

“Looking to the Future, Now”
Mackenzie and Area Seniors Needs Project
Background Literature Report

prepared by:

Rachael Clasby, Neil Hanlon, and Greg Halseth

Geography Program
University of Northern British Columbia

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Greg Halseth, Neil Hanlon, Virginia Pow, and Rachael Clasby
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Availability

Copies of all reports associated with the Mackenzie and Area Seniors Needs Study are available in a number of locations. In Mackenzie, copies have been deposited with the District of Mackenzie and the public library. At the University of Northern British Columbia, copies have been deposited at the Weller Library or can be accessed on Greg Halseth's website:
<http://web.unbc.ca/geography/faculty/greg>

Project Reports

- Methodology Report
- Background Literature Report
- Population Background and Trends
- Northern Seniors Housing and Support Services Report
- Final Report
- Executive Summary

Contact Information

For further information about this topic and the project, feel free to contact one of the principal researchers at UNBC:

Greg Halseth
Geography Program
University of Northern BC
Prince George, BC
V2N 4Z9
tel: 250-960-5826
fax: 250-960-6533
email: halseth@unbc.ca
<http://web.unbc.ca/geography/faculty/greg>

Neil Hanlon
Geography Program
University of Northern BC
Prince George, BC
V2N 4Z9
tel: 250-960-5881
fax: 250-960-6533
email: hanlon@unbc.ca
<http://web.unbc.ca/geography/faculty/neil>

Mackenzie and Area Seniors Needs Project

Background Literature Report

1.0 Project Description

The purpose of the Mackenzie and Area Seniors Needs Project is to examine housing and support service needs for seniors in the District of Mackenzie and surrounding area. The work was carried out by a research team from UNBC with the goal to provide decision-makers and community groups with information relevant to decision-making over community planning and infrastructure investments. The project was carried out over the summer of 2004.

Since the 1980s, Canada's population has been aging. In small towns, the provision of housing, services, and facilities influence the decisions of individuals when choosing to retire in a community. In Mackenzie, there were about 50 people over the age of 65 in 1991, but by 2001 there were approximately 140 people over age 65 (Statistics Canada, 2001). The increase in the number of older residents, and the increase in the number of residents who wish to remain in Mackenzie when they retire, has raised the level of interest in how the community, local services, and available housing options will meet the needs of a growing seniors' population. As a result, UNBC and the District of Mackenzie are working together to assess the housing and service needs for older residents.

This report introduces and describes a range of issues associated with aging and the provision of services for an older population. It draws upon previous research conducted

in these topic areas, with a special focus upon their applicability in small towns. The report begins with an introduction to the topic of aging and the different components that make up the older age groups. The second section describes how this aging process may be working in small resource-dependent towns, places where ‘aging-in-place’ is a relatively new experience. The third section examines issues associated with health and wellness in an older population. This includes topics such as maintaining seniors’ independence and the provision of social support. The final section extends some of these topics around a specific discussion of service provision. With a focus upon small towns, the challenges of service provision, housing supply, transportation, and recreation and leisure are reviewed.

2.0 Population Aging

Demographic Trends

Two major demographic trends are shaping the North American landscape: migration and population aging (Moore *et al.*, 1996; Bryant and Joseph, 2001). This section outlines some of the key issues driving both of these processes and their relevance in Canadian small towns.

Historically, Canada has been a mobile population, with most of the growth in towns and regions the result of in-migration. This migration has tended to be fairly age specific, involving younger cohorts who were moving in search of employment opportunities (Halseth, 1999). This has changed somewhat over the past 20 years as the retirement age population has demonstrated some very specific types of migration patterns. Research in the United States in particular has looked at specific migration streams, with one of the most developed literatures tracking different retirement migrations as people age (Biggar *et al.*, 1980; Flynn *et al.*, 1985; Rogers and Woodward, 1988; Meyer and Cromley, 1989). The general pattern is one where recently retired people relocate to amenity locations and remain active there as long as their general health conditions hold. In many

cases, people in this group may hold more than one residential property and move between them over the different seasons. Many communities in the southern US have capitalized on geographic characteristics like location or natural amenities to create new economies based on tourism, vacation developments, or retirement living (Hallman, 1990; Bowles and Beesley, 1991; Wilkinson and Murray, 1991; Dahms and McComb, 1999). Such changes are also underway in many former resource hinterland areas (Halseth and Sullivan, 2002). For example, Nelson (1997) has tracked retirement and amenity migration to the United States' 'non-metropolitan west'. Climate, quality of life, retirement, availability of services, and affordability of land are important elements in the rapid growth many of these former resource-dependent non-metropolitan west regions have experienced (Gober *et al.*, 1993; Nelson, 1999; Nelson and Sewall, 2003). This research has also tracked a counter-flow to this retirement pattern. This counter-flow typically occurs as people age and their need for greater medical care or personal assistance necessitates a move to locations where family or service support exists. In many cases, this relocation is 'back' to the community these retirees consider being their hometown.

Population aging occurs primarily through aging-in-place and the net out-migration of younger populations. The most significant component of population aging in Canada derives from the long-lasting effects of the baby boom generation that followed World War II (Moore and Rosenberg, 2001). As this large share of the Canadian population begins to enter the retirement years, their numbers will demand that considerable attention be directed to the service and housing needs of older residents. Net out-migration of young people is the main process causing population aging in rural and small town Canada, especially in towns that depend on primary industries (Bryant and Joseph, 2001). Economic restructuring in these towns, in the form of flexible job descriptions and the increased substitution of technology for labour, has meant that fewer workers are required to operate the production process (Grass and Hayter, 1989; Norcliffe and Bates, 1997; Rose and Villemaire, 1997; Carroll *et al.*, 2000; Fisher, 2001). Job reductions have accelerated the net out-migration of younger people who are in search of work opportunities. In addition, numbers of 'baby-boomers' had expected to

leave resource towns as they aged, but a growing proportion is now choosing to stay. As a result, Canadian towns with resource-based economies are experiencing both an aging-in-place of the baby boomer generation and an out-migration of younger people (Moore and Pacey, 2003). Together, these processes create a quickly increasing proportion of the population over age 65.

Composition of the Elderly

Seniors, as a group, are a tremendously diverse segment of the population. With gains in longevity, ‘old age’ may now occur over a period of 40 years or longer, and individual socio-economic characteristics have been shown to be a major influence over how healthy or enjoyable this time of life can be. While demographers and policy makers often employ convenient, though somewhat arbitrary, age markers for statistical purposes (i.e.; the age of 65 as a cutoff), there is a need to break down the seniors’ population and recognize the diversity among this age group. Recognition of their diverse characteristics and needs is especially crucial for designing services and housing which are able to serve this population effectively over time.

Previous research has shown that recognition of this diversity needs to, at a minimum, differentiate between the experiential worlds of the ‘young-old’ (65-74), ‘old-old’ (75-84), and the ‘very old’ (85 years and older) (Rowles, 1986). There are, for example, distinct differences between the experiences of the young-old and the very-old with respect to how they are able to interact with their environments. Other research has suggested that attention to the “near elderly” (aged 55-64) is needed to capture a broader spectrum of changes in activity levels, general health, and the demands placed on services and housing (Moore and Rosenberg, 2001).

Gender differences in the composition of the seniors’ population is illustrated by the sex ratio (i.e.; males per 100 females). Across Canada, sex ratios have generally decreased for the younger elderly while at the same time they have become more pronounced at older ages (Moore *et al.*, 1996). The sex ratio has decreased for the young elderly (65-74)

and those between 75 and 84 years because men are experiencing better health and increased longevity. The sex ratio is more pronounced for the very old elderly (85 years and older) because there are more women surviving than men. The predominance of women who are very old will have implications for the provision of both informal and formal support because very old women who are living alone are at greater risk of institutionalization (Moore *et al.*, 1996).

The links between aging and social change make it important to identify the differences between individual aging and population aging (McPherson, 1990). Individual aging refers to the life course events that are critical benchmarks in people's lives. These events include retirement and the deterioration of an individual's health. Population aging refers to the relative size and attributes of the elderly population as a whole. The most significant component of population aging is the population born in the post World War II baby boom. Moore and Rosenberg (2001, 146) suggest there are "real geographical issues in the discussion of both individual and population aging". Individual experiences of aging are different in rural and urban environments, and population aging is sensitive to the variations of economic restructuring which attracts or pushes younger individuals to an area.

Trends in Morbidity and Mortality

At one time, increased life expectancy was expected to be accompanied by longer periods of poor health conditions and rising levels of disabilities. Over the past 20 years, however, researchers have noticed that increases in remaining life expectancy have not been accompanied by these longer periods of poor health outcomes for individuals (Barer *et al.*, 1995; Wolf, 2001). As life expectancy has increased, so to has the proportion of people's lives which are spent being relatively healthy (Crimmons and Saito, 2001). The 'compression of morbidity' hypothesis suggests that technological and medical advances have been able to postpone the symptoms of chronic disease or functional breakdown until the very end of life at a rate faster than our life expectancies have increased (Ulysse, 1997). In other words, while the population is generally living longer, the period of time

during which we are suffering from disabling, chronic, or degenerative diseases has actually decreased. This is important because an increase in our ‘healthy life expectancy’ is reflected in declining institutionalization rates and a decreasing dependence on formal care (Moore *et al.*, 1996).

According to Caitlin (1999), it is important to understand that an increase in the remaining life expectancy is not experienced the same way by all older Canadians. The rate at which an individual experiences a compression or expansion of morbidity is very dependent on their socio-economic status. Research has shown that the socio-economic factors which most influence the outcomes of healthy or unhealthy life expectancy are education and income. Those with more education and higher incomes are less likely to be disabled and more likely to have an increase in healthy life expectancy than are those with less education and lower incomes (Caitlin, 1999; Wolf, 2001). The socio-economic differences are significant. People with higher levels of education have up to 50 percent lower disability rates than do those with less education (Cutler *et al.*, 2001). Lower life expectancy is also associated with those who are institutionalized for physical or mental health problems, and those living with an ‘activity-limiting’ disability (Crimmons and Saito, 2001). The overall length of healthy life provides a good summary indicator of the total health impacts of differences in socio-economic well being.

Trends in Mobility

Trends in mobility fluctuate in response to economic and demographic change. Overall, mobility in Canada has declined since 1976 as a response to both the entry of the baby boomer population into the labour market and increasingly tough economic times. Mobility is defined as a change in permanent residence at any geographical scale; however, it is important to distinguish between ‘residential mobility’ (or moves within a local community) and ‘migration’ (or long distance moves) (Moore and Rosenberg, 1994). Residential mobility is usually associated with adjustments in housing and living arrangements in local areas, while migration is generally associated with a disruption in daily activities and social networks as a person or household relocates to a different

region. Migration is the most important factor affecting the structure of a local population, and rural and small town places across Canada have been greatly influenced by its processes (Everitt and Gfellner 1996). The net out-migration of younger people as a reaction to economic restructuring is greatly influencing the demographic structure in northern resource towns by accelerating the rate of aging-in-place.

3.0 The Greying of Resource Communities

Economic Restructuring

It is important to understand the processes of economic restructuring in resource-dependent towns to explain the patterns of population change. Population aging is influenced by the economic conditions which underlie the differential growth in local economies. Moore and Pacey note how (2003, 22) “sudden shifts in regional economic performance could well produce rapid shifts in the pattern of aging if the net migration effects changed from ameliorating aging to reinforcing it”. Economic restructuring in Mackenzie is influencing the rate at which population aging is occurring.

Since 1980, BCs forest industry has been experiencing an accelerating pace of change (Hayter, 2000). This has included corporate consolidation, changing regulations in response to environmental and market pressures, the increasing application of technology (especially computer driven technology), and international topics such as trade agreements and the uncertainty and costs of the softwood tariff debate between Canada and the United States (Cloke and Goodwin, 1993; Cocklin and Wall, 1997; Hayter, 2003). While such changes are dramatic and have significant local affects, they are not unique to Mackenzie; rather they are part of a much larger restructuring of resource-dependent towns in Canada (Canada Employment and Immigration Advisory Council, 1987).

Like all resource towns, Mackenzie is situated in a global economic context (Department of Regional Economic Expansion, 1979). There will be positive and negative swings in general economic cycles, and there will be fluctuations in both the demands and prices for their respective commodities (Freudenburg, 1992; Freudenburg and Frickel, 1994). The bust side of a resource boom-and-bust cycle can be devastating within even the most comprehensively planned towns (Himmelfarb, 1977; Bradbury, 1978, 1988). The realities of a resource bust cycle can have significant consequences for such key local characteristics as population levels, employment stability, and home ownership which, in turn, can have impacts upon the viability of the local retail sector, voluntary organizations, and general community development (Halseth, 1999). Many Canadian towns continue to suffer the effects of major boom-and-bust cycles as a result of our continuing economic dependence on minimally processed resource commodities or ‘staples’ which are traded in a global marketplace (Barnes and Hayter, 1994; Barnes, 1996).

Economies that are static or declining are more likely to experience a net out-migration of the younger population at a faster rate than for older individuals (Kusel *et al.*, 2000). Many resource-dependent towns in BC show evidence of a proportionally larger out-migration of young people. This process, if sustained over time, will produce shifts in the local age structure because both the structure and processes of population aging are intimately linked to the economic geography of the national landscape (Moore *et al.*, 1996). As a result, economic restructuring in Mackenzie is enhancing the aging-in-place phenomena and creating a faster approaching need for the support and infrastructure that an elderly population demands.

Aging-in-Place

Many elderly today are choosing to age-in-place. This is a challenge for many rural and small town places in Canada that are not experienced in providing services to an older population (Everitt and Gfellner, 1996). Aging-in-place is defined as the ability to remain in the community as one gets older (Rowles, 1993; Cutchin, 2003). Baduik (1990, 36)

says “aging-in-place has two dimensions; at one level it reflects a belief in the value of independence and the right of seniors to remain in their own homes. At another level, aging-in-place is also concerned with the specific and tangible ways of assisting the elderly to do so”.

Aging-in-place has to do with our attachment, experience, and images of our homes and the communities in which our homes are located (Rowles, 1993). Aging as a biological, psychological, and social process is seen to influence the way in which individuals experience their environment. A person’s interaction with the environment usually deteriorates as their functional health, social roles, and cognition declines (Haldemann and Wister, 1994). Programs and policies that promote aging-in-place respond to the needs of an aging population by allowing them to remain active in their environment for as long as possible.

Hanlon and Halseth (forthcoming) argue that, in resource hinterland settings, the historic pattern of growth through in-migration of young families has been replaced by population decline and aging-in-place. The experiences of the elderly in communities that have aged primarily through the out-migration of younger people are very different from those which have aged primarily through the in-migration of older persons (Joseph and Martin-Mathews, 1993). In rural and small town Canada, where people are aging-in-place, these experiences are characterized by the absence of a continuum of social support, housing, and health services. Providing appropriate facilities and programmes in social, cultural, and medical areas for small settlements is usually difficult as a result of the size and location of these places (Hodge, 1987; Desjardins *et al.*, 2002). The rural and small town context is characterized by few alternative sources of services, and large distances to be traveled in order to obtain these services. Therefore, the elderly living in rural and small town places must overcome issues of mobility and accessibility in order to age-in-place.

Elderly Mobility

Most elderly relocation involves local moves, often reflecting changing life circumstances (Rowles, 1986). Many elderly move because of a life cycle change that alters their housing or service needs. The young elderly who have recently retired are more likely to consider long distance moves, while the older elderly are more likely to experience shorter distance moves as a reaction to the need for assistance resulting from the loss of a spouse, declining income levels, and health related problems (Everitt and Gfellner, 1996). The propensity to move for older people declines as they age. If they can no longer maintain their independence, however, they most often relocate into an institutional setting or to where they can obtain assistance from informal or formal support networks.

Stimson and McCrea (2004) use a behaviouralist ‘push-pull’ framework to highlight many of the factors that the elderly take into consideration when they move. Four push factors (change in lifestyle, home maintenance, social isolation, and health and mobility) explain most of the variation in reasons why retirees leave their home and move to a more suitable location, while three pull factors (built environment and affordability, location, and maintenance of existing lifestyle and familiarity) explain the underlying reasons why retirees are attracted to higher amenity areas.

Elderly are motivated to move for many reasons which are mostly influenced by retirement, health, and housing adjustments. Moves associated with retirement are generally to high amenity areas or retirement villages. Retirement encourages moves for the purpose of enjoying physical amenities such as milder climate, more scenic landscape or better recreation opportunities (Moore *et al.*, 1996). Most often it is the more affluent elderly who are more likely to experience these types of moves to the Sunbelt or coastal areas (Joseph and Hollett, 1992). Retirement can bring increased financial stress such that single-detached dwellings (and its upkeep) could be a financial burden for many elderly on a fixed income. Housing adjustments are most often accomplished by a local move into a lower cost, and low maintenance, dwelling (Moore and Rosenberg, 1994). A

decline in health most often requires a shift in the types of support an individual needs. This could facilitate a move closer to friends, family, or other sources of social support.

The mobility of the elderly population creates shifts in the composition of the elderly in rural and small town places, and as a result can influence the demand for services. The demand for elder services is based on the congregation and concentration of the elderly. Congregation is the aggregate number of the elderly in a town, while concentration is the proportion of elderly in the town. The processes that lead to an increase in the congregation of the elderly are aging-in-place and the net in-migration of elderly. The concentration of the elderly is the main concern for planners and policy makers because an increase in the concentration of the elderly can increase the demand for services (Joseph and Martin-Mathews, 1993).

4.0 What Keeps Seniors Healthy and Happy?

Independence

Seniors' independence, or the ability to remain in their own communities, is directly related to their health and happiness. Health status depends on both physical and mental health, the availability of formal and informal support, and the utilization of services within their communities (Rosenberg, 1998). Evans and Stoddard (1990) argue that any 'determinants of health framework' must consider the individual's response to wellness and illness as part of a set of linkages with the social and physical environment, genetic endowment, health care availability, and economic prosperity. It is important to recognize that seniors' independence is not solely a function of a persons' health status, but rather incorporates the social, physical, and cultural aspects of their lives. Together, these form the keys for maintaining seniors' independence.

The degree of seniors' independence varies. Two commonly employed categories for assessing independence focus on the need for assistance with the 'activities of daily

living' (ADL) and the 'instrumental activities of daily living' (IADL). ADL refers to personal care (such as eating, bathing, and dressing) or moving about within the residence. IADL refers to additional tasks involved in household maintenance (such as grocery shopping, meal preparation, light or heavy housework, or going out for short trips) (Chen and Wilkins, 1998). In rural and small town places, informal networks greatly influence the ability of seniors to maintain their independence because formal support mechanisms are not always readily available (Coward and Cutler, 1989). Formal sources of help refer to voluntary organizations, government agencies, or private organizations. Informal sources of support refer to the individual's spouse, children, relatives, friends, and neighbors (Chen and Wilkins, 1998; Chappell, 1992).

Rosenberg and Everitt (2001, 142) argue that "if seniors are to remain in their communities, they need to have access to health and social services either through home care or the ability to transport themselves by private or public transportation to these vital services". This suite of service needs is commonly referred to as a 'services package' (Joseph and Fuller, 1991; Moore and Everitt, 2001). The focus upon a services package has developed from the 'theory of integration', which asserts that the full integration of the elderly within their communities is the best way to ensure their independence for as long as possible. Joseph and Fuller (1991) proposed an integrative framework that highlights the interrelationships between housing, services, and transportation issues, and displays their structural characteristics.

Housing Settings and Associated Service Support and Transportation Characteristics

	Housing Setting	Service Support Characteristics	Transportation Characteristics
Old Elderly	'Restrictive' - for the dependent elderly - Chronic Care Hospitals - Nursing Homes - Homes for the Aged	Personal and health care services on site. Some need for facility - based acute care services.	Limited and specific transport needs.
Middle Elderly	'Moderately Restrictive' - for the semi-dependent elderly. - Rest Homes - Homes of Children - Retirement Village	Limited mix of informal/ formal support services on site. May be extensive demand for delivered, community care services. Some use of facility-based health, social and cultural services.	Increasing incidence of transport-dependence accompanied by decline in physical mobility.
Young Elderly	'Least Restrictive' - for the independent elderly. - Seniors Apartments - Retirement Subdivision - 'Family' Home	No formal support services on site. Limited demand for delivered community care services but extensive use of some facility-based health, social and cultural services.	Transport not an issue for most elderly. Transport-dependent within some elderly households.

Note: Adapted from Joseph and Fuller 1991.

This integrative framework purposes an 'ideal' planning initiative for an aging population. The challenge for rural and small town places will be to use their creativity in trying to provide the best services package to meet their older populations' needs.

Social Support

Social support is instrumental in maintaining independence for the elderly. Both informal and formal support networks assist the elderly to remain in their homes for as long as possible. Social support refers to assistance with IADL's, that is, activities that are not essential for survival but are important for independence. Independence often declines with age, and many elderly are faced with the prospect of moving to an institutional setting that provides a range of health services and social support. The likelihood of making this transfer from the community to institutional living is a function not only of health status but also of the availability of social support in the community, particularly from kin (Moore *et al.*, 1996). The elderly in rural and small town Canada may need to

rely on informal networks more heavily because support services may not always be available or accessible compared to the elderly living in urban centres (Coward and Cutler, 1989; Joseph and Martin-Mathews, 1993).

Intergenerational and family ties, marital status, and gender influence the amount of social support or informal networks that may be available to assist seniors in maintaining their independence. Informal care is the most common source of care to seniors (Chappell, 1992). The family provides companionship, affection, and other primary group rewards for its members. Older aged children, especially daughters, are seen as the main providers for social support (Rosenthal and Gladstone, 1994; Chappell, 1994). Socio-demographic changes, such as increases in single parent families, substantially-increased female employment, the out-migration of children, and geographical dispersion of family members create challenges to the reliance on family as primary elder caregivers (Kemp and Denton, 2003; Chappell, 1983). This will have implications for seniors' who rely on informal sources of care to maintain their independence in rural and small town places that are challenged in providing formal care services. As noted in the survey, the presence of family and close friends is one of the most important determinants as to whether people plan to retire in Mackenzie.

5.0 Service Implications

Small Town Challenges

Hanlon and Halseth (forthcoming) suggest that a process of 'resource frontier aging' is underway in northern BC. This is comprised primarily of workers and their spouses who have survived the restructuring of the 1980s and 1990s, and who are choosing in ever increasing numbers to remain in the region. For many, they hope to remain at least as long as they are able to stay in their own homes. As we will discuss in the following section, many of these individuals are aging in communities that have little experience providing health and social services to seniors.

The provision of basic social, health, education, and infrastructure services in rural and small town places provides a crucial foundation for both day-to-day activities and community economic development during periods of restructuring and change (Beckley, 1994; McTiernan, 1999; Halseth *et al.*, 2003). A range of research on community revitalization, population retention and recruitment, and youth out-migration suggests that service availability plays a significant role in maintaining rural and small town places (Furuseth, 1998; Tremblay, 2001; LeBlanc, 2002; Malatest and Associates, 2002). However, rural and small town service provision has experienced considerable change over time. At present, stress from health care reorganization and the withdrawal of the public sector from non-metropolitan places, has made it difficult for small places to retain and recruit health professionals, economic activities, and residents (Desjardins *et al.*, 2002) and will make it even more difficult to cope with the impacts of an aging local population (see also Meyer and Cromley, 1989; Everitt and Gfellner, 1996).

In rural and small town Canada, service provision has moved through at least three eras (Halseth *et al.*, 2003). Historically, small and remote places were isolated and few services were provided by the State. Most places had to look after their own service provision, with the result being tremendous variability from place to place (Sanderson and Polson, 1939). From about 1950 to 1980, the State expanded its social safety net role, and principles such as ‘universality’ meant that funding for health care, and access to health services, became more readily available. The net result was expansion of rural and small town services.

Through the past two decades, however, there has been a retrenchment of these services. Increasingly, urban-based models of efficiency and market parameters have been applied to welfare service evaluation, funding, and provision (Pinch, 1985; Hanlon and Rosenberg, 1998). A repeated result has been the closure of rural and small town services (Carter, 1990; Robinson, 1990; James, 1999; Reed, 1999). The application of urban or market-based models is often unsuited to the needs and realities of rural or small town circumstances, and this application of inappropriate models also affects community

sustainability. Troughton (1999, 28) argues that “as the reductionist process goes on, the loss or retention of key institutions, including local hospitals or health centers, can represent the difference between community survival and collapse”. Even those aspects of welfare reform not necessarily related to retrenchment, such as the ‘quality’ movement and efforts to promote greater flexibility and ‘consumerism’ in welfare services, have been more problematic to implement in smaller and more dispersed markets.

In rural and small town BC, this has resulted in at least two rounds of change. Starting in the 1980s, the federal government withdrew rural services such as post offices, employment insurance offices, and human resources offices (Halseth *et al.*, 2003). This pattern is being repeated by the provincial government. Through the 1990s, the BC government closed health, education, and line-ministry offices in rural and northern BC (Lawlor, 7 August 2002; CBC News, 16 August 2002) and has recently initiated an ‘off-loading’ process that has meant many services such as courthouses or road maintenance are no longer being carried by the provincial tax base (CBC News, 15 August 2002; Armstrong, 27 August 2002).

In addition to recent challenges posed by urban or market-based service models, the provision of services in rural places has long faced the challenge of geography (Blacksell *et al.*, 1988; Martinez-Brawley, 1990; Bedics and Doelker, 1992; Northern and Rural Health Task Force, 1995; Carrier, 1999). As Furuseth (1998, 236) argues:

even under ideal circumstances there are economic barriers to providing adequate community services in rural locales. The demographic reality of rurality means dispersed populations and low relative population density. The consequence is that the potential demand for services delivered from discrete facilities is dispersed and the per capita costs of providing services are higher than in urban or suburban settings with greater population densities.

Regardless of the service provision era, rural and small town places have struggled to deal with their servicing mandate (Adali and Donzier, 1992). The medical geography literature in particular has highlighted the difficulty of rural and small town places in providing even basic health services (Joseph and Bantock, 1984; Gesler and Ricketts, 1992). Issues associated with the retrenchment of service availability have been shown as

important in both Canadian (Armstrong *et al.*, 2001; Hanlon, 2001) and international settings (Kearns and Joseph, 1997; Barnett, 2000), and to have specific impacts on vulnerable populations such as the frail and elderly (Hayslip *et al.*, 1980; Windley, 1983; Aronson and Neysmith, 1997; Cloutier-Fisher and Joseph, 2000; Crampton *et al.*, 2001).

Housing

The aging of the Canadian population brings forth new challenges for planners and policy makers in the field of housing. There is considerable variation in the housing needs of the elderly population, therefore housing options must reflect this diversity and identify the wide range of shelter, tenure, and financial needs (Baduik, 1990). The three main types of housing options for an aging population are ‘independent’, ‘semi-independent’, and ‘dependent’ living units. Independent living is characterized by very little assistance from family and friends when residing in a single detached dwelling or an apartment style home. Semi-independent living is characterized by the use of more extensive support services from formal or informal networks of care. This is generally within the senior’s own home. Dependent living is often associated with a withdrawal from the community into an institutional care setting for persons in need of extensive health care services and personal care.

The main housing concern of the elderly today is to avoid institutionalization for as long possible and to age in their homes and communities. The traditional form of shelter for the needy elderly was government funded institutions; however, the high costs associated with institutions have shifted efforts to accommodate a range of shelter needs that are provided by the public and private sector (Haldemann and Wister, 1994). Five major housing related needs that compromise the ability of the elderly to remain in their homes are:

- affordability,
- safety and security,
- structural adaptability to accommodate mental and physical changes,
- availability of in-home supportive assistance, and

- easy access to personal care and health services (Prosper and Clark, 1994).

The availability of affordable housing alternatives is a further important consideration influencing the choice of destination for the aging population (Northcott, 1988).

In rural and small town places, the single detached house is the most common type of housing, with home ownership being the most common form of tenure. The current demographic shift affecting housing demand and the aging of the population will increase demand for low maintenance housing with services and amenities (CMHC, 2003a). Rental housing is often limited, and if an elderly person wishes to move from their home to eliminate burden/cost they face problems of finding suitable, affordable, rental accommodation in small towns. Low income elderly are faced with even a greater challenge of finding suitable housing and often face a premature move into an institutional setting (CMHC, 2003b). The lack of housing alternatives in rural and small town places will have implications for elderly people who need to make a housing adjustment based on changing life circumstances. While a range of housing options are available in today's market for the elderly (from independent living to dependent or institutional living arrangements), in rural and small town places the variety of options is often restricted by costs. Again, this may cause the premature institutionalization of the elderly. The absence of housing options for an aging population to choose from may restrict the option for people to age-in-place (Rowles, 1986).

Health Care, Continuing Care, and Long Term Care

Recent efforts to combat the rising costs of institutional care have included attention to ways by which older persons can remain longer in their own homes. These efforts have been reflected in the expansion of community-based health and support services (Coward *et al.*, 1994). Eales *et al.* (2002) indicate that people are more likely to be healthy if there is a good balance between the needs of the elderly and the resources in their environments that are available to support them.

As a result of welfare service restructuring, there has been a shift from institutional services to community home care (social support) services (Chappell and Prince, 1994). Long term care is an umbrella concept that is used to describe a complex service delivery system comprising a full range of care and support for persons who are at risk of chronic health conditions or activity limitations (Chan and Kenny, 2001). The three components of long-term service delivery systems are ‘institutional care’, ‘community-based services’, and ‘home-based services’. In many ways, there is a linkage between these levels of care arrangements and the main types of seniors housing options of dependent, semi-independent, and independent living units.

Institutional care provides 24 hour assistance to individuals who are no longer able to live in their homes because they need assistance with their activities of daily living. Residents of these facilities may suffer from chronic diseases or from disabilities that reduce their independence and generally cannot be cared for in their homes.

Community-based services include a broad range of services provided outside of institutional settings that help maintain the independence of seniors. Krout (1994) stated that these services may include:

- home care (home health, personal care, homemaker),
- nutrition services (congregate and in-home),
- mental health,
- information and referral/ outreach,
- case management,
- senior centers,
- respite care,
- adult day care,
- housing, and
- transportation.

For older rural and small town residents who have chronic health problems, but do not require long hospital stays, community based services could help them maintain their independence.

The home care strategy has held particular appeal in rural regions, where cost factors have usually inhibited the development of intermediate housing forms catering to the semi-independent elderly and promoted premature institutionalization (Joseph, 1992). An increase in a healthier elderly population over the last twenty years is reflected in policy trends de-emphasizing institutional care and promoting the development of a continuum of in-home and community based services (Prosper and Clark, 1994). For seniors, provision of home care may help avoid or delay institutionalization. Home care services include meals-on-wheels, home repair and maintenance, and in-home nursing care.

However, cost is an issue for the elderly when they need to use home care services because many of these formal services are not covered under Canada's health care system (Chappell, 1992). As a result, the prevalence of unmet needs for home care was greater among those in lower-income households and among those with relatively little education (Chen and Wilkins, 1998). At present, there are deficits in the rural health care system which are experienced by the elderly, particularly in home-based and community-based care services such as home nursing care, physical therapy, respite for family care-givers, and hospice care (Coward *et al.*, 1994). These services are most often needed by frail, severely impaired older persons who are struggling to remain living independently in a community setting. The retrenchment of these services may lead to premature institutionalization of the elderly who would otherwise be able to live semi-independently.

Transportation

Independence for many seniors includes the ability to transport themselves to social, cultural, and recreational events, and to perform routine tasks such as grocery shopping or attending doctor's appointments. In this respect, reductions in mobility can affect an

older person's quality of life (Metz, 2000). The reliance on a personal vehicle for an active lifestyle is important for the elderly living in small town settings where high costs prohibit the provision of public transit or special needs transportation (Bess, 1999). Access to personal transportation may be restricted by physical abilities, economics, or personal choice (McGhee, 1983; Schauer and Weaver, 1994), which creates a dependence on informal networks such as volunteers, or family and friends, to transport them to various services, appointments, or social events. The rural and small town setting again embodies a challenge. As Schauer and Weaver(1994, 44) suggest, "in most rural areas the family is no longer the transportation option that it once was, given the dispersion of youth to other areas of economic opportunity". Many elderly are at risk of living in isolation without the ability to drive or to access other formal or informal transportation options.

Recreation and Leisure

Given recent governmental policies focusing on maintaining seniors' independence, it is important to understand the role recreation and leisure programs can play for assisting seniors with maintaining and pursuing active lifestyles. While physical activity tends to vary inversely with age, recent trends suggest that the number of elderly who are physically active is increasing (Ouellette, 1994). Research shows that physical activity can improve health and evidence suggests that inactive persons may be more likely to engage in unhealthy behaviors such as substance abuse and tobacco use, while physical activity leads to other positive lifestyle behavior choices and changes (Division of Aging and Seniors, 2002).

The provision of the appropriate programs for seniors is an important consideration for policy makers and planners. They need to be aware of what affects the participation rates of the elderly, such as cultural and societal norms towards active living, restrictive illnesses or disabilities, and the time constraints or other barriers to participation. Therefore, recreation and leisure programs for seniors need to respond to the diversity of needs of a range of older populations, identify barriers to participation (i.e.;

transportation, cost, scheduling, and location), and create an awareness of the programs that they are providing. Overall, recreation and leisure programs promote well-being and assist in maintaining seniors' independence in the community.

6.0 Summary

In summary, the provision of services in rural and remote places has long faced the challenge of geography. Large distances, coupled with low population densities, have meant higher service delivery costs. Recently, both public and private service providers have been withdrawing from costly service areas. A repeated result has been the closure of services in rural and remote places. Yet, services are an increasingly important component of community economic development in an age of flexible capital and global markets. They are especially important as rural and small town places deal with aging-in-place and the growth of a local seniors' population.

When planning for an elderly population it is important to realize that the elderly of the future are likely to have different characteristics from those of the past. They are more likely to have the time and desire for recreation and leisure activities, to have better education and income levels, and increased opportunities for healthy and active lifestyles which mean they will have different demands in contrast to younger age cohorts (Rosenberg and Everitt, 2001). According to Hodge (1990) the environmental needs of an aging population are neighbourhood form and composition, transportation, housing, and health and social services. The services that are provided in an aging community should be focused on maintaining the independence of the elderly for as long as possible to delay institutionalization. In rural and small town places, improvements in older people's health will raise the age of entry into institutions, which will require adequate provision of home and community based services to promote independent living.

Socio-economic differences can influence the need for senior services. As mentioned already, older residents with lower education and income levels are more likely to

experience an expansion of morbidity, while the upcoming baby boom is expected to be in better health as it approaches the retirement years. Declining disability, says Cutler (2001, 11) can have “enormous implications for the elderly’s quality of life if they are better to engage in enjoyable activities and work to later ages”. Communities that are planning for an increase in the concentration of the elderly population are more likely to be planning for a population experiencing a compression of morbidity.

7.0 Bibliography

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