

Seniors' Housing:

# **CHALLENGES, ISSUES, AND POSSIBLE SOLUTIONS**

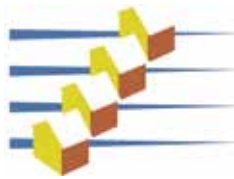
for Atlantic Canada



FINAL REPORT

Atlantic Seniors Housing Research Alliance (ASHRA)

2010



Atlantic Seniors Housing  
Research Alliance  
Alliance pour la recherche  
sur le logement des  
personnes âgées dans  
les provinces de l'Atlantique  
[www.ashra.ca](http://www.ashra.ca)

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# **CHALLENGES, ISSUES, AND POSSIBLE SOLUTIONS**

for Atlantic Canada

Final report of the Atlantic Seniors Housing Research Alliance (2010)



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## CONTENTS

	Preface . . . . .	5
1.	INTRODUCTION . . . . .	9
2.	KEY MESSAGES . . . . .	21
3.	POLICY ISSUES . . . . .	27
4.	THE ASHRA CASE STUDIES: Examples of Seniors' Housing Solutions . . . . .	53
	How did we select our subjects? . . . . .	54
	CASE STUDY – Continuing Care Retirement Community . . . . . Hartrigg Oaks, New Earswick, England	65
	CASE STUDY – Abbeyfield Houses . . . . . Abbeyfield St. Peters Society, Victoria, British Columbia	69
	CASE STUDY – Co-housing . . . . . Glacier Circle Senior Community, Davis, California	72
	CASE STUDY – Assisted Living Community . . . . . Plejacentret Lillevang, Farum, Denmark	77
	CASE STUDY – Naturally Occurring Retirement Community . . . . . Village-to-Village Network, Boston, Massachusetts	79
	Best Practices. . . . .	80
5.	WHERE DO WE GO FROM HERE? . . . . .	83
	Appendix A: Lifetime Home Standards (Joseph Rowntree) . . . . .	87

*continued*

Appendix B: Analysis of Findings in Relation to Canada's Social Determinants of Health. . . . .	92
Appendix C: The Policy Working Group Membership . . . . .	99
Endnotes . . . . .	101
References . . . . .	102

## PREFACE

### *Being there for our parents:* **As we sow, so may we reap**

I have had the rare privilege of studying how members of our aging population in Atlantic Canada view their homes and the challenges of continuing to live in them.

Home constitutes, for almost all of us, simple rituals that link us with sequences of the day and patterns of time. These are the rituals that surround the gathering of food, cooking, washing, eating, sleeping, and cleaning, and they connect us to almost all of humanity.

We do very little, however, to celebrate or pay tribute to those rituals that centre on and link us to that diverse but collective experience of “home.” The meaning of home, of a protected refuge, is very often connected with comfort, relationships, family, relatives, friends, and those traditional rituals that give meaning to our lives. This is borne out by the trauma people experience after a break-in or the loss of home through a natural disaster or a relationship split. Perhaps the most difficult situation comes when an elderly person or couple is forced to move out of their home because they can no longer manage their physical surroundings.

People can experience both positive and negative feelings about their home at the same time. For example, a place may be important psychologically because it has connections with the past, but it may offer a poor physical environment that no longer meets a person’s physical needs. This is a common experience for many older Atlantic Canadians.

All change demands some personal or psychological adjustment involving more or less stress. Research has shown that fears of a major change of environment and living circumstances were viewed as a major obstacle to moving.

How people cope with adjustment is at the heart of change. In terms of changing homes, this can often relate to their attachment to where they have come from and to the impact that moving may have on their self-identity in relation to issues of belonging, permanence, and security. Overwhelmingly, our elders want to continue to live as long as possible in their current homes. If they must move, they want to stay in the communities where they have a network of friends and neighbours so that these connections are not lost.

What is making this unlikely to happen is older homes not designed for ease of movement and safety, compounded by rural communities where there are few options to move to smaller, more appropriate accommodation.

In my opinion, my generation, the Baby Boomers, will be judged by our children as they watch how we treat our elders, and our offspring will then act in similar ways towards us as we grow older and need help with everyday living.

We need to do more now to help our aging parents stay longer in the homes they love. Then, perhaps, things will be better for us as we age. This report presents our conclusions on the research into Atlantic seniors' housing, present and future, and suggests how policies at all levels of government might be changed to make staying in their own homes longer a reality for more seniors.

Donald V. Shiner, PhD  
Principal Investigator  
Atlantic Seniors' Housing Research Alliance

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—DVS





# INTRODUCTION

## **History of the ASHRA Project – Background and Project Rationale**

The population of seniors in Atlantic Canada differs from that in other Canadian provinces in three main respects.<sup>1</sup>

First, the proportion of the region's senior population is higher and growing faster than in other provinces, resulting in a greater demand for a wider variety of housing options. With the exception of Newfoundland at 14.4%, the Atlantic Provinces have the highest percentages of seniors in the country. For example, the total population of Nova Scotia is expected to decline by approximately four and a half percent (4.69%) between 2007 and 2033. The 55–64 age group will decline similarly (4.86%) between 2007 and 2033. In contrast, the seniors' population (65+) is projected to increase 86.3% between 2007 and 2033 to 257,874.

The second feature that distinguishes Atlantic Canada is that the income level of the region's seniors is lower than the national average, and housing solutions available in other parts of the country may not be financially feasible for many Atlantic Canadian seniors.<sup>2</sup>

Finally, when compared to the rest of Canada, a larger proportion of the Atlantic Provinces' population, including seniors, live in rural areas. While a variety of urban-area housing options are being developed, rural areas may need to devise different strategies.

It is clear that when people begin to approach their senior years, their available choices for living arrangements may narrow as they become less able to cope with the everyday demands of living due to changes in health and/or financial status. Some people will be reasonably healthy and have sufficient financial security to live where and how they want, but many will not. The number and type of housing options that are available to Atlantic Canada's rapidly aging population begin to narrow as the everyday demands of living become more onerous and increasing assistance is required.<sup>3</sup> Health status and income levels are important determining factors for the types of housing options and

support services that will be available to an individual.<sup>4</sup> Further, the needs and wants of contemporary seniors are very different from those of their parents and very little is known about how these differences will impact future living choices.<sup>5,6</sup> As the Baby Boomer generation continues to move into older age and the proportion of seniors within Atlantic Canada's population increases, it is clear that the housing needs of successive age cohorts, including those now upon us, will have very different housing needs and wants.<sup>7</sup>

Studies on seniors' housing consistently report that seniors prefer to remain in their own homes for as long as possible.<sup>8</sup> The studies also report that seniors want to make their own decisions with respect to their needs and lifestyle.<sup>9</sup> Seniors say that the benefits of aging in place include a feeling of independence and control, safety and security, the ability to be near family, and having familiarity with their surroundings.<sup>10</sup>

Major barriers to aging in place include the inability to maintain property, followed by inadequate finances, illness, the need for safety and security, inadequate family support, and transportation access issues.<sup>11</sup> To overcome these barriers, creative housing initiatives are needed. Aging-in-place initiatives must also take into account the diversity of situations and needs of seniors given differences in age, physical ability and mental health, economic/financial status, gender, rural/urban status, current housing situation, culture, and personal preferences.

When the Atlantic Seniors Housing Research Alliance (ASHRA) project was conceived, it was understood that little was known about the housing needs and preferences of either those already in their senior years or the Baby Boomer cohort (rapidly turning 65). Further, it was not known how these needs and preferences would impact our society in the future. Therefore, the research design of the ASHRA program had to be multi-faceted and multi-disciplinary in nature in order to build a detailed picture of aging Atlantic Canadians and their potential living arrangement needs over the future 20 years.

For such a multi-faceted research design to be successful, the involvement and input of a diverse array of individuals and organizations is required – researchers/academics; representatives from all levels of government (particularly policymakers); housing developers and planners; support service providers; communities at large; and perhaps most importantly, senior citizens.

## **Formation of the Atlantic Seniors Housing Research Alliance**

The formation of the alliance known as the Atlantic Seniors Housing Research Alliance (ASHRA) has its roots in a series of events that began in 2002, when

the Nova Scotia Centre on Aging (NSCA) at Mount Saint Vincent University (MSVU) in Halifax, Nova Scotia, co-hosted a two-day workshop entitled “Building Capacity in Continuing Care: Bridging Researchers and Decision Makers in the Atlantic Region.” Over 40 people from across Atlantic Canada attended that workshop, including representatives from federal and provincial government departments, community-based organizations, and researchers/academics. As a result of the collaborative discussions that took place during this workshop, the NSCA decided to conduct a literature search to investigate the current status of assisted living developments within Canada and the United States. From the literature, a synthesis report was prepared: “Assisted Living: Policy Implications in the Atlantic Provinces.”

In April 2003, six months after the MSVU “Building Capacity...” workshop, the Atlantic Region Conference on Assisted Living was held in Halifax. This conference was hosted by the Continuing Care Association of Nova Scotia (CCANS) and attended by approximately 80 representatives from diverse backgrounds. This conference underscored the need for ongoing dialogue and information sharing and the particular need to address public-policy issues related to the rapidly growing area of supportive housing.

In September 2003, the NSCA “Synthesis Report” was presented to a group of community stakeholders at a meeting jointly convened by the NSCA and CCANS in Halifax. Participants included representatives from seniors’ organizations, government, housing developers, and service providers. The group agreed to continue to meet as an Assisted Living Stakeholder Group to 1) provide input into the development of research proposals, and 2) articulate public-policy issues and solutions related to supportive housing.

The Assisted Living Stakeholder Group in Nova Scotia continued to meet throughout the fall and winter of 2003. They identified seniors’ housing needs as the primary area in which further research was needed. In keeping with this priority, the group also identified two specific research questions:

- 1) What will the housing needs of aging Atlantic Canadians be over the next 20 years?
- 2) What housing options should be developed to meet these needs?

To answer these questions, a challenging research initiative was proposed, entitled *Projecting the Housing Needs of Aging Atlantic Canadians*, the focus of which was seniors’ housing issues in the Atlantic Region and in particular, the demand for seniors’ housing over the future 20 years, as well as the options, services, and policies needed to address this demand.

A Letter of Intent (LOI) was submitted to the Social Sciences and Humanities Research Council of Canada (SSHRC) in early December 2003. This LOI described a five-year Community-University Research Alliance (CURA) research project focused on seniors' housing issues, both current and future. Through the 2002 "Building Capacity..." workshop and the 2003 CCANS conference, it was known that research on seniors' housing was of interest to key organizations across the four Atlantic Provinces; therefore, representatives from across the Atlantic region were invited to participate in the proposed five-year CURA project. As a result, the proposal garnered the support of seven co-applicants (Co-Investigators) from universities across all four Atlantic Provinces: MSVU and Dalhousie University in Nova Scotia, the University of New Brunswick, the University of Prince Edward Island, and Memorial University of Newfoundland.

As the development of the proposal continued, the Principal Investigator (PI) and the seven Co-Investigators (CIs) began to recruit collaborators and partners from government and community-based organizations to support the proposal under the governance of a collaborative CURA-based management structure that would guide the direction of the proposed research. This supporting group was the beginning of the formation of the region-wide Atlantic Seniors Housing Research Alliance (ASHRA) and the four Stakeholder Groups within it – one in each of the Atlantic Provinces. By the time the CURA was awarded in 2004, ASHRA membership was 37 strong. Over the five years of the project, this membership continued to grow, and by the end of the project it stood at over 120 organizations and individuals!

## **CURA Project Management**

Of major importance to the future of seniors' housing in Atlantic Canada is a framework for coordinated and collaborative dialogue that could be supported by the management system of the project. During the development of the formal proposal, Dr. Shiner (the PI) and the CIs worked with government and community-based partners and collaborators who supported the LOI to develop a collaborative structure for project governance and participation. This structure integrated the research expertise of the university-based team members with the research interests, policy development experience, and knowledge of the grassroots issues possessed by government and community-based participants, all of whom were instrumental in ensuring informed design and implementation of the research at all stages, as well as accurate interpretation of the data analyses results.

## **Overall Framework for Project Governance**

The implementation of the CURA project was carried out using a multi-tiered management structure. Under the PI's direction, the general management of ASHRA activities was structured to incorporate the expertise and insight of the diverse groups within "the Alliance" (ASHRA), as well as to enable the continual building of stakeholder capacity in each of the four Atlantic provinces.

In developing the CURA proposal, the PI and team of CIs collaborated with interested community, seniors', and government organizations for several months, facilitating dialogues about seniors' housing issues within provincial and regional settings. The value of the ASHRA model of participation for the collaborators and community partners is that it allowed interested stakeholders to be involved with the research at various levels of commitment. The reality for many organizations, particularly nonprofit associations, is that they have very limited resources, both staff and volunteers. However, the proposed CURA enabled organizations to contribute the resources already available to them and helped them to develop their research capacity by equipping them with skills and knowledge respecting the conduct and dissemination of research.

### **Home Office Team**

Mount Saint Vincent University (MSVU) in Halifax, Nova Scotia, is considered to be the Home Office for ASHRA. The offices of the Principal Investigator (PI) and the Project Manager (PM) are situated at MSVU. Although the project research activities have now concluded, the PI and PM remain as the Home Office team and are ultimately responsible for the development, management, and coordination of all ASHRA communications and activities. The Home Office will function until the project ends in September 2011.

### **Research Management Team**

The PI, PM, seven CIs, and several key Collaborators form the Research Management Team (RMT). Most of the CIs are PhDs who teach at or are affiliated with one of ASHRA's five partnering universities and have research-oriented backgrounds. Most of the persons designated as "Collaborators" (collaborators are also a part of the ASHRA Stakeholder Group in their province) also have research-oriented backgrounds. The RMT is consensus-based and, during the first five years of the project, worked side by side with the Home Office team to make important decisions regarding research design and implementation. Now that

the project is winding down, the RMT continues to meet via teleconference every two months to ensure the successful completion of all closing tasks and reports.

### **Provincial Stakeholder Groups**

As mentioned previously, there is one Stakeholder Group in each province. Although referred to as “Stakeholders,” it is important to note that this term includes the provincial CIs (three in NS, two in PE, one in NL, and one in NB), Collaborators, partners, and additional supportive organizations and individuals interested in the housing issues faced by Atlantic Canadian seniors.

The ASHRA Stakeholder Groups continue to be central to the CURA. Over the course of the project, their input has enhanced the project design, along with the interpretation and understanding of the ASHRA research results across public and private service domains and at all economic levels. The ASHRA Stakeholder Groups have also played a critical role in the success of the ASHRA research and knowledge dissemination activities. For example, stakeholders were involved in the development and implementation of all aspects of the research through participation in the project’s Working Groups (described below), all of which were geared toward the development and implementation of a specific research activity to be undertaken as a part of the ASHRA project, such as the Atlantic Seniors’ Housing and Support Services Survey and focus groups conducted in Phase 2.

Stakeholders were also essential to helping ASHRA achieve its knowledge transfer (KT) goal of reaching wide and diverse audiences. Almost all stakeholders have an active internal communications program with newsletters and websites through which the ASHRA results were published. In addition, in 2010, PowerPoint slide presentations designed for use at community meetings were made available to interested stakeholders to present to their organizations, advisory boards, etc., to continue to “get the word out” about the research results.

The active support of the provincial Stakeholder Groups ensured that the project results reached seniors no matter where they live in Atlantic Canada. During the course of the project, these groups convened face-to-face meetings twice a year, spring and fall. Formal agendas were prepared for these meetings and used to facilitate in-depth discussions on the research findings and related public-policy issues presented later in this document.

## **Who are the ASHRA Stakeholders?**

*Co-Investigators and Collaborators* – As noted above, the term “Stakeholder Groups” encompasses several types of individuals and organizations: provincial CIs, Collaborators, partnering organizations, and individual seniors. CIs and Collaborators are individuals who agreed to take on their specific roles on the ASHRA project in a letter of support that was submitted with the CURA proposal. As noted above, Collaborators are, like CIs, usually from a research-based background, though they may or may not hold a professional position within a partnering university. As a part of their project responsibilities during the active research phases of the project, one CI and one Collaborator served as co-chairs for the Stakeholder Group in each province. Today, although the research is complete, the CIs in each province continue to communicate and meet with the stakeholders to disseminate the project results and plan for the future of seniors’ housing and related support services.

*Project Partners* – Like CIs and Collaborators, project partners also committed their support to the project in a written agreement that was submitted with the CURA proposal. However, in contrast to CIs and Collaborators, partners are organizations, not individuals. Still, from the project’s inception, partners did identify one person to act as the project contact and most of these people carried out this role throughout the five years of the grant. In cases where a person was unable to continue over the years of the project, the partnering organization usually designated a replacement to act as the ASHRA contact. Project partners contributed intellectually to the project design and implementation in its initial stages and agreed to continue to do so for the life of the project.

## **Project Working Groups**

Each Working Group was established to focus on the development and implementation of a specific ASHRA research objective. Working Groups were chaired or co-chaired by any ASHRA member with specific knowledge in that area plus an interest in leading that particular research objective. Therefore, Working Group chairs could be the PI, a CI, a Collaborator, a member of a partnering organization, or any other stakeholder. Members of the Working Groups included academic, government, and community-based stakeholders, with steps taken to ensure diversity of representation across the four Atlantic Provinces. Working Groups met monthly via teleconference throughout the life of the project, with most interim correspondence being conducted by e-mail.

All major research activities throughout the four phases of the ASHRA

project were guided and monitored by the Working Groups. For example, two of the largest tasks undertaken by ASHRA in Phase 2 were 1) developing and implementing the project's Atlantic Seniors' Housing and Support Services Survey and 2) conducting 15 focus groups region-wide. To plan for these major research activities and ensure success, the Survey Working Group (SWG) and Focus Group Working Group (FGWG) were formed, respectively.

Other working groups included the Case Studies Working Group (CSWG); the Policy Working Group (PWG), which divided into three subcommittees: the Policy Map Subcommittee, the Data Analysis Subcommittee, and the Gap Analysis Subcommittee; and the Knowledge Transfer Working Group (KTWG), which continued its work into the 2010 extension year to spread the word about the importance of the ASHRA research results to the planning for the future of seniors' housing in the Atlantic Provinces.

The ASHRA Working Groups are acknowledged as a major reason for the success of this project, because they involved ASHRA stakeholders in all aspects of the research, and often the stakeholders were able to use the research results directly in their planning and work.

In a similar fashion to the Working Groups, a Conference Steering Committee was formed to guide ASHRA's Atlantic Seniors' Housing Needs Conference. This committee included ASHRA stakeholders from all sectors – provincial and federal government, seniors' and community housing organizations, and academic researchers – with input continuously sought from the RMT and the four-province stakeholder membership at large. Several stakeholders and Co-Investigators also led presentations and workshops during this highly successful three-day event attended by approximately 150 participants in May 2009.

## **Student Involvement**

One of the goals of the CURA was to increase the capacity of both academic institutions and other organizations to learn about and gain experience in conducting community-based research. The involvement of students at participating universities was central to this intention, with project funding set aside for this specific purpose – for students to acquire the knowledge and skills essential to addressing the critical issue of housing for the aging Atlantic Canadian population. Over the course of the five-year project, ASHRA hired and awarded student assistantships to 37 graduate and undergraduate students from the partnering universities. Through their work with ASHRA, these students gained proficiency in community-based research development and in data collection and analysis. Several students chose to use ASHRA data

as the basis for their Master's theses.

ASHRA has benefitted greatly from the contributions of all students, who have brought a diverse and wide range of skills to the table. Students were supervised by the PI or PM or by one or more of ASHRA's CIs, depending on the research objective. All hiring was approved by the Research Management Team.

## **Project Overview**

### **Goals**

As previously noted, the ASHRA project was designed to answer two primary questions regarding the future of housing options for the aging demographic of Atlantic Canadian seniors:

- 1) What will the housing needs of aging Atlantic Canadians be over the next 20 years?
- 2) What housing options, support services, and policies should be developed to meet these needs?

The primary goal for the project was to answer these two questions through a series of research activities, while concurrently building capacity among academic researchers and community organizations to conduct meaningful and useful collaborative research.

### **Objectives**

The ASHRA project was driven by four major research objectives, each of which corresponded to a series of related research activities in sequential phases:

- 1) To predict the likely housing needs of the 50+ population in 2026 based on current trends in population growth, health, and wealth. (Phase 1)
- 2) To determine the current needs, challenges, and issues in seniors' housing that are faced by seniors. (Phase 2)
- 3) To examine seniors' housing solutions that are emerging around the world and determine if and how these could be applied in Atlantic Canada. (Phase 3)
- 4) To analyze ASHRA survey and focus group data in conjunction with research on the available housing programs for Atlantic Canadian seniors and conduct a gap analysis to determine how supply and demand impact seniors' housing

and how we might better match seniors' housing needs in the future. As a part of this research objective, ASHRA used the diverse knowledge base within its membership to develop policy recommendations. (Phase 3-4)

### **Research Activities**

Phase 1 began in early 2005 and was completed in December 2005. It addressed objective 1) (above) through the development of an on-line geo-demographic community profile model (GDM). The model is based on the 2001 Census and other Statistics Canada data. It allows anyone with access to the Internet to profile the senior population of any community in Atlantic Canada based on age, sex, health, and wealth up to the year 2026. The model has been successfully used by government and community groups to understand the changing housing needs of seniors in their regions as they develop projects and plan for the future.

Phase 2 began in January 2006 and was designed to fulfil objective 2) (above). The goal of Phase 2 was to gather information from as many seniors as possible from all four Atlantic Provinces about their experiences, needs, and plans for the future as related to housing and support services. To give these seniors a voice, ASHRA conducted two major field research studies:

- Atlantic Seniors' Housing and Support Services Survey – Over 1700 seniors across the region completed a 68-page, detailed survey about their housing and support service needs. The survey process actively involved our community partners and resulted in a detailed picture of the housing and support service situation and needs of Atlantic Canada's seniors. The complete report contains detailed information on the survey methodology and sample characteristics.
- Focus Groups with Distinct and Underrepresented Seniors – another approximately 120 seniors participated in 15 focus group discussions about their housing. These focus groups were moderated by trained and experienced community partners. The focus groups engaged seniors from distinct groups with unique housing needs, as well as those who were underrepresented in the survey above (e.g., Aboriginal seniors and immigrant seniors).

Phase 3 began in the summer of July 2007. It addressed objectives 3 and 4 (above). During this phase of the project, ASHRA explored the current policies and programs at all levels of government that impact housing and support services for seniors. Gaps were elucidated by comparisons of what is available with the actual needs and plans of seniors identified in Phase 2. Finally, Phase 3

explored emerging innovative approaches to seniors housing around the world through a series of case studies and examined the possibility of these solutions being applied in Atlantic Canada. A publication identifying all of the policies that impact seniors and housing in the four Atlantic Provinces was published.

Phase 4 focused on the dissemination of the knowledge developed as a result of the research conducted in Phases 1–3 and the development of policy recommendations to government, community, and the private sectors as they plan for future improvements to seniors' housing and support services. Phase 4 culminated in a region-wide Atlantic Seniors Housing Needs Conference in May 2009 that brought together ASHRA community partners and stakeholders and other interested parties to review the findings of the project and plan for future action.

## **Information Used to Generate This Report**

We based our ideas in this report on survey, focus group, and policy/program data collected as part of the ASHRA project research, as well as on input from conference participants and key informants. Three reports have been published that summarize the research findings within some of the phases. These reports are available on the ASHRA website at [www.ashra.ca](http://www.ashra.ca)

### *Report on the Atlantic Seniors' Housing and Support Services Survey*

[www.ashra.ca/documents/SurveyEngwcover\\_001.pdf](http://www.ashra.ca/documents/SurveyEngwcover_001.pdf) (English)

[www.ashra.ca/documents/FRENCHOverviewReport-finalw.cover\\_001.pdf](http://www.ashra.ca/documents/FRENCHOverviewReport-finalw.cover_001.pdf) (French)

### *Seniors' Housing in Atlantic Canada: Focus Groups with Distinct and Underrepresented Seniors*

[www.ashra.ca/documents/FGew.covers\\_001.pdf](http://www.ashra.ca/documents/FGew.covers_001.pdf) (English)

[www.ashra.ca/documents/FGFw.covers\\_001.pdf](http://www.ashra.ca/documents/FGFw.covers_001.pdf) (French)

### *Review of Programs and Services Related to Seniors' Housing in Atlantic Canada (2008)*

[www.ashra.ca/documents/Policy%20Map%20Document%20\(cover,%20title%20page,%20document\).pdf](http://www.ashra.ca/documents/Policy%20Map%20Document%20(cover,%20title%20page,%20document).pdf)

(For a qualitative analysis of the ASHRA research results using the Social Determinants of Health lens to interpret the data, see Appendix B on page 92 of this document.)





## KEY MESSAGES

Eleven key messages were drawn from the survey and focus group data. Two-page fact sheets were created on each topic. Below are the messages and some of the supporting data. ASHRA made the communication of these messages to all Atlantic Canadians a priority in the final phase of the project and continues to work to disseminate this information across the Atlantic Provinces in 2010–2011. Some of these messages are particularly important to the current senior population.

### **1. Seniors want to age at home and in their communities.**

- 53% of Atlantic Canadian seniors have lived in the same community for over 35 years.
- Very few seniors have made plans for a future move; only 13% of seniors plan to move in the next 12 months.
- Family members are the number one source of assistance to Atlantic Canadian seniors for tasks that require the greatest physical exertion.
- Seniors are willing to pay for services that will help them to age in place.
- One-third of seniors have made modifications to their home to make it more accessible.

### **2. Seniors are not thinking about housing alternatives.**

- Seniors in Atlantic Canada want to age in place, in their own homes and current communities, but are not preparing for changing needs as they age.
- The most common reason identified for choosing a future move is to be closer to family and friends.
- Only one-third of seniors identified where they are now as their future ideal living arrangement.

### **3. Seniors prefer seniors-only housing.**

- Only 19% of Atlantic Canadian seniors are interested in housing for people of all ages.
- Senior citizens' housing is the most common accommodation being sought for the future; apartments are the second most common, and single-family detached homes are third.
- More than three-quarters of seniors prefer housing for adults only (i.e., middle-aged or older).
- The preference for seniors-only housing increases with age.
- Focus group participants discussed the importance of seniors being consulted and providing their input into the future development of seniors' housing so that future developments are appropriate to their needs and preferences.

### **4. Seniors have home repair needs.**

- Over half of seniors' homes need some form of repair.
- 32% of seniors' homes built before 1946 have major repair needs.
- 21% of seniors' homes need repairs related to corroded pipes, damaged electrical wiring, and crumbling foundations.
- Many seniors have concerns with safety and accessibility, such as windows (76%), entrance areas (82%), and storage spaces (84%).
- Over 48% of seniors report that they need to make some sort of improvement to the energy efficiency of their home. These concerns are particularly important in light of the rising costs of home heating fuel and electricity and increasing pressure to conserve energy.
- Focus group participants spoke of financial concerns related to home maintenance, issues related to finding hired help, and difficulties with landlords over maintenance and repairs.

### **5. Many seniors are not aware of available housing programs.**

- More than half of seniors are not aware of such programs.
- Among those aware of programs that provide financial assistance to seniors with low income, only 15% had actually applied and received funding from these programs. This suggests that low-income seniors may be missing out on financial assistance that could help them modify, repair, or restore their homes.

## **6. Seniors spend a disproportionate amount of income on housing.**

- Close to half of seniors report a household income of less than \$30,000 per year.
- Almost half (47%) of seniors spend more than 30% of their income on shelter costs and are therefore at risk of having housing affordability problems.
- One in five (20%) seniors spends 40% or more of their income on shelter.
- 19% of seniors report that their income does not allow them to live adequately and still meet all of their housing-related costs.

## **7. Seniors' health impacts housing.**

- The majority of seniors report good to excellent health (68%).
- Despite this finding, there is a high prevalence of arthritis, heart-related conditions, and diabetes – long-term conditions that can impact a senior's ability to remain in his/her own home:
  - 53% of seniors have arthritis
  - 26% of seniors have a heart-related condition
  - 20% of seniors have diabetes
- 36% of seniors who planned to move identified personal health as one of the reasons.
- 23% of seniors who planned to move identified the health of their partner as one of the reasons.
- The prevalence of chronic conditions, such as arthritis, increases with age and can affect seniors' ability to perform daily activities of living, thereby affecting their independence. Among seniors who reported a serious problem with performing activities of daily living, going up and down stairs and doing chores around their dwelling posed the greatest difficulties.
- Seniors are resilient and develop coping strategies as a way to remain in their own homes. However, day-to-day challenges may influence housing decisions. Moreover, almost half of seniors report a change in health status in the last 5 years, indicating that while the present for some may be manageable, the future may be less so.

## **8. Some seniors do not have social support.**

- Almost 1 in 5 seniors (16%) do not have someone to listen to them when they need to talk.
- More than 10% do not have someone to turn to for suggestions (12%), do not

have someone to give them advice (11%), or do not have someone to help take their mind off things (11%).

- When seniors receive social support, it is primarily from family as opposed to neighbours/friends or individuals from volunteer organizations or formal agencies:
  - 94% of seniors receive love and affection from family.
  - 90% of seniors rely on family to give advice about a crisis and to receive help from family with personal problems.
  - 89% of seniors share worries and fears with family, and these are the individuals whose advice they want.
- Neighbours and friends also play a role in providing social support but in less intimate or personal ways, such as having someone to relax with (16%) or to have a good time with (14%).

### **9. Many seniors participate in volunteer organizations.**

- Almost half of seniors (47%) said that they had participated in activities of community organizations in the past year. Of those who had participated, most said that they did so on a regular basis. This involvement can increase seniors' attachment to the community in which they live and want to remain.
- Almost half (44%) participated in community activities at least once a month.
- More than one-third (35%) participated in community activities at least weekly.
- Seniors derive satisfaction from remaining involved in their community and helping others. This can contribute to maintaining and enhancing their own emotional and physical health.
- Many seniors contribute valuable services through their involvement with volunteer organizations (e.g., transportation, meal preparation). These supportive services can help seniors remain in their homes and their communities, especially in areas where formal services are limited.

### **10. Most seniors do not participate in seniors' programs.**

- Only 12% of Atlantic Canadian seniors attend a seniors' centre or other seniors' program, despite almost two-thirds (64%) having a centre in their community.
- Less than half (38%) of seniors would attend a seniors' centre if available in their community.
- There are several factors that may influence seniors' participation in pro-

grams that could support their health and well-being and, in turn, influence their housing decisions: transportation, timing, fees, and program relevance are such considerations.

- Understanding who participates in such programs and who does not may help to shape future programs and activities. Almost 200 survey respondents said they participated in available seniors' programs:
  - Two-thirds were women (66%).
  - Average age was 74 years; age range was 63 to 95 years.

## **11. Many seniors live in rural areas.**

- If rural is defined as villages having fewer than 1,000 residents, then 42% of Atlantic Canadian seniors live in rural communities.
- 83% of rural seniors live in single-family homes, compared to 60% of urban seniors.
- Only 7% of rural seniors live in apartment buildings, compared to 24% of urban seniors.
- Seniors living in rural areas more commonly live in older homes.
- Rural seniors have considerably fewer options in several categories:
  - The range of housing options available to them (i.e., apartments or condominiums, assisted living facilities)
  - Support from nearby family and friends
  - The services available to help them repair their homes
  - Public transportation services
  - Home care and supportive care services
- Many focus group participants discussed their experiences, both positive and negative, with rural living and how the physical location of their homes affects their daily lives.

As noted earlier, ASHRA created the Knowledge Transfer Working Group to guide the process of getting these messages out to Atlantic Canadian seniors. This has involved media planning and strategic article writing combined with the use of networks of seniors' groups to spread these messages.





## POLICY ISSUES

In this chapter we

- 1) present the key issues that we identified through our review and analysis of the ASHRA survey, focus groups, policy map, and case studies; and
- 2) pose policy-related questions that arise from the key issues.

We have written this chapter for people who are interested in seniors' housing issues in Atlantic Canada, including the following:

- Current and future seniors
- Planners and decision-makers
- Builders and designers of housing
- Providers of in-home and community services to seniors
- Stakeholders in the ASHRA project

### **How Do We Define Policy?**

As a part of the ASHRA project, a Policy Working Group (PWG) was formed to help direct the course of the project's policy research. The PWG membership, therefore, included representatives from all four Atlantic Provinces and from all sectors: government, both provincial and federal; seniors' organizations; community groups; and academics (*See Appendix C for a full list of members of the PWG and its subcommittees*).

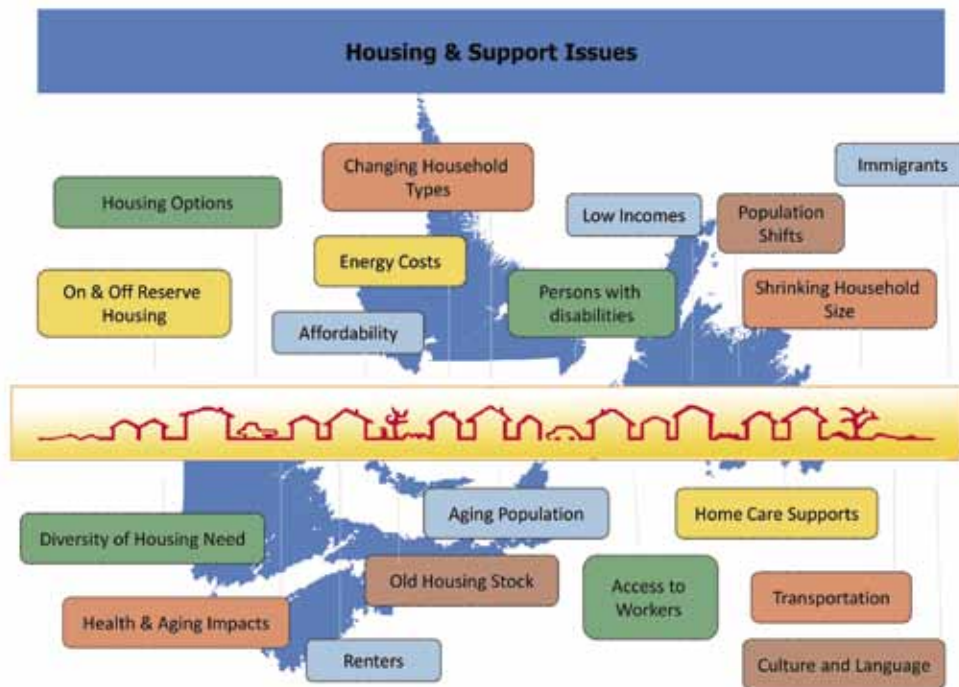
The PWG defined policy as the actions (or inactions) of government or others and the intentions that determine those actions. Defined this way, policy may exist at several levels: as broad directions, as actions specific to a sector, as issue areas, or as operational policies.

The broad policy direction of interest to the ASHRA project is aging in place. The PWG identified several broad policy issue areas related to aging in

place that cut across sectors:

- Accessible, safe, and secure housing design
- Sustainability of housing and communities
- In-home and community supports
- Affordability of housing

## Overview of Housing Issues



The complexity of housing and support issues in Atlantic Canada

Designed by Kim Stewart, Co-chair, Policy Map Subcommittee, ASHRA Policy Working Group

Housing for seniors is a complex topic. The chart above illustrates many of the issues we need to consider in order to address the housing needs and preferences of Atlantic Canadian seniors.

The population in the four Atlantic Provinces is aging more rapidly than in the rest of the country. This fact compels us to consider the housing requirements of our older citizens and how best to meet them. The high proportion of

seniors in rural areas (up to 30% of the population in some small towns) and the prevalence of older housing stock are additional important considerations in Atlantic Canada.

Availability of resources, both personal (such as income and family support) and community (such as home care and transportation), are also important issues related to housing for seniors. In the past five years, some cost-related factors, such as fuel costs and property taxes, have created unanticipated housing problems for some seniors.

Seniors are a diverse group, with differing housing needs and preferences. Needs and preferences differ by age, health, and wealth. Different communities of interest, such as francophone, multicultural and immigrant, persons with disabilities, and those with low incomes, can also have particular housing needs and potential vulnerabilities.

Housing-related public policy is also complex and housing issues are often multi-jurisdictional. For example, while housing is a provincial responsibility, zoning is essentially a municipal issue, and federal programs often impact the funds available for new affordable housing, public housing, and residential repairs and adaptations. Some housing, such as aboriginal on-reserve housing, falls under the federal government. In contrast, housing, home care, and income support policies all fall within provincial jurisdictions, but are often administered by different departments.

When we identify housing issues, we need to recognize their complexity. We also need to consider the shared responsibility of governments, communities, and citizens in addressing housing issues. The private sector is an important partner in meeting housing needs: according to the Canada Mortgage and Housing Corporation (CMHC), 80% of Canadians meet their housing needs in the private market, without government assistance.

## Nine Key Issues

Focus group and survey data were re-analyzed in order to identify key policy issues. Other sources of information were also utilized:

- *The Review of Programs and Services Related to Seniors' Housing in Atlantic Canada (2008)* was used to identify service gaps and issues.
- The ASHRA Atlantic Seniors' Housing Needs Conference was held in May 2009 and hosted about 150 participants who were ASHRA stakeholders and other groups and citizens interested in learning about housing. One day of the conference was devoted to the participants' review of research findings

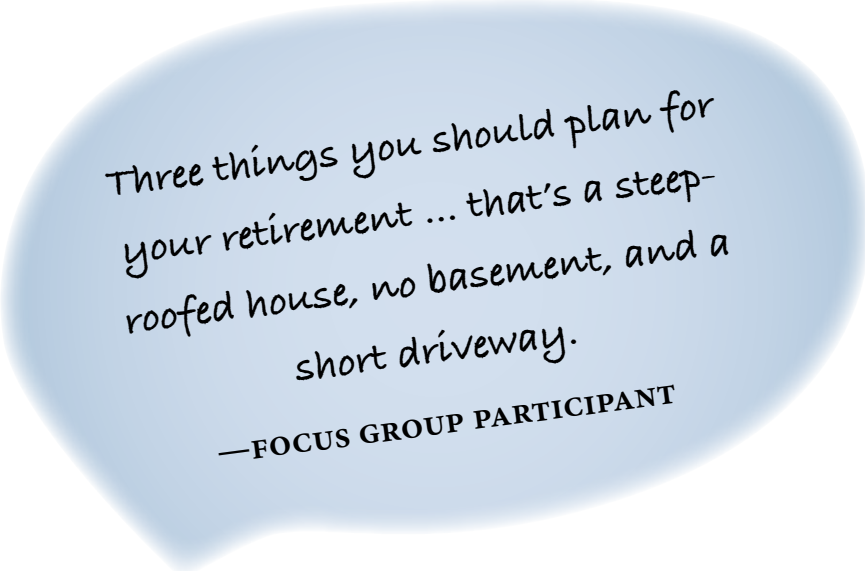
and identified opportunities for action. A fundamental aspect of these action opportunities is a collaborative, participatory, intersectoral approach to community capacity building.

- Key informant interviews with service and community leaders from many sectors added new knowledge and helped to refine our understanding of identified service gaps and issues. Participants' sectors included public housing, community services, planners and builders, multicultural, francophone, and disability.

From these sources, the nine key issues were identified that we believe are important to consider in order to improve housing for seniors in Atlantic Canada:

- 1) Housing design: safe, accessible, lifetime housing
- 2) Availability of home supports
- 3) Availability of a continuum of housing choices
- 4) Availability of transportation when and where needed
- 5) Supports for housing transition planning
- 6) Recognizing housing costs and affordability issues
- 7) Housing needs of seniors who are vulnerable or socially excluded
- 8) The potential for community capacity building
- 9) Planning for tomorrow's Atlantic Canadian seniors

Below, we outline these nine issues in more detail. For each issue, we will highlight recommendations and topics for discussion and action.



Three things you should plan for  
your retirement ... that's a steep-  
roofed house, no basement, and a  
short driveway.

—FOCUS GROUP PARTICIPANT

## Issue 1. Housing Design: Safe, Accessible, Lifetime Housing

### What Atlantic Canadians Told Us

The four Atlantic Provinces have among the highest rates of home ownership in the country and the rates are even higher in the rural areas of these provinces. Most of the seniors in Atlantic Canada live in dwellings that they own. Survey respondents pointed out problems with safety and repair of their homes. Survey and focus group participants could identify features that would make their current or future home more livable such as level access, no stairs, lower maintenance requirements (e.g., easy-to-maintain windows), and bathroom equipment. Many participants spoke of housing for seniors that, in their opinion, is not well-designed.

Conference participants saw the promotion of universal design as an opportunity for action, using collaboration and partnerships, including CMHC, contractors, and realtors to move this issue forward. Participants highlighted opportunities to learn from international examples of housing design. They raised additional points:

- Safety and accessibility are design priorities. People are interested in housing designs that can adapt to changing needs.
- Design includes location, community design, opportunity for participation.

- Education of buyers is needed so they understand the role of design features in determining if a home is suitable in the later stages of life.
- Limitations of current housing repair programs (low income to qualify, low funds available) prevent many from finding assistance to stay where they want.
- Current housing is not always the best solution due to changing resident needs or poor housing quality.
- Worry-free housing (limited maintenance requirements) should be a priority.
- Housing with social supports is needed.
- Choices in types of housing in/near the person's current community are highly desired.
- Choices for people who cannot afford current market options, such as high-end assisted living, are very limited and more needs to be done for these seniors.
- Choices for people who have specialized needs or require specialized supports will grow in importance as our population ages.

Among key informants, there was debate over the need to adopt universal or lifelong housing design as part of housing design. Builders function in a market economy, essentially building what their customers demand. Those in public housing, in contrast, are seen as being more subject to guidelines or rules about housing design. Key informants also expressed that there is a difference between younger and older seniors. Seniors younger than 75 were viewed as primarily having housing needs, many of which might be met by the private housing market. Those over 75 were seen as having both housing and support needs, much less likely to be seeking a house built for their purpose, and more likely to be looking at alternatives to the single detached dwelling.

Key informants further noted barriers with renovation programs, most notably the complexity of application for assistance to renovate one's home and long waiting lists. Additional problems are the low-income threshold and low amount of funding available (although recent infrastructure funds have been channeled toward increasing available funding).

### **Recommendations**

Both current and new housing need to incorporate design that allows for safer, more comfortable living with fewer barriers. Current housing can be adapted and new housing planned to incorporate accessible design that allows for people who walk with difficulty; who need help or supervision; or who use wheelchairs, walkers, or canes.

- Lifetime housing and flexible designs are needed. Lifetime housing incorporates 16 design features that allow wheelchair access, but also make homes easier for everyone to move around in. Key features include level access to the front door, wide doorways, an accessible bathroom, and a sleeping area on the main floor (if the dwelling is multi-level). FlexHousing™ is a concept in housing that incorporates, at the design and construction stage, the ability to make future changes easily and with minimum expense, to meet the evolving needs of its occupants. Housing is designed to maximize adaptability, accessibility, and affordability and the health of the occupants and environment.
- Education is needed so that younger home buyers are aware of design features that will make homes adaptable to changing needs as the family ages.
- Housing design needs to include location and community design, so that services and social opportunities are nearby and accessible to support seniors' participation in their communities.
- Housing is not just where people live, but where people do the things that they need and want to do. Housing design needs to incorporate features that allow for this (for example, room for power wheelchairs or scooters and their batteries, and space to pursue hobbies or have overnight guests).
- Current programs for housing repair and adaptation are useful to assist people in making changes to existing housing. However, the amount of funding available is limited and the income limits for eligibility are low.

### **Positive Steps**

- The Canada Mortgage and Housing Corporation (CMHC) provides excellent information about accessible housing and flexible housing design.
- Recently, CMHC announced additional funding for its residential rehabilitation programs. In Atlantic Canada, these programs are cost-shared with the provinces.
- The federal government recently announced, as part of the housing component of the federal economic stimulus package, \$1 billion in funding across the country to renovate the existing social housing stock (i.e., public housing, cooperatives, and nonprofit housing projects). Provinces must match the federal contribution.

### Issues for Discussion and Action

- In Canada, we have national housing standards that provinces choose to follow by adopting them as provincial building codes. Currently, we encourage accessible design features through “best practices” and pilot projects. Should we move from a system of “best practice” to housing “best policy” to create age-friendly, health-promoting communities?
- The United Kingdom has adopted national housing standards that will require all new housing to meet lifetime housing standards (such as level entryway, bathroom, and space for one bedroom, all on main level). Should we adopt a timetable for a gradual introduction of these standards and/or pursue other initiatives such as mortgage incentives to incorporate basic accessibility features into new housing?
- Are there mechanisms available (more funding, tax breaks) to encourage people to improve the accessibility/livability of their current housing beyond CMHC programs?
- There is often a point at which continuing to live in the current home is neither safe nor cost-effective. For example, people’s needs for support might exceed what can be provided or older housing in poor repair might not be suitable for rehabilitation.

## **Issue 2. Availability of Home Supports**

### **What Atlantic Canadians Told Us**

Many focus group participants voiced concerns about who would help them when they got older if they were unable to do things for themselves. In communities with a high proportion of older people, some respondents described the available support as “seniors helping seniors.” Many spoke positively of home supports as a resource for staying in their own homes. Some were concerned that the amount of help was insufficient for their needs and that eligibility requirements posed barriers to using home supports. Focus group participants also stated that getting help with small repairs and maintenance tasks was difficult – there was a lack of availability of people to do the work and costs for work were often high.

Conference participants emphasized that home supports are of equal importance to the development of housing. Support for family members who may be providing support to older adults was also emphasized. Conference participants listed addressing gaps in home support as an opportunity for collective advocacy and action.

Key informants noted that there were many programs available to support seniors to stay in their own homes, although these programs vary from jurisdiction to jurisdiction and seniors may not know about them. There is also great variation in home care provision among the four Atlantic provinces.

### **Recommendations**

Many of the supports currently available are based on the recipient’s medical condition. If our goal is to help people to live well in a setting of their choice, we need to rethink supports so that they focus on people in context (where and how they live, social supports available), rather than on their medical problems:

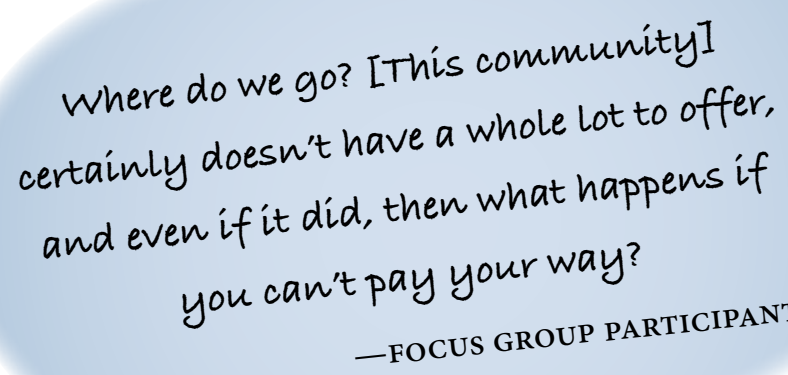
- As well as supports for daily living tasks, seniors need home maintenance supports, such as help with snow removal, lawn maintenance, and simple repairs, such as fixing a leaking faucet.
- Community services and opportunities to make social connections are a part of the supports that older Atlantic Canadians require.

### **Positive Steps**

The Veterans Independence Program (VIP) is a program that provides in-home assistance to eligible veterans and their spouses. This program is appreciated by users for its flexibility and the wide scope of in-home supports available, including groundskeeping. The recently released final report of the Senate Committee on Aging recommended the expansion of this program to all war service veterans.

### **Issues for Discussion and Action**

- There are considerable differences in home care programs among the four Atlantic Provinces. There are good home care programs in place, but they are often underfunded, which results in wait lists or restricted eligibility criteria. There is a need to increase community programs, both to provide in-home care and to promote health.
- There are often difficulties with obtaining services to meet ongoing needs of people with long-term disability or chronic illness. Coping with constant changes in care providers is stressful. People are placed in positions of vulnerability when services are reduced or withdrawn.
- There is a need for active collaboration between sectors to keep people in their own homes if this is desired and appropriate (for example, timely access to funds for renovations for people who have experienced disabling illnesses and are awaiting hospital discharge).
- Publicly funded supports might be available for those judged to be most in need (lower income, greater health problems). What are alternatives for other citizens (those with more income or less serious health issues)?
- Can capacity be developed in communities to meet some needs (for example, the needs for small repairs or needs for socialization)?
- How do we develop and sustain community services in areas that are sparsely populated or where young people are leaving?



Where do we go? [This community] certainly doesn't have a whole lot to offer, and even if it did, then what happens if you can't pay your way?

—FOCUS GROUP PARTICIPANT

### Issue 3. Availability of a Continuum of Housing Choices

#### What Atlantic Canadians Told Us

Most ASHRA survey respondents indicated that they were not thinking of moving. However, focus group participants described their worries about where they would move to next if their health or financial situation required a move. Many expressed an interest in worry-free housing – housing that requires no maintenance and offers access to services (housekeeping, personal care) if needed. They wanted this housing to be located in or near their community. Many expressed the belief that moving to a housing choice with more supports would be too costly.

Many key informants noted that there is a lack of housing choices, particularly for low-income seniors, along the continuum from being in one's home with supports to being in a nursing home or similar facility. Affordable assisted/supportive living options are lacking. Although apartments are often available, other housing options that have low maintenance demands (condominiums, townhouses) are often built with barriers such as multiple living levels that may not be suitable for seniors.

Regarding both universal design and provision of a continuum of housing choices, key informants from many sectors expressed that it is important to consider public housing as a different entity than market housing. Key

informants could see the need to develop public housing that was better designed for seniors' accessibility and social needs (such as the need to have a room for family visitors). However, there was some debate over needs vs. luxuries. Some saw the role of public housing as meeting basic needs of low-income seniors, which might not include meeting their preferences for more space, ability to keep a pet, etc.

### **Recommendations**

A continuum of housing choices is needed in order to meet the needs of seniors at all income levels within their community or within a cluster of rural communities.

### **Positive Steps**

In Atlantic Canada, there are several examples of private-sector development of housing “campuses” that offer a variety of living situations for seniors, where seniors in independent living units can share access to social and meal services with those in other types of accommodation.

### **Issues for Discussion and Action**

- Some forms of housing, such as garden homes or in-law suites, have the potential for seniors to take advantage of help from friends or family members. However, there can be difficulties with zoning and utilities (septic, water, and electrical systems) that create barriers for their construction or use. Community attitudes (“not in my backyard”) also limit the acceptability of some housing options.
- There appear to be gaps in availability of housing with supports, particularly for people with limited incomes:
  - In the gap between independent housing and assisted living, housing might include on-call help for a variety of personal and housing-related needs, but primarily independent, worry-free living (no yard or house maintenance). Public housing for seniors is targeted at seniors who are capable of independent living. There

are “high-end” options in some of the major centres in Atlantic Canada, but there are few assisted living options for persons of “moderate/modest” income.

- People who live with mental illness are often in need of affordable housing with supports and supervision, but they do not necessarily need help with tasks.
- In the gap between assisted living and nursing home living, housing might be more home-like than nursing homes but offer more supervision than is currently available in assisted living.

## **Issue 4. Availability of Transportation When and Where Needed**

### **What Atlantic Canadians Told Us**

Transportation, for both urban and rural dwellers, has an impact on where people can live. Most Atlantic Canadian seniors drive even when they find it difficult to do so. Driving is seen as necessary to community living, particularly for rural people.

Even when public transportation is available, it does not always meet the needs of seniors. Some seniors report that bus stops are not located conveniently, and that getting to bus stops is difficult because sidewalks are either lacking or unsafe. When seniors describe ideal public transportation, they are looking for door-to-door service; yet, there is a recognition that such services are difficult to provide, particularly in rural areas.

Conference participants emphasized that transportation, particularly rural transportation, should be a fundamental part discussions about housing.

Key informants and conference participants noted that some transportation problems could be minimized through innovative housing and community designs, for example, structures with shops on a main level and accommodations above, designs in evidence in other regions with harsh winter weather such as Denmark.

### **Recommendations**

Efforts to enhance the safety of senior drivers and develop alternatives to driving are needed in order to promote aging in place and community participation.

Housing for seniors should be located so that there is easy access to services by walking/wheeling, or there is ready access to easy-to-use public transportation.

### **Positive Steps**

- Rural transportation initiatives are currently under development in several Atlantic Canadian provinces.
- Ride-sharing and car-sharing programs show promise in some rural areas of Canada.
- The Public Health Agency of Canada is funding the National Blueprint for Injury Prevention in Older Drivers. This blueprint is looking at creating a strategy to prolong the safe driving period, with a special focus on driver refresher courses.

### **Issues for Discussion and Action**

- Should there be a requirement to locate seniors' housing where transportation and/or services are readily available, e.g., by offering grants contingent upon these conditions? For example, municipalities could include provisions in their planning documents that the development of new multiple-unit housing be located within "x" metres of public transit routes where public transit exists.
- Is publicly funded door-to-door transportation feasible? If not, what type of transportation services would seniors use?
- Most seniors are still driving. Are there ways to promote driver safety beyond educational sessions?

## Issue 5. Supports for Housing Transition Planning

### What Atlantic Canadians Told Us

Comments from seniors who participated in focus groups indicated that they were often unaware of services or facilities in their areas. Many had misinformation regarding the costs of housing or supports. Several seniors commented that they did not know how to obtain information about services and that they did not know how they would manage if something happened to their health. They were also concerned about finances, both about having the money to maintain their current dwelling and about having the money to move to alternative housing. Few planned to move.

Conference participants saw proactive personal planning as an important opportunity for action. Information sessions and tools (website, media blitz, print materials) need to highlight age-related planning for housing, transportation, health, financial matters, social support, legal arrangements (wills, enduring power of attorney), funerals, etc.

Key informants also emphasized the need to educate seniors, although ideas of what that education might include varied. Some key informants advocated educating seniors about the actual costs of housing and transportation choices, availability and cost of home supports, eligibility for public housing, wait lists, etc. Others emphasized that seniors need education about how to live in smaller-sized accommodation, the realities of apartment life, etc. Another area for education is the continuum of housing choices and the wide variety of supports that may be included with such housing. A third area for education is in the area of health promotion – the importance of keeping physically active and socially engaged – since maintaining health is key to being able to live where and how one wants to live.

Through key informant interviews with all sectors, a common theme was that seniors need to be more aware of their options and the availability of services. What is not clear is how much of this information should be provided in a proactive fashion vs. how information can be more readily available to seniors when they are in a need-to-know situation (those who require supports some day vs. those who require supports today).

Given the interest of private builders in building to the demand of their customers, it makes sense to educate seniors about good housing design and available supports.

## **Recommendations**

There is a role for a program that provides information and advice to seniors to help them plan for their housing needs and to cope with housing transitions. This includes the assessment of individuals' needs, the current condition of their housing, and financial planning.

## **Positive Steps**

Recent initiatives in the Atlantic Canadian provinces regarding primary health care and chronic disease self-management have a broad focus on enhancing well-being, and may have the potential to assist seniors with housing information.

## **Issues for Discussion and Action**

- Current attitudes and policies often focus on keeping seniors at home at all costs. And yet, we know that some homes are unsuitable for a variety of reasons. What changes are required so that people think about “making a home” rather than “staying in the home,” so that people feel “at home” wherever they are located?
- Current services that discuss housing options focus primarily on assessment for home care or nursing home placement, rather than discussion of housing and transition planning. Is there a role for housing and transition planning services or for primary health care services to provide information and assistance with housing transitions?

## Issue 6. Recognizing Housing Costs and Affordability Issues

### What Atlantic Canadians Told Us

Many survey respondents appeared to be in core housing need – many were in older housing stock that was in poor repair and were spending more than 30% of their income on housing. People who were single, women, and renters were particularly vulnerable. Seniors noted that there were very few low-cost housing alternatives in most communities.

Income has a direct relationship to housing affordability. We know that single people who receive only basic public pensions (disability pensions, social assistance, or Old Age Security and Guaranteed Income Supplement) are likely to be in core housing need. Immigrants do not qualify for Old Age Security or the Guaranteed Income Supplement for their first 10 years of residence. The current recession may further impact on seniors' incomes because of the declining value of investments and reduced incomes of family members due to job losses.

Other housing-related costs were of concern. Focus group participants noted that some costs, such as property taxes and fuel costs, were rising sharply and making it increasingly difficult to maintain the home. Property taxes and mechanisms to defer them vary across regions.

Key informants emphasized the need to support low-income persons to own homes as a way of ensuring that people have equity as they age. This might be achieved through low-cost homes, through community building projects (such as Habitat for Humanity), or through subsidies that would allow low-income persons to purchase homes at market price.

Key informants also note that housing-related costs can put low-income

*I have limited income ... and with the way that the rents are going up all the time, I don't know, I may be living in a cardboard box.*

**–FOCUS GROUP PARTICIPANT**

*I'm a single senior living in my own house and it's falling down around my ears.* —FOCUS GROUP PARTICIPANT

persons into crisis. There is a need for financial counselling, but also a need for affordable housing, fuel, and taxes.

### **Recommendations**

There is a need for more affordable, low-cost housing for seniors and persons with disabilities in Atlantic Canada.

The impact of housing-related costs (such as fuel costs and property taxes) on seniors who own their homes must be addressed.

### **Positive Steps**

- Federal infrastructure funds have recently been released to improve public housing. The Federal government has stipulated that some of the housing funds must be spent on providing affordable housing to seniors and to individuals with disabilities. This condition is applicable to all provinces.
- Some jurisdictions (e.g., Prince Edward Island) are allowing deferral of payment of tax increases for low-income seniors until properties are sold.

### **Issues for Discussion and Action**

- How do we develop a senior-friendly solution for rising property taxes that can be adopted across regions?
- How do we encourage the development of affordable seniors' housing, including public housing and privately developed housing?
- How do we encourage municipalities to facilitate the development of a range of housing types, such as duplexes, row houses, and apartments, that are more affordable than detached dwellings?

## **Issue 7. Housing Needs of Seniors Who are Vulnerable or Socially Excluded**

### **What Atlantic Canadians Told Us**

Our analysis of the comments of participants in focus groups highlighted the following points:

- Some groups appear to have very low expectations regarding housing: immigrants, aboriginal people, single/divorced, seniors in poverty, and people with mental illness or developmental disability. These people experience frequent moves and substandard housing, and usually have very low incomes. Seniors who are not connected with supportive family members are also vulnerable.
- Family situations, such as co-residence, may lead to financial strains or abusive situations, compounding other housing vulnerabilities.
- People in housing transition are often dealing with personal or family losses, thus may have difficulty adjusting to new living situations.
- While elder abuse was not discussed by focus group participants, we know that it exists. Responding to elder abuse usually involves displacement of the senior into a new living situation.

### **Vulnerability**

Key informants emphasized the interrelationship of housing and health. People with poor health often end up in vulnerable housing situations; similarly, people poorly housed are subject to poor health. Both health and housing are fundamentally related to income and wealth.

Key informants noted the particular needs of immigrants and refugees. It is important to distinguish between the two groups. Immigrants arrive in Canada under particular terms and conditions that are known to them and their sponsors. Refugees arrive under duress and need extra supports to acquire the skills and tools (language, training, work, etc.) that make obtaining housing possible. Some seniors are vulnerable because of breakdowns in sponsorship. Generally, seniors are not entitled to pensions until they have been in Canada for 10 years, which may create financial strain in families and, in turn, impact on housing choices.

## **Social exclusion**

For groups marginalized by culture and/or disability, isolation and social exclusion are issues that frequently impact on housing and certainly impact on supports and community connectedness. These groups often lack wealth and income, which directly impact on housing opportunities.

The lives of those marginalized by physical and mental health issues are often compromised by little stability in their housing situations and limited access to support services. Moreover, their health circumstances stand in the way of developing strong social support networks, in part because of the need to move frequently from one community to another. Another key informant noted that people with disabilities do not just want support, but also socialization. Strategies to socially connect disabled seniors, who may be isolated by their living situation (whether living independently or with family members), is important.

Key informants emphasized isolation that is caused by language issues. Often this isolation is twofold: people are isolated from the dominant (English) culture, and elders may be isolated from younger family members who do not speak or use the elder's first language. In their past working life, language issues stood in the way of employment and income for multicultural groups. While language creates barriers to service use, it often creates barriers in social connections with the family and community as well. Language issues can be compounded by literacy issues, especially in the senior population. People may not be literate in their first language or in the dominant language.

One key informant noted that there are a high number of older women living alone in urban environments, perhaps as the result of a recent move. These women can be isolated by fear or unfamiliarity.

## **Recommendations**

We need to recognize the vulnerabilities of some groups and individuals when planning housing for seniors and make meeting their needs for housing and support a priority.

Vulnerable seniors need adequate incomes in order to find safe, appropriate housing.

**Issues for Discussion and Action**

- How do we ensure that housing-related policy has the capacity to assess and address issues of vulnerability and marginalization?
- How can housing, social service, and health sectors work together to address these issues?

## Issue 8. The Potential for Community Capacity-building

### What Atlantic Canadians Told Us

Many Atlantic Canadians are involved as volunteers in their home communities. They recognize their communities as an important source of information, services, and social life. Some participants felt isolated from the communities in which they lived or marginalized because of their culture, language, responsibility for providing care for family members, or limited mobility and inability to leave their homes.

Conference participants identified opportunities for actions in these areas:

- Fostering municipal engagement of seniors and educating municipal governments about age-friendly communities.
- Engaging communities to support and include older adults by providing appropriate services and opportunities for participation.

### Recommendations

Government services, communities, and individuals all have a role in addressing housing and support needs of seniors. Communities potentially have the capacity to be involved in many aspects of housing and community improvement, such as

- provision of supports and social opportunities,
- education of builders and citizens regarding housing design,
- transportation, and
- participation in the planning of seniors' housing and services for older adults.

### Positive Steps

Many communities are using funds derived from Age-Friendly Communities or New Horizons programs to support seniors' organizations, provide information to seniors, and promote opportunities for social connections

**Issues for Discussion and Action**

- What is the current involvement of seniors and communities in planning and service provision?
- What is the role of public policy in developing community capacity?
- How do we ensure the sustainability of community-led initiatives?

## Issue 9. Planning for Tomorrow's Atlantic Canadian Seniors

Tomorrow's seniors are likely to differ from today's seniors in important ways:

- More will be located in urban areas.
- They will be more mobile, more accustomed to travel, perhaps more willing to relocate.
- They will have higher expectations of services and housing.
- Different family structures will result from higher divorce rates and fewer children.
- They will be more knowledgeable about technology and computer use.
- They will be healthier.

During ASHRA's Atlantic Seniors' Housing Needs Conference held in Halifax in May 2009, conference participants identified the need for a continuing advocacy strategy to inform public policy regarding housing and supports. Participants advocated using strategies such as pilot projects; developing a collective vision, philosophy, and theoretical approach; and making use of current organizations. Each Atlantic province is currently working on ways to continue the collaborations developed through the ASHRA provincial stakeholder memberships.

*A support system [is] as  
important as a house.*

**-FOCUS GROUP PARTICIPANT**





## THE ASHRA CASE STUDIES: Examples of Seniors' Housing Solutions

A case study provides a unique, integrated, tangible example to communicate a fully realized idea (Regnier 2002). It can be a useful way to learn about the qualities and characteristics of that idea, be it a building or a community. A well-described case study can allow us to compare, contrast, and examine the strategies that brought the project to life and to understand it better in the context of other settings that strive to achieve similar goals.

Our case studies examined housing solutions focused on the aging consumer (for the purposes of these studies we are using a general reference point of age 60+). We only looked at housing that does not include institutionalized care. The case studies below provide examples of leading-edge alternatives that combine innovation with acknowledged success:

- Hartrigg Oaks (England)
- Abbeyfield St. Peter's Society (British Columbia)
- Glacier Circle (California)
- Plejecentret Lillevang (Denmark)
- Village-to-Village Network (Boston)

The case study process also included the shooting of five videos to help document the case situations above. The video files were edited into five short "films," which were burned onto a DVD that is included between the French and English versions of this report.

## How did we select our subjects?

Regnier (2002) says that the design of seniors' living spaces should be guided by 12 principles that can help in setting priorities and detecting weaknesses in a proposed design:

- privacy
- social interaction
- control/choice/autonomy
- orientation/wayfinding
- safety/security
- accessibility/manipulation
- stimulation/challenge
- sensory aspects
- familiarity
- aesthetics/appearance
- personalization
- adaptability

These factors illustrate the importance of addressing the physical, socioeconomic, and psychological needs of elderly people in order for them to function as independently as possible. We used these factors from both lists above as a part of our consideration for the case studies. Other considerations included the degree of innovation, the ability to see evidence of a positive impact, and the potential to see the example transplanted in Atlantic Canada.

The following five housing categories and their accompanying definitions based on the work of Schafer (1999) were proposed as the basis for setting the case studies framework for Phase 3 of the ASHRA program. The Case Studies Working Group reviewed a number of possible case study subjects, then identified those with the highest priority for further exploration.

### Design criteria suggested at ASHRA Stakeholder Meetings

- Affordability
- Cultural sensitivity and appropriateness
- Relevance to Atlantic Canadian settings
- Both urban and rural options
- Both private and public options
- Both ownership and rental options
- Environmental sustainability
- Intergenerational interaction
- Integration into the community
- Mixed-use options (i.e., combo of commercial, residential, social, green space, and services)

**CATEGORY ONE: Conventional Housing for the 60+.****This includes all conventional housing without any special support arrangements (other than the help of family members).**

Many seniors will elect to live in conventional housing until they are very old and infirm. When asked, today's seniors overwhelmingly say that they would prefer to remain in their own homes as they age (Schafer, 1999). There is no reason to believe that they will feel any differently about this 30 years from now. More importantly, many of tomorrow's seniors will have the money and the technology to do so. As they age and experience increased difficulties in performing daily activities, seniors will find that a whole new industry of home services has grown up to serve their special needs. This will include labour-intensive personal services and new assistive equipment and devices.

In addition to having a greater array of in-home services available to them, increasingly tomorrow's elderly will modify their homes to compensate for the loss of mobility and other problems related to aging. Currently, seniors can accommodate impaired mobility with ramps, grab bars, and more accessible cabinetry and appliances, but the future holds the potential for dramatic possibilities that we can barely imagine today, such as gyro-balance wheelchairs that can navigate uneven ground and climb stairs.

Another type of conventional living arrangement is the Life Lease. There are five different styles of Life Lease in Canada. The Life Lease model that we use is based on a nonprofit corporation obtaining a bulk long-term mortgage, with the Life Lease residents providing a Refundable Entrance Fee and paying a proportionate share of the monthly operating costs.

<b>Examples of Conventional Housing</b>	
<b>Name</b>	<b>Description</b>
Joseph Rowntree Foundation and Housing Trust New Earswick, England	Home for Life or Universal Design
FILCASA Housing Coop Winnipeg, Manitoba	A seniors- and family-based community housing co-op in an award-winning renovated historic building. Apartment-style living with much indoor amenity space.
Aware Home Research Initiative Georgia Institute of Technology Atlanta, Georgia	The Aware Home Research Initiative is a focused research program whose goal is to develop the requisite technologies to create a home environment that can both perceive and assist its occupants. The scope of the projects carried out within this program range from fundamental technical development to cognitive and ethnological studies that assess the most appropriate and compelling technological strategies.
Vernon Woods Retirement Community LaGrange, Georgia	Offers both assisted living and independent living residences for senior adults. Winner of the National Association of Home Builders Gold Award in 2002.

**CATEGORY TWO: Supported Housing for the 60+.**

**This includes all conventional housing where the household receives supportive help in their home from an organization or individual who is not a family member.**

The definition of supportive housing varies across jurisdictions both within Canada and internationally. Supportive housing, as the term is generally used in Canada, is neither fully independent living in which seniors function on their own (possibly with the assistance of friends/family and/or home support services), nor institutional housing or long-term care with a heavy reliance on on-site medical care. Although there is no accepted official definition, a good working definition of supportive housing in Canada has been provided by the Canada Mortgage and Housing Corporation:

Supportive housing is the type of housing that helps people in their daily living through the provision of a physical environment that is safe, secure, enabling, and home-like, and through the provision of support services such as meals, housekeeping, and social and recreational activities. It is also the type of housing that allows people to maximize their independence, privacy, decision-making and involvement, dignity, and choices and preferences.

Congregate housing, or congregate living offers independent living in separate apartments and opportunities to share activities of daily living with other residents, as one chooses. There may be rental or ownership units or include a buy-in.

Today, congregate living communities are sometimes hard to tell apart from senior apartments since both can offer many services and opportunities to do activities with other residents. In congregate housing communities, the main difference may be in the additional levels of care that are available within the same community as the congregate housing. These levels of care may include assisted living, skilled nursing, or Alzheimer care. Active senior apartments offering meals, services, transportation, and planned activities will generally not include additional levels of care within the same community.

Abbeyfield housing is a well-developed form of congregate housing. Abbeyfield offers a warm, family-style House and a balance between privacy and companionship and between security and independence, combined with the special caring element provided by dedicated volunteers and the consistency of a single House manager.

### Examples of Supported Housing

*Tinted examples in this and following tables are the ones explored later in this chapter as Case Studies.*

Name	Description
<p>Hartrigg Oaks, New Earswick, England</p>	<p>Hartrigg Oaks is the first continuing care retirement community in the U.K. to be based on an actuarial model. This works in a similar way to an insurance scheme, so that a need for care does not lead to an increase in fees. It is this unique feature that allows residents to have peace of mind with regard to costs if they choose the pooled-finance option.</p>
<p>Consumer Directed Community Supports (CDCSs) Bloomington, Minnesota</p>	<p>CDCS is an unlicensed service option for people who receive home- and community-based services. CDCS provides a person with support, care, and assistance that prevents institutionalization and allows a more inclusive community life. CDCS can create more individualized and effective support services by giving the person and his or her support team both more flexibility and more responsibility for planning and managing the supports that will best meet their needs.</p>
<p>Abbeyfield House Abbeyfield St. Peter's Society Victoria, British Columbia</p>	<p>The Abbeyfield concept is simple. Each house provides accommodation for 9–12 persons. Residents live in bedsitting suites that they furnish themselves. Each suite has a private bathroom, usually equipped with a shower. Residents enjoy lunch and dinner prepared by the live-in house coordinator and have breakfast at their leisure. The coordinator is responsible for shopping and for food preparation and service and oversees the day-to-day operation of the house. Laundry facilities are provided. There is no provision for acute or long-term care.</p>

**CATEGORY THREE: Shared Housing for the 60+.**

This category includes any housing arrangement where a non-elderly person who is at least 18 years of age moves in with an elderly person or an elderly person moves in with a non-elderly person who is at least 18 years of age for the purpose of assisting.

Seniors can share their home or share the home of another. The roommate need not be a senior. Professional organizations that specialize in these arrangements match the two parties based on needs on one side, and abilities to provide assistance on the other. They screen before matching and follow up afterward to help ensure that the match works out. Most organizations that do this are non-profit and supported from sources other than those seeking their help.

Examples of Shared Housing	
Name	Description
State of Illinois	Has a licensing system for shared living arrangements
Vermont	Shared Housing Alternatives for Rural Elders (SHARE)
HomeSharing, Inc. Bridgewater, New Jersey	Not-for-profit society

**CATEGORY FOUR: Unassisted Communities for the 60+.**

**This includes any living arrangement within an age-restricted community where there are no support services.**

A senior community can be like any other neighbourhood or community except it is usually restricted either to people 55 and over or 62 and over. Minimum age is typically established when the original community entitlement and funding is obtained. Those with a 55+ restriction require one resident to be 55+. Other residents must be over 18, but are permitted to be younger than 55. In a 62+ community, all residents must meet the minimum age requirement. American regulations at one time required amenities, activities, and services that catered to seniors to be provided or available. Although no longer required by law, age-restricted communities are continuing to offer amenities, activities, and services in order to competitively attract retirees.

Unassisted Communities are oriented toward an active lifestyle, or “younger-thinking” seniors. They might offer golf, tennis, swimming pool and spa, exercise rooms, and a variety of clubs and interest groups.

Examples of Unassisted Communities	
Name	Description
Eldershire/ West Lake Village Sherburne, New York	An Eldershire Community design involves grouping private homes in a manner that promotes interaction among the residents. Residents share indoor and outside spaces, as well as facilities such as gardens, gathering areas, trails, and play spaces. A common house is used for shared meals, meetings, workshops, offices, mail, and activities. A vehicle-free central campus and other shared spaces foster the connection among residents, neighbours, and guests.
Glacier Village Davis, California	“Co-housing” developments are based on a concept borrowed from Denmark in which residents have their own private townhouses or condos, but share a central “common house.” Nearly 200 co-housing developments have been started in the U.S. since 1991. One is under way in Colorado that could become the model for “elder co-housing” across the country.
Las Palmas Grand Mesa, Arizona	A manufactured homes community aimed at active retirees. Award-winning.

**CATEGORY FIVE: Assisted Communities for the 60+.**

**This includes any living arrangement within an age-restricted community combined with support services.**

Continuing Care Retirement Communities (CCRCs) or communities offering life care are designed to offer active seniors an independent lifestyle and a private home from which to enjoy it, regardless of future medical needs. They may require buy-in or an up-front annuity purchase followed by monthly payments covering services, amenities, and needed medical. The buy-in may be refundable in part or not at all. They provide the availability of multiple levels of care, without the uncertainty of wondering where one will live if care needs increase.

Examples of Assisted Communities	
Name	Description
Plejecentret Lillevang Farum, Denmark	Designed as the multi-purpose nursing home of the future. It consists of 4 groups of 24 units (96 total units), plus an activity center. The 24-unit cluster is further sub-divided into 3 smaller 8-unit self-contained "families," where meals are provided. An activity centre is located in the centre of all the blocks. Rooms within the activity centre are multi-functional and include a dementia day care centre, the central kitchen and cafeteria, hairdresser, dentist, and a chiropody and rehabilitation centre.
Gyngemosegard Copenhagen, Denmark	A Danish example of integration with half of the units consisting of families with children.
Vernon Woods Retirement Community LaGrange, Georgia	Offers both assisted living and independent living residences for senior adults.

<p>Kokoro Assisted Living San Francisco, California</p>	<p>Kokoro Assisted Living is a nonprofit housing community servicing Japanese American elders. Kokoro seeks to promote and enhance the independence, well-being, and security of older people through the provision of housing and assisted living services in an environment centred on Japanese culture.</p>
<p>The Fountains at La Cholla Tucson, Arizona</p>	<p>A Sunrise Senior Living Community, Arizona's award-winning, full-service community. Both independent and assisted living are offered.</p>

As the case study planning progressed, it was decided that the number of studies that could be completed in the available time could not include all of the possibilities above. A process of review resulted in the choices listed below.

Category One provides a foundation for promotion of the Lifetime Home Standards or universal home design, so there is not a specific residence to be discussed as a case under this category. However, the Lifetime Home Standards are treated in more detail under Category Two, Hartrigg Oaks, and in Appendix A.

- Category One: Joseph Rowntree Foundation and Housing Trust Home for Life or Universal Design, New Earswick, England
- Category Two: Hartrigg Oaks, New Earswick, England, and Abbeyfield St. Peter's Society, Victoria, British Columbia
- Category Three: Not included in the ASHRA case studies
- Category Four: Glacier Village, Davis, California
- Category Five: Plejecentret Lillevang Assisted Living, Farum, Denmark

A new category emerged as part of this selection process, that of Naturally Occurring Retirement Communities or NORCs, and we present a case study on that phenomenon.

**CATEGORY SIX: Naturally Occurring Retirement Communities (NORCs) for the 60+. This is usually a geographic area where more than half of the residents are at least 60, although there are variations to this definition as noted below.**

A NORC is a community with a large concentration of older adults within a geographically defined area (Hunt & Gunter-Hunt, 1985; Hunt & Ross, 1990; Marshall & Hunt, 1999). According to Hunt and Gunter-Hunt, NORCs are different from traditional senior housing developments because these communities are formed naturally by migration patterns and are age-integrated with younger residents. Because they are not marketed as retirement communities, the high concentration of older residents is often unnoticed by persons who do not live or work in the community. The criteria for designating a community as a NORC vary, but a geographic area is generally defined as a NORC if more than 50% of the residents are at least 60 years old, although the proportion has been reported as low as 25% and the minimum age as 50 (Hunt & Ross, 1990; Ormond, Black, Tilly, & Thomas, 2004).

Naturally Occurring Retirement Communities	
Name	Description
Village-to-Village Network Boston, Massachusetts	In regular neighbourhoods with a significant senior population, the Village-to-Village approach establishes membership-driven organizations run by small staffs and volunteers who coordinate affordable services including transportation, in-home medical care, home repairs, and other day-to-day needs, enabling individuals to receive care at home.



### *CASE STUDY – Continuing Care Retirement Community*

## **Hartrigg Oaks, New Earswick, England**

Hartrigg Oaks is the first continuing care retirement community (CCRC) in the U.K. After more than 10 years of planning and research, building began in New Earswick on the outskirts of York in 1996. The development was completed in 1998. The community is spread over a 21-acre site. It consists of 152 one- and two-bedroom bungalows and 42 ensuite, bedsitting hospital rooms in the Oaks Care Centre. Hartrigg Oaks is managed by the Joseph Rowntree Housing Trust. The Trust has been managing high quality housing in York since 1902.

### **Defining CCRCs**

In the U.K., the term “extra care” housing describes accommodation for both fit and frail people. The housing is described as a socially supportive, stimulating environment in which older people may live wholly independently and also receive extensive care and support services when required (Tetlow, 2006). The following features characterize CCRCs:

- Self-contained apartments or houses. Dwellings incorporate design features, equipment, and technology to facilitate independence and provide a safe environment
- Provision of an appropriate package of care in the individual’s own dwelling
- Catering facilities with one or more meals available each day
- 24-hour care staff and support available on site
- More comprehensive communal facilities than sheltered accommodation – restaurant, lounge(s), activity rooms, library, health suite, computer suite, etc.
- Domestic support services, including help with shopping, cleaning, and making meals
- To help meet the needs of frail or disabled residents, facilities for electric wheelchair charging and storage, and specialized equipment such as hoists
- Social and leisure activities/facilities
- Mobility and access assistance such as pooled cars and bus service

Each bungalow in Hartrigg Oaks has been built to the Lifetime Home Standards, offering high levels of convenience, safety, and security. The Lifetime Home Standards was established in the mid-1990s to incorporate a set of principles that should be implicit in good housing design. Good design, in this context, is considered to be design that maximizes utility, independence, and quality of life, while not compromising other design issues such as aesthetics or cost effectiveness.

The Lifetime Home Standards seeks to enable “general needs” housing to provide, either from the outset or through simple and cost-effective adaptation, design solutions that meet the existing and changing needs of diverse households. This offers the occupants more choice over where they live and which visitors they can accommodate for any given time period. It is therefore an expression of “Inclusive Design.” Appendix A contains the current copy of the 16 criteria of the Lifetime Home Standards. Here they are in outline:

Primary Requirements (in the home):

1. Communal Stairs – Communal stairs will provide easy access and, where homes are reached by a lift, it should be fully accessible.
2. Doorways and Hallways – The width of internal hallways varies between 900 and 1200 mm depending on the width of doorways from the hall and whether or not the approach to the doorway is head-on. There should be a 300 mm nib or wall space to the side of the leading edge of the doors on the entrance level.
3. Wheelchair Accessibility – There will be space for turning a wheelchair in dining areas and living rooms via a 1500 mm turning circle and adequate circulation space for wheelchairs elsewhere.
4. Living Room – The living room will be at entrance level.
5. Two or More Storey Requirements – In houses of two or more storeys, there will be space on the entrance level that could be used as a convenient bed space.
6. Water Closet (WC) – In houses with three or more bedrooms there will be a wheelchair-accessible toilet (1500 × 2200 mm) at entrance level, with drainage provision enabling a shower to be fitted in the future.
7. Bathroom and WC walls – Walls in the bathroom and WC will be capable of taking adaptations such as handrails.
8. Lift Capacity – The design will incorporate provision for a future stair lift and a suitably identified space for a through-the-floor lift from the ground floor to the first floor; for example, to a bedroom next to the bathroom.
9. Main bedrooms – The design and specification will provide a reasonable route for a potential hoist from a main bedroom to the bathroom.

10. Bathroom Layout – The bathroom will be designed for ease of access to the bath, WC, and wash basin.
11. Window Specification – Living room window glazing will begin no higher than 800 mm from the floor level and windows should be easy to open/operate.
12. Fixtures and Fittings – Switches, sockets, ventilation, and service controls will be at a height usable by all (i.e., between 450 and 1200 mm from the floor).

Secondary Requirements (outside the home):

13. Car Parking – Where car parking is adjacent to the home, it should be capable of enlargement to attain 3.3 m width.
14. Access from Car Parking – The distance from the car-parking space to the home must be kept to a minimum and be level or gently sloping.
15. Approach – The approach to all entrances will be level or gently sloping.
16. External Entrances – All entrances will be illuminated, have level access over the thresholds, and have a covered main entrance.

Housing that is designed to the Lifetime Home Standards will be convenient for most occupants, including some (but not all) wheelchair users and disabled visitors, without the necessity for substantial alterations. A Lifetime Home will meet the requirements of a wide range of households, including families with walkers, as well as some wheelchair users. The additional functionality and accessibility it provides is also helpful to everyone in ordinary daily life; for example, when carrying large and bulky items.

### **Living in Hartrigg Oaks**

Hartrigg Oaks residents pay two types of fees when they move to the village. The first is a residence fee that covers the purchase and occupation of a bungalow and, when required, a room in the Oaks Care Centre. In essence, this is a one-time fee based on the current market value of each home. Residents purchase their home and when they leave/die, the full amount of their purchase price is repaid to the resident or the estate. In 2007/2008, this fee went from \$375,000 for the Hart, a two-bedroom bungalow of 78.9 square meters; to \$426,000 for the Hart Plus, a two-bedroom bungalow (112.5 square meters) with an upstairs study. There are two other models of homes that are smaller and less expensive – the Rigg at 54.5 square meters (\$291,000) and the Rigg Plus (\$347,000) at 87.2 square meters.

The second fee is called a community fee. This fee covers the cost of running Hartrigg Oaks, including the provision of care support, both in a resident's bungalow and in the Oaks Care Centre. The amount of this fee is dependent on your age when you join the village, so that the younger you are, the lower the fee over your years as a resident. The fee does not increase as a resident's need for care increases. In 2007/08, the community fee for a 67-year-old was set at \$8869. This fee can increase yearly by the British Retail Price Index plus a maximum of 3 percent. Individuals/couples can apply from age 55 upward. The average age at Hartrigg Oaks is 78 in accommodation and 90 in the care home. At times there have been as many as 500 names on the waiting list to enter the village.



*CASE STUDY – Abbeyfield Houses*

**Abbeyfield St. Peters Society – Victoria, British Columbia**

In 1956, Major Richard Carr-Gomm resigned his commission with the British army and bought a property at 50 Eugenia Road, South London, for £250. It was run down, had six rooms and no bathroom, just an outdoor lavatory and two cold taps. It was to provide housing for four people – the only qualification being loneliness. He was the first housekeeper and was dubbed by the press “The Scrubbing Major” (What is Abbeyfield?, 2008).

This prototype has provided a vision and the impetus for hundreds of Abbeyfield Houses operating around the world. Worldwide there are 1100 Houses serving the needs of over 9000 residents. The organization is present in 17 countries, including Japan and Mexico. In Canada today, there are 40 societies, 29 Houses, and 10 more Houses planned or under construction.

Features of the Abbeyfield Concept:

- Involve local Abbeyfield volunteers in setting up and managing each House, where the residents will pay their share of the running costs.
- Every household will have its own housekeeper to look after the House, to provide meals, and to care for the residents.
- Residents will have their own rooms, furnished as they wish, where both their privacy and their right to invite visitors are assured. (What is Abbeyfield?, 2008)

Each Abbeyfield House is owned and operated by a local nonprofit society of volunteers who care about their community. It is this community aspect that sets Abbeyfield Houses apart from the alternatives. Within an Abbeyfield House, meals are prepared by staff (breakfast is often offered as self-serve), and maintenance tasks are handled by volunteers. Abbeyfield residents are free to live active lives of their choosing with friends and relatives within their local community.

Abbeyfield Houses form a “family-sized” community, usually with eight or ten residents, although some Houses are larger. Abbeyfield is for active seniors who want a quality of life without domestic burdens. Abbeyfield offers independence, community, and affordability.

## **Independence**

The bed sitting room at Abbeyfield is the resident's private space, with the furnishings and decorations they bring as part of their home. Some rooms may have private patios or balconies, or they may be designed for wheelchair accessibility – every Abbeyfield home is different, and each has been designed for comfort and convenience.

## **Community**

Common rooms such as a living room, solarium, foyer, kitchen, dining room, and laundry area are shared with other residents of the home. There is always time to share in activities within the house as individuals choose. Each House is a part of the larger community in which it is located – it may blend in with other homes nearby, being just a little larger, and is often surrounded by gardens.

## **Affordability**

Abbeyfield Houses in British Columbia charge an all-inclusive monthly rent, which is always competitive with, and usually lower than, the cost of senior residency in institutional settings in that community. Usually, the rent includes all meals and snacks, home maintenance of the common areas, and garden and grounds maintenance. Phone service is usually the responsibility of the resident, as may be cable/internet connection fees. There are no hidden or “additional service” charges.

Most seniors who qualify for old age pension and supplements, such as the provincial SAFER (Shelter Aid for Elderly Residents) program will find that Abbeyfield residency is within their means. Some societies with the resources to do so may offer a rent discount in cases of need. Affordability should rarely, if ever, be a barrier to living in an Abbeyfield home in British Columbia.

## **Residency**

Applicants for residency in an Abbeyfield home should enjoy reasonably good health, have a degree of independence, and most of all, a desire to live a good life in fellowship balanced with privacy. Most Abbeyfield units are designed for single persons; occasionally married couples can be accommodated. Applicants for residence should have a sponsor, who is usually a close relative such as an

adult child. Families play important roles in the lives of most residents: they are welcome to visit and to stay overnight in those homes that have a visitor suite.

### **Abbeyfield House St. Peter's Society**

Abbeyfield House St. Peter's Society is one of twenty-nine Abbeyfield House organizations in BC. The House is located in Victoria. It is run with assistance from the provincial and federal governments, and managed by volunteers of the Abbeyfield House St. Peter's Society. This society is a registered charitable organization launched 17 years ago. Administered by volunteers, the society works very hard to make sure the residents feel that Abbeyfield House is their retirement home.



### *CASE STUDY – Co-housing*

## **Glacier Circle Senior Community–Davis, California**

*(Write-up from [www.abrahampaiss/ElderCo-housing/GlacierCircle.htm](http://www.abrahampaiss/ElderCo-housing/GlacierCircle.htm))*

### **Background**

Founding member Ellen Coppock held the first meeting in her home in Davis, California, in March 2002. About two dozen people attended this initial meeting, which included friends from the local Unitarian Universalist Church (UUC). Among the attendees was Muir Commons Co-housing developer, Virginia Thigpen, also a UUC member, who became an advisor to the project. Seven of the eight original households came from this first meeting.

Early on, the group of 12 future residents (four couples and four singles) hired lawyers and architects. The community was actively guided by Virginia, who helped with site acquisition and budget issues. It was she who suggested that the co-housing group consider the .83 acre site in a larger planned and mixed-use neighborhood that Randolph and Lynne Yackzan of West Davis Associates were developing in Davis, California, a short drive (about 4 miles) to downtown. The project took 3 years of planning before construction was ready to begin.

### Group's Mission Statement

*The mission of Glacier Circle Senior Community is to create and maintain a small cooperative-style housing community of seniors who share some expenses, skills, and visions in mutual support and friendship. We are committed to being a welcoming community of independent outlooks and shared values.*

In addition, the community has a Covenant which is read aloud at the start of every meeting.

*We, the members of Glacier Circle, covenant [pledge]:*

*To listen deeply and thoughtfully in our dialogs, mindful that our relationships are sacred.*

*To be patient with each other, appreciating our differing gifts and welcoming creative ideas. When necessary, we will confront courageously with love.*

*We agree to assume appropriate leadership roles and to participate fully in the group process.*

*While we value our time together, we also respect our members' need for privacy.*

*We will remember to assume the good intent of others and to strive to treat other members as well as ourselves with loving kindness.*

## **Membership**

Members ranged in age from 70 to 84 at the start of planning. All of the members are now retired. Their professions include

three psychotherapists,  
a schoolteacher and a watercolour painter,  
a university professor and a writer,  
a physicist,  
an education college professor, and  
an environmental health scientist.

## **Group Process**

The community makes decisions by consensus. Members of the Glacier Circle community have known each other for a long time, in some cases for 40–50 years! Group members see each other regularly through social activities outside of the co-housing project. Some are members of a dream group and some are in a writing group, while several others participate in a women's group.

The community holds weekly two-hour business meetings after which the attendees go out to dinner. To help get the business work done, three positions

were created: president, secretary, and treasurer. There are no formal teams. Says Ellen Coppock, “When something needs to get done, Stan, our president, asks people to volunteer. The person best suited is the one who volunteers.”

The community participated in a facilitation training course at the local university. This program included a personality test so that members could learn more about each other’s strengths and challenges.

### **Common Interests**

Seven of the eight households are members of the Unitarian Universalist Church of Davis. No marketing was required.

### **Expanded role of the Architect**

First-time co-housing architect Julie Haney was brought into the project in February 2003, while working for Laura Macaulay of Macaulay + Architects. Julie facilitated the site programming, Common House design, and the programming for the individual homes. While working with the group, Julie became aware of how people felt as they were downsizing into a smaller townhome. She offered hand-holding and customization as they prepared for their last home. She met with each member individually, measured their furniture, and helped them to see how their furniture would fit into their new house.

### **Location**

Glacier Circle is built within a larger planned neighbourhood, with both residential homes – single detached, low-income, and affordable – and commercial outlets. The neighbourhood is within walking distance of a greenbelt area that has a walking path and wildlife pond. A medical building is adjacent to the property and a major hospital is four blocks away. Mass transit and shops are close by.

### **Project Challenges**

Two of the biggest challenges were around parking and insurance. City planners insisted that parking accommodate the turning radius for big cars as they “had preconceived notions about old ladies driving Cadillacs,” said architect Julie Haney. “In reality, the group members were all driving Priuses (hybrid gas-electric autos) and small compact cars.” The project builder initially could not get an affordable wrap-up insurance policy in California as requested by the owners because one of the buildings is five attached units. Once the

owners agreed to go with a standard single-family insurance policy, the insurance issue was resolved.

### **Energy-efficient Design**

The eight homes range in size from 1,000 to 1,400 square feet, and are placed along an east/west access, all facing south for maximum solar gain. Three homes have photovoltaic panels and solar water heating with a tankless gas water heater for a backup. All of the buildings incorporate daylight from skylights and suntubes (tubular skylights) and use fluorescent lighting for general room illumination.

### **Age-in-Place Designed**

Contrary to typical co-housing design where parking is placed on the edge of the site, in Glacier Circle each household has a single-car garage and a parking space in the driveway. Doors are three feet wide, larger bathrooms allow for wheelchairs, including wheelchair-accessible showers. The foundations are flat foundations (no steps) and all homes but two are one-storey. The two-storey homes were designed with stairs that could be retrofitted with an electric stair chair and a downstairs that could be adapted to be a master bedroom. Bright lighting was important: homes have skylights with blinds that are operable by electric motor as well as ample general lighting. Extra storage space was also emphasized.

### **Common House Apartment**

The Common House has an affordable second-floor apartment that the community offered to a couple in exchange for helping with cooking and maintenance of the community. This situation may be especially helpful in the future as residents age.

### **Importance of the Garden**

Many members of the community are gardeners and in some cases, knowing there would be a garden made it easier for members to leave their existing home and move to Glacier Circle. The gardens include some citrus and fruit trees, vegetables and flowering plants, and a common garden that unites the three

buildings. Landscaping uses drip irrigation to conserve water. Native plants were chosen with no grass.

### **Resident-led with Developer Input**

The project was conceived by the group members. However, multi-family developer Virginia Thigpen had an active guiding hand all along the way.



*CASE STUDY – Assisted Living Community*

**Plejecentret Lillevang, Farum, Denmark**

Plejecentret Lillevang, located in Farum outside of Copenhagen, was designed as the multi-purpose nursing home of the future. In North American terms it is a combination of an assisted living complex with level one care. The design was unique when the complex opened in 1998 and it has since been replicated in several other countries. One of the main aspects of the design was that the residents' self-determination and ability to influence their personal situation, along with the opportunity to use their own resources, would not be limited. Privacy is respected, while community is encouraged by the design.

The community consists of 4 groups of 24 units (96 total units) plus an activity center. The 24-unit cluster is further subdivided into 3 smaller 8-unit self-contained "families," where meals and activities are provided. In many European settings, meals are still cooked from raw ingredients or delivered in bulk and finished in a small residential-scaled kitchen.

The kitchen is a multi-purpose space designed to accommodate residents' medications and ad hoc care activities. A table located adjacent to the kitchen might be used for charting, coffee-drinking, meals, or small group activities. Tables are flexible pieces of furniture that allow the kitchen and dining area to support a range of activities that add life to the place.

Each "family" has 200 square meters of communal space for use only by the residents of the 8 units. The underlying idea of the design is that all necessary daily chores are central elements in the everyday life of the housing units. Each group of 8 residents decides what they want to eat and they eat together. Residents help with meal preparation and clean-up.

Each "flat" is 40 square meters in size with a moveable partition wall separating the living area from the sleeping and bathroom area. Bathrooms are constructed so that two care assistants can work under the best conditions, with the design allowing for a hoist to be installed between the bedroom and bathroom. Each flat has direct access to the communal garden and to the resident's own private terrace. In addition each 8-unit "family" shares a common area of 24 square meters that provides three areas of comfortable seating. The residents

decide how they want to decorate and use these areas, and many serve as a large living room with several glass areas providing light.

An activity centre is located in the centre of the whole Plejecentret community and is open to the surrounding community. Rooms within the 1,400-square-meter activity centre are multi-functional, and include a dementia day care centre, the central kitchen and a cafeteria, hairdresser, dentist, and a chiropody and rehabilitation centre.

Residents pay monthly fees for their room (\$950 Cdn), a heating charge (\$128 Cdn), and their TV and cable (\$26 Cdn). These fees do not include meals and personal items such as toiletries. The resident picks the personal items they want from a list and if they purchased all choices, the tally would be \$541 Cdn per month, making the maximum monthly fee approximately \$1,650 Cdn. The Danish government pays most or all of this, depending on the individual's circumstances.

One is struck by the commitment to allowing the individuals to be in control of every aspect of their lives no matter what their condition. The design of the complex encourages a sense of community and family, while offering flexibility in the level of care and support and how these are delivered. Covered walkways connect all of the buildings and encourage walking and interaction. Three-wheeled bicycles are available outside every cluster, and it is common to see residents riding to the main activity centre!



*CASE STUDY – Naturally Occurring Retirement Community*

**Village-to-Village Network – Boston, Massachusetts**

Studies have shown that older people would prefer to stay in their homes as they age, but they often need some help around the house. With that in mind, neighbours in the Beacon Hill section of Boston started the first intentional community about nine years ago. The idea soon caught on in other neighbourhoods.

A recent AARP study (Guengerich, 2009) of Washington, D.C., seniors who joined “aging-in-place” networks reported that the move has made them feel more engaged in their communities and more comfortable with their decision to stay in their own homes. Researchers from AARP interviewed residents and volunteers from five “villages” to find out what works and what doesn’t in these grassroots communities, which have proliferated the region the past few years.

In some graying neighbourhoods, residents have banded together and paid a yearly fee for social activities and access to a network of volunteers, or they have vetted contractors who can help them in areas such as transportation and computers. In some larger villages, the network is managed by an executive director or other paid staff.

Villages are consumer-driven nonprofits that help people 50 and over to stay in their own homes throughout their lives. There are currently 40 open villages and hundreds starting up around the United States but the movement has not yet started in Canada. The Village-to-Village approach establishes membership-driven organizations run by small staffs and volunteers who coordinate affordable services including transportation, in-home medical care, home repairs, and other day-to-day needs, enabling individuals to receive care at home.



## Best Practices

Two common themes run through all of the case studies:

- 1) The first is the focus on building a sense of community, reducing isolation, and giving the residents control over their everyday living. This friendship and community feeling is what set each of the five case studies apart from typical seniors' housing.
- 2) The second is that every one of the projects except the NORC incorporated the 16 standards developed by the Joseph Rowntree Foundation for the Home for Life.

There have been a number of studies into the costs and benefits of building to the Lifetime Home Standards. These have concluded that the additional construction costs range from \$888 to \$2632 per dwelling, depending on

- the experience of the home designer and builder,
- the size of the dwelling (it is easier to design larger dwellings that incorporate the Lifetime Home Standards cost effectively than to design smaller ones),
- whether Lifetime Homes design criteria were designed into developments from the outset or a standard house type was modified (it is more cost effective to incorporate the standards at the design stage rather than modify standard designs), and
- the level of adoption of the Lifetime Home Standards (the net cost of implementing Lifetime Homes will diminish as the concept is more widely adopted and as design standards and market expectations rise).

The most significant factor when considering costs was whether the home had been designed to incorporate the Lifetime Homes Standard from the outset or a pre-existing design had been modified.

In 1997, Sangster looked at costs of incorporating the Lifetime Home Standards from the design stage and found that extra costs could be as low as \$146 for a three-bedroom, five-person, social rented house; and \$163 for the same size of house in the private sector. The study found that most of the Life-

time Homes design criteria cost nothing when designed in at the beginning. The inclusion of a downstairs toilet, with the possibility to incorporate a shower later, incurred the highest cost. With the exception of the two-bedroom, four-person house, the extra cost associated with the toilet was \$112.

Taking the same approach as the Sangster study, Martin updated the costs in 2006 and estimated additional costs to be:

<b>Feature meeting Lifetime Homes criterion</b>	<b>Costs per dwelling (\$)</b>
Communal stairways and lifts	Negligible
Doors and hallways	Negligible
Entrance-level WC and shower drainage	195
Bathroom and WC walls	82
Entrance-level bedspace	163
Stair lift/through-the-floor lift	78
Tracking hoist route	45
Increasing floor area of two-bedroom houses to 70 square meters	312
<b>TOTAL</b>	<b>876</b>

A study commissioned in Northern Ireland estimated the additional costs of building to the Lifetime Home Standards to be between \$269 and a maximum of \$888.

We cannot easily apply the Lifetime Home Standards to our existing housing stock, but governments in Canada need to act quickly to change our building code, making these 16 standards mandatory.





## WHERE DO WE GO FROM HERE?

The two fundamental conclusions of the ASHRA Project are that

- 1) as we age we want to stay in our homes for as long as possible, and
- 2) having support in and around us in our communities is essential to fostering successful conditions for this to occur.

We have reported elsewhere that the reasons behind this desire to age in place include fear of the unknown and change, and comfort with what is known (familiar); wanting to be in control of their lives; and a desire not to be a burden on others. The numbers of seniors reporting that this is what they want is over 90%.

So why does this not happen? Why do many aging Atlantic Canadians fear that they will not be able to live out the last years of their lives in the homes and communities they love? The reasons are many and intertwined. We know that our housing stock is older and not designed for accessibility for any age, particularly when walkers and wheelchairs become part of the equation. We know that in most rural communities the option to move to a more suitable living space just does not exist. We know that as our population ages, there are challenges with providing appropriate care in the home, in particular in the many small rural communities. We know that if we made homes more accessible, people would be able to live in them longer, yet it seems we insist on acting like Peter Pan, building homes designed for people who will never get old or ill.

We know that keeping our aging population in their homes and communities for as long as possible is important now and going to be even more important in the future. As the costs of acute care in Canada grow (these are already over \$1,000 a day)<sup>12</sup> and the number of bed spaces diminishes in proportion to the growing demand, our society will be forced to find other solutions. Another compelling factor is the pending shortage of trained employees to take care of a growing senior population. Despite these trends, the obvious solution of making it possible to age in place is not being championed.

Part of the answer is that the vast majority of seniors do stay in their homes. In fact, couples often have developed compensating competencies that allow them to stay independent by exercising interdependence. But when one of the couple dies or is institutionalized, it can become increasingly more difficult for the other to stay independent in the community.

The physical environment is often not the major problem or barrier. In fact, horrible environments can be overcome by excellent home care support, while the best physical setting will never make up for poor home care assistance. Attaching grab bars, widening doors and making “behavioural adjustments” such as sleeping downstairs in a two-storey house or taking a sponge bath rather than a tub bath are common lifestyle adjustments that older people employ. Although many home modifications are not without costs, they are often one-time-only expenses.

The major barrier to aging at home appears to be the availability of affordable home care. Home care services are often poorly packaged for the multiple needs of older frail people. Their needs are often occasional and sporadic and best doled out in 15-minute increments. However, home care is frequently delivered in two- to four-hour blocks of time. Northern European countries have developed much better systems that slice home care into smaller chunks of time, but the government also heavily subsidizes these visits.

There are three things that could happen now that would help with this challenge:

The first is a program of education aimed at both those now over 70 and those under 70. The goal would be to make both groups aware that they have to take responsibility now when they are well and able to prepare for future living in their homes when they will not be as healthy. We need to make both age groups aware of the types of home modifications and adaptations that will make a significant difference as they age and, in particular, we need to make those under 70, who may be considering new construction, aware of the Home for Life standards, so that they construct for access in any state of health. The third group that should be directly targeted in an education program is property developers and builders. We need them to understand the positive impact Home for Life designs will have on our country in the longer term, and how little additional cost is involved in meeting these standards.

The second action would be supporting demonstration projects that highlight the full range of emerging assistive technologies to aid aging in place.

These technologies are quickly developing, but we need to prove how well they work in addressing the problems of an aging demographic. We talk of delivering in-home tele-health and resident monitoring, but we have to prove the value of these types of costly solutions in real-life situations.

The third action would be a commitment to transfer types of care currently given to seniors in acute care facilities (hospitals) into the homes of tomorrow's seniors. If we could move 25 percent of acute care services to the home by 2020, Canada would be much better positioned to support the age wave. This strategy does not require the construction of large numbers of very expensive acute care rooms in acute care facilities. The direct costs of providing acute care in the home are very similar to those incurred in a hospital but without the expense of building more acute care beds.

In addition to these major actions, there are several positive steps that policy-makers could focus on. Here are a few:

- A home accessibility audit program much like the energy efficiency programs of the past. These audits would provide the homeowner with the knowledge of what is needed and what is possible within their current home.
- A tax rebate program designed to encourage aging in place. One approach would be an escalating tax rebate, starting at say, \$500 at age 75 and growing by \$200 a year for every year the senior remains in their own home.
- Changing the building code by 2016, so that the 16 criteria of the Lifetime Home Standards are compulsory. Homes could be certified by inspectors drawn from the senior population.

While some of these recommendations are beyond the scope of the ASHRA project, they reflect the views of many we heard, both the elderly and those rapidly approaching older age. It is important for everyone to accept personal responsibility for preparing their own homes so that they can age in place if that is what they wish, but it is also important that all levels of government work towards policies that support this goal.



## APPENDIX A

### The Lifetime Home Standards (Joseph Rowntree)

*Please note that references to Part M in this table are a direct quote from the Joseph Rowntree Lifetime Homes (LTH) criteria and apply to the U.K. only. Likewise, Building Regulations (NI) 2006 Part R apply to schemes in Northern Ireland.*

*Source for the 16 criteria:*

[www.dsdni.gov.uk/print/hagsd-tb15-joseph-rowntree-lth.pdf](http://www.dsdni.gov.uk/print/hagsd-tb15-joseph-rowntree-lth.pdf)

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#### 1. CAR PARKING

Where car parking is adjacent to the home, it should be capable of enlargement to attain 3.3 m width.

*Explanatory Note:* The general provision for a car parking space is 2400 mm width. If an additional 900 mm width is not provided at the outset, there must be a provision (e.g., a grass verge) for enlarging the overall width to 3300 mm at a later date or, subject to Road Service approval, the footpath adjacent to lay-by parking may be acceptable.

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#### 2. ACCESS FROM CAR PARKING

The distance from the car parking space to the home should be kept to a minimum and should be level or gently sloping.

*Explanatory Note:* It is preferable to have a level approach. However, where the topography prevents this, a maximum gradient of 1:12 is permissible on an individual slope of 5 m or 1:15 if it is between 5 and 10 m, and 1:20 where it is more than 10 m. Paths should be a minimum of 900 mm width.

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#### 3. APPROACH

The approach to all entrances should be level or gently sloping. (See Explanatory Note at Criterion 2 above.)

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#### 4. EXTERNAL ENTRANCES

All entrances should be illuminated, have level access over the threshold, and have a covered main entrance.

*Explanatory Note:* The threshold upstand should not exceed 15 mm.

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#### 5. COMMUNAL STAIRS

Communal stairs should provide easy access, and where homes are reached by a lift, it should be fully accessible.

*Explanatory Note:*

Minimum dimensions for communal stairs:

- Uniform rise not more than 170 mm
- Uniform going not less than 250 mm
- Handrails extend 300 mm beyond top and bottom step
- Handrail height 900 mm from each nosing
- 

Minimum dimensions for lifts:

- Clear landing entrances 1500 × 1500 mm
  - Minimum internal dimensions 1100 × 1400 mm
  - Lift controls between 900 and 1200 mm from the floor and 400 mm from the lift's internal front wall
- 

#### 6. DOORWAYS AND HALLWAYS

The width of internal doorways and hallways should conform to Part M, except that when the approach is not head-on and the hallway width is 900 mm, the clear opening width should be 900 mm rather than 800 mm. There should be a 300 mm nib or wall space to the side of the leading edge of the doors on entrance level.

*Explanatory Note:*

<b>Doorway clear opening width (mm)</b>	<b>Corridor/passageway width (mm)</b>
750 or wider	900 (when approach is head-on)
750	1200 (when approach is not head-on)
775	1050 (when approach is not head-on)
900	900 (when approach is not head-on)

The clear opening width of the front entrance door should be 800 mm.

## **7. WHEELCHAIR ACCESSIBILITY**

There should be space for turning a wheelchair in dining areas and living rooms and adequate circulation space for wheelchairs elsewhere.

*Explanatory Note:* A turning circle of 1500 mm diameter or a 1700 × 1400 mm ellipse is required.

## **8. LIVING ROOM**

The living room should be at entrance level.

## **9. TWO OR MORE STOREY REQUIREMENTS**

In houses with two or more storeys, there should be space on the entrance level that could be used as a convenient bed space.

## 10. WATER CLOSET (WC)

In houses with three or more bedrooms, there should be a wheelchair-accessible toilet at entrance level with drainage provision to enable a shower to be fitted in the future. In houses with two bedrooms, the downstairs toilet should conform at least to Part M.

*Explanatory Note:* Dwellings with three or more bedrooms

For dwellings with three or more bedrooms or on one level, the WC must be fully accessible. A wheelchair user should be able to close the door from within the closet and achieve side transfer from a wheelchair to at least one side of the WC. There must be at least 1100 mm clear space from the front of the WC bowl. The shower provision must be within the closet or adjacent to the closet (the WC could be an integral part of the bathroom in a flat or bungalow). In entrance level WCs, it is important to meet Building Regulations (NI) 2006 Part R dimensions specified for each side of the WC bowl.

For more information go to: Table 5: LTH – Additional DSD Requirements. ([http://www.dsdni.gov.uk/index/hsdiv-housing/ha\\_guide/hag-index/hagds-design-standards-contents/hagds-lifetime-homes.htm](http://www.dsdni.gov.uk/index/hsdiv-housing/ha_guide/hag-index/hagds-design-standards-contents/hagds-lifetime-homes.htm))

## 11. BATHROOM & WC WALLS

Walls in the bathroom and WC should be capable of taking adaptations such as handrails.

*Explanatory Note:* Wall reinforcements should be located between 300 and 1500 mm from the floor.

## 12. LIFT CAPACITY

The design should incorporate provision for a future stair lift and a suitably identified space for a through-the-floor lift from ground floor to the first floor, for example to a bedroom or next to a bathroom.

*Explanatory Note:* There must be a minimum of 900 mm clear distance between the stair wall (on which the stair lift would normally be located) and the edge of the opposite handrail/balustrade. Unobstructed “landings” are needed at the top and bottom of the stairs.

### 13. MAIN BEDROOM

The design and specification should provide a reasonable route for a potential hoist from a main bedroom to the bathroom.

*Explanatory Note:* Most timber trusses today should be capable of taking a hoist and tracking. Technological advances in hoist design mean that a straight run should no longer be a requirement.

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### 14. BATHROOM LAYOUT

The bathroom should be designed for ease of access to the bath, WC, and wash basin.

*Explanatory Note:* Although there is no requirement for a turning circle in bathrooms, sufficient space should be provided so that a wheelchair user could use the bathroom.

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### 15. WINDOW SPECIFICATION

Living room window glazing should begin no higher than 800 mm from the floor level and windows should be easy to open/operate.

*Explanatory Note:* People should be able to see out of the window when seated. Wheelchair users should be able to operate at least one window in each room.

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### 16. FIXTURES & FITTINGS

Switches, sockets, and ventilation and service controls should be at a height usable by all (i.e., between 450 and 1200 mm from the floor; 600 mm recommended).

*Explanatory Note:* This criterion applies to all rooms, including the kitchen and bathroom.

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## APPENDIX B:

### Analysis of Findings in Relation to Canada's Social Determinants of Health

Both the survey and focus group data identified that many Atlantic Canadian seniors are in a position of vulnerability regarding their housing. Many face housing problems compounded by other significant issues such as poverty, chronic illness, and social exclusion. These circumstances "...are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices" (World Health Organization, 2010). In order to examine the interconnectedness of such issues, we looked at the ASHRA data from a "social determinants of health (SDH)" approach. This approach recognizes that health and well-being are influenced by many factors, of which health services is only one.

The Canadian Health Promotion framework focuses on 12 social determinants of health (Public Health Agency of Canada, 2008):

- income and social status
- social support networks
- education and literacy
- employment and working conditions
- social environments
- physical environments
- personal health practices and coping skills
- healthy child development
- biology and genetic endowment
- health services
- gender
- culture

Housing is a part of the physical environment and is explicitly named as a determinant of health by the World Health Organization (2010), and in the recent Special Senate Committee on Aging Final Report (2009).

In the earlier research report on ASHRA's survey of Atlantic seniors we reported that "as we age, it appears we become more attached to our homes and our community" (*Report on the Atlantic Seniors' Housing and Support Services Survey*, page 7). We also discussed the importance seniors place on being able to stay in their homes for as long as possible, as familiarity with their surroundings helps

them to both keep feelings of independence and control and maintain contacts and friendships. Examining the ASHRA research through the lens of the social determinants of health can broaden our understanding of the issues seniors face.

Seniors identified that the fixed incomes they had planned to rely on prior to retirement are not proving adequate in retirement, as “everything is costing more and more.” Women who rely solely on government pensions are even more impacted. Analysis using the **income and social status determinant of health** framework showed there were significant and reoccurring financial and status issues for many of the focus group participants. Limited income for focus group participants was identified as leading to a loss of independence and freedom to decide where or how they lived. Among the 1519 survey participants reporting their income, 49.4 percent had household incomes of less than \$30,000 per year. Of these respondents, 20 percent spent 40 percent or more of their income on shelter costs.

For the mentally ill, and more particularly for immigrant women, lack of income and social status meant minimal choices in housing and support services. This was closely tied to the SDH of **employment** for many immigrants and people with disabilities, who had small public pensions or no pension at all and difficulty finding work. Single aging individuals without family or an income are losing their status and the support required to find housing that meets their needs.

*... of course [the] thing is money. She's not working. That's really important because going back home, where she was like, brother, sister and her family, all of them they were helping together you know. (Focus Group participant)*

Social support networks are an important resource for seniors and are closely linked to the SDHs of income and social status. These networks are particularly beneficial for those with little income. It is interesting to note that older men and women participants valued and took active roles in the social networks that exist in their communities, providing food, care, social support, and home maintenance services to both friends and neighbours. With many older seniors living in rural areas or somewhat isolated in urban centres, **social support networks** act to buffer the impact of social isolation.

*It is important to have good friends; people to help shovel snow and cut grass. You have to know the right people to help you. (Focus Group participant)*

The ASHRA survey data showed that 33.5 percent of the respondents want to stay in the area where they presently live and if they did move, 20.1 percent would like some form of seniors' housing/apartments. Their reasoning is clear: remaining in one's home community as they age in place or transition to a new dwelling ensures that their social support networks are known and already in place.

ASHRA data show that Atlantic seniors have a number of chronic illnesses that are affecting young elderly as well as the very old. Among the survey respondents, more than 44 percent reported that changes to their health status had more than doubled in the previous five years. Although some **personal health practices and coping skills** are frequently used to examine ill health, a lifetime of positive practices and training is critical for seniors adapting to chronic illness. In the following from the focus group data, an active, although physically and progressively impaired young senior, describes the in-home services that she utilizes in order to maintain her active and involved lifestyle.

*I have a person who comes in and does my bath for me and we pay her through Community Services long-term care and I have a cleaning person that comes in. We set our own schedule as well. So that works out pretty good right now. (Focus Group participant)*

However, not all seniors are as knowledgeable and as capable as the participant above. Low-income seniors with mental health issues require **social environments** to assist them financially and creatively in managing loneliness and developing plans that address their reoccurring housing and support needs.

*That's an idea of something that we call kind of "assisted living," where people have their own independent suite, but there's social space and there's meal support sometimes if you need it, housekeeping support if you need it, and that's something that seniors can access, usually in the city, if they have a lot of money. But right now there's not a lot of options like that for folks who have fixed or limited incomes. (Focus Group moderator)*

The percentage of seniors in the ASHRA study with life-long low incomes continues to have a strong impact on their choices and was particularly evident among focus group participants when seen through the **physical environment** determinant lens.

*Having raised my children in low-income housing, I feel that even the seniors' housing has become ghettoized. I think we see that in the housing on \_\_\_ Street and just down the corner where the drug lords and prostitutes have taken over and threatened the residents to do or die. The size of the buildings, it has a hundred fifty to two hundred. I don't know what the larger buildings are, but I think that's again, part of the ghetto concept of how a lot of seniors came from their own home to live in these units and they're not used to having a hundred fifty neighbours. (Focus Group participant)*

**Physical environments** (WHO, 2004) include “the built environment, factors related to housing, indoor air quality, and the design of communities and transportation systems [that] can significantly influence our physical and psychological well-being.” Urban and rural seniors envision their physical environment in many ways, including the continuum of active aging to that of very old seniors as imagined by a rural participant.

*Well, like the cottages, we have a cottage there where people can live as if growing old, and when they get to a point when they can't look after that, or it's too much, they can move down to the complex. Then, if you also had a seniors' home, where you had full care ... well, not in the hospital. Please, I mean, who in the devil wants to go in a home where you're connected to a hospital ... well, I'm going to end up there tomorrow or the next day. That's not right ... there should be flowers around. There should be nice trees around ... have people go out and sit down in the garden and have a cup of tea if you wanted it. Stuff like this, but it's not happening, I mean, it's like you're shuffled away. Once you get out of the house, you're gone and forgotten. It's, it's, it's, that's not the way I want it. (Focus Group participant)*

The participant's voice reflects the imagination and vision of the built environment described by many rural participants. Such a vision of the physical environment supports an active life into old, old age. Healthy Aging Communities (WHO, 2004) include the physical environment as an integral part of Primary Health Care. ASHRA survey data showed that seniors living in the community see their family physician 44.4 percent of their travels within the community. Most frequently, seniors went to the post office (68.1 percent), to church (58.2 percent) and to the bank (53.9 percent), among a lengthier list of their destinations in the community.

WHO (2004) defines **health services** as “those designed to maintain and promote health, to prevent disease, and to restore health and function that contribute to population health. The health services continuum of care includes treatment and secondary prevention.” Many survey respondents received support with activities required to live well in their own homes, mostly from family members, but several indicated that they needed, yet did not receive help with important aspects of everyday living such as cooking (2.4 percent) or bathing (1.7 percent). In-home nursing care was provided to 2.7 percent, but a further 1 percent indicated that they needed, but did not receive such care.

Travelling to receive services is a way of life for many older Atlantic Canadians. In the ASHRA survey, 31 percent of survey respondents received care from a family physician outside of their communities and 58 percent obtained tertiary care outside their communities. Some seniors experienced difficulties with transportation as well as with accommodation when needed.

**Biology and genetic endowment** can influence health and how a person ages. For instance, genetic endowment provides an inherited predisposition to a wide range of individual responses that affect health status. Although socioeconomic and environmental factors are important determinants of overall health, in some circumstances, genetic endowment appears to predispose certain individuals to particular diseases or health problems. For example, many chronic illnesses or diseases that have a genetic component can seriously affect mobility.

*The nerves in the hands and feet ... have never functioned as they should ... [I] have no sense of feeling ... painless fractures ... wasn't able to walk anymore the bones are just soft and brittle ... I have to be in a wheelchair. (Focus Group participant)*

Strong **social support networks** and the appropriate **physical environment** have sustained this participant to live life to the fullest in a church-sponsored apartment building.

**Education and literacy** are frequently linked with income and wealth. Educational achievement beyond high school was attained by 51 percent of survey participants and 60 percent of focus group participants. The percentage of focus group participants with degrees was much higher in the multicultural and francophone groups as compared with other groups. It was also noteworthy that much of the education discussed in the focus groups was about teaching young people and preparing them for a healthy, productive life within their culture. For example, Aboriginal Focus Group seniors described the value of

educating youth to respect their elders and, in turn, themselves.

*What I think is important is bridging the gap between the elders and the youth, and the elders and the little ones ... nobody's teaching them respect, and we need to go back to that ... so it starts with all of us showing a good example, so to me that's important. (Focus Group participant)*

These values were also shared by multicultural seniors, along with the desire to spend time with their grandchildren and to educate them with traditional meals and family story time.

At the same time, focus group participants were critical of seniors' knowledge of health issues and the need to be educated about what is available for their use.

*Education is the key to that. I mean, find some way to, you know, find some way to be able to inform our seniors as to what is available, what they can get and what they can avail themselves. (Focus Group participant)*

The **healthy child development** and **employment** SDH concepts were illustrated by a Rural/Remote participant and how he taught youth the traditional way of life that had supported him.

*I sometimes address youth groups and stress to them the importance of going out on the land and a traditional way of life. I tell them the answer to a lot of our problems of the day ... is to get out on the land and exercise your rights. That is, I always had the feeling the land has a healing effect on our modern day problems. (Focus Group participant)*

Atlantic Canada is largely rural as shown in the survey data. The **culture** of rural and remote groups was reflected in their civic behaviour to maintain social support networks, as shown in the following quote.

*Every year I go caribou hunting ... kill caribou for a lot of seniors ... I mean this year I killed 15 or 20 and brought them home for other people ... there are seniors and other people who can't get out to get their caribou and that's how they lived all their lives. Now I'm over 70*

*years old and I lived a traditional lifestyle and I like to carry on that tradition. (Focus Group participant)*

By examining the ASHRA research using the 12 social determinates of health, we can see how housing and community play an important role in each determinate. Seniors' living environments, starting with their home and then expanding to their community, influence health in many ways. People experience qualitatively different material environments depending on their housing quality. Overcrowding allows for transmission of respiratory and other illnesses. Some Canadian homes, especially on Aboriginal reserves, lack even clean water and basic sanitation – a fundamental public health risk. Housing provides a platform for self expression and identity. High housing costs reduce the resources available to support other social determinants of health. Living in poor housing creates stress and cultivates unhealthy means of coping, such as substance abuse.

**APPENDIX C:****The Policy Working Group Membership**

Many ASHRA Stakeholders contributed to the policy-relevant discussions of ASHRA findings. We would like to acknowledge the contribution of the following groups to the policy chapter of this document:

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## Endnotes

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