CMHC Nursing Home and Hostels
Design Guideline Study

Working paper no.4

A.W. Cluff and P.J. Cluff
Architects and Planners

WORKING PAPER # 4

A HISTORY OF LONG-TERM CARE FACILITIES FOR THE ELDERLY IN CANADA

CMHC NURSING HOME AND HOSTELS
DESIGN GUIDELINES STUDY

Barbara Emodi

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A.W. Cluff and P.J. Cluff
Architects and Planners

History of Long-Term Care Facilities for the Elderly in Canada

The Emphasis of this Paper:

For reasons explained in the Appendix: A Note on Sources, the emphasis of this paper will be placed on the conceptual, rather than on the detailed level. Supporting this emphasis is the basic premise on which the paper is founded. This premise is that the history of extended care facilities for the aged in Canada can prove indispensable to an understanding of the contemporary situation and problems. In examining the history of institutions for the aged, priority has been placed on the identification of the attitudinal and institutional roots of current practice. Less emphasis has been placed on descriptions of the institutions of the past or on the favoured eccentricities of detail that are often interesting, but conceptually irrelevant. In short, it has been regarded in the best interests of this study to separate the history that helps us understand the past, from the history that helps us understand the present, and to deal primarily with the latter.

The Historical Perspective on Aging and Extended Care:

The Elderly as a New Social Group:

The history of extended care institutions for the aged in Canada has been heavily influenced by changing population characteristics.* To begin with, the proportions of elderly people to the rest of the population have exhibited a nearly constant increase. In 1921, for example, 4.8% of the Canadian population was over the age of 65, and in 1971 the figure was 8.1%. Furthermore, population projections made by both Statistics Canada and the Science Council of Canada anticipate that by the year 2001 the percentage of the population over 65 will easily be 11.8% of the total. In terms of rate of growth these figures reveal that there were more than four times as many people over 65 in Canada in 1971, than there were in 1921. Assuming, as Statistics Canada does, that the period up to 2001 will reflect a low level of fertility, it can also be observed that "for the first time in Canadian history" [our emphasis]"there may be an absolute decrease of young people(0-19)" while at the same time, "45-64 year olds increase by nearly 67 per cent by 2001, while the population over 65 nearly doubles". In the same period, it is also expected that, at least until the year 2001, the age group between 20 and 44 will also increase in both relative and absolute terms. [1]

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* For a fuller discussion of these changes, please see Working Paper # 2, "User Profile".

1. Science Council of Canada, Perceptions 2: Implications of the Changing Age Structure of the Canadian Population, (Ottawa: Science Council of Canada, 1976) p. 8.

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These figures reflect the modern phenomenon of the "aging society", and the equally recent phenomenon of the "elderly" as a distinct group, identifiable by both size and rate of growth. Although demographic statistics rarely exist, or are rarely reliable for any but the modern period, contemporary observations suggest that, in the past, old age was not a majority experience and that the elderly were not perceived as a separate social group. Life expectancies were lower, the age of retirement higher (usually to the limits of the individual's productivity), and institutionalized care, for the specific ailments of aging was almost non-existent.

Institutionalized Care and the Elderly:

The most distinct factors relative to the elderly in the period before this century, were that they were not identifiable on the basis of age as a separate group, and that they were seen more often as merely the older members of other social groups. Obviously, these perceptions were extended to include institutional care. The institutionalized elderly were characteristically contained in institutions for reasons other than their age. In the period before the introduction of old-age pension schemes, they were most frequently maintained in public or charitable facilities when they could no longer afford to take care of themselves. They were also institutionalized because of acute sickness, chronic illnesses (i.e. tuberculosis), or because of mental disorders. Senility could and did, for example, provide cause for internment in an asylum.*

But despite the fact that early Canadian society rarely identified the elderly primarily in terms of age alone, in retrospect it is possible to make several observations on the contexts in which they are mentioned, to gain some insight into the social and economic condition of a majority of elderly persons in this period. An inspector of the House of Industry in Toronto, a workhouse for the municipality's poor, for example, noted that "some of the old people have been residents of the House for long periods, one for 20 years, one for 19 years, and two for 15 years, and many from 6 to 10 years". [2]

Although the aged are never referred to as a separate entity in this period, and although "Homes for the Aged" specifically named did not appear in Canada until the end of the nineteenth century, it would appear that facilities defined in other terms were in fact serving as institutions for the elderly. At the beginning of the nineteenth century, for example:

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* See for example, the table for "Supposed or Assumed cause of Insanity since November, 1875" contained in the Report of the Medical Superintendent of the Provincial Lunatic Asylum at St. John, N.B., for the year 1891, (St. John, N.B.: The Legislature, 1892), p.22

2. Ontario Sessional Papers, Vol. III, Part II, Session 1870-71, (Toronto Hunter Ross, 1871), p. 75.

> "..... the only institutions suitable for caring for indigents were the gaols. Although they were designed to detain persons charged with or convicted of crime, they became crowded with persons whose only crime was their inability to care for themselves. This included the aged, poor and the destitute insane."[3]

In 1873 the provincial inspector of charitable institutions, observed of the House of Refuge in Hamilton, that, "nearly all of the adult inmates were aged, inform and helpless; four of the women were blind, and one was insane".[4]

The Cultural - Historical Roots of Canadian Institutions for the Elderly:

A. The Religious Tradition:

The charitable institutions that cared for the sick, destitute, insane, and of course the aged, were in many cases the historical and ideological products of centuries of religious sentiment. The Christian precept to care for the needy and helpless was undoubtedly an influence, as was, to a greater extent, the Christian tendency towards institutional demonstrations of faith.

The Christian church in the East was the first to establish charitable institutions, and by the third and fourth centuries, there were Ptochia for the care of the poor and helpless, Mosocomia for the sick, and Gerontochia for the elderly.[5] The existence of the Gerontochia is particularly interesting as the concept of a separate institution for the aged seems to have disappeared after this period, and only to have regained dominance at the end of the nineteenth century.

The church in Western Europe was much slower in establishing charitable refuges, but there is evidence that by the medieval period, almshouses and houses of pity "for the aged, destitute, sick and disabled"[6], were a regular feature of European life. These institutions were run by

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3. Passmore, G. W. Development of Homes for the Aged in Ontario, (Toronto: Department of Social and Family Services, 1967) p.1.

4. Ontario, Sessional Papers, Vol V. Part I, Session 1873, (Toronto: Hunter, Ross and Co., 1873), p.87

5. Peter Townsend, The Last Refuge, (Londong: Routledge and Kegan Paul, 1964), p.12.

6. Peter Townsend, The Last Refuge, p. 13

religious orders, and the care they offered reflected the spiritual values of compassion and dedication.

1. The Influence of this Tradition in Canada:

In those countries that escaped the Protestant Reformation of the sixteenth century, in the "Catholic countries" of France, Spain, Portugal, Italy, and in Quebec, the religious tradition of care has continued. In Beyond Shelter - A Study of National Housing Act Financed Housing for the Elderly, published by the Canadian Council for Social Development in 1973, the observation was made that, "while figures indicate that Quebec made few claims on NHA money for housing its old people, until recently the care and accommodation of old people in the province of Quebec was largely considered solely the prerogative and responsibility of charitable institutions"[7]. Most of these presumably, were religious.

2. Characteristics of the Religious Tradition:

Critics of this approach to care argue that the religious bias has been to accept things as they are, and that an over-developed sense of compassion has occasionally stood in the way of the rehabilitation and the education of the disabled and handicapped. The religious tendency, they argue, has been to induce a form of care that is more custodial than active. Although undoubtedly this argument is to some extent valid, it can in no way be accepted as the definitive judgement. We must question whether the tendency towards custodial care is an institutional or a religious characteristic, and consider the arguments made by some historians that the care delivered by religious orders was often more sensitive to the user's needs than that dispensed by the more "efficient" secular organizations.*

B. The Secular Tradition:

1. The English Model:

One of the most immediate effects of Henry VIII's break with Rome in 1534 was the dissolution of the monasteries and other religious institutions. This action created a crisis in the organized care of the

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7. Canadian Council for Social Development. Beyond Shelter - A Study of National Housing Act Financed Housing for the Elderly, (Ottawa, n.p. 1973), p.39.

* For example see Terry Copp, The Anatomy of Poverty, (Toronto: McClelland and Stewart, 1974), in which it is argued that the poor relief administered by the religious charities of Montreal at the beginning of this century, was often more considerate of the recipient's psychological needs, i.e. the need not to be stigmatized, than the relief systems administered by the municipalities. The Role of Private Charities in the Distribution of Relief: Toronto 1929 - 1939, by Barbara Emodi (unpublished paper), confirms this opinion, particularly in reference to the work of the Jewish charitable organizations.

sick, destitute, disabled and elderly, and it became obvious that some other means of meeting the need for care would have to be found. The only obvious alternative was local government, and so the parishes began to supply "such care as there was".[8] In 1601 the Poor Relief Act was passed, and this system was codified in what became known as the "Poor Law", an attitude towards relief that dominated at least until the passage of the English Old Age Pension Law in 1909, and the National Insurance Act in 1911.

2. The Influence of this Tradition in Canada

The English Poor Law system, characterized by the concepts of the workhouse and municipal responsibility, was the greatest single influence on the evolution of extended care in English Canada. In this tradition Passmore has observed that as:

"... early as 1830, in England, there developed the idea of caring for the poor in houses of industry and industrial farms where they could be made to support themselves. Housing of the poor, especially the able bodied poor, in the gaols was considered a waste of manpower and the idea of houses of industry soon spread through Upper Canada."[9]

Accordingly, the Legislature of Upper Canada passed the House of Industry Act in 1837. This act gave the local districts responsibility for the erection and maintenance of these institutions, which were to be financed by municipal taxation, and stipulated that they were to accommodate:

"... all poor and indigent persons who are incapable of supporting themselves; all persons, able of body to work and without any means of maintaining themselves, who refuse to or neglect to do so; all persons living a lewd, dissolute vagrant life or exercising no ordinary calling or lawful business sufficient to procure an honest living; all such as spend their time and property in public houses to the neglect of their lawful calling, and idiots."[10]

Although the Union of Upper and Lower Canada in 1841 prevented this act from being implemented, its tone is significant, and it was in this spirit that Houses of Industry were established in Toronto and Kingston, and Houses of Refuge founded in Toronto, Kingston, Ottawa,

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8. Townsend, The Last Refuge, p.12

9. Passmore, Development of Homes for the Aged in Ontario, p.1

10. Passmore, Development of Homes for the Aged in Ontario, p.1

Brantford, Guelph, Peterborough, and London; all in operation by 1867. [11] These institutions maintained the poor and the disabled, many of whom, we have seen, were elderly.

3. Characteristics of the Secular Tradition

a. Municipal Responsibility:

The tradition of municipal responsibility for the care of the aged, diabled, and destitute has been consistent.

In 1866, during the Union Period, a Municipal Institutions Act was passed which made it "mandatory for all counties, cities and separated towns to establish independently or jointly, a house of industry and, or refuge, essentially on the same terms as provided under the House of Industry Act of 1837".[12] The Municipal Institutions Act also provided for an inspector, matron or "keeper", whose tasks were to be defined by municipal bylaw. The legislation governing these institutions developed somewhat during the succeeding period, and varied from province to province, but what is significant is that at least until after the Second World War, the themes established by the Acts of 1837 and 1866 remained remarkably consistent. The concept of local responsibility as a solution to what was essentially a much wider problem, produced the same jurisdictional fragmentation that still plagues the administration of present-day institutions. Even in the 1890's when the provincial governments began to intervene on a serious level, largely by the introduction of provincial inspectors, wrangling and uncertainty over management matters, particularly financial, continued. The phenomenon of a custodial institution financed by a municipality and perhaps by the province, inspected by provincial inspectors, but governed by both provincial regulations and municipal bylaws has shaped this aspect of Canadian history. In fact, it is a phenomenon that still continues, if the additional intervention of the Federal government through the National Housing Act, and various pices of social security legislation passed since the war are also considered.

b. The Concept of the "Deserving Poor":

The second influential characteristic of the secular tradition is the concept of the "deserving poor"; which it should be noted, inherently contains the equally influential concept of the "undeserving poor".

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11. Passmore, Development of Homes for the Aged in Ontario, p.1.

12. Passmore, Development of Homes for the Aged in Ontario, pp 1-2.

This concept is part of the English heritage of the Protestant work ethic and the Victorian house of industry. It is based on the fundamentally Protestant idea that an industrious life is a manifestation of God's favour, and the day-to-day application of this theory in the popular judgement that the poor are inherently sinful.

In practice, this ideology was most prominent in the feeling that only the absolute essentials necessary for the minimal maintenance of the individual should be provided in any of these institutions. Anything more than the minimum, it was believed, would corrupt the indigent, and make the institutions so attractive that those in need would lose all motivation for self-support. It was an effective policy, and the notorious conditions in most refuges made almost any other alternative more attractive. J. S. Woodsworth noted that:

"'Work' Houses, Homes of Refuge, Old Folks' Homes, under whatever name, are at present a necessity, yet generally the dread of the aged poor. Too often the 'deserving poor' have been herded with criminals or placed in institutions in which there is scant comfort".[13]

The priority in most public instituions tended to be, it seemed, economy and not the resident's comfort, treatment, or rehabilitation. As the medical superintendent of the Provincial Lunatic Asylum in St. John, New Brunswick (which accommodated many elderly patients) observed:

"This institution has always run very close in the line of frugality, and indeed it has earned, or held, at all events, the doubtful distinction of maintaining its people; i.e. its officers, employees and patients, at the very minimum of cost .... We are quite ready to supply the proof of our presentation of this matter should it be considered desirable, but it may be observed that this is a question that has two sides and therefore what might be grateful to the economist might not be so pleasant for those who happen at the time to have relatives or friends guests of the institution".[14]

The intention to have the residents work for their keep whenever possible was also an aspect of the "deserving poor" ideal. In effect, it was only by working that a resident could demonstrate himself to be deserving. In fact up until the Second World War programmes and activities of the recreational or rehabilatative

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13. J.S.Woodsworth, My Neighbour, (Toronto: University of Toronto Press, 1972, first published, 1911), p.166.

14. Report of the Medical Superintendent .... 1891, p.10.

model were a rarity, and most work done in the institution was seen as contributing towards the costs of maintenance. For example, the Ontario Houses of Refuge Act, 1914 (Chapter 290) states:

"Section 11(1) The council or the Board of Management, as the case may be, may provide for requiring every person sent to the house of refuge to perform such work or service at such times, for such hours, and at such trade or labour as he may appear to be fit for, and for buying material therefor, and for selling the articles manufactured therefor, and for applying the earnings, or part of the earnings of such person, for his maintenance or for the maintenance of his wife and children, or for the general maintenance of the house of refuge...."15

As further aspects of the punitive atmosphere of public institutions of the period, it may also be remembered that until the passage of the new Elections Act in 1954, residents of Homes for the Aged were not allowed to vote. The Manhood Sufferage Act of 1888 had stated that:

"No person shall vote, who at the time of voting, is maintained in whole or in part, as an inmate receiving charitable support in a municpal poor-house or house of industry, or as an inmate receiving charitable support or care in a charitable institution receiving aid from the province under any statute in that behalf". 16

In 1908 the section dealing with charitable institutions was modified, but it is interesting that the section dealing with residents of municipal or regional homes (the category relevant to a large number of Homes for the Aged) was allowed to stand under 1954.

c. Private Facilities:

I. Traditional Alternatives for the Non-Institutionalized Elderly Person:

i) Home Care:

Of course in the past, as in the present, only a minority of elderly people were care for in institutions. As we have seen most of those who received

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15. Ontario. Revised Statutes, Houses of Refuge Act, Chapter 290, Section 11(1) p. 3522.

16. Passmore, Development of Homes for the Aged in Ontario, pp. 8-9.

institutional care did so for reasons other than age, the most common cause being poverty. Whenever possible the aged person was cared for at home by members of his own family. As institutionalization was associated in the popular mind with the stigmas of insanity, terminal illness, or destitution, the family generally felt it in its own interests to provide home care as long as it could.

For further evidence that historically poverty, and not age was a primary cause of institutionalization, it is interesting to observe that at the beginning of this century "it was believed that the introduction of old age pensions would keep many people out of the workhouses. It was also believed that the gradual improvement in living standards would make it easier for families to look after their aged members". 17. The fact that this has not been the case, despite the introduction of extensive social security programmes and a rising standard of living, suggests that other factors besides poverty, now precipitate institutionalization. These factors appear to be the emotional and geographical break-up of the traditional nuclear family, which makes home care no longer practicable, and the emergence of the aged as a separate and "outcast" social group.

ii) Communal Care:

Another traditional variation on home care was the customary practice of rotating responsibility for the care of an elderly member of the community. As it was practised in eighteenth and nineteenth century America, for example, the elderly person no longer capable of caring for himself had two choices. These were for him to find a relative willing to assume responsibility for him, or to become the responsibility of the town or village. It he chose the latter, as was usually the case when there were no relatives present, he was placed in 12 different homes, for the duration of one month each, over a one year period. Rotating this way, the town paid each householder a small remittance for the elderly person's upkeep, although it

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17. Townsend, The Last Refuge, p.16

has been observed that "the small payment received from the town by each home owner hardly covered the cost of food, much less of nursing care". [18] It is difficult to determine the extent to which communal care of this type was practised, but it certainly seems to have been a feature of care common to the self-contained communities of rural America.

II. The Evolution of Private Care:

i) Informal "Boarding-House" Arrangements:

Impoverished elderly people were generally forced into public charitable institutions, but the aged of better circumstances usually had more choice. As their families were more prosperous, persons of this class were often maintained more regularly at home, and often their care was supplemented by periodic professional help. When circumstances made it impossible for the aged person to be maintained at home, however, it was usual for the family to make its own arrangements to have someone care for the aged member in a variety of genteel "boarding-house" settings. In some cases these facilities were little more than private interpretations of the worst standards of public institutions, and in others they precursed the private hospitals of a later period.

ii) The Private Hospitals of the 1920's and 1930's.

In many ways the "private hospitals" that sprung up in Canada during the 1920's and 1930's provide a link between the modern nursing homes of today, and previous facilities. The best description of their development in this period comes from an article published by John Braddock in Hospital Administration in Canada, in 1973. In this article Mr. Braddock explains:

"The private sector that sprang up in the '20's and '30's was ad hoc. The growth came as much from the necessity of operators as from the necessity of their patients. For the operators were often qualified nurses forced to extend their income by taking private patients, or forced by family or personal reasons to work at home. They'd take, say, two patients. Then

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18. Landon Hooper and Paul A. MacWilliams, Care of the Nursing Home Patient, (Boston: Little, Paroun and Company, 1967), p.2.

two more. And as the economics of the operation continued to show imbalances, they'd increase the numbers as space and staff permitted until the most efficient level was reached."[19]

The medical judgement on such establishments has, at times, been harsh. Harvey Agnew for instance, writes in his Canadian Hospitals, 1920 to 1970, that hospitals of this period:

".... provided little more than food and shelter and offered practically no nursing service .... Some of these institutions had no laboratory facilities, no medical supervision, no physiotherapy nor hydrotherapy, no occupational nor recreational therapy, no dietition, no orderly service, and were not deserving, in fact, of the name hospital". 20.

The Canadian Facility for the Elderly as a Charitable, rather than Medical Institution:

To a large extent, the poor care received in institutions for the aged was a by-product of one aspect of the hospital tradition: the tendency away from extended care. It has been astutely observed that:

"The role of voluntary hospitals in treating the aged sick was insignificant ... their resources were limited and increasingly they became more selective of those whom they treated, preferring the acute to the chronic sick. By admitting the acute sick it was easier to satisfy a growing number of specialists, to provide a concentrated variety of patients for teaching and research purposes and to present impressive appeals to the public for funds". 21.

Agnew has also noted that, "one of the greatest gaps in the health care system in Canada has been the perpetual insufficiency of beds, services, and other facilities, specifically designed for convalescent and chronically ill patients".22. The reasons for this he states are that "most extended care patients have less need for expensive facilities such as oxygen, air climatization, sophisticated radiological equipment, diagnostic laboratories, operating rooms and so on, there is a reluctance to put such

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19. John Braddock, "It's a Rocky Road for British Columbia's Private Hospitals", Hospital Administration in Canada, December, 1973, p.32.

20. G. Harvey Agnew, Canadian Hospitals, 1920 to 1970: A Dramatic Half Century, (Toronto: University of Toronto Press, 1974), pp. 204-205.

21. Townsend, The Last Refuge, p.13.

22. Agnew, Canadian Hospitals, p.203

patients in the acute general hospital". 23. This reluctance alone has not been the problem, but rather the failure until recently, to develop alternate facilities suitable to the very specific needs of the elderly.

A. The Charitable Tradition:

The charitable tradition of administration persisted as a dominant theme in the development of Canadian facilities for extended care for several reasons. First, the fundamental lack of medical interest in the field of gerontological care was a constant hinderance to the development of appropriate facilities, programmes and services. Secondly, the ideologies of the workhouse and the "deserving poor" were difficult to change as long as they remained compatible with the interests of the status quo and economy. Furthermore, this compatibility was ensured as long as the greater part of the responsibility was left to individual municipalities and their very limited resources.

The evidence that the municipal facilities were dominated by the model of the workhouse and the fear of providing more than the absolute minimum is striking. For example an inspector's report on the Home for Aged People, London, Ontario, submitted in 1895, describes an institution that was:

".....some half a mile distant from the city sewer system, and has therefore to depend on the cesspool method of getting rid of its sewage. The pool is situated in the yard only a few yards from the building, and is emptied by means of a pump. I made an effort to see how the apparatus works when the wind is blowing towards the building, and concluded at once that the cesspool is a menace to the health of the inmates. The stench was abominable. Another matter also that needs attention is the question of fire escapes. The building is very deficient in this respect. Although it is a new building, it is rapidly beginning to look as though it would fall to pieces."24

Revealing the priorities of his time, the inspector follows his description of the physical facilities by commending the institution for its "management and bookkeeping" which he has found to be "very satisfactory". 25

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23. Agnew, Canadian Hospitals, p. 204

24. Ontario, Sessional Papers, Vol. 27, Part 3, Session 1895 (Toronto: Lud. K. Cameron, 1895), p. 31.

25. Same as above.

B. The Effect of this Tradition on the Purposes and Quality of Care:

One of the most distinctive features of institutions in the charitable tradition has been their tendency towards custodial care. It is, in fact, at this point that the religious and secular traditions converge, and this suggests that the phenomenon is a characteristic of institutionalization itself, and not a reflection of any particular approach.

The custodial attitude to care has, historically, stressed the physical maintenance of the resident and neglected his psychological and social needs. Traditionally, it was felt that the provision of meals and shelter alone constituted adequate care. This attitude often allowed the elderly to be placed indiscriminately among other care groups of distinctly different needs. Agnew has noted, for example, that in the first half of this century, "severe psychiatric illnesses, as well as much retardation and senility were treated in provincially owned and operated institutions, many of which were designed by prison architects and contained anywhere from 400 beds to 600 beds". In fact, he adds, by 1929 "there were almost as many patients in mental institutions as in all the public general hospitals", 26, and many of these patients were elderly.

C. Reflections of Tradition in the Institutions of the Present:

Since the Second World War there have been many innovations that have improved the position of the elderly in Canada. Most significant of these has been the introduction of old age security at the federal level, and old age assistance at the provincial level. In addition, it has only been in the post-war period that the concept of the elderly as a unique special care group, and of facilities for the aged as specific institutions, has been accepted, at least in general theory.

Those close to the problems of aging, however, recognize that elements of the old charitable and custodial traditions are still in evidence and still influential. In only four of the ten provinces are there any regulations at the present time dealing with social and recreational activities, and in only four provinces are social spaces included in the regulations covering physical design standards.*

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26. Agnew, Canadian Hospitals, p. 206

* Only British Columbia, Alberta, Ontario and New Brunswick have legislation concerning social and recreational activities, and only British Columbia, Manitoba, Ontario and Prince Edward Island have physical requirements for social space.

A.W. Cluff and P.J. Cluff
Architects and Planners

Perhaps an appreciation of how deeply the charitable and custodial traditions are entrenched in the history of extended care institutions in Canada will help to explain both their influence and persistence.

A.W. Cluff and P.J. Cluff
Architects and Planners

APPENDIX

A NOTE ON SOURCES

An interested researcher wishing to investigate the history of long-term care facilities for the elderly in Canada, suffers under several disadvantages. The first of these is that almost nothing has been written on the subject. G. W. Passmore wrote Development of Homes for the Aged in Ontario in 1967, but regretably this is only the study of one province and only a short essay. We understand that Mr. Passmore has continued his work in this field, but unfortunately nothing has yet been published.*

In fact, when examining the existing literature for information on the history of long-term care institutions in Canada, one is forced to rely almost entirely on indirect references to the subject made in other, more specific, works. For example, Harvey Agnew's Canadian Hospitals 1920 to 1970, published in 1974, offers some data on what are referred to as "convalescent or chronic hospitals". The Last Refuge, (1964) by Peter Townsend examines the British scene, but is able to throw some light on the religious and cultural roots of the Canadian experience. In addition, the writings of the early reformers such as J. S. Woodsworth's My Neighbour (1911), can be used to trace traditional approaches to the problems of age and destitution in Canada.

References of this kind can begin to describe the situation, but they cannot, of course, be considered to provide a comprehensive or definitive treatment of the subject. To do this one would begin as an historian would by examining the primary material. In research terms, "primary" means original material, and in this case, the body of historical documents that record the history of extended care institutions in Canada, and not the literature that discusses or interprets them. If, for example, we consider Passmore's, Agnew's and Townsend's books to be secondary material, then we can consider the records and reports of the institutions of the past to be primary sources. In a sense we could also consider Woodsworth's treatise to be a primary document as it is the product of a specific period, and not a retrospective discussion of it.

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* In a telephone conversation held with Mr. Passmore on June 15, 1977, he informed our researcher, Barbara Emodi, that his work on this subject had continued over the last ten years, but declined to give further details.

A.W. Cluff and P.J. Cluff
Architects and Planners

As may be appreciated in any historical study a thorough examination of all relevant primary documents is the only way to ensure that the subject can be treated comprehensively, in the sense that only a full knowledge of the facts can produce objectivity. It may also be appreciated that in the case of the records and documents kept by all the extended care institutions in Canada, the task is enormous. Obviously, the ideal situation would be to undertake such a study, but an exercise of this nature cannot be considered consistent with the task at hand, as defined by time, budget, and project goals. Therefore, while emphasizing that a complete study may be appropriate elsewhere, we have tried to devise a "middle road" that we hope can best combine the resources of both the primary and secondary literature in the interests of this project.

The steps that we have followed in researching the history of long-term care facilities for the elderly in Canada, have included:

A. An extensive search through the secondary literature. This search confirmed the absence of comprehensive studies of the topic.

B. A review of other literature that related in a general way, to the development of extended care institutions in Canada.

C. A preliminary cut into the primary sources. This included a limited look at the provincial legislation and at the inspectors' reports on various institutions contained in the Sessional Papers. This exercise made us aware of the potential of these sources, and offered some interesting insights into the attitudes of early administrators and institutional practice.

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