THE NACA POSITION ON
COMMUNITY SERVICES IN HEALTH CARE
FOR SENIORS: PROGRESS AND CHALLENGES

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THE NACA POSITION ON COMMUNITY SERVICES IN HEALTH CARE FOR SENIORS: PROGRESS AND CHALLENGES

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National Advisory Council on Aging

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WHAT IS THE NATIONAL ADVISORY COUNCIL ON AGING?

The National Advisory Council on Aging (NACA) was created by Order-in-Council on May 1, 1980, to assist and advise the Minister of Health on issues related to the aging of the Canadian population and the quality of life of seniors. NACA reviews the needs and problems of seniors and recommends remedial action, liaises with other groups interested in aging, encourages public discussion and publishes and disseminates information on aging.

The Council has a maximum of 18 members from all parts of Canada. Members are appointed by Order-in-Council for two- or three-year terms and are selected for their expertise and interest in aging. They bring to Council a variety of experiences, concerns and aptitudes.

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NACA BELIEFS

NACA believes that:

- Canada must guarantee the same rights and privileges to all its citizens, regardless of their age.

- Seniors have the right to be autonomous while benefitting from interdependence and to make their own decisions even if it means 'living at risk'.

- Seniors must be involved in the development of policies and programs.

- Seniors must be assured of adequate income protection, universal access to health care, and the availability of a range of programs and services in all regions of Canada that support their autonomy. These policies and programs must take into account their individuality and cultural diversity.

THE NACA POSITION IN BRIEF

In this report, NACA assesses the progress made in developing community services in health care for seniors across Canada and identifies impediments and gaps. This report is based on a review of recent policy literature as well as a telephone consultation with 42 informants, representing seniors' organizations, service-providers, provincial seniors advisory councils, provincial government officials and experts in the field of community care. NACA considered the progress made with respect to the following areas: decentralization of decision-making, planning and delivery of service; establishment of a coordinated system of care with a single point of entry; reallocation of resources to community-based care; elimination of fragmentation between medical and social services; the provision of a continuum of care that includes institutional care; and the provision of culturally-sensitive services. Based on the information gathered, NACA has formulated the following recommendations to improve community-based services for seniors.

To ensure that seniors' needs for community-based services are met in the context of decentralization of decision-making and service delivery, NACA recommends that:

Provincial/territorial governments ensure that senior consumers be fully represented in local health decision-making and planning.

Provinces and territories provide a core package of services that covers the continuum of care in' all regions and establish province-wide service standards and protocols.

To provide community services in a manner that enhances quality of care and cost-effectiveness, NACA recommends that:

Single-entry models of access to all services be made available in every community, to assure that seniors have access to the full continuum of care.

The federal and provincial/territorial governments direct public education efforts on the advantages for seniors and caregivers of the single-entry system of care.

To assure that community-based services are adequately financed, NACA recommends that:

Provincial/territorial governments allocate the funding required to meet the needs of each region for community-based services.

Provincial governments and regional health boards involve the community care sector as a full and equal partner in all health care decision-making and planning.

To reduce the fragmentation between health and social services in many provinces, NACA recommends that:

The federal government set national criteria governing accessibility and the provision of a core package of services for the transfer of funds to the provinces/territories for social and health-related services.

To ensure that institutional facilities remain a viable option for seniors in the continuum of care, NACA recommends that:

Provincial/territorial governments plan for an adequate number of places in long-term care institutions.

Finally, to meet the service needs of seniors from ethnocultural minorities, NACA recommends that:

The federal and provincial/territorial governments provide support and training to volunteers and voluntary associations that facilitate seniors' access to culturally-sensitive community health and social services.

THE NACA POSITION ON COMMUNITY SERVICES IN HEALTH CARE FOR SENIORS: PROGRESS AND CHALLENGES

INTRODUCTION

Since its creation in 1980, the National Advisory Council on Aging (NACA) has recognized the importance of shifting the emphasis from institutional to community-based health care to meet the health needs of a growing seniors population. To guide the expansion of community-based services that had been recommended in many provincial reviews of health policy in the late 1980s, the Council published *The NACA Position on Community Services in Health Care for Seniors* (1990). NACA strongly recommended that community-based services be recognized as an integral part of the health care system in providing care to an aging population because they prevent or delay institutionalization, promote the social integration of seniors, respond to their changing health needs in a flexible and holistic manner and provide support to informal caregivers.

Four years and a major economic recession later, the Honourable Diane Marleau, Minister of Health, asked the Council to advise her on "the gaps that may be created in the health care system in the transition from institutional to community care. " NACA thus undertook to assess the progress made in developing community services across Canada and to identify impediments and gaps. Recent reviews and critiques of health policy were examined and a telephone consultation was conducted with 42 informants, representing seniors' associations, service-providers, provincial seniors advisory councils, provincial government officials and experts in the field of community care. Based on the information gathered, NACA has formulated specific recommendations to improve community-based services for seniors.

1. COMMUNITY-BASED SERVICES IN HEALTH CARE: THE ADVANTAGES

Community-based services are services which are provided to persons living in the community to help individuals maintain or regain a maximum degree of autonomy and independence by addressing their physical, mental or social needs. These services broadly include information and referral services, co-ordination services, services of health professionals, as well as a variety of other support services (personal and social support, housing services, health promotion, respite services and transportation).[1**] These services are organized, funded and delivered from a base in the community.[2] Community-based services can be less costly substitutes for hospitalization and long-term institutional care,[3] they constitute a more appropriate response to the chronic disabilities experienced by many seniors and, most importantly, they respect the wish of most seniors to age at home, or to "age in place" as long as possible.

Participants in the consultation conducted by NACA in 1994 reaffirmed that community-based services contribute to seniors' quality of life in several ways; for example:

- By remaining in their own homes, seniors retain their self-assurance and decision-making power; this sense of control reduces stress and provides peace of mind

- Because the home is a normal life setting, it promotes the maintenance of valued contacts with family members and friends

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** **All notes are presented at the end of the text**

- By continuing to live in the same neighbourhood and cultural milieu, seniors retain a sense of security and of belonging that helps them feel socially integrated, despite disabilities.

2. THE EVOLUTION OF COMMUNITY-BASED CARE

At its inception in the early 1970s, Canada's health care system was oriented to curing illness through hospital care and medical services. Insured care for persons with disabilities or chronic diseases was provided through placement in long-term care institutions (e.g., nursing homes, chronic hospitals). The provinces soon realized that this model of care was not appropriate for the growing number of seniors with functional disabilities: not only was the addition of more long-term care hospital beds costly, but also demands for care in the community on the part of seniors and their advocates became more insistent.

In the late 1970s, the provinces implemented programs of community-based services, not by reallocating resources from the acute-care sector, but by adding new money.[4] Because support services were generally not considered medically necessary, most provinces developed a system combining universally insured health services and means-tested social services, partially covered by the Canada Assistance Plan. Typically, the health and social components were delivered by different ministries or by different branches within a ministry.

The following decade was marked by a dramatic change in the federal-provincial funding arrangements for health care and by the beginning of a gradual reduction in federal transfer payments for health care. Under the *Established Programs Financing Act* (1977), the provinces obtained greater flexibility to allocate health care resources other than strictly to hospitals and medical services; on the other hand, provinces were obliged to finance an increasingly larger share of their health care expenditures. The rising costs of the health care system, demographic pressures,

lobbying from seniors' groups and the availability of research suggesting cost-effective service alternatives led to major reviews and plans for health reform in all provinces.

Plans for health reform have been remarkably similar in all provinces and are consistent with the health care needs of an aging population.[5] Indeed, with respect to the care of seniors, all policy reports stress the values of independence, self-determination, security and social integration. Common proposals touching community-based health care include:

- Decentralizing decision-making, planning and delivery of service
- Establishing a co-ordinated system of health and social care with a single-entry point
- Reallocating resources to shift the focus to community-based from institutional care
- Eliminating fragmentation between health and social services
- Assuring a continuum of care that includes institutional care.

These proposals are driven by overarching policy goals common to all jurisdictions. These include improving the effectiveness and efficiency of health care, contributing to the maintenance of good health, meeting demands for greater patient and citizen participation in decision-making[6] and making the process of priority-setting and resource allocation more transparent and accountable.[7]

3. RECENT DEVELOPMENTS: A REPORT CARD

Through consultation and review of pertinent reports, NACA has identified the progress made relative to these provincial policy proposals and some of the challenges that remain.

3.1 Decentralization of health care decision-making and delivery

Participants in NACA's consultation confirmed that most provinces have put in place, or are proposing to put in place, regional health boards. The creation of health boards is designed to decentralize health care delivery and to enhance consumer participation. Many participants pointed out the importance of having the decision-making process closer to the community. Consumers' participation in the regional health boards is also seen positively. Nevertheless, concern was expressed that consumers sitting on these boards will have less real power than service-providers or administrators. Another fear is that regionalised decision-making will lead to unequal access to services, or to unequal standards of service.[8]

To ensure that regionalisation of health care fulfils the principal objectives of community empowerment,

NACA recommends that:

Provincial/territorial governments ensure that senior consumers be fully represented in local health decision-making and planning.

To ensure that the right of all Canadians to equal care is respected. in the process of regionalisation,

NACA recommends that:

Provinces and territories provide a core package of services that covers the continuum of care in all regions and establish province-wide service standards and protocols.

3.2 Single-entry model of care

The single-entry model of service co-ordination is considered a 'best practices' system because it is a cost-effective approach that improves the flexibility, continuity and quality of care for clients.[9] By using an individualized approach with each client, co-ordinated service agencies help seniors and their caregivers understand their needs, set service goals and gain appropriate and timely access to the full range of service options available in the community. A single-entry model of long-term care has been introduced (e.g., British Columbia, New Brunswick, Alberta, Manitoba), or is being introduced (e.g., Ontario, Prince Edward Island) in various provinces.

Those who were consulted by NACA are generally pleased with this development because it will lead to better service co-ordination and provide the capacity to meet individual needs promptly and appropriately. There are apprehensions in some provinces, however, which may be appeased once the central co-ordination of services is fully implemented. For instance, concern was expressed that seniors who do not live in a town where a single-entry system is located will not be well served. Another concern was that the single-entry-point structure is very bureaucratic and that seniors may lose their power to make their own choices once they are 'in the system'.[10] This fear may be accentuated by proposals to make the single point of entry not only a co-ordinating body but the chief agency responsible for the delivery of services.[11] Thus,

NACA reiterates the recommendation it made in 1990, to the effect that:

Single-entry models of access to all services be made available in every community, to assure that seniors have access to the full continuum of care.

To help alleviate fears and suspicions which may impede their acceptance and use,

NACA recommends that:

The federal and provincial/territorial governments direct public education efforts on the advantages for seniors and caregivers of the single-entry system of care.

3.3 Funding of community-based services

Community-based services are a small component of health care expenditures; they are estimated to account for 2-4 percent of total provincial monies allocated for hospitals, institutions and community care.[12] Although provinces have increased their community care budgets to some extent, there is as yet no evidence that there has been a significant reallocation of funds to the community sector, despite clear recommendations to this effect made in health policy reports.[13]

Concerns regarding the adequacy of funding of community-based services were raised by several persons consulted by NACA. Cut-backs to hospital and institutional services are apparent, but the corresponding financial support for the extension and strengthening of community care is not evident. The concern expressed in the consultation is echoed by gerontologist Neena Chappell as follows: "If medical care is cut back without an expansion of community care, seniors are left not with a new

health care system, simply a less adequate old one.[14] Also concerned about such an occurrence, the Queen's - University of Ottawa Economic Project on the Cost-Effectiveness of the Canadian Health Care System advised that "community and alternative services should be in place before hospitals are closed down. This will ensure that patients will have access to necessary services . . . ."[15]

NACA has evidence that efforts to extend community services without sufficient extra funding are leading to a reduction of service to individual clients. The 1993-94 Annual Report of the Seniors Advisory Council for Alberta observes that:

> Although funding for the Home Care Program has increased, it still falls short of what is needed. The Home Care Program is being asked to take on a greater variety of clients, including younger disabled persons, handicapped children and early discharges from acute care hospitals. In some cases, this has resulted in assistance being denied to older people who need support services but who are not at immediate risk of institutionalization.[16]

In the same vein, a senior executive of a home care company that provides service in seven provinces notes that:

> In many provinces, provider agencies have noticed that governments are buying less care per client (in terms of hours of service or professional visits) although agencies are serving many more clients than a few years ago.[17]

One consequence of inadequate provision of community care to compensate for cut-backs in hospital services is poor after-care for patients discharged from hospitals. This problem was noted during NACA's consultation and was mentioned again by the Seniors Advisory Council for Alberta.[18]

> Another negative effect is an increase in the burden of care borne by informal

caregivers, who already assume about 80% of seniors' care needs.[19] Failure to provide adequate community-based services will increase health care costs in the long run. First, the physical and mental strain of caregiving engenders greater use of

health care services among caregivers.[20] Second, overburdened caregivers who do not receive the support of formal community services withdraw from caregiving, leaving no recourse other than institutionalization for the senior care recipient.[21]

Some explanations of the failure to reallocate savings realized in the institutional sector to community care have been suggested. One is that the rhetoric of health care reform masks the real intention to off-load care of frail seniors onto the family-mainly women-as a way of controlling the costs of an aging population.[22] A second is that savings gained from cut-backs to hospitals and other institutions are eaten up by rising drug expenditures.[23] The final explanation given is that, as a minor player in terms of budget and status, the community care sector is not well represented in health care decision-making. Thus, the impact on community services of measures such as hospital or long-term bed closures is not adequately considered and resources are not redistributed accordingly to community services.[24]

Provincial governments must allocate greater resources to community services if they mean to achieve the desired health reform. The barriers to funding adequacy must be addressed. Although funding increases are necessary, no set funding target can be suggested because the level of funding required depends on the needs for care in the community.

NACA recommends that:

Provincial/territorial governments allocate the funding required to meet the needs of each region for community-based services.

Provincial governments and regional health boards involve the community care sector as a full and equal partner in all health care decision-making and planning.

3.4 Service fragmentation

Another concern raised in NACA's consultation is the fragmentation between medical services and social services, which is reflected in wide disparities among provinces/territories in the services available. A preliminary reason for this fragmentation lies in the differences in the federal-provincial arrangements for health and social services. In contrast to health care, there is no common core of services available in each province through the Canada Assistance Plan (CAP) nor are there uniform criteria for eligibility for social services.

The federal government has indicated that it is considering block funding for health, social services and education. Block funding to the provinces/territories without national criteria could lead to further disparities, as provinces/territories would be completely free to determine the allocation of the federal transfers. In the public discussion paper on Social Security Reform, the federal government affirmed its commitment to "protect the funding of a wide range of vital social services, including services for seniors and health-related spending."[25] This commitment could be fulfilled by making funding for social and health-related services conditional on the provinces' meeting federal requirements to provide core services with similar criteria for access in every region.

NACA recommends that:

The federal government set national criteria governing accessibility and the provision of a core package of services for the transfer of funds to the provinces/territories for social and health-related services.

3.5 Long-term care facilities

Seniors aged 85+ represented 9% of the population aged 65+ in 1991. By 2011, they will constitute 13% of the senior population. Currently, an estimated 23% of

men and 36% of women 85 and older reside in institutional settings.[26] Improvements in education and income (and possibly in health status) among future cohorts of seniors may decrease the proportion who require institutionalization.[27] Similarly, the development of an effective community-based system of care may slow the rise in demand for institutional placement or even decrease the demand.[28] Nevertheless, it is likely that the need for long-term care facilities will grow as the sheer number of older seniors increases: it is estimated from demographic and health trends that the number of seniors requiring institutional care will rise from 195,080 in 1986 to 312,300 in 2011.[29]

Provinces have been limiting the growth of long-term care facilities to control health care expenditures. There is a danger that this trend may result in an insufficient number of institutional beds for seniors who are too disabled to remain in the community. The participants in NACA's consultation were concerned that the emphasis on community care could lead to an insufficiency of high-quality long-term care facilities. This concern was especially strong in rural communities.

NACA recommends that:

Provincial/territorial governments plan for an adequate number of places in long-term care institutions.

4. MEETING THE NEEDS OF SENIORS FROM ETHNOCULTURAL MINORITIES

Since the introduction of the policy of family reunification in immigration, the number of seniors from ethnocultural minorities has increased. About 17% of Canadian seniors were born outside Canada. In the population of Canadian residents who speak neither English nor French, 55% are 45 and older.[30] Language barriers, religious and cultural differences, and economic dependency conspire to reduce the access of seniors from ethnocultural minorities to community-based health and social services. This is

especially the case outside major urban centres and among less well-represented or established ethnic groups.

Participants in NACA's consultation observed that improving the access of minority-group seniors to community-based services typically is limited to providing services in the seniors' language, in particular, information and referral services. Mainstream community service agencies in large urban centres may provide ethnoculturally sensitive services if staff have received training in responding appropriately to individuals from minority groups or if the staff includes members of ethnocultural groups. If an ethnic population is sufficiently large, ethno-specific services may be developed with a large measure of financial and volunteer support from the ethnic community.

To address the needs of seniors from ethnocultural minorities, NACA recommended in *The NACA Position on Gerontology Education* (1991) that pre-employment and continuing education programs in gerontology/geriatrics include education on ethnocultural issues and that grants or scholarships be made available to train health and social service personnel from ethnocultural minorities to serve seniors. These recommendations remain pertinent to ensure the access of minority-group seniors to community services. Recognizing that the success of both ethno-specific and ethnoculturally-sensitive mainstream services depend upon the willing participation of many volunteers from ethnocultural communities,

NACA further recommends that:

The federal and provincial/territorial governments provide support and training to volunteers and voluntary associations that facilitate seniors' access to culturally-sensitive community health and social services.

CONCLUSION

In reviewing the progress made in implementing community-based services for an aging population, NACA was pleased to note the consistency in the stated policy directions of all provinces/territories and the development of certain key elements, in particular, regional health boards and single-entry points to the service network. Nevertheless, the Council is concerned that resources are not being reallocated from other sectors of health care to adequately expand and strengthen community-based services, and that the availability of and access to the non-health components of care-which are often the most important services to maintain independent living-is uneven in most provinces/territories.

In *The NACA Position on Community Services in Health Care for Seniors* (1990), the Council affirmed that, to effectively meet the changing health needs of an aging population, the three service sectors, i.e., informal, community-based and institutional (acute and long-term), must be recognized as complementary to one another and integral and equally important parts of a complete service delivery system. Present evidence gathered from reports and from the consultation with seniors, service-providers, government officials and experts suggests that the community-based sector is not growing in tandem with the cut-backs in the institutional sector; this may lead to an overreliance on the informal sector that is already heavily burdened.

Health reform means more than controlling costs to achieve an affordable health care system. It means providing appropriate and effective care that is responsive to the changing needs of Canadians. NACA urges provincial/territorial governments to follow through on their commitment to expand and strengthen community-based services while maintaining sufficient institutional services for seniors. The Council also encourages the federal government to use its leadership and financial leverage to support the provinces/territories in this task.

NOTES

1) A more detailed listing of community-based services is as follows:

information and referral services

co-ordination services

services of health professionals: includes namely physicians, home care nurses, physiotherapists, speech therapists, occupational therapists, podiatrists, nutritionists and social workers

personal support services: homemaking (meal preparation, meals-on-wheels, wheels-to-meals, laundry, cleaning, home and yard maintenance), shopping, banking

personal care: help with dressing, bathing, eating and moving about

social support: social or recreational services, friendly visiting, reassurance calls or visits

supportive housing: homesharing, congregate housing, garden suites

health promotion/prevention services: group fitness activities, personal development and health education programs

caregiver support services: adult day care, overnight or other temporary care in an institutional setting or at home, caregiver support groups, counselling or training programs

transportation services: adapted transportation for disabled persons, transportation clubs

National Advisory Council on Aging. *The NACA Position on Community Services in Health Care for Seniors*. Ottawa: 1990.

2) A distinction is made between community-based services and institutional outreach services which, like community-based services, are delivered in the community but are organized, funded and delivered from a hospital or other institutional facility. Because these outreach services are part of an institutional budget, they are vulnerable to funding pressures in other parts of the institution (for instance, a hospital can decide to reallocate funds from its home nursing program to the cardiology unit). Outreach services are also deemed to be less sensitive to community needs than community-based services.

3) A study of the cost-effectiveness of residential, community and home-based services led

Marcus Hollander to conclude that "community-based services can be cost-effective in a properly structured system of service delivery."
Hollander, M.J. *The Costs and Cost-effectiveness of Continuing-care Services in Canada*. Working paper. Project on the Cost-effectiveness of the Canadian Health Care System. Queen's - University of Ottawa Economic Projects, 1994.

4) Shapiro, E. Community and long-term health care in Canada. In *Limits to Care: Reforming Canada's Health System in an Age of Restraint*, Blomqvist, A. and D. M. Brown (ed.). Toronto: C.D. Howe Research Institute, 1994: 327-362.

5) Bé1and, F. and E. Shapiro. Ten provinces in search of a long term care policy. In *Aging: Canadian Perspectives*, Marshall, V. and B. McPherson (ed.). Peterborough: Broadview Press, 1994: 245-261.

Mhatre, S.L. and R.B. Deber. From equal access to health care to equitable access to health: A review of Canadian provincial health commissions and reports. *International Journal of Health Services*, 22, 4, (1992): 645-668.

6) Hurley, J., Lomas, J. and V. Bhatia. When tinkering is not enough: Provincial reform to manage health care resources. *Canadian Public Administration*, 37, 3, (1994): 490-514.

7) Angus, D.E. et al. *Sustainable Health Care for Canada*. Synthesis Report. Project on the Cost-effectiveness of the Canadian Health Care System. Queen's - University of Ottawa Economic Projects, 1995.

8) The delivery of health and social services has been decentralized in Quebec for several years in the Centres locaux de services communautaires (CLSCs). In his December 1994 report, the Auditor General of Quebec criticized the absence of uniform standards of community care provided by the CLSCs. For instance, there are differences in the number of weekly hours of home care provided, as well as in the qualifications of persons responsible for providing care.
Vérificateur général du Québec. *Rapport du Vérificateur général du Québec*. Québec: 1994.

9) Hollander, M.J., op. cit.
A series of studies of community health services in Southern Ontario demonstrated that "a recurring pattern of lower expenditures for community health service utilization and equal or better client outcomes was associated with well-integrated proactive services when compared to individual fragmented, reactive approaches to care."

Browne, G. et al. *More Effective and Less Expensive: Lessons from Five Studies Examining Community Approaches to Care*. Working Paper 93-1 1. Hamilton: System-Linked Research Unit, McMaster University, 1993.

10) In the words of one participant, "seniors are afraid that once they are pulled into the system through the single-entry points they will not be able to get out of it and will end up being institutionalized."

11) Ontario passed legislation in 1994 to create multi-service agencies (MSAS) throughout the province that will provide a wide range of community health and social services. At least 80% of services will be provided directly by the MSAS, with the remainder purchased by the MSAs from other non-profit or commercial agencies.

12) Shapiro, E., op. cit.

13) Shapiro, E., op. cit.

Chappell, N. *Health Reform--Implications for Informal Caregivers*. Unpublished report. Consultative committee on Social Policy, 1993.

Evans, R. *There and Back Again: Coming Home from Hospital*. Keynote presentation to the Canadian Association on Gerontology. Winnipeg: 1994.

14) Chappell, N., op. cit.

15) Angus et al., op. cit.

16) Seniors Advisory Council for Alberta. *Annual Report 1993-94*. Edmonton: 1994.

17) Personal correspondence from Lewis Nickerson, Vice-President Administration, Comcare Canada, July 29, 1994.

18) "In one major urban area, some 'at risk' older persons have been discharged prematurely from active treatment hospitals before satisfactory care arrangements were made, and with family members being told that they must now be responsible. Older adults from rural areas have been discharged after very short stays from urban hospitals without adequate information being provided to the rural services (hospitals and home care programs) who need to provide ongoing care."

Seniors Advisory Council for Alberta, op. cit.

19) Canada Seniors. *Ageing and Independence: Overview of a National Survey*. Ottawa: Health and Welfare Canada, 1991.

20) The Canadian Study of Health and Aging. Patterns of caring for people with dementia in Canada. *Canadian Journal on Aging*, 13, 4, (1994): 470-488.

Zarit, S.H., Reever, K.E. and J. Bach-Peterson. Relatives of the impaired elderly:

Correlates of feelings of burden. *The Gerontologist*, 20, 4, (1980): 649-655.

21) Shapiro, E., op. cit.

22) Chappell, N., op. cit.

Rosenthal, C.J. Editorial: Long-term care reform and 'family' care: A worrisome combination. *Canadian Journal on Aging*, 13, 4, (1994): 419-422.

23) Evans, R., op. cit.

24) Shapiro, E., op. cit.

25) Human Resources Development Canada. *Improving Social Security in Canada: A Discussion Paper*. Ottawa: 1994.

26) Statistics Canada. *Profile of Canada's Seniors*. Catalogue No. 96-312 E. Ottawa: 1994.

27) Carriére Y. and J. Légaré. Vieillissement démographique et institutionnalisation des personnes Âgées: des projections nuancées pour le Canada. *Cahiers québécois de démographie*, 22, 1, (printemps 1993): 63-92.

28) The Planning and Resource Allocation Framework developed in British Columbia in 1989 pro-actively reallocated future resources from residential to community-based services. This approach resulted in a reduction of bed utilization from 71.6 beds per 1,000 in the 65+ population in 1983-84 to 57 beds in 1991-92 while waiting lists have remained fairly steady. Conversely, there was an increase in community-based clients from 89.5 per 1,000 in the 65+ population in 1983-84 to 115 in 1991-92.

Hollander, M.J., op. cit.

29) Rosenberg, M.W. *Health, Housing and Social Support for an Aging Population in 2011:An Assessment Using CEPHID*. Unpublished report. Ottawa: Policy and Consultation Branch, Health Canada, 1994.

30) Among all persons in Canada unable to speak English or French, 26% are aged 45-64, and 29 % are 65 +.

Statistics prepared from the 1991 Census Public Use Microfile by Policy Coordination and Strategic Planning, Citizenship and Canadian Identity, Canadian Heritage.

POSITION PAPERS
OF THE
NATIONAL ADVISORY COUNCIL ON AGING

7. The NACA Position on the Goods and Services Tax, February 1990.

8. The NACA Position on Community Services in Health Care for Seniors, February 1990.

9. The NACA Position on Informal Caregiving: Support and Enhancement, September 1990.

10. The NACA Position on Lifelong Learning, October 1990.

11. The NACA Position on Gerontology Education, December 1991.

12. The NACA Position on Managing an Aging Labour Force, February 1992.

13. The NACA Position on Canada's Oldest Seniors: Maintaining the Quality of their Lives, January 1993.

14. The NACA Position on the Image of Aging, February 1993.

15. The NACA Position on Women's Life-Course Events, September 1993.

16. The NACA Position on Community Services in Health Care for Seniors: Progress and Challenges, March 1995.

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