



Service Provision for Seniors: Challenges for Communities in Atlantic Canada*

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Abstract

The delivery of services for seniors in Canada today is inherently complex and challenging. Canada's aging population is affecting the demand for services and changing the face of service provision (i.e., how and where services are delivered; the types of services available). Regionalization of health services, ongoing fiscal constraints, advances in technology and medicine, shifts to community-based care, societal and family changes and the prevalence of chronic disease combined with an aging population are factors contributing to challenges in service delivery for seniors. In this paper, the results from the Atlantic Canada component of a national study about service provision for seniors are reported. Analysis indicates that there are several common challenges that communities in Atlantic Canada face. The results of this study contribute to a better understanding of service provision challenges for seniors for communities across Canada.

INTRODUCTION

Canada is widely recognized as a good place to live and grow old and as a place where a large proportion of seniors enjoy economic security and good health well into old age (Plouffe 2003). Canadians' experience of aging varies from community to community and is highly influenced by a

myriad of factors, such as where one lives, socioeconomic status, access to health services and marital status, which results in communities aging at different rates. Moore and Rosenberg (1997) demonstrated that not only are communities across Canada aging at different rates, but that the forces underlying these rates, such as aging in place and migration, vary from community to community. The authors argued that this results in some aging communities being "service-rich," where seniors have higher health status and are financially better off, and other communities being "service-poor," where seniors have lower health status and are limited financially.

There is a clear downward gradient in the health of Canadians between urban and rural Canada. Those living in rural areas are more likely to higher health risk behaviours, such as smoking and being overweight, and tend to rate their health as poorer (Mitura and Bollman 2003; Shields and Tremblay 2002). As communities change through aging and migration, so too do their ability and capacity to support the needs of their different populations.

The delivery of services for seniors in Canada today is inherently complex and challenging. Canada's aging population is affecting the demand for services and changing the face of service provision (for instance, how and where services are delivered; the types

of services available). Regionalization of health services, ongoing fiscal constraints, advances in technology and medicine, shifts to community-based care, societal and family changes and the prevalence of chronic disease combined with an aging population are factors contributing to challenges in service delivery for seniors (Raphael et al. 2001).

Atlantic Canada has not been immune from the forces for change identified by Raphael and colleagues (2001). It is a commonplace that the economy of Atlantic Canada, oil and gas developments notwithstanding, is much poorer than that of the rest of Canada. Out-migration is a distinctive feature of Atlantic Canada as is the dependence on a predominately resource-based economy. As Table 1 indicates, the picture for Atlantic Canada is one of static or declining population, less urbanization, income levels that are at least 20% below the national level, higher unemployment rates and a marginal higher percentage of seniors.

In this paper, the results from the Atlantic Canada component of a national study about service provision for seniors are reported. The paper begins with an overview of the methods and design of the national study. This is followed by a discussion of the key findings and the challenges confronting communities as they strive to meet the service provision needs of seniors.

*An earlier version of this paper was presented at the 3rd International Conference on Health Economics, Management and Policy, University of Athens, Athens, 3-4 June 2004.

Table 1

	New Brunswick	Nova Scotia	Newfoundland and Labrador	Prince Edward Island	Canada
Population 2001	729,498	908,007	551,792	134,557	30,007,094
Population 1996	738,133	909,282	512,930	135,294	28,846,761
Percent Change	-1.2	-0.1	-7.0	0.5	4.0
Percent Urban	50.4	55.8	57.7	44.8	80
Percent Rural	49.6	44.2	42.3	55.2	20
Percent Aged 65+	13.6	13.9	12.3	13.7	12.9
Medium Income	18,257	18,735	16,050	18,880	22,120
Unemployment Rate	9.8	8.8	15.6	11.3	7.2

Source: Statscan 2001 Census Data and 2001 Community Profiles

It concludes with a commentary on the prognosis for change.

DATA AND RESEARCH DESIGN

This research is part of a larger project entitled *Aging Across Canada: Comparing Service-Rich and Service-Poor Communities*, in which key informants from communities across Canada were interviewed about how and why communities are aging differently, and what factors distinguish a service-rich and healthy community from one that is not. The national study had four components or modules. The first module used data from the 1991 and 1996 censuses to demonstrate that differences between aging in place and migration significantly affect the rate at which communities age. The second component, using factor analysis, combined socio-economic data on the population of communities, data on acute healthcare services and health personnel and information on long-term medical and non-medical services, to identify a number of distinct clusters of health regions in Canada. The analysis produced 10 distinct clusters:

- Major metropolitan centres, high immigration, above average income,

high social deprivation (SD), better than average community health (CH)

- Large cities, high income, moderate immigration, low SD, good CH
- Medium-size cities, average income, SD, CH
- Semi-rural regions, above average income, low SD, good CH
- Semi-rural regions, average income, low SD, good CH
- Semi-rural, low income, high SD, below average CH
- Northern Prairies, low income, high aboriginal population, high SD, poor CH
- Northern semi-urban, above average income, moderate aboriginal population, low SD, average CH
- Northern urban, high income, low SD, below average CH
- Northern rural, low income, high aboriginal population, high SD, poor CH

The result of the cluster analysis was mapped for the country, and it was on the basis of the distribution of the clusters that communities were to be selected for further investigation.

The third component of the study was the purposeful selection of

communities from across the country that corresponded to each of the 10 clusters. One community per province was selected for further analysis. In addition to being identified statistically as “service-rich” or “service-poor,” the communities were selected to reflect the different sizes of places, rural and urban environments and northern and southern dichotomies in Canada.

Three clusters dominate in Atlantic Canada: Cluster 3 – medium-size cities, average income, social deprivation, community health; Cluster 5 – semi-rural regions with average income, low social deprivation and good community health, and Cluster 6 – semi-rural regions with low income, high social deprivation and below average community health (Moore and Rosenberg 2002). The data reported here are from in-depth case studies of four communities in Atlantic Canada: Moncton, NB; St John’s, NL; Summerside, PEI; and Sydney, NS. St. John’s is indicative of Cluster 3, Moncton Cluster 5 and Summerside and Sydney, Cluster 6.

The four communities individually are microcosms for Atlantic Canada and the clusters they represent (see Table 2). For example, Moncton is the most affluent of the four, with the highest medium income and lowest unemployment rate, whereas Sydney is clearly the poorest, with the lowest medium income and an unemployment rate that is more than double that of Moncton. St John’s and Summerside occupy the middle ground between the other two.

The data for this research document the perceptions and understandings of

Table 2

	Moncton, NB	Summerside, PEI	St. John's, NL	Sydney, NS
Population 2001	61,046	14,654	99,182	105,968
Population 1996	59,313	14,525	101,936	114,733
Population Change	2.9%	0.9%	-2.7%	-7.6%
Population 65+	14.8%	15.4%	12.7%	16.4%
Medium Income	\$20,066	\$19,275	\$19,442	\$16,618
Unemployment Rate	8.2%	11.4%	11.7%	19.4%
Ratio Female/Male Population 65+	1.40	1.62	1.63	1.49

Source: 2001 Statscan Community Profiles

service providers from local governments, development authorities, healthcare institutions and voluntary organizations about service provision for seniors in their community. A broad range of informants from various sectors were contacted in order to capture the complex dimensions of service provision in Atlantic Canada. A total of 31 in-depth interviews were conducted with key informants in the four communities in the spring and summer of 2003. The key informants were drawn from senior officials and administrators from local municipal governments, chambers of commerce, economic development authorities, healthcare institutions (health authorities, hospitals, long-term care facilities and home care providers), seniors' associations, seniors' advocacy groups and voluntary and non-profit service agencies (healthcare, home care, housing, and recreation).

The key informants were asked a series of semi-structured and open-ended questions about the current dimensions of the formal service environment for seniors in the community. The interviews followed a common format (see Appendix 1) in which participants were asked to identify the strengths and weaknesses

of the current situation, define a service-rich community and comment on the local constraints to becoming service-rich. All interviews were taped and transcribed. Responses were combined with secondary data sources and supplemented by field observation. Data analysis entailed thematic content analysis of the data in which emergent and recurrent themes were identified and responses were categorized.

RESULTS

The findings demonstrate that communities in Atlantic Canada face similar challenges in the provision of services for seniors. The challenges identified are grouped under four categories: broad systemic challenges, lack of housing and care options, lack of integration and coordination of services and disparities between rural and urban geographies. Where relevant and appropriate, selected comments of particular key informants have been inserted into the text. The use of such comments is intended to illustrate the prevalent perceptions of certain commentators. Although each grouping is addressed as a discrete entity, many of the challenges identified are related and overlapping.

SYSTEMIC CHALLENGES

Participants in every community identified broad systemic challenges that affected seniors and service providers in a less than positive manner. Many of these issues concern access to health services, for example, long waiting lists for services such as hip/knee replacement surgery and limited or no access to a family physician in some communities. Health system reforms have resulted in shorter hospital stays and a shift to community-based care. Service providers indicated that shorter hospital stays are putting more pressure on home care services and informal caregiving networks. Home and community care services were noted to be "resource-poor" with limited capacity to provide for the growing needs of seniors. The healthcare system in Atlantic Canada, in common with elsewhere in the country, relies heavily on informal or family caregivers and several health services providers observed that caregivers could use more support: for example, greater access to home care services, workplace programs, unemployment benefits, income tax breaks. Interestingly, home care providers spoke not about shortages in support for seniors, but about the challenges in recruiting and retaining home care workers: a job in Atlantic Canada that is often characterized by low wages, difficult working conditions and unstable working hours.

There should be some benefits or some ways that if you've got a natural caregiver, that the caregiver can take some time off work without penalties to take care of an elderly person or sick person at home...maybe you should go through unemployment benefits to have a block of time you can take off to help an elderly or sick person. (Senior Health Authority Administrator)

There was a strong sentiment among acute care providers who felt they were directly affected by broad systemic problems, such as under-funded home care programs. It was their contention that many seniors occupying acute care and emergency room beds could be maintained by home care service but are prevented from doing so because such services are either limited or unavailable in many communities. Service providers felt that they were the “catch net” for all the clients for whom home and community care services could not provide.

A big gap here is resources in the community for seniors; it's not our mandate but the community doesn't seem to be responsive or doesn't take responsibility. If there is a person who really should be maintained in their home on high-level care, they don't have the resources. But they're backed up in acute care and we get them. (Senior Health Authority Administrator)

Long-term care and home care are not considered to be “medically necessary” and therefore are not insured services under the Canada Health Act, resulting in variations across the country in the level of care that is provided and who pays for it. In Atlantic Canada, service providers and seniors noted that current long-term care funding mechanisms were unfair compared to other parts of Canada where the medical component of long-term care is subsidized to varying degrees. In Atlantic Canada, although policy and practice vary between provinces, generally service users with the ability to pay are responsible for most, if not all, of the full cost of care. Participants felt this condition unduly affected seniors and families who often are forced to utilize their “hard-earned” assets, such as selling the family home

in order to cover the cost of long-term care. Nursing homes in some communities were noted to be older and in need of repair and modernization (e.g., establishments that accommodate four to a room versus single person accommodation and/or rooms without washroom facilities). Long-term care providers commented that shifts to community-based care have also resulted in seniors entering long-term care at an older age with higher acuity than in the past (e.g., clients are wheelchair bound and/or often incontinent).

Nursing homes are terribly expensive. The healthcare portion [of] Medicare is supposed to pay for everything. But if you go to a nursing home you have to pay the whole shot. Not only accommodation and meals, also the healthcare which if you weren't in a nursing home would be provided free by Medicare. (Representative of Seniors Association)

The big issue though that comes up all the time is certainly a sense of unfairness with people who have to go into nursing home care who have to give up their property in order to do that. It's a big issue...people buy homes and maintain property because they want to leave it to their children. That has been a time, centuries-old tradition, right? And people who have to go into nursing home care and are forced to sell off their property to pay for nursing home care don't feel that that is fair. (Chamber of Commerce Representative)

About 10 to 15 years ago many of the residents that we look after now would have been in the hospital in their extended care units where people would be paying nothing for their service. And now...as a single entry point system came in and all the community

programs were put into place in the early and mid-nineties, people that we used to get are now staying in home. So people coming into us now are often incontinent, often in a wheelchair, often require a lot of help with the activities of daily living. (Long Term Care Administrator)

LACK OF HOUSING AND CARE OPTION

Participants in every community identified serious gaps or deficiencies with respect to housing and care options for seniors. Service providers stated that options for seniors were generally limited to two extremes: in-home supportive services and institutional nursing home care. Providers commented that a weakness in their community was the ability to provide a continuum of care and alternative models of housing/care, such as adult day programs, self-managed care, enriched housing, group homes, cooperative arrangements and subsidized seniors' apartments. Deficiencies in housing and care options can result in a situation of “forced institutionalization” where seniors have no other option than facility-based care before it is actually necessary. Providers were concerned that being admitted to a nursing home too early can have a negative impact on seniors' health, activity level and ability to be members of the community and can generate feelings of isolation. Service providers were of the opinion that the majority of seniors in their community were in good health and did not require highly specialized care. Rather, resources are needed to improve services that help with the activities of daily living (e.g., home care) and those that focus on socialization and stimulation.

We still have gaps in services. Particularly in the assisted living

category there is not much between living in your own home and going to a nursing home. There are not many alternatives in this system. (Senior Health Authority Administrator)

Most of senior people are in fairly good health. They don't need a physician or specialized healthcare. What they need is help for daily activities, and most of all to go out, to stay connected with other living people. If you are parked in a nursing home and you barely go out of there and the only thing you do is watching television and playing bingo once a week, it's sensorial deprivation. You deteriorate just because of that. (Senior Health Authority Administrator)

In communities where there was a greater variety of alternative care and housing arrangements, the demand for these services was felt to be greater than the supply. Providers expressed a need for housing and care options that respond to individual and changing needs and services that focus on “aging in place.” Participants also noted that there were even fewer options for seniors with more specialized care needs (e.g., psycho-geriatric, dementia/Alzheimer’s disease, aggressive behaviour). Acute care providers felt pressured particularly by the lack of options in their facilities for dealing with increasing numbers of seniors who cannot be maintained by home care services and who occupy acute care beds waiting for placement in appropriate facilities. Providers believed that communities that were “richer” had greater options for seniors, due in part to the larger number of seniors and more seniors with the ability to pay privately for services. Correspondingly, rural and isolated communities with their small population base have greater difficulty providing a variety of

housing and care options for seniors.

We do have the continual services here right from the community into the institutional sector. Where we are weak is that we don't have the alternatives in the community so that people have more choice in terms of where they live and at what point they have to enter into an institutional setting. What we don't have are things like alternative living arrangements, cooperative arrangements where more than one senior could live in the same housing complex, special units where people with dementia live in the community...in a protective environment in a more home like setting. Those are the kinds of services, those alternatives in the community, that we have not well-developed. (Home Care Provider)

Again in the small communities where you don't have enough people it is difficult to have you know, a continuum and all the different types of housing, and at an acceptable price too. If you are rich, you have no problem, but it has to be affordable. (Senior Health Authority Administrator)

LACK OF COORDINATION AND INTEGRATION

Service providers and seniors stated that the services for seniors were not well coordinated or integrated in Atlantic Canada, especially non-acute services in the community (e.g., home care services, not-for-profit volunteer services). Services are not coordinated in any formal systematic way; rather, there is an element of luck or “getting in touch with the right person” when it comes to accessing and coordinating services. In acute care settings, services are often coordinated through informal meetings and conversations with colleagues and clients, especially in smaller facilities and towns. At the

community level, informal networks are heavily relied upon (e.g., through neighbours, family, church community) in rural areas to coordinate services for seniors. New Brunswick is an exception to this, where the extensive Extra-Mural home care program has improved the coordination and integration of services for seniors, particularly for those going from acute care to community settings.

Well, they're well coordinated if the senior gets to the right people. It's knowing where to start. Some of the seniors have never needed help before and maybe don't have a close family right here in town. Once you get them in touch with the right people, the right social agency or hospital or home care, then it's okay. But it's getting that first step – some of them wait far too long. They talk to their old neighbour next door who doesn't know anything more than them. Once they get in touch with the right agencies it is fairly well coordinated. (Seniors Association Representative)

A contributing factor to poorly coordinated and integrated services is a lack of awareness about what services are available in their community. Communities with seniors’ resource centres were better equipped for keeping providers aware of available services. Many providers, it appears, simply refer seniors to local resource centres for information. However, not all seniors have the capacity to seek out services on their own. Seniors with a greater capacity to ask questions or make phone calls were at a clear advantage vis-à-vis other seniors. Participants suggested that a more formalized “one-stop shopping” approach could be implemented that would make it easier for seniors to get access to and organize services. Providers also expressed a need

for greater collaboration and integration among service providers to promote awareness of service, avoid duplication and raise current seniors' issues and for networking opportunities.

I think it is not coordinated. If it was coordinated, then we might be able to see that we had more services. But I look around and I see people who come in who have never had a contact with any service whatsoever. Who come in with obvious things that we could fix. People who have had poor foot care, people who have some memory lapses, people who aren't taking their medication, people who haven't had a social outing or any kind of social interaction for a while. And I think that we could, with a more coordinated approach, give them choices. (Senior Health Authority Administrator)

I was talking to a group of special care homes and you know, I was telling them, well, you can have the services of the VON and you can have the services of this and that and they said where do we get that information. So people need some more kind of education and work about how to get these services, how to network. (Seniors Advocacy Group Representative)

RURAL AND URBAN GEOGRAPHIC DISPARITIES

Regionalization in healthcare and municipalities entails that service providers are responsible for both the urban core of cities and towns as well as the rural peripheries. Service providers noted great disparities between the services available for seniors in urban versus rural areas, and the many challenges there are in providing services to rural and remote parts of Atlantic Canada. Providers noted that rural hospital services have been reduced or eliminated, that,

rural areas do not have easy access to '24/7' emergency services and pharmacies and that some are without family physicians. Recruiting and retaining health practitioners in rural areas is a major challenge.

Access to good transportation, especially public transit, is an important concern of seniors (Bryant et al. 2004). Without good access to transportation, seniors, especially those in rural communities, often feel isolated and unable to fully benefit from recreational activities and support networks. Transportation is a serious concern in rural communities. Few municipalities provide public transportation in rural areas, and private services are limited and costly. Thus, there is almost a complete reliance on private car ownership. While noting that rural service provision can be challenging, key informants also highlighted the positive attributes of rural communities. Rural communities were noted to be more active in addressing seniors' issues and to have great problem-solving capabilities. Rural communities were also considered to be "close knit" and to rely on each other more than in urban environments.

Sometimes little communities will get organized on their own, depending on key people in the community seeing a need and wanting to make sure that that need is met. You've got a closer knit community. And a lot of people who are used to helping out, who are probably retired and the kids have moved out of that community. (Senior Health Authority Administrator)

DISCUSSION

The results of this study reflect service provision for seniors in Atlantic Canada; however, the challenges identified are not unique to these provinces. Similar challenges have been identified

elsewhere in the country (Cloutier-Fisher and Joseph 2000; Bryant et al. 2004; Hanlon and Halseth 2005). In an analysis of place and scale effects on service provision for seniors in two communities in Ontario, Rosenberg and Skinner (2003) reported lack of funding, co-ordination, transportation and home care were significant barriers to providing more adequate services. Regionalization, ongoing fiscal constraints, advances in technology and an aging population have contributed to major health system reforms in Canada (Bergman et al. 1997). With fewer and smaller acute care facilities, the long-term care of older people has shifted to homes and communities, increasing the pressure on primary and continuing care networks and families (Bergman et al. 1997). The present system of service delivery for seniors is a complex network of policies and programs that have evolved slowly on a piecemeal basis (Keefe 2002). The current system is characterized by lack of coordination, lack of knowledge about services, fragmentation of services, inappropriate and costly use of acute care hospitals and long-term care institutions and increasing pressure on the quantity and quality of publicly funded community-based resources (Bergman et al. 1997; Wiles 2003).

Reduced government funding continues to plague the provision of services for seniors in Canada (Bryant et al. 2004). The reduction of federal and provincial funding without additional resources being made available to community care was perceived by respondents in this research to be a significant barrier to providing quality care. Even where governments have looked for alternative solutions to address the inadequacies of the current system, the results have been mixed. The Government of Ontario's move to a managed competition model for long-

term care paradoxically only added to the diversity and uncertainty that was already evident in the existing service provision equation (Cloutier-Fisher and Joseph 2000). In New Zealand, efforts to expand the role of the “third sector” (non-government; non-profit) raised important policy concerns. Crampton and colleagues (2001) noted that, while “third sector” providers, “may be convenient for proponents of reduced state involvement in funding and provision of health care,” they have serious concerns about the consequences for equity and social cohesion.

There was a widespread recognition that the current challenges are only going to be exacerbated by the growth of the aging population, particularly the “baby boomer” demographic group (Foot 1989). When asked what constraints communities are facing in becoming more service-rich, nearly all of the responses emphasized the need for more resources. Service providers commented that they could soon be facing a crisis situation if they did not “get it right soon” and address the barriers to care. They looked towards the future with anxiety. Policy makers and the media have rather uncritically accepted that the future growth of the elderly population will have dire consequences for health and social policies unless substantial changes take place in federal and provincial programs (McDaniel 1987). Recognition does not equate to action; Canada is still a country without a national home care policy or national housing strategy. This policy vacuum persists despite the strong recommendations contained in the Final Report of the Commission on the Future of Health Care in Canada (2002) and the Final Report on the State of the Health Care System in Canada of the Standing Senate Committee on Social Affairs, Science and Technology (2002). The question that remains is

who will address these challenges and how. Progress on this has not been promising. The most recent attempt at mapping out a national home care plan apparently has failed to get off the drawing board (Laghi and Smith 2004).

CONCLUSION

Service providers must determine how to balance the increasing pressure from population aging with decreasing resources, without compromising the quality of service for seniors. A start would be to seek the views and values of seniors, the “forgotten stakeholders” (Gallagher and Hodge 1999). Another way forward would be to recognize the strengths that exist in communities: seniors’ knowledge of simple measures for sustaining health care, the array of established community-based networks, both formal and informal, and better utilization of the range and skills of community-based health professionals (Averill 2003).

Currently, however, reduced government funding, increasing costs and lack of options are seen as threatening the quality of life for seniors in communities in Atlantic Canada. Consequently, unless policy makers, service providers and stakeholders find ways to address the four challenges articulated above, the prognosis is not encouraging for the development of service-rich communities in Atlantic Canada.

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Acknowledgments

The authors acknowledge gratefully the financial support for this research from the Canadian Institutes of Health Research (CIHR Grant No. YY1 44646). The objectives of the project are: 1) demonstrate how communities are "growing old" as a result of aging in place and migration; 2) identify service-rich and service-poor communities; 3) identify the factors that lead individuals [aged 45 and over] to move in anticipation of greater service needs and/or to move as a result of decline in health status that necessitates greater use of services; and 4) carry out in-depth case studies in selected service-rich and service-poor communities to understand what makes a community "service-rich" and why communities become service-poor.

APPENDIX 1

Interview Guide

(1) Current dimensions of formal service environment for seniors in the community:

- Please explain what health/ non-health services and facilities are available to seniors in your community.
- Please describe the organizations that provide services for seniors in your community.
- Please explain how services for seniors in your community are delivered (i.e., are they delivered by professionals, volunteers, some mix of the two, for-profit, non-profit, directly by government, etc.).
- Please describe the overall scale of operation for services in your community (i.e., minimal, moderate, extensive).
- Please explain how services for seniors in your community are coordinated.
- Please explain the relationship between the services that are provided in your community and the local / regional health authority.

Specific questions for individual organizations:

- What services does your organization provide to seniors in your community?
- What is the administrative structure of your organization?
- To whom does your organization report?
- What are the roles and responsibilities of your organization with respect to seniors in your community?
- What capacity does your organization have to provide services for seniors?
- From where does the funding for services provided by your organization come?

(2) Impressions of formal service environment for seniors in the community:

- What is your overall impression of the current services available for seniors in your community?
- What are the strengths of the services that are currently provided to seniors in your community?
- Which services for seniors in your community work well? Please explain why.

- What are the weaknesses of the services that are currently provided to seniors in your community?
- Which services for seniors in your community do not work well? Please explain why.
- What services for seniors do you think your community needs most? Please explain why.
- Do you think your community is attractive to seniors? Please explain why.
- Do you think your community is supportive of seniors' independence? Please explain why.
- Does your community actively try to encourage seniors to remain in the community?
- Does your community actively try to encourage seniors to move into your community as a retirement destination?
- What difficulties do you think your community has in attracting seniors?
- What difficulties do you think your community has in supporting seniors' independence?
- What initiatives/solutions have been taken or are planned to deal with difficulties and constraints regarding services for seniors in your community?

(3) Definition of a service-rich community:

- How would you define a service-rich community?
- How would you define a service-poor community?
- What constraints does your community face in becoming more service-rich?
- Do you believe that your community is service-rich or service-poor with respect to seniors? Please explain why.