LEE LI MING
PROGRAMME IN
AGEING URBANISM

Housing for Older Population[1]

Canada

Belinda Yuen

Canada's population is ageing. In 2011, the median age of its population was 39.9 years as compared with 26.2 years in 1971. The population aged 65 and older are expected to double from 5 million in 2011 to 10.4 million by 2051. Older adults will make up 25% of Canada's population by 2036. Ageing in place is a widely held preference of older adults; less than 8% of Canadians aged 65+ lived in collective/institutional dwellings in 2011. Many factors influence ageing in place including individual physical functioning, demographic and socio-economic status, availability of formal and informal support and care, housing conditions and neighbourhood socio-economic infrastructure. Of relevance is the issue of accessibility. There are three aspects of accessibility to consider:

1 This is an evolving database. We will be adding more examples and cases over time.

Accessible housing – this involves hardware like appropriate modifications to the built environment (e.g. first floor bathrooms with walk-in shower stalls or tubs) to subsidies for structural accommodations, city services (e.g. garbage fees), rent and property taxes; awareness and information broadcasted into the home (e.g. through TV, radio, mail), and health, homemaking and home support assistance (e.g. buddy system through telephone, mailbox, monitoring and daily door to door checks to detect needs and ameliorating isolation);

Accessible neighbourhoods – this is fostered by creating more opportunities for community building (e.g. frequent neighbourhood social and cultural events, free or low cost space to congregate, seniors' discounts for transportation, events, etc, buddy walkers as part of safe street practice, neighbourhood barter exchange where older adults would 'trade' supports, services and resources); inclusive zoning to enable development of liveable communities (e.g. ensure an adequate number of benches and public washrooms, provide well-lit sidewalks, ramps, broad aisles and doorways in retail spaces) and more affordable supportive/assisted housing options; and

Accessible agencies – this is implemented through the introduction of more flexible programme eligibility, more multi-lingual materials, information portals and interpreters (e.g. using libraries and community information centre as information and health promotion hubs), more outreach to isolated seniors and ethno-cultural and faith communities, empowering older adults to participate in decision-making, peer programming and community led advocacy.

Models of Integrated Community Care

Frail elderly persons often rely on assistance from social and health care programmes to continue to remain in the community. While these programmes are fragmented in many places, several models of integrated community care are emerging in Canada. We introduce some of them here.

Programme of All-Inclusive Care for the Elderly (PACE) and Comprehensive Home Option of Integrated Care for the Elderly (CHOICE)

are models of integrated care aimed at enabling older adults (55+ and in some states, e.g. Alberta, CHOICE is available to adults 60+) with chronic care needs to remain in the community and live in a PACE/CHOICE service area as long as possible. Modelled on similar programmes in USA, these programmes provide the entire

continuum of care and services through a single portal, typically an adult day centre with a multi-disciplinary team who assess and support seniors and their families. The single portal is managed by one organisation that may contract out certain services. The evidence suggests that these programmes have been remarkably successful in keeping the frail elderly out of hospital and delaying their admission into long-term homes; the cumulative risk of nursing home admissions for PACE participants was low, less than 15%. All PACE participants must be certified to need nursing home care to enrol in PACE.

Programme of Research to Integrate the Services for the Maintenance of Autonomy (PRISMA) – This is a model of integrated community care delivery that emphasizes coordination across organisations and relevance (response to needs) of care and services for people with diminished independence. It offers a single entry point case management model with individualised care plans and coordination between decision-makers and case managers. The mechanisms and tools developed by PRISMA include integrated network, client tracking, clinical assessment of individuals, development of an individualised service plan and service continuity indicators, single service point andcomputerised clinical file. The evidence suggests a promising decline in the number of older adults who would need to leave the community and move to institutionalised settings and decline in caregiver burden.

System of Integrated Community-based Care (SIPA) – This model relies on community-based multi-disciplinary teams to deliver integrated care through the provision of community health and social services and the coordination of hospital and nursing home care. The multi-disciplinary team case management retains clinical responsibility for all the health and social services required and the capacity to mobilise resources as required and according to the care protocol. The evidence suggests greater care satisfaction with no increase in caregiver burden and without increasing the burden on the elderly persons and their relatives.

Source: M J Stewart, A Georgiou and J I Westbrook (2013) Successfully integrating aged care services: A review of the evidence and tools emerging from a long-term care programme, International Journal of Integrated Care Vol 13:1-14; Statistics Canada (2012) Living Arrangements of Seniors, 2011 Census of Population, Census in Brief No. 4; J Glasby and H Dickinson (2009) Perspectives on Health and Social Care Partnership Working in Action, Wiley-Blackwell.