NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Previously copyrighted materials (journal articles, published tests, etc.) are not filmed.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

Les documents qui font déjà l'objet d'un droit d'auteur (articles de revue, tests publiés, etc.) ne sont pas microfilmés.

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30.

Canada

THE UNIVERSITY OF ALBERTA

The Health Care System for the Aged in Edmonton: A Functionalist Analysis

by

A.J. (Béa) van Beveren

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

OF Master of Arts

Department of Sociology

EDMONTON, ALBERTA

Spring, 1987

ISBN 0-315-43263-2

THE UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR A.J. (Bea) van Beveren

TITLE OF THESIS The Health Care System for the Aged in Edmonton: A Functionalist Analysis

DEGREE FOR WHICH THESIS WAS PRESENTED Master of Arts

YEAR THIS DEGREE GRANTED Spring, 1987

Permission is hereby granted to THE UNIVERSITY OF ALBERTA LIBRARY to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly or scientific research purposes only.

The author reserves other publication rights, and neither the thesis nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

(SIGNED) A.J. van Beveren

PERMANENT ADDRESS:

13904 - 86 Street

Edmonton, Alberta

T5E 3C1

DATED January 12 1987

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled The Health Care System for the Aged in Edmonton: A Functionalist Analysis submitted by A.J. (Béa) van Beveren in partial fulfilment of the requirements for the degree of Master of Arts.

.....
Supervisor

.....

.....

Date...January 14/87...

Abstract

The study examined the historical evolution of the present Alberta government financed, Edmonton based health care system for the aged from 1950 to 1986. A functionalist perspective provided the theoretical framework for this research. The theoretical problem undertaken was how to justify continued investment of resources into the aged health care system when rewards from doing so appear limited.

The general hypothesis was that over time a gradual shift in the orientation of the health care system occurred from a primarily affective (goals being of a passive, custodial nature) toward an instrumental orientation indicative of an holistic approach to health care for the aged. Viewing the aged as contributing to the social system, that is, as a benefit to the instrumental sphere, was recognized as one method to justify expenditures for aged health care.

The EHCSA was examined historically using the functional prerequisites (goal-attainment, adaptation, integration and latency). It was argued that over time change in the goal-attainment prerequisite necessitated a change in the supporting elements of adaptation, integration and latency; this precipitated a change in the orientation

of the health care system for the aged. Required resources, motivations and values were also examined in order to verify whether or not genuine change occurred in the health care system for the aged.

As was hypothesized, historically benefits for society from investment in the health care system for the aged were seen as affective. Supporting aged health care was seen as a moral obligation. It was offered as a reward for past services rendered. Later, affective benefits to solely justify supporting aged health care were viewed as too expensive to maintain. Instead, instrumental benefits were used to justify continued support for aged health care.

In the past decade, the government has demonstrated its support for a rehabilitative approach to health care for the aged by providing some financial assistance for its implementation. What is lacking, however, is a clearcut strategy for the development of an holistic rehabilitative health care system for the aged. The development of such a strategy is imperative if the government wishes to uphold a rehabilitative policy and remain committed to aged health care.

Acknowledgements

I enjoyed the support and assistance of a number of superb people in the process of developing, researching and finalizing this thesis. I will single out only a few.

I am indebited to my supervisor, Dr. R.W. Hetherington, who was, to me, both a source of knowledge and inspiration. He patiently guided me through the crucial initial stages of the study devoting countless hours explicating theoretical and methodological issues. From the beginning to the end, he was readily available for consultation and, I must say, this was often.

The committee members, Dr. S. McIrvin Abu-Laban and Dr. C.A. Meilicke, generously offered their encouragement and expertise throughout the study. I am grateful to them for their assistance.

I thank the Department of Sociology for the instruction and support I received as a graduate student. To all those I met in the course of my studies, both professors and students alike: thank you.

Last, but certainly not least, I thank my parents who instilled in me the value of higher education and the virtues of patience and perseverance.

[redacted] of Contents

Chapter — Page

I. INTRODUCTION 1

A. Descriptive Basis of the Study 1

B. Theoretical Background of the Study 2

C. Research Methodology 5

The Specification of the Sociological Item- EHCSA 6

II. GOAL-ATTAINMENT PREREQUISITE IN THE EHCSA 11

A. Introduction 11

Policy-making 13

Co-ordination 14

B. Policy-making in the EHCSA 16

Policy-making in the EHCSA during the 1950's 16

Policy-making in the EHCSA during the 1960's 20

Policy-making in the EHCSA during the 1970's 25

Policy-making in the EHCSA during the 1980's 32

C. Co-ordination in the EHCSA 38

Co-ordination in the EHCSA during the 1950's and 1960's 40

Co-ordination in the EHCSA during the 1970's 47

Co-ordination in the EHCSA during the 1980's 51

D. Goal-Attainment Conclusion 57

III. ADAPTATION PREREQUISITE IN THE EHCSA 61

A. Land Resources in the EHCSA 63

Land Resources available in the 1950's and 1960's 63

Land Resources available in the 1970's and 1980's 70

B. Labour and Entrepreneurship-organizing Ability 73

Labour Resources available in the 1950's and 1960's 73

Labour Resources available in the 1970's and 1980's 77

C. Capital Resources in the EHCSA 83

Capital Resources available in the 1950's and 1960's 83

Capital Resources available in the 1970's and 1980's 86

D. Adaptation Conclusion 94

IV. INTEGRATION PREREQUISITE IN THE EHCSA 96

A. Introduction 96

Consumers 96

Producers 97

B. Producers in the EHCSA 98

Producers during the 1950's and 1960's 98

Producers during the 1970's and 1980's 102

C. Consumers in the EHCSA 106

Consumers during the 1950's and 1960's 106

Consumers during the 1970's and 1980's 109

D. Integration Conclusion 113

V. LATENCY PREREQUISITE IN THE EHCSA 117

A. Introduction 117

Definition 117

Hypothesis 119

Method 119

B. Attitudes toward the EHCSA in the 1950's 122
C. Attitudes toward the EHCSA in the 1960's 125
D. Attitudes toward the EHCSA in the 1970's 128
E. Attitudes toward the EHCSA in the 1980's 129
F. Attitudes toward the EHCSA in 1985 131
G. Latency Conclusion 135
VI. FUNCTIONALISM REVISITED 137
A. Overview of the EHCSA 137
The Theoretical Problem 137
Meeting the System Prerequisites 138
B. Problems in Functionalism 144
The Problem of Tautological Explanations ..145
The Problem of Social Change 150
C. Theoretical Conclusion 156
VII. REFERENCES 160
VIII. BIBLIOGRAPHY 163

List of Tables

Table 1a — Physical type of Facilities in the EHCSA 64

Table 1b — Social type of Facilities in the EHCSA 65

Table 1c — Recreational type of Facilities in the EHCSA 66

Table 2 — List of Lodges and Self-Contained Units in the 1960's 68

Table 3 — List of Contract Nursing Homes at December 1964 68

Table 4 — Number of Staff Employed in Nursing Homes in Edmonton at December 31, 1964 75

Table 5 — Financial Expenditures of Lodges and Self-Contained Units in 1964 85

Table 6a — Preventive Social Services Program Expenditures, 1969-75 87

Table 6b — Preventive Social Services Program Expenditures, 1976-1981 88

Table 6c — Family and Community Support Services Expenditures 1982-84 89

Table 7 — Benefits Derived from the Activities of the Department of Geriatric Medicine 92

Table 8 — Canadian and American Academic Journals from 1950-1985 121

List of Figures

Figure 1 Divisions of the Alberta Government Involved with the EHCSA in 1950 41

Figure 2 Divisions of the Alberta Government Involved with the EHCSA in 1960 42

Figure 3 Divisions of the Alberta Government Involved with the EHCSA in 1970 43

Figure 4 Divisions of the Alberta Government Involved with the EHCSA in 1980 44

Figure 5 Divisions of the Alberta Government Involved with the EHCSA in 1985 45

I. INTRODUCTION

The study examines the historical evolution of the present Alberta government financed, Edmonton based health care system for the aged (from now on abbreviated as 'EHCSA') from 1950 to 1986. A functionalist perspective provides the theoretical framework for this research. The study analyzes the changes in the goals of the EHCSA, and how this has led to the establishment of an holistic geriatric facility in Edmonton. Also included is an assessment of the adequacy of the current EHCSA and suggested directives for future development.

The general hypothesis of the study is that over time there is a gradual shift in the goals of the EHCSA from a primarily affective orientation (goals being of a passive custodial nature) toward an instrumental orientation, suggesting active involvement goals, indicative of an holistic approach to aged health care.

A. Descriptive Basis of the Study

Shifting goals in the EHCSA from affective to instrumental can be seen as largely due to changes occurring in the environment. Changes in the environment such as the escalation of medical costs, an increased aged population and/or a decline in the economy, place restrictions on resources available in society. Restrictions on resources require the health care system for the aged to justify its expenditures.

Theoretically, the problem for aged health care is how to justify expenditures when it is difficult to identify concrete benefits for society. Traditionally, benefits for society from investments in the HCSA have been affective. Investing in the HCSA was valued as a benefit in itself. In capitalist societies, affective activities are supported as long as they do not interfere with production or reduce resources to the instrumental dimension beyond a critical level. As resources become scarce, it becomes increasingly difficult to justify expenditures for aged health care solely on an affective basis.

One method to justify allocating resources to aged health care is to consider the aged as productive. That is, as a benefit to the instrumental sphere. Viewing the aged as contributing to the social system helps justify expenditures for their health care. Such a shift in orientation toward a greater emphasis on the integration of the aged into productive roles may even come to be regarded as necessary for continued future investments into aged health care.

B. Theoretical Background of the Study

A functionalist orientation has been adopted for this study.[1] Basically, this perspective tries to explain the existence of structures through their contributions to the

---

[1] Controveries concerning the adequacy of functionalism as a sociological theory are recognized (e.g., the problem of tautological explanations). These problems will be examined in the final chapter of this study.

stability and order of the social system. From a functionalist perspective, the basic structure of the social system is assumed as a 'given' and change is seen to take the form of refinements and adjustments to that structure (Zeitlin, 1973:1-21). In contrast, other perspectives may assume problems of the social system are inherent in the nature of its basic institutions.

In functionalism, the social system is regarded as having functional needs. Parsons describes four such needs. He calls them adaptation, goal-attainment, integration and latency. Two of these needs, adaptation and goal-attainment, are part of an "instrumental" dimension; the other two, integration and latency, are part of an "affective" dimension. These needs must be fulfilled for any social system to persist.

Structures arise to meet these functional needs. All structures, according to Merton, have both functions (manifest and latent) and dysfunctions. By comparing functions and dysfunctions of a given structure, a 'net balance' (Merton, 1949:21-81) can be determined for that structure. This 'net balance' indicates how well the structure is fulfilling one or more of the system needs. If, for example, dysfunctions are greater than functions, meaning a negative net balance, change in the structure should result.

In functionalist terms, the health care system contributes to stability and order in society by meeting

integrative needs.[2] This is accomplished by regulating social deviance (illness) and reintegrating deviants into productive roles in society. Within the health care system, deviants are rehabilitated from their illness and recycled back into the labour market. This fulfills an integrative need. Theoretically, there is a problem of rationalizing and justifying expenditures of resources such as capital, personnel and technology for any health care service which does not clearly fulfill an integrative need.[3]

A major problem of health care for the aged is how to justify expenditures when direct benefits for the system are not evident. Parsons describes benefits for the system in terms of instrumental and affective dimensions. "Instrumental benefits" implies that investments are means to attain productive ends. "Affective benefits" implies that activities are valued as ends in themselves. They are valued for themselves and not necessarily as means to other ends (Parsons, 1951:49,79-88). Benefits for society from investments in the health care system for the aged have traditionally been seen as affective.

In Parsons' model, the instrumental and affective spheres are interrelated. They are not independent of each other. Ideally, the two spheres are in harmony and in

---

[2]The health care system is of course not the only structure to satisfy integrative needs (e.g., educational system also does).

[3]In any system, "expenditures of resources" includes more than just financial considerations, although these are of great concern. Expenditures also involve, for instance, resources within what Parsons terms the "motivational economy".

balance. It does, however, occur that the dimensions become unbalanced and tensions arise in the system. Since resources in the social system are scarce, competition for these resources by activities in the two spheres may create instability in the system.

The 'net balance' of functions and dysfunctions of a structure suggest how to balance its contributions to the system to obtain the greatest benefits. Emphasizing the potential instrumental benefits of aged health care is one solution to justify the theoretical problem of continued 'investments' in activities unclearly benefiting the larger society.

In summary, in an achievement oriented society, there is a theoretical problem in justifying continued 'investments' in activities whose benefits for the system in terms of the predominant instrumental dimensions are unclear. One solution is to clarify and emphasize potential instrumental benefits, and to restructure activities to maximize them.

C. Research Methodology

The study combines the theoretical concepts of Parsons and Merton. Merton's framework for functional analysis is used as a general outline for the study. This framework identifies the procedures and problems central to a functionalist approach. It may be summarized in four steps (paraphrased from Turner, 1978:101):

1. Specify the sociological item under investigation.
2. Analyze the item in terms of its direct consequences for meeting the "needs" of the social system (the manifest functions of the item).
3. Focus on the latent, dysfunctional consequences, and on functional alternatives to the item.
4. Assess the net balance of consequences of the item.

This study only addresses the first step in Merton's framework: the specification of the sociological item under investigation. The other three steps, although important for a complete functionalist analysis, is beyond the scope of the present study.

The Specification of the Sociological Item- EHCSA

The "sociological item" in this study is the formal or contractual arrangements specifically created to provide holistic health care services for an aged population in Edmonton and financed in whole or part by the Alberta government. "Holistic health care" includes physical, psychiatric, social and recreational services. This definition limits the sociological item to the formal system and to aspects of it which are at least in part government financed.

---

* In contrast to the study definition, the total EHCSA would include all services that enable the aged to remain and meaningfully participate within their community. It is composed of formal and informal arrangements serving the aged population. Formal arrangements refer to publicly accessible facilities, services, personnel and technology; personnel employed are financially reimbursed for their services. Informal arrangements refer to services privately

An holistic approach to aged health care focuses on both the traditional medical approach to health care and on developing social skills for daily living, thus promoting independence. This approach includes services that enable the aged to remain in their community and meaningfully participate in all societal institutions (political, education, economic, family and religion).

A geriatric facility exists in Edmonton that emphasizes this approach to health care for the aged.[5] The Alberta government, by taking the responsibility for financing the implementation and operation of this geriatric facility, has indicated its support for an holistic approach to health care for the aged in Edmonton.

This study analyzes the historical evolution of the present EHCSA since 1950, leading to the establishment of the current holistic facility. The method is based on Merton's first step: the specification of the sociological item under investigation.[6] The sociological item (EHCSA) is described in terms of Parsons' affective and instrumental dimensions.[7] These dimensions are comprised of the system

---

[4](cont'd) accessible such as family, friends and volunteers; services offered are not financially reimbursed.

[5] The geriatric facility is understood as the Department of Geriatric Medicine, Youville Memorial Wing, Edmonton General Hospital.

[6] According to Merton, the description of the sociological item should include five parameters. These are:
1. location of participants in the pattern within the social structure;
2. consideration of alternative modes of behavior excluded by emphasis on the observed pattern;
3. the emotive and cognitive meanings attached by participants to the pattern;
4. a distinction between the motivations for participating

prerequisites referred to above: adaptation, goal-attainment, integration, and latency. The description of the EHCSA involves an analysis of the effectiveness of the EHCSA in meeting the four prerequisites. The emphasis is on the evolution of structures to meet the system prerequisites.

By examining each of the prerequisites, the study attempts to establish the following historical trends:

1. Goal-attainment: Goals which were largely of a passive and custodial nature shifted to goals with an emphasis on rehabilitation.
2. Adaptation: Resources required for the attainment of early goals were largely institutional facilities and a labour force trained in traditional approaches to health care for the aged. An holistic health care system for the aged requires, for example, greater specialization in problems of the aged (e.g., gerontologist, geriatrician).
3. Integration: Motivations in service of early goals were to encourage the elderly to enter nursing homes; there was little incentive for involvement in the EHCSA or society. An emphasis on remaining in the community and

---

(cont'd) in the pattern and the objective behavior involved;
5. regularities of behavior not recognized by participants but which are associated with the central pattern of behavior (1967:114).

This method for describing the sociological item deals with information that is difficult to trace historically; for example: the motives and cognitive meanings of actors and participants. Thus, Parsons' system prerequisites are substituted.

enhancing self and collective activities is expected to have evolved over time.

4. Latency: Values in service of early goals would emphasize indebtedness of society to the elderly for their past contributions, plus lack of potential for current contributions. In contrast, greater sensitivity to aged needs and an awareness of their potential is anticipated to prevail at present.

Based on the foregoing, it is argued that over time there was a shift in goal-attainment that necessitated a change in the nature of adaptation, integration and latency needs. However, changes in the goals of the subsystem (EHCSA) may be more apparent that real. One way to examine this is to see whether or not the resources, motivations and values changed in the predicted direction.

In summary, the study examines two points in analyzing the EHCSA. First, the historical shift from an affective to instrumental orientation in the EHCSA. This shift is seen to occur as the resources for the EHCSA, traditionally allocated on the basis of affective benefits, become scarce. One method suggested to justify continued resource expenditure for the EHCSA is to view the aged as productive, as a resource, benefiting the instrumental sphere. The second points deals with changes in the ways in which the

EHCSA over time has met its functional prerequisites (AGIL).

The next four chapters examine the above two points. The last chapter, Functionalism Revisited, addresses the problems encountered in using functionalism to analyze the EHCSA.

II. GOAL-ATTAINMENT PREREQUISITE IN THE EHCSA

A. Introduction

As we head toward the 21st century, demographers are predicting an increased greying of the population. Such news only reinforces to gerontologists the urgent need for extensive planning and co-ordination of health care services for the elderly. Efficient administration of health care services for the elderly today is essential if governments wish to control financial costs while still providing quality care for the elderly.

In the last 30 years, the federal and provincial governments have spent billions of dollars establishing facilities such as schools and children's hospitals for the babyboomers. Now, they are faced with the realization that this bulge in the population is slowly aging. So far, governments have been cautious, often reluctant, to place vast sums of capital into health care for the elderly. In fact, governments aren't sure what to do about this upcoming generation of seniors who will not only be proportionally larger than the previous but more costly.

The issue facing all levels of government today is how to rationalize expenditures for aged health care when there are numerous other demands for support within the health care field. In the past, it may have been sufficient to explain costs by citing the great contributions of the previous generation; the elderly were not expected to

further contribute. Today, such an explanation can not be regarded as sufficient to support increased investment for the health care of the elderly.

One way to justify aged health care today, as has been previously cited, is to consider the aged not as useless but as useful, active citizens. Emphasizing the importance of utilizing the skills acquired by our elderly is an instrumental rather than affective benefit and suggests benefits for supporting aged health care. Benefits such as increased participation of the elderly in the EHCSA, may mean less expenditure in the long run on aged health care. Such benefits become all the more important as the proportion of aged in the total population continues to increase and governments recognize spending must be curtailed.

In this chapter, interest is in how resources for the benefit of the EHCSA can be obtained. Goal-attainment is defined as the power to mobilize resources. Resources made available by activities related to adaptation needs are organized in order to obtain desired goals. Goal-attainment includes two types of activities: policy-making and co-ordination. Of significance in this section are the policies and co-ordinating mechanisms that have developed in the EHCSA from 1950 to the present.

Policy-making

Policy-making involves setting official and operative goals. Official goals are not necessarily designed for implementation but rather for legitimation and as such reflect the value system of the organization (Perrow, 1961:855). Changes over time in the values are reflected in official goals. A shift over time from affective to instrumental values is expected (e.g., goals that were largely of a passive custodial nature such as those found in nursing homes to one of rehabilitative care).

Operative goals are those which are actively implemented (Perrow, 1961:855). The performance of operative goals can be established by determining whether or not the official goals have been fulfilled over time. If official goals have been met, then this indicates that operative goals were probably the same as official goals.

Organizations such as nursing homes, home care and the geriatric facility are of major interest in this study. Resources available to these organizations suggest how well certain goals have been implemented. To the extent that government controls the availability of funds to these organizations, goals are affected. Since government financed facilities are the focus in this study, government policy regarding these facilities and the policy influencing the aged in general is of particular importance.

It is hypothesized that over the years, the policy of the EHCSA shifted from a custodial (e.g., institutional

care) to a rehabilitative orientation (e.g., community based services). Such a shift may be seen to occur as changes in the environment, for example the economy, place restrictions on expenditures for aged health care. Over time a custodial orientation may be seen as too expensive for the Alberta government since benefits are not necessarily means to obtain productive ends. In later years, with increased expenditures for aged health care, the Alberta government in order to continue supporting aged health care would be expected to change its policy toward offering a rehabilitative approach.

Co-ordination

Co-ordination is another area of goal-attainment. It is an important concern for the maintenance of the system. From a functionalist perspective, satisfying the goal-attainment prerequisite depends on the existence of co-ordinative mechanisms which keep the system effectively and efficiently operating. Co-ordination provides for effective system performance (e.g., as the system expands, co-ordination needs increase to maintain effective functioning). Co-ordination involves both vertical and horizontal mechanisms (Daft, 1983:207-221).

Vertical co-ordination refers to the amount of control exerted by management. This could be measured by the number of rules and regulations put forward, the number of reports required and the restrictions placed by management on the

use of funds. In a multi-organizational system, such as the EHCSA, vertical co-ordination would also consider controls placed on member organizations by a central body, such as the government.

Horizontal co-ordination refers to the interrelationships among the types of facilities. Interrelationships over time will be identified, for example, by the number of task forces set up among facilities, and whether a central co-ordinating body exists (e.g., central placement office, senior citizens' bureau).

It is hypothesized that as the EHCSA expands to include a variety of different services needed to meet rehabilitation rather than custodial goals, increased co-ordination of both a vertical and horizontal nature will be needed. On the other hand, if rehabilitative and holistic care goals are merely official and not operative, realisitic efforts to effectively co-ordinate this wide variety of services will not be pursued.

The two activities, policy-making and co-ordination, determine the direction and the performance of the EHCSA. The success of the goal-attainment prerequisite for the EHCSA depends upon its ability to accomplish its stated goals and initiate strategies for the effective operation of the EHCSA. The historical development of these two activities in the EHCSA between 1950 and 1986 is the topic in the following section.

B. Policy-making in the EHCSA

Policy-making in the EHCSA during the 1950's

The EHCSA in the early 1950's did not receive top priority with the Alberta government. The rapid population growth as a result of the influx of immigrants and migrants to the city of Edmonton and a depressed economy did little to encourage expenditures for aged health care.[1] The consequent lack of clearcut policies for the EHCSA is apparent from the virtual absence of facilities in the EHCSA during this time.[2]

The establishment of facilities in the EHCSA began only in the late 50's facilitated by the governments' Home for the Aged program.[3] The Senior Citizens' Lodge Program offered only food, shelter and supervision.[4] The government provided few incentives for the provision of medical,

---

[1] The Public Welfare department, ultimately responsible for aged affairs, had other more immediate concerns. Services for the elderly had a difficult time competing for resources with such programs as child care and single mens' branch.

[2] The only organization involved in the EHCSA was the psychiatric institution (Oliver), although this was not solely for the care of the elderly.

[3] In 1954 the government started offering grants to municipalities for the purchase or construction of homes for the aged. Edmonton did not take advantage of these grants. In fact, the whole grant program was a disappointment for the Alberta government. Thus, the government saw no alternative but to directly provide accommodation for seniors.

[4] The Alberta senior citizens' lodge program of 1958 was the most comprehensive senior housing program in existence in Canada. It took however, approximately 4 years for Edmonton to begin constructing their first lodges and housekeeping units. By 1964, there were 6 lodges and 6 housekeeping unit homes in the city and more were to follow.

nursing care, social, rehabilitation or other specialized care for the elderly. The official goals proclaimed by the government for the EHCSA were strictly custodial: provide accommodation. The following statements present the government's rationale for senior lodges:

> "The facilities of our high capital and maintenance cost active treatment hospitals are strained to the breaking point, and bed space for people needing immediate bed care in these institutions is unavailable. There are, however, a large number of persons occupying active treatment hospitals beds who could be cared for adequately in existing chronic hospitals were it not for the fact that these facilities are taxed to the limit in caring for a high percentage of elderly persons *who need no care* apart from that which could be given to them in homes for the aged, which are relatively low capital and maintenance cost structures as compared to active treatment hospitals" (Public Welfare Annual Report, 1958/59:25). (emphasis mine)

The following quotation reflects another reason for government's endorsement of senior citizens' lodges:

> "The humane and spiritual aspects of a program to provide accommodation for the elderly citizens of the province who contributed so much at tremendous sacrifice to the development of this country is apparent to all, and in the last year or so has

become the subject of much thought by citizens generally" (Public Welfare Annual Report, 1958/59:24).

Other reasons for senior housing suggest the government believed institutions "could save the elderly from a life of chronic invalidation through proper supervision and diet" (Public Welfare Annual Report, 1958/59). Further, these homes were seen as being able to provide " a continuing state of healthful, happy living through the facilities to be provided where surroundings conducive to a full life among people their own generation will be available" (Public Welfare Annual Report, 1958/59:25/26).

The most important reason for the development of lodges was apparently economic: active treatment facilities were just too expensive for the chronically ill and the elderly. It is questionable whether the government would have implemented the senior citizens' lodge program had the cost of maintaining the elderly in acute care hospital beds not been so high. The government realized however, it could not successfully achieve its goals by solely promoting the cost/benefit aspect of the lodge program.[10] Thus, the government skillfully focused on the tremendous sacrifice the elderly had made for the prosperity of the province.

Homes for the aged were promoted as a reward for the

---

[10]The government took great care not to alienate those who equated lodges with the 'poor houses' or 'flop houses' of the 1920's and 1930's.

past contributions made by the elderly.'' Such sentiments focused public attention on the affective benefits of the program. This strategy allowed the government to successfully gain public support for its goals and thereby justify expenditures for homes for the aged.

For the Alberta government, the development of lodges for the custodial care of the elderly was a public success, regardless of the government's motives. '' This is apparent from the following government statement;

> "These homes are filling a real need for the ageing people in the province for comfortable and personal companionship. As a result, the space available is steadily occupied" (Public Welfare Report, 1963/64:8).

and further,

> "The elderly can live in dignity and comfort with individuals of his own age group without requiring extra assistance for his maintenance"(Public Welfare Report, 1960/61:25).

The government went on to add,

> "All evidence points to the fact that the

''Aged were praised for their past contributions. No mention was made of the possible present or future benefits of aged involvement.

''The success of the lodge program was further achieved through government legislation and subsidy. The passing of legislation forced municipalities, such as Edmonton who had prior to this been unco-operative in accepting the grants for housing to co-operate with the government in developing lodges. The government fully financed the construction of the lodges.

psychological barrier existing in the minds of the elderly people is being overcome and there are many indicators that this form of life is proving more acceptable to those senior citizens who desire a form of supervised association with others in pleasant surroundings"(Public Welfare Annual Report, 1961/62:33).

It is evident from the above reports that the government was able to successfully implement its goals for the EHCSA. The government had valid reason to pride itself. The Alberta government had dealt with the problem of expensive acute care beds and implemented an alternative program that rivalled any other in the country.

In sum, the official policy on aged health care as set out by the provincial government emphasized institutional type of care. During the 50's, the official policy of the government became operative. The government was able to establish lodges as a form of institutional care. Although it seems apparent that economic factors largely influenced the establishment of lodges, the government skillfully used affective benefits to justify the development of lodges. The government appealed to the significant contribution the elderly had made to the development of the province.

Policy-making in the EHCSA during the 1960's

The policies of the 60's were reminiscent of those introduced a decade earlier. The introduction of the

Nursing Home Act in 1964 continued to reflect this custodial care policy. [1] Unlike the provisions set out for the lodge program, the regulations for the nursing homes did stipulate recreational and diversational opportunities suited to the needs of the individual. [2] The government however, did not enforce this regulation nor did it offer any incentives to nursing home operators for its fulfillment. [3] Institutions continued to offer only a maintenance type of care without supplementing basic nursing care with any rehabilitative services or specialized personnel.

The custodial care orientation of the 1950's changed little in the 1960's. The following suggests some of the reasons for the development of additional custodial type institutions in the 1960's.

---

[1] Nursing homes existed before the 1964 Act. However, prior to this time the provincial government did not monitor these institutions. Only occasional inspection was carried out by the city inspectors and mainly for sanitary reasons.

[2] According to the regulations of the nursing home act, nursing home services also included reactivational activities 'to prevent deterioration to the extent possible and the provision of individual and group activity, recreational and diversational opportunities suited to the needs interests of its patients' (Alberta Nursing Home Plan, 1964:39).

[3] Contract nursing homes were paid on daily occupancy rates. Additional staff beyond that required by the government to provide special activities would have to be funded by the nursing home operator. One reason the Nursing Home Act(1964) was revised in 1985 was to provide more guidelines on the services to be offered in such institutions.

[4] None of the nursing homes in the 1960's in Edmonton offered any reactivational activities for the aged unless for example, T.V. or the occasional craft project can be considered.

1. The availabililty of additional custodial care institutions was seen to reduce the cost associated with elderly occupying expensive acute care hospital beds unnecessarily.
2. The inclusion of nursing homes in the institutional care program would help bridge the gap that existed between the auxiliary hospital program and the senior citizens' lodge program (Interim Report, Custodial Care Committee, 1963:49).
3. Another reason for additional custodial type institutions was the importance of 'co-ordinating private and public facilities in this area to assume adequate accommodation and nursing care for those whose physical condition is such that they could not use the facilities of the senior citizens' home or qualify for admission to a chronic hospital' (Alberta Nursing Home Plan, 1964:1).

The need of additional institutional facilities especially for the elderly was also recommended by the Alberta Commission on Health Services (1962).

> "There is a need for extensive geriatric services, either by creating more institutions such as Rosehaven, Camrose within the Mental Health Services proper, or the establishment of a somewhat autonomous geriatric service in its own right. This would go a long way to reduce the active mental hospital services to their proper psychiatric

function, that is, treating and rehabilitating to prevent hopeless chronicity" (Royal Commission on Health Services, 1962:56).

The general consensus in the early and mid 60's was that the elderly needed adequate housing and care. Institutional type of care facilities was felt as solving this problem. The main reason for the continued development of these facilities appears to be economic: the elderly burdened active treatment facilities.

Economic considerations were conspicuous in both the development of lodges and nursing homes. For the government, economic benefits were emphasized chiefly because high cost maintenance facilities continued to be overutilized by the elderly. By the late 60's, lodges too were experiencing full occupancy rates. The government continued to emphasize affective rationales for aged health care, such as past contributions of the aged, in order to support institutional care. There was however, a growing realization that continued investment in institutional care was not profitable. A new approach to aged health care was recognized as necessary.

In the 1950 Speech from the Throne, the Alberta government had announced the provision of preventive services. At that time, the Health Survey Committee (1950) also recommended preventive services in the geriatric field, but little had materialized. Not until 1966 did the Alberta government establish a committee to look into preventive

services. The committee, among other things, recommended planning 'a co-ordinated service to assist the older section of society to retain the best functioning of their physical and mental attributes possible' (The Report of the Special Legislative and Lay Committee Inquiry into Preventive Health Services in Alberta, 1966:15).

The aim of preventive social services according to the department of public welfare was to develop social resources. Social resources was defined as "activities available to all members of the community to allow them to enrich their physical, mental, spiritual and social well-being" (Department of Public Welfare, Annual Report, 1967/68:30). This new direction suggested the government was willing to allocate resources to help the elderly remain in their community.

The preventive social services (P.S.S.) provided two benefits for aged health care. First, it provided assistance for those willing to remain in their community. By the late 60's only the 'meals on wheels' program, funded partially by the P.S.S. program, was available. It was however, a beginning. Second, the P.S.S. program provided another way in which the government hoped to reduce unnecessary costs associated with placing the elderly in hospitals or homes for the aged. The need to reduce costs of institutional care is clear from the Preventive Health Report (1966:70,71).

"The provision of alternate facilities within the

community would render possible the discharge of a proportion of the chronically ill to the community thereby in part relieving the pressure on the institution".

The establishment of P.S.S. provided a sense of the direction in which the government was willing to go in the next decade.

In sum, as in the 50's, the government was able to fulfill its official goal of custodial care. Institutional facilities increased sharply during this period. Again, the government was able to rationalize its expenditures for aged health care by focusing on the affective benefits. By the late 60's there was a noticeable shift in official policy from custodial to rehabilitative type of care. Actually implementing the official rehabilitative policy had yet to occur.

V

Policy-making in the EHCSA during the 1970's

By the late 1960's, changes occurred in government policy toward the EHCSA. No longer was the government strictly endorsing custodial care and advocating institutions as the ideal place for seniors. Instead of encouraging dependence and reliance on the state through the implementation of more institutions, the government advocated independence and participation of all ages in society. The preventive social service act (1966) provided

the first major incentive for this new approach.'' For the elderly, it meant that they could partake in more programs sanctioned by the government. ''

In the 1972 Speech from the Throne, a new emphasis was placed on the needs of senior citizens by the government of Alberta. The government announced that one of its top five priorities was 'to understand the difficult circumstances of many of the seniors in Alberta'. A number of benefits such as relief from Medicare payments and the provincial education tax were offered to seniors in the Speech from the Throne.

The new direction the government was heading was apparent from the following statement from the throne.

> "During this session, my government will introduce an entirely new policy to assure better accommodation and recreation facilities for seniors. This unique new policy will be designed to allow private, volunteer and nonprofit groups in partnership with government, to provide a wider

---

'' The P.S.S. Act was a bill not directed at senior programs alone. It provided grants for the personal enhancement of all Albertans. If the city of Edmonton wished to emphasis senior needs it was its prerogative. The role of the province was seen as largely consulatative (Social Services and Community Health Annual Report, 1975/76:12).

''It is important to note that the government did not actively seek to assist in discharging residents from nursing homes or lodges. These facilities were left in place with little improvement in the services offered here. The programs sponsored under the P.S.S. Act were directed at seniors in the community not at those in long term care facilities.

range of alternatives to assist in the improvement of our pioneers' quality of life" (Speech from the Throne, Alberta Legislative Assembly, Feb. 15, 1973: 3)

For seniors as well as all Albertans, the government further outlined its philosophy in its 1973 Throne Speech.

"A society which provides individual citizens the maximum opportunity for personal initiative and resourcefulness to determine their own destiny without undue government interference."

The move away from custodial care was also evidenced in the mental health field.

"My government has accepted the philosophy of decentralization and community based mental health services as advocated in the Blair Report" (Speech from the Throne, Alberta Legislative Assembly, Jan. 29,1970:5). '' The trend in the early 70's was away from custodial institutional type of care toward a rehabilitative, self-reliance approach, in the mental health field and health care for the aged. The government not only endorsed rehabilitative care but emphasized the significance of independence and self-reliance for all Albertans. The emphasis was on personal initiative and resourcefulness, that is, the instrumental benefits of care for the elderly.

'' The controversial report conducted by Dr. Blair in 1969 entitled, Alberta Mental Health Study, popularly referred to as the 'Blair Report', frankly addressed the state of mental health care institutions in the province and among other things, criticized the practice of placing senile elderly patients in mental facilities.

The year 1975 witnessed further endorsement of a rehabilitative approach by the government as was evidenced in the 1975 Speech from the Throne.

> "A number of important programs will fulfill my government's commitment that these citizens shall enjoy their late years with dignity and respect" (Speech from the Throne, Alberta Legislative Assembly, 1975:2).

The government further announced:

> "We are committed to policies which encourage the participation of older people in all aspects of community and provincial life. An opportunity for them to have a voice in the planning and carrying out of policies related to them will be stressed" (1975:4).

The primary reason provided for this new orientation toward senior services was summed up in the following statement from the throne:

> "It is in the interest of all Albertans that these citizens have active, contributing lives. They have given much to the development of our province and richly deserve satisfying and secure later years" (1975:4).

The above statement by the Alberta government acknowledged the potential present and future contribution of the elderly. In the past, only the past contribution made by the elderly to the province was recognized. Now

there was recognition of the instrumental benefits of providing health care for the aged. The government not only announced new policy and directives for aged health care in 1975 but also supported a number of facilities such as the Senior Citizens' Bureau, the Council on Aging as well as various social activities. It seems apparent that the government was not merely reciting honourable words. Effort on the part of the government allowed official policy to become to a large degree operational.

Government support for a few community based facilities was not deemed adequate by the Senior Citizens' Advisory Council. In its recommendation to the Ministers of Housing and Public Works and Municipal Affairs, the Council was not satisfied that the rehabilitative orientation was being fully pursued by the government.[20]

> "The Council recommends that the government of Alberta endorse the principle that senior citizens be encouraged and supported to stay in their own homes, whether single dwellings or apartments, for as long as they wish and is possible; that each department be asked to examine its policies, programs, and practises to ensure it is supporting this principle" (1977:2,3,16).

The Council strongly urged that all government policies should reflect this principle. Apparently it was not.

---

[20] Members of the Senior Citizens' Advisory Council are appointed by the Alberta government. The Council was established in September of 1976 and produced its first annual report in 1977.

In practise, a rehabilitative philosophy was difficult to accomplish for the EHCSA. In the 1950's and 60's, the custodial care policy could be realized through the establishment of institutions. The goals of the new rehabilitative orientation were rather vague however, in specifying the resources necessary for its successful implementation. It was impossible to precisely predict the resources required for the EHCSA or determine the financial responsibility of the government.

It seems apparent that the Alberta government believed a rehabilitative approach in the 70's would be more economical than supporting massive expenditures for institutional care. In the 50's and 60's, the government had introduced the homes for the aged program to overcome the high cost of active treatment facilities occupied by the elderly. It was well known by the late 60's that more facilities would be necessary if the aged were to be accommodated in these institutions.[21] Thus, a rehabilitative approach was considered as an affordable alternative to custodial care.

Encouraging the aged to remain in their own community and increase their independence was a good public relations strategy. Such an approach appeased groups (e.g., Council on Aging) that had demanded less emphasis on institutional care and greater community services for the elderly. Implementing a rehabilitative policy was not however an easy

---

[21] Lodges were filled to capacity in Edmonton and there were waiting lists by the late 60's.

task not an instant cost saving device. By the late 70's, massive capital had been spent on rehabilitative facilities, yet the need for more continued. [22] It would seem that the government had not supported its goals wholeheartedly. However, no overall plan was in force for the development of the EHCSA. The government's priorities for the development of the EHCSA were unclear. This resulted in a variety of services being created without any real co-ordination. The absence of a 'plan of action' created problems in implementing a rehabilitative orientation. Official goals may be in place but bringing these in operation requires more than financial aid. There was a growing awareness by the late 70's, particularly by the Senior Citizens' Advisory Council, that a co-ordinated system of care needed to be in place otherwise facilities would continue to expand haphazardly and costs would spiral.

In sum, the 70's witnessed a change toward a rehabilitative orientation. No longer was the government solely interested in offering passive, maintenance type of care. The government began to emphasis 'quality of life' issues for seniors and the significance of personal motivation and the potential contribution of the elderly. In the past investment in aged health care was rationalized in terms of affective benefits. That is, the emphasis was

---

[22] The emphasis on reducing financial expenditures is clear from the fact that a rehabilitative orientation did not apply to institutions. There was no incentive to assist the aged within institutions to return to their community. In fact, the custodial care policy for institutions remains in effect in the 1980's.

on the past sacrifices seniors had made to the province. In the 70's, the government recognized the possible sacrifices seniors could still make. The official rehabilitative policy was considered as more economical than custodial type of care, particularly in light of the instrumental benefits. Throughout the 70's, health care facilities for the elderly increased dramatically. It would seem that the government's policy was to a large extent becoming operational. By the late 70's investment in rehabilitative care for the elderly became more difficult as the demand for more facilities continued. It became evident that a rehabilitative approach in order to be cost effective required a systematic plan of action for its development. Such a plan was not operating in the 70's.

Policy-making in the EHCSA during the 1980's

By the late 70's, it was apparent that costs for these new services had greatly exceeded government expectations. The new services that emerged were heavily used. Existing services continued to expand as did their costs. [23] The cost benefit from this new approach were not readily apparent. The rehabilitative approach first advocated by the

---

[23] The Edmonton Home Care(1973) program is such an example. The program offered both physical and social services to enable its clients to remain independent and in their own environment. The goals of the program was to prevent institutionalization. Utilization of this program was greater than expected as was the cost of the operation. The financial cost of operating the program tripled in a 5 year period. In 1978, the program was terminated and replaced by one that was hoped would reduce costs.

government in the late 60's, became increasingly difficult to uphold. Yet, it was not abandoned.

The government continued to promote a rehabilitative policy for aged health care. The government continued to offer funds for a variety of services (e.g., Alberta Pioneer Repair Program, Alberta Assured Income Plan).

> "In continuing recognition of their contribution to our country and our province, senior citizens who qualify for Alberta Assured Income Plan will have their benefits increased. This will aid in meeting rising costs for food and shelter" (Throne Speech, April 2, 1981:6).

From the above statement, it is apparent that the government was willing to support a rehabilitative approach. The government recognized the contribution seniors were making to their community. The government continued to stress the instrumental benefits to justify further investment in aged health care. The establishment of such facilities as senior drop-in centres, adult social day and the geriatric facility in the late 70's and early 80's was evidence of the government's endorsement of a rehabilitative philosophy. However, there was a subtle shift in government policy away from offering just more services toward trying to implement a continuum of care approach.

A continuum of care approach meant establishing a more co-ordinated program that could reduce overlaps and fill gaps in service delivery thereby provide a greater amount of

independence and choice for the aged. This approach was advocated by the Senior Citizens' Advisory Council. The Council stressed "not simply more services but a shift in services that will not only reduce government involvement and support but will add to the independence of future generations of older people" (S.C. Advisory Report, 1980:8).[24] This approach aimed at co-ordinating all services thereby reducing overlaps and avoiding gaps in the system.

The Senior Citizens' Advisory Council suggested three points as comprising this new approach.

1. The "developmental" issue focused on the attitudes, policies and services that give older people opportunities for continued involvement in living.
2. The "supportive" issue addressed the development and delivery of services needed to help older people utilize their strengths.
3. The "protective" issue suggested the way to provide a sheltered and protected environment with appropriate care and rehabilitation (1980:8).

This new philosophy for aged health care in the 1980's was also expressed in the report of the Nursing Home Review Panel (1982:xi):

"The care of the elderly and disabled must be based on respect for the individual as an independent

---

[24] Whether the government should decrease its involvement in the EHCSA is debateable. It would seem that the government has not had enough involvement in the EHCSA. The government may provide financial expenditures but has not thoroughly examined what is really necessary for the EHCSA.

member of society who has the right to make decisions about his/her life and to function with those choices in as normal a setting as possible. For most of the frail and elderly needing minimal care, this can best be achieved through care services that allow the individual to remain at home."

Today, the philosophy advocated is not only advantageous for the elderly but also for the government. Expenditures for aged health care by the late 70's suggested the demand for more facilities would continue. A change toward greater integration of services, as has been mentioned earlier, in the short run means additional funds. However, in the long run it not only reduces expenditures but enables the aged to make their own decisions about the type of services desired.

One indication of the direction this holistic, rehabilitative approach should take became clear in the establishment of the geriatric facility (Youville) in 1982. This facility provides a model of a rehabilitative rather than a maintenance type of care orientation. Within this facility services are co-ordinated to encourage the elderly to return to their community and lead an independent lifestyle. At the same time, this facility attempts to reduce the cost associated with placing elderly persons in active treatment facilities for which they are ill suited.

At present the geriatric facility (Youville) offers a model of a rehabilitative approach to health care for the aged. For a rehabilitative approach to succeed continued recognition from the government beyond monetary support is required. The government needs to adopt policies that promote a rehabilitative orientation if the existing geriatric facility is to fulfill it original mandate. [25]

The EHCSA established policies that exemplify an holistic approach. The task now is to bring these policies into practise. This requires rallying the public, seniors and particularly the government behind the aims of the EHCSA. Such a task if accomplished successfully will enable the EHCSA to provide quality care for the aged even in the 21st century at a reasonable cost to the government.

In sum, we expected that custodial care policies would dominate in the past. These policies did dominate the 50's, 60's and even the 70's. The institutions that developed as a result of this approach were based on the attitude that the aged only required a maintenance type of care. Although, the government continued to wholeheartedly acknowledge the great past contribution of the elderly, the

---

[25] One distinctive characteristic of a successful geriatric facility is its close proximity to an active treatment facility. A successful geriatric facility implies access to centralized services for its elderly clients. It means that necessary services, resources and technologies are available under one roof without having to transfer clients from one facility and from one specialist to another. This is particularly important when dealing with a geriatric client population. The proposed transfer of resources (e.g., radiology) to the new Mill Woods facility may substantially reduce the Youville's ability to successfully operate.

primary reason for the construction of these institutions was economic: reduce the high cost of elderly in active care facilities.

The change toward a rehabilitative approach in the 70's followed a similar pattern as earlier decades. Again, the underlying reason for this shift was economic. The construction of custodial type of facilities increased dramatically in the 60's and the need for more of the same was not diminishing. Instead of citing the past achievements of seniors, the potential present and future contribution of the elderly was used in the 70's to justify further investment in aged health care. Further in the 70's, the government stressed the importance of seniors remaining in their community and leading independent and fulfilling lives. Promoting instrumental benefits of investment in aged health care was seemingly successful. The rehabilitative philosophy promoted by the Alberta government to a large extent was being implemented in the 70's. Numerous social and recreational facilities developed during this period.

In more recent years, it has become apparent that increased costs for a rehabilitative approach requires a substantial amount of funds for any amount of success. Although the government has accepted a rehabilitative approach and recognizes the elderly as a potential resource to the province, the government realizes services for the elderly can no longer be established haphazardly. This

means that if the government is serious about implementing a rehabilitative approach for the EHCSA, it must strive to develop a co-ordinated system. In the short run, a co-ordinated system requires initial additional expenditure in the EHCSA; in the long run this is a sensible route to follow. Without such a co-ordinated system, the official holistic policies will experience a difficult time becoming operational.

Rehabilitative policies are in place in the 80's. Facilities developed in the 70's to satisfy the rehabilitative goals. In the 80's, maintaining a rehabilitative apporach is problematic. Resources to satisfy this approach can no longer be provided haphazardly. A 'plan of action' for the development of the EHCSA needs to be set out. Without such a strategy satisfying rehabilitative goals in the 80's is not possible.

The next section examines the historical patterns of co-ordination in the EHCSA. Effective co-ordination is essential if the policies set out for the EHCSA are to be implemented.

C. Co-ordination in the EHCSA

Co-ordination determines the performance of the system. It provides the mechanisms for the effective implementation of the goals of the system. It offers an indication of the extent to which goals have been successfully achieved. Changing goals requires changing strategies for the system

to effectively operate.

For the EHCSA, co-ordination allows the system to offer better services for the elderly, avoid duplication of services and fill gaps in the existing services thus reducing costs.

In this section, it is hypothesized that as the EHCSA expands, that is, develops from custodial type facilites to those promoting a rehabilitative approach, co-ordinating mechanisms for the EHCSA will need to increase as well. Increased involvement in the EHCSA by management and particularly government is anticipated. Vertical co-ordination can be exerted, for instance, by requiring additional study reports (e.g., Lodge Program Study; Nursing Home Review Panel); and increased surveillance through the appointment of committees (e.g., Board of Visitors, Greater Edmonton Foundation).

It is also expected that facilities co-operate together to provide better services for the elderly. This underlies the horizontal co-ordination task which can be determined for example by the number of networks between facilities of the same type and those of different types (e.g., Assessment Committee, Society for the Retired and Semi-Retired; Senior Citizens' Bureau).

These two aspects of co-ordination are essential for the successful fulfillment of the goals of the EHCSA and its further expansion. Figure 1-5 show the relationship between facilities in the EHCSA over time. More discussion on the

diagrams follows in later sections of this chapter.

Co-ordination in the EHCSA during the 1950's and 1960's

Just as there were few policies in the early 1950's for the development of the EHCSA so there was little co-ordination in the EHCSA, this is evident from Figure 1. Not that there was much need for any co-ordinating mechanisms since few organizations existed. [2] Instead, it seems clear that the government was uninterested in expanding the EHCSA and co-ordinating existing organizations.

By the late 50's with the establishment of the lodge program, the Alberta government began exercising some control over the development of aged health care. The following quotation indicates the government's role in the development of lodges within the EHCSA:

> "Control over the basic aspects of procedure and administration to maintain standardization of operation throughout the homes was the responsibility of the government" (Public Welfare Annual Report, 1958/59:25).

Control over the lodges in the city was exercised through the Greater Edmonton Foundation which provided a liaison between the lodges and the government. The

---

[2] As was mentioned earlier, the psychiatric institution (Oliver) was the only organization involved in the EHCSA. During the 50's, the Local Board of Health nor the city welfare dep't kept contact with the institute. No attempt was made to establish a network to assist discharged patients.

FIGURE 1

DIVISIONS OF THE ALBERTA GOVERNMENT INVOLVED WITH THE EHCSA IN 1950

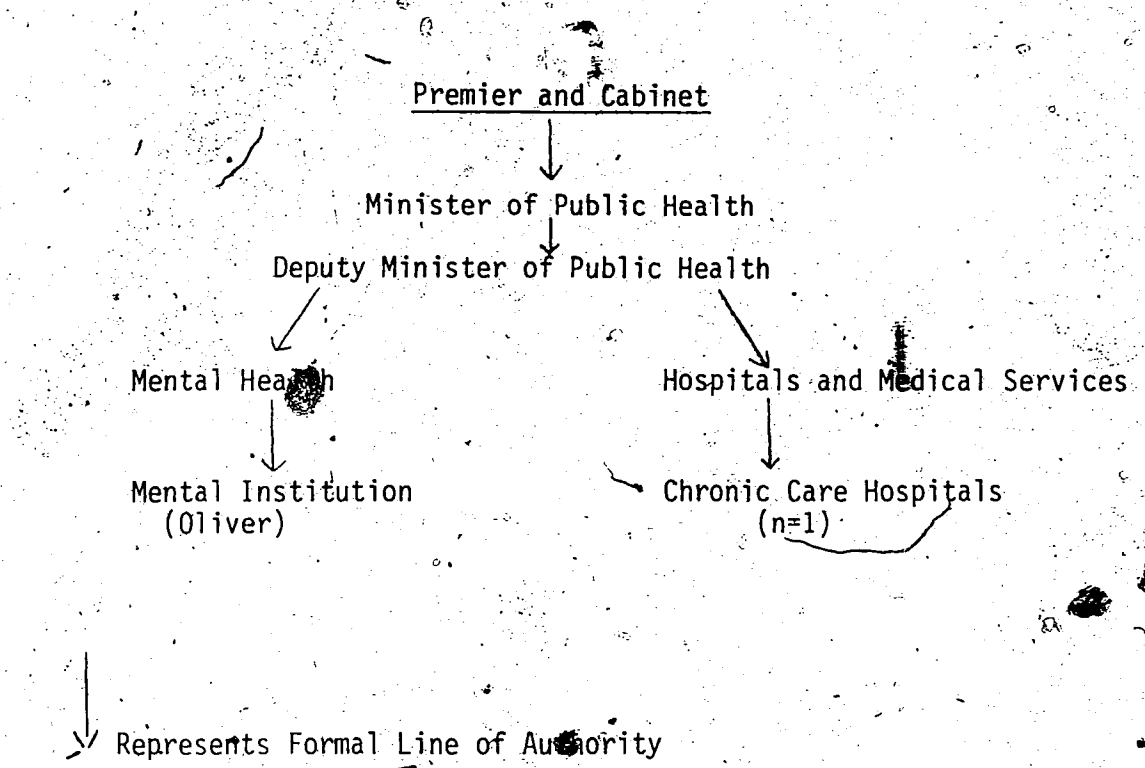


FIGURE 2

DIVISIONS OF THE ALBERTA GOVERNMENT INVOLVED WITH THE EHCSA IN 1960

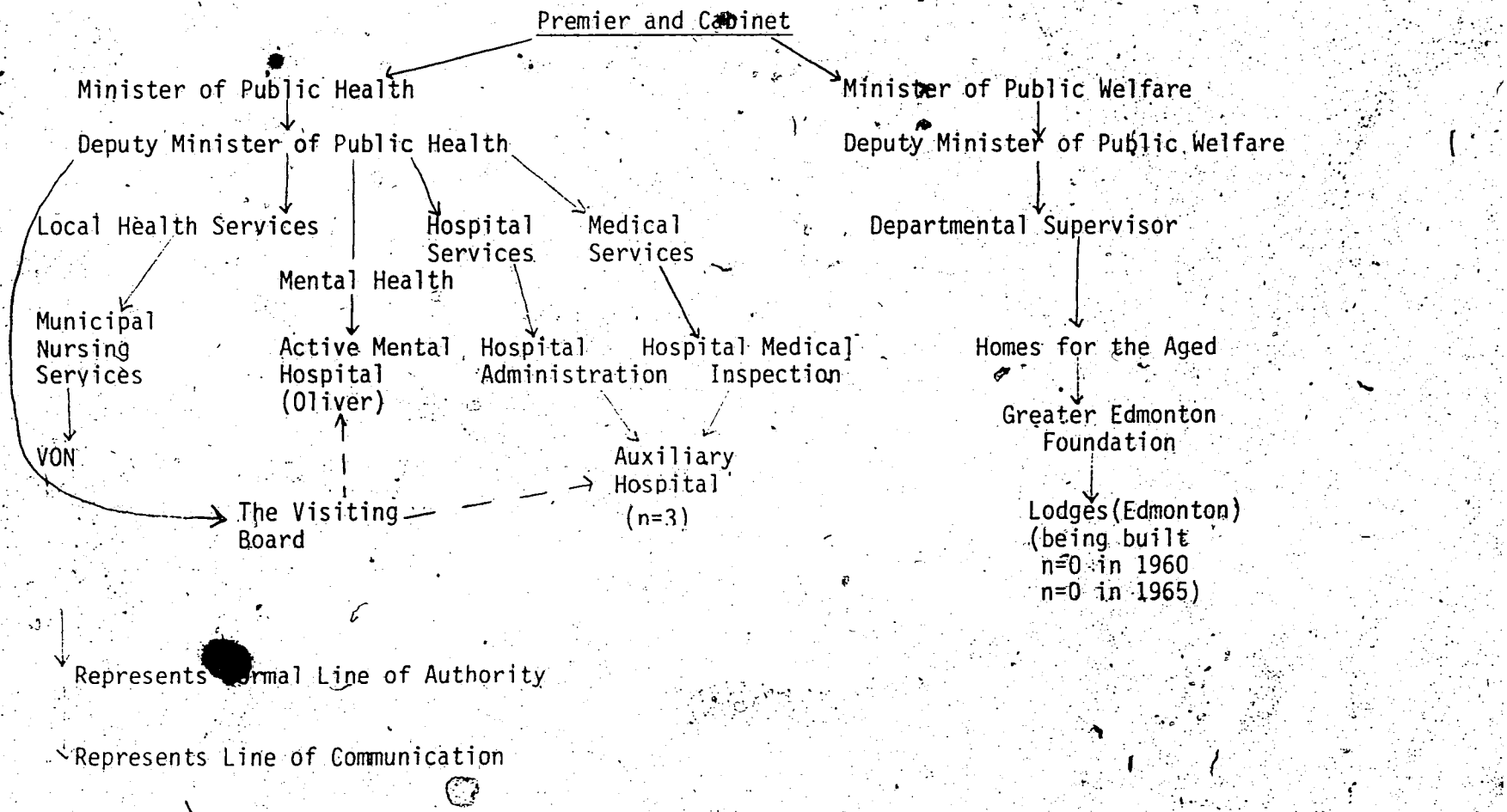


FIGURE 3

DIVISIONS OF THE ALBERTA GOVERNMENT INVOLVED WITH THE EHCSA IN 1970

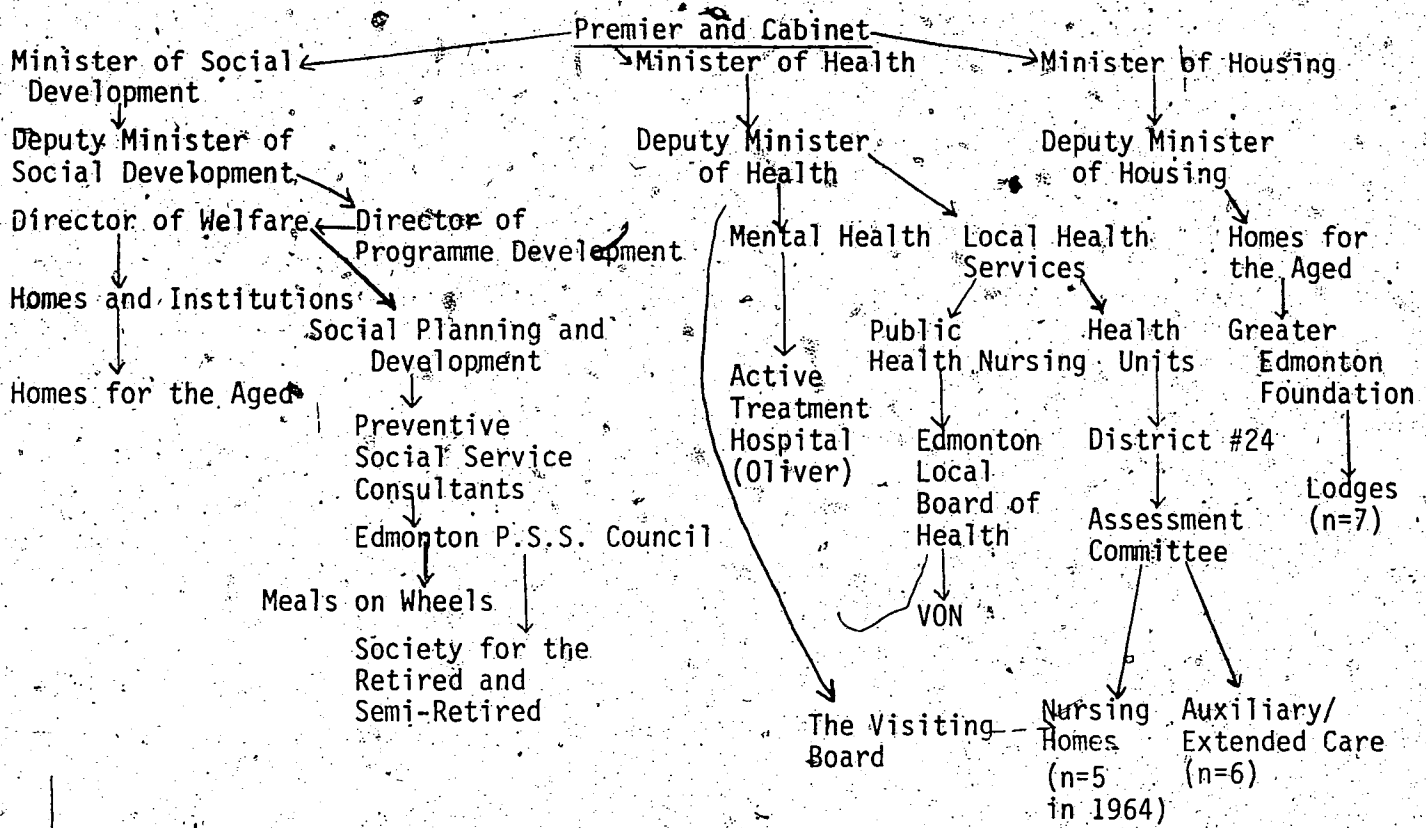


Figure 4

DIVISIONS OF THE ALBERTA GOVERNMENT INVOLVED WITH THE EHCSA IN 1980

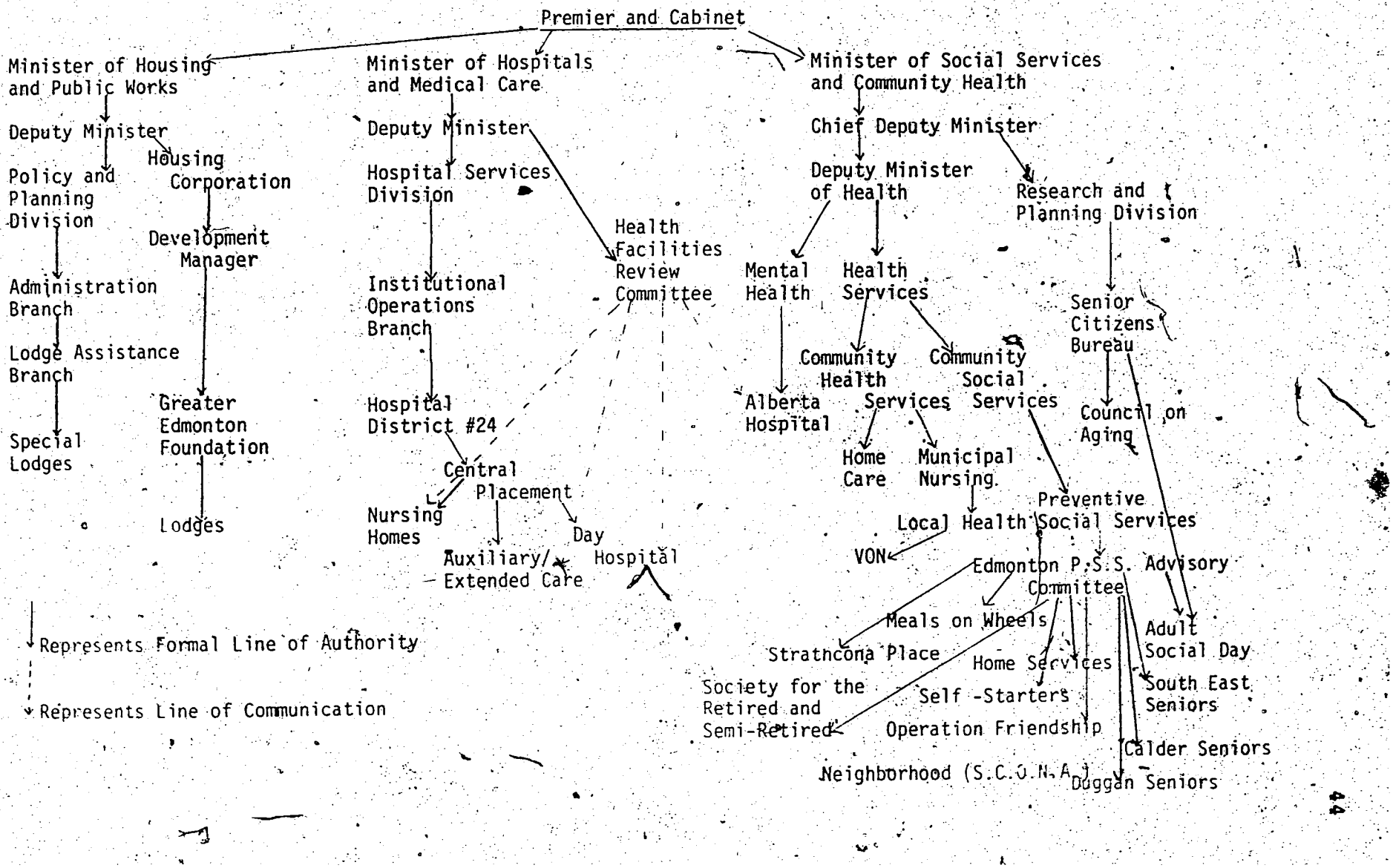
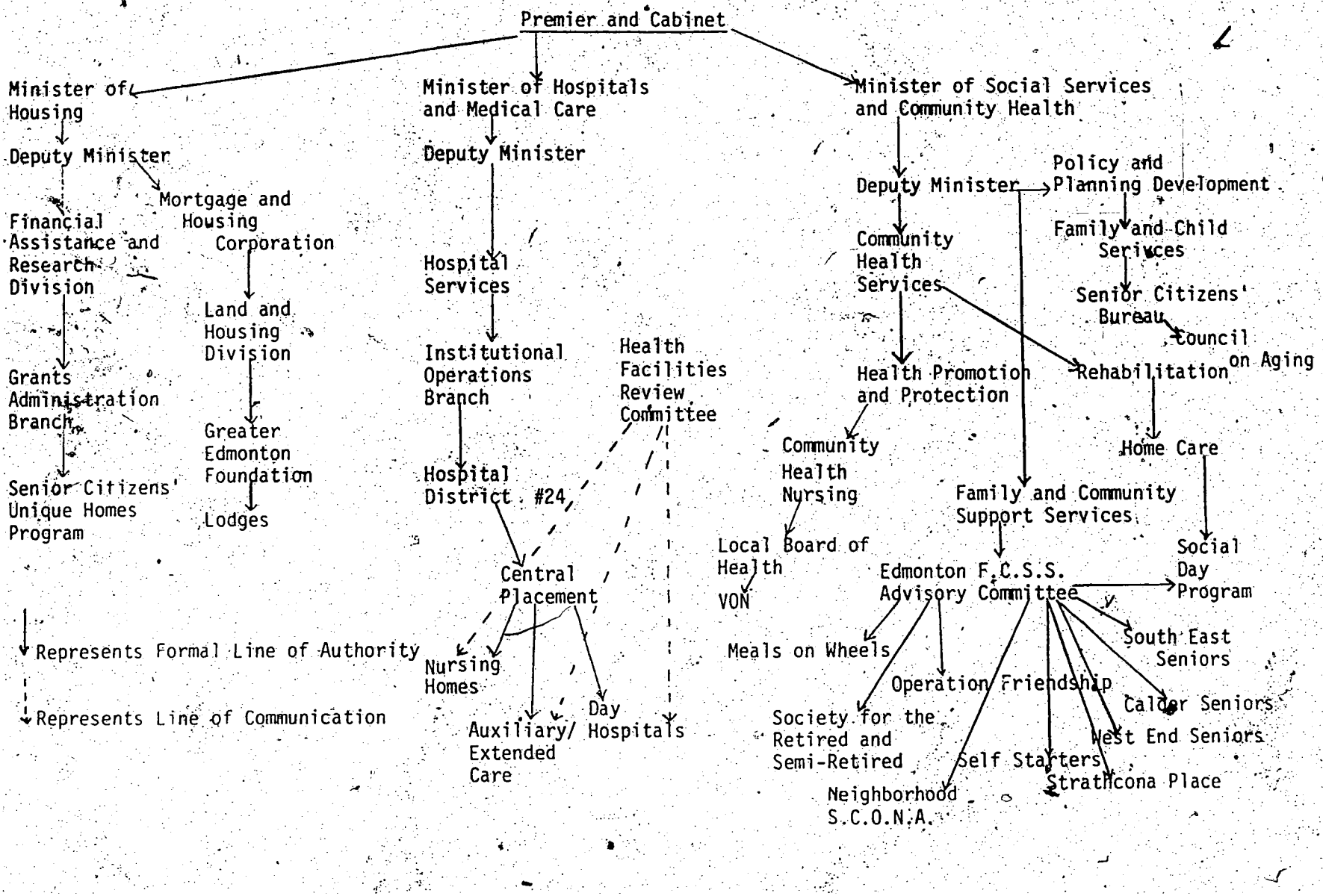


Figure 5

DIVISIONS OF THE ALBERTA GOVERNMENT INVOLVED WITH THE EHCSA IN 1985



Foundation was directly responsible to the government for providing necessary information about the lodges in its district (e.g., operating expenses).[27] The provincial government had the authority to require formal reports from each lodge, although this was not done.

By the mid 60's, nursing homes were added to institutions as providing custodial care as evident from Figure 2. Through the passing of the Nursing Home Act (1964), the government was also able to regulate this type of institutional care. The government authorized the establishment of a committee: the Edmonton and Rural Auxiliary Hospital and Nursing Home District #24 in order to provide a linkage between nursing homes and auxiliary hospitals.

The government at this time also recommended the establishment of an assessment committee to set standards of care and review applications for admissions to nursing homes.[28] The government had the power to inspect, supervise and determine the type of records kept and the reports to be made by the operators of the contract nursing homes, according to the Nursing Homes Act. In general however, the committee District #24, provided the reports on activities

---

[27] Basic day to day regulations were set up by the local administrator/matron.

[28] In Edmonton, this committee was composed of representatives of the medical staff of each of the auxiliary hospitals. In 1971, this committee was replaced by the Central Placement Office under the direction of a R.N.

of the nursing homes in the area.[29]

Vertical co-ordination existed in the EHCSA during the 50's and 60's in the form of the Greater Edmonton Foundation, District #24, and the Board of Visitors.[30] The government did not establish additional task forces either externally or internally to monitor institutions. Nor was there during this period any formal communications or horizontal co-ordination between or within types of facilities in the EHCSA (e.g., within nursing homes in the city or between nursing homes and lodges).

Co-ordination in the EHCSA during the 1970's

The late 60's saw a change in the orientation of the EHCSA. The government continued to regulate institutional care, however, the government also became involved in community based services for the aged. Figure 3 shows the expansion of the EHCSA in 1970 and the amount of co-ordination between facilities as witnessed by the number of arrows linking facilities. The Alberta government

---

[29] The government set the rates to be paid by the elderly and the daily payments provided to the nursing home operators from the government. This payment was based on occupancy rates.

[30] The government appointed the Board of Visitors in 1960. This board was required to inspect the conditions within institutions, although not just homes for the aged. Unfortunately, this committee had little political clout with the government. Officially, this committee had an important mandate but, in actuality the recommendations provided to the government were seldom implemented (Mental Health Study, 1968:230). 1971 was the last year an annual report was filed by the Board.

provided grants to the city of Edmonton through the P.S.S. program. The Alberta government provided a lump sum of monies for the P.S.S. program, but the city regulated the amount of funding for senior programs and the type of agencies to be supported. [31]

Earlier decades had seen the government enforce its custodial policies through legislation. Through legislation the government stipulated the rules and the institutions were required to comply. Now, the Alberta government did not have direct influence on the priorities established by the city of Edmonton. The city was under no obligation to fund services for seniors.

The government, however, continued to monitor the expansion of the EHCSA. This is apparent from the fact that in 1975, the government set senior services as a priority for P.S.S. funding. [32] A prime example of the extent vertical co-ordination was exercised in the EHCSA was the establishment of the Co-ordinated Home Care Program in 1978. The city of Edmonton had already in 1973 established its own home care program but with the implementation of the provincial-wide home care program, this was terminated. Although, the directors of the program and the city social services department disapproved of the philosophy of the new

---

[31] 80% of P.S.S. funds came from the government of Alberta and at least 20% had to come from the city of Edmonton.

[32] 1975 was the only year the Alberta goverment set priorities for spending P.S.S. funding. The two areas receiving special consideration was child care and senior services.

program, the city had to conform to the government's new program (Bella, 1980:76/77). [33]

In other areas of the EHCSA, those not receiving P.S.S. funding, such as nursing homes and lodges, the government retained full responsibility. With the new emphasis on rehabilitation it would have been expected that the government would re-examine the types of activities offered and possibly re-organize institutions to offer services in line with the new orientation emerging in the 70's. A few additional committees were appointed to monitor institutions for the aged; however, this was more a political move than providing any substantive changes. [34] In the 1970's, the

---

[33] The city of Edmonton and the directors of the Home Care program wanted the new program to retain both the social and the physical aspects as equally necessary. The province did not, however. The Senior Citizens' Advisory Council (1977) also stressed the need for a strong social support component together with the physical one. This was repeatedly stressed in all their annual reports. Thus far, (1985) it still has not been heeded.

Unlike other municipalities, Edmonton had, prior to the government home care program, initiated its own. The city had defined the goals it wished to see fulfilled. With the new program, the philosophy changed. The basic reason for the government's reluctance to support a strong social component was economic: an emphasis on the physical component of the program meant only those who were recommended by their physician qualified for the program. This significantly reduced potentially eligible clients.

[34] In 1972 a new political party came to rule the province and no doubt changes can be attributed in part to this. In 1971 The Hospitals Services Commission was established with the responsibility to administer and determine the financial support to operate programs of active care, chronic care, rehab services, and auxiliary hospitals. In 1978 the power of this commission was transferred to the Minister of Hospitals and Medical Care.

The Hospitals Visitors Committee was established by the government in 1972. This committee was to visit health care facilities throughout the province for the purpose of receiving and inspecting them. These facilities included

government refrained from setting up any type of study group and essentially allowed, for example, nursing home operators to maintain the same brief, unstimulating activities as they had been accustomed to.[35]

Another example of the lack of control exerted by the government over institutions was the lack of knowledge about the level of care officially administrated in these institutions. In principle, guidelines had been established for the type of care to be provided. In practise, enforcing these guidelines proved difficult. Many reports have cited incidents in which clients have received less than adequate care for their condition but no single study actually investigated the levels of care offered. Adequate placement of residents is indirectly the responsibility of the provincial government in Alberta. Unfortunately, the government failed to monitor institutions sufficiently and thus failed to convince the public that they are serious about a rehabilitative approach to aged health care.

The lack of co-ordination in the 1970's was cited in the annual report of the Alberta Health Facilities Review

---

[34](cont'd) auxiliary hospitals, nursing homes, mental facilities and homes for special care. Lodges and contract nursing homes were excluded. The committee did not have the power to investigate individual treatment records and finacial records of these institutions. In 1978, this committee was replaced by the Alberta Health Facilities Review Committee and its mandate extended to include contract nursing homes and lodges.

[35] An extensive investigation of the lodge program was finally conducted in 1979. Only in the 80's did the government appoint a committee to re-examine the Alberta Nursing Home Act (1964).

Committee (1978:10).

> "The Committee believes that there is a need for greater co-operation between districts, between institutions in the same district and between facilities and services that are under the jurisdiction of different ministeries. Such co-ordination should be encouraged at all levels. This would facilitate efficient use of resources and comprehensive delivery of services."

The need for co-ordination of services became an important priority in the 80's as becomes apparent in the following section.

Co-ordination in the EHCSA during the 1980's

Throughout the 70's and even in the 80's, no overall co-ordinating mechanism existed in the EHCSA. In Figure 4, it is apparent that there are few linkages between or within type of facilities in the EHCSA. The EHCSA has definitely expanded since 1950 but an overall co-ordination of these facilities is not evident from Figure 1-4. Organizations, such as the Society for the Retired and Semi-Retired tried to establish networks with other services, however, they remained mainly a major referral and information source. The same can be said of the Senior Citizens' Bureau, although here, there is more contact due to its ties with the provincial government. Other facilities such as the central placement office provided co-ordination only between

institutional facilities (nursing homes, auxiliary hospitals and extended care facilities). Attempts at horizontal co-ordination in the EHCSA have been made but have failed.

In the early 80's, the Alberta government attempted to establish greater co-ordination between its departments. The Long Term Care Committee (4 departments) and the Committee on Senior Citizens' (11 departments) are examples of co-operation with the government. Also during this period the government increased its control on the EHCSA by appointing the Alberta Health Facilities Review Committee. In addition, a few study groups were set up to look into specific aspects of the EHCSA. Examples of this are the Lodge Program Study (1979) and the Hyde report on Nursing Homes (1982). To a degree this has increased vertical co-ordination in the EHCSA. [3] After the Spring 1986 election, the Alberta government did recognize the Senior Citizens' Bureau, renamed the Senior Citizens' Secretariat, as the official voice on seniors' affairs. For this the government must be commended. It waits to be seen whether the position and role of the Senior Citizens' Secretariat represents more than just a name change. The biggest problem facing the EHCSA in the 80's remains the lack of horizontal co-ordination among facilities.

The lack of horizontal co-ordination among facilities in the 80's has been well documented. The Senior Citizens'

---

[3] Several states in the U.S.A. have attempted to co-ordinate facilities by establishing a department on Aging (e.g., Rhode Island, California, Connecticut, Illinois, Kansas).

Advisory Council, the Hyde report on nursing homes, and the Interdepartmental Committee on Long Term Care all stressed the need for greater co-ordination among facilities in order to facilitate co-operation; avoid duplication of services; reduce unnecessary expenditures; and provide better services for the aged. The lack of co-ordination of facilities for those afflicted with psychogeriatric illness also became an issue in a session of the legislature. The Minister of Hospital and Medical Care in answer to a question from the Leader of the Opposition on May 13, 1981 acknowledged that the government had no strategy in place to assist seniors to receive proper psychogeriatric health care services although some type of strategy was being developed (Alberta Hansard, Legislative Assembly, 1981:717).

The absence of a co-ordinating mechanism in the EHCSA has been repeatedly stressed by the Senior Citizens' Advisory Council. In 1977 (Annual Report, p.7), the Council cited lack of co-ordination along with the inaccessibility of services as the two major problems facing the health care system for the aged. In 1982, the Council made the following recommendation in its annual report (1982:11):

> "The Council recommends that the Ministers encourage and support in principle a more co-ordinated system of service delivery at the local or regional level to meet more effectively the needs of older people."

The Council urged the development of a co-ordinated, integrated system of service. The Council felt that no

significant advances could be made and no changes in the need for and use of institutional services until such a system is operating effectively.

The Nursing Home Panel Review Committee in 1982 reiterated the recommendations of the Senior Citizens' Advisory Council. The committee recommended a co-ordinated system as the following statement to the government indicates (1982:16):

> "That a system be developed to coordinate the provision of all institutional and institutional continuing care services including auxiliary hospitals, lodges, nursing homes and the Coordinated Home Care Program. That the system provide for funding on the basis of need; contracting and coordinating services; program development; and input from the community."

The present system is one in which services are planned and delivered by each level of care in isolation (e.g., lodges, nursing homes, home care). It would be beneficial to provide a continuum of care for the elderly and the disabled based on a single delivery agency which could be responsible for user assessment, delivery and auditing of the services provided (1982:16).

The recommendation by the Nursing Home Panel Review committee was taken up for review by the Interdepartmental Committee on Long Term Care. Part of this recommendation has been addressed: a model for assessment and placement has

been developed and will be pilot test in the coming year (Interdepartmental Committee, Sept. 5, 1985).

This model was developed in response to the lack of co-ordination among facilities. The model is an integrated assessment which determines whether a client is in need of community based services or long term care. At present, a client may go through several procedures to determine eligibility for a specific program; this duplicates services unnecessarily (Interdepartmental Committee, Sept. 1985).

The one shortfall of the proposed model is that it is directed at the co-ordination of long term facilities. It does not attempt to co-ordinate other services for seniors. The co-ordination of long term facilities, although not yet a reality, is a necessary first step in the eventual co-ordination of all facilities in the EHCSA. The fact that a co-ordinating network is not in place in 1985, not even one co-ordinating long term care, strongly suggests the government has neglected the EHCSA even though it has the authority and responsibility to control the EHCSA. This is unfortunate not only for the citizens most affected by the EHCSA: the elderly, but also for the government. It indicates the government has not adequately monitored the expenditures wisely for the EHCSA.

The Committee on Long Term Care sums it up nicely in stating the importance of co-ordinting long term facilities:

> "Finally, failure to look at new ways to coordinating our long term care services will mean

> that we, in the future, will fail to use our resources most effectively to meet the health and social service needs of a small, but vulnerable segment of our population -- frail and the functionally dependent older person and younger severely disable persons. Alberta needs to provide long term care services in a way that provides more client choices, is more satisfying to the clients and promotes their maximum functioning and involvement in community and family life (quality of life)" (1985:33).

The greatest task facing the EHCSA today is establishing a horizontal co-ordinating network. Even in 1985, such a network does not exist as can be seen from Figure 5. The lack of such a central co-ordinating body prohibits the EHCSA from offering the best care for their clients, results in the duplication of existing services thus increasing government expenditures.

The initiative for a co-ordinating network or developing horizontal co-ordination should be expected to come from the government. The absence of this mechanism reinforces the position that the government has not sufficiently monitored either long term facilities or community based services. This suggests the government has not provided adequate control of or vertical co-ordination in the EHCSA. This negligence on the part of the government further suggests the government lacks interest in expanding

the EHCSA. At best, the government provides some financial support or incentive but does not seriously monitor expenditures; suggest the necessary mechanisms to regulate the facilities; nor promote co-ordination and co-operation between facilities.

D. Goal-Attainment Conclusion

Theoretically, the problem of goal-attainment is to set policies for the system and utilize resources for the successful fulfillment of the goals of the system. In Parsons' model, goal-attainment acts as the central sphere stimulating changes in other dimensions. There is continues pressure on goal-attainment through, for example, environmental forces.

In the past, as was hypothesized, benefits for society from investments in the health care system for the aged have been seen as affective. That is, benefits were valued as ends in themselves and not as means to obtain productive ends. Providing for the elderly was seen as a moral obligation. The custodial care goals of the EHCSA reflected this orientation. Institutions were offered as an ideal haven for the elderly in their latter years. It allowed the elderly to rest from their labours. The elderly were not expected to further contribute to society.

Traditionally, it was beneficial to support such a maintenance care orientation. However, as was mentioned in the preceding section, the custodial approach was not so

much seen as an affective benefit for the system as an instrumental gain. That is, affective benefits for the EHCSA were used to justify the real motive for institutional care: economic. A custodial care approach was supported by the government and successfully implemented simply because continued expenditure for active treatment facilities was considered as too expensive.

In the present and particularly in the future with an increased proportion of the population as seniors, the traditional view of aged health care can not survive. The traditional view relies too heavily on a passive institutionalized view of the elderly and more importantly is far too costly to administer. Today, the affective benefits for investing in a custodial care approach to aged health care are not emphasized.

One way to succeed in obtaining continued support for aged health care is to attract productive benefits for the system. The official policy of the EHCSA today advocates the elderly as leading a productive, active lifestyle in society. Pursing such an approach allows the goal-attainment dimension to fulfill its rehabilitative goals. The affective benefits of this new approach to aged health care may continue to be used to legitimate support for the EHCSA, however, today the instrumental benefits must be taken into account.

So far, the theme of the elderly as a productive force has only just become recognized as essential. The

government has not yet fully recognized the potential of elderly citizens. The official policies may be in place and the government has indeed attempted to implement these. Yet, the government has not exercised its responsibility toward ensuring that the facilities available for seniors are in accordance with the rehabilitative, holistic goals. That is, the government has not ensured the co-ordination of facilities for seniors.

The lack of government support in co-ordinating health care services for the elderly, of both a vertical and horizontal nature, suggests the government is not serious about furthering an holistic approach. The government has officially endorsed an holistic policy but realistic efforts to effectively co-ordinate this wide variety of facilities has not been pursued. This means that at present the study hypothesis can not be supported. Policies may be in place today but implementing these have not been in accordance with the rehabilitative goals.

One of the reasons the government has not fully implemented its holistic goals may be the economic cost involved. In the past it was suggested that a custodial care approach was too costly to uphold. Now, it is increasingly evident the government believes supporting a rehabilitative orientation is also costly. However, the government has not fully implemented a rehabilitative approach to aged health care. Health care facilities for seniors have not been co-ordinated. It has been suggested

that a co-ordinated system of care may help reduce costs. It could reduce unnecesary gaps and overlaps in service delivery. Without such a system in place, expenditures for seniors will no doubt increase through haphazard investment in facilities.

The task of goal-attainment remains to continue to mobilize resources for an holisitic EHCSA. This includes implementing its goals and developing an integrated, co-ordinated system of service delivery. Initially expenditures for an holistic policy will no doubt increase. In the long run, expenditures will likely diminish as overlaps in facilities are reduced and gaps in service delivery are filled. For the government, a co-ordinated system of care means a high standard of health care for its senior citizens is possible even as the proportion of seniors in the population increases significantly. Pursing this new approach will enable the goal-attainment prerequisite to successfully motivate and stimulate other dimensions to correspond to the changes it seeks.

The next chapter discusses the adaptation prerequisite in the EHCSA.

III. ADAPTATION PREREQUISITE IN THE EHCSA

Adaptation (instrumental dimension) refers to obtaining resources from the environment and marketing the product (Black, 1961). Exchanges of resources for products are characteristic of all systems - social, cultural, personality, biological. For social systems, the resources exchanged are the traditional factors of production: land, labour, entrepreneurship-organizing ability, and capital.

1. **Land**, as used in this study refers to type of facilities(e.g., physical, psychiatric, social and recreational), their location (e.g., the distribution of facilities within each type), and the quantity (e.g., the number of facilities in each type.

2. **Labour** includes the quality of personnel (e.g., education, certification), categories of personnel (e.g., gerontologist), and the number in each category. Also considered here are services and technologies employed. On the demand side, the primary interest is in the proportion of the aged in the total population.

3. **Entrepreneurship-organizing** in this study refers to the expertise of the management staff in facilities for the aged. This includes the quality (e.g., education, certification), and the quantity (e.g., the number in various managerial roles). For the purpose of this study, labour and entrepreneurship-organizing ability are grouped together.

4. **Capital** refers to the amount of funding and the source of funding. The amount of funding indicates the total budget allocated to services for the aged and the source of funding refers to where resources are coming from (e.g., government, client, donor, private).

Obtaining resources in the adaptation dimension can present problems in periods of resource scarcity. As a consequence, resources may be limited and pressure exerted to support expenditures that offer visible rewards for the system. That is, activities which produce instrumental benefits. These problems confront the EHCSA. Continued investment in aged health care is jeopardized as expenditures for resources to meet changing goals increase and productive benefits for the system are not recognized.

Historically, resources needed to meet goals of the aged health care system were institutions and traditional labour skills. These resources were appropriate for custodial care goals. Goals changed and resources necessary to meet the new holistic policy for aged health care requires greater specialization among personnel and facilities (e.g., geriatric facility, geriatrician). Gaining these resources for the EHCSA requires justification of rehabilitative goals, specifically in terms of how achieving such goals are of benefit to the larger system.

In the next section each of the factors of production in the adaptation dimension will be examined historically to determine how resources were obtained and how they relate to

the changing policies of the EHCSA.

A. Land Resources in the EHCSA

One of the tasks of adaptation is to secure land resources for the operation of the EHCSA. Land as a factor of production provides the EHCSA with desired facilities to enable the elderly to be adequately serviced. To be successful, facilities need to meet the policies established by the EHCSA (e.g.,custodial care).

Over time land requirements may change as goals of the EHCSA change. Changes in the goals of the EHCSA would require a re-examination of the type of facilities available (e.g., social, recreational); their accessibility and their usefulness for aged health care. Tables 1a-c indicates the changes that have taken place in the land requirements between 1950 and the present. These changes will be further discussed below.

Land Resources available in the 1950's and 1960's

Health care facilities for the elderly in Edmonton were rare in the early 1950's. This is evident from the facilities indicated in Tables 1a-c. What was available for the elderly existed in conjunction with facilities for the entire population. These were categorized as long term care facilities for the infirm and elderly. [7] No social or

---

[7] Chronic or auxiliary hospitals provided service to the elderly. The Alberta Hospital Edmonton (Oliver) serviced the psychiatric population which included a proportion of elderly patients.

Table 1a Physical Type of Facilities in the EHCSA

Facility	1950	1960	1970	1980	1985
Auxiliary/Extended Care					
St. Joseph's	x	x	x	x	x
Royal Alex Annex		x	x		
Good Samaritan		x	x	x	x
Allen Gray			x	x	x
Norwood			x	x	x
Lynwood			x	x	x
Grandview			x	x	x
Dickensfield				x	x
St Michael's					x
Millwoods Shephard Care Centre					x
Day Hospitals					
A. McGugan/Dickensfield				x	x
Youville					x
Central Placement Office				x	x
Youvilles Memorial Hospital					x
Contract Nursing Homes			x	x	x

Table 1b Social Type of Facilities in the EHCSA

Facility	1950	1960	1970	1980	1985
Senior Citizens' Lodges/Units			x	x	x
Meals on Wheels			x	x	x
Society for the Retired and Semi-Retired			x	x	x
Edmonton Home Care				x	x
Home Services for Seniors				x	x
Strathcona Place				x	x
Operation Friendship				x	x
Neighborhood Ass. (S.C.O.N.A.)				x	x
Senior Citizens' Bureau (Secretariat)				x	x
Council on Aging			x	x	x
Adult Social Day Programmes				x	x
Self Starters					x
South East Seniors					x
West End Seniors					x
Calder Seniors					x
Duggan Seniors				x	

recreational facilities specifically for the aged existed during this time. The absence of facilities specifically for the elderly was reflective of the government's largely nonexistent policy on aged health care.

The adoption of a custodial care policy occurred toward the latter half of the 1950's. As a result there emerged a surge in institutional care strictly offering accommodation for the aged.[38] These lodges and self-contained units were planned by the provincial government and located in various areas around the city in close proximity to all amenities. Lodges and units were named after the location in which they were situated. This is apparent from Table 2. These dwellings were to accommodate 800 elderly people in Edmonton (Department of Public Welfare, Annual Report, 1958/59:24).[39] By the end of the fiscal year, March 31, 1964, Edmonton had 5 lodges plus self-contained units in operation with a total capacity for 500 persons. Occupancy rates for these homes were 100 percent with waiting lists of applicants (Department of Public Welfare, Annual Report, 1963/64:31).[40]

---

[38] Lodges (meals and laundry only) and self-contained housekeeping units were built in 1958 under the Senior Citizens' Lodge Program.

[39] The Edmonton authorities had decided to establish 8 different 4 sites with the combined units for 100 persons on a 5 acre plot (Department of Public Welfare, Annual Report, 1959/60:20).

Each lodge would accommodate 18 double bedrooms and 14 single rooms for a total of 50. Each bedroom contained its own toilet and washbasin. The lodges had 5 lounge areas and a large dining room with table for four adjacent to the kitchen (Department of Public Welfare, Annual Report, 1960/61:25/26).

[40] In 1965, the design of the homes were changed to meet the

Table 2 LIST OF LODGES AND SELF-CONTAINED UNITS IN THE 1960's

LODGES	OPENING DATE	SELF-CONTAINED UNITS*
Belvedere	Sept. 1962	Belvedere
Elmwood	March 1962	Elmwood
McQueen	March 1962	McQueen
Rosslyn	Sept. 1964	Rosslyn
Ottewell	Oct. 1963	Ottewell
Northway	April 1962	Northway
Bethany	Aug. 1966	Bethany

* Self-contained units are on the same property as the lodges.

Table 3 LIST OF CONTRACT NURSING HOMES AT DEC.31, 1964

Central
Hardistry
Jubilee
Sherbrooke
Venta

In 1964, the provincial government established the nursing home plan. As a result, previously privately owned nursing homes, on the approval of the government, came under government contract. In 1964, 5 nursing homes came under contract with the government. These are shown in Table 3.[41] Securing these lodges and nursing home institutions in the 1950's and 1960's posed little difficulty for the EHCSA mainly because the government saw these as serving two useful functions: reducing the costs associated with active treatment facilities and appeasing groups that felt the elderly required suitable housing.

For the next decade and a half, the government remained an avid advocator of institutional care facilities. Institutions served the government's economic interests, fulfilled the custodial goals of the EHCSA and received wide public support. The success of the institutional program was evident from the high occupancy rates and the waiting lists for entry into these institutions.[42]

With the demand for institutional care facilities rising along with the cost of construction, the government recognized by the late 60's that creating more institutions was potentially problematic. Instead, some innovative method was required in order to meet the health needs of the

---

[40](cont'd) demand for more single rooms (Department of Public Welfare, 1966/67:35).

[41] Unlike lodges, nursing homes offered basic nursing care.

[42] In 1969, there were 500 people on the waiting list for self-contained units in Edmonton.

aged.

Land Resources available in the 1970's and 1980's

A new philosophy adopted and sponsored by the government in the 70's encouraged the elderly to enjoy their latter years in the comfort of their own homes and familiar surroundings. The government offered services and resources but the real responsibility for aged health care began to shift toward the elderly themselves. The government believed focusing on the independence of the elderly and at the same time supporting these community based programs could be a great cost saver.

The emergence of this new policy significantly halted the creation of custodial care institutions. Now, rehabilitative types of facilities (combined social, physical, recreational and psychiatric) began to spring up in the city. [43] Tables 1a-c shows the tremendous increase in rehabilitative facilities in the 70's compared to either the 50's or 60's. Home care exemplified this new approach integrating both social and physical services. [44] Other facilities such as Meals on Wheels, Home Help and Senior centres also developed about this time. The primary aim of

---

[43] To a large extent, the rehabilitative policy of the EHCSA was encouraged by the government's introduction of the P.S.S. Act. This program provided grants to municipalities for the establishment of eligible projects for the aged.

[44] Home Care was terminated in 1978 and replaced by the Coordinated Home Care Program. This new program was tailored after the medical care model; social services were seen as providing ancilliary support.

all these facilities was to reduce and/or delay institutionalization.

By the late 70's, expenditures for rehabilitative services had risen sharply and the demand for more resources had increased beyond expectations. The government realized offering more facilities without some form of restraint was financially imprudent. It became increasingly difficult to ascertain the economic benefits from increased expansion of health care facilities for the aged. In fact, there seemed to be no limit on the number of facilities necessary for the EHCSA. The EHCSA was continually vying for more facilities for the aged.

The dramatic increase in facilities in the 70's was largely due to the government's aim to rapidly develop rehabilitative facilities for the elderly. However, the government and the EHCSA failed to implement an overall strategy for the expansion of aged health care facilities. Various facilities had been supported with only a vague sense of the direction the EHCSA should take. It became clear in the 80's that a comprehensive strategy for the development of the EHCSA was desirable. This would allow the government to focus on the expansion of specific types of facilities thus reducing costs associated with haphazard development.

An holistic facility in the 80's attempting to coordinate services for the elderly is the geriatric facility. The government in the early 80's supported the

establishment of the Youville. It is regarded as a model of a first rate holistic geriatric facility. Unfortunately, it seems that the government has not continued to fully support this facility. The reduction of support services for the geriatric facility with the intended transfer of the active treatment services offered at the General Hospital will hinder the performance and full functioning of the Youville as a geriatric facility. The failure of the government to implement a strategy for the development of the EHCSA has not only allowed haphazard development to occur, but allowed potentially excellant facilities to become neglected.

In sum, institutions were built in the 50's and 60's to satisfy the custodial type of care advocated by the government. By the late 60's the demand for institutional care facilities outstripped all expectations. Rehabilitative facilities such as home care and "meals on wheels" developed in the 70's as a result of the government's new policy. The government began supporting a variety of health care facilities for the elderly. By the mid to late 70's it was evident that the demand for rehabilitative type of care facilities was great and likely to continue. Further, the costs of providing this new type of care was escalating. Although the government had been willing to support rehabilitative services in the late 60's, mainly to avoid the high cost of institutions, the government had not developed a strategy for the establishment of rehabilitative facilities for the elderly.

Today, rehabilitative facilities continue to remain in demand. Yet, the government continues to lack a comprehensive plan for its future development. This suggests that while the government has adopted a rehabilitative policy efforts to implement and co-ordinate facilities for the fulfillment of these goals have not been successful. Without such a strategy official goals may be in place but realistic efforts to secure land resources for the EHCSA will not become operational.

B. Labour and Entrepreneurship-organizing Ability

Besides requiring land resources, adaptation also needs to secure adequate labour resources. Satisfactory labour requirements necessary to maintain the various goals outlined by the EHCSA is discussed in the following section.

Labour Resources available in the 1950's and 1960's

Qualified health care professionals were in short supply throughout the 50's and 60's in Edmonton. [45] Health care for the elderly had to compete for professionals alongside the general health care system. The custodial care policies introduced in the 50's, however, did not officially require qualified health care workers such as

---

[45] The whole health care system had an acute shortage of professionals such as social workers and therapists. These were trained outside the province. A public health care program and an nursing aide school were set up in the late 50's in Edmonton. One of the main reasons why Alberta faced difficulties recruiting professionals even in the late 60's was the low salaries offered.

physicians or nurses trained in geriatrics nor any other specialized service in institutions. Those employed in the EHCSA, like the general health care field, were trained in the acute care mode rather than chronic care. The elderly were not considered as requiring specialized treatment.

Specialized personnel were not required in lodges nor were they required in nursing homes. This allowed the EHCSA to staff its facilities with less qualified personnel (e.g.,. nursing aides). [46] Table 4 shows the personnel employed in contract nursing homes at Dec. 31,1964. The only other institutional facility in the EHCSA, the psychiatric institution (Oliver) did require specialized and qualified staff aside from nurses and physicians, although these were few. In 1956, for example, Oliver had one psychiatrist for a total hospital population of 1,614. During that year, 198 patients were admitted over the age of 60. [47] Qualified personnel in the EHCSA were at a minimum during the 50's and 60's mainly because educational programs were lacking both in the city and in the province.

Educational programs for the general health care field were minimal. Those for the training of geriatric health

---

[46] The nursing home care policies did not require any specialized personnel. Besides nursing aides, only one registered nurse was required for every 75 patients in a nursing home (Alberta Nursing Home Plan,1964:41). This still remains in effect in 1986.

[47] By 1969, Oliver had five occupational therapists and 7 aides for a population of 1,059. During that year 277 patients over 60 years were admitted. It is doubtful however whether elderly patients were a priority for the occupational therapy department.

Table 4 Number of Staff Employed in Nursing Homes in Edmonton at Dec. 31,1964

	Registered Nurses		Certified Nurses		Orderlies		Other Ward Staff		Total General Staff		Number of Approved Beds.
	F	P	F	P	P	F	P	F	F	P	
Central	4	3	1	-	3	-	20	3	28	6	124
Hardistry	3	5	2	3	1	4	14	3	20	15	98
Jubilee	2	1	3	-	1	-	20	5	26	16	126
Sherbrooke	1	-	-	-	1	-	7	-	9	-	29
Venta	1	-	1	-	-	-	4	-	6	4	28

care professionals were nonexistent. In the area of medical training for example, the Health Survey Committee stated (1950:106):

> In the past, medical education has been aimed at the cure of acute disease, but recently attention has been paid to other problems. The Survey Committee approves of this change in emphasis in Alberta and feels that this trend should be further completed along the lines of the following recommendation: new grads should have, among other things, an orientation in:
>
> 1. emotional and social problems of the ill;
> 2. the care of chronic condition;
> 3. preventive program.

This represented a first step in incorporating a geriatric health care component in the medical program. Geriatric health care however, was still in its infancy and had not yet been recognized as an area of pursuit even in the EHCSA. The custodial care goals advocated by the EHCSA did not require formal training in geriatrics. It is not surprising therefore that the lack of educational programs hindered the availability of qualified personnel.

Throughout the 50's and 60's, the EHCSA had the manpower and equipment to implement its custodial care policies simply because the policies established by the government required no more than a passive maintenance approach to health care for the aged. Professionals in the

EHCSA were not qualified in geriatric health care. Few specialists such as psychiatrists or social workers existed. No geriatrician or psychogeriatrician was available during the 50's and 60's. Nurses and physicians were clearly the main participants in the EHCSA but these were in great demand in the health care field in general.

Labour Resources available in the 1970's and 1980's

The development of new policies for the EHCSA in the 70's away from maintenance care toward rehabilitative ones required the recruitment of specialized personnel (e.g., social workers, therapists) as well as specialized programs and equipment (e.g., recreational activities, courses and educational upgrading). Unlike the custodial care approach in the previous years, the new approach viewed health care for the aged as requiring expertise in chronic care. Although guidelines for recruiting personnel became more specific in terms of educational qualifications, personnel were still recruited primarily on the basis of availability.

As in previous decades, the EHCSA continued to experience an acute shortage of specialized professionals trained in health care for the elderly. To a large extent, trained personnel did not exist because educational programs were not in place in Edmonton. The lack of educational programs in geriatric health care is evident from the recommendation of the Senior Citizens' Advisory Council and repeated in subsequent annual reports, to the Minister of

Social Service and Community Health as well as other appropriate Ministers. The Council advised, "to consider ways to undertake an enabling program to make it financially feasible for community general practitioners to avail themselves of educational opportunities in geriatrics (1977:11,12)."

The medical component of the EHCSA was not the only professional group lacking training in geriatric health care. The Senior Citizens' Advisory Council placed educational programs on their priority list (1977:9):

> "That Council recommends that there be combined support for the development of a community based institution for science, education and research in gerontology." ••

In the social, recreational and psychiatric areas, personnel too were unqualified to treat the elderly. •' Many of the social facilities such as senior citizens' centres were staffed with dedicated personnel but they were often not trained to deal with the special needs of the elderly. The Senior Citizens' Advisory Council in their report (1977) noted this lack of expertise among staff:

> "In addition, many people working with the elderly while dedicated and sincere, lack the professional

---

•• Since the establishment of the Council, an Centre for Gerontology had been recommended as a resource base for teaching and research. This centre was finally realized in 1982.

•'In the 70's, for example, those in recreology were not qualified to teach physical fitness to the elderly.

knowledge and expertise required to plan and deliver services that help older people function at their optimum level."

Volunteer workers, many of them senior citizen made up a large percentage of the staff in these social and recreational facilities. Although perhaps not always qualified they attended to numerous services that would otherwise have been impossible to deliver. The 'meals on wheels' program, for example, in 1970 delivered 7,707 meals and involved over 70 volunteers to provide the service (Edmonton Social Service, Annual Report, 1970:2). By 1976 with the assistance of 490 volunteers, 44,755 meals were delivered to shut-ins (Edmonton Social Service, Annual Report, 1976:6). By 1980, approximately 600 volunteers with a total of 25,402 hours of service delivered 59,000 daily meals and 1,500 weekend meals to 1,288 shut-ins. (Edmonton Social Service, Annual Report, 1980). It is evident that volunters offer a tremendous service. Without their dedication it is unlikely that this program for example, could be the success it is today. Not with standing the great service volunteers offer the community, the absence of proper training facilities for them as well as for others, pose difficulties in providing a rehabilitative approach to aged health care.

The lack of educational training programs at all levels remained a major obstacle in the recruitment of personnel in the 70's. Recruiting professionals from outside the

province was one option and in some instances was possible; however, it was an extremely costly option and did little to establish needed educational programs in the city. However, even in areas such as nursing home care where skilled personnel could have been placed but this was not done. [50] The government offered no incentives for a rehabilitative approach within institutions. [51]

Greater awareness of the need for geriatric training for professionals continued in the 80's. The establishment of the geriatric facility in 1982 was heralded as an advance both for the delivery of health care was well as the educational training in geriatric medicine. [52] In 1980 the first geriatrician in Edmonton was appointed to head the Youville geriatraic facility. [53] At that time a division of the Faculty of Medicine at the University of Alberta in geriatrics was established affiliated with the Youville

---

[50] More educational training for all health care workers, particularly those in institutions was also cited as urgent in the 1978 (p. 12) annual report of the Alberta Health Facilities Review Committee.

[51] Nursing homes for profit were unlikely to employ extra staff at their own expense especially when it was not regulated by the government.

[52] "Only recently has the Royal College of Physicians and Surgeons of Canada formally recognized Geriatric Medicine as a new subspeciality within Internal Medicine" (Letter from Albert Health and Social Services Discipline Committee to the Senior Citizens' Bureau dated Oct. 22, 1979).

[53] Aside from geriatricians, the Youville at present also employs psychogeriatricians, psychiatrists, social workers, therapists (e.g., physical, recreational), and community nurses.

A unique unit at the Youville facility is the palliative care program which provides comfort to those dying.

geriatric facility.** Although geriatric medicine as a field of study received greater attention with its establishment as a division of the Faculty of Medicine, it is not at all clear whether medical students receive greater exposure to this field of study.

From the University of Alberta Calendar 1985/86, courses in geriatric medicine are noticeably absent. No doubt interested medical students can pursue this area by taking a reading course or enrolling in graduate research. The only indication that the department of geriatric medicine at Youville teaches courses at the University of Alberta is from the departments' annual report (1984). In its report it states that the Youville taught five undergraduate courses as well as some graduate courses during that year. From the course description in the U of A calendar only one course description states that it deals with the special needs of the terminally ill. Unfortunately, it is not clear from the U of A Calendar that courses are offered specifically in geriatric medicine. Even though a division of geriatric medicine has been created at the University of Alberta Medical Faculty the benefit of its existence for the medical student is unfortunately not formally acknowledged.

'Medical Students are Ill-equipped for the Future' was the heading of an artic in the Globe and Mail dated Sept.

** Most of those involved with the University of Alberta Faculty of Medicine, division of geratrics were employed at the Youville (University of Alberta, Calendar, 1985/86:x1-x3).

7, 1985. This expressed the sentiment of Dr. D. Waugh, past executive director of the Association of Canadian Medical Colleges.

> "Medical schools neglect their 'social contract' with patients and governments by not teaching students what society wants from them. There is not enough communication between the profession and the public it serves."

According to a survey of medical education published last July in the Canadian Medical Association Journal, it was concluded that when choosing an area of specialty, medical students do not take into account future health care needs. Within the next 50 years, for example, physicians will be confronted with unprecedented numbers of elderly patients, but students are not rushing to specialize in geriatric care (Globe and Mail, Sept. 7, 1985). Seeking qualified producers in geriatric health c[illegible] is a problem faced not only in Edmonton but throughout the entire country.

In sum, the EHCSA obtained required labour resources in the 50's and 60's to meet its custodial care goals. In the 70's, policies changed. Qualified personnel required to deliver the rehabilitative approach were not in sufficient supply. Health care facilities for the aged existed in the city but personnel were not sufficiently qualified to effectively plan and utililze services and technology at hand.

The lack of qualified personnel is also evident in the 80's. The lack of geriatric training programs hinder the recruitment of personnel to the EHCSA. The EHCSA can not fulfill its rehabilitative goals in the 80's without adequate labour and entrepreneurship-organizing abilities. The lack of adequate labour suggests that while the government has adopted a rehabilitative approach to aged health care it has not ensured the means to recruit qualified personnel. Unfulfilled goals means the elderly are not receiving the proper care and in the long run this signals greater expenditure for the provincial government.

C. Capital Resources in the EHCSA

An important factor of production is capital. Sufficient capital is necessary (but not sufficient) for the goals of the EHCSA to be attained. Without capital even the best policies could not hope to succeed. The adaptive task is to obtain necessary capital for the financing of the goals of the EHCSA. The following section discusses how the EHCSA has secured capital for its development.

Capital Resources available in the 1950's and 1960's

Like any other enterprise, the EHCSA requires financial investment for its development. The major financial supporter of the EHCSA throughout the years has been the government. Without the financial support of the government, the existing programs in the EHCSA could not

have materialized.

In the 1950's, the Homes for the Aged project was the first major facility supported entirely by the provincial government. [55] Table 5 shows the financial expenditures for lodges and self-contained units in 1964. It illustrates the great costs incurred by the government in maintaining these facilities. Residents were also expected to pay for their accommodation. In the 1959/60 annual report of the department of Public Welfare (p. 20), it states that an order-in-council was passed setting the rates to be charged residents in a home. Irrespective of income, maintenance rate for a person occupying a bedroom for double occupancy was set at $65.00 a month. Residence in a bedroom for single occupancy was priced at $60.00 a month. [56]

The nursing home plan established in 1964 was supported and partially subsidized by the provincial government. The government provided payment to contract nursing home operators based on patient utilization. In 1964 the benefits consisted of a payment of $4.50 per day (Alberta Nursing Home Plan, Annual Report, 1964:1,4). Patients eligible under the nursing home act were also required to pay an amount not exceeding the following: $2.50 for a

---

[55] The Senior Citizens' Lodge Program (1958) received full financial support for the construction and furnishing of lodges and units from the government.

[56] Persons who had not established residency in Alberta for welfare purposes could be charged rates of $65-70 a month. Applicants were not subject to a means test. Accommodation was however restricted to elderly suffering from any chronic disease which incapacitates them.

Table 5

HOMES FOR THE AGED Annual Financial Statement - 1964

HOME	RENENUE	FOOD	SALARIES	UTILITIES	INSURANCE	DIRECTORS	OTHER	TOTAL	RESIDENCE
Edmonton Lodges	$184,399.25	$56,246.11	$81,766.44	$14,656.86	$899.69	-	$29,905.96	$183.475.06	284
1. Belvedere	34,789.00	9,503.61	14,784.28	2,750.70	175.09	-	5,790.37	32,924.05	49
2. Elmwood	34,983.00	10,161.85	15,394.52	3,293.56	175.03	-	5,956.29	34,981.25	46
3. McQueen	35,398.75	11,558.05	15,410.58	2,544.49	175.03	-	5,543.99	35,232.14	47
4. Rosslyn	34,703.50	11,100.42	15.247.08	2,559.29	175.03	-	5,040.19	34,122.01	49
5. Ottewell	34,797.00	9,462.60	15,730.19	2,645.65	151.51	-	5,320.47	33,310.42	49
6. Northway (4 mons)	9,728.00	4,459.58	5,279.79	863.17	48.00	-	2,254.65	12,905.19	44
Self-Contained Units									
Edmonton	78,462.50	-	9,309.17	16,377.27	899.00	-	16,787.99	43,373.12	288
1. Belvedere	14,400.00	-	1,735.76	3,264.64	175.09	-	3,073.08	8,248.57	48
2. Elmwood	14,400.00	-	1,735.76	3,688.60	175.03	-	3,964.47	9,563.86	48
3. McQueen	14,415.00	-	1,735.77	2,697.67	175.03	-	3,207.39	7,815.86	48
4. Rosslyn	14,400.00	-	1,735.77	2,949.34	175.03	-	3,020.47	7,880.61	48
5. Ottewell	14,400.00	-	1,735.77	2,908.18	151.50	-	2,899.96	7,695.42	48
6. Northway (4 mons)	4,447.50	-	629.34	868.84	48.00	-	622.62	2,168.80	48

Taken from: Annual Report - Homes for the Aged, The Government of Alberta, Department of Health, 1964

standard room per day, $4.50 for a semi private room per day and $7.50 for a private room per day. The tremendous interest shown in institutional facilities by the government was largely the result of the elderly over utilizing active treatment care facilities. The government felt the erection of institutions could reduce this high cost burden at low cost capital to the government.

During the 50's and 60's, the EHCSA was able to obtain funding for its policies through the generous aid of the government. The EHCSA expanded and had little trouble securing capital for institutional care. In fact, without the government's insistence lodges would not have been built and later it was the government who offered support for nursing home care. Thus, it appears that custodial goals of this period were operative goals.

Capital Resources available in the 1970's and 1980's

With the shift away from institutional care in the late 60's, the government continued to provide financial support to the EHCSA for its goals. The government's oil and gas revenues in the 70's left the province wealthy and able to fund various social services. The EHCSA therefore had little difficulty obtaining financial backing to provide for its rehabilitative policies. Table 6a-c provide an indication of the many rehabilitative facilities supported over the years by the government through the P.S.S. and the tremendous cost involved.

Table 6 Expenditure For The Preventive Social Services Program

	1969	1970	1971	1972	1973	1974	1975
Meals on Wheels	-	6,040.	14,500.	16,485.	13,324.	15,400.	12,700.
Society for the Retired/Semi-Retired	-	5,000.	19,101.	27,607.	29,595.	42,300	50,500.
Strathcona Place	-	-	10,441.	29,907.	31,041.	43,300.	49,500.
Home Care.	-	-	-	-	26,610.	99,500.	368,700.
Operation Friendship	-	-	-	-	-	1,000	17,100
Home Services for Seniors	-	-	-	-	-	-	47,800 (partial year)

Table 6 b — Expenditure For the Preventive Social Service Program (cont'd)

	1976	1977	1978	1979	1980	1981
Meals on Wheels	15,200.	16,275.	28,800.	27,268.	89,252.	82,382.
Society for the Retired/Semi-Retired	71,600.	82,675.	117,945.	118,851.	120,969.	159,655.
Strathcona Place	59,600.	60,600.	80,550	90,605.	97,500.	116,900.
Home Care	414,500.	550,407.	877,728.[1]	2,285,056.	2,561,581.	2,970,679.
Operation Friendship	24,200.	21,560	26,390.	30,238	39,385.	66,678.
Home Services for Seniors	157,000.	153,711.	166,653.	189,195	218,287.	368,316.
Senior Citizens' Opport. Neigh.Ass't	-	4,000.	11,500.	23,560	34,500.	41,336.
Adult Day Care	-	-	-	-	5,000.	16,572
Self Starters	-	-	-	-	900.	25,301.
South East	-	-	-	-	4,000.	21,708.
Calder (N.E.)	-	-	-	-	6,590.	9,263.
Senior Citizens'Prog.	-	-	-	-	3,374.	-
Duggan	-	-	-	-	5,635.	-
West Edmonton Seniors	-	-	-	-	-	19,081.

[1] P.S.S. expenditures for Home Care(1978) includes expenditures funded by the Local Board of Health. If this is excluded, this expense figure should be approximately $277,513.
Figures for 1979-81 also include amounts from the Local Board of Health.

Table 6c Family and Community Support Services Expenditures (Edmonton) (cont'd).

	1982	1983	1984
Meals on Wheels	106,782.	130,643.	147,977.
Society for the Retired and Semi/Retired	163,492.	170,882.	172,874.
Strathcona Place	131,470.	134,723.	128,000.
Home Care			
Operation Friendship	54,226.	53,750.	57,750.
Home Services for Seniors			
S.C.O.N.A.	41,730.	46,781.	50,420.
Adult Day Care	35,132.	37,932.	48,897.
Self Starters	19,901.	20,112.	17,612.
South East	26,601.	27,442.	28,945.
Calder (NorthEast)	27,387.	29,210.	41,806.
West End Seniors	29,488.	34,017.	37,420.

Source: Edmonton Social Service, Annual Reports, 1969-1981.
Information for the years 1982-84 received through personal correspondence with the department.

Many of the services for the aged established during this period unlike the 50's and 60's was the initiative of the city or local volunteer groups. The cost of operating these type of programs unlike earlier periods was often cost shared with city, province or volunteer agencies. [1] The 'meals on wheels' program is such an example. This program received $20,000 from P.S.S. funds and $75,500 from fees and charges in 1975 for a total of $95,500 (Edmonton Social Service, Annual Report, 1975). In few cases did the government entirely fund services for the aged; mostly it was indirect funding. [2] In most cases, clients were also required to pay a small fee for costs incurred for rehabilitative care just as they did for institutional care. [3]

By the late 1970's and early 80's, Alberta had entered into a period of economic recession. Continued growth in expenditures for facilities had to be curtailed. [4] Capital

---

[1] With regard to the P.S.S. program, the city of Edmonton was required to pay 20% of the cost of funding programs, the provincial government then provided the remaining 80%. In 1982, the P.S.S. program was disbanded and replaced by the Family and Community Support Services program. The same stipulations for funding received from the provincial government applied.

[2] Senior Citizens' Bureau is one of the few agencies entirely funded by the government since 1975.

[3] In some cases fees are based on the ability to pay (e.g., VON, Home care), in other cases a nominal fee is charged (e.g., Adult social day).

[4] An example of the growth in expenditures is in the Home Care program established in 1973 and terminated in 1978. In 1973, $26,610.57 was received from the government, by 1977 this had increased to $550,407 (Edmonton Social Service, Annual Report, 1973, 1978).

for the further development of the EHCSA diminished. In special cases, such as the geriatric facility, the EHCSA successfully acquired funds from the government. Since its inception, the Youville has attempted to be a viable cost effective facility offering rehabilitative services. An annual report of the department of geriatric medicine included a savings estimate of its activities. According to the report, based upon yearly (1984) estimates, the total savings estimated to be due to the programs at Youville was $15,408,402 per year. This included a saving of $4,102,527 for 262 (47%) patients expected to require nursing home and a savings estimated at $11,305,875 for 295 auxiliary hospital patients (Annual Report, Department of Geriatric Medicine, 1984:12-13). Proving to the government and the EHCSA that the Youville is actually cost effective is not always an easy task. However, it remains an important task particularly as securing funds for the EHCSA becomes problematic.

Today, securing funds for the EHCSA remains problematic. Expansion of the EHCSA has declined. The EHCSA has not been able to obtain necessary resources for such programs as home care. Recently, the Edmonton home care program was forced to cut back its service. According

---

'The annual report of the Youville outlined the benefits derived from its activities. One of the aims of the Youville is to discharge patients to their home environment whenever possible. From Table 7 it appears the Youville has attempted to do this. As can be seen, lodges are included in this 'home' category. However, it would have been interesting to exclude lodges from this category.

Table 7 Benefits Derived from the Activities of the Department of Geriatric Medicine (Youville)

Orign of Patients Admitted to the Department in 12 Calendar Months (1984)

From		
Nursing Home	91	6%
Auxiliary Hospital	31	2%
Active Treatment Facilities	686	45%
Home (own, family, lodge)	716	47%
	1,524	

Disposition of Patients from Department of Geriatric Medicine in 12 Calendar Months (1984)

To		
Nursing Homes	215	17%
Auxiliary Hospitals	56	4.5%
Active Treatment Facilities	87	7.0%
Home (own, family, lodges)	878	71.1%
Total Live Discharges	1,236	

Source: Annual Report, Department of Geriatric Medicine, (Youville) The Edmonton General Hospital, 1984

to the director of home care interviewed for an article in the Edmonton Journal dated Dec. 11, 1985, "we can't continue to provide what we provide - there are just not sufficient dollars to do so." [2] The lack of capital for the home care program raised the concern that those reliant on the program may be forced to move into nursing homes or stay longer in active treatment facilities. (Edmonton Journal, Dec. 21, 1985).

The EHCSA has obtained much capital from the government over the years to support its activities. It is evident from Table 6 that programs such as Home Care over the years received tremendous financial support from the government. This type of support while expensive needs to continue if the elderly are to be serviced well now and in the future as the proportion of the elderly in the population soars.

Long term planning is crucial to avoid unnecessary spending and to provide the right type of resources and services for the elderly. Such planning will not only benefit the elderly in the future but also the government who remains a major financial sponsor of health care for the elderly.

---

[2] In 1985 the home care budget was set at $5.5 million compared to $3.8 million for 1984. During that time the demand for services increased 47% between July 1984 and July 1985. At the end of 1985, 1,900 persons were receiving home care benefits for which the provincical government provides 100% of the funding.

D. Adaptation Conclusion

Theoretically, the adaptive task is to secure resources from the environment for the operation of the system as well as justify its necessity. Without adequate resources, the social system cannot survive. To obtain these resources it must be clear that they benefit the system in some meaningful manner.

Historically, it is clear that the necessary capital to meet custodial care goals of the system was available. The provision of lodges and nursing homes for the elderly suggest this. Personnel employed in the EHCSA were trained in acute care. The elderly were not considered as requiring special treatment for their ailments. Investment in aged health care was rationalized in terms of affective benefits. Providing institutional type of care was seen as a reward for the past contributions of the elderly. Institutional type of care was seen as more suitable for the elderly than active treatment care. Further, these facilities were considered as too costly for the care of the elderly.

In recent years, the official goal of the health care system for the aged view expenditure of resources as potentially having instrumental benefits. However, resources have increasingly become scarce. The influence of environmental forces as well as the lack of planning for the development of the EHCSA has made it difficult to secure necessary investments. The lack of resources has created gaps and overlaps bot[redacted] facilities desired and qualified

personnel.

Without adequate resources available in the EHCSA today, the elderly of the future will not have the health care service they require. The EHCSA can not continue to operate effectively if the holistic approach advocated is not embraced and the needed personnel, technology and facilities not forthcoming.

What is necessary for the EHCSA is long term planning. This is essential since both the cost of investing resources in the EHCSA and the proportion of elderly in the population will continue to increase in the future. Planning a rehabilitative approach benefits the elderly and the government. And ultimately, it is the government that bears the burden of aged health care.

The next chapter, integration, examines the involvement of consumers and producers in the EHCSA.

IV. INTEGRATION PREREQUISITE IN THE EHCSA

A. Introduction

The term 'integration', part of the Parsons' affective dimension, refers to establishing and maintaining cohesion in the system. It is the process of achieving and maintaining appropriate motivations among those co-operating to fulfill the goals of the system. The integration task is to create and maintain solidarity despite strains which may develop in the value orientation of the participants.

A self-orientation does not consider the integrity of the system. On the other hand, a collective orientation is one where actors uphold the integrity of the system (Parsons, 1951:60). Choosing one orientation over the other results in strains (Parsons, 1951:97). Individuals must balance their role obligations to the system with their personal interests.

The integration problem for the EHCSA involves motivating those participating to fulfill the goals of the system. Participants in the EHCSA include both producers and consumers.

Consumers

Motivating consumers to participate in the EHCSA is theoretically less of a problem than encouraging producers since both self and collective orientations tend to coincide among consumers. What is involved among consumers is

encouraging the aged to organize and participate in activities through such mechanisms as publications and association memberships (e.g., senior newsletter, summer games). Involvement in such activities may result in increases in feelings of self worth and create group consciousness.

In this section it is anticipated that as the goals of the EHCSA change the value orientation of the participants must also change to support the policies set out by the EHCSA. It is hypothesized that to attain the goals of the EHCSA, in the 50's and 60's, elderly consumers were encouraged to enter institutions (e.g., lodges and nursing homes). There was less incentive in the past to encourage the elderly to participate in community affairs. Today, it is expected that the aged are encouraged even enticed to remain in their own homes, enhance personal interests and be active in their community.

Producers.

Motivating people to become producers, to care for the aged, requires both the government and organizations to provide incentives. Such incentives may take a number of forms. For instance, the provision of research and teaching grants, educational upgrading, post-doctoral programs and competitive salaries. Recruitment into the geriatric field can also be enhanced through creating associations between the EHCSA and prestigious social institutions like the

university.

Motivations of producers however is problematic, since these types of incentives while effective in the short run do not generate identity with the aged community. If, for example, greater prestige and material rewards are offered in some other field, the tendency will be for producers to defect.

Few benefits existed for producers in the EHCSA during the 50's and 60's. Further, there was little motivation to employ them. Today, it is anticipated that greater benefits are available for caregivers in the EHCSA than ever before. Also, there appears to be more activity to recruit qualified producers to work for the goals of the EHCSA.

B. Producers in the EHCSA

Producers during the 1950's and 1960's

Throughout the 1950's, there were serious problems motivating producers to participate in the EHCSA. Encouraging caregivers to join the health care field was difficult let alone trying to persuade professionals to work with the elderly. In all areas of the health care profession, and not just in the EHCSA, an acute shortage of personnel existed.

The lack of health care professionals during this period can primarily be contributed to the low salary levels. This is evident from the report prepared by the

Alberta Health Survey Committee (1950:31):

> "Public health work in general is an interesting assignment but before it can continue to attract and retain the type of individuals who will give good community services, salaries throughout the entire field need to be raised until they approach the levels of those paid to similarily trained workers in other fields.
>
> The discrepancy is very marked in the case of medical officers and quite noticeable in that of other public health workers. This is a serious problem both at the local and provincial levels. On investigation, the Survey Committee has found that public health salaries as a rule, have not been raised in Alberta in proportion to the great rise in the cost of living during the past few years."

The Survey Committee (1950) further recommended to the provincial government that salary schedules be raised if health standards were to be above standard.

> "That adequate salary schedules be established throughout the public health field to attract and hold competent staff at all levels of public health service."

The lack of personnel and the low salary rates were also noticeable in the mental health field during this time. Concern over the lack of mental health specialists such as psychiatrists was expressed by the Alberta division of the

Canadian Mental Health Association in the mid 50's. To reverse this trend the report advised the government to 'buy the brains available'.

> "The mental health field has a lower prestige status than other areas of public health thus if Alberta wants to obtain a high standard of mental health facilities it must be prepared to attract the personnel" (Treatment or Treadmill, 1956).

The report bluntly stated that if the government wants 'second rate man in these facilities then you pay second rate salaries'. ''

Financial incentives however, were not the only type of rewards needed to recruit professionals. Other benefits such as educational training and research grants were also important. However in the 1950's, few benefits were offered to attract professionals to the health care system for the aged. As was apparent from the section on 'labor' in adaptation, educational programs were not available in geriatrics during this period. In fact, the custodial care goals did not require qualified educational training programs. The lack of general health care educational

---

'' The salary schedule for a psychiatrist was the same as a physician at the psychiatric institution (Oliver) in 1954. The following illustrates how low salaries for physicians and psychiatrists were in mental health facilities.

Grade 1 - $4,290--5,400
Grade 2 - $5,700--6,540
Grade 3 - $6,240--7,140

In comparision, a psychiatrist in the province of Saskatchewan could earn up to $11,500 in 1954. The maximun in Alberta at this time was $7,140 (Treatment or Treadmill, 1956).

programs as well as those in geriatrics no doubt hindered the recruitment of qualified personnel to the EHCSA.

The custodial care policy advocated by the government involved a passive, maintenance approach to the care of the elderly. The general attitude toward the health care for the aged in the 50's and 60's was that the elderly did not require any specialized treatment. The elderly were not consider as being active, independent, contributing and productive members in their latter years. The whole health care system during this period emphasized acute care. Facilities offering chronic care for the elderly or the disabled were not seen as a priority. Thus, the lack of specialized producers in the EHCSA was due to the custodial care policy in place. Thus, the EHCSA was able to provide care for its elderly members based on its custodial care goals.

In sum, the period from 1950-60 represented few if any qualified personnel in the EHCSA. Aside from the fact that salaries were low for professionals and educational programs lacking, the policies in effect during this period did not encourage recruitment to the EHCSA. The custodial care policies of the EHCSA and adopted by the government offered basic treatment for the elderly - at the most, a small amount of nursing care. The government did not require nor encourage professionals in the EHCSA. Those involved in the EHCSA were more likely to be dedicated to its philosophy than financially rewarded for doing so.

The next decade witnessed change not just in the orientation of the EHCSA but also in the quality of producers in the health care field for the aged.

Producers during the 1970's and 1980's

The previous two decades had experienced a tremendous shortage of professionals not just in the EHCSA but in the entire health care system. By the 70's, the climate for recruiting professionals to the EHCSA became much more favourable than at any time before. The health care field in general was able to employ sufficient caregivers and this opened the way for the EHCSA to begin recruiting specialized personnel. By this time the goal of the EHCSA had shifted toward recruiting personnel to deliver a rehabilitative approach to aged health care.

The new rehabilitative approach toward aged health care required the recruitment of specialized professionals. Prior to this time, the general health care system, like the EHCSA, consisted predominantly of physicians and nurses. These professionals were trained in acute care. Training in the care of the chronically ill or the elderly had not been a priority. The elderly were not treated as requiring any special attention. In the past, ailments associated with old age were considered as 'natural' and not requiring extra care largely because intervention was not seen as 'curing' the process of aging. The rehabilitative approach changed the way in which health care for the elderly was to be

carried out.

With the emergence of an rehabilitative approach, health care for the aged shifted to adopt a view not of 'curing' the elderly specifically, but of providing 'care' and 'comfort'. The shift in emphasis to the treatment of the elderly required specialized training. In the main, those trained in the acute care mode were not qualified to treat the elderly client. The absence of educational facilities geared toward the care of the elderly hampered the recruitment of skilled producers dedicated to the aims of the rehabilitative approach. Regardless of the financial incentives and other benefits necessary to motivate personnel, educational programs needed to be in place in order to recruit and motivate caregivers.

The 1980's differed little from the 70's except that there was a greater awareness of the general needs of the elderly. The establishement the Geriatric Facility (Youville) in the 80's, was an attempt to attract professionals and educate personnel to the aims of the EHCSA. The establishment of the Youville as a teaching and research facililty affiliated with the U of A is one good example of creating a prestigious association that not only enhances the status of Youville but allows professionals to be associated with others in a research oriented environment.

The establishment of the geriatric facility affiliated with the division of geriatric medicine in the Medical

Faculty at the University of Alberta is only one facility with the potential of offering geriatric programs. As was indicated in the section on 'labour', under adaptation, geriatric educational programs for medical students has not become fully realized. It is not cleat if geriatric care is seen as a priority and taught alongside acute care. Thus, it is questionable whether professionals in the medical field are serious about integrating geriatric medicine with general medicine. Hesitancy in accepting geriatric health care as an important component of the health care system hinders the recruitment of excellant, specialized producers.

Attracting personnel to the EHCSA requires not only offering a variety of incentives, but also requires motivating professionals to enhance the prestige of the EHCSA. The EHCSA seeks those loyal and committed to its philosophy. In the past, those participating in the EHCSA did not become involved for its material rewards. Their involvement was more likely due to compassion with the principles of the EHCSA. At present, and especially in the future, the possibility that producers resign for lack of sufficient gains, be it financial or other, is more realistic. These dangers will continue to face the EHCSA as it expands in the future just as it does the general health care field today.

The possibility of disloyalty however, does not mean the EHCSA should reduce benefits for its personnel. In more instances than not, such advantages as educational training

and upgrading as well as colleague affiliations allow greater involvement in the system and in turn produce greater productivity. If the rehabilitative goals of the EHCSA are to be accomplished, recruitment of qualified personnel needs to be continued and this requires further investment into geriatric educational programs.

Recently, the geriatric facility (Youville) has lost excellant, qualified staff through the resignation of its director as well as some of his colleagues (Edmonton Journal, June 21, 1986). This is a serious loss not only for the geriatric facility and the elderly, but also for the medical community. For the medical community this sighals the loss of valuable expertise in geriatric medicine. It is too early to speculate on the future of the Youville. However, if the Youville is to remain a centre for geriatric medicine, at this time it seems questionable whether the government considers this a priority, the recruitment of professionals need to continue. Educational programs need to be in place and most of all the government must come to view this as a priority area and not as an issue that can be ignored.

In sum, the custodial care goals in the 50's and 60's did not require producers with specialized training. To a large extent this allowed the custodial goals to be accomplished. The shift in policy toward a rehabilitative approach in the 70's meant personnel specialized in geriatric health care needed to be recruited. The absence

of educational programs with an emphasis on chronic rather than acute care even in the 80's makes it extremely difficult to recruit professionals to the geriatric health care field. It appears that producers are not sufficiently trained in geriatric care. Further, it seems that the value orientation of producers, particularly those in the medical profession, have not changed to wholeheartedly support the rehabilitative policies of the EHCSA. The EHCSA has not been able to secure professional allegiance to the goals of a rehabilitative and holistic approach. The lack of quallified professionals dedicated to geriatric health care hinders the fulfillment of the rehabilitative goals set out by the EHCSA.

The challenge today is to recruit professionals to the aims of geriatric health care and retain those already dedicated.

C. Consumers in the EHCSA

Consumers during the 1950's and 1960's

In the early 1950's, there was little discussion about the needs of the elderly and no organization rallied behind them. Seniors were basically on their own. Those who were ill went to acute or auxiliary hospitals, the psychiatric hospital or one of the privately operated nursing homes in Edmonton. Besides family and friends, formal support services were not available for the elderly. The elderly

were not regarded as 'special' with unique needs.

With the government's implementation of the Senior Citizens' Lodge program in 1958, the government began urging the frail elderly to enter these institutions. These institutions were promoted by the government as offering the ideal lifestyle and environment suitable for those seniors who could manage physically and mentally on their own yet required a minimal amount of attention. [‘‘] The fact that Edmonton had an 100% occupancy rate as well as people on waiting lists in the first year of its operation suggests that the government had successfully motivated the elderly to enter these institutions. Particularly for the poor elderly, these lodges were desirable since they offered reasonable rates, clean surroundings, food and some supervision.

The success of institutional living was apparent in the 1960's with the government's endorsement of nursing home care. Once again the government successfully urged the elderly to reside in these institutions. For those without family and friends, little income and in need of some nursing care, these places were portrayed as offering the basic necessities of life. For many seniors there was little choice but to accept institutional care. During the early 60's, the nursing program and the VON nurses provided some care for those requiring a few hours per week or month

---

[‘‘] It is important to keep in mind that lodges were meant to provide no more than food, shelter, laundry and supervision. No nursing care was provided.

but for those in need of greater assistance no alternative existed.

Even in the late 60's, Edmonton had limited formal support services. The addition of 'meals on wheels' and some home care for many elderly was not sufficient. Institutionalization was the only option although this provided no more than the basic maintenance type of care. The government's policy on custodial care did not encourage the elderly to participate in institutional decision-making or offer other resources for personnel enhancement.

The only organization at this time actively interested in the needs of the elderly was the Alberta Council on Aging. Started as a volunteer group in 1967 and later funded by the government, the Council lobbied the government on behalf of the elderly. This group was largely instrumental in developing the services that came into existence in the 70's. In the 1960's it was the only lobbying group advocating a return to the community and involvement in personal and public affairs for the elderly. At this time senior citizens had not yet organized themselves to form formal senior centres or any other formal activities.

In sum, institutionalization for the elderly was encouraged by the government in the 50's and 60's. The government was successful in promoting these facilities and its custodial care policies largely because no alternative existed for those elderly requiring care. Alternatives did

not exist because the elderly were not considered as requiring greater assistance nor able to offer benefits to their community. Institutions offered no incentives for involvement either in personal pleasures or at the societal level. Basically institutionalization meant that the elderly were prematurely released from their community.

Consumers during the 1970's and 1980's

In the 1970's, there was a subtle shift away from encouraging the elderly to enter institutions. Instead of institutionalization, the new approach encouraged aged involvement in their community. The importance of citizens participating in society was expressed by the Alberta government in its Speech from the Throne dated Feb. 15, 1973).

> "A society which provides individual citizens the maximum opportunity for personal initiative and resourcefulness to determine their own destiny without undue government interference."

Providing choices and alternatives styles of living for the elderly was promoted as desirable.

The emphasis in the early 70's was directed at engaging the elderly in self-gratifying activities (e.g., social, recreational and educational programs). The introduction of senior services, such as 'meals on wheels' and home care, was the start of this increased emphasis on aged participation. As these services became available, the

elderly actively utilized them and proved that the elderly could do more than wait idly in an institution.

For the elderly, it was advantageous to enjoy these new programs. The government generously assisted seniors to organize their own cultural and recreational centres through grants from the Facility Grant Program. As a result, many senior cultural centres developed such as the Romanian, Ukranian and Chinese centres.

In the 70's and 80's, the government offered financial incentives to organize their own activities with few government regulations. The New Horizons program is a good example of government providing financial incentives to start new activities or expand existing ones. Although a federal government program, the New Horizons program provides funding to groups of 10 or more retired persons to carry out projects of their own choosing for the benefit of themselves and others in the community. Such incentives offered by the federal government no doubt encouraged the elderly to participate in community projects. For seniors willing to initiate their own projects, the government offered financial support.

Senior involvement in the community was not just limited to pursing purely self-gratifying activities. In many instances, seniors became involved in projects to enrich the lives of others. In Edmonton, a high school program paired students with seniors. Students assisted seniors with physically demanding tasks like mowing the lawn

and in return seniors taught history to students (Edmonton Journal, Sept. 19, 1980). Other examples exist of seniors joining together to offer service to their community. [1] Providing a service to the community was the case with the establishment of Edmonton Kosher Meats and Deli. Four seniors decided to leave their recreation and relaxation to other 'more retiring' types in order to provide what they felt was lacking in Edmonton: fresh Kosher meat (Edmonton Journal, July 31, 1985). Seniors providing service not only for their own enjoyment but also for the benefit of their community is no longer the exception.

By the late 70's, the potential of the elderly and potential for their self-sufficiency in the EHCSA was well recognized. The involvement of the elderly in community affairs drastically increased the profile of the EHCSA. Elderly volunteers became an integral part of the EHCSA, attending to services that would otherwise have been impossible. Many social and recreational activities were operated by the elderly; seniors working for seniors. Seniors' involvement includes such organizations as the Society for the Retired and Semi-Retired, and the Senior Citizens' Bureau. These two agencies publish newsletters and brochures and receive the majority of their membership and support from seniors. [2]

---

[1] The Society for the Retired and Semi-Retired offers a program called 'Heritage'. Seniors are encouraged to offer their expertise on the past to school children.

[2] These offices are staffed by many volunteers who contribute a tremendous amount. Meals on Wheels, for example,

Today the EHCSA has an active group of seniors working on its behalf. The involvement of seniors in community affairs and defending their 'rights' was particularly evident in the spring of 1985 when the government proposed the de-indexing of old age security. The elderly were successful in preventing the government's proposed plan. This type of activism represents a sharp reversal from the days when the Alberta government recommended institutionalization and offered no incentive for the aged to participate in any form of decision-making.

The holistic policy today advocates a life long, continual involvement in both private and public affairs. At present the EHCSA has little difficulty motivating consumers to orient themselves to a rehabilitative approach. Unlike previous decades, the government provides incentives to encourage the elderly to participate. Today, seniors are displaying an incredible amount of energy volunteering their time for the betterment of the EHCSA and their community. This consumer group is not only growing in size but it is growing in strength and becoming more vocal in pursing its goals. The future will no doubt see more seniors engaged in both personal and community based pursuits. This group represents a formidable force. No doubt the government will hear more from these citizens in the future.

''(cont'd) had 270 volunteers in 1971 many of whom were seniors citizens; by 1980 this had increased to 600 (Edmonton Social Service, Annual Report, 1971 and 1980).

D. Integration Conclusion

The integrative task in this study is to persuade both consumers and producers to enhance their personal and collective activities for the fulfillment of system goals. This task is most demanding when either the self or collective orientation of the producer or consumer are not in harmony with the goals of the system. In such instances, in order to achieve integration mechanisms for resolving tensions and creating a balance in the system must be in place.

In the past, the goals of the EHCSA were not viewed as incompatible with the value orientation of the participants. Historically, the elderly consumer was encouraged to reside in institutions. The elderly complied and the government was successful in promoting this type of living arrangement. As was hypothesized, no emphasis was placed on engaging the elderly in the EHCSA or in community affairs.

Like consumers, producers were not inspired to become involved in the EHCSA. Educational programs were not available and the custodial care goals did not require qualified personnel. The custodial care policy did not view the elderly as a special group with unique needs. The emphasis in the EHCSA like the general health care field was on acute care. Chronic care was not a priority. The custodial care policy promoted by the government did not encourage either producers and consumers to become engaged in the EHCSA.

More recently, the policy of the EHCSA has changed toward emphasizing active participation of both the elderly and the caregiver in the EHCSA. For the elderly consumer, it is advantageous to pursue self-satisfying activities (e.g., trips, recreational and educational activities). It is also beneficial for the consumer to be engaged in activities of a collective nature (e.g., senior groups, newsletters). These type of involvements strengthens the EHCSA and provides manpower and energy to strive for improvements in the EHCSA. In many ways the government actively persuaded the elderly to become involved in their community (i.e., financial incentives). As was expected, motivating the elderly consumer was not problematic since this type of action on the part of the elderly produces benefits both directly and indirectly for the aged and the EHCSA.

For the producer, benefits from participation in the EHCSA are not readily apparent. In some instances, it may be self-gratifying to assist in the care of the elderly. It may also represent a challenge for caregivers to become involved in a new and growing area of health care. Whether it be self satisfaction or a humanitarian endeavor that induces caregivers to become involved, it is clear that there are different forces at work not necessarily compatible with one another.

To prompt potential producers to the health care system for the aged requires different incentives than those

offered to the elderly consumer. Rewards such as financial and educational are necessary to attract producers and allow them to remain both individually and collectively involved in the EHCSA. These type of incentives are being offered on a small scale to potential producers. Rewards for involvement in the EHCSA remain few. Loyalty among those involved in the EHCSA does not seem to be a problem although this may change in the future. At present, the major difficulty facing the EHCSA is to persuade producers to adopt a value orientation in line with the rehabilitative approach. The task of the EHCSA remains to persuade the government and the medical profession and others engaged in the health care profession that geriatric health care is a priority area. Without the support of the government and the health care profession, rehabilitative goals can not be successfully accomplished.

Involving both consumers and producers in the EHCSA is beneficial for the system. In the past, the lack of participation of both consumers and producers was due to the government's custodial care policies. Little was required of consumers and producers and little was provided for them. Today, the holistic approach advocates greater involvement by both the elderly and the caregiver.

Active participation by all implies greater involvement of the elderly in decision-making positions within the EHCSA. In the future, with an increased proportion of the population designated as 'seniors', aged involvement in the

EHCSA signals greater realization of the goals of the EHCSA. Greater involvement of producers in the EHCSA means greater expertise in aged health care issues. The involvement of qualified producers would allow the EHCSA to provide high standard health care to the elderly. For the government, motivating consumers and producers to work for the EHCSA helps reduce expenditures for aged health care. Decreased expenditures for the EHCSA by increasing the involvement of all in the goals of the system is an attractive strategy for the government.

In the next section, the latency prerequisite is discussed.

V. LATENCY PREREQUISITE IN THE EHCSA

A. Introduction

Definition

Latency (affective dimension) is the degree to which subsystem values (e.g., values in the EHCSA) reinforce or are reinforced by dominant societal values. It involves reconciling the various norms and demands imposed by participating in both the subsystem and society. Such reconciliation, if effectively accomplished, results in establishment of legitimacy for the system, and provides energy for action. "The pattern maintenance function (latency) is the point of contact between system of action and the symbolic and cultural universe. The latter has a special bearing on systems of action in that it supplies them with symbols, ideas, modes of expression and judgements necessary for the creation of motivation and its direction towards action" (Rocher, 1975:42).

Symbols, ideas, modes of expression and judgements reflect societal values. These symbols and ideas maybe embodied, for instance, in a personality characterizing the role of a typical aged (e.g., grandparent); a service considered widely used by the aged (e.g., nursing home); and the activities of the aged (e.g., leisure). Common modes of expression are found for instance, in the mass media, jokes and advertisements. These representations of the elderly

identify the prevailing attitude, status and prestige allocated to old age either portrayed in a negative or positive fashion.

Stereotypes of the aged are embedded in society and are thus difficult to eliminate (Thomas, 1980). Changes in public opinion (reflected in mass media, journals, books) over time in the characterization of old age are gradual (Kearle, 1982). A greater degree of sensitivity to the aged can be expected in the present day but negative sterotypes of the aged will persist (shifts in public opinion in Edmonton as well as in Canada will be reviewed). Subsystem values are derived at least in part from organizations in the EHCSA (i.e., facilities in 'land', official goals in 'goal-attainment'). These values can provide a vehicle to combat negative images of the aged through presenting them in a positive manner, and encouraging activism.

One major problem for latency occurs when societal and subsystem values do not coincide and public opinion is unfavourable toward the aged. Societal values may thus hinder the legitimation of subsystem values (EHCSA). The other side of this may also be a problem, however, That is, there may be a failure on the part of the subsystem to capitalize on positive aspects of the larger culture. Examples are the failure to utilize the influence of elder statesmen, failure to identify the aged as a group systematically discriminated against, failure to enhance employment capabilities based on new technology.

Hypothesis

It is hypothesized that in the past values in service of custodial care goals of the EHCSA emphasized the indebtedness of society to the elderly for their past contributions. This also included the lack of potential for further contribution by the elderly. Over time a shift in values in the EHCSA occurred. A greater degree of sensitivity to the elderly can be expected to exist today although negative stereotypes of the aged will persist. The shift from a custodial care orientation to a rehabilitative one will also be reflected in an increased awareness of the potential of the aged.

Method

Identifying symbols, ideas and modes of expression reflecting societal values toward the elderly and the EHCSA are commonly found in the mass media. A popular medium in the creation of public opinion is the newspaper. In this section both The Edmonton Journal and the Toronto Globe and Mail for the years 1950, 1960, 1970, 1980, and 1985 are reviewed. Information from The Edmonton Journal are significant in detecting the values the general public is exposed to here in Edmonton. The Globe and Mail will present a more national picture of the characterization of the elderly.

Another important source of information is academic journals. Instead of detecting ideas and images the public

is daily exposed to, it is possible in examining journals to note the importance of the elderly in academic research. The following journals are selected for review: The American Sociological Review; American Journal of Sociology; Canadian Journal of Sociology; Canadian Review of Sociology; Canadian Journal of Public Health; Social Science and Medicine; International Journal of Aging and Human Development; and the Canadian Journal on Aging. These journals represent the Canadian and American scene; the sociological; health care and the gerontological literature available. These journals are reviewed for the years 1950, 1960, 1970, 1980 and 1985. Indeed, other journals such as Essence, Omega, Journal of Gerontology, Journal of Social Problems could have been chosen. However, examining all the available literature is not necessary rather an attempt is made here to capture a cross-section of the available journals. The purpose of this section is to examine the images and attitudes toward the elderly over time, the frequency with which researchers deal with these issues and the changes in the official policy of the EHCSA. The extent to which changing goals in the EHCSA is reflected in newspapers and academic journals is of importance here. Table 8 shows the academic journals reviewed and the frequency with which issues in social gerontology are discussed.

Table 8 CANADIAN AND AMERICAN ACADEMIC JOURNALS FROM-1950-1985

	1950	1960	1970	1980	1985
1. AMERICAN SOCIOLOGICAL REVIEW					
Total Number of Articles	57	58	48	45	30
Total Number relating to the Elderly	0	0	0	0	0
2. AMERICAN JOURNAL OF SOCIOLOGY					
Total Number of Articles	40	50	51	34	30 (Nov.1985 missing)
Total Number relating to the Elderly	0	0	0	0	0
3. CANADIAN JOURNAL OF SOCIOLOGY				1981	
Total Number of Articles	-	-	-	18	12
Total Number relating to the Elderly	-	-	-	1	0
4. CANADIAN REVIEW OF SOCIOLOGY					
Total Number of Articles	-	-	16	20	16
Total Number relating to the Elderly	-	-	0	0	0
5. CANADIAN JOURNAL OF PUBLIC HEALTH(1950-80)	66	58	50	29	
Total Number of Articles	66	58	50	29	
Total Number relating to the Elderly	0	0	0	0	
6. SOCIAL SCIENCE AND MEDICINE(1970/80)					
Total Number of Articles	-	-	30	80	
Total Number relating to the Elderly	-	-	0	3	
7. INTERNATIONAL JOURNAL OF AGING AND HUMAN DEVELOPMENT					
Total Number of Articles	-	-	28	38	51 (1983)
Total Number relating to the Elderly	-	-	21	30	45
8. THE GERONTOLOGIST					
Total Number of Articles	-	-	43	76	78
Total Number relating to the Elderly	-	-	all	all	all
9. CANADIAN JOURNAL ON AGING					
Total Number of Articles	-	-	-	18 (1982)	17(1984)
Total Number relating to the Elderly	-	-	-	all	all

B. Attitudes toward the EHCSA in the 1950's

During this period, newspapers provided a valuable form of information and were largely instrumental both in shaping and reflecting the ideas, beliefs and attitudes of the general public. Compared to other forms of expression, for instance, television and books, newspapers were popular, economical and widely utilized. Thus, newspapers can be seen as useful in detecting public opinion toward the elderly at this time.

In the 1950's, interest in the elderly and their needs was just emerging. Demographers for example, were beginning to recognize that the proportion of elderly in the population was increasing. But few facilities existed specifically for the elderly and few policies were directed at the care of the elderly in Edmonton. Also at this time, few articles were devoted to the concerns of the elderly.

From the few articles devoted to senior concerns, the majority dealt with retirement. The commonly accepted notion of retirement at age 65 was beginning to be challenged. The following is an excert from the Edmonton Journal, Reader Box, dated Jan. 9, 1950:

> "Here is a man who has given 20 years of good and satisfactory service, still hale and hearty, still capable of doing his work effectively, suddenly discharged. Why?
>
> For dishonesty? No. For breach of regulation? No. For any misdemeanor whatever? No. Then why?

> Because he had a birthday! That is all. It happened to be his 65th birthday. That is the offense. What an offense! He dared have a birthday."

In a similar vein, a 70 year old gentleman who had spurned retirement is quoted on March 27, 1950 in the Edmonton Journal as saying the following:

> "This retirement is a queer thing. I believe in it. I believe there have been many men who wanted to retire. I believe they were happy in retirement. I have met many young men who are looking forward to retirement with pleasure. I have never met one - not one - elderly man at retirement age, who wanted to retire."

There was a general consensus in the 50's that retirement was a mistake. Dr. Gumpert, a New York geriatrician in 1950, stated that the conventional concept of retirement is plain idiotic ("Meet a Geriatrician", Globe and Mail:June23,1950). Even business leaders expressed a similar view. As a busines representative,the chairman of the Executive Council of the Canadian Chamber of Commerce in an article entitled "Response of Industry For Aging Employers Urged" (Globe and Mail, May 23,1950) stated the following:

> "It would be the responsibility of business to take a new look and disregard the step it took 15 years or so ago in setting 65 as the retirement age. We

have to find employment for those over 65 who can still work... We've got to retain more of them."

The Globe and Mail like the Edmonton Journal also addressed retirement as an important issue in the lives of seniors. The key theme running through the articles was 'keep active even in old age'. Although there seemed to be mixed reaction to the institution of retirement in our society, the consensus suggested that the elderly should be active in their latter years regardless of whether they have retired from a wage-earning occupation.

The following quotation best sums up the reaction to retirement:

> "There should be no age limit in learning, to exploring new fields of activity, experiences and interests. Best to prepare for retirement years before it comes. Best to have firm areas of interest established all your life" (Globe and Mail, Feb. 28, 1950).

The theme for the year 1950, as portrayed in both newspapers, was retirement. There seemed to be a preoccupation with the influences of retirement on the individual.

From the journals reviewed and in existence during the year 1950, none dealt with geriatric health care as can be seen from Table 8. Of all the journals only the Canadian Journal of Public Health discussed issues influencing the geriatric health care field. It is clear from these few

articles that there was an acute shortage of public health workers in Canada during this period. Another major issue raised was the lack of educational training programs for health care professionals. These issues again illustrate that in the 50's a health care system for the aged was not fully recognized in Edmonton or elsewhere. Problems in the general health care field overshadowed any attempt at the development of the EHCSA.

C. Attitudes toward the EHCSA in the 1960's

Retirement as a commonly accepted activity continued to be challenged in the newspapers of 1960. According to Dr. Penfield, director of the Montreal Neurological Institute and a frequent contributor to both newspapers during 1960, the elderly should embark on a second career. He stated that most men upon reaching age 65 would continue in a 2nd career, but are being paralyzed by a psychological malady. This malady he labelled as a 'false senility': the male retires and believes he is useless and his condition soon confirms his worst fears.

> "By age 60 the body has passed its greatest strength but the brain normally is ready for its best performance in certain areas. It may be that the last work of the old man's hand will serve society best, and him as well" (Edmonton Journal, May 14, 1960).

Dr. Penfield's advice as well as other contributors in the newspapers of 1960, advocated continued activity in later life. 'Retirement should be the time to make the maximum use of willing ability. To that end, all educational institutions, companies and governments should be required to use this brain power' (The Globe and Mail, Jan. 6, 1960).

Aside from discussion on retirement and the importance of activity in one's life, institutionalization of the elderly was being debated in Edmonton at this time. During the late 50's the provincial government had established the lodge program. By 1960, the city of Edmonton urged on by the province, was seriously seeking suitable sites for the construction of these lodges. Of specific interest here is the report prepared by the Canadian Welfare Council against the isolation of the elderly.

> "Family homes should have an attached, self-contained unit for old folks, an arrangement which would reduce the emphasis on 'segregation of the generations'" (Edmonton Journal, Jan. 9, 1960).

According to the report, old folks homes and low rental units are not the answer to the problems of the elderly. There should in fact be an overall plan of community services aimed at helping the elderly stay out of institutions. This article in the Edmonton Journal was significant in providing an alternative position opposing institutionalization. At this time the provincial

government was still trying to sell custodial care to the public, particularly the elderly.

The government's eagerness to persuade seniors to accept institutionalization was evident during the summer of 1960, when the first lodges in the province were ready for occupancy. It was then reported that elderly men and women were moving out of 'squalid shacks' and 'dingy rooms' and taking up 'new lives of luxury'. According to the director of the home program, J.K.G. Austin, 'nothing but the best of private clubs has appointments equalling those in these homes' (Edmonton Journal, July 5, 1960). The Minister of Welfare for the province told Journal reporters that the furniture in the homes were more expensive than he could afford and that he would recommend these facilities to his mother (Edmonton Journal, July 6, 1960).

It is quite clear that institutionalization was not widely accepted. Apparently, public opinion on custodial care goals was not in line with the provincial government's platform. Newspaper articles of the day were more inclined to report the importance of activity among the elderly particularly after retirement. In the face of this, the Alberta government had to actively persuade the people of the province that these homes were not just 'poorhouses'.

Two themes sum up the newspaper articles in the year 1960: activity in retirement and skepticism about institutional care. Like the 1950's, academic journals in 1960 neglected dealing with issues on the elderly as is

illustrated in Table 8. The lack of interest shown in the EHCSA can be attributed largely to the fact that the general health care field was still experiencing growing pains.

D. Attitudes toward the EHCSA in the 1970's

A change occurred in the newspaper articles in 1970. Rather than focusing on the concept of retirement as had been the case in previous decades, the focus was on the 'quality of life' for seniors. The theme 'quality of life' for seniors was cited in terms of housing, independence, social activities as well as physical needs. This approach was similar to the new rehabilitative goals of the EHCSA emerging in the 70's. More and more articles discussed the importance of the elderly in their community and their stay in their own homes for as long as possible. Home care, for example, was advocated as a means to allow the elderly to stay at home even though at this time a home care program was not yet in existence in Edmonton.

Quality of life for seniors at the societal level also became important. This is evident from an article entitled "Senior Power Politics" dated March 4, 1970 in the Edmonton Journal:

> "The potential political power of millions of aged voters increasingly hurt by inflation is attracting serious attention among American politicians and aged themselves."

Although seniors in the 70's were becoming more involved,

this was seen more as the exception than the rule. Overall, the status of the aged in society was along the lines of Dr. Bunzel's statement (Globe and Mail, Oct. 24, 1970):

> People suffer from a fear of aging, which he termed 'Gerontophobia' an unreasonable fear and irrational hatred of the elderly. Even the elderly suffer from it, through a self-fear of their own advanced age.

As far as academic journals in 1970 were concerned, only two journals dealt with the concerns of the elderly: The Gerontologist and the International Journal of Aging and Human Development. Sociological journals continued to ignore research in the field of aging (see Table 8). Although not specifically dealing with the elderly, the Canadian Journal of Public Health provided insights into areas of concern. Like previous decades, educational issues remained a priority. Interest was also expressed in developing a social, preventive approach to health care, particularly for the elderly.

E. Attitudes toward the EHCSA in the 1980's

The importance of addressing aged issues and concerns continued in the 80's. The Edmonton Journal, for example, by 1980 had established a weekly Senior Journal page entirely devoted to issues affecting seniors. Two themes stand out during that year: involvement of the elderly in activities and the issue of the abolition of mandatory retirement.

The first of the two themes could be seen in the involvement of seniors and the public in attempting to eradictate the notion that usefulness ends at age 65. An example of this was the introduction of a special high school program at St. James Catholic School in Edmonton. Grade nine students were paired with seniors. Students helped seniors with physically demanding tasks and in return seniors made history come alive for the students (Edmonton Journal, Sept 19/80).

The second theme in 1980 was the end to mandatory retirement. Edmonton Journal readers throughout 1980 questioned whether it was right to force people to retire at age 65. The general opinion indicated that the public saw no magic age for retirement.[']

During 1980, sociological journals for the most part continued to ignore research on aging as is evident from Table 8. Only gerontological journals addressed the elderly and their needs. The fact that only gerontological journals address the needs of the elderly is significant. In the past gerontological journals were generally not available. Only in the late 1970's gerontological journals became available and in greater numbers. From the increased number of publications in the area of aging it is becoming apparent that social gerontology is finally becoming a recognized area of research. The single most significant issue that

---

['] May 10, 1985, seniors in Alberta were victorious in abolishing mandatory retirement. Approximately a year later the Federal Government followed suit.

consistently appeared in the journals was education. Training in geriatric health care continued to be seen as the important area of concern for the health care system for the aged.

In sum, greater awareness to the problems facing the elderly continued to receive attention. The issues that emerged in 1980 such as educational retraining and activism in old age reflected the rehabilitative policies of the EHCSA during this time. In comparison to other decades, 1980 stands out as expressing the sensitivities of the elderly. 1980 stands out as the decade in which social gerontological publications increased significantly and became recognized as a vital area for research.

F. Attitudes toward the EHCSA in 1985

1985 can be hailed as an important milestone for the aims of the elderly. It was a year, as evidenced from newspapers, that seniors acted on issues, fought battles and won. In this regard we can see definite changes since 1950. 1950 did not witness political activism on the part of seniors. Seniors did not and were not expected to fight for their self-interests. Today, seniors are fighting for their self-interests.

The real strength of the elderly was apparent after the Federal Government's May 23, 1985 budget. In that budget, the government asked seniors to help reduce the federal deficit by supporting the government's proposed de-indexing

of old age security pension. The government in defense of its proposed cuts claimed that seniors accept and are willing to help the government by reducing their incomes. In fact, numerous articles in both the Edmonton Journal and the Globe and Mail indicated that seniors across Canada and in Edmonton were willing to fight against the de-indexing of old age security. The prime minister had promised during his 1984 election campaign to continue to adjust pensions according to the cost of living. He had broken that promise and seniors were ready to protest.

In June of 1985, an editorial in the Edmonton Journal criticized the Federal government's proposed cuts and asked the question, "Is it because Ottawa believes seniors are too accepting, too disorganized to complain?". Not only did Ottawa receive bad publicity from seniors across the nation but also from business groups. As a major beneficiary and most solid supporter of the federal budget, business groups joined the ranks of seniors in protesting the government's proposed action (Edmonton Journal, June 13, 1985). Within weeks, June 27, 1985, the government decided against ratifying its plan on de-indexing pensions. Seniors had shown the public and the government that they were not only organized as a solid group but that they were willing to act to protect their interests.

In Alberta, the strength of the senior citizens' movement has obviously impressed the provincial government. This was evidenced by the government's recent publication

entitled, "In Partnership with Senior Citizens Listening to Experience". This brochure was circulated to residents as part of the government's 1986 election campaign strategy material. The pamphlet begins by stating:

> "In the 1986 throne speech, new initiatives for seniors were announced ..... because Don Getty and his Team care about the views and concerns of our increasing senior population."

The brochure continues by citing a number of programs the government provides seniors all of this information placed under a bold typed heading called "A NEW EMPHASIS".

There really is nothing new about the programs outlined. What is really a new emphasis is the government's awareness that they need the support, that is, the voting support of seniors. It seems that the government has finally recognized that they must attentively listen to senior citizens. Time will only tell if the goverment actually will listen to seniors. It is too early to speculate whether the government will fulfill its promises to seniors. One would only hope the government would be wise enough to seriously address aged concerns before the next provincial election.

In sum, compared to previous decades, the 80's seem glorious years for seniors. Now more than ever, seniors are being assisted in remaining in their own homes for as long as possible; seniors are involved in their community; seniors have showed that they have the political will and

power to act; and seniors have gained the right to work beyond 65 years of age.

From all accounts it would seem that past stereotypes of the aged have been largely dispelled and largely through the influence of seniors themselves. Nevertheless, the National Advisory Council on Aging still devoted its entire 1985 Spring issue of 'Expression', their newsletter, to dispelling the myths of aging. The National Council on Aging sees the image of the elderly in society as still basically negative. The vast majority of seniors are participating fully in the life of the community, yet, for the most part society has not fully accepted their new lifestyle. Today, seniors are aggressively taking up new challenges and developing their talents. Although involved in society, society has for the most part not tapped the resources seniors have to offer.

The rehabilitative policies of the EHCSA today encourage the elderly to contribute to society and lead a satisfying fulfilling life. These policies can only fully be realized through society's recognition of the potential of the aged. No doubt in the future as the proportion of people designated as 'seniors' increase, society will find it not only beneficial but necessary to utilize their skills and talents.

G: Latency Conclusion

In this chapter, latency attempted to establish the various values, expression and ideas encountered in society and their influence on the development of the EHCSA. The latency task is to harmonize these diverse symbols and attitudes.

This chapter began by hypothesizing that values in the past emphasized the significant contributions of the elderly. Further, there was an emphasis on the fact that the custodial care goals of the EHCSA did not consider the current or future benefit of aged participation. It is clear from the newspapers during 1950 and 1960 that the elderly were conventionally thought of as unproductive, nonprofitable, disengaged members of society. The institutional goals of the EHCSA reflected this as well. However, it is also clear from both newspapers of the time that this representation of the elderly was [redacted] challenged.

In more recent years a shift occurred in the orientation of the EHCSA. It was hypothesized that a shift in the values of the EHCSA had resulted in a greater degree of awareness for the needs of the elderly. Newspapers during 1970 and 1980 dealt with quality of life issues. Quality of life in all aspects for seniors became a major issue. In the 80's for example, the power of senior activism became widely felt.

Progressive strides have been made in the characterization of the elderly. Although many of the ideas and expressions concerning the EHCSA and those of society reflect a rehabilitative orientation about the elderly, there is still concern that a more positive image of the elderly needs to be expounded.

Societal images negatively portraying the elderly remain with us today, although much improved compared to the past. Rehabilitative policies are in place today, yet more could be done to actually enable aged participation in society. It almost seems societal attitudes toward the elderly are willing to accept the elderly as they are and encourage their participation but the government has not actively encouraged the participation of the elderly either in the EHCSA or society. No doubt in the future as the proportion of the elderly in the population increases, the elderly will demand to participate more fully in society and they will get their opportunity.

VI. FUNCTIONALISM REVISITED

First, this final chapter summarizes the conclusions of the preceding four chapters. These chapters examined the EHCSA historically in its ability to satisfy the four functional prerequisites. Next, this section provides a discussion of the problems in functionalism and the problems encountered in applying functionalism to the EHCSA.

A. Overview of the EHCSA

The Theoretical Problem

The study examined the historical evolution of the EHCSA from a functionalist perspective. It analyzed the changes in the goals of the EHCSA and how this led to the current EHCSA. The theoretical problem undertaken was how to justify continued investment of resources into the aged health care system when rewards from doing so appear limited.

One way to rationalize further expenditure of resources, as has been reiterated throughout this study, is to change the orientation of the EHCSA to consider the aged as productive (i.e., as a resource for the system rather than as a liability). The general hypothesis follows from the above statement. Overtime it was anticipated that a gradual shift occurred in the orientation of the EHCSA from a primarily affective (goals being of a passive custodial nature) toward an instrumental orientation indicative of an

holistic approach to aged health care.

Meeting the System Prerequisites

Historically, the EHCSA was able to secure resources to fulfill its custodial care goals. Institutions were established in the 50's and 60's reflecting a passive, maintenance approach to aged health care. Personnel employed in these institutions were trained in acute care like personnel in the general health care field. The elderly were not considered as requiring any specialized treatment.

As was hypothesized benefits for society from investment in the EHCSA were seen as affective. That is, benefits were valued as ends in themselves and not as means to obtain productive ends. Institutional type of care was promoted as a reward for the past contributions of the elderly to society. Institutions were said to allow the elderly "to live in dignity and comfort with individuals of his own age group without requiring extra assistance for his maintenance" (Department of Public Welfare, 1960/61:25). The elderly were not expected to further contribute to society. No emphasis was placed on engaging the elderly in the EHCSA or in any community affairs.

The custodial care goals adopted for the EHCSA were a success. Official goals became operative goals. From chapter 3, it is apparent that the necessary resources (land, labour, capital) were attainable in the 50's and

60's. As was anticipated, consumers and producers were not active participants in the EHCSA. The value orientation of consumers and producers concurred with the policies in place during this time as is evident from the chapter on 'integration'. Further, historically values in the EHCSA and those in the larger society coincided. The images and ideas portrayed presented the elderly as a group willing to accept the custodial care goals of the EHCSA.

From the above, it is apparent that the necessary resources, motivations and values were created to deliver a custodial care policy. The EHCSA was able to implement its official custodial policy by appealing to the affective benefits of supporting health care for the aged.

By the late 60's resources to maintain a custodial care orientation became scarce. Prior to this time, institutional type of care was considered cost effective. It was seen as a good alternative to the high cost of maintaining the elderly in active treatment facilities. But as the demand for institutional type of care rose and financial expenditures skyrocketed, it became increasingly difficult to justify a custodial care orientation by advocating affective benefits. A new approach was necessary in order to continue supporting a health care system for the aged.

The rehabilitative approach that came to dominate the 70's no longer solely emphasized the affective benefits of supporting health care for the aged. The change in

orientation offered a new basis for allocating resources for aged health care. The rehabilitative approach viewed investment in aged health care as an instrumental benefit. That is, support for health care for the aged was justified in terms of the productive benefits for the system. The official rehabilitative policy advocated the elderly as living a productive, active lifestyle. The elderly were expected to continue to contribute their skills to society.

The rehabilitative approach in the 70's necessitated a change in the type of resources required for the EHCSA. Community based facilities became necessary to enable the aged to remain in their community and use their skills. The change in orientation required specialized personnel. Personnel were sought trained in chronic care rather than acute care. Further, consumers and producers were expected to alter their value orientation so as to support a rehabilitative approach. Values in the larger society were also required to shift toward advocating a rehabilitative approach to aged health care. The government advocated this type of rehabilitative policy in the 70's and attempted to implement this policy.

By the late 70's, rehabilitative facilities for the elderly had expanded greatly compared to the previous decades and more were deemed necessary. Qualified professionals were however difficult to attract to the EHCSA mainly because educational training programs in aged health care were lacking. Only in 1980 did Edmonton receive its

first geriatrician. ** Encouraging consumers to become involved in the EHCSA posed little difficulty. In fact, it was advantageous for the elderly consumer to participate in the EHCSA both to further their self and collective interests. It was much more difficult attracting producers to the EHCSA. It is questionable whether the value orientation of producers changed to adopt a rehabilitative approach to aged health care. Indeed from the chapter on 'integration' it seems doubtful whether the medical profession has accepted geriatric health care as an integral component of the general health care field. Official policies were in place but by the late 70's it appeared that making these policies operational would require increased investment in aged health care. Creating resources, motivations, and values to fulfill official goals of the EHCSA became problematic as has been evident from the chapters on 'adaptation' and 'integration'.

The major problem recognized by the late 70's in implementing a rehabilitative approach was the lack of a comprehensive strategy for the development of the EHCSA. There was no concrete knowledge of the resources necessary to fulfill a rehabilitative approach. The government had not ensured the co-ordination of facilities in the EHCSA, either of a horizontal or of a vertical nature. This hindered the implementation of a holistic, rehabilitative approach to aged health care. Furthermore, it suggested the

---

** This was also a first for Alberta.

government was not serious about furthering an holistic approach. The government had officially endorsed an holistic policy and had provided financial assistance but realistic efforts to effectively co-ordinate this variety of facilities had not been pursued.

A rehabilitative approach remains in place today. This official policy is endorsed by the government. The government continues to use instrumental benefits to rationalize expenditures for aged health care. The elderly are expected to remain in their community and contribute their energy for the productive segment of society. In fact, society has a great awareness of their potential as contributors to society and the EHCSA compared to past decades. There is a greater sensitivity to aged concerns as witnessed in the chapter on 'latency'.

The lack of a plan for the co-ordination of the EHCSA hampers the pursuit of a self-sufficient, active lifestyle for the elderly. The government's lack of a co-ordinated system of care prohibits the elderly from receiving the best care possible. It appears that to a large extent society is willing to provide an environment in which the elderly can pursue their own activities but the government has not responded sufficiently. Further, the absence of a co-ordinated system of care in the 1980's does not attract qualified producers to the EHCSA. It provides producers with little incentive to become committed to a rehabilitative approach.

As the major financial supporter of the EHCSA, the government has the largest stake in the development of the EHCSA as well as the greatest responsibility. If the government wishes to offer high standard health care for the elderly in the future, a co-ordinated system of care needs to be implemented. In the long run this type of action is cost effective for it enables gaps in service delivery to be filled and overlaps in services to be avoided.

In short, it was hypothesized that a shift in the orientation of the EHCSA would occur in order to justify supporting aged health care. This was found. In the past, custodial care goals were supported for affective benefits. Supporting aged health care was seen as a moral obligation. It was offered as a reward for past services rendered. Later, affective benefits to support aged health care were viewed as too expensive to maintain. Instead, instrumental benefits were used to justify continued support for aged health care. The government remains committed to this approach yet the government has not fully put this into practice.

At present the government's rehabilitative official polity does not appear to be operative. The government has provided some financial assistance but has not ensured that the EHCSA is following a rehabilitative approach. The lack of a clearcut strategy for the development of the EHCSA has placed such facilities as the Youville at risk. At present the future of the [redacted]le as a geriatric facility is not

clear. It is clear that the Youville may lose part of its uniqueness. The absence of an active treatment facility in close proximity to the Youville may hinder the Youville from being able to use the active treatment facility for investigative purposes. It is the government that must take the initiative to promote an holistic, rehabilitative orientation for aged health care. The failure to ensure such an approach is detrimental to the government politically and financially since the elderly are unlikely to idly sit by as the government decides their future.

B. Problems in Functionalism

Throughout this study, functionalism has been the guiding theoretical framework. In this section, the problems in functionalism and the challenges encountered in applying a functionalist perspective to the EHCSA are faced.

Traditional functionalism has received wide criticism from various theoretical camps. Many of the problems in traditional functionalism have however already been addressed by functionalists themselves, particularly Merton.[*] Still the criticisms concerning functionalism has not waned. The following provides a list of some of the criticism addressed to functional theory. These include the proliferation of tautological and teleological explanations;

---

[*] Merton in his article, 'Manifest and Latent Functions' in On Theoretical Sociology, New York: The Free Press, 1967 addresses some of the major issues and obstacles confronting traditional functionalism. Here Merton provides clarification and improvements for functionalism.

the inability to compare and generalize from functional analysis; its ahistorical nature; failure to account for social change; the over-emphasis on the normative aspects; the stress on the harmonious aspects of the social system; the avoidance of social conflict and the conservative nature of functional theory.

The list of critique on functionalism seems endless. Out of this list only two issues will be examined:

1. The first issue addresses tautological explanations. This was selected because it is the most common criticism directed at functionalism.
2. The second issue examines the avoidance of social change in functionalism. This questions the usefulness of functionalism as a sociological theory in explaining social reality.

These two issues address major flaws attributed to functionalism.

The Problem of Tautological Explanations

Tautology refers to the unnecessary repetition of similar ideas in different words, true by virtue of its logical form alone. Critics have long cited examples in functionalism as containing tautological explanations. The following examines the problem of tautological explanantions in relation to the EHCSA.

In traditional functionalism, the concept of functional prerequisite is based on the premise that if these

requisites are not fulfilled the system is in jeopardy. In making such assertions traditional functionalists have often failed to specify the level or degree of failure that may threaten the survival of the system. Critics have questioned the conditions necessary for the system to disintegrate or fail. Since functionalism often can not state these conditions precisely, the theory tends to lapse into a tautology: the very persistence of any system demonstrates the conditions are inoperative. "One posits certain conditions for a society's survival as proof that the functional prerequisites have been satisfied"(Zeitlin, 1973:5).

The question is how can the system meet its functional prerequisites without having to wait for the system to disintegrate in order to claim that the prerequisites were not met. In examining the EHCSA one question has been: are the official goals of the EHCSA being satisfied. This immediately prompts the question: how can we tell if the goals have been fulfilled? The simplest route would be to say that the EHCSA has fulfilled its official goals if the appropriate resources, motivations and values are created in the other prerequisites. But this isn't very clear. It again raises the question of how can we tell whether the appropriate resources, motivations and values have been created and what is considered sufficient to state that a specific level of resources is satisfactory to fulfill the goals of the EHCSA?

It is evident from the foregoing that determining whether a prerequisite has been satisfied is not clearcut. There is no certainty as to when a prerequisite has been satisfied. For example, how many goals need to be fulfilled, all of them or the most important ones, before one can state that the goals of the system have been satisfied? How many resources does the system require in order to be satisified that it has enough? Specific specifications as to what is necessary to fulfill a prerequisite is difficult to estimate. Just when is a need being fulfilled is not clearcut in functionalism.

In the chapter on goal-attainment, it was stated that in order for the prerequisites to be fulfilled policies and co-ordinative mechanisms need to be in place. We concluded that in the past official policies were implemented since resources were available. However in the early 50's, policies for the EHCSA were nonexistent. How should this be interpreted? Does this mean that official policies in the past were never really implemented successfully because in the early years policies were lacking? It was also concluded that historically co-ordinative mechanisms were not in place. The lack of a co-ordinative mechanism seems to suggest that the goal-attainment need was not met in the past. It is also possible to argue that a co-ordinative mechanism was not required as part of the official custodial policy. The custodial policy did not deem it necessary to co-ordinate facilities in the EHCSA, therefore the fact that

a co-ordinative mechanism did not exist points out that official goals were fulfilled.

Based on the foregoing, it would seem that the goal-attainment need was not satisfied. We concluded that official policies were not operative and co-ordinative mechanisms were not in place. The question however is what is necessary for a rehabilitative approach to operate? Do we need ten geriatricians or a dozen senior citizens' centres before we can say a rehabilitative approach is being fulfilled? How much co-ordination (vertical and horizontal) is necessary for the EHCSA? Is it possible to demarcate when too much co-ordination prohibits the goals from being met? Functionalism does not provide an obvious answer to the question of when is a need fulfilled. Even if we say that the goal-attainment prerequiste has not been fulfilled, what implication does this have for the rest of the prerequisites and the EHCSA?

From the foregoing, it is not at all clear whether the EHCSA has survived. It would be simple to say that since the EHCSA is still here the prerequisites must have been fulfilled. But that would constitute a tautological explanation.

It is quite possible that the EHCSA has not survived. From the conclusions it would seem that the EHCSA has not survived. Today, resources are not available to carry out the official rehabilitative policy. Official policy is only partially becoming operational. Co-ordinative mechanisms

are not in place to strengthen the system and enable the policies to be met. Educational facilities in geriatric health care are not in place to enable a rehabilitative policy to be implemented. Further, it is unsure whether producers are willing to adopt a specialized care orientation for the elderly. Even though society is willing to accept the elderly as contributing active members there is still some reservation about wholeheartedly accepting a changed view of the elderly. All in all, it would seem the EHCSA could not survive with such forces opposing the rehabilitative approach.

How many prerequisites need to be met in order for the system to survive? Indeed it would be much easier to revert to a tautology. Since the EHCSA is still presumably here the prerequisites must have been fulfilled. But how can we tell if the system is still surviving? Is it possible that the EHCSA has collapsed? And how can we tell if it has?

The concepts of functionalism like 'survival' and 'need' are rather vague in specifying what is required of them. The absence of any specifications on how to handle these concepts has placed those using functionalism in a rather unique position. It allows the user of functionalism to determine the conditions under which a need has been fulfilled. Using the available data, the researcher can specify the boundaries in order for a 'need' to be met. Functionalism can thus be seen as providing a basic framework and leaving the rest to the discretion of the

researcher. Obviously this is not ideal. It leaves functionalism susceptible to critique. And of course, it leaves the researcher with the responsibility of defending functionalism as a viable theory.

The Problem of Social Change

Critics have long cited the inability of functionalism to deal with social change. Functionalism has been regarded as a theory dealing with stability, consensus and order rather than with the process of social change.

Traditional functionalists like Parsons, however do not deny the existence of social change. For Parsons, a constant flow of interaction and exchanges between units occur in society which produces some degree of social change (Rocher, 1974:48). Internal change is part of the normal flow of interaction occurring between unit parts. Within the system pressures for change are generally restrained through the institutionalization of norms and values. In Parsons' model there is no sudden shifts or inbalances that upset the system. The system inherently strives to remain stable and orderly.

Functionalism is basically concerned with change to the extent that it threatens the stability of the system. Social change is likely only when tensions reach the level of latency and values. As tensions penetrate the level of culture and its values, change is eminent.

Just how this change in the system comes about is not clear. It is not clear how social change can be explained when all the parts of the system are apparently well integrated and pressures exist for it to remain so? It would appear that internal pressures for change are not envisioned as problematic in functionalism. For functionalists, social change is best explained as coming from environmental factors rather than within the system. External factors threaten the stability of the system and this results in change.

There are problems with a theory that explains change as a result of environmental forces impinging upon the system. For this seriously limits the systems power to adequately address social change. Every theory has to contend with external factors some which are controllable others unpredictable. In either case change may result; this is a normal reaction. Functionalism is such a theory that looks to external factors to explain social change. It is thus hard pressed to explain social change since it does not have built in mechanisms for change.

The basic assumption in functionalism is that the system is always striving to remain stable and orderly. Modifications in the system may occur with the intent to strengthen the functioning of the system but this does not constitute real social change. Conflict theory, on the other hand, views social change as inherent in its basic structure. The social system is never stable or harmonious.

The system would be stagnant if change was not evident. Change and conflict in a system is part of its nature.

Functionalism as a theory tends to look for the harmonious positive aspects of a systems functioning. Conflict theory tends to dwell on the conflictural aspects of relations in a system. Within a system such as the EHCSA tensions are evident but focusing on these tensions would not promote growth and development. The EHCSA has deficiencies that need to be addressed; however, the positive aspects of the system must be emphasized. The EHCSA could not have developed as it has today based on a conflictual model of social reality. This type of philosophy would have impeded the EHCSA at the onset.

Functionalism is far from perfect in its ability to explain social change within the system. Yet, its insistence on stability and order in a social system is necessary when dealing with the EHCSA. Functionalism may not be as specific in its ability to explain social change as conflict theory is; but, it does not deny the utility of social change in a system. There needs to be an acceptance of social change when dealing with the EHCSA but not a preoccupation with social change. As a functionalist, Merton is one who addresses the issue of social change in order to further the functioning of the social system.

Merton uses his concept of 'net balance' to identify sources of social change. Net balance involves comparing and assessing functional and dysfunctional consequences of

the units of a system. Functions are "those objective consequences which make for the adaptation and adjustment of the system" (Merton, 1967:105). Dysfunctions are "those that lessen the adaptation and adjustment of the system" (Merton, 1967:122). "Functional analysis assumes that when the net balance of the aggregate of consequences of an existing social structure is clearing dysfunctional there develops a strong and persistent pressure for change" (Merton, 1967:94). Change then occurs everytime dysfunctions outweigh functions. The following paragraphs look at social change as it occurs in the EHCSA.

From the previous chapters it is apparent that change occurred in the EHCSA. The custodial care approach operating in the late 50's and 60's emerged as a result of an increased aged population using active treatment facilities. Institutional type of care was envisioned as acceptable for the elderly. It was functional to consider the elderly as inactive, unproductive members of society. It solved the problem of providing for their health care.

In later years as financial costs of maintaining and constructing institutions rose, as well as the proportion of the elderly, it was no longer practical to maintain a custodial care approach. Providing for unproductive members became an costly expense; that is, it became dysfunctional. The result was an inbalance in the system. Restrictions on resources facilitated a change in the value orientation of the EHCSA. Instead of institutionalized living the emphasis

was placed on community based services that could allow the elderly to remain in their community. Considering the aged as a resource to the system emphasized the potential benefits of providing for aged health care.

Today, the EHCSA is again faced with curtailment on resources. In the chapter on 'goal-attainment' and 'adaptation' it was apparent that resources and facilities for the elderly are in demand but that a 'plan of action' for the EHCSA has not been established. The development and implementation of such a plan would go a long way toward ensuring that the elderly are adequately provided for in the future. It would ensure that overlaps and gaps in the delivery of services are avoided. Without some clear guidelines, first of all as set forth by the government, the future of the EHCSA is dim. It is becoming more and more dysfunctional today to support an holistic health care system for the aged. In fact, the net balance is shifting toward greater dysfunctions in the system. The lack of a 'plan of action' may mean the demise of the EHCSA. It may mean that the elderly are not receiving the best possible health care.

The net balance in the EHCSA is shifting to dysfunctions. The 'need' for change is great. Today, what the government really needs is a 'plan of action'. A plan for the future development of the EHCSA. Such a plan would assist in rectifing the inbalance of functions and dysfunctions in the EHCSA. From the analysis of the EHCSA

as presented in the previous chapters, it is possible to state that at present there is an inbalance in the system. This inbalance must be rectified now not in 10 years.

Is it posssible to accurately predict social change? According to Merton everytime the dysfunctional aspects in a system outweigh the functional aspects the potential for change is great. Just what are the dysfunctional elements in a social system such as the EHCSA? Is it possible to dissect the functional from the dysfunctional? And how is this net balance arrived at? All these questions are answered not with great ease? If there was an objective measuring instrument to determine this net balance accurately these questions would be easier to answer.

It is clear that the need for change is necessary when the continued existence of the EHCSA is in doubt. Change, however, is often required prior to the systems malfunctioning. Judging the net balance and deciding the appropriate time for change requires first a clear understanding of the development of the EHCSA in terms of policies; an insight into the operation of the EHCSA; and knowledge of the gaps and weak links in the system.

A thorough overview and insight into the EHCSA is mandatory prior to determining the net balance. Although it may appear to involve a great deal of understanding about the operation of the system, it is not an impossible mandate. Merton himself stated the necessity of a complete examination of the sociological item in order to establish

the functions, dysfunctions, functional alternatives and net balance. Only in this way is it possible to justify the need for social change. Ideally, procurring the services of more than one sociological observer is desirable in establishing reliability. It is not a requisite, however. Often a researcher is faced with a situation that prohibits the availability of other observers.

C. Theoretical Conclusion

The major task in this final section is to sum up the state of functionalism. This includes addressing the utility of functionalism as a theory and its practical application in analyzing the EHCSA in day to day practise and research.

The utility of functionalism as a theory has often been questioned by critics. Functionalists have never been frightened by these criticisms. In fact, functionalists like Merton have acknowledged the difficulties and have attempted to address them. This straight forward approach has been respected even by opponents of functionalism. Identifying and addressing the problems in functionalism are two crucial steps in building and strengthening a theory.

In previous sections of this chapter two problem areas in functionalism were addressed: tautological explanations and social change. We admitted that there are deficiencies in functionalism and that these must not be overlooked. But are these inadequacies in functionalism severe enough to

discard this theoretical framework? I think not? Indeed functionalism has difficulty specifying the level or degree of failure that may threaten the survival of the system. It has difficulty identifying when a prerequisite is being met. It is not clear even how many prerequisites need to be met in order for the system to survive. All in all, it is quite evident that functionalism tends to lapse into a tautology.

In analyzing the EHCSA the tendency for tautological explanations makes it difficult to assess whether or not the goals of the system have been met. It isn't clear whether the appropriate resources, motivations, and values were created in the past and present to fulfill the goals of the EHCSA. Yes, it is problematic evaluating the extent to which policies are being adhered to. But it is not an impossible task. Rather it requires that the researcher become intimately involved in the development and operation of the EHCSA.

The same applies to the problem of social change. The fact that functionalism is hard pressed to explain social change within the system has been pointed out. It is not always easy to identify the sources of social change and to know when change is appropriate in the EHCSA. But it was also noted that while functionalism has problems explaining social change it does not deny or neglect social change. Identifying the weak points is the first step in overcoming them. It is then the responsibility of the researcher to seek solutions and ways and means to overcome these

difficulties. It must be stressed that the problems faced by functionalism are not unique. Every sociological theory has its weak points that need to be addressed. It is only through identifying and sorting out these problems that theory building can proceed.

In earlier sections deficiencies in functionalism were acknowledged but these were not seen as sufficient to discard functionalism as a sociological theory. Neither should functionalism be discarded as a viable framework for analyzing systems such as the EHCSA. Functionalism has its place in basic and applied research. It is a useful theory alongside other perspectives particularly in comparing and contrasting other orientations.

The focus of functionalism on the stability and order in the internal functioning of the system is applicable to many social systems. Concepts such as 'prerequisite', 'function', 'dysfunction', 'functional alternatives', and 'net balance' can be used to analyze any social system. These concepts offer a method to evaluate and weigh units in social systems. Indeed, it may not always be appropriate to use only functionalist terminology or attempt to include all concepts devised by such functionalists as Parsons or Merton. But, this does not hamper the application of functionalism in research. Functionalism has room for modifications. Functionalism as a theoretical model can be altered to suit the situation without creating a watered down theory.

The beauty of functionalism is that functionalists such as Parsons and Merton accept modifications and alterations to the theory. Parsons was continually expanding and revising his interpretation of social systems.

The ability of a theory to accept alterations is necessary in applied research. After having applied functionalism to the EHCSA, I can appreciate the utility of functionalism. I now regard the functionalist concept of system as composed of interrelated units working for a collective goal as necessary in explaining social systems. Is it possible that a system has disconnected parts opposing each other? Yes, it certainly is. But, I do not believe it is a good premise from which to start examining a social system. It is much more strategic to view units in the social system as striving toward harmony rather than conflict. A researcher is not immune to events occurring in a social system. I believe it is thus beneficial to emphasize a positive rather than a conflict philosophy. By no means does this deny the potential for change and conflict occurring in a social system. After having applied functionalist concepts to the EHCSA, I can say that a functionalist approach to social systems is relevant and applicable both in basic and applied research.

VII. REFERENCES

Alberta Health Facilities Review Committee
1978 *Annual Report*

Alberta Hospitals and Medical Care.
1982 *Report and Recommendations*, Alberta Nursing Home Review Panel, March.

1985 *Overview of the Implementation of the Nursing Home Review Panel*, Sept, 5.

Alberta Housing and Public Works
1979 *Senior Citizens' Lodge Study*, March.

Alberta Legislative Assembly
1950 *Speech From the Throne.*

1966 *The Report of the Special Legislative and Lay Committee Inquiry into Preventive Health Services in Alberta.*

1970 *Speech From the Throne.*

1972 *Speech From the Throne.*

1973 *Speech From the Throne.*

1975 *Speech From the Throne.*

1981 *Speech From the Throne.*

Alberta Progressive Conservative Party
1986 *In Participation with Senior Citizens Listening to Experience.*

Alberta Public Health
1950 *Health Survey.*

1962 *Alberta Royal Commission on Health Services.*

1963 *Interim Report*, Custodial Care Committee, December.

1964 *Annual Report*, Alberta Nursing Home Plan.

1968 *Mental Health Study.*

Alberta Public Welfare
1958-59 *Annual Report.*

1959-60 *Annual Report.*

1960-61 *Annual Report.*

1961-62 *Annual Report.*

1963-64 *Annual Report.*

1966-67 *Annual Report.*

1967-68 *Annual Report.*

Alberta Social Service and Community Health
1975 *Annual Report.*

1975 Provincial Senior Citizens' Advisory Council, *Annual Report.*

1980 Provincial Senior Citizens' Advisory Council, *Annual Report.*

1981 Provincial Senior Citizens' Advisory Council, *Annual Report.*

1982 Provincial Senior Citizens' Advisory Council, *Annual Report.*

Bella, Leslie
1980 *The Development of Alberta's Preventive Social Service Program*, Department of Recreation Administration, University of Alberta.

Black, Max
1961 *The Social Theories of Talcott Parsons.* Englewood Cliffs, New Jersey:Prentice-Hall, Inc., (revised 1976).

Canadian Mental Health Association.
1956 "Treatment or Treadmill", *Alberta division of the Mental Health Association.*

Cohen, Percy S.
1973 *Modern Social Theory.* London:Heinemann.

Daft, Richard
1983 *Organization Theory and Design.* St Paul:West Publishing.

Edmonton General Hospital.
1984 Department of Geriatric Medicine, *Annual Report.*

Edmonton Social Service
1970 *Annual Report.*

1971 *Annual Report.*

1973 *Annual Report.*

1974 *Annual Report*

1976 *Annual Report.*

1980 *Annual Report.*

Interdepartmental Committee on Long Term Care.
1985 *An Assessment/Placement Model for Long Term Care Services in Alberta.*

Kearle, M.C.
1982 "An Inquiry into the Positive Personal and Social Effects of Old Age Stereotypes Among the Elderly," *International Journal of Aging and Human Development*, 14:277-290.

Merton, Robert K.
1949 *Social Theory and Social Structure.* Glencoe, Ill: The Free Press (revised in 1957 and 1968).

1967 *On Theoretical Sociology.* New York: The Free Press.

Parsons, Talcott
1951 *The Social System.* New York: The Free Press.

Perrow, Charles
1961 "The Analysis of Goals in Complex Organizations", *American Sociology Review*, 26:854-866.

Rocher, Guy
1974 *Talcott Parsons and American Sociology.* London:Nelson.

Thomas, Q.C.
1980 "The Expectations Gap and the Stereotype of the Stereotype: Images of Old People". *The Gerontologist*, 21:402-408.

Turner, Jonathan H.
1978 *The Structure of Sociological Action.* (revised edition), Homewood, Ill.: Dorsey Press.

Zeitlin, Irving M.
1973 *Re-thinking Sociology: A Critique of Contemporary Theory.* Englewood Cliffs, New Jersey: Prentice-Hall.

University of Alberta
1985-86 *Academic Calendar.*

VIII. BIBLIOGRAPHY

Health Care for the Aged

Brody,S.J., W. Poulshock and C.F. Masciocchi
1978 "The Family caring unit: A major consideration in the Long-term Support System." *The Gerontologist*, 18:556-561.

Cowgill, Donald and Lowell D. Holmes (Eds.)
1972 *Aging and Modernization*. New York: Appleton-Century, Crofts.

Cumming, Elaine and William E. Henry
1960 *Growing Old: The Process of Disengagement*. New York:Basic Books.

Economic Council of Canada
1979 *One in Three: Pensions for Canadians to 2030*. Ottawa: Minister of Supply and Services.

Fischer, David
1977 *Growing Old in America*. New York: Oxford University Press.

Fleishman, R., and A. Shmueli
1984 "Patterns of Informal Social Support of the Elderly: An International Comparison." *The Gerontologist*, 3:303-312.

Graebner, William
1980 *A History of Retirement: The Meaning and Function of an American Institution*, 1885-1978. New Haven: Yale University Press.

Haberk Carole
1983 *Beyond Sixty-Five:The Dilemma of Old Age in America's Past*. New York: Cambridge.

Havighust, Robert J, Bernice L. Neugarten and Sheldon S. Tobin
1968 "Disengagement and Patterns of Aging," In B.L. Neugarten (ed.), *Middle Age and Aging*. Chicago: University of Chicago Press.

Hickey, Tom
1980 *Health and Aging*. Belmont, California: Brooks/Cole.

Karcher, Charles J. and Lemard L. Linden
1974 "Family Rejection of the Aged and Nursing Home Utilization." *International Journal of Aging and Human Development*, 5(3):231-243.

Lawton, M. Powell
1981 "Community Supports for the Aged." *Journal of Social Issues*, 37(3):102-113.

Maddox, George L.
1968 "Persistence of Life-style among the Elderly," In B.L. Neugarten (Ed.), *Middle Age and Ageing*. Chicago: University of Chicago Press.

1980 "The Continuum of Care: Movement toward the Community." In E.W. Busse and D.G. Blazer (Eds.), In *Handbood of Geriatric Psychiatry*. New York: Reinhold Co.

Marshall, Victor W. (Ed.)
1980 *Aging in Canada: Social Perspectives*. Toronto: Fitzhenry and Whiteside.

Riley, Matilda White, John W. Riley, Jr., and Marilyn E. Johnson
1969 *Aging and Society*. New York: Russel Sage Foundations.

Rosow, Irving
1967 *Social Integration of the Aged*. New York: The Free Press.

Schonfield, David
1982 "Who is Stereotyping Whom and Why?" *The Gerontologist*, 22:267-276. 22:267-276.

Schulz, James H.
1980 *The Economics of Aging*. (Second Edition) Belmont, California: Wadsworth.

Shanas, Ethel
1979a "The Family as a Social Support System in Old Age." *The Gerontologist*, 19:169-174.

1979b "Social myth as Hypothesis: The Case of the Family Relations of Old People." *The Gerontologist*, 19:3-9.

1980 "Older People and their Families: The New Pioneers." *Journal of Marriage and the Family*, 42:9-15.

Stout, R.W.
1979 "Hospital Care of the Elderly: General or Geriatric Medicine?" *Age and Aging*, 8:137-140.

Tibbett, Clark
1979 "Can We Invalidate Negative Stereotypes of Aging," *The Gerontologist*, 19:10-20.

Townsend, Peter
1981 "The Structured Dependency of the Elderly: A Creation of Social Policy in the Twentieth Century." *Aging and Society*, 1:5-28.

Treas, Judith
1979 "Family Support Systems for the Aged: Some Demographic Considerations." *The Gerontologist*, 17:481-491.

Troll, Lillian, Sheila J. Millar, and Robert C. Atchley
1979 *Families in Later Life*. Belmont, California: Wadsworth.

Theoretical

Aberle, D.F., A.K. Cohen., A.K. Davis., M.J. Levy,Jr., and F.X. Sutton.
1950 "The Functional Prerequisites of a Society." *Ethics*, Vol. LX, 100-111.

Adriaansens, Hans P.M.
1980 *Talcott Parsons and the conceptual dilemma*. London: Routledge and Kegan Paul.

Bengston, Vern and James J. Dowd
1980 "Sociological Functionalism, Exchange Theory and Life-Cycle Analysis: A Call for More Explicit Theoretical Bridges." *International Journal of Aging and Human Development*, 12(1):55-73.

Bottomore, Thomas and Robert Nisbet (Eds.)
1978 *A History of Sociological Analysis*. London:Heinemann.

Campbell, Colin A.
19[illegible] "A Dubious Distinction: An Inquiry into the Value and Use of Merton's Concept of Manifest and Latent Function. *American Sociological Review.*, *Vol 47, 29-44.*

Coser, Lewis A., and Bernard Rosenberg
1976 *Sociological Theory: A Book of Readings*. (fourth edition), New York: Macmillan.

Durkheim, Emile
1964 *The Division of Labor in Society*. New York: The Free Press.

Freidson, Eliot
1971 *Profession of Medicine*. New York: Dodd, Mead.

Giddens, Anthony
1979 *Emile Durkheim.* England: Penguin Books.

Martindale, D.
1981 *The Nature and Types of Sociological Theory.* (second edition), Boston: Houghton Mifflin.

Mills, Wright C.
1958 *The Sociological Imagination.* London: Oxford University Press.

Parsons, Talcott, Robert F. Bales and Edward A. Shils
1953 *Working Papers in the Theory of Action.* Glencoe, Illinois: The Free Press.

Parsons, Talcott, and Edward A. Shils (Eds.)
1951 *Toward a General Theory of Action.* Cambridge: Harvard University Press.

Parsons, Talcott, Edward A. Shils, Kasper D. Naegele, and Jesse R. Pitts (Eds.)
1961 *Theories of Society.* Volume I. New York: The Free Press of Glencoe.

Health Care for the Aged in Edmonton

Alberta Treasury Bureau of Statistics
1984 *Population Projections* 1984 Update: 1984-2011.

Alberta Senior Citizens' Bureau
1984 *Older Persons in Alberta: Their Use of Programs and Services.*

Anholt, L.M.
1978 "U.A.H.S.C. Issue #38: *Should an Acute Geriatric Evaluation and Rehabilitation Unit be developed at the U.A.H.S.C.* Unpublished Paper, University of Alberta Hospital.

Brown, Kenneth
1983 *The Evolution of Hospital Funding in Alberta.* Master's Thesis - Health Services Administration and Community Health.

Clarkson, Graham
1977 "Health Services and the Elderly." Paper presented at the Conference, '*Coming of Age in Canada.*' Trent University.

"The Development of Comprehensive Geriatric Services." Unpublished paper, Faculty of

Medicine, University of Alberta.

Edmonton Social Service
1969 *Edmonton Services to the Elderly.*

1986 *Edmonton Services to the Elderly.*

Englemann, M. and C. Stevenson
1980 "Profile of older persons in Alberta: Demographic Characteristics and Service Utilization." Staff working paper, Research and Planning Division, Alberta Social Services and Community Health.

Irvine R. E., and K.N. Davies
1978 "Geriatric Services in Lethbridge." Unpublished Paper, Faculty of Medicine, Calgary.

General Health Care

Coburn David., Carl D'Arcy., Peter New., and George Torrance
1981 *Health and Canadian Society.* Toronto:Fitzhenry and Whiteside.

Enthoven, A.C.
1978 "Cutting cost without cutting the quality of care." *New England Journal of Medicine,* 29:1229-1238.

Hall, Emmett M. (Hon.)
1980 *Canada's National-Provincial Health Program for the 1980's: A Commitment for Renewal.* Ottawa: National Health and Welfare.

Illich, Ivan
1976 *Limits to Medicine: Medical Nemesis - The Expropriation of Health.* Toronto: McClellan and Steward.

McKeown, Thomas
1979 *The Role of Medicine.* Oxford, London: Basil Blackwell.

Mechanic, David
1979 *Future Issues in Health Care.* New York: The Free Press.

Meilicke, Carl A. and Janet L. Storch
1980 *Perspectives on Canadian Health and Social Policy: History and Emerging Trends.* Ann Arbor:Health Administration Press.

Taylor, Malcolm G.
1978 *Health Insurance and Canadian Public Policy.* Montreal: McGill-Queen's University Press.