

The health of Canada's elderly population: current status and future implications

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Abstract

THE GROWING SIZE OF CANADA'S ELDERLY POPULATION and its use of health care services has generated much discussion in policy circles and the popular press. With data from the National Population Health Survey, undertaken in 1994–95, the authors examine the health status of Canada's elderly population using 3 sets of measures: level of activity limitations, prevalence of chronic illnesses and self-assessment of overall health. They also analyse the utilization of physician and institutional services. The profile of this population the authors develop is in many respects not much different from that of the remaining adult population, until the age of 75. People aged 75 and over are much more likely than other adults to have health problems and use health care services. Also, elderly women living alone and with low income are identified as an especially vulnerable group who need access to medical and nonmedical services if they are to remain in the community. Using Statistics Canada projection data the authors discuss some aspects of the elderly population's health status in the future. Their look into the future raises issues about the preparedness of health care providers and our health care system to meet the challenges of tomorrow's elderly population.

Résumé

LE VIEILLISSEMENT DE LA POPULATION DU CANADA et l'utilisation qu'elle fait des services de soins de santé suscitent de nombreuses discussions dans les milieux stratégiques et dans la presse populaire. Se fondant sur des données tirées de l'Enquête nationale sur la santé de la population, entreprise en 1994–1995, les auteurs examinent l'état de santé de la population âgée du Canada au moyen de 3 ensembles de mesures : niveau des limitations de l'activité, prévalence des maladies chroniques et autoévaluation de l'état de santé général. Ils analysent aussi l'utilisation des services médicaux et institutionnels. À de nombreux égards, le profil que les auteurs tracent de cette population n'est pas très différent de celui du reste de la population adulte jusqu'à l'âge de 75 ans. Les personnes âgées de 75 ans et plus sont beaucoup plus susceptibles que d'autres adultes d'avoir des problèmes de santé et d'utiliser des services de santé. En outre, les femmes âgées qui vivent seules et ont un revenu faible constituent un groupe particulièrement vulnérable qui a besoin d'avoir accès à des services médicaux et autres pour demeurer dans la communauté. Se fondant sur des projections de Statistique Canada, les auteurs discutent de certains aspects de l'état de santé à venir de la population âgée. Leur analyse prospective soulève des questions au sujet de l'état de préparation des fournisseurs de soins de santé et de notre système de soins de santé afin de relever les défis posés par la population âgée de demain.

Over the past 10 years, there has been substantial discussion and debate in both the professional policy literature¹⁻⁸ and, more recently, on the best-seller list⁹ about how today's elderly population is affecting our health care system and what will happen when the baby boomers grow old in the next century. Much of the discussion has focused on such issues as whether the elderly population overutilizes the health care system, whether the current health care system is responding appropriately to the needs of the elderly population and



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whether the health care system in the future will be able to cope with an elderly population double the size of today's.

To provide substance to these issues, we need to bring the health status of today's elderly population and their use of health care services into sharper focus. To do this, we collected some basic demographic data as well as data on the various aspects of the health status and health care utilization of Canada's elderly population obtained mainly from the first wave of the National Population Health Survey (NPHS).¹⁰ We focused on the links between health status and the use of general practitioners (GPs). With these observations as a reference point, we projected the future size of the elderly population, their health status and what this might mean for health care utilization.

Canada's elderly population

In 1991 Canada's total population was just over 27 million, and elderly people (those aged 65 and over) accounted for nearly 3.2 million (11.7%) of the total.¹¹ Most of the elderly people were women (1.8 million [56%]), representing 13.4% of all women; the preponderance of women was even more noticeable at higher ages (75 years and over). The elderly male population was just over 1.3 million, representing 11.7% of all men. The differences in sex distribution are both a function of relative changes in mortality¹² and reflect the relative sizes of the aging cohorts.¹¹ Such differences are particularly important when considering health status and utilization at older ages, because the health needs of elderly women are likely to be substantially different from those of elderly men.

Being an elderly woman is associated with other attributes relevant to health, particularly the likelihood of living alone and having a low income.¹³ Living alone is especially important when thinking about service provision, because those living alone are the least likely to have informal support networks and therefore most likely to be dependent on formal services when in poor health and in need of help to remain in the community.

Current health status

Although there are several sources of data for evaluating the health of the Canadian population, the first wave of the NPHS is the most current one. It is the first comprehensive national population health survey with a longitudinal component to be produced in Canada and will offer researchers the opportunity to examine health and health utilization over time as subsequent waves are released.

The first data-collection cycle was carried out in June, August and November 1994 and in March 1995. Except for a small number of cases in British Columbia, most of the interviews were carried out by trained interviewers in

the home with a "knowledgeable household member." This person provided information for members of his or her family about their health status, their use of health services and sociodemographic information. The person provided more detailed information about his or her own general health, height, weight, preventive health practices, smoking status, alcohol use, physical activities, injuries, stress, drug use, mental health and social support. About 27 000 households geographically representative of the country were included; the response rates were 88.7% for the households and 96.1% for the selected people interviewed.¹⁴

Using weighting procedures provided by Statistics Canada, we produced estimates for the population, subject to sampling variability. The population estimates are presented in cross-tabular form by age and sex. Logistic regression analysis was used to determine whether various chronic conditions increased the likelihood of a person visiting a GP more than once annually when age and sex were controlled. The dependent variable — the additional number of annual visits — was converted into a binary variable: a value of 1 if more than 1 visit was made, and a value of 0 otherwise. Further, we calculated odds ratios to measure the effect of the independent variable (e.g., having diabetes) on the relative likelihood of making additional visits after controlling for other chronic conditions, which are treated as independent variables in the logistic regression model, and for age and sex.

We chose 3 sets of measures from the NPHS to provide various perspectives on the health status of Canada's elderly population: (1) the ability to carry out activities of daily liv-

Table 1: Proportion of elderly Canadians with an activity restriction, 1995*

| Age, yr | % of women | % of men |
|---------|------------|----------|
| 55-64 | 30.0 | 29.6 |
| 65-74 | 34.7 | 36.5 |
| ≥ 75 | 48.0 | 43.9 |

*Source: National Population Health Survey (NPHS), 1994-95.¹⁰

Table 2: Proportion of elderly Canadians with a physical limitation, 1995*

| Age, yr | Physical limitation; % of elderly population | | | | |
|--------------|--|---------|--------|----------|---------|
| | Vision | Hearing | Speech | Mobility | Agility |
| Women | | | | | |
| 55-64 | 3.8 | 2.0 | 1.1 | 3.4 | 0.8 |
| 65-74 | 5.8 | 5.9 | 2.3 | 6.9 | 1.2 |
| ≥ 75 | 16.0 | 8.7 | 0.8 | 23.5 | 1.3 |
| Men | | | | | |
| 55-64 | 2.7 | 4.3 | 1.0 | 2.6 | 0.3 |
| 65-74 | 3.8 | 6.1 | 2.3 | 6.3 | 0.9 |
| ≥ 75 | 7.1 | 11.7 | 3.2 | 14.8 | 1.4 |

*Source: NPHS.¹⁰ Adapted, with permission, from *Health Reports* 1996;8(3):10-1 (Statistics Canada, cat no 82-003).¹⁹



ing (ADLs) and instrumental activities of daily living (IADLs); (2) the presence of chronic medical conditions; and (3) how individuals *perceive* their health status overall.

Ability to perform activities of daily living

In the NPHS and other surveys examining aspects of health¹⁵⁻¹⁷ respondents were asked a series of questions about their ability to carry out ADLs and IADLs. Questions about ADLs measure an individual's degree of functioning in regard to basic activities such as walking a given distance, climbing stairs, reading a newspaper, hearing a voice on the telephone and cutting up food. IADLs, such as shopping, meal preparation and housework, are derivative of more basic activities but also contribute to quality of life. Determining restrictions to such activities is a widely accepted approach to measuring health status. Detailed questions on functional limitations were separate from those concerning help with ADLs and IADLs. Responses to the questions on functional limitations define mobility, agility, vision, hearing and speech disabilities. These can then be linked to ADL and IADL responses. This approach is obviously a weaker prognostic tool than those provided by clinical assessment, but it defines more accurately an individual's ability to cope with daily living.¹⁸

The NPHS data show that about one-third of Canadians aged 65 to 74 had health problems that restricted their activities to some degree (Table 1). The proportion increased to almost half of those aged 75 and over. When examined in more detail (Table 2), the data show that, among elderly women, mobility and vision limitations were most common.¹⁹ Mobility limitations were also most common among elderly men, but for them the second most common limitation was hearing. The rates tended to be higher among the women than among the men, regardless of the limitation or age group. For example, 23.5% of women aged 75 and over indicated a mobility limitation, as compared with 14.8% of men in the same age group.

The proportion of the elderly population needing help with ADLs and IADLs is presented in Table 3. Slightly more than 22% of women aged 65 to 74 indicated that they needed help with heavy housework; among those aged 75 and over, slightly more than 46% required help with heavy housework, and more than 25% also needed help with everyday housework and shopping. The pattern of need was similar among elderly men, but the rates were substantially lower, even among those aged 75 and over. These sex-related differences are linked to the much higher proportion of women living alone regardless of age group. The need for help was also strongly linked to severity of limitation: the more severe the physical limitation, the more likely the need for help.

Although measures of the need for help with ADLs and IADLs are important indicators of the need for nonmedical in-home services, they also have implications for the provision of health care services. Failure to meet the demand for these services through the community places pressure on GPs and family physicians, other health care providers charged with providing in-home medical services and informal caregivers to find alternative ways of providing non-medical help. Ultimately, it leads elderly people into residential care or even acute care facilities. There is also the question of whether elderly people who needed help with ADLs and IADLs before entering an acute care facility, compared with those who did not need such help, are more likely to have slower recovery periods after discharge or are more likely to have postoperative complications necessitating a return to an acute care facility.

Chronic conditions

In the second set of measures to determine the health of Canada's elderly population, respondents to the NPHS were asked about the prevalence of chronic conditions diagnosed by a health care professional (Table 4). Among the women 65 to 74 years old, the most prevalent condi-

Table 3: Proportion of elderly Canadians requiring help with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), 1995*

| Age, yr | % needing help with ADLs | | % needing help with IADLs | | | |
|--------------|--------------------------|---------------------------|---------------------------|--------------------|--------------------------|-----------------|
| | Personal care | Moving about inside house | Heavy housework | Everyday housework | Shopping for necessities | Preparing meals |
| Women | | | | | | |
| 55-64 | 0.7 | 1.0 | 13.6 | 6.2 | 4.2 | 1.4 |
| 65-74 | 1.6 | 1.4 | 22.1 | 9.6 | 6.9 | 3.6 |
| ≥ 75 | 8.4 | 5.7 | 46.3 | 25.8 | 26.8 | 14.3 |
| Men | | | | | | |
| 55-64 | 1.1 | 0.5 | 7.6 | 1.8 | 2.0 | 1.5 |
| 65-74 | 1.4 | 1.9 | 15.1 | 5.1 | 3.9 | 2.5 |
| ≥ 75 | 9.5 | 2.8 | 27.0 | 15.9 | 13.9 | 11.7 |

*Source: NPHS.¹⁰ Adapted, with permission, from *Health Reports* 1996;8(3):10-1 (Statistics Canada, cat no 82-003).¹⁹



tions were arthritis or rheumatism, high blood pressure, nonarthritic back problems and nonfood allergies. Although arthritis or rheumatism and high blood pressure were also the most common conditions reported by those 75 and over, the next most prevalent conditions were cataracts and heart disease. The pattern was similar among the men: the most common conditions among those 65 to 74 were arthritis or rheumatism, high blood pressure, nonarthritic back problems and heart disease, and among those 75 and older they were arthritis or rheumatism, heart disease, high blood pressure and cataracts. Among both the elderly women and men, the proportion who reported none or only 1 diagnosed chronic condition tended to decrease with age, whereas the proportion reporting 2 or more conditions tended to increase.²⁰

Notwithstanding the limitations of how these data have been collected, one can ask whether the types of multiple health problems the elderly population is likely to have are being considered by those training health care professionals and by those who are making the decisions to restructure provincial health care systems. One can also ask whether our reconfigured health care systems will be prepared to deal with the health problems of the elderly population in the future.

Self-assessed health status

It is customary in population health surveys to ask respondents to rate their health overall. In the NPHS, re-

spondents were asked to rate their health in general as excellent, very good, good, fair or poor (Figs. 1a and 1b). Almost 42% of women and men aged 65 to 74 rated it as excellent or very good; this figure increased to more than 75% when those who rated their health as good were included. Even among people 75 years and over, slightly more than 37% of women and almost 39% of men rated their health as excellent or very good, and more than 66% rated it as good to excellent. There was, however, a marked aging effect: the proportion of elderly people who rated their health as fair or poor increased with age.

A paradox

The first 2 sets of measures appear to differ from how elderly people rate their health overall. On the one hand many elderly people reported that their activities were restricted (Table 1), that they had disabilities and diagnosed chronic conditions (Tables 2 and 4) and that they required help (Table 3), but on the other hand the overwhelming majority also perceived that their health was good to excellent. A likely explanation is that many elderly people adapt their lifestyle to their health conditions if they are not severe. Indirect evidence of this is found in Figs. 2a and 2b. Among those 75 years and over, regardless of sex, the proportion of people who explained that their health problems were the result of aging was almost the same as that of people who indicated that they resulted from disease or illness, and over half indicated that the question did not apply to them because they did not report a health

Table 4: Proportion of elderly Canadians with chronic conditions, 1995*

| Condition | Age, yr; % with condition | | | | | |
|---------------------------------------|---------------------------|-------|------|-------|-------|------|
| | Women | | | Men | | |
| | 55-64 | 65-74 | ≥ 75 | 55-64 | 65-74 | ≥ 75 |
| Arthritis or rheumatism | 33.1 | 42.7 | 50.4 | 20.4 | 31.2 | 38.1 |
| High blood pressure | 22.6 | 30.4 | 36.1 | 18.4 | 25.0 | 20.6 |
| Back problem, nonarthritic | 20.1 | 18.4 | 19.2 | 22.2 | 18.6 | 14.2 |
| Nonfood allergy | 17.3 | 15.2 | 11.8 | 12.1 | 8.9 | 6.9 |
| Heart disease | 5.0 | 11.1 | 21.6 | 8.7 | 16.8 | 22.1 |
| Diabetes | 6.0 | 9.9 | 10.4 | 6.9 | 12.5 | 13.0 |
| Cataracts | 2.9 | 12.2 | 25.6 | 3.1 | 5.4 | 17.1 |
| Bronchitis or emphysema | 4.5 | 4.4 | 7.8 | 5.0 | 6.6 | 9.1 |
| Ulcers | 4.9 | 5.1 | 4.6 | 5.8 | 5.6 | 4.0 |
| Asthma | 5.5 | 4.5 | 4.5 | 4.3 | 5.5 | 4.5 |
| Migraine | 8.7 | 5.9 | 4.0 | 3.0 | 3.0 | 2.1 |
| Cancer | 3.9 | 4.3 | 5.9 | 2.2 | 5.1 | 5.2 |
| Glaucoma | 1.5 | 3.6 | 7.5 | 2.3 | 3.0 | 5.9 |
| Urinary incontinence | 2.2 | 3.8 | 4.9 | 1.4 | 2.5 | 6.4 |
| Effects of stroke | 1.1 | 2.3 | 4.7 | 1.9 | 4.6 | 5.5 |
| Epilepsy | 1.0 | 0.5 | 0.8 | 0.5 | 0.7 | 0.1 |
| Alzheimer's disease or other dementia | 0.1 | 0.3 | 1.2 | 0.1 | 0.3 | 0.7 |

*Source: NPHS.¹⁰ Adapted, with permission, from *Health Reports* 1996;8(3):10-1 (Statistics Canada, cat no 82-003).¹⁹



problem. Other evidence shows that when elderly people have been asked to compare their health status with that of their peers, the overwhelming majority rated it as being either better or the same; only 9% rated it as worse.²¹

Summary

The evidence from the NPHS suggests that much of the elderly population is in good health or has a perception of being in good health, having adapted to health conditions. There is, however, a segment of the elderly population, especially among those aged 75 and over, who have chronic health problems, are disabled and need help with ADLs and IADLs. Other research shows strong statistical relations between those in this segment and those who are living alone, have a low income and are female.¹¹

Utilization of health care services

The NPHS data can also be used to assess the utilization of health services by Canada's elderly population. Similar to many other sources of data, the NPHS shows that with increasing age, utilization by elderly people of hospital and home-care services and of medications (prescription and over-the-counter drugs) increases. We, therefore, focused primarily on the links between the health status of the elderly population and the use of services provided by GPs and specialists.

The NPHS data show that virtually all elderly people in Canada (over 90%) had a regular physician in 1995. This was also true of most other Canadian adults. The number of times a GP was consulted annually, however, rose sharply with age (Fig. 3). When we examined this re-

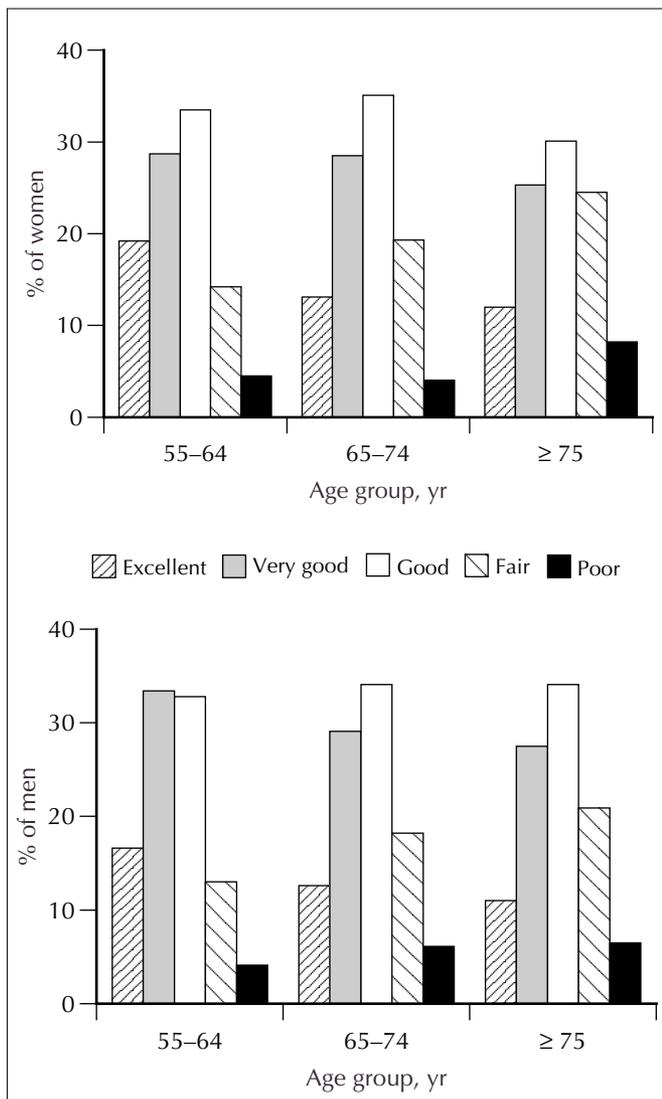


Fig. 1: Self-assessed health status of Canadian women (top) and men (bottom) aged 55 years and older, 1995. [Source: National Population Health Survey (NPHS)¹⁰]

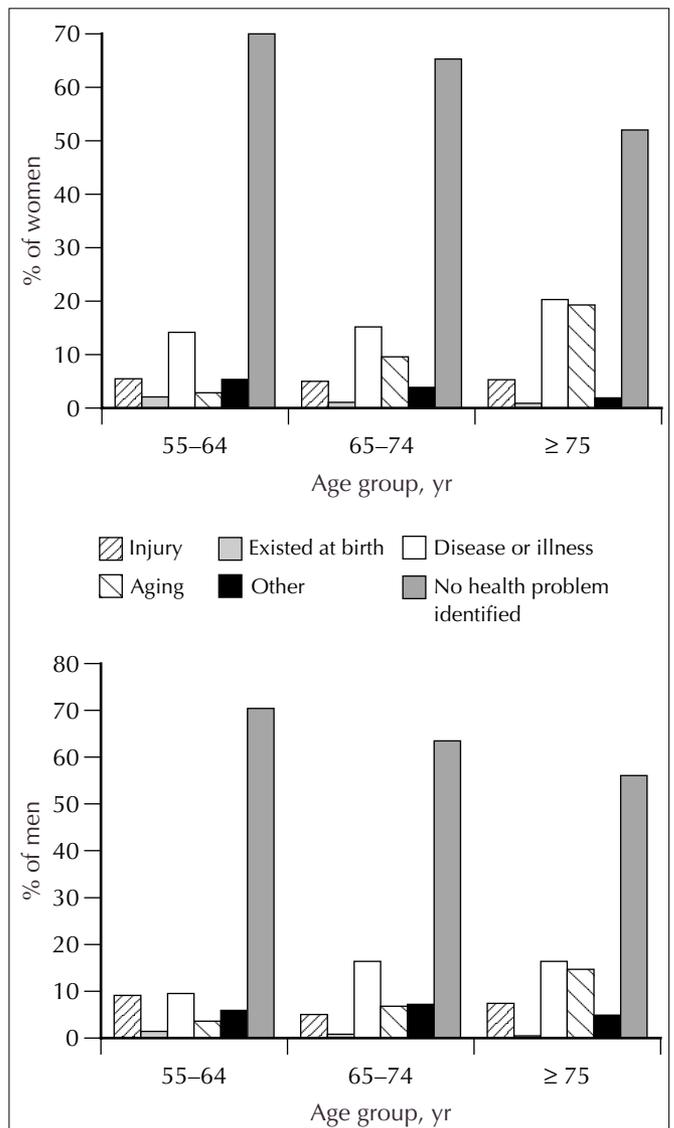


Fig. 2: Distribution of women (top) and men (bottom) by main cause of health problem, 1995. [Source: NPHS]



relationship more closely with respect to health status, we found little age effect for those in poor health. For those in good health, utilization increased with age, especially among men. The implication is that a significant proportion of visits to GPs are made by those who see themselves in good to excellent health. Similar trends were found when the data were reclassified to compare those in very good to excellent health with those in good to poor health; this suggests that these trends are more than an artifact of the classification system.

In a logistic regression model, we entered the added number of visits to a GP each year as a binary dependent variable and chronic conditions as the independent variables, controlling for age and sex. We found that elderly people with diabetes, disability, heart disease, cancer, high blood pressure, bronchitis or emphysema, ulcers and migraine were significantly more likely than other elderly people to have added visits (Table 5). Taken together, Fig. 3 and Table 5 tell us that chronic conditions and aging, regardless of perceived health status, lead to increased use of GP services.

When asked where they last had contact with a GP, over 70% of elderly people identified the physician's office (Table 6). Less than 15% of elderly people saw a GP at any of the other possible sites (walk-in clinic, outpatient clinic, emergency department, community health centre, at home). These results differ slightly from those for

other Canadian adults, among whom a slightly higher proportion used walk-in clinics.

Analysis of the NPHS data in terms of utilization of specialist services revealed that more than 60% of elderly people did not consult a specialist on a regular basis. Of those who did, more than half consulted a specialist 2 or more times regardless of their age group. These results are similar to those for the remainder of the adult population. They are also consistent with the pattern of utilization of GP services among those in poor health — that is, there was less variability in the number of visits made by those in poor health. As for location, most of those who consulted a specialist did so at his or her office. The second most likely site for a consultation was in a hospital outpatient clinic.

So far, we have focused our analysis on elderly people living in the community. It is also important to consider those who are in an institutional setting (i.e., residential care facility, long-term care facility or acute care facility), who by definition have chronic conditions and are receiving some form of medical attention. Although less than 10% of elderly people aged 65 to 74 were in institutions in 1991, this figure increased rapidly with age. Among those 85 and over, more than 40% of women and 30% of men were living in institutions.²²

Moore and associates²³ estimated lower bounds on the proportions of the elderly population entering institutions between 1986 and 1991. For various reasons these proportions are likely to be underestimates. However, even if these values are used and it is assumed that “the propensities to be institutionalized do not change, the pressure for institutional spaces will escalate rapidly as the size of the elderly population grows.”²³

When linked to the previous discussion of the health

Table 5: Effects of chronic conditions on annual visits to general practitioners (GPs)

| Condition | Odds ratio for added no. of annual visits* |
|----------------------------|--|
| Alzheimer's disease | 1.87 |
| Arthritis or rheumatism | 0.79† |
| Asthma | 0.39 |
| Back problem, nonarthritic | 0.56† |
| Bronchitis or emphysema | 1.56† |
| Cancer | 1.89† |
| Cataracts | 0.33 |
| Diabetes | 2.25† |
| Disability | 2.13† |
| Effects of stroke | -0.15 |
| Epilepsy | 1.33 |
| Glaucoma | -0.76‡ |
| Heart disease | 1.91† |
| High blood pressure | 1.67† |
| Migraine | 1.13† |
| Ulcers | 1.36† |
| Urinary incontinence | -0.09 |
| Living alone | 0.63† |
| Living alone, female | 0.96† |
| Income | -0.18† |

*These coefficients are derived from a larger model that also controlled for age and sex.
 †p < 0.001.
 ‡p < 0.01.

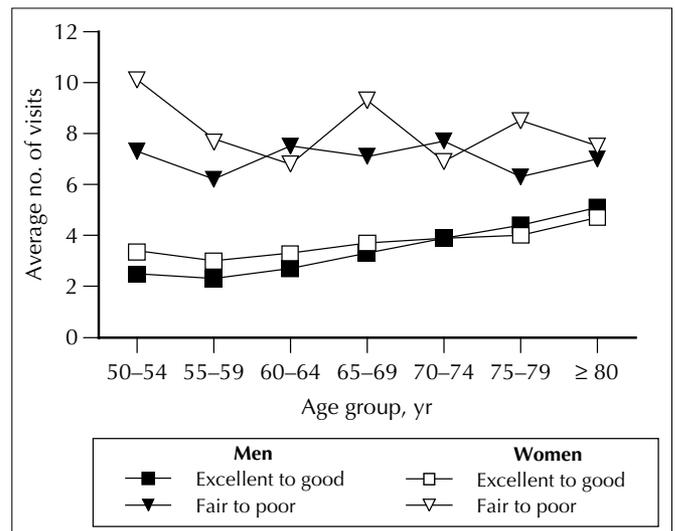


Fig. 3: Annual number of visits to general practitioners, by age, sex and self-assessed health status. [Source: NPHS]



status of the elderly population, the data presented in this section indicate that, until the age of 75, utilization of physician services does not differ much between elderly people and the remainder of adults in Canada. Beyond the age of 75, utilization increases rapidly, which is consistent with the decline in health status but even more so with the self-assessment of health as good to excellent. These findings suggest that the challenge to service providers will be how to provide services for the oldest part of the elderly population of Canada as it increases in size in the coming decades. A second issue is whether the high utilization of GP services *really* represents overutilization. Would reduced utilization among elderly people lead to higher consumption of other services (i.e., more use of specialists or even higher hospital admission rates)? A third issue is whether there will be substantial growth in the number of visits by elderly people who perceive themselves to be in good health or whether these people have adapted to their chronic conditions and require those visits. How one interprets this issue raises significant challenges for health management in the future. The fourth issue is how we plan for elderly people who require intensive long-term health care services. Even with increasing resources being focused on home-care services, will there be enough places for the growing elderly population, and in what settings will they be?

The future

In 2011 (the medium term), Canada's total population is projected to be about 35.4 million, 5 million (14.1%) of whom will be 65 and over. Almost 16% of all women will be over 65, and of these, more than 32% will be over 80. The corresponding figures among men will be slightly more than 12% and more than 22%.

Using only projected population growth rates and assuming that disability rates in 1991 will hold constant,

Moore and associates²³ estimated that in 2011 about 1 million elderly people living in the community will have some level of disability and that it will be severe for almost 300 000. About 100 000 elderly people will need help with ADLs, and another 300 000 will need help with IADLs. Under the same set of assumptions, Fig. 4 shows the increases in proportions of elderly people who will have arthritis, heart disease, glaucoma, stroke and Alzheimer's disease.

In the longer term, Canada's total population is estimated to be about 41.2 million in 2031.²⁴ The elderly population will account for 8.9 million (22%) of the total; 56% will be women and 44% will be men. Elsewhere, we have argued that, although no one expects linear increases in the size of the elderly population with disabilities,

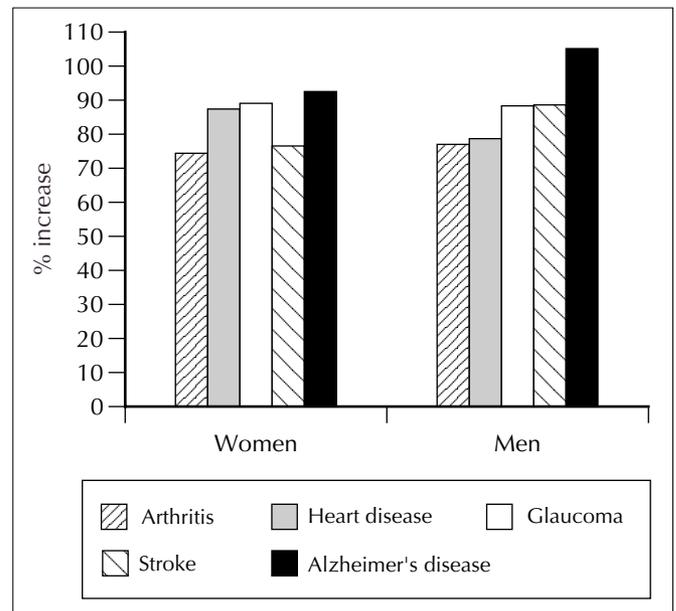


Fig. 4: Projected increases in elderly population from 1991 to 2001, by chronic condition. [Source: NPHS]

Table 6: Location of most recent consultation with GP, 1995*

| Location | Age, yr; % of elderly population | | | | | |
|-----------------------------|----------------------------------|-------|------|-------|-------|------|
| | Women | | | Men | | |
| | 55-64 | 65-74 | ≥ 75 | 55-64 | 65-74 | ≥ 75 |
| At home | 0.1 | 1.4 | 4.9 | 0.0 | 1.4 | 3.5 |
| Community health centre | 0.9 | 1.7 | 1.1 | 0.9 | 1.2 | 0.1 |
| Emergency department | 0.4 | 1.1 | 2.3 | 2.6 | 1.2 | 0.4 |
| GP's office | 74.5 | 74.5 | 73.6 | 62.6 | 72.9 | 79.1 |
| Hospital outpatient clinic | 2.4 | 1.4 | 1.7 | 3.2 | 2.5 | 3.0 |
| Walk-in clinic | 5.6 | 4.6 | 3.2 | 6.3 | 6.1 | 3.8 |
| Telephone consultation only | 0.5 | 0.6 | 1.0 | 0.7 | 1.3 | 0.3 |
| Other | 0.0 | 0.0 | 0.3 | 0.2 | 0.8 | 0.1 |
| No contact | 15.2 | 14.4 | 11.4 | 23.4 | 12.1 | 9.7 |
| Not stated | 0.4 | 0.1 | 0.6 | 0.2 | 0.4 | 0.0 |

*Source: NPHS.¹⁰



among elderly people who need help with ADLs and IADLs or require a place in an institutional setting, many more will require high levels of care and places in institutions that do not currently exist and are not likely to exist given the decisions being made in the restructuring of provincial health care systems.²⁵ Ultimately, this raises the question of whether Canadians will regret the closure of health care facilities when, in the future, additional facilities, at all levels of health care, will be needed to meet the growing demand of our elderly population.

Conclusions

Most elderly Canadians are healthy and living actively and independently in their communities. There is, however, a minority of the elderly population, and the proportion increases after age 75, whose activities are limited and who need help with ADLs and IADLs. Among those who are likely to be in the greatest need of help are elderly women living alone on a low income. People 75 and older with health problems are increasingly likely to have multiple health problems.

The utilization of medical services by people aged 65 to 74 does not differ much from that by the remainder of the adult population. After 74, however, it increases rapidly. Paradoxically, this is especially apparent among those who rate their health as good to excellent. The prevalence of chronic conditions also increases the likelihood of utilization of physician services. At the other end of the spectrum, there remains a significant proportion of the elderly population living in institutional settings. Deinstitutionalization and hospital closures are having a growing impact on community-based services. Whether the expansion of community-based services will be sufficient to cope with that part of the elderly population, who require intensive, long-term health care, remains a question.

Both the health status and utilization patterns of Canada's elderly population raise many questions about how new physicians and other health care workers are being trained and about how provincial health care systems are being restructured. It has been suggested that as life expectancy increases, the number of disability-free years will increase,²⁶ and no one can predict what breakthroughs might occur in medical science. Even if we are optimistic about future events, the sheer growth in the absolute number of elderly people, especially those 75 and over, will present a major challenge to the people responsible for providing health care.

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