7 Health Status and Health-Care Transitions in an Aging Context

Chapter Overview

This chapter provides you with an understanding of what affects health over the life course and how aging processes are interrelated with our health-care system. The health status of an individual changes over his or her life course. These alterations are the result of an array of factors associated with the chronological, physiological, psychological, and social processes of aging. This chapter is one of the largest in this text, reflecting a substantial sub-field.

Learning Objectives

By the end of this chapter, you will be able to do the following:

- Define what health is and what constitutes good health.
- Distinguish which models of health and health care are used or could be used in Canada.
- Evaluate the evidence as to whether older persons are becoming healthier over time and whether baby boomers are healthier than prior generations, and why.

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- Determine the extent to which health and health behaviours are influenced by perceptual, cultural, lifestyle, and social structural factors.
- Understand how the inability to cope with change and stress in later life and/or a decline in physical health may lead to mental-health problems.
- Build an argument against the statement that older people will destroy the health-care system because of their increasing numbers and overuse.

Key Facts

- Approximately 43 per cent of persons 65 and over have a disability.
- In 2014, about 60 per cent of older adults had two or more chronic conditions; the most common illnesses among older adults living in the community included hypertension (47.3 per cent), arthritis (41.7 per cent), diabetes (18.2 per cent), heart disease (16.3 per cent), asthma (7.9 per cent), and chronic obstructive pulmonary disease (COPD) (7.1 per cent).
- In Canada, about 8 per cent of persons aged 65 and over and about one in three aged 85 and over have mild, moderate, or severe dementia.
- Between 10 and 20 per cent of older adults are diagnosed with mild to severe depression.
- About 40 per cent of hospital days are used by the 5 per cent of patients who are hospitalized for more than 30 days. Of these patients, two-thirds are 75 years of age and over.
- Canada spends only about 15 per cent of its public funds for long-term care on home care, whereas the Netherlands, France, and Denmark spend 32 per cent, 43 per cent, and 73 per cent, respectively.

Key Terms

comorbidity The condition of having more than one illness at a given time, typically connected to an index disease (e.g., persons with diabetes who have one or more other chronic conditions). (p. 199)

compression of disability With increasing life expectancy, there is a tendency for the onset of disability (functional status) to occur closer to the end of life (see also morbidity compression). (p. 202)

disability-free life expectancy A measure of the average number of years of life remaining without experiencing disability. (p. 202)

e-health A term used to describe the application and storage of information and communications technologies in the health sector. (p. 216)

health According to the World Health Organization, a state of complete physical, mental, and social well-being and the capacity to perform activities of daily living and to function with some degree of independence; not merely the absence of disease. (p. 198)

health literacy The ability to seek and understand health information. (p. 216)

health transitions The changing states of health as individuals age. These occur because of the dynamic interplay among individual decisions, personal history, and social conditions. (p. 199)

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healthy-immigrant effect The tendency for life expectancy and general health to be higher for immigrants than for persons born in Canada and for this health differential to decline with duration in Canada. (p. 213)

healthy lifestyles Clusters of health behaviours that influence the health risk faced by individuals as the result of life chances and choices and the social context in which these occur. (p. 215)

incidence The frequency of new occurrences during a specific period of time, usually one year. (p. 199)

medical iatrogenesis Illness that is induced through contact with the medical system (surgery, hospital-induced infections). (p. 200)

mental health The ability to think, feel, and interact with others as we encounter challenges in daily life. (p. 220)

mental illness A disorder of thinking, feeling, and acting that can range from a stressful disorder to an organic brain disease with severe disorientation and memory impairment. The causes of mental illness may be social, psychological, or physical. (p. 220)

morbidity A state of disease or chronic illness. (p. 208)

morbidity compression The theory supporting the notion that as people live longer, there is a tendency for the onset of disease to occur closer to the end of life. (p. 201)

prevalence The number of cases of a phenomenon in a population at a specified point in time, such as the number of cases of elder abuse per 1000 older persons. (p. 199)

prolongevity A significant extension of average life expectancy or maximum lifespan. (p. 231)

self-care The actions and decisions that an individual takes to maintain and improve health; to prevent, diagnose, and treat personal ill-health; and to use both informal support systems and formal medical services. (p. 216)

self-efficacy The perceived confidence that one can accomplish a behavioural change or adopt a new behaviour; deemed an important precursor to making an actual shift in behaviour. (p. 211)

social capital A major determinant of health that involves aspects of the community that facilitate mutual support, caring, self-esteem, sense of belonging, and enriched social relationships. (p. 211)

social determinants of health A number of changeable elements in a person's economic and social environment, including socio-economic status, living and working conditions, and social support from family, friends, and the community. (p. 211)

Study Questions

See below for answers.

1. What are the two models of health care and how do they complement each other, especially when applied to aging and age-related health?

2. What is the influence of rural and remote living on health of older people when compared to older people who live in urban centres?

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Additional Resources

Articles

Alzheimer Society of Canada. 2016. Prevalence and Monetary Costs of Dementia in Canada.

Canadian Institute for Health Information. 2017. Seniors in Transition: Exploring Pathways across the Care Continuum.

Chappell N.L., & Cooke H.A. 2013. Age Related Disabilities: Aging and Quality of Life. In J.H. Stone & M. Blouin (eds.). *International Encyclopedia of Rehabilitation.*

Mikkonen, J and Raphael, D. 2010. Social Determinants of Health: The Canadian Facts.

Public Health Agency of Canada. 2014. Mapping Connections: An Understanding of Neurological Conditions in Canada.

Videos

Baycrest Health Sciences. 2014. Evelyn: Experience with Late Life Depression. (3:08 minutes)

This is a candid story of major depression in late life, including a suicide attempt. I have a newfound and deep appreciation for life. I will fight for life regardless of my health and I will ask for help when I need it. I am sharing my story. I want the discussion of depression put on the table, not kept under it.

Goldman, B. 2017. Seniors tell Dr. Brian Goldman what it's really like to live in long-term care. White Coat, Black Art, CBC Radio. (27:06 minutes]

Sharron Cooke and Devora Greenspon speak frankly about life in long-term residential care, from the loss of freedom to advocating for those who can't do it themselves.

Health Force Ontario, 2017. Orientation to the Canadian Health Care System, Part I (3:45 minutes), Part II (3:20 minutes)

Part I focuses on the role of the federal and provincial/territorial governments in the Canadian Health Care System and the five principles that our health care system is built upon. Part II focuses on the provincial delivery of health care including the importance of patient-centred care, safe, competent and ethical practice, inter-professional collaboration, information on levels of care and regulated health professions.

Websites

Canadian Coalition for Seniors Mental Health, www.ccsmh.ca

Canadian Home Care Association, www.cdnhomecare.ca

Fountain of Health, https://fountainofhealth.ca

Health Canada, Seniors, www.canada.ca/en/health-canada/services/healthy-living/just-for-you/seniors.html

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Study Questions—Answers

1. The medical model focuses on the incidence, causes, and treatment of disease, and the emphasis is on treating or curing health problems with surgery, medications, bed rest, rehabilitation, or, for elderly patients, moving them to a facility offering 24-hour nursing care. This model perpetuates the idea that health status is caused by physiological and biological systems. The social model of health care builds on the medical model. It views health as having a social (one's socioeconomic status or social support network), psychological (stress), physiological, biological, and genetic basis. This model stresses the role of agency in health decisions, self-care, and any changes in health behaviours and beliefs. Thus, it places more emphasis on prevention and less on medications, surgery, and hospital stays. (pp. 199–201).

2. Older women (65+) residing in rural areas had more chronic conditions, such as hypertension, diabetes, and heart disease, than those residing in urban areas. Moreover, the health of rural elderly women appears to be influenced by factors different from those influencing the health of urban older women. These factors include diet, lifelong health habits, and perhaps a rural culture that fosters different health beliefs and practices. Since many rural and remote communities have a shrinking population base, it is difficult to develop a sufficient and efficient health-care system for them. While more than 20 per cent of older Canadians live in rural areas, many public policies overlook this sector in the allocation of health-care resources. The situation has worsened in recent years, with fragmentation of services, the closing of small rural hospitals, restructuring and regionalization of health services, and the continuing difficulty that rural communities encounter in attracting and retaining physicians and other health-care and social-service workers. Older adults in rural and remote areas of British Columbia had a lower rate of using physician services than those living in urban areas. Fewer health and social services in rural areas also likely contributed to longer hospital stays by rural seniors. (pp. 214–215).

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