

Aging in Atlantic Canada: Service-Rich and Service-Poor Communities

Vieillir dans le Canada atlantique :
communautés riches en services et
communautés pauvres en services



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Abstract

The delivery of services for seniors in Canada is increasingly complex and challenging. Communities across Canada age at different rates, and the forces underlying the differences, such as “aging in place” and migration, vary from community to community. We have identified two types of aging communities: service-rich communities, in which seniors have good health status and better amenities, and service-poor communities, in which seniors have poor health status and limited amenities. We also report on results for Atlantic Canada from a national study of service provisions. Three issues stand out: (a) the impact on communities of migration and aging in place, (b) the factors that distinguish service-rich and service-poor communities and (c) the conditions necessary to create a service-rich community. All levels of government in Atlantic Canada must work together to develop policies and programs that create and sustain service-rich communities.

Résumé

Au Canada, la prestation de services pour les aînés est de plus en plus complexe et pose de plus en plus de défis. Les communautés au Canada vieillissent à des rythmes différents et les forces sous-jacentes à ces différences (telles que le « vieillissement sur place » et les migrations) varient d’une communauté à l’autre. Nous avons déterminé deux types de communautés vieillissantes : les communautés riches en services, dans lesquelles les aînés présentent un bon état de santé et où les installations sont meilleures, et les communautés pauvres en services, dans lesquelles les aînés présentent un faible état de santé et où les installations sont limitées. Nous faisons également rapport, dans le cadre de la région de l’Atlantique, sur une étude nationale portant sur la prestation des services. Trois enjeux s’en dégagent : (a) l’impact, sur les communautés, de la migration et du vieillissement sur place, (b) les facteurs qui distinguent les communautés riches en services de celles pauvres en services et (c) les conditions nécessaires pour mettre en place une communauté riche en services. Dans le Canada atlantique, tous les niveaux de gouvernement doivent travailler de concert pour élaborer des politiques et des programmes qui permettent la mise en place et le maintien de communautés riches en services.

Canadians are living longer and with fewer disabilities in old age. A large proportion of Canadian seniors enjoy economic security and good health, and for these and other reasons Canada is recognized as a good place to live and to grow old (Plouffe 2003). However, well-being in old age is not shared equally among seniors, and it is influenced by several factors. The social determinants of health – such as income and social status, social support networks, physical and social environ-

ments, personal health practices and coping skills, and health services – are all factors that have a strong impact on seniors' well-being (Raphael et al. 2001). In addition, the growth and distribution of the elderly population, major reforms in healthcare, budget constraints and the advancement of technology also affect seniors' quality of life in Canada.

Communities across Canada are aging at different rates. Canadians' experience of aging is highly influenced by a myriad of factors, such as where one lives, socio-economic status, the physical environment, access to health and other services, and marital status (Bryant et al. 2004). Moore and Rosenberg (1994, 2001) show that not only do communities across Canada age at different rates (the number of seniors in each place varies), but the contributing factors underlying these rates – such as “aging in place” and migration, and access to services and support networks – vary greatly from community to community.

No single community experiences aging in the same way, and in no community is the population of seniors perfectly homogeneous with respect to the social determinants of health. There are, however, two clear types of seniors' communities that can be distinguished: service-rich and service-poor. Service-rich communities generally are those that have very good services and resource networks, where the majority of seniors are in good health, have higher social status and are better off financially. Service-poor communities typically have lower levels of services and less developed resource networks, where the majority of seniors have poorer health and lower social status and are financially less well off (Rosenberg et al. 2004).

This paper draws on a national study that asks, in the context of service provision for seniors, how and why communities are aging at different rates. It also attempts to identify the conditions necessary to create a service-rich community. The research design blends the main theories of three bodies of literature (the meaning of community; the nature of rurality; the provision of services to seniors) into a service-rich/service-poor framework for the purposes of investigating service provision for seniors (Rosenberg et al. 2005). The purpose is to explore the service provision environment for seniors in four communities in Atlantic Canada in order to document how and why seniors age differently in such communities, and the conditions necessary to create a healthy and service-rich community.

The paper begins with a discussion of the literature that provides the conceptual approach to understanding the concepts of service-rich and service-poor. This section is followed by an overview of the underlying research design and data collection. Next, specific findings of the research are outlined. The paper concludes with an exploration of some of the determining factors that distinguish service-rich and service-poor communities in Atlantic Canada.

The Service-Rich and Service-Poor Context

To the best of our knowledge, the concepts of service-rich and service-poor communities, and their linkage to the aging population, are new ways of conceptualizing the dynamics among Canada's aging population and urban and rural development across Canada. The conceptual approach to this research draws on three different but not mutually exclusive areas of literature: (a) the geography of aging and migration, (b) aging in small towns and rural Canada and (c) aging, health and social policy. We contend that the integration of the concepts and findings of these literatures provide a useful framework for understanding the context underlying service-rich and service-poor communities. A brief synopsis of the main aspects of each of the three areas now follows.

The geography of aging and migration

The literature of geography of aging and migration in Canada suggests that much of Canada's elderly population "ages in place"; that is, migration flows of the elderly are much smaller than those of the working-age population. Migration flows are highly selective, and the motivations for migration among the elderly population are complex. In Canada, age-selective migration is strongly influenced by regional economic differences (Shaw 1985). Changes in health and marital status take on greater relative meaning in comparison to economic factors among the non-elderly population. Declining health status, loss of independence, a need to be closer to family, friends, other forms of informal and formal support – all need to be factored into an understanding of whether and why seniors choose to move (Litwak and Longino 1987; Wiseman 1990; Che and Stevenson 1998). Migration behaviour of seniors is often linked to retirement, especially for the more affluent elderly and the "young elderly" (Northcott 1988). Places with high recreational and amenity values – such as Vancouver Island and the Okanagan Valley in British Columbia, the Muskoka region and Niagara-on-the Lake in Ontario, and Prince Edward Island – appear attractive to these groups (Bergob 1995).

Indeed, elderly migration seems to conform to a life-course model whereby three distinct forms of migration can be discerned: retirement, social support and institutionalization. The first type of migration often occurs upon retirement, with the elderly moving to areas that offer amenities and other benefits more suitable to retirement living. The second type of migration usually occurs when the elderly, whether through illness, disability, death of a spouse or financial constraints, require social and other supports that are not available locally. The third type of migration results when the elderly, their caregiver(s) or both are no longer able to cope, with the result that institutionalization is the only option (Marr and Millerd 2004). Thus, the elderly move for reasons that are very different from those of younger people.

Aging in small towns and rural Canada

Research about aging in small towns and rural Canada tends to be diffuse, focusing more on transportation problems of the rural elderly, the future of the family farm, how seniors are transforming the countryside, and the “housing trap.” Research suggests that the rural elderly are particularly dependent on private transportation because of the lack of public transport in rural areas (Nemet and Bailey 2000; Grant and Rice 1983). Migration among the elderly to small towns from more rural areas is common, especially among women after the death of their spouse. Elderly populations living in small towns and rural areas are less likely to have the informal support networks of children and relatives nearby because of the selective migration of younger, working-age cohorts to larger urban areas (Moore et al. 1997).

The decision for rural seniors to relocate to larger, more urban areas is sometimes hindered by the “housing trap,” in which the value of housing in rural areas is lower than urban values, and the difference can block or prevent a move, especially for low-income elderly (Moore and Clark 1987). The availability of alternative housing arrangements can make the transition from the family home to a larger area much easier (Everitt and Gfellner 1996). At the same time, the movement of seniors with higher incomes and health status from urban areas to rural areas and small towns is transforming some locations (Averill 2003). These seniors bring with them a different set of “urban” values that generate demands for different kinds of services. As a result, tensions can arise among the local population as property prices increase beyond the means of locals (Halseth and Rosenberg 1995).

Poverty and socio-economic status can determine levels of independence, and the linkages among poverty, health and aging are well documented in the literature. Two consistent themes on aging and poverty are the improvements, especially with regard to pension plans and taxation policies, that have produced a decline in the overall level of poverty among Canada’s elderly (Hayward and Coleman 2003). The other is the continuing percentage of single, elderly women living alone who remain in poverty (Dooley 1994; Moore and Rosenberg 1994). Income and educational attainment are also strongly correlated as determinants of seniors’ independence (Wolfson 1989).

Informal support networks play both a psycho-social and functional role in maintaining seniors’ independence. However, not all seniors have family members living near them to play this role. There are many reasons for the absence of family members regardless of geographic proximity (Aronson 1994; Connidis 1994; Rosenthal and Gladstone 1994; Stone 1993). Formal support networks traditionally have been defined as the combination of physicians, hospitals and chronic care facilities located within a community or region. In the literature up to the early 1990s, small towns and rural areas were consistently demonstrated to have fewer physicians and hospital beds compared to larger urban centres (Anderson and Rosenberg 1990; Rosenberg and James 1994). More recently, the trends have been reductions in hospital stays, closure

of hospitals and consolidation of services for seniors through single entry point systems. These trends have resulted in more opportunities for seniors to remain in the community as much and as long as possible, and have caused several problems with respect to service delivery not necessarily anticipated by provincial governments. For instance, the supply of home care services has not expanded fast enough to meet the growing demands of seniors who need them (Hanlon and Rosenberg 1998).

The literature on aging in small towns and rural areas thus provides an indication as to why seniors are moving at different geographic scales (urban-dwelling seniors moving to more rural areas; rural seniors choosing to move to larger urban areas). The research begins to explain what might constitute a service-rich, compared to a service-poor, community. For example, it suggests that service-rich communities are those that have health and transportation services and alternative forms of housing that cater to the needs of seniors, their level of independence, health status and income.

Aging, health and social policy

The literature on aging, health and social policy has tended to focus on Canada's aging population as a "problem paradigm" (McDaniel 1987). This focus suggests that policy makers and the media have accepted uncritically the assumption that the future growth of the elderly population in and of itself will have dire consequences for health and social policies unless substantial changes take place in federal and provincial programs. The role that the elderly population will play in the generation of healthcare costs has also been extensively studied. The view of the elderly population as a problem paradigm is now entrenched among the public, and the future growth of the elderly population has become a national focus of both concern and opportunity (Northcott 1994; Foot 1996). Restructuring of provincial healthcare systems, the argument to treat long-term care as part of the continuum of healthcare services, and an insured health service under the *Canada Health Act* have combined to add a new element to this debate (Havens 1995). One policy response has been to increase home care services as a cost-effective substitute for the elderly population, although this view is not necessarily shared by all researchers (Rosenberg 1999).

We contend that the integration of the concepts and findings from these bodies of literature into a service-rich and service-poor framework provides a useful lens for understanding how and why communities are aging differently and what it takes to create a service-rich community. There is also a need to identify what constitutes service-rich and service-poor communities beyond those factors suggested by the evidence. The importance of this research is that it attempts to bridge this gap by qualitatively identifying how and why communities are aging differently and the characteristics that distinguish a service-rich community.

Data and Research Design

The Atlantic Canada component of the research is part of a larger national project funded by the Canadian Institutes of Health Research (CIHR) entitled *Aging Across Canada: Comparing Service-Rich and Service-Poor Communities* (Rosenberg et al. 2005), in which similar community profiles were completed across Canada.

The Aging Across Canada studies set out to understand how and why communities age differently, and what it takes to create a service-rich community that supports seniors' "aging in place." Fourteen qualitative case studies were completed between 2002 and 2004 by a team of regional investigators from the CIHR project. The specific study sites were identified through an analysis of demographic, population health and health services data that produced distinct types of aging communities across Canada based on population size and levels of income, social deprivation and community health (see Rosenberg et al. 2004).

The data reported in this paper are from the in-depth case studies of four communities in Atlantic Canada (one community each in New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland and Labrador). The communities represent varying sizes and populations: three larger regional cities (populations between 100,000 and 170,000) and one smaller city (population 16,000). The communities represent the three clusters that dominate in Atlantic Canada: (a) medium-size cities, average income, social deprivation, community health; (b) semi-rural regions with average income, low social deprivation and good community health; and (c) semi-rural regions with low income, high social deprivation and below-average community health (Moore and Rosenberg 2002).

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

Data were collected through a common questionnaire and interview protocol designed to ensure consistency across the country. The key informants were asked a series of semi-structured and open-ended questions about the current dimensions of the formal service environment for seniors in the four communities. Participants were asked to identify the strengths and weaknesses of the current situation, define a serv-

ice-rich community and outline any constraints to becoming (more) service-rich. All interviews were tape-recorded and transcribed to ensure authenticity. The transcribed interviews were coded by the first author and subjected to content analysis based on grounded theory. The major themes identified were combined with secondary data sources and supplemented by field observation to produce a narrative that is the descriptive and analytical core of the communities in this Atlantic Canada component of the study.

Results

The reporting and discussion of the findings are based on the structure that guided the research design: (a) how communities are “growing old” as a result of aging in place and migration, (b) the factors that lead individuals to move in anticipation of greater service needs and/or to move as a result of decline in health status that necessitates greater use of services and (c) the determinants that distinguish service-rich and service-poor communities.

Aging in place and migration

Aging in place and migration effects are shaping how communities age in Atlantic Canada. Aging in place is most common in communities where seniors have access to a wide range of formal services. These communities are rich in services such as acute care, primary care, public and private home care, long-term care, housing options, public transportation, not-for-profit agencies, volunteers and recreational activities. A community with a high level of formal services was described as a service-rich community by many respondents, particularly among service providers. For example, one long-term care provider described his community as service-rich because of the services available: “I think it would be service-rich. I can’t think of anything that’s really missing, there is a myriad of programs here, a myriad of housing and service options, availability of nursing homes. There are all kinds of service agencies.”

Migration patterns among the young and old are changing the face of communities in Atlantic Canada. Four distinctive migration patterns are apparent: (a) selective out-migration of youth from Atlantic Canada to other parts of Canada, (b) selective in-migration of youth from rural to urban areas of a province, (c) selective in-migration of seniors from rural to urban areas and (d) selective in-migration of expatriates retiring in Atlantic Canada. There is evidence from respondents that selective migration among the younger generation is strongly influenced by differences in regional economies. The decline or collapse of several resource-based economies in the Atlantic Provinces, such as fisheries, forestry, coal mining and steel production in Nova Scotia, have resulted in an increase in selective migration among younger populations. Many

respondents spoke about losing their young, educated population to other parts of the province or country, the growth in the 65-and-over demographic and the impact that these trends will have on communities in the future. The out-migration of younger generations to such provinces as Ontario, Alberta and British Columbia, however, is not a new phenomenon in Atlantic Canada. For generations, younger populations have “gone west” for greater employment opportunities. The difference with the current generation is that some young people have no choice but to move because of limited employment opportunities. Provincial in-migration from rural to urban areas is also motivated primarily by employment searches among younger populations.

When younger families leave rural areas, their parents are often left behind to fend for themselves without the support of informal networks. One respondent said: “Families are not available to care for aging parents. The out-migration has caused this real group of young families to be gone. They are no longer there ... and their parents are left by themselves.” As a result, many seniors are migrating to urban areas to be closer to informal support and services. Sometimes this migration is selective; sometimes it occurs out of necessity. For example, in Newfoundland and Labrador, many of the remote outport fishing communities are “disappearing” or “dying” according to respondents, and as a result, so are formal health services. Many small cottage hospitals and physician practices have long since closed or are anticipated to close in the near future. Thus, seniors who require health services and support as they age have little choice but to migrate to places where they can access primary healthcare (i.e., a family physician), acute care and nursing home care.

Migration motivations among seniors

The primary motivation among seniors in the study to migrate is the desire to be closer to formal services. This is a strong recurrent theme in all the provinces. Respondents noted many factors that contributed to the desire to be closer to formal services: declining health status, loss of a driver’s licence (or anticipation of losing it), loss of a spouse, a more general concern about “getting older,” anticipating being sicker and less mobile in old age. A secondary motivation to move is to be closer to family and informal support networks.

The majority of these seniors move from rural areas or townships to larger urban centres because such places typically have more formal services. At a certain age, many seniors decide to sell the family home and move “in town” to smaller homes or apartment complexes in the suburbs. Another motivation to move closer to a centre is simple convenience – to be closer to such amenities as pharmacies, doctors’ offices, shopping centres, hospitals and recreational/volunteer-based activities. A service-rich community is described by respondents as one that offers many opportunities for socialization and recreation for seniors. In every community, respondents described

their local seniors as healthy, active contributors to community life.

Many respondents spoke about the challenges that seniors face as they age and move to urban centres. For example, the desire to be closer to relatives and informal support networks is difficult for many of today's families. Many today are dual-career families that do not have the capacity to take care of their parents. One service provider described a typical situation at a local hospital: "An elderly patient comes in the hospital. Mom says, 'I can't take her, I don't care what you do, but I work full-time, my husband works full-time, we have three kids, and no one is there to take care of her.'" Thus, there are challenges for seniors and their caregivers, as well as for service providers.

Another significant challenge noted by respondents is the lack of care and housing options for seniors. Respondents in every community described the need for affordable seniors' apartment complexes, shared accommodations for seniors and housing that offers various levels of support and supervision. There is also evidence of the "housing trap"; however, this is generally tied in with the larger theme of lack of affordable alternative models of housing for seniors. Communities with more options are perceived as more supportive of seniors' independence. The ability of a community to support independence is another component used to describe service-rich communities. Respondents mentioned several system challenges that seniors experience in Atlantic Canada, such as wait lists for services, under-resourced home care and home support services, discriminatory long-term care funding policies and others (Davenport et al. 2005).

Identifying service-rich and service-poor communities

The initial definitions of service-rich communities provided by respondents suggest that many specific conditions are necessary for a service-rich community, including a variety of formal services (i.e., acute care, home care and long-term care; a mix of public, private and not-for-profit services; housing; recreational/volunteer-based activities; transportation). Further analysis indicates the hidden depths and layers of these necessary conditions. For example, the services themselves must be "service-rich." One respondent stated: "Service-rich to me would be a community where all of the services are available. And they are accessible to people in a way that makes sense to the people trying to access them. That is service-rich." A variety of formal services is the primary requirement, but the services must be available at the right time, at the right place and for the right duration. Respondents felt that "accessible" also means no waiting lists and services that are affordable for everyone.

I would say that if I were a senior and whatever service I needed I could very quickly and easily access it. That's what I would say is service-rich. That I wouldn't have to wait three months to get into a nursing home, that I wouldn't

have to go on a wait list for community services such as the handyman helper or the home support, that kind of thing. Or that I wouldn't have to pay big bucks for that kind of service. That's what I would consider service-rich.

A second observation is that many respondents linked their definition of service-rich with the determinants of health. A service-rich community is one that satisfies all the determinants of health with respect to seniors. In the words of one service provider: "To me, if you could satisfy those determinants in the eyes of a senior in terms of housing, in terms of affordability, in terms of recreation, economy and all that, then yes, you could probably be defined as service-rich." Others described a service-rich community as one that has a variety of services that meet people's economic, health, cultural and spiritual needs. Respondents recognized the inherent challenges in having services that address all the determinants of health. The message is that a service-rich community does not just have a large hospital and access to physicians and nurses; it does much more than treat illness.

In contrast, respondents living in communities with low incomes, low education, high unemployment and poor health status often labelled their community service-poor because they felt the services did not adequately address the determinants of health. It is also notable that service-rich communities focus upon health promotion and prevention as integral parts of their service delivery.

Housing plays a large role in seniors' level of independence, and respondents spoke repeatedly about the deficit in housing options for seniors in Atlantic Canada. Providers felt there were few options available between home care and long-term care and as a result, some seniors enter nursing homes sooner than necessary. For example, one provider said: "I think the big thing would be supervised types of housing ... we have enough nursing home beds but we have in some of [them] people who should be out in their own home with community-based services or in a personal care home, who probably just need supervision with their medication." Providers referred to this situation as "forced institutionalization." Access to transportation is also considered key in supporting seniors' independence and necessary for a service-rich community. Many other factors contribute to a senior's level of independence; respondents spoke about the small things that can make a big difference, such as keeping sidewalks free of snow and ice during winter so that seniors are not isolated in their homes.

Discussion

In the context of aging across Canada, Atlantic Canada is experiencing a unique migration pattern of older (and sometimes more affluent) former residents returning to the region to retire. This new "expatriate phenomenon" is, in fact, an extension of a generations-old tradition rooted in the culture of the Atlantic Provinces, where

those who moved away and remained away for most of their working lives have always longed to come “back East.” Provinces such as Prince Edward Island and Nova Scotia are actively pitching marketing efforts at expatriate retirees, extolling the low cost of real estate, the culture, the beautiful landscape, friendly people, slower pace of life and safe communities. Some provinces have also succeeded in attracting seniors from other provinces, and other countries, to retire in Atlantic Canada. This influence is not always benign, as in some situations, tensions have arisen between locals and newcomers over rising property costs and the rapid consumption of property and land by “outsiders,” a problem identified in other parts of Canada (Halseth and Rosenberg 1995). There is also the question of whether returnees have greater expectations of a “service-rich” community.

A condition for a service-rich community is that available services be coordinated in a formal way. Respondents often said that their community has all the right components to be service-rich but the services are not coordinated or organized. As a result, services for seniors are fragmented. Many seniors do not know what is available or how to access it. A service-rich community must also offer continuity of care, from the home through acute care and long-term care. Without continuity of care, respondents felt that some seniors “fall through the cracks” or continually get treated differently by different providers (e.g., when patients come to emergency rooms). Respondents also spoke about a lack of collaboration and communication between acute care providers and those who provide care in the community, such as not-for-profit agencies, volunteer groups and so on. The message was clear: it is not enough to have several types of services to be service-rich. Rather, the services must be coordinated and provide seamless continuity of care.

This may be a tall order. As Keefe (2002) notes, the present system of services for seniors is a complex, piecemeal network of policies and programs that has evolved over time. In short, the picture is one of fragmented provincial policies that undermine rather than strengthen and support service-rich communities. What is needed are policies that foster and support service-rich communities. In Atlantic Canada, Nova Scotia’s recently published Continuing Care Strategy (NS Department of Health n.d.) is an example of a policy instrument that, if implemented, should both support aging in place and ensure that communities are service-rich.

A final observation is the notion that “service-rich” does not necessarily mean a community that is urban. While the majority of formal services tend to be found in urban centres, many components of a service-rich community are found in rural areas. Rural areas were commended for their citizens’ ability to solve problems creatively and “take care of one another” without formal support or resources. As an example, churches in rural areas provide informal support to seniors with volunteer visiting, provision of meals and transportation. Service providers talked about the power of informal networks in these areas and their ability to use “connections,” networks and

“word of mouth” to offer services for seniors. Respondents also thought a service-rich community would support informal and family caregivers (e.g., through tax breaks, respite or paid time off work, although the decisions to provide these types of services are often made by a higher level of government and therefore remain out of local communities’ control).

Other key conditions necessary for a service-rich community for seniors are good quality of life and independence. Quality-of-life services focus on the social, psychosocial and spiritual needs of seniors (e.g., those that provide socialization and recreation). Services that support independence facilitate a senior’s remaining at home when home is appropriate. These would include day programs and services that help seniors with basic household management, shopping and meal preparation.

Conclusion

The community profiles that emerge from this study illustrate the significance of the service-rich and service-poor framework as a way to conceptualize the dynamics of Canada’s aging population and in the Atlantic Canadian context. This research illuminates how communities in Atlantic Canada “age in place” and demonstrate unique migration patterns. Using the results of community profiles in Atlantic Canada, this study enabled us to identify conditions necessary for a service-rich community – one with a variety of services that meet seniors’ needs, is accessible, addresses the determinants of health, includes health promotion and prevention, focuses on quality of life, promotes independence, has strong informal support networks and is coordinated in a formal way. The analysis demonstrates the qualitative components of a service-rich community and the importance of looking beyond statistical evidence alone.

What remains unanswered is the extent to which communities are willing or able to fulfill the components of a service-rich community, whether provincial governments will be able to provide the resources necessary to meet the demands of communities and the aging population and whether communities will end up service-rich or service-poor. A service-rich community for seniors will require not only resources, but a shift in providing care for seniors that meets all their needs beyond illness and disease.

Moore and Pacey (2004) argue convincingly that the changing geography of aging is as much a national issue as it is a regional or local one in its potential impact on public policy. The implications are potentially profound, especially with respect to the growing demand for healthcare and social services. If the disparities among areas resulting from the effects of economic migration and fragmented government policies and programs are not addressed, there is an increased risk for the elderly that the “landscape of *have* and *have-not* communities will become even more pronounced” [emphasis in original] (Moore and Pacey 2004: S19).

The consensus from the interviews is that all levels of governments in Atlantic

Canada must work together to develop policies and programs that create and sustain service-rich communities. Failure to do so will result in fewer service-rich communities, thus undermining the very attributes that governments use to encourage returning expatriates and confounding attempts to encourage and support seniors to age in place. The lessons being learned in Atlantic Canada are also demanding attention in other developed countries as populations age and communities either thrive (become service-rich) or decline (become service-poor).

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