Report on the action taken on the recommendations of the Special Committee of the Senate on Aging, 1966.

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APPENDIX TO THE DEBATES OF THE SENATE

October 22, 1974

REPORT ON THE ACTION TAKEN ON THE RECOMMENDATIONS OF THE SPECIAL COMMITTEE OF THE SENATE ON AGING 1966

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INTRODUCTION

The Special Committee of the Senate on Aging tabled 92 recommendations on February 2, 1966. The following study reports on the action taken on the various recommendations. Of the 92 recommendations, 25 were implemented, 54 were partially implemented and 13 were not implemented.

ORDER OF REFERENCE

Extract from the Minutes of the Proceedings of the Senate, Tuesday, July 29th, 1963:

"With leave of the Senate,
The Honourable Senator Connolly, P.C., moved, seconded by the Honourable Senator Vaillancourt:

That a Special Committee of the Senate be appointed to examine the problem involved in the promotion of the welfare of the aged and aging persons, in order to ensure that in addition to the provision of a sufficient income, there are also developed adequate services and facilities of a positive and preventive kind so that older persons may continue to live healthy and useful lives as members of the Canadian community and the need for the maximum co-operation of all levels of government in the promotion thereof;

That the said Committee be composed of the Honourable Senators Blois, Brooks, Croll, Dessureault, Fergusson, Gershaw, Grosart, Haig, Hollett, Inman, Jodoin, Lefrançois, Macdonald (Brantford), McGrand, Pearson, Quart, Roebuck, Smith (Kamloops), Smith (Queens-Shelburne) and Sullivan;

That the Committee have power to engage the services of technical, clerical and other personnel as may be necessary for the purpose of the inquiry;

That the Committee have power to send for persons, papers and records, to print such papers and evidence from day to day as may be ordered by the Committee and to sit during sittings and adjournments of the Senate;

That the evidence received and taken on the subject at preceding sessions be referred to the Committee; and

That the Committee be instructed to report to the Senate from time to time its findings, together with such recommendations as it may see fit to make.

After debate, and—
The question being put on the motion, it was—
Resolved in the affirmative."

J. F. MacNEILL,
Clerk of the Senate.

The Committee was reconstituted during the three succeeding sessions of Parliament. See Journals of the Senate, February 19th, 1964, April 6th, 1965, and January 19th, 1966.

The Final Report of The Special Committee of the Senate on Aging was tabled on Wednesday, February 2, 1966. The Report contained ninety-two recommendations under the following headings:

(1) Income Status and Security.
(2) Employment Status and Opportunities.
(3) Health Status and Health Care.
(4) Housing Status and Needs.
(5) Community Services for Older People.
(6) Research and Statistics.
(7) Planning and Co-ordination.

The Final Report of The Special Committee on Aging was debated in the Senate on February 7, 8, 9, 23 and 24, 1966.

(1) RECOMMENDATIONS THAT ARE IMPLEMENTED

Recommendation 1

The Committee endorses in principle the institution of an income guarantee program for all persons aged 65 and over and recommends to the Federal Government that this proposal be given immediate study.

ACTION TAKEN

This recommendation has been implemented as follows:

1. Beginning in 1966 the qualifying age for universal Old Age Security pension was reduced annually by one year so that by 1970 the plan was universal for all individuals 65 years of age and over.

2. In 1967 a Guaranteed Income Supplement was initiated that pays to the aged, on an income tested basis, a supplement that is reduced by one dollar for every two dollars of other income received (excluding Old Age Security benefits). According to the provisions of that Act the basic amount of the monthly pension was seventy-five dollars; the amount of the supplement was thirty dollars in 1967 and in any year after 1967, forty per cent of the amount of the pension paid, minus one dollar for each full two dollars of the pensioner's monthly base income.[1]

(1) Revised Statutes of Canada 1970, Old Age Security Act, Volume V, Chapter O-6, pp. 2-5.

3. In 1972 legislation was passed that assured that benefit levels would be fully adjusted once a year to keep pace with the cost-of-living index.[2] During 1971 the basic amount of the monthly pension was eighty dollars. This was adjusted according to the Consumer Price Index so that in 1972 the basic monthly pension was eighty-two dollars and eighty-eight cents. As of April 1971, the amount of the supplement varied as to the category of the pensioner. Pensioners who were single or pensioners who were married to a person who was not receiving a pension received a maximum of fifty-five dollars. Pensioners who were married to a person who was receiving a pension received forty-seven dollars and fifty cents each. These amounts were changed because of the Consumer Price Index, and in 1972 a single person or a married person whose spouse is not a pensioner received a supplement of sixty-seven dollars and twelve cents. Those married pensioners whose spouses were also pensioners received fifty-nine dollars and sixty-two cents.

4. In September 1973 the Government announced that adjustments would be made quarterly to commence in October 1973.[3] The adjustments would be made as of October first, January first, April first and July first.

The following table illustrates the amount of basic payments and supplement payments from 1967 to the present.

(2) Statutes of Canada, 1972, An Act to Amend the Old Age Security Act, Chapter 10, pp. 101-104.
(3) Bill C-219, An Act to Amend the Old Age Security Act September 6, 1973, Chapter 35, pp. 3-4.

TABLE 1

AMOUNT OF SOCIAL SECURITY PAYMENTS AND GUARANTEED INCOME SUPPLEMENT

1967–1974

Category of Pensioner	Social Security Plans	Jan. 1967	Jan. 1968	Jan. 1969	Jan. 1970	Jan. 1971	April 1971	Jan. 1972	April 1973	Oct. 1973	Jan. 1974	April 1974
		$	$	$	$	$	$	$	$	$	$	$
Single Person or Married Person Whose Spouse is not a Pensioner	Old Age Pension.....	75	76.50	78	79.58	80	80	82.88	100	105.30	108.14	110.09
	Maximum Guaranteed Income Supplement...	30	30.60	31.20	31.83	33.61	55	67.12	70.14	73.86	75.85	77.22
	TOTAL.....	105	107.10	109.20	111.41	113.61	135	150.00	170.14	179.16	183.99	187.31
Married Person Whose Spouse is a Pensioner	Old Age Pension.....	75	76.50	78	79.58	80	80	82.88	100	105.30	108.14	110.09
	Maximum Guaranteed Income Supplement...	30	30.60	31.20	31.83	33.61	47.50	59.62	62.30	65.60	67.37	68.58
	TOTAL.....	105	107.10	109.20	111.41	113.61	127.50	142.50	162.30	170.90	175.51	178.67

Table 2 illustrates by province:

(1) number of Old Age Security pensioners;
(2) number of recipients receiving Guaranteed Income Supplement;
(3) number receiving maximum Guaranteed Income Supplement;
(4) average amount of Guaranteed Income Supplement paid to pensioners;
(5) average number of pensioners paid while outside Canada during the quarter ending December 1973.

TABLE 2[1]

Province	(1) OAS Pensioners	(2) GIS Recipients	(3) Maximum GIS Recipients	(4) Average GIS Payment	(5) Quarterly Average Number of OAS Pensioners Paid While Outside Canada December 1973
				$	
Newfoundland	34,273	28,948	19,978	65.27	106
Prince Edward Island	12,849	9,883	5,262	62.72	77
Nova Scotia	75,655	51,890	26,427	62.45	430
New Brunswick	57,349	39,183	20,926	61.76	404
Quebec	447,404	284,289	148,366	61.91	3,701
Ontario	678,995	339,245	125,372	58,33	5,869
Manitoba	100,533	62,945	25,991	59.79	642
Saskatchewan	98,371	60,286	25,126	58.14	432
Alberta	125,536	76,584	33,353	60.44	740
British Columbia	218,104	122,809	48,799	57.49	2,677
Northwest Territories	917	764	631	71.85	1
Yukon	530	331	231	66.23	10
National	1,850,516	1,077,076	480,462	59.97	15,089

SOURCE: DSS Statistical Report for December 1973.

[1] House of Commons Debates, March 18, 1974, p. 588.

Recommendation 6

That in line with the recommendation of the Economic Council of Canada, the NES, "as the key operational agency for implementing manpower policies" be responsible for analyzing basic supply and demand conditions and for administering the range of programs required to facilitate adjustment to technological change and to assist the movement of workers from areas of declining to those of increasing employment opportunities.

ACTION TAKEN

In 1967 the National Employment Service (NES) offices were renamed Canada Manpower Centres to reflect the emphasis on counselling, training, labour force mobility, skill up-grading etc.

The Canada Manpower Mobility Program was introduced in 1967 to assist workers who cannot afford to relocate to obtain employment or to take advantage of training. The program provides three types of assistance:

1. Trainee level grants to enable adults to take training courses not available in the area;
2. Exploratory grants, to enable workers to search for employment in other areas when work is not available in their community;
3. Relocation grants.

The Manpower Consultative Service is available to help labour and manpower resolve problems resulting from technological or other industrial changes.

During the 1972-73 fiscal year, $11,599,984 was expended on the Mobility Program. This expenditure aided the relocation of 10,653 families, and provided 10,725 workers with exploratory grants. Trainee travel and commuting assistance was given to 50,296 persons, making a total of 71,674 persons who received assistance under the Canada Manpower Mobility Program.[1]

Recommendation 7

That, in particular, the NES seek the cooperation of individual employers' associations and unions in developing procedures in relation to staff layoffs and

(1) Canada. Manpower and Immigration *Annual Report, 1972-73*, p. 13.

adjustments from whatever cause which, unless planned carefully well in advance, may have serious if not disastrous effects on the employment prospects of displaced older workers.

ACTION TAKEN

1. Under Part III of the Canada Labour Code effective January 1, 1972, an employer must give an employee with ten years or more service, eight weeks' notice or payment in lieu. Where an employer terminates fifty or more, or 10 per cent or more, of his employees whichever is greater, in any four week period he must

(b) give the employees the following notice:

(i) eight weeks' notice if the employment of fifty or more persons and fewer than 200 persons is to be terminated at an establishment;

(ii) twelve weeks' notice if the employment of 200 or more persons and fewer than 500 persons is to be terminated at an establishment; and

(iii) sixteen weeks' notice if the employment of 500 or more persons is to be terminated at an establishment.[1]

2. Most industrial contracts negotiated by management and unions provide for consultation in the event of layoffs or changes affecting workers of all ages.

3. During the fiscal year 1971-72 the Labour Management Consultation Branch of the Department of Labour devoted considerable effort to generating meaningful dialogue between unions and management in all sectors of the economy by actively promoting the formation of joint consultation committees and providing a variety of support services to existing committees. As of March 31, 1972 there were 497 committees representing 180,381 workers in industries under federal jurisdiction and 2,219 committees representing 631,371 employees in enterprises under provincial jurisdiction. Some 60 educational seminars were held to assist both management and workers to come to a better understanding of their roles within the collective bargaining process. Three area labour-management conferences were held in 1971-72. The Branch is also engaged in publishing pamphlets and committee aids dealing with joint consultation. A Branch newspaper, "Teamwork in Industry" is published ten times a year.[2] These are designed to meet the needs of all age groups.

Recommendation 10

That an examination be made of those training programs provided for under the Technical and Vocational Training Assistance Act, which have as their object the up-grading of employed workers and the retraining of the unemployed with a view to determining the reasons for the limited use currently being made of them, and that such measures as are indicated be taken to improve their effectiveness in attracting and holding students especially in the older age range.

ACTION TAKEN

The Adult Occupational Training Act of 1967 replaced the Technical and Vocational Training Assistance Act of 1960-61 under which the Federal Government had shared with the provinces the cost of many training activities.

The A.O.T. Act provides that the Department may purchase training for adult members of the labour force and pay training allowances. Since it has accepted the responsibility for the selection and referral of trainees, the Federal Government pays the full cost of training allowances.

Training services are purchased from Provincial Governments, private schools and industry. Allowances are paid directly to trainees in public and private institutions. In the case of training in industry the employer is reimbursed up to a specified limit for wages paid to employees while in training.[3]

In July 1972 amendments to the Adult Occupational Training Act involved:

(1) the removal of the three year labour force attachment requirement for training allowance eligibility;

(2) the introduction of $30.00 per week basic allowance for adults in training who live with an employed parent or spouse;

(3) the redefinition of eligibility criterion with regard to the period adults must have been out of school as being any 12 consecutive months rather than the 12 months immediately preceding referral to training.[4]

During 1972-73 there were 316,188 adults in Canada Manpower Training Program.[5]

The percentage of trainees aged 45 and over enrolled in institutional full-time training has increased from 9.3 in 1967-68 to 11.7 in 1972-73. In 1972-73 only 2.3 per cent of these were in the age group 55-64. The percentage of older persons participating in training-on-the-job is much lower. In 1972-73 only 5.4 were in the age group 45-65. The greatest impact of training-on-the-job is in the age group 20-24 which was 35.4 per cent of the total number.[6]

The Older Workers' Section of the Department of Manpower and Immigration is preparing material for

(1) Regulations made under the Employment Standard Act 1968, as amended. (Part III of Canada Labour Code). Standards relate to only 9 per cent of labour force under federal jurisdiction.

(2) Canada. Labour Canada *Annual Report, 1971-72*, Ottawa.

(3) Canada. Department of Manpower and Immigration. *Annual Report*, 1967-68 p. 5.

(4) Statutes of Canada, 1972, Chapter 14, July 1972, pp. 157-160.

(5) Canada Manpower and Immigration. *Annual Report, 1972-73*, p. 6.

(6) Canada Manpower and Immigration. Training Branch. Letter dated October 15, 1973.

staff training of counsellors in this field. An effort is being made to develop a psychology oriented towards continuing education rather than seeking employment in the same type of work which may be redundant. In the past workers aged 45 and over considered themselves unemployable if their trades were phased out. It is necessary to encourage such older workers to take training.

There has been a marked improvement in the number of married women over 40 who seek and get training since elimination of the eligibility requirement for three years' experience in the labour force.

The Department forecasts that the policy to provide a "second chance" by way of continuing education will increase the number of older trainees within the next five years.

Recommendation 11

That the NES devote greater attention to the field of part-time employment with a view to discovering the nature of the demand and offering a more effective placement service.

ACTION TAKEN

Manpower Centres have a "Casual Pool" which is concerned with part-time employment of five days or less. Applicants for employment are requested to state whether they desire full or part-time employment. Counsellors are aware of agencies which employ part-time employees and an effort is made to arrange placements according to the demand.

Recommendation 26

(a) That provincial departments of health and/or hospital commissions determine as quickly as possible the place and function of nursing homes in the total spectrum of required health facilities; and

(b) That, assuming nursing homes to be accepted as an essential health facility, vigorous steps be taken to increase the present supply of those capable of providing a high quality of nursing and rehabilitation care; and

(c) That approved nursing homes, operated on a non-profit basis, be made part of the hospital services system, and be included in the federal-provincial hospital insurance arrangements; and

(d) That approved nursing homes, operated on a non-profit basis, be eligible to receive from federal-provincial sources capital grants under the hospital construction program, operating costs under the hospital insurance program to ensure the maintenance of desirable service standards and training grants to provide training for staff in rehabilitation nursing; and

(e) That all nursing homes be licensed and supervised by a health agency and that consultation services be made available to all nursing homes by local and provincial health departments covering not only medical and nursing care including rehabilitation, but also nutrition, recreation and other important aspects of administration. The selection and in-service training of nursing home staff should receive particular attention.

ACTION TAKEN

The operation cost of nursing homes which provide hospital care is acceptable for sharing with the Federal Government under the Hospital Insurance Act. Chronic convalescent care cases are also covered where there is a medical necessity for those patients to be admitted to those institutions.*

Provinces have endeavoured to divide their care facilities into two categories: those requiring full-time nursing care, which come under the Department of Health, and those which have mainly a social need, which come under the jurisdiction of the department dealing with social services. For example, in Ottawa St. Vincent Hospital and the Perley Home come under the Health Department, whereas St. Patrick's Home is under the jurisdiction of the Department of Community and Social Services. Similarly, in Saskatchewan levels of Care 1, 2 and 3 are considered as mainly social needs and therefore come under the Department of Social Services; Levels 4, 5 and 6 have a major health component and as a result are an insured service and come under the Department of Health. The problem is in discharging patients from the health level, which is an insured service, to the social level which is the responsibility of the patient. In January 1973 the Province of Saskatchewan proposed a grant system to ease the financial burden of nursing home care on its residents. The proposed amounts were graded downward from Level III. "This new grant system represents a serious attempt by our Government to place the financing of special-care homes on a rational basis and to provide a solid base for the future development of services for the aged in the years to come."(1)

In 1971 the responsibility of administering the British Columbia Community Care Facilities Licensing Act was transferred to the Health Branch. More recently, the Health Branch was given the major responsibility in designing, constructing and probably operating several "personal care" homes. According to 1972 planning, these will provide beds for ambulatory persons who do not require services in an extended-care hospital but who need more

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* Specifically excluded are tuberculosis hospitals and sanatoria, hospitals or institutions for the mentally ill, as well as care institutions such as nursing homes and homes for the aged. The definition of "nursing homes" enters into the assessment at this stage.

(1) Government of Saskatchewan, Press Release, January 18, 1973.

care than can be provided in a rest home[1] In December 1972 personal care homes which represent the range of care between extended care and boarding home were not licensed.[2] As of December 1972 grants of 35 per cent are made to non-profit societies wishing to construct personal care facilities in British Columbia if there is a local contribution of at least 10 per cent. Such societies must indicate they can operate the new facility without a direct provincial subsidy. To understand more fully the relationship offered by the Health Branch and other services, the Government of British Columbia, late in 1972, commissioned a study entitled "Health Security Research Project".

A joint study (Alberta Council on Aging and Department of Health and Social Development) of the general needs of institutionalized and non-institutionalized senior citizens across Alberta was scheduled for mid-1973.

The consensus is that approved nursing homes, operated on a non-profit basis, should be included in the federal-provincial hospital insurance arrangements. If this barrier were lifted there should be little difficulty in putting the right patient in the right bed at the right time.

The School of Rehabilitation Medicine at the University of Alberta conducted a study to measure, in Auxiliary hospitals and Nursing Homes, the effects upon patients of intensive, multi-disciplinary rehabilitation (Staff) education and related consultative services.[3] Results indicated that Staff attitudes tended to shift to a greater degree of acceptance of patients as individuals. This Staff also demonstrated increased knowledge and skills in rehabilitative nursing.

As of July 1, 1973 personal care homes in Manitoba[4] came under the provincial hospital insurance scheme. Positive steps have been taken to increase the supply of nursing care facilities:

December 31, 1972	Actual nursing home beds	6,589
December 31, 1973	Projected	6,898
December 31, 1974	Projected	7,316

All areas where there is a demonstrated need for more personal care home beds are benefiting from the program of development of additional facilities.

Manitoba's position is that nursing homes, particularly those providing extended care services, should come under the federal-provincial hospital insurance arrangements.

All nursing homes are licensed and supervised by the Department of Health and Social Development.

(1) British Columbia. Health Branch, *Annual Report, 1972*, Victoria.
(2) Social Planning and Review Council of British Columbia, *A Study of Community Care for Seniors*, Vancouver, 1972 p. 37.
(3) Bostrom, M. and K. Gough (eds.), *Geriatric Reactivation Study*, School of Rehabilitation Medicine, University of Alberta, Edmonton, 1972.
(4) Manitoba. Department of Health and Social Development. Letter dated December 2, 1973.

Since the introduction of the extended health care program in Ontario[5] in April 1972, the supply of nursing home beds in this province has increased by approximately 2,000 or 10 per cent of the total available at the time. A further 3,500 beds have been approved for construction and are in either the developmental stage or the construction stage at this time. When these beds become available this will provide roughly 25 per cent more beds than there were in April 1972. This increased supply will be capable of providing a high quality of nursing care and, within the definition of the Insured Extended Health Care Benefit, a reactivation program. The precise role of the proprietary fields, in relationship to the non-profit field, with public support, has yet to be determined by the Government. In the Province of Ontario the extended health care program, which provides benefits in licensed nursing homes, deals almost exclusively with profit-oriented facilities. In the past year and a half the nursing homes have been made part of the hospital system in Ontario with referrals to nursing home accommodation coming primarily from active treatment hospitals. However, the program is not included in the Federal-Provincial Hospital Insurance arrangements. Similar care is also available in charitable and municipal homes for the aged.

Regarding capital financing of nursing homes, it is the view of the Province of Ontario that sufficient mortgage funds are available in the private sector. "Caution is exercised in approving capital grants to non-profit nursing homes so that the taxpayer is not burdened with capital grants which can be found through the private sector."

Under the Extended Health Care program in Ontario operating costs of nursing homes are provided under the hospital insurance program by means of a daily per diem rate which is paid for residents of nursing homes eligible for the extended health care benefits. Some 100 per cent provincial capital grants are made to co-sponsor facilities with municipal and non-profit charitable corporations and these may include Extended Care Services. In such cases there is also eligibility for loans under the National Housing Act. The province does approve capital grants, mainly on the basis of residential services rather than Extended Care Services and this is subject to the general review within the province.

Community colleges are training "health care aides", the majority of whom come from the staff of nursing homes, as well as from municipal and charitable homes for the aged.

Prior to the introduction of the Extended Health Care Program on April 1, 1972 all nursing homes in Ontario were licensed by a health agency and supervised by local health units. This did not allow for standardization. Now the inspection of homes is under direct provincial jurisdiction with inspection staffs located in London, Ottawa and Toronto. In addition to the inspection component, which is comprised of registered nurses, public health inspectors, fire safety inspectors and sanitation personnel,

(5) Ontario, Minister of Community and Social Services. Letter dated November 28, 1973.

consultation services are offered to the nursing homes in the field of nutrition, administration, finance, as well as consulting services in the fields noted under inspection services.

Seminars and discussion groups are also held for nursing home staff. In the case of charitable and municipal homes for the aged, consulting is available from Toronto in all areas of care standards; in addition, in-service training and other programs are available from the province in conjunction with the Ontario Association of Homes for the Aged.

New Brunswick[1] engaged consultants to study its hospital facilities in 1969 and has stated its policy: the main objectives in the nursing home program is to ensure that each resident of the province who is in need of care does in fact receive the care required. Regulation 71-73 of the Health Act has greatly improved the number and quality of nursing care facilities in the province. As in other provinces, approved nursing homes, operated on a non-profit basis in the province, are not part of the hospital services system but come under the Social Welfare Act. The Department of Social Services is authorized to provide financial assistance for persons unable to pay for nursing home care. Although construction grants for nursing homes do not come under hospital construction, under Chapter 39, An Act to Amend the Health Act, the Minister may grant to charitable organizations an amount of two thousand dollars per bed toward the cost of new construction of nursing homes. Operating costs are reviewed by the Department of Social Services to determine the rate per day to provide financial assistance. Nursing homes are licensed and supervised by the Provincial Department of Health and consultation services are provided in the field of rehabilitation staffing, dietary and administrative services.

In February 1973 the first report of the Nova Scotia[2] Council of Health was released. The Council had been directed to undertake a complete review of the health system in the province.

Among its recommendations was that the province adopt the "progressive care" approach and define levels of care, including active treatment; nursing home care designed for long-term patients; home care designed as a hospital alternative for patients who require regular nursing care and some physician attention; ambulatory care for those who require extended therapy and personal care for those who need support to maintain themselves.

The emphasis is on non-institutional care.[3]

The implementation of the proposed plan hinges on changes in federal-provincial cost sharing, i.e., sharing to be related to payment for health care to population.

(1) New Brunswick. Department of Health, Public Health Services. Letter dated August 17, 1973.
(2) Nova Scotia Council of Health, *Health Care in Nova Scotia —A New Direction for the Seventies*, Halifax 1973, 187 pages.
(3) *Canadian Medical Association Journal*, March 3, 1973, Volume 108, p. 661.

In Prince Edward Island[4] private nursing homes operate without public financial assistance and are licensed and supervised by the Hospital Services Commission under Regulations passed under the Hospitals Act to ensure suitable standards of accommodation and service. Their services are supplemented by manors operated by the Department of Social Services located in all major urban centres in the province. All private nursing homes and public institutions have Registered Nurse supervision and such ancillary staff as may be needed to meet the requirements for nursing care of the patients therein.

In the Annual Report[5] for 1973 of the Newfoundland Department. of Social Services and Rehabilitation it was reported that sufficient emphasis has not been placed on the urgent need for beds where nursing care can be provided. Approval for the construction of five new Homes for Senior Citizens at Lewisporte, Grand Bank, St. Anthony, Grand Falls, and Stephenville Crossing was granted. Approximately 25 per cent of the bed capacity will be for nursing care.

Recommendation 39

That Central Mortgage and Housing Corporation (CMHC) conduct a sustained educational campaign to make everyone concerned aware of the opportunities, under the NHA as amended, to provide new and converted housing of many varieties for the use of older people and that in such a campaign attention be called to such particulars as:

(a) The desirability of spreading housing for old people throughout the community and/or incorporating it in housing for other age groups;

(b) the additional opportunities available under the revised public incomes; and

(c) the importance, when hostels and other special group living arrangements are being considered for old people able to get about, of selecting a convient site, ensuring a homelike atmosphere, keeping the size of the project as small as is compatible with economical operation, and of blending it in with the general housing of the area.

ACTION TAKEN

The 1971 CMHC Report *Urban Canada: Problems and Prospects*".[6] includes a monograph which has particular relevance for policy and program planners concerned with housing the elderly.

(4) Prince Edward Island. Department of Health. Letter dated August 28, 1973.
(5) Newfoundland. Department of Social Services and Rehabilitation, *Annual Report for the Year Ending March 31, 1973*, p. 49.
(6) Central Mortgage and Housing Corporation *Urban Canada: Problems and Prospects*, Ottawa, 1971.

Social Development Operations of CMHC, organized in 1970-71provides the focus for a continuing response to the social needs of the elderly and other occupants of low-income housing. Social Development Officers at the Regional level work closely with community groups, tenant associations and non-profit organizations concerned with low-rental and public housing in an effort to improve the social environment and amenities of federally-financed housing developments.

A broad range of educational material covering every aspect of housing the elderly, from pamphlets and brochures to panel exhibits, film strips and coloured slides, is available on request from CMHC.

Trained professional people are available as speakers at service clubs, etc. about the housing requirements of the elderly.[1]

Recommendation 40

That, on the initiative of CMHC, periodic conferences be held on a national and regional basis, made up of people from the variety of public and voluntary bodies concerned with old people's housing but also including architects, developers and builders, for the purpose of sharing experience, of discussing common problems and encouraging new and imaginative developments.

ACTION TAKEN

CMHC regularly provides both funds and personnel for conferences and workshops that have relevance to housing programs for the elderly.

A conference in 1968 organized by the Canadian Welfare Council and financed largely by a grant under the National Housing Act examined the housing situation of all Canadians. Further studies by the Council (now the Canadian Council on Social Development) are also being funded by CMHC.

In 1972 CMHC funded a study undertaken by the Extension Department of the University of British Columbia. This was an action-oriented study which will stimulate discussion between the groups identified in Recommendation No. 40 plus consumers, educators, health and recreation people.

In 1973 a study of CMHC housing for the elderly, built up to the end of 1970, was completed by the Canadian Council on Social Development. It is entitled "Beyond Shelter".[2] This study was funded by CMHC, published and distributed by the Canadian Council on Social Development.

The 48 recommendations formulated from the findings covered a variety of topics. The principal objective is that as wide a variety and range of choice of housing as possible should be available to senior citizens. Furthermore, it is recommended that responsibility for housing the elderly be affirmed at the provincial level. Several recommendations also noted particular design suggestions such as a suitable balance of accommodation for both married and single persons.

Sponsors of housing developments have a responsibility for more than simply providing shelter. Recommendations outline the responsibility of sponsors in terms of developing a health program, providing social services, or contacting existing social service agencies, and for developing a recreation program using both their own facilities and those of the community. The need to provide contact with other community groups and organizations was emphasized in several recommendations, as well as the need to obtain resident participation in all aspects of the residential environment.

The remainder of the recommendations dealt with management policies, staff members, finances and the need for further study on the desirability of different types of residential environments for the elderly.

A proposal is being formulated to have CMHC fund a series of regional meetings for the purpose of discussing the findings of the study. The meetings would bring together sponsors, managers, tenants of senior citizen housing as well as those who deliver services beyond the shelter component.[3]

Recommendation 41

That CMHC develop plans and specifications for a wide variety of housing arrangements for old people and that the latter include low-cost one-bedroom houses suitable for couples and for two single people living together.

ACTION TAKEN

Professional architects within CMHC have developed plans and specifications for a variety of housing units for the elderly, including bachelor and one-bedroom apartment units, hostel accommodation, back-to-back row housing, motel-type units and relocateable semi-detached units.

In 1972, CMHC published its second edition of *Housing the Elderly*.[4] This is an advisory document dealing with desirable standards of housing designed specifically for elderly people who are sufficiently healthy and mobile to live independently in self-contained dwelling units. It is not a mandatory set of rules, but rather suggestions. The Corporation has built one-bedroom houses—mainly in small communities on the Prairies where land is less of a cost factor than in urban areas.

The decision, as to permitting two single people to rent a unit in a low-cost housing project, belongs to provincial

(1) Central Mortgage and Housing Corporation, Information Division. Letter dated November 2, 1973.
(2) Canadian Council on Social Development, *Beyond Shelter*, Ottawa, 1973, 479 pages.
(3) Central Mortgage and Housing Corporation, Information Division. Letter dated November 2, 1973.
(4) Central Mortgage and Housing Corporation, *Housing the Elderly*, Ottawa 1972, 38 pages.

and local administrators. In 1973 the Ontario Housing Corporation experimented with this idea in a building going up in Etobicoke—a Toronto suburb.[1] The Dundas Maybelle Housing Development will contain 510 units, 58 of which are buddy units. These buddy units are specifically designed for aged single people. The two single people have individual bed-sitting rooms but they share the kitchen and bathroom facilities. The building is scheduled for completion in December, 1974.[2]

Recommendation 42

That CMHC develop manuals for use by housing authorities and private sponsoring groups, giving precise information and advice regarding varieties of accommodation needed, housing designs including safety features, site selection, financing, and the procedures to be followed under the limited dividend, non-profit and public housing sections of the NHA.

ACTION TAKEN

CMHC acts in an advisory capacity. Adherence to CMHC specifications, while recommended, is not a requirement. Pamphlets and brochures covering every aspect of accommodation for the elderly are available from CMHC offices across Canda.

Housing the Elderly—1972[3] examines the provision of housing in relation to the needs and preferences of the elderly, the aging process, the housing market, type of accommodation available and sponsors for housing for the aged. This brochure also deals with various safety features which contribute to the enjoyment of their homes by the elderly.

Housing the Handicapped will be published by CMHC in 1974. Although an advisory document dealing with desirable standards of housing for physically handicapped persons of all ages, it is also especially useful to those involved in the design and provision of housing for the elderly.[4]

Recommendation 43

That CMHC appoint to its staff one or more persons with specialized knowledge relating to housing for old people and that their advice and technical assistance be available to housing authorities and other sponsoring groups.

ACTION TAKEN

The advice and assistance of professional CMHC personnel is readily available to organizations and individuals interested in sponsoring housing for the elderly. Social Development officers, appointed 1968-69, focus on the implementation of guidelines and policies to improve the social environment of low-income housing, and have a thorough understanding of the needs of our senior citizens.

At CMHC Head Office an advisory group was formed from people in the Corporation who have considerable involvement with the provision of housing for the elderly. The group includes, architects, planners, economists, appraisers, administrators, policy formulators and those advising on research issues. These people are available both to Head Office and Branch staff as well as to the public.[5]

Recommendation 44

That a review be made of experience to date in rehousing within the area old people dispossessed by urban renewal schemes and that consideration be given to further measures, such as assistance with the purchase of small homes or rent subsidies for a limited period, which might be taken to ease the impact of the changeover and to assist generally in the process of resettlement.

ACTION TAKEN

In any urban assistance plan, every effort is made to relocate families and individuals in their own neighbourhoods. High density apartment complexes that make the best use of expensive land, are built in core urban areas for the elderly who might otherwise have to be rehoused in an unfamiliar setting. In addition it is a pre-requisite of both the newly introduced (1973) Neighbourhood Improvement Program and the Site Clearance Assistance Program that dwelling units, equal in number to those removed, be provided as part of the rehabilitation program.[6]

Recommendation 45

That insured NHA loans be provided to finance the construction of hostel, dormitory and similar type accommodation for elderly persons who could afford to pay a rent set by the normal operations of the market.

ACTION TAKEN

The National Housing Act was amended in 1969 to include provisions, under Part I of the Act, for insured loans for the construction of hostel and dormitory type accommodation for the elderly who can afford open market rental rates.

(1) Central Mortgage and Housing Corporations, Information Division. Letter dated November 2, 1973.
(2) Ontario Housing Corporation. Telephone conversion of April 17, 1974.
(3) Central Mortgage and Housing Corporation, *Housing the Elderly*, Ottawa, 1972, 38 pages.
(4) Central Mortgage and Housing Corporation, Information Division. Letter dated November 2, 1973.
(5) Central Mortgage and Housing Corporation, Information Division. Letter dated November 2, 1973.
(6) Central Mortgage and Housing Corporation, Information Division. Letter dated November 2, 1973.

By the end of 1970, 7,906 hostel beds had been built under the National Housing Act for senior citizens.[1] Canada as a whole had 4.5 hostel beds (financed under NHA) per thousand population aged 65 at the end of 1970.[2] On a provincial basis, Manitoba has built the highest ratio of senior citizen hostel beds under the NHA per thousand aged population, followed by New Brunswick, Saskatchewan, British Columbia, Nova Scotia, Prince Edward Island, Newfoundland, Quebec, Ontario and Alberta.[3]

The study by the Canadian Council on Social Development also found that there was a wide variation on the emphasis that provinces placed on senior citizens' hostel accommodation as opposed to self-contained dwelling units. New Brunswick concentrated to a greater extent on hostel accommodation than other provinces, followed by Quebec, Saskatchewan, Newfoundland, Alberta, Manitoba, Nova Scotia, British Columbia and Prince Edward Island.[4]

This study also noted that

> "Over the years, the National Housing Act provisions have been broadened to allow funding of a large range of hostel accommodation. This accommodation varies widely in and between provinces, ranging from buildings in which the only service provided other than that found in private apartments is a dining-room, to accommodation that is practically identical to that found in a nursing home. This accommodation has been supported at the provincial and local levels by a wide variety of programs, usually administered by social service departments."[5]

Recommendation 46

> That CMHC, in collaboration with DBS, review the present data collected and analyzed on the housing situation of old people with a view to filling the gaps that exist and introducing such changes as seem desirable in the definitions employed and the classifications provided. (Reference has been made earlier to the difficulty at present of correlating incomes and housing).

ACTION TAKEN

CMHC regularly confers and exchanges data and information with a variety of government departments and agencies in an effort to improve the resource material.

A CMHC "Housing Needs Study" was initiated in 1973 and will identify the elderly as a distinct housing consumer group within the total population. Their housing consumption patterns will be examined and analyzed in relation to a variety of characteristics such as, household composition, income, dwelling unit type, cost and condition. This will be a two year study.

Recommendation 47

> That CMHC undertake or support, possibly in collaboration with the Department of National Health and Welfare, a major research project to determine the housing needs and preferences of old people, and their evaluation of existing housing opportunities. (The Age and Opportunity Bureau of Winnipeg, among other organizations, stressed the "deplorable" lack of information regarding the housing problems of the elderly.)

ACTION TAKEN

A 1970 study within CMHC made use of data gathered from a number of sources including Statistics Canada and the Department of National Health and Welfare to examine the financial resources and expenditure patterns of the elderly, and their related ability to find accommodation within their means.

In 1971, the CMHC gave a grant of $38,000 to the Canadian Welfare Council (now the Canadian Council on Social Development) for a study of housing arrangements for the aged.[7] The object was to look at independent and semi-independent accommodation for the aged. This project was completed, and the report entitled *Beyond Shelter* was published in 1973.[8]

In 1972, CMHC also published a bibliography of Canadian sources in geronthology, and geriatrics from 1964-1972, *The Seventh Age.*[9] One of the sections in this bibliography is "Living Arrangements".

State of the Art,[10] a report prepared by Environics Research Group Limited for CMHC, is a brief over-view of services to the elderly in Canada, and the position of each province regarding services for the elderly.

In late spring of 1974 a report of the study "Demographic and Economics Aspects of Housing Canada's Elderly", will be published. The purpose of this study is to systematically analyze on a provincial and municipal basis, the changing concentration of the older population and to examine the changing economic distribution of these groups from 1961 to 1971. All municipalities over 30,000 (81 in total) were examined.

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(1) Canadian Council on Social Development, *Beyond Shelter*, Ottawa, 1973, p. 383, No. 1.
(2) *Ibid.*, p. 383, No. 3.
(3) *Ibid.*, p. 384, No. 5.
(4) *Ibid.*, p. 384, No. 7.
(5) *Ibid.*,p. 385, No. 15.
(6) Central Mortgage and Housing Corporation, Information Division. Letter dated November 2, 1973.
(7) Canadian Council on Social Development, *On Growing Old*, March, 1971.
(8) Canadian Council on Social Development, *Beyond Shelter*, Ottawa, 1973, 479 pages.
(9) Central Mortgage and Housing Corporation, *The Seventh Age*, Ottawa, 1972, 290 pages.
(10) Central Mortgage and Housing Corporation, *State of the Art*, Ottawa, 1964.

zens. All senior citizens' housing developments built with Quebec Housing Corporation assistance have been categorized as "non-profit" as they are administered by non-profit groups. The Federal-Provincial Housing Review Committee of Saskatchewan provides for monthly discussion of requirements.

Recommendation 54

That the provincial department or agency appoint the necessary staff members equipped to assist the municipalities and voluntary organizations in the determination of need and the development and implementation of housing programs.

ACTION TAKEN

With the exception of New Brunswick and Newfoundland which have no special staff assigned for this purpose, the other provinces feel that they have implemented this recommendation either through the provincial planning staff or regional offices. For example, Prince Edward Island Housing Officers travel throughout the Island giving assistance to communities in need of housing accommodation for their senior citizens. Nova Scotia, in addition to its planning staff at its provincial head office, has four regional offices staffed by field representatives and construction supervisors who keep in contact with the municipalities and assist in the implementation of housing programs.

Ontario at the present time has some 39 local housing authorities. In areas where there are housing developments under the auspices of the Ontario Housing Corporation there are resident managers, representatives of the Corporation. In the event that a municipality is just initiating a housing program, the local Council communicates with the Ontario Housing Corporation who undertakes the survey and lends the necessary technical assistance and advice.

Recommendation 55

That, in particular, funds and grants be provided in such amounts as to reduce to no more than token payments the capital funds required by voluntary organizations to qualify for loans under the limited dividend section of the act.

ACTION TAKEN

The National Housing Act was amended in 1969 to provide a broader framework for the provision of loans covering up to 95 per cent of lending value to both non-profit organizations and private entrepreneurs interested in the construction of housing for the elderly. In 1973 the Act was further amended to provide loans to private and municipally-owned non-profit organizations to cover up to 100 per cent of lending value plus a CMHC contribution of up to 10 per cent of cost for application against loan repayment and, in the case of private organization, a grant of up to $10,000 for use as "starter funds" to bring the organization to the point where it can apply for a loan.[1]

Recommendation 57

That the provincial department or agency establish and enforce strict regulations concerning the design, siting and general operations of private homes or institutions offering individual or group living accommodation, short of medical care, to elderly people.

ACTION TAKEN

Organizations sponsoring low-rental housing for the elderly adhere to provincial standards and to those of Central Mortgage and Housing Corporation if financed by that corporation. In the case of private homes, the legislation governing their operations usually comes under the Department of Social Services, Community Services or Health and Welfare, or the Welfare Homes Act as in the case of Alberta. Provincial standards are applicable in all cases.

Recommendation 58

That, as at the provincial level, housing for the aged be entrusted to the municipal department or agency which is also responsible for low rental housing in general and that a committee of representative citizens be established to assist the department in an advisory capacity.

ACTION TAKEN

Many communities are too small in population and economic base to undertake subsidized housing for senior citizens. Because of this provinces such as Newfoundland, New Brunswick and Prince Edward Island[2] operate with a provincial organization depending on advice from its board of directors and Housing Authority members some of whom are private citizens. In the case of Nova Scotia[3] recommendations on future needs are the responsibility of the municipal housing authorities composed of local residents. Quebec[4] has its regional health and social service councils which encourage areas to define their needs and plan for them. Ontario[5] has 39 area Housing Authorities who submit their requirements for low rent housing to the Ontario Housing Corporation. The Manitoba[6]

(1) Central Mortgage and Housing Corporation, Information Division. Letter dated November 2, 1973.
(2) Newfoundland and Labrador Housing Corporation. Letter dated August 7, 1973. New Brunswick Housing Corporation. Letter dated October 26, 1973. Prince Edward Island Housing Authority. Letter dated August 6, 1973.
(3) Nova Scotia Housing Authority. Letter dated August 28, 1973.
(4) The Canadian Council on Social Development. *Beyond Shelter*, July 1973, p. 67.
(5) Ontario Housing Authority. Telephone Information, April 4, 1974.
(6) Manitoba Housing and Renewal Corporation. Letter dated August 8, 1973.

Housing and Renewal Corporation has no committee of knowledgeable citizens to advise the Minister responsible for housing but consider the Winnipeg Age and Opportunity Bureau and Manitoba Public Housing Work Shop as adequate forums for the presentation and discussion of housing requirements for both families and senior citizens. In rural areas of Manitoba there are housing authorities consisting of at least six members of whom two must be tenants which assures complete involvement. The Saskatchewan Housing Corporation Act, 1973,[1] may incorporate public housing authorities which report to the Corporation. Alberta[2] has set up some fifty-four foundations to administer senior ciizens' housing. The boards of directors of the foundations are elected members of the municipal councils and are responsible to the electorate. The foundations determine the housing needs within their administrative areas. British Columbia housing legislation is under review. According to the study carried out by the Social Planning and Review Council of British Columbia[3] (December 1972) the first official contact for the citizen impetus committee on housing for senior citizens in the Community Care Facilities Board through the local Medical Health Officer. The impetus committee forms a non-profit society and incorporates and then gets in touch with CMHC and the Provincial Secretary.

Recommendation 82

(a) That homemaker service be accepted as a shareable cost under the Canada Assistance Plan.

(b) That homemaker service be accepted as a shareable cost under the Canada Assistance Plan not only for persons on public assistance but for all others to whom this service is provided free by the provinces and their municipalities.

ACTION TAKEN

Provincial and municipal governments underwrite the costs of providing homemaker service to recipients of social assistance but the maximum daily rate they are prepared to contribute may fall short of the full cost of the service to the homemaker agency. The province is reimbursed 50 per cent of these costs by the Federal Government under the Canada Assistance Plan. The legislation also permits federal sharing of the costs of subsidizing persons other than those on assistance whose incomes are insufficient for them to pay the prescribed fee; provinces and municipalities differ widely in the extent to which they have chosen to make this assistance available to low-income families. The maximum family income below which public welfare departments are prepared to subsidize fees depends on the province in which the applicant happens to reside.[4]

In British Columbia these services receive small provincial grants and local support, but must rely on fees from clients, thus, frequently, making the service beyond the means of older people.[5]

Homemaker services in Alberta[6] are supported through the Preventive Social Services Act which may also cover payments not eligible for federal cost-sharing under the Canada Assistance Plan. Establishment of the eligibility of projects for provincial-municipal cost-sharing is based on approval of budget figures provided by the municipality, together with an agreement to provide the service on a sliding scale of fees. The net deficit of such projects is shared up to 80 per cent by the province, the remaining 20 per cent is paid by the municipality.

In Saskatchewan,[7] funds for purchase of homemaker service, based on financial need, are available through the Saskatchewan Assistance Plan.

Extensive homemaker services are provided in Manitoba[8] under the Social Allowance Act and the Child Welfare Act, as amended 1966. For families or aged persons eligible for a social allowance, payment is made for homemaker service during illness or other emergency as required.

In Ontario[9] the breakdown of sharing is 20 per cent for the regional government, 30 per cent for the provinces and 50 per cent for the Federal Government. The fee paid by the recipient depends on his income and the state of the budget of the municipality. Lower income persons pay a nominal rate, while the mid-income group pay more although that group receives some assistance through the United Way Fund. Upper income brackets pay the full cost. The service operates under the Ontario Nursing and Homemakers' Services Act and is regarded as permissive legislation as the cost of the service to the recipient varies according to the budget of the municipality.

Under the Quebec[10] Public Charities Act, assistance is given for the provision of visiting homemaker services. The homemaker service program is administered by voluntary agencies recognized by the province. Under the legislation, the full cost of the service to needy persons is paid by the Department of Social Affairs.

Financial aid for homemaker services is available in Nova Scotia[11] under the Social Assistance Act. When

(1) Saskatchewan Housing Corporation. Letter dated August 2, 1973.
(2) Alberta Housing Corporation. Letter dated August 20, 1973.
(3) Social Planning and Review Council of B.C. *A Study of Community Care for Seniors*, Vancouver 1972, 179 pages.
(4) Canadian Council on Social Development, *Visiting Homemaker Services in Canada*, Report of a Survey with Recommendations, March, 1971. pp. 20-21.
(5) Social Planning and Review Council (SPARC), *A Study of Community Care for Seniors*, Vancouver 1972, p. 39.
(6) Canadian Council on Social Development, *Op. Cit.*, p. 102.
(7) *Ibid.*
(8) *Ibid.*
(9) Ontario Ministry of Community and Social Services. Letter dated November 28, 1973.
(10) Canadian Council on Social Development, *Op. Cit.*, p. 104.
(11) *Ibid.*

municipal budgets include estimates for funds to provide homemaker services and the budget is approved by the Department of Public Welfare, these funds are available to municipalities up to an approved amount.

Prince Edward Island and New Brunswick[1] have no provisions specifically for homemaker service under their social legislation but do use the Canada Assistance Plan to share costs with the Federal Government on a 50/50 basis when housekeeper service is provided to families in financial needs.

The Social Assistance Regulations of the Department of Public Welfare for Newfoundland and Labrador[2] provide for the payment of a housekeeper allowance to recipients of social assistance who require this service.

Recommendation 83

That counselling services provided by the local public welfare department for the elderly and others in the community be accepted as a shareable cost under the Canada Assistance Plan.

ACTION TAKEN

Counselling services are covered under the Canada Assistance Plan and the funding of these services to municipalities depends on the individual province and the municipality.

Health and Welfare Canada published a pamphlet *Your Agency and the Canada Assistance Plan*[3] which describes the funding available to agencies.

(2) RECOMMENDATIONS THAT ARE PARTIALLY IMPLEMENTED

Recommendation 2

The Committee recommends that the National Employment Service (NES) continue and intensify its efforts to correct prevailing misconceptions and to overcome current resistance to the hiring of older workers through educational programs aimed at employers as a group, but more particularly through direct contacts with individual employers; and that in such efforts it enlist the support of management and labour, possibly through the holding of employer-labour institutes sponsored by universities and community groups, as is done in the United States with leadership from the employment service.

ACTION TAKEN

In 1967 the "National Employment Service" offices were renamed "Canada Manpower Centres" to reflect the emphasis on counselling, training, labour force mobility, skill up-grading etc. In 1972-73 there were 390 Canada Manpower Centres where counsellors assist workers and provide consultative services relative to changed conditions of work. Employment was found for 1,030,148 people during 1972-73. This is an increase of twelve per cent over the previous year[4].

The Canada Manpower Adjustment Program functions as a catalyst to bring management and labour together to solve employment problems created by economic, technological or organizational changes in a company, an industry or an area.

The current philosophy of the Older Workers' Section is that working should be ageless, that is, the emphasis should be on skill not age. During 1973 staff members of the Older Workers' Section, the Canada Manpower Division of the Department of Manpower and Immigration, interviewed older workers across Canada to identify difficulties and to learn more about the conditions affecting older workers. The results of this internal fact-finding survey will be used by the section to determine a policy statement. The Older Workers' Section encounters some difficulties in meeting with employers because of the variation in labour legislation among the provinces. Pending a study of the facts obtained in this survey, no funds have been allotted to cover the expenses associated with conferences or seminars.

The Labour Gazette, published by Labour Canada contains information for employers about recent studies and conferences on older workers. Projects on older workers conducted by the organization for Economic Co-operation and Development (OECD) of which Canada is a member, as well as American research studies are regularly reviewed.

In June 1970 the Age Discrimination Division of the Ontario Human Rights Commission sponsored a conferenced entitled, "The Older Worker in Today's Economy and Community".[5]

Recommendation 4

The Committee recommends that the NES maintain a check on applicant qualifications as specified by employers, such as age and education, in an effort to ensure that these are realistically related to the requirements for successful performance in the jobs to be filled.

ACTION TAKEN

In five provinces the prohibition against discrimination has been extended to include age. *The Individual's Rights Protection Act of Alberta 1972*,[6] *The Human Rights Act of British Columbia 1969*,[7] *The Human Rights Code of*

(1) *Ibid.*, p. 105.
(2) *Ibid.*
(3) Canada. Health and Welfare Canada, *Your Agency and the Canada Assistance Plan*, Ottawa.
(4) Canada. Manpower and Immigration, *Annual Report, 1972-73*. p. vii.
(5) Ontario Department of Labour, *Task*, Volume 5, No. 2, Summer 1970, p. 13.
(6) Statutes of Alberta, 1972, Chapter 2.
(7) Statutes of British Columbia, 1969, Chapter 10.

New Brunswick Amended 1973,[1] *The Human Rights Code of Newfoundland* 1969,[2] and *The Human Rights Code of Ontario* Amended 1972[3] provide that no employer shall refuse to employ or refuse to continue to employ or otherwise discriminate in employment because of age. These provisions are applicable to persons between the ages of 45 and 65 in Alberta, British Columbia and Newfoundland. *The New Brunswick Code* defines "age" as 19 years of age and over. In Ontario, a reference to age means any age of 40 years or more and less than 65 years. Trade unions shall not exclude from membership, expel or suspend a person in these age groups. An employer may not publish an advertisement in connection with employment which expresses directly or indirectly any limitation, preference or discrimination in employment because of age. These provisions do not apply to the operation of a bona fide retirement or insurance plan.

The Canadian Labour Code does not mention discrimination on the basis of age. Employers must not discriminate on the basis of race, national origin, colour or religion.[4]

The policy of the Department of Manpower which is governed by the Unemployment Insurance Act is to refer to the prospective employer the best qualified people available irrespective of age.

Recommendation 5

(a) The Committee recommends that studies be made by the Federal Department of Labour of experience with gradual retirement programs now in effect in private business and the public service and that the findings of these studies be used to stimulate wider interest in such programs on the part of management and labour.

(b) That programs of counselling and planning in preparation for retirement be more widely adopted by private business and the public service, and that Federal and Provincial Departments of Labour provide to interested employers and unions the technical consultation necessary for their successful operation.

ACTION TAKEN

(a) There are very few gradual retirement programs in industry and there is no Federal policy relating to employees in the Public Service. No department has been charged with responsibility for studies.

(b) The Federal Government has issued no policy statement on this subject and no department of government has been given an mandate to assist with programs or provide counselling.

Some departments of the Federal Government sponsor retirement programs both at headquarters and in their districts. The Department of Indian and Northern Affairs collaborates with the universities in Saskatchewan, Alberta and British Columbia to provide employees with programs on retirement. There are at least four Government departments active in this field—Indian and Northern Affairs Department, Public Works Department, Statistics Canada and Supply and Services Canada.[1]

Paramount Retirement Counselling,[2] Montreal, is unique in Canada. This agency began operations mid 1972 and by the end of 1973 had contracts with eight provinces to provide information on pre-retirement as well as post-retirement planning. The agency has some 20 booklets for distribution, one being produced each quarter of the year. In addition there are newsletters suitable for insertion with pension cheques. Research is conducted on a contract basis on various subjects such as nutrition, dental care, leisure activities, etc.

Maurice Miron,[3] program director for aging of the Canadian Council of Social Development said he knows of no company in Canada with its own pre-retirement program. But it is not all the fault of management he added. The Northern Electric Company had such a program but abandoned it when workers made it plain they did not want to hear about retirement, even on company time.

The Alberta[4] Department of Manpower and Labour has instituted a study which will more specifically identify the preparation needs with regard to retirement. This is a three year study and it is being carried out in co-operation with several departments of the Alberta Government, private industry and several retired citizens. It is intended that the results of this study will provide the department and other provincial agencies with the necessary information to plan programs of employer and union consultation as well as support programs in the area of retirement preparation.

The Extension Department of the University of Saskatchewan, Regina has formulated a course entitled "Preparation for Retirement" which is supported by the Saskatchewan[5] Department of Labour. In addition to supplying resource material for use in teaching of the course, various officials of the Department of Labour (e.g. Superintendent of Pension Plans) are available to assist with the discussion of various topics covered by the course material.

The Manitoba[6] Department of Labour has not acted in any formal way upon the recommendations, but some assistance is given to individuals who contact the department directly. The Age and Opportunity Bureau in Winnipeg assists in this area.

(1) Statutes of New Brunswick, 1973. An Amendment to The Human Rights Code of New Brunswick, Chapter 45.
(2) Statutes of Newfoundland, 1969, Chapter 75.
(3) Statutes of Ontario, 1972, An Amendment to The Ontario Human Rights Code, Chapter 119.
(4) Revised Statutes, Vol. V, 1970, Chap. L-1, 5(1).

(1) Indian and Northern Affairs Department. Mr. McCrank Telephone communication, April 23, 1974.
(2) Paramount Retirement Counselling, Montreal. Telephone communication October 25, 1973.
(3) *The Ottawa Journal*, June 13, 1972.
(4) Alberta. Department of Manpower and Labour. Letter dated March 26, 1974.
(5) Saskatchewan. Department of Labour. Letter dated March 29, 1974.
(6) Manitoba. Department of Labour. Letter dated April 1, 1974.

The Ontario[1] Ministry of Labour does not provide programmes of counselling and planning in preparation for retirement or offer the technical consultation necessary to interested employers or unions. An in-house Pre-Retirement Counselling Program has been implemented in this Ministry and the initial result indicated that it is an effective method of dealing retirement problems.

The Senior Citizens Bureau, Ministry of Community and Social Services is the agency of the Ontario Government with the chief responsibility for dealing with problems of aging. The Senior Citizens Bureau offers both counselling and technical consultation to an individual, employer, employee or union aproaching the Bureau and asking for advice. Printed resources, in the form of pamphlets and other publications, are also available to the public

The Nova Scotia[2] Department of Labour does not administer legislation pertaining to retirement plans. Conciliation and Mediation Officers of the Department will assist labour and management during the drafting of a new or renewal of a collective agreement. The Prince Edward Island[3] Department of Labour has not taken any action since it is felt that the problem is virtually non-existant in that province.

The New Brunswick[4] Department of Labour has been assigned the responsibility of responding to the specific problem of pre-retirement training and preparation. Accordingly, a program has been started to carry out the general duties of counselling and planning. The first project is near completion and will result in a two-day seminar May 4 and 5, 1974 in Memramcook, New Brunswick, for members of all CUPE locals in the Province between 62 and 65 years of age. Departmental staff and a committee of CUPE have organized the seminar. Representatives from all agencies federal and provincial, who have identifiable programs affecting retirement have been invited to attend and explain the functions and services of their respective agencies.

In a recent survey of Family Life Education programs[5] sponsored by community agencies and voluntary associations in Canada, pre-retirement programs were conducted in larger metropolitan areas. The Victoria Citizens Counselling Centre of Victoria, British Columbia reported programs of this type. The Jewish Family Service of Baron de Hirsch Institute of Montreal also conducted pre-retirement programs as well as The Centre de services sociaux of Trois-Rivières, Quebec.

(1) Ontario. Ministry of Labour. Letter dated April 11, 1974.
(2) Nova Scotia. Department of Labour. Letter dated April 9, 1974.
(3) Prince Edward Island. Department of Labour. Letter dated March 26, 1974.
(4) New Brunswick. Department of Labour. Letter dated March 29, 1974.
(5) Reynolds Barbara Plant. "A Survey of Family Life Education Programs Sponsored by Community Agencies and Voluntary Associations in Canada", unpublished, The Vanier Institute of the Family, Ottawa, 1974.

Recommendation 8

That the NES strengthen and improve its services to older workers in respect of counselling and job finding and that in larger centres a special officer be appointed to carry these responsibilities.

ACTION TAKEN

Manpower Counsellors are trained to service all age categories on the basis of individual need. "By this means it is hoped to make a broader range of opportunities available to all and avoid labelling individuals as 'old', 'disadvantaged', etc."[1]

Canada Manpower has implemented a new Manpower Delivery System which will apply services and programs in a more effective and comprehensive way. The concept is to provide three levels of service tailored to the individual client's needs. The first level is assistance to make the client job ready and features the use of self-help methods. The key to this process is a Job Information Centre where job vacancies will be displayed enabling clients to decide themselves which jobs they think they can fill. Level I service to clients will also include an Employment Opportunity Library which will contain information on the services and programs of the department as well as appropriate information on the services and programs of other government departments and agencies; and other assistance which can be provided without formal counselling.

Level II is similar to the service now provided, but in the future will be specifically directed to those people who, while basically job ready, require additional counselling and help. This could involve training or retraining through the Canada Manpower Training Program, assistance in finding employment in another area and in moving to that area through their clearance system and the Canada Manpower Mobility Program, or other of our services to gain employment.

Level III consists of concentrated in-depth counselling and the application of programs and services designed to help those clients most in need. Counsellors may also utilize outside agencies for special assistance to help remove whatever barriers exist in order to make the client job ready. Once this is done, these clients may be referred to a job, or may make job selections as in Level I.[2]

Recommendation 12

That periodic health appraisals be more widely available to older people from physicians in solo and group practice and also on an experimental basis in outpatient departments and through programs initiated by local health departments: and further that the cost of such appraisals be covered by prepayment plans.

(1) Manpower and Immigration. H. L. Douse, "On Growing Old", April 1969.
(2) Canada Manpower and Immigration. *Annual Report, 1972-73*, pp. 3-4.

ACTION TAKEN

The Medical Care Act of 1966-67, Chapter M-8 of the Revised Statutes of Canada, 1970, authorized payment by Canada toward the cost of insured medical care services incurred by provinces pursuant to provincial medical care insurance plans. All the provinces participate in this scheme, either on a prepayment basis or, in some cases, without charge to residents.

A Background Study prepared for the Science Council of Canada, August 1973, reports that there has been a definite trend in the direction of group practice to service all age groups which should become more prominent as the advantages, such as efficiency and ability to provide continuing and more complete service to the patients and continuing education to the doctor, become move evident. Group clinic practice is well established notably in the West but many problems remain of which two are of the greatest importance:

> "those having to do with distribution, for the sitting of these group clinics is dictated by economic factors not necessarily related to the need for service; and those respecting the provision of comprehensive care. So long as the only source of income is payment for specific medical services rendered to patients, a clinic will not be able to offer in sufficient quantity the auxiliary services (social, welfare, preventive) so necessary for the provision of comprehensive care in many, particularly urban, districts."[1]

The Manitoba Health Service Commission[2] has undertaken a study, supported by a 1972 National Health and Welfare Grant, to test the hypothesis that efficiency in the delivery of health services is increased by the formation of group practices in the light of proposed ambulatory care facilities.

There is no closed form of group practice in Canada similar to those in the U.S. where medical help is available on a contract basis with a group. Medicare in Canada makes it possible to seek care on a private basis. If there is a group practice such as that at the Sault Ste. Marie Health Centre[3] the province pays a set fee per member per month to cover all the medical care needs of its members.

The Saskatchewan Regional Health Services Branch promotes the principles of positive health, providing preventive health services and coordinating the work of health agencies, public, private and voluntary.[4] Alberta[5] has 25 health units besides those in the cities of Calgary and Edmonton Health Departments providing preventive public health services to almost the entire population of Alberta.

At the present time an annual health examination is a benefit of the Ontario[1] Health Insurance Plan. However, the conclusion of the task force of the Ontario Council of Health was "that periodic health examinations for planning purposes be restricted to the following: (a) during the first five years of life there should be approximately seven routine health examinations to be programmed at the discretion of the physician; (b) between the ages of 5 and 44, routine examinations should be carried out approximately every ten years, e.g., at the ages 14, 24, 34 and 44 and (c) beyond age 44, examinations should be carried out every five years, e.g., at ages 49, 54, 59, 64, 69 and 74."

Recommendation 13

> That more experiments be undertaken with multiple screening for chronic diseases, not only by physicians in dealing with their patients, and by health institutions when patients are admitted, but on a broader community basis by local health departments and/or voluntary health organizations.

ACTION TAKEN

Multi-phasic screening is still regarded to be in the experimental stage. Multi-phasic screening was pioneered by the Kaiser-Permanente group, Oakland, California in the 1950s and computerized in 1964.

> "Critics of the multi-phasic test, in general, claim that much of the testing is in vain, that it detects very few abnormalities that would not be detected in any event, and that getting abnormalities early has little affect upon the outcome of most diseases; but simply consumes more physician time with worried people. The Kaiser-Permanente people readily admit that they have no scientific answer for such a charge and that the effectiveness of the system is open to challenge. However, they continue to process some 2000 per month."[2]

A number of specific screening programs are being carried on in Canada. These cover various populations for different conditions, for example, for psychological, mental and visual problems, metabolic abnormalities, genetic hearing defects, cardiovascular faults, cancer, etc. Of these only eight are primarily concerned with the

(1) *Background Study for Science Council of Canada*, August 1973. Special Study No. 29, Health Care in Canada, A Commentary, p. 95.
(2) Health and Welfare Canada. Research Projects and Investigations into Economic and Social Aspects of Health Care in Canada, 1972 p. 15.
(3) Science Council of Canada. Background Study for Special Study No. 29, August 1973, p. 96.
(4) Saskatchewan. Department of Public Health. Letter dated September 12, 1973.
(5) Alberta. Department of Health and Social Development, *Annual Report, 1971-72*, p. 8.

(1) Ontario. Ministry of Community and Social Services. Letter dated November 28, 1973.
(2) Robertson, H. Rock, *Health Care in Canada: A Commentary*, Background Study for the Science Council of Canada, Ottawa, 1973 p. 124.

evaluation of the screening process itself.[1] These eight projects are carried out by the following groups.[2]

Study #782 University Hospital of Saskatchewan, Saskatoon, Saskatchewan

#790 Provincial Department of Public Health of Saskatchewan

#791 University of Western Ontario, London,

#794 University of Manitoba, Winnipeg, Manitoba

#798 Provincial Department of Health of British Columbia

#810 Ontario Cancer Institute, Toronto, Ontario

#821 St. Paul's Hospital, Vancouver, British Columbia

#823 University of Toronto East General Hospital

Screening clinics for specific diseases such as glaucoma, are open to various age groups in the provinces. Most provinces commented about the need to establish the value of multi-phasic screening for chronic diseases before undertaking such an expensive service.

Recommendation 14

That health counselling of people middle-aged and older, including matters as diet, rest, recreation and living habits be provided through well adult clinics, day care centres, health services in housing projects, pre-retirement courses and health maintenance programs generally: and that initiative in establishing such programs and facilities be taken by the local health department.

ACTION TAKEN

The survey conducted by the Canadian Council on Social Development and reported in *Beyond Shelter* shows that social work counselling was available on site or as a special development service in 6.1 per cent of all developments; in or for the general community in 44.5 per cent and not available in 49.4 per cent. Medical chekup was available in 11.1 per cent on site or as a special development service; 8.0 per cent in the community and not available in 80.9 per cent of the cases studied.[3]

The Report goes on to state that "except in hostel and mixed developments (particularly those that contained a high proportion of very old and incapacitated residents) sponsors generally left health services to private physicians and nursing agencies. They did not concern themselves with the prevention of health problems; rather they restricted their role to ensuring that residents received treatment in emergency situations. For example, only 19 per cent of developments reported that their residents had a regular medical checkup service available."[4]

At the University of Ottawa Medical School researchers are using a $38,000 grant to see how well a public health nurse promotes and maintains the health of senior citizens in seven publicly-run apartment complexes.[2] This is a three-year project that will be completed in 1975. Through the use of control and experimental groups, the study will measure the effects of public health nursing on the health of senior citizens. The health of the senior citizens is measured in terms of their functional ability using a morale scale which measures psychological well-being and an index of independence which measures ability to do self care activities such as bathing and dressing and instrumental activities such as shopping, cleaning.

Dr. Gustave Gingras, world-renowned specialist in rehabilitation medicine and President of the Canadian Medical Association, in a talk on the medical plight of Canada's elderly, expressed his disappointment by the lack of any day hospital or day-care programs for the elderly. "There is much talk of keeping people out of institutions, yet while the talk goes on the emphasis remains on placement in institutions."[3] Some Day Care Centres are available in the larger cities, e.g. Greater Vancouver which takes in almost 50 per cent of the total British Columbia population, has a Day Care Centre Project and the North Shore Day Care Centre, developed under a LIP grant, has established a need for such a service in that area.[4]

The Community Care Services (Metropolitan Toronto) Incorporated[1] was issued a Charter by Letter Patent on December 13, 1971 with the following objectives.

A. To enable aged, handicapped, chronically ill and convalescent persons to remain in familiar settings and retain involvement with their neighbourhood by:

(i) the daily provision of a well-balanced meal;

(ii) relieving some of their isolation and loneliness through friendly visits, group participation in social and recreational events and formal programs, and such social care services as day camps, shopping, escort services, telephone chains, transportation,

(1) *Ibid.*, p. 138.
(2) Science Council of Canada. Telephone Communication April 19, 1974
(3) Canada Council on Social Development. *Beyond Shelter*, Ottawa, 1973, p. 128. This report is based on data up to and including 1970.

(1) *Ibid.*, p. 391.
(2) *On Growing Old*, June 2, 1973.
(3) *Ibid.*, p. 3.
(4) Social Planning and Review Council of British Columbia. *A Study of Community Care for Seniors*, Vancouver, 1972, p. 91.
(5) Social Planning Council of Metro Toronto, *The Aging—Trends, Problems, Prospects*, Toronto, 1973, p. E30.

learning opportunities for employment and volunteer services and other such similar activities;

(iii) offering counselling and advisory services and other types of assistance peculiar to our individual agencies.

B. To encourage the development of similar dietary, social and community health services where they do not exist.

C. To operate such enabling services for the aged as are provided for under the Elderly Persons Centres Act, 1966 and Regulations, as amended from time to time, and to cooperate with others who provide services provided under such acts of the Provincial and Federal Governments as are compatible with the objectives of the organization.

In 1971 a Health Research grant was given to Deer Lodge Hospital, Winnipeg,[1] to determine the feasibility of having a voluntary agency, such as the VON, supervise a hospital-based activity and therapeutic program in a Day Hospital for the elderly.

The Annual Report of the Department of Social Services, Government of Saskatchewan,[2] 1971-72 lists an expenditure of some $60,000 in grants to community services for the aged; these include two Day Centres and two Senior Care Centres. A Day Care Hospital was recently approved for Edmonton. Ottawa has just opened a day care centre for the elderly. The main deterrent to the operation of such centres is the lack of transportation.

The Victorian Order of Nurses,[3] working with municipal health departments, provides health counselling to Senior Citizens Organizations on a group and individual basis. Good nutrition is an important element of a health program and has always been a concern of VON branches. Six branches now coordinate and administer Meals on Wheels programs, providing meals to some 3,000 recipients. An evaluation of this service is being made in the Richmond-Vancouver Branch to determine if the function should be broadened. Meals on Wheels programs are, for the most part, operated by voluntary organizations which leads to fragmentation and lack of continuity, depending on the voluntary help. The Annual Report for 1971-72 mentions counselling service for senior citizens only in connection with the Windsor-Essex County and Peel Branches.

The Ontario Ministry of Community and Social Services[4] is particularly interested in sponsoring pre-retirement courses and in 1972 issued a brochure "Retirement and Preparation for Retirement"—a Selected Bibliography and Sourcebook. An Ontario Government survey showed that those between 45-65 are not interested in concrete plans for retirement. Slightly more than half of those surveyed had plans for the use of leisure; fewer than half had considered health or exercise programs, although 89 per cent had financial plans. The survey also showed that only 10 per cent of workers from 15 urban areas in Ontario intended to enrol in retirement planning courses and 43 per cent did not know that such courses existed. Pre-retirement courses are offered in most large urban areas as night-school options.

(1) Health and Welfare Canada Research Projects and Investigations into Economic and Social Aspects of Health Care in Canada, 1971, p. 123.
(2) Saskatchewan. Department of Social Services, *Annual Report, 1971-72*, Regina.
(3) Victorian Order of Nurses *Annual Report, 1972*, p. 23.
(4) Ministry of Community and Social Services, November 28, 1973. Letter plus enclosures.

Recommendation 16

That research be undertaken into the effects of regular exercise, various types of organized recreation, and other forms of group and individual activity on the physical and mental health of older people, and that grants under the Fitness and Amateur Sports Act be made available for this purpose.

ACTION TAKEN

In 1971 the Fitness and Amateur Sports Branch convened a conference in Ottawa to state national goals, to define clear objectives and to enumerate priorities for research in recreation. On this basis research grants-in-aid programs are structured. Programs are aimed at the Canadian people as a whole rather than any specific age group. Again in December 1972 the National Conference on Fitness and Health recommended:

Recommendation 21[1]

It is recommended that the Federal Government make available funds to support pilot training programs in physical recreation for the aged and handicapped.

The conference recommends more specifically that:

—television exercise programs for the aged be established;

—the Federal Government explore the possibility of establishing scholarships in cooperation with the provinces to provide the opportunity for study of physical recreation programs for the aged and disabled.

The National Advisory Council on Fitness and Amateur Sport will issue a publication in the near future describing to what extent each recommendation has been implemented. As of April 1, 1974 the Research and Planning section of the Fitness and Amateur Sport Branch provides grants for research in the area of physical fitness. Individuals or groups who wish to conduct research in the area of fitness and aging can submit proposals to this section.

(1) Canada. Health and Welfare Canada. *Recommendations of the National Conference on Fitness and Health*, Ottawa, 1972, p. 16.

The Fitness and Amateur Sport Branch does not work actively in programming, but rather it acts as a consultant to other groups. Future plans include a booklet on physical activities for the aging, a film and a videotape for leaders of fitness classes.

The Department of Community and Social Services of Ontario is tentatively planning a conference on Fitness and Aging for the Fall of 1974. The Fitness and Amateur Sport Branch hopes that this will serve as a model for other provinces.

Recommendation 17

(a) That Home Care programs for elderly people be greatly extended for those who are discharged early from hospital or who would otherwise require to be admitted; and

(b) That these programs include medical and nursing care, physiotherapy and other forms of rehabilitation, visiting homemaker service and use of sick room equipment; and

(c) That the cost of such programs be provided for under the Hospital Insurance Diagnostic Service Act, through Health Grants or under a more comprehensive Health Plan.

ACTION TAKEN

As the Hospital Insurance and Diagnostic Services Act and the Medical Care Act (effective July 1, 1968) extend services to virtually all Canadians, the voluntary organizations are enabled to concentrate their services in areas complementary to medical rehabilitation e.g. psychological assessment, sheltered workshops, or to continue to provide medical rehabilitation service in the home and the community on a fee-for-service basis, purchased by the provincial or local governments aided by federal-provincial cost-sharing programs. Organized Home Care programs may mobilize the resources of a number of voluntary agencies and provide coordinated rehabilitation services to include medical and nursing care, physiotherapy, patient aides and related services to the patients who can undergo a phase of rehabilitation in their own homes.

The British Columbia[1] Hospital Insurance Service Level 8—Home Care—includes a range of services and programs which enable an individual to maintain and remain in his own home. The basic philosophy is to maintain the individual's maximum capacity to function independently and to prevent or delay hospitalization.

There are three pilot Home Care projects in the province: Simon Fraser Health Unit, Coquitlam; South Central Health Unit in Kamloops; and Greater Victoria. These three projects will provide valuable information regarding costs and staff requirements. However, the focus is on home care as a basis for earlier hospital discharge, not a continuing service nor an alternate to hospital admission. These projects were developed as a result of concern over the high cost of hospital care rather than from a concern for home care as a preferable alternative.

The Department of National Health and Welfare, through its Medical Services, provides a community service to Indian people throughout the province. The Pacific Region is divided into four zones—South Mainland (Vancouver office) Vancouver Island (Victoria), North East Zone (Prince George) and North West Zone (Prince Rupert). Each zone has approximately seven health unit offices with public health nurses who provide a health care program including home nursing and supervision to registered Band Indians. There may be some overlapping of services with the provincial health units.

The Province of Alberta[1] as of 1971 had not set up an overall program for home care, probably because it has been able to provide a high level of acute hospital care, nursing home care and care in senior citizens' lodges. However, the Victorian Order of Nurses does provide home care in Calgary as a pilot project and a small number of home visits are made by public health nursing staff throughout the province. The Home Care program for Edmonton was scheduled for 1973 but would not seem to have materialized.

The first formal Home Care program in Saskatchewan[2] was developed in 1959 by the department of rehabilitation medicine at University Hospital, Saskatoon. Starting with just 10 patients with neurological disabilities, the program in 1971 had an annual caseload of nearly 400 patients referred from all four hospitals in the city and from the community at large. Since March 1971 each hospital is responsible for services and supplies for its own discharged patients and for patients who would ordinarily be admitted to that hospital, while a full-time coordinator works with all hospitals. The average age of patients treated in the Saskatoon program in 1971 was 61. The province participates with University Hospital in financing the home care plan. Within each region of the province, teams of psychiatrists, social workers and community nurses are responsible for clinic and domiciliary services for out-patients living in their own foster homes. Home Care programs are active in Moose Jaw, Prince Albert, Saskatoon and Regina, in the last mentioned the VON operates the program. In 1972, 52 per cent of those receiving home care were over 65. Home Care is not an insured health service in Saskatchewan. Some programs are financed by health grants and others are an extension of regional health services.

(1) Social Planning and Review Council of British Columbia, *A Study of Community Care for Seniors*, Vancouver, 1973, pp. 37-8.

(1) *Hospital Administration in Canada*, December 1972, "Home Care Across Canada", p. 32.
(2) Saskatchewan. Department of Public Health. Letter dated September 12 1973.

In Manitoba[1] Home Care programs have been in operation in all Winnipeg hospitals for several years but only for selected patients who were being discharged from hospital. Care Services branch of the Department of Health and Social Development have also operated a Home Care program for their clients. The nursing care in both these programs is given by VON staff. Home Care programs were being established for rural Manitoba as of July 1, 1973.

Ontario's[2] local Home Care programs are available to 99 per cent of the population of the province with no specific age limitation. It is not regarded as a substitute for chronic hospital care or accommodation in nursing homes or homes for the aged. Therefore at the present time, it does not include patients whose needs are for maintenance or indefinite support services, categories which include a predominance of aged persons.

Quebec[3] Home Care programs serve 75 per cent of the population. All Home Care programs in the province are members of l'Association des Services de Soin à Domicile de la Province de Québec which was formed in 1968. Most of these services are hospital-based. The VON operate two Home Care programs in Hull and Montreal funded by the Provincial Government.

A Home Care program was established as pilot projects in three areas in New Brunswick[4] in 1972. In 1973 the program was under study for expansion to other areas and for the possible coverage of drugs and other supplies.

Nova Scotia[5] has no Home Care program as yet. The Nova Scotia Council of Health first report (February 1973) emphasized the need for a well-organized and effective Home Care program.

A Home Nursing Care program has been introduced in Prince Edward Island[6] and will eventually cover the Island. It is under the direction of the Division of Public Health Nursing of the Department of Health, and involves registered nursing care and consulting physiotherapist services. The entire cost is borne by the Department of Health with no charge being made to the patient.

Hospital based Home Care programs has been established in Grand Falls and in St. John's, Newfoundland.[7] The program was only initiated in the Fall of 1972.

(1) Manitoba. Department of Health and Social Development. Letter dated December 2, 1973.
(2) Ontario. Ministry of Community and Social Services. Letter dated November 28, 1973.
(3) *Hospital Administration in Canada*, December 1972, "Home Care Across Canada", p. 35.
(4) New Brunswick. Department of Health. Letter dated August 17, 1973.
(5) Nova Scotia. Department of Public Health. Letter dated October 31, 1973.
(6) Prince Edward Island. Department of Health. Letter dated August 28, 1973.
(7) Newfoundland and Labrador. Department of Health. Letter dated August 10, 1973.

In February 1970 a Federal Government grant was given to Deer Lodge Hospital, Winnipeg, to study the role of day hospitals in Home Care programs for the elderly and to demonstrate the feasibility of having a voluntary agency such as the VON supervise a hospital-based activity and therapeutic program in a day hospital.

The Department of National Health and Welfare funded under the Grants Welfare program a study of Visiting Homemaker Services in Canada under the auspices of the Canadian Council on Social Development (formerly known as the Canadian Welfare Council). Their report was released in 1971,[1] based on data collected in 1968-69.

The Report contains the following:

> "The Canada Assistance Plan, enacted in 1966, made federal financial assistance available for homemaker services and has stimulated the further growth of the service as evident in the 29 new services reported to have been established in the period 1965-69. In addition, many of the thirty agencies on which information was not available either through the original sample interviews or the mailed questionnaire are known to have been established during this period."

"Scope of Homemaker Services" includes:

> "In the care of the aged, chronically ill or disabled who need continuing part-time assistance on a long-term basis in order to remain in their homes. Although until now homemaker service in Canada and indeed in other countries, has mainly been for a limited period of time, there is growing recognition of and effort to meet longer-term need of this kind."[2]

Transportation is the main problem to the extension of this service to rural areas.

The only specific legislative act for homemaker service is in Ontario which passed the Homemakers and Nurses Services Act, 1958, as amended by the Homemakers and Nurses Services Amendment Act, 1968-69. The remaining provinces use their social assistance legislation to encourage the development of homemaker services. The 50-50 sharing with the Federal Government by all provinces of the cost of this service under the Canada Assistance Plan covers those "in need" or who "might be in need" if they did not receive the service. The Canada Assistance Plan does not apply to Home Care programs.

(1) The Canadian Council on Social Development. *Visiting Homemaker Services in Canada. Report of a Survey with Recommendations* Ottawa, 1971, 157 pages.
(2) *Ibid.*, p. 5.

Recommendation 18

That facilities be provided more widely in the community to which sick elderly people could go or be brought for on-the-spot assessment, treatment counselling, rehabilitation and related services, such facilities to include outpatient departments of hospitals, geriatric clinics and special clinics as required, concerned with mental health, speech and vision defects, dental care and rehabilitation.

ACTION TAKEN

A National Health Grant was awarded to Dr. J. E. F. Hastings,[1] University of Toronto, to head a research group to examine the economic and social implications in the development of community health centres. The Committee on the Cost of Health Services had recommended that priority be given to establishing community health centres in Canada and this was adopted by the Conference of Health Ministers in June 1971. The Hastings project had as its general purpose to study and make recommendations on the delivery of ambulatory care at the community level through various type of health centres and on how to encourage the development of such centres. Many forms of service were examined (hospital clinics, university clinics, private medical groupings, community clinics, nurse practitioner units, combined health-social service units, public health clinics, mental health clinics, etc.). Another research project on the same subject was undertaken by Dr. A. Peter Ruderman, Ph.D., with the assistance of a grant from National Health and Welfare. His project set out to make an analysis of available data to determine whether community health centres offered economic advantages over other forms of medical practice.

In the Hastings Report, which was submitted in July 1972, the concept of a health centre was defined as one which must promote a better balance between health promotion and prevention, diagnosis and treatment, and rehabilitation. "The emphasis of a community health centre must be on high quality initial and continuing care for meeting the health needs of individuals and families. There must be a balance in services among health promotion and prevention, diagnosis and treatment and rehabilitation. There must also be provision for dealing with urgent problems. Health promotion includes counselling to prepare people for the various phases of life, education to improve living habits, family planning... For providing the basic medical services the minimum service unit should consist of personnel whose continued skills are those usually now found in the general or family physician... The basic dental service unit should consist of personnel whose combined skills are those usually now found in the dentist, dental hygienist and chairside assistant..."[2]

(1) Canada. Health and Welfare Canada. *The Community Health Centre in Canada*, Ottawa, 1972.
(2) *Ibid.*, p. 1.

The Hastings Report concluded that no examples of the full concept of a community health centre presently exist. There are local community service centres in Ontario, Quebec, Saskatchewan and Manitoba which attempt to integrate health and social services for the total family. The Report recommended that:

> "Community health centres should be established and linked with hospitals and other health services in a fully integrated health services system... Community health centres should be established as non-profit corporate entities and in sufficient numbers so that new funding methods develop to promote the best use of resources.
>
> Community health centres must offer a setting where care is provided through a multidisciplinary team. Pay systems, alternative to the present form of fee-for-service, which are conducive to the team approach and which are attractive to health professionals must be developed.
>
> They must promote a better balance between health promotion and prevention, diagnosis and treatment and rehabilitation. They must, as necessary, relate to other health care services and community social services on a coordinated and integrated basis."[1]

The Hastings Report has the general endorsement of the Federal and Provincial Governments.[2] These comments and recommendations submitted by the Hastings group deal with family care health centres rather than centres directed towards the treatment of one age group, such as the over 65. There are few geriatric clinics in Canada.[3] Clinics such as those operated by Dr. Goldstein in Ottawa and Dr. Bayne in Hamilton are regarded as innovative and worthy of reporting in the Canadian Medical Association Journal.

In Ottawa Dr. S. Goldstein, M.D. has established a psychogeriatric services at the Royal Ottawa Hospital which is regarded as a community based program. He works with the Social Welfare Department, Homes for the Aged and Nursing Homes in the Area. Surveys show that the proportion of mental patients in nursing homes is as high as 60-80 per cent.[4]

In Ottawa, the Nursing Homes and Special Care Branch of the Carleton Social Welfare Department has, since 1957, operated an Assessment and Placement Service. More than half the nursing home beds in Ottawa are occupied by patients assisted by this Service. In Hamilton, since 1971, Dr. J. R. D. Bayne has developed a similar Assessment and Placement Service for the aged.

(1) *Ibid.*
(2) Standing Committee on Health, Welfare and Social Affairs, May 29, 1973.
(3) Dr. E. David Sherman, M.D., address to VON Annual Meeting, May 1973, "Current Concepts in the Health Needs of the Elderly".
(4) *Canadian Medical Association Journal*, March 3, 1973, p. 579.

According to Statistics Canada, List of Canadian Hospitals and related Institutions and Facilities, 1973,[1] there are only 21 convalescent/rehabilitation centres with a bed capacity of 2,521 for all age groups. In addition, Toronto, Trois Rivières and Quebec City are credited with rehabilitation centres.

The Toronto Rehabilitation Centre is an out-patient facility dating back to the early 1920's. Originally it offered only occupational therapy, and physiotherapy but over the years it has been expanded to include speech therapy, social service. From the beginning, therapy has been given in the home as well as in the Centre. Since 1958 the Home Care Program for Metro Toronto has referred cases requiring therapy to the Centre's Mobility Therapy Department. Consequently, in 1971 nearly half of the Centre's total caseload was handled by the Mobile Therapy Department. Reasons for referral to the mobile therapy department were—tolerance too low to tolerate transportation to the Centre, old age, an important factor in the winter months, and unsuitability for transportation such as obesity, steep stairs which could only be negotiated by stretcher, etc. In 1971 the percentage of home patients receiving occupational therapy had fallen, while the percentage of those getting physiotherapy had risen. In the Centre, on the other hand, there was little change in the relative proportions of the two caseloads. Since the Mobile Therapy Department was in a supportive role, the Centre did not assume responsibility for the patient's overall care. The Home Care Program must coordinate all of the services being given to the patient. In 1971 the Government medical insurance covered the cost of transportation of a therapist to the home, but not the cost of the patient to the out-patient clinic. Therapy in the home creates problems from both the patient's and the therapist's point of view and is more costly.[2]

In British Columbia[3] assessment and treatment services are provided by eighteen health units throughout the province and by nine health units in the Greater Vancouver region. The availability and comprehensiveness of these services vary from one region to another based on population numbers and distribution. Many of the large health units have to cope with enormous distances and limited travel budgets, frequently almost inaccessible areas and extreme weather.

In 1973 Alberta[4] established three geriatric "day" hospitals; one in Edmonton and two in Calgary—on a pilot project basis. Patients spend several hours in therapeutic activity and return home the same day. Patients are transferred by two buses which accommodate wheelchair as well as ambulatory patients.

Saskatchewan[1] has community health and social centres in rural areas where regular medical clinics provide medical assessment of health problems. Manitoba[2] also operates 16 health units throughout the province which provide a service to the total population including the elderly.

There is no Canada Assistance Plan sharing in the operating and maintenance grants for Day Centres which would include some assessment, treatment, counselling, rehabilitation and day care. Ontario, under the Elderly Persons Centres Act provides 100 per cent capital funding in conjunction with the municipalities and non-profit organizations for the development of Day Centres.

In Quebec the Maimonides Hospital and Home for the Aged in Montreal added a Day Hospital to its facilities in 1966. In June 1971 the average daily attendance was 25. The objective of the day hospital is

> "to provide for aged people who were suffering fairly severe psychiatric and medical disorders and were too deteriorated emotionally and physically to utilize the existing services of social clubs and recreation centres which would help them function well enough to continue living in their own homes, thus making their admission into an institution unnecessary."[3]

The Baycrest Centre for Geriatric Care in Toronto is operated on a similar basis.

The Prince Edward Island[4] Department of Health reported that general diagnostic and treatment services are available equally to persons of all ages.

New Brunswick[5] is divided into 5 regions with a major clinic centre in each region. There are also mobile clinics which travel to smaller communities.

Community health services are under study in Nova Scotia.[6]

On-the-spot assessments and required services are provided universally in all out-patient clinics in Newfoundland and Labrador.[7] An extensive Community Care Program (i.e. Boarding Care) exists in Mental Health with continual supervision and assessment.

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(1) Statistics Canada. Cat. 83-201, List of Canadian Hospitals.

(2) Kavanagh, T. "A Two Year Comparative Study", *Canadian Medical Journal*, July 10, 1971, The Science Council of Canada Study No. 29 concluded that "the importance of Rehabilitation Medicine has not yet been fully realized, the Centres are still struggling for recognition".

(3) Social Planning Council of British Columbia, *A Study of Community Care for Seniors*, Vancouver, 1971, p. 35.

(4) Alberta. Department of Health and Social Development, News Release, March 21, 1973.

(1) Saskatchewan. Department of Public Health. Letter dated September 12, 1973.

(2) Manitoba. Department of Health and Social Development. Letter dated December 2, 1973.

(3) Novick, Louis J. "A Geriatic Day Hospital Program", *On Growing Old*, Volume 9, No. 2, June 1971.

(4) Prince Edward Island. Department of Health. Letter dated August 28, 1973.

(5) New Brunswick. Department of Health. Letter dated August 17, 1973.

(6) Nova Scotia. Department of Public Health. Letter dated November 19, 1973.

(7) Newfoundland and Labrador. Department of Health. Letter dated August 10, 1973.

Recommendation 19

That bedside nursing in the home be extended to urban areas now without them, and increasingly to rural areas, and that these services be provided or integrated closely with local or district health departments.

ACTION TAKEN

The Medical Care Directorate of the Health Programs Branch of National Health and Welfare Canada organized a survey in 1971-72 of "outreach" facilities available across Canada for all age groups. "Outreach facilities" denote those offering non-institutional special care programs which contribute to the health and welfare needs of special population groups. The VON, YMCA and social action organizations are included in certain provinces.

The attached table shows the total number of "outreach" facilities across Canada for all age groups. A further breakdown shows that in Ontario slightly less than half of the facilities were located in Toronto; facilities are almost equally divided between Montreal and the rest of Quebec and Vancouver has 204 units available while the rest of the province has 281 centres. However except in a few instances home nursing services are not included in their lists of facilities and services. The majority of the services relate to clinical services, alcoholism, drug addiction, family planning, etc.

NON-INSTITUTIONAL SPECIAL CARE FACILITIES AND PROGRAMS 1971-72

CATALOGUE 83-519

CANADA

TABLE 1. TOTAL NUMBER OF FACILITIES

Province	Number of facilities	%
Newfoundland	20	0.71
Prince Edward Island	26	0.92
Nova Scotia	188	6.63
New Brunswick	123	4.34
Quebec	386	13.61
Ontario	849	29.83
Manitoba	284	10.01
Alberta	300	10.58
Saskatchewan	175	6.17
British Columbia	485	17.10
CANADA	2,836	100%

TABLE 2

BREAKDOWN OF CANADIAN TOTAL BY CATEGORIES

(1) Medical, nursing, or paramedical programs or services		27.60%
(a) Offering wide range of services	5.99%	
(b) Nursing (e.g. Victorian Order of Nurses)	1.02%	
(c) Associations for Rehabilitation etc	2.57%	
(d) Offering more limited range of services	18.02%	
(2) Comfort and/or distress centres		46.16%
(a) Day care programs and nurseries	1.59%	
(b) Hostels	6.42%	
(c) General	38.15%	
(3) Community and ethnic development groups		6.67%
(a) Community development	3.39%	
(b) Ethnic development	3.28%	
(4) Educational programs and groups		3.42%
(5) Information centres		7.12%
(6) Legal help or information		2.79%
(7) Financial support programs		6.03%
(8) Other		0.21%
Total		100%

The establishment of organized home care programs was initially slow but by 1967 there were 26 programs including a number in rural areas in the provinces of Quebec and Saskatchewan, while several in the Province of Ontario extended their catchment areas beyond the original city limits. The Province of Quebec, Ontario and Saskatchewan have developed province-wide plans for home care. Most of the major cities in Canada now have provisions for home care beyond the traditional home nursing services organized in Canadian municipalities by the Victorian Order of Nurses and Les Infirmières Visiteuses in Quebec and the catchment areas served by local or regional health units and city health departments.

Voluntary associations such as the VON which provides nursing care, the Canadian Arthritis and the Rheumatism Society which provide physiotherapy, and the Canadian Red Cross Society which provides patient aids and homemaker services have made major inputs to the development of home care in Canada.[1]

Home Care programs are financed by the provinces and are not shared with the Federal Government. With one or two exceptions all the provinces have developed or are in the process of developing programs, usually in collaboration with the Victorian Order of Nurses.

Newfoundland[2] offers home care in three large centres. Prince Edward Island[3] is in the process of introducing the system under the Department of Health. The entire

(1) Canada. Health and Welfare Canada. Health Care Series No. 27, *A Report to the United Nations, International Labour Organization and World Health Organization*, January 1971.
(2) Newfoundland and Labrador. Department of Health. Letter dated August 10, 1973.
(3) Prince Edward Island. Department of Health. Letter dated August 28, 1973.

cost will be borne by the province. Nova Scotia[1] has no public supported home care program, but it is under study.

New Brunswick[2] in 1972 introduced three pilot projects financed by the Department of Health. The public Health Nursing Service has an adult health supervision and treatment program. The geriatric program provides treatment and service in the home environment, thereby allowing the individual to remain in his home, avoiding the possibility of hospitalization and/or premature placement in a nursing home.

In Quebec VON groups in Hull and Montreal have been part of special study committees to look at Government funded programs such as home care services.[3]

In Ontario[4] bedside nursing in the home exists in all urban areas and most areas as an integral part of Home Care. Bedside nursing services are purchased from local providers. Victorian Order of Nurses is the predominant local provider in most locations and makes available its nursing services to other "purchasers" outside the scope of Home Care as well. About six local areas are not served by the VON and nursing service is obtained by Home Care as a special Health Unit project. In the latter situations home nursing frequently is not available to persons who are not admitted to or not eligible for Home Care. In virtually all locations served by voluntary nursing organization, there is excellent coordination between the voluntary nursing organization, the local Home Care Program and the local and district Health Department.

Home Nursing services are being introduced in the Prairie Provinces. In April 1973 the Manitoba[5] Government proposed to extend financial help to care for people at home. Saskatchewan[6] has the system working in 6 urban areas and 12 rural areas but it is not an insured service. Some programs are financed by health grants and others are an extension of the regional health service.

In Alberta[7] the development of Home Care programs is one of major areas of concern of the VON branches. The Calgary program, with VON administration, has completed its two-year pilot stage and is now assured of funding for the next three years. Programs in the other cities are at various stages of planning and it is anticipated home care will start in Edmonton in late 1973.

(1) Nova Scotia. Department of Health. Letter dated November 19, 1973.

(2) New Brunswick. Department of Health. Letter dated August 17, 1973.

(3) Victorian Order of Uurses for Canada, *Annual Report, 1972*, Ottawa, p. 52.

(4) Ontario. Ministry of Commuunity and Social Services. Letter dated November 28, 1973.

(5) Manitoba. Department of Health and Social Development. Letter dated December 2, 1973.

(6) Saskatchewan. Department of Public Health. Letter dated September 12, 1973.

(7) Victorian Order of Nurses, *Annual Report, 1972*, Ottawa, p. 42.

In British Columbia[1] a coordinated home care service is being developed on a trial basis in Victoria by the province and Municipal Departments of Health.

The Federal Government has proposed to the provinces a new formula for fiscal arrangements which eventually would be based on the per capita. If accepted, the provinces will be able to use their gross funds to meet their most urgent requirements. With this new flexibility home care programs could be expanded if desired.

Recommendation 21

> That arrangements be developed to make all these services available also in rural areas, by training lay personnel to assist the health professionals, and by ensuring prompt communication and transportation services.

ACTION TAKEN

Saskatchewan[2] has extended its services to rural areas more extensively than over provinces which have confined themselves to major urban areas.

Transportation to rural areas is always a problem but the Annual Report for the VON, 1972, states that "branches are extending their boundaries so that service can be available to a larger number of people particularly those who live beyond the limits of towns and cities." Voluntary agencies are also organized to provide transportation to older people who receive treatments from clinics, etc. The VON Annual Report also goes on to say that "clerical and other auxiliary staff such as homemakers and home aides are being used in an effort to increase the efficiency of professional personnel." "Educators of health personnel, aware of the shift in emphasis from institutional to community care, are seeking more opportunities for observation or experience for professional and paraprofessional students with community agencies. VON branches cannot meet all the requests for student experience..." The VON is aware of the need to improve management of human resources and question whether "nurses have been relieved of all responsibilities that can be done by clerical personnel? What level of preparation is required to provide nursing care at a safe and acceptable level?"[3]

Ontario[4] sponsors a Senior Volunteers in science program whereby senior citizens are trained to assist professionals and in Prince Edward Island[5] many senior citizens work as volunteers in the sheltered workshop.

(1) Social Planning and Review Council of British Columbia, *A Study of Community Care for Seniors*, Vancouver, 1972, p. 38.

(2) Saskatchewan. Department of Public Health. Letter dated September 12, 1973.

(3) Victorian Order of Nurses for Canada. *Annual Report* Ottawa, 1972.

(4) Ontario. Ministry of Community and Social Services. Letter dated September 12, 1973.

(5) Prince Edward Island. Department of Health. Letter dated August 28, 1973.

In Manitoba[1] some lay workers are presently being employed on a part-time basis as homemaker/aides. Courses are currently being given or are in the planning stage. It was noted that aides to the health professional should be employed under the same criteria in both urban and rural settings and perform similar functions.

Recommendation 22

(a) That definite decisions be reached without delay about the range of institutional facilities and services essential for the short and long-term care of the chronically ill; and

(b) That particular attention be given to the definition of various kinds of sheltered accommodation; and

(c) That where essential facilities are in short supply the capital costs involved in providing them be eligible for assistance under the hospital construction program or such modification of the latter as may be necessary; and

(d) That in planning the above facilities due account be taken of the new possibilities of short-term active treatment and rehabilitation with early discharge home as contrasted with long-term largely custodial care, in dealing with chronic disease.

ACTION TAKEN

No national standard terminology has been arrived at for institutions which provide care for the elderly chronically ill. Not all so-called nursing homes provide nursing care. The function of the establishment differs from province to province. Individual provinces are developing a "level of care" system but the type of care provided at various levels differs.

The Federal Government no longer provides grants for the construction of hospitals; these terminated in April 1970.

Hospital requirements are under study in both Newfoundland[2] and Prince Edward Island[3] in an effort to arrive at a sound basis for planning for necessary care facilities.

Nova Scotia[4] reports that assistance under provincial construction grants has been expanded. The Health Services and Insurance Commission has established guidelines as to the range of institutional facilities and services that are essential for short and long-term care.

(1) Manitoba. Department of Health and Social Development. Letter dated December 2, 1973.

(2) Newfoundland and Labrador. Department of Health. Letter dated August 10, 1973.

(3) Prince Edward Island. Department of Health. Letter dated August 31, 1973.

(4) Nova Scotia. Department of Public Health. Letter dated November 19, 1973.

The Department of Health in the Province of New Brunswick[1] has developed definitions and descriptions of the types of facilities required for short and long-term chronic care. The planning of facilities in the province is based upon age and sex-related norms.

The New Brunswick Department of Health has defined the various levels of care within the nursing homes as well as in other sheltered accommodation such as rehabilitative and extended care.

Hospital construction plans take into consideration the type of facilities required for chronic and rehabilitative care. Capital grants are provided by the Provincial Department of Health for the construction of approved new nursing home facilities. Plans take into consideration such new concepts as day care surgery which will enable the patient to be discharged from hospital at an early date. The province also has an active home care program to complement the shortening of the length of stay of active and chronic care patients.

Department of Social Services in Quebec[2] has plans to initiate new regional reception centres where persons needing care will be interviewed, assessed and allocated to the appropriate category of care institution. A criteria is being established to standardize admission procedures throughout the province. This plan was announced by the Deputy Minister at a Seminar on Gerontology held in Montreal in November 1973.

In Ontario[3] chronic hospitals and nursing homes have been supported to fill the need for the short and long-term care of the chronically ill. Homes for the Aged, Adult Charitable Institutions, Group Homes, Foster Homes, Homes for Retarded Persons, including the aged, handicapped and retarded, have been developed and supported to fill this need. Capital grants are available for many of these from the Province; operating and maintenance grants are shareable, in most instances, under the Canada Assistance Plan Agreement.

Attention is being given to a clearer definition of the various types of sheltered accommodation. At the present time a Committee composed of representatives of the Ministry of Health together with the Ministry of Community and Social Services, is undertaking a study of Institutional Care with a view to developing an inventory of the facilities as they presently exist in both Ministries. As a part of this exercise levels of care are being defined for the various Institutional Service components. At this time (November 1973) five such levels have been determined: domiciliary care, supervisory care, nursing or other professional care, continuing nursing or other professional services and diagnosis and intensive treatment.

(1) New Brunswick. Department of Health. Letter dated August 31, 1973.

(2) Ouellet, Aubert, "Politique du Ministère des affaires sociales relative à l'hébergement des personnes âgées," given at Symposium on Gerontology, Hôpital Notre-Dame de la Merci, Montreal, November 17, 1973.

(3) Ontario. Ministry of Community and Social Services. Letter dated November 28, 1973.

These levels represent the spectrum which exists from purely domiciliary or rest home care at level one to highly active treatment oriented centres for both physical and mental disorders at level five.

Simultaneously with this study group is another Government study of "group homes" which includes a categorization of this type of accommodation by intensity of care of community based homes which are provided for and operated by a number of Ministries within the Provincial Government. This group should provide a comprehensive review of the total community based sheltered accommodation provided by all Ministries of the Provincial Government of Ontario.

As part of the current Government policy is to shift from institutional to community care for the handicapped, particularly the mentally retarded, primary responsibility for services to the retarded is being transferred, as of April 1, 1974, to the Ministry of Community and Social Service.

The Province of Ontario also recognizes and funds short-term active treatment and rehabilitation facilities. Priority is given in the provincial capital program for facilities of this type.

Manitoba is in the process of conducting a special study "Aging in Manitoba".[1] No doubt this study will reveal gaps in the service. Manitoba provides cash grants and fund for debt retirement. It is expected that the extension of the home care program will lessen the demand for institutional services.[2]

Institutional facilities and community support services have increased in Saskatchewan.[3] Each health region (ten plus the Northern Health District) has either an extended care facility or approval for additional beds through conversion or renovations.

Many communities have health care programs to assist the patient in his home following discharge from an institution or, as an alternative, prior to admission to in-patient care. The service varies considerably due to the local resources. The more sophisticated type of home care can be found in the cities of Regina, Saskatoon, Prince Albert and Moose Jaw. The regional programs mainly provide the services of nursing, homemaking and limited drugs, medical supplies and equipment. A home care service has been added as an alternate to a small hospital in nine areas. In communities where the small hospital has closed, assistance is available to establish a health and social centre to consist of an out-patient service, on-call nurse, home care program and social activities for the aged.

(1) Manitoba. Department of Health and Social Development, *Aging in Manitoba*, Volume 1, Winnipeg, 1973. This is the first of ten volumes.
(2) Manitoba. Department of Health and Social Development. Letter dated December 2, 1973.
(3) Saskatchewan. Department of Public Health. Letter dated September 12 1973.

Particular attention has been given to the definition of various kinds of sheltered accommodation through the development of a levels-of-care system. Each institution is designated as providing certain levels of care which dictate the type and extent of service available.

In addition to hospital construction grants in Saskatchewan there are grants for special care homes and provisions for long-term financing through CMHC.

A joint (Alberta Council on Aging and Department of Health and Social Development) study of the general needs of institutionalized and non-institutionalized senior citizens across Alberta was planned for 1973.

The final report of the Geriatric Reactivation Study carried out by the School of Rehabilitation Medicine of the University of Alberta, September 1972, reported that there were 28 auxiliary and 71 nursing homes caring for some 8,500 people with an average age over 75. The purpose of the study was to test the hypothesis that upgrading of staff in extended care facilities results in improved over-all patient condition.[1]

Auxiliary hospitals in Alberta care for long-term patients. Nursing Homes have a less disabled population. Only a few auxiliary hospitals and no nursing homes provide rehabilitative nursing care.

A study of community care for seniors was conducted by the Social Planning and Review Council of British Columbia[2] and a report was submitted in December 1972. The preface commented that "day services, home care and nursing in the home, for instance, had not been fully included in the planned health care system for all British Columbia which was developed primarily in hospitals and extended care facilities... In general throughout the entire province the lack of comprehensiveness of service was most apparent in (1) home care and (2) intermediate, chronic or special care." The report went on to remark that in many cases the income level made senior citizens ineligible for special care facilities and yet they had insufficient funds to pay the rates in private hospitals and rest homes.

Recommendation 23

> That patients with chronic illnesses be cared for in wards or wings of general hospitals, or in other facilities integrated with the hospital system, instead of in completely separate and often isolated institutions as so frequently at present.

ACTION TAKEN

As stated under No. 22, health requirements are under study in all provinces.

Newfoundland[3] reports that the integration of patients with chronic illnesses into the regular hospital system is

(1) Bostrom, M. and K. Gough (eds.). *Geriatric Reactivation Study*, School of Rehabilitation Medicine, University of Alberta, Edmonton, 1972.
(2) Social Planning and Review Council of British Columbia, *A Study of Community Care for Seniors*, 1972, p. 1.
(3) Newfoundland and Labrador. Department of Health. Letter dated August 10, 1973.

being considered in present planning. A comprehensive survey of the whole system of health services and related social services is now being conducted in Prince Edward Island.[1] The matter of integration of chronically ill patients within a general hospital is under consideration.

The recommendation has not been fully accepted by planners in the Province of Nova Scotia[2] as tuberculosis care is still being provided on a segregated basis. Centres such as Yarmouth, Windsor and Sydney Mines are providing two levels of care in their hospitals.

In New Brunswick[3] it is already the practice that patients with chronic illnesses are cared for in wards or wings of the public hospital.

The Ministry of Health for the Province of Ontario[4] agrees with the general intent of the recommendation and particularly with the necessity of integrating the chronic illness facilities into the overall system. The province is promoting the concept that chronic patients would be cared for on a programatic basis which involves assessment of each patient in a particular geographic area and then referral to the facility which will best meet the needs of that particular individual. Quebec[5] has a similar concept.

This practice of integration has been the policy in Manitoba[6] for several years. Extended Treatment Units (chronic care) are all located adjacent to general hospitals.

Saskatchewan[7] reports that most extended care facilities now have an affiliation with a general hospital. One exception is the Souris Valley Extended Care Hospital at Weyburn; it is attached to an acute psychiatric care centre with a general hospital reasonably close. A policy statement issued in June 1973 stated that the government had adopted the policy that acute care general hospital beds would be used for the care of patients requiring extended or chronic care (level 4) in those communities that do not now have organized level 4 services in separate level 4 facilities or in conjunction with general hospitals.

The Social Planning and Review Council of British Columbia[8] in their December 1972 report commented on the lack of comprehensiveness of services throughout the whole province in personal care (known also as intermediate, chronic or special care). It was the view of the Council that this level of patient "requires initial and continuing medical assessment..." These patients should be treated in the Extended Care Unit of an acute hospital, or in an extended care hospital (or in a private hospital, in which case, the BCHIS is not responsible for coverage).

One of the recommendations of the Interdisciplinary Ad Hoc Committee on Teaching, Research and Service in Geriatrics[1] within the University of Toronto (1973) related to the establishment of acute geriatic units in General Hospitals where the multiplicity of problems of the elderly can be dealt with by those with special interest in, capability for, and awareness of these problems. It was also suggested that there should be more long-stay units associated with acute hospitals and the Committee suggested that instead of closing active beds, they should be converted to long stay beds.

Recommendation 24

> That in all institutional facilities a positive attitude be adopted toward the possibility of rehabilitating elderly people and that provision be made for programs designed to return them "from helplessness and dependency to self care and a considerable degree of independence.

ACTION TAKEN

There is a definite trend, though slow, towards rehabilitation of the elderly but some provinces have been able to make more progress than others. Rehabilitation Services are available under the Medical Care Act, the Hospital Insurance and Diagnostic Services Act and the Canada Assistance Plan.

The Maritime[2] provinces report that a positive attitude towards the possibility of rehabilitating elderly people is one of their objectives. The Health Services and Insurance Commission of Nova Scotia[3] reported that recently, through a crash program, they were successful in sponsoring eleven students in Occupational Therapy, with the anticipation that they would work in provincial hospitals providing needed services to the elderly.

In Ontario[4] activation and rehabilitation programs in Homes for the Aged, both charitable and municipal, have long been a focus of attention. The adjuvant program and related care programs have given great stress to

(1) Prince Edward Island. Department of Health. Letter dated August 31, 1973.
(2) Nova Scotia. Department of Public Health. Letter dated November 19, 1973.
(3) New Brunswick. Department of Health. Letter dated August 31, 1973.
(4) Ontario. Ministry of Community and Social Services. Letter dated November 28, 1973.
(5) Ouellet, Aubert, "Politique du Ministère des Affaires sociales relative à l'hébergement des personnes âgées". Symposium sur la gérontologie, Hôpital Notre-Dame de la Merci, Montréal, 17 novembre 1973.
(6) Manitoba. Department of Health and Social Development. Letter dated December 2, 1973.
(7) Saskatchewan. Department of Public Health. Letter dated September 12, 1973.
(8) Social Planning and Review Council of British Columbia, *A Study of Community Care of Seniors*, Vancouver, 1972.

(1) Faculty of Medicine, University of Toronto. Letter dated November 23, 1973.
(2) Newfoundland and Labrador. Department of Health. Letter dated August 10, 1973.
New Brunswick. Department of Health. Letter dated August 17, 1973.
Prince Edward Island. Department of Health. Letter dated August 28, 1973.
(3) Nova Scotia. Department of Public Health. Letter dated November 19, 1973.
(4) Ontario. Ministry of Community and Socal Services. Letter dated November 28, 1973.

this, as have the activities programs and the full use of volunteer groups, such as the Home Auxiliary.

The 1970 Report of the Ontario Council of Health on Rehabilitation Services (Health Care Delivery System, Supplement No. 6) was critical of the province's system for the delivery of rehabilitation services on the basis that a multiplicity of public and voluntary agencies and organizations have developed limited services to meet specific demands, without concern for the effect each development might have on the overall pattern. This has resulted in unnecessary duplication in many areas, gaps in others.

Acceptance of their expanding role in the field of chronic illness has stimulated a number of general hospitals to organize chronic care units and co-ordinated home care programs have been developed across the province. Services necessary for more comprehensive programs of care are being added by the more progressive hospitals, nursing homes and homes for the aged. Increased attention has been given in some quarters to the development of ambulatory day care programs designed to provide a transition between the hospital and community life and to maintain as many people as possible out of hospitals of all types.

In Manitoba[1] the system for assessment of residents in personal care homes and those applying for placement is designed to require rehabilitation assessment.

In designing the level of care criteria for extended care patients in Saskatchewan,[2] one sub-group (4(c)) is specifically tailored to encourage rehabilitation even though it may be required at a slower and modified pace. Two comprehensive rehabilitation centres have been approved for the province, one for the south and one for the north. They are encouraged to provide the support services for the outlying areas and are funded to provide the sophisticated staff and equipment required for the patient in need of comprehensive rehabilitation. School of Rehabilitation Medicine, University of Alberta, 1972, Geriatric Reactivation Study, experimented with a Travelling Rehabilitation Team which was to provide formal and specific instruction to staff at institutions caring for the aged.

In Alberta a Geriatric Reactivation Study[3] was undertaken by the School of Rehabilitation Medicine by the University of Alberta to measure the effect of intensive, multi-disciplinary rehabilitation (staff) education and related consultative services. Results indicated that staff attitudes tended to shift to a greater degree of acceptance of patients as individuals. This staff also demonstrated increased knowledge and skills in rehabilitative nursing.

(1) Manitoba. Department of Health and Social Development. Letter dated December 2, 1973.

(2) Saskatchewan. Department of Public Health. Letter dated September 12, 1973.

(3) Brostrom M. and K. Gough, *Geriatic Reactivation Study*, School of Rehabilitation Medicine, University of Alberta, Edmonton, 1972.

The SPARC study of British Columbia[1] estimate that there are approximately 500 beds in rehabilitation units in six provincial hospitals and two federal hospitals in Vancouver and Victoria. The standard of .5 beds per 1,000 total population (all ages) would place the provincial overall need at 1,093 beds. Many hospitals throughout the province have a physiotherapy department, frequently shared with or provided by the Canadian Arthritis and Rheumatism Society which offers in-patient and out-patient as well as home treatment to arthritics and non-arthritic patients referred by a physician.

The Science Council of Canada, Special Study No. 29 concluded as follows with respect to rehabilitation services in general.

> "A multiplicity of public and voluntary organizations and agencies have developed services to meet specific needs, without sufficient study of the effect each development might have on the overall pattern. This has resulted in unnecessary duplication in some areas, gaps in others, and organizational fragmentation which has led to a lack of continuity in patient care, inefficient use of manpower and physical resources, and rising costs...
>
> The picture is a familiar one, typical, in some respects, of most other elements of the Health Care System. But the importance of Rehabilitation Medicine has not yet been fully realized, the centres are still struggling for recognition. It can only be urged here that in the regional planning that must come about, the place of rehabilitation will receive full attention."[2]

Recommendation 25

> That provision for meeting the needs of mentally ill and confused older people be greatly improved, inter alia, through adequate assessment, which is regarded by the Canadian Mental Health Association as "the first essential in a comprehensive program", a wider use of smaller facilities, including nursing homes and foster homes located close to the places in which the aged live, and a "more hopeful attitude" towards programs of rehabilitation which should be extended, especially in psychiatric hospitals and psychiatric units of general hospitals.

ACTION TAKEN

The services available to those requiring health care, especially mental health service, can only be assessed in terms of the total social and cultural milieu, the nature of the aged population's housing, the existence of resources which will help them remain in their own homes, provision for day care, the availability of hospital

(1) Social Planning and Review Council of British Columbia. *A Study of Community Care for Seniors*, Vancouver, 1972 p. 35.

(2) The Science Council of Canada, *Health Care in Canada: A Commentary*. Special Study No. 29, Ottawa, 1973. p. 100.

care, including acute, extended care and rehabilitation facilities and the role of the provincial psychiatric hospital nad its policies.[1]

In British Columbia[2] the mental health services are provided as community services. There are 24 mental health centres established throughout the province which serve their local community and other communities by travelling clinics. These services are directed to all age groups and a variety of problems, of which psychogeriatrics and family counselling are basic to service to older people. Those in outlying areas must travel to a designated centre to obtain these services. "The community health services have expressed concern about the fact that the centres are not involved to any great extent in offering services to the elderly patient. Other programs under the Mental Health Branch, such as boarding homes, in-patient services and sheltered workshops provide services which enable the long-term hospital patient to return to the community and tend to bring more of this older group to the community health centre."[3]

The Province of Alberta[4] is reported to have probably the largest number of auxiliary hospitals and nursing home beds per capita in the country and they are endeavouring to put these into an integrated system to facilitate the transfer and movement of patients from one to the other. The Mental Health Services Division in Alberta is in the process of encouraging what it calls "Approved Homes", with a graduated rate of fees depending on the level of attention required. The number of patients in such homes will be small, probably three as a maximum. Volunteer programs are active in some regions which are designed to brighten the day of patients in nursing homes and auxiliary hospitals.

Saskatchewan[5] reported a remarkable reduction in the patient population in mental hospitals from 3,111 in January 1963 to 307 in January, 1973. This has resulted from the considerable growth of out-patient services and of services rendered in general hospital psychiatric units and a tremendous growth in follow-up services, domiciliary visits having risen from a very small number in 1903 to around 30,000 in 1973. Approved homes are being widely used as an alternative to long-term hospitalization.

Under the Manitoba[6] Mental Hospital Foster Home Program 2,000 patients have been placed in the community since 1967.

The lot of the elderly has improved in Ontario[7] but it is still difficult to help the mildly confused elderly person with limited means to obtain a protective setting unless there is concomitant physical "illness" which justifies coverage of nursing home care by public funds. Of major concern also is the case of the ex-psychiatrist patient discharged into residential Homes for Special Care. Not all benefit from the reduction in services.

In the Province of Quebec,[1] Bill 65 has brought services organized on a regional basis in order to make treatment available to all and in addition has helped in the classification of patients in psychiatric hospitals between those requiring medical services and those requiring custodial care. Classification provides directions as to what policy to follow in order to help those people.

Prince Edward Island[2] has not the comparative facilities to deal with the acute mentally ill as the physically ill. Two new buildings are on the planning board for the use of chronically ill patients. During the past ten years the chronically ill have been placed in foster homes which has worked quite well if the patient is able to be involved in the community life. Similar improvements and similar problems are evident in the other Atlantic Provinces.[3]

A problem common to most areas is the lack of professional and trained staff to care for the mentally ill and confused older people.

Recommendation 27

> That, as in the case of nursing homes, study be given by the appropriate authority to the place and function of homes for the aged, and that in particular attention be given to prevailing admission policies, the possibility of alternative accommodation in sheltered semi-independent housing for relatively well ambulant patients, the place of rehabilitation or "reactivization" programs, and the careful selection and training of the staff.

ACTION TAKEN

The March 1971 issue of *On Growing Old* (a quarterly publication of The Canadian Council on Social Development) reports on a shift in emphasis regarding policies for old people: the newly organized Department of Social Affairs in Quebec[4] announced a change in policy which would enable old people to live out their lives independently rather than in institutions. Thus, approval for 40 out of 107 projected homes for the aged was dropped pending a study of need in the field. On the other hand, the same periodical for June 1971 commented on four new homes for the aged in Nova Scotia[5] as well as proposed new homes which would provide some 350 beds. Recent trends in the fields of aging indicate that more and more persons formerly cared for in institutions will

(1) Canadian Mental Health Association. Letter dated September 27, 1973.
(2) *Ibid.*
(3) Social Planning and Review Council of British Columbia. *A Study of Community Care for Seniors*, December 1972, p. 35.
(4) Canadian Mental Health Association. Letter dated September 27, 1973.
(5) *Ibid.*
(6) *Ibid.*
(7) *Ibid.*

(1) *Ibid.*
(2) *Ibid.*
(3) *Ibid.*
(4) Canadian Council on Social Development, *On Growing Old*, Volume 9, No. 1, March 1971 p. 9.
(5) Canadian Council on Social Development, *Op. Cit.*, Volume 8, No. 2, June 1971.

receive services in their own homes and communities. Hence the pressure to expand community services to carry additional loads formerly handled in other ways will be heavy during the 1970s. This same view was expressed at the Workshops held during the annual meeting of the Canadian Council on Social Development held in Ottawa in September 1973. The great need is to help people maintain their independence by extending assistance to those living in their own homes. The expansion of "Meals on Wheels" and other voluntary services is towards this end, but professional social workers would prefer that such services be organized under a social scheme to avoid the gaps that arise when the whole program relies on voluntary help.

The Social Planning Review Council of British Columbia in "A Study of Community Care for Seniors" commented on the lack of "comprehensiveness of services" in Home Care and Personal Care.[1] One of the big problems is that congregate personal care in the private sector is beyond the means of those needing care, particularly those with some income which makes them ineligible for special care facilities.

Under what are termed "master agreements" Alberta bears the cost of constructing and equipping homes for the aged and housing units on municipal land. Projects are operated by provincially incorporated foundations which include municipal councillors in their membership; net costs of operation are borne by the municipalities. The Welfare Homes and Institutions Branch of the Department of Social Development is responsible for the licensing and maintaining of standards in homes for the aged and infirm. The Senior Citizens Shelter Assistance Act, 1972, provides homeowner assistance grants in an amount equal to the provincial school levy for homeowners aged 65 and over in respect to their private residence or when they reside in an "eligible mobile unit". This Act also provides an annual renter assistance grant for senior citizens.[2] Alberta also had a Pilot Project published in July 1973 on the Medical Problems and the Use of Medical Services Among Senior Citizens in Alberta. During 1973 the University of Alberta conducted a "geriatric reactivation study" in nursing homes to determine the effectiveness of intensive, multi-disciplinary rehabilitation (staff) education and related consultative services.[3]

Saskatchewan[4] is giving consideration to having a "common admission and discharge committee" for all levels of care in a particular region. The Department of Social Services is promoting reactivation and a rehabilitation philosophy is encouraged. In Saskatchewan, the aged and infirm persons are cared for in a provincial special-care home in three provincial geriatric centres, two under the jurisdiction of the Department of Welfare and one under that of the South Saskatchewan Hospital Centre, and in municipal, voluntary and proprietary homes for the aged. Capital grants, amounting to 20 per cent of actual construction costs are available for special care homes, such as nursing homes, supervisory care homes or sheltered care homes. Further, an annual maintenance grant of $12 per bed is paid to such homes.

The total bed capacity for "personal care homes" and hostels in Manitoba in 1972 was given as 6,230 compared with 2,900 beds in 1960.

The White Paper on Health Policy for Manitoba[5] no doubt reflects problems common to all provinces in the education of persons associated with health care:

> "Programmes for different types of levels of workers are compartmentalized. Training for different levels is not cumulative. For example, a licensed practical nurse who is interested in taking more training to become a registered nurse cannot add to her already completed training and experience. Neither can a student who has completed a community college course as a welfare worker, with experience and training, easily extend her training to become a social worker . . . Only infrequently are courses structured in such a way that students begin working in 'teams' with their classmates in other professional groupings."

"Aging in Manitoba—Needs and Resources" is an ongoing research project.

In Ontario[6] mechanisms are now being developed to integrate the planning of nursing homes and homes for the aged, so that there is neither a duplication of parallel type facilities in the community nor are there gaps allowed in specific geographic regions by virtue of the fact that neither a home for the aged nor a nursing home is provided.

Since 1972 the Ontario Ministry of Community and Social Services has been working with the Ontario Association of Homes for the Aged and other related agencies, to develop a new admissions policy that will limit the over-utilization of institutional care when alternatives may be found which are more desirable in terms of psychosocial and other reasons. Community outreach programs are being developed such as Foster Homes, Meals-on-Wheels, Day Centres, Vacation Care and sheltered, semi-independent housing.

Community Care Services, (Metropolitan Toronto) in its 1972 Annual Report stated that although some supportive care services do exist, many more are needed to close the gaps in the health and social care systems. "The hope of closing these gaps lies with grass root organizations."

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(1) Social Planning and Review Council of British Columbia. *A Study of Community Care for Seniors*, Vancouver, 1972.
(2) Canada. Health and Welfare Canada, *Social Security and Public Welfare Services in Canada*, 1972.
(3) Bostrom, M. and K. Gough (eds.), *Geriatric Reactivation Study*, Edmonton, University of Alberta, School of Rehabilitation Medicine, 1972.
(4) Saskatchewan. Department of Public Health. Letter dated September 12, 1973.
(5) Manitoba. Department of Health and Social Development *White Paper on Health Policy*, Winnipeg, 1972.
(6) Ontario. Ministry of Community and Social Services. Letter dated November 28, 1973.

In Quebec[1] the Aged Couples Homes Act authorizes the province to erect and maintain homes for aged couples or to make agreements (including the provision of grants) for their erection, upkeep and administration with persons, societies and corporations, public or private. In November 1973 Quebec promulgated a new socio-health policy that would screen applicants for domiciliary care so that the elderly will be directed to appropriate treatment centres and many others encouraged to remain independent with the assistance of supportive services.

In New Brunswick[2] the Department of Health has studied the place and function of homes for the aged: "A Study of Extended Care for the Aged, Chronically Ill and Disabled in the Province of New Brunswick". Several nursing homes are presently building accommodation for relatively well persons along with reactivation programs and training of staff.

In Nova Scotia[3] all admissions to Homes for Special Care are arranged through a Provincial Classification Committee. The primary functions of the Committee are to consider and examine all requests for admission to Homes for Special Care and to arrange periodic reviews of patients whose physical and/or mental condition may have changed. Private homes caring for elderly citizens are inspected by the Public Assistance Division and licensed under the provisions of the Boarding Home Act. Consultative Services are provided in respect to staffing, budgeting and maintenance. The Department of Public Health provides a regular consultative service in respect to diets and nutrition for patients in all homes and, in addition, gives technical, medical and nursing information to homes providing accommodation for the aged. Homes for Special Care include: Licensed Nursing Homes, Licensed Boarding Homes, Senior Citizens' Residences and Homes for the Aged. Each municipally-operated home requires the appointment of a Board of Visitors who inspect the home at least four times each year and report to the municipal council operating the home. Copies of the reports are also forwarded to the Minister of Public Welfare.

The first report of the Nova Scotia Council of Health[4] (February 1973) proposed a "progressive care approach" and defined a number of levels of care ranging from active treatment to personal care for people who are not ill but need support. The emphasis was on non-institutional care.

In their Annual Report for 1973 the Newfoundland Department of Social Services and Rehabilitation reported that sufficient emphasis has not been replaced on the urgent need for beds where nursing care can be provided.[5] There has been a very significant decrease in recent years in the number of applicants seeking accommodations who are ambulatory. During that fiscal year approval for the construction of five new homes was given. Provision is being made in each of these new homes for nursing care to the extent of approximately 25 per cent of the bed capacity.

The study of NHA-financed housing for the elderly—"Beyond Shelter" concluded there is a need for better liaison between housing developments of the type studied and other forms of accommodation, such as community foster care programs, intermediate or special care homes in order to produce continuity of care for old people.

Recommendation 29

> That, on the lines proposed by the Royal Commission on Health Services, a Nation-Wide Universal Health Service program be instituted to provide a comprehensive range of services including Medical Care, Nursing Care, Dental Care, Home Care, Prescription Drugs and Prosthetic Appliances: and that, if staging is required in the introduction of all or any part of this program, older people be given special consideration.

ACTION TAKEN

Under the Medical Care Program established under the Medical Care Act, the coverage provided by the various provinces varies somewhat but the basic coverage is the same throughout Canada. Routine dental care and prescription drugs are not covered by Medicare to out-patients. Welfare recipients are provided with necessary drugs.

There is no nation-wide program for nursing care, drugs, or prosthetic appliances.

The only dental program for the older population exists in Alberta.[6] The Council on Health Care of the Canadian Dental Association announced at their March 1974 meeting that in Alberta persons over 65 years and their dependents will be eligible for dental services up to a limit of $1,000 for each two consecutive year period. The Provincial Government will pay 90 per cent of the cost of dental work up to June 30, 1974, and they will pay 95 per cent of the cost from July 1, 1974 to December 31, 1975.[7]

Recommendation 30

> That the above comprehensive program be financed mainly, if not altogether, by tax payments so that premiums, if any, may be kept to a minimum and the use of the means test, which we unequivocally reject, may be rendered unnecessary.

(1) Canada. Health and Welfare Canada, *Social Security and Public Welfare Services in Canada*, 1972, p. 52.
(2) New Brunswick. Department of Health. Leter dated August 17, 1973.
(3) Nova Scotia. Department of Public Welfare, *Annual Report, 1971-72*, p. 55.
(4) Nova Scotia. Council of Health. *Health Care in Nova Scotia, A New Direction for the Seventies*, Halifax, 1973, 187 pages.
(5) Newfoundland. Department of Social Services and Rehabilitation, *Annual Report, 1973*, St. John's, Newfoundland, p. 49.
(6) Canada. Health and Welfare Canada, Dental Health. Telephone communication, March 28, 1974.
(7) *Journal of Canadian Dental Association*, Vol. 40 No. 3, 1974, p. 186.

ACTION TAKEN

Under "Medicare", established under the Medical Care Act, the Federal Government contributes half of the average national cost of insured services to those provinces operating medical care insurance plans which meet certain minimum criteria. Residents aged 65 and over pay no medical premiums in any of the provinces except Quebec and British Columbia. In Quebec the premiums are based on the amount of taxable income. In British Columbia those with limited incomes may receive up to 90 per cent subsidy. Ontario has a one year residency requirement before premiums are eliminated. In both Ontario and Manitoba and premiums for the family unit are eliminated once either spouse reaches 65.[1]

A serious bottleneck in the provision of health services for old people is the shortage of professional personnel interested and trained in this field, e.g., physicians, nurses, physiotherapists, occupational therapists, orthotists, prosthetists, social workers, podiatrists.

Recommendation 31

(a) That professional schools which train professional workers for the above specialties place greater emphasis in their curricula on the medical, social and economic aspects of aging; and

(b) That grants under the Health and Welfare Training programs of the Federal Government be used to increase the supply of workers equipped for work in the field of Old Age; and

(c) That programs to stimulate greater interest in geriatrics on the part of the various professions indicated above be provided by the professional societies concerned in post-graduate refresher courses, in conferences and institutes and by means of professional literature.

ACTION TAKEN

With few exceptions Schools of Social Work[2] report that elective courses in geriatric care have been offered but there was not sufficient interest on the part of students to implement the course. Similarly elective seminars have been advertised with the same result. There is no direct financial input either by the Federal Government or professional societies to stimulate interest in geriatrics within the Schools of Social Work. On the whole the Directors feel that there is an increasing emphasis on aspects of aging particularly in social policy and planning.

Some work is being done in Schools of Social Work in Ontario in the field of aging. The Faculty of Social Work, University of Toronto[3] has three professors interested in the subject on a personal basis. For example, Dr. Nathan Markus, used his sabbatical leave to continue his studies in research in the field of aging. Health and Welfare Canada supported his research. Two other professors have been active in accommodation problems for the elderly and in income security. Field work opportunities for students in the Faculty of Social Work have been expanded and there are more placements in institutions and programs for the aged this year than in previous years.

On a statistical basis little progress has been made: of 398 Master of Social Work theses completed at the Toronto School of Social Work, between 1942 and 1962, only thirteen are related to the field of aging; in the period 1963-1973, of 440 individual Master of Social Work theses only 18 dealt with the aged. In addition, three group research reports, out of a total of 44, dealt with the aged. Between 1966 and 1973, a total of 729 Master of Social Work degrees have been granted by the University of Toronto, an average of 104 graduates per year. It is estimated that between 5 and 8 per cent are engaged in the field of aging. From the above it is evident that there has been little movement on the part of social work students and graduates to do research and to practices in the field of aging.

The School of Social Work, University of Windsor,[4] offers a half-course option (Services for Aging) in the fourth year and a half-course option is again available to the graduate students on Intervention for the Aged. They have had two Master's theses on aged persons in the last two years. They also arrange field work placements in the fourth and fifth years in settings where work is directly with the aged persons.

Wilfrid Laurier University[5] is increasing interest on problems of the aged in its clinical and social policy courses. There is a university project on pre-retirement planning carried on by the educational services and this has been quite successful.

The School of Social Welfare, University of Calgary,[6] reports that they have two graduates of their master's program who are particularly involved in the geriatrics field. A serious drawback is the lack of provision either in the form of finances or professional staff for the supervision of students in field situations.

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(1) Canada. Health and Welfare, Medical Care Division. Telephone communication, March 28, 1974.

(2) Replies were received from ten Schools of Social Work:
University of Toronto, Toronto, Ontario
University of Windsor, Windsor, Ontario
Memorial University, St. John's, Newfoundland
University of Saskatchewan, Regina, Saskatchewan
Dalhousie University, Halifax, Nova Scotia
University of Calgary, Calgary, Alberta
Carleton University, Ottawa, Ontario
McGill University, Montreal, Quebec
Wilfrid Laurier University, Waterloo, Ontario
University of British Columbia, Vancouver, British Columbia

(3) University of Toronto, Faculty of Social Work. Letter dated October 24, 1973.

(4) University of Windsor, School of Social Work. Letter dated August 20, 1973.

(5) Wilfrid Laurier University, School of Social Work. Letter dated August 30, 1973.

(6) University of Calgary, School of Social Welfare. Letter dated October 9, 1973.

While specific instruction in Geriatric medicine is not now available at the majority of the schools of medicine across Canada, several have plans to introduce some aspects into their curriculum or clinical training.[1] For example, the University of Calgary,[2] a new school of medicine, plans for the provision of information to the health needs of elderly people in their residency training in family practice. Consideration is being given to structuring a geriatrics department at University of British Columbia Faculty of Medicine.[3] Students at the School of Rehabilitation Medicine receive lectures on rehabilitation problems in old age. The School of Nursing also has a lecture course on geriatric nursing. Shaughnessy Hospital, which has well established geriatric programs, will be a setting for more formal teaching of this subject.

The Faculty of Medicine at Western Ontario[4] has established an ad hoc committee on Geriatric Medicine which is considering ways and means of giving greater emphasis to Geriatrics in the undergraduate medical curriculum. The Continuing Education Program is also provided a refresher Day in Geriatric Medicine April 10, 1974.

The Faculty of Medicine at the University of Alberta[5], has provided fragmentary exposure to elective programs in geriatric medicine. In 1970 the Continuing Medical Education Division conducted a workshop in Geriatric Medicine which they hoped would attract some 20 physicians. In fact, only nine attended in addition to 44 nurses. Another effort was made in April 1974. The consensus is that it has not been possible to stimulate sufficient interest in the medical problems of the elderly to influence graduates to do full time work in the field.

There has been considerable progress at the University of Manitoba[6] where as early as 1968 the Curriculum Revision Committee recommended that 12-15 hours of instruction in geriatrics be provided in the Core Curriculum for medical students. The second year student now has 12 hours. In January 1972 there was established a Geriatric Clinical Teaching Unit at Deer Lodge Hospital available to third year medical students, as well as students from other disciplines such as Nursing, Physiotherapy, Occupational Therapy and Environmental Studies. The Royal College of Physicians and Surgeons of Canada recognize up to 12 months of experience on the Geriatric Clinical Teaching Unit as accepted training. However, professional training in the medical field is somewhat impeded because the Royal College of Physicians and Surgeons of Canada does not have a subspecialty of Geriatrics. A third year major elective is also available to third year students.

Queen's University[7] in 1967 established a School of Rehabilitation Therapy which has already graduated three classes of physiotherapists and occupational therapists. While specific instruction is not being given in Geriatric Medicine, Rehabilitation Medicine, which is an important part of the modern concept of health care delivery to older people, has been established as a department in the Faculty of Medicine at Queen's. The establishment of a Division of Geriatric Medicine is presently underway in the University Department of Medicine with a clinical base in the university-affiliated hospital at St. Mary's on the lake in Kingston.

A Residency Training Programme in Rehabilitation Medicine has been established within the Faculty of Medicine and a number of postgraduate and continuing medical education courses in the area of Rehabilitation Medicine and Geriatric Medicine have been offered in recent years. At least one recent graduate from Queen's is engaged in Rehabilitation in the Geriatric age groups.

A study in the area of Geriatric health care delivery is also being conducted by the Department of Community Medicine at Queens.

Within the Institute of Medical Science, the University of Toronto,[8] a major study on the epidemiology of psychiatric disease in the elderly is being carried out at the Clarke Institute. Within the Faculty of Medicine various departments are engaged in different approaches to the problems identified by the Senate Committee:

Department of Behavioural Science.

Department of Obstetrics and Gynaecology—two members have special interests in geriatric gynaecology in addition to undergraduate and graduate programs regarding the problems of aging in the female.

Department of Opthalmology—special studies on "Electroretinogram in senile macular degeneration". In this connection a visual testing service has been set up at the Toronto General Hospital to detect early functional defects in aged people.

Department of Pharmacology—maintains a part-time appointment for clinical pharmacologist with special experience in geriatrics.

Department of Preventive Medicine—Specialist in Gerontology has assembled a study group on teaching of geriatrics within the medical school.

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(1) Replies were received from nine Medical Schools:
University of Calgary, Calgary, Alberta
University of British Columbia, Vancouver British Columbia.
University of Western Ontario, London, Ontario
University of Alberta, Edmonton, Alberta
University of Manitoba, Winnipeg, Manitoba
Queen's University, Kingston, Ontario
University of Toronto, Toronto, Ontario
Dalhousie University Halifax, Nova Scotia
McGill University, Montreal, Quebec

(2) University of Calgary, Faculty of Medicine. Letter dated August 14, 1973.

(3) University of British Columbia, Faculty of Medicine. Letter dated August 20, 1973.

(4) University of Western Ontario, Faculty of Medicine. Letter dated September 18, 1973.

(5) University of Alberta, Faculty of Medicine. Letter dated September 18, 1973.

(6) University of Manitoba, Geriatric Clinical Teaching Unit. Letter dated October 16, 1973.

(7) Queen's University, Department of Rehabilitation Medicine. Letter dated October 2, 1973.

(8) University of Toronto, Faculty of Medicine. Letter dated November 23, 1973.

Although there is considerable activity in this field at the University of Toronto, the Dean of Medicine has expressed the view that it is difficult to assess the effect of these programs in relation to recent graduates who have specialized in working with the aged, since geriatrics, per se, is not a separately categorized discipline. Canada boasts at most 25 gerontologists.[1]

Although Schools of Social Work and Medicine have not acknowledged any federal grants for geriatric study, Health and Welfare Canada (Welfare) have provided the following information relative to welfare services for the total population.

An increased supply of welfare workers and improvements in their qualifications is encouraged by the provisions of the Canada Assistance Plan of 1966 and the National Welfare Grants program. Funds are not allocated to any particular field of welfare, but are allocated in response to demand.

The Canada Assistance Plan provides for federal sharing (50 per cent) with the provinces in extensions and improvements of welfare services since the base year 1964-65. Included as items of shareable costs are those associated with attendance at conferences and seminars if the topics are related in a direct way to the planning, development or provision of welfare services. Shareable expenditures related to training costs include costs of in-service training programs, including fees for instructors hired for the purpose, and costs of employees taking formal training on a full or part-time basis. The primary objective of these provisions is to support improvement of the social work qualifications of personnel engaged in the provision of welfare services. Training in other disciplines can be supported if there is clear evidence that the skills obtained will be used on a continuing basis in the provision of welfare services. In addition to graduate training, social service training at the technical level is covered by these provisions. However, full-time undergraduate university training is excluded since it is more appropriately covered under other arrangements.

The National Welfare Grants program provides funds for manpower utilization and development, including grants to Schools of Social Work for teaching and field instruction, welfare scholarships, and welfare fellowships to individuals seeking advanced training in the social welfare field.[2]

The basic nursing education course has no special content related to geriatrics as the nurse must be prepared to meet general situations. If a specialty is required in operating room nursing, urology, etc., competence in the chosen field is acquired through special courses which may be a certificate course or by in-service training. If a nurse were interested in specializing in geriatric care, she would be advised to apply for employment in an institution which is noted for its expertise in this field. Other training is acquired through "institutes" which may be of three days or three weeks' duration. From information available there are no "certificate courses" available in geriatrics. Graduates in nursing science may also take a Master's degree in a specialty which could be geriatics.[3]

Community colleges in Ontario which are now involved in preparing students for a nursing career include nursing homes for the elderly as centres where practical experience may be gained. For example, Algonquin College in Ottawa channels their students through six nursing homes on the basis of two days a week over a period of approximately four months.

Recommendation 32

That at the local level devices be developed to ensure cooperative planning and action between the Departments of Health and Welfare in Municipal Governments and between them and other local Government Departments and the various voluntary and professional organizations in the community concerned with the health and welfare of the elderly.

ACTION TAKEN

The Social Planning and Review Council of British Columbia[4] in their report—A Study of Community Care for Seniors—released in December 1972—commented on the lack of instructional resources and programs for the elderly in British Columbia. Particular reference was made to the lack of coordination of community services: overlapping and missing areas; lack of uniformity in funding or costs of services; lack of uniformity in geographic units for planning and delivery of services and lack of communication between government departments, between community agencies (public, private and institutional), between professionals.

The Alberta study (Medical Problems and the Use of Medical Services Among Senior Citizens in Alberta April 1973) recommended that at the local level in Edmonton, the Socal Service Advisory Committee assume a strong coordinating role, acting on behalf of all city departments in closer liaison with various private agencies in the city. The report referred to programs for the elderly sponsored by L.I.P. and O.F.C. and commented that basic programs cannot be left to casual efforts only. "In all cases health and related service programs should be strengthened and/or developed in the context of the overall blueprint..."[5]

(1) Canadian Council on Social Development *On Growing Old*, 2 June 1973.
(2) Canada. Health and Welfare Canada. Letter from Deputy Minister of Welfare, dated February 12, 1974.
(3) Canadian Nurses Association. Ottawa. Telephone Communication, April 10, 1974.
(4) Social Planning and Review Council of British Columbia. *A Study of Community Care for Seniors*, Vancouver 1972.
(5) Snider. Earle, *Medical Problems and the Use of Medical Services Among Senior Citizens in Alberta: A Pilot Project*, Edmonton, Medical Services Research Foundation of Alberta, 1973.

In their report to the Government of Saskatchewan, the Senior Citizen's Commission recommended that "the provincial government establish an Agency as part of a new deal for the elderly in Saskatchewan."[1] This agency would consist of a provincial council, regional councils and local council to ensure co-operation in planning. The objectives and purposes of each council are set forth in this report.

A similar comment was made in the White Paper on Health Policy for Manitoba July 1972: "If the strength of the public health services in Manitoba lies in its internal structure, its weakness is found in its relationship to other services. In most parts of the province, public health personnel do their work quite independently of the local hospital and the local practising physicians. There is no formal integration."

In February 1971 the Section on Aging, Ontario Welfare Council submitted its report of the Health Aids Committee.[2] It considered the provision of an initial assessment and referral service at points where older people tend to gather, such as Elderly Persons Centres, senior citizens housing and senior citizen organizations as an effective way of building a bridge between services for older people. It endorsed the recommendation of the Select Committee on Aging that the province make grants-in-aid for the establishment of information and referral services for the aged in every community, using available community welfare councils, regional welfare offices, health departments or units and other appropriate agencies. A study prepared by the Public Policy Concern for Information Canada in March 1971 recommended that the Government of Canada pursue the objective of supporting the efforts of the Canadian people in the 1970s to create Community Information Centres as person-centred, two-way media of enquiry and expression. In 1970 Ontario launched a community information centre project to investigate through involvement the role of the government in such centres. One of the recommendations that came out of this study was that specialized centres, such as information centres for the aged, be supported by the appropriate government departments.

Quebec's[3] proposed policy (November 1973) emphasizes decentralization and the establishment of regional centres which will determine the individual's need.

In February 1973 the Minister of Public Health of Nova Scotia released the first report of the Nova Scotia Council of Health. The council was asked to study the health system of the province and recommend a program designed to improve the delivery of health care in the future. The report recommended a complete restructuring of the administration of personal health services emphasizing administrative boards at the local level. These community boards would be responsible for the administration of all health services in their area and would be able to integrate health services with other social services. Regional boards, made up of representatives of community boards, were also proposed. They would assist with joint planning between communities in specified areas and develop and administer cooperative programs. The new organization is intended to encourage a new and more flexible approach to health care delivery that will emphasize community-oriented treatment programs concentrating on improved home care and ambulatory care and emphasizing prevent.[4]

A comprehensive survey of the whole system of health services and related social services is now being conducted in Prince Edward Island.[5] The Provinces of New Brunswick[6] has established an Inter-departmental Committee on the Care of the Aged. This Committee has not yet made a final report, but is expected to do so within the next few months.

Recommendation 33

> That Provincial Departments of Health establish special branches to concern themselves with the health problems of older people and that there be a continuing liaison between such branches and corresponding branches in Departments of Welfare in order to endure joint consideration of matters of mutual concern, such as rehabilitation service, care of elderly people in institutions, organized Home Care programs, etc.

ACTION TAKEN

Concern has been voiced about the need to establish special age-structured sections within the Department of Health. There appears to be a growing emphasis on health programs for the total population.

The Province of Alberta does not have a special section within the Department of Health and Social Development, although there are other age-structured sections such as the Department of Culture, Youth and Recreation.[7]

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(1) Saskatchewan. Department of Social Services, *If you feel . . . change is possible*, Report by the Senior Citizen's Commission, Regina, 1974, p. 64.

(2) Ontario Welfare Council Section on Aging. *Report of the Health Aids Committee*. February 1971, p. 7.

(3) Ouellet, Aubert, "Politique du Ministère des Affaires sociales relative à l'hébergement des personnes âgées". Symposium sur la gérontologie, Hôpital Notre-Dame de la Merci, Montréal, 17 novembre 1973.

(4) Canadian Medical Journal. March 3, 1973. Vol. 102, No. 5, *Special Report*.

(5) Prince Edward Island. Department of Health. Letter dated August 28, 1973.

(6) New Brunswick. Department of Health. Letter dated August 17, 1973.

(7) Snider, Earle, *Medical Problems and the Use of Medical Services Among Senior Citizens of Alberta: A Pilot Project*, Edmonton, Medical Services Research Foundation of Alberta, 1973, p. v.

A recent report by the Senior Citizen's Commission in Saskatchewan[1] recommended that the services to the aged provided by the Departments of Public Health and Social Services be integrated formally into an agency.

In 1972 the Department of Health and Social Development for the Province of Manitoba[2] established a branch for the elderly with a social worker as the director.

It is not anticipated in Ontario[3] that the formal structure of the Ministry of Health will include special branches responsible for age-structured components of the population and more specifically for the health problems of the elderly.

New Brunswick[4] has recently appointed an Extended Care Consultant to provide consultative and advisory services to all divisions of Health. There is also an interdepartmental Committee on the Care of the Aged.

Although there are many services being provided to the aged, it has not been deemed necessary to establish a separate department to correlate the function of such services in Nova Scotia[5] or to Newfoundland.[6] In Prince Edward Island[7] there is a Division of Aging in the Department of Social Services but not in the Department of Health.

Recommendation 36

> That the data related to the aged which is provided by provincial hospitalization and health insurance schemes be more fully analyzed, interpreted and made more readily available.

ACTION TAKEN

Statistics Canada staff coordinates information provided by the provinces. The staff do not analyze information re specific age groups.

A change has been made in the statistical program to show a breakdown in the category age 65 and over into 65-74 and 75 in the annual publication of hospital separations from 1969 onwards.[8]

Recommendation 37

> That statistics relating to the health of the aged, as currently assembled by the Department of National Health and Welfare and the Dominion Bureau of Statistics, be reviewed with a view to their extension and improvement: and that in this connection particular attention be given to the definition of various kinds of sheltered accommodation.

ACTION TAKEN

Statistics are always under review and a working party on patient classification system has produced a revised draft which is now with the provinces for study. Other changes which have taken place are:

(1) The publication of new primary sites of malignant neoplasms by age, including 65-69, 70-74, 75-79, 80-84 and 85.

(2) The initiation of a program to list and survey special care facilities which would include nursing homes and homes for the aged. Funds are currently being sought to accelerate and improve the coverage of this survey.[9]

Recommendation 38

> That greater financial assistance be provided for research into the nature of aging, the cause and control of diseases and disabilities with a high incidence among old people, and into the effectiveness of existing programs of prevention, diagnosis, treatment and rehabilitation.

ACTION TAKEN

The Deputy Minister of Health made the following statement to the Standing Committee on Health, Welfare and Social Affairs on May 20, 1971:

> "I do not think we have figures on geriatrics.... (It) is pretty hard to identify as being geriatric research because cardiology, for example, or respiratory disease research—a lot of it is for geriatric patients. It is not identified as such..."
>
> "I think a lot of the research which is not called geriatrics is really research in geriatrics."

The following is taken from the introduction to Volume I, "Aging in Manitoba, Needs and Resources, 1971"—

> "Historically, within the field of special gerontology and that of health and welfare services to the aged, research has proceeded at an irregular pace with a great diversity of problems being investigated. Both the problems being considered and the pacing have reflected continuously changing emphases with resultant stop-gap measures to cope with pressing problems in a manner appropriate to emergency solutions rather than to long-range planning..."[10]

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(1) Saskatchewan. Department of Social Services, *If you feel a change is possible*, Regina, 1974, p. 64.
(2) Manitoba. Department of Health and Social Development. Letter dated December 2, 1973.
(3) Ontario. Ministry of Community and Social Services. Letter dated November 28, 1973.
(4) New Brunswick. Department of Health. Letter dated August 31, 1973.
(5) Nova Scotia. Department of Public Health. Letter dated October 29, 1973.
(6) Newfoundland. Department of Health. Letter dated August 10, 1973.
(7) Prince Edward Island. Department of Health. Letter dated August 31, 1973.
(8) Canada. Statistics Canada. Letter dated August 24, 1973.
(9) Canada. Statistics Canada. Letter dated August 24, 1973.
(10) Manitoba. Department of Health and Social Development. Division of Research, Planning and Program Development. Report 1.1.73.

NOTE: See Recommendation 80.

Recommendation 51

That consideration be given to the advisability of establishing a committee of knowledgeable citizens to be advisory to the minister and the department or agency on all aspects of social housing.

ACTION TAKEN

In Newfoundland[1] the Newfoundland Association for the Aging has been organized with the objective of bringing the housing and other needs of the aging to the attention of the government and the public generally. There is close liaison between organization and the Newfoundland and Labrador Housing Corporation (1967).

The Nova Scotia[2] Housing Commission and its Executive Committee are composed of knowledgeable citizens to whom staff members are responsible.

There is a Board of Directors of the New Brunswick[3] Housing Corporation charged with this task. In addition the province has a committee on Care for the Aged and a Task Force on Housing Needs. The Department of Social Service has a "Desk for the Aged" to provide advisory services.

The Prince Edward Island[4] Housing Authority (1969) has a Board of Directors representative of citizens from outside the Public Service. In cooperation with the Department of Development and CMHC, an Island study of housing requirements is being undertaken.

Quebec[5] now has regional health and social service councils charged with the responsibility of encouraging regions to define their housing priorities and submit their plans. The councils will regulate and supervise charitable institutions within their territory, presumably including non-profit housing sponsors.

Ontario[6] Housing Corporation's Board of Directors has representatives along the lines suggested.

Manitoba[7] has no citizens advisory committee as such. An effort is made to involve senior citizens through meetings with various groups both urban and rural.

Saskatchewan[8]—The Saskatchewan Housing Corporation Act (1973) provides for the establishment of a Housing Advisory Committee.

Alberta[9] Housing Act provides for an Alberta Housing Advisory Committee which to date (August 73) has not been constituted. Annual briefs are submitted by Alberta Senior Citizens Homes Association and Alberta Council on Aging. Only in 1970 did the province take advantage of NHA funds to assist its housing foundations program for elderly.

The administration of public housing in British Columbia[10] is undergoing a restructuring at the present time. The British Columbia Housing Management Commission created in 1967 brought together the three levels of public servants involved in housing: two representatives from CMHC, two from the province and one from the municipality.

Recommendation 56

That the provincial department or agency accept as a matter of principle the importance of enabling old people to continue in their own homes as long as possible and that where group living short of medical care, is desired or required, it be provided in relatively small projects scattered throughout the community rather than in large institutions.

ACTION TAKEN

The principle of enabling older people to stay in their own homes as long as possible is generally accepted across Canada but few provinces have taken constructive action to assist those occupying privately owned homes.

The National Housing Act has provision for rehabilitation grants to improve neighbourhoods, but as of September 1973 not all provinces* had signed the federal-provincial arrangements.

Provinces differ as to the best location for senior citizen housing: Manitoba prefers to build close to downtown, within walking distances of shops and amenities; in New Brunswick public housing may only be built in municipalities with hospitals and auxiliary homes. To overcome the difficulties faced by the elderly who have to go to shopping centres for their marketing, a modern senior citizen development at Pierrefonds, Quebec, provides free transportation for its residents to nearby shopping centres.

"Beyond Shelter"[11] records that, up to 1970, of the 746 developments built under the provisions of the National Housing Act, 244 developments or 33 per cent had 20 or less dwelling units and/or hostel beds; 153 developments or 20 per cent had 21-40 units and/or hostel beds; 199 developments or 27 per cent had 41-80 units and/or hostel beds; 95 developments or 13 per cent had 81-149 units and/or hostel beds; and 55 developments or 7 per cent had 150 or more units and/or hostel beds. Thirty-two per cent were located in metropolitan areas; 7 per cent were situated in major urban areas and 61 per cent in small towns.

(1) Newfoundland and Labrador Housing Corporation. Letter dated August 7, 1973.
(2) Nova Scotia Housing Commission. Letter dated August 28, 1973.
(3) New Brunswick Housing Corporation. Letter dated October 26, 1973.
(4) Prince Edward Island Housing Authority. Letter dated August 6, 1973.
(5) Canadian Council on Social Development Ottawa. *Beyond Shelter*, 1973, p. 67.
(6) Ontario Housing Corporation. Letter dated July 31, 1973.
(7) Manitoba Housing and Renewal Corporation. Letter dated August 8, 1973.
(8) Saskatchewan Housing Corporation. Letter dated August 2, 1973.
(9) Alberta Housing Authority. Letter dated August 20, 1973.
(10) Canadian Council on Social Development Ottawa. *Beyond Shelter*, 1973, p. 87.
* Ontario.
(11) The Canadian Council on Social Development. *Beyond Shelter*, 1973, p. 43.

A British Columbia study of community care for seniors, included among "Pressing Needs" supportive services to help maintain the elderly in their own homes, including assistance with shopping, home repairs, library services and transportation. Sixty per cent of the homemakers interviewed indicated a wide gap in this service to senior citizens.[1]

The Prairie Provinces lead in this field. In May 1973 Saskatchewan[2] passed Bill No. 59 which provides for grants to certain elderly persons to assist them in making repairs to their homes with a view to enabling them to remain independent longer. Manitoba's[3] provincial employment program included work activity projects directed towards improving the standard of housing privately owned by senior citizens. The program has now reached out to 10,000 homes and is judged a success. The Alberta[4] Hospital Services Commission is giving a priority to home care programs to enable the elderly to remain as long as possible in their own homes. Programs are already available in cities and a few towns and plans are underway to extend the services to smaller communities.

In November 1973 the Minister of Social Affairs for the Province of Quebec[5] released a "White Paper" which set out proposals to establish policy for those in "The Third Age" group. The main emphasis is on future planning oriented toward community assistance to enable the elderly to remain in their own homes as long as possible.

The Advisory Task Force on Housing Policy[6] submitted its report to the Province of Ontario in June 1973. Forty-six briefs were submitted to the Task Force and fifteen public meetings were held dealing with special housing needs of senior citizens. All aspects of housing problems were covered: the need for "in-home services" to assist more elderly people to remain in their homes, the pros and cons of high-rise buildings, the type of units, integration with young adults with children, etc. The Ontario Welfare Council[7] has been working with senior citizen groups, with elderly individuals and with relevant social agencies to find out what the priority problems are and what might be done to relieve them with special emphasis on helping the elderly to maintain their independence. Recommendations will be included in the Agency's 1974 annual brief to the Ontario Government.

(1) Social Planning and Review Council of British Columbia. *A Study of Community Care for Seniors*, Vancouver, 1972, p. 39.
(2) Saskatchewan Housing Corporation. Letter dated August 2, 1973.
(3) Manitoba Housing and Renewal Corporation. Letter dated August 8, 1973.
(4) Alberta Housing Corporation. Letter dated August 20, 1973.
(5) Ministère des Affaires Sociales—Document de travail. Document préliminaire visant à l'établissement d'une politique du MAS à l'égard du troisième age. November 1973.
(6) Ontario. Advisory Task Force on Housing Policy. Report, June 1973.
(7) Ontario Welfare Council. *Ottawa Journal*, December 27, 1973.

New Brunswick[8] endorses the objective of maintaining senior citizens in self-contained accommodation. Group homes are usually small.

The Nova Scotia Housing Corporation,[9] through the Municipal Housing Authorities, only accommodates those elderly people who wish to move from their existing housing. The type of building used by N.S.H.C. ensures continued independent living with the advantages of being part of a group in cases of emergency and for reasons of social comfort. Only in the Halifax Metropolitan Area is the N.S.H.C. forced, by reasons of economics, to build senior citizen housing projects of greater size than twenty to thirty apartments.

The Prince Edward Island Housing Authority[10] policy is to supply senior citizens' housing in localities in or near where the demand has been established. In most instances units have been built in small groups—generally six to ten units on any one site. The main exception to this has been in Charlottetown.

Newfoundland[11] also agrees with the concept and assists wherever a need is demonstrated.

Recommendation 59

> That, with the advice and financial assistance of the two senior levels of Government, each municipality survey the nature and extent of local need and develop a comprehensive and balanced plan for meeting it, with the understanding that such plan must fit in with that of the province, and at the same time be integrated with the municipality's own total housing program.

ACTION TAKEN

As a result of amendments to the National Housing Act, the Federal Government provides 90 per cent of financing and the province the other 10 per cent which means that the municipality has no financial responsibility to assume in respect of housing accommodation. Newfoundland[12] and Prince Edward Island[13] assume full responsibility for the programs for the municipalities (except in the few large centres in each province) because of the lack of any economic base in the municipalities. Studies are now being carried out in this area by New Brunswick.[14]

Nova Scotia[15] requires a resolution from the municipality.

(8) New Brunswick Housing Corporation. Letter dated October 26, 1973.
(9) Nova Scotia Housing Commission. Letter dated August 28, 1973.
(10) Prince Edward Island Housing Authority. Letter dated August 6, 1973.
(11) Newfoundland and Labrador Housing Corporation. Letter dated August 7, 1973.
(12) Newfoundland and Labrador Housing Corporation. Letter dated August 7, 1973.
(13) Prince Edward Island Housing Authority. Letter dated August 6, 1973.
(14) New Brunswick Housing Corporation. Letter dated October 26, 1973.
(15) Nova Scotia Housing Commission. Letter dated August 28, 1973.

As of the Summer of 1973, Ontario[1] required the municipality to determine its need if family and senior citizen housing is managed by a Housing Authority. The Ontario Task Force report of August 1973 criticized the system prevailing during the period of its review:

> "Municipal development regulations are almost always administered in the absence of a municipal housing policy. The housing goals of most municipalities are not explicitly formulated, but are simply implicit in the numerical distribution of population and residential density. These are intended to control the development of land rather than ensure adequate accommodation. Regional development planning is a provincial responsibility, but proceeds with little reference to housing... The Province has indicated that it intends to delegate responsibility and authority for regulating community development to municipalities particularly at the regional municipality level. The formulation and application of provincial regional plans has proceeded with little regard to this intention, at least in the Central Ontario Region."[2]

Manitoba[3] and Saskatchewan[4] emphasize that they implement housing programs in close cooperation with the municipality which must substantiate any requests made to the province. Saskatchewan has a research team investigating the need for additional housing especially in smaller municipalities which were formerly excluded from the Act. Alberta[5] develops its planning and programs in collaboration with the municipalities.

Recommendation 60

> That through the cooperation of municipal health and welfare departments and with financial aid from the Provincial Government ancillary services be made available and accessible to elderly people.

ACTION TAKEN

Supportive programs which help elderly persons to remain active and involved in their community and to remain in their own home need to be expanded to be accessible and responsive to the distinctive needs of the elderly. They are:

Meals on wheels
Friendly visiting
Telephone checks
Transportation
Counselling
Information
Home Aid
Day Care
Recreational and social clubs
Employment skills unlimited
Sheltered workshops
etc.

In British Columbia over 50% of the supportive services to the elderly, such as meals on wheels, friendly visiting, recreational camps and summer centres for seniors are being provided by church groups or informal groups of persons rendering supportive person-to-person services. These programs were developed and operated by volunteers. More than fifty per cent of the volunteers in the programs are over 65 years of age. Some 70 senior citizens located in key population areas throughout British Columbia[6] assist their contemporaries to solve their problems whatever they may be. The Counsellors are volunteers who are assisted financially with individual expenses up to $40 a month. The program was administered by the Division of Aging, Department of Rehabilitation and Social Improvement.

In Ontario, the Community Care Services (Metropolitan Toronto) Incorporated evolved because of the desire of voluntary services to cooperate with groups providing complementary services. It is a type of umbrella organization that deals with all levels of government, with other voluntary groups and with funding sources with and on behalf of the groups involved. It makes use of the provisions of the Elderly Persons Centres Act, 1966 and Regulations.[7]

The Canadian Council on Social Development, *Beyond Shelter*[8] reported that public housing residents had a considerably lower rate of physical incapacity than non-profit housing residents: 76 per cent of public housing developments reported that over three-quarters of their residents had no physical incapacity—compared with 55 per cent of non-profit developments. This difference may be accounted for by the large proportion of hostel accommodation in the non-profit sector. There was not a great deal of regional variation in residents' health—except in Quebec. There only nine per cent of developments reported that over three-quarters of their residents had no physical incapacities.

The Study also reported that a homemaker service was available as a special development service in 7% of the developments and as a community service in 33%. A homemaker service was available in four per cent of the self-contained developments, compared with 18 per cent of the hostels and mixed developments. In 39% of the self-contained developments it was available in the community. Such services are more likely to be available in Ontario and least likely in the Atlantic Provinces.

(1) Ontario Advisory Task Force on Housing Policy, Toronto, 1973.
(2) *Ibid.*
(3) Manitoba Housing and Renewal Corporation. Letter dated August 8, 1973.
(4) Saskatchewan Housing Corporation. Letter dated August 2, 1973.
(5) Alberta Housing Corporation. Letter dated August 20, 1973.
(6) British Columbia. Department of Rehabilitation and Social Improvement. Division on Aging. *Annual Report 1972*, p. N57.
(7) Social Planning Council of Metropolitan Toronto. A Special Report in the Trends Series, 1972-73. *The Aging.*
(8) Canadian Council on Social Development. *Beyond Shelter*, Ottawa, 1973, p. 108.

Meal delivery was available in six per cent of the developments; in another 32 per cent it was available as a general community service. This service is more likely to be available in metropolitan and large urban areas than in small towns. Again it is more available in Ontario than in other provinces.

Home nursing was supplied as a special development service by public health nurses or the Victorian Order in only eight per cent of the developments; in another 65% it was available as a general community service. Seventy-five per cent of self-contained developments had the service available from the community. Home nursing was most available in Ontario and least available in Quebec. This is explained by the fact that most Quebec developments have nurses on their own staff although not necessarily providing "home nursing" to particular residents.[1]

Only nineteen per cent of the developments provided a regular medical checkup for residents. In 11% it was provided on site and in the other 8% in the community. Again such a service was more available in metropolitan developments than in major urban and small town areas. A full-time physician was on staff in only two developments. In three per cent a physician made regular daily or weekly visits. In another 29% a doctor was available on call. Of course a physician was more likely to be available to developments with a high proportion of incapacitated residents—and much more likely in Quebec.

Telephone contact service was operated in 17% of the developments surveyed, and was most likely to be available in British Columbia, Quebec, Prairies, Ontario and Atlantic Provinces, in that order.

Volunteer transportation was being provided for 24 per cent of all developments: thirty per cent of non-profit developments had service but only 14% of the public housing developments for senior citizens. Public transport systems were non-existent or ineffective in most developments. The Social Planning Council of Metropolitan Toronto considered the lack of adequate public transportation as a special problem in their 1973 report. "It is not only access to transportation that is important. Suggested improvements include consideration of vehicle design, rerouting buses, maintaining buses on subway lines and adjusting traffic signals and safety installations."[2]

Many municipalities provide cheaper transportation to their senior citizens. The Provincial Government in British Columbia, according to the annual report of the Department of Rehabilitation and Social Improvement (March 1972) subsidize British Columbia Hydro bus transportation for a nominal fee, valid in the Greater Victoria and Greater Vancouver areas.[3]

(1) *Ibid.*, p. 132.
(2) Social Planning Council of Toronto, *The Aging* Toronto 1973, p. E32.
(3) British Columbia. Department of Rehabilitation and Social Improvement, *Annual Report 1972*, Victoria.

The Manitoba Housing and Renewal Corporation[4] reports that they require any plan submitted to them for the housing of elderly people to include space for centres which are generally organized on behalf of the tenants by the tenants or by private social agencies.

The Department of Social Affairs, Province of Quebec[5] has announced new policies for the care of the aged. The emphasis is now on providing supportive services to the aged to enable them to maintain their independence.

Recommendation 61

> That the municipal department or agency responsible for housing cooperate with other municipal departments and voluntary organizations in the community in the establishment of advisory and referral centres to assist old people with their housing and other problems related to their changing conditions and needs.

ACTION TAKEN

With few exceptions organized information and referral services are operated as a department or services of social planning councils in large centres. Elderly people seem to be unaware of the services offered and do not usually consult them.

British Columbia has its senior citizen counsellor program who are assisted financially with individual expenses up to $40 a month. Referral Services are provided to a limited degree from the Provincial Department of Rehabilitation and Social Improvement, from private family agencies and centres in Vancouver and Victoria. Skilled counselling services are very limited throughout the province. Information centres have been set up in many communities in the Lower mainland. These are community operated to offer assistance to all age groups.[6]

The Prairie Provinces seem to be particularly well organized in this field, e.g., the Alberta[7] Housing Corporation has a liaison with the Hospital Services Commission and the Department of Social Development as well as a consulting service with the Alberta Senior Citizens' Homes Association and the Alberta Council on Aging. In Manitoba[8] the Age and Opportunity Bureau in Winnipeg is active in this area and in Saskatchewan[9]

(4) Manitoba Housing and Renewal Corporation. Letter dated August 8, 1973
(5) Ouellet, Aubert, "Politique du Ministère des Affaires sociales relative à l'hébergement des personnes âgées. Symposium sur la gérontologie, Hôpital Notre-Dame de la Merci, Montréal, novembre 1973.
(6) Social Planning and Review Councils of British Columbia, *A Study of Community Care for Seniors*, Vancouver, 1972, p. 39.
(7) Alberta Housing Corporation. Letter dated August 20, 1973.
(8) Manitoba Housing and Renewal Corporation. Letter dated August 8, 1973.
(9) Saskatchewan Housing Corporation. Letter dated August 2, 1973.

there are advisory and referral centres to assist the elderly with their housing and other problems. These include the Provincial Inquiry Centre, Community Switch Boards, Senior Citizens' Commissions. The province also assists in the organization and support of pensioners organizations in all communities throughout the province.

In Ontario[1] the housing element is the responsibility of the Ontario Housing Corporation while the other elements are channeled through the appropriate Ministries.

New Brunswick[2] has an interdepartmental committee which is now in the process of studying such problems as setting up adequate advisory facilities for its senior citizens. In Nova Scotia[3] the municipality housing committee is in contact with municipal welfare and health departments but does not have a formal referral system. In Prince Edward Island[4] and Newfoundland[5] the Provincial Housing Corporation will be organizing activities because of the small economic base.

Recommendation 62

That changes be made in zoning laws where necessary to make a variety of housing accommodation, such as cooperative residences, small houses and flats, boarding houses, etc., more widely available throughout the community.

ACTION TAKEN

In most provinces the municipality initiates by resolution its requirement for public housing for the elderly and for others requiring low cost housing accommodation. If there is a local Housing Authority it establishes the need and the method to carry out the project. The Provincial Corporation has the overall responsibility as it finances the project and assumes responsibility to completion.

Canada's small rural towns present special problems to those wanting to develop satisfying housing for the elderly chiefly because the population base is too small to afford many public facilities and services. New Brunswick[6] uses central planning to probably a greater extent than other provinces. Zoning is a municipal responsibility. Prince Edward Island[7] has special arrangements with CMHC whereby senior citizens units are constructed on sites not served by sewage collection and treatment because of the many areas in Prince Edward Island which have not this service.

(1) Ontaro Housing Corporation. Letter dated July 31, 1973.
(2) New Brunswick Housing Corporation. Letter dated October 26, 1973.
(3) Nova Scotia Housing Corporation. Letter dated August 28, 1973.
(4) Prince Edward Island Housing Authority. Letter dated August 6, 1973.
(5) Newfoundland and Labrador. Housing Corporation. Letter dated August 7, 1973.
(6) New Brunswick Housing Corporation. Letter dated October 26, 1973.
(7) Prince Edward Island Housing Authority. Letter dated August 6, 1973.

The Nova Scotia[8] Housing Commission is attempting to make full use of the available by-laws in its land assembly areas to make a wide variety of housing available to the public. The Newfoundland and Labrador[9] Housing Corporation is investigating current and future needs of housing for the aged; they will be working closely with Municipal Governments particularly in the larger urban centres.

The Prairie Provinces state that because of the availability of land, zoning has not become a problem. In Saskatchewan[10] it has not been necessary to change the zoning laws to allow for a variety of housing accommodation for the elderly. Because of the relative availability of land, the types of houses constructed have met with zoning regulations and where there have been minor technicalities involved, the municipal councils have been very co-operative in allowing minor changes to permit the construction of the desired units. Alberta[11] has encountered no major problems in zoning and the Housing Corporation reported that the co-operation of the municipalities has been excellent. Zoning procedures in Manitoba[12] provide for a general mix of housing types. It has been regarded by the Manitoba Housing Corporation as a wise policy to try to disperse housing as much as possible throughout the community to avoid the problems created by adverse community reaction to huge housing projects.

Recommendation 63

That the municipal department or agency include on its staff one or more specialized persons to assist voluntary sponsoring groups and, in particular, to provide information regarding monies available from all sources, building regulations, local bylaws, siting, procedures, etc.

ACTION TAKEN

Few municipalities have staff qualified to assist voluntary sponsoring groups except to refer them to the proper Housing Authority which is qualified to do this. Town Clerks are qualified to supply information regarding zoning bylaws, etc.

Recommendation 65

That Municipal Governments accept responsibility for providing leadership and initiative in the planning and development of the range of community services required for the well-being of old people, themselves establishing or financing those services that fall under their statutory jurisdiction while working with voluntary agencies or other levels of Government in the establishment of others.

(8) Nova Scotia Housing Commission. Letter dated August 9, 1973.
(9) Newfoundland and Labrador Housing Corporation. Letter dated August 7, 1973.
(10) Saskatchewan Housing Corporation. Letter dated August 2, 1973.
(11) Alberta Housing Corporation. Letter dated August 20, 1973.
(12) Manitoba Housing Corporation. Letter dated August 8, 1973.

Recommendation 66

(a) That on the initiative of the Municipal Government, the local welfare council or other appropriate body, a representative committee, including appointees from the Municipal Government, be established for the purpose of surveying the local situation with respect to community services and facilities available to old people, and

(b) That this committee include in its investigation not only those health and welfare services, such as visiting nurses and homemakers, which would enable the aged to live in their own homes rather than in institutions, but also facilities and programs in the areas of recreation, education and community service which would enable them to continue as participating and contributing members of society, and

(c) That on the basis of the above survey, a plan be developed (i) to ensure communication and cooperation among all organizations and groups seeking to serve the aged and (ii) to extend and improve existing facilities and programs, and to establish new ones as required, and

(d) That in the implementation of this plan financial and technical help be sought from provincial and federal authorities along the lines indicated in later sections of these recommendations.

ACTION TAKEN

In Newfoundland[1] and Prince Edward Island[2] the province accepts the overall province-wide leadership in arranging community programs because of a lack of a financial base in small communities.

In 1968 Halifax, Nova Scotia[3] established a Social Planning Department which recommends programs and services to meet the needs of the elderly and to collaborate with others to provide an umbrella of services. In 1971 a study was carried out by the city of Halifax on the Problems Encountered by Aging.

In Quebec,[4] health and welfare are provincial matters; the municipalities only show an interest in recreation and leisure programs.

The Ontario[5] Select Committee on Aging, 1967, reiterated the views expressed by the Senate Committee Recommendations. Sixty per cent of the recommendations of the Select Committee have been fully or partially implemented. The remainder are still under review or are considered "not practical for Ontario alone without cooperative changes at the federal level" or are no longer applicable.

In Manitoba,[6] the Provincial Government accepts responsibility for overall province-wide leadership, and only in the city of Winnipeg, through its public health program, does a municipality take an active role. The Department of Health and Social Development has undertaken an extensive survey of the needs and resources concerning older persons. Volume one was published in 1973[7]

In Saskatchewan[8] the Municipal Governments are becoming increasingly involved in encouraging the development of community services for the aged. Provincial grants are made to community based projects such as meals-on-wheels, information and referral services, etc. The Municipal Parks and Recreation Boards in most provinces take an active part in providing facilities for older people and in arranging programs for them.

The 1973 study on the needs of the elderly in Alberta[9] recommended that at the local level in Edmonton, the Social Service Advisory Committee assume a coordinating role, acting on behalf of all city departments in closer liaison with private agencies.

The Social Planning and Review Council of British Columbia completed a study of the needs of the aged in British Columbia.[10] At the moment British Columbia is in the midst of considerable reorganization of its social services, and further information is not available.

Generally speaking, the services and resources available to elderly people depend to a large extent on municipal funds, the demand on these funds and the local potential for planning and developing programs. All services must be supported by the total citizen group by taxes, voluntary efforts and contributions. The financial assistance provided under the Canada Assistance Plan has been effective in releasing funds of voluntary agencies to accelerate community projects.

Senior citizen groups are very active in all provinces but they are not supported from public funds. A few organizations such as "The Good Companions" in Ottawa receive assistance from the United Appeal and, in this case, the accommodation was provided by a local service organization.

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(1) City of St. John's, Newfoundland. Letter dated August 15, 1973.
(2) Prince Edward Island. Department of Social Services. Letter dated August 24, 1973.
(3) City of Halifax, Nova Scotia. Letter dated November 23, 1973.
(4) City of Montreal, Quebec. Letter dated August 14, 1973. City of Sherbrooke, Quebec. Letter dated August 2, 1973.
(5) Ontario. Ministry of Community and Social Services. Letter dated November 28, 1973.
(6) Manitoba. Department of Health and Social Development. Letter dated December 2, 1973.
(7) Manitoba. Department of Health and Social Development. *Aging In Manitoba*, Volume I—Introductory Report, Winnipeg, 1973.
(8) Saskatchewan. Department of Social Services. Letter dated August 21, 1973.
(9) Snider, Earle. *Medical Problems and the Use of Medical Services Among Senior Citizens in Alberta: A Pilot Project*, Edmonton, Medical Services Research Foundation of Alberta, 1973.
(10) Social Planning and Review Council of British Columbia. *A Study of Community Care for Seniors*, Vancouver, 1972.

The Social Planning Council of Metropolitan Toronto in their "Trend Series, 1972-73" remark:

> "Existing service systems are changing but remain inadequate to meet the demands for services by the elderly. What is needed is a concept for a continuum of services and facilities from which individuals can select in accordance with current and changing needs. To this end it is necessary to examine the range of requirements of those in need of services, modify patterns of delivery and create more and possibly new systems tailored to the requirements of the elderly...
>
> Administrators of health and social services are becoming extremely sensitive to social, economic and political forces and to their impact on their institutions. Such administrators are well on their way to bringing about changes that are required to make our hospitals comprehensive community health centres.
>
> The Government is becoming the enunciator of social policy on health and social service matters and increasingly a purchaser of services. Services are beginning to change from a production to a marketing orientation and organizations are looking to the people they serve."[1]

Recommendation 68

> That the Municipal Government, through its local public welfare department where such has been instituted, accept responsibility for seeing that an information and referral centre is established for the use of old people and others in the community seeking advice on their problems.

ACTION TAKEN

Neighbourhood information centres are to be found in many Canadian cities in a variety of shapes and guises. *Information Centres: A Handbook for Canadian Communities,*[2] published by the Consumers' Association of Canada lists Information Centres in Canada. The following table[3] illustrates the number of Information Centres by province:

Alberta	6
British Columbia	17
Manitoba	7
New Brunswick	2
Newfoundland	1
Nova Scotia	3
Ontario	43
Prince Edward Island	1
Quebec	19
Saskatchewan	2
Yukon	1
TOTAL	102

(1) Social Planning Council of Metropolitan Toronto, *The Aging—Trends, Problems, Prospects*, Toronto, 1973, pp. E14-15.
(2) Consumers Association of Canada. *Information Centres: A Handbook for Canadian Communities*, Ottawa, 1973.
(3) *Ibid.*, p. I—i-iii.

Some are financed entirely through local United Appeal contributions, some entirely by their Municipal Government and others through a mixture of Government grants and contributions from the community at large and/or from voluntary organizations. A review of community information centres for all age groups was carried out by the Government of Canada in December 1970.

In March of the same year the Canadian Welfare Council (now the Canadian Council on Social Development) issued a report of their Committee of the Division on Aging on Information and Referral Services for the Aged in Canada.[4] They found that direct services for the aged were in short supply practically everywhere in Canada. With few exceptions, organized information and referral services are operated as departments or services of social planning councils in large centres. Services provided appeared to be oriented to the types of problems which the general public identified with "welfare". The bulk of the information was given by telephone and personal visits were discouraged.[5]

In the Spring of 1971 the Canadian Council on Social Development initiated a National Consultation on Community Information and Referral Services.[6] The steering committee in its recommendations emphasized the necessity for the neighbourhood information centre to reflect the characteristics, needs and aspirations of the neighbourhood in which it operates and that the centre should be supported but not controlled by funding bodies including Governments. Among the guiding principles to be followed was the recommendation that the centre should provide information to cover all aspects of social development including: income security, social welfare, health, manpower and employment, recreation, legal assistance, consumer protection. The Report set out the responsibilities of the three levels of Government: Federal, Provincial and Municipal.

Partners in Information, a study of community centres in Ontario, was published in December 1971. At that time some 15 provincially supported centres were included in the study.[7]

In 1971 the Consumers' Association of Canada sponsored a study of community information centres in Canada. The study, undertaken in conjunction with the Canadian Computer-Communications Task Force, presented a comprehensive overview of the centres, their functions and activities.[8] As a follow-up the Association sponsored a further investigation with the assistance of the Federal Department of Communications with the special view of determining the role of data banks in assisting the centres in handling requests for information for their users.

(4) Canadian Welfare Council, *Information and Referal Services For The Aged in Canada*, Ottawa, 1972, 18 pages.
(5) *Ibid.*, pp. 6-8.
(6) The Canadian Council on Social Development. *Issues for Citizen Information Services*, Ottawa, 1971.
(7) Government of Ontario. *Partners in Information*, Toronto, 1971.
(8) Starrs, Cathy, *Making Connections*, Consumers Association of Canada, Ottawa, 1973.

A Handbook for Canadian Communities—Information Centres (1973)—has been compiled and is being prepared for publication. It lists the various centres throughout Canada showing the various groups which the centre serves such as native people, ethnic groups, immigrants, alcoholics, drug addicts, welfare and legal requirements, etc. Senior Citizen Information is provided by some centres.

Basic services are available in British Columbia through the provincial offices of Rehabilitation and Social Improvement, from private agencies in Vancouver and Victoria and from the social services departments of several hospitals. SPARC survey in 1972 reported that skilled counselling services were limited throughout the province.[1]

The survey on the medical problems and the use of medical services among Senior Citizens in Alberta[2] found that the physician was the "father confessor" for the aged rather than organized services of which the elderly were frequently unaware. It was found that counselling, a necessary health-related service for the aged, was badly needed. The Annual Report of the Alberta Health and Social Department 1971-72 lists three information and Referral Centres in its preventative social services.

Saskatchewan[3] reports that some communities have information and referral services established by interested people in the area. They rely heavily on provincial subsidy. In Manitoba[4] information and referral centres are available in larger urban areas such as Winnipeg and Brandon. The main information and referral services, outside Government offices, used by the elderly in Winnipeg are those offered by the Age and Opportunity Centre, a private agency funded by United Way and provincial and municipal grants.

Recommendation 69

> That the Municipal Government, through its public welfare department where such has been established, and the voluntary family welfare agency, if such exists, extend and improve counselling services to old people, and that, under the auspices of one or both, a carefully supervised foster home placement service for old people be developed.

ACTION TAKEN

The problem of terminology is encountered under this item. In some provinces "foster home" refers to homes for children only; in other provinces it relates to persons released from mental institutions who still require some degree of supervision and are placed with private families who provide the necessary care and supervision.

The 1972 study conducted by the Social Planning and Review Council of British Columbia[5] concluded that skilled counselling was very limited throughout the province although some 70 volunteers are paid a nominal sum by the province to provide advice and referral services to the elderly at various places throughout the province. The study recommended that there be an increase in counselling services at the municipal level to assist those senior citizens who wish to maintain their own homes. British Columbia in 1972 had some 7,400 beds in licensed boarding home care facilities, i.e., for mobile persons whose physical and/or mental disability is such that they need supervision. These homes are licensed under the Community Care Facilities Licensing Act if the capacity is over three boarders.

The 1973 report on the problem and the use of medical services among the senior citizens in Alberta[6] observed that present programs tend to overlook the vast majority of senior citizens who live on their own and attempt to remain independent. "More health and related programs should be of the 'outreach home-centered' variety. Programs today rely too often on individual initiative and physician care exclusively.... Greater efforts should be made towards the establishment of counselling and visitor programs to help reduce feelings of anxiety and loneliness among the elderly." The Annual Report of the Department of Health and Social Development for Alberta, 1971-72 commented that they were working towards the acquisition of private homes for patients discharged from hospitals.

Saskatchewan[7] reports that there are no counselling centres set up specifically for the aged nor are there supervised foster homes placements available to the elderly in the province.

In Manitoba[8] counselling services are available in Winnipeg and the large urban centres; otherwise the availability and quality vary. Provincial Care Services in Winnipeg provide a program for those in need of out-of-hospital care, including foster homes.

One of the recommendations of the Ontario[9] Select Committee on Aging 1967 was that studies be initiated of requirements in each region of Ontario for domiciliary, sheltered and foster care for aged persons. This has been done. Homes for special care and supervised boarding homes come under the Ontario Nursing Homes Act. The term "foster home" is usually reserved for accom-

(1) Social Planning and Review Council of British Columbia. *A Study of Community Care for Seniors*, Vancouver, 1972, p. 7.
(2) Snider, Earle. *Medical Problems and the Use of Medical Services Among Senior Citizens in Alberta: A Pilot Project*, Edmonton, Medical Services, Research Foundation of Alberta, 1973, p. vi-v.
(3) Saskatchewan. Department of Social Services. Letter dated August 21, 1973.
(4) Manitoba. Department of Health and Social Development. Letter dated December 2, 1973.
(5) Social Planning and Review Council of British Columbia. *A Study of Community Care for Seniors*, Vancouver, 1972.
(6) Snider, Earle. *Medical Problems and the Use of Medical Services Among Senior Citizens in Alberta: A Pilot Project*, Edmonton, Medical Services Research Project, 1973.
(7) Saskatchewan. Department of Social Services. Letter dated August 21, 1973.
(8) Manitoba. Department of Health and Social Development. Letter dated December 2, 1973.
(9) Ontario. *Final Recommendations of the Select Committee on Aging*, 1967, 5th Session, 27th Legislature, 15-16 Elizabeth II.

modation for children. In 1967 counselling on family and indivdual problems of aging was available in 20 Ontario cities at family service agencies.

The economic status of municipalities in Newfoundland[1] and Prince Edward Island[2] do not permit independent programs. Provincial authorities assume responsibility except in the capital cities where voluntary organizations participate.

Nova Scotia[3] has been active in the foster home program for adults discharged from mental hospitals. Municipalities share in the cost and are active in the regional boards. The city of Halifax reported that a shortage of foster homes prevented them from launching a more extensive program to provide for others.

Recommendation 70

> That local institutions and agencies serving adults, including the schools and universities, the churches, social agencies, the public library, art galleries and museums, community centres and other recreational groups, experiment with changes in their programs and procedures with a view to encouraging greater participation on the part of older people.

ACTION TAKEN

There has been an increased awareness of the senior citizen all across Canada. They enjoy reduced fares on almost every form of transportation, public buses, airlines, etc. However, some municipalities have not found it possible to reduce fares for senior citizens on local transportation facilities. (Example—Halifax). Admission to theatres is also available at a reduced rate and the National Arts Centre in Ottawa not only provides reduced admission prices for some events but also arranges special programs for senior citizens.

The United Church of Canada prepared an outline of a series of evening programs to assist congregations who are concerned with the problems of the aged.[4] Within the past year, the United Church of Canada has also engaged a commercial research organization in Toronto to study various aspects of the requirements of the elderly.[5] The theme for the social action branch of The Canadian Catholic Conferences in 1972 was the rights, dignity and needs of the elderly to promote parochial action in this field.[6]

Senior citizens are organized across the country and have been very effective in making their cultural and recreational requirements known to their municipalities. In Ottawa civic staff of the Department of Parks and Recreation are working at 20 subsidized housing developments, supervising recreation programs such as swimming, crafts classes, etc. The city also provides transportation to various events organized by voluntary agencies. Community colleges and some universities provide courses in continuing education which are of interest to senior citizens. Pre-retirement courses are also offered at the secondary education level in most large centres and in regional secondary schools.

A Canadian Institute of Religion and Gerontology is being organized in Toronto with the aim of helping churches and religious orders to set up programs for the aging for retirement. It is also hoped to provide enriching study for senior citizens in such subjects as cultures, scripture, etc.[7]

Recommendation 71

> That municipalities, in seeking to fill the gaps between existing and needed services and facilities, give particular attention to the possibility of establishing homemakers' services and day-care centres.

ACTION TAKEN

A "homemaker" differs from the domestic in that he or she works under professional supervision. In some areas training is mandatory, some being provided at community college level, whereas in other areas no special training is required. In the period 1958-69 the total number of homemakers in Canada increased more than five-fold, much of this increase having been aided by federal cost-sharing since 1969 under the Canada Assistance Plan. A survey[8] by the Canadian Council on Social Development released in March 1971 reported that homemaker services tend to be concentrated in the larger cities with 42% of the agencies and two out of every three homemakers located in urban centres of over 100,000 population. Within Canada the supply of homemakers was unevenly distributed as between provinces and population centres of different sizes. At that time Manitoba was the most favourably endowed with the equivalent of 32 full-time homemakers per 100,000 population, followed by British Columbia with 21 and Ontario with

(1) Newfoundland and Labrador. Department of Health. Letter dated August 10, 1973.
(2) Prince Edward Island. Department of Social Services. Letter dated August 24, 1973.
(3) Halifax, Nova Scotia. City Planner. Letter dated November 23, 1973.
(4) United Church of Canada. *Resources for Senior Adult Work*, Toronto.
(5) Environics Research Group Ltd., *Survey of Media Patterns and Preferences of Senior Citizens in Metropolitan Toronto*, Toronto, 1972, 13 pages and 19 page questionnaire.
(6) Canadian Catholic Conference, Social Welfare Bureau, *The Aged in the Family of Man*, Ottawa, 1972.
(7) Canadian Institute of Religion and Gerontology, Toronto. Letter dated December 8, 1973.
(8) Canadian Council on Social Development, *Visiting Homemaker Services in Canada*, Ottawa 1971, pp. 13-14.

11. The survey covered the total need for homemakers by families including the elderly. Rural areas and communities under 10,000 population were the least well served with the notable exception of British Columbia. *Beyond Shelter*[1] (1973) reported that homemaker service was available in 7% of the NHA developments and as a community service in another 33%. The service was most likely to be available in Ontario and least likely in the Maritime Provinces.

The cost of the service to the recipient is geared to income; the recipient of an old age pension with the supplement pays nothing whereas those with independent income pay the full cost. The local United Appeal usually contribute to the cost of this program.

The Visiting Homemakers Association of Canada located in Ottawa report a shortage of homemakers to meet the demand for their services.

The term "Day Care Centre" is usually associated with the care of children. Because of this it is impossible to determine from provincial annual reports whether the statistics refer to "Day Care Centres" for children or the elderly. Prince Edward Island[2] reported that there were no day care centres for the elderly and Halifax was endeavouring to find a location for one centre.[3] Ottawa[4] in the fall of 1973 opened its first Day Care Centre for the elderly and it is reported that the great deterrent is the lack of transportation to and from the centre.

The Social Planning and Review Council of British Columbia[5] reported that Vancouver is in the process of developing personal care and supervision along with socialization and activity programs. Vancouver has one Day Care Centre and the North Shore area under a LIP program has established a need for such a service.

A day hospital is a facility which enables patients to arrive in the morning, spend several hours in therapeutic activity and return home the same day. In March 1971 the Health and Social Development Minister of Alberta announced that three geriatric "day" hospitals would be established in Edmonton and Calgary, on a pilot project basis.[6] Two will be located in Calgary, the other in Edmonton.

(1) Canadian Council on Social Development, *Beyond Shelter*, Ottawa, 1973.
(2) Prince Edward Island. Letter dated August 24, 1973.
(3) City of Halifax. Letter dated November 23, 1973.
(4) Island Lodge. Telephone Communication, November 28, 1973.
(5) Social Planning and Review Council of British Columbia, *A Study of Community Care for Seniors*, Vancouver, 1972, p. 91.
(6) Government of Alberta, News release, March 21, 1973.

Recommendation 72

That careful consideration be given also by Municipal Governments to the need for sheltered workshops open to all persons in the community, including the aged, who are unlikely to enter or re-enter the labour market, but who require work activity in a protected setting.

ACTION TAKEN

The Canadian Council on Social Development in their survey of NHA-financed housing for the elderly found that there were crafts rooms in 25 per cent of the developments; in another 12 per cent there was one nearby in the community.[7] Such a room was much less likely to be available in self-contained units than in hostel and mixed accommodation; only 13 per cent of self-contained developments had a crafts room, compared with 61 per cent of hostel and mixed. A crafts room was more likely to be in non-metropolitan areas.

Senior Citizen Organizations have taken advantage of grants under New Horizons to establish handicraft centres where articles are produced for sale; such centres are to be found in St. John's, Newfoundland and in Sydney, Nova Scotia.

There are only two sheltered workshops for the elderly in Canada; both of these are operated by Jewish welfare organizations, one in Toronto and one in Montreal.

Recommendation 73

That, in line with their constitutional responsibility for the provision of essential welfare, educational and recreational services, Provincial Governments give particular attention to the serious gaps and deficiencies currently existing in all of these fields, as they relate to the needs of old people.

Recommendation 74

That, with a view to bringing about the changes called for in the above situation, Provincial Governments through their departments of health, welfare and education provide strong leadership to local communities and in particular assist their efforts through initiating and publicizing a program of technical advice and field service and through the preparation of materials for program planning and staff training.

ACTION TAKEN

Although all the provinces are falling short in what should be done to fill the serious gaps and deficiencies existing in all fields related to senior citizens, most provinces are as active as their budgets permit, taking

(7) Canadian Council on Social Development, *Beyond Shelter*, Ottawa, 1973.

NOTE: See Recommendation No. 81.

into account the demands made by other problems such as pollution control, etc. Some of the provinces have divisions on aging.

Since 1967 the functions of the Division on Aging in the Department of Rehabilitation and Social Improvement for the Province of British Columbia[1] have been gradually directed toward service-oriented programs for the elderly. Over 70 senior citizens located in key population areas throughout the province assist their contemporaries to solve their problems whatever they may be. These counsellors are volunteers who are assisted financially with individual expenses up to $40 a month.

Persons in receipt of any portion of the Federal guaranteed income supplement of the Provincial Supplementary Social Allowance are entitled to free transportation over the British Columbia Bus system in Greater Vancouver and Greater Victoria on payment of a $5 fee every six months.

Over 25 activity centres for adult handicapped persons during the period under review were assisted in various amounts from $300 to $1,700 per month.

The Division on Aging maintains almost daily contact with many senior citizen and pensioner organizations.

In Alberta a joint (Alberta Council on Aging and Department of Health and Social Development) study of the general needs of institutionalized and noninstitutionalized senior citizens across Alberta was scheduled for 1973. The pilot project on Senior Citizens in Alberta[2] (1973) stressed the need for more activities for Senior citizens.

The Senior Citizens Commission of Saskatchewan assumed the responsibility of examining deficiencies and making recommendations regarding new programs, especially for small communities. Their report[3] issued in January, 1974, recommended that the provincial government establish an Agency as part of a new deal for the elderly in Saskatchewan. Guidelines for the duties and responsibilities of various levels of this Agency are outlined.

The Manitoba[4] Department of Health and Social Development reported that the Provincial Government has taken more responsibility over the past decade in the development of courses for staffs in care facilities, for encouraging and assisting administrators of care facilities in developing programs, holding seminars and particularly in assisting care facilities in the development of activity programs and the training of staff for such.

In 1967 Ontario[5] established a Select Committee on Aging. As of October 1973 42% of the recommendations of the Committee which dealt with all aspects of aging, had been implemented and another 18% had been partially implemented. There was a 9% increase in the implementation of recommendations between May 1971 and October 1973. In March 1970 the Department of Social and Family Services of the Ontario Government held the first Ontario Elderly Persons Centres Conference to discuss the best way to develop a provincial network of high quality day centres for older people. Again in Ontario the province sets aside one week each year devoted to the aging. Kits are prepared and sent to communities and organizations; in 1973 the emphasis was on "Living can be Ageless". For the first time the Provincial Government introduced a province-wide pre-retirement campaign directed toward men and women who are 40 years of age and over.

During the years 1967-70 the Government of Quebec[6] funded a program to train people in the specialized care of older persons. The program was conducted by the Grey Nuns of Montreal.

Nova Scotia[7] has a Social Development and Rehabilitation Division within its Welfare Department which emphasizes the importance of community participation to determine the needs of the people. During 1971-72, 30 students were employed to plan activity programs in 15 Homes for the Aged and Disabled. There is also a Social Research and Planning Division which serves as a coordinating and resource body for the planning and organization of research projects, studies and briefs relating to the changing needs of the Department and as an instrument for disseminating information on welfare programs in Nova Scotia. One of the projects has been the preparation of a directory of social services in the Halifax-Dartmouth region. Although the emphasis is on family and youth, many of the programs could be used by the aging.

In New Brunswick[8] The Community Relations Division coordinates the Department of Welfare Programs with private welfare services. This involves promoting and participating in programs for the full involvement and education of community groups, client groups, voluntary agencies and the general public with regard to services, goals and objectives in social welfare.

In Newfoundland[9] the Department of Rehabilitation and Recreation is responsible for aging. Prince Edward Island[10] has a Division of Services to Aging within their Department of Social Services.

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(1) British Columbia. Department of Rehabilitation and Social Improvement, Division on Aging. *Annual Report 1972*, p. N57.
(2) Snider, Earle, *Medical Problems and the Use of Medical Services Among Senior Citizens in Alberta: A Pilot Project*. Edmonton, Medical Services Research Foundation of Alberta, 1973.
(3) Saskatchewan. Department of Social Services *If you feel... Change is possible*, Regina, 1974, 144 pages.
(4) Manitoba. Department of Health and Social Development. Letter dated December 2, 1973.
(5) Ontario. Ministry of Community and Social Services. Letter dated November 28, 1973.
(6) Canadian Welfare Council. On Growing Old. Vol. 9, No. 1, March 1971, p. 9.
(7) Nova Scotia. Department of Public Welfare. *Annual Report for year ending March 31, 1972*, pp. 61 and 78.
(8) New Brunswick. Department of Social Services. *Annual Report 1971-72*.
(9) Newfoundland and Labrador. Department of Health. Letter dated August 10, 1973.
(10) Prince Edward Island. Department of Social Services. Letter dated August 24, 1973.

Recommendation 75

That grants be made available by Provincial Governments, independently or on a shared basis with the Federal Government, for:

(a) The construction and operation of day-care centres, community recreation centres and sheltered workshops;

(b) The conduct of training courses and institutes for professional, technical and volunteer workers in the area community services; and

(c) Demonstration projects for old people in fields like meal service, recreation programs, camping, preparation for retirement and adult education.

ACTION TAKEN

The Federal Government does not contribute by way of capital assistance to workshops but will contribute to the operational cost. Capital grants are made by Ontario and Alberta. All provinces share in the operational cost. Provincial grants are available for day care centres which are few for the elderly. The term "day care centre" in most provinces relates to facilities for children. Day care centres, where organized, are financed by the province, municipality, volunteer agencies and the United Appeal. Senior citizens recreation centres, where separate from the community centre, are usually provided by a local service agency. Operational costs come from fees, United Appeal and Municipal Parks and Recreation.

Ontario[1] is the only province to provide both capital and operating grans to elderly persons' centres and community centres. Ontario also reported that they are sponsoring many training courses and institutes for professional, technical and volunteer workers in the area of community services for the aged. Although Ontario does not have specific demonstration projects, the province supports a number of programs related to recreation, preparation for retirement and adult education, from at least two areas of the Ministry of Community and Social Services.

Manitoba[2] reports that some action has been taken in this area especially in the larger centres but much has to be done in the rural areas.

Many of the grants made by the Saskatchewan Government[3] for welfare or community services are cost-shared by the Federal Government. The grants are more related to program and staffing than toward capital costs of construction.

(1) Ontario. Ministry of Community and Social Services. Letter dated November 28, 1973.
(2) Manitoba. Department of Health and Social Development. Letter dated December 2, 1973.
(3) Saskatchewan. Department of Social Services. Letter dated August 21, 1973.

Beyond shelter[4] commented that group leadership or group work to assist residents to organize activities for themselves was available in only 9 per cent of the developments built under the NHA. In another 6 per cent of the developments, it was available elsewhere in the community. Hostel and mixed accommodation were considered more likely to have the services of a group worker on-site than were self-contained developments: the service was available in only 5 per cent of self-contained developments, compared with 17 per cent of hostel and mixed developments. Quebec had a considerably higher proportion of developments with group leadership services than other regions—perhaps because of its predominance of hostel accommodation as well as more widespread appreciation of social animation techniques in the province.

Recommendation 76

That the cost of homemakers be shared with municipalities on a basis which would permit the latter to provide this important service free to all old people who have a taxable income below a specified minimum, say $1,200 for a single person and $2,000 for a couple.

ACTION TAKEN

Financial assistance for homemaker service is available to a greater or lesser extent under provincial social legislation in all Canadian provinces.

Provincial and Municipal Governments underwrite the costs of providing homemaker service to recipients of social assistance. The service is on a "needs test basis" by virtue of the Canada Assistance Plan Agreement requirements.

Recommendation 77

That encouragement be given to local welfare departments to improve their counselling services and to make it available not only to people in financial need, but to all others in the community, including especially the elderly, and that the province share in the cost of this development.

ACTION TAKEN

Counselling and referral services come within the terms of the Canada Assistance Act but these services depend upon the province's and the municipality's ability to pay their share of the cost. Counselling services are usually available through regional offices but the problem seems to be that the majority of elderly people do not know of such services or where they are available. The study

(4) Canadian Council on Social Development, *Beyond Shelter*, Ottawa, 1973, p. 127.

by the Canadian Council on Social Development[1] found that in housing development surveyed social work counselling was available as follows:

	Available on site or as a special development service	Available in or for the general community	Not Available
In all Developments	6.1%	44.5%	49.4%
In Self-contained Developments	4.1%	45.1%	50.8%

Briitsh Columbia[2] has a senior citizen counsellor program. These counsellors are volunteers who are assisted financially with their nidividual expenses up to $40 per month. The program which comes under the Department of Rehabilitation and Social Improvement has been in operation for some years and has been well received.

The study on the Health Care and Non-Institutionalized Senior Citizen in Edmonton[3] recommended "greater efforts... towards the establishment of counselling and visitor programs to help reduce feelings of anxiety and loneliness among the elderly." The study found that the family doctor had become the "father confessor" and professional services where available were not being used to their maximum capacity.

The Province of Saskatchewan[4] plans to reorganize its social service department so that social workers will be able to devote more time to social services such as counselling for all age groups. Public Health nurses[5] made some 6,600 visits (34 per cent of total visits) to people over 65, one of their main aims being to promote rehabilitation activities.

Manitoba[6] reported that it funds the counselling offered through departmental offices and also makes funds available to the Age and Opportunity Centre and to the Brandon Senior Citizens Incorporated for counselling services.

Ontario[7] encourages local social service departments to increase counselling services through the media of such legislation as The General Welfare Assistance Act, the District Welfare Assistance Act, the District Welfare Administration Boards Act and a number of other programs of the Ministry of Community and Social Services.

(1) Canadian Council on Social Development, *Beyond Shelter*, 1973, pp. 128-129.
(2) British Clumbia. Department of Rehabilitation and Social Improvement, *Annual Report, 1972-73*, p. N 57.
(3) Snider, Erle L. Department of Sociology, University of Alberta. April 1973. The Medical Services Research Project: *Health Care and the Non-Institutionalized Senior Citizen in Edmonton*, p. 149.
(4) Saskatchewan. Department of Social Services. Letter dated August 21, 1973.
(5) Saskatchewan. Public Health *Annual Report, 1971-72*, p. 47.
(6) Manitoba. Department of Health and Social Development. Letter dated December 2, 1973.
(7) Ontario. Ministry of Community and Social Services. Letter dated November 28, 1973.

A research team from the Canadian Council on Social Development in a survey of NHA-financed housing developments for the elderly found that social work counselling was more available in Quebec[8] than in other provinces. In the housing developments surveyed in Quebec, social work counselling was available in relation to 51 per cent of the developments: in 6 per cent of the cases it was available on-site and in 45 per cent of cases it was provided elsewhere in the community. However, social work counselling was available on-site in only 4 per cent of the self-contained developments and in 12 per cent of hostel and mixed developments.

In New Brunswick[9] the Department of Social Services administers social assistance under a comprehensive program and in Nova Scotia[10] municipalities are reimbursed by the province for at least 75 per cent of the costs of assistance, services and administration. In Nova Scotia[11] municipal welfare departments work in close liaison with the Social Development and Rehabilitation Division of the Provincial Department of Public Welfare and many persons are referred to this division for counselling and rehabilitation services.

In Newfoundland and Prince Edward Island[12] the province assumes full responsibility for the costs of assistance and services to all needy persons.

Recommendation 78

> That the Welfare Branch of the Department of National Health and Welfare establish a special division for the purpose of providing technical advice and up-to-date information with regard to day care centres, homemakers, meal services, counselling and such other welfare services for the elderly as come within the department's terms of reference.

ACTION TAKEN

The Welfare Research Division of the Welfare Branch of Health and Welfare Canada has a Consultant on Aging who, on request, will provide information on various welfare services.

Recommendation 79

> That the Department of Labour, similarly, through such of its branches as is appropriate, assist the provinces in the development of services for older people in occupational training, placement, and rehabilitation.

(8) Canadian Council on Social Development. *Beyond Shelter*, 1973, p. 127.
(9) Health and Welfare Canada. *Social Security and Public Welfare Services in Canada*, 1972, p. 49.
(10) *Iid.*
(11) Nova Scotia. Department of Public Welfare. *Annual Report, 1971-72*, p. 54.
(12) Social Security and Public Welfare Services in Canada, *op. cit.*

ACTION TAKEN

The Department of Manpower and Immigration has an Older Workers Section, Special Programs Branch, which provides information on this subject.

Recommendation 80

That consideration be given to the possibility of earmarking for use in the field of aging a portion of the funds available for research, training and activity projects under the National Health Grants, the National Welfare Grants and the National Fitness and Amateur Sport Programs.

ACTION TAKEN[1]

Funds are not earmarked for specific purposes as each request for a grant is considered on its own merits. Otherwise funds may lie dormant awaiting worthy projects. The following are some projects carried out with the help of welfare grants:

1. Canadian Council on Social Development—Seminars for the development of administrators of Homes for the Aged and Training Institutes for directors of Senior Citizen Centres.
2. Jewish Home for the Aged Toronto—Activity Programs for Mentally Impaired Aged, 1969 to 1973 —Final Report.
3. Windsor, Hants County, N.S.—Research project on existing facilities and those required for the Community Care of the Elderly, 1967/68 grant completed.
4. Department of Health and Social Development, Manitoba—A survey of the aged to determine factors associated with successful placements in foster homes (1967/68 grant).
5. Social Planning and Research Council, Hamilton and District—Effects of Aging Process (1967/68 grant).
6. Saskatoon Senior Citizens Services Association and the Social Planning Council of Saskatoon—Factors which contribute to the Social and Economic Independence of People Over 60, and an evaluation of community services for senior citizens (1967/68 grant).
7. Conseil des Oeuvres et du bien-être de Québec— A study of homes for the aged in the Québec Diocese (1967/68 grant).
8. During 1970-71 a welfare grant was awarded to Laval University to study the relationship between certain events which occur during the second part of an individual's life and his adaptation to change.

In 1973-74 the University of Calgary will be studying "Successful Aging and Future Activities".

Among Health grants are the following:

University of Ottawa—A grant to evaluate the effectiveness of public health nursing in helping the elderly to maintain the independence required for living in an apartment building.

New Mount Sinai Hospital, Toronto—A grant to evaluate the role of hearing rehabilitation in the elderly; to study quality control of currently available hearing aids and to investigate the feasibility of organizing a health care delivery program for aural rehabilitation in the elderly.

When Dr. Roxburgh appeared before the Standing Committee on Health, Welfare and Social Affairs in 1971, he assured them that the total research program relating to the problems of the aging is growing, particularly with respect to heart and stroke and this type of disease entity. An examination of the 1972 listing of research projects and investigations into economic and social aspects of health care in Canada reveals that at least 12 projects have a direct relationship to the health care of the aging. The Canada Assistance Plan also makes funds available on a shared cost basis to provincial and municipal departments of welfare for research in welfare services. Priorities are determined by the provinces.

Activity programs are encouraged under the New Horizons program introduced in September 1972. Under this program funds are provided to groups of retired persons to enable them to participate in community life. To February 4, 1974 a total of 1675 projects had been approved for a value of close to $10 million.

Recommendation 84

That research be undertaken with a view to learning more about the daily life of older people and, in particular, about their leisure time interests and their attitudes to community programs of various types in this area provided for their benefit.

Recommendation 85

That in view of our present lack of knowledge about the leasure time needs and interests of older people, programs in this field be envisaged frankly as experiments with provision for the careful evaluation of the results achieved.

ACTION TAKEN

A special committee was appointed by the National Committee of the Division on Aging of the Canadian Welfare Council in June 1967 to explore learning opportunities for older people.[1] The Committee gave

(1) Canada. Health and Welfare Canada. Letter from Mr. A. W. Johnson, Deputy Minister of Welfare, dated February 12, 1974.

(1) Canadian Welfare Council, *Report of a Special Committee on Learning Opportunities for Older People*, Ottawa, 1970.

priority to the discussion of learning situations which seemed most meaningful to older people with some emphasis on how older people learn. It began by experimenting with the guided conversation, in an attempt to discover what older people themselves see as their educational needs. It continued by reviewing and discussing a few successful programs for older people which had a large learning component. The Committee also recognized that information services designed to serve elderly people and their relatives on a city-wide basis might have an excellent source about the educational needs of elderly people. This expectation was confirmed in a report made to the Committee about requests received by the Information Service of the Social Planning Council of Metropolitan Toronto.

The report by this special committee also included a description of some training event. The Prairie Christian Training Centre Experimental Event for people who work with older persons was held at Fort Qu'Appelle, Saskatchewan. The main objective of this four-day workshop was to discover more adequate ways for developing leadership for work with older people. A similar training event was held in May 1969 at Naramata Centre for Continuing Education in British Columbia.(1)

In 1972 the Communications Committee of the Toronto Area of the Presbytery of the United Church of Canada presented a brief to the Canadian Radio Television Commission on the general neglect of senior citizens' special needs by the broadcast media. A follow-up research project on the media patterns and the needs of senior citizens was designed.(2) There are four phases to this project: (1) the assessment of existing programming for senior citizens, (2) a survey of senior citizens' media patterns and preferences, (3) participation of various community organizations in defining the needs of senior citizens and experimentation with new programs, and (4) project evaluation and recommendations.

The Canadian Council on Social Development (formerly Canadian Welfare Council) included two workshops on the elderly at its annual conference in September 1973. The consensus was that planning agencies should find out what senior citizens want rather than provide what the agency thinks they need.

In an address to the Canadian Association on Gerontology, October 18, 1973, on "Under-valuing knowledge and over-valuing Research", Dr. David Schonfield, University of Calgary commented as follows:

> "When we consider the study of aging, that young science of gerontology, a conflict between knowledge and research might seem far fetched. Investigations of aging processes have attracted very few scholars and Canadian neglect of this area is truly lamentable. Funding by the Federal Government is less than 2 per cent of the comparable United States figures, probably less than 1 per cent, at a time when American gerontologists complain bitterly of inadequate Government support. It is only too easy to begin listing the research gaps where Canadian practitioners are, or should be, crying out for more knowledge —effects of our cold climate on activities provided for the aged; industrial gerontology in general and problems of retraining older workers in particular; influences of inflation on early retirement; comparisons between services in public and private nursing homes; causes and prevention of accidents in traffic and in the home. It is easy to begin such a list; it is difficult to stop. Nevertheless there can be little doubt that our first priority should be in the training of those who work or intend to work with the aged and the aging. Acquisition of existing knowledge, however limited, must take precedence over creating new knowledge."(3)

He went on to decry the lack of responsibility for making proposals about aging:

> "This vacuum of responsibility is a major cause of the history of failure among many Canadian enterprises established on behalf of the older part of our population. The Division on Aging of the Canadian Welfare Council has disappeared, as has the Institut de Gerontologie at L'université de Montréal. The journal, Vivre Longtemps has published its last issue and the minute Aging Section of the Federal Department of Manpower has a reduced establishment. There are rumours that the Office on Aging of the Ontario Government is on its way out. Undervaluation of knowledge and experience is demonstrated when such entreprises are allowed to disintegrate instead of being cherished.(4)

Recommendation 86

> That the foregoing activities be encouraged and that particularly in the Dominion Bureau of Statistics and the Department of National Health and Welfare, staff and budget be provided to strengthen existing programs of research and fact-finding in the aging field.

ACTION TAKEN

Although Health and Welfare Canada only show one office as being specifically assigned to work in the field of aging, studies in various branches encompass the over 60 group as well as other age groups of our population. Similarly in Statistics Canada, studies on the aged are

(1) *Ibid.*, pp. 13-16.
(2) Enivronics Research Group Ltd., *Survey of Media Patterns and Preferences of Senior Citizens in Metropolitan Toronto*, Toronto 1972, 13 pages and 19 page questionnaire.
(3) Schonfield, David. "Under-Valuing Knowledge and Over-Valuing Research", University of Calgary, 1973, p. 5.
(4) *Ibid.*, p. 7.

included in the overall picture. Statistics Canada report that the following changes have been made in their statistical program:

1. The breakdown of the category age 65 and over into 65-74 and 75 in the annual publication of hospital separations from 1969 onwards.
2. The publication of new primary sites of malignant neoplasms by age, including 65-69, 70-74, 75-79, 80-84 and 85.
3. The initiation of a program to list and survey special care facilities which would include nursing homes and homes for the aged. Funds are currently being sought to accelerate and improve the coverage of this survey.[1]

In the Department of National Health and Welfare, Treasury Board has approved increases in staff and budget for the Research Programs Directorate.[2]

Since the Report of the Special Committee of the Senate on Aging was published, the National Welfare Grants administration has strengthened its consultative services in all areas of its responsibility. Expenditures for Research grants have increased also but are subject to budget restrictions.

Funds available on a shared-cost basis under the Canada Assistance Plan to the provincial and municipal departments of welfare for research are not limited, that is, sharing is limited only by the amount of the claims submitted by the provinces.

Recommendation 87

(a) That on the initiative of DBS consultations be instituted at an early date with appropriate Federal and Provincial Government Departments, and non-governmental organizations interested, for the purpose of improving present statistics related to aging.

(b) That, further, DBS, take the measures necessary to match its achievements in the field of economic statistics with an integrated system of social statistics, which would contain a section on aging.

ACTION TAKEN

(a) See Recommendation No. 86.

(b) There is no special section on aging; information on this subject is on the same basis as other age groups.

Recommendation 88

That the Federal Government review the experience it has had with research grants in health, welfare, and related fields such as housing and rehabilitation, and give consideration to means that might be employed, possibly through earmarking certain of these grants, to encourage the development of research on aging, especially in those areas of major need and expenditure that are now neglected.

ACTION TAKEN

During the 1971 review of National Health and Welfare Estimates by the Standing Committee on Health, Welfare and Social Affairs,[3] the question was asked if there had been an increase in the money spent on research in the geriatric field. The Deputy Minister replied that it was "pretty hard to identify as being geriatric research because cardiology, for example, or respiratory disease research— . . . a lot of it is for geriatric patients. It is not identified as such. I do not think we have figures on geriatrics". Speaking for the Medical Research Council, the witness states:

> ". . . this is not broken down as a separate item in the way in which we look at our grants. So I really cannot answer your question. I can assure that it is growing, at least as fast as the total program, because these areas are of active concern, particularly with respect to heart and stroke and this type of disease entity. . . .One of the areas of concern to the Medical Research Council is related closely ot this, and this is rehabilitation medicine. There is very little activity in research in rehabilitation medicine in Canada, and it is an area in which the Council has attempted to arouse further interest and activtity. This is not all related to geriatrics, of course, but a good deal of it is."

A comprehensive study of housing for the elderly financed by CMHC under the provisions of the National Housing Act was published in July 1973 by the Canadian Council on Social Development. It was supported by a grant from Central Mortgage and Housing Corporation.[4]

Health and Welfare expects the evaluation of the effects of the New Horizons programs to produce findings which may have implications for other departmental programs in the area, for example, of unmet needs of the elderly.

Health and Welfare Canada through its health grants are sponsoring increasing numbers of research projects dealing exclusively with the problems of the elderly and other projects which are related to the total population

(1) Canada. Statistics Canada. Letter dated August 24, 1974.
(2) Canada. Health and Welfare Canada, Health Manpower. Letter dated August 8, 1973.
(3) Standing Committee on Health, Welfare and Social Affairs. May 20, 1971.
(4) Canadian Council on Social Development. *Beyond Shelter*. Ottawa, 1973.

but are of great importance to senior citizens, such as home care, day hospitals, community centres, etc.[1]

The problem of aging such as

1. Prevention of disease and deterioration in the aged; and
2. Rehabilitation of senior citizens

are considered to be priority areas for the National Health Grant Program.[2]

Recommendation 90

That in all municipalities and/or appropriate local regions, on the initiative of the public authority where necessary, an officially recognized body be established to plan and coordinate programs, facilities and services for older people and that the concern of such bodies embrace not only the areas of health and welfare but also living arrangements, employment, education and leisure time activities.

ACTION TAKEN

A survey of municipalities of various sizes across Canada showed that civic coordinating and planning groups are concerned with the total population rather than one segment. A unique umbrella organization is the Community Care Services (Metropolitan Toronto) Incorporated (1971) which provides a correlated system for the organization and management of resources to assist the aged, handicapped, chronically ill and convalescent persons. The city of Pembroke has used a LIP grant to establish a Pembroke and Area Community Service Corporation which is interested in the requirements of the area's senior citizens. In Quebec the municipalities are only concerned with recreation and cultural facilities; other requirements are dealt with by the province.

Recommendation 91

That Provincial Governments accept responsibility for the establishment of appropriate bodies for the planning and coordination of programs for older people within their jurisdiction and, that in doing so consideration be given to the proposals contained in the Saskatchewan and Ontario reports.

ACTION TAKEN

Six provinces have separate branches or divisions of Government to deal with the problems of the elderly (British Columbia, Manitoba, Newfoundland, Ontario, Quebec and Prince Edward Island). The proposals contained in the Saskatchewan and Ontario reports were not implemented.

(2) Canada. Health and Welfare Canada. *Research projects and investigations into Economic and Social Aspects of Health Care in Canada*, 1971, 1972.

(3) Canada. Health and Welfare Canada. Letter dated August 8, 1973.

(3) RECOMMENDATIONS THAT ARE NOT IMPLEMENTED

Recommendation 3

The Committee recommends that, on the initiative of the Federal Department of Labour, research be continued into the characteristics of older workers and the effect of age on specific abilities; and that efforts be made to get the findings of such studies translated into enlightened personnel policies and into conditions of work related to the changing capacities of the older worker.

ACTION TAKEN

Since 1966 the responsibilities of the Department of Labour have been altered. There is no research program on this subject being conducted within the Federal Government agencies, although studies and reviews are undertaken by the Older Workers Section of Canada Manpower. Dr. Leon Koyl of Sunnybrook Hospital, Toronto has developed a profile for measuring an individual's physical and mental capacities for work.

Investigation of aging process has attracted very few scholars. For example, of 398 Master of Social Work theses completed at the School of Social Work, University of Toronto,[3] between the years 1942-1962, only 13 are related to the field of aging. Between 1963-1973 of 440 Master theses, 18 dealt with the aged. It would appear that there is relatively little increase of interest among students in pursuing gerontological research questions.

Recommendation 9

That the Federal-Provincial Vocational Rehabilitation program be enlarged and strengthened to provide in greater measure for the rehabilitation of older workers, whose disability arises mainly from prolonged unemployment.

ACTION TAKEN

Health and Welfare Canada administers rehabilitation programs under the Vocational Rehabilitation of Disabled Persons Act.[4] Under this Act the Federal Government enters into agreements with the provinces for costs incurred by the province in undertaking a comprehensive program for the vocational rehabilitation of disabled workers. The province defines the eligibility of persons who are to be included; the main emphasis is on those persons who are suffering from a physical or mental disability.

The Rehabilitation Services Division of Health and Welfare Canada also includes a Work Activity Section. This section administers Part III of the Canada Assistance Plan which provides for shared funding by the Federal

(3) Correspondence School of Social Work, University of Toronto, October 24, 1973.

(4) Revised Statutes of Canada, 1970, Chapter V-7, Vocational Rehabilitation of Disabled Persons Act.

and Provincial Governments of programs to prepare unemployed persons for future employment. These programs use a comprehensive approach and include lifeskills, academic upgrading, counselling, family participation, and work exposure. Suggestions for programs are initiated by the provinces; projects may be sponsored through an agency or private group. The Federal Government pays fifty per cent of the cost; the remainder may be paid totally by the province, as is the case in Manitoba and New Brunswick, or the remaining fifty per cent may be shared by the province and the local municipality. At the present time the number of older workers involved in rehabilitation programs is minimal.[1]

Recommendation 15

That mass education programs for people of all ages with emphasis on the maintenance of good health throughout life as well as on the early detection of disease symptoms, be promoted extensively by Governmental and voluntary agencies, with the advice and cooperation of medical associations.

ACTION TAKEN

Health Education is under the Community Health section of Health and Welfare Canada. This section focuses on health education for people of all ages, not just the aging population.

Surveys conducted by organizations in British Columbia, Alberta and Ontario found that the majority of older people are unaware of the facilities, benefits and agencies which are already organized to assist them. There is great reliance on their physician to direct them when they are faced with a problem. Generally health literature is not for any one age group but is prepared for the total population. There is very little health education aimed at the elderly.[2]

"The benefits from effective instruction (in the promotion of health, information about illness, the available services and how to use them, etc.) could be very great, yet neither the effectiveness of such educational programs as do exist, nor the best ways of educating the public in matters of health so that they actually do something about it, have been studied in Canada... Only a considerable research effort, particularly in social and behavioural fields, can hope to provide some of the needed answers."[3]

Senior citizens in cooperation with Provincial Governments organize Senior Citizen Weeks. In Ontario in 1973 the theme was "Living can be Ageless."

(1) Canada. Health and Welfare Canada, Rehabilitation Services Letter dated March 28, 1974.
(2) Gibbon, Mary. "Health Maintenance Nursing: Implication of a Community Nurse", Victorian Order of Nurses Annual Meeting, Ottawa, 1973.
(3) Background Study for the Science Council of Canada, *Health Care in Canada: A Commentary*, August 1973, Special Study No. 29, p. 135.

Recommendation 20

That local health and/or welfare departments keep a register of all people aged 65 and over in their communities and that public health nurses and/or social workers make contact with such older people and visit them periodically if such visits are necessary and desired.

ACTION TAKEN

Except in a few isolated cases such as Pembroke and Woodstock, Ontario, local health and/or welfare departments have no registers of people over 65 except in those cases where welfare assistance is being provided.

In some major urban areas public health nurses visit senior citizen housing developments on a regular basis. The Ontario Housing Corporation has stated that it has no special health program policy but according to the Ottawa Housing Authority public health nurses and a community relations officer visit each senior citizen development once a week when they are available on call to residents.[4]

Recommendation 28

That all provisions of the Hospital Insurance and Diagnostic Services Act be extended to cover the use by the individual of all approved institutional facilties for health care, including tuberculosis and mental health hospitals.

ACTION TAKEN

The Hospital and Diagnostic Services Act[5] of 1957 has not been amended to include tuberculosis and mental health hospitals. These are the responsibility of the provinces.

Recommendation 34

That, similarly, at the Federal level a special branch or division concerned with the Health Care of the aged be established under the Director of Health Services in the Department of National Health and Welfare, and that close liaison be maintained between this branch and the corresponding body on the welfare side, as well as with the staff of other departments which carry responsibility for the health of older people, such as the Department of Veterans Affairs, and the Civilian Rehabilitation Branch of the Department of Labour.

ACTION TAKEN

There is no branch or division on the "health" side of National Health and Welfare concerned specifically with the health care of the aged to correspond with the "Consultant on Aging" who operates within the Welfare Research Division.

(4) *Ottawa Journal*, July 18, 1973, "Woman's death brings call for nurses".
(5) Revised Statutes of Canada, 1970, Chapter H-8, pp. 3753-3759.

Dr. M. Kozakiewicz, Senior Consultant, Rehabilitation, of Health Standards and Consulting of the Health Programs Branch is heading a committee on aging. This nine member committee will analyze the recommendations of the various reports on aging, particularly the Special Senate Committee on Aging, and determine which recommendations affect the socio-health needs of Canadians, which recommendations have been implemented and which can be implemented given the economic situation.[1]

Recommendation 35

That periodic surveys be made of the health status of older people in order to provide comprehensive, reliable and up-to-date information as a basis for health planning.

ACTION TAKEN

Surveys such as the National Nutrition survey covered the aged as well as other groups.[2]

There is no reliable data on a national basis to cover any group. Health and Welfare Canada in its brief to the Science Policy Committee recommended that national surveys be carried out to indicate the prevalance of various disabilities. There has been no such national survey since 1951.

Recommendation 49

That CMHC give consideration to the establishment of a national committee, analogous to the recently appointed national council on welfare, to advise on matters of policy and program in the field of housing for low-income families and for the elderly.

ACTION TAKEN

There is no national advisory committee as such but the Corporation makes grants under the NHA for the formation of study or advisory groups.[3]

Recommendation 64

That arrangements be made whereby old people requiring short-term hospital or nursing home care may retain for a reasonable period the right to return to their previous living quarters in assisted housing projects.

ACTION TAKEN

The cost of senior citizen accommodation in housing developments is usually geared to income. The length of time accommodation is kept depends on the individual's ability to pay.

(1) Canada. Health and Welfare Canada. Telephone Communication with Dr. Kozakiewicz on March 28, 1973.
(2) Canada. Health and Welfare Canada. *Nutrition Canada National Survey*, Ottawa, 1973.
(3) Central Mortgage and Housing Corporation Information Division. Letter dated November 2, 1973.

Recommendation 67

That Municipal Governments take advantage of the municipal winter works program, the national health grants program, the national welfare grants program, the national fitness and amateur sport program, and also special provincial programs where they exist, to secure assistance with the cost of constructing facilities and developing services for the benefit of old people.

ACTION TAKEN

The extent to which municipalities participate in the provincial programs to extend and improve "care" facilities for the aged depends to a large extent on the financial priorities established for the municipality and its economic base. Health and Welfare Canada no longer provides direct financial assistance for the construction of hospitals, etc. Cost sharing is available under the Canada Assistance Plan for many services, such as counselling, etc., but again this depends on the municipality's ability to pay its share of the program.

National Health Grants are intended to support applied research and innovative methods of supporting health services. No capital funding is provided. Generally speaking, grants under this item are not designed for municipal participation. Similarly the National Welfare Grants Program relates to innovative programs in the research or demonstration fields. The latter refers to short-term projects which have as an objective the delivery of a service in an innovative way. A review of inventories for the past few years indicates that such programs have had no appeal at the municipal level.[4]

Local governing bodies have demonstrated an interest in participation in Local Initiatives Programs. Records of activities in such programs related to the aged were segregated for the first time in 1973-74. The objective of the L.I.P. is to reduce seasonal employment among the labour force in regional or specific areas. One of the conditions for awarding a contract under this program is that the discontinuance of financial assistance at the end of the contractual period will not create undue hardship in the communtiy. Activities resulting from this program provided a service to senior citizens such as mobile food services, shut-in markéters, leisure time activities, communications and transportation in rural areas.

(4) Health and Welfare Canada. Health Economics and Management Services and National Welfare Grants Directorate. Telephone Information. April 9 and 8, 1974, respectively.

The following shows the contracts awarded by provinces to local governing bodies and to local action groups:

Local Initiatives Programs 1973-74

(Corresponds to a Winter-Works Program)

	Local Governing Bodies		*Local Action Groups*	
	No. of Projects	*Value*	*No. of Projects*	*Value*
Newfoundland	Nil		Nil	
Nova Scotia	Nil		2	54,215
Prince Edward Island	Nil		Nil	
New Brunswick	Nil		2	30,544
Quebec	Nil		36	1,220,970
Ontario	13	152,858	25	453,505
Manitoba	6	71,671	2	21,772
Alberta	9	103,005	2	49,062
Saskatchewan	2	23,480	2	78,332
British Columbia	13	245,802	6	193,414 (1)

The National Conference on Fitness and Health met in Ottawa December 4, 5, and 6, 1972. Among its recommendations were the following:

Recommendation No. 20

> It is recommended that the federal government take steps to ensure the establishment of minimum standards for physical recreation facilities and programs in institutions for the care of the aged and disabled.(2)

More specifically, the Conference feels that the federal government should provide a strong leadership role to ensure:

—that an on-going physical recreation program be offered to the aged and disabled in institutions, to maintain an optimal level of function and prevent physical and psychological deterioration;

—that minimum standards of recreational programs and staffing be met in order to qualify for public construction of operational grants;

—that accessibility and use of all recreation facilities for the disabled and aged is adequate, (i.e., construction of ramps, doorways and washrooms).

There is no information on subsequent action.

Recommandation 81

> That the Department of Labour and/or the Department of National Health and Welfare give encouragement to the provinces and their municipalities in the provision of sheltered work and the establishment of sheltered workshops, and that this encouragement, in addition to technical advice, promotional aids and help in developing standards include Federal-Provincial sharing in the costs of facilities where indicated and in the provision of work allowances.

ACTION TAKEN

There are approximately 350 sheltered workshops for the handicapped in Canada; the bulk of these are located in Ontario. Although such projects may benefit some older workers, they do not serve those of retirement age. The greatest number given assistance are the retarded. A survey conducted in 1973 showed that about 15,000 handicapped were assisted per day.

The Federal Government provides no capital assistance. Ontario provides 25 per cent capital assistance and Alberta has some provision for capital assistance. The Federal Government shares the operational cost but the initiative and the funding must come from the province in the first instance.

The Federal Government lends assistance to developing standards for the use of manpower counsellors in purchasing services, and determining the fitness of applicants for sheltered employment.

The subject of sheltered workshops will be given attention in the two-year review of the total social security system now underway. The review was begun in 1973 by the Federal Minister of Health and Welfare and the provincial Ministers of Welfare. A working party on social services will include the subject of rehabilitation services among its studies and in so doing may include those aspects of this subject which may have application for the aged.

The term "sheltered workshop" if broadly interpreted, ranges from the industrial type of workshop to activity centres. New Horizon programmes have relevance for leisure time activities.(3)

Recommendation 89

(a) That consideration be given to the establishment of a national council on social research, as recommended to the Government in the past by such national organizations as the Social Science Research Council of Canada; the Commonwealth Institute of Social Research and that specific provision be made within the program of the council for research in gerontology;

(b) That the council conduct or commission research on its own, particularly in the area of social policy, but that it should also make, or approve, grants for social research and training in social research to universities, professional schools, and non-profit organizations;

(c) That the council be composed of outstanding social scientists and laymen, including a number with

(1) Manpower and Immigration. Data Records to March 14, 1974.
(2) Canada. Health and Welfare Canada. *Recommendations of the National Conference on Fitness and Health*. Ottawa, 1972, p. 15.
(3) Canada. Health and Welfare Canada. Letter from Mr. A. W. Johnson, Deputy Minister of Welfare dated February 12, 1974.

specific interest in gerontology, and that it also include up to one-third of its membership, representatives of Federal Government departments and agencies that are concerned with social research;

(d) That the advice and services of the council be available on request to Provincial Governments, universities and non-profit organizations;

(e) That in order to avoid duplication in the health field responsibility for the conduct and support of research in geriatrics be carried by the medical research council and that the latter give high priority in its program to the biological and medical aspects of aging, and to those diseases and illnesses which have a high incidence among older people;

(f) That the proposed council maintain close relations with the Dominion Bureau of Statistics and the various Government departments and agencies having responsibility in the area of social research, including the universities, with a view to reducing overlapping and ensuring that the efforts of all are mutually supportive;

(g) That, with particular reference to the field of aging, the council seek the cooperation of the Dominion Bureau of Statistics and departments of the Federal, Provincial and local Governments, and the major voluntary organizations concerned:

(i) in improving the collection and analysis of statistical data,

(ii) in stimulating and correlating research programs, and

(iii) in undertaking the variety of needed research that is recommended elsewhere in this report.

ACTION TAKEN

The recommendation that a National Council on Social Research be established has not been implemented. There are some private groups such as the Canadian Association on Gerontology whose founding meeting was held in Montreal on October 15, 1971. The objectives of the Association are summarized as follows:

"(a) To bring together persons interested in gerontology in the fields of biological sciences, medical sciences, psychology, social sciences and social welfare;

(b) To promote the study of aging in all its aspects;

(c) To promote improvement in the well-being of older people;

(d) To strengthen and improve communication between the relevant scientific disciplines and between persons engaged in research, education, professional practice and other interested workers;

(e) To promote and broaden education about aging at all levels;

(f) To promote active financial support for gerontological research and the application of its findings in the practical situation;

(g) To print, publish, distribute and sell journals, periodicals, and publications for the professional advancement of the members of the Association."[1]

Recommendation 92

(a) That the Federal Government establish a national commission on aging for the purpose of giving leadership in all matters concerned with a fuller life for older people in Canada;

(b) That the functions to be performed by this commission include the following:

(i) to examine intensively and follow up the recommendations contained in this Report of the Special Committee of the Senate on Aging,

(ii) to keep under review the needs and problems of older people and to develop recommendations on policy and program for dealing with them,

(iii) to develop working relationships with Federal Government departments and agencies, national voluntary organizations, and Provincial Government planning bodies concerned with aging, to the end that planning and coordination may be achieved,

(iv) to serve as a clearing house for information on projects, studies and developments generally in the field of gerontology, and to publish a bulletin and other literature for the dissemination of this information,

(v) to provide technical and financial assistance in the area of program development and staff training on request to provinces, local communities, universities, and other organizations, to the extent this assistance is not provided already through existing programs,

(vi) to sponsor and cooperate with other agencies in conducting conferences, seminars, and training courses for workers in the field of aging;

(c) That, until the national council on social research, recommended in the previous chapter, is established, the commission, in addition to the above functions, carry responsibility for the conduct, collation and support of research in the field of gerontology;

(d) That the chairman and members of the commission be selected because of their status, experience and competence, in various aspects of the field of aging, and that they include, up to one-third of their number, representatives of federal departments and agencies that carry major responsibility for services and programs for old people;

(e) That the basic budget of the commission be furnished by the Federal Government but that the commission be enabled and encouraged to receive contributions from other public and private sources;

(f) That the commission report annually to parliament;

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(1) Central Mortgage and Housing Corporation, *The Seventh Age*, Ottawa, 1872, p. 18.

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