.

VAN-GUNSTEREN, Hermann and Martin REIN (1985). "The Dialectic of Public and Private Pensions," *Journal of Social Policy*, 14 (2), April: 129-149.

VERBRUGGE, L.M. (1989). "Gender, Aging and Health." In K. MARKIDES (ed.), *Aging and Health: Perspectives on Gender, Race, Ethnicity and Class* (p. 23-78). Newbury Park, CA: Sage Publications.

WAGNER, D.L. and G.G. HUNT (1994). "The Use of Workplace Eldercare Programs by Employed Caregivers," *Research on Aging*, 16 (1): 69-83.

WALKER, A. (1983). "The Origins and Maintenance of Interest Groups in America," *American Political Science Review*, 77: 390-406.

WILKINS, Kathryn (1995). "Causes de décès: différences entre les sexes," *Rapports sur la santé*, 7 (2), Statistique Canada, Cat. No. 82-003, pp. 39-50.

WILKINS, Kathryn, Susan MORRIS and Rachel LANE (1988). "Mortalité et morbidité dans la population âgée du Canada: Rétrospective," *Maladies chroniques au Canada*, pp. 85-90.

WYKLE, L. May and Marie R. HAUG (1993). "Multicultural and Social Aspects of Self-Care," *Generations*, 17 (3), Fall: 25-28.

YEE, K. Barbara and Gayle D. WEAVER (1994). "Ethnic Minorities and Health Promotion: Developing a 'Culturally Competent' Agenda," *Generations*, 18 (1), Spring: 39-43.

TABLES AND CHARTS

TABLE 1
Percentage of persons aged 65 and over in Canada, by province, 1971, 1981, 1986, 1991

PROVINCE	PERCENTAGE OF PERSONS AGED 65 AND OVER			
	1971	1981	1986	1991
Newfoundland	6,2	7,7	8,8	9,7
Prince Edward Island	11,0	12,2	12,7	13,2
Nova Scotia	9,2	10,9	11,9	12,6
New Brunswick	8,6	10,1	11,1	12,2
Quebec	6,9	8,8	10,0	11,2
Ontario	8,4	10,1	10,9	11,7
Manitoba	9,6	11,9	12,6	13,4
Saskatchewan	10,2	12,0	12,7	14,1
Alberta	7,3	7,3	8,1	9,1
British Columbia	9,4	10,9	12,1	12,9
Yukon	2,8	3,2	3,7	4,0
Northwest Territories	2,2	2,9	2,8	2,8
Canada	**8,1**	**9,7**	**10,7**	**11,6**

Source: Statistics Canada, Cat. No. 93-310.

TABLE 2
Average income of elderly unattached individuals by sex in constant (1994) dollars Canada, 1980-1994

YEAR	MEN	WOMEN
1980	18 617	14 854
1985	20 394	16 394
1990	21 749	18 175
1994	23 782	17 106

Source: Statistics Canada, Cat. No. 13-207.

TABLE 3
Distribution of low-income elderly by marital status
Canada, 1980-1994

YEAR	INDIVIDUALS IN FAMILIES	UNATTACHED INDIVIDUALS	TOTAL (%)
1980	6,8	12,4	19,2
1985	5,3	10,3	15,6
1990	3,3	11,6	15,0
1994	2,8	10,1	12,8

Source: Statistics Canada, Cat. No. 13-207.

TABLE 4
Average income deficiency in constant (1994) dollars
for low-income elderly
Canada, 1980-1994

	1980	1982	1984	1986	1988	1990	1992	1994
By marital status								
Individuals in families	4 147	3 794	4 121	3 487	3 781	3 343	3 154	2 972
Unattached individuals	4 651	4 164	3 924	3 493	3 338	3 199	2 968	2 755
By sex								
Men	4 698	3 864	3 548	3 170	3 174	2 860	2 714	2 549
Women	4 635	4 236	4 020	3 571	3 371	3 283	3 022	2 796

Source: Statistics Canada, Cat. No. 13-207.

TABLE 5
Average income of elderly economic families compared to that of all economic families, in constant (1994) dollars Canada, 1984-1994

YEAR	ALL ECONOMIC FAMILIES	ELDERLY ECONOMIC FAMILIES
1980	53 877	37 521
1985	52 323	38 148
1990	55 905	41 943
1994	54 153	40 183

Source: Statistics Canada, Cat. No. 13-207.

TABLE 6
Average income of elderly unattached individuals compared to that of all unattached individuals, in constant (1994) dollars Canada, 1980-1994

YEAR UNATTACHED	ALL UNATTACHED INDIVIDUALS	ELDERLY INDIVIDUALS
1980	22 523	15 891
1985	23 139	17 327
1990	24 909	19 049
1994	23 746	18 780

Source: Statistics Canada, Cat. No. 13-207.

TABLE 7
Labour force participation rate (percentage) of men and women aged 55 and over in Canada, 1966-1990

YEAR	MEN	WOMEN
1966	56,7	18,0
1975	50,5	17,6
1980	46,5	18,3
1985	42,1	17,9
1990	37,4	17,4

Sources: Schellenberg Grant, 1994; Historical Labour Force Statistics, 1992.

TABLE 8
Distribution of elderly by income bracket in 1990

INCOME BRACKET	PERCENTAGE	CUMULATIVE PERCENTAGE
No income	0,8	0,8
Under 5 000	4,6	5,4
5 000- 14999	54,1	59,5
15 000- 24 999	20,5	80,0
25 000- 49 999	15,2	95,2
50 000-100 000	3,9	99,1
Over 100 000	0,9	100

Source: Statistics Canada, Cat. No. 96-312F, p. 46.

TABLE 9
The 10 leading causes of hospitalization for elderly men in Canada, 1973-1992 (per 100 000 population)

CAUSE OF HOSPITALIZATION	RANK (CANADA)	ASMR	AVERAGE % CHANGE	
			1983-1992	1973-1982
Coronary heart disease	1	3825,66	0.08	-2,34
Stroke	2	2061,63	-1,97	-0,02
Symptoms referable to systems	3	2042,37	0,68	4,87
Chronic bronchitis, emphysema and asthma	4	1965,10	-1,19	4,79
Accidental falls	5	1457,52	0,58	N/A
Pneumonia	6	1436,88	0,60	-0,97
Hernia	7	1292,01	-1,15	0.06
Prostate cancer	8	1122,90	0,41	1,39
Lung cancer	9	960,06	-0,95	3,28
Intestinal illnesses	10	884,18	-0,17	0,71

Source: Julie Huang and Joan Lindsay, 1996.

TABLE 9.1
The 10 leading causes of hospitalization for elderly women in Canada, 1973-1992 (per 100 000 population)

CAUSE OF HOSPITALIZATION	RANK (CANADA)	ASMR	AVERAGE % CHANGE	
			1983-1992	1973-1982
Coronary heart disease	1	2352,37	-1,30	-3,14
Accidental falls	2	2183,11	-0,47	N/A
Symptoms referable to systems	3	1619,22	-0,29	5,48
Stroke	4	1472,70	-1,97	-0,93
Spinal fractures	5	1129,06	-0,52	-1,26
Chronic bronchitis, emphysema and asthma	6	950,36	1,90	5,08
Intestinal illnesses	7	944,97	-0,59	-0,45
Pneumonia	8	744,31	1,29	-1,70
Liver disease	9	723,22	-1,21	-5,70
Diabetes	10	630,14	-6,53	-3,17

Source: Julie Huang and Joan Lindsay, 1996.

TABLE 10
Leading causes of death in men aged 65 and over
1971, 1981, 1986 (in descending order for 1986) (per 100 000 population)

CAUSE OF DEATH	RANK 1971	ASMR	RANK 1981	ASMR	RANK 1986	ASMR	DIFFE-RENCE (%)
Cardiovascular disease	1	2606,44	1	2092,43	1	1814,38	-30,4
Lung cancer	3	327,30	3	428,12	2	478,09	+46,1
Stroke	2	819,17	2	588,23	3	466,07	-43,1
Chronic bronchitis, emphysema, asthma	4	268,30	4	332,15	4	385,84	+43,8
Pneumonia	5	24,40	5	221,60	5	258,59	-2,2
Prostate cancer	7	202,48	6	209,66	6	225,48	+11,4
Colorectal cancer	6	102,85	7	295,03	7	204,28	+0,7
Diabetes	9	123,22	9	97,82	8	116,02	-5,8
Aortic aneurysm	11	89,60	10	93,59	9	93,76	+15,1
Urinary tract cancer	10	97,35	11	90,18	10	86,62	-11,0
Stomach cancer	8	141,51	8	99,72	11	84,49	-40,3
Kidney diseases	12	78,54	13	77,38	12	84,08	+7,1
Pancreatic cancer	13	78,13	12	79,32	13	79,11	+1,3
Lymphoid cancer	16	50,24	14	64,43	14	74,67	+48,6
Accidental falls	14	74,21	15	62,62	15	64,06	-13,7

Source: Kathryn Wilkins, Susan Morris and Rachel Lane (1988). Adapted from Statistics Canada data.

TABLE 10.1
Leading causes of death in women aged 65 and over
1971, 1981, 1986 (in descending order for 1986) (per 100 000 population)

CAUSE OF DEATH	RANK 1971	ASMR	RANK 1981	ASMR	RANK 1986	ASMR	DIFFE-RENCE (%)
Cardiovascular disease	1	1601,45	1	1186,75	1	1044,33	-34,8
Stroke	2	707, 08	2	483,24	2	406,20	-42,6
Colorectal cancer	3	163,87	3	151,01	3	148,19	-9,6
Pneumonia	4	155,38	5	114,35	4	147,55	-5,0
Breast cancer	6	121,95	4	128,17	5	138,30	+13,4
Lung cancer	12	39,21	7	82,37	6	120,68	+207,8
Chronic bronchitis, emphysema, asthma	11	45,54	8	67,83	7	106,43	+133,7
Diabetes	10	133,00	6	96,54	8	199,22	-24,6
Pancreatic cancer	8	47,32	9	52,65	9	55,20	+16,7
Accidental falls	9	70,16	10	49,61	10	51,90	-26,0
Kidney diseases	14	47,74	12	46,26	11	50,54	+5,9
Lymphoid cancer	13	35,23	13	42,38	12	47,73	+35,5
Cancer of ovary/ fallopian tube/uterus	7	38,22	14	39,40	13	40,16	+5,1
Stomach cancer	15	70,97	11	48,56	14	38,09	-46,3
Chronic rheumatic fever	14	34,86	15	33,58	15	33,49	-3,9

Source: Kathryn Wilkins, Susan Morris and Rachel Lane (1988). Adapted from Statistics Canada data.

TABLE 11
Prevalence of dementia in persons aged 65 and over by sex and age group Canada, 1991

AGE GROUP	NUMBER OF CASES		TOTAL
	MEN	WOMEN	
65-74	62	78	140
75-84	176	297	473
85 and over	111	401	512
Total	**349**	**776**	**1125**

Source: Canadian Medical Association Journal, 1994:906.