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PERSONNEL AND INSTITUTIONAL RESOURCES FOR MEETING THE NEEDS
OF THE ELDERLY IN CANADA

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The Background in Canada

Before turning to the specific areas of this background paper, it is useful to have a broad picture of the size and other major characteristics of the elderly population in Canada now and as projected for the immediate future. In the 1971 census, 8.1 percent (1,744,4000 people) of Canada's population were aged 65 years and over. By 1981, even by conservative estimates of future rates of fertility, mortality and migration (Health Services for the Elderly, 1976), this percentage is expected to rise to 9.3 percent (2,272,300 people) and by the year 2001 to 10.9 percent (3,341,800 people). During this period 1971-2001, the general population is projected to increase by 42 percent, whereas the population 65 years and over is expected to increase by more than 90 percent. Within the age group of 65 years and older, the projected increases are 23 percent for the 65 - 74 year group, 113 percent for the 75 - 84 year age group, and 156 percent for the 85 year and older age group. Thus, the aging population is itself an aging population, and it is the older aged who have the more severe social and health problems, including institutional care requirements. Another aspect of the demographic data is the expected much greater increase both in numbers and as a percentage in every age group of the older population of females as compared to males. In summary, by 2001, the older population will be much larger num-

erically and as a percentage of the overall population, will be proportionately far older in its internal structure, and will be more heavily female in composition.

Schwenger in assessing the significance of these data (Schwenger, 1975) points out that:

1. "Less than 10 percent are in any type of institution on any one day and over 90 percent are "at home" in the generally accepted sense of the word.
2. Although they spend on the average 8 days per person per year in general acute hospitals compared with about 2 days for all ages, they are out of hospital on the average for 51 weeks out of 52.
3. While 15 percent are severely and permanently disabled, compared with 3 percent for the general population, 85 percent are mobile and independent.
4. Although 80 percent suffer from some chronic condition, over one-half of all older people are not limited in any way by chronic conditions. Moreover, they have comparatively fewer acute illnesses, such as infectious diseases.
5. Social scientists have shown that in general old people in North America age successfully. Studies in American cities have shown that the majority of old people are not dependent, do accept their age, are able to provide for themselves new sources of satisfaction, retain their self esteem, and are certainly not depressed or disconsolate".

Nonetheless, the projections do remind us forcibly of the major implications for Canada in the next decades for planning to meet the socio economic and health needs of the older segment of its population.

INSTITUTIONAL RESOURCES AND PATTERNS

Canada has a high rate of institutionalization for its elderly population. Statistics Canada data show that on any given day in 1976, approximately 8.4 percent of people 65 years of age and over were in some kind of institution. (Schwenger and Gross, 1980). The provincial range was from 9.4 percent in Alberta to 5.6 percent in Newfoundland. Broken down for types of institution the percentages were for general and allied special hospitals (including chronic care hospitals) 2.3 percent, nursing home and residential care facilities 5.8 percent, and psychiatric care facilities 0.4 percent. Again there are variations from province to province depending in part on the general availability of various types of institutional resource and also on some differences in the definitions used.

If one looks at the picture for another perspective, that of how long people have been in institutions, data for Canada are unavailable but recent studies in Ontario (Gross, 1978; Schwenger, in publication), indicate that in 1976 about 1.0 percent were in short-stay care (defined as less than one month), and 7.5 percent were long-term care, (defined as care given over a continuous period equal or exceeding one month). It is reasonable to assume that the experience for Canada as a whole is not greatly different. Further analysis by Schwenger (Schwenger, in publication) shows that an old person has a likelihood of greater than one in four of spending some time in a long-stay institution prior to death.

Why does Canada have such high rates of institutionalization for its elderly population? Schwenger and Gross (1980) discuss this at some length. In part it may be attributed to the aging within the aged population itself. There are not only proportionately more people 65 years of age and older than in the past but also the relative increase in those in the upper ages has been greater than for the older age group as a whole. These older people need more institutional and other care than do the younger old people. Thus, for example in 1976 for Ontario over one-third of the population 85 years of age and above were in some kind of institutional setting on any day. (Schwenger, in publication).

Factors such as geography and climate are important, especially in parts of the country where the population is low, distances are great, relative isolation is common and winter conditions are severe. Institutionalization often makes both social and economic sense under these circumstances. The increasing population mobility, the general decline in family size and the increasing proportion of women working outside the home, have meant that family care is less readily available. Financial support is unavailable generally to encourage relatives to care for the aged at home.

Another influence has been the staged manner in which health insurance has been developed in Canada. Universal public hospital insurance was introduced in 1958 across Canada and medical care insurance from 1968, but comparable coverage for home care was not available. Similarly for the well-elderly, homes for the aged and nursing homes have been built or supported to varying extents by the provinces, whereas support for community and home care services until recently was quite limited. Although most

provinces now support home care programs, these still tend to be limited in scope and in most instances are aimed at post-hospital care rather than to other home care service needs of the elderly.

It should be noted that in other areas, such as the handicapped, child-care, criminals, etc., Canada's institutionalization rates are also comparatively high. As well, public or publicly supported institutions are often used as a means of economic support for communities where other sources of economic development are few.

Governments faced with increasing cost concerns, especially for health care, now are attempting to contain these costs by placing limits on acute hospital expansion and on annual budget increments for hospitals and the medical care insurance fee schedule. As well there are active steps to reduce the number of beds in many communities where these are greater than the established bed/population ratios. Provinces are attempting to reduce the use of psychiatric care institutions, including that by the elderly and the rate of building residential care facilities has slowed somewhat in several provinces. There are active programs of support for extended care facilities development and for nursing home care, as well as for extending home care as alternatives to acute hospital care. But as noted earlier, there is comparatively little emphasis on support for community and home care alternatives to institutional care for the well or frail elderly. The Canada Pension Plan by itself provides only a minimum standard of living and does not allow for special care or services, which must be covered otherwise.

There are, however, important cautions to be kept in mind. Long established and accepted social and health care patterns and programs are not

easily changed because of resistance from the public, professionals and communities. It is also difficult to try to hold costs in line while also stimulating the development of alternative forms of care. Genuine reduction is hard to achieve and alternatives all too often are additions to expenditure rather than replacements. Moreover, an excessive concern with cost containment and reducing institutional beds can sometimes lose sight of the real need by a proportion of older people for institutional care because of health or social reasons and differences in need. The experience of the rapid shift in psychiatric care from an institutional emphasis to a greater community emphasis has demonstrated the necessity to have community services in place or real hardship can result.

Although co-ordination among governments in relation to responsibility, planning, definitions, and financial support is improving slowly, jurisdictional and professional inflexibility and differences remain as formidable obstacles to a balanced and interrelated system. Health, social support, recreation, housing, income maintenance and education continue as separate responsibilities in most governments. Common assessment of need and placement are rare. A few examples, such as the Baycrest Centre for Geriatric Care in Toronto, with its co-ordinated complex of support programs and institutional services, ranging from home support day care, residential care to full long-term care and close liaison with an acute general hospital (Ruth and Rudin, 1977), and the Placement Co-ordination Service of the Hamilton Wentworth District Health Council have remained for many years as models with few replications.

PERSONNEL

The range of health care programs and institutions serving the general population, including the elderly, and those serving the elderly specifically, are generally well-staffed with both professionals and other personnel but comparatively few have had more than relatively limited training in dealing with the particular needs and problems of the aged. Training has been mainly of short-course and in-service types. In the case of non-health care programs, the proportion of professionals is generally lower. However, within the past few years there has been a rapid increase in the number and range of formal programs and training facilities by universities, community colleges and social and health agencies themselves, often with government support.

As might be expected, there is a pervading absence of co-ordination and many courses have been essentially ad hoc and little thought out responses to a generally perceived need. Many are heavily applied in focus and have little theoretical and conceptual content. Most are discipline or task focused. Many are being provided by instructors with little systematic preparation themselves. Even in higher educational institutions most teaching is discipline-focused and an incidental part of other teaching rather than having been planned with a broad gerontologic objective (Report of the Task Force on Gerontology, 1976). The comparatively few formal courses in gerontology and geriatrics reflect not only discipline specificity in many cases but also the current confusion and controversy between so-called "medical" and "social" models and among the competing self-interests of different professional groups. Few are truly broad, comprehensive, and inter-disciplinary in concept and content.

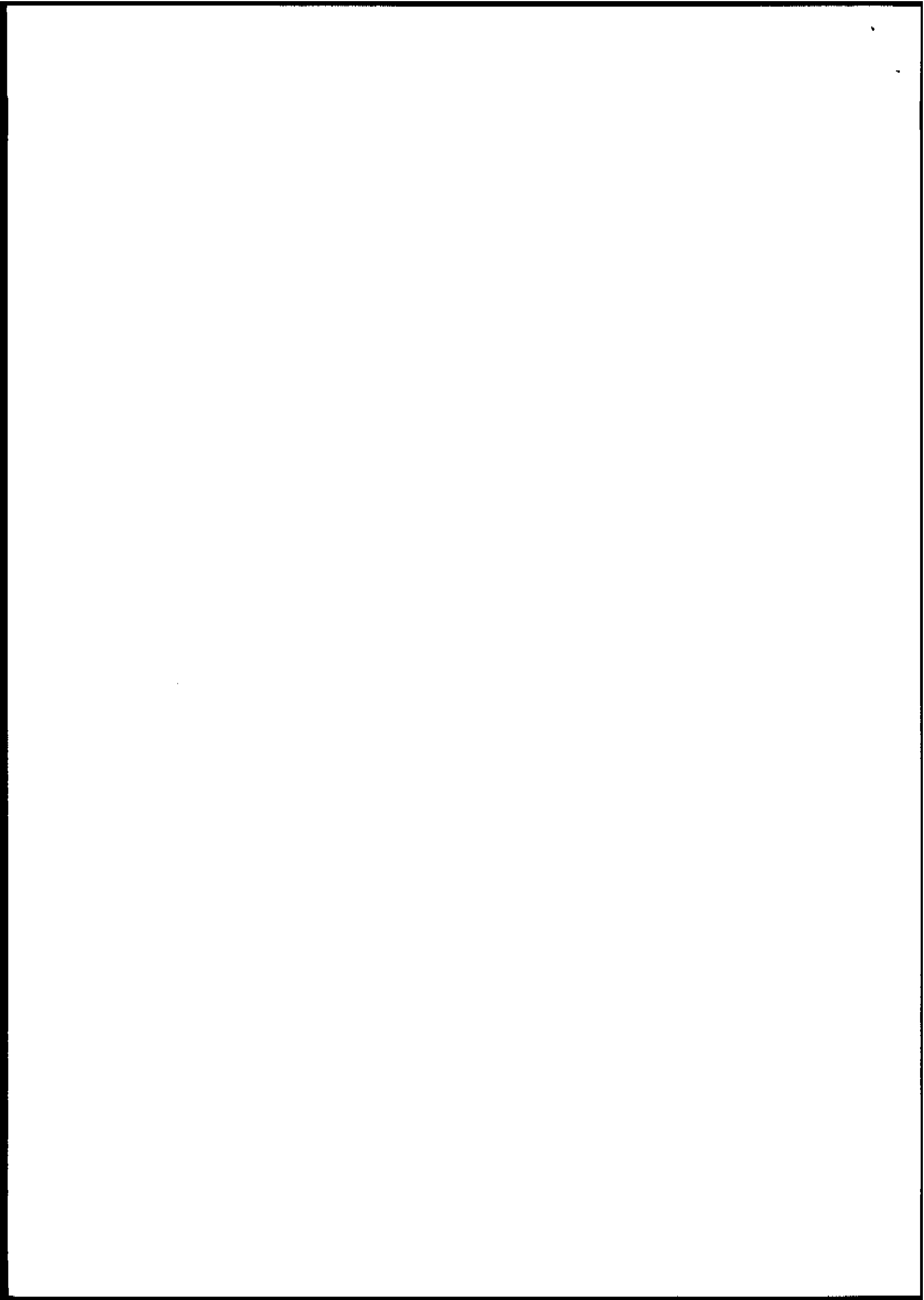
At the University level (Wigdor, 1980), the University of Toronto Program in Gerontology which was started in 1979, is the only program to date that is all-university and multidisciplinary in scope, working through the various disciplines to introduce concentrations in aging, for example as part of the Master of Social Work, Master of Nursing, and Master of Health Science in Community Health, but with no separate degree in gerontology. It has training, research, facilitating, information, and service purposes and reports to the President's office. A postgraduate diploma course of two years, through part-time study, for those already working in the field is to begin in 1981. The separate Office on Aging at McMaster University provides training in several faculties, such as nursing and social work. Most other universities in Canada offer some discipline specific courses as well as continuing education programs. Some universities, such as Guelph and Waterloo offer a concentration on aging through family studies programs. A few universities, for example Mount St. Vincent, and the Ryerson Polytechnical Institute, offer two year certificate programs in gerontology. As well there are individual researchers in most universities.

Training in geriatrics in Medical Faculties in Canada is expanding quickly, both in family medicine and in internal medicine, as well as to a varying extent in other specialty areas, such as community medicine and rehabilitation medicine. Although there are divisions or programs in geriatrics in almost all medical schools, there are no full departments. The overall involvement in both education and research is growing but still modest by comparison for instance to paediatrics, a similar grouping by age. The familiar jurisdictional issue between internist geriatricians and family

physicians has come also to Canada. While not as bitter as in some other countries, in the author's observation it is hindering the development of education and training in geriatrics in Canada's Medical Schools.

Outside the universities (Wigdor, 1980), Community Colleges and the CEGEP level of training in Quebec have developed certificate programs in gerontology or have added courses in a range of fields aimed primarily at technological, paraprofessional, and assistant types of personnel who are numerous in the staffing of programs for the elderly. For many personnel and in particular for non-professionals and volunteers but also for professional staff already working in the field, a major avenue for training is by short in-service courses and workshops developed to meet specific training needs. Usually those courses are organized by the service agencies themselves and by government ministries, often in collaboration with professional and educational institutions. Professional associations are active generally in short-term and continuing education to their members. Thus, for example courses of this type have been offered for nurses, social workers, physiotherapists, administrators for hospitals, nursing homes, and homes for the aged, and nursing aids, homemakers, and social work aides, etc.

In summary, there is a burgeoning concern and interest in developing education and training in gerontology and geriatrics in Canada. To date the field reflects a general absence of co-ordination in the planning and offering of programs and in most instances courses are basically applied task focused, and short-term in nature.



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