

Ageing in the *Right* Place: Supporting Older Canadians to Live Where They Want



AGEING IN THE
RIGHT PLACE

October 2022

NINA NATIONAL
INSTITUTE
ON AGEING *

National Institute on Ageing

Suggested Citation:

National Institute on Ageing (2022).
Ageing in the Right Place: Supporting
Older Canadians to Live Where They Want.
Toronto, ON: National Institute on Ageing,
Toronto Metropolitan University.

ISBN: 978-1-77417-048-9

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About the National Institute on Ageing

The National Institute on Ageing (NIA) is a public policy and research centre based at Toronto Metropolitan University (formerly Ryerson University). The NIA is dedicated to enhancing successful ageing across the life course. It is unique in its mandate to consider ageing issues from a broad range of perspectives, including those of financial, psychological, and social well-being.

The NIA is focused on leading cross-disciplinary, evidence-based, and actionable research to provide a blueprint for better public policy and practices needed to address the multiple challenges and opportunities presented by Canada's ageing population.

The NIA is committed to providing national leadership and public education to productively and collaboratively work with all levels of government, private and public sector partners, academic institutions, ageing related organizations, and Canadians.



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List of Acronyms

- Activities of Daily Living (ADLs)
- Ageing in the *Right* Place (AIRP)
- Canada Pension Plan (CPP)
- Canadian Community Health Survey (CCHS)
- Canadian Institute for Health Information (CIHI)
- Canada Mortgage and Housing Corporation (CMHC)
- Cardiovascular Disease (CVD)
- Chronic Disease Prevention and Management (CDPM)
- Chronic Obstructive Pulmonary Disease (COPD)
- Emergency Department (ED)
- Gross Domestic Product (GDP)
- Home-Based Primary Care (HBPC)
- Long-Term Care (LTC)
- National Institute on Ageing (NIA)
- Naturally Occurring Retirement Communities (NORCs)
- New Horizons for Seniors Program (NHSP)
- Odds Ratios (OR)
- Organization for Economic Co-operation and Development (OECD)
- Parliamentary Budget Office (PBO)
- Personal Emergency Response Systems (PERS)
- Public Health Agency of Canada (PHAC)
- Quebec Pension Plan (QPP)
- Total Health Expenditure (THE)
- Variable Payout Life Annuities (VLPAs)
- World Health Organization (WHO)

*Does not include acronyms of programs from the rapid review

Executive Summary

Canada is currently undergoing its most significant demographic transition. Canadians aged 65 years and older now represent its fastest growing demographic group, and by 2031, when the oldest baby boomers begin turning 85, nearly a quarter of Canadians will be aged 65 years and older. Supporting an older population requires the right combination of health and social services to meet the unique and complex care needs of older adults.

Canada's health care and support systems, however, have not kept pace with its rapidly ageing population. Currently, Canadians aged 65 years and older comprise about one-fifth (19 per cent) of the population,¹ but already account for almost half (47 per cent) of all health care spending.² One large driver of these public health care costs is the provision of long-term care (LTC) services — through both publicly funded LTC homes and home care in private dwellings — for which demand will only continue to grow in the coming years. Yet Canada's provinces and territories are already struggling to meet the needs of their older populations.

Canada spends a significantly larger share of its LTC expenditures on institutional care in LTC homes compared to home and community-based care, despite the latter being overwhelmingly preferred by Canadians. Moreover, not all adults with complex care needs require care in LTC homes, with estimates suggesting that between 11 and 30 per cent of Canadians admitted to LTC homes could have potentially remained at home and in their communities if adequate home care and

community supports were available.^{3, 4} Prioritizing institutionalized care despite the higher costs makes Canada's current LTC systems both inefficient and unsustainable. Governments need better, more cost-effective solutions to meet the LTC needs of their ageing populations.

Supporting older adults to age in their own homes and/or communities for as long as possible, commonly referred to as "ageing in place," can help Canada's already-strained LTC systems. Yet doing so effectively also requires responsive systems and services that can enable what the National Institute on Ageing (NIA) calls "*Ageing in the Right Place*." Recognizing the growing importance of supporting older Canadians' ability to age successfully while remaining engaged members of their communities, this report aims to present a practical definition and framework to understand what ageing in the *right* place (AIRP) is and what is required to make it work. It also highlights existing best practices and opportunities that can reduce unnecessary LTC home admissions and better support the implementation of successful AIRP policies and programs across Canada and beyond.

The NIA defines Ageing in the ***Right*** Place (AIRP) as "***the process of enabling healthy ageing in the most appropriate setting based on an older person's personal preferences, circumstances and care needs.***"

Based on this definition, the NIA has further identified four pillars that are fundamental to enabling AIRP:

1. *Promoting Preventive Health and Better Chronic Disease Management*
2. *Strengthening Home and Community-Based Care and Supports for Unpaid Caregivers*
3. *Developing More Accessible and Safer Living Environments*
4. *Improving Social Connections to Reduce Loneliness and Social Isolation*

These distinct yet interconnected pillars represent the NIA's comprehensive framework of factors that are essential to better supporting older adults to remain in their own homes and communities for as long as they wish. This framework can be used to support AIRP policies and practices at the individual, local, regional, and federal levels, while recognizing that AIRP policies and practices exist in an evolving context of varied social, economic, political and environmental factors. For each of the four pillars, the NIA has examined the evidence to show how and why it is critical to supporting AIRP and reducing unnecessary LTC home admissions, and the specific initiatives that can help better achieve the intended goals of each pillar.

The NIA has also conducted a supporting rapid review to identify the availability of current policies and programs focused on supporting AIRP across Canada related to each of the four pillars. This rapid

review provides an overview of how well Canada's federal, provincial and territorial governments are enabling AIRP. Numerous programs were identified across all four of the AIRP pillars, with many services identified as being either available to older adults or designed specifically to support them. Alberta, British Columbia and Ontario were the most well-represented jurisdictions, with multiple programs aligning with each of the four AIRP pillars. However, there were fewer services available in the territories, especially in Nunavut. A common trend that emerged during the review was the limited availability of programs based on location, with many being offered only in certain regions of Canada's provinces and territories.

Finally, the NIA has developed 10 evidence-informed policy recommendations to provide policy- and decision-makers with pragmatic solutions to better address the gaps identified through our review and more effectively support AIRP policies and practices across Canada:

1. Provide adequate and sustainable LTC funding
2. Adopt a deliberate public policy response that shifts more LTC resources from the provision of institutional care to home care and community-support services and ensures that only individuals requiring care in LTC homes are admitted to them
3. Implement care models and policies that enable more older Canadians to live at home and in their communities with greater independence
4. Establish community-care navigator roles to ensure that LTC recipients receive timely, appropriate care and have opportunities to remain engaged in their communities

5. Enable local governments and stakeholders to provide more inclusive, accessible and safe housing options
6. Support greater investments in more accessible and flexible transportation options
7. Integrate screening and solutions for social isolation and loneliness into the delivery of health care, home care and community-support services
8. Implement more focused and coordinated efforts to promote falls awareness and implement evidence-based, effective and accessible fall-prevention strategies
9. Improve financial and non-financial supports for unpaid caregivers
10. Continue to support research on factors that can enable AIRP, as well as potential interventions to support the development of evidence-based policies and practices

Background and Context

Canada is currently undergoing an unprecedented demographic transition as Canadians aged 65 years and older now represent its fastest-growing demographic group. Two principal factors — significant advances in medicine that are allowing people to live longer, healthier lives, and declining birth rates — are fuelling the rapid ageing of Canada's population.

Between 1920 and 2020, life expectancy in Canada increased from 60 to 82 years of age, and is now one of the world's highest.⁵ Furthermore, Canada's "baby boom" generation, the large cohort of individuals born after World War II, began reaching 65 years of age in 2011 and 75 in 2021.⁶ By 2031, when baby boomers begin turning 85, nearly a quarter of Canadians will be aged 65 years and older. As a result, the age structure of Canada's population is rapidly changing. In 2015, Canadians aged 65 and older began to outnumber children aged 15 and younger for the first time; they will continue to do so for the foreseeable future. Moreover, the number of Canadians aged 85 and older is expected to more than triple over the next 30 years.⁷

Canada's current health and social infrastructure and support systems are ill-equipped to handle its rapidly ageing population. When the country established its universal health care system, known as "Medicare," in 1966, the median age of Canadians was 25.5, and most Canadians did not live beyond their late 60s or early 70s.⁸ The system was designed with a focus on treating acute illnesses and ensuring all Canadians had universal access to primary care and hospital care. Similarly, the Canada

Health Act, implemented in 1984, did not actively address the universal provision of long-term care, pharmacare or dental care, as other countries providing universal health care coverage were already doing for their rapidly ageing populations.

Today, Canada's population looks markedly different than it did in 1966, yet its health care and support systems have not kept pace with the evolving needs of its ageing population.

In other words, while Canada's population has changed, its systems haven't. As they age, older adults are more likely to experience declining physical and cognitive health, leading to a greater demand for health and social services. In addition to requiring more care in general, older adults require different types of care and services than younger people. Older adults are more likely to be living with multiple chronic diseases or disabilities and complex care needs, requiring a more flexible and responsive system offering care, services and supports across the continuum of care. Building capacity to meet the demands of a growing population of older adults will thus not only require expanding LTC services, but also transforming the way that care is provided.

Key Terms

Long-Term Care (LTC): The NIA defines long-term care as a range of preventive and responsive care and supports, primarily for older adults, that may include assistance with activities of daily living (ADLs) and instrumental activities of daily living (iADLs), provided by either not-for-profit or for-profit providers, or unpaid caregivers in settings that are not location-specific. LTC services can be provided in designated buildings designed for that purpose (including nursing homes, retirement homes, assisted living facilities and supportive housing) or in home and community-based settings.

Activities of Daily Living (ADLs): The World Health Organization (WHO) defines these as “the basic activities necessary for daily life, such as bathing or showering, dressing, eating, getting in or out of bed or chairs, using the toilet, and getting around inside the home.”⁹

Instrumental Activities of Daily Living (iADLs): The WHO defines these as “activities that facilitate independent living, such as using the telephone, taking medications, managing money, shopping for groceries, preparing meals and using a map.”¹⁰

Home Care and Community-Support Services: This term refers to care that is provided in home-based settings rather than in a hospital or a LTC home, and which allows individuals to remain independent in the community.¹¹ Home care can be grouped into two types: home care services and homesupport services. The former principally focuses on the provision of health care services by trained professionals, whereas homesupport services focus on facilitating ADLs and include non-medical services (e.g. personal care).¹² Home care may be supplemented with community-based support services (e.g. adult day programs) to help older adults engage with their social and physical environments.¹³

The increasing demand for health and social services, including LTC, is also increasingly threatening the fiscal capacity of Canada's health- and social-care systems.

Canadians aged 65 years and older comprise nearly one-fifth (19 per cent) of its total population,¹⁴ but already account for almost half (47 per cent) of its health care spending.¹⁵

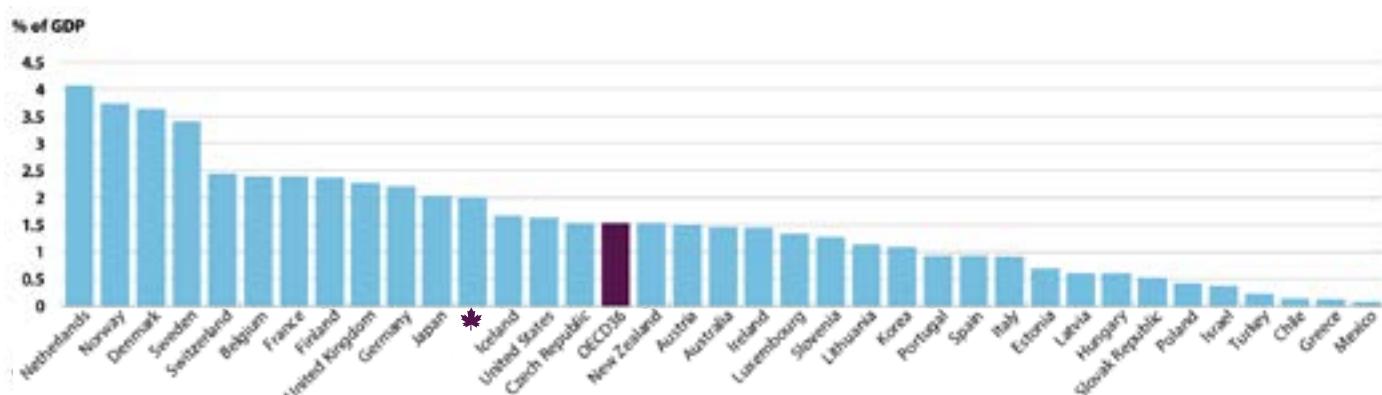
While the average Canadian aged 64 years and younger costs the public health care systems \$2,700 per year, the average Canadian aged 65 years and older costs them \$12,000 per year.¹⁶ A large and growing proportion of public health care spending for older Canadians goes toward LTC services, including both publicly funded LTC homes and home care in private dwellings. The National Institute on Ageing (NIA) estimated that in 2019, \$22 billion was spent on publicly funded LTC services across Canada, including both home care and LTC homes. This figure is expected to triple over the next 30 years,

increasing to an estimated \$71 billion by 2050. Furthermore, demand for home and community-based care is expected to increase by 120 per cent over the same period.¹⁷

While government spending on LTC is increasing across Canada, it still falls below that of other Organization for Economic Co-operation and

Development (OECD) countries. While Canada spent two per cent of its gross domestic product (GDP) on LTC services in 2019, almost 25 per cent above the OECD average, it still trailed 11 other countries such as Denmark, Germany and Japan — and spent half as much of its GDP on LTC services as the Netherlands (**Figure 1**).¹⁸

Figure 1. Total LTC Spending as a Share of GDP, 2019 (or Nearest Year) Across OECD Countries



Source: OECD. (2021). *Health at a Glance 2021: OECD indicators*. OECD iLibrary. Retrieved August 1, 2022, from: https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2021_ae3016b9-en

Canada's LTC expenditures accounted for 18.5 per cent of its total health expenditures in 2019, which was relatively low compared to other OECD countries such as Norway (29.5 per cent), the Netherlands (28 per cent), Sweden (26.3 per cent), Denmark (24.9 per cent) and Belgium (22.5 per cent).¹⁹

In the 2021 federal budget, Canada's government announced its intention to both improve the provision of LTC and support more ageing-in-place initiatives. The government pledged \$90 million over three years for a new Age Well at Home initiative that would assist community-based

organizations in providing support to older persons. The government also announced \$3 billion in funding over five years to improve the delivery of care in Canadian LTC homes by developing and implementing new national LTC standards. During the subsequent 2021 election, the re-elected Liberal Party expanded its \$3 billion commitment to \$9 billion, including \$1.7 billion over five years to raise wages for personal support workers and \$500 million to train up to 50,000 new personal support workers. It also pledged to create a committee to offer recommendations for establishing a new Aging at Home Benefit.

On October 6, 2022, the Ministers of Seniors and Health announced that the National Seniors Council will serve as an expert panel to provide recommendations for establishing the Aging at Home Benefit.²⁰

Traditionally, Canada's spending on LTC has been more heavily weighted toward institutional care than the home and community-based care that is both less expensive and overwhelmingly preferred by Canadians.

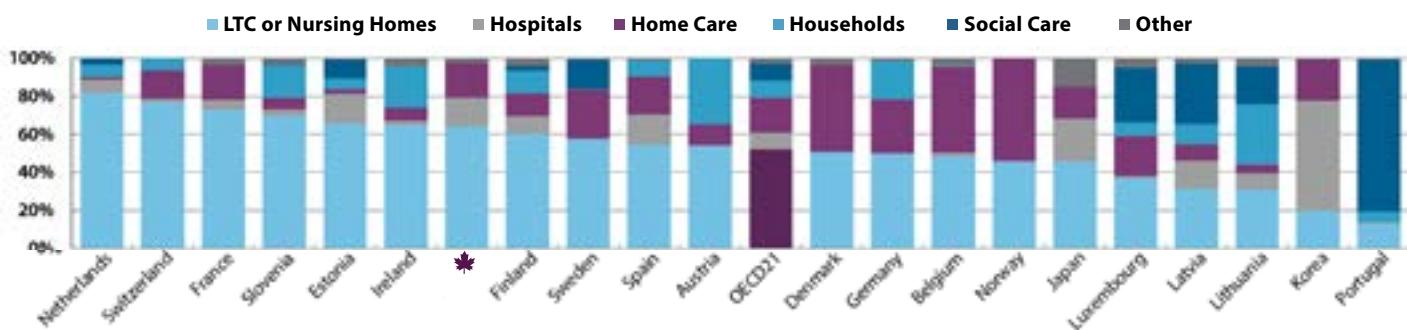
The OECD's most recent available estimates reveal that in 2019, 64 per cent of Canada's LTC expenditures was allocated to institutional care in nursing or LTC homes (compared to an OECD average of 52 per cent); 15 per cent on providing this care in hospitals (OECD average: 9 per cent) and 18 per cent on providing home and community-based care (OECD average: 36 per cent) (**Figure 2**).²¹ This is an improvement since 2017, when the OECD reported that only 13 per cent of Canada's LTC expenditures were allocated to home and community-based care and 87 per cent to institutional care.²² Regardless, several OECD countries spend a much higher proportion of their LTC expenditures on home and community-based care, including Norway, Sweden, Denmark, Belgium and Germany (**Figure 2**). For example, Germany and Denmark each allocated 50 per cent of their 2019 LTC expenditures on home and community-based care.

In Denmark, the shift to spending more on home and community-based care began more than 30 years ago, when it was facing demographic and fiscal challenges similar to Canada's.^{22,24} The country focused on providing more home-based LTC services,

along with developing more supportive housing units and assisted living supports that have allowed more people to age in their own homes and communities for longer.²⁵ Within 10 years of implementing this approach, Denmark achieved a 12 per cent overall reduction in its LTC spending for adults aged 80 years and older.²⁶ The country was further able to reduce the demand for care in LTC homes, while maintaining its level of health care spending at reasonable levels.²⁷ Most remarkably, Denmark closed thousands of hospital beds and avoided the development of any new LTC homes for close to 20 years.²⁸

The 2020-21 figures from the Canadian Institute of Health Information (CIHI) National Health Expenditure Database show that Canada now spends 33 per cent of its total LTC budgets on home and community-based care options, and 67 per cent on LTC homes.²⁹ However, these spending allocations vary significantly across the provinces, with Quebec allocating the largest share to LTC homes (78 per cent) and Newfoundland and Labrador allocating the lowest share (58 per cent). Nevertheless, these figures make it clear that compared to other countries, Canada significantly prioritizes LTC care in institutions over home and community-based care.

Figure 2. Government and Compulsory Insurance Spending on LTC (Health) By Mode of Provision, 2019 (or Nearest Year) Across OECD Nation



Not all adults with complex care needs require care in LTC homes.

Recent estimates suggest that between 11 and 30 per cent of older adults admitted to LTC homes across Canada could potentially have remained at home and in their communities if adequate home care and community supports were available.^{30,31}

The NIA report Bringing Long Term Care Home (2020) found that the Ontario government could save an average of approximately \$240,000 in infrastructure costs for every LTC home bed it would no longer need to build or redevelop by better meeting the needs of its ageing population to age at home.³²

Furthermore, it costs less to provide home care for individuals with complex care needs than to provide care for individuals

with similar needs in LTC homes. According to Ontario's Ministry of Health, the province supported more than 131,180 LTC homeeligible clients of all ages to live in their own homes in 2021-22, of whom more than 97,700 clients were 75 years and older.³³ It estimated that the cost of supporting LTC homeeligible clients to be cared for in their own homes was close to \$1.3 billion.³⁴ This is only a fraction of the Ministry of Long-Term Care's projected \$6.4 billion in spending on care across nearly 79,000 publicly funded LTC home beds in 2021-22.³⁵

In addition to reducing costs, better supporting older adults to age in their own homes for as long as possible would also align with their own preferences. A 2013 RBC survey found that 83 per cent of Canadian adults would prefer to age in their own homes.³⁶ The COVID-19 pandemic has only intensified this sentiment. A 2020 NIA/Telus Health survey found that 60 per cent of all Canadians, and nearly 70 per cent of Canadians aged 65 years and older, reported that the pandemic had changed their views on whether they would arrange for themselves or a loved one to live in a LTC or retirement home. Moreover, 91 per

cent of Canadians and nearly 100 per cent of Canadians aged 65 and older reported that they planned to support themselves to live in their own homes for as long as possible.³⁷ Similarly, in a more recent 2020 survey conducted by the NIA and the Canadian Medical Association during Canada's second wave of the COVID-19 pandemic, 85 per cent of Canadians and 96 per cent of Canadians aged 65 and older reported that they would do everything they can to avoid going into a LTC home.³⁸

There is an urgent need to redesign Canada's financial, health and social support systems for older adults to better address their needs and reduce the negative social and fiscal impacts of the current systems.

Canada's changing demographic imperative presents an opportunity to strengthen both its retirement-income security systems and the delivery of LTC services to better enable ageing in place.

Several studies have shown that supporting individuals to remain at home and in their communities is not only more fiscally sustainable but also significantly improves individuals' overall health and well-being. For example, older adults, especially those with dementia, have been found to express a greater quality of life, less loneliness and fewer depressive symptoms when living at home compared to in a LTC home.^{39,40,41} The ability to live safely at home rather than an institutional setting has also been associated with "improved quality of life, social connectedness to friends and family, and fewer health care complaints."⁴²

However, Canada's provincial and territorial LTC systems do not currently provide enough financial incentives and supports to reduce the barriers and costs associated with ageing in place. Home care services are becoming increasingly unaffordable, and only 52 per cent of Canadians who receive these services get them solely through publicly funded sources. The estimated cost of private home care services ranges from \$1,000 to \$3,500 per month,⁴³ with costs for those with complex care needs reaching up to \$25,000 per month in Ontario.⁴⁴

This report examines how we can better support older adults to age in their own homes and communities for as long possible, in order to both address the desires of older Canadians and to help Canada's already-strained LTC systems better meet the needs of its ageing population. The first section of this report reviews the existing use of LTC services in Canada, and where those services are being delivered. Recognizing the growing importance of supporting older Canadians' ability and preference to age successfully in their communities, this report then aims to present a practical definition and framework to understand what the NIA calls "*Ageing in the Right Place*" (AIRP). It also highlights existing best practices and opportunities that appear to reduce unnecessary LTC home admissions and support the implementation of successful AIRP policies and programs across Canada and beyond. The report then presents a supporting rapid review of existing government programs and services focused on supporting AIRP across Canada, before finally presenting 10 evidence-informed policy recommendations to address the gaps identified through our rapid review and effectively support AIRP across Canada.

How Many Older Canadians are Currently Receiving LTC Services?

Approximately 6.6 million Canadians, or 93.9 per cent of those aged 65 years and older, are currently living in their own private residences.⁴⁵ Nevertheless, ensuring the greater accessibility of home care services that meet the care needs of older Canadians could likely enable many more to do so.

Only a small proportion of older Canadians currently receive any LTC services at all. In 2016, an estimated 709,500 Canadians aged 65 years and older were receiving LTC services, whether in LTC homes or in their own homes with home care and community-support services.^{46,47} This was equivalent to 12 per cent of the Canadian population aged 65 and older that year.⁴⁸ Among these individuals, about 198,000 (3.3 per cent of Canadians aged 65 years and older) received care in LTC homes,⁴⁹ while approximately 511,500 (8.6 per cent) received care in their own private dwellings from home care and community-support service providers.⁵⁰

Based on the most recent 2021 census data, an estimated 205,000 Canadians aged 65 years and older were receiving care in LTC homes.⁵¹ Among those aged 85 and over, almost 120,000 were living in LTC homes,⁵² representing 13.8 per cent of Canadians in this oldest age group.⁵³

While more recent estimates on the number of older Canadians receiving care in their own homes are not available, provincial figures suggest that the number has increased since 2016. For example, as of 2021-22, more than 449,380 older adults were estimated to receive home care services in Ontario alone, suggesting that the national figure is now much higher.^{54,55}

Despite the relatively small proportion of older adults receiving LTC services, Canada's provinces and territories are already struggling to meet the growing demand for publicly funded LTC — both in institutional and home-based settings.

More than 52,000 Canadians were estimated to be on waiting lists for a placement into a LTC home in 2021,⁵⁶ while more than 430,000 Canadians adults were estimated to have unmet home care needs, with about 167,000 of them being aged 65 years and older.⁵⁷

While there will be growing demand for additional LTC beds in the future, greater resources and targeted efforts are also needed to improve the availability of home and community-based care. Current estimates suggest that up to one in three Canadians admitted to a LTC home could have been better suited to receive home care. Moreover, if adequate home care and other community supports are not available in future, older adults may continue to be prematurely institutionalized, further straining Canada's already overburdened LTC homes.

Enabling more older Canadians to age successfully in their homes for as long as possible will therefore require systems and services that enable what the NIA calls "Ageing in the *Right Place*" (AIRP) rather than simply "ageing in place." Supporting older Canadians to age in the *right* place presents a powerful policy and political option that both aligns with strong societal desires and promotes a more fiscally sustainable future for all Canadians.



Defining Ageing in the *Right* Place

Ageing in place has long been studied in the societal and academic discourses on ageing, but there is no standard or broadly accepted definition of it. Bigonesse and Chaudhury (2020) explain that this lack of consensus is attributable to several underlying theoretical perspectives on ageing in place. Firstly, the biomedical perspective of ageing in place is rooted in the concept that as people age, their functional abilities decline, which therefore frames ageing in place as a way to improve individuals' functioning and overall health. Secondly, the structuralist perspective conceptualizes society as a set of social structures that lead to inequalities and stratification, which means ageing-in-place approaches empower older adults through autonomy and inclusion. The structuralist perspective is similar to the phenological perspective, which focuses on the lived experiences of individuals, whereby ageing in place approaches account for the individual experiences of ageing by factoring

in the meaning of place and identity. The last theoretical model is the ecological perspective, which views older adults in constant and dynamic interaction with the environment, and therefore recommends ageing-in-place approaches that account for this.

Overall, the ageing-in-place literature mostly emphasizes theoretical perspectives rather than practical approaches to enable it,⁵⁸ leaving a need for innovative models and knowledge-translation mechanisms to apply and evaluate ageing-in-place approaches in real-world settings. Therefore, the primary aim of this report is to help present a practical definition and framework to understand not just ageing in place but ageing in the *right* place; to highlight existing best practices and opportunities that appear to reduce unnecessary LTC home admissions; and to support the implementation of successful AIRP policies and programs across Canada and beyond.

Defining Ageing in the *Right* Place

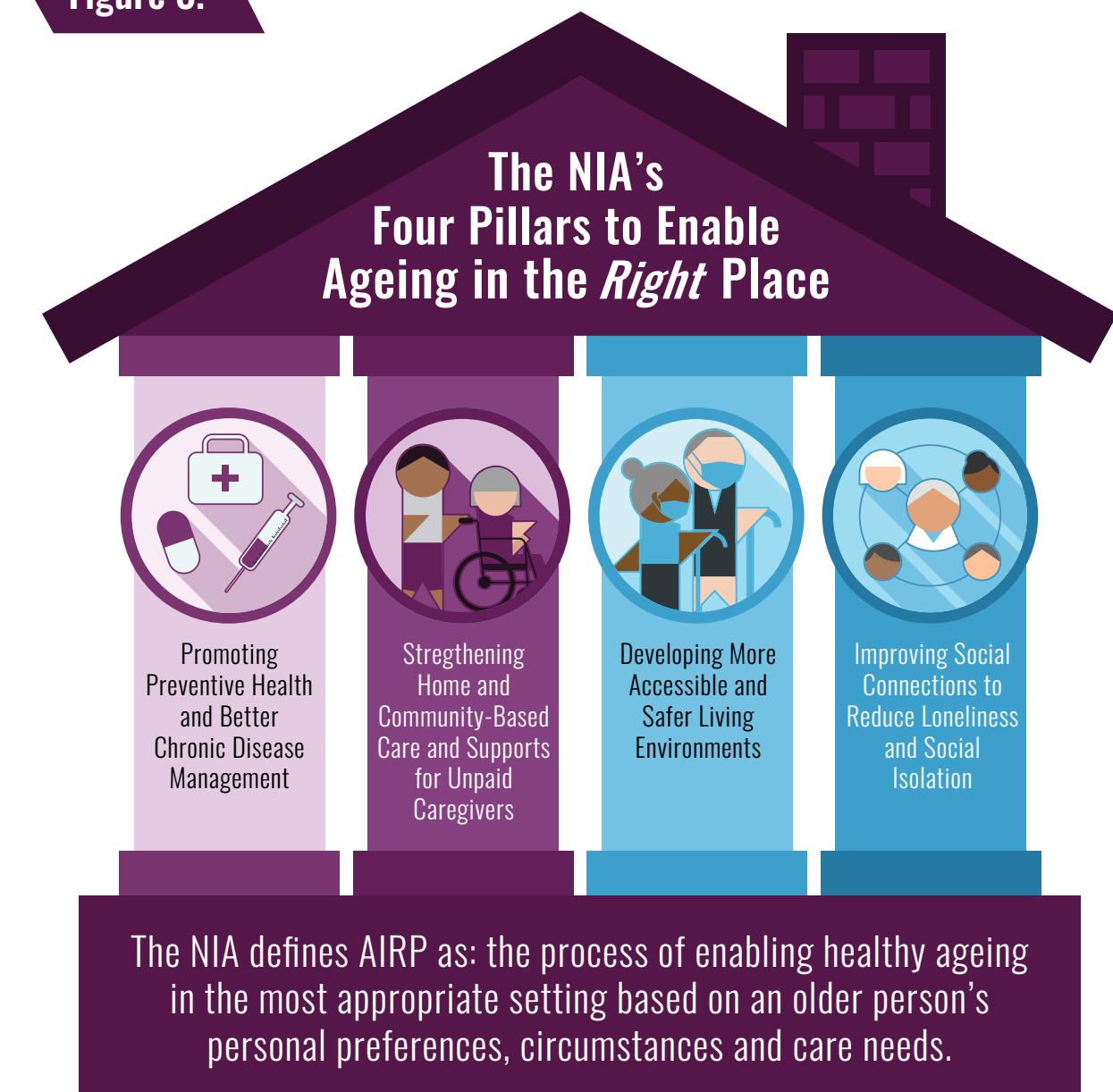
After extensively reviewing the existing literature, the NIA has defined **Ageing in the Right Place** as “the process of enabling healthy ageing in the most appropriate setting based on an older person’s personal preferences, circumstances and care needs.” Based on this definition, the NIA has further identified four “pillars” fundamental to enabling AIRP:

- 1. Promoting Preventive Health and Better Chronic Disease Management**
- 2. Strengthening Home and Community-Based Care and Supports for Unpaid Caregivers**
- 3. Developing More Accessible and Safer Living Environments**
- 4. Improving Social Connections to Reduce Loneliness and Social Isolation**

These distinct yet interconnected pillars provide a comprehensive framework of the most important factors that enable older adults to age in the *right* place. This framework can be used to support AIRP approaches at the individual, local, regional, and federal levels. It further recognizes that AIRP takes place in the context of a broad range of social, economic, political and environmental factors, and that none of the identified pillars exists in isolation.

The second aim of this report is to identify the current extent of federal, provincial and territorial programs and policies focused on supporting AIRP across Canada. The NIA's proposed AIRP definition and framework are designed to be practical and pragmatic; therefore, this report concludes with several policy recommendations designed to enable AIRP with support at local, provincial and federal programmatic and policy levels.

Figure 3.



What are the Main Factors Currently Driving LTC and Retirement Home Admissions in Canada?

Two key reports provide an understanding of the main factors that currently lead to LTC home admissions among older Canadians.

The first is the 2017 Seniors in Transition report from the Canadian Institute for Health Information (CIHI).⁵⁹ By linking three years of data from publicly funded LTC systems across 35 health regions, the report identified pathways to receiving either publicly funded home-based care or care in a LTC home among more than 59,000 older adults. The report then tested 33 factors potentially associated with LTC home admissions, identifying the most impactful predictors. The full set of factors is listed in **Box 1**. The study also examined how factors predicting LTC home admissions may further differ among older adults after a period of receiving home care.

The second report is the 2018 Transitions to Long-term Care and Residential Care Among Seniors report⁶⁰ from Statistics Canada. It also identified significant predictors of admission to a LTC or retirement home among older Canadians. The report linked data from the Canadian Community Health Survey (CCHS), the Canadian Mortality Database and the 2011 Census to identify more than 81,000 older individuals who moved from their private residence at the time of their CCHS interview to a LTC or retirement home by census day. The purpose of this study was to identify which demographic, health and socioeconomic factors increased or decreased older Canadians' likelihood of

transitioning from a private dwelling to a LTC or retirement home. The full set of factors is listed in **Box 2**.

Together, these two studies reveal many factors that can significantly increase an older adult's risk of being institutionalized for LTC. In particular, chronic conditions such as dementia appear to be especially significant in predicting whether older Canadians transition into institutional care settings. Similarly, both falls and hip fractures appear to be significant predictors of transitioning into a LTC home, which may also indirectly contribute to LTC home admissions through hospitalizations and a loss of physical functioning, both of which were among the strongest predictors of LTC home admissions among older adults. In addition to health status, the findings also highlight the key role played by factors related to older adults' social environments. Living alone and the availability of caregivers were found to be especially significant. CIHI's analysis found living alone to be among the strongest predictors of transitioning into a LTC home, while Statistics Canada's study found it was among the most important factors for women, highlighting the different experiences of ageing between men and women. Both studies are discussed in more detail in the **Appendix**.

Box 1: Predictor Variables Tested in CIHI's Seniors in Transition Report (2017)

CIHI's 2017 report, Seniors in Transition, examined predictors of transitions into LTC homes among older adults after receiving an initial assessment to identify their need for either home care or institutional care. Based on consultations and a review of relevant literature, CIHI identified and analyzed 33 factors that may predict transitions into these care settings.

Sociodemographic predictors: age, sex, income quintile, urban/rural residence, living alone

Health and care measures: initial assessment for continuing care received in hospital, hospital use, caregiver distress, caregiver unable to continue, requiring physical assistance (ADL Hierarchy Scale), cognitive impairment, responsive behaviour, wandering, instability (CHESS Scale), falls, bladder incontinence, bowel incontinence, oxygen, daily pain, dementia, signs of depression, any psychiatric diagnosis, diabetes, heart disease, congestive heart failure, emphysema/chronic obstructive pulmonary disorder/asthma, hypertension, stroke, Parkinson's disease, cancer, arthritis, hip fracture, osteoporosis

Box 2: Predictor Variables Tested in Statistics Canada's Transitions to Long-term Care and Residential Care Among Seniors Report (2018)

Statistics Canada's 2018 Transitions to Long-term Care and Residential Care Among Seniors report examined predictors of living in a LTC or retirement home in Canada. The report considered a range of sociodemographic and health status predictors.

Sociodemographic predictors: marital status, age, household income, home ownership, living arrangement, province of residence, immigrant status

Health measures: self-rated general and mental health, smoking status, body mass index, having been an overnight patient in a hospital, nursing home or convalescent home in the past year. Several chronic conditions were also analyzed: asthma, arthritis, back problems, high blood pressure, emphysema, chronic obstructive pulmonary disorder, diabetes, heart disease, cancer, ulcers, the effects of a stroke, urinary incontinence, bowel disease, Alzheimer's disease or other dementia, mood disease, anxiety disorder



The NIA's Four Essential Pillars Supporting Ageing in the *Right* Place



Pillar 1: Promoting Preventive Health and Better Chronic Disease Management

Nearly all LTC home admissions are attributable to declining health, well-being or a loss of physical or cognitive function. The prevalence of hospitalizations, falls and chronic conditions, including dementia, is only expected to increase as Canada's population continues to age. Based on the main predictors of LTC home admissions in Canada, we have identified four specific intervention areas to improve wellness, preventive health and chronic disease management across Canada with the aim of reducing future LTC home admissions:

1. Chronic Disease Prevention and Management
2. Dementia Prevention and Support
3. Preventing Falls and Promoting Safety
4. Supporting People's Activities of Daily Living at Home

Chronic Disease Prevention and Management

The majority of Canadians aged 65 years and older are currently living with at least one

chronic disease, while a growing number are living with multiple chronic diseases.⁶¹ The 2017-18 CCHS estimates that about 37 per cent of adults aged 65 years and older report having at least two common chronic diseases, and almost half of those aged 85 and older report having multi-morbidity (defined as two or more conditions).⁶²

Both globally and in Canada, chronic disease prevalence and deaths are highly concentrated among four diseases: cancer, cardiovascular disease (CVD), diabetes and chronic respiratory disease. In Canada, these four diseases accounted for more than 60 per cent of total deaths in 2016. More specifically, CVDs are responsible for the most hospitalizations in Canada.⁶³ Among Canadians 65 years of age and older, the most common chronic diseases are hypertension (65.7 per cent), periodontal disease (52.0 per cent), osteoarthritis (38.0 per cent), ischemic heart disease (27.0 per cent), diabetes (26.8 per cent), osteoporosis (25.1 per cent) and cancer (21.5 per cent).⁶⁴ However, some chronic diseases pose more risk than others to the health of older adults and their ability to remain at home independently. The CIHI Seniors in Transition



report notes that the four chronic diseases most prevalent among community-dwelling older adults entering LTC homes were hypertension (66.5 per cent), arthritis (54.3 per cent), dementia (39.3 per cent) and heart disease (26.4 per cent).⁶⁵

Research shows that health care service use among older Canadians is largely driven by the number of chronic diseases they have and not necessarily their age.

Among adults aged 65 years and older, those with three or more chronic diseases have nearly three times as many health care visits as those with none.

Moreover, while only a quarter of older Canadians have three or more chronic diseases, they account for roughly 40 per cent of health care use among older Canadians. It is estimated that nationally, chronic conditions and other illnesses cost \$68 billion annually in direct health care costs.⁶⁶ Multi-morbidity is the presence of two or more diseases or conditions.⁶⁷

Estimates suggest that 31.3 per cent of community-dwelling older Canadians are living with at least two chronic diseases,⁶⁸ making the burden of managing multi-morbidity an additional challenge for older adults seeking to age in the *right* place.

A recent German study looking at a population cohort for more than five years found that people with multi-morbidity had a higher rate of LTC dependency than those with no multimorbidity.⁶⁹ Those with Parkinson's disease and dementia had the highest rates of LTC dependency.⁷⁰ Those with various "neuropsychiatric disorders" had a 79 per cent greater rate of LTC dependency than those without.⁷¹ In Canada, longitudinal research has demonstrated that as the number of chronic diseases increases, so does the likelihood of LTC home admission.⁷²

What Initiatives Can Support Better Chronic Disease Prevention and Management?

Given the growing prevalence of older adults living with multiple chronic conditions, successfully managing chronic diseases will be essential to support older Canadians seeking to age in the *right* place.

Specific Chronic Disease Management Programs and Interventions

Numerous studies have researched chronic-disease management approaches or interventions and their impact on hospitalizations. Many of these have analyzed interventions using tele-monitoring supports for patients with chronic obstructive pulmonary disease (COPD) and heart failure. In terms of COPD, two studies found positive results, with one noting lower hospital admission rates (0.49 per patient per 10 months compared to 1.17) and the other noting an increase in patients not being readmitted to hospital (51 per cent versus



33 per cent).⁷³ However, another study found tele-monitoring was not effective in delaying hospital admissions compared to usual care for patients with COPD.⁷⁴

With respect to heart failure, studies have also shown positive results in reducing hospital admissions and re-admissions for up to eight years,^{75,76,77} with one study finding that interventions can reduce the relative rate of hospitalizations to half that of control groups.⁷⁸ Another systematic review of tele-monitoring of patients with heart failure found a reduction in hospitalizations of 14 to 55 per cent.⁷⁹ In an analysis of in-home care interventions for heart failure patients, these patients experienced on average one less unplanned hospitalization, 1.5 fewer emergency department (ED) visits, and were 12 per cent less likely to experience mortality and hospitalizations compared to those given the usual care.⁸⁰

Studies have also examined how different types of chronic disease management programs impact LTC home admissions. At-home comprehensive geriatric assessments with referral to other services have been found to significantly reduce LTC home admissions (0.67 to 1.3 per cent).⁸¹ Similarly, programs to improve medication management among community-dwelling frail older adults, using both health educators and calendar cards, have been found to prevent admissions, with the control group receiving usual care 2.94 times more likely to be institutionalized compared to the group receiving the intervention.⁸² There is also evidence to suggest that both the prevention of chronic diseases and better support with chronic-disease management could help reduce future hospitalizations, which often hasten LTC home admissions.

Remote Patient Monitoring-Programs

Other interventions that have shown great promise in supporting improved chronic disease management in community settings include traditional remote patient-monitoring programs — such as those using pulse oximeters, blood-pressure monitors, weight scales and other traditional monitoring devices — and the support of community-based nurses or paramedics to encourage their effective use.⁸³ There is also a growing interest in the development of “smart textiles” and “wearable sensors” that could more easily support individuals to better manage their chronic health conditions, such as heart failure and COPD, as well as wound treatments. These can all serve as examples of the evolving field of remote patient monitoring, which can allow for continuous, unobtrusive and unattended monitoring. This may significantly reduce the need for home care services by paid care providers such as nurses and personal support workers, who typically provide chronic-disease and wound-management support, and subsequently eliminate barriers to accessing health care.

Community Paramedicine Programs

Finally, some care models have shown promise in reducing hospitalizations and resulting LTC home admissions among community-dwelling older adults. For example, community paramedicine programs, in which trained paramedics work with health care professionals to reduce hospital visits and improve quality of life, have been shown to improve chronic disease management.⁸⁴



A Toronto study of paramedic-initiated home care referrals over a 24-month period found significant reductions in 911 calls (10 per cent) and ambulance transports to the ED (7 per cent).⁸⁵ Similarly, a three-year demonstration project by Canada Health Infoway, in which community paramedics provided chronic disease self-monitoring supports, achieved a 32 per cent reduction in hospital admissions, a 26 per cent reduction in ED visits, and a 35-41 per cent reduction in hospital re-admissions.⁸⁶

Dementia Prevention and Support

Dementia is also a chronic health condition, but one that warrants specific attention due to its high prevalence among older adults and the unique consequences it poses for one's overall health and ability to live independently in later life. Dementia is not a specific disease but rather a general term for diseases or conditions that can lead to the deterioration of cognitive function — memory, thinking and decision-making — and interfere with a person's ability to perform everyday activities and live independently.⁸⁷ The deterioration in cognitive function caused by dementia goes beyond what might be expected from normal ageing, and if left undetected and untreated, it can adversely affect one's overall quality of life and care. Alzheimer's disease is the most common form of dementia.

Dementia is perhaps the greatest predictor of LTC home admissions.^{88,89,90,91,92}

For example, a recent Ontario study found that nearly 50 per cent of community-dwelling older adults who are admitted to LTC homes are diagnosed with dementia within five years.⁹³ Additionally, it is estimated that close to 70 per cent of LTC home residents are living with a diagnosis of dementia.⁹⁴

In 2020, an estimated 597,300 Canadians were living with a diagnosis of dementia, of whom 569,600 were aged 65 years and older.⁹⁵ Driven largely by population ageing, the incidence of dementia in Canada will only continue to rise.

The Alzheimer Society of Canada projects that by 2030, nearly one million Canadians will be living with dementia — a 65 per cent increase from 2020.⁹⁶

By 2050, the number of Canadians living with dementia will almost triple to 1.7 million.⁹⁷

While 8.4 per cent of Canadians aged 65 years and older had some form of dementia in 2020, that is expected to increase to 13.2 per cent by 2050.⁹⁸ The greatest increase in cases will come from Canada's oldest adults, as the number of Canadians aged 85 years and older is expected to more than triple over the next 30 years, and the incidence of dementia within this age group is expected to increase about 30 per cent faster than within the overall population.⁹⁹



In addition, there were an estimated 350,000 care partners or unpaid caregivers supporting individuals living with dementia in 2020, providing an estimated 26 hours of care per week.¹⁰⁰ This amounts to 470 million hours of care per year.¹⁰¹ Based on the federal hourly minimum wage of \$15.55, unpaid caregivers provided more than \$7.3 billion worth of care related to dementia in 2020.¹⁰²

Additional projections estimate that total health care costs and out-of-pocket caregiver costs related to dementia will reach \$16.6 billion by 2031.¹⁰³

Dementia also has major implications for chronic-disease management, because it makes it increasingly difficult for someone to independently manage their chronic health conditions. This highlights the need to prevent the development of both dementia and other chronic diseases in community-dwelling older adults, along with the importance of developing better ways to support chronic disease management at home, especially in persons living with dementia.

What Initiatives Can Enable Better Dementia Prevention and Support?

Dementia Risk Factor Modification

Implementing preventive measures that target key risk factors for dementia early enough in life to prevent or delay the onset of the condition is critical to supporting Canadians to

age in the *right* place. Evidence from a recent *Lancet* report suggests that 40 per cent of dementia cases could be prevented or delayed if certain preventive measures targeting 12 risk factors were pursued.¹⁰⁴ The review indicates that just by tackling depression (3.9 per cent), social isolation (3.5 per cent) and physical inactivity (1.6 per cent), dementia occurrence could be reduced by a total of 9 per cent.¹⁰⁵ This could be raised to 16 per cent by addressing another risk factor, "less education," in adults below the age of 45. Achieving this could, in the short term, reduce the number of people in LTC homes by an estimated five per cent for those aged 80 years and younger and 6.7 per cent for those older than 80 years.¹⁰⁶

Community Care Co-ordination

One pharma-led study investigated the impact of treatment (using either donepezil, memantine, rivastigmine or galantamine) and care management on nursing home admissions in patients newly diagnosed with Alzheimer's disease.¹⁰⁷ Untreated patients tended to be older and have more severe comorbidities, but the study showed that after controlling for comorbidities, patients who were medicated and provided with care co-ordination supports had a 20 per cent lower risk of being admitted to a LTC home at six months.¹⁰⁸ This speaks to the potential importance of better supporting older persons living with dementia, as well as their unpaid caregivers, with early diagnosis and interventions that could enable AIRP. A current challenge is that close to two-thirds (61.7 per cent) of community-dwelling older persons with dementia in Canada and around the world remain undiagnosed, meaning



they are likely not accessing appropriate interventions and support.¹⁰⁹ A common theme in the literature is the effectiveness of community care co-ordination. This involves assessing individuals with dementia, referring them to services, and providing information and support as needed.¹¹⁰

In a systematic review of various non-pharmacological interventions, community care co-ordination appeared to be the only one that reduced rates of LTC home admissions.¹¹¹ Another review found that individuals receiving case-management interventions (similar to community care co-ordination programs) were significantly less likely to be admitted to LTC homes at both six months (OR 0.82) and 18 months (OR 0.25), compared to those receiving the usual care.¹¹² However, the effects of the intervention at 10 to 12 months and at 24 months were uncertain.¹¹³ Thus, while community care interventions may not eliminate the need for a LTC home, they at least have promise in helping to delay it.

Better Management of Neuropsychiatric Symptoms of Dementia

Dementias commonly manifest as neuropsychiatric symptoms — e.g. aggression/agitation, paranoia, hallucinations, wandering, etc. — which can be managed by non-pharmacological or psychological interventions.¹¹⁴ It could be expected that better addressing neuropsychiatric symptoms would help to reduce caregiver burden and

make it easier for a person to live longer and with greater independence in the community, but studies examining the impact of these approaches in reducing LTC home admissions have not been common. However, one study looking at the use of reality-orientation therapy showed that it was able to reduce the risk of institutionalization.¹¹⁵

Preventing Falls and Promoting Safety

Falls and their associated consequences for older adults are a serious public health issue. According to the WHO, about a third of older adults fall each year. Moreover, older adults are more likely to experience a fall as they age, with the likelihood increasing from 28-35 per cent among adults aged 65 years and older, to 32-42 per cent in those aged 70 years and older. In addition, when an older adult has fallen once, their risk of falling again doubles.¹¹⁶ This makes falls one of the most common preventable health care issues for older adults.^{117, 118, 119, 120, 121}

Falls are the leading cause of injury, injury-related hospitalizations and deaths among Canadians aged 65 years and older.¹²²

In addition, falls and their resulting injuries impact quality of life, admissions to LTC homes and caregiver duties, and contribute to substantial health care costs.¹²³



As the Canadian population ages, the absolute number of falls has been increasing. The Public Health Agency of Canada (PHAC) reports that from 2003 to 2009-10, there was a 43 per cent increase in the number of individuals aged 65 years and older who reported a fall-related injury.¹²⁴ According to more recent estimates, falls accounted for 61 per cent of reported injuries among Canadians aged 65 years and older in 2017-18.¹²⁵

Falls have also been driving more hospitalizations for Canada's older population. Between 2008-09 and 2019-20, there was a 47 per cent increase in the number of fall-related hospitalizations among individuals aged 65 years and older, from 49,152 to 72,392. Hospitalizations have increased despite the crude and age-standardized rate of fall-related hospitalizations remaining relatively constant over the same period, at roughly 15 per 1,000 people, due to overall population ageing.¹²⁶

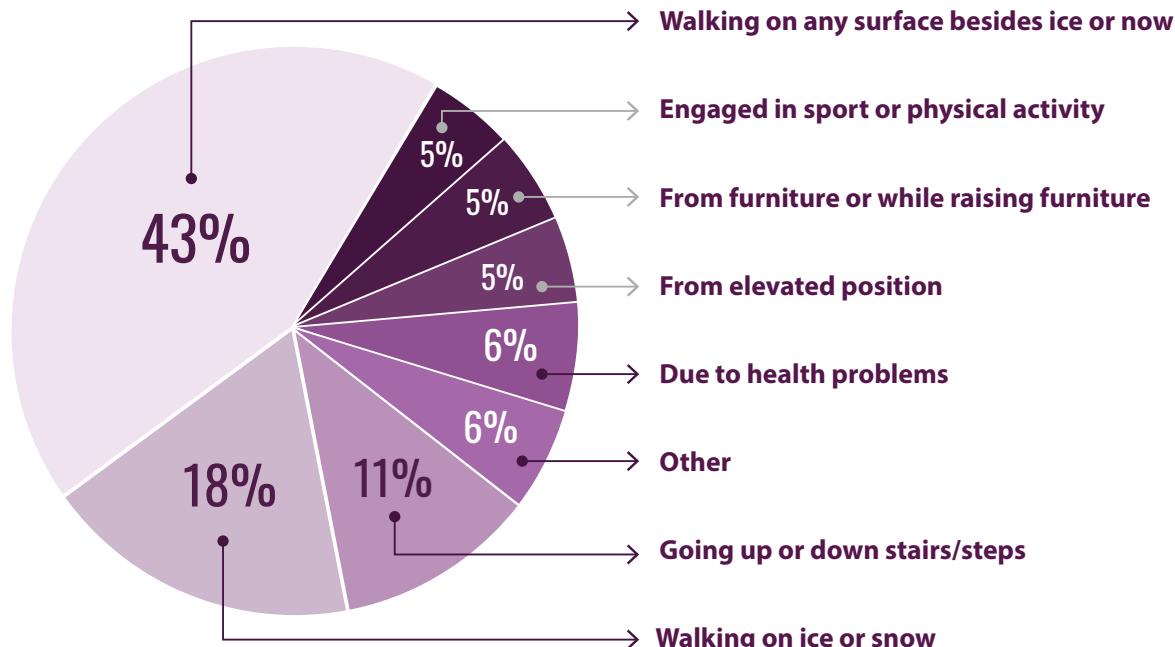
Even more concerning is that deaths from falls have also been rising among older Canadians — both the annual number of deaths and the age-standardized mortality rate for deaths due to falls.

Mortality data from Statistics Canada reveals that between 2003 and 2008, the number of deaths due to falls increased by 65 per cent among Canadians aged 65 years and older, from 1,631 to 2,691.¹²⁷ More recent mortality data revealed that deaths from falls among older Canadians have continued to increase over the last decade, with the total number of annual deaths reaching 5,581 in 2019. The age-standardized mortality rate from falls has more than doubled among older Canadians over the last two decades, from 41 per 100,000 in 2001 to 86.4 per 100,000 in 2019.¹²⁸

There are many factors that put older adults at increased risk of falls and fall-related injuries, including chronic health conditions and disabilities, acute illnesses, balance or gait deficits, cognitive impairments and sensory issues, inadequate nutrition, medications, social isolation, and factors related to the built and social environment.¹²⁹ **Figure 4** shows the types of activities most often associated with fall-related injuries in Canadians aged 65 years and older. The most common is slipping while walking — whether on ice, snow or any other surface — which is responsible for 61 per cent of fall-related injuries among adults aged 65 years and older.



Figure 4: Activity Associated with Fall-Related Injuries, Household Population Aged 65 years and Older, Canada, 2017-2018



*CV is between 15.0% and 35.0%

Activities of older adults that are associated with fall-related injury. Reprinted from Surveillance Report on falls among older adults in Canada, Retrieved from: <https://www.canada.ca/en/public-health/services/publications/healthy-living/surveillance-report-falls-older-adults-canada.html>

The societal and personal consequences of falls among older adults are widespread. There are substantial costs to health care systems: estimates suggest that in 2018, the direct annual cost of fall-related injuries among older adults in Canada was \$5.6 billion, more than double the cost associated with falls among individuals aged 25-65 years.¹³⁰

Falls are also the leading cause of injury-related hospitalizations among older adults in Canada, causing 87 per cent of these hospitalizations,¹³¹ and most Canadians hospitalized due to falls are older adults. Between 2016 and 2017, there were 654,000 reported ED visits for injuries from unintentional falls, accounting for close to a third of all ED visits due to injury and trauma

in Canada.¹³² Even though patients younger than 65 years make up 72 per cent of ED visits for falls, patients aged 65 years and older make up 71 per cent of hospital stays.¹³³ Older adults who are hospitalized for a fall tend to remain in hospital longer than those hospitalized for any cause.¹³⁴

In Canada, 137,568 (51 per cent) of injury-related hospitalizations were for older adults in 2017-18,¹³⁵ an increase of nine per cent over the previous two years.¹³⁶ Eighty-one per cent of these hospitalizations were due to falls, also representing an increase of 9 per cent over the previous two years.¹³⁷ Most of these hospitalizations were due to a head injury and/or hip fracture.¹³⁸



For older adults, the consequences of falls include chronic pain, reduced mobility and loss of independence, all of which limit the ability to age in the *right* place.

Falls are also a strong catalyst for transitions into LTC homes among older Canadians.¹³⁹

In fact, falls are the primary type of injury responsible for older Canadians to be admitted into a LTC home, and according to PHAC, 35 per cent of older adults who were hospitalized from falls in 2008-09 ended up being discharged into a LTC home, nearly double the proportion who were already living in LTC homes initially.¹⁴⁰

Falls are also the direct cause of 95 per cent of hip fractures,¹⁴¹ which further contribute to LTC home admissions. In 2019-20, hip fractures accounted for about one-third (34 per cent) of fall-related hospitalizations among older adults in Canada, down from 40 per cent in 2008-09.¹⁴² But while that percentage has been decreasing, the total number of fall-related hospitalizations due to hip fractures has been increasing, again largely due to population ageing.¹⁴³ Between 2008-09 and 2019-20, the number of older adults hospitalized with a fall-related hip fracture rose from around 20,000 to more than 24,000.¹⁴⁴ Older adults with fall-related hip fractures spend more days in hospital than those whose hip fractures were not fall-related,¹⁴⁵ and 25 per cent of community-dwelling older adults enter a LTC home within one year of having a hip fracture. Fall-related hip fractures also led to death in 20 per cent of cases.^{146,147,148}

Fall-related injuries are the most common cause of death from injury in older persons, as well as in the broader Canadian population.¹⁴⁹

However, the majority of fall-related injuries do not lead to death. Instead, they inhibit the ability of older adults to function and perform activities of daily living (ADLs) on their own. Regardless of whether falls lead to injury, they are found to be negatively associated with a person's health-related quality of life.^{150,151} This can be seen in how both the fear of falling and multiple previous falls limit older adults' activities.¹⁵² Overall, community-dwelling individuals who experience fractures caused by falls are more likely to be institutionalized in an LTC setting.^{153,154,155}

Enabling older adults to safely age in the *right* place will require limiting their risk of falls. However, health care providers are often unable to recommend useful interventions to prevent falls or provide timely treatment because less than 50 per cent of older adults inform their health care providers when they have fallen.¹⁵⁶ This may further help to explain why in Canada, about a third (30.2 per cent) of older adults who reported a fall-related injury in 2017-18 did not receive medical attention from a health professional in the 48 hours post-injury.¹⁵⁷

Canadian estimates suggest that older adults living in their own homes may be especially at risk of falls and their consequences. Most fall-related hospitalizations among older Canadians



appear to be the result of community-dwelling older adults falling at home. Of all the fall-related hospitalizations among Canadians aged 65 years and older between 2015-16 and 2019-20, more than half (52 per cent) stemmed from a fall occurring in a household residence. By comparison, falls that occurred in a LTC home accounted for 17 per cent.¹⁵⁸ Moreover, while more Canadians have been hospitalized for falls over the last two decades regardless of where they live, the increase has been larger for older adults living in their own homes than for those in LTC homes. The number of fall-related hospitalizations increased by 36 per cent for older adults living in LTC homes between 2008-09 and 2019-20, from 8,900 to 12,081, and by 50 per cent for older adults living at home during the same period, from 40,252 to 60,311.¹⁵⁹

Finally, older Canadians who experience fall-related injuries while living in their own homes generally spend more days in hospital than those living in LTC homes. In 2019-20, acute care hospitalizations due to falls were longer for household residents aged 65 years and older than for older adults of any age living in LTC homes.¹⁶⁰ Fall-related alternate level of care hospitalizations, which are non-acute hospital stays, for adults aged 80 years and older were also longer for those living at home than those living in an LTC home, whereas for those aged 65-79 years, the average stay was shorter for private household residents than LTC home residents.¹⁶¹ These longer fall-related hospitalizations suggest that older Canadians living in their own homes are not likely to have the necessary supports

in place in order to be discharged to fully recover at home. Either way, the most recent Canadian figures leave no doubt about the importance of preventing falls and their wide-reaching consequences as part of supporting Canada's ageing population to successfully age in the *right* place.

What Initiatives Can Better Prevent Falls and Promote Safety?

Preventing falls and minimizing their associated outcomes is critical to enabling AIRP. Findings from CIHI suggest that as many as 23 per cent of LTC home admissions are attributable to falls. Moreover, preventing falls also helps reduce the wide-reaching consequences of falling found to increase LTC home admissions, such as hospitalizations, loss of physical functioning and greater isolation.

Enabling Canada's growing population of older adults to age in the *right* place will require effective practices and interventions to prevent and minimize the negative consequences of falls. Thus far, PHAC has made a concerted effort to raise awareness of fall-prevention strategies nationally, alongside many provincial and local fall-prevention programs. For example, PHAC has published numerous materials intended to help older adults and their families reduce the occurrence and impact of falls.¹⁶² These types of materials should be widely circulated and made easily accessible.



Behavioural and Environmental Interventions

In terms of other interventions that can reduce falls and falls-related injuries among older adults, research shows that various types of behavioural and environmental changes can also protect against falls among older adults.¹⁶³ Examples of behavioural changes include moderating alcohol consumption, getting appropriate physical exercise and not smoking.¹⁶⁴ An important aspect of environmental change is home modifications that reduce fall hazards (e.g. lighting, handrails, surfaces that prevent slips).¹⁶⁵ Another is creating age-friendly design in public settings.¹⁶⁶

Multi-component Interventions

Overall, evidence shows that multi-component interventions, which combine two or more types of interventions, are more effective than single-component programs at preventing falls among older adults.¹⁶⁷ Moreover, it has been found that interventions based on risk assessments and addressing factors associated with health and environment are highly effective in preventing falls among older adults.^{168,169,170} Aspects of successful multi-component programs include education and training, managing foot/shoe issues, addressing visual problems, reviewing medication, and making the appropriate changes.^{171,172,173}

According to a summary of available data, literature and existing knowledge by PHAC, multifactorial interventions based on individual assessments of risk factors are the best approach to enabling falls prevention among older adults.¹⁷⁴

While single-factor programs are not as effective as multiple-component interventions, some of them have helped reduce falls among older adults living in the community.¹⁷⁵ Such programs include removal of psychotropic medications, home safety assessments and changes, and exercise regimens that improve strength and balance.^{176,177} Prescribed and individually tailored exercise initiatives have been found to be more effective than group exercise programs,¹⁷⁸ with the exception of tai chi (a Chinese martial art).^{179,180} On the other hand, education and self-management approaches were found to be ineffective for community-dwelling older adults when used on their own.¹⁸¹

Digital and Technological Solutions

There is also a growing number of digital and technological solutions that could potentially enable older adults to more safely remain in their own homes. For example, personal emergency response systems (PERS) are signalling devices that can automatically detect an emergency and easily summon help. These can help older adults age in the *right* place by detecting falls and leading to a faster response from family members, friends and health care professionals. There are various types of PERS but they all tend to include three basic components: electronic hardware, a link to an emergency-response centre, and the ability to dispatch appropriate help.¹⁸² Most PERS are worn on-person in the form of a necklace or bracelet. They are designed to be easy to use, and in many cases consist of a large help button to initiate an alert. A few function as cordless phones, allowing two-way voice interaction if the client is unable to reach their main telephone device. The devices



usually require an independent power source (e.g. battery) and the majority are wirelessly connected to a telephone base unit.¹⁸³

While PERS don't prevent falls, they can help older adults cope with unexpected falls and other emergencies, and receive necessary medical support sooner than they would without one. Studies show they provide a number of benefits related to AIRP, including dispatching faster assistance in emergencies; extending the time users are able to live at home; increasing users' sense of security; reducing anxiety about falling; and increasing confidence in performing everyday activities.^{184,185}

Moreover, because assistive technologies like PERS can generate a faster response from health care professionals, they can also prevent the additional complications that result from spending prolonged periods of time on the floor following a fall, such as dehydration and hypothermia. Many older adults who experience a fall do so under conditions where they do not have immediate help. One 2008 study of adults aged 90 years and older found that 82 per cent of falls occurred when the person was alone, and 80 per cent of those who fell were unable to get up after at least one fall.¹⁸⁶ The same study found that 30 per cent of those who suffered a fall had lain on the floor for an hour or more.¹⁸⁷ Studies indicate a direct correlation between how long people lie on the floor after a fall and their recovery. Indeed, one study found that 50 per cent of those who had lain on the floor or ground undetected for more than an hour died within six months of the fall.¹⁸⁸ By detecting falls and getting users help quickly, assistive technology like PERS can

improve safety and help older adults feel more comfortable remaining in their own homes as they age.

Research on technological interventions has also found wearable sensors to be beneficial in supporting AIRP. Wearable sensors have been found to improve fall-risk assessments compared to current standards of care,¹⁸⁹ and provide vital mobility-related information including instability, balance confidence and gait measures.^{191,192,193} They have also been found to accurately detect falls, demonstrating sensitivity (62.5-98.6 per cent) and specificity (99.3-99.5 per cent),^{193,194} and improve balance through the use of biofeedback systems.^{195,196}





Research on ambient sensor technologies — which include infrared motion, video, pressure, sound, floor and radar sensors —¹⁹⁷ has also shown promise in improving care for older adults and delaying or preventing admissions into LTC homes.^{198,199} Multi-sensor systems (wearable or ambient) have demonstrated high accuracy, sensitivity and specificity (all greater than 93 per cent) for falls detection,^{200,201} with higher values than many single-sensor programs.²⁰² They can also accurately determine a person's risk of falling (71.52 per cent).²⁰³ Other technological interventions that research shows have the potential to effectively prevent falls and reduce falls-related injuries include exergaming (exercise programs delivered through video games)^{204,205,206} compliant flooring technologies (flooring systems or coverings that have a certain degree of shock absorbency),^{207,208,209,210} and sensor-based walking aids.^{2011,212,213}

While research evidence on the impact of technology-based interventions on falls and fall-related injuries has been promising, for many of these initiatives, the research has not clearly demonstrated whether or how they would meaningfully reduce falls and fall-related injuries in the real world. Moreover, the cost-effectiveness, accessibility and affordability of these devices for older Canadians has not been investigated. Finally, research on technological solutions has stressed that new technology must be co-designed with care providers and care recipients to ensure intended outcomes and avoid creating unintended additional burdens or interfering with caregivers' ability to provide care.²¹⁴

Although there is strong evidence showing that some innovations can significantly prevent falls and subsequent LTC home admissions, these innovations have not achieved a significant level of impact in terms of becoming broadly implemented. For example, a 2021 survey conducted by the NIA and TELUS Health found that while Canadian health care practitioners regularly discuss emergency situations, including falls, with their older patients, only 11 per cent of these discussions include the use of assistive technologies such as alarms or PERS to better support a patient's overall safety — even though more than 75 per cent of practitioners are familiar with PERS. Moreover, general practitioners reported thinking that their older patients feel mostly positive towards PERS, but when they were asked what proportion of older patients they discuss PERS with on a monthly basis, their response was only about one in six.²¹⁵ Finally, cost and feasibility may be barriers to the widespread adoption of certain practices or technologies; these issues must be further considered when determining how to promote the broader uptake of promising technologies or practices that can better enable AIRP.



Supporting People's Activities of Daily Living at Home

Activities of Daily Living (ADLs) are essential and routine tasks that relate to a person's ability to care for themselves and that reflect their functional abilities, such as personal care, cooking, cleaning and transportation. When older adults are unable to accomplish ADLs independently — due to frailty, disability or other health conditions — this can lead to unsafe conditions and a poorer overall quality of life. Canadian research shows that among older adults, both frailty and disability significantly increase the risk of LTC home placements and hospitalizations.^{216,217} In addition, evidence suggests that older adults who have inadequate access to support to help manage their ADLs are not only more likely to be institutionalized, but ultimately end up requiring more health care resources.^{218,219,220}

While Canadians today are living longer than ever before, a large proportion of their later years will be spent living with disabilities. In fact, while gains in life expectancy among Canadian men have been partially due to the addition of healthy years, a larger part of the increase has been in disabled years.²²¹ Among Canadian women, gains in life expectancy have been driven almost completely by increases in disabled years.²²² This means that older Canadians are now spending more years facing challenges in managing their ADLs.

Research shows that in addition to older adults, disability rates may also be increasing among Canadians in mid-life.²²³ This could lead to more Canadians requiring additional assistance in the future, as both the percentage and number of Canadians living with disabilities will increase. As such, supporting the health and well-being of older Canadians, and thus their ability to live independently in their own homes, will increasingly depend on the availability of interventions that improve accessibility and support those living with a disability.





Pillar 2: Strengthening Home and Community-Based Care and Supports for Unpaid Caregivers

Improving the Provision of Home and Community- Based Care

Canada's care systems have not kept pace with the evolving needs of its population, remaining ill-equipped to treat older patients with complex care issues and struggling to adequately care for the country's growing number of older adults. Across levels of government, the response to the ageing of the population thus far has largely focused on expanding institutional care, resulting in significant gaps and shortages in other types of care that better meet the needs of older adults, such as home and community-based care.

Home and community-based care refers to care provided in home-based settings rather than in a hospital or LTC home, and which allows individuals to remain independent in the community.²²⁴ Broadly, home and community-based care services can be grouped into two types of care and support: **home care** and **home support services**.²²⁵ The main distinction between the two is that home care services principally focus on health care services provided by trained professionals, while homesupport services often refer to those that support older persons with their ADLs and functioning. Home care services include a wide range of services, such as palliative care, therapy and rehabilitation, and nursing care. These services help meet medical

needs and many (but not all) require licensed health care professionals such as nurses, occupational therapists and dieticians.^{226,227,228} Homesupport services include non-medical services related to personal care, housekeeping and meal preparation.^{229,230,231} Home care and homesupport services are supplemented by community-based support services, such as adult day programs, meal services, transportation, home maintenance, and companionship and recreational programs to help older adults engage with their social and physical environments.^{232,233,234} Therefore, while home care services assist with older adults' medical, physical and mental health needs, home and community-support services better address the social aspects of one's health and well-being.²³⁵

As a country, Canada currently does not prioritize home and community-based care, with LTC expenditures disproportionately being devoted to institutional care. However, LTC expenditures vary substantially across Canada's provinces and territories in the amount spent per capita and the proportion of spending allocated to home and institutional settings. Quebec spends the least on home and community-based care (\$247 per capita), while Newfoundland and Labrador spends the most (\$624).²³⁶

In addition to improving quality of care, strengthening home and community-based care would also have significant economic advantages. The current prevailing policy



focus on institutionalized care has led to inappropriate and costly utilizations of resources. For example, on any given day, thousands of Canadians occupy beds in expensive hospital settings as “alternate level of care” patients while they wait for a more appropriate care setting to become available. Recent estimates from CIHI suggest that in 2019-20, one in 11 hospital patients had their hospital stay extended until home care services were available, with more than half of them being aged 81 years and older.²³⁷ A recent OECD analysis further showed that 20 per cent of Canada’s LTC expenditures are spent on housing people in publicly funded hospitals, owing largely to a lack of capacity to support these individuals with in-home services or in a LTC home (see **Figure 2**).

One Canadian study notes that the cost associated with Canadians receiving LTC services in publicly funded hospitals is at least \$2.3 billion each year²³⁸

By contrast, in countries such as Denmark, a negligible portion of LTC expenditures is devoted to funding the provision of long-term care in hospitals.

Similarly, as noted earlier, two recent studies by CIHI show that between 11 and 30 per cent of older adults admitted to LTC homes across Canada could potentially have remained at home if adequate home and community-based care were made available.^{239,240} Thus, a substantial portion of Canada’s LTC population may not require LTC home level care but have likely been placed in such settings due to a lack of home and community-based care.

Home and community-based care has been shown to be far more cost-effective than providing equivalent care in hospitals and other institutional settings such as LTC homes.²⁴¹

Home care services such as early supported discharge programs, which shift care and rehabilitation services into a patient’s home, have consistently demonstrated their ability to reduce the cost of treating health issues associated with ageing, such hip fractures and strokes.²⁴² Studies have found that home care services were 40 to 75 per cent less costly than providing the same care in a LTC home.^{243,244} Even when factoring in the true costs of care from unpaid caregivers, home care is still less expensive to provide than institutional care and its related infrastructure costs.^{245,246} Re-orienting health care delivery towards more home and community-based settings can thus reduce costs stemming from unnecessary, expensive facility-based care.

Home care services have further economic advantages as they require fewer inputs to deliver the same quality of care compared to LTC homes or other institutional settings.²⁴⁷ This results in less waste and more time for health care providers to deliver additional services. For example, four health regions in British Columbia were examined over a four-year period. Two of the regions cut home care staff for people who were at the lowest level of care need, and the other two did not. In the regions that cut staff, the people no longer receiving home care cost the health care system an additional \$3,500 annually, due to increases in hospital visits and admissions to LTC homes.²⁴⁸



Home and community-based care has also been found to prevent adverse events and acute and chronic conditions, resulting in lower costs, fewer institutional admissions over the long-term, and freeing up additional costs that can be reallocated to patients with more complex care needs.²⁴⁹ Delaying placement in a LTC home for people who do not need that level of service — even by just one month — by providing them with appropriate support in the community would have profound implications for increasing overall system capacity when multiplied across an entire service population. Likewise, eliminating wait times in hospitals for home and community-based care would help reduce overcrowding and strains on the hospital system, and in turn help lower demands for budget increases from hospitals.²⁵⁰ Improved access to targeted home and community-based care thus has the potential to greatly improve the overall efficiency and quality of care for older persons.

What Initiatives Can Improve the Availability and Quality of Home and Community-based Care?

The health and financial implications of shifting resources from institutional LTC to home and community-based care will enable more older adults to age in the *right* place. Home and community-based care programs can also target the specific needs of older adults, including chronic disease management, dementia care and ADL support. Integrating evidence-based alternative models of care and policies into Canada's LTC systems could facilitate the shift from expensive institutionalized care towards more cost-effective home and community-based care.

Reablement

Home and community-based care could be expanded to include more preventive services, such as those targeting falls and chronic conditions. For example, “reablement” services help older adults with physical or mental limitations adapt to their conditions by learning or re-learning the skills needed to function in everyday life.²⁵¹ In taking a restorative approach to care, reablement programs have the goal of promoting and optimizing an individual’s functional independence. Integrating reablement services into home care programs would help optimize the independence of older adults by ensuring they can effectively manage both the acute and gradual declines in function that commonly accompany the onset of frailty and old age. Thus, adapting home care programs to include reablement services could enable community-dwelling older adults to continue living in their own homes by encouraging them to develop the skills and confidence to complete their functional tasks independently.²⁵² Moreover, reablement services could be efficiently integrated into the delivery of home and community-based care in the Canadian context because such services can be successfully delivered by non-professional care providers, such as personal support workers and health care aides, in addition to therapists.

Internationally, several countries have implemented a deliberate reablement policy approach in their delivery of home and community-based care, enabling restorative care to become a key feature of their programs. For example, in Denmark,



municipalities are required by law to assess whether an older person who is receiving home care could benefit from a time-limited reablement program adjusted to their needs and capabilities.²⁵³

Home-based Primary Care

Similarly, home-based primary care (HBPC) interventions, which are designed to support homebound individuals with multiple chronic health issues, could also be integrated into home and community-based care. Such programs could help address the ongoing care needs of older adults who cannot easily access office-based primary care. HBPC programs use integrated interprofessional primary care teams, which may include geriatricians, nurse practitioners, physiotherapists and general practitioners, to provide the care homebound individuals need directly in their own homes.²⁵⁴ Other common components in most of these programs are weekly interprofessional care meetings, comprehensive geriatric assessments, and after-hours telephone supports.²⁵⁵

A growing body of evidence demonstrates that HBPC programs for community-dwelling, homebound older adults not only reduce hospital admissions by 23-31 per cent, but also LTC home admissions by 10-25 per cent.^{256,257,258}

An evaluation of the United States' Independence at Home Demonstration Project also found that HBPC reduces LTC home utilization and costs.²⁵⁹ This was because HBPC program recipients had lower expenditures in services from skilled nursing facilities (SNF), temporary residences for those undergoing rehabilitation treatment, both during the first and second year since starting HBPC compared to those who didn't use HBPC services, with reductions in expenditures ranging from \$365 in the first year after starting HBPC to \$135 in the second year.²⁶⁰ Such differences were most evident in end-of-life expenditures among those who died during the 24-month study period, with reduction in SNF expenditures being more than \$1,500 for HBPC recipients.²⁶¹

LTC Home Alternative Models of Care

Integrating care models and policies focused on improved co-ordination of services could also help strengthen home and community-based care for older Canadians and further reduce LTC home admissions. For example, the United States' Program for All-Inclusive Care of the Elderly (PACE) provides a broad range of co-ordinated and tailored services to help individuals stay in their homes and communities.²⁶² This is achieved through an interdisciplinary team of support-service providers and clinicians who provide care through adult-health day centres and in-home services as required.²⁶³ The team completes participant assessments, co-ordinates 24-hour care, and conducts care planning.²⁶⁴ First developed in San Francisco, the PACE program has since spread to more than 133 organizations across 31 states.²⁶⁵ Numerous studies have shown the PACE model successfully reduces hospitalizations



and LTC home admissions and enables more older adults to live in their own communities despite experiencing increased cognitive and overall impairment.^{266,267,268,269} In fact, one study indicated that after three years, only 15 per cent of participants ended up in LTC homes.²⁷⁰

Community Care Navigator Roles

Another approach is to implement community care navigator roles. While Canada currently has co-ordinators for various types of home and community-based care, they sometimes fail to provide a holistic perspective when it comes to helping older people and their families navigate the full spectrum of available care and support options to facilitate AIRP. To address this, several countries have introduced community care navigators to identify and manage the care journeys of older adults. For example, Japan and Taiwan have care-plan managers who are responsible for co-ordinating care for individuals within communities.^{271,272} Generally, care navigators assess the care needs of older adults, develop and modify their care plans based on individual care needs, and find and contract the appropriate care providers to deliver care based on the preferences of the older adults. Care navigators work continuously with older adults, ensuring that they are always receiving the right care in the *right* place at the right time. They can also co-ordinate and design preventive care plans for older adults, reducing the need for more intensive or institutional forms of care in the future.

Taiwan's advanced care co-ordination program is known as the "ABC" program. The program leverages care networks consisting of home and community-based care providers that are co-ordinated by care navigators. The network is divided into a three-tier "ABC" system.²⁷³ Care navigators evaluate older adults, identifying their level of care needs and connecting them with the necessary service providers within their networks (Part A). Service providers then provide clients with the required care (Part B). The care providers and care navigators continuously collaborate on the client's care plan and search for ways to keep them engaged in their communities.²⁷⁴ Adopting a network-based, care navigator-centric approach to the care of older adults has the potential to improve co-ordination, continuity and suitability of care across Canada. Including community engagement as one of the core responsibilities of community care navigators could also reduce social isolation and loneliness among older adults.

Financially Supporting an Individual's Future LTC Needs

Ensuring that older Canadians can access home and community-based care that adequately meets their needs requires solutions to address the growing pressures on both the publicly funded LTC system and Canadians' ability to finance their LTC needs. Already, more than 430,000 adult Canadians are estimated to have unmet home care needs, of whom more than 160,000 are aged 65 years and older — the equivalent of 2.8 per cent of the Canadian population over 65.^{275,276}



Moreover, many Canadians are forced to rely on private-pay care solutions. Estimates suggest that only 52 per cent of Canadians have their home care services funded solely by public sources, while roughly 35 per cent pay for them out-of-pocket or via insurance coverage.²⁷⁷

At the same time, home care services are becoming increasingly unaffordable. The estimated cost of private home care services can range from \$1,000 to \$3,500 per month. In Ontario, the cost of home care for clients with complex care needs requiring 24/7 support can reach up to \$25,000 per month.²⁷⁸

A person relying on the average Canada/Quebec Pension Plan (CPP/QPP) payment, plus Old Age Security (OAS) and Guaranteed Income Supplement (GIS), will only receive around \$1,730 per month.²⁷⁹ The reality is, Canadians have always been responsible for saving money to support their own retirement. Workplace pension plans have historically helped to fill this gap, but nearly two thirds of Canadians do not participate in a workplace pension plan,²⁸⁰ and the overall median value of retirement assets among Canadians aged 55-64, without a workplace pension plan, is just over \$3,000.²⁸¹

The growing number of older adults who will need care — combined with a shortage of publicly funded LTC beds, increasing life expectancy and a projected decline in the availability of unpaid care from family members — means that Canadians will need financial solutions to cover the costs of their

future LTC needs. From a personal financing perspective, one solution available to all working Canadians that can help boost income in later life is to delay claiming their benefits from the Canada Pension Plan (CPP) or its Quebec counterpart, the Quebec Pension Plan (QPP). CPP and QPP provide a worry-free monthly payment in retirement that keeps up with inflation and pays out for life, but Canadians are not required to begin receiving CPP/QPP benefits as soon as they retire. Benefits can be taken as early as 60 or as late as 70 years of age, and the benefit amounts are adjusted according to the age of the individual when they start receiving payments. Delaying CPP/QPP benefits until after the age of 65 years comes with a sizeable financial advantage.²⁸² If benefits start after 65, payments increase by 8.4 per cent per year up to a maximum of 42 per cent at age 70 (after which there is no additional advantage to delaying benefits).²⁸³ By contrast, for every year of uptake before age 65, benefit payments decrease by 7.2 per cent per year up to a maximum reduction of 36 per cent at 60 years of age. A recent NIA report concluded that for Canadians who can afford it, delaying CPP/QPP is an advantageous financial strategy for enhancing lifetime retirement-income security.²⁸⁴

Canadians can also defer their Old-Age Security (OAS) benefits. OAS becomes available at age 65 but older Canadians can defer their payments for up to five years in exchange for monthly payments that are 0.6 per cent higher for each month of deferral, up to a maximum of 36 per cent at age 70.²⁸⁵ Moreover, the Canadian government recently increased OAS payments by 10 per cent for Canadians aged 75 years and older.²⁸⁶ This increase has made delaying



OAS until age 70 even more financially rewarding, offering ageing Canadians another potential financial solution to help cover the costs of their future LTC needs.

Private LTC insurance (LTCI) is another option for Canadians, although the sustainability and affordability of such programs are challenges due to adverse selection, which leads to market failure. Private insurers struggle to offer affordable LTCI premiums because of both the small pool of individuals who can afford it and the high probability that the insured will require services. The small selection pools have forced insurers to raise their premiums, making private insurance even more unaffordable and further decreasing the potential pool of individuals for whom private LTCI is a viable option.

Private-market financial products that can help Canadians finance their future LTC needs work by pooling retirement savings in a way that maximizes ongoing, secure income for life. For example, a new and promising solution is Dynamic Pensions (also known as Variable Payout Life Annuities, or VPLAs) — a new type of financial product that aims to provide older Canadians with higher expected lifetime income while also protecting them from running out of money.²⁸⁷ These financial products can be a vehicle for secure lifetime income at advanced ages — a time when individuals may face chronic health conditions, widowhood, depletion of financial savings, fixed retirement-income erosion from compounding inflation, and declined cognitive abilities that may make it difficult to manage their financial affairs.²⁸⁸ Higher, more secure late-life income would enable more older Canadians to maintain their living standards and sustain enough income for expenses from declining health — especially the LTC services many will need, whether in LTC or retirement homes or through home and community care services.²⁸⁹ It also gives older Canadians unlimited flexibility in choosing the care they desire — whether it be to pay for formal care services or to compensate a family member for their traditionally unpaid assistance.

In 2018, a coalition of retirement income system experts, seniors' advocates and organizations came together to ask the federal government to amend the Income Tax Act to allow for Dynamic Pensions.²⁹⁰ The government responded in Budget 2019 by announcing the intention to pass federal legislation that would enable VPLAs,²⁹¹ and the Income Tax Act was amended in 2021 to allow for VPLAs. More recently, the





government announced in its 2022 budget its intention to amend federal pension legislation to introduce a framework for VPLAs.²⁹²

A number of countries with LTC pressures similar to Canada's have tackled these challenges by establishing national LTCI programs, including Germany, Japan, the Netherlands, South Korea, Taiwan and most recently and the US state of Washington. These programs are primarily funded through social contributions at the national level, with supplemental revenue generated from co-payments and/or general taxation, and guarantee a specified level of service and financial coverage in return. By collecting premiums from a national population, a national, public LTCI program collects revenue from a large population pool and redistributes the potential risks and costs of future LTC services across the population. This better protects individuals financially by subsidizing the risk of high LTC utilizers against the risk of low LTC utilizers, leading to a more sustainable financing mechanism and more equitable access to LTC services. A national LTCI program would also avoid the problem of adverse selection.

It is important to note that national LTCI programs are not meant to reduce overall LTC costs, but to address the increasing need for LTC services from a rapidly ageing population by guaranteeing a level of LTC service and financial coverage. However, this is a solution Canada may have the capacity to implement. Canada already uses both general taxation and social contributions — the financing methods commonly used to generate revenue for national LTCI — to fund other national and provincial programs, including

Medicare and CPP/QPP.²⁹³ It could therefore earmark revenue from these sources at the national and/or provincial levels to cover unpredictable future LTC needs.

Such a program also could represent an opportunity to establish a new social contract between governments and Canadians that helps to more clearly establish an individual's expected contributions towards their future possible LTC needs, and the LTC benefits and financial level of protection that will be provided in return. It also could have the benefit of building in defaults that incentivize home and community-based care over care in LTC homes. In South Korea, for example, co-payments are lower for a home care option than for a LTC home option. Establishing a national LTCI program could also be a key way to encourage the greater standardization of LTC policies and programs across Canada. However, it is important to note that while Canada may have the capacity to implement a national LTCI program, it first needs to determine if this would be the best way to help Canadians manage their future LTC demands.

Whether the provision of publicly funded LTC services continues to be funded in Canada through general taxation, a new social insurance program or another mechanism, it is very clear that additional forms of revenue will be needed to ensure appropriate annual LTC expenditures can occur to better meet the needs of Canada's ageing population.



Interventions to Support Unpaid Caregivers

In Canada, family and friends are the greatest source of ongoing care for older people. Unpaid caregivers play a vital role in supporting older Canadians to age in their own homes and communities and ensuring the overall sustainability of the health care system. This is because they provide alternatives to costly facility-based care by supplementing the limited care currently available through the publicly funded home and community care systems.

Based on data from 2019, the NIA estimates that about 75 per cent of the home care supports older Canadians received was being provided for free by their family members.²⁹⁴

The NIA also estimates that, based on an assumed cost of \$30 per hour (\$18 for salary and \$12 for overhead costs), unpaid caregivers provided just under \$9 billion in additional free care to Canada's publicly funded health care systems.²⁹⁵ As the number of older Canadians with chronic health conditions increases in the coming years, unpaid caregiver support will become even more important. The number of older Canadians who will require the support of unpaid caregivers is projected to more than double by 2050, from 345,000 to 770,000,²⁹⁶ with the estimated cost of home care provided by unpaid caregivers expected to

increase to at least \$27 billion.²⁹⁷ Yet the NIA has also projected that due to declining birth rates, there will likely be 30 per cent fewer close family members (e.g. spouses, adult children) and friends available to provide unpaid care in 2050. Moreover, those who are available will need to increase their efforts by 40 per cent to keep up with care needs on account of fewer available caregivers per older adult.²⁹⁸

Since this data was compiled in 2019, the pandemic has accelerated the cost of labour. The current cost of an hour of care may be \$35, if not higher, with the federal government recently pledging to guarantee workers a minimum wage of at least \$25 per hour.²⁹⁹ Therefore, assuming an hourly rate of \$35, the 2019 value of unpaid caregiving, around the home care supports older Canadians are being provided for free by their family members, in today's dollars is approximately \$10 billion, with a projected future value of more than \$30 billion by 2050.

While unpaid caregivers save Canada's health care systems billions of dollars annually by providing a higher level of care and independent living options for older people, this support has unfortunately come at a considerable cost to the caregivers themselves. Unpaid caregivers face an enormous toll on their personal health, well-being and finances, including lost wages, lower retirement income and caregiver burden and distress. For example, a 2020 CIHI report found that a third of caregivers experience distress, up from 16 per cent in 2010.^{300,301} Numerous studies have demonstrated that the burden and distress experienced by unpaid caregivers often increases the chances of care recipients



being admitted into a LTC home.^{302,303,304} One study found that when caregivers are highly stressed, the chances of LTC home admissions within one year increased by 13.4 per cent, and within two years by 17.5 per cent.³⁰⁵ In Canada, estimates from CIHI suggest that approximately eight per cent of Canadian LTC home admissions among publicly funded home care recipients are due to caregiver distress. The current level of support provided by unpaid caregivers is likely unsustainable, and will only lead to higher rates of institutionalization among older adults.

While the federal, provincial and territorial governments have introduced a variety of financial and other supports for unpaid caregivers over the last decade, there remains a need for more interventions that equitably acknowledge the needs of unpaid caregivers and the value of their unpaid labour. Financially, some provinces offer refundable tax credits for unpaid caregivers, while most Canadian jurisdictions and the federal government only offer non-refundable tax credits that are treated as income.³⁰⁶ The federal government introduced the Canada Caregiver Credit in 2017 — meant to be a more accessible tax credit — which provides eligible unpaid family caregivers approximately \$7,000 in tax relief. However, to be eligible for this non-refundable credit, caregivers must be employed or earning a sufficient taxable income through other sources.³⁰⁷ The credit also fails to consider the increasing unpaid caregiving contributions of non-relative friends and neighbours. Therefore, financial assistance barriers remain a reality for many low-income unpaid caregivers, as well as those who are not direct family members. However, some provinces have

implemented targeted initiatives that address these gaps, such as Nova Scotia's caregiver benefit for low-income unpaid caregivers and Quebec's refundable caregiver tax credit.

In addition to financial supports, provinces and territories also provide non-financial supports for unpaid caregivers. However, there is currently no process for unpaid caregivers to have their needs recognized and formally assessed separately from the care recipient, and no national minimum standard of services and care that unpaid caregivers and their care recipients can expect to receive.³⁰⁸ In addition, while all provinces and territories provide some form of respite supports for unpaid caregivers, the availability, levels of support and eligibility criteria for these services are not standardized and vary greatly across Canada.

Better caregiver supports and interventions are needed to mitigate arguably the largest risk to the Canadian LTC system: the unsustainability of Canada's unpaid caregiving support system, which currently delivers 75 per cent of home care hours, and is under threat owing to changing demographics, socio-economic practices and caregiver distress. The collapse of unpaid caregiving would result in a downward spiral of poorer health outcomes among older Canadians and more and earlier admissions to LTC homes.



Better recognizing and supporting unpaid caregivers not only has the potential to preserve a practice that is under severe threat, but can also support ageing Canadians to remain in their homes and communities longer. Interventions to address the economic security of unpaid caregivers, as well as non-financial interventions to support their overall well-being and quality of life, are critical to enabling AIRP.

What Interventions Can Help Better Support Unpaid Caregivers?

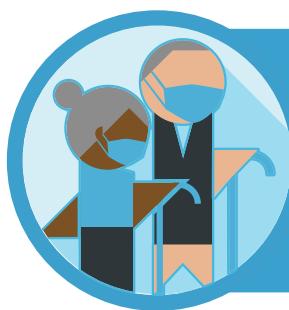
Financial Supports

Existing evidence demonstrates that financial support for unpaid caregivers can significantly protect against both caregiver distress and LTC home admission rates.^{309,310} One study found it can reduce the probability that their dependents will be admitted to a LTC home by as much as 56 per cent.³¹¹

Evidence about the impacts of non-financial caregiver interventions on caregivers and LTC home admissions has been more mixed. Non-financial interventions include more caregiver education and training, as well as access to more supports that provide home care, respite care and access to adult day programs to decrease caregiver burden.^{312,313} The existing body of evidence shows that psychosocial interventions for unpaid caregivers can effectively reduce caregiver distress, depression and psychological morbidity, and improve caregivers' quality of life.^{314,315}

Non-financial Supports

Evidence on the effectiveness of non-financial caregiver interventions in preventing transitions into LTC homes has also been somewhat varied. For example, while respite services are understood to be very important to support the health and well-being of unpaid caregivers,³¹⁶ a systematic review found that adult day services were effective in reducing caregiver burden but hastened rather than delayed LTC home admissions.³¹⁷ Nevertheless, other non-financial interventions have been found to successfully reduce LTC home admissions, including caregiver education, counselling or support groups, community care co-ordination, and multi-component interventions.^{318,319,320,321} Successful interventions have been characterized by elements such as involvement of both caregiver and care recipient, continued support to caregivers, intervention flexibility, and meeting a variety of caregivers' needs.^{322,323}



Pillar 3: Developing More Accessible and Safer Living Environments

The environments in which older Canadians live and engage must be designed to better accommodate and address the physical and cognitive limitations that often lead to unnecessary institutionalization. The NIA's National Senior Strategy and the WHO's Age Friendly Cities initiative both highlight the importance of "enabling the creation of age-friendly physical environments and spaces"³²⁴ through creating more affordable, safe and accessible housing and transportation options. Indeed, well-designed transportation and housing services are both critical factors for enabling AIRP.

Providing Safe, Accessible and Supportive Housing

The Canadian Mortgage and Housing Corporation (CMHC) has defined acceptable housing as being adequate, suitable and affordable. Housing is adequate when it requires no repairs, suitable when it has a sufficient number of bedrooms, and affordable when it costs no less than 30 per cent of the resident's income before tax. CMHC deems housing up to standard when all three criteria are met.³²⁵ A Government of Canada report assessing the housing needs of older adults using the CMHC definition of housing added three additional criteria for acceptable housing: adaptability, accessibility and safety.

A recent report by SE Health on behalf of the CMHC National Housing Strategy Solution Lab estimated that 65 per cent of older Canadians are in the "missing middle" of housing options, meaning they have "few or no housing options that meet their financial, medical, functional and personal preferences and needs."³²⁶

In 2019, 24.9 per cent of older adults lived below the CMHC standard of acceptable housing. Among these individuals, 19.4 per cent lived in unaffordable housing, 2.6 per cent lived in inadequate housing, and 2.6 per cent lived in unsuitable housing. Single older adults were most affected, with 42 per cent living in substandard housing. Further, older women living with a disability were more likely than men to be impacted by housing issues (24 per cent compared to 20 per cent).³²⁷ Even in the midst of increased public investment in accessible housing,³²⁸ there continues to be high demand and long wait times.^{329,330} CBC News recently reported that in British Columbia alone, there are 3,996 people living with disabilities waiting to find an accessible home.³³¹



It is well documented that the accessibility of an older adult's home environment impacts their ability to age in the *right* place.^{332,333,334} There are various terms used to describe accessibility, but many share the underlying principle of improving the design of homes to meet the diverse needs of residents.³³⁵ One commonly cited concept is universal design, which refers to principles that make environments accessible for any individual regardless of age, size or disability.³³⁶ The seven universal design principles are: "equitable use, flexibility in use, simple and intuitive use, perceptible information, tolerance for error, low physical effort, and size and space for approach and use."³³⁷

Home modifications to support AIRP can be major or minor.³³⁸ Accessibility can be improved by making physical alterations to improve the functionality and safety of homes, such as removing hazards, installing assistive devices, moving bedrooms and washrooms to the main floor or widening doors.^{339,340} Based on the Canadian government's expanded criteria for adequate housing, a quarter of older adults in Canada had challenges with at least one cognitive or physical limitation that made their housing inadequate. Many older Canadians live in older homes, typically built between 1960 and 1990, which frequently lack design features that accommodate the needs of older adults, such as ramps, appropriate lighting and adaptations for mobility-enhancing technologies such as motorized scooters.³⁴¹

Inaccessible housing may also create safety hazards: 50 per cent of falls among older adults in 2014 were found to have occurred at home, with building and furniture design cited as main risk factors.

Risk factors for falls further extend out to the community, with poor stair design, lighting, handrails, and sidewalk issues also contributing to falls among older adults.³⁴²

There is limited research on the impact of home modifications on older adults in Canada, but multiple international studies have been conducted on this topic. A systematic review of accessible home environments for people with functional limitations by Cho et al. (2016) found that mobility devices reduce the risk of adverse events and promote well-being. Two Australian studies have demonstrated how home modifications can reduce falls. One conducted a randomized control trial, finding falls to be significantly lower over a one-year period for participants who implemented home modifications suggested by an occupational therapist than for those who did not.³⁴³ The second study found that older adults who live in houses with more environmental hazards — such as poor lighting, lack of handles and rails, and slippery flooring — are at nearly triple the risk of injury.³⁴⁴ The same study also found that having more than five hazards and less frequent home visits by health care providers was associated with a higher rate of accidents and falls.



A person's ability to maintain their home is also an important dimension of AIRP. Maintenance tasks can include vacuuming, tidying, changing bed sheets, doing laundry, mowing the lawn and cleaning gutters.

Currently there is a lack of Canadian-specific research on adults' ability to maintain their homes as they age. However, a longitudinal study from the United States found that in the previous two years, only 13 per cent of older adults were able to perform physical alterations inside their home, eight per cent performed maintenance tasks, and 22 per cent performed major repairs.³⁴⁵ These results show that older adults' ability to maintain their houses declines as they age, especially as many older Canadians live in older homes that will require greater upkeep and alterations in order to support AIRP.

However, an older adult's inability to maintain their home should not be the primary reason they can no longer age at home. Instead, older adults should have access to the supports they need to either fulfil these tasks or find a home that requires less maintenance. Such support would help to keep older Canadians out of institutional care settings like LTC homes and improve their overall health and well-being, while reducing public and personal costs in the short- and long-term.

What Initiatives Can Provide More Accessible and Safer Housing?

Accessible design features and principles are being implemented across Canada.^{346,347} Canada's National Housing Strategy has adopted a human-rights based approach, committing to improve access to affordable, accessible housing for

Canadians experiencing a disability. Under the strategy, 20 per cent of newly built units must meet accessibility standards, meaning they are barrier-free or use universal design principles.³⁴⁸

The CMHC, which shares responsibility for the National Housing Strategy, has found it is most cost-effective to implement universal design principles at the time of construction.^{349,350} CMHC and the National Housing Strategy Solutions Lab provide information for homeowners and builders on a number of accessible home options, including: adaptable housing, which can be altered over time to address changing needs, such as adding extra apartments or reallocating living spaces; information for homeowners and builders on how to modify homes for accessibility; homeowner guidance on how to select a contractor; and specific modifications to help older adults living with dementia.^{351,352}

There are also some local examples of efforts to improve access to accessible housing. The town of Caledon, Ont., implemented a universal design policy as part of its Adults 55+ Strategy Plan, requiring that any developers who are planning to build a new subdivision "must include at least one floor plan model that incorporates universal design features to receive draft plan approval from the municipality."³⁵³ In British Columbia, the SAFERhome Standards Society has partnered with the province's social housing agency to review the accessibility of all public housing units built after 2019 and certify those that meet its accessibility standards.³⁵⁴



Examples of Housing Models to Support Ageing in the Right Place

Supporting older Canadians to age in the *right* place requires developing innovative housing models and infrastructure that support their independence, safety, health and social well-being. Some of the innovative models that have been piloted across Canada include Naturally Occurring Retirement Community (NORC) programs, HomeSharing and co-housing.

Naturally Occurring Retirement Communities (NORCs)

NORCs are communities that over time come to house a large proportion of older adults.^{355,356} NORCs do not have consistently agreed-upon parameters; however, they usually exclude communities purpose-built for older adults, such as LTC or retirement homes. NORCs have been used to support the delivery of programs that integrate health, social and physical services, often with the goal of supporting older adults to age in place.^{357,358} A key aspect of NORC programs is that they tend to include intentional opportunities for older adults to inform what types of programs and services are needed in the community.^{359,360,361}

There are several examples of NORC programs in Canada. In 1996, the first documented NORC program in Canada, the Cherryhill Healthy Ageing Program, started as a pilot in London, Ont.³⁶³ The program aimed to enable the significant population of older adults living in the 13-building community to age in place by providing an integrated health, resident-led model of support services.^{363,364}

When the program started, 85 per cent of

residents were older adults and many of them had unmet health care needs, experienced social isolation, and had varying degrees of cognitive or memory impairment.³⁶⁵

The Cherryhill NORC program consisted of a health information centre, preventive and clinical health programs and program innovation and research activities.

The Oasis Senior Supportive Living NORC model was led by the Frontenac Kingston Council on Aging in an apartment building in Kingston, Ont., in 2009 and has recently expanded across Ontario and into British Columbia.^{366,367} The Oasis program includes catered and communal meals, social activities, exercise programs, a program co-ordinator and a participatory decision-making model to support their activities.³⁶⁸

HomeSharing

HomeSharing is another innovative living arrangement that allows two or more people who are typically not related to live together in the same residence under a mutually beneficial arrangement. A typical HomeShare arrangement provides each person with their own private space and a shared common area. Landlords can continue living in their own homes while tenants pay them a subsidized rent in return for specified, regular support activities such as household maintenance and groceries. HomeShare Programs have been established in Alberta, Newfoundland and Labrador, Quebec and Ontario, and a new non-profit organization called CanadaHomeShare is looking to create more HomeShare programs across Canada.³⁶⁹



Co-housing

Co-housing is designed to provide a group of individuals with a home that includes communal spaces, shared activities, and private bedrooms and bathrooms.³⁷⁰ The goals of co-housing projects are often to reduce cost of living while providing opportunities for social interactions and support. Many co-housing models involve residents in designing and implementing the community.³⁷¹ An example of co-housing in Canada is the Abbeyfield model. There are 19 Abbeyfield Houses across Canada, which consist of a household of up to 15 low-income older adults whose daily activities are supported by a house co-ordinator.³⁷² A recent qualitative study of older adults living in co-housing communities across Canada found that the model offered social support and was able to adapt social activities during the COVID-19 pandemic, and stressed the importance of this model in creating supportive and sociable communities.³⁷³

Providing Accessible Transportation Services

Transportation is a key factor for enabling AIRP, as it ensures that older persons can continue to access essential services and maintain an active role in their communities. An inclusive transportation system can allow for more seamless movement between locations and transportation nodes, so that all people can reach their desired destinations without interruptions or limitations.³⁷⁴ Moreover, an inclusive transportation system accommodates the needs and preferences of older adults, which can vary by location, income level and physical and cognitive health status.

Older Canadians use transportation for several reasons, most commonly for reaching appointments and visiting with family and friends. In Canada, on a weekly basis, 81 per cent of older adults aged 65-84 years use some form of transportation for scheduled appointments, and 60 per cent use transportation to visit family and friends.³⁷⁵ The majority of older adults prefer to use cars for these trips, as a 2012 Statistics Canada report found 61 per cent of older adults aged 65-85 years cited their own vehicle as their preferred method of transportation. The report also found that older Canadians tend to reside in areas where cars are the main form of transportation, thus driving or being a passenger in a car have become their primary method for getting around their communities.³⁷⁶ A comparatively low proportion of the older adults use public transit or walking. Only 6.8 per cent of older Canadians aged 75 to 85 years use public transit as their main form of transportation, and only 3.6 per cent reported walking or biking. More specifically, only 18.5 per cent of Canadians aged 75 to 85 years reported using public transit in the past month, while 31.1 per cent reported walking or biking. Despite these findings, it is important to consider older Canadians' transportation preferences will evolve as newer generations age.

As the average older person stops driving approximately 10 years before they die, they must rely on others to drive them, or have access to other practical ways to get around their communities, in order to age in the *right* place. A lack of transportation options can limit a person's social participation, lead to social isolation and loneliness,^{377,378} and in turn negatively impact their overall health and well-being.³⁷⁹



Older women are particularly vulnerable, as they are less likely to have a driver's licence or be able to access public transit.³⁸⁰ The latter issue may be related to both safety concerns and the fact that older women tend to experience more late-life poverty as they age, which can further limit their ability to do drive a personal vehicle. Transportation was the primary reason Canadian women aged 85 years and older reported not being able to participate in social activities after having health problems.³⁸¹

Another vulnerable group is older Canadians living in rural and remote areas.³⁸² The low density of suburban and rural areas makes establishing public transportation systems a challenge.³⁸³ Many rural areas have limited alternative transportation options, such as public transit or taxi services,^{384,385} or no alternative options at all.³⁸⁶ Forty-nine per cent of older Canadians in rural areas report not having access to inclusive transportation.³⁸⁷ This means the loss of a driver's licence is often "life-changing" for rural-dwelling older adults.³⁸⁸ Many rural communities are far from the urban centres where they access essential amenities and services, which amplifies the loss of nearby services,³⁸⁹ and a lack of transit between urban and rural areas can be an additional challenge.³⁹⁰

For example, in rural and First Nations communities in British Columbia, persons with disabilities face gaps in access to taxi services or free transportation.³⁹¹ Existing public services may have limitations, such as the Health Connections bus — a subsidized service that provides transportation for rural residents to travel to health services, but only runs two days a week and must be booked

two days in advance. In Mirza and Hulko's qualitative study of rural-dwelling older adults in British Columbia, the authors found that accessing health care was emotionally and financially challenging due to limited or non-existent transportation options. In another study of older adults living in rural communities outside of Hamilton, Ont., most participants reported having few or no transportation options outside their own vehicle. There was a lack of safe and accessible infrastructure for walking or biking, and it was expensive to use taxis or rideshare services.³⁹² In a study of rural Ontarians, asking for rides from friends or neighbours was identified as a primary means to attend social events, as the loss of a personal vehicle or a lack of financial means to pay for private transportation otherwise restricted access to age-friendly programs or events.³⁹³

Access to affordable and accessible transportation services impacts where older people can live. One study on the impact of driving status and LTC home admissions noted that both former drivers and those who have never driven have a higher risk of entering a LTC home compared to current drivers.³⁹⁴ This likely reflects correlated causal factors, such as an individual's worsening health status or lack of financial resources preventing them from continuing to drive. Those who do not have any other drivers in their house were also more likely to enter a LTC home.³⁹⁵ Other research has also concluded that the need for transportation services or lack thereof plays a pivotal role in older adults having to move into LTC homes.^{396,397} Currently, however, CIHI is not collecting or reporting Canadian data to help determine to what degree a lack of transportation options influences LTC home admissions.



What Initiatives Can Make Transportation Services More Accessible?

While Canadian-specific research on access to transportation among older adults is limited, examples from comparable high-income countries can provide generalizable results that have implications for the Canadian context. A study in the United Kingdom that provided free bus passes to older adults found that free bus pass holders were 10 times more likely to use public transit than non-free bus pass holders.³⁹⁸ Another study looked at the effects of group travel instruction or transit-training programs for older adults, which also included having participants take a field trip to apply their new knowledge.³⁹⁹ Not only did this program lead to high participant satisfaction and the acquisition of new knowledge and skills, but it also led to higher public-transit usage for participants after completion of their training (44 per cent vs. 38 per cent).⁴⁰⁰

Improving Rural Transportation Supports

There have been a number of initiatives across Canada aiming to improve access to transportation for older adults and other residents of rural communities. For instance, the federal government recently pledged \$250 million over five years to support transit solutions for rural communities, with 10 per cent of that directed to Indigenous communities.⁴⁰¹ In 2010, Quebec started to fill gaps in rural public transit by improving co-ordination among the provincial

government, municipalities and transit providers, and requiring municipalities to develop transit options for people with disabilities, resulting in seamless transit between communities.⁴⁰²

There have also been community-driven initiatives to improve transportation options in Ontario. For instance, the Ministry of Transportation ran a pilot from 2014 to 2018 that provided funding to municipalities to partner with community organizations to improve transportation services.⁴⁰³ The pilot funded 22 programs, most of which provided a new service or enhanced an existing service and used vehicles that had no more than 10 passengers. Most of the programs were located in small- to mid-sized communities; 82 per cent provided services to older adults and 59 per cent offered services for people living with a disability. The pilot projects aimed to improve the flexibility of routes, improve capacity for services, and provide transportation for routes outside the community. Importantly, “12 pilots provided service to communities with no prior service.” The pilots showed improvement in transportation services, number of clients served per year and access to community amenities, including health care services and housing. Alternatives to public transit have also been explored. The suburban community of Innisfil, Ont., partnered with ride-sharing company Uber to subsidize its service as an alternative, less costly option to providing traditional public transit.⁴⁰⁴



Targeted Outreach and Education

There have also been local efforts to raise awareness about existing transportation services — more relevant in urban areas with public transit systems — or to educate older adults about the transition to other forms of transportation following the loss of a driver's licence.^{405,406} For example, the Hamilton Council on Aging has hosted a "Let's Take the Bus" information session for many years, helping older Hamilton residents understand the transit system and address safety concerns.⁴⁰⁷ At the University of Alberta, the Medically At-Risk Driver Centre conducts research and advocacy work to ensure transportation is safe for all Alberta residents. The centre also produced a detailed step-by-step toolkit to help urban and rural municipalities develop transportation options for older adults.⁴⁰⁸





Pillar 4: Improving Social Connections to Reduce Loneliness and Social Isolation

Ensuring that older adults can maintain relationships and social connections as they age is also critical to enabling AIRP. Meaningful relationships and consistent social engagement have significant implications for physical, emotional and mental health and well-being and play a vital role in overall quality of life. Yet older adults are vulnerable to diminishing social networks and less frequent social interactions as they age, leading to social isolation and feelings of loneliness.

Although often used interchangeably, social isolation and loneliness are related but distinct concepts. Generally speaking, social isolation refers to a measurable deficiency in the number of contacts, family or friends. Loneliness, on the other hand, is an undesirable internal experience; it is a person's emotional state when their social and intimate needs are unfulfilled.⁴⁰⁹ Whereas social isolation is the objective state of lacking connections, loneliness is a subjective internal experience. They are not the same because people can be alone and isolated yet not feel lonely, just as people can also have many relationships and frequent, regular contact yet still feel lonely.⁴¹⁰ Drawing a distinction between the two concepts helps remind us that subjective perceptions of social resources do not always reflect the actual social context.

Despite their distinctions, there are similarities in the predisposing factors and outcomes related to both social isolation and loneliness.^{411,412} Older adults are at higher risk of experiencing social isolation and loneliness due to the presence of more factors that can weaken social networks in later life. The ageing process is often characterized by multiple transitional life events such as retirement, widowhood, death of friends and relocation.^{413,414,415} Older adults also experience declines in health and functional mobility as they age, limiting the extent to which they can maintain or establish existing and new relationships. Certain sub-populations of older adults are at greater risk for experiencing loneliness, including those with health issues (e.g. individuals living with dementia), low-income status, newcomers, unpaid caregivers and those identifying as 2SLGBTQIA+.^{416,417}

Demographic shifts such as decreased fertility rates, increased divorce rates and reduced intergenerational living arrangements are also making it increasingly common for older adults to have fewer family members to rely on, live alone and be more geographically separated than in past generations. These population-level changes may also contribute to increased experiences of social isolation and loneliness in later life.



Research has consistently shown that both social isolation and loneliness are associated with numerous negative health behaviours, including a lack of physical activity, smoking, drinking and an increase in consumption of psychoactive medications.^{4118,419} Studies have also linked social isolation and loneliness to a range of adverse health outcomes, including cardiovascular disease, dementia, mood disorders, depression, cognitive decline and malnutrition, metabolic disorders and multi-morbidity.^{420,421,422,423,424,425}

Perhaps most concerning, both social isolation and loneliness have been identified as significant independent predictors of premature mortality.^{426,427,428,429}

In fact, one prominent analysis found that the health effects of prolonged social isolation are equivalent to smoking 15 cigarettes a day.⁴³⁰

Social isolation and loneliness have been found to significantly increase the use of health care services among older adults. Loneliness has been found to be associated with more frequent physician visits and increased use of outpatient and primary-care services, even when accounting for overall health and health behaviours.^{431,432,433,434} Similarly, social isolation has been associated with increased hospitalization, ED utilization and risk of readmission to hospital.^{435,436,437,438} Studies have found that the negative health implications of social isolation and loneliness may also be contributing to excess health care

costs due to prolonged hospitalizations.⁴³⁹ Conversely, having a strong social support network has been associated with having fewer health problems and a lower level of health care utilization.⁴⁴⁰

Although there are few studies in the Canadian context, social isolation and loneliness have been determined to be key predictors of LTC home admissions.

CIHI's Seniors in Transition report (2017) found that older adults who live alone were twice as likely to enter a LTC home than those who lived with their primary caregivers.⁴⁴¹

Other studies have found that community-dwelling older adults who live alone have significantly higher rates of LTC home admissions, even after adjusting for other factors.^{442,443,444,445,446} In fact, some studies have indicated that between 19.9 and 26.5 per cent of LTC home admissions could be attributed to loneliness.^{447,448}

While the negative consequences of social isolation and loneliness are well documented within the existing literature, a lack of consistent definitions and measurement tools make it challenging to fully characterize the scope of the problem in Canada. Not only are the terms "social isolation" and "loneliness" used interchangeably in research, policy and the media, multiple definitions are regularly used for each. In addition, across disciplines and research contexts, various indicators and instruments are commonly used to measure each of these concepts (e.g. Lubben Social



Network Scale, UCLA Loneliness Scale).^{449,450} In Canada, data to understand these issues comes from a variety of population-based surveys which have diverse indicators for both concepts, and which are less likely to be inclusive of the entire older-Canadian population. This heterogeneity in definitions and measures makes it difficult to compare findings across studies, generalize conclusions, and accurately estimate how many older Canadians experience social isolation and loneliness.

Due to these limitations, current estimates of social isolation and loneliness in Canada vary widely. This makes it difficult to get a true sense of the issue among older Canadians. Reports from Statistics Canada estimate that 525,000 Canadians (12 per cent) aged 65 years and older feel socially isolated and more than one million (24 per cent) wish they could participate in more social activities.⁴⁵¹ Another Canadian literature review found that one in six older Canadians are socially isolated,⁴⁵² while estimates suggest that about 30 per cent of older adults in Canada are at risk of becoming socially isolated.⁴⁵³ In terms of loneliness, Statistics Canada's 2008-09 CCHS found that about 19 per cent of Canadians aged 65 years and older report feeling lonely. More recent estimates have found that about 25 per cent of older women and 20 per cent of older men report feeling lonely at least some of the time.⁴⁵⁴ Overall, the prevalence of social isolation among community-dwelling older Canadians appears to range anywhere from six to 43 per cent,⁴⁵⁵ while 10 to 50 per cent report feeling lonely.^{456,457,458}

Despite the range in estimates, it is clear that social isolation and loneliness have significant implications for the health and

well-being of many older Canadians. It is also clear that the COVID-19 pandemic has only exacerbated issues of loneliness and social isolation among older Canadians.

A recent NIA and TELUS Health (2020) survey found that 40 per cent of Canadians older than 55 years of age reported experiencing a lack of companionship and regular social connections with other people, especially during the COVID-19 pandemic.

Furthermore, 67 per cent of Canadians reported believing that a lack of social connection with other people negatively impacts their overall health and well-being.⁴⁵⁹ The growth of the ageing population will only increase the number of at-risk older Canadians.

What Initiatives Can Help Prevent and Address Social Isolation and Loneliness?

The Canadian government has made concerted efforts to raise awareness about and address social isolation and loneliness in Canada. One key initiative has been the New Horizons for Seniors Program (NHSP), which provides annual funding to for-profit and not-for-profit organizations to support projects that mitigate the risk of social isolation by promoting social participation, mentoring and volunteering. The NHSP's goals are to empower and encourage older adults to share their knowledge, skills and experience with others in the community, enhance social well-



being and community vitality, and address social inclusion.^{460,461} Since 2004, more than 23,600 projects have been funded.^{462,463} The federal government announced in its 2019 budget an additional \$100 million over five years for the NHSP,⁴⁶⁴ and added another \$20 million over two years in the 2022 budget.⁴⁶⁵ One example of a multifaceted initiative from the NHSP, Hamilton Seniors Isolation Impact Plan (HSIIP), has indicated both significant population-level outcomes and improvements in isolation among individuals.⁴⁶⁶

There have also been provincial efforts to fund organizations to create initiatives for older adults. One example is the Seniors Community Grant Program in Ontario, which supports hundreds of projects that support older adults' community involvement. Initially, the province committed \$3 million in 2019-20,⁴⁶⁷ but has increased it to \$6 million in 2022-23 to fund local projects through municipalities, community organizations and Indigenous organizations.⁴⁶⁸ The main interventions at the local level include physical or virtual contact programs, initiatives that build connections to the community, and programs that connect older adults to services and information.⁴⁶⁹

Health and Social Programming Interventions

It is not clear from existing research which interventions are most effective in either the short- or long-term, due in part to variability in measurement and lack of data. One type of health care intervention is "social prescribing," in which prescriptions are written for non-pharmacologic interventions such as engaging in social activities or

exercise.⁴⁷⁰ Studies have shown positive impact from such interventions, with a national social prescribing program being found to reduce loneliness and improve well-being and confidence.^{471,472} Other promising interventions include education and social activity groups, and programs to improve social skills, enhance social support, increase opportunities for social interaction and address deficits in social cognition.^{473,474}

Preventive Home Visits

Another initiative could be preventive home visits, such as those available to older adults in Denmark. Since 1998, Danish legislation has required annual preventive visits to be offered to all citizens aged 80 years and older, as well as those aged 65 years and older who are considered to be socially vulnerable.⁴⁷⁵ The purpose of these visits is to identify the need for assistance, prompt productive discussions about older adults' well-being and current life circumstances,⁴⁷⁶ and offer guidance about health and supportive services and activities that can help older adults maintain their social resources and functional capabilities.⁴⁷⁷ Denmark serves as an example of how political decision-making can lead to preventive approaches that effectively limit the number of older adults who become socially isolated and/or lonely, further supporting the ability of its older population to age in the *right* place.

Rapid Review of Ageing in the *Right* Place Services and Programs Across Canada

The NIA conducted a rapid review of existing programs and services to provide an overview of how well federal, provincial and territorial Canadian governments are supporting older Canadians to age in the *right* place across its four key pillars:

- 1. *Promoting Preventive Health and Better Chronic Disease Management;***
- 2. *Strengthening Home and Community-based Care and Supports for Unpaid Caregivers;***
- 3. *Developing More Accessible and Safer Living Environments;***
- 4. *Improving Social Connections to Reduce Loneliness and Social Isolation.***

While there is little consensus on what exactly constitutes a rapid review, they are typically conducted within a shorter timeframe, and thus employ a more streamlined search strategy to synthesize evidence. In this case, standard internet searches using the Google search engine were conducted, using search terms such as “seniors,” “older adults” and “ageing” to locate programs and services that targeted age-related issues. Across the four pillars, the NIA identified specific subsections of relevant programs and services that are key to enabling older Canadians to age in the *right* place. For each of the subsections, more specific terms were used to locate programs within each province and territory that fell within the scope of the respective subsection (e.g. “dementia prevention programs in British Columbia”). Our review focused primarily on

top search results (i.e. Google results that were displayed on the first page), with the exception of programs that were presented on government or organizational websites or those of other programs (i.e. one program linking or advertising related programs).

The scope for this rapid review was generally limited to Canadian websites. Any programs or services that were presented as documents (rather than as websites) were only considered if they were prepared after 2010. This search focused primarily on provincial- or territorial-funded programs and services. However, some well-established or exemplary regional programs (i.e. programs only available within a given city or region) that received provincial or territorial funding have also been included. The programs and services of interest were those providing relevant AIRP supports at little or no cost to older adults. Federal programs were also considered. The search was conducted in the spring and early summer of 2022.

While some programs identified during the search do not specifically target older adults, they were included in the rapid review if they clearly corresponded to the types of programs or services of interest under any of the NIA’s pillars and were available to older adults. The only exception was for Pillar 4 (Improving Social Connections to Reduce Loneliness and Social Isolation), which focused only on programs and services targeted to older adults. On the other

hand, apart from some programs targeting low-income individuals, the NIA did not include programs exclusively targeting specific groups such as Indigenous populations, rural populations and individuals with disabilities (except for the assistive devices and home modification programs subsection).

This rapid review therefore provides a high-level overview of how jurisdictions across Canada are addressing the four pillars based on publicly available information, and is not meant to be a definitive resource or a comprehensive or systematic review. A heat map summarizing its findings is presented to demonstrate how well each province and territory is doing in supporting AIRP initiatives. More detailed information about each of the programs identified during the rapid review can be found [here](#) on the NIA's website.

An important limitation of the rapid review is that it was internet-based, meaning it may have missed important initiatives not advertised online. Moreover, because the search focuses on government programs, it does not cover the important work being done by charitable and non-profit organizations to support ageing Canadians. It is also important to note that some of the variation observed between the provinces/territories could be explained by their governments delegating responsibility for programs and services to regional health authorities or charitable organizations (i.e. Alzheimer Societies). Nevertheless, with the important role provincial and territorial governments have in promoting accessible and equitable services to their older populations, ensuring that there is some level of co-ordination at the provincial and territorial government level for these programs remains key.

A common trend that emerged during the review was limited availability based on location. Many programs are only offered in certain areas or regions — often highly populated urban centres. Further, across all four pillars, there were routinely fewer programs available in the territories. Nunavut appears to be especially lacking key services and programs. In comparison, Alberta, British Columbia and Ontario offer many programs for each of the sub-sections across the four pillars.

Pillar 1: Promoting Preventive Health and Better Chronic Disease Management

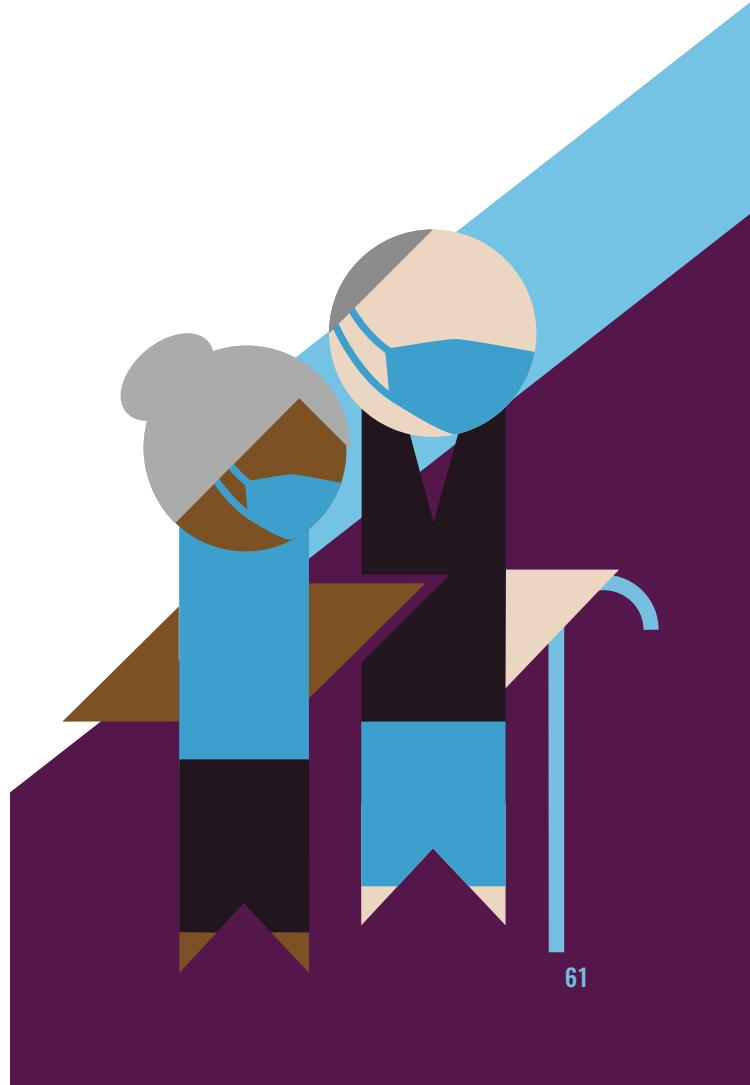
The first pillar of the NIA's AIRP framework includes three specific types of interventions or subsections: chronic disease prevention and management (CDPM), dementia prevention and support, and fall prevention. While many jurisdictions provide programs for older adults across all three of these subsections, our review found that there are gaps in the availability of fall prevention programs.

In particular, our review found that Manitoba, Prince Edward Island, Saskatchewan and Yukon have CDPM programs and Dementia Prevention and Support Programs, but no Falls Prevention programs were identified in these jurisdictions. On the other hand, Alberta, British Columbia, New Brunswick, Newfoundland and Labrador, the Northwest Territories, Nova Scotia, Ontario and Quebec have programs and services for older adults across all three subsections. Nunavut was the only jurisdiction where we were unable to identify any relevant Falls Prevention and Dementia Support Programs.

Overall, dementia prevention and support programs are the most widely available type of intervention of those included in Pillar 1, with designated programs available in every province and territory other than Nunavut. This seems to be partly due to the widespread provision of First Link, a program offered by Alzheimer Societies in every province and the Northwest Territories. First Link connects individuals living with dementia and their caregivers to key resources, services and supports within their communities. Another common type of program also being offered in collaboration with Alzheimer Societies in seven provinces across Canada is Minds in Motion, a social program that incorporates physical activity and mental stimulation for people with dementia and their care partners. The NIA's review also identified adult day programs in many provinces as another type of community service that can help older adults living with dementia to age in the *right* place. Provincial government support for these types of places was observed in Alberta, British Columbia, Manitoba, New Brunswick, Nova Scotia, Ontario, Prince Edward Island, Quebec and Yukon.

Various types of CDPM programs were included in our review: general CDPM, prescription drugs, optometry, audiology and dental services. In regards to general CDPM programs, none of the jurisdictions had services that specifically serve older adults. As many of these programs broadly target chronic diseases, their purview of assisting older adults is implied, so long as other chronic health-related requirements are met. However, the lack of a specialized lens for older adults could be a barrier to ensuring their unique health care needs are adequately supported.

Other types of CDPM programs — those offering prescription drugs, eye care, dental care and audiology — were offered either to the general public or specifically to older adults, with the amount of funding assistance mostly depending on the individual's ability to pay for services. It is important to note that most programs targeted those requiring income assistance. Prescription-drug and eye-care programs were implemented in all provinces and territories predominantly for older adults, with a few jurisdictions offering programs to certain resident groups. In terms of dental care programs, jurisdictions were split on whether programs were provided with or without an age range/cut-off, apart from Manitoba which did not provide any dental care services. Audiology programs are unique



compared to the other CDPM services as each jurisdiction generally offered audiology programs with no age range/cut-off, apart from the three territories which provided specific services for older adults (ex. Yukon's Extended Health Care Benefits and Pharmacare for Seniors). Also, audiology programs were the only services (compared to dental, prescription drugs, optometry) where non-profit organizations were also involved (ex. Personal Services Program - Easter Seals New Brunswick). The other three CDPM services were funded and provided by the provincial and territorial governments.

At the national level, the only CDPM services provided are tax refunds for various medical expenses (e.g. dental services, hearing aids, medications, prescription drugs). However, starting in 2022, Health Canada plans to provide a national dental care program for families with an annual income of less than \$90,000.^{478,479} Even though only children under 12-year-olds will be covered initially, older adults are one of the groups that will also be covered by the program next year.⁴⁸⁰

Finally, there appear to be gaps in the availability of Falls Prevention programs across Canada to effectively support older Canadians to AiRP. The NIA's review identified fall-prevention programs in only eight of Canada's 13 provinces and territories, and even among jurisdictions where available, fewer initiatives were identified than for CDPM and dementia support. Most existing initiatives are education-based programs that offer older adults a short, time-limited series of classes on strategies and/or exercises to prevent and reduce falls. Some provinces also have larger-scale fall-prevention programs for older adults,

such as the Finding Balance program, which was first developed in Alberta. Finding Balance is an education program and public awareness campaign designed to reduce the risk of falling and encourage older adults to live active and independent lives. Finding Balance programs are now available in British Columbia, New Brunswick and Newfoundland and Labrador. While the resources available in each province vary, the programs are aimed at educating and empowering older adults to prevent falls.

Pillar 2: Strengthening Home and Community-based Care and Supports for Unpaid Caregivers

To limit the scope of the review for this pillar, the NIA selected six key types of interventions and programs: assistive devices and home modification programs; home oxygen therapy; at-home care and support services; at-home palliative care; reablement services; and support for unpaid caregivers. Our review found programs for each type of intervention in most provinces and territories. Home oxygen and reablement programs were the only types of services that our review did not identify in some jurisdictions. Reablement programs in particular were the least available intervention under Pillar 2 in Canada, with such services only available in nine of the 13 provinces and territories. However, it is important to note that the term "reablement" is not commonly used across Canadian jurisdictions. For this reason, the review also considered similar rehabilitative and restorative care programs. However,

New Brunswick's Rapid Rehabilitation and Reablement program is an example of a more clearly-defined program that specifically targets the provision of reablement care and support.

Every province and territory in Canada has a publicly funded home care program to offer LTC and support services to older adults in their own homes. All of these programs also offer some level of support for what would be considered ADLs. However, home care programs vary in the level of ADL supports they offer, their qualifying criteria, and whether they are offered for free or require some level of co-payment. The programs offered in some provinces, such as British Columbia's Home Support Services and Quebec's Support Program for the Autonomy of Seniors (SAPA), explicitly note ADLs and list specific services including, but not limited to, mobility, nutrition, lifts and transfers, and bathing and dressing. Another commonly offered type of at-home care and support service offered across Canada are meal delivery programs, notably the 'Meals on Wheels' program. However, these programs are offered at varying levels within each province.

For several of the other types of programs within this pillar, their purview of support is not entirely defined by age. For example, many assistive devices/medical equipment programs being offered are not specific to supporting older adults; some eligibility requirements are related to having a specific illness (e.g., March of Dimes Canada in British Columbia). Further, home oxygen therapy eligibility tends to include a medical requirement (e.g. hypoxemia at rest) beyond

just an age requirement. to note that some programs provide a range of services that fall into more than one sub-section under Pillar 2, as is the case with the Extra-Mural Program in New Brunswick, which is a homehealthcare program in the province.

The review found palliative care programs were largely available across Canada, but many only target the costs of palliative care. Most jurisdictions in Canada do also offer some forms of direct palliative care-related services, but they vary widely in the degree to which they offer such services within the home. One common program across many provinces is the training of paramedics to support palliative care patients at home, rather than taking them to the hospital. This service is provided in Alberta, New Brunswick, Nova Scotia, and Prince Edward Island.

Finally, the review found that support for unpaid caregivers was categorized across four types of programs: support services, employment leaves, benefits and tax credits. Only five provincial-level organizations provided support services (Alberta, British Columbia, Nova Scotia, Ontario, and Quebec). All of them provided resources, and most co-ordinated a provincial helpline (except Alberta) and support groups (except Quebec).

In terms of employment leaves, all jurisdictions provided varying amounts of time off work to care for critically ill family members who were critically ill and/or have a significant risk of death. For example, Saskatchewan provided a

compassionate care medical leave which allowed employees to take up to 28 weeks of unpaid, protected time off work. The federal government also provides financial assistance for such time off work through employment insurance benefits. Only British Columbia, Newfoundland and Labrador and Quebec, however, provided unpaid short-term leaves (5 to 10 days) that also cover caregiver responsibilities such as accompanying the care recipient to medical appointments. In terms of tax credits, both the federal and provincial/territorial governments allow caregivers to claim different types of expenses (ex. medical, amount for an eligible dependant).



However, several caregiver-related benefits and tax credits (ex. Primary Caregiver Tax Credit [Manitoba], Caregiver Benefit [Nova Scotia]) were not listed in this summary as they are conditional on care recipients having a disability or impairment,^{481,482} whereas our search focused on programs targeting older adults.

Pillar 3: Developing More Accessible and Safer Living Environments

The NIA's third pillar focuses on developing safe and accessible environments, with two sub-types of interventions: safe-housing supports and accessible transportation services. Our review found some version of housing and support programs in all provinces and territories. Transportation services for older adults are also relatively widely available across Canada, but they vary in the types and extent of support available.

Two types of housing supports emerged: funding or financial assistance for housing-related costs, and lodging or housing options for older adults who are not in health care or an LTC home. The provinces and territories generally offer two types of financial assistance programs: programs that help cover the costs of home repairs or modifications to support a safe living environment; and programs that help cover the costs associated with living in the home, such as rent or heating. Examples of these programs are Nova Scotia's Senior Citizens Assistance Program that provides assistance to older homeowners to cover

repairs that are a threat to health and safety and the Shelter Aid for Elderly Renters program in British Columbia which helps individuals aged 60 or older pay their rent. In terms of lodging or housing options, most jurisdictions offer subsidized housing programs either exclusive to older adults or directly targeting them, while British Columbia and Manitoba also provide subsidized housing with on-site supports for older adults and people with disabilities. Our review also identified Senior Lodges in Alberta as a provincial program that provides housing options for older adults that are an alternative to independent living. In New Brunswick, Special Care Homes and Memory Care Homes are provided to give daily support to residents, with the latter specifically assisting older adults with a diagnosis of dementia.

The NIA's review of transportation services identified a number of services available across Canada not exclusively for older adults, but for lower-income people more generally. Province-wide programs to subsidize the costs of public transportation were identified in British Columbia, New Brunswick, Ontario and Saskatchewan. British Columbia also offers the Community Travel Training Program to provide public transit training for older adults. Even though two municipal services funded by provincial governments were found to reduce the costs of public transportation within Nova Scotia and Alberta, but it is assumed that there are considerably more public-transportation assistance programs organized at the municipal level, which was outside the scope of this review. Examples include the Brampton City Council approving free

Brampton Transit fares for older adults⁴⁸³ and the City of Montreal increasing discounts for older adult transit riders.⁴⁸⁴ As this review looked specifically into provincial/territorial-funded programs, these types of services were not looked into further.

Programs and services to support older adults' ability to continue driving were identified in British Columbia, Northwest Territories, Nunavut and Prince Edward Island, which reduce driving-related fees such as the costs of drivers' licences. Prince Edward Island also offers the 55 Alive/Mature Driver Refresher Course to help older adults update and improve their driving skills. Alberta was the only province that co-ordinated a ride program through provincial government funding. However it is assumed that like in the case of public transit, other jurisdictions offer such programs at the municipal or regional level. In five provinces, the only kind of transportation services provided to older adults were strictly for transportation related to medical needs or hospital visits.

Finally, some of the transportation services available to older adults are specifically only for medically-related/hospital transportation needs. Examples include Manitoba's Out-of-Province Transportation Subsidy Program for Approved Out-of-Province Medical Referrals, Newfoundland and Labrador's Medical Transportation Assistance Program (MTAP), and Quebec's Ambulance Transport for Seniors over 65. Along with New Brunswick and Yukon it was found during our review that these were also the only type of transportation services identified for these five jurisdictions.

Pillar 4: Improving Social Connections to Reduce Loneliness and Social Isolation

The NIA's fourth pillar focuses on improving social connections to reduce loneliness and social isolation. The review focused broadly on programs designed to prevent and/or reduce loneliness and social isolation among older adults, which were found in varying forms in nine of Canada's 13 provinces and territories. We were unable to identify any relevant programs designed to reduce loneliness and social isolation among older adults in Newfoundland and Labrador, Nova Scotia, Nunavut and Yukon.

Among the jurisdictions offering programs related to this pillar, there was variation across the provinces and territories in the types of initiatives available to effectively support older adults' ability to remain socially engaged. There also appears to be a greater emphasis on offering programs and services at the regional level for this pillar than the other three.

More recent programs tend to have a stronger focus on diversity, equity and inclusion. This may be a reflection of the growing public and government consciousness around the need for more inclusive programming for vulnerable populations, including but not limited to racialized communities, immigrants and newcomers, low-income persons, individuals with disabilities and Indigenous populations. This pillar's emphasis on social connection and support may also lead it to focus more on specific communities compared to the other three pillars.

One common type of initiative the review identified was seniors' centres, which can be viewed as a form of programming that promotes active ageing and combats social isolation and loneliness for older adults. They support networking opportunities for older adults, and provide opportunities for activities and learning, to name a few. Four provinces also provide Seniors' Centre Without Walls programs, which are free, interactive telephone services that connect older adults who have difficulty leaving the home to various events and activities. The program is offered differently across jurisdictions, with Ontario having numerous organizations across the province provide the service, whereas Alberta, Manitoba and Saskatchewan have one provincial program for all residents. Some regions in British Columbia also offer this program, but they are not provincially funded.^{485,486}

A number of provinces also provide a range of connector programs to connect isolated and lonely older adults with community volunteers and resources, such as British Columbia's Social Prescribing Program for Senior Patients where community connectors connect older adults in Surrey to non-clinical community programs in the region. Similarly, Manitoba provides the Connect Program that matches community volunteers with isolated older adults for weekly one-hour visits. New Brunswick also provides the Community Connectors Healthy Seniors Pilot Program that is training drivers of the Meals on Wheels program in Fredericton to identify and address isolated and lonely older adults, refer them to pre-existing community

activities and provide coaching. At the federal level, our review identified the Red Cross Friendly Calls Program, which offers older adults regularly scheduled social calls with a Red Cross volunteer or staff member.

General Trends and Overview

A common trend that emerged during the NIA's search for and review of programs and services available to support AiRP was limited availability based on location. Many programs are only offered in certain areas or regions – often populated, urban centres. Some examples of these programs include Specialized Community Services Outreach Team (SCSOT) which offers older adults in Burnaby, British Columbia reablement services, the Calgary Fall Prevention Clinic in Alberta, the Self-Management Program Central West in Ontario to help older adults in the region manage their chronic conditions, and the Reablement Program in Whitehorse, Yukon. Further, across all four pillars, there were routinely fewer programs available in the territories. Nunavut appears to be especially lacking key services and programs, with only a handful of programs available across the four pillars. In comparison, Alberta, British Columbia and Ontario seem to be the most well-represented provinces; this review often found many programs for each of the sub-sections across the four pillars.



The NIA's Rapid Review of Ageing in the *Right Place* Programs and Services Available Across Canadian Jurisdictions

PILLAR 1: Promoting Preventive Health and Better Chronic Disease Management			PILLAR 2: Strengthening Home and Community-Based Care and Supports for Unpaid Caregivers							PILLAR 3: Developing More Accessible and Safer Living Environments		PILLAR 4: Improving Social Connections to Reduce Loneliness and Social Isolation
	CDPM	Dementia Support Programs	Falls Prevention	Assistive Devices and Home Modification Programs	Home Oxygen	At-home Care and Support Services	At-home Palliative Care	Reablement^	Support for Unpaid Caregivers	Housing	Transportation	Social Isolation & Loneliness
Alberta 	Better Choices, Better Health	First Link	Adult Day Programs	Finding Balance Alberta Falls Prevention Program & Campaign	Alberta Aids to Daily Living (AADL)*	Alberta Aids to Daily Living Program (AADL)*	Alberta Aids to Daily Living (AADL) - Respiratory Benefits Program*	Alberta Special Needs Assistance for Seniors	The Good Samaritan Society CHOICE Program (Edmonton)	Programs and Services from Caregivers Alberta	Rent Supplement Program Community Housing Program Seniors Self-Contained Housing Program Senior Lodge Seniors' Home Adaptation and Repair Program Seniors Property Tax Deferral Program	Pan-Edmonton Group Addressing Social Isolation for Seniors (PEGASIS) Drive Happiness Ride Transit Program (Edmonton) Seniors' Centre Without Walls
	Alberta Aids to Daily Living (AADL)*			Move 'n Mingle Fall Prevention Exercise Program (Calgary)								
	Coverage for Seniors Program			Minds in Motion								
	Alberta Adult Health Benefit			Calgary Fall Prevention Clinic (Calgary)								
	Dental and Optical Assistance for Seniors			Better Balance Fall Prevention Program (Edmonton)								
	Alberta Health Care Insurance Plan (AHCIP)											

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British Columbia	Complex Chronic Disease Program (CCDP)										
	Self-Management British Columbia Programs								Line 58729 – Medical Expenses (II)	Shelter Aid for Elderly Renters	
	PharmaCare					Safe Seniors, Strong Communities (SSSC)*				Autoplan Insurance: Seniors' Savings	
	Medical Services Plan (MSP)			March of Dimes Canada		Meals on Wheels & Community Meal Delivery Program (Maple Ridge)			Programs and Services from Family Caregivers of British Columbia	B.C. Seniors' Home Renovations and Tax Credit	Discounted Driver Licensing Fees for Seniors
	Optical Supplements	First Link Dementia Support	Finding Balance B.C. Campaign	Home Adaptations for Independence		B.C. Palliative Care Benefits			Family Responsibility Leave	Home Owner Grant for Seniors	Community Travel Training Program
	Programs and Services from the Canadian Hard of Hearing Association – B.C. Chapter	Minds in Motion	Strategies and Actions for Independent Living (SAIL)	Home Renovation Tax Credit for Seniors and Persons with Disabilities	Fraser Health Home Oxygen Program (Fraser Health)	Assisted Living	Palliative Care at Home (Vancouver Coastal Health)	Specialized Community Services Outreach Team (SCSOT) (Burnaby)	Compassionate Care Leave	B.C. Ferries (Coastal Ferry Routes)	Seniors Connect (Nanaimo)
	The B.C. Adult Cochlear Implant Program			Home Owner Grant for People with Disabilities		Independent Living B.C. Program			Line 58160 – Amount for an Eligible Dependant	Discounted Fees for Older Adults	Social Prescribing Program for Senior Patients (Surrey)
	VCH Deaf, Hard of Hearing & Deaf-Blind Well-Being Program			Low Income Grant Supplement for People with Disabilities		Provincial Home Support Services			Line 58689 – Medical Expenses (I)	Subsidized Housing	E-Hub & Brochure Project (Vancouver)
	Emergency Dental Supplements					Better at Home*			Line 58729 – Medical Expenses (II)	Supportive Housing	Seniors' Supportive Housing
	Denture Supplements									B.C. Bus Pass Program	Better at Home*

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Manitoba 	Healthy Together Now									Rent Supplement Program				
	Prairie Mountain Health Chronic Disease Education Program (Prairie Mountain Health Regional Health Authority)	First Link Dementia Support	Minds in Motion	Home Care Services – Supplies and Equipment	Manitoba Home Oxygen Concentrator Program (HCOP)	PRIME Program (Winnipeg)	Meals on Wheels Winnipeg (Winnipeg)	Palliative Care Drug Access Program	Winnipeg Regional Health Authority (WRHA) Palliative Care Program (Winnipeg)	Hospital Home Team (HHT) (Winnipeg)	Compassionate Care Leave	Social Housing Rental Program	Out-of-Province Transportation Subsidy Program for Approved Out-of-Province Medical Referrals	Senior Centres Connect Program
	Pharmacare	Adult Day Services									Line 58160 – Amount for an Eligible Dependant	Affordable Housing Rental Program		Modern Services for Seniors Outreach Program
	Manitoba Health										Line 58400 – Caregiver Amount	Rent Assist		Seniors' Centre Without Walls
	Seniors Eyeglass Program										Line 58689 – Medical Expenses (I)	Supportive Housing		
	Deaf and Hard of Hearing Services (Manitoba Possible)										Line 58729 – Medical Expenses (II)	Seniors' School Tax Rebate		
New Brunswick 	Health Services Orthopedic Program	New Brunswick Adult Day Centres	Finding Balance New Brunswick	Health Services Hearing Aid Program	Health Services Wheelchair/ Seating Program	Health Oxygen Program (Extra-Mural Program**)	Meals on Wheels of Fredericton Inc. (Fredericton)	Palliative Care Project	Rapid Rehabilitation and Reablement	Compassionate Care Leave	Public Housing		Canadian Red Cross Connection New Brunswick	
	New Brunswick Drug Plan	Adult Protection Program	Home First				Extra-Mural Program**			Line 58160 – Amount for an Eligible Dependant	Rent Supplement Assistance Program	Social Assistance Program	Community Connectors Pilot Program (Fredericton)	
										Line 58400 – Caregiver Amount	Residential Property Tax Credit	Special Benefits		

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	New Brunswick Prescription Drug Program (NBPDP)			Housing Assistance for Persons with Disabilities		Long-Term Care Services for Seniors			Line 58689 – Medical Expenses (I) Line 58729 – Medical Expenses (II)	Property Tax Allowance Property Tax Deferral Program for Seniors Social Assistance Program Special Care Homes Memory Care Homes		Nursing Homes Without Walls (Southeast New Brunswick)
	Medicare											
	Health Services Hearing Aid Program											
	Personal Services Program (Easter Seals New Brunswick)			New Brunswick Seniors' Home Renovation Tax Credit								
	Social Development Equipment Recycle Program (Easter Seals New Brunswick)			Minor Home Repairs Grant								
	Dental Program											
Newfoundland and Labrador 	Improving Health: My Way	First Link	Finding Balance Newfoundland and Labrador	Special Assistance Program – Medical Equipment and Supplies	Special Assistance Program	Provincial Home Support Program	Palliative Care at Home (Central Health)	See Notes	Paid Family Caregiving Option Family Responsibility Leave Compassionate Care Leave	Provincial Home Repair Program Rental Housing Program	Medical Transportation Assistance Program (MTAP)	
	The 65Plus Plan			Home Modification Program (HMP)		Home Modification Program						
	Vision Care											

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	The Canadian Hard of Hearing Association Newfoundland and Labrador							Line 58160 – Amount for an Eligible Dependant		
	Adult Dental Program							Line 58400 – Caregiver Amount		
	Surgical Dental Program							Line 58689 – Medical Expenses (I)		
								Line 58729 – Medical Expenses (II)		
Northwest Territories 	Extended Health Benefits for Specific Disease Conditions Program	First Link	Minds in Motion	Elders in Motion	Extended Health Benefits for Seniors' Program*	Seniors Aging-In-Place Program	Extended Health Benefits for Seniors Program*	Home and Community Care*	Home and Community Care*	Compassionate Care Leave
	Extended Health Benefits for Seniors' Program*				Repairs and Enhancements	CARE Mobility				Family Caregiver Leave
	NWT Health Care Plan									Line 58160 – Amount for an Eligible Dependant
										Line 58400 – Caregiver Amount
										Line 58689 – Medical Expenses (I)
										Line 58729 – Medical Expenses (II)
										Emergency Repair Funding
										Public Housing Program
										Seniors and Disabled Persons Property Tax Relief
										Senior Home Heating Subsidy
										Reduced Licence Costs
										NWT Seniors' Society Working Together with Elders

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Nova Scotia 	Chronic Pain Self-Management Program								The Senior Citizens Assistance Program	
	Your Way to Wellness								Parent Apartment Program	
	Chronic Disease Management Incentive Program								Public Housing for Seniors Program	
	Seniors' Pharmacare Program	First Link							Canada-Nova Scotia Targeted Housing Benefit	
	Hospital Insurance	Minds in Motion	Ageing Well Together						Income Assistance	
	Optometry Program		Adult Day Programs						Free Annual Halifax Transit Bus Pass (Halifax)	
	Hearing & Speech Nova Scotia									
	The Dalhousie Hearing Aid Assistance Program-Community Services (DHAAP-CS)									
	Oral and Maxillofacial Surgery Program									

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	Maxillofacial Prosthodontics Program Dental Coverage under Exceptional Circumstances											
Nunavut 	Nunavut Health Care Plan Extended Health Benefits (EHB) Seniors' Coverage			Department of Health – Extended Health Benefits Senior Citizens Home Repair Program** Senior and Persons with Disabilities Preventative Maintenance Program*	See Notes	Home and Community Care Program*	Home and Community Care Program*	Home and Community Care Program*	Compassionate Care Leave Line 58160 – Amount for an Eligible Dependant Line 58400 – Caregiver Amount Line 58689 – Medical Expenses (I) Line 58729 – Medical Expenses (II)	Senior Citizens Home Repair Program** Senior and Persons with Disabilities Preventative Maintenance Program** Senior Fuel Subsidy Public Housing Program Home Renovation Program Emergency Repair Program Senior Citizens and People with Disabilities Property Tax Relief Program	Reduced Motor Vehicle Fees	

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Province	Program Name	Eligibility Criteria	Program Description	Eligible Expenses	Eligible Locations	Eligible Caregivers	Eligible Services	Eligible Interventions	Eligible Benefits	Eligible Tax Credit	Eligible Seniors' Benefits	Eligible Ontario Benefits	Eligible Provincial Benefits
Ontario	Self-Management Program Central West								Programs and Services from Ontario Caregiver Organization	Senior Homeowners' Property Tax Grant			
	Online Chronic Disease Self-Management Program	First Link	Exercise and Fall Prevention Seminars	Assistive Devices Program					Caregiver Support Services (Toronto)	Seniors' Home Safety Tax Credit*			Seniors Active Living Centres (SALCs)
	Ontario Drug Benefit Program	Finding Your Way Wandering Prevention Program	The Champlain Stay on Your Feet Program (Champlain Local Health Integration Network)	Tax Exemption for Seniors and Persons with Disabilities*	Assistive Devices Program	MODC's Home & Vehicle Modification Program	Ontario Community Support Program	Meals on Wheels	Family Caregiver Leave	Tax Exemption for Seniors and Persons with Disabilities*			Seniors' Centre Without Walls
	Ontario Health Insurance Plan (OHIP)	Minds in Motion		Seniors' Home Safety Tax Credit*	Home and Community Care				Assess and Restore (A&R) Interventions	Family Medical Leave		Ontario Seniors' Public Transit Tax Credit	Bernard Betel Centre Healthy At Home (Toronto & York Region)
	Assistive Devices Program	Adult Day Programs		Toronto Renovates Homeowners Program (Toronto)					Home and Community Care	Critical Illness Leave	Property Tax Relief for Low-Income Seniors and Low-Income Persons with Disabilities		Senior Persons Living Connected Adult Day Program (Scarborough)
	Ontario Seniors Dental Care Program									Line 58160 – Amount for an Eligible Dependant	Line 58400 – Caregiver Amount		Seniors Peer Connector Program (Hamilton)
										Line 58689 – Medical Expenses (I)	Line 58689 – Medical Expenses (II)		
										Line 58729 – Medical Expenses (II)		Canada-Ontario Housing Benefit	

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									Ontario Electricity Support Program		
									Low-Income Energy Assistance Program		
									Special Rules for Low-Income Customers		
Prince Edward Island 	CHANGE Program										
	Beck Exercise Physiology - Exercise for Health Program										
	Seniors' Drug Program	First Link	Adult Day Programs	See Notes	Seniors Safe @ Home Program	Home Oxygen Program	Home Care Program	Provincial Integrated Palliative Care Program	Compassionate Care Leave		
	Hear, Hear PEI (P.E.I. Senior Citizens' Federation Inc.)						COACH Program	Paramedics Providing Palliative Care at Home Program	Line 58160 – Amount for an Eligible Dependant	Designated Parking Permit Program	P.E.I. Senior Citizens' Federation Inc. Friendly Visitor Program
	Audiology Services						Seniors Independence Initiative*		Line 58400 – Caregiver Amount	Seniors Housing Program	Immigrant & Refugee Services Association Seniors' Social Integration Program
	Medical Services Plan								Line 58689 – Medical Expenses (I)	Seniors Home Repair Program	Seniors Independence Initiative*
	Provincial Dental Care Program								Line 58729 – Medical Expenses (II)		Native Council of P.E.I. Elders Empowering Elders

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Quebec 	Quebec Public Health Program	First Link Adult Day Programs	Fall Prevention: STAND UP!	Assistive Devices Program		Meals on Wheels		See Notes	Programs and services from L'Appui	Grant for Seniors to Offset a Municipal Tax Increase	Ambulance Transportation for Seniors over 65	Community Health and Social Services Network (CHSSN) Senior Wellness Centres
	Prescription Drug Insurance			Independent Living Tax Credit for Seniors		Support Program for the Autonomy of Seniors (SAPA)	Palliative Care		Short-Term Family Obligations			
	Quebec Health Insurance Plan			Home Adaptation Program	National Program for Home Oxygen Therapy (NPHOT)	Tax Credit for Home-Support Services for Seniors			Extended Absence Family Obligations	Independent Living Tax Credit for Seniors*		
	Hearing Devices Program			QST Refund for the Purchase and Installation of an Automatic Door Opener					Tax Credit for Caregivers - Line 462	Shelter Allowance Program		
	Assistance for Dental Care and Dentures			Small Accessible Institutions (PEA) Program								
Saskatchewan 	Saskatchewan Aids to Independent Living**	First Link Minds in Motion		The Special Needs Equipment Program		Meals on Wheels		Intermediate Care	Critically Ill Adult Care - Medical Leave	Seniors' Income Plan	Discounted Bus Pass Program	Reducing Isolation of Seniors Collective
	Chronic Disease Management Program (Livewell)			Home Repair Program - Adaptation for Independence	Saskatchewan Aids to Independent Living (SAIL) Program*	Individualized Funding for Home Care*	Home Care*		Compassionate Care - Medical Leave	Seniors Housing Program		
	Saskatchewan Health Services			Seniors Income Plan (SIP)					Line 58160 – Amount for an Eligible Dependant	Social Housing Program		

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	Supplementary Health Benefits								Seniors Education Property Tax Deferral Program		
	Seniors' Drug Plan							Line 58400 – Caregiver Amount			
	Palliative Drug Care Coverage							Line 58689 – Medical Expenses (I)	Saskatchewan Low-Income Tax Credit		
	Seniors Income Plan (SIP)							Line 58729 – Medical Expenses (II)	Saskatchewan Home Renovation Tax Credit		
	Specialized Audiology Services										
Yukon 	Chronic Conditions Supports							Compassionate Care Leave	Social Housing		
	Chronic Disease and Disability Benefits Program	Shine a Light on Dementia		Chronic Disease or Disability Assistance		Home Care Program*	Home Care Program*	Leave Related to Critical Illness of an Adult	Rent Reduced in Social Housing		
	Extended Heath Care Benefits and Pharmacare for Seniors	Yukon Community Day Program (Whitehorse)		Home Repair Program*	See Notes	Community Day Program	Palliative Support - Hospice Yukon	Line 58160 – Amount for an Eligible Dependent	Canada-Yukon Housing Benefit	Medical Travel Coverage	
	Hearing Services						Reablement Program (Whitehorse)	Line 58689 – Medical Expenses (I)	Pioneer Utility Grant		
	The B.C. Adult Cochlear Implant Program							Line 58729 – Medical Expenses (II)	Home Repair Program*		
									Seniors' Property Tax Deferment		

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Nation-Wide		Yukon Health Care Insurance Plan									

Notes:

* - These programs have been noted more than once in the table.

^ - This sub-pillar includes not only reablement programs, but also similar rehabilitative and restorative care programs.

Newfoundland and Labrador – There are initiatives being set in place to improve senior reablement, but they are not yet active.

Nunavut - Despite there being no provincial home oxygen program, Extended Health Benefits (EHB) for Seniors' Coverage covers the full cost of prescribed medical supplies and appliances, their fitting and shipping.

Prince Edward Island – Initiatives have been proposed to better specialize care options for seniors.

Quebec – There are various existing papers that highlight the effectiveness of reablement, written with the intention of advising Quebec to implement more funding and attention towards reablement.

Yukon - Despite there being no provincial home oxygen program, the Pharmacare and extended health care benefits programs assist registered seniors with the cost of medical-surgical supplies and equipment.

10 Policy Recommendations to Support and Enable Ageing in the *Right* Place Across Canada

The NIA has identified four pillars of actions that are critical to enabling AIRP. Promoting Preventive Health and Better Chronic Disease Management includes chronic disease prevention and management, dementia prevention and support, preventing falls and promoting safety and supporting people's ADLs at home. Strengthening Home and Community-Based Care and Interventions for Unpaid Caregivers is about shifting the emphasis of Canada's LTC systems from institutionalization to care in people's homes and communities, and providing adequate supports for unpaid caregivers. Developing More Accessible and Safer Physical Environments identifies the need to ensure older adults live in environments adapted to their physical and cognitive needs and can easily navigate their communities. Improving Social Connections to Reduce Loneliness and Social Isolation underscores how social circumstances impact the health and well-being of older adults.

To enable these four pillars, the NIA has developed 10 recommendations. Adopting them will require a collective effort, but giving all Canadians a better chance at AIRP would greatly improve their quality of their life while addressing long-standing, systemic issues within Canada's LTC systems.

The NIA's recommendations are:

1. Provide adequate and sustainable LTC funding
2. Adopt a deliberate public policy response

that shifts more LTC resources from the provision of institutional care to home care and community-support services and ensures that only individuals requiring care in LTC homes are admitted to them

3. Implement care models and policies that enable more older Canadians to live at home and in their communities with greater independence
4. Establish community care navigator roles to ensure that LTC recipients receive timely, appropriate care and have opportunities to remain engaged in their communities
5. Enable local governments and stakeholders to provide more inclusive, accessible and safe housing options
6. Support greater investments in more accessible and flexible transportation options



7. Integrate screening and solutions for social isolation and loneliness into the delivery of health care, home care and community-support services
8. Implement more focused and co-ordinated efforts to promote falls awareness and implement evidence-based, effective and accessible fall-prevention strategies
9. Improve financial and non-financial supports for unpaid caregivers
10. Continue to support research on factors that can enable AIRP, as well as potential interventions to support the development of evidence-based policies and practices

Canadian LTC homes by developing and implementing new national LTC standards. During the subsequent 2021 election, the re-elected Liberal Party expanded its \$3 billion commitment to \$9 billion, including \$1.7 billion over five years to raise wages for personal support workers and \$500 million to train up to 50,000 new personal support workers. It also pledged to create a committee to offer recommendations for establishing a new Aging at Home Benefit. On October 6, 2022, the Ministers of Seniors and Health announced that the National Seniors Council will serve as an expert panel to provide recommendations for establishing the Aging at Home Benefit.⁴⁸⁸

1. Provide adequate and sustainable LTC funding

Appropriate LTC funding is fundamental to enabling AIRP. However, Canada's annual LTC expenditure, measured as part of its total health expenditure, currently lags behind most OECD countries.⁴⁸⁷ Given Canada's ageing population, and the unprecedented level of unmet need for care, increasing its overall LTC expenditures will be crucial.

In the 2021 federal budget, Canada's government announced its intention to both improve the provision of LTC and support more ageing-in-place initiatives. The government pledged \$90 million over three years for a new Age Well at Home initiative that would assist community-based organizations in providing support to older persons. The government also announced \$3 billion in funding over five years to improve the delivery of care in

The commitments promised during the 2021 budget and election were a necessary step toward increasing public spending on LTC. Nevertheless, significantly greater investments will be needed from Canada's federal, provincial and territorial governments to meet current and future demand for LTC services. Canada's Parliamentary Budget Office (PBO) recently estimated that public spending on LTC would have to increase by \$13.7 billion per year just to implement the basic improvements to the delivery of LTC across Canada that were proposed during the COVID-19 pandemic.⁴⁸⁹ For example, the report estimated that with approximately 52,000 Canadians on the waitlist for a place in a LTC home, meeting this demand would necessitate a 26% increase in the number of existing LTC beds across Canada at a cost of \$3.1 billion. The PBO also estimated that increasing the proportion of LTC spending Canada allocates to home and community-based care to bring it in line with the OECD average of 35 per

cent would take an additional \$5.2 billion annually.⁴⁹⁰ Thus, federal, provincial and territorial governments will need to invest significantly more into LTC if they are to meet current demands for care, let alone the future needs of Canada's ageing population.

There also needs to be more consideration — among both the retirement-finance service industry and public policy discourse — of sustainable population-level funding and financial-service products to support LTC costs for older Canadians. Discussions in this space have focused almost exclusively on strengthening Medicare, CPP/QPP, OAS and the Guaranteed Income Supplement (GIS). Public-facing research has great potential to raise awareness and propose solutions that better integrate and balance the needs of individual Canadians, provincial and federal tax systems and social-support programs, and industry products, services and practices. This could also help to inform the unique role and purpose a new proposed national Aging at Home Benefit could fulfill.

In addition, Canada should further explore the possibility of implementing a national LTCI program. Six international jurisdictions have already established public LTCI programs: Germany, Japan, the Netherlands, South Korea, Taiwan and most recently and the US state of Washington have already done. Such programs collect revenue from a large population pool and redistribute the potential risks and costs of LTC services across the population, providing more equitable access and a sustainable financing mechanism for possible future LTC needs. A national LTCI program could also help to establish a new social contract between governments

and Canadians, while also standardizing LTC policies and programs across Canada. It is important to note that while Canada may have the capacity to implement a national LTCI program, it is not yet clear if this would be the best way to help Canadians manage their future LTC demands and costs.

Whether publicly funded LTC services continue to be funded in Canada through general taxation, a new social insurance program or another mechanism, it is clear that additional forms of revenue will be needed to ensure appropriate annual LTC expenditures that better meet the needs of Canada's ageing population.

2. Adopt a deliberate public policy response that shifts more LTC resources from the provision of institutional care to home care and community-support services and ensures that only individuals requiring care in LTC homes are admitted to them

All levels of government need an overarching change in perspective to recognize the benefits of shifting more services for Canada's ageing population to the home and community. As two recent CIHI studies reveal, an estimated 11 to 30 per cent of older adults admitted to LTC homes could have potentially been supported through home and community-based care.^{491,492} Prioritizing appropriate home and community-based care



over institutional care, and setting stricter LTC admissions criteria to ensure that only individuals who actually need to be in a LTC home end up there, could ensure that more Canadians receive the right care in the *right* place at the right time. Such a public policy response could reduce nursing home admissions in Canada by more than 30 per cent — without relying on the success or failure of new and novel interventions.

Ensuring that home and community-based care services are available and accessible would also help reduce inappropriate and costly stays in hospitals and other acute-care settings for older Canadians, freeing up acute-care resources for other patients who need them. Current estimates suggest this could save health care systems up to \$2.3 billion

a year.⁴⁹³ Expanding home and community-based care would thus offer governments a cost-effective alternative to facility-based care while generating considerable savings, and it would align with older Canadians' preference to remain in their own homes.

Canada's federal government announced its intention to improve the provision of LTC and support more AIRP initiatives as a part of its 2021 budget. Specifically, it pledged to "invest in providing increased quantity and quality of home care to ensure care at home is the primary Canadian model of seniors' care."⁴⁹⁴ Committing to directly fund home and community-based care would be the first step in fulfilling this pledge.

Canada could learn from countries such as Denmark that have grappled with similar demographic and fiscal challenges and proactively addressed the needs of their ageing populations by prioritizing home and community-based care services. Within 10 years of implementing this approach, Denmark successfully achieved a 12 per cent reduction in LTC spending among adults aged 80 years and older.⁴⁹⁵ Moreover, Denmark was able to close thousands of hospital beds while avoiding the development of LTC homes for close to 20 years, all while maintaining its overall health care spending at reasonable levels.⁴⁹⁶

3. Implement care models and policies that enable older Canadians to live at home and in their communities with greater independence

In addition to addressing funding gaps, evidence-based policy reforms are also necessary to improve the ability of older adults to remain in their own homes as they age. Among such reforms is the deliberate integration of care models and policies that would reduce the cost of ageing at home. For example, reablement services, which help older adults with physical or mental limitations adapt to their conditions by learning or re-learning the everyday skills should be a core component of home and community-based care. As the NIA's rapid review demonstrated, few jurisdictions across Canada focus specifically on offering reablement services. Integrating reablement services into home care programs would help optimize the independence of older adults by ensuring they can effectively manage both the acute and gradual declines in function that commonly accompany the onset of frailty and old age.

Canada could again follow in the footsteps of Denmark, which has implemented a deliberate policy approach to make restorative care a key feature of any home and community-based care it provides. Canada's LTC systems could take a similar approach, requiring reablement interventions as part of their home and community-based care

services for recipients who would benefit from restorative care. Reablement approaches could be efficiently integrated into home care services in the Canadian context because they can be successfully delivered largely by non-professional care providers like personal support workers and health care aides. Reablement programs would also have the added benefit of reducing the need for continuing support and health care services, thereby also reducing government spending on LTC services.⁴⁹⁸

Similarly, home-based primary care (HBPC) interventions, which are aimed at those with multiple chronic health issues, should also be developed and implemented as a part of both primary care and home and community-based care services. HBPC programs have integrated interprofessional primary-care teams that provide the care homebound individuals need directly in their own home, which may include geriatricians, nurse practitioners, physiotherapists, and general practitioners.⁴⁹⁹ Other common components in most of these programs are weekly interprofessional care meetings, comprehensive geriatric assessments, and after hours telephone service.⁵⁰⁰ Such programs help to more effectively address the ongoing care needs of older adults who cannot easily access office-based primary care, with a growing body of evidence demonstrating they are effective at reducing both hospital admissions and LTC home admissions among community-dwelling older adults.^{501,502,503,504}

Finally, this report highlighted the United States' Program for All-Inclusive Care of the Elderly (PACE) as an alternative model of care that provides a comprehensive range of co-ordinated and tailored services to better support LTC-eligible individuals.⁵⁰⁵ Numerous studies have found the PACE model to be effective in reducing hospitalizations and LTC home admissions and enabling more older adults to live in their own communities at a lower cost.^{506,507,508,509}

4. Establish community care navigator roles to ensure that LTC recipients receive timely, appropriate care and have opportunities to remain engaged in their communities

In Canada, there are currently roles that exist to coordinate various types of care, such as home care, community mental health, and social services. However, these roles do not always provide a more holistic perspective and level of support to help older people and their families navigate their full spectrum of care and support options that could enable AiRP. To address this, several countries such as Japan and Taiwan have introduced community care navigators to identify and manage the care journeys of older adults.^{510,511} Generally, care navigators assess the care needs of older adults, develop and modify their care plans based on those needs, and find and contract the appropriate care providers. Care navigators work continuously with

older adults, ensuring that they are always receiving the right care in the *right* place at the right time. They can also co-ordinate and design preventive-care plans, reducing the need for more intensive or institutional forms of care in the future.

Within any health region in Ontario, there can be multiple home and community care co-ordinators and service-provider organizations delivering many of the same services in the same neighbourhood — or even the same building. Therefore, assigning a community care co-ordinator to work with a group of individuals in the same geographical area can allow them to better understand local resources, care providers and opportunities to enable AiRP at a neighbourhood level. The Toronto Region tried to address this challenge with a Neighbourhood Care Team Program that aimed to integrate home care delivery to better meet the diverse needs of people living in high-density urban neighbourhoods.⁵¹² While early results showed promise, the pilot program was not continued. Currently, no gold-standard care-navigation model appears to exist in Canada.

As Canadian jurisdictions consider crucial care-navigation functions, they could look to Taiwan's ABC advanced care co-ordination program, which leverages networks of community providers that are co-ordinated by care navigators, and provides both care and social engagement opportunities.⁵¹³ Adopting a network-based, care navigator-centric approach to the care of older adults has the potential to improve care co-ordination, continuity

and suitability across Canada. Furthermore, including community engagement as a core responsibility of community care navigators has the potential to reduce social isolation and loneliness among older adults.

5. Enable local governments and stakeholders across Canada to provide more inclusive, accessible and safe housing options

The NIA's National Senior Strategy and the WHO's Age-Friendly Cities initiative both highlight the importance of "enabling the creation of age-friendly physical environments and spaces" through creating more affordable, safe and accessible housing and transportation options. Canada should consider investing in a broader array of supportive living arrangements for older adults.

It is important that older adults remain safe in their homes as they develop physical and cognitive limitations. Home modifications and repairs have the potential to greatly reduce the risk of falls — and therefore future LTC home admissions — among older adults. Despite recent federal investment through the National Housing Strategy, the demand for accessible housing is outpacing supply. Fixing this will require both building new forms of accessible housing and modifying existing housing. According to the CMHC, it is most cost-effective to include accessible features at the time of construction. For homes that are already built, several provinces currently support older Canadians to modify their homes through subsidies, tax

rebates and low-interest loans. Prince Edward Island, Nova Scotia, Newfoundland, British Columbia, and Alberta provide subsidies for older adults to repair and modify their homes. Nova Scotia also provides low interest loans (up to \$25,000 over 10 years at a fixed interest rate) for families to make additions to renovate their homes to support an older family member to live in. Expanding these homemodification programs is critical for ensuring that older adults can continue living in their homes as they age. Greater efforts should also be made to help older Canadians identify what types of home modifications they may need and how to best take advantage of home modification programs.

There also is a need for government investment in promising housing models that aim to provide a range of support and services to older adults directly within their communities. NORC programs, co-housing and HomeSharing programs are examples of innovative housing models that aim to address multiple community-level challenges, from social isolation, to health care access and co-ordination, to improving aspects of the built environment. In addressing these challenges, these housing models add customizable levels of support for older adults within homes and communities that were not purpose-built for ageing.

A nationwide strategy could identify communities that would benefit from these models, as well as best practices for their implementation. As these housing models leverage the capacity of local networks, all levels of government will have a role to play in better supporting the unique housing needs of their communities. These models are inherently flexible, and a community engagement approach will be critical in identifying the needs of residents and local stakeholders.

There are existing sources of localized innovation in these housing models that can serve as a jumping off point for further investment. For example, there is an opportunity for further investments in HomeShare Programs and collaboration with organizations such as Canada HomeShare, which is looking to create more HomeShare programs across Canada, would help increase the availability of practical housing options for both older and younger Canadians. By offering subsidized rent to tenants in return for specified support activities such as groceries and household maintenance, HomeShare programs provide a unique solution that helps address both the growing demand for community support services by ageing Canadians and the housing affordability crisis faced by Canada's younger generations. Thus far, HomeShare Programs have been established in Alberta, Newfoundland and Labrador, Quebec, and Ontario,⁵¹⁴ and increasing their availability across Canada would help more older Canadians to AiRP. NORC programs also have the potential for leveraging the natural density of

older adults living in one place to provide tailored, community driven programs and services. There are two exemplary models of NORC programs in Canada, the Oasis model and the Cherryhill Healthy Ageing Program, and a state-wide NORC program in New York, that can provide valuable insights into expanding NORC program models across Canada.

6. Support greater nationwide investments in accessible and flexible transportation options

Transportation is an essential determinant of health and well-being for all adults, and becomes increasingly precarious with age. This is particularly concerning given that the baby boomer generation has historically been highly dependent on their cars, and many older adults reside in communities that require a personal vehicle to access day-to-day amenities. There are diverse challenges impacting the transportation options for older adults depending on the infrastructure of the community and personal circumstances, such as having access to a vehicle. There is an urgent need for co-ordinated, nationwide initiatives that support older adults to transition away from driving a personal vehicle, identify alternative transit options and address barriers to using these options.

The NIA's 2016 National Seniors Strategy identified a need for more inclusive transportation systems. Since then, work

has been underway across Canada to improve the availability and accessibility of paratransit and public transit systems. For instance, the federal government has pledged funding for transit in rural and remote communities, and recognized that stronger policies are required to ensure that interprovincial transit operators under the jurisdiction of the Canadian Transit Agency (air, rail, marine and intercity bus services) adhere to minimum standards for accessibility.⁵¹⁵ Accessibility Standards Canada has identified transportation as a priority area for ensuring Canada is barrier-free for people living with a disability by 2040.⁵¹⁶ Many provinces have also taken action to improve the accessibility of their intraprovincial transit systems, such as by setting future targets to make them 100 per cent accessible.^{517,518,519,520,521}

However, further action is needed to ensure all older Canadians have their public transportation needs met. Communities with public transit systems can enhance them, e.g. by providing free or subsidized fares for older adults, but many communities across Canada have few, if any, transportation options other than driving a personal vehicle. Thus, there is a need for sustained investment in transportation infrastructure in rural and remote communities and in addressing transportation gaps between communities. There are also opportunities to leverage volunteer networks to temporarily address gaps in publicly funded transportation. For example, Canada could consider a program modelled on the Independent Transportation Network (ITN) in the United

States, a non-profit, low-cost transportation network for older adults that leverages volunteer drivers. ITN members can request a ride for any reason including doctor visits, shopping trips and social activities to enable their AIRP goals.⁵²²

Many Canadian communities are experimenting with small-scale, innovative transportation models that may be more efficient and flexible in small communities than building traditional public transit systems. The success of these initiatives will rely on establishing sustainable funding models to ensure that local communities have continuous access to accessible and equitable transit options. Communities across Canada would also benefit from knowledge-sharing of best practices in implementing new transportation solutions for an ageing population.



7. Integrate screening and solutions for social isolation and loneliness into the delivery of health care, home care and community-support services

There must be a greater understanding among health care and service providers of the health consequences of social isolation and loneliness, and a greater focus on finding effective strategies and interventions to combat these growing issues. Appropriate screening strategies should be integrated into health care settings and home and community-based care programs as a means to identify at-risk individuals who are socially isolated or lonely, which would facilitate primary prevention and help mitigate adverse health effects. Adopting screening tools in other settings, such as community centres and libraries, could also be helpful.

Interventions to address social isolation and loneliness should be increasingly considered in both primary-care settings and home and community-based care programs. One type of health care intervention is “social prescribing,” in which prescriptions are written for non-pharmacologic interventions such as engaging in social activities or exercise.⁵²³ Studies have shown positive impact, with a national social-prescribing program being found to reduce loneliness and improve well-being and confidence.^{524,525} More programming interventions focused on social isolation and loneliness should

be incorporated into community services targeting older adults. While research has not yet been able to identify which interventions are most effective in either the short- or long-term, promising interventions include education and social-activity groups, and programs to improve social skills, enhance social support, increase opportunities for social interaction and address deficits in social cognition.^{526,527}

More targeted support programs are also needed to address social isolation and loneliness among older Canadians who are experiencing or at risk of experiencing social isolation and loneliness. While the Canadian government has made concerted efforts in this space through initiatives such as the New Horizons for Seniors Program, additional funding and resources must be dedicated to addressing the risk of social isolation and loneliness among a growing population of older adults. Such funding should go towards building the capacity of existing programs and organizations working to improve the social well-being of older Canadians, establishing new organizations in under-served communities, and building the collective capacity of organizations to co-ordinate service delivery. Moreover, governments could follow in the footsteps of Denmark, which has implemented legislation that ensures all citizens aged 80 years and older are offered an annual preventive visit to proactively connect them to supports and services that can help combat social isolation and loneliness.⁵²⁸

8. Implement more focused and co-ordinated efforts to promote falls awareness and implement evidence-based, effective and accessible fall-prevention strategies based on best practices

Canada needs more public awareness about the risks and dangers of falling to older adults, safety tips to minimize the number and impact of falls, and the importance of consulting a health care provider after experiencing a fall. While PHAC continues to raise awareness of fall-prevention strategies nationally (along with many provincial and local programs), it could play a strengthened role as the key knowledge-translation mechanism to support the greater adoption of fall-prevention programs and services across the country. As the NIA's rapid review for this report showed, there are gaps in the availability of programs and services supporting fall prevention across Canada. Canada's provinces and territories should be supported to adopt low-cost and evidence-informed fall-prevention programs with a record of success.

Older adults should also be assessed at least once a year by health care providers who can ask about the frequency of falling and difficulties with gait and balance, and conduct a comprehensive risk assessment when necessary.⁵²⁹ Risk factors identified during the assessment should subsequently be targeted with multifactorial interventions.⁵³⁰ Fall awareness and prevention activities should

be provided at no out-of-pocket cost to older adults, delivered in accessible locations, and incorporate solutions to other common participation barriers such as transportation. Advancing the adoption of successful, low-cost and evidence-informed fall-prevention programs has the potential to generate significant reductions in fall-related health care spending, while also addressing related issues that must be effectively addressed to enable AIRP, such as social isolation.

Finally, additional research on the real-world effectiveness of potential interventions should be a priority. There are a growing number of technologies that could potentially enable older adults to live at home more safely, such as wearable sensors and ambient sensor technologies, with considerable research devoted to advancing these technologies. While research on sensor-based interventions has been promising, it has not clearly demonstrated whether they would lead to a meaningful reduction in falls and fall-related injuries in the real world. Other initiatives that could be further examined include exercise programs delivered through video games, compliant flooring technologies and sensor-based walking aids. Governments can fund further research into these technologies to determine whether they can reduce falls and fall-related injuries and ultimately allow older Canadians to age in the *right* place; whether these technologies are useful for caregivers; and ultimately, which technologies merit wider adoption.

9. Improve the provision of both financial and non-financial supports for unpaid caregivers

Adequately recognizing and supporting the invaluable work that unpaid caregivers provide in enabling older Canadians to age in their homes and communities will be crucial to better meeting future care needs. While federal, provincial and territorial governments have made investments over the last decade to provide a variety of financial and other supports for unpaid caregivers, there remains a need for more supportive interventions that equitably acknowledge the needs of unpaid caregivers and the value of their unpaid labour.

Financially, while some provinces offer refundable tax credits for unpaid caregivers, most Canadian jurisdictions and the federal government only offer non-refundable tax credits that can be applied against a form of earned income. These types of credits penalize caregivers who are not employed or earning a sufficient taxable income through other sources.⁵³¹ They also fail to consider the increasing unpaid caregiving contributions of non-relative friends and neighbours. Financial assistance barriers must be removed for low-income unpaid caregivers, as well as caregivers who are not direct family members. Looking to existing initiatives that address these gaps, such as Nova Scotia's caregiver benefit for low-income unpaid caregivers or Quebec's refundable caregivers tax credit, would be valuable in informing Canadian strategies to adequately support unpaid caregivers.



There is a general lack of awareness among Canadian unpaid caregivers about the benefits available to them.⁵³² Moreover, information about accessing these supports is often only available on government tax websites and explained in confusing, inaccessible language. More efforts are needed to raise awareness about the financial assistance available to unpaid caregivers and make it easier for them to access it with user-friendly information and tools.

Canadian jurisdictions should further examine the potential of public policy and labour-market responses to better recognize the value of the unpaid labour provided by caregivers —thereby better supporting this large and growing group of Canadians while reducing avoidable LTC home admissions. They can learn from the experiences of other countries and adapt their interventions to the Canadian context.

There is also a need for more access to non-financial caregiver supports. Firstly, to ensure caregivers have more access to services that meet both their needs and those of their care recipients, a process should be established to assess their needs separately. Secondly, while all provinces and territories provide some form of respite supports to bolster the health and well-being of unpaid caregivers, the availability, level of support and eligibility criteria for these services are not standardized and vary greatly across Canada. Establishing a national minimum standard of services and care for all unpaid caregivers and their care recipients would ensure that services are more streamlined, better reflect needs and increase overall access.⁵³³ Finally, there should be more research into non-financial interventions to support caregivers' well-being, such as education and training, counselling or support groups, and access to adult day programs.

10. Continue to support research on factors that can enable AIRP, as well as potential interventions to support the development of evidence-based policies and practices

More research is needed into how to best support older Canadians to remain in their own homes and communities as they age. Robust research findings and a body of evidence that is context-sensitive, timely, relevant and, most importantly, feasible for policy-makers can properly inform decision-making processes, funding and resource allocation, and best practices to support Canadians to age in the *right* place.

Currently, however, there are a number of research gaps that must be addressed to inform practical, evidence-based policies and practices. In particular, there is a need for more research on the primary causes of transitions into LTC homes, as well as the factors that best protect against them. There have been three recent Canadian studies on the factors that influence entering long-term care among older adults, two of which are highlighted earlier in this report and more fully in the **Appendix**. While this research has provided initial insights into the various predictors of LTC home admissions, more studies are needed to better understand which factors are the most important, and the degree to which they influence such transitions. This is especially important given that the CIHI and Statistics Canada studies have conflicting findings for some predictors.

Access to more data and appropriate analyses are also needed to support stronger linkages between research and effective policies and practices. For example, while loneliness and social isolation have been determined to be important predictors of LTC home admissions, there are no Canadian studies examining this relationship. There is also a need for multiple studies analyzing the same or similar factors, especially using representative population-level data sources to enable comparisons. Such studies would make it possible to conduct meta-analyses of identified predictors of LTC home admissions to generate a better understanding of the effect of each predictor and its interactions with sociodemographic characteristics through more precise estimates.⁵³⁴

Similarly, additional research is needed into potential interventions to support AIRP. Specifically, research funding agencies such as the Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council, Social Sciences and Humanities Research Council and National Research Council of Canada should prioritize research into the efficacy and effectiveness of interventions to demonstrate how well they support older Canadians to maintain their independence in their own homes and communities. Overall, more research will be key to help identify and implement effective and validated interventions to better enable AIRP.

Conclusion

Ensuring Canada is a place where people can safely and successfully age in the *right* place will require the right long-term care policies. Canada's current spending allocation, which is heavily weighted toward more expensive institutionalized LTC, is unsustainable and goes against the preferences of the overwhelming majority of Canadians. Shifting LTC priorities towards more home and community-based care models to better support AIRP would not only provide the growing ranks of older Canadians with options that reflect their wishes, but also offer their governments more cost-effective and fiscally sustainable care solutions. By advancing the NIA's 10 policy recommendations, federal, provincial and territorial governments can begin to take critical steps towards better supporting Canadians to age in the *right* place.



APPENDIX

Factors that Lead to Long-Term Care Admissions Among Older Canadians

The NIA examined the findings from two key reports on the main factors and pathways that lead to long-term care (LTC) home admissions among older Canadians. In 2017, the Canadian Institute for Health Information (CIHI) released its Seniors in Transition Report.⁵³⁵ The report tested 33 factors potentially associated with LTC home admissions, identifying the most impactful

predictors of these care transitions. In 2018, Statistics Canada released its Transitions to Long-term Care and Residential Care Among Seniors Report,⁵³⁶ also identifying significant predictors of Canadians living in a LTC or retirement home. Statistically significant findings from both studies are presented in Tables 1 and 2 in the form of odds ratios from logistic regression models.

Logistic Regression and Odds Ratios

Logistic regression is a statistical method used to assess the likelihood of one of two possible outcomes occurring when the influence of factors that can have an impact on the outcome are taken into account. The result of logistic regression analysis is an odds ratio, which compares the odds of an event occurring in one group with the odds of it occurring in another group (for example, older adults with dementia compared to those without). Odds ratios that are greater than 1 indicate that the event is more likely to occur when the predictor variable is present (if the predictor is categorical) or increases (if the predictor is continuous).

CIHI's Seniors in Transition Report identified six factors that greatly increased the odds ($OR = >1.5$) of entering institutional care after an initial assessment: Initial assessment in hospital ($OR=6.37$), requiring extensive physical assistance ($OR=3.30$), having a moderate cognitive impairment ($OR=3.21$), living alone ($OR=2.02$), caregiver unable to continue ($OR=1.90$) and wandering

($OR=1.73$). As Table 1 shows, other significant but less meaningful factors associated with LTC home admission included hip fractures ($OR=1.24$), cancer ($OR=1.22$), dementia ($OR=1.20$), instability ($OR=1.20$), being a high user of hospital services ($OR=1.19$), caregiver distress ($OR=1.18$), falls ($OR=1.18$), responsive behaviour ($OR=1.14$), and psychiatric diagnosis ($OR=1.10$).

CIHI's Seniors in Transition Report also identified factors associated with an increased likelihood of transitioning into residential care among older adults receiving home care. Each of the six factors found to greatly increase the likelihood of entering residential care following an initial assessment were also associated with a transition to residential care after a period of receiving home care. However, as Table 1 reveals, additional factors were also significantly associated with admission to a LTC after receiving home care, with some increasing the likelihood of entering residential care considerably more for older adults receiving home care. Overall, the study identified eight factors that greatly increased the odds of being admitted to a LTC home among older Canadians who were already receiving home care: having a moderate cognitive impairment ($OR=5.64$), requiring extensive physical assistance ($OR=3.06$), living alone ($OR=2.10$), wandering ($OR=2.00$), instability ($OR=1.95$), dementia ($OR=1.78$), falls ($OR=1.69$), caregiver distress ($OR=1.53$), and caregiver unable to continue ($OR=1.90$). Other factors that were significant but less meaningful contributors included responsive behaviours ($OR=1.28$), hip fracture ($OR=1.14$), bowel incontinence ($OR=1.13$), signs of depression ($OR=1.11$), psychiatric diagnosis ($OR=1.10$), and heart disease ($OR=1.07$).

In terms of sociodemographic characteristics, sex is a significant predictor of LTC home admission, with men less likely than women to be admitted to LTC, whether following an initial assessment ($OR=0.92$) or following home care ($OR=0.89$). Living alone also significantly increased the odds of entering institutional

after care after an initial assessment ($OR=2.02$) and after receiving home care ($OR=2.10$). Finally, while age was significant only for older adults following an initial assessment ($OR=1.02$), living in an urban region only significantly reduced the odds of being admitted to a LTC home for older adults after receiving home care ($OR=0.84$).

Statistics Canada's 2018 report found sex, marital status and home ownership to be three important socio-economic predictors of LTC or retirement home admission in Canada. In particular, as Table 2 shows, women are more likely than men to live in a LTC home or retirement home compared to men. In terms of marital status, those who have lost a spouse are significantly more likely to be living in a LTC or retirement home ($OR=4.3$ for women, $OR=3.7$ for men for LTC home; $OR=4.2$ for women, $OR=3.5$ for men for retirement home) compared to those who remain married. Similarly, those who were not married were also more likely to live in a LTC or retirement home ($OR=2.0$ for women, $OR=2.4$ for men for LTC home; $OR=$ Not significant for women, $OR=2.7$ for men for retirement home) compared with those who remained married. Individuals who did not own their home were also significantly more likely to be living in a LTC or retirement home ($OR=2.1$ for women, $OR=2.3$ for men for LTC home; $OR=2.6$ for women, $OR=2.9$ for men for retirement home) compared to those who did.

This report also found that hospitalization and chronic diseases were major health predictors of LTC or retirement home admissions. Among chronic diseases, dementia was found to be the greatest

predictor of LTC home admission for both women and men, and retirement home admission for women (OR=6.7 for women, OR= 6.2 for men for LTC home; OR=4.4 for women for retirement home). Diagnoses of diabetes (OR=1.5 for women for LTC home; OR=1.4 for women, OR=1.8 for men for retirement home) and urinary incontinence (OR=1.3 for women entering a LTC or retirement home) were also found to be predictors of LTC or retirement home admissions compared to those who are not diagnosed with the corresponding chronic conditions. In addition, adults who were previously hospitalized were more likely to enter LTC or retirement homes (OR=1.8 for women, OR=1.9 for men for LTC home; OR=1.8 for men for retirement home) than those who were not previously hospitalized.

Individuals' self-reported health was also associated with LTC home admissions, with men reporting "poor health" (OR=2.3) and women reporting "fair health" (OR=2.0) significantly more likely to transition into a LTC home than those who reported "excellent health". However, self-reported health status was not a significant predictor of transition into a retirement home among either men or women.⁵³⁷

Finally, it is important to note that while some factors had varying or conflicting associations between the two studies, that does not mean these factors play no role in shaping transitions into LTC homes among older adults, given that other factors, including some not captured by the data, may interact to influence this likelihood.⁵³⁸

Table 1. 2017 CIHI Seniors in Transitions Study Odds Ratio (OR) Findings around Factors Increasing the Likelihood of Entering a Long-Term Care Home

Factor	Odds of Entering a Long-Term Care Home	
	OR Following Initial Assessment (58,542)	OR Following a Period of Receiving Home Care (43,574)
Age (Mean)	1.02	NS
Male	0.92	0.89
Location of Residence (Urban)	NS	0.84
Living Alone	2.02	2.10

Hospital (Initial Assessment)	6.37	—
Hospital (High User)	1.19	—
Caregiver Distress	1.18	1.53
Caregiver Unable to Continue	1.90	1.90
Requires Physical Assistance (ADL Hierarchy Scale)		
<i>6 Total Dependence</i>	5.67	2.50
<i>5 Dependent</i>	5.99	4.20
<i>4 Maximal</i>	4.12	3.50
<i>3 Extensive</i>	3.30	3.06
<i>2 Limited</i>	2.06	2.27
<i>1 Supervision</i>	1.64	1.88
Cognitive Impairment		
<i>6 Very Severe</i>	2.15	2.50
<i>5 Severe</i>	3.05	4.32
<i>4 Moderately Severe</i>	3.09	4.53
<i>3 Moderate</i>	3.21	5.64
<i>2 Mild</i>	1.68	3.22
<i>1 Borderline</i>	1.25	1.84

Responsive Behaviour	1.14	1
Wandering	1.73	2.00
Instability (CHESS Scale)	1.20	1.95
Falls	1.18	1.69
Bowel Incontinence	NS	1.13
Daily Pain	0.89	0.88
Dementia	1.20	1.78
Signs of Depression	NS	1.11
Any Psychiatric Diagnosis	1.1	1.10
Diabetes	0.89	0.88
Heart Disease	NS	1.07
Congestive Heart Failure	NS	0.89
Stroke	1.13	NS
Cancer	1.22	0.77
Arthritis	0.88	NS
Hip Fracture	1.24	1.14

Notes:

-NS= Not Significant

-All Odds Ratios (OR) presented are significant at the 95% confidence level

-Only factors found to be significant in predicting transitions into residential care either following an initial assessment or after the receipt of home care are presented; factors that were statistically insignificant for both groups are excluded.

Table 2. 2018 Statistics Canada, Transitions to Long-Term Care and Residential Care Among Seniors Report Study Odds Ratio (OR) Findings

	Men		Women	
	Long-Term Care Home	Retirement Home	Long-Term Care Home	Retirement Home
Demographic Characteristics				
Age (75-79)				
80-84	NS	3.5*	1.9*	2.2*
85-89	3.0*	9.8*	4.0*	4.7*
90 and older	6.3*	19.4*	8.0*	7.1*
Marital Status (Remained Married)				
Loss of Spouse	3.7*	3.5*	4.3*	4.2*
Not Married	2.4*	2.7*	2.0*	NS
Living Alone	NS	NS	1.5*	2.6*
Dwelling Not Owned by a Household Member	2.3*	2.9*	2.1*	2.6*
Self-perceived General Health (Excellent)				
Very good	NS	NS	0.7*	NS
Fair	NS	NS	NS	2.0*
Poor	2.3*	NS	2.0*	NS

Self-perceived Mental Health (Excellent)

Very Good	1.6*	NS	1.4*	NS
Good	1.6*	NS	1.5*	NS
Fair	2.7*	NS	2.0*	NS
Poor	6.0*	NS	NS	NS

Health Measures**Chronic Conditions**

Diabetes	NS	1.8*	1.5*	1.4*
Dementia	6.2*	1.9	6.7*	4.4*
Urinary Incontinence	NS	NS	1.3*	1.3*
Mood Disorder	NS	NS	1.7*	1.8*
Overnight as a Patient in a Hospital, Long-Term Care Home, or Convalescent Home in Past Year	1.9*	1.8*	1.8*	NS

Notes:

- NS= Not Significant
- All Odds Ratios (OR) presented are significant at the 95% confidence level
- Only factors found to be significant in predicting transitions into long-term care and residential care are presented; factors that were statistically insignificant for both men and women are excluded

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