



Assisted Living

*A Potential Solution to
Canada's Long-Term
Care Crisis*

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EXECUTIVE SUMMARY

BACKGROUND

Canada's age 65 and older population is projected to continue its strong growth over the next two decades. This group is expected to increase in size by 85 percent between 1998 and 2021 and will represent 18% of Canada's total population, up from the current 12.3 percent. Even more significantly, Canada's elderly population is becoming top-heavy with persons in the oldest age brackets. By 2021, 29 percent of Canada's seniors will be in the age 75-84 bracket and 13 percent will be age 85 and over. Persons at such ages are at increased risk of chronic health problems and physical and cognitive impairments that threaten their ability to maintain independent households.

These vulnerable elders rely mostly on spouses, daughters, and other family members to help maintain their dwellings and conduct everyday activities. Families, however, are finding it increasingly difficult to fulfill their caregiving responsibilities, and even the most well intentioned persons sometime provide incompetent care. Future demographics and lifestyle changes are expected to result in family members becoming an even less viable source of informal care. Hiring a full-time, privately paid caregiver may be an option, but usually only for wealthier seniors. All Provinces and Territories offer publicly subsidized home-based services, but demand for this assistance now outstrips supply. The unmet needs are especially great for elders with chronic disabilities who require continuous personal care and nursing services if they are to avoid having to move to a long-term care institution. Elders who live in less-populated rural areas are more disadvantaged than others.

The backbone of Canada's organized response to elder frailty, its publicly subsidized nursing homes, are also in short supply in most Provinces and Territories. Provinces, such as Ontario, Alberta, and British Columbia, have long waiting lists for nursing homes, and seniors often cannot be admitted into their first choices. Current occupants of these facilities, moreover, are at serious risk of losing their dignity and individuality and many professionals interviewed for this study agree that a significant percentage of nursing homes are of poor quality. Providing appropriate shelter and care to satisfy the needs of frail elders is further threatened by other nursing home admission policies. Provinces and Territories, worried about the increasing costs of publicly subsidized nursing home care, are beginning to restrict admittance to only the frailest elders. Thus, a growing number of seniors will no longer be able to avail themselves of this option – whatever its inadequacies – and will be forced to find alternative shelter and care arrangements to deal with their chronic disabilities. Yet government leaders have offered no new

strategies for dealing with the care needs of this ever larger group of seniors, who will still require assistance to live independently in their own dwellings.

A relatively new shelter and care option in Canada, the assisted living facility, offers promise as one solution. Already widely available in the United States, it is primarily developed by for-profit developers and targeted to upper middle- and high-income seniors. The best designed and operated of these assisted living facilities accommodate physically and mentally frail older Americans who require a protective environment, regular and unscheduled assistance with daily living activities, and some nursing care. Unlike, however, the more medically oriented environment of a nursing home, assisted living offers a “social” or “residential” care model that more closely resembles an inn or hotel in both its appearance and operation. Residents have individual apartments, can lock their doors, and have more say in their own care. Moreover, even as they need assistance to cope with their vulnerabilities, they are still able to maintain their dignity, independence, control, individuality, and privacy. Canada’s for-profit sector is beginning to provide these newer shelter and care facilities, but various social, economic, and political barriers now impede their efforts. Most importantly, they are having difficulty creating accommodations that are affordable to the majority of Canadian seniors.

The confluence of unmet senior consumer needs, the failings of current available options, and the disincentives for change present a crisis in the making. An urgency exists for proactive initiatives by both the public and private sectors to make the noninstitutional assisted living facility a widely available and affordable option for Canadian seniors.

GOALS OF REPORT

- What types of assisted living facilities are now available in Canada, particularly in the provinces of Alberta, British Columbia, and Ontario?
- What can be learned from the United States experience, where assisted living is one of the fastest growing shelter and care options. Specifically, how available is the assisted living alternative in the United States, what are its characteristics, and what recent developments are influencing its future status?
- What factors are influencing the status and future growth of for-profit assisted living facilities in Canada? What are the impacts of the following inter-linked influences?
 - Inconsistent terminology describing Canada’s shelter and care alternatives
 - Nursing homes as competition to assisted living facilities
 - In-home services as competition to the assisted living facility alternative
 - Shelter and care regulatory policies in British Columbia, Ontario, and Alberta
 - Potential cost savings for Provinces and Territories that adopt the assisted living model
 - Attitudes of Provincial and Territorial governments toward the private and nonprofit sectors
 - Availability of financing for for-profit shelter and care facilities
 - A lack of professional organizations representing the shelter and care industry
 - Conventional market demand and supply factors
- In light of these influences, what actions should the public, for-profit, and nonprofit sectors take to realize the full potential of the assisted living facility as a response to the unmet needs of Canada’s frail elderly constituencies?

- Why is it critical for the public, for-profit, and nonprofit sectors to take these actions?

METHODOLOGY

Information was collected from four sources over a five-month period:

1. Reviews of past studies of shelter and care alternatives in Canada and the United States.
2. Site visits at nursing homes, assisted living facilities, and supportive housing developments in Vancouver, British Columbia, and open-ended interviews with their administrators.
3. Open-ended telephone interviews with developers, architects, providers, managers, and policymakers in British Columbia, Ontario, and Alberta.
4. Consensus opinions of professionals who design, develop, and manage housing for frail Canadians on the challenges facing the seniors' housing industry and the solutions needed to create more available and higher-quality noninstitutional housing options. These opinions were identified through the Nominal Group Technique, a small-group information-gathering strategy.

KEY FINDINGS

1. In the U.S., assisted living facilities have emerged as an important shelter and care component to accommodate the needs of frail seniors. Their growth was especially striking during the 1990s, and there are now over 775,000 assisted living units in over 27,000 facilities.
2. Since the mid-1990s, for-profit developers in Canada have produced shelter and care facilities that resemble the U.S. model of assisted living. As is true in the United States, the industry is becoming dominated by a small group of larger developers and experienced management firms. U.S.-based assisted living facility corporations are aggressively pursuing development opportunities in Canada.
3. Comprehensive Federal or Provincial/Territorial surveys or enumerations of available noninstitutional shelter and care units found in Canada are lacking. Thus, generalizations are difficult to make about the number of assisted living facilities in Canada, about the design, physical infrastructure, organizational features, and costs of these facilities, or the social, economic, and health profiles of their elder occupants.
4. Assisted living facilities in Canada differ in several important ways from the prototype U.S. version. They are less likely to be freestanding and are more likely to be physically linked to a nursing home. They are less likely to employ dedicated on-site staff to assist residents with their personal care and nursing needs, but rather hire or subcontract an "outside" home support or home care agency that responds to resident requests as-needed. Canadian facilities are less likely to be occupied by very frail seniors. They have lower staff-resident ratios and are less likely to provide unscheduled personal care assistance or nursing services. A smaller percentage of facilities have wings or units that can accommodate seniors with Alzheimer's Disease.
5. In Canada, Federal and Provincial/Territorial governments, health care professionals, developers, management firms, academics, and the press use the term assisted living very inconsistently. An inconsistent and confused product identity is not helpful to elderly

consumers or their family members who must make informed decisions. It is also not helpful to professionals charged with referring clients to appropriate shelter and care choices, marketing professionals attempting to advertise and sell the concept, or financial institutions risking large capital sums to develop these facilities. It also makes this shelter and care option more difficult to distinguish from the more familiar nursing home.

6. Based on published statistics, Canadian elders are more likely than U.S. seniors to occupy institutions like the nursing home, even as these long-term care alternatives are now considered to be in short supply in provinces such as Ontario, Alberta, and British Columbia. Certain provinces have notably higher rates of nursing home occupancy than others. Moreover, a significant share of the existing supply of nursing home beds is considered by many professionals to be in poor quality facilities, thus further reducing the real choices of many elder consumers. To reduce demand, several provinces are planning to increase the frailty threshold levels of seniors they will admit into their publicly subsidized nursing homes, thus requiring less frail seniors to find other alternatives. Altogether these factors suggest a large and growing latent demand for assisted living facilities by frail Canadians who would otherwise occupy nursing homes.
7. Several factors are making it difficult to provide assisted living facilities to meet this potential demand. First, given current development and management costs, most assisted living facilities charge monthly fees that make them unaffordable to most Canadians. Even higher income seniors are reluctant to pay substantial out-of-pocket costs for a private-pay assisted living facility given their prevalent view that long-term care is an entitlement, the cost of which should be mostly assumed by their government. Second, Provincial and Territorial governments, for their part, have not seriously considered the possibility of subsidizing these alternatives as they do nursing homes even though such a policy shift would result in real long-term care cost savings. Third, potential developers of this shelter and care option currently confront various financial, regulatory, management, and marketing disincentives and barriers. And fourth, gatekeepers in the health care system, who are responsible for helping frail seniors cope with their activity limitations, are accustomed to steering their clients to nursing homes.
8. Most Canadian seniors cope with their physical or mental disabilities and chronic medical conditions with the help of spouses or other family members in the comfort of their own houses or apartments. They also rely on the relatively low-cost publicly funded Provincial and Territorial home support (e.g., personal care and homemaking) and home health care assistance (e.g., services delivered mostly by nurses and therapists) programs. These services, however, are often unavailable when needed and cannot always be relied on to provide high quality outcomes. They are especially inappropriate for elders with multiple chronic impairments who require ongoing, unscheduled assistance and nursing care. These inadequacies are expected to worsen. Provinces will experience further pressure on their limited home-based service budgets as demands increase for post-acute and rehabilitative home care and as nursing homes stop admitting less frail seniors. Altogether, these factors suggest the urgency of offering the assisted living facility as an alternative because of its ability to provide more reliable and high-quality personal assistance and nursing services.

9. The regulatory oversight of noninstitutional shelter and care facilities, like assisted living facilities, in the provinces of Ontario, British Columbia, and Alberta ranges from nonexistent to weak. This inadequate regulatory environment leads to the following four unfavorable consequences:
 - Disincentives for the development of assisted living facilities
 - Poorly distinguished noninstitutional shelter and care products and a confused Canadian consumer
 - Noninstitutional shelter and care alternatives that now fall short of providing a desirable assisted living model of care
 - The perception and the reality that current noninstitutional shelter and care facilities are providing poor quality care

10. The prospect of slowing the growth of their long-term care expenditures is a major incentive for Provincial and Territorial governments to stimulate the production of assisted living facilities. Fiscal savings can be realized in several ways:
 - Higher income frail seniors are attracted to better-quality private pay assisted living facilities and a smaller share of this group occupies publicly subsidized nursing homes.
 - Provincial and Territorial governments subsidize the care in for-profit assisted living facilities. They incur savings by diverting elder consumers from more highly subsidized nursing homes.
 - The government's cost of providing care to older people in their geographically dispersed residences will often be greater than providing the same care to residents concentrated in an assisted living facility. Service delivery economies of scale are more likely to be realized in assisted living facilities staffed with full-time service providers. To the extent that elders are better served in assisted living facilities than their own dwellings, they will also delay relocation to the more expensive government-subsidized nursing homes.
 - Compared to their costs of building nursing homes, Provincial and Territorial governments could reduce their development/construction expenditures if they build less costly assisted living facilities.
 - A more business-friendly Provincial and Territorial environment will encourage more builders and providers to enter the for-profit assisted living facility market. Increased competition may drive down assisted living facilities' prices, and in turn the per diem subsidization rates of Provincial and Territorial governments.

11. Canadians and their social institutions frequently identify the for-profit sector's financial and self-serving motives as sources of concern. In some provinces more than others, this results in the public sector's mistrust of for-profit housing developers. For-profits are suspected of charging excessive prices, offering less service, and producing housing that leads to poorer-quality outcomes. This results in government policies that discourage the building of noninstitutional shelter and care facilities, such as assisted living facilities, and in missed opportunities for mutually beneficial collaborations between the two sectors.

12. Currently, only a few banks, life insurance companies, trust companies, and pension funds in Canada provide the majority of debt and equity financing for noninstitutional assisted living facilities. These lenders, however, are usually only interested in financing

new facilities if developers have secured loan insurance from the Canada Mortgage and Housing Corporation (CMHC). Conventional (noninsured) debt financing is less available, requires the developer to have greater equity, and often results in higher loan costs. The reticence of Canada's financial institutions to provide capital to this emerging shelter and care industry and the stringent insured mortgage underwriting standards of CMHC have restricted the growth of this alternative. Only the larger and most experienced private developers have been able to operate successfully in this difficult lending climate.

13. The for-profit senior shelter and care industry lacks a national professional organization that adequately represent its interests. This results in missed opportunities for voluntary self-accreditation and self-policing; public relations and image building; lobbying and advocacy; research and data gathering about industry products; the expansion of financing opportunities; member training; and member network building.
14. Certain provinces more than others have become attractive markets for assisted living facilities. Ontario, British Columbia, and Alberta are particularly distinguished by their larger and higher-income age 75 and over populations. Nonetheless, consumer markets in these provinces are still narrowly defined because higher-income seniors are still predominant users of subsidized home-based services and nursing homes.
15. Various challenges face those developing and marketing assisted living facilities:
 - Canadian consumers are largely uninformed about this alternative and have difficulty understanding how it differs from the conventional nursing home.
 - Developers have to overcome the negative press coverage of noninstitutional shelter and care products (such as in Ontario).
 - Developers themselves are sharply divided as to the types of building, operating features, and housing tenure (owner vs. renter) elderly consumers find most attractive.
 - Data are unavailable from methodologically valid, large scale, national surveys or enumerations that identify senior consumer shelter and care preferences.
 - For-profit assisted living facility developers must deal with the prospect of a changing regulatory environment, uncertain Provincial and Territorial policies toward subsidizing their housing products, the uncertain availability and cost of financing for their developments, the prospects of more stringently insured loan policies of Canada Mortgage and Housing Corporation (CMHC), and the emergence of newer generations of seniors with different service preferences and different attitudes toward paying for long-term care.
 - Developers of assisted living facilities often have difficulty finding experienced and sophisticated management firms to operate their facilities' care component.
 - In certain urban markets, land prices are especially high, thus driving up prices charged by assisted living facilities.
 - In certain provinces more than others, labor unions demand higher wages for their members and more generous benefit packages, thus driving up prices charged by assisted living facilities.

- In certain municipalities more than others, community and neighborhood associations attempt to use zoning or land-use regulations to block the introduction of a new noninstitutional shelter and care facility.

AN AGENDA FOR ACTION

The report makes twenty-seven recommendations designed to improve the visibility, acceptance, availability, and quality of the assisted living facility option, and to make it more affordable for frail older Canadians. These proposals require actions by Federal and Provincial/Territorial governments and for-profit sponsors. Nine broad categories of actions are critical:

1. Federal/Provincial/Territorial governments must recognize the assisted living facility option as a legitimate noninstitutional long-term care approach that can fill a big gap in the currently available elder shelter-care continuum. They must recognize how Canada's traditional bulwarks of long-term care – publicly subsidized home-based services and nursing homes – are increasingly unable to satisfy the new realities of senior consumer demand.
2. Federal/Provincial/Territorial governments must initiate new programmatic, regulatory, and fiscal policies to make assisted living facilities easier to develop and manage. They must establish partnerships and alliances with both the for-profit and nonprofit sectors to increase the availability of this noninstitutional shelter and care alternative.
3. Federal/Provincial/Territorial governments should develop educational and media campaigns, targeted to consumers and professionals that promote the individual and societal advantages of assisted living facilities.
4. Federal/Provincial/Territorial governments must view the assisted living facility as an option not just for wealthy Canadians, but also for seniors who currently cannot afford this alternative. Thus the public sector must be willing to subsidize this noninstitutional alternative, recognizing that over the long-run it can realize large fiscal savings by not having to rely only on publicly subsidized home-based service and nursing home alternatives.
5. Federal/Provincial/Territorial governments must create a regulatory environment overseeing the assisted living facility alternative that protects senior consumers and insures high quality accommodations and care. While current regulations are unsatisfactory, the standards replacing them should not violate the ideal principles of this shelter and care option. There is justifiable apprehension about the possibility of mimicking the oppressively micro-managed regulatory structure now overseeing Canada's nursing homes.
6. The for-profit community must aggressively promote the assisted living facility as a critical component of Canada's shelter and care continuum. Together, its major stakeholders must create a professional organization with Provincial affiliates dedicated to promoting their specific interests.

7. The for-profit community must provide Canada's financial institutions with more cogent arguments for the greater availability of capital to invest in the development of noninstitutional shelter and care alternatives like assisted living facilities.
8. Local governments must initiate land use and zoning policies that make it administratively easier for developers to locate their assisted living facilities.
9. For-profit sponsors, perhaps in conjunction with universities, should research the availability and characteristics of the current inventory of noninstitutional shelter and care facilities, the characteristics of their developers and managers, the socio-economic, health, and psychological profiles of their occupants and potential consumers, and resident outcomes.

CONCLUSION

Now is the time to act. A crisis is in the making. The shelter and care demands of a growing population of frail seniors cannot be addressed through a business-as-usual attitude. Both the public and private sectors in Canada must proactively respond to the growth in seniors needing noninstitutional shelter and care alternatives, such as assisted living, to cope with their age-related frailties. Steps must now be taken to avert the inevitable stresses that Federal, Provincial and Territorial governments will confront as they attempt to satisfy the unmet needs of their current and future frail elderly constituencies. The Canadian senior will be the biggest loser if such attempts fail.

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INTRODUCTION

Canada's population has aged considerably in the past three decades. People age 65 and over now represent over 12 percent of the country's total residents, up from 8 percent in 1971 and 10 percent in 1981 (Exhibit 1). Over this period (1971 to 1998) the senior population grew by 112 percent (Exhibit 2). These trends are expected to continue. The size of the senior population is projected to increase by 85 percent between 1998 and 2021, whereupon it will represent 18 percent of Canada's population (Colin 1999).

Far more significant because of its impact on the social, economic, and political fabric of Canadian society is that the elderly population is becoming top heavy with the very old. This past decade, the population age 75 and older grew at more than twice the rate of the younger group of seniors, age 65 to 74 (Exhibit 2). By 2021, almost 2.9 million persons will be age 75 and older. Even more significantly, between now and then the oldest old – that is, people age 85 and older – will be the fastest growing age segment. By 2021, 29 percent of Canada's seniors will be age 75 to 84 and 13 percent age 85 and over.

These demographics are highly significant because increases in chronological age are accompanied by increased risk of physical health problems, physical impairments, and cognitive deficits. This means that seniors are more likely to need various types of assistance to conduct everyday activities, ranging from eating, bathing, and dressing to just getting around. A house or apartment and its neighborhood setting, once suitable for a person in an earlier stage in life, become incongruent with new disabilities and lifestyles. The onset of cognitive deficits from dementias, such as Alzheimer's disease, greatly magnifies the need for assistance and care.

Exhibit 1. Number and Concentration of Elderly Population in Canada, 1951-2031

Year	Number Age 65+	% of Canada's Total Population Age 65+	Older Age Groups As % of Age 65+ Population			
			65-74	75-84	85+	Total
1951	1,086,300	7.8	68.9	26.3	4.8	100.0
1961	1,391,200	7.6	63.9	30.3	5.8	100.0
1971	1,762,300	8.0	61.8	30.3	7.9	100.0
1981	2,377,200	9.6	62.6	29.2	8.2	100.0
1991	3,217,100	11.4	59.8	31.3	9.0	100.0
1998	3,735,700	12.3	56.9	32.9	10.2	100.0
2021	6,891,100	17.8	58.3	29.2	12.5	100.0
2031	8,936,500	21.7	54.4	33.4	12.2	100.0

Source: (Colin 1999)

Exhibit 2. Decade Percentage Change Growth Patterns of Older Canadians by Age Group

Date	65-74	75-84	85+	65+	75+
1951-1961	18.8	47.7	53.9	28.1	48.6
1961-1971	22.4	27.0	72.3	26.7	34.3
1971-1981	36.6	29.9	40.5	34.9	32.1
1981-1991	29.3	44.9	47.3	35.3	45.4
1991-1998	10.5	22.3	32.0	16.1	24.4
1951-1998	183.8	331.5	624.4	243.9	377.1
1961-1998	138.9	192.3	370.7	168.5	221.0
1971-1998	95.2	130.2	173.2	112.0	139.1
1981-1998	42.9	77.2	94.4	57.1	81.0
1998-2021	89.0	63.8	126.0	84.5	78.4
1998-2031	128.7	142.6	187.0	139.2	153.1

Source: (Colin 1999)

Notably, the physical and mental vulnerabilities of an aging population do not automatically produce pressing societal needs or problems (Gee and Gutman 2000). This report and dozens like it would be unnecessary if old age could be strictly a private affair, that is, if the problems of older people could be assessed and coped with by older people themselves or their families – spouses, adult children, siblings, and other kin. But this has never been a reality. While the family unit was more often the exclusive purveyor of assistance in the past, there were still subgroups of elders who had to rely on extra-familial, societal resources. This trend is more pronounced today and is expected to become even stronger in the future.

Seniors who live alone are especially at risk of receiving inadequate family care. Having a spouse, in so many obvious ways, can buffer the worst assaults on an elderly individual's independence and psychological well-being. Dealing with the same vulnerabilities when one is alone is so much more difficult. Adult children are often helpful, but some cannot endure the emotional and physical demands of serving as full-time caregivers. Some children just live too far away; others are simply unwilling to assume the responsibility; others cannot easily balance work and family demands; others simply do not know how best to act.

The multiple demands on today's family force seniors to elicit help from other social institutions. This assistance is variously available from all sectors of Canadian society. Nonprofit organizations – including religious, fraternal, ethnic, or charitable-based organizations – the public sector – encompassing Federal, Provincial, Territorial, and local jurisdictions – and the for-profit sector have produced many different community-based and home-delivered services and alternative residential accommodations (Canada Mortgage and Housing Corporation 1999, 2000; Gutman, Clarke-Scott, and Gnaedinger 1999). By most accounts, however, these

alternatives are falling short of satisfying all the unmet needs of this country's growing frail elderly population.

One very promising way to deliver this most needed help to Canadian seniors, and the focus of this report, is a category of shelter and care developed primarily by the for-profit sector and known as the "assisted living facility." In the U.S. this option is widely offered and is one of the fastest growing planned group housing alternatives targeted to frail seniors. This report looks at the availability of this alternative in Canada, particularly in the provinces of British Columbia, Alberta, and Ontario, and assesses the many factors influencing its appearance, operation, and effectiveness. What this analysis reveals is that this option is not being fully developed in Canada because of inaction, and disorganized and reactive actions by the for-profit and public sectors. This report considers why this is so and offers a series of recommendations designed to address an obvious vacuum in Canada's response to its aging senior population.

SOURCES

This report's conclusions are based on information collected from four types of sources over five months. Initially a review of past studies was conducted, surveying the appropriateness of planned and unplanned residential accommodations and community- and home-based options. Literature from both Canada and the U.S. was consulted (see References). Second, open-ended, on-site interviews were conducted with the administrators of selected nursing homes, assisted living facilities, and supportive housing developments in the Vancouver area. Third, open-ended telephone interviews were conducted with developers, architects, providers, managers, and policy-makers in British Columbia, Ontario, and Alberta. Fourth, Simon Fraser University's Gerontology Research Centre hosted an all-day information-gathering workshop with professionals variously involved in the development and management of housing for frail persons. The "nominal group technique" approach was used to obtain consensus both on the challenges facing the seniors' housing industry and recommendations to assure more and better noninstitutional shelter and care options for Canadian seniors (Appendix A).

Readers should be aware of the limitations of the information-gathering approaches used by this study. First, only a very limited Canadian literature has explored factors influencing the availability and characteristics of specialized housing options for seniors. Second, funding and time limitations demanded that only small samples of respondents could be interviewed, thus limiting the ability to generalize the findings.¹ Third, this investigation primarily focused on the shelter and care of seniors and public policy responses in only three provinces – British Columbia, Ontario, and Alberta.

¹Nonetheless, much care was taken to assure that the sources used in this study were knowledgeable and unbiased, and that they represented current understanding of this important area.

THE EMERGENCE OF ASSISTED LIVING: A NONINSTITUTIONAL SHELTER AND CARE ALTERNATIVE FOR FRAIL SENIORS

In the U.S., and to a lesser extent Canada, a shelter and care approach has emerged that many seniors, family members, professionals, and government leaders believe holds promise of accommodating frail persons who do not need the heavier care or services found in nursing homes. In the U.S. these residential developments, known as assisted living facilities, are primarily developed and managed by the for-profit sector. The American product is currently being marketed primarily to middle- and high-income seniors in their mid 70s and older; however, both the Federal and state governments are seeking to make this alternative financially accessible to lower-income elders.

The best designed and operated assisted living facilities can accommodate older persons with physical and cognitive deficits who require a protective environment, regular and unscheduled assistance with daily living activities, and some nursing care. Such facilities provide residents with a "social" or "residential" model of shelter and care that recognizes the importance of maintaining their dignity, independence, control, individuality, and privacy. The architectural setting and organizational environment of this model more closely resembles a residence, an inn, or a hotel than a hospital or nursing home. Unlike more medically-oriented long-term care settings, or very small, house-like traditional board and care facilities, residents do not have to share their dwellings, but rather have their own apartments, can lock their doors, and have their own bathroom and kitchen facilities. They have much more say about how they conduct everyday activities, such as when they eat or recreate, and they play a more active role in deciding what services they receive and when they receive them. Proponents of this alternative argue that a nursing home or institutional setting is often unnecessary to address the everyday needs and behaviors of even the most physically and cognitively frail older population. Thus, they believe that assisted living facilities can accommodate many of the elder occupants now found in nursing homes. A Canadian developer (Clarke-Scott 1999, p. 115) enthusiastically describes this U.S. housing product:

"The development industry responded with a new form which stressed the principle of autonomy, which provided a physical setting that is residential not institutional, and a service package which provides real care. The value of autonomy reflected the desire of residents to continue to be empowered in their lives as much as possible, to hold on as long as possible to the sense they enjoyed while living independently. This approach raised the issue of managed risk. It was found that residents and family were anxious to be part of the process of assessing and managing risk. It meant involving the resident or their advocate in decisions about service planning and capabilities of daily living. It meant a written contract with each resident concerning their service plan."

"The physical setting that was built again reflected the value of autonomy. When you visit assisted living projects you will find residents enjoy the privacy of access to their apartments with a locking door, their right to cook is maintained with a kitchenette and a private bathroom supplied. Care is provided in the privacy of their own space. The common space is residential in style, not like an institution or hotel, but like a comfortable house. The scale is smaller, some

projects are viable as small as 25 units. Finally, the service package is comprehensive. Yes, all the basic hotel services: meals, laundry, cleaning, social and recreational are offered, but also care. Today these projects provide assistance with most of the normal activities of daily living. This includes eating, dressing, grooming, bathing, ambulation, but also incontinence, oxygen and catheter care."

In summary, the following are the key features of the ideal prototype assisted living facility:

- It allows physically and mentally frail elders to avoid or at least delay a move to a nursing home.
- It offers 24-hour scheduled and unscheduled supervision and assistance with daily living activities and health-related services.
- It offers a "social" or "residential" model of shelter and care.
- Architecturally, the setting resembles a residence, inn, or hotel.
- Residents have own apartments and do not have to share their dwellings.
- Residents can lock their doors.
- Residents have own bathroom and kitchen facilities.
- Residents have say on how they conduct their everyday activities.
- Residents retain their dignity, independence, control, individuality, and privacy.

THE U.S. ASSISTED LIVING MODEL AS A STANDARD

Rationale

This report relies heavily on the U.S. exemplar of the assisted living facility to judge the appropriateness of Canadian shelter and care alternatives. This is not to suggest that the U.S. model is culturally superior or represents the optimum shelter and care approach. The housing options that evolve in Canada may differ in many advantageous ways from those in the U.S. (Pynoos and Golant 1996; Pynoos and Liebig 1995; Redfoot 1993). Rather, this analytical decision is driven by four factors.

First, it is necessary in the interest of clarity. What quickly becomes apparent when considering shelter and care alternatives – anywhere in the world – is the wide array of available options and the confusing language and terminology by which they are identified (Exhibit 3). Thus, it is critical to use an unambiguous as possible industry standard for comparison. The U.S. assisted living alternative has been researched and analyzed more than any other shelter and care option, thus providing a large benchmark literature (Mullen, Singer, and Keirn 1998; Mullen et al. 1998; National Investment Conference 1998; Wylde and Zimmerman 1999).

Second, this considerable American literature has pointed to the many desirable features of this shelter and care alternative and the relatively high levels of consumer satisfaction (Assisted Living Federation of America (ALFA) 1999; Golant 1998b; Kane and Wilson 1993; Regnier 1994). In short, it is worth examining as one component of shelter and care in the total long-term care network.

Exhibit 3. Key Characteristics of Major Types of Purpose-Built or Rehabilitated Senior Shelter and Care Settings in the United States

Congregate Living Facility or Supportive Housing or Independent Living Facility

This is typically a multi-family occupied apartment building with self-contained rental units marketed to a predominantly independent senior population paying a monthly rent or fee. Its supportive services are typically restricted to housekeeping, meals, security, transportation, social activities, recreation, and service and health-need counseling. Personal assistance or health care services by in-house staff are usually not offered except as a home-based delivered option. A variant of this model is the higher-end residential hotel in which seniors occupy rooms rather than apartments. In the past, nonprofit sponsors predominantly owned these facilities, but for-profit sponsors' role is increasing. This housing category may or may not be licensed by the state.

Assisted Living Facilities

This is typically a professionally managed housing facility with self-contained rental units marketed to higher-income seniors. It usually offers all the supportive services of congregate care. It additionally offers personal assistance and nursing services to seniors, who require assistance performing everyday activities; and it often offers some health care services but usually not 24-hour skilled nursing care. The monthly rent covers the costs of the shelter and some of the services, but an additional fee is also sometimes charged for specific personal care/nursing services. Some facilities only house Alzheimer's Disease residents, while others may have part of their facility dedicated to this resident group. This option is primarily owned by for-profits (73%) as opposed to nonprofits (27%). State governments usually regulate these facilities, although they may or may not be referred to as assisted living facilities. This category also sometimes misleadingly includes "board and care" facilities (see below).

Board and Care Facilities

This is typically a large, conventional "single family" house occupied by three or more, but usually less than twenty unrelated adult persons who pay a monthly fee. These "mom and pop" facilities are usually operated by a married couple or single person who lives on the premises and is responsible for all shelter aspects (e.g., housekeeping, meals, laundry) and the care of their occupants. Seniors, ranging from the relatively independent to the somewhat frail, will occupy a bed sitting room, often with its own bathroom. This room is often shared by two or more seniors. Residents share all other space, such as a common living room, kitchen, and recreation areas. Residents are predominantly lower-income and these facilities are mostly owned by for-profits (80%) as opposed to nonprofits (20%). These facilities may or may not be licensed by the state.

Shared Group Housing

This is typically a large conventional residential structure (often a single family house) that operates as a single housekeeping unit occupied by three or more, but usually less than twenty unrelated adult persons (e.g., the Abbeyfield houses in Canada). Relatively independent seniors will typically have their own bedsitting room and sometimes their own bathroom, but they will otherwise share the kitchen, living room and other common living areas. They will also share responsibility for the usual residential upkeep and homemaking tasks, although one or more hired persons may do the housekeeping, laundry, home repairs, meal preparation, and provide transportation assistance. A full-time manager often takes care of the facility, and sometimes, but not always, will reside full-time in the house. These facilities are predominantly owned by for-profits and may or may not be licensed by the state.

Nursing Homes or Care Facilities

Skilled nursing and rehabilitative care and sometimes subacute care are offered in a hospital/institutional-like building that is occupied by the most physically and cognitively impaired elderly population. In the U.S. about 66% of nursing home facilities are owned by for-profit firms, 26% by nonprofits, and 8% by government agencies. These facilities are usually licensed and regulated by a state government.

Continuing Care Retirement Communities (CCRCs)

Most CCRCs (77% in the U.S.) incorporate congregate living, assisted living, and nursing home care within a single building or several buildings on a campus-like site. Other combinations include: assisted living and nursing care, but not congregate care (3%); congregate living and nursing care, but not assisted living (12%); and congregate living and assisted living, but not nursing care (8%). CCRCs usually offer at least a one-year contract

that guarantees residents access to all its offered levels of care at specified prices. For this “insurance” residents often pay a one-time “entrance fee” (variously refundable) along with a monthly fee covering shelter and services. Over 90% of CCRCs are owned by nonprofits; the remainder, by for-profits. A facility’s levels of shelter and care may be licensed by multiple state/Federal agencies.

Sources: (American Association of Homes and Services for the Aging 1999; Anikeeff and Novitzki 1998; Golant 1992; National Investment Conference 1997; National Investment Conference 1998; Promatura Group 2000; Strahan 1997)

Third, the assisted living model, as it is developed in the U.S., is clearly influencing the practices of a current generation of Canadian architects, developers, and management firms. As one of many indicators, many professionals in Canada belong to the Assisted Living Federation of America (ALFA) – a major organization representing participants in this industry – and attend its conferences and workshops.²

Finally, large U.S.-based corporations that build and manage assisted living facilities are actively building facilities in Canadian provinces, thus introducing Canadian seniors and the development community – whatever their receptiveness – to this American product.

The Status of Assisted Living Facilities in the U.S.

In the U.S., the growth of assisted living facilities was especially striking during the 1990s. Between 1991 and 1998, the number of assisted living properties increased by almost 50 percent and the number of beds increased by almost 115 percent (Promatura Group, LLC 2000).³ Over three quarters of the facilities are owned by for profit companies (American Seniors Housing Association 2000) and marketed to a higher-income elderly consumer group. To that end, the professionally managed assisted living facility industry has actively sought to dissociate itself from the smaller, mom and pop, board and care facility (National Investment Conference 1997). This latter shelter type is often criticized both by state governments and the press for its poor quality, and it is more likely to be occupied by low-income seniors receiving government assistance.

Assisted living facilities were originally developed as a Scandinavian model of residential long-term care and emerged only in the late 1980s as a distinctive category of housing in the U.S. Their existence predates their terminology, however. Assisted living facilities were much earlier created as part of Continuing Care Retirement Community (CCRC) facilities (Exhibit 3). Just under 20 percent of current CCRCs, which have been predominantly developed by nonprofit sponsors, were operating before 1960, and a large number of developments were built in the 1970s (Hawes, Rose, and Phillips 1999; Scruggs 1996; American Association of Homes and Services for the Aging 1999; American Seniors Housing Association 2000).

²Nineteen Canadian senior housing professionals are members of the Assisted Living Federation of America/ALFA, the major professional organization representing the assisted living industry in the U.S. (Judy Conover, Executive Director of the International Assisted Living Foundation, personal communication).

³Studies that enumerate these facilities use different data sets and include different categories of facilities. For example, some studies routinely lump board and care facilities in the assisted living category, while other enumerations keep them separate.

Despite the increased prevalence of the “assisted living” terminology, like alternatives are still known by a confusing array of other names, including residential care, personal care, basic care, domiciliary care, housing with services, and board and care (American Health Care Association 1998). These various labels are symptomatic of the many different versions of this housing product (Mollika 2000). Moreover, even alternatives that identify themselves as assisted living often present very different physical or architectural styles, offer varied types of care and services, and use different organizational strategies to deliver care. In considerable part, this inconsistency results from the idiosyncratic influence of state governments, each differently regulating the appearance and operation of these facilities.

Nonetheless, over time we have witnessed a less ambiguously defined housing product better known and more accepted not only by consumers, but also by professionals in the health care and financial sectors. State governments in turn are now more likely to recognize this category of shelter and care, even though their rules and regulations governing its appearance and administration still vary considerably. Currently, the term “assisted living” is used in the regulations or statutes in 29 states (Mollika 2000). (The Federal government has no regulatory role.) Increasing product uniformity is also a result of the emergence of several large U.S. assisted living corporations that produce and/or manage large portfolios of these facilities.

Further, several professional organizations have emerged to represent participants in this industry, including developers, management, financial institutions, and service providers. These include the American Seniors Housing Association, American Association of Homes and Services for the Aging/AAHSA, National Academy for State Health Policy, National Center for Assisted Living/American Health Care Association, National Investment Center for the Seniors Housing and Care Industries, and Assisted Living Federation of America/ALFA. They offer various services – advocacy, education, public policy updates – to their membership, and most importantly are now consistently using the same terminology. Two organizations, the Rehabilitation Accreditation Commission and the Joint Commission on Accreditation of Healthcare Organization have developed voluntary self-accreditation standards for the industry to insure minimum standards concerning operational procedures, performance outcomes, services, management practices, and consumer protection.

Although viewed positively by most professionals, the assisted living facility alternative is not without its downsides.⁴ Some recent surveys offer troubling statistics revealing that a significant percentage of facilities deviate significantly from the ideal model summarized above (Golant 1998b). In some facilities, for example, residents must share their dwelling units with three or more unrelated persons; other facilities include units that do not contain a full bathroom; and in still others the physical plant and operations still resemble aspects of a nursing home. Other facilities will not always accept or retain seniors with moderately severe cognitive impairments, those with more severe locomotor disabilities, or those needing nursing services (Assisted Living Federation of America 2000; Hawes, Rose, and Phillips 1999; Stone 2000). A nationally publicized report by a Federal governmental agency (U.S. General Accounting Office 1999) also strongly criticized the quality of care found in some assisted living facilities in four states. Incidences of litigation against assisted living facilities have correspondingly increased, as

⁴ Learning from the weaknesses of the U.S. assisted living experience is yet another reason to focus on the American model.

the legal community has discovered the existence of resident neglect and abuse. Responding to these concerns, some states are beginning to impose tougher regulations on their facilities.

Both the product and the industry producing it are also in constant flux. Among the more important recent developments (Assisted Living Federation of America 2000; Mollika 2000):

1. Many assisted facilities are accommodating more physically and cognitively frail residents.
2. Managements of these facilities are reporting that they are having difficulty obtaining and keeping qualified staff.
3. Many insurance companies have increased the costs of their liability insurance, while others are withdrawing entirely from providing coverage.
4. In several markets throughout the country, assisted living facilities are currently overbuilt and there have been some visible bankruptcies. Consequently, most large assisted living corporations have slowed their development of new facilities.
5. A considerable amount of consolidation has occurred in the industry and large corporate players are increasingly dominating it.
6. Through the use of Medicaid waivers (a joint federal-state subsidy program), an increasing percentage of assisted living residents are now low-income. The past two years alone saw a 50 percent increase in the allocation of beds/units to lower-income seniors.
7. Although the past decade has witnessed a large increase in and greater diversity of capital sources for financing this housing product, in the past year the capital markets have become more restrictive and financing opportunities are less available and more costly than in the past.
8. Assisted living corporations are increasingly developing new facilities, selling them but retaining minority ownership interest, and then establishing long-term operating/management contracts with the new owners.

Number of Assisted Living Facilities in the U.S.

Estimating the number of assisted living facilities in the U.S. and the size of its senior resident population is part science and part art. No agreed-upon master list of assisted living facilities exists, and the identification of facilities as assisted living varies depending on the research effort. Moreover, different studies also have significantly different response rates from their survey samples. The task is further complicated because assisted living facilities are not only freestanding facilities, but also are included as a level of care in other shelter and care facilities.

Data published by the National Investment Center for the Seniors Housing and Care Industries (Promatura Group, LLC 2000) indicate that 777,801 assisted living units or beds were found in some 27,277 properties representing about 2.25 percent of the total U.S. elderly (age 65 and over) population (Exhibit 4).⁵ They also find that 67.9 percent of assisted living beds/units were found in freestanding facilities, 13.9 percent were part of a continuing care retirement community (CCRC) facility, 8.5 percent were part of a congregate living facility, and 9.7 percent were part of a nursing home.

⁵These estimates include smaller board and care facilities (under 11 units) in the totals. Another national study estimated U.S. assisted living facilities can accommodate only about 611,000 seniors (Manard and Cameron 1997).

Exhibit 4. Estimated Supply of Elder Purpose-Built Shelter-Care Accommodations in the United States, 1999

Type of Housing	Number of Properties	Number of Units/Beds ^a	Beds/Units As Percent of 1999 U.S. Age 65+ Population
Specific Housing Categories Summary			
Freestanding Congregate Care	3,214	338,981	0.98
Freestanding Assisted Living (30+ units)	3,781	279,789	0.81
Freestanding Assisted Living (1 to 29 units) ^b	19,333	248,284	0.72
Freestanding Skilled Nursing ^d	15,640	1,560,425	4.52
Continuing Care Retirement Communities (CCRCs)	1,900		
Independent Living		317,076	0.92
Assisted Living		108,183	0.31
Skilled Nursing ^d		208,391	0.60
Congregate Care and Assisted Living	850		
Congregate Care		49,319	0.14
Assisted Living		65,899	0.19
Assisted Living and Skilled Nursing	1,413		
Assisted Living		75,646	0.22
Skilled Nursing ^d		159,898	0.46
TOTAL	46,131	3,411,891	9.88
Broad Housing Categories Summary^c			
Independent Living and Congregate Care	5,964	705,376	2.04
Assisted Living ^b	27,277	777,801	2.25
Skilled Nursing ^d	18,953	1,928,714	5.58
TOTAL	46,131	3,411,891	9.88

^aCongregate Care is reported in units. Assisted Living and Skilled Nursing are reported in beds.

^bIncludes Board and Care facilities

^cThe "number in properties" will not sum to total (46,131) because units may be found in more than one category of facility..

^dIncludes hospital-based facilities, private-pay facilities, and facilities managed by Department of Veterans Affairs

Source: Modified table from ProMatura Group, LLC (2000)

Exhibit 5. Comparison of Modern Assisted Living Facilities with Other Facilities

Feature	Modern	Other Communities
Mean age of community (years)	3.3	9.2
% licensed by state	98.0	90.2
Mean number of units	51.2	50.4
Mean percent of studio apartments	60.3	56.6
Mean percent of one-bedroom apartments	29.3	34.0
Mean percent of two-bedroom apartments	10.4	8.8
Mean occupancy of all communities (%)	82.0	90.3
Mean occupancy of communities opened 18+ months (%)	93.6	90.7
Mean occupancy of communities opened <18 months (%)	47.6	77.8
Mean number of semi-private apartments	10.2	9.4
Mean size of studio apartments (sq. ft.)	317.0	318.2
Mean size of one-bedroom apartments (sq. ft.)	448.2	448.0
Mean size of two-bedroom apartments (sq. ft.)	544.0	616.7
Mean monthly rate for studio apartments	\$1,843.00	\$1,827.00
Mean monthly rate for one-bedroom apartments	\$2,330.00	\$2,104.00
Mean monthly rate for two-bedroom apartments	\$2,367.00	\$2,167.00
% of communities that have require permission to leave	35.0	25.6
% of communities that restrict visiting hours	10.2	9.0
Mean number of FTE staff	27.3	24.6
Mean FTE staff-resident ratio (open 18+ months)	0.61	0.59
% communities employing nurse	85.7	82.3
% licensed to administer medications	77.6	70.0
% residents using home health services	15.7	9.3
% with special unit for Alzheimer's residents	30.6	10.5
% of residents who receive assistance bathing	62.0	60.4
% of residents who receive assistance dressing	39.6	32.9
% of residents who receive assistance using toilet	30.7	22.2
% of residents who receive assistance eating	5.8	6.0
% of residents who receive mobility assistance	20.2	14.4
Mean number of ADL deficiencies among residents	1.6	1.2
% of communities with refrigerators in units	60.8	55.7
% of communities with stoves in units	9.9	22.5
% of communities with microwaves in units	43.9	23.2
% of communities with auto/van transportation	73.6	89.8
Admit residents who use a wheelchair	93.9	85.2
Admit residents incontinent of bladder who self-manage	89.8	90.3
Admits residents incontinent of bladder who need help	81.6	50.0
Admit residents incontinent of bowel who self-manage	71.4	63.6
Admit residents incontinent of bowel who need help	58.3	27.5
Admit residents who are bedfast	10.2	6.6
Admit residents who need help to transfer	71.4	43.0
Admit residents who are mildly confused	100.0	97.5
Admit residents who are moderately confused	83.3	66.1
Admit residents who have catheters or ostomies	52.1	56.8
Admit residents who use oxygen	81.6	84.6
Admit residents who use ventilators	12.8	10.9
Admit residents who have behavior problems	64.6	37.5

Source: Modified table from (National Investment Conference 1998)

Attributes of U.S. Assisted Living Facilities

Similar research and sampling issues make it difficult to generalize about the characteristics of U.S. assisted living facilities. The data are again drawn from surveys by the National Investment Center for the Seniors Housing and Care Industries (National Investment Conference 1998). One of the advantages of these data (Exhibit 5) is their distinction between “modern” and all “other” communities. “Modern” communities were opened in 1990 or later, were freestanding, were for-profit, and were intended to be assisted living facilities. “Other” facilities include those built or substantially renovated since 1982 and those built or converted from some other use; may be either for-profit or nonprofit; and may be freestanding or part of a nursing home, CCRC, or congregate living facility.

Irrespective of the “modern/other” distinction, several generalizations are possible. Facilities tend to be small (around 50 units); are over 90 percent occupied if operating more than 18 months; are predominantly licensed by the state; have only a small percentage of shared apartments and predominantly contain studio apartments; and charge an average monthly rent ranging from just over \$1,800 to just under \$2,400. Staffing levels are relatively high, with an average of over 25 full-time equivalent (FTE) staff and a FTE staff-resident ratio of 0.6. A high percentage of facilities employ a nurse and are licensed to administer medications. Substantial percentages of the residents require assistance with bathing, dressing, using a toilet, and getting around. While the majority of communities provide refrigerators in units, few provide stoves. Facilities are admitting residents with relatively high acuity levels, as indicated by the higher percentage of new residents with various physical or cognitive impairments and behavioral problems.

Most facilities provide a number of personal services as part of the basic monthly fee (Exhibit 6). These usually include bathing, toileting, medication assistance, and escort service within the building. Only about 50 percent of the facilities, however, provide incontinence management as part of the basic package. For an additional fee, however, most facilities provide assistance with these activities. Only toileting assistance and incontinence management are not provided by a significant percentage of facilities (12.4 percent and 19.4 percent, respectively).

When residents were surveyed about why they selected their facility, about three-quarters identified the following four reasons: the services offered, the convenience for family or friends, the appearance of the residence, and the staff (Exhibit 7).

“Modern” assisted living facilities differ from “other” facilities in a number of significant ways. Many of these differences may be linked with the much higher percentage of modern facilities that contain special units for Alzheimer’s Disease residents. Predictably, modern facilities tend to have a higher percentage of studio apartments, charge higher monthly fees, are more likely to employ a nurse and be licensed to administer medications, typically have a more impaired resident profile, and generally are admitting a more impaired senior population. They are also more likely to require permission for a resident to leave and are less likely to allow stoves in units.

Exhibit 6. The Types of Basic and Extra Services Provided

Service	% Included in monthly fee	% Available for an additional fee	% Not provided by residence	Total
Housekeeping	97.7	1.7	0.6	100.0
Flat linen service	91.9	2.3	5.8	100.0
Personal Laundry	61.8	36.4	1.7	100.0
Transportation to medical appointments	62.8	20.9	16.3	100.0
Transportation to shopping/leisure	78.4	10.5	11.1	100.0
Assistance with bathing	72.8	24.3	2.9	100.0
Medication assistance	75.6	22.1	2.3	100.0
Escort service within the building	75.6	22.1	2.3	100.0
Toileting assistance	61.8	25.9	12.4	100.0
Incontinence management	50.0	30.6	19.4	100.0

Source: (National Investment Conference 1998)

Exhibit 7. Most Important Reason Resident Selected the Assisted Living Facility

Reason	% Residents
Services offered	31.9
Convenient for family or friends	21.7
Appearance of residence	12.9
Staff	6.6
Only available choice	5.4
Lower monthly fee	3.3
Family member selected it	2.5
Apartment selection	2.6
Convenient to shopping & services	2.0
Size of apartment	2.0
Referral	1.3
Other	7.8
Total	100.0

Source: Modified table from (National Investment Conference 1998)

THE PRESENCE OF ASSISTED LIVING FACILITIES IN CANADA

Background

Through the 1950s and 1960s, the facilities offering provincially subsidized long-term care in Canada primarily included convalescent hospitals, mental hospitals, nursing homes, and homes for the aged. As the growth rate of seniors accelerated in the 1970s, and as the government incurred increased medical and care costs, the Federal and Provincial governments began to restrict both the capital and operating funds available to the nursing home industry (the more generic terminology). As early as the late 1970s, access to these facilities was increasingly limited to people with serious health problems (Haldemann and Wister 1993). Because provinces controlled the rate of development of shelter-care housing and social programs, different models emerged in each of the provinces to serve their growing populations of frail elders (Regelous 2000).

During the 1960s and 1970s, larger private entrepreneurs demonstrated little interest in creating housing options for seniors (Davis 1991). A relatively large number of small shelter and care facilities, however, emerged during this period. These were primarily privately owned and operated mom and pop retirement homes that were both unlicensed and nonsubsidized by their respective Provincial governments. They usually offered congregate type services (food, housekeeping, security, social support), though many also provided limited personal care assistance (Regelous 2000). They were more likely to be found in certain provinces than others. Few such mom and pop facilities, for example, were created in British Columbia. On the other hand, by the mid-1980s in Ontario, conservatively about 114 of such “residential care homes” existed, containing about 4,000 beds. These facilities were not covered by Provincial legislation, nor were they under the jurisdiction of any Provincial ministry. They were only regulated under municipal legislation governing the most basic fire, safety, and accommodation standards. The most expensive ones charged \$100 per day, although the average was about \$30 per day (Forbes, Jackson, and Kraus 1987).⁶

The period 1960 to 1990 also witnessed the production of a large number of low-rent apartments for low-income seniors (or “social housing”).⁷ Development of these units was greatly encouraged by generous capital grants and operating subsidies from the Canada Mortgage and Housing Corporation (CMHC, the major Canadian agency to administer the Federal government’s housing policies through various financial mechanisms). Poulton (1995, p. 64) observes, for example, that “between the late 1960s and the late 1970s, the proportion of public housing units built for families with children in Ontario fell from 80 percent to 20 percent of the total, while the proportion built for senior citizens moved in precisely the opposite direction.” For modest income elders, during the 1980s, Davis (1991, p. 37) notes “CMHC committed, through a number of social housing programs, over 100,000 dwelling units across Canada in projects designed solely for seniors...” With large Federal deficits, in the late 1980s, however, CMHC stopped its major funding commitments for social housing products because they were viewed as too expensive to build. Currently, it is estimated that of the more than 650,000 social housing units built throughout Canada, almost 40 percent – or more than 240,000 units – have been committed to seniors (Rodriguez 1997).⁸ These housing developments sometimes contained recreational and social amenities (Davis 1991), but have generally not contained supportive services that might benefit their less independent elderly occupants (Appleyard 1994). As Wister and Gutman (1991, p.25) emphasize:

“...sponsoring groups were told not to worry about the seniors who, virtually from the day these buildings opened, would get sick and/or require some degree of assistance with activities of daily living. The assumption was that these individuals would willingly move out when they were no longer fully independent...No one was thinking much about the long-term.”

The 1980s also witnessed the emergence of larger for-profit developers building congregate living facilities for higher-income Canadian seniors. Many were previous nursing

⁶ Residential care homes in Ontario differ substantially as to their size and daily charges. Estimating facility numbers is also difficult because of unreliable data (Forbes, Jackson, and Kraus 1987, pp. 36-37).

⁷ Social housing in Canada includes Public Housing, operated by federal, provincial, or municipal government agencies, and third sector housing owned and operated by co-operatives and nonprofits (Fallis 1995).

⁸The number of units excludes those committed under unilateral provincial programs (Rodriguez 1997).

home developers who had redirected their efforts from the declining nursing home industry. These buildings were often very physically attractive and occupants had their own private living quarters. They sometimes were offered at least one meal a day in a common dining room, housekeeping assistance, and 24-hour security. Some project amenities were more extensive and included a hobby room, library, lounges, beauty parlor/barber and minibus service. Some made personal care and nursing staff available to residents of the congregate living facility through home-based service delivery, but most did not provide this assistance with their own staff (Davis 1991).

Some of these new entries in the marketplace were unsuccessful. Their developers had not built senior housing facilities before and inexperienced managers administered them. Thus, along with many success stories, there were also significant failures, as many of these developments were poorly designed and did not offer the services needed or wanted by seniors. As a consequence, they did not achieve their projected fill-up rates, and the late 1980s and early 1990s witnessed facility failures and CMHC repossessions.

Since the mid-1990s four important trends have become apparent. First, developers are producing shelter and care facilities more like the U.S. version of assisted living. Second, the shelter and care industry is consolidating. Many long-time players are moving out of the business and are being bought up by public companies, REITs, and large, aggressive private investors. Thus, a relatively few larger developers are producing most new facilities. Third, a small number of experienced management firms have emerged that is more knowledgeable about how to operate these newer shelter and care facilities. And fourth, several U.S.-based assisted living facility corporations are aggressively pursuing development opportunities in Canada. These trends seem likely to continue for the foreseeable future, as capital markets remain tight, the complexity of the product increases, and many developers realize their facilities must include on-site care provided by their own staff.

Current Status of Assisted Living Facilities in Canada

Generalizations are still difficult to make about the presence and characteristics of noninstitutional shelter and care facilities in Canada. Unlike in the U.S., systematic national focused facility surveys or enumerations are lacking. Canada has not benefited from the information-gathering efforts of nonprofit professional organizations that in the U.S. represent the senior housing industry.

Nonetheless, an excellent study has recently been conducted for the Canada Mortgage and Housing Corporation presenting revealing case studies of the six major types of seniors housing available in Canada (Gutman, Clarke-Scott, and Gnaedinger 1999). This typology helps clarify the varied types of specialized housing options available to Canada's seniors. The last two housing categories in this study are of particular interest because they may include assisted living facilities. This report will refer to these last two levels with the generic label of "noninstitutional shelter and care" to avoid confusion. The six categories include the following:

- 1. Shelter structures that allow seniors to live near their family household**
Exemplars: accessory apartments, garden suites (ECHO housing, granny flats), bifamily units

2. **Large shared houses occupied by 7 to 10 unrelated persons, each with own private living quarters**
Exemplars: Abbeyfield housing, group homes, and shared housing
3. **Planned retirement communities (with few planned services)**
Exemplars: retirement subdivisions, retirement residences, mobile home communities, and university-linked communities
4. **Low-density, lifestyle-oriented housing, offering social and recreational opportunities**
Exemplars: retirement villages and communities
5. **Shelter with support services**
Exemplars: congregate housing, sheltered housing, and assisted living
6. **Shelter with increasing levels of health services⁹**
Exemplars: multi-level care, continuing care or life-care retirement communities

A consideration of the examples in this report, along with the other sources of information, suggest that the Canadian version of assisted living usually differs in the following ways from the prototype U.S. version:

- More frequent reliance on the split care model
- Lower staff-resident ratios
- Less likely to provide unscheduled personal care assistance
- Less likely to admit more frail elder residents
- Lower percentage of facilities with wings or units that can accommodate seniors with Alzheimer's Disease
- Less likely to provide heavy personal care/nursing services
- Less likely for Provinces or Territories to regulate as a purpose-built noninstitutional elder shelter and care category
- Less likely developed as rental units; more likely developed as condominiums
- Less likely to be freestanding; more likely part of multi-level care facility
- More limited and costly capital markets to finance developments
- Fewer professional organizations representing industry interests

Facilities with a split model of shelter and care resemble congregate living facilities in appearance and operation. Type of tenure can vary from rental to strata-owned (condominium ownership). Residents are usually accommodated in conventional apartments (often scaled-down in size) and enjoy hotel-like services, such as meals, housekeeping, transportation, recreation, and emergency alert systems. The operator provides personal care and some nursing services by subcontracting an "outside" home-based service agency that responds to resident requests as-

⁹The complete shelter and care continuum would also include a seventh category, institutional (skilled nursing) care. In Canada, this would include the exemplars of nursing homes and public and private chronic care hospitals. The sixth category may also include nursing homes as a care level found in the multi-level care facility.

needed. Staff from such an agency (at least one full-time worker) sometimes but not always provide all-day on-site assistance (e.g., 9:00 a.m. to 9:00 p.m.). Through this organizational approach, the facility, at least officially,¹⁰ does not itself provide the personal assistance or care component. In this respect, it operates not much differently than a private residence in which the senior receives in-home support and care from a community-based agency. Operating like a conventional home, it falls outside a Province's or Territory's long-term care/nursing home regulatory environment.

The prevalence of a split model of care also partly explains the lower staff-resident ratios and the less frequent provision of both scheduled and unscheduled personal care assistance. Low ratios are also likely a result of the smaller staffs available for recreation and social activities. More generally, Canadian facilities have admitted less frail elder residents. Predictably, dedicated wings or facilities specially designed for the Alzheimer's Disease resident, are less available in Canada than in the U.S. Finally, the lower staff-resident ratios are consistent with a shelter and care inventory that is more top heavy with congregate living facilities than with assisted living facilities.

These staffing patterns are also consistent with the greater prevalence of multi-level care facilities in Canada. This alternative can assume various forms (Davis 1991). On the one hand, it refers to the different regulated licensed care levels found within a long-term care/nursing home facility. On the other hand, it refers to some combination of two or more levels of shelter and care located in a single building or on a campus-like setting. This often includes a congregate living facility occupied by relatively independent seniors and offering little personal assistance that is physically adjoined to a licensed long-term care facility offering skilled nursing care. While the multi-level facility may also contain a U.S.-style assisted living facility, more often, the personal care and assistance is offered by an outsourced home support or care agency.

One version of the multi-level facility, the Continuing Care Retirement Community (CCRC), is less common in Canada (Exhibit 3). The U.S. exemplar requires both a substantial one-time entrance fee and a monthly rental fee. The one-time entrance fee is considered a form of insurance purchased by the resident to guarantee nursing home occupancy, often at below-market rates. Not surprisingly, in Canada, this organizational model is less in demand because residents are confident such care will be publicly subsidized.

The Canadian shelter and care product has three other distinguishing features. First, more so than in the U.S., developers produce condominiums for ownership rather than rental units. Residents of such units purchase a flexible, personalized package of retirement life style, personal assistance, and health care services. Second, Canadian developers have more limited access to capital markets willing to finance the assisted living product. And third, professional

¹⁰The facility may have various ownership or contractual relationships with the home-based service agency. The operation of the agency may or may not be under the managerial umbrella of the retirement facility. In practice, some shelter and care facilities themselves establish a standalone home care agency that is then contracted out to provide the home support/care services. The same company will own both the facility and the home care agency. While no problems have been documented with these kind of arrangements, the potential for abuse, conflict of interests, and bad press coverage obviously exist.

organizations are lacking that represent the stakeholders in Canada's noninstitutional elder shelter and care industry.

The following sections explore the reasons for and implications of these and other distinguishing characteristics of Canada's noninstitutional shelter and care products.

FACTORS INFLUENCING THE CURRENT STATUS AND FUTURE GROWTH OF FOR-PROFIT ASSISTED LIVING FACILITIES IN CANADA

Many interdependent social, political, and economic factors are influencing the current availability of shelter and care products for frail Canadians, their design and organization, and the prospects for their future growth. A veteran observer of Canada's health and social systems put it simply (Havens 1995, p. 250): "*Changes within one sector of the continuum (of care) very often will affect one or more components in one or more other sectors of the continuum.*" It is possible to identify nine such interlinked influences:

- Inconsistent terminology describing Canada's shelter and care alternatives
- Nursing homes as competition to assisted living facilities
- In-home care as competition to the assisted living facility alternative
- Shelter and care regulatory policies in British Columbia, Ontario, and Alberta
- Potential cost savings for Provinces and Territories that adopt the assisted living model
- Attitudes of Provincial and Territorial governments toward the private and nonprofit sectors
- Availability of financing for for-profit shelter and care facilities
- A lack of professional organizations representing the shelter and care industry
- Conventional market demand and supply factors

Inconsistent Terminology Describing Canada's Shelter and Care Facilities

It might appear trivial to think that how a society identifies a shelter and care option could affect its current viability and future status. Those doubters, however, might be reminded that, at least in the U. S., corporations often spend millions of dollars developing and marketing a logo to communicate their desired image.

In Canada, however, it is clear that Federal and Provincial/Territorial governments, health care professionals, developers, management firms, academics, and the press refer inconsistently to the assisted living concept.¹¹ Its usage in the province of Manitoba is an example. Here, the term, assisted living, refers to "congregate level living," while "supportive housing" refers to the U.S. notion of "assisted living" (Strain and Grabusic 1999). Assisted living facilities may not be identified at all as part of Canada's long-term care strategies. A recent report by Canada's National Advisory Council on Aging conceives of "housing" as either "private dwellings in the

¹¹Nursing homes in Canada are also known by various names depending on jurisdiction. "The same level of care is provided by facilities with different names in different provinces. Even within a province, the same level of care can be provided by facilities that have different names, and a given facility can provide more than one level of care" (Forbes et al. 1987, p. 20).

community” or “institutions.” That a broad range of shelter-care arrangements will not fit into this very traditional dichotomy goes unnoticed. To the agency’s credit, on the other hand, the report recommends that “*there is a marked need for the development and application of clear Provincial housing standards for the variety of housing options being developed for seniors, particular those involving group arrangements*” (National Advisory Council on Aging 1999, p. 48). The concept is also not readily accepted by some organizations. According to one prominent Provincial official advocating for more affordable assisted living facilities in British Columbia, it was a major coup just to have the concept identified in a recent report reviewing the province’s “continuing care services” (Keith Anderson, personal communication). Here the definition of assisted living mimics U.S. usage, to which specific mention is made (BC Ministry of Health 1999, p. 21):

“This approach involves delivering personal care and health services in a housing environment rather than a care environment. By living and receiving services in a home environment (such as an apartment, private care home or group home), instead of in a traditional residential care facility, clients maintain their independence, privacy and dignity.”

“Supportive housing” is the term used most frequently in Canada (Social Data Research Ltd. 2000). It is often employed as a catchword designating almost any type of residential shelter offering more than the most conventional or typical real estate services (Social Data Research Ltd. 2000). These additional services can range from housekeeping and meals to nursing care assistance. This is the way, for example, CMHC uses the term. Thus, for this agency, “assisted living” is a “service enriched” version of supportive housing. CMHC, it might be added, was one of the earliest government agencies to refer to the U.S. assisted living product (Davis 1991).

The supportive housing concept may also refer, however, to a specific category of shelter and care. Its usage then deviates substantially from the more generic interpretation by CMHC or practitioners in the U.S. (Promatura Group, LLC 2000). The province of British Columbia, for example, offers the following definition of supportive housing (British Columbia, Ministry of Municipal Affairs 1999, p. 3): “*Supportive housing is a supportive, but not a health care environment, not regulated as a care facility. Supportive housing should be distinguished from assisted living, in which care services are offered on site, usually on an as-needed, flexible basis.*” Thus, “supportive housing” unlike “assisted living” excludes care services such as medication management, blood pressure monitoring, catheter changing, and wound care.

Such inconsistent and confusing terminology makes it difficult for elderly consumers and their family members to make informed decisions about “what’s out there” and which housing option will accommodate their physical and cognitive impairments. Ambiguous product identity also makes it more difficult for professionals charged with referring their clients to appropriate shelter and care choices. Unclear terminology is also a major problem for those marketing this alternative and advertising costs will be higher when it is necessary to overcome poor or misleading name recognition. Financial institutions, risking large capital sums, also will be dissuaded from investing in an ambiguous, nonstandardized product line with unclear parameters and outputs. Ambiguous language also increases the possibility of undeserving bad press. This

has recently occurred with the media's exposé on Ontario's retirement home industry. As one developer expressed:

"Part of the confusion, rests with the recent exposé done by The Toronto Star, on the retirement home industry. The difficulty is that "retirement home" covers a vast array of different types of facilities – ranging from domiciliary care (welfare patients) to facilities that have mentally retarded adults to facilities that have discharged mental patients, to your high-end, upscale assisted living facility."

Finally, clear terminology is especially important in a country that for a long time has presented consumer "continuum" of care choices as a dichotomy: either deal with old age at home or enter a nursing home. To that end, assisted living facility proponents must make a special effort to communicate how this alternative offers a distinctive level of care in a setting very different from a nursing home.

Nursing Homes as Competition to the Assisted Living Alternative

A recent study conservatively estimated that approximately 15 percent of nursing-home residents in the U.S. could be accommodated in lower levels of care because they needed help with less than three activities of daily living, were continent, did not have substantial rehabilitation or medical needs, and did not exhibit serious behavior problems (Spector, Reschovsky, and Cohen 1996). This assessment is significant for providers of assisted living facilities, because of the possibility that their accommodations can tap into a major market of frail elders who would otherwise enter nursing homes. No one has performed a comparable study in Canada, but experts here have long offered similar observations about the Canadian nursing home population (Chappell 1988; Schwenger and Gross 1980).

Skeptics may observe that nursing homes in Canada already accommodate a much more frail senior population than in the past. Factors that have produced this trend include the disproportionately greater growth of the age 85 and older population, more home-based alternatives allowing older persons to cope with their less severe frailties without moving, restrictions on the development of new nursing homes, and higher acuity levels required for publicly subsidized nursing home admission (National Advisory Council on Aging 1999). The following evidence nonetheless suggests that Canada's nursing homes are still top-heavy with seniors who do not require the heavy care offered in these facilities.

First, the current institutionalization rate of Canadian seniors (7.3 percent) is still high compared with the U.S. rate (5.6 percent) (Bishop 1999; Colin 1999; Promatura Group, LLC 2000).¹² Second, the rate of institutionalization is especially high in certain provinces, such as Prince Edward Island (8.4 percent), Quebec (9.7 percent), Alberta (7.8 percent), and Saskatchewan (7.2 percent).¹³ Third, these higher institutionalization rates take on greater significance given that in contrast to the U.S., Canada's senior population consists of a smaller percentage of age 85 and older persons who are at greater risk of being institutionalized. Fourth,

¹²The actual size of the rate difference requires more careful empirical inspection. The Canadian definition of "institution" may include facilities that in the U.S. are considered noninstitutional shelter and care accommodations.

¹³In contrast, the elderly institutionalization rates are lower in B.C. (5.4%), Manitoba (6.6%), Ontario (6.4%), New Brunswick (6.7%), Nova Scotia (6.0%), and Newfoundland (6.7%).

provinces such as British Columbia believe that it is feasible to raise the frailty level threshold used to accept new residents into their subsidized nursing homes.

Effects of Size and Quality of Nursing Home Bed Inventory. – While the possibility of a lower rate of institutionalization in Canada would make assisted living facilities more attractive to frail elders, certain Provincial policies may dampen this demand. Ontario, for example, is currently putting the lion's share of its shelter-care subsidies into heavy-care nursing homes, most capable of accommodating seniors with Alzheimer's Disease. The province is committed to build 20,000 new beds by 2004 and to refurbish 16,000 existing beds by 2006 (Lu 2000). This would be the first opening of new beds in about 10 years. Moreover, the new facilities are expected to offer larger private rooms, more attractive common spaces, and a more home-like atmosphere. Most developers interviewed suggested that this new influx of beds would dampen the demand for other noninstitutional shelter and care options. While it seems unlikely that a significant percentage of families will move their elders out of their current retirement homes into the new facilities, it seems equally clear that adult children newly contemplating where to accommodate a parent are more likely to place them in these better quality, heavily subsidized nursing homes. As a consultant who handles the financing of both nursing homes and unlicensed retirement homes expressed:

"I think that when the 20,000 new nursing home beds come in line, especially in our big cities, we will have an overbuilt situation in other group shelter types (like assisted living). Those that have built their facilities to accommodate heavy care or Alzheimer's elderly – they are going to find themselves in the wrong niche of the business. They will be directly competing with nursing homes because these will be better and cheaper. There will be business failures and crises. In small towns it will be less of a problem because of the excess demand over supply and fewer options."

Importantly, not all experts agree. A prominent architect still believes there will be a shortage of nursing home beds because many existing nursing home facilities will simply be scrapped. Thus, on net, the new nursing home additions will not really add that many "new" beds to the inventory. Furthermore, the appeal of current nursing homes is diminished by their physical unattractiveness and design deficiencies. Experts in both Alberta and British Columbia, like those in Ontario, assign poor marks to the quality of nursing homes in their provinces. In the words of one British Columbia developer: *"Probably 70 percent of our care beds are in wretched condition. I wouldn't put our dog into them. So in addition to the inadequate availability of our existing funded nursing bed stock, a lot of facilities need to be rebuilt."* Even with these quality issues, Ontario, Alberta, and British Columbia have long waiting lists for nursing home beds, and seniors often cannot be admitted into their first choices. On balance, then, the shortage of good quality nursing homes should result in a larger share of Canadian elders and their family members – at least those who can afford to – looking favorably on noninstitutional shelter and care alternatives like the assisted living facility.

This shift in consumer sentiment may not happen quickly. Two other important conditions must exist. First, the for-profit sector must have the motivation, financial resources, and expertise – both with respect to development and management issues – to produce and administer an assisted living facility alternative that has consumer appeal and can compete

aggressively with the nursing home product. Second, for the assisted living facility option to flourish, those gatekeepers must endorse it in the health care system who have traditionally steered their frail elderly consumers to nursing homes (Havens 1995).

Effects of Canadian Views on Entitlement. – The nursing home supply-demand relationship is not the only influence, however, on whether assisted living facility providers can increase their market share. Most Canadians believe they are entitled to affordable nursing home care in the same way they are entitled to medical and hospital care. Specifically, they expect their long-term care to be accessible, comprehensive, portable, publicly administered and, most importantly, universally available. These principles of the Canada Health Act, the universality assumption in particular, “are often pointed to as defining much of what it means to be Canadian...” (Havens 1995, p. 246). That these five principles do not officially apply to “extended health care services,” such as home care and nursing home occupancy, which are not covered by the Canada Health Act, is likely viewed as unimportant by most Canadians.¹⁴

Canadians do pay income-related out-of-pocket costs when they occupy a nursing home, but this amount is usually very affordable¹⁵ (Havens 1995). In British Columbia, for example, the co-payment currently varies from \$25 to \$40 a day (for the highest income persons). Throughout Canada, older persons whose only incomes are their public pensions can typically afford a basic double-room and still have an adequate monthly spending income (Kane, Kane, and Ladd 1998). Thus, the more difficult question to answer is how many Canadian seniors (or their family members) are willing to pay themselves for the assisted living product given their eligibility in most provinces for heavily subsidized care in nursing homes. One shelter and care developer in Ontario zeroed in on the problem:

“Today you can be a resident in a nursing home getting a lot of care for a price of \$58 a day in a private room. That dominates everything else because to run a well-established assisted living or retirement home you have to charge more than \$58 a day for a private room and give less care for more money.”

The belief by Canadian seniors that their government should subsidize their long-term care needs in old age obviously underscores their society’s philosophy towards the availability of care. This value system, however, shifts responsibility for dealing with the burden of care from the individual to the government. The result is a strong disincentive for Canadian citizens to either plan or save for their own shelter and care needs in old age. This same issue is debated in the U.S. Here, however, a vocal group of critics decry the availability of subsidized care for those who could afford other alternatives. They emphasize that wealthy Americans too easily become eligible for Medicaid-funded nursing home beds meant for low-income seniors. Their arguments – summarized below¹⁶ – stand in stark contrast to the dominant Canadian view (American Seniors Housing Association 1999, p. 11):

¹⁴That is why, Canadians can be charged user fees in long-term care facilities and why most continuing care services are not portable across provinces (Hollander 1999).

¹⁵This amount primarily covers the cost of the shelter in these accommodations.

¹⁶This is best articulated by Stephen A. Moses, president of the Seattle, Washington- based Center for Long-Term Care Financing (<http://www.centerlrc.org>).

“The bottom line is that readily available, publicly financed nursing home benefits lead to a denial of long-term risk. This denial discourages individuals from planning and saving for their long-term care, and ironically leads them to the long-term care option many feel is the least desirable: institutionalization in a nursing home paid for by Medicaid.”

“People prepare for and insure only against imminent risks and hesitate to pay for something that’s perceived as being available for free. If the social safety net disappeared, and individuals really had to become impoverished before the government helped them out, they’d quickly realize they could no longer enjoy the luxury of denial. They’d plan ahead for long-term risks, buy insurance, and pay privately for most appropriate levels of care they could afford.”

Still, generalizations about Canadian seniors’ views on entitlement must be made with care. As Havens (1995, p. 246) emphasizes: *“Canadians are very diverse and, despite holding values that stress the collective well-being, Canadians are committed to the values of individuality, risk-taking and the right to make their own choices.”* This is exemplified by the following situation reported by a prominent British Columbia operator of a multi-level care facility that included both a congregate living facility and a very attractive private-pay nursing home:

“In our nursing care facility, persons may enter thinking they will pay themselves until their name comes up in a government subsidized facility. However, often when their name comes up for “free” nursing care, they opt to remain in our private pay facility. We always encourage people to put their name on the waiting list for subsidized care, just in case income might be an issue.”

A possible lesson: exposed to higher-quality shelter and care, seniors who can afford it may reject the subsidized alternative, especially if it is perceived as offering inferior accommodations. Future generations of seniors may hold this sentiment even more strongly. Unlike today’s users of long-term care who experienced the hard economic times of the 1930s, they may be less likely to expect that it is their government’s inalienable responsibility to provide such individual entitlements.

Certain provinces also do not assume the same obligation to provide subsidized nursing home care. The modest user-fees most provinces charge for nursing home occupancy contrasts with long-term care policies in the Atlantic provinces, where seniors may be income means-tested up to the total cost of nursing home care and thus bear the full cost of care.

This debate about individual responsibility and universal entitlements may become moot for a more practical reason. This could occur if Provincial or Territorial governments opt to subsidize assisted living facilities in the same manner as they subsidize nursing homes. If they do, it will not be for unselfish motives. Rather, it will be the recognition that it will cost them less to provide shelter and care to frail elders occupying assisted living facilities. Such public policy shifts, however, will not necessarily occur throughout Canada. The country’s decentralized health and long-term care system allows provinces considerable discretion as to how they address the needs of their frail elderly populations. Some provinces will find it philosophically more difficult than others to change their longstanding senior care policies.

In-Home Services as Competition to the Assisted Living Facility

In Canada and elsewhere (American Association of Retired Persons 1990), most seniors want to cope with their physical or mental disabilities and chronic medical conditions in the comfort of their familiar apartments and houses. This desire to stay put is by far the most formidable competition to the assisted living facility alternative. Thus, any understanding or prediction of the viability and growth of assisted living facilities in Canada must consider the pros and cons of coping with the vulnerabilities of old age in ordinary dwellings.

The Attractions of Staying Put. – Seeking continuity in their lives – with respect to both their physical surroundings and social ties – most older persons shun the uncertainties and stresses associated with moving elsewhere (Golant 1984,1997). They are especially averse to relocating to a residential setting thought of as an “old age” home, where they fear staff will treat them as anonymous and unimportant tenants, patients, or boarders (Golant 1992,1998b). To the extent that homeowners are more likely than renters to hold such views, the homeownership rate of older Canadians becomes an important predictor of staying put, and in turn a measure of the relative unattractiveness of other shelter alternatives.

Seniors also want their family members – particularly spouses, daughters, and daughters-in-law – to help them deal with their frailty. This sentiment appears especially strong among many ethnic and racial groups with strong extended family networks. If these significant others are not available, seniors (or their family members) want a say about the workers and services that will help them remain independent.

New technologies have made it more possible for seniors to realize these preferences, especially if they have the financial wherewithal. Few disabilities, post-acute care conditions, chronic health problems, and problem behaviors, now exist that cannot be tolerated in the home setting. A wide array of preventive, diagnostic, therapeutic, rehabilitative, and long-term maintenance services – from washing dishes to intravenous therapy and chemotherapy – can be delivered into the home (Freeman 1995). Most technological or biomedical equipment is small or portable enough to be used in a home. Similarly, many adaptations can make a home safer and easier to use for an impaired elderly person.¹⁷

Four possible societal trends in Canada and elsewhere, however, may weaken seniors' ability to remain in their conventional homes. First, future seniors' adult children may be less available as caregivers. Several researchers have predicted that when the baby boomer generation reaches old age (the second decade of the 21st century) its members will have experienced higher divorce rates and will have had fewer children, and thus will lack reliable informal caregivers (Himes 1992). Second, women's employment responsibilities will leave them less time and energy to assist. Third, larger geographic distances will separate seniors and their children. And fourth, future seniors may be more disposed to live in seniors' only developments if they become viewed as attractive home-like settings where the members of the

¹⁷Thus, government initiatives encouraging dwelling design modifications to make it easier and safer to deal with old age (Canada Mortgage and Housing Corporation 1999) are paradoxically a form of competition to the assisted living alternative.

older baby boomer generation can maintain their individuality, independence, and dignity (Golant 1998a).

The Quality of the Informal Home Care Experience. – The desire to stay put may also be tempered by seniors' and their family members' unfavorable views of the home care alternative. Family members provide most of the assistance and care received by frail seniors (Chappell and Blandford 1991; National Advisory Council on Aging 1999). While they often provide thoughtful and competent care, this is not necessarily so. Even family members with the best intentions can be inept caregivers. They lack training and experience delivering health services and personal care, and thus are at considerable risk of making mistakes when they administer medications, diagnose physical and mental ailments, and carry out nursing procedures. They may not be able to sustain the psychological stresses connected with providing care. Seniors themselves who are confined to their homes may find themselves cut off from friends and relatives. These risks undoubtedly increase among caregivers with less formal education – often a correlate of low income. The care may be unwittingly delivered in an unsafe dwelling lacking the most basic adaptations for older persons, including lighting, ventilation, and appliance modifications (Pynoos et al. 1987) and with unaddressed household hazards (e.g., slippery showers, loose throw rugs) that pose accident risks. Even worse, in some situations caregivers abuse their family members – psychologically, physically, or financially.

These problems are exacerbated in most provinces by the limited fiscal resources for home adaptations, counseling or respite care for family caregivers (Liebig 1993; Anderson and Parent 1999). As Schwenger and Gross (1980, p. 256) aptly warned over 20 years ago: The slogan, “*Keep the old folks at home, can be a cruel and onerous message to some elderly persons and their relatives.*” As consumers, health care professionals, social workers, and politicians become more aware of the difficulties of dealing with frailty in conventional dwellings, they are also more likely to view shelter and care alternatives like assisted living more favorably.

The Fiscal Resources Dedicated to Publicly Funded Home Health Care and Supports. – While seniors depend mostly on family caregivers, they are still significant users of professionally delivered in-home services, often through their Provinces' or Territories' publicly subsidized programs. Two service categories are important to identify. The first, “home (health) care,” consists of nursing, therapy, and related services for older persons with acute care needs. Such services are often provided after a hospital stay or during a short-term illness or medical condition. Professionals, such as physicians, therapists, and dieticians, mostly deliver these services. The second category, “home supports,” consists of personal care (that is, help with ADL or activities of daily living deficits), homemaking, and transportation services to meet the long-term needs of older persons with stable or slowly declining physical and mental disabilities or chronic medical conditions. Unregulated, part-time, and relatively low-paid workers mostly deliver these services. Importantly, seniors often need both categories of services at once.

Every Province and Territory provides these home services. Moreover, despite the mid-1990s introduction of government fiscal constraints, total public funding for such care in Canada has more than doubled from 1990-91 to 1997-1998, increasing by an average annual rate of 11 percent. Still, home service expenditures represent at most only 6 percent of any Province's or

Territory's health expenditures (highest in British Columbia, Manitoba, New Brunswick, and Ontario) (Health Canada 1999). It is expected that the more resources provinces shift to their home support and care services for elderly constituencies, the less attractive the assisted living facility option will appear.

Access to Publicly Funded Home Support and Care. – Availability of home services differs among provinces and territories, which fund and operate these services at their own discretion (Health Canada 1999).¹⁸ Overall, however, they offer a similar basic services package and have many of the same eligibility and payment requirements. In particular, they do not charge fees or apply income tests to assess a client's needs or to deliver professional nursing care, both of which home care programs provide (Health Canada 1999). Yet, important Provincial/Territorial differences do exist in service delivery standards, the flexibility of administrative procedures, eligibility requirements, and the types and mix of their services (e.g., relative emphasis on post-acute, long-term, or preventative care). This results in differing availability and quality of home based services throughout Canada's Provinces and Territories and sometimes within different jurisdictions of the same province.

Seven provinces require a co-payment (out-of-pocket expenses or third-party insurance), based on the income of the elder consumer, for nonprofessional services, such as personal care and homemaking assistance. At least two provinces, New Brunswick and Newfoundland, consider the assets of elderly clients when determining out-of-pocket costs. On the other hand, Quebec, Manitoba, Ontario, Yukon, and the Northwest Territories lack an income means-testing assessment process for home support services, while Quebec targets care to low-income persons and Manitoba gives priority to persons with no other care options.

These differences must be placed in proper perspective. In provinces that require co-payment contributions, the typical out-of-pocket cost is still relatively small (Health Canada 1999). Moreover, it is fair to speculate that when most older Canadians consider the relative costs of home service delivery as opposed to living in an assisted living facility, they mistakenly make an apples vs. oranges comparison. Most seniors and their family members will undoubtedly fail to consider (perhaps because of poor marketing by assisted living providers) that the monthly costs of a typical assisted living facility covers meals, housekeeping, safer and more secure living quarters, and more service for their dollar. Consequently, their comparisons probably indicate that receiving publicly funded home support and care is significantly less expensive than occupying an assisted living facility.

Provincial and intraProvincial differences in home-based service programs are more apparent with respect to client eligibility rules, the caps or restrictions on their allowed duration of care, and the availability of trained and reliable home support or care workers (Health Canada 1999). For example, nursing and therapy services are not equally available in all Provinces and Territories. They are also less available in rural and geographically isolated areas and certain urban markets, such as Toronto or Montreal, where demand for home services outpaces supply. Certain provinces also limit the amount of public funding for home support services, such as personal care and homemaking. Above these thresholds, provinces consider subsidized nursing

¹⁸Home care and home supports are not insured in the same way as hospital and physician services under the Canada Health Act.

home care to be the more cost-efficient program. Co-payment requirements also will vary for certain items – such as prescription drugs, medical supplies, or adaptive equipment – although these may be covered by a province’s acute care program or by its nursing home program.

In some provinces, unwieldy regulations make home care programs more difficult to use. For example, British Columbia’s publicly funded home care program (regulated under its Continuing Care Act) requires billing for services in one-hour units. While some home care providers attempt to avoid this with creative billing, it often results in the inefficient use of a home worker’s time. That is, some clients might benefit more from four 15-minute service episodes throughout the day, rather than a single one-hour unit. As another example of administrative inflexibility in this province (and undoubtedly others), medication management is only administered under the home care program (viewed as a professional/nursing service), but not under the province’s home support program. These restrictions mean that Jane Q. Senior gets help with bathing from one worker and help with medication management from another. This artificial bifurcation of “health” and “social” services is inconsistent with the multiple needs of older persons who require both health/professional and social support services to continue living independently (Hollander 1999). As Alfred Kahn, a noted American social worker, early observed (Kahn 1969, p. 152): “*People and their problems simply do not divide up as do agency functions and professional specializations.*” Provinces also variously limit the hours per week an elderly person can receive government-subsidized services, or they do not provide services on evenings or weekends (Health Canada 1999). Thus, even the most generous publicly funded home care program is often inadequate for older persons requiring 24-hour unscheduled or irregular assistance.

The Quality of Professionally Delivered In-Home Care. – The quality of publicly subsidized home-based care is also unpredictable. First, little or no regulatory oversight exists for most services delivered by home support workers, such as personal care and homemaking assistance. Many of these workers are poorly paid and trained. There is also a very high turnover among this worker group. This leads not only to less reliable service delivery but also less consistent personalized care, so important for the satisfaction of elders with long-term assistance needs.

When seniors cannot be confident of their access to needed services, when they face unreasonable limits on subsidized hours of weekly service (both home support and professional services), when they confront bureaucratic roadblocks to obtaining appropriate care, and when they cannot be confident of quality care, they are more likely to consider alternative ways to deal with their frailty. These conditions should make the assisted living facility a more attractive alternative.

A recent Canadian study (Anderson and Parent 1999) highlighted the problems faced by Provinces and Territories that are trying to provide for both home support and home care services with limited fiscal resources. The report finds: “*Home care is under-funded, undervalued, and overstressed*” (p. i). “*There does not appear to be a coherent strategy for developing home care*” (p. iii). “*...people working in the home care environment are over-extended and under considerable stress from difficulties in the workplace such as the working conditions, low wages, recruitment and retention, and training*” (p. iii). In laypersons terms,

“there are just not enough services out there...caregivers don't know what's out there, and the service resources are fractured and overlapping” (p. 47).

One professional also offers a revealing critique of home-delivered services (Appleyard 1994, p. 61):

1. *“Sick and frail seniors often have little knowledge about what services are available to them.*
2. *They have little energy, will or ability to make the necessary arrangements.*
3. *Being sick, they are easily annoyed and, on a whim, will phone and cancel a badly needed service.*
4. *There seems to be little supervision or follow-up to ensure that the correct services are delivered in appropriate quality.*
5. *Some services are provided by for-profit organizations whose primary interest does not seem to be the senior.*
6. *The service provider often just dashes in and out. The senior is left on his or her own to cope with loneliness and depression. In our rush to have people stay in their own homes for as long as possible we should not forget how important socialization is for all of us but especially for lonely and isolated seniors.”*

Further Organizational Stresses and the Appeal of Assisted Living Facilities. –These problems will probably get worse before they get better. Hospital stays have become shorter due to earlier discharges and an increased effort to reduce the “unnecessary” period elders spend in acute care settings. Outpatient surgery is more common and most Provincial governments have reduced their number of acute care hospital beds. The result is that provinces must spend a greater share of their resources on the more complex and technologically demanding assistance for elder clients needing short-term post-acute care. This leaves a much smaller slice of the budget for frail older persons requiring long-term home care and support services. As more public funds are diverted to home-based elders with short-term, acute care needs, the assisted living facility promises to become a more attractive shelter and care alternative because of its more reliable service delivery.

Further pressure on already fiscally strained home support and care programs will result from attempts by most Provinces and Territories to restrict their publicly funded nursing home beds to the most impaired seniors. Thus, older persons who would otherwise have dealt with their frailties in nursing homes will be forced to cope with their impairments in their own homes. Thus, they will become the newest and in many respects the most demanding consumers of publicly funded home-based services (Kane et al. 1998). In turn, they will also represent another pool of potential consumers for the assisted living alternative.

Shelter and Care Regulatory Policies in British Columbia, Ontario, and Alberta

Most noninstitutional shelter and care facilities developed and managed by for-profits that resemble the assisted living model are regulated by their provinces only weakly or not at all. This regulatory void has influenced the current availability and attributes of this alternative. British Columbia, Ontario, and Alberta regulate their noninstitutionalized shelter and care facilities differently, but the following generalizations appear valid.

First, only licensed nursing homes, whether private pay or publicly subsidized facilities, currently have stringent regulations concerning standards of care. In contrast, “assisted living” and like facilities are regulated in a back-door fashion. They are simply lumped together in a largely amorphous noninstitutional shelter and care category declared ineligible to service older persons whose frailty is beyond some specified level (for example, elders who require 24-hour skilled nursing care). Thus, the “regulation” of noninstitutional facilities is driven by the nursing home regulatory environment. In effect, the standards governing the look and operation of assisted living facilities become reduced to a footnote. Any downsides of this indirect regulatory approach are likely to become more apparent in the near future if provinces throughout Canada begin to admit only the frailest seniors into their publicly subsidized facilities. This will increase the likelihood that older persons with more serious physical and cognitive impairments – who would otherwise be in nursing homes – will find themselves in noninstitutional facilities operating in a regulatory void.

Thus, most noninstitutional for-profit shelter and care facilities are regulated no differently than conventional public buildings, under their usual landlord and tenant and public health acts (the precise labeling of this regulatory umbrella will vary by province and municipality). This means oversight is generally limited to food handling (if a commercial kitchen is present), sanitation, physical health and safety, and general cleanliness concerns. In Alberta, private sector funded (for profit or nonprofit) and publicly subsidized “assisted living” facilities are regulated differently. When facilities are publicly subsidized (most often operated by nonprofits) and providing what is labeled as “assisted care” (replicating the Oregon model), they are regulated by the province’s Regional Health Care Authority as a licensed care facility, under the province’s Nursing Home Act (Good Samaritan Society 1998). The province grants staffing level variances, however, because residents in these facilities have a somewhat lower level of impairment than the province’s nursing home residents. For-profit assisted living facilities in Alberta are weakly regulated (under the “Social Care Facility Act”) so long as they do not accommodate seniors requiring skilled nursing care.

The lack of regulatory oversight is especially stunning in Ontario. Whereas Alberta and British Columbia impose backdoor restrictions on the highest level of care allowed in their noninstitutional shelter and care facilities, Ontario’s laissez-faire policies allow a whole category of rest or retirement homes to be entirely unregulated (Deber and Williams 1995). As one developer expressed:

“If our clients are willing to pay the cost, they can live in our facilities for the rest of their lives. You have a very loosey-goosey regulatory structure with respect to for-profit retirement homes in Ontario (only fire marshal, and kitchen inspection). The government in 1985 and 1986 made it a policy of not wanting to even recognize the industry for fear that they might have to put some money into it. So, they really took the ostrich approach with respect to how they oversee the industry.”

Second, in all three provinces, an authorized professional or professional organization can deliver skilled nursing care to residents of a noninstitutionalized shelter and care facility, so

long as the care provider is considered “separate”¹⁹ from the facility owner. The scope of the regulatory environment thus depends on whether the staff person providing the care is employed by the shelter and care facility as opposed to being self-employed or employed by an “outside” home support/care company. When in-home services, such as nursing care, are provided by an acceptable “outside” agency (the “split” model of care referred to earlier in this report), then a shelter and care facility is not considered to be providing the same level of care as that found in a nursing home and thus is not regulated as such. If, on the other hand, the same nursing care were to be provided by an employed (dedicated) staff person of the noninstitutional shelter and care facility, it would be considered a regulatory violation.

In this respect, the provinces again treat these shelter and care facilities no differently than they do private conventional residences. In the private residence, no regulatory/quality oversight exists over the care delivered, especially if privately paid workers deliver it. It is a truism that high-income frail elders living in their own homes receive sophisticated nursing services all the time with little formal assessment of whether performance outcomes are satisfactory. It is similarly ambiguous the extent to which the provinces evaluate the quality of care and outcomes of the services provided by their subsidized home support and care agencies.²⁰ What is disturbingly clear, however, is that provinces differ as to the educational preparation levels and professional qualifications they require of home-service agency personnel who deliver homemaking, personal care, and nursing services to seniors in their homes (Health Canada 1999).

Third, in all three provinces, impaired seniors living in an unregulated noninstitutional facility can benefit from nursing services, as long as these are provided by staff persons employed by an adjoining or attached facility licensed as a care/nursing home facility.²¹ This situation typically occurs in a congregate living facility that is physically adjoining a licensed care facility. Provinces differ, however, as to whether staff persons are allowed to deliver these nursing services on the premises of the licensed care facility or whether they can provide them at the unregulated congregate living facility site. In Alberta, such staff mobility is allowed; in British Columbia, it is not. This is yet another example of how regulations applied to nursing homes drive, in a backdoor fashion, the level of care that can be provided by noninstitutional assisted living facilities.

Most developers, management companies, and even government administrators are content to leave this weak or absent regulatory environment alone. They are not enthusiastic about adding a regulatory layer to oversee assisted living facilities. One developer expresses a common sentiment: *“I would be in mortal fear of another layer coming in. While initially their rules may be simple, it doesn’t take them long to make the rules complicated.”* In short, the fear is that a new layer of regulation will lead to excessive micromanagement that will suffocate the ideal features of a “residential” assisted living model. While these are justifiable fears, the failure

¹⁹In practice, the notion of “separate” appears to be defined very loosely and inconsistently.

²⁰A recent national study of Provincial and Territorial home care programs was silent on this issue (Health Canada 1999).

²¹Presumably, if two facilities (one unregulated and one regulated) were owned by the same company and were across the street from each other, the same rule would apply.

to offer a regulated noninstitutional shelter and care product can lead to the following four unfavorable consequences:

- a) Disincentives for the development of assisted living facilities
- b) Poorly distinguished shelter and care products and a confused Canadian consumer
- c) Noninstitutional shelter and care alternatives that now fall short of providing a desirable assisted living model of care
- d) The perception and reality that current shelter and care facilities provide poor-quality care

Disincentives for the development of assisted living facilities. – Like many generalizations, this one does not always apply. The lack of a comprehensive and systematic regulatory structure has yielded two very different outcomes in Canada. In Ontario and to a lesser extent in Alberta, some of the higher end for-profit noninstitutional shelter and care facilities look and function like U.S. assisted living facilities. The inevitable conclusion is that they have emerged because these provinces impose few minimum physical plant or level of care standards. A Toronto newspaper reporter aptly characterized Ontario's "retirement homes" (Priest 1999):

"Retirement homes are often for those who have fallen between the health care cracks – seniors who need more supervision than home care can provide, aren't sick enough for hospital or frail enough for a nursing home."

On the other hand, in British Columbia, the absence of clear-cut regulations has created disincentives for developers to build shelter and care facilities for persons who require more than congregate living but less than the full-time 24-hour skilled nursing care found in the institutional setting. Currently, nursing homes in the province do not routinely admit seniors who only have "Personal Care" and "Intermediate Care 1" limitations. Thus, noninstitutional shelter and care developers must target a relatively narrow elderly market consisting of persons who are independently mobile and require minimal to moderate assistance with their daily living activities. When they build for such a small market niche, they risk financially slow fill-up and low occupancy rates. Potential elderly consumers, for their part, must de-emphasize the possible scenario whereby, soon after entering such a noninstitutional facility, they will exceed its frailty guidelines and have to face all the stresses of relocating again to a nursing home. An experienced administrator of a geriatric care center recently pointed to this continuum of care gap (Clarke-Scott 1999, p. 47):

"Aging in place is often a myth. With the resulting frailty of chronic conditions which are often degenerative in nature, an individual's ability to function independently in their environment is greatly reduced. There comes a point where independent living is no longer an option. This is often the result of assisted living and adaptive devices not being always available. Likewise, building codes and design guidelines have not been universally established. There is no personal or assisted living care presently available to most individuals who would otherwise qualify. Seniors often end up moving to a long-term care facility prematurely."

The circumstances recently experienced by a large and prominent assisted living facility developer in the U.S. (Sunrise Assisted Living) seeking to build in Victoria, British Columbia are informative. Confronted with no appropriate noninstitutional regulatory category for its project, it will develop and license its prototype assisted living facility as a nursing home/long-term care facility (specifically, as an “Intermediate Care 2” facility).²² While the developer obtained some variances from the province to prevent its facility from looking and operating like a nursing home, it nonetheless had to incur unexpected development costs. To finance this project, it also had to put up a higher than usual equity share because Canada’s lending institutions did not respond enthusiastically. This facility may end up being a success story, but how many developers will be willing or able to jump through such regulatory hoops? How many have been or will be dissuaded from entering British Columbia’s market because of these regulatory challenges? In short, the assisted living facility – at least conforming to the ideal prototype – becomes a higher-risk product even as developers and financial institutions are risk-averse. In sharp contrast, developers of publicly subsidized nursing homes operate in a very different provincial climate. While nursing homes are heavily regulated, the combination of a nursing home bed shortage plus generous subsidization agreements makes them a very attractive product from a developer’s perspective. The rate of financial return on a nursing home might be lower than other shelter and care alternatives, but developers are assured of almost 100 percent occupancy and a guaranteed monthly government cash flow.

Poorly distinguished noninstitutional shelter and care products and a confused Canadian consumer. – When Provincial and Territorial governments heavily regulate so many other health and social programs, elderly consumers, family members, and health professionals can reasonably inquire as to why these governments have not designated a separate regulatory category for the assisted living option. Does an absent regulatory layer imply that these governments do not take seriously, officially sanction, or, even worse, think poorly of a particular product or activity? Does this suggest an indifference that dooms the product? And does this inaction result in a more confused and skeptical consumer?

The “residential” identity of this noninstitutional alternative is also muddled by its being under the bureaucratic umbrella of a “healthcare” authority or district (or equivalent title) rather than a department of housing. The administrative responsibilities of housing departments in Canada’s Provinces and Territories are usually limited to social housing (rent-subsidized, affordable housing for low-income tenants) and other independent housing facilities that offer minimal support services. Given that health departments are staffed primarily by health, medical, or rehabilitative care professionals, consumers and professionals alike can reasonably question whether an assisted living facility option, if regulated, would be treated more like a “medical” (nursing home) than a “residential” (hotel) model of care.

The development of the U.S. assisted living facility prototype, as a “nursing home” by Sunrise Assisted Living is a case in point. A noninstitutional housing product regulated as a nursing home can only lead to a confused elderly consumer. In the short-run, this facility may be an economic success; in the long-run, it may be a public relations fiasco. Here we have a well-known U.S. “brand name” assisted living facility labeled as a nursing home. It is hard to imagine

²²Nonprofits are also similarly affected. In Alberta the Good Samaritan Society’s assisted living model, while similar to the Oregon model, is regulated under the province’s nursing home regulations.

a more ill conceived marketing approach. We have an industry seeking to distinguish its product line from that of the nursing home, whereupon it jumps into bed with the enemy. How can this possibly lead to anything but a bewildered older consumer?

Noninstitutional shelter and care alternatives that now fall short of providing a desirable assisted living model of care. – Two noninstitutional shelter and care approaches to accommodate frail seniors have emerged in the provinces of British Columbia, Alberta, and Ontario in apparent response to an absent or weak regulatory environment. We have referred to these earlier as the “split model of care” and the “multi-level” shelter and care setting. The following sections review some of their economic, administrative, and quality of care strengths and weaknesses.

The **split model of care** approach has allowed developers to circumvent otherwise restrictive long-term care regulations and has also allowed them to develop a product line more consistent with their real estate backgrounds. It has several positive features:

- Elderly residents only need purchase necessary care or services. This may be especially advantageous for a married couple, when one member is frail and the other is not (Manard and Cameron 1997).
- Housing operators can avoid the regulatory, financial, administrative, and legal obligations of delivering care.
- Housing operators can avoid the costs and administrative demands of having a physical plant (e.g., clinic space in building) necessary to provide on-site dedicated services to frail residents.
- Housing operators can avoid zoning problems, because the facility is considered ordinary multifamily housing.
- Provincial governments only have to oversee the service provider rather than the housing provider.

This shelter and care model, however, has a number of downsides, a direct result of the developer having to outsource the facility’s service/care component.

- It is unclear what organizational entity is ultimately responsible for evaluating, assisting, or monitoring the elderly resident and insuring high-quality outcomes. The fundamental question becomes: “Who’s in charge?” If a resident is found to receive deficient care, who should take the blame: the publicly funded home care agency, the private home care agency, the housing provider, or the private care worker? In practice, it may well be clear who is to blame, but at the very least various ethical issues regarding responsibility arise from the split model of care.
- The home-based services can conceivably suffer from all the limitations outlined earlier in this report (Health Canada 1999). As examples, care may be primarily provided only during daytime hours; unscheduled needs for assistance and care may be poorly met; and residents may have to deal with all the inconveniences and discontinuities of high staff turnover. Residents may also have certain types of problems, such as homemaking deficiencies or financial troubles that the home

service agency considers as outside its job description. More significantly, the home service agency is likely to provide assistance reactively rather than proactively. That is, it will respond to specific requests by seniors, but will unlikely initiate service visits if it is not formally called on. In contrast, in the well-administered assisted living facility, the frail elder residents can benefit from facility-hired staff offering not only unscheduled and spontaneous assistance, but also services to prevent future and more serious need episodes.

- No guarantees exist that facilities operating under the split model of care will implement appropriate physical design and architectural standards to help seniors optimally age in place. Yet, we know so much about how good physical design can help seniors compensate for their vulnerabilities (Canada Mortgage and Housing Corporation 1999; Gutman 1992; Gutman and Wister 1994). To their credit, many currently unregulated shelter and care operators implement at least some critical design modifications. Without agreed-upon standards, however, these design decisions are clearly left up to chance. Moreover, even some conscientious developers are unaware of innovative architectural adaptations that could be easily mandated through regulation.
- It is unclear to what extent the home support or home care agency assumes responsibility for resident problems arising from poor morale or social isolation. In contrast, if the assisted living facility has dedicated trained staff, it can easily address residents' social, exercise, and recreation needs, and monitor their psychological well-being.
- The split model of care has associated with it a number of economic and administrative inefficiencies. An example is offered by a British Columbia operator of a noninstitutional facility occupied by residents who have several ways to receive home-based services:

“In reality out of 100 suites, there may be 50 suites getting some sort of personal care, and the government contracts this out to a private home support agency. So they have their staff in the building serving their own clients (as part of Continuing Care publicly subsidized home support/Provincial program). We then are serving our clients with our own staff, which sometimes also includes some of their clients. We also help residents arrange to have some private agencies (nongovernmental – private pay connected) serving some residents. And at least one resident will hire a 24 hour attendant to assist her needs. We have no problem with that arrangement. We sell our services in blocks of time, and we are competitive. We offer residents the choice of how they get their home care (either with building staff, subsidized, or private pay home care). We make our money when our basic suites are filled. You can spread the cost of our staff person over the cost of the rental fee. But the result is a circus environment – you can have three different organizations providing care at the same time, and on a given day – even providing care to the same person). ...Paradoxically, home care staff from an outside agency who are less trained and qualified than our staff can administer medication and services and it is somehow O.K. This is silly. It also leads to potentially erratic and inefficiently delivered care. It is ludicrous; the government has to pay for home support travel time, and have a bureaucracy to organize it, where I the building manager can have a (dedicated) staff person at the door in

minutes. I can give you the same service at half the cost; you are wasting money – you (the government) should hire me to do this, provide the service – but they look at me as if I am from a different planet.”

In Alberta, some of these problems may be buffered by Regional Health Boards, which are more willing to work with the private sector. As one developer summarizes:

“Regional Health Boards will send home support/care personnel to provide the care up to a certain limit. When we have 300 hours of care on a continuous basis, they will turnaround and contract our staff to provide the care on a capitation basis. They are more readily willing to work with the private sector to provide the assistance in the most efficient way possible. In contrast, in BC, they try to have all their own staff inserted.”

A second shelter and care approach that accommodates frail seniors in Canada is the **“multi-level care facility.”** It typically contains only two levels of care, a (noninstitutional) congregate living facility and a nursing home,²³ but usually lacks the level of care offered by an assisted living facility. In this respect, it differs from most U.S. continuing care retirement communities (CCRCs) (Exhibit 3).

It offers an important benefit. Residents in the congregate living facility who become too frail can readily relocate to the nursing home in the same building, thus minimizing the stress of moving. As the nursing home is often publicly subsidized,²⁴ this is obviously a financially attractive option. Residents in the congregate care facility can also possibly delay such a move if the nursing home operator can allocate some of its staff’s time to offer them personal care and nursing services. These services are usually only offered on an as-needed basis or in emergencies, but at least consumers know assistance is available for short-term, intermittent needs.

This assistance can be more readily provided in some provinces than in others. For example, in British Columbia’s nursing homes, unlike those in Ontario and Alberta, the staff can deliver services only if the resident of the independent or congregate living facility is on the premises of the nursing home. For example, medication management can take place adjacent to the nursing station, but not in congregate living residents’ own dwellings.

The multi-level care facility, however, has an important downside. It lacks a level of care that functions as a bridge between independent living and nursing home care. For residents this often means that even a small increase in vulnerability requires them to move to the nursing home. Some facility operators like it this way and feel strongly that the “independent” parts of their building should be occupied by seniors who both look and act independently. As one operator related:

²³In some provinces, like British Columbia, the multi-level care facility refers also to a nursing home serving different levels of impairment, but all levels of care are licensed and regulated by the province.

²⁴In Ontario and Alberta, regulated nursing homes can only be operated if their beds are publicly subsidized. In British Columbia, regulated beds can either be private pay or publicly subsidized.

“We keep an eye on people. It is really obvious when residents need more care, especially when they start buying services from the care facility. It is way more practical for residents to move into the care facility; after all you can only do so much with bits and pieces of care. You can only provide a limited amount of assistance, whereupon it becomes impractical. It just evolves – more and more things fall through the cracks and we are calling their family members more and more frequently about issues. In any case, once they’re in a wheelchair we don’t allow them in the main dining room.”

Eventually – and not unreasonably – these vulnerable seniors (and their family members) tire of the hassles of trying to rely on portable services from nursing home staff and they have to move from the congregate living facility. As emphasized above, in British Columbia, this process is further hastened because seniors and family members must tolerate an additional irritation: seniors cannot receive these services in their apartments, but must physically travel to the nursing home. At the very least, the senior must experience emotional stress as a result of having to visit the nursing facility to benefit from services as basic as medication management or simple catheter insertion.²⁵ At worst, this additional effort is likely to speed up the transfer of borderline frail residents from the congregate living facility to the nursing home.

The multi-level facility has an additional downside, one rarely documented. It happens when bad outcomes arise from good intentions. It can occur when staff persons from one part of a facility provide services in a hit and miss fashion to residents in another part of the facility. Because the service outcomes are often not carefully monitored or followed-up, poor care outcomes are more likely.

The perception and the reality that current noninstitutional shelter and care facilities provide poor quality care. – Poor quality care may be linked to the split model and multi-level care approaches. It may also result from poor management practices, a result of unregulated facilities being left to their own devices. Even if such examples are infrequent, the perception that unregulated facilities offer frail elderly consumers an unsafe or poor-quality shelter and care experience hurts the industry. Predictably, it will lead to consumer and professional groups clamoring for governments to intervene and oversee the operation of these facilities. The danger, of course, is that new shelter and care regulations will threaten the viability of the assisted living facility “social” model.

The most recent (late 1999) report of care deficiencies in Ontario’s mostly for-profit retirement or rest homes is a case in point. Among the complaints: poor food, overcrowding, theft, lack of fire evacuation procedures, mistreatment, abuse, bad sanitation, inadequate medication care, and staff shortages (Priest 1999; Shephard and Brennan 2000). The Ontario situation represents a classic case study of what happens when poor care is suspected in the absence of regulation. Among the predictable events:

- Newspapers focus on the worst case episodes of care.
- There is a cry for radical regulatory responses to eliminate the problem.

²⁵ Apparently in some B.C. facilities, regulators “look away” and personal attendants and nurses actually deliver services on the site of the congregate living facility.

- Intergovernmental conflicts erupt over which bureaucratic unit is responsible for regulating such facilities.²⁶

Thus, absent regulation and its associated lapse in quality controls can produce the following four undesirable consequences:

- Real episodes of abuse and poor-quality care occur that physically or psychologically harm frail seniors.
- A whole category of shelter and care facilities, in this case “all” retirement homes, are unfairly indicted, even without evidence as to how many of Ontario’s 623 retirement home operators provide inadequate shelter and care.
- Facilities are arbitrarily assumed to belong to the category of care in question. This is true even if it is well-established (as in Ontario) that retirement homes encompass a wide array of care types, from low-end to high-end, from mom-and-pop-operated to professionally managed facilities. As one respected management firm complained: *“It’s unfortunate that we’re all painted with the same brush.”*
- In this crisis environment, an unsympathetic or hostile government, under pressure from constituents, may introduce a new set of regulations. These rules may be unfair or overly-stringent, may lead to undesirable micromanagement, and may fail to recognize that diverse facilities and residents with diverse needs are all being placed under the same regulatory umbrella.

Potential Cost Savings for Provinces and Territories that Adopt the Assisted Living Model

A factor that may most spur the growth of assisted living facilities will be the pressing need for fiscal constraint on the part of the Federal and Provincial governments. It is a familiar challenge (Havens 1995, p. 259):

“Every jurisdiction across Canada is grappling with finding new ways to reallocate funds within long-term care programs to reduce costs while increasing both the numbers of persons served and the units of service delivered per person without sacrificing the quality of care.”

The adoption of the assisted living model within a Province’s or Territory’s continuum of care can produce fiscal savings in several ways:

- When higher-income elderly consumers are attracted to better-quality private pay assisted living facilities, a smaller share of this group occupies publicly subsidized nursing homes. Thus, the nursing home government subsidy outlay grows more slowly.

²⁶In Ontario, debate centered on whether the province of Ontario or the City of Toronto was responsible (Shephard and Brennan 2000).

- Governments subsidize the care offered in for-profit assisted living facilities. They incur savings by diverting elder consumers from the more highly subsidized nursing homes.
- The cost of providing care to older people in their geographically dispersed residences is often greater than providing the same care to residents concentrated in an assisted living facility. Service-delivery economies of scale are more likely to be realized in assisted living facilities staffed with full-time service providers. To the extent that elders are better served in assisted living facilities than their own homes, they will also delay relocation to the more expensive government-subsidized nursing homes.
- Governments reduce their nursing home development/construction expenditures when they build less costly assisted living facilities.
- A more business-friendly government encourages more builders and providers to enter the market. Increased competition drives down assisted living facilities' prices, and in turn the per diem subsidization rates of governments.

Of course, these outcomes cannot be guaranteed. Increasing the availability of any type of long-term care produces an "out of the woodwork effect." That is, some older persons who would otherwise have delayed receiving any formal care will seek the subsidized care offered by the assisted living facility. There is also the danger that if government subsidies are set too high or are too readily available to the for-profit market, the price of occupying and receiving care in assisted living facilities will become prematurely inflated. Another fear expressed sometimes by government leaders is that facilities developed and operated by the for-profit sector will offer less care per dollar than facilities operated by the public or nonprofit sectors.

These are all possible but not inevitable outcomes. These downsides can be avoided or at least minimized with innovative and thoughtful public policies. Moreover, Canada stands to reap more fiscal savings than the U.S. by this less costly noninstitutional shelter and care approach. It can be safely assumed that a higher percentage of higher-income frail seniors in Canada than in the U.S. receive long-term care subsidies. Thus, other things being equal, Canada should have a potentially larger share of frail and wealthier elder consumers who do not have to be as highly subsidized, either because they can occupy less costly publicly subsidized or private-pay assisted living facilities.

Attitudes of Provincial and Territorial Governments Toward the Private and Nonprofit Sectors

To explain why they sometimes have difficulty producing noninstitutional shelter and care facilities for frail seniors, for-profit housing developers often point to the public sector's unreceptive and even hostile reactions that taint most of their transactions. One unintended and positive consequence of this antagonism between these two sectors, however, might be a greater role for nonprofit groups' shelter and care development initiatives.

The Basis for Conflict and Mistrust. – The private sector's profit and self-serving motives are frequently identified as sources of concern to Canadians and their social institutions. These

are often considered at odds with Canadians' basic values and expectations. As a consequence, for-profit enterprises often speak of how the government mistrusts their actions and is unsupportive of their planned projects. These sentiments, however, are more apparent in some provinces than others. Ontario's and Alberta's governments, for example, are considered more pro-business than the government in British Columbia, for example, which is viewed as an obstacle to private sector initiatives. Thus, it is probably not coincidental that Ontario's shelter and care facilities are the least regulated in Canada or that for-profit developers view Alberta's government as more sympathetic to their integrating supportive services with senior housing products.²⁷

The public's and government's mistrust of for-profit housing developers appears to be influenced by the same forces that account for their negative attitudes toward the private health care sector, namely, their deep-seated fears that economic concerns will primarily drive the allocation of medical care. As Rathwell (2000, p. 2) summarizes:

"In essence, there is a different ethos which underpins the public and private health sectors. The public sector ethos, generally, is one of inclusiveness or universal entitlement. The private sector ethos, generally, is one of exclusiveness or selectivity through individual choice."

This profit-motive, however, does not just threaten the denial of care to certain population groups but also threatens the quality of the care received. Thus, a second major reservation about the private sector's role is a fear that it will produce fewer and lower-quality services. As Wavrock (2000, p. 2) summarizes:

"The main weakness of the private sector in the provision of services to seniors has to do with the quality of services (assistance with feeding, qualified staff) and secondary needs such as leisure and pastoral service in nursing homes. In other words, in order to be profitable, privatization has a tendency to eliminate so-called essential services and could, as a result, deviate from the humanistic concept. The public sector has a more humanistic preoccupation with its clientele. Through its regulations, it attempts to ensure safety, eliminate abuse and ensure access to services."

It is simple enough to replace "services" with "shelter" and "care" in the above arguments. Thus, some Provincial and Territorial leaders resent that for-profit developers provide noninstitutional shelter and care products affordable only to a minority group of wealthier seniors. Like those concerned about the privatization of health care, they fear a two-tiered system, with one category of "nicer" shelter and care facilities for the rich and another "less nice" category for the poor (Rathwell 2000, p. 2). Similarly, some government leaders argue that profit-minded private developers and managements seeking excessive financial returns from their facilities will provide fewer services and amenities for the consumer's dollar than would the public or nonprofit sectors. They generally fear that they will have less control over the quality of shelter and care offered in a for-profit facility. This helps accounts for their reluctance to subsidize the delivery of personal assistance and care in for-profit-developed assisted living facilities. Rather, they feel more comfortable turning to nonprofit organizations,

²⁷Alberta, of course, has dominated the headlines in the past year because of its Premier's efforts to contract out certain medical and surgical services to the private sector.

considered to be more responsive to consumer needs and complaints. These organizations are also expected to better understand elderly constituencies' particular needs, reflecting their religious, ethnic, and fraternal group lifestyles.

Private developers of noninstitutional shelter and care facilities retort that private ownership of shelter and care is hardly unprecedented. They point to the more than one-third of Canada's nursing homes owned by the proprietary sector (Liebig 1993; Pitters 1995). A mix of for-profit and nonprofit agencies also administers home care, and the proportion of for-profit agencies is rising substantially (Anderson and Parent 1999). Most developers and managers further argue they can construct shelter and care facilities less expensively and operate them more efficiently, cheaply, and effectively than the public or nonprofit sectors. They also argue they can offer more features and resources demanded by consumers or their family members (e.g., innovative design features) and that their prices will still be relatively low because of competitive forces. They cynically point to the presence of poor quality and unattractive publicly owned and subsidized nursing homes throughout Canada even with the imposition of strong government regulations. British Columbia developers particularly argue that if they had the flexibility to staff their own facilities with persons providing personal care and nursing services, they could deliver assisted care far more cheaply than do either the current publicly subsidized home-based service programs or the province's nursing homes.

For profit developers are especially frustrated with the public sector's unwillingness to consider new ideas. The feelings expressed by British Columbia developers are probably representative. They generally are pessimistic about changing the "antibusiness" climate in the province. They complain about the province's resistance to take risks, its emphasis on the status quo, and its negative attitudes toward innovation. They argue that the province is afraid to experiment with new noninstitutional shelter and care housing products or to encourage new private-public partnerships. They complain that government bureaucrats have little incentive to have vision. Thus, while government regulators are keen to introduce new regulations to "prevent" something, they have no proactive ideas for innovative and beneficial end products. These sentiments are echoed by Hugh Segal, President of the Institute for Research on Public Policy (Segal 2000, p. A23):

"The key challenge is the lack of political will to effect change. This lack of political will is not due to political leaders lacking courage or determination or the compelling desire to do good. It is not due to politicians or governments seeking to avoid doing what is right. It is because our operative political culture has produced a fear of change and a risk-averse mindset that constrains not only good people from doing good things, but also honest people from asking tough questions."

For-profit developers in British Columbia respond that the only way attitudes towards them will improve is if there is a "change in government." They argue such change would open up opportunities to initiate mutually advantageous partnerships, alliances, and collaborative efforts with the public sector. They speak about various possible for-profit-public strategies allowing them to finance, develop, and manage noninstitutional shelter and care facilities more effectively.

What Role the Nonprofit Sector? – Both British Columbia and Alberta governments favorably view the possible role of nonprofit providers as sponsors of noninstitutional facilities for frail seniors. Nonetheless, this sector has so far not developed or managed many such shelter and care products. While nonprofit societies (especially churches, service clubs, fraternal, and ethnic groups) have traditionally owned and managed Canadian “social housing” accommodating lower-income senior populations (in British Columbia, over 85 percent of the social housing stock is nonprofit operated), these facilities have traditionally lacked the most basic supportive services. A commonly expressed fear is that such services would turn these developments into “old age homes.” Few Federally insured loans are now awarded to social housing projects targeted to low-income seniors, and only a small Federal program now exists to encourage collaborations between for-profits and nonprofits in the start-up of such affordable facilities. Moreover, most for-profit developers interviewed for this report have little desire to work with nonprofit organizations because they think these groups know little about real estate and housing development, and are not politically savvy. There are exceptions: some developers and management firms bemoan lost opportunities to work with nonprofits, especially on projects located on tax-exempt land.

There are nonetheless some examples of nonprofit groups successfully sponsoring affordable assisted living facilities. In Burnaby, British Columbia, for example, the nonprofit owned Seton Villa successfully combines 10 apartment building floors of assisted living with 7 floors of independent suites by relying primarily on a split model of care. In Alberta, four assisted living “pilot project” facilities (each about 30 units) were built under the sponsorship of the Good Samaritan Society. Their physical design and operations were modeled after for-profit assisted living facilities in Oregon. They diverge from U.S. examples in three significant ways: first, they are licensed under the province’s Nursing Homes Act (that is, as licensed care facilities); second, the care provided is subsidized by the province’s Regional Health Authority Act, and the maximum cost charged (that is, including shelter costs), is affordable by the lowest-income seniors in this province; and third, to be eligible for occupancy, a senior must be evaluated by the Province’s Health Authority (Good Samaritan Society 1998). In Manitoba, two shelter demonstration projects operated by nonprofits accommodate 32 frail persons (either under or over age 65). Manitoba Health initiated this project as part of its Supportive Housing²⁸ program. As in Alberta, Manitoba Health is responsible for policy development and operations and subsidizes the care. Unlike the effort in Alberta, however, several features in these facilities are more characteristic of those found in nursing homes (e.g., less available bathing facilities and restrictions on acceptable resident behaviors) (Strain and Grabusic 1999).

Overall, however, the nonprofit sector is currently not a major player in the generation of assisted living facilities, although this may soon change. In British Columbia, there are ongoing discussions focused on the possibility of the nonprofit sector developing an assisted living model like that found in Alberta.

²⁸ Readers are reminded that “supportive housing” in Manitoba is equivalent to the label of “assisted living” used in the U.S. and other provinces.

Availability of Financing

However strong the demand for a shelter and care facility, the competence of its management, and the attractiveness of its operations, the developer's ability to build a facility and price it competitively will depend on whether it can obtain attractive financing terms. Currently, only a few banks, life insurance companies, trust companies and pension funds in Canada offer debt financing for the noninstitutional shelter and care product. These lenders, however, are usually only interested in financing a new facility if its developer or sponsor has secured loan insurance from the Canada Mortgage and Housing Corporation (CMHC).²⁹ Various reasons account for this risk-averse mode of lending. Memories are still fresh of failed senior housing and nursing home projects in the late 1980s and early 1990s that could not achieve profitable fill-up rates; financial institutions are still uncertain about the risks associated with this housing product; advocacy by professional or consumer groups on behalf of this product are largely nonexistent; and finally, many financial institutions while comfortable about giving loans to developers of conventional residential real estate projects are suspicious about the profitability and viability of housing projects with on-site personal services and care.

Because most private developers must obtain CMHC insurance on their debt financing, this government agency has assumed a giant role as a gatekeeper of this industry. Its underwriting standards for making insured mortgage commitments are very high. Typically, the loan to value may not exceed 85% of the lending or economic value of a facility. This "value" is determined by CMHC, itself, and its appraisals are notoriously conservative. At the minimum, borrowers or the hired professional management firm must have at least 5 years of experience operating a comparable project.³⁰ The agency's requirement of relatively high debt service coverage ratios (1.30 to 1.40) also means that developers must achieve relatively high occupancy rates before a construction or interim loan is converted to a permanent or final take-out loan (Canada Mortgage and Housing Corporation 1999).^{31,32} The agency also charges a significant fee based on the amount of the insured loan (as high as 4.5%).

Thus, CMHC's role turns out to be much more than a government agency simply screening loan applications. It is not just deciding which assisted living products pass financial muster. Rather, in an unintended way, this conservative government agency has become the unofficial – and the only – regulator of the industry. By virtue of its stringent requirements, CMHC reduces the probability of poorly conceived projects, incompetent management firms, and inexperienced developers from producing the "bad apples" that might otherwise taint this industry. CMHC has become its policeman or guardian angel, depending on one's point of view. It has become a major influence of the growth and availability of noninstitutional shelter and care facilities in Canada.

²⁹Lower noninsured mortgages may be available through banks and trust companies, but with more conservative 75% loan to value financing. These are more difficult to obtain and available only to developers with strong past track records.

³⁰The minimum 15% equity contribution also helps restrict the playing field to relatively experienced developers with sound past records.

³¹For shelter-care projects that offer condominium ownership, lenders require a high percentage of presales to reduce their risk.

³²Failing this, a developer might secure construction funding from a lender (e.g., pension fund, private investors) demanding a minimum of a 25% equity position who will give a commitment of long-term debt financing.

The immediate future does not hold promise for any easing of this difficult financial environment. Predictions are that CMHC plans to tighten further its underwriting policies, by allowing only shorter mortgage terms, increasing its mortgage fees and charging specific premiums on shelter and care products identified as assisted living facilities. Financial institutions are also expected to become even more selective as future noninstitutional shelter and care products increasingly include accommodations for elders with Alzheimer's Disease. Given the reticence of Canada's financial institutions to provide capital to this emerging industry and CMHC's stringent insured mortgage underwriting standards, only the larger and more experienced private developers are likely to succeed. A more consolidated Canadian senior housing industry is likely.

A more difficult financing environment for the development of noninstitutional shelter and care accommodations is likely to have four distinctive downsides. First, the higher costs of capital will inflate the monthly outlays of operators and require them to charge higher rents. This can only narrow further the consumer market for these housing alternatives.

Second, if providers attempt to keep their rents down, even as they confront higher development costs, they may attempt to cut expenses by omitting desirable architectural features or by reducing staff and service resources. This will not only shortchange their senior occupants but will also be counterproductive to their gaining widespread public acceptance of the assisted living facility as an attractive and reliable long-term care alternative.

Third, overly expensive assisted living facility products will discourage the participation of the public sector as a fiscal partner. This will make it more difficult for private-sector interests and government planners to achieve a meeting of the minds as to how they might make for-profit accommodations affordable to lower-income frail Canadians. Provinces and Territories will be under pressure to demonstrate that their subsidy allocations are cost-effective, a more difficult task as the occupancy costs of these facilities increase.

Fourth, if capital becomes less available and more costly in Canada, larger and more experienced American assisted living corporations with access to less expensive financing sources may find it more attractive to enter the Canadian market. Whether more American players building and managing facilities in Canada is actually viewed as a downside will depend, of course, on the nationalistic leanings of this country's population.

A Lack of Professional Organizations Representing Shelter and Care Industry

This report earlier identified six different professional organizations in the U.S. that were actively representing memberships engaged in design, development, management, financial, legal, or service activities connected with assisted living facilities. A very different situation exists in Canada. Developers, architects, and management firms interviewed for this study confirm that the for-profit senior shelter and care industry lacks even one national professional organization that adequately represents their interests. There is however a growing acknowledgement that such an organization could play a number of needed roles. Among the most important: self-accreditation and self-policing; public relations and image building; lobbying and advocacy; research and data gathering about industry products; expanded financing opportunities; member training; and member network-building. One major developer articulated

the key role such an organization might play to fend off a province's overzealous regulatory efforts:

"My fear is that anyone can throw up a building and call it assisted living and cause some horror shows. On the other hand, I don't want the government coming in and putting up still another set of constraining regulations. I think what ultimately needs to happen, since we don't have any umbrella organization, is for the industry to self-police itself, to establish its own guidelines for minimum environments. That is where we are most vulnerable in Canada, and we are all going to suffer."

Perhaps not unexpectedly, not all participants see the need for such an organization. Most facility development activity in the past has been province-based³³ and the key players have been content to communicate informally over lunch. Some participants are also apathetic, perhaps because they believe their current governments are anxious to preserve the status quo. They despair, *"Why have an organization if it will be essentially powerless to bring about change?"*

It is important not to leave the impression that Canada is devoid of housing-related professional organizations. They do exist, but their activities are only tangential to national senior housing issues. Moreover, none is focused specifically on the activities of the for-profit community, especially its larger players. For example, in British Columbia, the B.C. Association of Private Care (PRICARE) falls short because for-profit players perceive it as primarily a voice for subsidized home care and nursing home facilities. As one developer expressed: *"Persons like me don't want to get anywhere near government or those that represent government interests."* While, this organization does include members involved in private pay housing activities, it has yet to develop a strong interest in addressing their professional needs. Another national association, the Urban Development Institute, also falls short because it primarily represents professionals involved in more conventional housing activities (e.g., condominium development and management) and has limited expertise on assisted living facility issues. It also lacks a dedicated organizational unit focused on senior housing consumers and their specific housing needs.

At the Provincial level, Ontario is the home of the only organization now considered to represent the interests of for-profit retirement housing developers, the Ontario Residential Care Association (ORCA). It has unilaterally been attempting to promote voluntary and relatively stringent self-regulation. Owners of facilities meeting these standards would then be able to advertise their compliance.

One dilemma faced by ORCA, however, is whether it can be the professional organization of choice for developers and operators catering to both high- and low-income senior constituencies and representing both for-profit and nonprofit interests. In Ontario, as noted, unregulated shelter and care providers include a diverse group of players. Professional organizations in the U.S. have had to make similar choices. For example, organizations here that represent assisted living facility providers and management firms have distanced themselves from mom and pop board and care facilities run by nonprofessionals and disproportionately occupied by low-income seniors. What organizational style is preferable or possible in Canada,

³³This is no longer true as the largest developers and management firms are active in multiple provinces.

given its universality ideology, is unclear. In any case, ORCA with its focus primarily on Ontario issues is not offering the representation needed by noninstitutional shelter and care stakeholders across Canada.

Conventional Market Demand and Supply Characteristics

When Canadian developers evaluate the financial feasibility of building new seniors' facilities, they must consider some issues that are especially significant in their country. They include questions regarding the effects of an absent or weak shelter and care regulatory environment, Canadian values that de-emphasize the responsibility of individuals to finance their own long-term care costs, and the appropriate roles of the public, private, and nonprofit sectors. Most of their considerations, however, are those faced by all developers. Canadian, just like U.S. builders, must consider the usual demographic, location, and competition factors. They must concern themselves with the cost and availability of short- and long-term financing; they must worry about the same success indicators, such as resident fill-up times and facility occupancy rates; and they must anguish over whether their projected rent revenues line up with their expected operating costs (Benjamin and Anikeeff 1998; Brecht 1998; Edelstein and Lacayo 1998; Sexton 1998). The next sections examine some of these issues.

Size of Market. – Canada's senior market is much smaller than found in the U.S. Informal communications with a few U.S. developers suggest this is an important disincentive for foreign firms to enter the Canadian market. It is also probably a disincentive for many Canadian developers. As perhaps an extreme illustration, in 1998 Canada was occupied by just over 1.6 million persons age 75 and over (the major age group targeted for the assisted living product); in the state of Florida alone, over 1.3 million persons were in this age group. Not surprisingly, three of the four provinces for-profit developers most frequently identify as having the most promising markets for their assisted living facilities also have the largest numbers of age 75 and over persons (Exhibit 8) and seniors with the highest average incomes in Canada. These include: Ontario (600,000), British Columbia (226,400), and Alberta (122,900). In 1997, unattached seniors (age 65 and over)³⁴ in British Columbia, Ontario, and Alberta had average incomes of respectively, \$22,811, \$21,132, and \$20,909. While Quebec had 374,000 age 75 and over persons, unattached seniors in Quebec only had an average income of \$17,479 in 1997 (Colin 1999).

Canada also has a more restricted market than in the U.S. because a higher percentage of its higher income seniors can enjoy subsidized home services and nursing home stays. Many wealthier Canadians have difficulty envisioning paying \$2,000 to \$4,000 for a housing product that they can obtain on the subsidized market for under \$1,500 a month. Nor is it obvious that they are willing to pay higher out of pocket costs for the privilege of occupying private versus semi-private accommodations. Thus, developers of shelter and care facilities are left to appeal to higher-income seniors for whom affordability is less of an issue.

³⁴Income statistics on unattached seniors (the most important subgroup) age 75 and over was not readily available.

Exhibit 8. Size and Concentrations of Older Populations in Canada, By Province, 1998

Province	Number in Age Group					% of Province's Total Population				
	65-74	75-84	85+	65+	75+	65-74	75-84	85+	65+	75+
Newfoundland	34,900	21,100	6,000	62,000	27,100	6.4	3.9	1.1	11.4	5.0
Prince Edward Island	9,300	6,100	2,200	17,600	8,300	6.8	4.4	1.6	12.8	6.0
Nova Scotia	65,600	43,400	14,200	123,200	57,600	7.0	4.7	1.5	13.2	6.2
New Brunswick	52,600	33,500	11,000	97,100	44,500	7.0	4.4	1.4	12.8	5.8
Quebec	537,400	288,800	86,100	912,300	374,900	7.3	3.9	1.2	12.4	5.1
Ontario	818,000	460,400	139,600	1,418,000	600,000	7.2	4.0	1.2	12.4	5.2
Manitoba	80,400	55,100	19,200	154,700	74,300	7.1	4.8	1.7	13.6	6.5
Saskatchewan	75,400	53,600	20,100	149,100	73,700	7.4	5.2	2.0	14.6	7.2
Alberta	165,600	93,800	29,100	288,500	122,900	5.7	3.2	1.0	9.9	4.2
British Columbia	282,700	173,800	52,600	509,100	226,400	7.1	4.3	1.3	12.7	5.6
CANADA	2,124,700	1,230,700	380,300	3,735,700	1,611,000	7.0	4.1	1.3	12.4	5.4

Source: (Colin 1999)

Developers interviewed for this report, however, do not all agree that Canada has a relatively narrow shelter and care senior market. Responses range from outright cockiness – that there is absolutely no lack of demand – to assessments that the market is close to being overbuilt in some locations. There is also uncertainty as to the depth of the very high-income consumer market. According to one developer: *“The most successful facilities appear to be the highest end, most deluxe, charging the highest costs and with the most affluent residents.”* Not all players, however, share this optimism. For example, several experienced observers expressed reservation about the economic viability of the soon-to-be-built facility in Victoria, British Columbia, developed by Sunrise Assisted Living, a U.S. based corporation. It plans to charge its residents \$4,000 to \$5,000 a month, possibly the most expensive facility of its type in Canada. There is legitimate concern about whether even wealthier seniors will be willing to pay this high an amount. One unsubstantiated explanation for this reluctance is that the current generation of older Canadians feels so strongly about the importance of transferring their wealth to their children that they are less willing to pay for their long-term care out of their own savings. Thus, they expect their government to assume most of the costs. A more conventional explanation from one developer focuses on the difficulty of appealing to the highest income elderly consumer:

“We know that we have to cater to elders who will pay rents of about \$2,000 to \$2,500 a month on the independent side and about \$3,000 to \$3,500 a month on the intermediate care. Thus, we are capturing the upper middle income rather than the upper. If we go too low, we are competing against government funded facilities; whereas if we charge too high we are butting up against the very high income group who can afford to pay for 24 hour a day private care in their large homes.”

The middle-ground position held by most developers is that an appropriate housing product in the right locale will always succeed. As one developer expressed: *“Anything will work if it fits the market.”* Developers, however, do not always agree on which provinces in Canada offer the best opportunities. Based on several indicators, Ontario – with its more pro-business economy, larger elderly population, and unregulated shelter and care – is considered most attractive. Others have reservations and speak of the glut of new attractive nursing homes

coming onto the Ontario market, the threat of new restrictive shelter and care regulation, and a current shelter and care vacancy rate of over 8 percent. British Columbia is considered attractive because it has a vacancy rate of only about 1 percent; however, others bemoan its anti-business climate and its unhelpful regulatory environment. Alberta is viewed as attractive for different reasons: most of its facilities are of the congregate living facility variety and only a very small percentage of its senior-occupied facilities now offer personal care. On the other hand, Alberta's downside is its relatively small income-qualified senior population.

Product Differentiation and Consumer Preferences. – Canadian developers confront a number of challenges when marketing their product to seniors. Canadian consumers – elders, family members, and professionals serving them – appear to be largely uninformed about the assisted living facility alternative. A national survey would probably reveal that most Canadians cannot distinguish assisted living facilities from nursing homes. As noted earlier, the Sunrise Assisted Living Corporation's recent decision to develop its prototype U.S. assisted living facility as a licensed care facility under British Columbia's Community Care Act (the province's regulatory authority over nursing homes) is not conducive to this product differentiation. The negative press coverage given to the Ontario rest home industry is also unhelpful. Stakeholders here lost an important opportunity to differentiate the province's higher end, professionally run facilities from its lower-end, mom and pop operations.

The dominant Canadian developers themselves do not agree about the desirability of certain shelter and care products. This is an industry still unsure about what the consumer wants. One example of this uncertainty revolves around the question of the relative desirability of developing consumer-owned (strata-titled units or condominiums) as opposed to rented (traditional monthly fee) shelter and care facilities. One group of developers argues that seniors' lack of interest in previous shelter and care products was because they did not want to relinquish their status as homeowners. Other developers disagree and argue that seniors are unwilling to tie up a significant percentage of their wealth in this type of product. Further, they argue that building facilities likely to be purchased only by previous Canadian senior homeowners further narrows an already restricted elder market. They also worry about the risk of condo developers defaulting on the provision of planned services and leaving elder occupants with an unused infrastructure (e.g., common spaces such as dining room, clinic areas). Other developers disagree about how best to link services with the shelter component of their facilities. Along with disagreeing about the desirability of the earlier discussed split model of care versus the dedicated facility-hired staff model, developers also disagree about how much choice residents should have selecting their service package. Some argue that seniors favor facilities that let them choose from different "service packages" or provide unbundled, flexible "a la carte" choices. Others suggest that too much choice creates overly complicated administrative problems and poor service delivery economies of scale. In one developer's words:

"... we give our residents three meals a day and snacks and you take it or leave it. Our philosophy is that mealtime is time for interaction and socializing".

Developers also disagree about the extent to which food, maintenance, and housekeeping services should be outsourced or provided by dedicated facility staff. They also struggle with

issues related to the minimum qualifications of nursing staff, whether to offer nursing services at all, and the relative desirability of freestanding versus multi-level facilities.

The amorphous regulatory environment found throughout Canada only increases these housing product uncertainties. Additionally, Canada's leaders are beginning to question the wisdom of their current long-term care approaches. Policy decisions are becoming more complex as the traditional boundaries between institutional and noninstitutional shelter and care alternatives become increasingly blurred and as a new market of seniors seek more than congregate living facilities (only offering housekeeping and food services).

Simple answers to how best to provide noninstitutional shelter and care that can accommodate both the wealthy and the poor will not appear soon. The future will be muddied by the uncertainties of privatized health care; imminent changes in Provincial and Territorial regulation of shelter and care; the uncertain role of financial institutions providing both short- and long-term financing; changing government policies with respect to the availability of subsidized home-based services and nursing home beds; and the aging of newer generations of seniors with different attitudes toward planning and paying for their long-term care and with more discriminating shelter and service demands.

It does not help that comprehensive and detailed national or regional data are not available to describe potential elderly consumers and their numbers, preferences and expectations, or the current supply and attributes of existing noninstitutional shelter and care facilities.³⁵ Sophisticated consumer demand models are also lacking, and there is a dearth of information on Canada-based web sites focused on senior housing issues relevant to either consumers or providers.³⁶ In such an information vacuum, smaller developers are more disadvantaged because of their inability to afford their own in-house market research.

When asked how informed developers are about the market, the president of a well-known firm specializing in concept development and the marketing of senior housing responded: 65 percent shoot from hip, 15 percent have moderate understanding; and 20 percent have a high level of understanding. As for the potential of nonprofit societies or church groups as housing providers, he replied: "*They have a heart of gold, but rely on luck*" (cited in Clarke-Scott 1999, p.109). The same "expert" betrayed his own lack of understanding of the market when he identified major consumer groups the industry must target for assisted living facilities. He named the typical groups – seniors, their peer groups, their children – but notably missed others, such as medical, nursing, and service professionals, who in the U.S. often refer seniors to appropriate shelter and care options.

Land and Labor Issues. –The successful operation of a "rental" assisted living facility often depends on charging appropriate rents. The monthly fee must be high enough to cover debt financing, return on capital investment, and all other operating costs, but not too high for the facility's targeted market to afford. If these costs are early expected to be too high, a facility may never get out of the planning stage. Alternatively, if costs are unexpectedly high on an already

³⁵A small elderly consumer response survey was conducted in 1991 in Alberta (Romank 1991).

³⁶Graduate students seeking to find material to complete an assignment in Professor Stephen Golant's visiting graduate seminar at Simon Fraser University, Gerontology Research Centre, performed search.

built facility, the need to charge excessively high rent risks slower fill-up and higher vacancy rates. Very high rents may reflect developer inexperience, often linked with unfavorable construction loan or long-term debt financing terms or poor decisions during the site and building development stage (Regelous 2000).

Rent levels in certain markets can be significantly influenced by two specific factors. The first is the cost and availability of land. In markets with a large latent demand for assisted living facilities, such as Vancouver, Victoria, and Toronto, land is very expensive. This often results in the building of high-end developments that can only be targeted to the highest income seniors. By contrast, the lower land costs in Alberta's urban markets offer an incentive to build. Building cycles also matter. If the multifamily rental market or condo market was strong in British Columbia, the sites recently acquired by developers of seniors' facilities would have already been gobbled up by other family development builders.

Labor union policies are a second factor influencing rental rates. Developers in British Columbia frequently point to very high wage levels and generous benefit packages demanded by the province's unions as either a disincentive to build or a reason for charging higher rental fees. In contrast, in Alberta, where labor unions are less organized and viewed as less influential (in part, because they do not demand expensive benefit packages), facility staff wages and benefits are estimated to be two-thirds less than in British Columbia. As one developer summed up: "A high end building in Calgary may be charging \$1,700 a month rent, compared with an identical sister building in Vancouver that is going for \$2,500 a month." In Ontario, where unions also keep wage levels relatively high, many developers emphasize that their union relationships are less fractious.

Management Practices. – The quality of a facility's management practices may make all the difference between a profitable and unprofitable operation. Many Canadian developers still have rather traditional, short-term real estate horizons and fail to recognize that assisted living facilities are not just housing developments but also care providers. They do not recognize that the success or failure of a senior housing facility depends not just on putting together a good real estate package but just as much on hiring a competent management team. Many of the interviewed developers complained about the short supply of high-quality housing managers. They specifically found it difficult to find managerial firms with the knowledge and experience to oversee the care component of their shelter and care facilities. A large, experienced Canadian developer summed up the problem (Regelous 2000):

"Well planned services provided in a secure, supportive, and comfortable atmosphere, tailored to the individual needs of this market are essential. Professional, well-trained and courteous staff is necessary to provide such services in an effective and cost-efficient manner. Unfortunately, some of the senior's housing products entering the market today have not focused much attention on the operating portion of the senior's housing equation. The lack of attention may be derived from the fact that many buildings have been developed by individuals from a real estate development background who are not familiar with the intricacies associated with the operation of a senior's project...Companies in the retirement and personal services industry must recognize that the product they are selling is substantially different from traditional real estate where the developer "walks away" after selling the building."

Local Government Policies. – Many Canadian developers report at least some difficulty securing local zoning approvals for their senior housing facilities. This is not a surprising result in provinces that do not have clear-cut regulatory language to distinguish shelter and care facilities like assisted living or fully recognize the economic contributions of assisted living development. Thus, the zoning and land use regulations of most municipalities are unsympathetic to the needs of noninstitutional shelter and care builders and often require unrealistic or unnecessarily expensive building and site specifications.

Developers also sometimes confront strong opposition to their planned projects. NIMBY (not in my backyard) problems result when a community or neighborhood association attempts to use zoning or land-use regulations to oppose the introduction of a senior housing facility in its locality. Whether such opposition is more apparent in Canada than in the U.S. is unclear. Developers suggest that most NIMBY reactions are based on incomplete and inaccurate information about a planned facility, its residents, and its likely impact on a neighborhood. In the U.S. objections tend to arise more in residential than commercial areas because the former are preferred by assisted living providers (Assisted Living Facility of America 2000). Whatever the basis for their opposition, neighborhood activists can effectively slow down the site approval process of a newly planned senior facility. Developers have reported as long as three years to get zoning approval in some areas. Developers complain that local planning boards simply react to these conflicts on a case-by-case basis, rather than taking steps to create comprehensive planning guidelines that would apply to specifically defined categories of senior housing. Thus, developers find themselves having to educate a community every time they propose a new facility. As one developer expressed: *“On a personal level, it is necessary to have the patience of Job and the hide of a rhinoceros in order to endure the agonizing process of development approvals”* (Ontario, Office for Senior Citizens’ Affairs 1991, p. 50). Piecemeal evidence suggests this situation is starting to improve, as more municipalities institute specialized zoning ordinances that recognize the distinctive land use requirements of seniors’ housing products (Howe, Chapman, and Baggett 1994).

AN AGENDA FOR CHANGE

- I. **Identify and evaluate the noninstitutional assisted living facility model as a legitimate public policy option**
 1. Urge the Federal/Provincial/Territorial Ministers responsible for housing and for seniors to establish an advisory committee that includes senior officials from these Ministries to develop a vision and principles for the assisted living facility model in Canada. In developing the vision and principles, the advisory committee should be mandated to consult broadly with key representatives of the for-profit, public, and nonprofit sectors. The issues to be considered in developing the vision and principles should include: financing options and opportunities, standardized definitions, standardized regulatory authority, labor needs of seniors housing industry, appropriate mix of publicly-subsidized and private-pay facilities, new roles of professional associations, tax incentives for consumers and developers of assisted living facilities, and public relations initiatives.

2. Urge the Federal/Provincial/Territorial Ministers responsible for housing and for seniors to establish a subcommittee of the advisory committee, formed above, to explore the following issues:
 - a) How new legislative, programmatic, regulatory, and fiscal policies could encourage the development of the assisted living facilities by both for-profit and nonprofit sponsors.
 - b) How current legislative, programmatic, regulatory, or fiscal policies dissuade for-profits from efficiently operating assisted living facilities.
 - c) How current legislative, programmatic, regulatory, or fiscal policies unnecessarily inflate development or operational costs of assisted living facilities and result in higher monthly rental fees to its frail elderly occupants.

3. Urge the Federal/Provincial/Territorial Ministers responsible for housing and for seniors to establish a subcommittee of the advisory committee, formed above, to collaborate with the Federal/Provincial/Territorial Minister of Health Advisory Committee on Health Services through its Subcommittee on Continuing Care to examine the following issues:
 - a) The benefits of legislatively, programmatically, and fiscally treating the assisted living facility as a distinctive and valid option in the overall continuum of elder care.
 - b) The benefits of allocating a greater share of government subsidies to for-profit assisted living facilities as a substitute for nursing home facilities.
 - c) The benefits of subsidizing the care provided in for-profit assisted living facilities to make this option affordable to low-income frail older persons.
 - d) How best to create a set of regulatory standards that would protect the rights and safety of elder consumers and guarantee minimal performance outcomes, but also maintain the “social model” integrity of this noninstitutional shelter and care alternative.
 - e) The regulatory barriers now discouraging for-profit assisted living facilities from assuming greater operational responsibility for the staffing and delivery of in-house personal assistance and nursing services.
 - f) The pros and cons of the current standards used by Canada Mortgage and Housing Corporation to assess and award the noninstitutional shelter and care insured mortgage loans to for-profit developers.

- g) How publicly subsidized home-based services can be organizationally better tailored to meet the needs of the elderly who now occupy for-profit assisted living facilities.

II. Establish multi-sector partnerships and alliances to encourage the development of the assisted living model of shelter and care

4. Encourage each Provincial/Territorial government to discuss with representatives of the for-profit sector how innovative and flexible legislative initiatives, and programmatic partnerships or alliances could help increase the supply of affordable assisted living facility units (e.g., through new construction, rehabilitation, or new service delivery mechanisms).
5. Through Federal-Provincial/Territorial partnerships, create new legislative, programmatic, regulatory, and fiscal incentives for nonprofit organizations and for-profit companies to jointly develop and manage the assisted living shelter and care model.
6. Through Federal-Provincial/Territorial partnerships, create new legislative, programmatic, regulatory and fiscal incentives for nonprofit organizations to convert a small number of their current supportive housing facilities (social housing) into affordable assisted living facilities.

III. Public awareness initiatives

7. Provincial/Territorial governments should develop educational campaign/public relations efforts targeted to health care, social workers, and human service workers and other professionals that promote the individual and societal advantages of assisted living facilities.
8. Provincial/Territorial governments should develop educational campaign/public relations efforts targeted to senior consumers and their family members that promote the individual and societal advantages of assisted living facilities.

IV. Explore cost savings

9. Provincial/Territorial governments should assess the cost savings realized if they delivered subsidized personal care and nursing services to frail seniors in assisted living facilities as opposed to helping them with home-based service programs or nursing home care.
10. Provincial/Territorial governments should identify those localities (e.g., rural, geographically isolated) where they would experience the largest savings if they

delivered personal care and nursing services to frail seniors in assisted living facilities, as opposed to helping them with home-based service programs or nursing home care.

V. Initiatives by the for-profit sector

11. Create a new national professional organization with Provincial/Territorial affiliates dedicated to promoting the interests of the for-profit shelter and care industry. Its mission statement should include the following activities: self-accreditation and self-policing; public relations and image building; lobbying and advocacy; research and data gathering about industry; product education; creating financing opportunities; member training; and member network building.
12. Achieve consensus on how to define or specify the appearance and operation of a prototype Canadian assisted living facility.
13. Create a consumer guide for Canadian seniors and their family members that addresses the pros and cons of the assisted living alternative (in its various forms) and addresses their likely concerns.
14. Establish a task force of leading stakeholders in the seniors' housing field to begin deliberations on a voluntary model of self-regulation and accreditation that might fend off the need for government-imposed regulations.
15. Improve the public image of the for-profit shelter and care industry through media campaigns.
16. Assess the extent to which a restricted or costly pool of labor negatively impacts the development or operation of the assisted living facility alternative.
17. Conduct nominal group technique sessions (small group information-gathering strategies) with members of the financial community to identify their reservations about financing the development of assisted living facilities and to recommend strategies by which the industry could alleviate their concerns.
18. Identify exemplary assisted living facilities throughout the country that represent "best practices" of the assisted living model.
19. Identify localities or settlement categories where the nursing home occupancy rate is unjustifiably higher.
20. Conduct research to assess the economic benefits accruing to communities that encourage the development of assisted living facilities.

VI. Local government initiatives

21. Identify exemplary local governments that have successfully created zoning/land use ordinances recognizing the distinctive design and operating features of assisted living facilities.
22. Encourage local governments to create “floating zone” ordinances specifying the design and operational requirements for senior housing that could be applied to any particular parcel of land considered appropriate for a seniors’ housing facility.
23. Encourage local governments to adapt a set of building codes sensitive to the design and operation of assisted living facilities.
24. Encourage local governments to eliminate barriers that restrict choices of where to locate assisted living facilities.

VII. Conduct research on the availability, quality outcomes, occupant profiles, and consumer demand of shelter and care facilities for Canadian seniors

25. Conduct surveys and draw on other available data to construct a comprehensive database describing the size, availability, occupant profiles, design, service, financial, and operating characteristics of Canada’s planned seniors’ noninstitutional shelter and care inventory.
26. Increase the amount of government-funded research devoted to assessing the economic, social, health, and psychological outcomes associated with offering assisted living facilities as a widely available option for elder Canadians.
27. Increase the amount of government-funded research that explores Canadians’ awareness and assessment of the assisted living facility alternative.

NOW IS THE TIME TO ACT

Maintaining the status quo is not acceptable. Canada’s frail elderly population is growing rapidly. By 2021 about 2.9 million persons will be age 75 and over with more than 4 of every 10 seniors in this age group. At these ages, persons are at greater risk of experiencing a variety of physical and cognitive impairments and chronic health problems that make it difficult for them to maintain their accustomed independent living arrangements.

Families, the most important source of caregiving, are having increasing difficulty allocating their time and energy to help their loved ones cope safely with their vulnerabilities in their own homes. Moreover, even families with the best intentions often provide incompetent

care. In the future, experts predict that the family will become an even less reliable source of this informal assistance.

At the same time, Provinces and Territories throughout Canada are finding it increasingly difficult to pay for the growing costs of their publicly subsidized home-based service programs. The evidence is growing that this source of assistance is under fiscal stress even as demand continues to outpace supply. The reasons are clear. Changes in the health care delivery system are resulting in shorter hospital days and a greater emphasis on outpatient surgery. Provinces and Territories must therefore allocate a larger share of fiscal resources to serve elders who require short-term post-acute and rehabilitative care. The greatest threat to the independent living arrangements of most older Canadians, however, stem from their long-term, chronic impairments and health problems. Home-based service programs are falling behind in their efforts to provide the ongoing homemaking, personal assistance, and nursing services needed by this group. The situation is not helped by home-based programs' organizational features that are often insensitive to seniors' multiple and unscheduled needs, or by the high turnover rate of workers depended on to provide consistent and personalized care. These problems are especially present in some areas more than others. Demand is clearly outstripping supply in some of Canada's larger metropolitan areas. In many rural areas, also, in-dwelling assistance is very expensive and erratic, because of the time and geographic distances service providers must negotiate. Moreover, recent assessments of the publicly subsidized home support and care programs have documented occurrences of serious lapses in quality.

Moving to a nursing home, the usual way seniors deal with frailty when they cannot rely on family supports or the delivery of home-based services, is also becoming a less satisfactory choice. By most accounts, Provinces and Territories face a major shortage of nursing homes and long waiting lists, while seniors are often not admitted into the nursing homes that they or their family members prefer. Further, many knowledgeable professionals believe that a significant percentage of existing nursing homes are poorly designed, inadequately equipped, and generally of poor quality. While building new nursing homes and refurbishing existing facilities will help, in some provinces like Ontario, many of the new beds will simply be replacing those put out of service. Provinces and Territories are also trying to reduce (or at least slow) the demand for nursing homes, by restricting their occupancy to only the most physically and cognitively frail. This policy will undoubtedly help reduce demand, but it will also create a new group of frail seniors with unmet needs. These persons may not require the intensive, 24-hour skilled nursing supports of a long-term care institution, but they still will need regular and continuous homemaking assistance, help with everyday activities, and less skilled nursing services. This group will have to turn to either family members or publicly subsidized home-based service programs, alternatives already overtaxed. Private-pay, home-based help or nursing homes will be options only for the very wealthy.

The assisted living facility offers promise as a solution to alleviate the increasing incongruence between elder demands and available care. It is only now becoming available in Canada, although it is one of the fastest growing shelter and care options in the United States. When optimally operated and designed, it offers a physically attractive setting and a supportive and caring environment that can accommodate all but the most physically and cognitively frail seniors. Thus, these seniors can avoid the many downsides of home-delivered services, the

vagaries of family assistance, or the occupancy of a nursing home with its undesirable institutional qualities. Rather, seniors can live in a place where they can maintain their dignity, independence, control, individuality, and privacy even as they suffer from the impairments of old age.

Many versions of the assisted living facility alternative are now found throughout Canada. Most of these developments are in the provinces of Alberta, Ontario, and British Columbia. Most are products of the for-profit sector, although nonprofit organizations have also produced some very attractive facilities. Altogether, however, today's assisted living facilities are far from uniform products. Such diversity can offer many advantages including more choices for frail seniors and their family members. There are, after all, many favorable ways to combine needed supportive and nursing services within a residential setting. On the other hand, too much variability can be a downside. This can occur if the product deviates greatly from the ideal exemplar of the assisted living model, if it leads to a confused consumer who cannot differentiate this option from a traditional nursing home, and if it is connected with publicized instances of poor quality. Product ambiguity is also undesirable if it dampens the enthusiasm or increases the uncertainty of potentially important stakeholders – financial lending institutions, health care professionals, and provincial leaders.

A consideration of the factors now influencing the availability, attributes, and quality of this shelter and care alternative emphasizes the need for deliberate and vigorous actions by both the public and private sectors to make this a more viable option for wealthy and low-income frail Canadians alike.

A necessary step is for Federal and Provincial/Territorial government leaders to officially recognize the potential of this shelter and care alternative. The assisted living facility must be viewed as an option distinct from the traditional nursing home that can fill the large existing gap in the shelter-care continuum. This message must be communicated to senior consumers, family members, professionals, and the public at large. Government leaders must begin to appreciate how Canada's traditional bulwarks of long-term care – publicly subsidized home-based services and nursing homes – are increasingly unable to satisfy the new realities of senior consumer demand. Provincial and Territorial governments must consider how their current programs and regulatory policies might be modified to encourage development of this alternative and improve the effectiveness of its management or operation.

These government initiatives must include the for-profit sector as an active participant. Provincial or Territorial leaders must initiate new types of alliances and partnerships with for-profit stakeholders that will serve their vested interests. In some Provinces or Territories more than others, leadership views with suspicion the for-profit sector's motives and its ability to offer quality shelter and care. At the very least, the two sectors should talk about their mutual concerns. Both groups should also consider how new legislative and fiscal incentives might help to increase nonprofit organizations' participation as developers of this alternative, either alone or in partnership with for-profits and Provincial governments. Currently nonprofits play a relatively minor role as assisted living facility sponsors.

Provincial and Territorial governments must view the assisted living facility as an option not just for wealthy Canadians, but also for seniors who cannot now afford its costs. Governments must be willing to subsidize this noninstitutional shelter and care environment; otherwise, most Canadian seniors will be reluctant to consider such facilities because of their large out-of-pocket costs and because they expect their government to assume the major share of their long-term care costs. Provincial and Territorial governments must recognize that they have strong fiscal incentives to produce and operate such affordable shelter and care options. They can achieve substantial budgetary savings by delaying their senior constituencies' nursing home occupancy and by delivering more cost-effective care to older persons living in age-distinct facilities, as opposed to delivering home-based care to geographically dispersed residences. New research or demonstration projects should allay any doubts about the likelihood of this more positive fiscal outcome. If leaders fear incurring an untenable fiscal commitment by subsidizing assisted living facilities as they do nursing homes, they should at least consider establishing income means-testing requirements that would only subsidize the costs for low-income frail Canadians. An additional and undoubtedly more ambitious course of action would be to offer higher-income seniors (or their adult children) some type of Federal and/or Provincial/Territorial tax incentive to assume financial responsibility for their own long-term care needs. Whatever courses of action Provincial and Territorial governments contemplate, now is an appropriate time for their leaders to evaluate the fiscal savings that will result from adopting this more humane and less expensive shelter and care alternative.

A more satisfactory regulatory approach must be adopted to oversee the design and operation of assisted living facilities, to protect senior consumers and insure high-quality accommodations and care. The current regulatory environment sometimes discourages the development of this noninstitutional alternative; contributes to the poor identity of this product in the minds of consumers and professionals alike; results in noninstitutional shelter and care alternatives that fall short of providing a desirable model of care; and contributes to both the public perception and the reality that these facilities provide poor quality accommodations and care. While changes must be made in the way Provinces and Territories regulate this alternative, these modifications should not violate the ideal principles of assisted living. There is justifiable apprehension about the possibility of mimicking the oppressively micro-managed regulations now overseeing Canada's nursing homes.

Local governments must also assume a more conciliatory stance toward the construction of assisted living facilities in their communities. Too many horror stories still abound about the difficulties experienced by developers seeking to obtain zoning or land-use regulatory approval for their facilities. Municipalities must recognize that this use of land must be treated differently than conventional housing products or institutional uses. A far more flexible regulatory approach must recognize the distinctive building and site demands this noninstitutional alternative requires. Municipalities must recognize that their own senior population constituencies and local economies will benefit as a result.

The developers and managers of assisted living facilities must also assume a more active role in promoting their product, eliminating unclear and negative portrayals, and pointing to the many advantages they have over other shelter and care options. Their efforts, however, must extend beyond the usual facility-specific marketing campaigns. Their public relations efforts

must convince health care professionals that the assisted living facility is an appropriate alternative for their clients. They must prove to the financial community that assisted living facilities constitute a legitimate and profitable sector of the housing industry and an attractive investment opportunity. Moreover, they must demonstrate that Provincial governments can realize important fiscal savings if assisted living facilities are included as a housing alternative covered by their publicly subsidized programs.

For-profit stakeholders could facilitate such initiatives by establishing a nation-wide professional organization with Provincial affiliates that would be dedicated to such lobbying and advocacy efforts. The mission statement of this organization should also include a plan to construct a voluntary model of self-regulation and accreditation that might fend off the need for Provinces or Territories to impose inflexible regulations such as those now afflicting the nursing home industry. This organization would also offer a fitting forum for initiating research focused on obtaining better information about the current inventory of noninstitutional shelter and care products, the characteristics of professionals developing and managing them, and the socio-economic, health, and psychological profiles of their elderly occupants.

Now is the time to act. A crisis is in the making. The shelter and care demands of a growing population of frail seniors cannot be addressed through a business-as-usual attitude. Both the public and private sectors in Canada must proactively respond to the growth in seniors needing noninstitutional shelter and care alternatives, such as assisted living, to cope with their age-related frailties. Steps must now be taken to avert the inevitable stresses that Federal, Provincial and Territorial governments will confront as they attempt to satisfy the unmet needs of their current and future frail elderly constituencies. The Canadian senior will be the biggest loser if such attempts fail.

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APPENDIX A

WORKSHOP CONDUCTING THE NOMINAL GROUP TECHNIQUE

Procedures

Nine professionals who work in various capacities in the Canadian seniors' housing industry (architecture and design, building/development, management, research, property appraising, property finance, housing consulting) were invited to an all-day workshop conducted at the Gerontology Research Centre, Simon Fraser University at Harbour Centre, Vancouver, British Columbia. The purpose was to investigate factors influencing the future feasibility and growth of assisted living facilities in Canada. The responses of these persons were solicited through the application of the Nominal Group Technique (NGT). NGT is a well-established strategy used to help small groups of decision-makers problem-solve, generate ideas, and reach consensus by participants on complicated issues (Moore 1994). This approach was used to elicit majority beliefs on the following two questions:

- A. What are the current incentives and constraints for the for-profit development of assisted living facilities in British Columbia and other provinces?
- B. What strategies will stimulate and guide the growth of for-profit assisted living facilities in British Columbia and other provinces?

Beginning at 10:00 a.m. and ending at 3:30 p.m. on Tuesday, April 18, 2000, two NGT sessions were conducted over the one-day period. Dr. Stephen Golant was the lead facilitator and was assisted by two graduate students, Ms. Stacey Grant and Ms. Frances Hamm, who had received special training on this research approach. Dr. Gloria Gutman, Director of the Gerontology Research Centre, coordinated all the administrative arrangements for the workshop and provided a conference room to hold the session. The invitees were selected from lists provided by Dr. Gloria Gutman, Dr. Stephen Golant, and by Nancy Gnaedinger, a private gerontology consultant.

A morning session focused on the first question; an afternoon session focused on the second question. Prior to the workshop, each of the invited participants were provided with background materials describing the purpose of the session, the goals to be accomplished, and background materials describing issues facing the U.S. assisted living facility industry.

In each session, the nine participants were first asked to consider privately their responses to the question and then their positions were publicly recorded. Discussion followed on grouping and synthesizing the presented ideas. Based on the votes of all the participants, group consensus was reached on the relative importance of the provided answers through a mathematically pooling and ranking procedure. Summaries of each set of findings were reported to the entire group at the end of the morning and afternoon sessions. The facilitator, Dr. Stephen Golant, provided an overview of the consensus responses recorded for both sessions.

Results

Question 1: What are the current incentives and constraints for the for-profit development of assisted living facilities in British Columbia and other provinces?

MORE IMPORTANT RESPONSES

1. Concerns regarding the enforcing of regulations by Provincial government. Absence of government's entrepreneurial vision.
 - Individual regulators are afraid to take personal risk.
 - Regulators and the regulatory process, a product of the unfriendly political environment.
 - Current interest groups want to keep the status quo.
 - Restrictions on the viability of private-public partnerships.
 - Innovation perceived as not welcome.
2. The challenges of running assisted living facilities as a business; in particular the challenges of realizing cost effectiveness.
 - Balancing the competing needs/expectations of consumers, families, employees, and investors/partners.
 - Inherent constraints of higher return to investment after facility filled to capacity.
 - How to broaden the income spread of potential consumers.
 - How to judge the effectiveness of operators.
3. Lack of consistent standards/performance guidelines by which government approves assisted living product.
 - Opens up the danger of idiosyncratic interpretation of product by local and Provincial government regulators at the detriment of developer.
4. Difficulties of reading/identifying elderly consumer market and the absence of full-blown demand models.
 - Still an overemphasis on traditional medical market.
 - Overly narrowly defined elder market segment.
5. Lack of openness or acceptance of Provincial government to innovation in development of new housing products.
 - No incentives for the government to have vision.
 - No clear definition of possible end products.
 - Government regulates to prohibit (e.g., building codes).
 - Focus on process irrespective of results.
 - No vision to the process.
6. Consumer marketing resistance to any product that is associated with or thought of as a care (nursing home) facility.
7. Too few experts who are generalists.
 - Persons are needed who are as concerned about management (i.e., once doors open) as development – especially short-term aspects.
 - Persons are needed who are familiar with all aspects of developing and managing the assisted living product.

- Need to achieve the correct balance of inputs to development/design process.
 - Need to create confidence in the whole model of assisted living product.
8. Finding competent management teams.
- Management firms are often not experienced with seniors' housing.
 - Developers' have short-term horizons and don't recognize long-term support needs of elder residents.
 - Especially important issue given that funders have special concerns because it is not just a housing but also a care product.

LESS IMPORTANT RESPONSES

9. Market saturation occurring.
10. Access to financing.
11. Lack of information support for nonprofits.
12. Unavailability of plentiful models on which to create assisted living products.
13. The costs and operating restrictions imposed by strong unions in BC.
14. Government running out of money to finance assisted living products.
15. The availability and liquidity of the asset base of elder consumers.
16. Preoccupation with the medical model as a standard.
17. Difficulties of overcoming consumers' entitlement philosophy.
18. Better educated elder consumers with higher expectations.
19. Perception that long-term care facilities are inadequate.
20. Narrowing of developer base.
21. Elderly client profile is changing to consumers needing more care.
22. Small consumer population base in Canadian markets.
23. Developers are becoming more sensitive to the nature of elderly consumer market.
24. Challenges of dealing with an often longer project approval basis over which time the market characteristics have changed.

Question 2: What strategies will stimulate and guide the growth of for-profit assisted living facilities in British Columbia and other provinces?

MORE IMPORTANT RESPONSES

1. Establish rational standards and expectations by Provincial and municipal governments.
2. Create a uniform descriptive definition and language of assisted living to be used by government and for-profits.
3. Create a professional organization to represent for-profits for the purposes of self-accreditation, lobbying, training management, and empowerment and focusing public attention on the product.
4. Provide fiscal and tax incentives to both for profit developers and to potential elderly consumers to encourage the development and demand of assisted living facilities.
5. Create housing products that are consistent with changing consumer demands.
6. Create flexible and innovative approaches by which to package the same long-term care products (e.g., create alternative ways to satisfy the entitlement right).
7. Define the assisted living product on the basis of principles and outcomes rather than process (i.e., base on such outcome indicators as health, safety, independence—which indeed are BC government goals).
8. Create a database describing the size and attributes of the demand for assisted living facilities.

LESS IMPORTANT RESPONSES

9. Have the regional health districts get out of long-term care business (including nursing homes).
10. Shift the financial burden of funding from Federal government to private financial sector.
11. Replace the current Provincial government leadership that is now anti-business.
12. Create an innovative and flexible Provincial regulatory system that facilitates the creation of well-designed facilities with effective service infrastructures.
13. Give to a team of experts a set of principles and guidelines for the successful development and operation of assisted living facilities.
14. Devote more resources to the evaluation of the assisted living product.

15. Provide mechanisms by which what is now shelter-only housing group housing can become transformed into assisted living products.
16. Create business models that have 10-year planning horizons.
17. Create improved private-public partnerships that build on the benefits of the private sector's infrastructure, expertise, and economies of scale.
18. Facilitate the assisted living referral process by care professionals in order to create an alternative consumer pipeline.
19. Define the assisted living product as a legitimate self-administered and self-directed housing product.
20. Create a set of building codes unique to the assisted living product.

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ABOUT THE AUTHOR

STEPHEN M. GOLANT, a gerontologist and social geographer, has been conducting research on the appropriateness of the housing, neighborhoods, and communities occupied by the elderly population for the past 28 years. He has published over 90 papers on his research interests and has authored or edited seven books. He received his Ph.D. at the University of Washington in 1972, where he specialized in social gerontology and urban geography and completed his B.A. and M.A. degrees in urban geography at the University of Toronto. He has been a professor at the University of Florida since 1980 and was earlier an Assistant and an Associate Professor in the Committee on Human Development (Department of Behavioral Sciences) and Department of Geography at the University of Chicago.

Dr. Golant is a Fellow of the Gerontological Society of America, serves on the editorial boards of the *Journal of Gerontology* and *Journal of Aging Studies*, is on the Board of Trustees of the Florida Council on Aging, and has been Editor-in-Chief of the magazine, *Responses to an Aging Florida*, published by the Florida Council on Aging. He has been a consultant or adviser to various consulting firms, universities, state government agencies, foundations, and national organizations. He has also been a guest on various television programs, including the ABC's national news program 20/20.

He most recently completed The CASERA Project (Creating Affordable and Supportive Elder Renter Accommodations) with funding from the Retirement Research Foundation of Chicago. This two-year project evaluated the extent that older persons living in Florida's rent-subsidized apartment housing had unmet self-care and service needs and how housing sponsors and managers coped with their more frail tenants. The project outlined five service delivery models designed to link older tenants more effectively with the supportive services they needed to remain independent, and proposed over thirty specific recommendations to facilitate the aging in place of older persons in their current accommodations.

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ABOUT GERONTOLOGY RESEARCH CENTRE, SIMON FRASER UNIVERSITY

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The Gerontology Research Centre conducts research on aging and the aged, and consults on research design and program development and evaluation. Research activities are most intense in five areas:

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- Health and aging
- Prevention of victimization and exploitation of the elderly
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