NOTICE OF MEETING AND AGENDA
AGE-FRIENDLY COMMITTEE

Thursday, April 18, 2024, 2:00 PM
Village Office, 495 Hot Springs Road
Harrison Hot Springs, BC V0M 1K0

THIS MEETING WILL BE CONDUCTED IN-PERSON ONLY

1. CALL TO ORDER

Meeting called to order by Mayor Wood.

2. INTRODUCTION OF LATE ITEMS

3. APPROVAL OF AGENDA

4. ADOPTION OF MINUTES

(a) Adoption of Minutes **Page 1**
Recommendation:

THAT the minutes of the March 20, 2024 Age-Friendly Committee Meeting be adopted.

5. ITEMS FOR DISCUSSION

(a) Terms of Reference **Page 5**
Recommendation:

THAT the Age-Friendly Committee Terms of Reference be adopted.

(b) Update from the April 3, 2024 Regular Council Meeting

(c) 2015 Age-Friendly Action Plan

(d) Community Gardens

(e) Home-Based Business Event at Memorial Hall

(f) Office of the Seniors Advocate BC – Challenges Facing BC's Rural Seniors Report dated February 2024 **Page 7**

6. ADJOURNMENT

Amanda Graham
Corporate Officer

VILLAGE OF HARRISON HOT SPRINGS
MINUTES OF THE AGE-FRIENDLY COMMITTEE

DATE: Wednesday, March 20, 2024
TIME: 2:00 p.m.
PLACE: Council Chambers, Village Office
495 Hot Springs Road, Harrison Hot Springs, BC

IN ATTENDANCE: Mayor Ed Wood
Peggy Arndt
Alison Douglas
Laura Lanfranchi

Amanda Graham, Corporate Officer
Christy Ovens, Community Services Manager

ABSENT:

1. CALL TO ORDER

Mayor Wood called the meeting to order at 2:07 pm.
Mayor Wood acknowledged the traditional territory of Sts'ailes.

The Committee members introduced themselves.

2. INTRODUCTION OF LATE ITEMS

3. APPROVAL OF AGENDA

Moved by Laura Lanfranchi
Seconded by Alison Douglas

THAT the agenda be approved as amended as follows:

- by removing Items for Discussion (a) and (b), Introductions and Designation of the Chair;
- by switching the order of Items for Discussion (c) and (d), Report of Community Services Manager and Terms of Reference; and
- by adding a late item from Alison Douglas under Items for Discussion

CARRIED
UNANIMOUSLY
AFC-2024-03-01

4. ITEMS FOR DISCUSSION

(a) Review of Council Procedure Bylaw No. 1164, 2021

The Committee discussed the bylaw and how it pertains specifically to the Committee.

(b) Report of the Community Services Manager
Re: Age-Friendly Action Plan and Grant

Moved by Peggy Arndt
Seconded by Alison Douglas

THAT staff research other community gardens and add community gardens to the next Age Friendly Committee Meeting agenda.

CARRIED
UNANIMOUSLY
AFC-2024-03-02

Moved by Mayor Wood
Seconded by Alison Douglas

THAT all Committee members review the 2015 Age-Friendly Action Plan and identify what is of interest to them and bring that forward for the next Committee Meeting.

CARRIED
UNANIMOUSLY
AFC-2024-03-03

(c) Terms of Reference

Moved by Mayor Wood
Seconded by Laura Lanfranchi

THAT the Terms of Reference be amended by adding that meetings can be called at any time by the Chair.

CARRIED
UNANIMOUSLY
AFC-2024-03-04

Moved by Peggy Arndt
Seconded by Laura Lanfranchi

THAT Council consider allotting a budget of $5,000 to the Age-Friendly Committee in the 2024-2028 Financial Plan.

CARRIED
UNANIMOUSLY
AFC-2024-03-05

Moved by Mayor Wood
Seconded by Alison Douglas

THAT Council direct staff to develop a policy regarding a reporting structure between staff, Committees, Commissions and Council.

CARRIED
UNANIMOUSLY
AFC-2024-03-06

Moved by Alison Douglas
Seconded by Laura Lanfranchi

THAT Council direct staff to put out an expression of interest for additional members for the Age Friendly Committee.

CARRIED
UNANIMOUSLY
AFC-2024-03-07

Moved by Alison Douglas
Seconded by Laura Lanfranchi

THAT a home-based business event to be held at Memorial Hall be added to the next Age-Friendly Committee meeting agenda.

CARRIED
UNANIMOUSLY
AFC-2024-03-08

5. ADJOURNMENT

Moved by Alison Douglas
Seconded by Peggy Arndt

THAT the meeting be adjourned at 3:39 p.m.

CARRIED
UNANIMOUSLY
AFC-2024-03-09

Ed Wood, Chair
Age-Friendly Committee

Amanda Graham
Corporate Officer

VILLAGE OF HARRISON HOT SPRINGS

TERMS OF REFERENCE

Age-Friendly Committee

1. PURPOSE

To provide recommendations and advice to Council on matters relating to age-friendliness in the Village of Harrison Hot Springs (the Village). An age-friendly community benefits people of all ages and abilities.

2. MEMBERSHIP & MEETINGS

2.1 To the extent possible, the Committee's members will reflect the diversity of persons in British Columbia. The committee shall consist of up to seven (7) voting members, and should have a minimum of five (5) members at all times, as appointed by Council. One (1) member of the committee will be a member of Council. A quorum shall consist of a majority of voting members.

2.2 The Chairperson shall be appointed by the Mayor.

2.3 The Committee may meet as required and shall structure its activities to meet at least three (3) times per year. Meetings may be called at any time by the Chairperson.

2.4 The Committee meeting schedule will be posted on the Village of Harrison Hot Springs' website. Committee meetings are open to the public.

2.5 Meeting minutes will be taken by Village staff. Upon adoption, Committee meeting minutes shall be forwarded to Council for information.

2.6 If a Committee member is absent from a meeting for two (2) consecutive regularly scheduled meetings, that member may be disqualified from holding office as a Committee member. Disqualification will not apply if the absence is due to illness, injury or is with leave of the Chair.

3. RESPONSIBILITIES

The Age-Friendly Committee shall consider the following or other matters as directed by Council:

a) Provide recommendations on the implementation of the Age-Friendly Action Plan;
b) Promote awareness of age-friendly principles to residents, local agencies, and businesses;
c) Encourage the community to view policies, projects and programs with an age-friendly lens; and
d) Make recommendations to the Village to continue age-friendly initiatives.

The Committee may hear and consider representations by any individual, organization or delegation of citizens on matters regarding the above or as may be referred to it by Council.

In the provision of their services to the Village, the Age-Friendly Committee and its members have a responsibility to act in the best interests of the Village and within the procedures, policies and guidelines established by the Village.

4. REPORTING AND AUTHORITY

The Committee Chair will be the spokesperson for the Committee. The Committee does not have the authority to directly change bylaws or policies. All recommendations must be referred to Council.

Save with respect to matters expressly dealt with or provided for in this Terms of Reference, the rules governing proceedings of the Committee shall be those governing proceedings of the Council under the "Village of Harrison Hot Springs Council Procedure Bylaw No. 1164, 2021."

5. TERM

The term of the Committee shall commence upon approval of the Terms of Reference document and terminate annually on September 30th. This Select Committee exists at the pleasure of Council and may be reconstituted at the first meeting of Council in October of each year.

RESILIENT AND RESOURCEFUL

CHALLENGES FACING B.C.'S RURAL SENIORS

TABLE OF CONTENTS

B.C. encompasses a vast geography but 86% of the population is concentrated in a small number of urban centres occupying 4% of the land mass. While only 14% of the population lives in rural B.C., it produces the lumber, food, natural gas and electricity that allow all of us to enjoy a high standard of living. It has been described to me that rural B.C. is the "fuel" while urban B.C. is the "engine" of our province, and both are required for us to continue to move forward

Rural B.C. is attractive to people for many reasons, and this is reflected in the desire of those who live there to remain in their home communities as they age. I have heard from many rural seniors, in all parts of the province, about the strong connections they have to their communities, some going back for many generations. Rural seniors know their neighbors, and they help each other. Part of this is human kindness but part of it is also borne of necessity. Living in rural B.C. means you are more isolated from the services and supports found in urban centers and you need your family, friends and neighbors to help fill the gaps.

What is needed as we age is the same, regardless of where we live. We need medical support, a home that can meet mobility challenges, and people to help if we cannot do our own chores, personal care or drive. As I have travelled around the province, thousands of seniors have told me they find it difficult to remain in their own homes as they get older. While seniors everywhere are experiencing challenges, rural seniors face greater obstacles because they do not have the same level of access to services and supports as their urban counterparts

It will be surprising to some to learn that rural B.C. has both a faster growing and proportionately higher seniors' population than urban B.C. Despite this, on every measure, rural seniors enjoy less access to the infrastructure, services and supports they need

Highlights of the challenges experienced by seniors living in rural B.C. include:

- fewer personal resources as measured by income and wealth;
- fewer married seniors creating more demand for home support, assisted living and long-term care – the need for which more highly correlates to single seniors;
- although rural seniors have similar home ownership rates as urban seniors, they are twice as likely to live in a single-family home, and their home is, on average, two thirds less in value compared to urban seniors;
- there are 70% fewer acute care beds per 1,000 of population in rural areas;
- there is a 27% longer length of stay for alternative level of care (ALC) rural senior patients, and 85% of all ALC cases in rural area are seniors;
- there are 24% fewer home support clients per 1,000 rural population (65+) and they receive, on average, 19% fewer hours of care;
- there are 55% fewer publicly subsidized long-term care beds per 1,000 rural population (65+), and the median wait time to access a publicly subsidized long-term care bed is twice as long as in rural B.C.; and

- the rate of subsidized seniors housing units per 1,000 population (55+) is nearly 70% lower in rural B.C., and the rate of Shelter Aid for Elderly Renters (SAFER) clients per 1,000 population (60+) is over 50% lower in rural B.C. compared to urban B.C.

While advances in tele-medicine and expanded services in some rural hospitals have reduced the overall need for medical travel, it remains a reality for many rural seniors. The need to travel cannot be eliminated, however, the cost barrier can. I have heard first-hand about the inadequacy of the Province's current Travel Assistance Program (TAP), however, in the course of this review, we learned about a medical travel program that receives provincial funding called Hope Air which offers significant support. Unfortunately, few people are aware of it and one of my recommendations is to ensure eligible people are connected to the program.

Overall, while there are clearly unmet needs in the rural seniors' population, it cannot be overstated how resilient, resourceful and stoic they remain. It has been a privilege to travel throughout the province and meet seniors in communities far from the urban center of the lower mainland. In rural B.C., it is an "all hands on deck" approach to meeting the challenges of the day, whether they be helping an elderly neighbour who lives alone, responding to an evacuation order, travel interruptions from winter snowstorms or economic hardship from mill closures.

While I am inspired and heartened by the compassionate, community-minded nature of people who live in rural B.C., it's clear they need more support. There needs to be a cohesive plan developed that looks across all domains of healthy aging – housing, transportation, income, health care and community supports – and ensure seniors, regardless of whether they live in rural or urban B.C., receive equitable levels of support to allow them to age well in their home communities.

I want to thank the many people who have contributed to this report. Staff at my office, along with those in various ministries and government agencies who provided detailed information and analysis that form the foundation of this report; the British Columbia Rural Health Network for their support and sharing of information; the parliamentary secretaries for Health and Rural Development for sharing their thoughts and observations; and most importantly, to the hundreds of rural seniors I have met across B.C. who shared with me not just the challenges they face, but the pride they have in the communities they call home

Sincerely,

Isobel Mackenzie
Seniors Advocate
Province of British Columbia

AGING IN RURAL COMMUNITIES

Seniors, defined as people 65 years of age and older, represent 20% of British Columbia's population but this number is higher in rural B.C. where one in four residents is a senior. In addition, the proportion of seniors is growing faster in rural areas, a trend that is projected to continue. By 2032, 22% of B.C.'s population will be over the age of 65; in rural B.C., it will rise to 29%.

These demographics result from general aging of the population and changing migration patterns over the past 40 years. Significant overall population increases in Metro Vancouver and housing affordability issues in the urban centres of the lower mainland and southern Vancouver Island are part of what is driving rural communities to experience proportionately higher seniors' populations. This pattern reflects the benefits of a rural lifestyle that attracts people in both their working and retirement phases of life, and once retired, moving from rural B.C. to urban B.C. is more financially challenging than in past decades.

The physical aging process and what is needed to support it is the same regardless of where you live and caring for older people is producing financial and human resource challenges across the province. However, the ability to access the needed supports and services required as we age varies greatly depending on where you live - most particularly whether you are in a large urban centre or a rural community. In rural B.C., the challenges of aging are exacerbated by a greater lack of workers and infrastructure coupled with a proportionately higher seniors' population which makes accessing supports and services particularly difficult. In examining the data, it is clear that compared to urban centres, rural B.C. has a higher need based on its proportionately higher seniors' population, but offers fewer services and less supports.

WHAT IS RURAL?

Rural areas can be defined by several factors including population size, how spread out the population is around the core community and distance from a regional centre. The categorization of geographic areas (i.e., rural and urban) can shift over time as population and density changes. There is no universally acknowledged definition for rural or urban B.C., and there can be further distinctions between communities that are rural and communities that are remote.

This report uses the single term rural to capture any area not defined as urban using the Community Health Services Areas (CHSA) classification of remote, rural and rural hub centres. Most health data (i.e., health authority service delivery) is based on this classification and reflects both the size of the population and the percentage of the population that resides within the community centre. However, there are many communities in the province that may be considered 'rural' in a broader and/or geographical context. A rural hub of 5,000 people in northern B.C. faces different challenges than a community of the same size on the lower mainland or southern Vancouver Island. While the CHSA is not a perfect mapping matrix to delineate between rural and urban, it was the best option available to achieve the objectives of this report.

When rural areas are mapped, we find that 86% of British Columbians live on 4% of the land mass as the province's population is extremely concentrated in geographically small, but population dense, urban centres. The remaining 14% of the population is spread over the remaining 96% of the province.

FIGURE 1: URBAN AND RURAL GEOGRAPHIC AREAS IN BRITISH COLUMBIA (CHSA CLASSIFICATION), 2022

PROFILE OF RURAL SENIORS IN B.C.

In 2023, there were 1,058,462 seniors living in B.C., representing 20% of the total population. In rural B.C., there were 181,970 seniors representing 25% of B.C.'s rural population and 17% of all seniors in B.C. In addition to a proportionately higher seniors' population, rural B.C. also has a much faster growing seniors' population.

In the past five years, the total population of B.C. grew 6% and the seniors' population grew 16%. In rural B.C., the total population grew by only 4% and the seniors' population grew 17%. The fastest growing seniors' population is in Northern Health. Overall, the largest proportion of B.C. seniors in rural areas live within the Interior Health (43%) and Vancouver Island (25%) health authority boundaries. Fraser Health has the smallest proportion of seniors living in rural areas (9%) and the highest proportion of seniors living in urban areas.

TABLE 1: B.C. POPULATION BY AGE GROUP AND RURAL/URBAN, 2019 AND 2023

	2018/19			2022/23			% CHANGE IN 5 YEARS	
	TOTAL	65+	%OF 65+	TOTAL	65+	%OF 65+	TOTAL	65+
RURAL	702,244	155,999	22%	727,503	181,970	25%	4%	17%
URBAN	4,308,232	756,749	18%	4,591,821	876,492	19%	7%	16%
ALL	5,010,476	912,748	18%	5,319,324	1,058,462	20%	6%	16%

NOTE(S): CHSA Urban-Rural Classification, Urban-Rural CHSA Methodology, Urban/Rural Categories, as of April 3, 2023

TABLE 2: RURAL AND URBAN SENIORS (65+) POPULATION BY HEALTH AUTHORITY, 2018/19 AND 2022/23

	2018/19			2022/23			% CHANGE IN 5 YEARS	
	TOTAL	65+	%OF 65+	TOTAL	65+	%OF 65+	TOTAL	65+
INTERIOR HEALTH								
RURAL	266,738	67,654	25%	278,288	77,559	28%	4%	15%
URBAN	529,653	114,790	22%	564,418	131,913	23%	7%	15%
ALL	796,391	182,444	23%	842,706	209,472	25%	6%	15%
FRASER HEALTH								
RURAL	74,758	14,190	19%	79,075	16,179	20%	6%	14%
URBAN	1,798,084	277,898	15%	1,947,893	328,351	17%	8%	18%
ALL	1,872,842	292,088	16%	2,026,968	344,530	17%	8%	18%
VANCOUVER COASTAL HEALTH								
RURAL	68,310	15,032	22%	70,416	17,738	25%	3%	18%
URBAN	1,141,952	185,743	16%	1,195,137	211,570	18%	5%	14%
ALL	1,210,262	200,775	17%	1,265,553	229,308	18%	5%	14%
VANCOUVER ISLAND HEALTH								
RURAL	150,869	38,220	25%	157,013	45,121	29%	4%	18%
URBAN	683,676	157,238	23%	725,565	180,253	25%	6%	15%
ALL	834,545	195,458	23%	882,578	225,374	26%	6%	15%
NORTHERN HEALTH								
RURAL	141,569	20,903	15%	142,711	25,373	18%	1%	21%
URBAN	154,867	21,080	14%	158,808	24,405	15%	3%	16%
ALL	296,436	41,983	14%	301,519	49,778	17%	2%	19%
B.C.								
RURAL	702,244	155,999	22%	727,503	181,970	25%	4%	17%
URBAN	4,308,232	756,749	18%	4,591,821	876,492	19%	7%	16%
ALL	5,010,476	912,748	18%	5,319,324	1,058,462	20%	6%	16%

NOTE(S): CHSA Urban-Rural Classification, Urban-Rural CHSA Methodology, Urban/Rural Categories, as of April 3, 2023

In addition to the overall number and proportion of seniors in rural versus urban areas, there are other differences such as marital status, type of housing and driving habits. In urban B.C., 63% of seniors are married, but this falls to 51% in rural B.C. This is significant as marital status is a proxy for whether or not a senior lives alone, something that can trigger a greater need for home support, assisted living and long-term care.

Rural B.C. has a higher rate of home ownership, although the value of the homes is much lower. In 2023, the average assessed value of a home in urban B.C. was nearly $1.5 million, compared to $450,000 in rural B.C. While the overall home ownership rate in B.C. is about 70%, this drops to 62% in dense urban cores such as Vancouver.[1] The type of home is also different for seniors in rural B.C., who are almost twice as likely to live in a single-family dwelling than a townhouse or multi-unit dwelling compared to urban seniors.

Most B.C. seniors (80%) still hold an active driver's licence. More than half of all seniors maintaining an active driver's licence live in the Fraser Valley (29%) and on Vancouver Island (24%). Seniors living in rural areas rely more heavily on their vehicles as there is usually limited or no access to public transportation and they are more likely to retain their driver's licence than their urban counterparts. About 90% of older Canadians living in rural areas and smaller communities held a driver's licence compared to 85% in urban areas.[2]

RURAL SENIORS HEALTH STATUS

The percentage of seniors with low, medium or high complexity chronic health conditions is fairly similar between rural and urban seniors and has remained relatively stable over the past five years, with two areas of note. The percentage of rural seniors diagnosed with dementia (3.2%) or frail in long-term care and end-of-life care (2.2%) is lower compared to seniors in urban areas (5.2% and 3.7% respectively). In 2021/22, 15% of rural seniors and 13% of urban seniors did not use the health care system which is relatively stable from five years ago.

The degree to which these data are influenced by the lack of timely and appropriate access to diagnostics and treatment in rural B.C. is unclear. When combined with other data, it is reasonable to conclude that some issues, such as lower rates of dementia, could result from reduced access to physicians and diagnostics, and fewer seniors residing in long-term care could link to fewer available long-term care beds.

[1] Statistics Canada. 2021 Census of Population.
[2] Hansen, S. et al. To drive or not to drive: Driving cessation amongst older adults in rural and small towns in Canada. Journal of Transport Geography. [Online]. To drive or not to drive: Driving cessation amongst older adults in rural and small towns in Canada - ScienceDirect. (https://www.sciencedirect.com/science/article/pii/S0966692319307732#bb0285) June, 2020.

TABLE 3: LIVING WITH ILLNESS BY RURAL AND URBAN POPULATION, 2017/18 AND 2021/22

	2017/18		2021/22		% POINT CHANGE IN 5 YEARS	
	65+	0-64	65+	0-64	65+	0-64
DEMENTIA						
RURAL	3.4%	0.1%	3.2%	0.1%	-0.2%	0.0%
URBAN	5.4%	0.1%	5.2%	0.1%	-0.2%	0.0%
NON-USERS OF HEALTH CARE AND HEALTHY POPULATION						
RURAL	14.4%	57.4%	15.0%	57.2%	0.5%	-0.3%
URBAN	12.1%	60.0%	12.7%	60.2%	0.7%	0.1%
LOW COMPLEXITY CHRONIC CONDITIONS						
RURAL	28.9%	24.7%	28.6%	25.2%	-0.3%	0.6%
URBAN	29.2%	24.4%	28.9%	24.5%	-0.3%	0.1%
MEDIUM COMPLEXITY CHRONIC CONDITIONS						
RURAL	28.2%	5.7%	28.5%	5.7%	0.2%	-0.1%
URBAN	28.0%	4.4%	27.9%	4.4%	-0.1%	0.0%
HIGH COMPLEXITY CHRONIC CONDITIONS						
RURAL	18.1%	1.8%	18.4%	1.8%	0.2%	0.0%
URBAN	19.0%	1.4%	19.3%	1.4%	0.3%	0.0%
FRAIL IN LONG-TERM CARE AND END OF LIFE						
RURAL	2.5%	0.1%	2.2%	0.2%	-0.3%	0.0%
URBAN	4.1%	0.1%	3.7%	0.2%	-0.4%	0.0%
OTHER						
RURAL	7.8%	10.3%	7.4%	10.0%	-0.4%	-0.2%
URBAN	7.5%	9.7%	7.5%	9.4%	0.0%	-0.3%

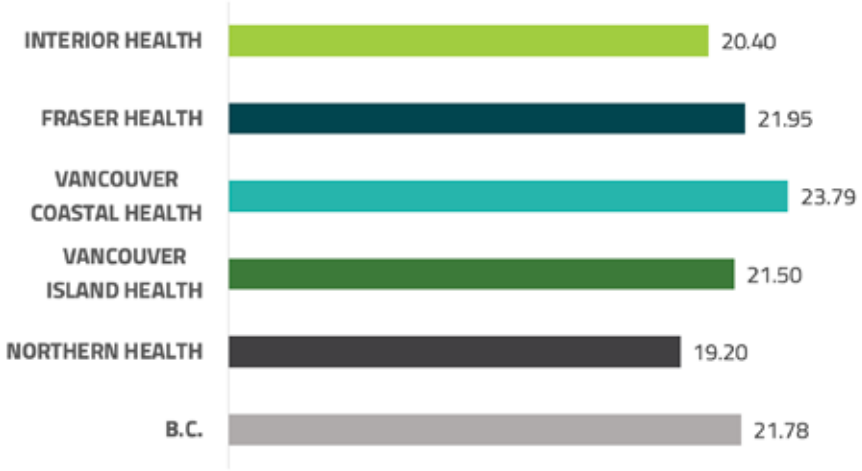
NOTE(S): Individuals who died during the fiscal year are excluded from the percentages of people with dementia. Population segments may not sum to 100% due to rounding. The "other" category includes individuals in the following population segments: adult major illness, child and youth major illness, severe mental health and substance abuse, maternity and healthy newborns, and cancer. Individuals may have health conditions that fall into multiple population segments but have been categorized into the highest level for this grouping.

Life expectancy is a measure of a population's ability to live a long life. Life expectancy at 65 is the average number of years that a person could expect to live after age 65. B.C. seniors who are 65 years of age can expect to live an additional 21.8 years. However, when the health adjusted life expectancy at age 65 is taken into account, only 16.8 of those 21.8 years will be lived in good health. Health expectancy is an indicator that incorporates mortality and health status into a single estimate that can be considered a measure of quality of life.

While it is difficult to accurately quantify what, if any, difference exists in life expectancy between urban and rural seniors, there is robust literature that show older adults living in rural areas have higher rates of chronic diseases, increased risk of multi-morbidity, lower quality of life and less access to health care and specialists.[3]

We can look at differences in life expectancy by health region and find its lowest in areas with more rural communities such as Northern, Interior and Vancouver Island health authorities and higher in Vancouver Coastal and Fraser health authorities. These data, combined with existing literature, support the view that life expectancy is lower, on average, in rural B.C., however it is difficult to quantify the exact difference or the root cause of the difference.

FIGURE 2: LIFE EXPECTANCY AT 65, 2022



[3] Krasniuk, S. and Crizzle, A.M. Impact of health and transportation on accessing healthcare in older adults living in rural regions. Transportation Research: Interdisciplinary Perspectives. [Online]. Impact of health and transportation on accessing healthcare in older adults living in rural regions (https://www.sciencedirect.com/science/article/pii/S259019822300129X?via%3Dihub) - ScienceDirect. September, 2023.

HEALTH CARE

Health care should be equally accessible to all British Columbians. In reality, it is not. There are several population groups who face systemic barriers to accessing the health care they need, including rural seniors. Whether it is access to a family physician, 24-hour acute care hospital services, diagnostics and laboratory, medical specialists, long-term care beds, home care or ambulance services, seniors in rural B.C. enjoy less access than their urban counterparts.

While there are physician shortages in urban B.C., current data suggests 17% of rural seniors do not have a family doctor (or nurse practitioner) compared to 13% of urban seniors; this has remained relatively unchanged over the past five years. However, if we look at a patient's attachment to a clinic (i.e. group practice), which is an emerging model of care, the urban and rural experience are more similar. Embedded in the clinic attachment numbers, however, are hours and days of access which are more limited in rural B.C. These factors combine to tell us that access to a primary care provider, such as a family physician, are more limited in rural B.C. For example, in Northern Health, seniors' attachment to a family physician is 75%, 8% points below the provincial average of 83%; attachment to a practice is 15%, almost double the provincial average of 8%.

EMERGENCY DEPARTMENT ACCESS

In B.C., there are a total of 77 emergency departments (EDs) in acute care hospitals, where 55% (42) are located in urban areas and 45% (35) in rural areas. While this may look somewhat equitable, it needs to be acknowledged that 55% of B.C.'s EDs are concentrated in 4% of the province geographically. Of the 35 EDs located in rural B.C., none are considered major trauma centres.

Another challenge for rural B.C. is the periodic closure of EDs, usually because of staffing shortages. This creates not only the hardship of the unexpected additional travel, possibly during inclement weather, but the stress of managing it during a medical crisis. Between January 1, 2023 and December 31, 2023, there were over 20 EDs[4] that reported closure notices with some hospitals reporting closures for 12 hours or 24 hours on numerous separate occasions, some for extended periods of time. Most ED closures were in rural areas of the province. A rural hospital in Interior Health was closed 24 separate times and lost over 300 cumulative hours due to closures. ED closures have been attributed by the Province to staffing shortages (i.e., limited physician and nursing staff availability). Many local governments in rural communities have raised significant concerns about the consistent closures of rural hospital EDs to the provincial government over the past several years.

ACUTE CARE ACCESS

The province's acute care hospitals are distributed across both rural and urban areas and offer inpatient admission. However, urban sites have a proportionally higher number of beds and offer a much wider scope of treatments, specialists, procedures and diagnostic testing.

[4] Limited information available for Northern Health Authority

Overall, there are 70% fewer acute care beds per 1,000 of population in rural areas compared to urban areas. The acute care beds per 1,000 urban population was 1.9 compared to 0.6 acute care beds per 1,000 rural population. Rural hospitals do not offer specialized cardiac procedures such as catheterization or coronary artery bypass grafts, high risk obstetrics or specialized pediatrics. Some, but not all rural hospitals perform orthopedic procedures such as hip and knee replacement and many perform cataract surgery. In terms of medical imaging, rural hospitals have x-ray, ultrasound and CT scan abilities but some lack the more detailed diagnostic capabilities of MRI. Laboratory services are offered in rural areas, with specialty diagnostics referred to larger urban labs. British Columbians requiring highly specialized services such as heart and lung transplants, complex pediatrics and severe burns must travel to the Lower Mainland to access this care.

When a person is diagnosed with cancer, they may need oncology care such as surgery, radiation, a bone marrow transplant, or they may participate in a clinical trial; all these factors influence the need to travel to an urban centre. More specialized cancer care generally requires travel to an urban site, especially when radiation therapy is needed, or if the type of chemotherapy cannot be accommodated by a rural pharmacy or hospital.

Most highly specialized services are located within urban settings to ensure access for all British Columbians and best use of specialized staff and equipment. This ensures high quality care and outcomes for clients. Virtual access to specialty care in rural areas is expanding, but many rural seniors still must travel to urban centres for in-person specialty care.

ALTERNATIVE LEVEL OF CARE OF RURAL PATIENTS

Alternative level of care (ALC) is a care level designation used when patients occupy a hospital bed after their treatment has ended and they no longer require acute care services. Seniors who are in an ALC bed are not able to access appropriate community supports (i.e., home health, home support) and/or long-term care and therefore remain in hospital.

More than 80% of ALC cases are seniors (65+). Of the approximately 20,000 ALC cases (65+)[5], about 10% are seniors from rural areas and 90% are seniors from urban areas. When we look at the total overall ALC cases of patients from rural areas (approximately 2,500 cases), 85% are seniors (65+).

The average ALC stay for a rural senior in an acute bed is 27% higher compared to a senior living in an urban area. In the last five years, this average ALC stay decreased 1% for urban based seniors but increased 9% for rural seniors. The overall number of ALC cases for seniors from rural areas has increased across all health authorities except for Interior Health over the past five years.

[5] ALC figures are based on the primary address of the patient occupying the ALC bed to determine if a patient is from a rural or urban area. Rural and urban is not based on the location of the hospital.

In 2022/23, the ALC average length of stay for seniors from rural areas was 26.4 days compared to 20.7 days for seniors from urban areas. This pattern varied across health authorities. The average length of stay for seniors from rural areas is shorter in the Interior Health, Fraser Health and Vancouver Coastal health authorities and higher for seniors from rural areas in Vancouver Island and Northern health authorities.

TABLE 4: ALTERNATE LEVELS OF CARE (ALC) IN B.C. BY SENIORS WHO LIVE IN RURAL AND URBAN AREAS, 2018/19 AND 2022/23

	2018/19			2022/23			% CHANGE IN 5 YEARS		
	ALC CASES	ALC DAYS	ALC AVG LOS	ALC CASES	ALC DAYS	ALC AVG LOS	ALC CASES	ALC DAYS	ALC AVG LOS
INTERIOR HEALTH									
RURAL	1,677	24,112	14	1,319	23,425	18	-21%	-3%	24%
URBAN	4,120	51,948	13	3,756	73,573	20	-9%	42%	55%
ALL	5,797	76,060	13	5,075	96,998	19	-12%	28%	46%
FRASER HEALTH									
RURAL	197	3,216	16	278	3,081	11	41%	-4%	-32%
URBAN	5,720	106,746	19	7,275	116,416	16	27%	9%	-14%
ALL	5,917	109,962	19	7,553	119,497	16	28%	9%	-15%
VANCOUVER COASTAL HEALTH									
RURAL	104	3,536	34	109	2,463	23	5%	-30%	-34%
URBAN	2,717	41,146	15	3,782	59,117	16	39%	44%	3%
ALL	2,821	44,682	16	3,891	61,580	16	38%	38%	0%
VANCOUVER ISLAND HEALTH									
RURAL	183	9,810	54	208	7,921	38	14%	-19%	-29%
URBAN	1,555	81,988	53	1,846	76,741	42	19%	-6%	-21%
ALL	1,738	91,798	53	2,054	84,662	41	18%	-8%	-22%
NORTHERN HEALTH									
RURAL	218	16,786	77	251	20,274	81	15%	21%	5%
URBAN	362	21,881	60	349	26,844	77	-4%	23%	27%
ALL	580	38,667	67	600	47,118	79	3%	22%	18%
B.C.									
RURAL	2,379	57,460	24	2,165	57,164	26	-9%	-1%	9%
URBAN	14,474	303,709	21	17,008	352,691	21	18%	16%	-1%
ALL	16,853	361,169	21	19,173	409,855	21	14%	13%	0%

NOTE(S): Counts are based on the primary address of the patient and identified as rural or urban based on CHSA.

For many seniors, part of their acute care trajectory requires support from home and community care services to enable a successful discharge home. These services support people to receive nursing, occupational therapy/ physical therapy and home support services at home. Many of the services are targeted to help seniors to live more independently in the community and avoid the need for hospital (re)admission. Most seniors wish to live in their own home, with additional support when needed. When this isn't possible, some relocate to long-term care or assisted living at a cost considerably higher than that of home support.

HOME SUPPORT

There are proportionately fewer home support clients in rural B.C. and they receive fewer hours on average than urban home support clients. In 2022/23, there were just over 5,000 home support clients (65+)[6] in rural areas, which is 12% of all home support clients (65+), with an increase of 4% (4,893) over the past five years. During this same time period, the number of home support clients (65+) in urban B.C. grew by 9%. The rate of home support clients per 1,000 population (65+ and 75+) is 24% and 14% lower in rural areas than in urban areas in B.C. respectively. In addition, the average hours per client (for people 65+ who receive home support hours) is 19% less in rural compared to urban B.C.

FIGURE 3: HOME SUPPORT CLIENT (65+) RATE PER 1,000 POPULATION, RURAL AND URBAN, 2022/23

[6] Includes long-term home support, short-term home support and CSIL, and excludes Northern health due to the incomplete data submission to HCCMRR.

TABLE 5: NUMBER OF HOME SUPPORT CLIENTS (65+) AND HOURS, 2018/19 AND 2022/23

	2018/19	2022/23	% CHANGE IN 5 YEARS
RURAL			
NUMBER OF CLIENTS	4,893	5,070	4%
NUMBER OF HOURS	944,688	885,335	-6%
AVERAGE HOURS PER CLIENT	193	175	-10%
CLIENT RATE PER 1000 POP. (65+)	36	32	-11%
CLIENT RATE PER 1000 POP. (75+)	99	84	-15%
URBAN			
NUMBER OF CLIENTS	33,108	36,249	9%
NUMBER OF HOURS	7,342,095	7,812,784	6%
AVERAGE HOURS PER CLIENT	222	216	-3%
CLIENT RATE PER 1000 POP. (65+)	45	43	-5%
CLIENT RATE PER 1000 POP. (75+)	105	98	-6%
ALL			
NUMBER OF CLIENTS	38,025	41,377	9%
NUMBER OF HOURS	8,289,150	8,705,548	5%
AVERAGE HOURS PER CLIENT	218	210	-3%
CLIENT RATE PER 1000 POP. (65+)	44	41	-6%
CLIENT RATE PER 1000 POP. (75+)	104	96	-7%

NOTE(S): NHA was excluded due to the incomplete data submission to HCCMRR. Data include short-term, long-term Home Support and CSIL clients who are 65 years old and above.

While there has been an increase in the absolute number of home support clients in both rural and urban areas in the past five years, the number of home support hours for rural clients has decreased 6% compared to an increase of 6% for urban clients. Although, when we examine the average hours per client, this dropped 10% for rural clients and only 3% for urban clients from 2018/19.

FIGURE 4: AVERAGE HOME SUPPORT HOURS PER CLIENT (65+), RURAL AND URBAN, 2018/19 AND 2022/23

ASSISTED LIVING

As of March 2023, there were 34 publicly subsidized assisted living (AL) sites with 518 units in rural areas, or approximately 3 publicly subsidized units per 1,000 rural seniors' population (65+). Comparatively, there were 101 publicly subsidized assisted living sites with 3,819 units in urban areas or 4 publicly subsidized units per 1,000 urban senior population (65+). In rural areas, more than half (56%) of publicly subsidized AL sites and 58% of AL units are in Interior Health while Fraser Health had the lowest proportion of AL units (4%) in rural areas in the province.

TABLE 6: PUBLICLY SUBSIDIZED ASSISTING LIVING RESIDENCES AND UNITS, MARCH 2023

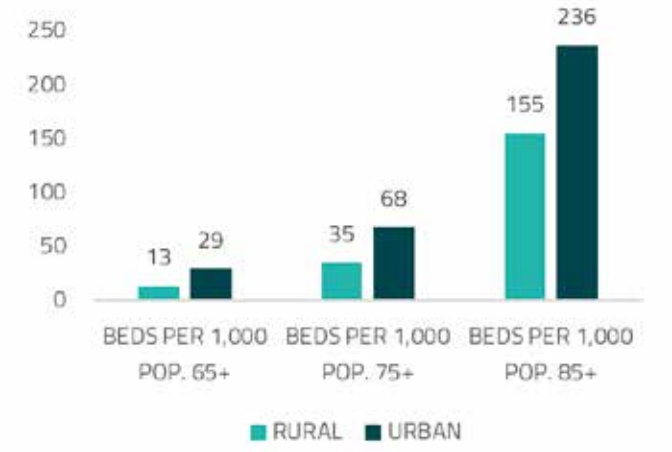
	RURAL	URBAN	ALL
NUMBER OF RESIDENCES	34	101	135
TOTAL UNITS	744	4,961	5,705
PUBLICLY SUBSIDIZED UNITS	518	3,819	4,337
UNITS PER 1000 POP. (65+)	3	4	4
UNITS PER 1000 POP. (75+)	8	10	10
UNITS PER 1000 POP. (85+)	33	35	35
PRIVATE UNITS	226	1,148	1,374

LONG-TERM CARE

As of March 2023, there were 2,399 publicly subsidized and 74 private pay (co-located) long-term care beds in rural B.C. This represents 9% of all publicly subsidized beds and 5% of all private beds in publicly subsidized long-term care facilities.

In 2023, there were approximately 13 publicly subsidized beds per 1,000 population (65+) in rural areas and 29 beds per 1,000 population (65+) in urban areas. The long-term care (LTC) bed rate per 1,000 population (65+) has declined in rural areas (16 beds per 1,000 pop.) and urban areas (33 beds per 1,000 pop.) compared to five years ago. This illustrates we are not keeping pace with the growth in the seniors' population throughout B.C.

FIGURE 5: PUBLICLY SUBSIDIZED LONG-TERM CARE BEDS PER 1,000 POPULATION, MARCH 2023



In rural areas, half (51%) of the publicly subsidized LTC facilities and 63% of the publicly subsidized LTC beds are in Interior Health. Less than 40% of publicly subsidized LTC beds are evenly distributed across the other four health authorities with the highest proportion in Vancouver Island Health (12%) to the lowest proportion in Fraser Health (7%).

The test of whether the number of publicly subsidized LTC beds is meeting current and future needs in rural and urban areas is to look at a trend over time based on population growth. The rate of care beds over the past five years has decreased relative to the number of seniors in both rural and urban areas, however, this trend is more pronounced in rural areas.

TABLE 7: PUBLICLY SUBSIDIZED LONG-TERM CARE FACILITIES FOR SENIORS, MARCH 2019 AND 2023

	MARCH 2019			MARCH 2023			% CHANGE IN 5 YEARS		
	RURAL	URBAN	ALL	RURAL	URBAN	ALL	RURAL	URBAN	ALL
NUMBER OF FACILITIES	59	232	291	59	238	297	0%	3%	2%
TOTAL BEDS	2,500	26,135	28,635	2,473	26,957	29,430	-1%	3%	3%
PUBLICLY FUNDED BEDS	2,423	24,791	27,214	2,399	25,665	28,064	-1%	4%	3%
BEDS PER 1000 POP. 65+	16	33	30	13	29	27	-15%	-11%	-11%
BEDS PER 1000 POP. 75+	43	76	72	35	68	63	-19%	-11%	-12%
BEDS PER 1000 POP. 85+	174	245	236	155	236	226	-11%	-4%	-4%
PRIVATE BEDS	77	1,344	1,421	74	1,292	1,366	-4%	-4%	-4%

NOTE(S): To be consistent with March 2023, some adjustments were made to the facility list in 2019: combining five special care units (Harmony Court Care Centre-Special Care Unit, Delta View Habilitation Centre, Berkley Care Centre - Special Unit, Fair Haven Vancouver – Special Care Unit, and The Priory - Hiscock) into their main facilities and removing Cariboo Place because its primary target population is not seniors. Therefore, the facility count is different from the long-term care directory summary report 2019.

EXAMPLE OF RURAL SENIORS' ACCESS TO PUBLICLY SUBSIDIZED LONG-TERM CARE OR ASSISTED LIVING

The OSA continues to hear about the lack (or shortage) for publicly subsidized assisted living or long-term care, including long wait times as a barrier for seniors living in rural areas and being concerned about the need to move out of their rural community and away from their families and friends.

Let's take a look at two seniors, one living in Smithers and the other living in Port Hardy.

A senior living in Smithers has access to a publicly subsidized an assisted living and a long-term care facility in their community. However, the average wait time for a long-term care bed at Bulkley Lodge is 309 days, and the average wait time for an assisted living unit at The Meadows is double the wait time, as there are only 14 units. A senior in Smithers may have to consider other housing options such as Prince George which is about 4.5 hours away.

Similarly, a senior living in Port Hardy can access a long-term care facility in their community with an average wait time of 271 days but would need to move to Campbell River to access the nearest publicly subsidized assisted living residence which is 233 kms away with an average wait time of 258 days.

LONG-TERM CARE WAIT TIMES[7]

In 2022/23, the median time for seniors waiting for a long-term care bed in rural areas was almost double the median wait time for seniors in urban areas – 43 days compared to 23 days.

In 2022/23, the median wait time for new admissions into publicly subsidized LTC facilities for seniors from rural areas increased 72% compared to 2018/19. The wait time for rural seniors admitted into publicly subsidized LTC facilities is the longest in Vancouver Island Health (average 318 days and median 170 days) and shortest in Fraser Health (average 55 days and median 12 days).

[7] Wait times are based on seniors who live in either a rural or urban area based on their home address and the time it took for that client to be admitted into a LTC facility located in the province.

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