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[ED]MONTON SOCIAL PLANNING COUNCIL

TASK FORCE ON:

DR. SNIDER'S REPORT

The Task Force on Dr. Snider's recommendations which come out of his report Medical Problems and the Use of Medical Services Among Senior Citizens in Alberta: A Pilot Project was formed in response to a request from the Public Affairs Committee of Edmonton City Council.

The Task Force is in agreement with Dr. Snider's recommendations which stress the need for co-ordination of health care services to the elderly. To co-ordinate these services a blueprint or plan is necessary. To develop such plans or blueprints the Province should take financial responsibility for providing funds to communities of elderly citizens to develop their blueprints to meet their needs.

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A PUBLICATION OF
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TASK FORCE COMMENTS

1. The Task Force agrees that a blueprint (plan) to co-ordinate and meet the diverse needs of the elderly is necessary in Edmonton. We feel that the provincial government should not take responsibility in liaison with public and private agencies in Edmonton to develop this (plan) blueprint. The Province should, however, take financial responsibility in providing funds to communities of elderly citizens to develop, in a community sense, their blueprint to meet their needs.

DR. SNIDER'S RECOMMENDATIONS

1. The provincial government in liaison with public and private agencies in Edmonton should establish a blueprint, a co-ordinated framework to act upon the diverse needs of the elderly in this city. Such a program should recognize the special needs of the elderly existing on restricted incomes, the handicapped, demographic groupings such as the oldest cohort and the widowed, and those who prefer to adjust to their problems on a more independent basis. It is critical to remember that not all programs established here need be universal but should be based on actual, established needs. Each time another political solution is implemented in the flow of political tides, each time another ad hoc or temporary program is established simply for the sake of doing so, each time we proceed with a program with no framework for evaluating its merits, and each time we defer establishing a proper framework for action, we make the possibility of such a coordinating program of action more remote.

Such a program would prevent overreliance on physicians and would result in a better blend and delivery of physician-agency services and facilities. The program should be flexible, recognizing the broad concerns of the elderly but with a view to shifting priorities as the need arises. Above all, the programs should not be based upon the established services and facilities but rather a continuum of need as discharged by present and future agencies. Some other legitimate concerns of the blueprint are presented in the remaining recommendations.

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2.(a) We neither agree or disagree with this recommendation. Members of the Task Force would prefer to see the establishment of a blueprint first and let the blueprint(s) determine the need for a division or department to deal with the concerns of senior citizens at the provincial level.

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2.(a) The provincial government should formally establish a branch or section within the Department of Health and Social Development, to be known as the Division on Retirement and Aging, with a government view to establishing a separate Department. It is noted there now exists a formal Department of Culture, Youth and Recreation: on the assumption that culture and recreation are not the sole domain of the young and given that the over-65 cohort is increasing numerically and proportionately, a strong legislative and administrative focus on the elderly is not undeserved.

This division, with the power to plan and coordinate would be charged with developing the blueprint(s), establishing research priorities, assisting in the flow of relevant information, preparing an annual Social Report on the Aged in Alberta, and other related activities. It must be underlined that the intention is not to create a "super-agency", only a formal mechanism at the provincial level with the vested interests of the elderly as its basis for operation and the responsibility for planning-coordination (blueprint) as its goal. The overwhelming reliance on government by senior citizens in this study as the chief support vehicle should be sufficient justification for such action on the part of the government. The strong governmental efforts in this area already and the need for a provincial focus (flexible enough to relate to local needs) also add further credibility.

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2.(b) Again the Task Force feels that local Edmonton co-ordination both public and private should be determined by the blueprint(s).	2.(b) At the local level in Edmonton, the Social Service Advisory Committee should assume a strong coordinating role, acting on behalf of all city departments in closer liaison with various private agencies in the city. Non-governmental coordination could best be handled by the Society for the Retired and Semi-Retired, whose stated objectives are to enable the integration of senior citizens with all facets of the community, the provision of services to meet the special needs of the senior citizens, and the coordination of services to the senior citizen. Their "gatekeeper role," in terms of information and referral, should be recognized and strengthened. The society should serve a neutral function and not assume other specific program activities but rather facilitate such activities for others, especially senior citizens.
2.(c) We concur. We would like to emphasize the need to co-ordinate O.F.Y. and L.I.P. projects with other services provided for the elderly. The nature of L.I.P. and O.F.Y. projects are such that little continuity is provided for in them. Once a service is started and senior citizens become dependent on it, there is a moral obligation to continue that service. Governments must be aware of this. In working with the elderly, professional staff providing service must be prepared to allow senior citizens to put forward their ideas and allow senior citizens to take over in many areas of programming for the elderly.	2.(c) Basic programs cannot be left to casual efforts only. O.F.Y. and L.I.P. activities can serve senior citizens well (minor repairs, shovelling snow, cutting grass, etc.) When it is obvious that such programs are not meeting established priority needs, more permanent steps must be taken to ensure their continuity. <u>Provincial and local efforts should be applied to relate the temporary-casual programs in the health care (for the elderly) area to the overall blueprint.</u>
3. Concurs subject to previous comments on the establishment of a blueprint(s).	3. Programming should reflect chronic health needs in at least two different ways: general programs for those in poor health

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4. The Task Force agree with this recommendation. At the same time we would like to emphasize the necessity for medical practitioners to familiarize themselves and their staffs with other services in the community. Moreover, medical practitioners should give serious consideration to joining

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as established by objective standards and reinforced by social-psychological difficulties; and when the elderly person becomes ill or is hospitalized. As the data indicate, those with many friends and relatives have a cushion of sorts against the negative aspects of poor health and low morale. Generally those without such background tend to rely more on their own (impeded) resources. The number of available programs should not be confused with choice factors within any program. For example, it is one issue as to whether Meals-On-Wheels, visiting nurse, and snow shovelling programs will be provided; it is quite another issue as to whether or not Meals-On-Wheels will operate as it now does on a voluntary basis serving a restricted variety of meals or will go into the mobile restaurant business!

As mentioned earlier, in all cases health and related service programs should be strengthened and/or developed in the context of the overall blueprint. Many of these programs could and should be problem-specific rather than universal. For example, establishment and application of specific health care programs should be focused upon those with low functional health and other objectively established health problems as reinforced by perceived lower health levels by the client group.

4. Physicians should be recognized as a prime vehicle for the delivery of health and related care to senior citizens. Given current health care program biases and responded evaluation, it is preferable not to disregard what works especially since it has resulted in a high level of health

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other professionals in a multi-service centres to deliver services to the elderly.

It was felt by some members of the Task Force that although Dr. Snider's Report does deal with the quality of health care delivered to the elderly, it does not do so in any great detail. As a consequence, there is an urgent need to review the quality of health care delivered. In such a review, consideration should be given including other professional services rendered to the sick, such as nursing services, physiotheraphy, counselling, psychiatric and other para-medical services, under the Health Insurance Commission.

One major area of health care not discussed or dealt with in the Report is the whole area of mental health and mental health facilities to the elderly. It was noted by one member of the Task Force that there is no geriatric centre in Edmonton.

5. With regard to information, we would like to emphasize the need for information at the community level (West 10, Glengarry, and Open Door) as well as on a city-wide basis as already exists in A.I.D. and through the Society for the Retired and Semi-Retired. Information at the community level is often the first point contact and thereby becomes the most crucial in serving the elderly. We would like to place special emphasis on the last paragraph.

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care even in terms of contact. Physicians must recognize,however, that they should also serve as field coordinators, referring elderly (and other) patients to agencies and services which would be of (further) assistance to such patients.

The use of nurse practitioners, para-medics, etc. working in doctors' offices, should also be viewed as a positive force in this direction to counsel, explain, and answer questions as in the dentist-dental hygienist relationship. All such services and programs should be viewed as extensions or variations of health care, not as qualitative differences. A friendly chat can be as (more) crucial to an elderly person than any prescription.

5. Information on health and related services and facilities for senior citizens should be channeled to them in a language (reflective of ethnic and cultural differences) they can comprehend. The message should be reinforced by underlining the general nature of the programs and the rights and benefits of such programs for senior citizens. Wide publication (newsletters, billboards, etc.) of general information phone numbers such as A.I.D. (429-6227) and the Society for the Retired and Semi-Retired (423-3770, 424-4721) is also encouraged. The purpose is not to sell services (other studies indicated high misuse or further non-use would result) but to ensure that when the need arises <u>at least</u> one

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6. We concur with special emphasis on:

> "Further, it must be remembered as well that small monetary increases will not meet the complex needs of the elderly and are more likely to avoid the issue."

7. There should be no consideration of new programs on the part of the government until a blueprint(s) for services has been established. It is the feeling of members of the Task Force that a decentralized approach to programming for elderly citizens is essential. Members of the Task Force point to the success of senior citizen clubs in smaller centres like Killam, Camrose and Grande Prairie. There was some doubt expressed by some members of the Task Force about this

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DR. SNIDER'S RECOMMENDATIONS

telephone number will be available and considered as an alternative to physicians only. Physicians should encourage use of other agencies and the services they provide but <u>retain the active treatment role</u>.

Any continuum of care, is to be employed correctly, must be based on a proper flow of information. The lack of (proper) information can only frustrate the best of intentions and assist in the degeneration of even modest attempts at programming and coordination.

6. Those interested in the income levels of the elderly should focus their attention more on the need for increased Guaranteed Income Supplements rather than the basic pension itself. Further, it must be remembered as well that small monetary increases will not meet the complex needs of the elderly and are more likely to avoid the issue. The combination of higher incomes for those who need it most and comprehensive health and social planning will go much further in meeting the real needs of the elderly than a few more dollars a month alone for all. Further, a few more dollars should not be confused with what (that) money cannot buy.

7. Government and private agencies should reconsider their programming with respect to social and recreational activities for the elderly in the light of such facts as most senior citizens do not belong to formal clubs and organizations. Indeed, those who do belong now also have dropped participation in other formal activities. Structured activities are obviously not the prime vehicle then and the addition of more programs of this sort only will

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recommendation. It was felt that the recommendation is not supported by the study and that the whole area of programming for the elderly needs further study.

8. We concur. We would, however, add that visitor programs need people who are supportive listeners. We would also like to add that feelings of anxiety and loneliness are often accompanied by feelings of stress and ill-health.

9.(a) We concur.

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attract primarily those who are already involved and would probably drop some to participate in others (new). This does not infer that activities such as New Horizons projects, Pensioners Concerned, etc. are of limited value -- actually they are very useful to those who are attracted to them -- only they must be seen in the context of other health and related programming needs. Emphasis on organized activities alone is only a partial solution to the complex problem of aging.

8. Greater efforts should be made towards the establishment of counselling and visitor programs to help reduce feelings of anxiety and loneliness among the elderly. This is extremely critical during periods of ill-health. Temporary support and encouragement are limited by the social-psychological assistance recipients will accept; such programs are not substitutes for family and personal friends nor can they compensate for an unhappy childhood. Physicians should make good use of such programs by referring patients as the need arises. Problems of loneliness can be softened, especially in later years, by prompt attention to the personal needs of the elderly beginning soon after the period of living alone begins, not waiting for several years until the not readily reversible low morale problems are well entrenched. Widowed persons are one group which merit such attention.

9.(a) Consideration be given to the extension of restrictions regarding present coverage areas as approved by the attending physician. This rider is attached to prevent ambulances, for example, being used as taxis, yet accepting that health needs might dictate more than $100 of use per year in

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	this category.
9.(b) We concur. We would like to emphasize that this recommendation is terribly important. It causes much anxiety and confusion among the elderly.	9.(b) Consideration be given to eliminating the $15.00 yearly deductible charge under each plan. It is especially difficult for those on restricted incomes to produce that extra amount.
9.(c) With elimination of the $15.00 yearly deductible, elderly citizens should be informed that they can use a Blue Cross consignment form whereby the pharmacist can bill the Alberta Blue Cross for 80% of the prescription cost and the patient only pays 20%. It would be much more preferable, however, to eliminate the 20% paid by the elderly patient. We think the Province should pick up 100% of the costs of prescription for the retired.	9.(c) Consideration be given to waiver of 100% of drug costs, especially for those on limited incomes. Drug stores should be required to submit claims for the 80% (or 100%) of drug costs automatically on behalf of the elderly rather than assuming they have the necessary savings.
9.(d) We concur. This is badly needed particularly for those items which are costly.	9.(d) Consideration be given to amending programs to cover such items as dentures, prescription glasses, hearing aids, and canes and wider coverage for rehabilitative programs such as physiotherapy and occupational therapy. The justification for these and other changes should be demonstrated needs with respect to chronic health problems and financial constraints of recipients.
10. We would emphasize the need for three kinds of programs under this recommendation: 1) Outreach services like Operation Friendship. 2) Home-care, that is care in the home which is short-term and nurse centered. 3) Day-care, care that is long term and takes place out of the home - a place where the patient goes daily but goes back home at night.	10. More health and related programs should be of the "outreach, home centered" variety, attempting to reach and/or serve the needs of senior citizens in their familiar environments. Programs today rely too often on individual initiative and physician care exclusively. As a result useful programs become misused through overuse and nonuse, the latter especially by those who could benefit from such services and ...continued

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	facilities. Home care programs (minor ailment treatment, post-hospital care, light housekeeping, companionship or emotional support, yard and sidewalk cleanings, etc.) should also be encouraged in this context. Day-care hospitals (recently approved for Edmonton) are a positive step in the outreach direction since they provide an institutionalized level of care yet permit patients the luxury of staying in their own homes as outpatients. All such programs can make good use of volunteer workers but direction must flow from permanent, high-calibre, paid positions. The general purpose of all such programs should be to prevent dependency by enabling old people to postpone, or avoid altogether, the restraints and isolation of institutional living.
11. We concur. It is important that the Alberta Council on Aging perform a co-ordinating role and that it be given the funds to hire the staff to fulfill that role.	11. Multi-dimensional groups such as the Alberta Council on Aging and locality-specific groups should continue to establish applied research priorities in gerontology (and pre-retirement) areas and that relevant funding agencies continue to support such proposals. It is of high concern that projects be useful and coordinated with relevant on-going activities.
12. We concur, and suggest that this should apply to all people supplying services to the elderly.	12. Those persons and agencies responsible for dispensing health and related care to the elderly should do so with maximum of dignity, passion, understanding, and courtesy.

CONCLUSION

The Task Force would like to point out, and we are sure that Dr. Snider would agree with us, that medical problems and medical services to the elderly cannot be dealt with in isolation from many other services delivered to and problems experienced by senior citizens.

In our opinion, the problems of the senior citizens must not only be dealt with in an integrated fashion but they must also be delivered in a decentralized non-bureaucratic way. Elderly citizens are no different than other groups in society who experience difficulty in relating to highly structured and centralized bureaucracies. If anything, they experience more difficulty because they were not born into a highly urbanized, bureaucratic and institutionalized society. The problems of the aged must therefore be dealt with on a localized level with the maximum degree of autonomy given at that level. By localized we do not mean a city-wide basis but rather on a community council basis. Such community councils and community centres as West 10, Area 13 Co-ordinating Council, Glengarry and Duggan Service Centres are logical and more acceptable localized centres for the delivery of service to the elderly. Even these on closer examination may be too large to adequately serve the needs of the senior citizens.

If we accept Dr. Snider's statement that medical doctors should be recognized as a prime vehicle for the delivery of health and related care to senior citizens then we emphasize that physicians must also recognize this and that they and their staffs must become more familiar with the services of social agencies and must be prepared to co-operate with them to care for the total health needs of the senior citizen.

One very large area which seriously affects the health of the elderly is their housing and the community design in which that housing is located. The design of communities and housing are not erected with the senior citizen in mind. They are structured around families, schools and children. When a school closes down, too often the community closes down as well. The report makes no recommendations in this area. It is our understanding that Dr. Snider will deal with this in a subsequent report. Nevertheless, housing and community design remain a serious problem for the elderly and must not be forgotten when we look at health and related needs of this group.

Finally, we would like to re-emphasize the need for a blueprint. The blueprint, however, must determine the need for a division or department of government and not the other way around. Furthermore, any blueprint(s) should be developed on a localized level by senior citizens themselves with the help of a limited number of professionals.

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These people are active in the following groups:

The Society for the Retired and Semi-Retired
Pensioners Concerned
Alberta Council on Aging
St. Stephen's College
Canadian National Institute for the Blind
Edmonton Social Planning Council

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APPENDIX I

PROCEEDINGS OF CONFERENCE ON EDMONTON'S OLDER CITIZENS - A COMMUNITY DESIGN.

held on May 31, 1973 - (sponsored by The Society for the Retired and Semi-Retired and the Church and Society Institute of St. Stephen's College.

The Workshop was held primarily to give those in Edmonton concerned with the problems of aging an opportunity to learn of the findings of Dr. Earle Snider's study of the health needs of Edmonton's senior citizens. In addition it was intended to permit the participants at the Conference to raise issues of concern either related to Dr. Snider's findings or going beyond them. The morning consisted of Dr. Snider's presentation, followed by a reactor panel. The afternoon consisted of three discussion groups as follows: - 1) the concerns of the independent elderly, 2) the concerns of those independent, but needing assistance, and 3) the institutionalized elderly.

The proceedings include summaries of the significant concerns raised by the participants, plus comments on or questions raised by these concerns. Also included are the text of Dr. Snider's speech, some concerns and questions regarding the speech and a list of introductory issues raised in Workshop I, inserted because of their outline of the general problems of aging in society.

The proceedings are distributed because they list some of the primary concerns of aging people in Edmonton. It is hoped that this will serve as a catalyst by those agencies and individuals concerned to improve the position of elderly people in this city. These are not intended as polished working papers.

Your comments and suggestions would be appreciated.

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II. Introductory Issues from WORKSHOP I.
III. "Towards a Community Design for Edmonton's Senior Citizens" - Dr. Snider.
IV. Some questions arising out of Dr. Snider's report on the Health and Related Needs of Edmonton's Senior Citizens.

I ISSUES RAISED IN PANEL AND WORKSHOP DISCUSSIONS.

1. The Need for a Blueprint of Services.

An overall plan or blueprint is necessary to ensure coordinated planning and development of services for older persons in the City of Edmonton. Establishing such a plan or design would force us to set priorities and look at discrepancies between program content and accomplishment. The design must include a full range of needs from those elderly who are independent to those who are institutionalized. The blueprint should set forth some fundamental value assumptions underlying its objectives and in particular should emphasize maintenance of independence.

COMMENTS: How do we effect this? Dr. Snider has suggested that this could be the responsibility of the provincial government and that a Division on Retirement and Aging should be established. This is also one of the recommendations that came out of the Alberta Council on Aging annual meeting, and the Council will be bringing this concern to the attention of the provincial government. The Public Affairs Committee of City Council (following letters received from the Local Board of Health and City Council) has recommended the establishment of such a provincial office.

2. Elderly Should Shape and Control programs designed to serve them.

This means to be involved in the planning process and the governing bodies of programs both private and public in addition to obtaining employment from such programs where appropriate.

COMMENTS: All persons working with older people must keep this in mind. Continuing concern must be taken to ensure that governmental and non-governmental programs for older people are held accountable for this involvement. This could apply to studies such as Dr. Snider's as well.

3. Elderly Political Action.

WORKSHOP I suggested there is a need for elderly political action if the concerns of the elderly are to be taken seriously. The problem of organizing and forming coalitions was recognized, however, there are models of such activity such as the Gray Panthers in the U.S.A.

4. The Need to maintain a sense of independence.

The present generation of elderly lived through the depression years and managed on their own. Many have unpleasant memories of agencies and are thus reluctant to use services that could be helpful to them. They fear a threat to their independence. It is important that agencies be aware of this concern and sensitive to it if they expect to improve their ability to reach the elderly. In addition, the sense of being able to manage and to be in control is critical to the maintaining of good morale, as well as health for older people. There was real hostility shown to the easy equation of old age with dependence and illness. Specifically mentioned was the new Home Care program in Edmonton. Those developing this program should be sensitive to the need.

5. Value of Outreach and Visiting Programs.

Support and money should be provided for out-reach visiting programs in those parts of the city where there are high concentrations of elderly. These programs were seen to be valuable in reaching isolated and lonely elderly. While the visitor can never replace the support of family and friends (Dr. Snider), the visitor can be the "somebody" who helps the older person to be aware of and use the available resources (many older people are reluctant to approach the unfamiliar), and he can also be relied upon to be available in crisis times.

COMMENTS: There are presently several such programs beginning in the city. Operation Friendship (city centre), City Social Service Units - Jasper Place and Glengarry, West-10, Southside Senior Citizens Project, Oliver Social Action Committee. There is a good informal coordination and co-operation between these agencies. However, with the exception of OSAC, they are operating on temporary funding for paid people to coordinate the programs. Such visiting programs, to be fully effective, must have some skilled staff to direct and be responsible, as well as volunteers (Snider's report). If we truly believe that such programs are needed and the initial step that enables the older person to reach a service, why do we as a community provide only temporary (New Horizons, STEP, LIP) funding? Where can we get on-going support?

6. Community based programs.

From WORKSHOP II - Community based programs for older people should have the following components (a) personal contact for older people - visiting, telephoning, etc;; (b) transportation - available drivers for special needs; (c) housing - a choice of housing and assistance in finding housing; (d) income supplementation - available cash resources or services without requirement for immediate payment; (e) home help - facility care, cleaning, simple repair help, snow removal etc.; (f) personal services - specialized counseling, meal preparation, shopping help, medical attention in home, physio- and occupational-therapy. While this array covers the gamut of needs, there was a strong call for the potential of screening clinics (medical), to form the basis of the beginning of neighborhood centered services. Winnipeg and Vancouver were mentioned as possible models. There was a strong emphasis on the need for the development of new communities in the urban scene. The inadequacy in approach, and of services in geriatric psychiatry was strongly emphasized. Both the government and the medical profession were subjected to criticism.

COMMENTS: The emphasis on community delivery of services was aiming at the general lack of community in the urban scene, and in particular communities that include all age groups. This is a particularly acute problem for people who have reached a stage in life when new contacts are hard to make, and old relationships are disappearing. The emphasis needs to be on communities which facilitates the development of new relationships even under the most adverse conditions. This means a considerable, but necessary revolution in urban design.

7. Housing.

WORKSHOP I also raised the question of housing and senior citizens - the cost of housing, relationship of senior citizen housing to community services and health services. Operation New Roof, a housing study presently being conducted by a group of 10 retired persons with New Horizons funding, may provide some concrete information and direction for future planning. These questions are being explored in this study. Existing studies are inadequate as a sound basis for policy, primarily because of study methodology.

COMMENTS: The role of housing, its design, upkeep, neighborhood setting, funding etc., all have been inadequately examined both with regard to health as well as to community development. Housing rates top priority concern for the elderly as well as for the rest of the populace. Adequate housing for the elderly is far more complex that the presently proposed solutions and assumptions upon which they are based. The problem is essentially one of community design and there are few North American precedents to draw upon. The dictates of present land use and development policies in Edmonton can only lead us up a blind alley. The fact that neighborhoods are now built around the needs of schools, and thus primarily of children, is a critical issue. Where single family homes are predominant, the aging of the neighborhood causes a decline in use of available child-oriented facilities, without provision for facilities for the aged. This decline leads younger families to seek new housing elsewhere, thus accelerating the decline and encouraging the planners and developers to rezone because the area is no longer viable. As a result we lose neighborhood after neighborhood. Garneau is a perfect example.

8. Coordinated Information Service.

One or two information numbers should be made generally available to older people in Edmonton and these information services should be coordinated. It was suggested that there is no simple method of providing people with information and that extensive information services were not the answer. People are flooded with information and "tune out" that which they do not immediately need.

Also brought out was the fact that many resources and services are now available to older people, but they are simply not aware of them. The information is not reaching those who need it when they need it. It was suggested that information be presented in simplified form, that description of benefits be available in simplified form and that some translations be made for those elderly people who are not fluent in English.

COMMENTS: The Society for the Retired and Semi-Retired appreciates these comments (this organization and AID were specifically mentioned in the Snider report). Any suggestions for publicizing the information service will be appreciated. The Society is now preparing simple explanations of some benefits for distribution (through members and visiting programs). Parts of the booklet "Services in Edmonton for Senior Citizens" have been translated into German by the Southside Senior Citizens project. Perhaps the Society and other groups (Pensioners Concenred, Alberta Council on Aging) should encourage government officials in particular to make information about benefits, and forms, clear, simple and uncomplicated.

9. Problems of reaching the majority of uninvolved elderly.

Programs for the elderly should find ways of reaching the vast majority of older persons who are not using, and show no inclination to use the (Snider) "structured" programs available, and yet who do not want to "sit and drink tea". They must be assisted to find ways of discovering what they want to do. It was felt that church groups can be of great assistance in reaching this group, since churches are the organizations with the most wide-spread contacts in the elderly community.

COMMENTS: This point was made because one of the recommendations of the Snider study was that there is a need for the establishment of more activities for the elderly - "that they are interested in keeping busy" and that "it is mainly our inability to provide proper tasks, environments, and incentives that prevents the inactive from becoming active". The "how" of doing this was not discussed and also not discussed was whether this should be the role of already established "senior citizen programs" or the role of the community groups which have a representation of all ages - example, community leagues, churches. This seems to us a subject that could be pursued further. Perhaps we should encourage general community groups to consider how they involve older citizens. Workshop I felt that there should be "mutual respect for generations of each other which can only be obtained through restructuring of society, so that the elderly are equally valued and people live together across the generations". And from the panel discussions it was emphasized that young people should be used as visitors for the generations have a need to relate to each other. In view of the scope of the church's contact with the elderly they have a particular opportunity (as yet relatively untouched) to help society focus and deal with the problems of the elderly.

10. Improvements to Medical Care Delivery.

From Workshops I and II - Workshop II recommended the establishment of a medical clinic for senior citizens in the city centre area, and Workshop I suggested comprehensive neighborhood centered clinics. Workshop I also asked that physicians be encouraged to give attention and time to treating elderly patients (not "writing them off as senile") and that they be encouraged to use para-medical personnel, thereby relieving themselves of some of the burden of care. Agencies must publicize their services through physicians, offices.

The inadequacy of psychiatric services both inpatient and outpatient, plus the stereotyped attitudes of persons in the mental health field, eas strongly emphasized. There was a discussion of the lack of availability of psychiatric beds and the misuse of medical beds for the mentally ill.

COMMENTS: Further consideration and discussion should be given to these suggestions. Certainly, the Snider report illustrated the need for close co-operation between physicians and health-related services for fully effective services for older people. Work in the city centre area has shown that a street-level clinic in that area, closely tied in with other services (drop-in, visiting) could be most helpful and provide care for some of the medical needs before they become so serious that the older person requires hospitalization.

11. Restructuring Coordination of services.

From Workshop III - This group felt that one of the major problems in working with the elderly is the lack of knowledge about what others are doing and that some way must be found to help agencies and groups become more aware of each others services. This will enable them to share resources and use eath other more effectively. This was believed to be more important than establishing new services. This group suggested that the Society for the Retired and Semi-Retired convene an informal committee of representatives from various programs and groups which would meet on a regular basis. The purpose would be getting to know each other and sharing information.

COMMENTS: This ties in with the suggestion concerning the availability of information (point 6). Not only older persons need information and help to link in with resources, but agencies and institutions find it difficult to keep abreast of the available resources. This suggestion, and ways of implementing it should be seriously considered. Should it be the Society which follows through with this? Should the Society make a greater effort through personal contact (not only the Newsletter and the Booklet) to provide information to agencies and groups?

12. Issues for the religious community.

Several references were made to the strength and clarity of perspective gained by those elderly, and particularly those terminally ill elderly, who had strong religious ties. At the same time Dr. Snider's report points toward the need of the churches to give more attention to those elderly who consider themselves church-related, but frequently cannot participate.

COMMENTS: The religious community with its extensive contacts with the elderly could provide significant leadership for the Edmonton community in the field of aging. We need insight into our value assumptions as well as new ways of creating an urban environment where all ages live together in a way that permits us to develop a sense of wholeness about our journey through life. The church and synagogue remains an untapped resource. Some homework is needed.

IV. Some questions and reflections with regard to Dr. Snider's report.

This report undoubtedly helps us focus on the concerns of the elderly in Edmonton. It contains much valuable data, though a great deal of it is inadequately culled for the average reader in the professions that need to use it. The summary and conclusions provided are helpful, but some of them do not appear to clearly follow from the report. This may be because the author is going beyond his data, or it may be that he simply has a grasp of the published data (as well as that which is unpublished) that is beyond the average reader. An example of this is his recommendation that "structured activities aren't the way of reaching the inactive" He doesn't adequately define the inadequacies of "structured activities" of what the unstructured alternatives may be, though one finds oneself immediately nodding in general agreement.

One clear warning for anyone using this study. The method of gathering data does not adequately attempt to determine hidden meanings to answers or the

reasons for the answers given. This is a particular problem in any study dealing with the elderly. Thus, for example, one would have to be very careful in accepting at face value the high level of satisfaction with income which was found. Were the psychological reasons for this response adequately considered in the interview.

Another consideration is that this report, while addressing itself to health issues, goes beyond mere physical health to broader issues of the relationship between mental status and health. The recommendations however, do not go as far as the data might tend to lead. For example, it might have been possible for Dr. Snider to comment on the needs of the elderly for new community relationships. There are many references that should be made known to those who are concerned about aging, but the author has chosen to omit them. Dr. Snider states that one purpose of his study was to evaluate current medical service programs. He provides little evaluation of the quality of care given by the physician, yet this is the primary source of medical care. This is an area where considerable information is needed. If. Dr. Snider does not have it, we need to get it.

These comments are not intended to detract from the value of the study. They are intended rather as warnings against -

(a) too simple a reading and acceptance of its data and conclusions.

(b) a failure to recognize that the problems pointed out have roots in some of the most fundamental assumptions of our society and not merely in the physical and mental process of growing old.

To any individual or agency concerned about this aspect of life the question is, to what extent are we willing to go beyond symptoms to root concerns.

II INTRODUCTORY ISSUES RAISED IN WORKSHOP #1.

1. Society tends to look upon old age as a kind of shameful secret that should not be mentioned, particularly with the elderly.

2. We are embarrassed to confront old people honestly because somehow we are guilty about our youth, and we assume they want to avoid being confronted by what we consciously or unconsciously see as a terrible tragedy, namely, that people can't live forever, that they do decline, that they do not have all of the capabilities that they once had, and that yough becomes an offence.

3. Society cares about the individual only insofar as he or she is profitable or has power. What are the implications of this fact for the elderly? Generally the aged are seen by our society as neither profitable nor powerful, and thus become easy victims in the struggle for goods and services. Frequently they don't get their share of the pie unless they demand it, for they aren't seen as a primary element of society.

4. The Biblical view of old age presented by the Hebraic-Christian faith is that it is"a time of reward for a life well lived". Is there a contradiction between the Biblical view and the status of elderly people in our society today?

5. The whole meaning of life is in question in the future that is waiting for us. If we do not know what we are going to do then we cannot know what we are. Thus we must be able to recognize ourselves in this old man or that old woman. This must be done if we are to take upon ourselves the entirety of our human state. Of all realities, old age is perhaps that reality of which we retain a purely abstract notion for the longest period of our lives.

6. It has been said that the quality of a civilization can be measured by its treatment of its elderly.

7. Those who have the most comfortable and rewarding old age are those who had the most comfortable and rewarding youth and middle years.

8. In our production-oriented economy old age is hidden from us in our youth. We are encouraged to live now, and spend now. We are discouraged, indeed blinded from viewing the future by that very orientation. We are encouraged to produce and consume, and not plan ahead because the intent of our society is growth, a process dependent upon immediate production and consumption, not postponement, and not a measured sharing.

9. Our urban society has been developed without regard to the continuum of life. Age groups are separated from each other. Services are only provided for those who are productive, or who demand them. As a result cities tend to reinforce our isolation from our future, and when we most need community it doesn't exist. Urban societies aren't designed to enable elderly people to develop new community relationships as they move away from, or lose (through death) old ties.

10. All services, to be valid, must relate to the entire spectrum of ages. For example, city parks must be designed for and made accessible to all ages.

11. Concern was raised about the unattractive and sterile environment for elderly people in Edmonton during the winter.