OFFICE OF THE
SENIORS ADVOCATE
BRITISH COLUMBIA

RESILIENT AND RESOURCEFUL

CHALLENGES FACING B.C.'S RURAL SENIORS

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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%

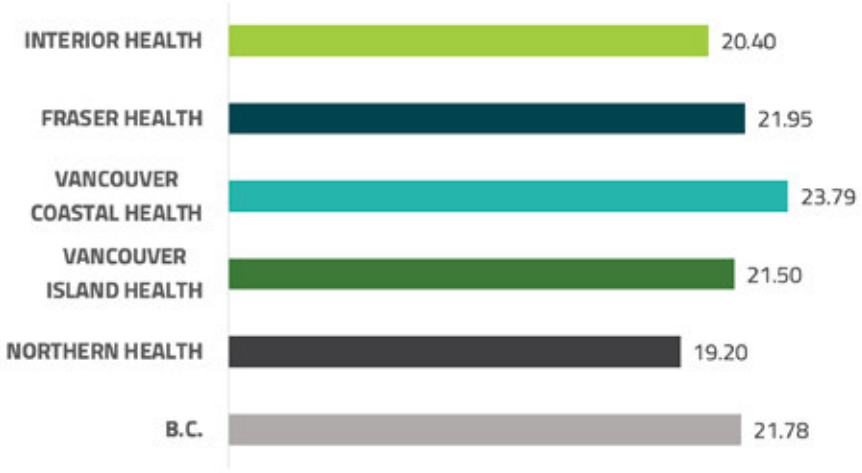
NOTE(S): Individuals who died during the fiscal year are excluded from the percentages of people with dementia. Population segments may not sum to 100% due to rounding. The "other" category includes individuals in the following population segments: adult major illness, child and youth major illness, 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

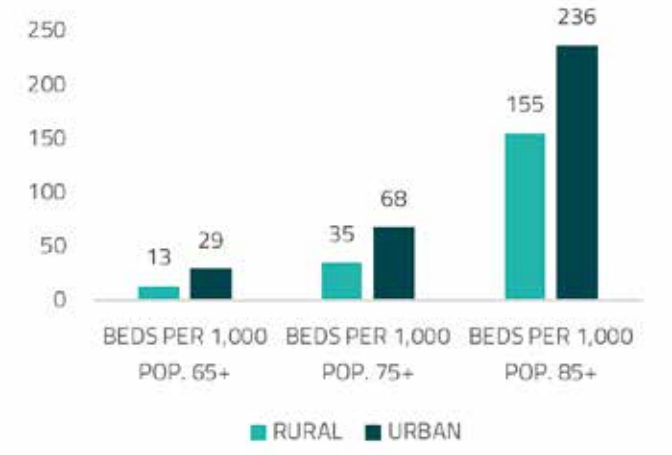
	RURAL	URBAN	ALL
NUMBER OF RESIDENCES	34	101	135
TOTAL UNITS	744	4,961	5,705
PUBLICLY SUBSIDIZED UNITS	518	3,819	4,337
UNITS PER 1000 POP. (65+)	3	4	4
UNITS PER 1000 POP. (75+)	8	10	10
UNITS PER 1000 POP. (85+)	33	35	35
PRIVATE UNITS	226	1,148	1,374

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.

LONG-TERM CARE RESIDENTS WITH LOWER COMPLEXITY OF NEEDS[8]

In 2022/23, 62% of rural seniors admitted into publicly subsidized LTC facilities received no long-term home support in the 90 days prior to admission; this proportion increased 5% from 2018/19. By comparison, 60% of urban seniors admitted into publicly subsidized LTC facilities received no long-term home support in the 90 days prior to admission - a 1% decrease from 2018/19.

The proportion of rural seniors admitted into publicly subsidized LTC facilities received no long-term home support in the 90 days prior to admission in rural areas varied across health authorities ranging from 87% in Vancouver Coastal Health to 53% in Fraser Health.

In 2022/23, 15% of rural seniors newly admitted into publicly subsidized LTC without home support in the 90 days prior to admission were ADL 2 or less and CPS 2[9] or less compared to 13% of urban seniors with wide variation across health authorities (ranging from 47% in Vancouver Coastal Health, 20% in Northern Health, 18% in Vancouver Island Health, 12% in Interior Health and 3% in Fraser Health).

TRAVEL FOR MEDICAL

Seniors living in rural areas often need to travel from their home communities to receive required medical care. Scheduled appointments for medical procedures, diagnostics, specialist care or an unplanned emergency requiring transport by ambulance are all circumstances that can require medical travel.

In a given year, more than 7,300 patients[10] are transported to hospitals for emergency medical treatment by air ambulances within B.C. and many other British Columbians travel from their rural community to an urban centre for planned medical appointments and procedures. For seniors who arrive at an urban hospital for an emergency procedure, the cost of ambulance transport (ground or air) is covered by the BC Emergency Health Services' flat fee of $80. However, once they are discharged from the hospital, there is no assistance provided to support their return home.

There is no provincial data capturing the number of British Columbians traveling to access medical care; the only data available are the number of patients accessing the provincial Travel Assistance Program (TAP), which was about 31,000 patients (nearly 50% were seniors) in 2022/23. This is a significant underestimation of B.C. patients who travel outside their community to access care and largely reflects people who live in coastal communities and receive the benefit of free ferry travel, which is the only fully funded direct benefit of TAP.

Advances in telehealth and other technologies have improved local access for some medical needs that would otherwise require long distance travel. Developing the full potential of telehealth, providing better financial incentives for specialists to provide services in rural B.C., and eliminating the closures of EDs are all initiatives

[8] The rural/urban classification is based on the home address location of the client prior to admission to care.
[9] The Cognitive Performance Scale (CPS) is used to evaluate cognitive impairment and the Activities of Daily Living (ADL) scale reflects a person's physical function. A score of 2 or less on either of them may indicate the senior could potentially be cared for at home with supports in place.
[10] BC Emergency Health Services (BCEHS). Provincial Health Services Authority. Factsheet: Air Ambulance Service. [Online]. Fact Sheet AIR AMBULANCE.pdf (http://www.bcehs.ca/our-services-site/Documents/Fact%20Sheet%20AIR%20AMBULANCE.pdf).

that would improve access to health care for rural seniors. However, the reality will remain that certain conditions and events will require rural seniors to travel long distances to receive the health care they need. The stress of these trips are significant enough without the added financial burden rural seniors must absorb as they seek the care that is readily available to urban seniors at no additional cost.

The OSA hears frequently from rural seniors about the cost burden of medically required travel. From the cost of gas or airfare to overnight hotel accommodations and restaurant meals. Some rural seniors are out-of-pocket several thousands of dollars, or sadly, some do not seek the care they need because they cannot afford to access health services in another community.

TRAVEL ASSISTANCE PROGRAM (TAP)

The provincial government offers rural British Columbians assistance to medical appointments through the Travel Assistance Program (TAP). TAP offers travel discounts to eligible B.C. residents who must travel for non-emergency medical specialist services not available in their community. TAP is a partnership between the Ministry of Health, BC Ferries and private transportation companies who agree to waive or discount their regular fees. TAP does not provide direct financial assistance to residents for travel costs. Meals, accommodations, transportation expenses other than ferries, are not included and it is the patient's responsibility to make their own travel and accommodation arrangements. While the premise of the program is promising, the reality of what is covered makes it of limited value to any rural senior who does not require ferry transportation, and the majority of rural seniors do not live in a coastal community.

Most B.C. residents pay significant out-of-pocket expenses to travel to urban centres to access care. These include expenses for: transportation (i.e., airfare, gas, bus, rental car, parking etc.,) food and accommodation. In addition, people who accompany the patient, such as a parent, caregiver or friend, may incur lost wages and also pay out-of-pocket for co-traveler expenses. Challenges with TAP include the burdensome approval process, there being no reimbursement for travel already taken, and the lack of assistance with mileage for private vehicles, accommodation and meals, all of which can be cost prohibitive for low-income seniors.

Eligible Services:

- Non-emergency medical specialist services available at the closest location outside the patient's community.
- Diagnostic procedures, laboratory procedures, diagnostic radiology, nuclear medicine procedures, BC Cancer Agency, Transplant Units, HIV/AIDS treatment at St. Paul's Hospital, specialty clinics at BC Children's Hospital and other tertiary care hospital services.
- Services not insured by Medical Services Plan (MSP) are not eligible for TAP.

See Travel Assistance Program - Province of British Columbia (https://www2.gov.bc.ca/gov/content/health/accessing-health-care/tap-bc/travel-assistance-program-tap-bc) for a list of eligible services and participants.

Eligible Individuals:

- Must be a B.C. resident and enrolled in the MSP.
- Patients must be referred by a physician, nurse practitioner or specialty clinic.
- A caregiver is eligible for TAP if the patient is incapable of traveling independently for medical reasons.
- Travel expenses must not be covered by third party insurance, such as an employer plan, extended medical plan, Insurance Corporation of BC, WorkSafeBC or federal government program (i.e., Veterans Affairs Canada).

Assistance available through TAP includes:

Ferry Transportation:

- Free BC Ferries travel for patients (and an escort where necessary) for those travelling for medical appointments. As of April 2023, passengers travelling under TAP no longer have to pay BC Ferries reservation fees, eliminating the possibility of them having to wait for long periods of time when they are not well or possibly missing their medical appointment.

Air Transportation:

- Discounts (up to 30% off regular fares) from the following airlines serving rural and regional communities: Central Mountain Air, Harbour Air Seaplanes, Helijet, Pacific Coastal Airlines and Seair Seaplanes.
- Angel Flight provides free air transport for cancer patients who need to travel between Vancouver Island, the Lower Mainland and the Sunshine Coast for treatment.

Ground Transportation:

- The Wilson's Group offers discounts on their BC Ferries Connector bus (15% - 20% discounts) between Victoria and Vancouver and on the Vancouver Island Connector (25% discount) which services communities from Port Hardy and Tofino down to Victoria.
- VIA Rail offers a 30% discount off their regular fares between Prince Rupert, Prince George and Vancouver.

Almost all of the travel assistance programs are based on scheduled appointments and procedures. There is a program delivered through a non-profit organization called Hope Air that provides fully funded airfares, up to two weeks accommodation for the senior and necessary travel companion, and daily meal vouchers as well as additional benefits. While the program receives provincial government funding, it is not widely advertised and many rural seniors, health care practitioners and local officials are unaware of its existence.

In addition to TAP and Hope Air, there is also medical travel assistance offered through the Health Authority – Health Connections Program, the Ministry of Social Development and Poverty Reduction, Canadian Cancer Society and Angel Flight East Kootenay.

HOPE AIR

Hope Air is a Canada-wide not-for-profit agency which provides travel assistance for patients who need help paying for non-emergency medical travel. It is not an actual airline but a charity that books and pays for flights on commercial airlines as well as for accommodation, meals, ground transportation and escort costs. In B.C., Hope Air provides seasonal small aircraft services through its Volunteer Pilot Program for patients living far from commercial airports. Patients are eligible for assistance through Hope Air if they have financial needs and have a confirmed appointment that is covered by MSP. Assistance available through Hope Air includes:

- Free return flights for the patient and escort if required
- Hotel accommodation for up to 14 nights (will be extended on a case by case basis) and accommodation for the escort while the patient is in hospital.
- Meal vouchers of $50 per day
- Uber voucher up to $120 for the trip for ground transportation between the airport, hotel and hospital.

In 2023, Hope Air reported a record high volume of activity. There were 14,132 travel arrangements made including, paying for flights, overnight accommodation, meals and ground transportation. This represent a 145% increase over the previous year.[11] (https://hopeair.ca)

HEALTH CONNECTIONS

Health Connections is a regional travel assistance program provided by three health authorities that offers subsidized transportation options to help cover costs for rural residents who must travel for non-emergency care outside their community. Eligible rural residents can access both TAP and Health Connections. Health Connections is offered by Island Health, Northern Health and Vancouver Coastal health authorities.

ISLAND HEALTH	In May 2023, Island Health announced a new transportation service five days per week for residents to access hospitals in Port Hardy, Port McNeill and Port Alice. The service includes a daytime and afternoon/evening route and provides daily return transportation to North Island hospitals in Campbell River and Comox Valley.[12] Island Health also provides an operating grant to Wheels for Wellness, a not-for-profit society (https://wheelsforwellness.com/about-us/) that provides transportation throughout Vancouver Island for residents needing to travel for non-emergency medical appointments more than 60 kilometers (one way) from point of departure.
NORTHERN HEALTH	NH Connections offers medical transportation for northern residents (including seniors and people with mobility challenges) travelling outside their home community for non-emergency health care or who need to get home after travelling by ambulance to another community. NH Connections offers several northern routes including Prince Rupert/Prince George, Prince George/ Vancouver, Dawson Creek/Fort St John, Valemount/Prince George, McBride/Kamloops. Fares range from $10 and up to $40 one-way depending on the route. Travel companions and immediate family members can travel with the patient who require supports while travelling. Northern Health in partnership with Eagle Transit operates a bus service for general travel between Masset and Daajing Giids, five days a week for $10. Medical passengers have priority and the fee is waived. (nhconnections.ca)
VANCOUVER COASTAL HEALTH	Vancouver Coastal Health funds patient transportation in the Central Coast and Bella Coola Valley. Bella Coola Valley Health Services funds a HandyDART bus service providing transportation to medical appointments, adult day programs, foot clinics, etc. Bella Coola Valley Health Services also covers 100 percent of medically required air travel for patients from the Central Coast. Vancouver Coastal Health (Travel & accommodation assistance | Vancouver Coastal Health (https://www.vch.ca/en/patients-visitors/fees-payments/financial-support-services/travel-accommodation-assistance)

[11] Island Health. Hope Air. British Columbia Patient Demand soars for medical travel programs in 2023. [Online]. https://hopeair.ca/british-columbia-patient-demand-soars-for-medical-travel-programs-in-2023/. January 25, 2024.
[12] Island Health. News Release. [Online]. (https://www.islandhealth.ca/news/news-releases/island-health-launches-dedicated-north-vancouver-island-transportation-service) May 26, 2023.

The health authority supported transportation is effective and sufficient for some rural seniors, but not all. The challenges that rural seniors and their family members have identified are generally related to a misalignment of the bus schedule with the medical appointments.

MINISTRY OF SOCIAL DEVELOPMENT AND POVERTY REDUCTION – MEDICAL TRANSPORTATION

Medical transportation supplements are available for eligible recipients of income assistance and disability assistance including medical services only recipients who have transferred from the provincial income assistance program to the federal OAS/GIS program at age 65. The medical supplement provides the least expensive appropriate mode of transportation when essential medical treatment is required. The supplement may include financial supports for expenses not covered by the TAP. This program is only available to an estimated 3% of seniors who receive medical only benefits.

CANADIAN CANCER SOCIETY

The Canadian Cancer Society has several assistance programs to help those who need to travel for cancer care:

- Wheels of Hope: volunteers drive patients to their appointments in the southern Interior, Prince George and Vancouver Island.
- Travel Treatment Fund: helps with transportation costs (income tested over $80,000).
- Hope Air: partnership with Hope Air for air transportation.
- Accommodation: Cancer lodges in Victoria, Vancouver, Kelowna and Prince George provide accommodation for patients and escorts. The recent government funding has eliminated lodge fees for the patient.

(https://cancer.ca/en/living-with-cancer/how-we-can-help/cancer-travel-and-accommodation-services-bc#travel)

ANGEL FLIGHTS

Angel Flight East Kootenay is a not-for-profit agency providing free air transportation to residents of the east Kootenays to Kelowna. They operate scheduled flights three days per week from Cranbrook airport to Kelowna airport. (angelflightek.ca)

INCOME

The OSA continues to hear from seniors living on low incomes who are struggling to make ends meet. In 2021, the median income[13] of B.C. seniors was $33,150 while the prime working age population median income was $57,290, 73% higher. About 45% of seniors have an income that is less than minimum wage, compared to only 6% of the labour force in B.C.

When we look at income differences between rural and urban B.C., both the median and average income skews lower in rural B.C. In addition, the difference between the average and the median income for urban seniors is greater (31% urban versus 26% rural). This tells us that high-income seniors, who are pulling up the average, are more likely to be located in urban areas.

In addition to the disparity in incomes between rural and urban seniors, there is significant disparity of wealth as measured by housing values which is an effective measure given the majority of a senior's wealth is the equity in their home. The average house value in rural B.C. is $450,000 compared to nearly $1.5 million in urban B.C. Therefore, while rural seniors are more likely to be homeowners and much more likely to own a single-family house, the value of their homes, which factors into their overall wealth, is much less.

TABLE 8: B.C. AVERAGE AND MEDIAN INCOME (SENIORS 65+), SELECT COMMUNITIES – 2021

	AVERAGE INCOME	MEDIAN* INCOME
RURAL	$43,592	$32,190
URBAN	$49,857	$34,546
B.C.	**$49,035**	**$33,150**

NOTE(S): *Urban median income is estimated based on median incomes for census metropolitan areas and census agglomerations, rural median income is estimated using non-census metropolitan areas

[13] Statistics Canada, Centre for income and socioeconomic well-being statistics, Annual Income Estimates for Census Families and Individuals (T1 Family File), Custom Tabulation

HOUSING

Most seniors living in both rural and urban B.C. are homeowners. Overall, the rate of homeownership in B.C. is about 70% but it drops as low as 62% in very dense urban cores such as the City of Vancouver. [14] The rate of seniors homeownership is slightly higher at 80% and is not dramatically different in the overall rural/urban split, however, there are differences in the type of homes owned in smaller and larger communities.

In urban B.C., only 43% of seniors live in a single detached house but this almost doubles to 80% for rural seniors who live in a single-family home. This is significant because single-family homes present a number of design challenges; the presence of stairs and maintenance requirements are barriers that are much more prevalent in single-family homes.

While seniors want to remain in their own homes, there are many factors influencing whether or not they are able to achieve this, including but not limited to:[15]

- Changes in health or personal circumstances (i.e., loss of spouse), difficulty with stairs, reduced ability to manage day-to-day tasks
- Rising costs in home maintenance, taxes, hydro and heating
- Rent increases and the need to find less costly accommodation
- Moving closer to adult children or family members
- Selling family home to access more cash/equity
- Need to move to different housing that offers personal care supports (i.e., meals, housekeeping, activities of daily living)

When presented with the need to move from a single-family home to somewhere more accessible, seniors in urban communities have many more options than seniors in rural areas. The lack of multi-unit housing in rural areas, namely condominiums to buy or apartments to rent, is pronounced. In urban areas, market forces have made the development of condominiums feasible and attractive, but the same economics have the opposite effect in rural B.C. There are many seniors in rural areas who would sell their single-family, non-accessible house and move to a condominium or townhouse but there is nothing for them to buy or rent in their community. This is less of an issue in urban areas.

For rural seniors who rent, the main challenge is the availability and accessibility of rental housing. In the last 10 years, market rents have increased 50%, while pension incomes have risen just 25%. In 2022, the average cost of renting a one-bedroom apartment in B.C. was $1,432, compared to $1,193 five years ago. While rents are lower in rural communities, they are still a challenge for lower income seniors. More significantly, the lack of available rentals leaves seniors who might want to sell their rural house and move into a rental apartment with little to no choice unless they move to a more urban area such as Kelowna, Kamloops, Prince George or Cranbrook where they will face much higher rental costs and lose their local community supports. For example, one-bedroom rent (2022) was just over $1,306 in Kelowna.

[14] Statistics Canada. 2021 Census of Population.
[15] Housing for Older Canadians: The Definitive Guide to the Over 55 Market, Canadian Mortgage and Housing Corporation, 2020

SHELTER AID FOR ELDERLY RENTERS (SAFER)

BC Housing delivers the SAFER program which provides a monthly subsidy to low-income senior renters aged 60 and older who pay more than 30% of their gross monthly income towards rent. While the program offers seniors the ability to live where they want and provides a subsidy to anyone who qualifies (there is no capitation on the annual amount allocated to the program), the amount of subsidy falls far short of what is needed in today's rental market.

The SAFER program uses rent ceilings in three zones throughout the province to limit the amount of subsidy that can be granted. Zone 3, which covers most rural areas, has a rent ceiling of $734 for singles and $800 for couples. These rent ceiling amounts have not been updated since 2018 and they do not reflect the reality of today's rental market or the inflationary lifts to pension incomes. Seniors living in rural areas with an income of approximately $29,500 will not qualify for any SAFER subsidy. This will leave the senior in Kelowna living on less than minimum wage required to spend more than 50% of their income on rent and utilities.

In the past five years, the average monthly rents in B.C. increased 20% while the income of SAFER recipients increased 10%, yet the average SAFER subsidy decreased 8% (from $215 in 2018/19 to $198 in 2022/23). The flawed SAFER formula fails to recognize the actual rent paid if it is more than the rent ceiling and an income cap that is not adjusted for inflation. The result is that rent will increase by more than your income, but your SAFER grant will still be reduced due to the rent ceiling policy.

The lack of available rentals in rural B.C. is also demonstrated in the lower utilization of SAFER. While rural seniors represent 17% of the seniors' population, they represent less than 10% of SAFER recipients.

SENIORS' SUBSIDIZED HOUSING

BC Housing offers housing units through the Seniors' Subsidized Housing (SSH) program for low-income seniors aged 55 or older or people who have a disability. Rents are based on income and seniors pay 30% of their gross income in monthly rent. In 2022/23, there were 32,279 SSH units available, a 6% increase from 30,506 units in 2018/19. But the units per 1,000 population (55+) decreased 3% (18 units per 1,000 population 55+) compared to 2018/19 (18.6 units per 1,000 population 55+).

The number of applicants applying for SSH offered through BC Housing continues to grow each year. In 2022/23, there were over 12,000 applicants with only 7% of applicants who received housing. As of March 31, 2023, there were 11,549 applicants waiting, a 20% increase over the previous year and a 60% increase from five years ago. This is not surprising given the significant housing affordability challenges in British Columbia. Over 50% of senior applicants waiting in the Interior and nearly 60% of seniors applicants in Northern Health regions have been waiting more than 2 years for a seniors' subsidized housing unit.

The data on geographic breakdown between the rural and urban split in seniors subsidized housing was only available from the BC Housing Registry. All of these units listed on the registry will be rent geared to income or co-op but some units are owned and operated by non-profit societies that do not have formal operating agreements with BC Housing. As of December 2023, there were 45,072 housing units for seniors and persons with disabilities, with 42,181 located in urban B.C. and 2,891 units in rural B.C. The rate of units per 1,000 (55+) population in urban B.C. is 28, which is more than three times rural areas with a rate of 9 units per 1,000 (55+) population.

TRANSPORTATION

Access to transportation allows seniors to carry out their daily tasks such as shopping, going to appointments, working, visiting family and friends and participating in social and recreational activities. While most B.C. seniors still hold an active driver's licence, data tell us that most seniors will move from driving to not driving while they are still living in their own homes.

Rural seniors require two types of transportation: rides for medical services that are outside their home community as outlined previously in this report, and the ability to get around for medical and personal care appointments, shopping, socialization and visiting with loved ones within their home community. For the latter, most seniors rely on driving their own vehicles, accessing public transportation, using a community-based program such as volunteer drivers, or asking friends, neighbors and family for a ride.

The rate of driving among rural seniors is higher than that of urban seniors. In part, this reflects the options that are available to urban seniors that make it more convenient to relinquish driving. In the Lower Mainland, there is a robust network of transportation options including SkyTrain, conventional transit buses, ride hailing (Uber, etc.), taxis and HandyDART. In rural B.C., ride hailing is absent there are little to no taxi services, limited conventional transit and much more restricted HandyDART.

VOLUNTEER DRIVERS

Seniors in rural areas may be able to access volunteer driver programs, including Better at Home, for attending medical appointments, but this depends on the availability of seniors services programs in the community and the supply of volunteer drivers. For example, seniors living in Grand Forks, Merritt or 100 Mile House do not have transportation services offered by Better at Home in their community.

TAXI SAVER PROGRAM

The taxi saver program allows seniors who qualify for HandyDART to purchase taxi vouchers that provide a 50% discount on the metered taxi fare. Unfortunately, the program is not offered in most rural communities either because the community does not have a taxi service, the taxi service does not participate in the program, or the local government does not fund the program.

BUSES

Public buses are available in 26 communities throughout B.C., however most rural communities have very limited service within the community and no service between communities. Decisions on service levels, which is driven by local tax revenue, are made by local and regional governments.

BUS PASS PROGRAM

The Bus Pass Program is available throughout B.C. and allows seniors who fulfill one of a number of qualifications (including receiving GIS, the federal spousal Allowance or federal Allowance for the Senior) to purchase a Bus Pass for a $45 per year administrative fee. The pass covers all regular bus rides, but not HandyDART services.

HANDYDART

There are 27 HandyDART systems in B.C. providing door-to-door service for people with physical or cognitive disabilities who cannot use regular buses without assistance. HandyDART can be effective for regular scheduled appointments that can be booked one week or more in advance. For seniors with unscheduled transportation needs, or who have an appointment that falls outside the scheduled HandyDART hours, the program is more limited in its value and this applies both in rural and urban B.C. In rural B.C., the limitations of HandyDART are exacerbated by the limited availability of the service.

BC BUS NORTH

When the Greyhound bus company stopped operating throughout B.C., seniors and others in rural areas found themselves without access to neighboring communities and regional centres. In 2018, BC Bus North was launched to service four major routes in Northern B.C.: Fort Nelson to Fort St. John, Prince George to Fort St. John, Prince George to Valemount, and Prince George to Prince Rupert. A shuttle program was subsequently added which service additional communities including Dawson Creek, Chetwynd and the District of Stewart.

While BC Bus North provides services to a large number of northern communities, it only operates two days per week to each destination and the cost may be prohibitive for some seniors. For example, the fare from Prince Rupert to Prince George is $77 and there are no seniors' discounts available.

COMMUNITY SUPPORTS

Aging successfully at home requires not just appropriate housing, transportation, and medical support, it also requires community support. Seniors need to stay engaged in society and they need a wide range of opportunities to achieve this.

In rural communities, seniors need to drive to almost everything and many areas deal with winter driving conditions for several months of the year. This makes access to physical activities like swimming, golf or pickleball, cerebral pursuits like bridge or adult education, or social pursuits such as lunch or coffee with friends, a greater challenge for rural seniors.

While many rural areas have thriving seniors' centres, some do not. Most seniors' centres in urban B.C. have the involvement of the local government either in directly funding, operating or both while local governments in rural communities have smaller tax bases and are unable to provide the same level of support to seniors' centres. Recreation centres face similar challenges. A swimming pool, walking track, gym and pickleball courts all require some investment by local governments and smaller communities find it very challenging to build the infrastructure needed to support an aging population.

While rural seniors lack the physical resources of their urban counterparts, it is important to recognize that many have a robust base of organized volunteers who run the seniors' centres, teach the chair yoga and cook the weekly lunches. The sense of community that develops from the necessity that everyone needs to help each other in rural B.C. is one of its greatest strengths, however, it is important to recognize this does not make it less deserving of government support and services.

NATURAL DISASTERS

B.C. is increasingly facing natural disasters. Floods and forest fires have all had a disproportionate impact on rural B.C. and therefore rural seniors. The ability for seniors to guard against these disasters and evacuate their homes if necessary is a burden experienced more often by rural seniors. There can be additional costs related to evacuation, insurance and decreased property values, as well as the stress of living in an area more prone to these events.

RURAL REPRESENTATION

Rural seniors are represented by elected officials at the local, provincial, and federal levels. Overall, when we look at local governments defined as a Mayor and Council or a Regional District Director, we find that given the number of smaller communities, representation in local governments and by extension in the Union of BC Municipalities, tips in favour of rural B.C. However, when we look at provincial representation, the scales tip in the other direction. In the 2024 provincial election there will be 93 ridings. Of these, 23% are considered rural ridings and 77% are urban – reflecting the underlying principle of representation by population.

In the current B.C. Cabinet, there are 27 members, with 11% representing rural ridings. There are two parliamentary secretaries for rural issues; one is focused on economic development and the other on health care.

British Columbia, like all Canadian provinces, has no mechanism within its form of elected government to balance population and geography. In the U.S., for example, there is a system of population-based representation found in the House of Representatives balanced against the geographic representation of the Senate based on two senators per state, regardless of population.

It is beyond the scope of the provincial government to alter the underlying structure of elected government, however, given the imbalance of population to geography, it is perhaps reasonable to consider a counterbalance mitigation strategy.

CONCLUSION AND RECOMMENDATIONS

Overall, rural B.C. has a proportionately larger and faster growing seniors' population than urban B.C., yet it has less infrastructure and resources to support its aging population.

On all metrics related to healthy aging, access to care, housing, transportation, community supports, and financial resources, rural seniors fall short of their urban counterparts. Most significantly, the challenges of today will only grow as the projected demographic shifts to bigger centres, intensifying the urban/rural dichotomy.

Building for the future will require a focused effort on the part of all levels of government, but most particularly the provincial government, to recognize the unique challenges facing rural seniors and the inadequacy of some of the current approaches. There is current work underway with the parliamentary secretaries that may touch on some of these recommendations. In particular, the Parliamentary Secretary for Rural Health has been tasked with most of the measures related to the health recommendations in this report.

It is recommended that the provincial government:

1. **DEVELOP AND IMPLEMENT A RURAL SENIORS HOUSING STRATEGY**
   The challenges that rural seniors face in finding appropriate housing as they age are unique. Unlike their urban counterparts who can sell their single-family home and move to a condominium, rural seniors have limited options as the private sector finds multi-family developments in rural B.C. less economically attractive. The current model of BC Housing focuses on providing only rentals and imposes income and asset tests that would likely exclude most seniors who sold their homes from accessing these rental units. Expanding BC Housing's mandate to include housing that allows capital contributions from tenants and ownership like what is offered through life-lease or co-operatives would meet the need of a greater number of rural seniors. The role that BC Housing will need to play in these developments would likely be significant as development expertise and capacity may be more limited within rural areas compared to urban communities.

2. **DEVELOP AND IMPLEMENT A RURAL HEALTH HUMAN RESOURCE STRATEGY**
   The recruitment and retention of rural health care workers from physicians to care aides needs to recognize what is needed to entice a workforce to rural B.C. Offering housing, significant recruitment bonuses and staffing rotations that allow for larger blocks of leave are all initiatives that could be better used to recruit public sector health care workers. Working with unions to determine how collective agreements could include rural targeted strategies will need to be included in this work.

3. DEVELOP AND IMPLEMENT RURAL SENIORS HOME AND COMMUNITY CARE STRATEGY

The traditional approach to home support of offering hours per day and workers travelling from one client to another is not effective in less densely populated communities. It becomes challenging to recruit staff when service models cannot support full-time work which results in reduced service for seniors. A strategy for rural seniors could recognize the merits of client-based funding for significantly isolated seniors and increase the scope of both the care plan of clients and the practice for care aides employed by the health authority to better support full-time work in health authority delivered home support.

4. DEVELOP AND IMPLEMENT A PROVINCIAL LONG-TERM CARE AND ASSISTED LIVING PLAN BASED ON EQUITY THROUGHOUT THE PROVINCE

The Province should develop and implement a 10-year plan to ensure sufficient and equitable publicly subsidized assisted living units and long-term care beds throughout B.C. Currently, there are proportionately fewer available units/beds in rural B.C. and the long-term care facilities are older. There needs to be an elimination of multi-bed long-term care rooms in all facilities, including those in rural B.C. The development of publicly subsidized assisted living needs to be incorporated into the plan. Assisted living can offer a more desirable and less costly level of support than long-term care but rural B.C. is lacking both the private and public sector investment in this housing option that is found more often in urban B.C.

5. DEVELOP AND IMPLEMENT A PROVINCIAL RURAL TRANSPORTATION STRATEGY

The Province should develop, implement and fund a multi-modal rural transportation strategy. Getting seniors out and about within their communities and to and from medical appointments is currently fragmented. There is no one mode of transportation that will address all issues but a cohesive plan that ensures more universal coverage is needed. The development of a universal BC Transit Pass for all modes of transit, including HandyDART, ride sharing and taxis that is available to all B.C. seniors with the cost sharing based on a sliding scale of income should be explored. The current BC Bus Pass is available only to seniors receiving the GIS and it does not include the cost of HandyDART.

6. IMPROVE AND BETTER PROMOTE BOTH THE PROVINCIAL TRAVEL ASSISTANCE PROGRAM (TAP) AND HOPE AIR

TAP enjoys wide awareness amongst rural seniors but is of little value to people living outside coastal communities and require free ferry travel. Hope Air offers significant support but is not well known. The possibility of combining the programs should be considered along with better awareness, particularly of Hope Air. In both cases, the ability to support seniors returning to their home community after an unplanned emergency transfer to an urban acute care centre needs to be included.

7. INCREASE RURAL REPRESENTATION IN GOVERNMENT THROUGH THE CREATION OF A MINISTRY OR MINISTER OF STATE FOR RURAL B.C.

Many of the challenges faced by rural seniors are experienced by all British Columbians who live in rural B.C. While every MLA has constituents who are seniors, most MLAs do not hear of the challenges faced by rural British Columbians. The geographic imbalance of the electoral map can be mitigated to some extent by elevation of rural issues to a stand-alone Minister of State or Ministry. While this will not necessarily result in addressing all rural issues, it will signal to rural British Columbians that their voice will not get lost in the urban mass. While there has been some recognition of this need through the creation of two parliamentary secretaries, one for Rural Economic Development and one for Rural Health, the breadth of issues unique to rural B.C. require a more consolidated approach.

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