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THE HEALTH OF THE CANADIAN ELDERLY

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INTRODUCTION

> ... there is more to health in later life than age itself.[1]

Who are the elderly and what determines their health? How and why do their health needs vary from those of other age groups? This paper considers the implications of these and other questions for health policy and the particular focus required to address the health concerns of an aging population. It highlights efforts across the country to provide services and evaluate their effectiveness in meeting the needs of our growing numbers of elderly people.

In the 1980s, in line with expanded concepts of health and with the recognition that aging in combination with other social changes poses particular demands, governments across Canada recognized the need to "coordinate healthy public policies" to meet the challenges posed by rapid and irreversible social change.[2] Such public policies for the elderly need to consider not just traditional health issues but also social and economic strategies that foster greater equity for the aging population.

In Canada, the Lalonde Report of 1974 was the first to recommend goals or strategies for health. For the older population, the report envisaged that the focus on curing illness should change to a focus on caring for chronic diseases. Its overall approach was two-pronged; it proposed, on the one hand, the reduction of mental and physical hazards for groups (such as the elderly) perceived to be at greatest risk, while, on the other hand, improving access

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(1) Health and Welfare Canada, *The Active Health Report on Seniors*, Supply and Services Canada, Ottawa, 1989, p. 5.

(2) Jake Epp, Minister of National Health and Welfare, *Achieving Health for All: A Framework for Health Promotion*, Supply and Services Canada, Ottawa, 1986, p. 10.

to health care for these groups.(3) A decade later, the Epp Report identified three national health challenges: reducing inequities, increasing prevention of illness, and enhancing people's capacity to cope. The particular needs of the elderly were to be addressed by three health-promotion mechanisms (self-care, mutual aid and healthy environment) to be implemented through public participation, strengthened community health services and a coordinated healthy public policy.(4) In addition, several provincial commissions, task forces and councils of health proposed action on health goals for the elderly, focusing on financial and human resources, organization, and management of health care in the context of an increasing elderly population.(5)

WHO ARE THE ELDERLY AND WHAT DETERMINES THEIR HEALTH?

The concept of "health" has changed over time to reflect the greater understanding of key determinants of health status. The World Health Organization has expanded the term to imply "a state of complete physical, mental and social well-being, and not merely the absence of disease." This concept was developed further in the 1986 Ottawa Charter on Health Promotion where health was viewed as "a resource for everyday life" for which the fundamental conditions and resources were seen to be "peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity."

The understanding of factors that determine health has taken us a long way from the assumption that more health care results in more health. The health of the older population depends not only on formal and informal provision of care but also on factors experienced over a lifetime, such as housing, nutrition, occupation or daily activity, use of tobacco, alcohol and other substances, and environmental circumstances. Thus, factors in the physical and social environment of older people will have determined their health status by the time they reach 60 years and will continue to determine it as they age.

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(3) Marc Lalonde, Minister of National Health and Welfare, *A New Perspective on the Health of Canadians*, Ottawa, 1974, p. 66-72.

(4) Epp (1986).

(5) Douglas Angus, *Review of Significant Health Care Commissions and Task Forces in Canada since 1983-84*, Canadian Hospital Association, Canadian Medical Association and Canadian Nurses Association, 1991.

Older people live longer and healthier lives as a result of preventive measures such as better sanitation, effective vaccines, and more healthful diets, as well as curative measures involving pharmacological and technological intervention. In spite of advances in public health, education, standards of living, sciences and technology, however, disparities remain among different groups within the older population, with such variables as age, socio-economic conditions, gender, ethnicity and marital status all affecting health status.

A. Age

The World Assembly on Aging, convened by the United Nations in Vienna in 1982, established 60 as the threshold of old age.(6) This baseline is primarily set for convenience, as a way of standardizing the starting point for discussions about the elderly. As far as the practical, physiological and psychological aspects are concerned, this choice of age is open to discussion. In Canada, the age of 65 years is used for the collection of statistical data and thus provides the most common first reference point for this paper. In 1991, there were 3.2 million people in the 65 and over age group in Canada. This group constituted 12% of the population, an increase from 10% a decade earlier.(7)

Whatever the threshold set, the people who fall into the category of the elderly are not a homogeneous group. The process of biological aging is continuous from birth to death and varies considerably from one individual to another. Age is one of the principal factors determining the nature and extent of an individual's health and social needs, but within the elderly population the oldest and younger members have lived through and been influenced by different economic, social and political events.

Currently, observers speak of three categories of old people: those 65 to 75 years are "young-old"; those 75 to 85 years are "middle-aged old"; and those 85 and over are "old-old." Figures from the 1991 census indicate that the age group over 65 years of age grew by 17.5% between 1986 and 1991, while the population in the 75-and-over age group, the heaviest users of health care services, grew by 21.7%(8)

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(6) United Nations, *Vienna International Plan of Action on Aging*, United Nations, New York, 1983.

(7) Statistics Canada, *Age, Sex and Marital Status*, Catalogue 93-310, Industry, Science and Technology, Ottawa, 1992, p. 1.

(8) *Ibid*., p. 1.

The fact that some diseases are age-dependent in that their origins and development are directly related to age, is significant; Alzheimer's, Parkinson's, strokes, and osteoporosis are in this category. The presence of these diseases suggests two things; that ways of preventing them must be found and that existing services must be adapted to address them. For example, osteoporosis, which affects about 25% of postmenopausal women, may be preventable. Given that "hip fractures related to osteoporosis result in death in 12% to 20% of cases and in disability in up to 75% of surviving patients," greater attention is required.(9)

Alzheimer's Disease, a progressive degenerative disorder that produces dementia, provides another example of why changes are needed. AD commonly appears after age 65, with the incidence increasing with age from a low of 3% for people between the ages of 65-74 to a high of 47.2% for those over 84 years.(10) Memory loss, followed by a slow disintegration of personality and physical control, leads to the necessity for total nursing care in later stages.

As the population ages, the health, social and legal challenges posed by Alzheimer's Disease will be enormous. It has been suggested that on the social front there is a need for supplemental support for caregivers and greater sharing of resources between expanded home care and institutional care. Some related legal issues are power of attorney for the victim and voluntary euthanasia. Health issues include the lack of available institutions for long-term care, particularly specialized units for AD sufferers, and the need for research and for the education of physicians and nurses.(11)

Other diseases are chronic in nature, marked by long duration and slowly progressing severity. People over 60 years of age are seen as members of a "population at risk" with respect to heart and circulatory disease, cancer, arthritis, rheumatism, diabetes and other diseases, all of which can be connected to the aging process.(12) In a 1985 survey of Canadian seniors, 55% reported arthritis-rheumatism, 39% hypertension and 24% respiratory difficulties.(13) The current focus on medical and institutional responses is not always

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(9) National Advisory Council on Aging, "A Quick Portrait of Canadian Seniors – Major Causes of Death?" *Aging Vignette #7*, Ottawa, 1993.

(10) Daniel Brassard, *Alzheimer's Disease*, BP-335E, Research Branch, Library of Parliament, Ottawa, May 1993, p. 3.

(11) *Ibid*., p. 14-15.

(12) Lalonde (1974), p. 59.

(13) National Advisory Council on Aging, "A Quick Portrait of Canadian Seniors: How Healthy? For How Long?" *Aging Vignette #6*, 1993.

appropriate for conditions where certain functional abilities are impaired but not acutely disrupted.

As with other aspects of their lives, seniors are not a homogeneous group in relation to their health status. In Canada, while approximately 80% of persons aged 65 years and over report one or more chronic conditions, only 20% report that their daily activities are so restricted that they must seek assistance.(14) Half of all seniors between the ages of 75 and 84 report a disability; for those over 85, this increases to over 75%.

B. Socio-Economic Factors

Average incomes for males and females decline after age 55 and the incidence of low income increases.(15) Unattached people aged 65 years and over, particularly women, are among the poorest Canadians. Some diseases show a strong association with socio-economic status; for example, the 1979 Canada Health Survey revealed that among women aged 70 and over, the rate of chronic hypertension was lowest in the highest socio-economic group and highest among those in the lowest socio-economic class.(16)

Canada's Health Promotion Survey in 1985 revealed that, as for younger Canadians, the self-rated health of seniors varied strongly with social and economic background, and not just with age itself. According to this survey, "those in the upper-middle income group are far more likely to report excellent or very good self-rated health than those in the poor or very poor income categories. Those in the very poor income group are more than five times as likely to report fair or poor health." In addition, "40% of adults 65 and over in the very poor income group report activity limitations, compared to only 11 % of those in the upper-middle income group."(17)

The Health Promotion Survey also found a very strong relationship between education and self-rated health, activity limitation, and happiness. For example, of people over 65 years of age, 34% of those with elementary education or less reported health that was only fair or poor compared to only 7% of those with complete post-secondary education. It was

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(14) *Ibid*.

(15) Statistics Canada, *Selected Income Statistics*, Industry, Science and Technology, Ottawa, 1993, p. 2 and 4.

(16) Leroy Stone and Susan Fletcher, *The Seniors Boom: Dramatic Increases in Longevity and Prospects for Better Health*, Supply and Services, Ottawa, 1986, section 4.9.

(17) Health and Welfare Canada, *The Active Health Report on Seniors*, Supply and Services, Ottawa, 1988, p. 18-19.

suggested that "health differences among people with varying levels of education may have more to do with subsequent employment history than with educational level itself."(18)

Average earnings before retirement also seem to have a clear influence on health after 65 years. In a study using Canada Pension Plan data, a strong relationship was revealed between average earnings in the 30 years before retirement and death rates after retirement. The men with the lowest average earnings were twice as likely to die between 65 and 70 years of age as the men in the highest earning groups.(19) Other studies have shown that life expectancies of people living in the poorer districts of Montreal are shorter by nine years than those of their wealthier neighbours.(20)

C. Gender

In Canada, life expectancy at birth increased steadily between 1975 and 1985. For men, the increase was from 70.2 to 73.1 years while for women, it was from 77.5 to 79.7 years. By 2011, it is projected that life expectancy for women will be 84 years and for men 77 years.(21) Women outnumber men among the elderly; in 1991, there were 138 women for every 100 men in the 65 and over age group. Among the population 85 years and over, women outnumbered men by more than two to one.(22)

The longer life span of women increases their problems of access to adequate resources for health, including food, housing and services. In 1991, of "primary maintainers," (i.e., those in a household who contribute the greatest amount toward shelter payments) aged 75 and over, 52% were female.(23) Older women tend to be poorer than older men. According to the Health Promotion Survey, about 57% of women over 65 are either poor or very poor,

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(18) Health and Welfare Canada, *Active Health Report on Seniors*, p. 20.

(19) M.C. Wolfson, G. Rowe, J.F. Gentlemen and M. Tomiak, *Career Earnings and Death: A Longitudinal Analysis of Older Canadian Men*, Canadian Institute for Advanced Research, Toronto, PHPWP.12, 1991.

(20) Cited in Maureen Baker, *The Status of the Elderly*, BP-164E, Research Branch, Library of Parliament, Ottawa, December, 1988, p. 8.

(21) National Advisory Council on Aging, "... How Healthy? For How Long?" *Aging Vignette #6*, Ottawa, 1993.

(22) Statistics Canada, *Age, Sex, and Marital Status* (1992), p. 2.

(23) Statistics Canada, *Dwellings and Households*, Catalogue 93-311, Industry, Science and Technology, Ottawa, 1992, p. 1.

compared to only 47% of men.(24) The lower social and political status of women affects their access to all resources, including health. The women most likely to have such problems are those over 80 years of age living in urban centres.

Because women reach the older age groups in greater numbers, they constitute a significant part of the population vulnerable to diseases that lead to institutional care, including dementia, coronary and arterial disease, and musculoskeletal impairment. In 1991, of the population aged 65 to 74 years living in collective institutional dwellings, more than half were women, while in the group aged 75 and over, women constituted close to three-quarters of the population in such dwellings.(25)

In the 65-and-over age group, however, hospitalization rates over the period 1980-81 to 1985-86 were higher for males than females.(26) This raises concerns about differences in medical care for men and women. At the 1993 annual meeting of the American College of Cardiology, researchers pointed out that women with heart disease were treated differently from men by physicians and with therapies developed primarily for men.(27) Increasingly, there is a recognition that "women have not been well served by the medical establishment and the health-care system."(28)

Both men and women experience age-related diseases, but stroke or cerebrovascular disease provides an interesting example of how age makes a difference. It is reported that "the relative risk of stroke is greater for males at all ages. However, due to the preponderance of women among the oldest age groups and the dramatic increase in stroke incidence with age, a greater absolute number of women die from stroke. Sixteen percent of women will eventually die of stroke, compared to only eight percent of males."(29)

While elder abuse is not limited solely to older women, they are the most frequent victims. As a societal problem, mistreatment of older people is still accorded a minimal profile; yet abuse, whether it is physical, psychological, material or due to neglect, can have devastating

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(24) Health and Welfare Canada, *The Active Health Report on Seniors* (1989), p. 17.

(25) Statistics Canada, *Dwellings and Households* (1992), p. 13.

(26) Statistics Canada, *A Portrait of Seniors in Canada*, Supply and Services, Ottawa, 1990.

(27) Daniel Haney, "Heart Treatments for Men Not as Useful for Women," *The Ottawa Citizen*, 18 March 1993, p. A6.

(28) Carolyn Green, "Group Will Monitor Women's Health Studies," *Medical Post*, 30 March 1993, p. 19.

(29) Mary Gordon, "Monograph Series on Aging-related Diseases: III. Stroke (Cerebrovascular Disease)," *Chronic Diseases in Canada* 14(3), Summer 1993, p. 68.

effects on the health and wellbeing of the elderly. This problem cuts across health, social and legal sectors and requires a coordinated vision and strategy.

D. Ethnicity

Ethnicity affects health status in several ways. Some studies have reported differences in the prevalence of certain age-related diseases among different racial groups. For example, rates of Parkinson's Disease have been lower among blacks than whites in the United States while cerebrovascular disease has been higher among the Japanese and Chinese than among the population in Western countries.(30) Some studies focused on ethnic seniors' problems of access to mainstream health care services, especially the language barriers to services for those who do not speak either English or French. As well, the health habits, expectations and preferences of seniors from some ethnic groups may differ significantly from those of the general population in Canada.(31)

Although many people who move from one country and culture to another experience stress, seniors are particularly prone to difficulties with adjustment. In 1991, the majority of the immigrant population were under 65 years of age but almost 800,000 people, or around 20%, were aged over 65.(32) According to one report on mental health issues affecting immigrants and refugees in Canada, elderly newcomers have particular needs: "They exist as an isolated minority within each ethno-cultural community, depending heavily on younger relatives for financial, social and psychological support."(33)

The effect of immigration on the use of health care services is not clearly documented. Some studies suggest that immigrant seniors seek out and use the services of general practitioners more often than their Canadian-born counterparts, but were less likely to follow through on referrals.(34) Various efforts to adapt the curriculum of medical schools and to

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(30) Judith Seidman-Ripley, "Monograph Series on Aging-Related Diseases: II. Parkinson's Disease," *Chronic Diseases in Canada*, 14(2), Spring, 1993, p. 40 and Gordon (1993), p. 68.

(31) Canadian Public Health Association, *Ethnicity and Aging: Report of the National Workshop*, Ottawa, 1988.

(32) Statistics Canada, *Immigration and Citizenship*, Industry, Science and Technology, Ottawa, 1992, p. 66.

(33) Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, *After the Door Has Been Opened*, Supply and Services, Ottawa, 1988, p. 79.

(34) *Ibid*., p. 82.

provide hospital services sensitive to multicultural needs must also address the particular needs of elderly immigrants.(35)

Seniors constitute a smaller proportion of the aboriginal population than of the general Canadian population. In 1986, 10% of the Canadian population were 65 years of age and older, but this was true of only 4% of the aboriginal population.(36) Growth in the over 65 group, however, may come about as a result of increases in life expectancy and amendments to the *Indian Act* permitting the reinstatement of adults in the Indian population. The greatest concentrations of Indians are found in the four western provinces (60%) and in Ontario (23%). The Inuit live primarily in the Northwest Territories, while the Metis reside predominantly in Manitoba, Saskatchewan and Alberta.(37)

In Canada, older aboriginal people have many health problems that contribute to a life expectancy below that of the general population: "Between 1976 and 1986, life expectancy at birth for status Indian males increased from 59.8 to 63.8 years, and for status Indian females from 66.3 to 71 years ... Life expectancy for Inuit in the Northwest Territories was estimated at 66 years in 1987."(38) Native people in Canada suffer from diseases that are often preventable. Poverty, inadequate nutrition and substandard housing contribute to diabetes and tuberculosis, diseases of particular concern for the whole aboriginal population, and to the diseases of the circulatory system that are the leading cause of death of aboriginal people over 65 years.

E. Marital Status

Among the broader social factors, the marital status of the elderly person has been linked to the need for health and social services. With the increase in divorce rates in Canada and the greater longevity of women, a high proportion of the elderly live in single-person households without the support of a spouse. An OECD report suggested that: "This is an

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(35) Olga Lechky, "Health Care System Must Adapt to Meet Needs of Multicultural Society, MDs Say," *Canadian Medical Association Journal*, 146(12), 15 June 1992, p. 2210-2212 and Olga Lechky, "Cultural Awareness Part of the Health Care Agenda at Toronto Hospital," *Canadian Medical Association Journal*, 146(12), 15 June 1992, p. 2212-2214.

(36) National Advisory Council on Aging, "A Quick Portrait of Canadian Seniors – Native Elders? Ethnic Seniors?" *Aging Vignette #3*, Ottawa, 1993.

(37) Health and Welfare Canada, Medical Services, *Aboriginal Health in Canada*, Supply and Services, Ottawa, 1992.

(38) *Ibid*., p. 33.

important trend, because there is a substantially lower institutionalisation rate of married couples who can provide each other with mutual support."[39]

For women who have been dependent on male spouses for economic support, the problems of being unattached are even greater. In Canada, at the time of the 1991 Census, more than three elderly males in four had a spouse, while this was true of less than one in two elderly females. While one elderly male in ten was widowed, one elderly female in two had this status.[40] According to 1990 data, many of these women without spouses had a low income: "38% of unattached senior women, compared with 26% of comparable men."[41]

Social isolation can sometimes accompany unattached status. People who are alone may be deprived of emotional and physical, as well as financial, support. Some studies suggest that mortality and morbidity are higher among people who lack social support.[42]

F. Geographic Location

In 1991, close to one third of seniors lived in rural areas and small towns, both of which tend to be under-serviced by physicians and other health care professionals who specialize in geriatrics.[43] A Manitoba study found that "seniors who reside outside Winnipeg are 1.6 times more likely to be hospitalized than their Winnipeg counterparts" and noted that "`region effects' of this sort are not uncommon in Manitoba." While pointing to the higher hospital-bed-to-population ratio in rural communities as one contributing factor, the study also noted the lack of availability of alternatives to hospitalization.[44]

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(39) Organisation for Economic Co-operation and Development, *The Future of Social Protection*, OECD, Paris, 1988, p. 47.

(40) National Advisory Council on Aging, "A Quick Portrait of Canadian Seniors: How Many? Men vs Women? How Old? All Married?" *Aging Vignette #1*, Ottawa, 1993.

(41) Edward Ng, "Children and Elderly People: Sharing Public Income Resources," *Canadian Social Trends*, Summer, 1992, p. 12.

(42) Pan American Health Organization, *Health of the Elderly: A Concern for All*, PAHO, Washington, D.C., 1992, p. 22.

(43) Thérèse Jennissen, *Health Issues in Rural Canada*, BP-325E, Research Branch, Library of Parliament, Ottawa, December, 1992.

(44) Neena Chappell and John Horne, *Housing and Supportive Services for Elderly Persons in Manitoba*, Canada Mortgage and Housing Corporation, Ottawa, 1987, p. 62.

HOW DO THE NEEDS OF THE ELDERLY AFFECT HEALTH CARE SERVICES?

A. Increased Need for Services

The population of the world is aging. Fertility, mortality and international migration rates have over the years been the key determinants of change in the age structure of a population. Today low fertility and mortality rates combine to reduce the number of births and to increase the proportion of people who are older. In Canada, it is estimated that the number of people over 65 years will double in the next 30 years.

It has been argued that "with increasing age the demand for health care and personal services rises steeply."(45) Thus, the aging of the population means that there will be more people with more age-related diseases making demands on services established to maintain health and to treat ill-health. In addition, shifts in family structures, combined with the wider participation of women in the paid labour force, make it more difficult for the family to care for elderly relatives and more essential that support services be available in the community.

Others insist that any increase in demand can be linked to the current dominance of the institution-based and curative approach to health care,(46) rather than to the biological aging process alone. "Sociogenic aging," that is, a societal view that people change significantly as they age, is also partly responsible for determining perceived needs. Some critics of the biomedical model of health and illness argue that this "has resulted in old age itself being defined as a problem considered solvable through the receipt of services, essentially medical services, at the individual level."(47)

There are a number of reasons why an increased demand for services might accompany old age. Some are related to broad determinants of health such as gender, ethnicity, marital status; others are related to the state of physical and mental health of a specific older person. Some are related to age-related diseases; others are related to the way health care is financed and organized. This last point is examined in greater detail in the following sections.

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(45) Organisation for Economic Co-operation and Development, *Ageing Populations: The Social Policy Implications*, OECD, Paris 1988, p. 27.

(46) National Advisory Council on Aging, *Intergovernmental Relations and the Aging of the Population: Challenges Facing Canada*, Supply and Services, Ottawa, 1991, p. 9.

(47) Neena Chappell, "Society and Essentials for Well-Being: Social Policy and the Provision of Care," in *Ethics and Aging: The Right to Live, The Right to Die*, James E. Thorton and Earl R. Winkler, eds., University of British Columbia Press, Vancouver, 1988, p. 147.

B. Financing Services

In Canada, each of the ten provinces and two territories currently plans and operates its own health care system with financial assistance from the federal government. The *Canada Health Act*, passed in 1984, re-affirmed the five basic principles of the Canadian health care system: public administration of provincial health insurance plans; comprehensive insurance coverage of all medically necessary services; universal coverage of the population; portability of insured benefits; and reasonable access to insured hospital and physician services. While the current health care system in Canada is publicly financed, services are primarily organized by private entities, physicians and hospitals. The role of physicians and hospitals is subject to considerable debate; both are said to have a major role in delivering services to the elderly and to be in some measure responsible for their increased use of services.

Evidence does suggest that providing health care to the elderly in its current form is costlier than providing it to the rest of the population. In 1974, health care spending on people aged 65 years and over was 4.5 times greater than for Canadians under 65 years. For those over 75, health care spending was 6.7 times greater than for the under-65 group.(48) The need is to shift resources from the present focus on acute care and curative measures to a focus on long-term care and prevention.

The increasing cost of health care for the elderly is a source of anxiety for provincial governments, who have witnessed seven adjustments by the federal government to the EPF formula since 1982.(49) The provinces' ability to finance not only basic health care but also long-term care has been affected. In 1986, it was estimated that the national cost of health-related long-term care was between 15 to 25% of health costs and somewhere in the order of $5 to $10 billion annually.(50) Institutions specifically for the aged took some $1.3 billion in 1982-83 at a time when the federal government paid the provinces less than $73 million dollars for this purpose.

In addition to the financing required for long-term institutional care, funds are required for home care and for rehabilitative measures. For older people, health is more than

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(48) Mary Anne Burke, "Implications of an Aging Society," *Canadian Social Trends*, Spring 1991, p. 8.

(49) Alistair Thomson, "Financing Health Care: A Discussion Paper," in *Exploring Options for Canada's Health Care System*, The Health Action Lobby (HEAL), Ottawa, 1992.

(50) S. Fletcher, L. Stone, and W. Tholl, *Cost and Financing of Long Term Care in Canada*, Health and Welfare, Ottawa, 1986, p. 8.

freedom from illness; it also involves the need to preserve one's functional capacities and autonomy. Thus, both measures to maintain people in their homes and rehabilitative care to ameliorate and restore physical and mental functioning take on particular importance.

C. Organizing Services

Cost concerns often predominate over concerns of efficiency and equity in the delivery of health services. According to some Canadian researchers, these costs may be due in large measure not to the declining health of the elderly, but rather to a health care system that focuses on curative rather than preventive measures, relies disproportionately on physicians rather than other health care providers, and favours hospitalization and institutionalization rather than home care.(51) This view was reiterated in relation to health care systems throughout the OECD area. A 1988 OECD report noted that: "inadequate attention is being paid to long-term care for the disabled and chronically ill, to preventive medicine, to the impact of environmental and behaviourial factors on health status and to the provision of care in non-institutional settings."(52)

Does older age itself, or the response of health care systems to older age lead to a major increase in services? In Canada, it is reported that most seniors, except when hospitalized just prior to death, use medical services no more often than younger adults. According to a large-scale Manitoba study, "59% of health care services are used by about 5% of the senior population (mostly the very elderly) and the largest costs are incurred just before death."(53) Factors other than age are suggested by the fact that the incidence of surgery as part of hospitalization is increasing for the non-elderly as well as the elderly population. Thus, 37% of all hospital discharges of elderly people in 1987, up from 29% in 1975, were related to surgery. For the non-elderly population, surgery was involved in 55% of all hospital discharges in 1987, up from 50% in 1975.(54)

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(51) Neena Chappell, Laurell Strain and Audrey Blandford, *Aging and Health Care, A Social Perspective*, Holt, Rinehart and Winston, Toronto, 1986.

(52) Organisation for Economic Co-operation and Development, *Ageing Populations: The Social Policy Implications*, OECD, Paris, 1988, p. 66.

(53) Cited in National Advisory Council on Aging, "The Canadian Health Care System: Myths and Realities," *Expression*, 8(2), Spring 1992, p. 5.

(54) Mary Beth Maclean and Jillian Oderkirk, "Surgery Among Elderly People," *Canadian Social Trends*, Summer 1991, p. 12.

Physicians can and do influence the amount of care made available, including the number of procedures and interventions offered. It has been suggested that "78% of the increase in health care costs in industrialized countries over the past 25 years was due to the number of physicians and to the number and level of services they provide per patient. Only 22% was due to demographic factors including population aging."(55)

Physicians are in turn influenced by the availability of medical technologies and pharmaceutical products. A 1988 OECD report noted that: "technological advances have greatly increased the potential for sustaining life, although often irrespective of a patient's future quality of life, or even his or her ability to function autonomously."(56) Such issues are non-medical and should involve non-medical as well as medical personnel.

The proliferation of medical technologies raises significant questions about their use to sustain and to prolong life. Medical intervention can now avert mortality in many instances of acute illnesses that would have resulted in death a few decades ago. Difficult ethical questions are being raised about "how to assess the value of additional therapy, how far expensive technology and intensive treatment should be used in sustaining the lives of terminally ill or senile patients, and to what extent such treatment should be financed out of public funds."(57)

The issue of prescription drugs and their apparent overuse by seniors is another area where physicians are seen to bear some responsibility. Currently in Canada, people over the age of 65 are the largest consumers of legal drugs and are increasing the number of prescriptions purchased annually.(58) This is at least partially due to the higher number of people with chronic diseases but also to the growth of the pharmaceutical industry and the rapid development of new and often competing drugs. Some observers suggest that part of the higher medication use among the elderly results from inappropriate over-prescription and poor coordination by health professionals.

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(55) National Advisory Council on Aging, "A Quick Portrait of Canadian Seniors: Consuming Health Services? At What Cost?" *Aging Vignette #10*, 1993.

(56) Organisation for Economic Co-operation and Development, *The Future of Social Protection*, OECD, Paris, 1988, p. 47.

(57) Organisation for Economic Co-ordination and Development, *Ageing Populations: The Social Policy Implications*, OECD, Paris, 1988, p. 67.

(58) Chappell, "Society and Essentials for Well-Being: Social Policy and the Provision of Care" (1988), p. 146.

Inappropriate prescriptions affect the health care system in two ways. One result is the higher costs for provincial prescription drug programs providing free coverage for people over 65 years. Provincial drug plans vary considerably across the country. In general, the western provinces have universal plans covering all residents, while the central and eastern provinces cover seniors and social assistance recipients. In Ontario, the cost of free drugs for seniors was estimated to be $1 billion annually and to be rising by 17% a year.(59)

The other result is the fact that between 5% and 15% of seniors entering hospital are admitted with a drug-related problem – from too many drugs, from the wrong dosage of drugs, or from a failure to take drugs properly.(60) In Canada, the Coalition on Medication Use and the Elderly has been working to coordinate the efforts of professional groups, drug manufacturers, government agencies, and seniors to address the problem of inappropriate use of prescription and non-prescription drug by many older Canadians.

Issues of efficiency and equity are of particular concern for the older members of the population. They include: apparent lack of coordination among various providers, inadequate or impersonal care, the over-medicalization of social problems, growth in waiting times for certain procedures, and use of costly medical technologies. Quantifying the effect of either preventive or curative approaches in order to assess their contribution to the survival and quality of life of the elderly is extremely difficult, as are attempts to determine the economic cost of the various approaches.

HOW CAN THE LONG-TERM HEALTH NEEDS OF THE ELDERLY BE MET?

Continuity is an important consideration in promoting the health and well-being of the elderly. An elderly person often enters the health or social system as the result of an acute episode requiring admission to a hospital. A recent survey in Saskatchewan, the Canadian province with the highest percentage of seniors in 1991, noted that many elderly patients in Saskatchewan hospital beds stayed there too long and would have been better off in home-care or outpatient programs.(61)

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(59) "Lives of Seniors At Risk,' Study Says," *Toronto Star*, 2 July 1992, referring to a report by the Senior Citizens' Consumer Alliance for Long-Term Care Reform.

(60) "Ills and Pills: An Overview for Leaders," *Live It Up!: A Guide to Healthy Active Living in the Senior Years*, ParticiPACTION, Toronto, n.d.

(61) "Hospitals Overused, Provincial Study Finds," *Globe and Mail* (Toronto), 1 June 1993, p. A6.

For those elderly who seek entry to health care in non-acute conditions, the challenges can be great. Community care resources are often uncoordinated, poorly integrated and difficult for elderly individuals or their families to access. Providing a balance between acute care and long-term care, between care provided by formal service providers and care provided by informal caregivers, between care provided in institutions and care provided in the elderly person's home is seen as the key to success.

Long-term care is different from acute care in that it requires health and social service support over a prolonged period. For older Canadians who need long-term care at some point in their lives, several options may be available, depending on factors such as health status, family status, and geographic area. Services can be received while living alone in one's own home, living with family or friends, or living in a residential or institutional setting. These services should be diagnostic, preventive, therapeutic, rehabilitative, and supportive and can be delivered by formal and informal caregivers for short-term or continuous periods.

Whether home care is more effective and less costly than institutional care is still open to debate.(62) Many of the existing studies emanate from the United States, where geriatric services are less coordinated and comprehensive. The current discussion in Canada is increasingly focused on finding a balance between cost-effectiveness and a good quality of life for older Canadians.(63)

There are particular organizational and structural aspects of health service delivery to the older population. If, as demographic projections indicate, the growth will be most pronounced in the numbers of those over 80 years of age, the sometimes frail elderly who are the heaviest users of long-term care, greater numbers of both formal and informal caregivers will be needed to provide long-term support. The current system of formal long-term services is seen as inefficient, uncoordinated and sometimes inappropriate for seniors' needs. It has been argued that expanded home care programs with greater support for both formal and informal caregivers may be the most effective and least costly way to provide health care to the elderly.(64)

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(62) Michael Gordon, "Community Care for the Elderly: Is It Really Better?" *Canadian Medical Association Journal*, 148(3), 1993, p. 393-396.

(63) A recent study in Quebec focused the issue on quantitative evaluations for quality of life. Louise Barnard, *L'Évaluation quantitative des résultats des programmes de longue durée sur la santé, le bien-être et la qualité de vie des personnes âgées en perte d'autonomie: Aspects conceptuels et méthodologiques*, Ministère de la santé et des services sociaux, Quebec, 1993.

(64) British Columbia Royal Commission on Health Care and Costs, *Closer to Home*, Report, Volume 2, 1990, p. B-101.

A. Providing Services Formally

Formal caregivers are those who provide paid services to the elderly through community-based or facility-based organizations. Such caregivers include visiting homemakers, nutritionists, physicians, nurses, social workers, physiotherapists who may go into homes or who provide services in day hospitals, and workers in day programs, respite care programs and other facilities based in the community.

In Canada, there is no national policy on long-term care. While home long-term care and institutional care are generally seen as a continuum, their relative positions and the ability to integrate them to meet the changing needs of elderly people is not yet a reality. Home care, home support and community services are frequently considered to be discretionary programs, for which people must often pay, while institutions, particularly hospitals, provide most care services without charge.

Providing health care to the elderly in their homes is considered to be the most effective strategy and in Canada, visiting homemakers are considered to be central to a community-based system. In addition, there have been suggestions for increased training for physicians, nurses and social workers in preventive approaches to primary health care and for greater provision of all services in rural areas.

Health care services delivered by professionals other than physicians can result in more appropriate use of existing acute care and long-term care services. In British Columbia, a random study found that adding a health promotion component administered by a public health nurse to the existing long-term care assessment process reduced the need for long-term institutional services for the frail elderly over 21 months of follow-up.(65) In New Brunswick, the extra-mural hospital program relies on public health units and VON nurses to provide backup care for elderly people transferred from general health care facilities to their homes.(66)

The Victoria Health Project is one of the most frequently cited examples of how a different approach can reduce the demand on acute care services. In this project, multidisciplinary Quick Response Teams of nurses, social workers, physiotherapists and

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(65) N. Hall, P.D. Beck, D. Johnson, *et al.*, "Twenty-One Month Outcomes of a Health Promotion Program for Frail Elders," Paper presented at the 14th International Congress of Gerontology, Acapulco, Mexico, June 1989.

(66) Anne Crichton and David Hsu (with Stella Tsang), *Canada's Health Care System: Its Funding and Organization*, Canadian Hospital Association Press, Ottawa, 1990, p. 88.

occupational therapists, working in conjunction with physicians, help elderly clients to recuperate at home in health circumstances that previously would have required hospitalization. Findings suggest that without the Quick Response Team approach, all of the frail elderly appearing at emergency wards would have been hospitalized; instead, only one in ten or 10% need to be admitted to the acute care hospital.(67)

B. Providing Services Informally

Governments everywhere rely on the community, particularly families, friends and neighbours, to provide for the needs of the elderly. In Canada, it has been estimated that family members and friends provide between 75% and 85% of all care for elderly people in the community.(68) Family and friends, while viewed by the elderly as their most important source of emotional and physical support, may find this task beyond their ability to cope. As seniors get older, the need for personal care services increases greatly and their families and friends cannot be expected to assume sole responsibility.

Within Canada's framework for health promotion, mutual aid is recognized as one of three essential factors, along with self-care and a healthy environment. In this context, mutual aid implies people helping each other to deal with their health concerns, "supporting each other emotionally, and sharing ideas, information and experiences."(69) Today, at the same time as the population of elderly is growing, family structures are changing as a result of geographic mobility, smaller families, more divorces and separation, and an increased number of women in the labour force.

Responding to the health needs of older Canadians may mean providing assistance with grocery shopping and meal preparation, work in and around the house, financial management, and personal care. According to 1985 data, up to 80% of seniors received help in at least one of these activities, with those over 80 receiving the most help.(70) According to

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(67) Susan Iles, "Victoria Health Project," Paper prepared for the Community and Institutional Relations Chapter of the "Canadian Health Care Management" Publication, April 1991.

(68) National Advisory Council on Aging, "A Quick Portrait of Canadian Seniors: Needing Support for Daily Living? From Whom?" *Aging Vignette #11*, 1993.

(69) Epp (1986), p. 7.

(70) National Advisory Council on Aging, "... Needing Support for Daily Living? From Whom?" *Aging Vignette #11*, 1993.

Statistics Canada, approximately 60% of women and 70% of men over 85 continue to live outside institutions.(71)

Some family members spend hours assisting older relatives, in addition to working their regular hours at paid employment. A recent Canadian study on eldercare found that 46% of employees surveyed had provided assistance to a relative aged 65 or over in the previous six months.(72) Of these respondents, 26% combined eldercare with childcare responsibilities. General eldercare, including assistance with shopping, transportation, financial arrangements household tasks, and memory and mood difficulties, took an average commitment of four hours per week. Personal eldercare that included bathing, dressing, eating, medications and toileting took an average commitment of nine hours, the equivalent of an additional work day.

It has been suggested that the care of the elderly by family members must be acknowledged in financial as well as social terms. Government committees, employers, unions and caregivers themselves have made some effort to address this issue with proposal for tax exemptions or offers of leave from work for those caring for elderly family members.

In Canada in 1990, the National Advisory Council on Aging, created in 1980 to advise the federal Minister of National Health and Welfare, unanimously voted to support and enhance the role of informal caregivers.(73) Discussed were the need to link formal and informal networks as well as ways to accommodate the needs of caregivers, particularly the economic implications of caring for others.

Also at the federal level, in 1993 a House of Commons Subcommittee on Senior Citizens Health Issues, examining abuse of the elderly, heard that informal caregivers, often family members, provide a wide range of daily services to older people who might otherwise be in institutions or calling on other services in the community. The members recommended that the federal government consider methods of recognizing such work in economic terms by providing payment to those who care for elderly relatives.(74)

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(71) L.O.Stone and H.Frenken, *Canada's Seniors*, Supply and Services, Ottawa, 1988.

(72) The Work and Eldercare Research Group, *Work and Family: The Survey*, Gerontology Research Centre, University of Guelph, Guelph, 1993.

(73) *The NACA Position on Informal Caregiving: Support and Enhancement* (1990).

(74) House of Commons, *Breaking the Silence on the Abuse of Older Canadians: Everyone's Concern*, Report of the Standing Committee on Health and Welfare, Social Affairs, Seniors, and the Status of Women, June 1993, p. 36-37.

Provincially, the Nova Scotia and the Saskatchewan governments have initiated measures to provide financial assistance to informal caregivers, while groups in Ontario and British Columbia are seeking government support for the concept.(75) The Family Caregivers' Network of Victoria, B.C. emphasizes the important cost-savings achieved by informal caregivers of the elderly. They cite research showing that hospitalization of the elderly often results from caregiver breakdown rather than increasing pathology of the older person receiving care.(76)

Though employers and employee associations sometimes assist informal caregivers, very few Canadian employers offer direct support to workers with family responsibilities for the elderly. More common are flexible work arrangements and family leave for illness. Unions do include issues related to family responsibilities on their agendas; however, the issue of eldercare is still peripheral and is secondary to concerns about childcare.(77)

CONCLUSION

This paper has examined some characteristics of the elderly and how these characteristics affect the demand for services in the present health care system. It has also explored the way that the current organization generates demands and has identified the need for a restructuring of the way health services are delivered and financed.

Health policy must determine the most effective way to integrate concern for the health of the elderly with concern for the health of the nation as a whole; to do this there must be a commitment to research into both the science of aging and how public policy can balance competing notions of the responsibility of the individual, of organized health care institutions, and of the state. There are divergent views on whether the costs of health care for the elderly are higher than those for other parts of the population. This points to the need for systematic information collection and consistent interpretation of any data on the use of health care services by older people, as well as careful analysis of how to meet demands for efficiency and equity.

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(75) National Advisory Council on Aging, *The NACA Position on Informal Caregiving: Support and Enhancement*, Supply and Services, Ottawa, 1990, p. 22.

(76) Barbara Brown, Katherine Cook, Faith Magwood, "A Self-Help Model for Caregiver Education and Support Groups," *Social Worker*, 61, Spring 1993, p. 41-44.

(77) Pradeep Kumar and Lynn Acri, "Unions' Collective Bargaining Agenda on Women's Issues: The Ontario Experience," *Industrial Relations*, 47(4), 1992, p. 623-652.

Canada has achieved near universal access to a basic, high-quality health care service for the elderly. Health services can be preventive as well as curative; they can be delivered on a short-term or a long-term basis, and can involve a range of service providers. All services will require significant investment in order to maintain current standards. Good quality health care, however, includes more than access to treatments for disease and disability; it should also include services to support the desire of the elderly to live secure and independent lives and reduce the sense of isolation and vulnerability that some older people feel as a result of their increasing physical infirmity and reduced mobility. Providing more resources for usefully engaging seniors in activities that could benefit the community and for helping them to stay fit might reduce consumer-generated demands on the health care system.

Worldwide, controlling health care expenditures and reforming ways of financing are proving difficult, while technological change and the growing requirements of older people may push up costs in the future. The varied needs of the different groups within the older population require flexible responses and an emphasis on the prevention, treatment and management of chronic conditions. Public policy must balance competing interests in developing programs to meet these challenges in an aging population.

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