IMPROVING
THE QUALITY OF LIFE
OF THE ELDERLY AND DISABLED
PEOPLE IN HUMAN SETTLEMENTS

IMPROVING THE QUALITY OF LIFE OF ELDERLY AND DISABLED PEOPLE IN HUMAN SETTLEMENTS

VOLUME I

A Resource Book of Policy and Programmes from around the World

United Nations Centre for Human Settlements (Habitat)
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FOREWORD

The world's population is ageing dramatically. The total number of people aged 60 and older grew from 200 million in 1950 to 400 million in 1982. Their number is expected to increase to 600 million in the year 2001 when 70 per cent of them will live in developing countries. This demographic revolution has major consequences on the way human settlements are designed, managed and used.

The United Nations and its agencies have undertaken many activities that recognize this reality. The General Assembly adopted the World Programme of Action concerning Disabled Persons and proclaimed 1981 the International Year of Disabled Persons. In 1982, 124 Member States adopted the International Plan of Action on Aging at the World Assembly on Aging. These two landmark events launched a variety of activities and studies during the United Nations Decade of Elderly and Disabled Persons.

The United Nations Centre for Human Settlements (Habitat) launched the decade with two important documents. *Designing with Care - a Guide to Adaptation of the Built Environment for Disabled Persons* was published as the result of cooperation between the United Nations, UNCHS (Habitat) and the Swedish International Development Agency (SIDA). This guide pointed out that implementation of suggested design guidelines and related policies and programmes would have to be undertaken by authorities, taking into consideration the economic, social and climatic conditions of the human settlement concerned. Human Settlements and Aging (HS/OP/82-14), was published by (UNCHS) Habitat in 1982, considered issues in developed and developing countries involved in incorporating the needs of the ageing in human settlements development.

To continue the momentum of work of the Decade, the United Nations Centre for Human Settlements (Habitat) undertook a study to examine policies and programmes that can be implemented in human settlements by local governments to improve the living conditions of those who are elderly and disabled. The contents of this report will also be supportive of efforts to implement the Global Strategy for Shelter to the Year 2000, adopted by the United Nations General Assembly in 1988. The objective of the Global Strategy is to facilitate the provision of shelter for all groups in all types of settlements, meeting the basic requirements of tenurial security, structural stability, infrastructural support and convenient access to employment, community services and urban facilities. This report sustains that effort by providing global guidance and specific examples of policies and programmes to meet the needs of those who are elderly or disabled.

The study is comprised of two volumes. In the first, information gathered through a literature search, the policy experience of cities (largely unpublished) and case studies is consolidated and distilled into guidelines to provide practical and specific ideas for local authorities. In the second, in order to provide more detailed information for the users of this research project, two case studies, prepared for the cities of Ottawa, Canada, and Madras, India, are presented.

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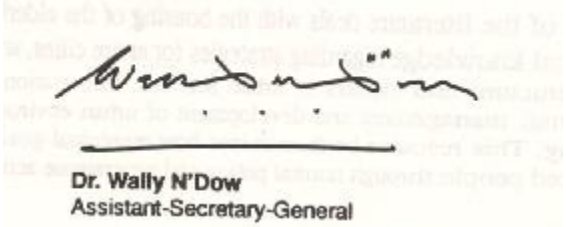

Dr. Wally N'Dow
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OBJECTIVES, SCOPE AND KEY TERMS

Objectives

This resource book identifies effective solutions that can be undertaken by local governments for improving the quality of life for elderly and disabled people in human settlements.

Its aim is to assist decision-makers in national and local government to develop effective and affordable strategies to address the common problems facing elderly and disabled people and to improve their daily lives. The work of officials, researchers, planners and architects working in areas related to the planning, management and development of human settlements will be facilitated by the information contained in this report.

The report consolidates research as well as policy experience. Successful policy experiences have been drawn from a large number of cities in many countries. However, the major proportion of the ideas has been drawn from two case studies. The first case study describes the policies and programmes for elderly and disabled people in Ottawa, Canada. The capital city of Canada has a population of about 300,000 and a northern climate. The second case study depicts the experience of the city of Madras, India, in dealing with the challenges of improving the living conditions for the elderly and the disabled in a tropical city of about 4 million inhabitants. The city has a wide spectrum of neighbourhoods with housing ranging from upper-income residential areas to slums.

The survey of policy and programme approaches has shown that creative and effective solutions are possible despite economic, social or climatic constraints. It has also shown that there is a high potential for international exchange of ideas and concepts which may then be adapted for local application. This resource book is a mechanism for the sharing of such information.

The scope of the study

A human settlement that is a good place in which to age serves its residents throughout the life cycle. The intent of this resource book is not only to provide suggestions for easing existing difficulties confronting elderly and disabled persons but also to improve living conditions in the future for all residents who live out their lives in an urban environment.

The increasing need to address the problems of the elderly and the disabled population, in their living environment has stimulated many research activities. The preponderance of these research studies has focused on the improved design of the built environment to accommodate the needs of these two population groups. The need now has shifted to policy research, identifying ways in which changes to human settlements can be accomplished. These policy solutions compete for administrative attention and public resources, therefore, they must be cost-effective as well as acceptable to the electorate. The study aims to consolidate effective policy strategies that have been successfully applied.

Much of the literature deals with the housing of the elderly and of disabled people. There is a dearth of practical knowledge regarding strategies for entire cities, with their mosaic of neighbourhoods, networks of infrastructure and clusters of urban services. Information on macro-level policies, which concentrate on planning, management and development of urban environments, including infrastructure and services is lacking. This resource book examines how municipal government can respond to the needs of elderly and disabled people through normal policy and programme activities.

The vast majority of the elderly and of disabled individuals will live in developing countries. It is essential that successful strategies are available to the developing countries where rapid urbanization is in progress. These developing countries can learn from the errors of developed countries as well as from their successful ventures.

There are opportunities for mutual exchange. In present conditions of economic restraint, developed countries are open to simple and inexpensive strategies which are often created by developing countries. It is also recognized that developing countries may have a trajectory of development that skips or speeds through phases of development. For example, technologies are purchased from developed countries rather than pursuing the slow process of product innovation. With the forces of globalization, development patterns are expected to change. Therefore, developing countries can prepare themselves by following policy development based on the experiences of developed countries. For example, in developed countries where telephones are found in almost every home, a variety of services such as telephone assurance, emergency service and telephone-based consumer and social services become possible. Though telephones are not yet widely available in developing countries, such programmes can be planned for in advance in the expectation that telephones will be commonplace in homes in the future.

Key terms used in this study

Definitions of terms vary greatly. The terms used and the background for their use are explained below.

Elderly people: Elderly people are often defined as citizens over the age of retirement but the age of retirement varies from country to country. Many low-income people and tradespeople work beyond the age of retirement for various reasons. The International Plan of Action on Ageing adopted by the World Assembly on Aging applied the term to persons over the age of sixty. However, in many countries people continue to work and function well beyond that age. Indeed, some countries have abandoned a mandatory age of retirement. Moreover, it is recognized that the functional capabilities rather than chronological age are more important for policy purposes.

In this study, where data are presented, the applicable definition of "elderly " is provided. Otherwise, the tern is used to identify those adults who may or may not be working, but as a group require special policy consideration because of needs associated with their age.

Disabled people: The response to disabilities has changed over the last decade as human rights issues have come to the fore. The World Health Organization defined disabilities as "any restriction or lack of ability to perform an activity in the manner or within the range considered normal for any human being". A disability may be visible or invisible; temporary or permanent; single or multiple; progressive, stable or regressive. There are several disabling conditions, arising from loss or impairment of mobility, agility, vision, hearing, cognition and size. Conditions due to allergies or disease may also be included. Changes in attitude are reflected in the terms used. When referring to people with disabilities, it is suggested that the disability be used as an adjective rather than a noun (thus, blind persons and not the blind). In some countries, stress is placed on abilities rather than disabilities. Terms such as the "differently abled" and "mentally challenged" are frequently used in some countries; however, in this report the tern "disabled people" was chosen for clarity. Specific disabilities are also used as adjectives such as deaf people.

Barrier free or accessible environments: The term "handicap" is not a synonym for "disability" in many countries.

> "A handicap is not looked upon as a characteristic of a person with a disability caused by injury or illness but as a relationship between the person and the environment… This is important because it places a responsibility on all organizers, both public and private, to see that the activities they run are accessible to all - also to disabled people, thus preventing a disability from becoming a handicap." *(Support for the Disabled in Sweden, Fact Sheets on Sweden, May 1986)*. This has led to the recognition that handicapping physical and social environments must be abandoned in favour of "barrier-free" or "accessible" environments. Such environments are defined as accessible or barrier-free when elderly or disabled people are, without assistance, able to approach, enter, pass to and from and make use of an area and its facilities. This reflects the current philosophy of individual rights, mainstreaming and integration rather than exclusion or special or

segregating design of the environment. Though special environments such as sheltered workshops and special homes for disabled people are still provided, the preference is to structure normal environments so that they are usable by everyone including those with disabilities. Universal design integrates the needs of disabled people into normal environments, encouraging self-reliance, independence and freedom to every citizen regardless of varying abilities.

Ageing-in-place: When elderly people are able to age in their own homes in the community relying on support services and their own social network, it is called ageing-in-place. Elderly people in developed countries. prefer to age-in-place, living independently in homes of their choice. In developing countries, elderly people are often dependent on their families for shelter and other household services, but they continue to live in the community. The alternative in both developed and developing countries is to live in segregated environments built specially for elderly or disabled people, mainly institutions, relying on public, private or volunteer services.

Local authorities, city governments and municipalities: Because of the great variation in definitions, these terms are used synonymously to refer to governing bodies with responsibilities for human settlements that can take action on behalf of elderly and disabled people as well as the urban environment and urban services.

HOW TO USE THIS RESOURCE BOOK

Municipal governments recognize that elderly and disabled people have problems that are exclusive to them which cannot be handled well by general policies. It is also accepted that as productive citizens they can contribute to as well as benefit from society and, therefore, the needs of each group must be addressed. This resource book presents the needs of elderly and disabled people from a policy perspective. When their needs are understood, measures can be taken that do not necessarily cost more because they reduce other costs to government.

To facilitate this process, this resource book suggests that city governments establish their own statement of responsibilities for the improvement of the quality of life for urban residents, including elderly and disabled people. To accomplish these responsibilities, each local government can develop its own set of principles for action. These principles are valuable when choices have to be made between alternate policy strategies and when decisions have to be made regarding the resources to be invested between competing demands.

This resource book is a compendium of practical solutions that have been tried successfully by several local governments around the world. These solutions have been gathered from published literature, two case studies, and unpublished policy information provided by cities. These are often highlighted in boxes. Where published sources are available, they are given. When a city where a solution is practiced is known, its name is given, so that further information may be gained by contacting the city. Where the solution has been implemented in several cities a more generic description is given.

Readers are invited to evaluate the living conditions of elderly and disabled residents in their own human settlements. Since many of the problems experienced by these groups are interrelated, clusters of problems can be identified. From this resource book, programmes and policy ideas that have potential to address these clusters of problems may be selected and then adapted for the specific political, economic and climatic needs of the human settlement.

The policies and programmes presented in this resource book may have three applications: first, current problems can be addressed; secondly, a strategy may not be immediately applicable but may be used eventually when resources and conditions permit, and, thirdly, strategies may prevent problems that may arise in the future.

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I. INTRODUCTION

There have been major demographic shifts in the world population. The decline of fertility is reducing the proportion of children while increased longevity is increasing the numbers of elderly people living longer. The proportion of the age group aged 65 and over is projected to double from 5 per cent of the world population in 1950 to 10 per cent in 2025. The elderly population in 2025 is expected to exceed 850 million people, of whom 70 per cent will be living in developing countries.

The number of disabled people is also expected to rise due to improved survival rates after congenital disabilities, disease or accidents. The current estimates are in the range of 500 million, of whom approximately 80 per cent live in developing countries. Furthermore, a high proportion of elderly people also have disabilities associated with age. Many elderly people have multiple impairments. As a consequence, as high as l person in 10 is estimated to have some disability in many countries.

Elderly and disabled people are among those who experience the greatest difficulties in their daily life in human settlements. Many of them have low incomes and, as a consequence, a low quality of life. Many human settlements are not designed or managed to meet the special needs of these groups. They are often excluded from the labour pool, the market place and the social networks of the city because of their inability to traverse the city. Indeed, the problems of elderly and disabled people are persistent because they suffer multiple deprivations, which do not respond well to single-issue policies.

Efforts to help the elderly and the disabled people in human settlements are not pursued for moral reasons alone. Non-participation of some groups in urban activities can extract a high cost from economic development. Furthermore, advances in human rights as well as national goals for social equity have stressed the value of all human resources, including elderly and disabled people. They are encouraged to contribute to national development rather than to simply be passive beneficiaries of it.

It is important, therefore, to develop worldwide strategies for the improvement of living conditions for elderly and disabled people in human settlements. Local governments play a leading role in effecting this reformation and they are also major beneficiaries from this change.

II. THE NEEDS OF ELDERLY AND DISABLED PEOPLE IN HUMAN SETTLEMENTS

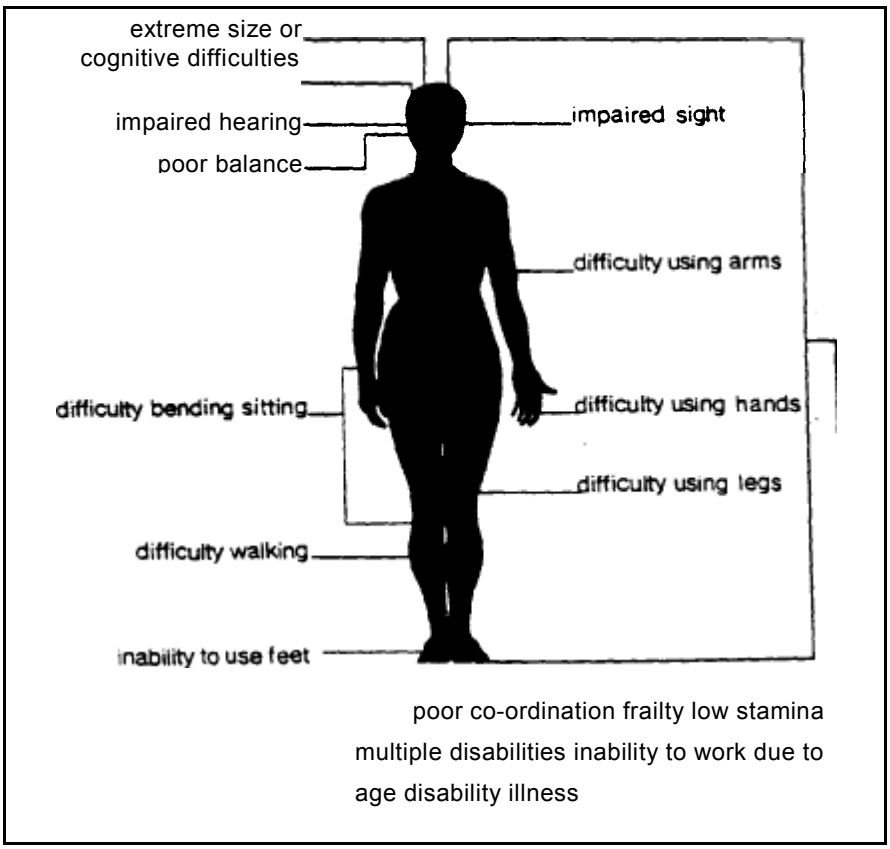
The cities and towns of the world work generally well for people who are healthy, able-bodied and solvent. But people who lack any one of these characteristics have to contend with a multitude of barriers that hinder their every day activities and their participation in urban life.
There are three major types of barriers:

(a) *Physical barriers*: Many environments that are taken for granted such as road intersections, airports or subway stations, pose enormous physical barriers to people who are elderly or disabled because they cannot see, hear or move as well as other people;

(b) *Institutional barriers*: These are processes and activities that pose a hardship for people with disabilities such as the requirements for applications in person or a credit rating which are difficult for member of these groups;

(c) *Systemic barriers*: Subtle systemic discrimination is a further burden because the needs of disabled people are, intentionally, or unintentionally, ignored. For example, much information is disseminated through printed media, which cannot be read by those with visual impairments.

Figure 1. Range of disabilities



These barriers cannot be overcome by individual efforts but require concerted action by the various levels of government. The removal of barriers may involve more of a certain activity, a better-designed activity or a different type of activity.

Yet before action can be taken, the needs of the elderly and disabled residents in human settlements must be understood. These groups are not homogeneous nor are their problems always similar. Because of increasing longevity, the period of retirement can span 30 to 40 years. Elderly people attempt to prepare for a financially secure retirement, though many of them are unsuccessful. Many of them have used the city intensively during their lives. During this period, the ageing process can affect people differently. While some age with little change in their abilities, others have minor and multiple impairments and still others are fragile or seriously disabled. Disabled people, on the other hand, can be of any age. The range of disabilities can vary: they can be visible or invisible; simple or multiple; permanent or temporary; progressive, stable or regressive. Many of them have congenital conditions and they have never used the city intensively. If there are few opportunities for work available to disabled people, they have financial difficulties.

The removal of barriers, even in developed countries, has been hindered in the past because much of the research categorized individuals according to their disabilities. Five groups were commonly identified: people with mobility impairments; people with difficulties of reach and handling; people with visual impairments§; people with hearing impairments; and people with cognition impairments recommendations for design of the environment or for its modification were then made for each of these groups.

Such an approach was problematic. This categorization of individuals did not include all those who had activity limitations. For example, those who had disabilities from diseases such as multiple sclerosis or frailty due to ageing were excluded. Although a lot of design information for specific disabilities is available, it is seldom applied. Even when recommendations are implemented, the results are not sufficient to improve the living conditions of those who are elderly or disabled-people.

There is now greater understanding of the reasons for these failures. Single-disability groups are too small to compete for policy attention. Furthermore, resources are more likely to be expended for the greater good of the majority, rather than to provide what may appear to be special benefits to small groups of citizens. For these reasons, little action is taken. When design changes are made for each disability, other groups are left out. For example, elderly people who have minor but multiple disabilities are not always well served by special designs for one disability. Because designs are not considered holistically, solutions for one group may pose problems for another. For example, when curb cuts are designed with smooth inclines to the street, blind people using a cane are unable to sense the edge of the street.

It has become clear that elderly and disabled people need to be considered as a group to reflect their population mass for policy purposes. Instead of searching for solutions for specific disabilities, policy-relevant disability variables must be identified. When the range of disabilities is understood, policies may be developed to overcome them without necessarily associating them with particular people. Policy-relevant variables focus attention on the nature of the problem rather than the numbers with the problem. Solutions developed from this perspective are more inclusive rather than specific. People with multiple disabilities, or with deficits that are not defined as disabilities such as frailty, are assisted by these solutions. Furthermore, policy strategies can be developed holistically.

To be policy-relevant, disabilities should be described according to the difficulties experienced without consideration of the disease or condition (see figure 1). Then, for each type of difficulty, the list of physical, institutional and systemic barriers must be identified.

Finally, policies and programmes must be developed to overcome these three types of barriers. Synergies and overlaps can be recognized, as well as conflicts. Comprehensive plans can be prepared and activities can be undertaken in order of priority.

The chart, in figure 2 lists the policy-relevant variables and the urban needs to be met, if physical, institutional and systemic barriers are to be breached. For example, the difficulties arising from frailty or low stamina can be considered. For them, the physical environment should be characterized by low energy-craving design. Hardware should be simple and not require a great deal of force or pressure to operate. Resting places should be provided to overcome institutional barriers; design regulations that improve physical design should be enforced. Since such people may move slowly, the timing of opening and closing of doors in elevators, subways etc, should be controlled. Emergency plans should include areas of refuge or plan for slow evacuation. Governments should review processes that require citizens to apply in person. The systemic response would examine all activities for discriminatory conditions. The availability of wheel chairs and porter services in public buildings

and transport centres would make them accessible to such people. This chart is illustrative rather than exhaustive, to provide a model blueprint for developing city-specific solutions.

Local governments should ensure that all citizens, regardless of ability, are able to make decisions regarding their own lives, live independently and carry out their responsibilities as citizens. How can this be accomplished? The following steps are recommended.

1. The municipal government should establish a mission statement, clearly expressing its responsibilities for elderly and disabled residents.

2. Based on this mission, a set of principles of action should be established. These principles are helpful when choices have to be made between alternatives, when priorities are to be set and when resources have to be allocated between competing demands.

3. With public participation, including that of elderly and disabled residents, the local government should be examined for physical, institutional and systemic barriers. The present and future needs of elderly and disabled people as a group and as a part of the total population should be estimated.

4. Policy and programme alternatives should be developed to meet the needs identified. Potential outcomes should be gauged in relation to the investment required Partnerships for implementation should be identified.

5. An action plan should be developed with clear objectives and time schedules to make orderly gains.

6. An independent public monitoring and evaluation group should report periodically on progress.

Figure 2.

Physical, institutional and systemic responses for the full range of disabilities among urban residents

Disability	**Physical response**	**Institutional response**	**Systemic response**
Difficulty dealing with information	Simple city and building configurations, clear signs	**Clear instructions for citizen responsibilities such as licenses, taxes etc.**	Personnel training for service to the public
Impaired sight, including colour blindness	Large and well-lit signs, information using other senses such as tactile or voice information	**Regulations that allow the use of seeing-eye dogs in office buildings, restaurants etc.**	Use of multi-media (radio as well as print) for information in the public interest
Hearing impairment	Systems to aid hearing in public spaces and buildings. Emergency signals for deaf people	**Regulations for the safety** and function of deaf people in work places and homes (e.g., alarms, special telephones)	Use of telecommunication devices for the deaf (TDD) or fax machines for the public to access government offices
Poor balance	Accessible design (e. g. level surfaces, limited cross-grade) and design for those using mobility aids	Regulations with regard to design and timing (e.g., elevator doors, automatic doors), security	Special entries, counters or other arrangements for service. Usable transport
Poor coordination or uncontrolled movements	Accessible design of spaces and hardware. Choice of entry (ramp, stair or elevator; automatic door or revolving door)	Regulations with regard to design, timing and security (e.g., use of automatic door openers). Review of "in person" requirements.	Special entries, counters or other arrangements for service. Usable transport
Frailty, low stamina	Low energy-craving design and hardware, resting places	Regulations for design, timing and security. Review of "in person" requirements	Availability of wheel chairs and attendants in public buildings. Porter service in transport terminals
Difficulty using arms for large motor movements	Accessible design of spaces and hardware, also accommodating those who use aids	Regulations for design (e.g. use of automatic features or suitable hardware at entrances of buildings, transport etc.)	Availability of attendants in public buildings. Porter service in transport terminals
Difficulty handling and fingering or fine motor movement with arms and hands -	Accessible design of spaces and hardware, also accommodating those who use aids	Regulations for the design of products and buildings	Acceptability of alternatives to signatures
Loss of gross leg movements	Accessible design for those using mobility aids. Choice of features (e.g., stair, ramp, escalator, elevator)	Regulations for design. Reduction of walking distances, location of toilets, entries/exits	Parking for special vehicles. Sheltered drop-off at entry.
Difficulty bending, kneeling, sitting	Accessible design, specially for resting areas, waiting areas and toilets	Regulations for design in buildings, public spaces and transport	Special toilet facilities for those who require the aid of attendants.
Difficulty walking or slow locomotion	Accessible design in areas of pedestrian movement. Accommodate mobility aids and wheel chairs. Security arrangements for evacuation	Regulations for accessible design in buildings, public spaces and streets specially for circulation and security. Location of essential amenities such as toilets	Parking for special vehicles. Sheltered. drop-off at entry
Inability to use feet	Accessible design to accommodate prosthesis or mobility aids	Regulations for accessible design in buildings, public spaces and streets. Location of essential amenities	Parking for special vehicles. Counters for use when seated
Extreme size (large or small) or weight	Design for users of a wide range of height & weight	Regulations for accessible design in buildings and public spaces	Review of requirements for height or weight for participation or employment. Counters for use when seated
Multiple disabilities or diseases	Requirements listed above	Regulations listed above	Requirements listed above
Inability to work due to age. disability or illness	Requirements listed above	Possibilities for independent living and meaningful activities	Income support and opportunities for civic participation

III. THE LIVING CONDITIONS OF ELDERLY AND DISABLED POPULATIONS IN HUMAN SETTLEMENTS

Disabled and elderly people face the risk of having a standard of life lower than that of their counterparts of equal social class living in similar neighbourhoods. This phenomenon holds true in both developed and developing countries. Why is this so?

There appears to be a chain of circumstances that affects the quality of life of elderly and disabled people. For example, a disability may limit work options resulting in low income that further limits opportunities to use goods and services that could improve the quality of life. The length of the chain varies with socio-economic factors so that an educated and well-to-do person with disabilities may have a short chain while a disabled person with low income and little training may have a longer chain. Thus, elderly or disabled people, who are economically well off, have a lower standard of life, primarily because they are unable to participate equally in the opportunities the city offers due to the physical, social and systemic barriers discussed earlier. Although they are able to overcome some barriers by extra expenditure, they are still faced with others, such as the inhospitable design of buildings and public spaces. They may be unable to visit museums, attend concerts or public meetings or shop in places of their choice. For those of less means, the chain is longer and it affects their current and future conditions. For instance, a disabled child who is unable to attend school or acquire occupational training is fated to have a low income throughout life. With inadequate income or with heavy reliance on public or charitable aid, disabled people are unable to overcome barriers to the enjoyment of a decent quality of life. Elderly people, who experience a fall in income in retirement as well as a decline in their abilities, find that they have to find some way to augment their income. Some continue to work but they have limited access to earning opportunities in the city due to physical, institutional and systemic barriers. They often work in casual or temporary jobs in the informal economy where they have little protection against exploitation. Others seek the support of families, charitable organizations or public aid.

Proportion of elderly and disabled people in the total population

The numbers of people who are elderly and disabled are hard to determine from existing sources of data such as the census. Most countries collect data based on age but are only now including information on health status or disabilities. Nonetheless, it is clear, that in urban settlements, the proportion of elderly and disabled people in the population is rising. This is, in part, because the average age of urban residents is rising because of a decline in the birth rate in cities, even in developing countries. It is also because elderly and disabled people stay in the city or move to the city so that they can have access to better health and medical services. Special services such as schools for blind children, sheltered industries for disabled people or meals-on-wheels for elderly residents are generally found in larger human settlements. The estimates of those who are disabled are as high as one in eight, particularly in developed countries. This is largely because the propensity for disability increases with age and the number of older people in cities is high. This trend is unlikely to reverse itself so there may be a relatively high proportion of elderly and disabled people among those with a low quality of life in cities. Uncared for, these groups can form persistent and sizeable ghettos of disadvantage and poverty in cities.

Health and activity status

The health and activity status of elderly and disabled people, particularly in developed countries, has improved tremendously in the past decade. Many prosthetics and aids has been developed to those are allow those who are disabled to function independently.

The life expectancy of citizens continues to grow in both developed and developing countries. For their age, most elderly people enjoy good health. There are, however, increases in age-related health and activity limiting conditions. Therefore, within the disabled population, those who are elderly form an increasing proportion. This is borne out in population surveys which indicate that about two thirds of disabled people are over 60 and around half are over the age of 70. In both developed and developing countries, the loss of sensory faculties among elderly and disabled people poses a major problem. Impairments to sight affect the ability of senior citizens to move around the city and impairments to hearing impact their social contact with others. Multiple deficits that may arise from arthritis or frailty pose limitations on the activities they undertake. This affects their ability to augment their income, carry out activities in their home or to interact with family and friends.

Sources of care

The family is the prime source of care in both developed and developing countries though the models of care giving are different. In the case of married couples, the spouse is the prime source of care. In developed

countries, where the expectancy of life is high, the numbers of elderly and disabled people living alone are also high. They tend to be widows or divorced women. In developing countries, three-generation families are common. The older women play an important role in the family, providing services in the home-as well as care and continuity to the family. Ties between grandchildren and grandparents are close.

This traditional model is, however, breaking down worldwide and is being replaced with new models of family care, which involve a mix of formal and informal care. The family is in transition in countries such as India, Japan and Russia, where traditional patterns are under strain due to demographic, economic and social changes. For instance, the availability of good-quality housing at affordable costs has unleashed pent-up demand and reduced the doubling-up of family generations. In many developed countries, while the nuclear family maintains an independent residence, the bonds of familial care continue to nurture the three generations. Recent studies in Canada and Sweden have shown that the role of the family in the care of older or disabled members of the family is still primary, though the families themselves live apart. Results also show that the exchange of care and services is reciprocal; however, the actual mix of services is undergoing change. Contact is still frequent, though often by telephone because of the distance and work responsibilities. But grand parenting is affected, as grandchildren are not in frequent contact with their grandparents. Earlier, women were solely responsible for care but due to dual-career families, both men and women provide services though women still retain the "lion's" share. Men provide financial and legal services (taxes, for example) and transport while women continue to be responsible for personal care (bathing and hygiene) and maintenance of the home of the elderly or disabled person. In developed countries, both the private and public sectors have developed formal cane systems, such as home health care, home-helpers and day care. These services complement the care available from families.

Sources of income

Elderly and disabled people have sources of income that are different from other groups. In developed countries, the primary source is a retirement or disability pension. When pensions provide insufficient income, additional public assistance is provided through "transfer payments" or "welfare payments" to needy individuals. Some elderly and disabled people may have some income from assets, either a home or insurance. In developed countries, disabled people have a low participation rate in the labour market and a significantly higher unemployment rate. This is due to short-term or part-time employment as well as because of the lack of support services.

In developing countries, the sources of income vary tremendously depending on the employment patterns and place of residence. Many experience a drastic reduction in income when they cease to work. Those who have worked in the formal or public sector tend to have access to a pension, protected for cost-of-living increases. Others may have some income from investing a lump sum received at retirement. Those who do not have access to a pension plan face difficulties.

Employment

In both developed and developing countries, elderly and disabled people work for their living, but at a lower participation rate. This has a negative impact on their ability to increase their income. In developed countries, young disabled workers face tremendous barriers in seeking work.

"In most developing countries, with their high levels of unemployment and underemployment, to contemplate placing the disabled in the open labour market is often just a pipe dream - the jobs simply do not exist." (Cooper, ILO European Symposium of Work for the Disabled, 1980.) Even when jobs or work in sheltered workshops are found, physical barriers are many and traversing the city to a place of employment is very difficult. Even when work is found, many disabled people spend more time on the journey to and from work than others. There is much discrimination in the work place as employers are reluctant to invest in equipment or aids that will allow disabled people to be productive. Disabled people are also deterred by the many disincentives to work, such as the high costs of drugs and aids which must be paid for if one is employed but which are paid for by public assistance if one is not. There continue to be sheltered work places where disabled people work together, but most disabled people wish to live and work in the mainstream. Furthermore, market jobs pay better allowing them to cover the additional costs of travel and equipment. Older workers in developed countries also face difficulties in the labour market in a period of economic restructuring. Many are unable to market their outdated skills or are faced with early retirement. Younger workers are preferred for retraining schemes rather than older workers who will have fewer years left in the work force.

In developing countries, both older workers and disabled workers are excluded by intense competition for jobs. Many of them work in the informal sector at low-paying jobs that are not desired by other segments of the

population. Some employers retain older workers for simple jobs as watchmen or nannies, as a reward for long years of loyal service. Some estimate that between a fifth and fourth of the aged population work at casual, part-time or informal jobs to augment their income.

Patterns of expenditure

Except among the wealthy, elderly and disabled people tend to spend a higher than average proportion of their incomes for essentials such as food, shelter, clothing and health care than others, in both developed and developing countries. This is due to the conjunction of low income and the higher cost of goods and services that are required by this group.

In developed countries, where there are well-developed plans for national health insurance, elderly and disabled people are protected from the high costs of medical care. Still, in many countries, they are exposed to some costs of drugs, dental or eye care, aids and prosthesis and transport costs, which are higher than, average. When "ageing in place" (elderly and disabled people continue to live in their own homes, using community-based care), their housing costs may be contained to maintenance expenses, operational costs and taxes. However, low-income earners are generally renters, and their shelter costs can rise. Those who require special housing or housing with care face high costs. Food, too, if special diets are required, can cost more. In addition, stores package food for families who could reduce costs by buying in bulk but are only now catering to the needs of the single householder who needs smaller amounts at competitive prices.

In developing countries, many elderly people may suffer a great reduction in income when they cease to work while their expenditures are difficult to cut. Many are not protected by health insurance, and the costs of medical care can be very high. Because of the nature of the family life cycle, many of them continue to carry family responsibilities. They may have to pay for the education of their children or for marriage expenses. As a consequence of straitened circumstances, many of them forgo legitimate expenditures, which further affect their quality of life.

Housing and neighbourhoods

Housing is a major problem in both developed and developing countries. The cost of housing is escalating at a tremendous rate due to the high price of scarce urban land. This has resulted in more dense development, with multi-unit structures. Therefore, housing that is accessible to elderly or disabled people is also more expensive because of its scarcity. The market has not responded to the needs of people using wheel chairs and most housing that is accessible to them is the result of extensive modifications of existing housing. In neighbourhoods where housing stock consists predominantly of one-storey structures, elderly and disabled people may be better served; however, accessibility depends a great deal on quality. Poorly designed neighbourhoods in developed countries and squatter settlements in developing countries are not barrier-free. Furthermore, because of low density, elderly and disabled people have to travel greater distances for such necessary amenities as post office or bank.

Because of low income, many elderly and disabled residents live in low-quality housing. Elderly owners find that they are unable to afford to upgrade or maintain their homes and suffer a decline in housing quality as a result. Many elderly and disabled people live in ageing stock with old-fashioned amenities and with little potential for renovation.

Even if the dwelling is accessible, or modified for the needs of an elderly or disabled occupant, many of them are virtual prisoners in their own homes because the neighbourhood is not accessible to people with disabilities. Many residential neighbourhoods do not have sidewalks or protected intersections. Amenities such as stores, banks, post offices, health clinics and pharmacies are beyond walking distance. In developing countries, commercial activities mingle with residential buildings, but the condition of roads and sidewalks do not permit their use by elderly and disabled people. Many of them are able to cope because of hawkers and of home-delivered services by the private sector. These services are re-emerging in developed countries.

Where elderly or disabled people have to move because of changes in their health or activity services, they compete for the few spaces available in homes that offer services at prices they can afford. These tend to be run by public, charitable or non-profit organizations and private-sector investment in such housing is embryonic. It is clear that the stock of such special housing with services on-site is abysmally small compared with the potential demand in cities everywhere. Because of the high cost of construction, many of them are built in peripheral areas. Residents who move into them rupture their social ties and are unable to use familiar areas of the city. In some countries, these special housing projects are regulated, so the residents have some assurance of

quality and some consumer protection. In other cases, the quality of the housing and the services is very variable. If the project is sold or is bankrupt, resident have no recourse.

The most disadvantaged do not have housing at all. In large urban centres in both developed and developing countries, the homeless live in whatever shelter they can find against inclement weather. Some of them construct shelters with salvaged materials such as cardboard, metal sheets and plastic.

Institutionalization

In the past, particularly in developed countries, housing the elderly and disabled people in need in institutions was considered as the appropriate option. When people become unable to function independently, institutional life was considered an acceptable option for their protection. Now there is a worldwide movement to support elderly and disabled people to live independently in the community. Institutions would be retained exclusively for those who cannot live in the community. The shift from institutional care to community care has progressed to various extents in different countries. Nonetheless, a major allotment of health costs is still associated with institutions, which house a minor proportion of the elderly and disabled population. The infrastructure for community care is developing slowly because countries have yet to redirect funds from institutional care to community care.

The proportion of elderly or disabled people living in institutions in various countries varies from 2 to 10 per cent. Low proportions may be due to the lack of institutional facilities while high proportions may be due to the inadequacy of community care. In either case, demand is met with inappropriate supply.

International research shows that high age, low income, poor health, mental confusion, the lack of family and the absence of a social network are key factors in institutionalization. Indeed, it has been shown that children in poverty grow up with health and disability conditions that place at high risk for institutionalization in old age. Therefore, strategies to reduce the numbers who are institutionalized must begin early in life.

Institutions, themselves, are undergoing a transformation. The philosophy has changed from rendering custodial care to care with dignity. In the first case, residents were housed in dormitory facilities with no control over the use of their time, energy or resources. In the second, residents, living in private quarters, are often part of the management team, demanding quality of life for fair costs.

Education and information

Educational institutions such as schools and colleges are in need of a major overhaul to meet the changing demands of present-day society in both developed and developing countries. In developing countries, the emphasis is on increasing literacy; however, disabled children are to a large extent excluded in the efforts to bring education to all children. In developed countries, few educational facilities are designed for the inclusion of disabled students. There are few facilities and arrangements to allow disabled students to participate in a fair manner in the educational process or in tests and exams. For example, time-limited tests discriminate against them and few schools allow disabled children to record their exams orally. In developed countries, it is only recently with the decline of the school-age population that the needs of adults are also being considered. Education at home, using radio, television, video recorders and computer networks, is relatively new.

The dissemination of information displays many discriminatory practices in both developed and developing countries. Many elderly and disabled people are unaware of the programmes and sources of help that are available to them. The media used is accessible in general to people with normal hearing and vision. Those who are unable to read rely on word of mouth from colleagues or family that who may not have accurate information. Moreover, the role models of elderly and disabled people used, particularly in advertising, are not positive.

Elderly or disabled people may not have access to television or radio in developing countries. If they cannot read, they are cut off from information, which may be important to them. In developing countries, in two- and three-generation households, they may not have access to the programmes they wish to watch, because children and working adults may assume first choice.

Transport

Transport whether within a city or between human settlements, present a major problem for elderly and disabled people. Cities often develop over time as a patchwork of residential neighbourhoods, commercial and industrial districts and recreation zones, and because of city size, transport is essential to travel between each of them.

Unless elderly and disabled people are able to use transport, they are effectively barred from using the opportunities the city offers.

In developed countries, there is a high reliance on the car though public transport, such as buses, trams and subways, is also available. A large proportion of urban land is consumed by this transport network. Furthermore, parking spaces consume space in the central city. In developing countries, though the use of private motorized traffic is rising, public transport is very important for the movement of people.

Transport, in both developed and developing countries, affects elderly and disabled people in four ways. First, private transport for the use of disabled people is expensive and parking spaces exclusively for their use in the central city are limited. Secondly, public transport is difficult for elderly and disabled passengers to use. The design and timing of public transport are designed for able-bodied passengers rather than elderly or disabled users. Buses and subways need to stop briefly and accelerate rapidly to be effective. Those using wheelchairs or even mobility aids are unable to use public transport at all. Thirdly elderly and disabled people are intimidated by fast traffic when they are pedestrians. Fourthly many elderly and disabled pedestrians are adversely affected by the pollution of transport vehicles because they circulate slowly and are often seated.

Taxi services are helpful but inadequate. The costs of taxis are often beyond the reach of elderly and disabled people. Many taxis cannot accommodate the users of wheelchairs.

Essential services

Essential services may be characterized as those required to protect life and to promote health. Many elderly and disabled residents, in both developed and developing countries are cut off from essential services by lack of income or lack of transport. The problems with essential services vary with the degree of development. In developing countries, elderly or disabled people may lack water and sewage services. Garbage collection may not be available. In some developed countries, snow removal may be a problem.

Elderly and disabled people are major users of health-care facilities but they find it difficult to visit them. Many are unnecessarily hospitalized for this reason, adding to personal and public costs.

In both developed and developing countries, police, ambulance and fire services tend to provide better service to more affluent neighbourhoods because of better roads and related services such as water and electrical supply. This is due to both political processes and design considerations. Elderly and disabled people who live in low-income neighbourhoods are less well served though they may be at greater risk. Health emergencies, such as heart attacks or fractures due to falls, require immediate attention, which may not be possible.

Social and recreation activities

Elderly and disabled people who do not have meaningful occupation find leisure a burden. Social and recreational activities are limited by income, physical design and transport facilities. Many of them will not carry out activities alone, because they lack the confidence to use the city. Elderly and disabled people benefit a great deal from some exercise, social contact and pleasurable activities of skill or fun, but they do not have the opportunity to do so.

Parks and public spaces, when available, are rarely designed to accommodate the special needs of elderly and disabled people. Concert halls, auditoriums and theatres are centrally located requiring transport. Many of them are not accessible to disabled people using wheelchairs and mobility aids and some patrons cannot hear or see well enough to enjoy using them. Sports facilities are rarely designed to include use by elderly and disabled spectators. Where facilities exist, they tend to be segregated for the use of only elderly or disabled clients, as is the case in several day-care centres. Though they serve an important function, they are secluded from mainstream activities.

Private buildings and facilities are often difficult to enter. These include doctor’s offices, hotels, art galleries, bars, clubs, shopping centres, stores and restaurants. Such buildings often have stairs, inaccessible to people with disabilities. Many restaurants and hotels forbid seeing-eye dogs. Even when access is possible, it is often through the loading dock or the kitchen entrance and requires a long, circuitous and tiring route for elderly and disabled patrons. Toilets are not accessible to those in wheelchairs, further inhibiting them from using such facilities.

For reasons discussed in the preceding sections, a substantial number of city residents could be experiencing a poor quality of life because they are elderly or disabled. The problems they face are not of their own making but

rather due to structural causes and the development conditions of the city. Local governments must address these problems if they are to ensure that the economic and social development of the city is to progress. Otherwise, elderly and disabled people are excluded from the benefits arising from city life while they add to welfare, health and social service costs of the city.

IV. LOCAL GOVERNMENT AND THEIR RESPONSIBILITIES FOR ELDERLY AND DISABLED PEOPLE

Local governments are closest to their citizens. When cities run smoothly, their residents credit local governments. Citizens usually relate the problems in their residential environments and their social institutions to a failure of local government services. Many citizens tend to exercise their civic responsibilities even if they may be with those that apply to higher levels of government. Local government is often the first link to provincial or national government.

The goal of local government is to foster well-functioning economic, social and civic activities. To achieve this, local governments generally tend to have the following responsibilities:

- They are a conduit for national and provincial funds and they implement policies locally for senior levels of government. These programmes may include health, transport or education services, though the actual programmes vary in each country.

- They collect taxes and provide local urban services such as police and fire services, road maintenance, park and recreation services and social services.

- They enforce regulations, particularly those concerned with urban development. Depending on the country, they may or may not develop byelaws that are particular to their jurisdiction.

These responsibilities must be carried out to result in fair and equitable outcomes for all residents of the city. In the past, every citizen was treated in an equal or similar manner, but this perspective does not respect variation among citizens. To treat all residents with respect, effort must be made to ensure that the right types of actions are taken to achieve equitable outcomes.

How do local governments carry out their responsibilities? To meet policy objectives they use the following mechanisms in conducting normal government activities. These must be carefully designed to match the varying needs of citizens in the city to ensure equal distribution of benefits.

(a) *Research and information dissemination:* They conduct research and distribute information to inform the public. They may provide information about problems or about programmes and services that are available in the city. These services may be public, private or non-profit. For example, cities may make public announcements about days when the pollution rates are high, when there are outbreaks of disease, which require precautionary measures, or when the streets are dangerous due to inclement weather. They may also provide information on vaccination clinics, street signs that quickly direct traffic to hospitals or the availability of spaces in institutions.

(b) *Financial incentives and disincentives*: Financial incentives or disincentives may be used to stimulate individual or organizational action to meet human settlements objectives. Financial incentives may include direct expenditures, such as grants or subsidies, or indirect expenditures such as tax deductions. For example, non-profit organizations may be offered a grant to start day-care centres or subsidies that may be used towards their cost of operation. Tax deductions may be offered to private-sector organizations that build hospitals. Tax rebates may also be offered to individuals as a form of income support. Fines may be imposed on persons who dirty the street.

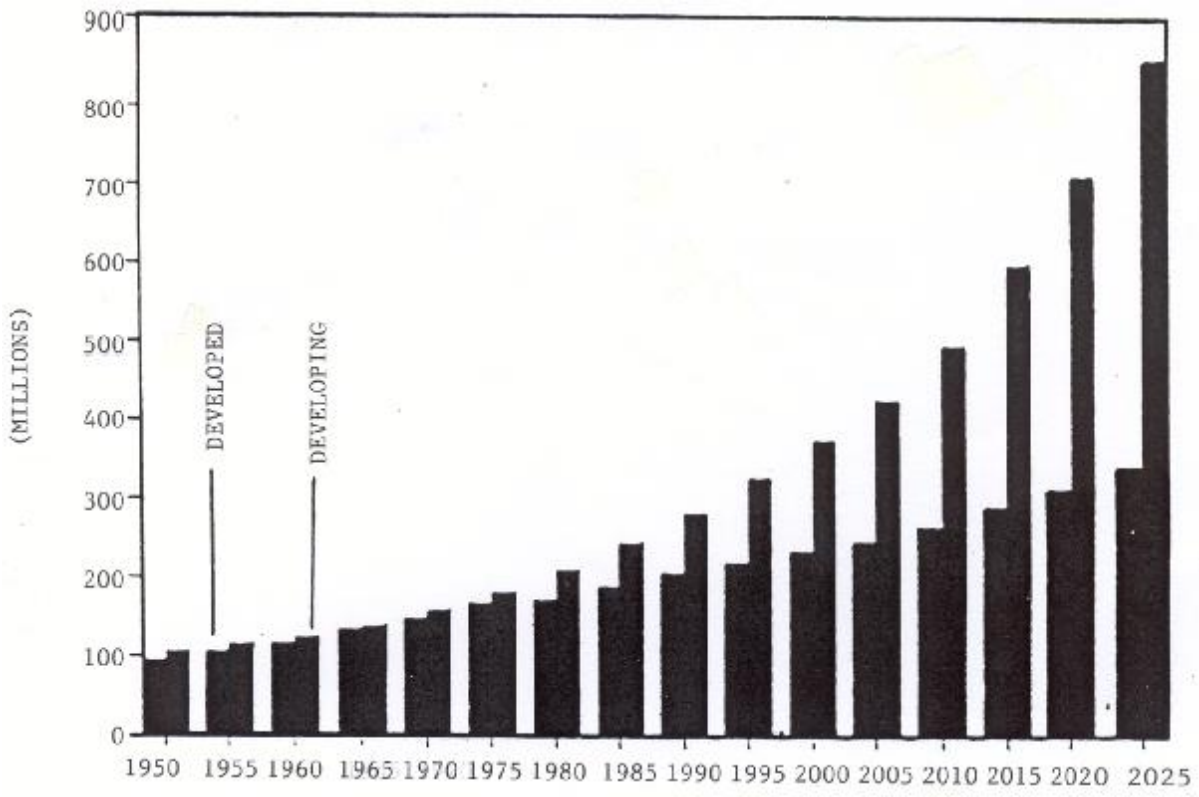
(c) *Standards and regulations*: Standards and regulations may be established by other levels of government and implemented by local government or they may be specific to the city. Standards and regulations are used to control and constrain activities by private, public and non-profit organizations, as well as individuals, to ensure that only activities that are supportive of accepted goals are undertaken. For example, a city may require that developers plan for roads of a certain width and build them with sidewalks on both sides. A city may forbid the burning of refuse in yards, which may add to pollution and pose the risk of fire.

(d) *Programme operation:* Programmes are operated where direct government action is felt to be the most effective way to deal with a need. Such programmes are usually related to income support, health, education, hygiene and cleanliness, or efficiency of city functions (e.g., transport). Some programmes may be funded by national or provincial governments but implemented by local government. These programmes may also involve other sectors that might carry partial responsibility. For example, a municipality may require households to put their garbage at collecting points. It may then run a public garbage-collection service or contract the collection of garbage to the private sector.

Two world trends occurring simultaneously have a major impact on the issues that are the focus of this study: the first is population ageing, and the second is urbanization.

The world's population is ageing at an unprecedented rate. On an average, 1 million persons a month cross the threshold of age 60. The total number of those aged 60 and over grew from 200 million in 1950 to 400 million in 1982 and the number is projected to grow to 1.2 billion by 2025. Over 70 per cent of them at that time will live in developing countries (see figure 3). The growth in people aged 80 and over is even faster.

Figure 3. The growth in the population aged 60 and older in developed and developing regions of the world, 1950-2025



Source: "Second review and appraisal of the implementation of the International Plan of Action on Ageing". (E/1989/13)

The world population in 2025 will be three times greater; the population aged 60 and older will be six times greater, while the population aged 80 and over will be 10 times the size they were in 1950 ("Global targets on ageing for the year 2001; a practical strategy" (A/47/339) para.5). Because of age-related disabilities, the number of those people who are disabled is also expected to increase rapidly. The World Health Organization projects an increase from 387 million in 1975 to 580 million in the year 2000, which does not include persons with disabilities due to ageing. The rapid growth of elderly people is expected to change these projections radically.

Secondly, the rates of urbanization are increasing around the world, and local governments are challenged by the need to manage the growth of cities. Most of the 10 largest cities are now located in Asia and in South America (see table 1). Some of them will grow enormously in the coming two decades. Some of these cities are already experiencing difficulties because of the high density and low quality of life. The density of Bombay is 120, 299 persons per square mile and the corresponding figure for Shanghai is 87,659.

Table 1. Projected Population growth in the 10 largest cities, 1992

Rank	City	Density/sq mile	Population in millions	
1	Tokyo	N.A	25.8	28.9
2	Sao Paulo	38,528	19.2	25.0
3	New York	11,473	16.2	17.2
4	Mexico City	37,314	15.3	18.0
5	Shangai	87,659	14.1	21.7
6	Bombay	120,299	13.3	24.4
7	Los Angeles	N.A	11.9	13.9
8	Buenos Aires	21,233	11.8	13.7
9	Seoul	45,953	11.6	13.8
10	Beijing	37,816	11.4	18.0

Source: United Nations Department of Economic and Social Development, *Urban Agglomerations* (New York, 1992.)
N.A. = Not available.

There are three important issues that are causing city governments to re-examine their relationships with elderly and disabled people.

First, the number of elderly people living in the city has been rising (see table 2). In many European cities, one person in five will be elderly by the turn of the century. Even in the cities of developing countries, where the proportion of senior citizens is not as high as in developed countries, the proportion is increasing, though due to different reasons. In developed countries, families with children who can afford to do so, move out from the city centre to the periphery and as a result, the average age of the resident in the urban agglomeration has been rising. In developing countries, the proportion of elderly persons in the population is still quite low compared with cities in developed countries. The percentage of persons aged 60 and over in the population in selected cities in developing countries at the last census was as follows: Beijing 11.53, Cairo 6.63, Delhi 4.48, Jakarta 3.16, Mexico City 5.72, Lima 7.08, Nairobi 4.78 and Seoul 4.76 (*Major Cities of the World, 1991*). However, continuing urbanization and the decline in birth rate in cities due to rising standards of living, will cause a rise in the average of the urban resident.

Table 2. Proportion of elderly population in major selected cities
1970-1980 (or nearest available years)
(Percentage)

	1970	1980
Copenhagen, Denmark	18.0	23.9
Vienna, Austria	20.0	20.5
Hamburg, Germany	17.0	19.2
Genoa, Italy	14.6	17.9
Rotterdam, Netherlands	13.5	17.2
Miami, United States	14.5	17.0
Perth, Australia	12.3	16.9
Vancouver, Canada	13.5	15.3
London, United Kingdom	13.2	15.1
Lisbon, Portugal	11.4	14.3
Barcelona, Spain	11.0	13.3
Dublin, Ireland	9.2	11.1
Kyoto, Japan	7.5	10.4
Ankara, Turkey	1.6	3.2

Source: The Urban Survey in Big Cities of the World, conducted by Institut d'Estudis Metropolitans de Barcelona, 1988, under the auspices of the United Nations Population Fund and the Spanish authorities, Ministerio de Obras Publicas y Urbanismo and Corporaci6 Metropolitana Barcelona.

As a consequence of these demographic changes, the number of voters in city elections who are elderly is high. They are, therefore, increasingly important clients of city governments.

Secondly, the numbers of women living in cities is growing (see table 3). There are more women than men at older ages and the difference is more pronounced with advancing age. This is noticeable in developed countries and there is evidence that this trend will also appear in developing countries. Many cities are inhospitable to women. They find it difficult to use the city for their needs during the day and they are fearful of the city at night. However, as they grow in numbers and as they move into the labour force, women are demanding that these conditions be changed. In addition, women live longer to ages where there are some disabilities associated with age. So older women are major clients of social services.

Table 3. Share of population by sex and age in selected cities
(percentage)

City	Total Population	Population 60 years and over
Beijing (1989)		
Males	50.1	48.6
Females	49.9	51.4
Lima (1990)		
Males	49.5	45.9
Females	50.5	54.1
Madrid (1988)		
Males	47.1	39.5
Females	52.9	60.5
Mexico City (1990)		
Males	47.9	4.6
Females	52.1	59.4
Stockholm (1989)		
Males	49.2	38.0
Females	50.8	62.0

Source: *Major Cities of the World*, 1991

Thirdly the protection of quality of life for the vulnerable results in improvements for all city residents as a whole. When certain elements of the urban quality are not available to certain citizens or certain areas, there are costs to all residents of the city. For example, if some population segments, such as the poor, the elderly or the disabled residents have problems, they tend to concentrate in low-income neighbourhoods in the city, retarding future development and growth of the city. Dilapidated areas attract other social problems such as crime. Residents from other areas of the city do not feel safe in such areas. When there are large numbers who are disadvantaged, city expenditures are higher, withdrawing funds that can be directed to growth and improvement of the city. Businesses considering investment in competing cities examine the advantages and disadvantages offered by each city. The internal problems of a city detract from any incentives that the city may offer. Therefore, cities are looking for ways to promote positive urban growth, while ensuring improvements in the quality of life.

Local governments, engaged in administration of the city and its services, can in addition take specific steps to improve the quality of life of elderly and disabled people by responding to their needs. The needs of each elderly or disabled person will vary with the mix of disabilities discussed earlier and the seriousness of the disabilities. Local governments take responsibility for those needs that fall under the purview of public policy, while the psycho-social needs are met by the individual and the family. The solutions must respond to their problems holistically. Public policy goals of inclusion, equality and mainstreaming are met by meeting these objectives associated with each of the following needs.

Physical and mobility needs: To make the city, residential neighbourhoods and dwellings accessible to people with physical or mobility disabilities so that they will be able to earn their living, live as independently as possible and contribute to the activities of the city.

Social and civic needs: To remove barriers so that elderly and disabled people can develop and maintain a social network and so that they can carry out their civic responsibilities.

Income needs: To ensure that all elderly and disabled people have access to income or are provided with sufficient basic income to ensure that they have a minimum acceptable quality of life.

While discharging their administrative responsibilities, local governments have to ensure that these additional objectives, with respect to elderly and disabled people are met. Each of these objectives may be met by using one or more of the mechanisms described earlier, such as research and information dissemination, financial incentives or disincentives, standards and regulations or a government programme with a specific objective. In the following section, examples of successful local government initiatives, using such mechanisms, are described in detail. This compendium of successful programmes is a source of ideas for city governments, which may select potential solutions for adoption and adaptation locally.

V. SUCCESSFUL POLICIES AND PROGRAMMES FOR ELDERLY AND DISABLED PEOPLE IN HUMAN SETTLEMENTS

There are many successful policy ideas that have borne fruit in cities located in both developed and developing countries that have conscientiously worked to improve the quality of life for their elderly and disabled residents. Some of the policies and programmes described here do not require expenditure. Others do not require new expenditures, but, through more cost-effective management, they actually could result in savings or payback from spin-off effects. There are some areas of municipal activity, such as transport or public buildings, where local governments are constantly acting to improve services and some of the ideas listed below can be used when such initiatives are undertaken. A few ideas require major investments and may not be within the immediate reach of cities .in developing countries but, if the intention is clear, then the infrastructure may be prepared for future implementation. Cities that are at various points in their growth can draw on the experiences of other municipalities for further development or for improving existing conditions. In each case, it is the concept for achieving an outcome that is transferable. The actual design of the policy or programme will have to be modified for the specific circumstances of the city.

A. Urban planning

Urban planning is a key tool for eliminating barriers and for inclusive practices in the development of land and buildings. Urban planning encompasses the official plan, strategies for city development and the body of byelaws and regulations.

A resident-oriented overall plan for city development

Many local governments develop an overall plan, which provides a framework for orderly growth and healthy development of the city. Many such plans, however, have a bias to development and commercial interests, referring to resident interests basically in terms of protecting investments in housing. A resident-oriented overall master plan for city development can state positions on the quality of life of its residents and measures addressing sustainable development. A mission statement for the city, spelling out the values, which guide planning and development decisions, can explicitly define the public interest.

Mission and policy statements for the city

The City of Ottawa has a mission statement that emphasizes the values of the city.

> *"City Council accepts that change is an on-going phenomenon in cities which must be managed within the parameters imposed by the overriding aim of preserving a lasting habitat for humanity and wildlife. It also recognizes that economic prosperity can provide us with the capability to support wise resource management, to meet the social needs and to improve environmental quality. Therefore, City Council supports an approach to managing urban development which balances the rights of the individual and the needs of society with the need to conserve our natural resource base and enhance the natural environment thereby promoting the health of Ottawa's inhabitants and communities".*

The guiding principles, developed from the mission statement delineate the application of the mission in concrete terms, including stressing development on a human scale, a pedestrian orientation and barrier free access to buildings and facilities. The city also has set specific objectives such as the encouragement of special needs housing "to facilitate the integration of living environments for people with special needs through out the city".

The City of Ottawa's Department of Recreation and Culture, adopted a "Barrier free Environment Policy" governing recreational and cultural programmes and services. The Policy commits the Department to providing the same level of services to people with a disability as is provided to able-bodied individuals, by ensuring choice of programmes, accessibility, awareness and education through consultation with appropriate community agencies.
Source: Improving Living Conditions of the Elderly and Disabled in Human Settlements, a Case Study of the City of Ottawa (UNCHS (Habitat), 1993).

Strategic decisions on new development

When large parcels of assembled land are released for development, often construction is guided by short-term return on investment. Some cities, particularly in developed countries, that assemble land ensure that there is a

rich mix of uses, including housing of different sizes and price. They may also require that all new development be designed to be accessible as well as at least a portion of the housing. In such cases elderly and disabled residents benefit from affordable and accessible housing choices within the city.

In cities in developing countries, many elderly and disabled people live in low-income areas often designated for redevelopment. When new construction is planned, appropriate steps must be taken to ensure that housing is provided to former elderly and disabled residents so that they continue to have access to familiar city services.

Requirement for affordable housing

T*he city of Toronto, Canada, where housing is very expensive, has benefited from provincial land-assembly projects because when land is released for development, a certain percentage of the land must be devoted to affordable housing. Some of these units are "special purpose housing", including accessible dwellings, group homes or housing with care.*

In Ottawa, in a new development on government-owned land, parcels of land were set aside for the development of a variety of housing options for elderly people. Older consumers were part of the planning process as part of the public participation and advisory committee process. A team of consultants with expertise in the health, social and housing related needs of older people worked to ensure that the resulting community would be supportive to elderly people.

The city of Tokyo, Japan, relies on "linking". When permits for commercial development are given for expensive land, a certain number of dwelling units must also be built on that land, or on land that is in the city. That ensures that housing is not squeezed out by commercial development when land costs are high and allows some cross-subsidization between housing and commerce. This also assures elderly and disabled residents that housing is available in central locations with access to the city.

Slum clearance is sometimes necessary but it is very disruptive to elderly and disabled residents who are displaced. In some cities in developed countries policies require that lodgings are found within walking distance of the former residence of such low-income residents who, because of their age or disability, need access to services in the area.

Sources: Ontario Ministry of Municipal Affairs and Housing, Urban Development and Housing Regulations; Brink, S. "Policies for housing in Canada and Japan - lessons from experience", Fifth International Research Conference on Housing, Montreal, July 1992; Improving Living Conditions of the

Zoning

Zoning regulations ensure compatible land uses adjoin each other, ensure efficient functioning of the city and protect investment. Though they are one of the most effective tools for urban planning, sometimes they may contribute to systemic discrimination by not permitting uses, which are required by elderly or disabled residents. For example, existing zoning regulations prevented the use of "granny flats" in many municipalities in Canada. "Granny flats" were pioneered by the Victoria State Ministry of Housing, in Australia. They are small, appropriately designed, movable dwellings, which are rented to families for a moderate sum during the lifetime of an elderly relative. The dwelling is temporarily placed on the lot of the child of the elderly persons. The proximity facilitates the exchange of informal care between the two dwellings. When the unit is no longer required, the unit is rented to another family and moved to its lot. However, temporary structures are forbidden in many well-established communities in developed countries. Others do not wish to increase neighbourhood density because this would imply greater traffic and parking on the street as well as increased use of urban services such as water.

In developing countries, zoning regulations are, in general, more relaxed in content and application compared with developed countries. Annexes to existing housing, particularly in informal settlements, are possible so as to accommodate ageing parents. However, other problems arise. In many cases, because of high densities and small lots, additions result in overcrowded conditions. Moreover, three-generation families often lack financial resources to build additions.

Zoning review from the perspective of elderly and disabled city residents

A zoning review in developed countries has assisted many cities to find creative solutions to sensible development which still includes possibilities that accommodate the needs of elderly and disabled people. The city of Montreal, Canada, revised many land use policies following such a review. It now includes measures for reducing housing costs and increasing choice of tenure and form. It also has measures that promote ageing-in place for elderly people.

Cities in the United States license "granny flats" annually, through variances, to ensure that they do not become permanent additions. For example, in Pennsylvania, the resident must be a relative, 62-years or older who qualifies for social security disability benefits.

In Vancouver, Canada, a review of regulations led to the revamping of regulations controlling "accessory apartments". Because of the shortage of small, centrally-located dwellings, many owners divided their dwellings to create small apartments. The city bye-laws now control the development and quality of "accessory apartments". These help elderly and disabled people in two ways. Owners of homes are able to increase their retirement income while increasing their security by the proximity of tenants. Other elderly and disabled people benefit from the availability of small, centrally-located dwellings.

Elderly people interested in "home sharing" are assisted by the city. A case worker carefully matches a renter with an owner to share the home and household responsibilities. In some cases, both parties are seniors or are disabled. Many zoning requirements prevent this arrangement by requiring families to be related by blood or marriage in single family housing zones. The more open zoning bye-laws in cities of developing countries allow many family constellations. In Ottawa, Canada the programme is called "Match and Share".

In Denmark, zoning regulations were reviewed to increase the density of development to be commensurate with the value of central-city land. When density was increased, city regulations required that at least some additions consisted of small and accessible units. This permitted elderly and disabled people to move to these smaller dwellings within the familiar community, while vacating larger units for families with children. The new housing often involved access to services that were attractive to elderly or disabled residents. The savings in housing costs improved the financial status of seniors.

Sources: "Habiter Montreal" (Ville de Montreal, 1989); City of Vancouver, Zoning regulations; Improving Living Conditions of the Elderly and Disabled in Human Settlements, a Case Study of the City of Ottawa (UNCHS (Habitat), 1993) Engburg, *E, " New trends in housing policy for the elderly in Nordic countries" Proceedings, IFHP International Conference, Mabnii, 1989*.

Integrated city planning

In the development of new towns or communities, a great opportunity is lost if the buildings and facilities are not sufficiently accessible to elderly and disabled people. Though the costs of accessible design are low in new construction, the costs of renovating an existing building for accessibility are high. A holistic view of city planning would have citywide regulations for accessibility linked with other requirements.

Integrated planning is also essential to ensure that financial and other resources such as land are used in the most effective way for long-term benefit. Links between land-use zones, development corridors and technical and social infrastructure must be integral parts of the city-planning process. A comprehensive development plan for the new community is an important first step before detailed plans are developed for physical development, infrastructure and other components.

A n accessible new town

In France, the new town, St. Quentin-en-Yvelines, produced a development protocol before the city was built which had to be complied with by all construction within the city limits. Any new plan was checked by city planners and also by a special office of accessibility before a building permit was granted. Elderly and disabled residents were thus assured that all streets, stores, offices and transport would be accessible. Where necessary, special services (such as sprinklering for fire protection where evacuation would be difficult) were installed.

B. Neighbourhood design

In the context of urban planning in both developed and developing countries, the design of neighbourhoods continue to be based on the ideal of good places to raise children. At present, however, with the increase in the older population of the city, the concepts for the design of neighbourhoods need to be revised. Indeed, many of the major renovations undertaken in city neighbourhoods of developed countries are expensive ways to accommodate older residents of the neighbourhood. Cities in developing countries that are aware of these expensive renovation programmes can take preventive measures now, which would substantially reduce the risk and cost of future renovation of neighbourhoods.

Neighbourhood nodes

In classic neighbourhood design, neighbourhoods were often built around a school. Present demands find that neighbourhood nodes must satisfy a wide variety of residents.

Neighbourhood centers

In some Scandinavian cities, neighbourhoods are being designed around neighbourhood centres. These may include buildings that are used by a variety of residents, at the same time or at different times. This ensures cost-effective and multiple use of expensive facilities such as kitchens while integrating residents of all ages. For example, the dining room of the school is used to serve a warm lunch for older resident persons when the school-children have finished eating. The swimming pool has times when arthritic persons may use the pool for therapy while others may use it for exercise at other times of the day. A community-centre building often houses a municipal office where case workers for the area may have their headquarters. Office space is rented to professionals on a shared basis, so that a geriatrician may provide services on Monday, a physiotherapist on Tuesday, a podiatrist on Wednesday, a pediatrician on Thursday and a psychiatrist on Friday. Rooms may be used in the morning for adult courses, in the

Responding to changed neighbourhood needs

The character of the neighbourhood and its residents change over time. The original amenities may no longer be as useful as before and should be redirected to current needs.

Day care for whom?

In the city of Madras, India, a group of seniors lobbied the city government to turn over an unused children's day-care facility to a non-profit organization to run a day -care programme for elderly people. There was sufficient demand for such a service that the city was willing to rent the facility to them. Many non-profit organizations perform a valuable service for the city,-and city governments form partnerships with them by subsidizing some of the overhead costs, such as rent or operation. Public buildings may be rented for a nominal sum or buildings rented by local government can be sub-let to non-profit organizations at subsidized rates if they provide a valuable service which otherwise will not be available.

Source: Improving Living Conditions of the Elderly and Disabled in Human Settlements, a Case Study of the City of Madras, (UNCHS, (Habitat), 1993).

Neighbourhood renewal

When neighbourhoods are dilapidated, many countries have programmes to upgrade the area by assisting in the renovation of housing. Some cities have realized that to renew a neighbourhood, the whole area must be renovated and enriched with necessary amenities and services, so they have acted to coordinate the flow of subsidies from all levels of government for housing and other urban services and to direct renewal for the long-term benefit of the city and the residents.

Neighbourhood renewal based on an inventory

In Sweden, city governments may apply to the National Government for funds to renew urban neighbourhoods. To be eligible, their case must be supported by two inventories. The first is an inventory of the housing stock, where the mix of housing and their quality is assessed with regard to the residents. The second is an inventory of services available to the neighbourhood. Again based on the residents, this is an evaluation of current services and the need for future services. On the basis of these inventories, the city develops a plan for funding. Invariably, a large proportion of the costs are for rendering the housing stock and the neighbourhoods accessible to elderly and disabled people. The services in the neighbourhoods are also diversified with shopping, post office facilities and banks, but also with services such as home care, security services and meals-on-wheels for older people.

Source: Brink, S. Housing Policy Directions Based on a Review of Environmental Design Research - a Comparative Study of Housing Policies for the Elderly in Canada, the United States, Sweden and France, 1988.

C. Public buildings

City offices and agencies

City offices and agencies have a constant flow of citizens. In cities in both developed and developing countries, many of them are designed to generate civic pride, often with grand entries with imposing flights of stairs.

Many disabled and elderly citizens have difficulty entering these buildings or are unable to have access to them at all. Inside the buildings, services are offered in a manner, which is not easily accessible to a majority of elderly or disabled people. For example, deaf patrons cannot telephone for information.
Municipal governments have to lead by example. When steps are taken to make local government accessible to all citizens, then the city culture is impacted positively. Private organizations and agencies also offer the same accessible quality of services to compete.

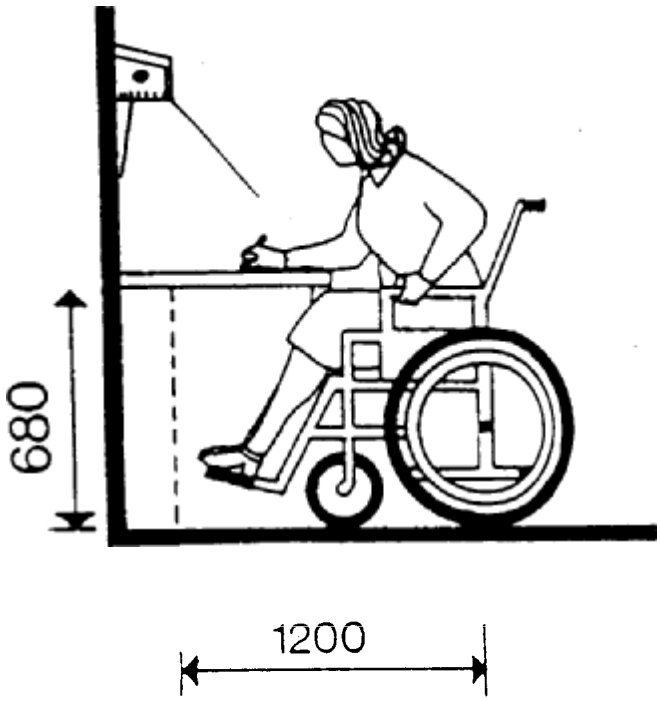
Reducing discrimination in city offices and agencies

Where the national building code does not ensure accessibility of buildings, several cities have developed self-regulatory design requirements for their own buildings. Although every city building cannot be modified at once, the municipal government sets a target such as 10 years, within which all buildings shall be accessible. Important buildings such as transport centres and police stations may be modified first. Detailed annual plans for changes to buildings are developed along with plans for regular upgrading or maintenance so the target is achieved. Changes made include the addition of parking for disabled people, ramps or elevators, automatic doors, wider doors, accessible toilets, accessible counters (see figure 4), accessible public telephones and seating in waiting areas. Barriers such as revolving doors, turnstiles, escalators and narrow doors are noted and accessible alternatives provided near them.

A task force with government employees and disabled or elderly citizens has been established by some Cities to examine the ways in which services can be improved. The city of Ottawa, Canada, conducted such as an "accessibility audit". Examples of solutions include, lowered counters with chairs or space for wheel chairs, telecommunicating devices for the deaf (TDD), orientation maps and signs with raised letters or plans that can be felt, and large print or tape-recorded information on regulations or programmes.

At city events, elderly and disabled attendance is assumed as a matter of course. Routes and spaces for disabled people using mobility aids or wheel chairs are planned. Speeches are interpreted into sign language for deaf people.

Figure 4. Accessible counters



Mainstreaming

Many public buildings, such as schools, stadiums and swimming pools could not be used by elderly and disabled people because of their design or because of their operation policies. These practices disadvantage them and segregate them from participating as equal citizens.

Strategies for mainstreaming

Municipalities are realizing that developing separate segregating environments for elderly and disabled people is expensive and counterproductive. Municipal governments first accept the principle that elderly or disabled people should have access to all public establishments. Then strategies are developed to provide such access, using a variety of strategies including regulations, financial incentives or programmes. Schools maybe given additional funding for each disabled child or teachers may be offered scholarships for special education. Stadiums may accept donations or set aside a percentage of receipts to make the stadiums accessible. Swimming pools may be retrofitted with ramps or with hoists to increase accessibility. The pool may be divided with a rope so that disabled or elderly patrons can use one area of the pool while the rest is used by other swimmers. Hydrotherapy programmes may be organized at certain hours of the day for elderly or disabled users.

Regulations ensure that establishments such as hotels and restaurants are able to serve disabled and elderly customers. Shopping centres and professional services such as doctors, dentists and therapists are encouraged to locate in buildings that are accessible.

Source: Access Design Guidelines (Access Review Committee, The City of Calgary, Canada. 1991).

Auditoria, theatres and convention halls

Many public auditoria and theatres have physical or other barriers that prevent potential elderly or disabled patrons from participating in the cultural life of the city. When spaces are available for people in wheelchairs, they often do not have a clear view. Hearing-impaired people are unable to hear performances. Solutions have been found by cities to overcome all of these problems through careful design, use of technology or through additional services. For example, a choice of viewing location for wheelchair users can be required through codes. Aids are made available to patrons with hearing impairments.

Accommodating elderly or disabled members of the audience at cultural venues

If regulations require that at least two positions with a clear view must be available for wheelchairs, without blocking the emergency route for egress, most public gathering places install removable seating that can be withdrawn when disabled customers attend.

Cities may also require that large assembly spaces be provided with assistive listening devices. Wireless sound-transmission systems, such as FM, infrared or magnetic induction loop, improve sound reception for those with impaired hearing. The systems should allow each listener to adjust amplification and to screen out background noise. These systems do not interfere with the listening enjoyment of the rest of the audience. FM and infrared systems broadcast signals to the entire room while induction systems require users to sit in the area circumscribed by the loop.

Fire alarms may operate both ¢ells and flashing lights. Exit routes may be lit along the floor as well as through the use of exit signs over the doors.

Source: Barrier Free Environments, Inc and Harold Russel, Inc.. The Planners Guide to Barrier Free Meetings (1980.).

Museums

Many museums house cultural and artistic treasures, which cannot be viewed by elderly and disabled people because of the design of the buildings or the programmes. Many museums are discovering that senior citizens are major supporters if they have access to their collections. Museums are also major tourist attractions and inaccessible museums cause losses of tourism traffic.

Accessible museums

New museums may be built to accessible standards, but many well-established museums, such as the Louvre in Paris, have undergone major renovations to become accessible. Once the building is accessible, other accommodations can be made through sensitive provision and special programmes. Many museums offer wheelchairs and baby -strollers at the entrance, which may be loaned or rented. Every room is furnished with comfortable seating with back and arm rests. Many signs, designed so that they do not compete with the exhibits, are too small to read. Large print guides are available at the front desk or in each room. These may be held as close to the eyes as needed. "Acoustic guides" (taped guided tour in a portable tape player) were developed for major exhibitions, but now many museums rent them for their permanent collections.

The national gallery of art, Ottawa, Canada, provides a monthly tour for visually impaired and blind visitors. Through the use of gaufrages (reproductions with raised impressions) of selected paintings and a tactile tour of selected sculptures, these visitors are introduced to works of art. Sign-language interpreters are available on certain tours of the Gallery.

In addition to offering courses in art and art appreciation like other museums, practical workshops are offered to groups of mentally-impaired children. The museum also has an outreach programme, taking mobile presentations to nursing homes, hospitals and schools.

Source: Programs for persons with special needs, (Ottawa National Gallery of Art).

Libraries

Libraries are wonderful resources for elderly and disabled readers, if only they are accessible. Modern libraries have an extended mandate as repositories of multi-media information. Many of them provide services on their premises as well as mobile services.

Accessible libraries

Libraries are diversifying and decentralizing their services. Municipalities are ensuring that the main library is well served by public transport routes and that there is plenty of parking space. Community libraries are distributed among city neighbourhoods moving closer to their users. Mobile libraries serve some neighbourhoods, as well as major concentrations of people in hospitals or nursing homes. In Ottawa, the Nome Reader Service delivers books to housebound city residents.

The Library of Montreal realizes that many users combine their trips to the library with outer activities. They have located a library at a major subway station for regular commuters.

Many libraries, including the Library of Congress, Washington, D.C., now stock books in large print, books in Braille, books on tape and video tapes. Visual aids, such as computers which magnify print or voice readers are available in selected locations. Many libraries also have a story hour or a reading, when an audience may gather to hear someone read aloud from printed material.

Source: Improving Living Conditions of the Elderly and Disabled in Human Settlements, a Case Study of the City of Ottawa (UNCHS (Habitat) 1993); Planning Barrier Free Libraries, (Washington D.C., National Library Service for the Blind and Physically Handicapped. Library of Congress. 1981.)

D. Housing

About half of the urban areas in the world are used for housing and it is obviously the most vital part of the city. Housing issues often require joint action by sectors dealing with financing, construction, renovation and distribution. In each of these areas, there are innovative steps being taken by cities to ensure that good-quality housing is available to elderly and disabled residents.

Housing financing

The availability of creditor subsidies has a great impact on housing production. In general, the housing market works relatively well for those who are well-to-do but the market fails those who have no access to credit or those who can afford only inexpensive housing. Low-income housing is not popular with builders because of the low profit margin. Governments in many developed and developing countries, offer loan guarantees to ensure that affordable housing is built in cities. In general, when cities offer subsidies, they have better leverage to require that the housing built be accessible to senior citizens and disabled people.

Financing affordable housing

Government programmes have been the traditional way in which to support the financing of low income housing. Many municipalities used funding from higher levels of government to construct publicly-owned and -operated housing which was then rented to low-income tenants. As costs escalate, many city governments are relying on non-profit organizations or housing cooperatives to build and operate low-income housing, group homes and nursing homes, subsidizing the construction, the operation or both. Aid may be offered as an annual subsidy or as a grant. All of the dwellings or a proportion of the dwellings may be required to be accessible.

Municipalities are hard-pressed to finance affordable housing themselves so they are using many strategies to find financing for affordable housing. Some municipalities in the United States have provided loan guarantees assuming the risk for private lenders who provide credit for low-income housing. Others have floated municipal bonds or sold lottery tickets to raise funds for subsidies.

Many municipalities, particularly in developed countries, have also offered assistance in kind. Long-term leases may be offered to non-profit corporations at reasonable rates, thereby lowering rents in the housing produced by them. The have covered site-servicing costs or offered tax rebates for a set period of time, also to reduce the cost of housing.'

In many developing countries, local government operating "site-and-service-programmes" give serviced lots on municipal land to households, who undertake to build housing of a specified plan and quality on the land, using "sweat equity". In such cases, the local government can require that the resulting housing be accessible while also ensuring that it is affordable and adequate. This type of ----programme has sometimes been a means of slum renewal or upgrading.

Since the number-of housing units of special design may be limited, the private sector may not respond without significant incentives. In Mat case, the municipal government may collaborate with non-profit organizations to build and operate them. Examples are group homes, homes for very disabled people, "granny flats" and retirement communities.

Even if accessible dwellings are available, in many cases elderly and disabled people cannot afford the costs. Municipalities either funnel rent subsidies from national programmes to low-income tenants or provide assistance to them from local budgets.

When elderly or disabled people are unable to afford their homes, they lose not only a major asset but also an entire way of life. Many municipalities in developed countries offer elderly home-owners a tax rebate to help them retain their homes. Or, municipalities allow elderly home-owners to accumulate a debt and the outstanding taxes are paid from the estate after the death of the owner.

Construction of accessible housing

Though the idea that all individuals should be able to age in their own home is widely accepted, housing is not generally constructed so that it can serve the changing needs of their occupants over time. As the proportion of older persons rises in cities, there is a greater interest in increasing the accessible housing stock in cities.

Accessible housing

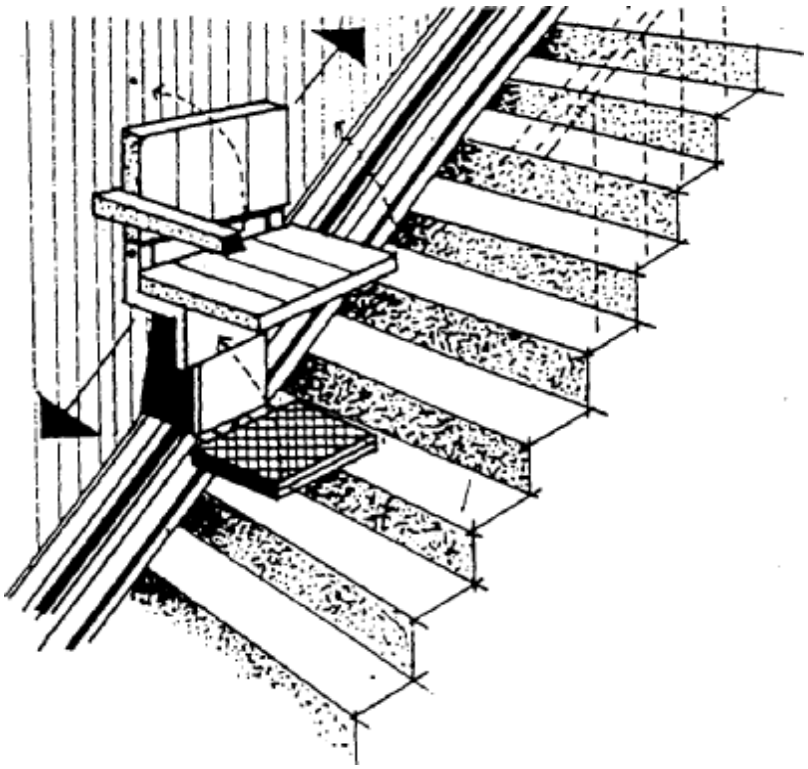
In almost all countries, cities collect and distribute information that is helpful for housing-investment decisions but so far they have mainly dealt with aggregate information such as population growth and the numbers of dwellings that may be required, given construction and demolition rates. Cities now realize that more sophisticated housing-stock management is required. Therefore, particularly in developed countries, they are publishing information on the ages of city households, age and condition of the housing stock, as well as the potential demand for accessible housing. They have stimulated targeted and high-quality renovation activity by providing good information on design standards for accessibility. They have also issued data on the potential market for special housing. For example, Sweden has published a major statistical report on elderly citizens and the availability of accessible housing and services.

For planning purposes, cities may also establish ratios for housing with care (called by various names, but they are segregated environments for elderly people, which offer shelter with varying degrees of health and social services: examples include old-age homes and nursing homes). For instance, the number of spaces required per 1000 people over the age of 75 may be set, depending on local conditions and availability of housing, community care and institutional care.

Regulations such as building codes are used in countries such as France to ensure that all multifamily units are built to accessible standards. In other countries where two storey homes are common with bedrooms on the second floor information is disseminated explaining the benefits of a bedroom and bathroom on the main floor for ageing-in-place. In Tokyo, regulations for the use of stair glides (See figure 5), to make two-storey homes accessible, are being developed. Housing ministries publish books of good housing design from which complete plans may be ordered at reasonable rates, offering considerable savings to consumers. These plans are often accessible.

Source: L'adaptabilite des logernents aux personnes handicapies dans les batinterus d'habitation, (Paris, Ministere d'urbanisme et de logemem 1982); Pensionarer - Levnadsfőrhallanden, Statiska centralbyrdn, Sweden. 1985.

Figure 5. Stair glide for residential use



Housing for groups marginalized by the market

The housing market operates well for those who are able to buy or rent dwellings. In some developing countries self-built housing continues to be legitimate if certain conditions are met, but in most countries such housing is illegal for reasons of public health, safety and standards. In a majority of large cities in both developing and developed countries, there are people who are unable to find housing under market conditions. In many cities, the numbers have swelled beyond the ability of responsible authorities to house them in public housing. Besides, many find the location of public housing inconvenient for their activities to earn a living. The lowest income group does not earn enough to pay a monthly rent for urban dwellings. Those with an irregular income or those dependent on pension or a disability income also have affordability problems. Some of these people live on pavements, in subway stations, colder bridges or other public spaces with few sanitary or urban amenities. Organizations traditionally working for the poor, such as religious and charitable organizations continue to provide food and other support but inexpensive centrally-located housing is still in short supply in almost all large cities in developed and developing countries.

Housing for the homeless

Local governments, sometimes with assistance from central governments, are taking action to house people who are unable to pay for their housing. City governments, particularly in developed countries, have formed partnerships with non-profit organizations to provide shelters for the homeless. Shelters are of many kinds. There are some that offer shelter for the night and a warm meal and bathroom privileges for a small fee. Others offer free overnight shelter but operate with strict rules (no drinking, for example). Many buildings that are unused during the night, such as gymnasiums are used to provide shelter.

Non-profit organizations are also forming cooperatives among pavement dwellers, so that jointly they can operate within the housing market. They buy or lease land, buy building materials at wholesale prices and work together to build a community. In India, the National Slum Dwellers Foundation is active in this regard and has links to similar organizations in other Asian countries.

Source: Oberlander, P. and Fallick, P., Homelessness and the Homeless- Responses and Innovations. (Vancouver, The Centre for Human Settlements, University of British Columbia, 1988)

Housing renovation

Housing-renovation activities, especially in cities in developed countries, have grown considerably: Much of the renovation activity is to upgrade housing to modem standards. Since many older, people have aged with their housing; their dwellings are prime candidates for upgrading. Renovation is also undertaken to improve accessibility. In some cases, small changes are made: a small ramp at the entrance, wider doors or grab-bars and handrails where they are needed. In other cases, more drastic renovation may be required, adding elevators in apartment blocks and changing the interiors of the flats. When disabled people are unable to find appropriately designed homes, they may be obliged to renovate a home.

Renovating housing for accessibility

In many developed countries, useful information on accessible design is distributed widely by housing ministries for those with means who are renovating their homes. Some municipalities also offer information on contracting and approximate costs, to ensure that advantage is not taken of elderly or disabled people by unscrupulous tradespeople. In the United Kingdom, non-profit organizations are funded to help elderly and disabled occupants carry out renovations.

In San Francisco, California, trainees carry out simple renovation tasks in the homes of elderly people as part of a training programme for unemployed persons.

The costs of renovation can be high and they are often beyond the reach of those who are elderly or disabled and who would benefit from accessible design. In Canada, low-income households are offered a low-interest loan for renovations to increate accessibility. The amount to be paid back depends on the income of the household. Variations of such subsidies are found in almost all developed countries.

In Ottawa, if improvements are made to improve accessibility, the property tax is not increased, though the value of the house may have increased.
In Japan, three-generation households are offered advantageous loans to allow them to add space or to renovate the dwelling to accommodate an ageing or disabled family member. Family members are then able to provide informal care in the home without having to travel.

Distribution of housing

Matching the housing stock with the needs of households is a major challenge for responsible authorities in both developed and developing countries. Consumers attempt to meet their needs in the choices they make in the housing market. Though supply usually responds to consumer demand for housing, special housing needs are often unmet. Households seeking accessible housing or housing with some attached services may not be able to find such dwellings at prices they can afford.

Services to match supply and demand for special housing

In a majority of cities in developed countries, municipalities or agencies funded by them operate housing registries. Some housing registries list all the accessible housing stock by neighbourhood so that elderly or disabled people maybe helped in their search. These registries are sometimes operated by voluntary organizations run by elderly and disabled people themselves.

Supportive housing registries may also be maintained, providing a comprehensive list of housing with services (for those with disabilities, the homeless, psychiatric patients and others with special needs such as alcohol or drug addicts). They monitor vacancies and help individuals to access such housing.

Linking services may also be provided by municipalities or by agencies to connect tenants with disabilities with property -owners with vacancies. In some cases, realty companies offer this service on a contract with city government. If necessary, the owner may receive some assistance to modify the apartment for the tenant.

Home-sharing is a strategy used by a home-owner, who wishes to age in place by sharing the costs, tasks and space with a compatible partner. Home-sharing is facilitated by a matching service, often run by non-profit organizations. Both home-seekers and home-providers are extensively interviewed and counseled. Agreements are worked out regarding the sharing of space, tasks, costs and meals that are signed by both parties. In developing countries, homes have been shared in an informal way, by relatives and friends: however, as such traditional customs break down, more formal home sharing agreements may have potential there as well.

Source: Improving Living Conditions Of Elderly And Disabled Persons in Human Settlements a Case Study of the City of Ottawa and a Case Study of the City of Madras (UNCHS (Habitat), 1993)

E. Public spaces

Public green and recreational spaces

Human settlements, whatever their size or location, are full of public spaces both large and small. These include city squares, green spaces, waterfronts, streets, plazas and traffic dividers. Many of these spaces are not accessible to elderly and disabled folk. With sensitive design, however, they can have access to these areas or use them for people watching or for exercise.

> ***Usable public spaces***
>
> *Given the high costs of land, even the interstices of the city must yield value as multi-use public space. Regulations can ensure that such spaces are accessible and that they are designed to be safe. In France' pensioners 'associations help to maintain flowers and greenery in the traffic dividers between the street and the sidewalk and receive remuneration for their efforts. The costs may be paid by the municipality or a private donor company. Small spaces with a view of either scenery or activity can be made into gathering places for the neighbourhood by the placement of park benches or building in a chess board on a table or the ground. In London and New York, empty lots are used for community gardens. In Scandinavia, cemeteries are maintained as gardens, cared for by local residents.*

Public toilets

The availability of sanitary public toilets contributes to the hygiene of city residents as well as to the cleanliness of the city. However, in many cities in developing countries, there are few public toilets and most of them are riot accessible to disabled users.

> ***Accessible public toilets***
>
> *In London and Paris, city ordinances require that all public buildings should be barrier free. As a consequence, both city governments have slowly replaced coin-operated public toilets that dotted the city with a model that is accessible to disabled users. These toilets are strategically located near areas of public activity, such as busy intersections, parks and playgrounds and city squares.*
> *Many cities in developing countries are building public toilets and they should ensure that they are designed to be accessible to elderly and disabled users. Once a disabled person has entered a public toilet, there should be at least one cubicle that is wide enough for use with a wheelchair. Grab-bars should be installed for support.*

Public telephones

The telephone is an important tool for communication in large cities. However, particularly in developing countries, the private telephone system is not well developed. Well-located public telephones are an important service for urban residents. These public telephones must also be accessible to disabled individuals. Cities that are installing such telephones would do well to install public telephones that are accessible in the first place. Public telephones designed for hard-of-hearing people should be provided in key points such as transport terminals, hospitals and post offices.

> ***Public telephones***
>
> *Even simple arrangements can make public telephones accessible. They should be in well-lit locations and operate from a seated position. When public telephones are located in areas where there is a lot of ambient noise, they are usually located in a booth. These booths should be large with an entry that is level with the ground. In places like airports, coin-operated fax machines allow deaf people to communicate.*
>
> *Special telephones for the hearing impaired are available and may be installed in high-use areas. Deaf people who have their own devices which help them to use telephones are assisted by having a shelf below the telephone on which it may be placed. Large number or raised-number touch-tone telephones are also available.*

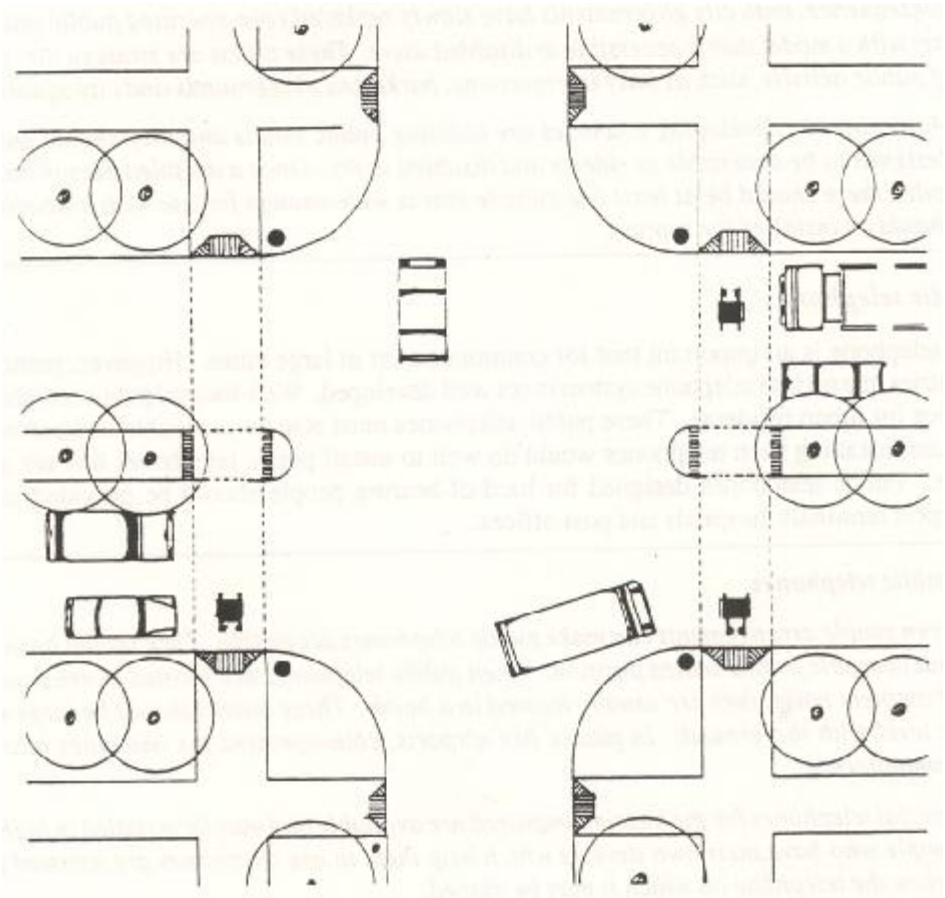
F. Public thoroughfares

Streets

Where once the object of street design was to widen and facilitate the fast movement of motorized traffic, many cities in developed countries are now focusing on reducing traffic in the central city, directing heavy traffic on to arteries and limiting traffic on smaller residential roads. It is recognized that the needs of pedestrian traffic have not been met. In the major arteries of cities in developing countries, because of the wide mix of vehicles and varying speeds of travel, it has become necessary to separate pedestrians, and slow (bicycles, carts) and fast moving traffic.

A network of streets links the neighbourhoods of the city. If the streets are not accessible, elderly and disabled people are limited to using only the routes that are traversable by them. Street design has been largely standardized for motorized traffic. It is only recently that greater attention has been paid to pedestrian traffic along the streets. In addition, to reduce the number of accidents where motor traffic and pedestrians use the same space, the design of intersections and parking spaces is being re-examined. Since standards for street design are being revised, this offers an opportunity to examine the accessibility of the streetscape as well.

Figure 6. Barrier-free intersection



Street design

Standards for streets are based on use. Therefore, positive changes for elderly and disabled people have to be made. Many high-traffic streets are dangerous to them and other users such as children, because they have traffic that is moving at different speeds. Cities are now building sidewalks and separating lanes for slow and fast traffic.

Where pedestrian and motor traffic intersect, design improvements have been made. Drain grates are now not located in paths of pedestrian travel. At key intersections, clearly marked pedestrian crossings offer a central waiting area at the street divider.

A majority of cities in developed countries have launched a curb-cut programme where by all new sidewalks will be built with curb cuts that allow wheeled pedestrian traffic to negotiate the height change comfortably while at the same time identifying the street margin for blind people using a cane (see figure 6). In Tokyo, a textured surface identifies the change in level as well as the direction of the pedestrian crossing. The textured area is bright yellow and clearly visible. Advisory committees of elderly and disabled people identify key intersections where curb cuts are installed in existing sidewalks. At key intersections the timing of the lights would be increased by 20 per cent to accommodate the slower crossing speed of elderly or disabled pedestrians. They also identify locations for the installation of light and sound signals for cross walks. Different sounds inform pedestrians whether or not it is safe to cross and whether they are crossing in an east-west direction or a north-south direction (In Ottawa, for example, peep-peep sounds are used for east-west crossings and cuckoo sounds for north-south). Pedestrians may press a button to activate the pedestrian crossing light. In some cases, where there is sufficient wheelchair traffic, wheelchair sensors may be installed.

The design of sidewalks had long taken second place to the design of streets. Many cities have now taken a policy decision to ensure that a third of the space is reserved for pedestrians. The sidewalks often have obstructions or hazards that pose a danger to elderly or disabled pedestrians and they also hamper the smooth flow of all pedestrians. Examples of hazards are traffic signs at head level, diagonal supporting guy lines, bollards with chains, uneven surface and projections from the sides or the ground such as signs or access holes (see figure 7). In addition, there are street vendors, parking for bicycles, park benches, kiosks, and garbage and recycling cans that are placed on the sidewalk. Strict design guidelines are now enforced to reduce hazards and to promote a pleasant street experience for pedestrians. Street furniture is strictly regulated to sidewalk spaces that are wide enough and located to ensure an orderly flow of traffic to and around them.

Source: Improving Living Conditions Of Elderly and Disabled Persons In Human Settlements, a case study of the City of Ottawa (UNCHS (Habitat), 1993.

Special street designs

In residential areas, high-speed traffic and rows of parked cars can reduce the visual quality of the neighbourhood. Many residential communities are working together to limit through traffic on their streets to protect small children, deaf people and those in wheelchairs from accidents. Special signs are posted.

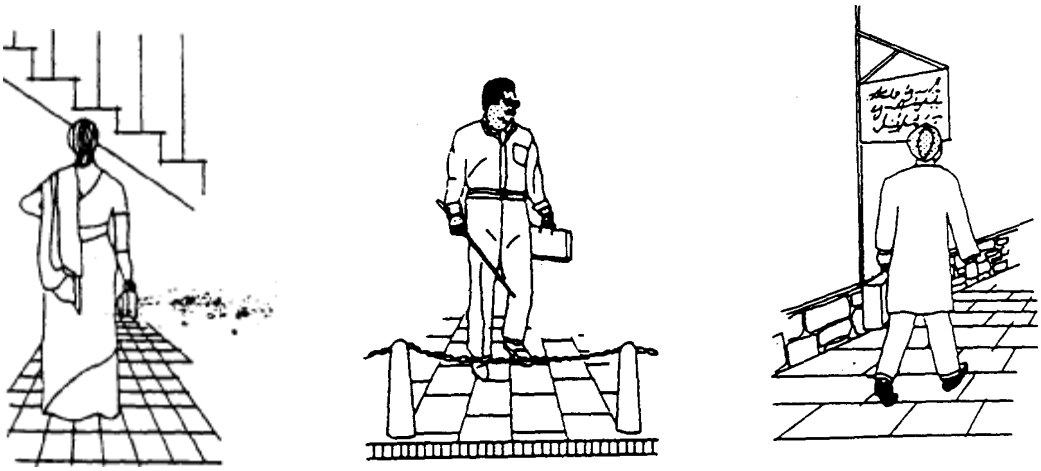
Woonerfs

The Netherlands has developed an amicable street-design solution for sharing of space between pedestrian and motor traffic in residential areas. Selected areas are designated woonerfs and they are clearly marked with a traffic sign based on the house (see Figure 8). The street design is modified giving priority to pedestrians. The pavement is built in such a way as to clearly demarcate areas where parking is acceptable. Through traffic is obliged to slow down by the judicious use of speed bumps and winding thoroughfares. The hardness of asphalt and concrete is softened with trees and flower boxes, small areas where children may play and benches where adults may visit with each other.

Separation of motor and pedestrian traffic

High-traffic areas are unpleasant for pedestrians because of the danger, the noise and the fumes. City planners are working to develop a network of pedestrian routes that are separate from motor traffic. Bicycle routes are also designed to be separate from both motor traffic and pedestrian traffic.

Figure 7. Sidewalk hazards for visually impaired pedestrians



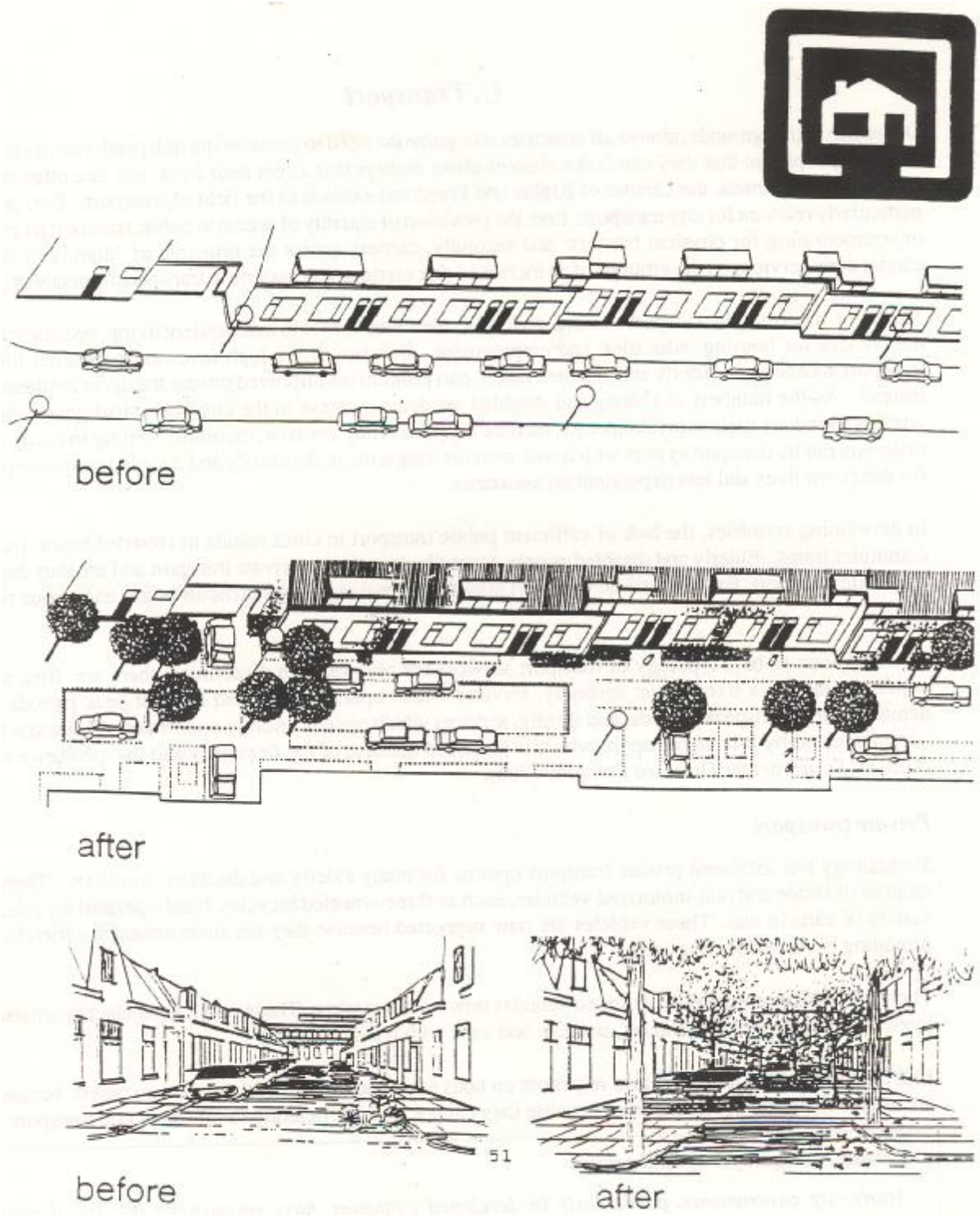
Pedestrian network

In Sweden, city- planning principles include the development of a separate pedestrian network that allows residents access to schools, recreation areas, shopping areas and public transport. While this is easier in new towns, even established cities such as Stockholm and Gothenburg are improving their pedestrian networks. Pedestrian networks are marked with the sign of an adult walking with a child. Pedestrian walkways are punctuated with rest areas with benches.

In Montreal and Toronto, Canada, the central-city buildings are linked by a vast network of underground pedestrian walkways lined with shops. Not only are pedestrians separated from the traffic overhead but they are also protected from inclement weather.

In Edmonton and Calgary, Canada, a system of pedestrian walkways called +15 link city buildings in the core. These are walkways that are 15 or 30 feet above the street, generally glassed in, so that pedestrians can orient themselves. The doors between buildings are automatic and ramps and elevators are used where there are height changes.

Figure 8. Woonerf



G. Transport

On human rights grounds, almost all countries recognize the need to promote the independence of elderly and disabled people, so that they can make choices about matters that affect their lives, just like other members of society. In Canada, the Charter of Rights and Freedoms extends to the field of transport. Two points are particularly relevant for city transport: first, the provision of equality of access to public transport by removing or compensating for physical barriers; and secondly, carvers accept the principle of "dignity of risk" and cannot deny services on the grounds of an increased risk carriers may assume in transporting disabled persons.

However, inaccessible transport continues to be a tremendous barrier to independent living, because it restricts the choices for housing, education and employment. Because of the high investment required for public transport accessible to elderly and disabled riders, early initiatives improved private transport for these groups instead. As the numbers of elderly and disabled residents increase in the city, municipal governments are anxious to reduce their expenditures for income support. They are now, therefore, willing to make changes to the city public transport system which will, over the long term, make elderly and disabled people responsible for their own lives and less dependent on assistance.

In developing countries, the lack of sufficient public transport in cities results in crowded buses, trams and commuter trains. Elderly and disabled people generally do not have private transport and are thus dependent on public transport. Existing public transport may be expensive and too difficult or too dangerous for them to use.

There appears to be a typology of transport services for persons with disabilities: there are, first, services which operate on a fixed route; secondly, services which operate on a fixed route at peak periods and on demand during off-peak periods; and thirdly, services which operate entirely on demand. These services are complemented by private transport, which is preferred because of the flexibility and independence it offers (OECD, Transport for Disabled Persons, 1986).

Private transport

Technology has increased private transport options for many elderly and disabled travelers. There are a number of stable and non-motorized vehicles, such as three-wheeled bicycles, hand-operated bicycles and a variety of carts in use. These vehicles are now supported because they are environmentally friendly while providing exercise for their users.

There are also appropriately motorized vehicles now on the market. These range from electric wheelchairs, three wheeled motorized vehicles, and cars and vans with hand controls.

Elderly and disabled travelers also rely more on taxis (cars and three-wheelers) than do others because they are unable to use public transport or because they cannot walk sufficiently far to use public transport.

> ***Private transport for special groups***
>
> *Many city governments, particularly in developed countries, have encouraged the use of private transport by licensing the use of private-transport vehicles of various kinds. These may be scooters, motorized three-wheelers or electric wheelchairs developed for use by disabled people. Street or pavement design has been modified to accept them. Such vehicles may require a sign indicating that they are slow-moving traffic.*
>
> *In Belgium, loans and grants are provided for car-adaptation costs and for training costs both of which allow disabled people to enter the labour force.*
>
> *Source: Transport for Disabled People* (Paris OECD, 1986).

Parking regulations

Parking of vehicles driven by urban residents is a major problem in almost all large cities around the world. Disabled and elderly vehicle users require parking close to their destinations, which poses an extra hardship. City governments take various steps to ensure that such parking is available.

Barrier free parking

In many cities, particularly in developed countries, disabled drivers are given a sticker which indicates that the vehicle is operated by a disabled person who has special parking privileges. Vehicles may stop at no parking zones solely for the purpose of discharging disabled passengers. They may also park in barrier free parking spaces.

Generally, city regulations require that at least one space located near the entry of all public and commercial facilities be reserved for disabled motorists. In a large parking area, at least one space in 50, located near a barrier free entry should be reserved for them. The parking spaces are clearly marked with a barrier free symbol. Vehicles without a sticker, making use of such spaces, are penalized.

Barrier free parking must be carefully designed. Many disabled people use vans and the height of shelters and garages must accommodate them. The parking space must be larger to allow the operation of lifts or ramps. When the disabled person has disembarked, there must be a safe route to a pedestrian walkway without passing behind parked cars since people seated in wheelchairs may not be seen by drivers backing out of their parking spaces.

Taxi services

Ideally all taxis should be accessible. Elderly and disabled people largely rely on taxi services but report a variety of problems. These include cost, lack of understanding for their needs and an insufficient number of accessible taxis. Many elderly and disabled travelers use taxis in cases of necessity or prudently because of the cost.

Accessible taxis

In Canada, the Province of Ontario has offered a grant to adapt taxis. Private-sector companies may adapt one or more of their fleet and provide regular service and they send accessible taxis to disabled passengers who call for them.

Cities, which license such accessible taxis, may also require that companies with large taxi f Bets have at least a few cars that are accessible. Municipal governments may also provide training free of cost to the drivers of such vehicles on how they may best serve disabled passengers.

Doctors in public hospitals may have taxi vouchers that may be given to elderly and disabled patients to ensure that they return for essential medical treatment. The value of these taxi vouchers may be deducted from municipal taxes paid by elderly and disabled people.

A variation on taxi service is the Dial-a-ride service that works in many cities in the United States and the United Kingdom. In Berlin, Germany, a "telebus" operates on the same principle. Often disabled passengers are given a transit card and they are allowed a certain number of rides.

Because of the inadequacy and costs of these services, escort services are operated by a number of voluntary organizations. Volunteers pick up and drive elderly or disabled person to important destinations such as doctors' appointments.

Source: Transport for Disabled People, (Paris, OECD, 1986).

Public bus service

In many cities, especially in developing countries, public buses are a key component of transport. However, the bus service is difficult for elderly and disabled riders to use. Even when large investments are made, improvements in service to address the needs of elderly and disabled passengers are difficult to accomplish.

Many city governments often take the opportunities to upgrade their fleets with accessible buses when old vehicles are replaced. Bus stops are modified. Service practices are also being changed. Sometimes, when changes are phased, an advisory committee of elderly and disabled users, advise authorities on which routes should be modified or upgraded first.

Accessible public bus services

In existing bus services, small changes can be made. A few seats in the front can be reserved for elderly and disabled riders. The driver can then watch that they are safely on board and seated before moving from a stop. A reduced fare for disabled and elderly passengers in non-peak hours maybe helpful.

In Ottawa, Canada, the Transecure Night Stop programme is offered after 9 p.m. Passengers worried about disembarking at a stop may be let off at a point on the route that is closer to their final destination if the driver is warned one stop ahead. This is particularly useful for elderly passengers.

Accessible design of public buses has made a great difference to elderly and disabled users. Many cities are investing in "kneeling" buses or "easy access" buses where the driver can lower the front end of the bus to seven inches above the ground, providing a lower step for elderly and disabled travelers. A visual and auditory alarm is activated during the lowering and raising process and a braking system prevents vehicle mobility. Entries have good lighting and steps and hand rails that are marked with bright colours. Stop request buttons are located within reach of all seating. These buttons near seats reserved for elderly or disabled users require no reaching.

Bus-stop design has been much improved. Accessible bus stops with shelters are increasing in number. Bus-stop signs must be clearly visible and lit. The routes and numbers must be posted in a well-lit spot so that people can move quite close to view the information. Such information is often posted on the back or side wall of the shelter so that it can be viewed from a seated position.

Many key bus routes are stable and can be made simpler to use. In Paris, the bus stops are numbered and named. The bus shelters are clearly marked in large letters with the number and the name. Route maps at the bus stops show the stops with the numbers and the names. The routes with the bus stops are also displayed inside the bus. Bus drivers have route maps that can be handed to passengers who need to hold them close to their eyes. It is possible to phone ahead to find out when the bus is due at a particular bus stop to reduce waiting time.

In many cities, elderly and disabled passengers are sold a transit pass at reduced rates which allows them to use the bus as frequently as they require. Many elderly and disabled people find it difficult to use fare boxes or to pay the fare while the bus is in motion. The transit pass helps them. In cities where there are subways and trams, these transit passes may be valid for them as well.

Source: Improving the Quality of Life of Elderly and Disabled persons in Human Settlements, a Case Study of the City of Ottawa (UNCHS (Habitat), 1993).

Parallel transport systems for persons with disabilities

Because of the need for flexibility, many cities, particularly in developed countries, have implemented parallel transport systems for people with a disability. While these systems do segregate disabled people, they provide personalized door-to-door service. A small number of special vehicles (cars, vans or buses) are purchased rather than modifying all public transport vehicles. Some of these systems are operated by non-profit organizations for municipal governments. So far in the cities where such systems exist, demand far outstrips supply and many disabled people are unable to commute to work using the system.

Parallel transport systems for persons with disabilities

The city of Edmonton, Canada, has a parallel system Disabled Adult Transportation System (DATS), which offers three types of services: First, by subscription for a regular more than once weekly trip door-to-door (this service accounts for most of the trips); and, secondly, by reservation for an occasional trip booked 24 hours in advance, and charter trips to groups.

Many cities in developed countries have small buses with platform lifts to help wheelchair passengers to board the bus. The front seats are equipped with wheelchair locks to secure them during the ride.

The city of Ottawa, Canada, has the Communibus programme (in addition to the Para-Transpo door-to-door service) for those with mobility impairments but who can reach a regular bus stop. The Communibus has kneeling capabilities, a ramp, space for wheelchairs and air conditioning. Attendants accompanying a user ride free of charge. Buses operate every 30 minutes on a fixed route in the central city and stop at all regular bus stops. Information is posted at the bus stop shelters, where benches have been installed for waiting passengers.

Source: Improving the Quality of Life of Elderly and Disabled Persons in Human settlements, a Case Study of the City of Ottawa (UNCHS (Habitat), 1993); Transport for Disabled People, (Paris, OECD, 1986).

Mass transit

Subway systems efficiently move large numbers of people quickly over large distances in and out of the city. Households can live in cheaper neighbourhoods at locations at the periphery of the city if convenient mass-transit services to the centre city are available. Many elderly and disabled people are unable to do so because mass-transit systems are not accessible.

Accessible mass transit

Modern subways are much better designed than early models. Stations are accessible and passengers with or without disabilities are able to board because the cars are level with the platforms. The surfaces are textured to provide a secure walking surface. Stops provide passengers ample time to embark and seat themselves. Smooth acceleration and deceleration reduces accidents. A wide variety of supports and hand holds are available offering alternatives. In Ville Nouvelle d'Ascq, France, the system is completely automatic (no driver) and fully accessible.

H. Income support

Evidence from all around the world indicates that elderly and disabled people prefer the alternative of earning income rather than relying on public income-support programs. When this is not possible, however, income-support with dignity must be provided. Many elderly people have had a full working life and have saved for retirement, but inflation, illness or unforeseen expenditures may have consumed their savings. Providing them partial assistance and enabling independence is far less expensive than providing them a full income. Small subsidies such as discounts for travel and tax rebates also increase the disposable income of elderly and disabled people.

Employment opportunities

Though both elderly and disabled individual s may have marketable skills, they may not have the mobility or the information to find appropriate jobs. Low labour participation among disabled workers is a problem shared by both developed and developing countries.

Job placement initiatives

Government programmes are essential in order to provide fundamental assistance as well as leadership. In Canada, under a programme called Access, disabled workers may be hired for six months at subsidized costs to the employer. If the employer is satisfied, the disabled worker may be retained as an employee. If that is not possible, the disabled person has gained valuable work experience. Line 1000, a community agency funded by the Government, provides job-placement services to disabled persons or those facing discrimination in the labour market. The agency meets with employers to identify jobs for clientele, matches clients to jobs, facilitates the process adaption of employer and employee through information and support and ensures the availability of assistive devices.

City governments set the standard for activities within the city. Many of them have taken the lead in hiring older and disabled workers and they have often set up an external monitoring group to monitor their performance in this regard. Some governments have reserved a certain number of jobs for disabled workers.

Non-profit agencies, working with some municipal funding operate employment agencies for elderly and disabled workers. In Japan, "silver employment agencies" locate employment opportunities for senior citizens. Professionals and managers may be connected with new or troubled companies who need short-term expertise. In Canada, assessment and employment preparation services are offered to disabled job seekers through the March of Dimes, a non-profit organization. In Ottawa, the Seniors Employment Bureau offers job placement services in the private and public sector for people aged SS and over.

Non-profit organizations operate sheltered workshops for people with developmental disabilities. Those who are unable to compete in the labour market have an alternative, which pays them an allowance and provides them with meaningful work. With some government funding, non-profit organizations also run programmes to graduate workers from sheltered workshops to the workplace. In Ottawa, Canada, a job coach identifies a job for an individual, performs the task at the work place, and then coaches the person to perform the job at the sheltered workshop until the person is ready. The job coach stays on the job site until the new employee and the employer are comfortable. The job coach remains available and monitors the situation for a period of time after placement.

Source: Improving Living Conditions of Elderly and Disabled Persons in Human Settlements, a Case Study of the City of Ottawa (UNCHS (Habitat), 1993).

Use of technology in the work place

Technology has increased employment opportunities for elderly and disabled employees, particularly in developed countries. Many countries offer workers subsidies to purchase the necessary aids so that they can be hired for jobs in the labour market. Technology also allows individuals to work at home. Many who are elderly or disabled are able to work at home and to communicate their work through technology. Examples are cartoonists and tax consultants who transmit their work electronically.

Breaking employment barriers with technology

The governments of many developed countries offer subsidies for assistive devices, particularly those that allow elderly or disabled people to earn their living. These aids include high magnification computers. Germany offers grants to disabled workers who need to purchase a modified car for work-related travel.

Investment assistance

Self-employment opportunities are attractive to many elderly and disabled people but they are hampered by the lack of credit.

Seed money for self-employment ventures

Some local governments, in both developed and developing countries, offer loans with small grants of seed money for promising self employment ventures. The Tamil Nadu State Government in India provides a small subsidy to disabled persons who are assisted to set up kiosks selling refreshments and snacks. The nationalized banks in India also offer loans on easy terms to low-income customers with disabilities for small ventures.

Source: Improving Living Conditions of Elderly and Disabled Persons in Human Settlements, a Case Study of the City of Madras (UNCHS (Habitat), 1993)

Income-security programmes

Welfare States have well developed income-security programmes, which provide elderly and disabled people basic income to meet their daily needs. Many of these are funded nationally. Some are administered locally. Local governments may supplement them.

Income-security programmes

In Sweden, the State provides income security through a public pension programme for elderly and disabled individuals who receive benefits depending on eligibility from public pension, disability pension, or dependent pension. In addition, the local government provides a housing allowance to low-income senior citizens to ensure that they have good quality housing. In other countries, income security may be funded and organized differently.

Some cities in developed countries operate foster family programmes, where the foster family y is paid a sum monthly for the care of one or two elderly or disabled adults. Though the payment is made to the foster family, security is assured for the fostered persons. The programme is less expensive than institutionalization.

Rebates and discounts

Tax rebates and discounts of various kinds under various conditions leave elderly and disabled people with increased disposable income. These rebates may be offered by various levels of government and they may work individually or in conjunction with one another.

Rebates and discounts

Central governments of many countries offer a variety of tax deductions. In some countries, disabled taxpayers are offered a second personal deduction from income taxes. In other countries, expenditures for making a home accessible may be deducted. In India, disabled people receiving assistive devices, prosthesis or medicines from abroad are exempted from customs duty.

Local governments, in general, are responsible for property taxes and some times school taxes. Elderly and disabled taxpayers are granted a tax rebate for these taxes in many cities in Canada. In some cities, when homes are made accessible, the property value is not raised and taxes are paid at the rate prior to the improvement. In some cases, elderly homeowners are allowed to build a debt for taxes due which is paid by the estate after the death of the person.

Consumption taxes (VAT) can be a burden for those with low incomes. In Canada, low-income households are given a tax rebate every quarter

Disabled drivers may be eligible for a gas tax rebate under certain conditions in Canada as they are very dependent on their vehicles for mobility. Discounts on fares are common in transport systems in both developed and developing countries.

In France, people over 70 years of age using over 60 hours of home help a month are exempt from social-security contributions.

Source: Improving Living Conditions of Elderly and Disabled Persons in Human Settlements, a Case Study c of the City c of Ottawa and a Case Study of the City of Madras (UNCHS (Habitat), 1993); Urban Policies for Ageing Populations (Paris, OECD. 1992).

I. Urban services

Many urban services require that the citizen carry out responsibilities as a city resident. Garbage has to he put in a collection place for removal by the city. The sidewalk in front of homes must be kept clear of leaves or snow. Lots are expected to be maintained for public health. Elderly and disabled residents may find these responsibilities difficult.

Help for heavy work

Some municipalities in the United States collect a small sum from elderly and disabled people which is used to build a fund from which unemployed people are paid to move garbage and clear the snow for these households.

Non-profit organizations in Canada offer Handy Andy services at nominal cost for heavy work. In cooperative housing organizations, some tenants carry out heavy tasks for elderly and disabled members while paying reduced rent.

Incentives for desirable activities

Incentives are often used to encourage participation in conservation and environmental protection.

Incentives for conservation

The cu y of Curitiba, Brazil is encouraging its residents to sort garbage to reduce garbage pick -up and dumping costs. Promotional information points out the environmental benefits of recycling and creating compost but it also points out sorting garbage reduces the amount of garbage that has to be carried out. In low income neighbourhoods, bags of sorted garbage are exchanged for bags of surplus vegetables. The service is appreciated by elderly individual.

Source: National Geographic, June 1993, p.137.

J. Social services

In both developed and developing countries, social services are usually the responsibility of local government. There are a large variety of social services demanded and consumed by urban residents. Where consolidation is possible, attempts are made. For example, the highly successful well-baby clinics are being enlarged into family health clinics, which focus on health promotion for all age groups. City governments are hard pressed to offer the variety of services and to meet demand. In many cases, cities select social services that are essential for quality of life. They work to ensue; the availability of essential services of good standard throughout the city. Municipal governments may opt to deliver the services themselves, to contract the services to private agencies or to non-profit agencies. Because of the support they receive from municipalities many non-profit and charitable organizations also provide services that are not directly contracted or funded.

Strategic short-term planning

Municipal governments in developed countries that are responsive to demands for social services without well-defined plans for the delivery of social services and for the costs and resources involved may run into difficulty. In developed countries, where there is a heavy reliance on formal care, it is important to avoid unexpected demands that cannot be met and, therefore, strategic short-term plans must be developed based on good neighbourhood level data.

Strategic planning to ensure client-oriented social service

Consumption of social services to elderly and disabled people can vary across neighbourhoods and over time. The municipal government of Gothenburg in Sweden maintains data on the demographic composition of the neighbourhood so that the potential demand over five years can be projected. The local authority also consolidates planning so that the resources can be allocated wisely between institutional care and community care. Thus, for example, the city government planned to reduce 900 hospital beds while adding 2000 group homes and service houses (rental apartments with services for seniors) and increasing day care and home care between the years 1989 and 1995 to meet anticipated needs of elderly and disabled persons.

Source: Brink, S., "Policy and programme responses to population ageing", Urban Policies for Ageing Populations. (Paris: OECD, 1992).

Partnerships with private and non-profit agencies

City governments in many countries form private and non-profit agencies to ensure that a full range of services is available in the city. They may share resources, facilities and costs.

Partnerships with private and non profit organizations

The city may form partnerships with other agencies, by sharing resources, facilities or costs. Where financial resources may be limited, payments in kind may be made. Financial incentives may be provided or contracts for operation may be signed.

The city may sub-let space in city -owned buildings at nominal rates to non-profit agencies so that they can offer services at reasonable rates. The city may also sub-lease space to private businesses on condition they offer some services. For example, a municipality may sub-let space at a lowered rent to a local convenience store in a neighbourhood on condition that deliveries are made to the home of elderly clients. The city may also rent space to a cafe on the ground floor of nursing home on condition that meals are prepared for the residents while also serving as a community-gathering place.

Coordinating services

To ensure that every person receives the right amount and the right mix of services, a variety of coordinating services may be offered. Municipalities may engage "case managers" who examine each case and arrange for the required services according to the needs of the elderly or disabled person, the available informal care and the available community care. Some of the case managers deal only with government services, others deal with specific services. The best arrangement is the single-window concept, where an elderly or disabled client can get access to all the services required, whether public, private or non-profit, through one case manager. Otherwise, the elderly person has to make separate contacts with each source of service.

Coordinating services

A community information centre finds answers to questions about community services in the city and makes referrals to service agencies. In Ottawa the centre has a database of services, including legal, financial assistance, consumer concerns, education, employment, leisure, housing, counseling and self-help groups. It may also publish and sell a directory of community services which is a valuable resource to professionals and care givers who need a guide to the key services in the community.

A housing placement coordinator works to find the appropriate type of housing for low-income clients on a waiting list. Elderly or disabled people with low-incomes may be housed in public housing, non-profit housing or housing with care. They pay 25 to 30 per cent of their income in rent.

A special needs coordinator acts as a referral agent for special needs low-income clients, connecting them with appropriate support services and finding suitable housing within the city inventory.

Case managers assist people to have access to the services that they need. Case management can be provided by non-profit organizations or businesses that charge for the service.

Source: Improving Living Conditions of the Elderly and Disabled Persons in Human Settlements, a Case Study of the City of Ottawa (UNCHS (Habitat) 1993).

Health services

Public health is a key objective in cities in both developed and developing countries, though it may be the responsibility of higher orders of government. Many services are administered by the city.

Health services

Health promotion may be stimulated through a healthy neighbourhood programme, working with groups of elderly or disabled residents. The services that can be offered are group health education classes, health counseling, advice to care givers and diet and nutritional advice. Immunization services for children prevent disabilities, particularly in developing countries.

Home health care or nursing services serve elderly or disabled people and people recovering from illness. These services allow them to return home earlier from hospital and to avoid institutionalization. Medical treatment and care are offered by a number of professional organizations. The cost is based on the ability to pay if it is not covered by health insurance.

Foot care, hair care, care for osteoporosis and other conditions may be provided at day centres.
Addiction therapy of various kinds, such as for alcohol or drug abuse, medication dependency, cigarettes and obesity may be offered by different voluntary or professional organizations.

In the City of Montreal, Canada, under the Medical Service Home Care Program, an elderly or disabled person is matched with a family physician who is willing to provide care for the patient at home. This service improves the health of the clients and reduces visits to emergency rooms of hospitals.

Nutrition services

Nutrition services are provided for two reasons: first, due to low or irregular income, elderly or disabled people may have insufficient food which exacerbates poor health and declining function, and secondly, elderly and disabled people who live alone able to prepare or eat nutritious meals. There are a variety of services associated with food.

Food-related services

Dietician services are intended to increase skills in choosing, preparing and eating healthy food. They are called a variety names. In Ottawa, it is called "Food for one is fun". The social aspect of working in a group to meet and discuss nutritional issues adds to the value. Demonstrations may be held, followed by meals together. Dieticians may also work closely with elderly or disabled patients who must follow special diets.

The meals-on-wheels programme, widely available in cities in developed countries, provides one hot nutritious meal, delivered to the person's home. There are variations where a set of frozen meals selected by the person is delivered to the home. The elderly or disabled person, can then select a meal from the set and microwave it and eat it at a personally chosen time. Elderly and disabled people may pay a reasonable fee for the service. This programme is now available in developing countries as well, often serving elderly people who cannot cook their meals but who can afford the service.

Elderly or disabled people may assemble at a neighbourhood site for a warm meal. These programmes are organized in many ways. When they are transported to the dining centre, the programme may be called "Wheels to meals". Elderly or disabled people may also be served meals at schools, nursing homes or hospitals at a certain time. These may be called "diners' club". In some cities in Scandinavia, elderly and disabled customers may purchase meals at a rebate at identified centres by showing their identity cards. The cafeterias may reclaim the rebate from the city.

In many cities in both developed and developing countries, churches, temples and other religious organizations serve free hot meals on their premises. Some charitable organizations run soup kitchens in central areas of the city where there are a lot of poor or hungry people.

Food banks operate in many cities in developed countries. These food banks collect left-over food from restaurants and grocery stores. They also rely on donations of food at large shopping centres. Those in difficulty are given a bag of food for the week.

Home-delivered support services

Home-delivered support services provide a variety of non-medical care to help elderly and disabled people to live independently in their own homes in developed countries. In developing countries, those who can afford it, often hire a person during the day to provide the required services.

Home-delivered support services

In developed countries, home-care or homemaker programmes offer personal care (bathing, hygiene and grooming) as well as home making (cleaning, laundry and light meals) services to elderly and disabled clients. These services may or may not be covered by health insurance. If they are not, clients pay according to their income. A care plan is developed by a multi-disciplinary team to ensure that home care is provided with other required services to support the client living at home.

Training in community living skills are directed to mentally retarded people. Counselors teach people budgeting, banking, shopping, cooking and use of community resources. These home-management and life-coping skills allow them to live independently outside of institutions. These skills are as important as skills training that enable them to earn a living.

Out-reach attendant care is available to disabled people in many developed countries under the health insurance programme. They are helped at home to bathe, dress, and groom themselves. Roughly three hours of care are provided per day, during visits in the morning and evening. In Ottawa, Canada, disabled or elderly residents living in special housing may be served by attendant care staff who have offices in the building. They may be paged at any time for regular assistance or emergency help. This service is offered to disabled students living in a dormitory at Carleton University in Ottawa.

Handy Andy programmes help elderly and disabled folk to live at home by extending help with small repairs and maintenance jobs. Chores include snow removal, changing of light bulbs and moving furniture.

Elderly and disabled people may also rely on individual or group escort services. As a group, they may be taken to grocery stores or shopping centres while they may be escorted individually for doctor or dentists' appointments.

Source: Improving Living Conditions of Elderly and Disabled Persons a Case Study of the City Of Ottawa and a Case Study of the City of Madras (UNCHS (Habitat), 1993).

Assistive devices and aids

Improved technology has increased the availability of devices and aids that improve considerably the quality of life of elderly and disabled persons in both developed and developing countries.

Assistive aids and devices

In many cities, charitable organizations help low-income elderly and disabled people with the purchase of dentures and eye glasses. Some organizations collect unwanted glasses for distribution to those in need.

Assistive devices and physiotherapy may be available under health insurance programmes. In other cities, the costs of the devices and therapy may be deducted as expenses from taxable income. A number of volunteer organizations, such as the Cancer society, may also provide partial funding or rent such devices.

In Tokyo, special aids such as hoists, hospital beds or wheelchairs may be rented through non-profit seniors associations.

Source: Improving Living Conditions of the Elderly and Disabled Persons in Human Settlements a Case Study of the City of Ottawa, (UNCHS (Habitat), 1993).

Educational and information services

Elderly and disabled people benefit from educational and informational services, which help them to develop skills, or interests that help them through life.

Educational and informational services

In North America, Elderhostel is a residential educational programme on college or university campuses for older adults aged 60 and over. The courses last one or two weeks and cover a wide variety of subjects. Fees are low.

Elderly volunteer organizations, such as "Third Age Learning," also establish learning circles that are self-programmed to work on courses. Subjects are topics of current interest such as the environment, modern history and low-risk investment.

Television companies have a series of educational programmes that are specifically targeted to senior citizens or those that are of general interest.

Governments may publish booklets informing elderly and disabled people of the public services that are available to them. They may be printed in large print. City governments may also encourage the publication of a newspaper with information for elderly or disabled persons. In the United States, elderly people may also link to a computer network for information about programmes.

*Source: Seniors Guide to Federal Programs and Services, (*Ottawa, Government of Canada*); Guide for Senior Citizens - Services and Program in Ontario, Canada.*

Clubs and seniors' centers

A large variety or services and programs, including foodservice, educational, recreational and social events, are organized by clubs and seniors centres in both developed and developing countries.

> ***Clubs and seniors' centers***
>
> *Clubs and seniors' centres, run by a range of non-profit organizations, attract elderly residents in the neighbourhood because of the variety of their programmes. They offer fitness classes, musical groups and choirs, dancing and social teas, bingo, chess or bridge nights, outings and travel and courses in subjects that range from cooking to genealogy. Where possible, elderly people are provided with transport to and from the centre. Much of the work is done by volunteers, many of them elderly themselves.*

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Services to care givers

Families continue to be the main source of care for elderly and disabled relatives, whether or not they live together or apart. However, care giving is heavy, time consuming and stressful work when the caregiver has no relief and works over a period of many years caring for a person who is in declining health. Cities realize the support given to care givers keep elderly and disabled people off the rolls for formal care.

Figure 9. The barrier-free symbol

Services to care givers

Cities provide some support to care-givers associations. In the United Kingdom, the National Caregivers Association not only provides services to its members but also lobbies government for programmes and financing.

Courses are offered to family members on care giving by non-profit professional organizations. These range from information on the condition or disease of the elderly person, the right ways to lift, move, bathe and care for the elderly person and counseling on the resources that may be tapped to deal with financial, physical and psychological stress.

Respite care is a valuable service providing relief to care givers. Relief may be provided over a weekend, for an annual holiday or in times of crisis. A professional care giver may be sent to the home or the care recipient may be moved to an institution for the duration.

Norway is one of the few countries that provides financial support to family care givers who take long-term leave from the labour force to provide care for an ageing parent. The care giver may also maintain pension payments for the time spent in giving care. In Japan and the United States care givers may be offered income tax credits.

Source: Urban Policies for Ageing Populations (Paris; OECD, 1992)

Day centers and day care centres

Day centres and adult day-care centres in cities in both developed countries and developing countries provide a wide mix of services to the elderly person who spends the day there. Some of them serve special groups such as mentally confused or Alzheimer clients. The centres may be free or they may charge according to income.

Day centres and day care centers

These centres may be located centrally in the community centres of neighbourhoods. Elderly people spend one or more days a week at these centres, for their own benefit and to provide relief for families. They are normally open during working hours and may be located at a work site. In the United States many large companies offer both child and adult day -care services for their employees. School buses may pick up and deliver clients after they have served the schools. Elderly clients at the centres may have access to services such as podiatry, bathing, hairdressing and therapy. Activities depend on the centre. In some, educational and recreational activities predominate. A resident artist may teach arts and crafts. Others may welcome museum programmes, choirs and cultural activities. They may watch television programmes and movies together. In developing countries, a warm meal may be prepared and served by the participants. In some day centres income-generating projects are conducted, such as the making of paper bags, jams and children's knitted clothing.

Source: Improving Living Conditions c of Elderly and Disabled Persons, a Case Study of the City of Madras (UNCHS (Habitat, 1993).

Assurance programmes

In developed countries, a large proportion of elderly and disabled people live alone. If their mobility is reduced they are isolated and lonely. This is mitigated to some extent if they have access to a telephone. Television brings the world to them. Some programmes are run by volunteer agencies to provide social contact and assurance.

Assurance programmes

One group of programmes ensures that the elderly or disabled person is visited weekly or even daily. The friendly visitor programme is run by charitable organizations in many countries of the world. The programme matches the visitor with the interest of the resident. The caring neighbour programme of cities in Scotland pays a neighbour to help the elderly resident by a daily visit and by the' performance of chores. Some cities in the United Kingdom use a block warden, who visits but who may also be called in case of need. In China, a "neighbourhood aunt" makes the visits.

The second group of programmes is based on the telephone. The telephone assurance programme may be designed in different ways and be run by elderly people or by others. Each elderly person is assured by a daily phone call and, if there is no response, emergency procedures are instigated. Some elderly groups have a round-robin of calls to each other. Some have a telephone chain with each person calling three others.

Counseling services

Elderly and disabled people may require counseling services of various kinds from time to time. These may include legal, financial, pastoral, family, psychological, bereavement and stress counseling services.

Counseling services

Counseling services may be provided free or at cost by a variety of professional or charitable organizations. These may be activated by a doctor or a case manager. Some of them may be linked with life events such as divorce, death of a child or spouse, loss of income or a disabling condition. For example, in Ottawa, Resource, Education and Advocacy for the Handicapped (REACH) is a group of lawyers and community members providing legal services to people who are disabled.

K. Civic services

The segregation of elderly and disabled citizens results in isolation and powerlessness to influence decision-making regarding the city and its activities. Municipalities that have recognized these groups as active members of society and, more important, a latent resource, have gained impressive benefits. Strategies with two types of outcomes have been sought. The first set of strategies are intended to include elderly and disabled people in civic activities which benefit them, while the second set of strategies involves them in civic activities that benefit the city as a whole.

The barrier free symbol

The barrier-free symbol is used worldwide to indicate spaces or activities that can be used by disabled people or that are reserved for them. It is hoped that one day such signs may not be required because the design of spaces and activities will treat all residents, regardless of their abilities, on equal terns. Until that time, the use of the barrier-free symbol must be used in a meaningful way.

Use of the barrier free symbol

The city government has an important role to play in managing the use of the barrier free symbol (see figure 9). Clear standards should be established, working with experts and disabled groups, on when the barrier-free symbol can be displayed. City governments may permit the use of the symbol to establishments that have earned the right to display them by complying with the standards. City inspectors may periodically renew the permit after inspection of compliance. Municipalities may also require the sign on special facilities for elderly and disabled people, which are obligatory, such as parking spaces and toilets reserved for their use. Those qualifying may be granted a permit bearing the symbol allowing them to use such facilities, particularly parking. Conversely, unauthorized use of the symbol may carry sanctions or penalties.

Ombudsman services

Many elderly and disabled people, even in groups, feel that the power of city government cannot be contested. An office of an ombudsman can be set up to ensure that citizens have the right of appeal if they feel the city government does not serve them well. The ombudsman investigates all sides of the issue and attempts to negotiate an agreeable solution to all parties. This type of office is particularly useful if there is no code of human rights for a country.

Ombudsman services

This service is not exclusively for elderly or disabled citizens but includes them in the appeal process offered by the city. Experience from Scandinavian cities shows that these groups often use this service. Issues cover all aspects of city government, from tax assessment to location of bus stops.

Aid to vote

Elderly and disabled citizens in both developed and developing countries are often unable to surmount the barriers to participating in local elections. They are not mobile enough to register as electors and are sometimes unable to reach voting sites. When they are able to participate, elderly citizens tend to participate at a higher rate than other groups. This helps them to put their needs forward on the policy agenda. Some elderly or disabled voters have stated that they do not wish to accept transport from political parties to the polling stations, because the parties then expect their vote.

Aid to vote

Municipalities are examining procedures to ensure that they are sensitive to the needs of elderly and disabled citizens. Workers for elector registration pay home visits. Early voting is allowed for these groups so that they do not have to compete with crowds. City governments support non-profit or elderly or disabled organizations which bring elderly or disabled voters to the polls.

Advocacy for elderly or disabled residents

City governments are lobbied by powerful interests from business, national political parties or industries. Elderly or disabled citizens have felt that they lacked a voice. City governments have supported independent non-profit organizations that could address policy issues from the perspective of groups of citizens or neighbourhoods.

Advocacy for elderly or disabled residents

Lobbying and advocacy is big business and elderly and disabled people lack the financial resources to buy such services. City governments support independent non-profit organizations by providing partial aid in money or in kind. In Ottawa, Canada, organizations such as the Council on Ageing, the Social Planning Council, Centre for the Hearing Impaired and the Disabled Persons Community Resource Centre, not only coordinate or provide services to their client groups but they also amass research and policy information about these groups for the purpose of advocacy and planning for future services for their constituents. Many of them have earned their credibility by solid community work and by providing effective liaison between the city and the clients.

Many countries have national pensioners' organizations. They communicate with their members through a newspaper and they lobby various levels of government. They also provide seminars to sensitize government, business and public to the needs of their elderly and disabled members.

Source: Improving Living Conditions of Elderly and Disabled Persons in Human Settlements a Case Study of the City of Ottawa (UNCHS (Habitat), 1993).

Advisory committees

Mayors often establish advisory committees on a number of subjects, which advise the city council on relevant decisions. Appointments may be made to these committees based on expertise, representativeness and commitment to cause. City governments are inviting elderly and disabled people to serve on committees that concentrate on issues that affect them as well as to have representatives on other committees that can speak for their interests.

Advisory committees

In Ottawa, Canada, the Disabled Citizens Advisory Committee was established in 1981 (International Year of Disabled Persons), "to recommend the development of policies to City Council and to monitor their implementation". The Committee consists of 13 people, at least half of whom are chosen from different disability groups and a one city councilor. The Committee is assigned a member of staff, who assists it and serves as a resource. The Committee was specifically instructed: to examine the City's employment system in order to identify barriers for people with disabilities; to recommend changes to the system to ensure that such people have equal employment opportunities at the City; to recommend methods to keep elected representatives, staff and citizens of Ottawa informed of the requirements of disabled people and of the existing programmes; to monitor the disbursement of funds approved by City Council for employment-related accommodation to facilitate the hiring, promotion and career development of disabled people; to monitor the development and implementation of bye-laws and regulations which have an impact on disabled people; to monitor services to disabled people; to examine the City's Accessible Housing Program; and to recommend formats to ensure information is accessible to the vision- and hearing-impaired.

Source: Improving Living Conditions of Elderly and Disabled Persons in Human Settlements, a Case Study of the City of Ottawa (UNCHS (Habitat), 1993).

Community-based service organizations for elderly and disabled people

With encouragement from cities in both developed and developing countries, community-based non-profit service organizations for elderly and disabled people have engaged in activities that provide valuable services to all city residents. These organizations work in addition to established organizations such as the Rotary Club, Lions Club, Shriners or Zonta to which many of them belong. Many of them also run programmes for elderly and disabled people such as delivering meals on wheels, Christmas hampers for low-income seniors, bingo games and outings.

Community service by organizations for elderly and disabled people

The services offered by non-profit organizations may be provided on a voluntary basis or on a cost -per-service basis. Services include the operation of a volunteer bureau (matching time and skills of volunteers to needed services), a visitors' welcome service (where people who can speak other languages welcome visitors at international airports), tourist information (a service provided at convention centres or airports), taping of books for blind readers, maintaining of vegetation in traffic circles and dividers, mending and alteration service, sorting and recycling service, literacy training service, children's reading hour in local libraries and traffic-crossing guides near schools.

The city from the perspective of elderly and disabled people

Many cities realize that the lack of information can be a serious liability for their own residents and for visitors to the city. They cannot always rely on tourist books and maps to provide accurate or necessary information about the city. Elderly or disabled travelers arriving in a city may find that they have to travel greater distance and spend more effort to find hotels or restaurants that accommodate them than other people. Large conventions, sports events, conferences, fairs and exhibitions now demand information on accessibility factors. Cities, which have to compete for such revenue-producing events, find that they can market themselves better with good up-to-date information about the accessibility of the city to all comers.

Accessibility of the city

Many cities are preparing or contracting the preparation of a book which will promote the facilities of the city in terms of their accessibility. City policies with regard to parking for disabled people openness to the use of seeing-eye dogs, and transport-terminal services for elderly and disabled travelers are presented. Street maps show curb-cut locations and street inclines which are of interest to mobility-impaired users. Important information on accessible transport to and from transport terminals and within the city is described. The attractions of the city and their accessibility are highlighted. Among the points made are well-distributed city resources such as accessible hospitals, schools and day care.

Accessible commercial establishments such as restaurants, hotels and shopping centres are listed. Professional services (doctors, nurses, dentists; child-cure workers, and pediatricians) available to disabled or elderly clients and those available on an emergency basis are noted. The Bank of Montreal in Canada provides bank statements in Braille so that the privacy of visually-impaired clients are not compromised. Automated teller machines may have instructions and keys marked in Braille.

In Ottawa, such a book was prepared by the Disabled Persons Community Resource Centre.

Source: The Ottawa Accessibility Guide (Ottawa, 1990).

L. Safety and security

Safety and security is a fundamental issue in cities for all residents but elderly and disabled residents are apt to feel particularly vulnerable. Many of them live alone and many of them are women. Fear of crime can be as powerful a barrier to mobility as stairs for many individuals in this group. Criminal elements in cities target them and their homes.

Many of them are also concerned that in a case of emergency they will be unable to get speedy help. City governments use information, regulations and programmes, while working independently or in partnership with other organizations or agencies.

Targeted safety programmes

Many policies would be too expensive to implement as a general rule but reduce other expenditures if targeted to groups at risk.

Regulations for nursing homes or other buildings with a high proportion of elderly and disabled residents

In some provinces of Canada, building code regulations require that all dwellings must have smoke alarms. This poses a relatively small financial burden for the gains in safety and fire fighting. A few provinces and cities further require that buildings such as nursing homes that have a high proportion of elderly and disabled residents must have a sprinkler system. Loss of life due to fires in such buildings has fallen. Although this requirement is expensive, targeted in this way, it has received widespread acceptance because of reduced insurance costs and less fire fighting, as well as lower property loss.

Areas of refuge in buildings are spaces that are safe from smoke or fire for specified amounts of time, if they follow strict technical specifications for construction. These spaces may be used by disabled people temporarily until fire-fighters evacuate them.

Community activities of the fire and police departments

Police and fire departments have very special roles but their every-day presence allows them to build strong alliances within the community. One of the ways in which they have successfully done so is to provide special attention to the needs of citizens who are elderly and disabled in the neighbourhoods that they serve. Community policing where the police beat is conducted on foot or bicycle, makes the officers more easily accessible to elderly or disabled residents who get to know them.

Police and fire department services for elderly and disabled residents

Police departments are moving to community policing models with more police officers on the beat. In Tokyo, each ward has a booth which provides information and directions. The police in many Canadian and United States cities visit community centres where they provide information on crime-proofing homes. They also visit individual homes on appointment and advise residents on security measures.

The Police Department in Ottawa publishes a Crime Awareness Pamphlet which lists a number of schemes that are specifically aimed at defrauding older people. Rules for avoiding fraudulent or pressuring offers are described.

The Fire Department in Ottawa holds lectures and demonstrations on request at large nursing homes or apartment complexes, explaining fire safety. A document entitled "Plan to get out alive" describes safe evacuation procedures in the case of different fire scenarios. It also maintains a computerized list (updated annually) of residents who require special assistance in case of evacuation. Senior-citizen buildings are also required to have a communication system by which residents may be instructed in the case of an emergency.

In many Canadian cities, the fire department also provides assistance in the case of medical emergencies. Because they are strategically distributed throughout the city, the response time is short. Five department staff are trained for cardiopulmonary resuscitation, first aid, water rescue and extrication of people from vehicles in accidents.

Source: Improving Living Conditions of Elderly and Disabled Persons in Human Settlements a Case Study of the City of Ottawa (UNCHS (Habitat), 1993).

Calling for help

Residents in most developed countries rely on the telephone to call for help. However, valuable minutes are lost because callers do not know the emergency numbers, because long strings of numbers have to be dialed or because the numbers may be busy when called.

911 Service

The 911 service is widely developed all over North America. The service, paid for by local government, is a partnership between the local telephone company and the fire department. Citizens in danger or in need of emergency help only need to dial 911 in order to be connected to help. The system is computerized and the operator answering the call can identify the address and location of the caller whether or not they are able to speak. Operators are able to direct police, fire or ambulance services to respond according to the need. Operators stay on the line until help has arrived.

Source: Improving Living Conditions of Elderly and Disabled Persons in Human Settlements a Case Study of the City of Ottawa. (UNCHS (Habitat), 1993).

Regulations for safety of elderly and disabled residents

Because of the vulnerability of very old and or disabled people, special regulations may be enforced by the city for their protection. There is public acceptance of the measure and the associated costs because there is sympathy for the needs of these groups.

Regulations for the protection of elderly or disabled people who are vulnerable

In France, protection is offered to elderly renters. Landlords not renewing the lease of low-income renters 70-years and over are required to find an alternative dwelling appropriate to the tenant's needs and finances in the same neighbourhood.

In some cities of the United States, an experimental regulation prevents the cutting-off of power, fuel or telephone without prior notification of the social service agency. This allows the agency to investigate and to arrange for emergency measures.

Source: Brink, S., Housing Policy Directions Based on a Review of Environmental Design Research - a Comparative Study of Housing Policies for the Elderly in Canada, the United States, Sweden and France. (Paris, Ministry of Construction and Housing, 1988).

Voluntary services for safety

There are two types of voluntary activities for safety. The first type of action may be undertaken by a company or an agency as a community service. In the second, community residents take joint action for their own safety and security. Examples of each are given below.

Voluntary services for safety

Mail carriers deliver mail everyday and are often familiar with houses where elderly or disabled people live. AS a volunteer activity, mail carriers may choose to participate in a programme called "mail carrier alert", in which its carrier reports to the police any unusual condition in the home, including accumulating mail. Police or social service personnel investigate.

In northern communities in Sweden, taxi drivers are paid to pick up confused elderly people and to drive them to day-care centres. As part of their duties, they ensure that the entries are snow free and that the elderly person is properly dressed for the climate.

The Neighbourhood Watch programme is a community-based crime-prevention programme common to many cities in North America. Information is provided to participating households on home security and identification of personal valuables. In return, residents monitor the neighbourhood and report any unusual activity to the police.

Partnership projects

City agencies and departments form effective partnerships with community groups or with non-profit organizations in both developed and developing countries to offer important security services to city residents. Special security services for groups at risk can be provided in this manner.

The Wandering Persons Registry

The Ottawa City Police is working with the Alzheimer's' Society on a joint project called The Wandering Persons Registry. Family members identify a person who is likely to wander to a Registry maintained by the police. The registrant can suffer from any condition associated with wandering behaviour such as Alzheimer's disease, head injuries etc. Information on the person's appearance, behaviour characteristics, medical needs and home address as well as the person to contact in case of emergency are computerized in the Registry. This helps the police to identify, assist and return a person who is found lost and wandering. The service is free and confidential.

Source: Improving Living Conditions of Elderly and Disabled People in Human Settlements - a Case Study of the City of Ottawa (UNCHS (Habitat), 1993).

M. Recreation

Recreation and leisure expenditures are often considered as expensive extras but they play a vital role in increasing the quality of life of cities. Indeed, many urban residents now consider recreation and leisure services as an essential characteristic of urban life. Elderly and disabled residents are often excluded because of the domination of sports or professional activities. There is a shift from athletics and spectator sports to activities, which increase personal growth and well being. For elderly and disabled people this would include opportunities to engage in exercise through walking, tai chi or social activities such as card games, reading circles or film clubs.

Information on activities and opportunities

Many elderly or disabled residents are unaware of the opportunities that are offered within the city. Information is a key tool.

> ***Information***
>
> *Municipal governments can disseminate information on recreation and leisure activities in the city in many ways. In several cities in North America, the city has a page once a week in all local newspapers in which information is published. Information on accessibility is included. Small municipalities mail out a calendar with their tax bills, listing the variety of recreation and leisure services and when they are available. Advertisements are also made in the public interest on local radio and television.*
>
> *Special programmes for elderly and disabled participants may also be advertised through publications and radio/television programmes directed to this group. They may also be promoted in places frequented by these groups.*
>
> *Many local neighbourhoods have local billboards where information may be posted. Others have recorded messages that may be received through the telephone regarding the activities for each day.*

Organized recreation programmes

City governments in both developed and developing countries organize a variety of recreation and leisure programmes, such as concerts, sports matches or activities in city parks.

> ***Organized activities***
>
> *Most city governments have active recreation departments with personnel who run a variety of programmes. Some cities have annual festivals or cultural events. In Calgary, Canada, there are the Stampede Days, and in Ottawa, the Tulip Festival. Elderly and disabled people are often important clients and contributors. Some services may be offered in city parks. Disabled children may mingle with other children in an accessible play programme or older adults may enjoy an exercise programme. Many disabled people learn to swim, to ski and to sail through these city-sponsored programmes.*
>
> *A number of special programmes may be operated in special facilities. Variety Village in Toronto is a huge sports complex that is fully accessible. Facilities are designed for disabled runners (track with aid for blind runners, cushioned track for runners with artificial legs, tracks for wheelchair racers). Swimming pools may have days when the water is maintained at warmer temperatures for arthritic or disabled users.*

Activities organized with the support of the city

Both private and non-profit organizations organize a variety of activities for elderly and disabled people with some support from the city. The support ranges from financial aid to advertising. Some of the activities are organized by groups of disabled or elderly people.

Private and non-profit recreation and leisure programmes

In North America, senior citizens, in search of pleasant and social exercise, have formed groups for "'mall walking" where elderly people are able to walk in safety, on even ground within enclosed shopping centres during morning hours before the mall opens. Mall management encourages the practice as it encourages shopping during store hours. This idea can be transferred to any building with long corridors, which is unused in the early hours of the morning.

The elderly and disabled groups form their own amateur sports or recreation organizations. There are wheelchair basketball teams operating in many cities in the United States. The city of Edinburgh has a theatre group composed of disabled actors.

VI. CONCLUSIONS

Because the populations of cities in both developed and developing countries are ageing, elderly and disabled people are becoming important clients of city governments. Therefore, there is an added impetus to make cities good places in which to age. The first step is for municipal governments to commit themselves to improving the quality of life for elderly and disabled people. Based on such a mandate, creative solutions can be found that are cost-effective. This resource book of policy ideas and strategies shows the results of this type of city activism. These ideas are presented here to stimulate other cities to borrow concepts and modify them for their own use. Elderly and disabled people are willing to work with cities, and their energies and skills can be harnessed to provide a rich array of services for their counterparts and other urban residents. By inclusive programmes and sensitive design, cities can become truly barrier-free.

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VOLUME II: CASE STUDIES

PART ONE

CITY OF OTTAWA: A CASE STUDY*

*This case study has been prepared at the request of the United Nations Centre for Human Settlements (Habitat). The views expressed are those of the authors.

Prepared by
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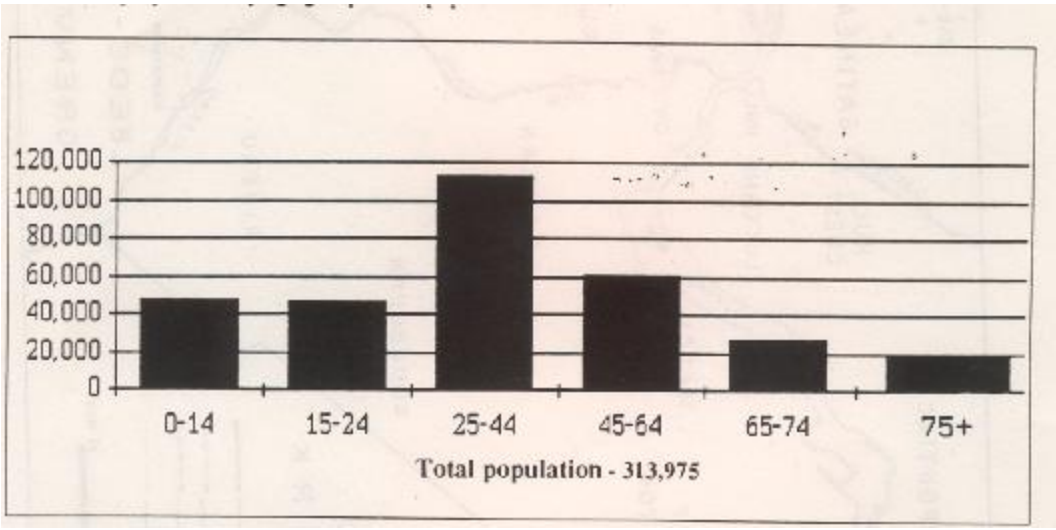
I. OVERVIEW OF THE CITY OF OTTAWA

History and demographics

Canada's capital, the City of Ottawa, is located on the Ottawa, River in the southeastern region of the province of Ontario. Originally founded by Colonel John By of the Royal Engineers in 1826, By-town as it was then known became the base camp for the construction of the Rideau Canal which was intended to join the Ottawa River with Lake Ontario at Kingston. It was incorporated as By-town in 1850 and as the City of Ottawa in 1885. The turning point in the history of the region was the selection, in 1887, of the City of Ottawa as the capital of the United Province of Canada. The City developed from a central point where the Rideau Canal joins the Ottawa River then spread east and west along the shores of the Ottawa River and south following the course of Rideau Canal.

A moderate-sized city, Ottawa has a population of 313,975[1] people living in an area of 119.9 square kilometres. Expectations are that Ottawa will grow at a very modest rate in the next 10 to 15 years achieving a population of between 320,000 and 324,000 by the year 2006.[2] Of particular significance is a marked trend towards an ageing population brought on by continuing low birth rates. Figure t illustrates the relative proportions by age group of the population in 1991.

Figure 1. City of Ottawa: population by age groups - 1991



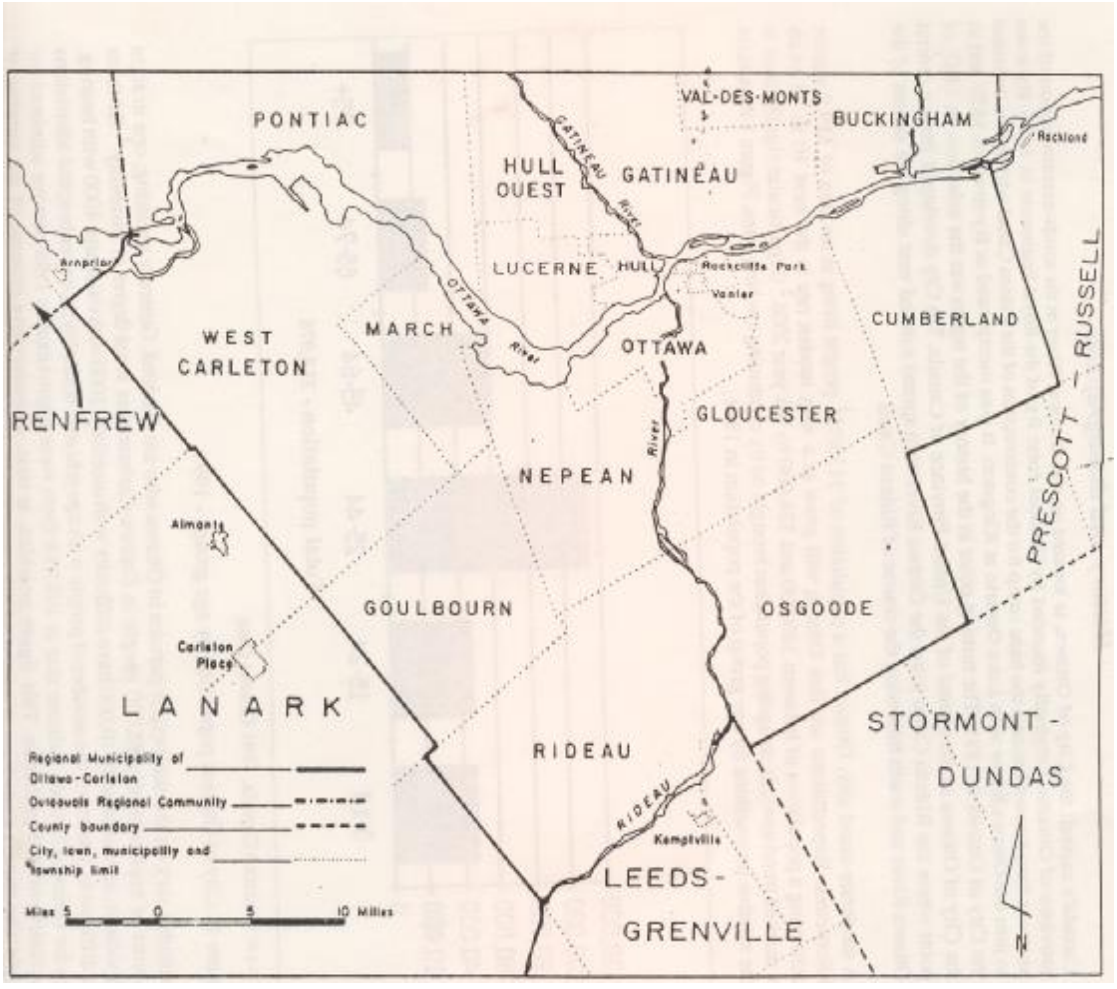
Estimates vary on the numbers of persons in Ottawa who are disabled. Generally speaking, one in eight persons or approximately 82,000 people in Ottawa-Carleton has some degree of disability.[3] Of these individuals, approximately 10,000 have difficulty with mobility, 5000 with vision and 4000 with hearing. It is difficult to determine the number of people with a psychiatric disability; however hospital admissions data for Ottawa-Carleton indicate that in 1987/88 there were approximately 1186 persons admitted for psychiatric-related problems. This figure provides, at best, a conservative estimate of the number of people who require some form of mental-health support, as many of these individuals remain disconnected from formal support networks and programmes.

[1] Statistics Canada, *1991 Census.*

[2] City of Ottawa Planning Department, *Research & Monitoring Report #1*, (1988).

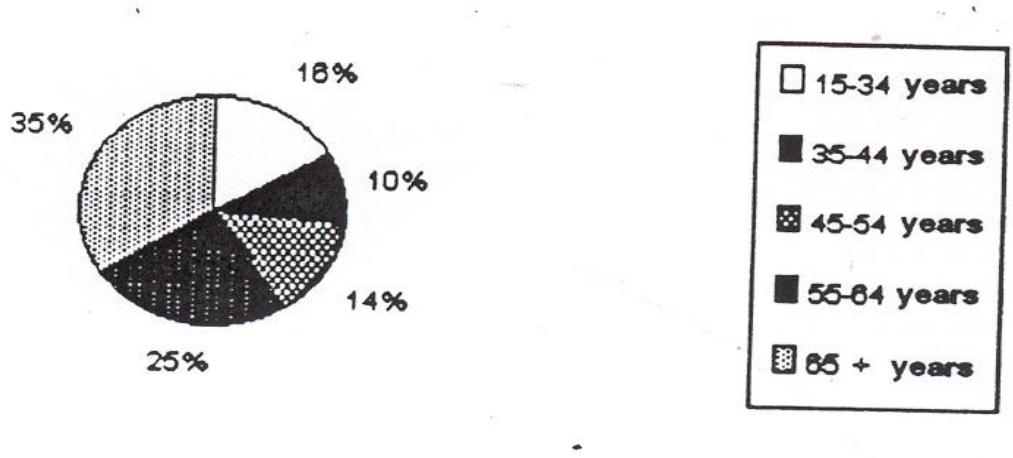
[3] The figures relating to disability presented in this report are based on the *Health and Activity Limitation Survey* (1987) and that they reflect the population of the Regional Municipality of Ottawa-Carleton (Ottawa is the largest of I 1 municipalities which together form the R.M.O.C.).

Figure 2. R.M.O.C. and adjacent municipalities



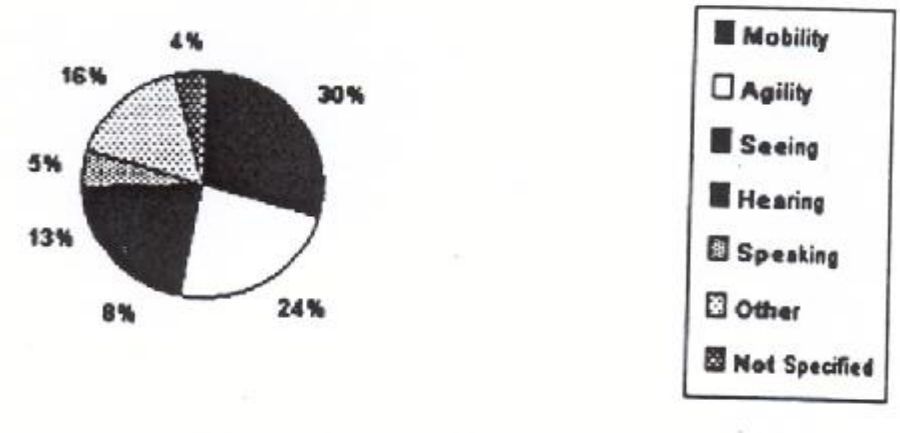
Source: Health Activity Limitation Survey (1987)

Figure 3. More severely disabled population, RMOC, 1986-87



Source: Health Activity Limitation Survey (1987)

Figure 4. Nature of disability among persons aged 15-65 residing in households, BMOC (Note: A person may have more than one disability).



Source: Health Activity Limitation Survey, (1987)

As figure 3 illustrates, the propensity of disability increases with age. One third of the adults with severe disabilities are between 55 and 64 years of age.[4]

Living arrangements

In 1986, 90 per cent of the people 65 and over (38,030) lived in private households while most of the remaining 10 percent lived in collective dwellings which included hospitals, boarding homes, residential care and institutional settings.[5] At that time it was estimated that approximately 4000 seniors lived in long-term institutions in the City of Ottawa. Figures are unavailable for the numbers of disabled adults living in private households; however, in 1987 there were 1029 individuals living in supportive housing arrangements such as group homes, supported housing projects and domiciliary hostels.[6] Waiting lists for these group homes and supported housing projects indicated a shortage of up to 4,500 spaces for this type of housing.

[4] R.M.O.C. Social Services Department, *1990 Caseload Data.*
[5] *Source:* Council on Aging, Fact Book on Aging in Ottawa-Carleton (February 1989).
[6] *Source:* Social Planning Council of Ottawa-Carleton, *A Framework for the Development of Special Needs Housing* (1987), (up-dated, 1990).

"Target Population"	Number of spaces
Physically disabled adults	130
Psychiatrically disabled adults	142
Developmentally disabled adults	204
Total	476

Source: Social Planning Council of Ottawa-Carleton, A Frame for the Development of Special Needs Housing (1987), (up-dated, 1990).

Employment

A glance at the unemployment rates for select groups in Ottawa-Carleton reveals that individuals who are disabled are less likely to participate in the labour market and that those who do participate have a significantly higher unemployment rate than the total population. The lower participation rate by these individuals can be attributed to a number of factors including a lack of support services such as on-site attendant care and transport and the many disincentives to work such as the high cost of drugs and equipment which is paid for by the government as long as an individual remains on social assistance.

Changes in the labour market are having a negative impact on the employment of older workers who are finding themselves laid off as jobs disappear and unable to regain employment due to outdated skills and the consequent need for retraining. In Ottawa-Carleton the duration of unemployment for the over-45 age group, which averaged 22.8 weeks in 1986, was nearly double the average rate for the 15-24 age group, which was 12.5 weeks.

Table 1. Unemployment and participation rates of select groups in Ottawa-Carleton

Select group		Participation Rate (percentage)	Unemployment Rate (Percentage)
Total population		70.1	6.7
Women		61.7	7.5
Native peoples	- Total	78.7	9.0
	- Females	72.2	10.1
Visible minorities	- Total	72.7	9.4
	- Females	64.1	9.9
Disabled persons	- Total	42.1	9.9
	- Females	28.9	10.2

Source: Statistics Canada, 1986 Census

II. PROBLEMS EXPERIENCED

An important distinction must be made between persons who are disabled and the elderly when developing services to facilitate an independent life for these individuals in the community. Though for the most part the problems they encounter are due to some loss of physical or mental functioning, the preference each will have for support services will differ as a factor of age and stage of life. Young adults are oriented towards gaining employment and achieving a lifestyle similar to that of their peers, hence services which enable them to be employed and to buy or rent the home of their choice are of priority to them. Older individuals will be more concerned about maintaining a lifestyle, being able to stay in their homes, personal security and recreation-oriented programming. Therefore, these two individuals would have quite different requirements of a transport service, for example. The young adult would require a service which was sufficiently flexible and dependable to accommodate job-related transport needs, while the older person's requirements for transport would likely be less stringent.

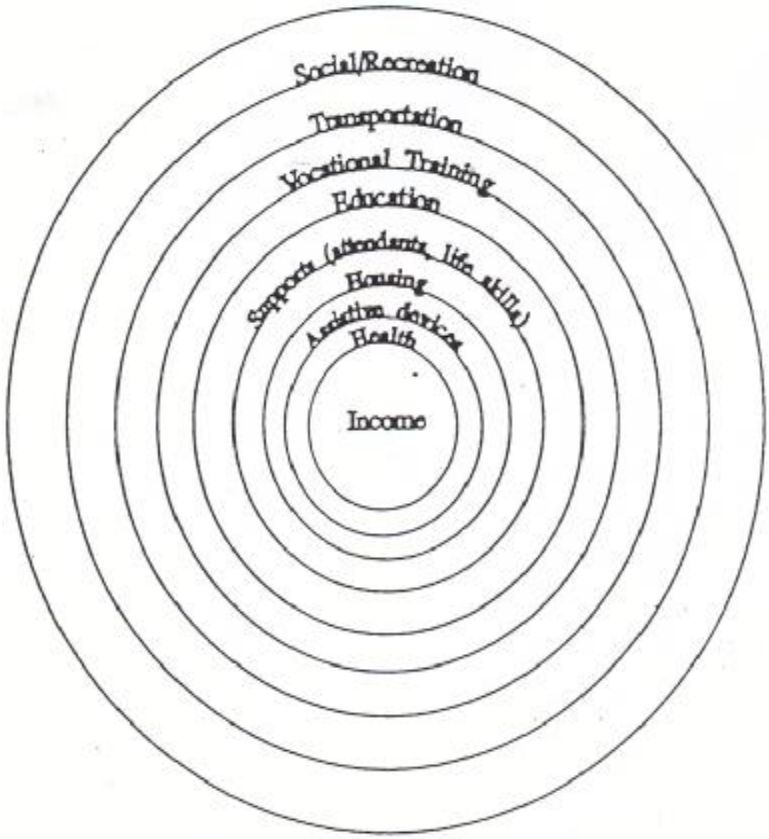
Generally speaking, our physical and institutional environment has been designed for people who are young and able-bodied. As a result, individuals who are disabled and/or elderly have to contend with a myriad of barriers as they carry on with their day-to-day activities. Our sidewalks, streets, homes, buildings, buses, trains, airplanes etc. are fine for a person who can walk up and down stairs, open doors and windows with their arms and hands, see signs and hear signals. A person who uses a wheelchair, however, cannot negotiate curbs or stairs, will likely have difficulty with doors, and may not be able to reach call buttons for elevators, telephones or light switches. A person who is visually-impaired cannot see the fire hydrants, signs, street crossings, stairs etc., and the person who is hearing-impaired cannot hear the car horns, the elevator bell or make use of a conventional telephone. Layered on top of this type of physical barrier are all of the institutional polices and practices which discriminate against individuals who are outside of the norm for which these systems were designed. These are the more subtle systemic barriers such as inadvertently restricting the advertisement of job openings to print media, thereby affectively screening out potential candidates who are visually impaired. The net result for persons who are disabled and/or elderly is a highly restricted lifestyle in which many basic rights which the general populace takes for granted being denied.

Building upon Maslow's hierarchy of needs, Resin-Todman[7] conceptualized the basic needs of individuals as a pyramid in which physical needs comprise the base and social and psychological needs form the top. She further expanded the concept and framed the core needs as a series of concentric circles (see figure 5) adding to these the "special needs" of individuals who are disabled. The general idea is that in most cases an individual must satisfy the core needs (those closest to the centre) before they can satisfy those in the outer rings. This conceptual framework is a useful tool for understanding the needs of persons who are disabled.

An adequate income is a key requirement which if attained opens the door to satisfying most of our basic needs. There are basically four sources of income, social assistance, private insurance, employment or a pension. As was indicated in the previous section, in 1986 only 42.1 percent of persons in Ottawa-Carleton who are disabled participated in the labour market. Many of those not in the labour market find life challenging enough without having to deal with a job in the event they could actually find one. Disincentives built into the social-assistance system keep many individuals from seeking employment. The best example of this is the loss of benefits such as coverage for drugs and wheelchairs when an individual accepts employment. These are significant expenses directly related to disability. Those who do venture out into the labour market find themselves up against all of the physical and systemic barriers described earlier as well as having to contend with the general perception by employers and the public - which they are unable to work.

[7] *Source:* S.R Torjman, Poor Places: Disability-related Residential and Support Services (Toronto, The G. Allan Roeher Institute, 1990).

Figure 5. Individual and special needs



Source: S.R Torjman, *Poor Places: Disability-related Residential and Support Services* (Toronto, The G. Allan Roeher Institute, 1990).

Housing presents another problem. Housing that is accessible to people in wheelchairs or who are visually-impaired is not readily available and support services which would enable individuals to live in their own homes are also lacking. As a result, individuals who have these needs are left with little housing choice, restricted for the most part to group homes and housing projects with support services built into the programme. Waiting lists for these indicate a shortage of up to 4500 spaces in 1990.[8]8 Units available in these projects are usually limited to one-bedroom and are only nominally accessible.

The education system is again designed for the able-bodied "normal" student. Students who are physically or otherwise disabled encounter inaccessible school buildings and practices such as time-limited examinations, which effectively discriminate against them. School-board budgets do not include sufficient moneys to pay for teachers' aides and other supports for students who are disabled. Post-secondary institutions as well tend to be inaccessible. In Ottawa-Carleton, one of the two universities is somewhat physically accessible. Students who are hearing-impaired or the culturally deaf have no choice but to attend special schools where they are segregated from the other students.

Public transport presents yet another problem. Accommodations are often necessary in order to make conventional transport modes accessible to persons who are elderly and/or disabled. City buses are not equipped to take on people who use wheelchairs and are poorly designed for the frail elderly who have difficulty negotiating the high steps into the bus. Strict schedules do not allow for the extra time required by passengers who are frail to board buses. A special service operates

[8] Social Planning Council of Ottawa-Carleton, *A Framework for the Development of Special Needs Housing* (1987), (up-dated, 1990).

to serve disabled and elderly passengers unable to use the public transit system; however the level of service provided does not match that provided by public transit. The requirement to book trips in advance removes the possibility for any spontaneous use of the service and limits its usefulness for work-related transport.

Recreational activities are limited by the same factors that have already been described, namely, income, physical access, support services and the available transport. Choices for social activities are often restricted to events and activities developed specifically for these populations in segregated settings. Even those individuals sufficient income to afford their own transport often cannot get into the movie houses and theatres as they tend to be inaccessible. Restaurants and lounges as well are not generally designed for wheelchair users or the visually-unpaired.

There are a number of everyday problems and barriers faced by elderly people that restrict their lifestyle and the standard of their living choices. As people age, physical, psychological and social changes occur which on their own or together influence how individuals cope with day-to-day fife. Physical changes include a loss in body weight and stature, a greater level of fatigue, a loss of speed of movements and other changes that affect a person's mobility.[9] Although when asked, most older people report their general health as good compared with others the same age, common ailments include arthritis, high blood pressure and heart disease. Social changes include a decrease in the network of family and friends as children move away, and spouses and older friends die.

Studies on factors related to the loss of independence for elderly people have consistently identified a number of health and social support related risk factors. These factors include age, income level, perceived health, number of health conditions, living arrangements, presence or absence of mental impairment and the quality and quantity of social contacts. Older people most at risk for institutionalization are those over the age of 85, living alone, living near or below the poverty line, reporting fair or poor health, reporting one or more health conditions, experiencing incontinence, having a form of mental impairment and having little or no daily social contacts with family or friends. The risk is highest for those reporting a combination of risk factors.[10]

A recent representative health survey of people aged 65 and older in Ottawa-Carleton[11] found that although most of the 400 people surveyed perceived themselves to be in good health, almost 85 per cent reported having at least one health condition and over half of the sample reported two or more conditions including arthritis, heart trouble or breathing problems. Questions concerning respondents' emotional and mental well-being were also asked and it was revealed that about 16 percent of the seniors interviewed could be classified as clinically depressed according to a standard scale used. Almost all of the respondents were maintaining close contacts with at least one friend or family member; however, there was indication that the extent of these contacts varied greatly.

The Ottawa-Carleton Health Survey identified daily activities that were proving to be difficult for a substantial proportion of older people in the Region. These were carrying our heavy housework indoors and out such as washing floors and windows, or shoveling snow; mobility-related difficulties such as getting on and off the bus and walking around the block; taking part in social and recreational activities because of a lack of transport or escort; preparing a main meal; and bathing and showering. Most respondents were receiving help with activities such as heavy housework and preparing the main meal; however, substantial number of seniors reported no help for the other difficulties.

The city of Ottawa and other municipalities across Canada have recognized a growing need for community support services - health social and housing - to supplement the help traditionally provided to older people with difficulties in daily living by family and friends.

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[9] Ministry for Planning and Environment, *Retirement Villages: An Interim Planning Guide* (Canberra 1987).
[10] E. Shapiro, and B. Tate, "Who is really at risk of institutionalization?" *The Gerontologist* (1988), vol. 28, No.2.
[11] Davis, C, *The Ottawa-Carleton Seniors' Health Survey: Final Report.* (Regional Health Department of Ottawa-Carleton, 1989).

III. MUNICIPAL GOVERNMENT RESPONSIBILITIES

Levels of government

In Canada there are four levels of government: the Federal Government, provincial governments, regional governments, and municipalities. Regional governments do not exist in all areas of the country. Each level of government has responsibility for maintenance of Canada's social safety net whether it is for the delivery of support services or providing the funds, which pay for them. Agreements in the form of legislation have been adopted which spell out the sharing of this responsibility among the levels of government. Adopted in 1966, the Canada Assistance Plan (CAP) is the best example of this form of agreement. The CAP has been an important source of funding for providers of social services. The Federal Government, through CAP, has provided 50 cents on the dollar to assist people in need or in danger of being in need. Of the remaining 50 cents, the Ontario Government pays 30 cents and the City of Ottawa pays 20 cents.

A concise description of the role each level plays and the interrelationships between the levels are provided in figure 6.

Figure 6. Government roles in the delivery of social services

FEDERAL GOVERNMENT	Cost-shares social assistance, social and health services for persons in need or likely to be in need (needs tested).
PROVINCE OF ONTARIO	Primary funder of health and social services cost shared with the Federal Government. Sets policy and provincial standards for health and Social services. Delivers service directly and indirectly through municipalities and transfer agencies in the volunteer sector.
REGIONAL MUNICIPALITY OF OTTAWA-CARLETON (R.M.O.C.) The R.M.O.C. is comprised of 11 municipalities including the City of Ottawa. Total population = 678,147 (1991 Census data)	Funder of health and social services within the region of Ottawa-Carleton as cost-shared with the Province of Ontario. Delivers service directly and indirectly through voluntary sector agencies. Responsible for delivery of social assistance (general welfare), emergency shelters, home care, public health, public transit etc.
CITY OF OTTAWA Total population = 313,975 (1991 Census data)	Delivers services directly and funds community services. Responsible for police and fire services, recreation, road maintenance. urban planning etc .

Many of the programmes and services in place within the boundaries of the City of Ottawa are the responsibility of the Regional Municipality of Ottawa-Carleton. In municipalities where no regional government exists, these same programmes and services would be provided by the city. For the purposes of this study, programs offered within the geographic area of the City of Ottawa are described regardless of the fact that they may be offered by the Regional government.

Service principles

Over the past 15 to 20 years the underlying principles which govern the delivery of social and health services have changed. Prior to this change people who required these services in order to live tended to be placed in segregated, institutionalized settings and to be treated as wards of the State with little or no control over their lives. Years of lobbying by individuals who are disabled and/or elderly have led an enhanced awareness by the general public and, more importantly, recognition by the government and service providers that fundamental rights were being denied to these individuals. One of the most significant trends, which has resulted, has been the closing-down of institutions and the movement of people back into the community. Unfortunately, an adequate support network for these individuals in most cases did not exist in the community and many people found themselves without appropriate supports and therefore unable to cope. Recent years have brought an increased demand for support services in the community, which calls for a response from government. The Government of Ontario is moving to solve this problem and its vision is reflected in a number of documents published in the last several years.

In 1987, the Ministry of Community and Social Services published Challenges and Opportunities,[12] a report which outlined the strategic directions the Ministry intended to take with services to individuals who are developmentally disabled (formerly referred to as mentally retarded). The service principles cited in the report were: (a) promotion of independence - promoting the concept of keeping these individuals in their own homes and communities and maximizing opportunities for self-direction; (b) protection - with emphasis placed on the right of access to advocates, guardians and appeal processes; (c) individual attention - programming tailored for their individual needs; and, (d) quality programmes. In the following year the Ministry of Health released a report entitled Building Community Support for People - a Plan For Mental Health in Ontario[13] which recommended the development of a comprehensive mental health system based on a number of principles including: a community focus - designed to keep individuals in the community; an individualized approach - care is appropriate, planned with and for the individual and their family; and, accountable to the community - consumers, family members and service providers involved in the development, operation and evaluation of services. Most recently, the provincial government presented its vision for the reform of services directed towards individuals who are physically disabled and/or elderly.[14] The renewed vision is guided by four principles as follows: (a) primacy of the individual, and his or her right to dignity, security and self-determination; (b) promotion of racial equity and respect for cultural diversity; (c) importance of family and community; and, (d) equitable access to appropriate services. These principles are the driving force behind the following goals:

- Integration of long-term care health and social services;
- Improved access to quality services;
- Creation of community alternatives to institutionalization;
- Greater consumer participation and control of the services they receive;
- Promotion of racial equity and cultural sensitivity.

[12] Ontario Ministry of Community and Social Services, *Challenges and Opportunities - Community Living for People with Developmental Handicaps* (Toronto, 1987)
[13] The Provincial Community Mental Health Committee, Building Community Mental Health: *A Plan for Mental Health in Ontario* (Toronto, 1988)
[14] Ontario Ministry of Community and Social Services, Ministry of Health and Ministry of Citizenship, *Redirection of Long-term Care and Support Services in Ontario - a Public Consultation Paper.* (Toronto, 1991)

To illustrate its commitment to these goals, the Provincial government has just announced that an amount of $440 million will be spent on community support services for seniors and adults with disabilities. An additional $200 million will be spent on long-term care facilities. (This is for a province with about 400,000 people over the age of 75 [1986 Census)) The latter are not new moneys but rather estimated savings as a result of a revamping of existing funding structures for institutional care. What this means for local providers of care beds is that it will be very difficult to obtain any additional care beds for the next decade.

Services provided under long-term care cover a wide array in a variety of settings including:

- Health, personal care, support and respite services provided in people's homes;
- Community support services such as meals-on-wheels, transport, security checks, friendly visiting, and adult day programmes;
- Alzheimer community programmes, supportive living programme;
- Long-term care facilities.

The redirection of long-term care and support services in Ontario is part of a clear trend within government to allocate a greater share of the resources into health promotion and prevention activities and to look for alternative ways to deliver traditional health services. This trend has definite implications for how services are planned and delivered at the local level and shifts more of the responsibility for services to municipal and regional governments.

The re-direction will also result in a change in the funding system for long-term care facilities. The current funding for long-term care beds is based on a mixture of the type of facility and the type of bed and is not linked to service needs of residents. This can and has resulted in different staffing and service levels for people who require the same type and amount of care. In the near future, the funding for nursing and personal care in facilities will be based on the service needs of the residents rather than the type of facility or bed the resident occupies.

IV. INNOVATIVE PROGRAMMES

Introduction

In Ottawa-Carleton, programmes and services directed at the elderly and persons with disabilities are extremely varied and complex. They run the gamut from highly specialized, intrusive, and costly medical services, to targeted housing and social services, to purely voluntary and self-determining social and recreation clubs. Some services are provided directly by government, others by the voluntary sector, and still others by the private sector.

"By far, the largest portion of funding for social and health programs comes from the federal and provincial governments, a reflection of their larger tax base..."[15] This leaves many of the decisions with respect to seniors' services in the hands of the two higher levels of government. Income security (mainly in the form of pensions) accounts for more than half of all funds directed at the elderly population; health care consumes about 30 per cent. Social services receive the smallest proportion of funding and, for the most part, are funded through other sources such as the United Way (funded by Voluntary donations) and local taxes.

The United Way of Ottawa-Carleton is anon-profit organization that raises money from local contributors and distributes it to member agencies. Many non-profit organizations serving seniors and persons who are disabled receive some of their funding from the United Way annual campaign. They have 12,000 volunteers who work on the campaign.

The Regional Municipality of Ottawa-Carleton receives moneys from the Province through cost-share agreements and collects tax money from municipalities, which is used to fund services.
The City of Ottawa (the capital of Canada) collects tax money from residential homeowners, and commercial businesses; and receives grants for lands used by the Federal Government, which enables the City to contribute to some programmes.

Urban Planning

A new Official Plan, A Vision for Ottawa, was adopted by the City Council in July 1991 and serves as a primary source of the following description of urban planning principles and polices.[16] The mission statement clearly emphasizes the social values of the City of Ottawa.

> "City Council accepts that change is an on-going phenomenon in cities which must be managed within the parameters imposed by the overriding aim of preserving a lasting habitat for humanity and wildlife. It also recognizes that economic prosperity can provide us with the capability to support wise resource management, to meet the social needs and to improve environmental quality. Therefore, City Council supports an approach to managing urban development which balances the rights of the individual and the needs of society with tire need to conserve our natural resource base and enhance the natural environment, thereby promoting the health of Ottawa's inhabitants and communities."[17]

The guiding principles spell out the City's responsibility for providing a full range of services which are fundamental to the overall quality of life including: secure, adequate and affordable housing; barrier-free access to buildings and public facilities for persons with disabilities; shopping areas designed on a human scale with a pedestrian orientation; and, increased opportunities for non-auto transport.

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[15] Social Planning Council of Ottawa-Carleton, *Services to Seniors in Ottawa-Carleton*, Sectorial Report Number l, August 1989.

[16] Although die newly adopted City Of Ottawa Official Plan has not yet been approved by tile Regional Government and therefore is not legally recognized by the Province of Ontario, the City bases current operations on the policies and objectives articulated in this Plan and therefore it is used as a source for the information provided.

[17] City of Ottawa, *City of Ottawa Official Plan - Volume l: The Primary Plan*, final draft, February 1991.

Increasingly, older consumers have been included in the planning process through their representation on advisory committees and participation in community forums. Planning has also taken a more multi-disciplinary approach. A recent example is the planning of a new neighbourhood on government owned land. A large section of the land was set aside for the development of a variety of housing options directed at an older market. Part of the planning process involved hiring a team of consultants with expertise in the health, social and housing-related needs of older people to ensure that the final plan of development recognized these needs so that the resulting community would be supportive to the elderly people.

The City has set a specific objective relative to the provision of "special needs housing" which is to "facilitate the integration of living environments for people with special needs in all neighbourhoods throughout the city".[18] Essentially, this objective is pursued by permitting housing which includes a support service element to be located in all areas zoned for residential use rather than defining these as institutions. "Special needs housing", however, is treated differently from other residences in the City of Ottawa, through a zoning bye-law which regulates their location and the number of residents as was well as related parking provisions. A requirement under the byelaw, that "special needs homes" is separated by a specified distance, severely limits the development of this kind of home and affectively works against the City's stated objective. The intent of the byelaw is to encourage a distribution of homes in any particular area. Proponents of this type of housing point out the human rights implications of this byelaw which zones people rather than land use.

The most commonly recognized form that this type of housing takes is the group home where several people live in a communal arrangement usually sharing kitchen and bathroom facilities. Most often the home appears no different from any other home on the outside in the neighbourhood and is distinguishable as you enter by the presence of staff who provide appropriate support to residents as required and perhaps by certain access features such as wheelchair ramps and grab bars. (A more precise description of some of the "special needs housing" projects in the City will be provided under "Housing and neighbourhood design")

Shopping-centre design and development address the needs of persons with disabilities and other special-needs groups thereby ensuring that everyone is well served. Design elements include sufficient parking strategically placed, access into and through the centre for people in wheelchairs and wheelchair-accessible public washrooms.

In keeping with the principle of promoting non-auto transport, the City sets an accessibility objective aiming to ensure that pedestrians of all populations, ages and health groups are able to travel the city's pedestrian ways. Sidewalks tend to present a problem for wheelchair users, particularly at intersections, as a result of the significant difference between the level of the sidewalk and the street. Recognizing this problem, the City has instituted a policy whereby curb cuts are installed at all controlled intersections, that is, intersections where there is a stop sign or traffic light. Basically the sidewalk is sloped at the intersection creating a mini-ramp down to street level thereby enabling a person in a wheelchair to cross the intersection. This policy currently applies to all new sidewalks as they are put in place and to already install sidewalks as they are being repaired and as the budget allows.

Transport

Public transport, as was discussed earlier, presents a problem for persons in wheelchairs or who are frail. The Province of Ontario has recently directed transit authorities to move towards improving the accessibility of their transit systems. In response to this directive, the Ottawa-Carleton Regional Transit Commission (OC Transpo) has formed the Accessible Transit Advisory Committee. The Committee is accountable to the Transit Commission and the majority of their memberships are persons who currently use the Region's special transport service, Para-Transpo. Its goals are twofold, to improve the accessibility of the regular transit system as well as to improve the quality of service provided by Para-Transpo.

[18] Ibid. chap. 3, p. 6.

Currently there are a number of easier-access transport programmes, which provide better, safer, and more efficient service for the elderly and challenged users. In addition, OC Transpo has responded to requests for safer transport stops by introducing a programme called "Transecure Night Stop". A number of pamphlets and newspapers are produced to inform the community and promote the various programmes available.

Easier-access buses have the capability of lowering the front end of the bus to seven inches (11 for refitted articulated buses) above ground providing a lower step for elderly or disabled persons. These kneeling buses produce a visual and auditory alarm while lowering or raising the bus as well as an automatic braking system preventing vehicle mobility during the process. These buses are used on routes with a high proportion of older and disabled users.

Besides the kneeling feature, additional safety features of the easier-access buses include grab rails marked with bright colours, improved lighting at the doorways and under priority_ seating, more visible and more frequent stop-request chimes and stop-request buttons beside priority seating (Priority seating is available' to elderly passengers, persons with disabilities, adults with small children and pregnant women) Special identification cards are available for a nominal fee.

The Communibus Program was introduced in May 1992 in a downtown area and is jointly funded by the local transport department and the provincial Ministry of Transportation. This is a service designed for people with mobility impairments. It is available to anyone who needs it and who can reach a regular bus stop. (Unlike Para-Transpo - a special door-to-door service described elsewhere.) The Communibus has "kneeling" capabilities, a ramp for users who are unable to negotiate stairs, space for two wheelchairs, all-priority seating and air conditioning. Attendants accompanying a user ride free without charge: Buses operate every 30 minutes on a fixed route and stop at all regular bus stops along the route. Information is posted at the stops, and shelters or benches have been installed at most waiting areas.

Transecure Night Stop is a new programme offered after dark (9 p.m.) to any passenger on a bus route who feels anxious about being let off at their regular stop. This anxiety is often felt by elderly people traveling alone at night. If the driver is notified at least one stop before the regular stop, the driver will let the passenger off closer to their actual destination. The driver must be able to stop safely and open the door. (This may not be exactly the spot that has been requested.) Users exit by the front door so that the driver can observe them.

Another service offered by the local transport department is a reduced fare for the elderly travelers. The reduced fare applies to monthly passes as well as individual tickets.

Para-Transpo is a door-to-door transport service jointly funded by the regional government and the Province of Ontario. The service employs automobiles and vehicles equipped with wheelchair lifts operated by drivers who are given special training. Available on a reservation basis, Para-Transpo serves persons who are physically unable to walk and board regular transit service. Potential users are required to apply directly to Para-Transpo for authority to use the system and to have their application form signed by an appropriate health care professional. The service operates seven days a week from 6.30 a.m. to midnight on Mondays to Fridays and 8.00 am. to midnight at weekends. Rides must be booked 24 hours in advance. Service availability is somewhat limited due to the fact that resources are insufficient to provide adequate cover to meet the need. When compared with the level of service provided by the regular transit system, Para-Transpo falls short as a result of the rigid booking requirement and availability limitations Individuals are not able to depend on Para-Transpo for work-related travel, for example, in the same way that regular transit users depend on their service.

A further experiment is currently being tested in the City of Ottawa which has licensed accessible taxis. These are operated by private taxi firms and provide regular service to any customer who happens to call while these cabs are on the road. An individual in a wheelchair calling for a taxi requests the accessible and is charged the same rate as any other customer. Drivers are provided with special training by the City. The experiment has not proved to be particularly successful for a number of reasons. Key among these is that there are not enough accessible taxis to ensure that at least one is always available and therefore, individuals find themselves stranded having been

brought to a location when a taxi was available only to find that when the time came for the return trip, no accessible taxis are on the road. Drivers also claim to lose money when driving the accessible taxis due to the fact that customers not in wheelchairs refuse to accept the special cabs. It would appear that a public education campaign would have helped. Ideally, all taxis should be wheelchair-accessible.

The Operations Department of the Ottawa-Carleton Region manages, implements and monitors the traffic patterns and signals on streets in the downtown core and major arteries of the City of Ottawa. A number of innovative programmes have been introduced in the Ottawa area to facilitate ease of movement across busy intersections by seniors, challenged persons, children etc. The Department studies the demographics of certain areas and determines when specific traffic signals should be installed. For example:

- If a facility or apartment building, housing mainly older residents is in close proximity to a shopping centre, the timing of the lights at the crosswalks to the centre allow for a slower walking speed of approximately 10-20 per cent than the standard.

- Wheelchair detectors have been installed at three or four locations in the city as persons in wheelchairs often have difficulty reaching the push button signals, especially in winter.

- Curb cut programmes are a design standard in the Region.

- Snow removal (the City of Ottawa is the contractor for snow removal within the city limits) is concentrated on areas which require a higher priority of service, such as areas with a large concentration of older residents, challenged residents, or higher-density populations in general. This service includes removal of snow around traffic signals as well as sidewalks and roads.

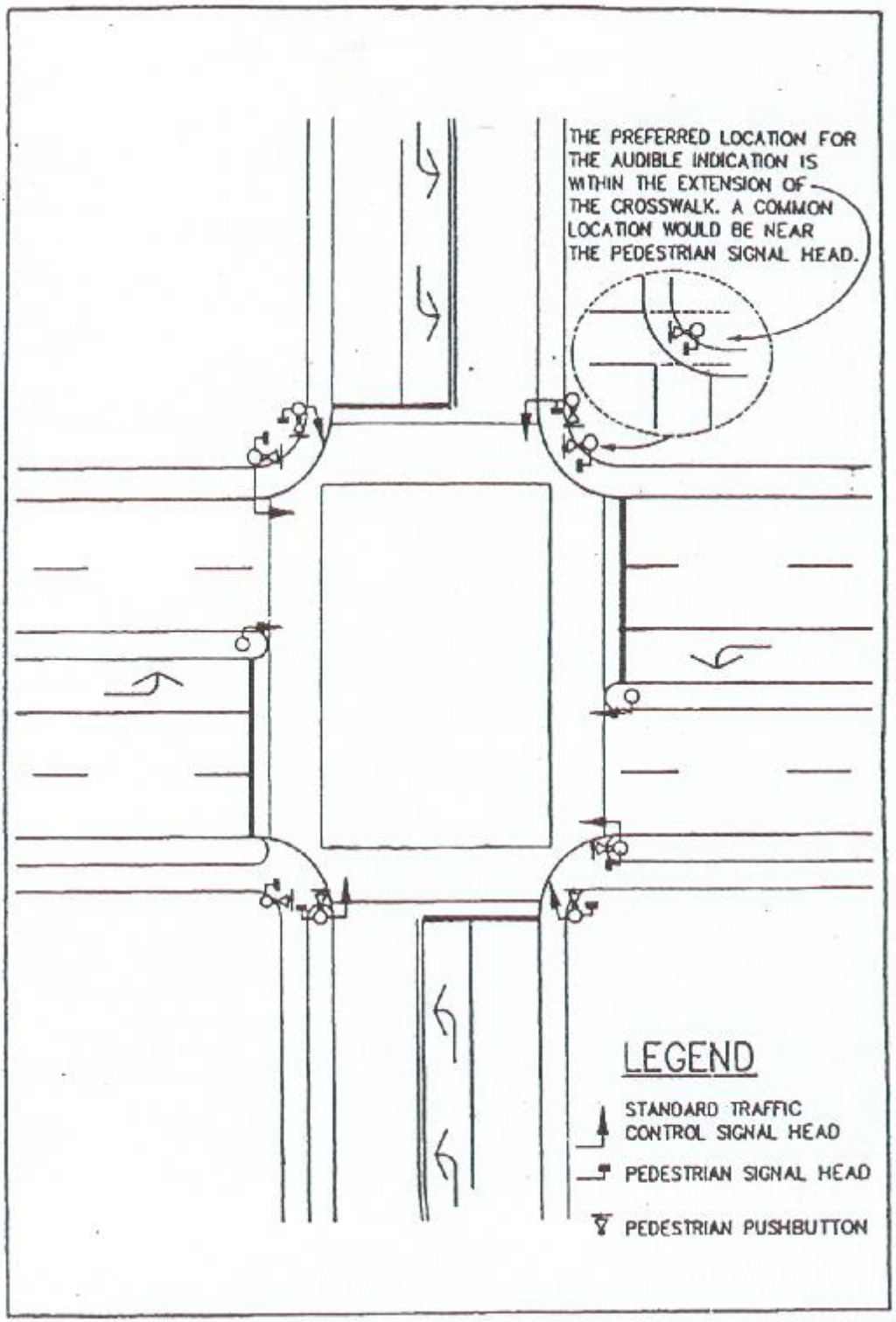
- Ottawa Carleton is one of two municipalities in the province to include audible signals for the sight-impaired at approximately 24 locations throughout the city. These signals also include the addition of Braille writing on the push button. The local branch of the Canadian National Institute of the Blind assists the region's Transportation Department in this endeavour. When it is determined that a particular location is used regularly by persons with a visual impairment or presents conditions that are particularly difficult for persons with a visual impairment, the Department will install these devices as the budget allows. The basic principle behind the devices is to complement the visual "WALK", "DON'T WALK" signals with audible sounds to indicate when it is safe to cross and not to cross. The operational details[19] of an audible indication are as follows:

(a) Under normal conditions, two bird calls are used: a "peep-peep" and a "cuckoo". If additional sounds are required due to complex signal phasing, two additional sounds may be used: a high frequency "beep-beep-beep" and a low frequency "beeeep".
(b) The "peep-peep" sound is used for pedestrians crossing in the east-west direction and the "cuckoo" for pedestrians crossing in the north-south direction.
(c) When choosing the signal sound, possible extraneous sources of similar sounds (such as truck back-up warnings or flocks of birds in nearby trees) are considered in order to eliminate potential confusion to the visually-impaired pedestrian.
(d) Whenever possible, audible pedestrian indications are actuated by a pushbutton, preferably the same button used for the visual signals.
(e) When operated, the sounds are emitted only during the "WALK" interval.

As an additional service, staff of the Operations Department are available on request to speak to citizens on traffic safety. A film on crossing road safety is shown and the use and function of push button signals is explained.

[19] Regional Municipality of Ottawa-Carleton. Signals and Communications Division, Department of Transportation.

Figure 7. Preferred audible pedestrian indication and pushbutton locations for an intersection with audible pedestrian indication



Source: Regional Municipality of Ottawa-Carleton, Signals and Communications Division.

The City of Ottawa ensures that parking is provided to persons who are disabled within oversized parking stalls which allow sufficient space between vehicles for wheelchair lifts to operate. Ramped sidewalks are located close to the parking stalls, which are placed in close proximity to building-access points, elevators, or public sidewalks.[20] These spaces are marked with the international access symbol and their use restricted to persons who have registered with the Province and display their disabled parking sticker in their vehicles where it can be easily seen. The right to park in these spaces is given to the individual whether or not they are themselves drivers or whether they are passengers in their own vehicle or that of a friends'.

Urban services

Both the Fire Departments and the Police Departments recognize the special needs of citizens who are elderly or disabled in the city of Ottawa. The Public Education Division of the Fire Department holds lectures and demonstrations on request for Senior Citizens Homes and high-rise apartment buildings (the building owner is responsible for the implementation of a fire safety plan), as well as the general public. A document entitled "Plan to Get Out Alive" is produced by the Department and contains general and specific information on Fire safety as well as a description of the educational programme demonstrated to residents of high-rise buildings or homes. The document lists several different scenarios in which fire safety rules may apply and describes safe evacuation procedures. In addition, special attention is paid to residents who may require assistance in the evacuation of a building. A list of these residents is computerized and updated on a yearly basis by the Department. A communications system is also available to seniors' buildings occupied by seniors, which will instruct the residents as to the safety of certain stairwells during evacuation of a building. The lectures include slides, demonstrations and audience participation.

The Fire Department is also highly involved in assisting citizens in medical emergencies. Since the fire stations are strategically located throughout the city, the response time is short. Oxygen equipment, cardio-pulmonary resuscitation, first aid, water rescue, extrication equipment for vehicle accidents or building collapses are all considered to be important services the Fire Department provides.

The Ottawa Police Community Services Section provides a number of services geared to the needs of the city's elderly citizens. A crime awareness pamphlet lists a number of schemes that are specifically aimed at defrauding older people. A description of con games, mail frauds, and so-called business opportunities involving large sums of money are described. Common-sense rules are listed for avoiding these fraudulent offers as well as general crime-prevention safety procedures at home and away from home.

The Neighbourhood Watch programme is very much a community-involved programme aimed at local citizens including the elderly people. This is a crime-prevention programme which informs the participants of home security, identification of personal valuables and monitoring of any unusual activities in their own neighbourhood.

In addition to the services listed above, the Ottawa Police Department is also working with the Alzheimer' Society of Ottawa Carleton in a joint project called The Wandering Persons Registry. Thus allows a family member to identify a person who is likely to wander to the Ottawa Police who, in turn, may use this information to assist in the identification and return of a lost or wandering person. The registrant can suffer from any condition which may be conducive to wandering behaviour. Alzheimer, head injury etc. This service is free of charge and confidential. Information provided by family members about the appearance of the person at risk, behaviour characteristics, medical needs and the appropriate contact person in case of an emergency are registered on the computer by the police. Special arrangements are made with "Medic Alert" and the use of a medic alert identification bracelet is encouraged.

A "911" service is managed by the Emergency Measures Unit of the R.M.O.C. and offers an enhanced level of security for all citizens of the Region. Essentially 911 is a partnership between

[20] *City of Ottawa. City of Ottawa Official Plan - Volume l: The Primary Plan,* final draft, February 1991, chap.7, P. 18.

the telephone company and the local police departments whereby citizens in danger or requiring some form of emergency assistance need only dial 911 in order to be connected to the appropriate support whether that is the police, fire department or emergency medical treatment. The system is computerized and the operator answering the call is able to identify the address and location of the caller whether or not they are able to speak. Operators also stay on the line with a caller until help has arrived. The 911 is funded by the Regional government and has an annual cost of $Can 2.3 million dollars. Currently the service receives an average of 500 calls per day.

The Department of Recreation and Culture of the City of Ottawa is celebrating the twentieth anniversary of the opening of its Senior Adults Division this year. This Department promotes, introduces and manages programmes and activities with the senior adult in mind. These programmes are run from a variety of locations across the city in community centres, recreational facilities etc. In addition to its scheduling of programmes, the Department produces a calendar of events and activities for seniors Seasons of leisure as well as a newspaper entitled Senior Adult News. The newspaper and calendar promotes city-wide events and participation in recreational and cultural activities.

Programmes include various forms of instruction in dance, bridge, art, exercise, gardening or topical discussion groups. In addition to instructional programmes, a wide variety of clubs are available to seniors who wish to socialize together while walking, playing bridge, dancing etc. Tours and short excursions are also available for seniors to enjoy leisure time within the region as well as outside of the region.

The City of Ottawa Department of Recreation and Culture has recently adopted a barrier-free environment policy governing recreational and cultural facilities, programmes and services. The goal of the policy is to address issues of integration, access and accommodation for persons with disabilities in a pro-active manner. The policy commits the Department of Recreation and Culture to providing the same level of service to persons with a disability as is provided to able-bodied individuals by ensuring programme choice, accessibility, awareness and education and through consultation with appropriate community agencies. Some of the practical ways by which the City Of Ottawa enables persons with a disability to participate in its recreational programming include recruiting volunteers to assist these participants and reducing fees to individuals who cannot afford to pay full fee. The City offers segregated programmes as well, which are designed specifically for individuals who are disabled.

The City of Ottawa South Branch Library operates two special visiting services - The Home Reader Service and The Mini Library Service - designed for the housebound and the elderly living in senior citizen apartments and residences. The Home Reader Service delivers books to housebound Ottawa residents in their own homes or health-care facilities. The Mini Library Service visits Ottawa senior citizens' residences and apartment buildings with a traveling collection of books. There is no fee but a library card is necessary which is purchased on a one tune basis for a minimal cost. The library has large-print books and books on audio cassette.

Other service provided by the Ottawa Public Library include: reading aids for the visually-impaired persons, a personal computer for the visually-impaired persons, and the Phonic Ear System for the hearing-impaired persons, all of which are available in the main library down-town.

Housing and neighbourhood design

The City of Ottawa and its surrounding municipalities offer a variety of housing options to the elderly. These include senior-citizen rental-apartment buildings designed for people who can look after their own needs as well as accommodation that includes rooms and a number of services such as the provision of meals, nursing-care and therapy. Housing options for persons who are disabled are more limited and generally fall within what is commonly referred to as "special needs housing".

The largest source of housing for individuals who are unable to afford market-value rent are the Ottawa Carleton Regional Housing Authority (OCRHA), the regional arm of the Ontario Housing Corporation and City Living, the City of Ottawa's non-profit housing provider. A number of private non-profit providers such as the Centretown Citizens Ottawa Corporation as well as a

multitude of housing cooperatives and community organizations also provide housing to people with affordability problems (who pay what they can but are subsidized by government). In the case of rental accommodation in cooperatives and non-profit buildings, rents are typically set at 25-30 per cent of people's income.

The Ontario Housing Corporation has many assisted rental buildings in Ontario that serve an older population. In Ottawa, OCRHA manages 26 such buildings with over 5000 apartments in total. Most of, the buildings were built in the 1970s and many tenants have lived there for 20 years or more. All of the buildings are high-rise elevator buildings and range in size from 100 apartments to over 300 in one building. About half have over 200 apartments. A typical building also has some social and recreational space - minimally a lounge with a small kitchen for preparing refreshments.

The apartments are either bachelor units (one-room) with a bathroom and kitchen; or one-bedroom units with a living/dining area, kitchen and bathroom. To-day the Housing Authority is having difficulty renting the bachelor units and is trying to make them available to people under the age of 60 who have low incomes and who are in need of affordable shelter. The seniors in the apartment buildings have expressed some objection to sharing their building with young people who might have a life-style incompatible with their own. The Housing Authority has tried to respect this concern and monitor the situation.

Financing for most of the capital expenditure on these buildings came through a Federal Government housing programme that is no longer used in Ontario. The Federal Government's housing arm - Canada Mortgage and Housing Corporation - has retired from most of its involvement in capital funding affordable housing but has remained active in the mortgage business -insuring loans. The operating costs are covered 50-50 under an agreement between the Federal and provincial governments. As the buildings age the maintenance costs increase. This is an onerous burden for both levels of government. However, affordable housing allows seniors to stay in the community and avoid institutionalization which is a costly alternative and less attractive to many seniors.

In the past year, OCRHA has created a special needs coordinator position and given this staff member responsibility for meeting the needs of individuals on the waiting list who have special requirements such as accessible accommodation or support service. The special needs coordinator acts as a referral agent for these individuals, connecting them with the appropriate supports as well as finding suitable housing within the OCRHA inventory or elsewhere in the city. Whereas OCRHA designates some of its buildings as seniors' buildings, projects are not set aside for individuals who are disabled.

The City of Ottawa Housing Department has established a non-profit public agency called City Living. This agency administers housing sponsored by the Municipality. Their seniors' housing portfolio has approximately 800 units. They have avoided building massive structures most of the time. When the cost of land is very high it often has to be developed to a higher density. The 12 seniors' buildings range in size from 4 apartments to over 200 in one project. These include one-, two- and three-bedroom apartments and townhouses and a limited number of four-bedroom apartments. City living currently ensures that 5 per cent of the units in each housing project it builds are wheel-chair accessible and at this time has approximately 170 accessible units throughout the city. Although the City itself does not manage any "special needs housing" projects it does enter into leasing arrangements with voluntary-sector groups who manage this form of housing.

There are also five seniors' cooperatives that range in size from 43 to 96 apartments in a building. These are buildings that have been sponsored by church groups, ethnic groups and cultural groups.

Recently some research was undertaken to look at the support services (health and social services) delivered to residents in senior public housing buildings. The purpose of the study was to develop a model to improve the coordination of existing community health and social services provided to residents and to respond to resident defined needs. As a result of the research, the provincial Departments of Health, Social Services and Housing have come together to sponsor a pilot project to implement a "Service Coordination and Tenant Support Model" as a test-case high-rise senior

apartment building. The pilot project will be evaluated over a two-year period. If found to be successful at improving the quality of life of seniors living in the building and reducing crisis medical intervention, the model may be implemented in other senior public housing buildings in the province. The model has two major components. The first is an on-site homemaking team and supervisor that will deliver services to needy residents from an on-site office. The second major component is a live-in tenant-support worker who will act as a link between the tenants and available services in the community and will stimulate self-help activities among the tenants themselves by actively working with the existing tenant volunteer groups.

In addition to the rent-geared-to-income seniors' apartments, the City of Ottawa is involved in two other housing programmes - The "Granny" flat or Garden Suite Demonstration Project, and Match and Share.

A "Granny flat" or garden suite is a small, portable self-contained living unit to be occupied by an older person or couple. The unit which is about 600-800 square feet is built on the property of a relative. The portability of the unit allows easy removal when the unit is no longer, required. Although an evaluation of the demonstration project indicated the viability of this form of housing, while improving the quality of life for both seniors and their families, zoning bye-laws have been the largest impediment to this type of housing. Currently, temporary zoning bye-laws have been introduced to accommodate garden suites until permanent legislation can be refined and introduced. An extensive application form must be filled out requesting a zoning change on a person's property to accommodate these portable units. The occupant must be a parent of the original property owner.

Match and Share is a programme offered by the Regional Government of Ottawa-Carleton. This provides a housing alternative to both home providers and home seekers, usually people living alone, by matching such people. Home providers who wish to remain in their home are matched with a compatible partner who can share accommodation costs, tasks, reinforce feelings of security and provide companionship. This programme allows the provider and the seeker to retain their independent lifestyles. Home sharing has allowed a number of older residents or people with disabilities to find housing at an affordable rate or below current market rates.

The Match and Share Programme provides counseling and interviewing of participants, trial arrangements, and follow ups on matches. At least one person in the match must be 55 years of age and older, but the programme is open to all ages. An extensive checklist is filled out to provide information on reasons for applying, views on sharing tasks and space, money issues, meals, and habits and preferences.

A service provided by the Regional Municipality of Ottawa-Carleton, Homelink connects persons with disabilities who are looking for housing with landlords who are looking for tenants. Homeseekers are advised about housing options in Ottawa-Carleton and provided with support to explore these options. Homelink maintains an inventory of housing units that are physically accessible and promotes public awareness about the housing needs of persons with disabilities.
People registering with Homelink are asked to indicate the general level of accessibility they require. Units in the inventory are assessed and assigned a level of access designation as follows:

Level 1 - Limited access. The unit and building are not wheelchair-accessible but may be suitable for people with some mobility impairment.

Level 2 - Limited wheelchair accessibility. The unit and building have some degree of wheelchair accessibility but some areas (kitchen, bedroom) are not fully accessible.

Level 3 - Wheelchair access. The unit and building have a minimum degree of wheelchair accessibility, such as wide doorways, low thresholds, no stairs, turning circles etc.

A unit is assessed as having a minimum degree of wheelchair access if it has:

I. Door openings - 81 cm wide
2. Door thresholds - I cm high or less

3. No stairs (or an accessible elevator serving all levels)
4. Smooth and continuous surfaces (on walkways, in corridors etc.)
5. Adequate turning circles (1.5m x 1.5m) in corridors and at elevators and doors
6. Adequate space for transfers to and from wheelchairs in bathrooms, parking and drop-off areas.

Level 4 - Special features - wheelchair modifications. The building and unit meet Level 3 requirement and they also has specially designed features (i.e., grab bars, accessible kitchen features, ramps).

Two subsidiary categories are possible and these are:

Special features - Vision (V)

The building and/or unit has special features for the visually-impaired residents such as contrasting floor and wall surfaces, tactile cues in elevators and stairways, and audible indicators in elevators.

Special features - Hearing (H)

The building and/or unit has special features for the hearing-impaired residents such as visual identification security systems and fire alarms with visual signals.

A variety of "special needs housing" or supported living arrangements are available within the city limits. For the most part these are operated by volunteer sector or non-government agencies, which receive funding from the province and/or the region in order to provide the service. Generally speaking this type of housing falls within three types: (a) group homes; (b) supported service living units; or, (c) domiciliary hostels.

Group homes are usually set up to serve a particular target group and hence there are homes for adults who require assistance with personal care, homes for adults who require mental-health support, homes for adults who are visually impaired etc. For the most part, the people living in these homes are lacking in the life skills required to live independently in the community though in some cases individuals remain in this type of setting because the personal supports they require are not available in the community.

An example of this type of living arrangement is the Carleton-Ottawa Residence for the Disabled (CORDI). CORDI is a home to eight adults who are mobility impaired. Staff remain on-sight 24 hours-a-day, 7 days-a-week to assist with personal care. Individuals living at CORDI are required to share in the household chores, including meal planning and preparation, grocery shopping and housecleaning. The house, located on a quiet, residential street, is a renovated duplex which has been converted to a single dwelling and made accessible for wheelchair users. CORDI is managed by a community board.

A slightly larger variation of the group-home arrangement is Parkway House which has 35 residents and was designed to serve people who have cerebral palsy. Parkway House is a relatively large building and more closely resembles an institutional environment set apart from the rest of the neighbourhood. The residents tend to be young adults most of whom are more severely disabled than those in CORDI. As with CORDI, staff are permanently on-site, but provide a more involved level of support to meet the higher needs of the residents.

Supported service living units (SSLUs) is the name given to a category of housing made possible through a partnership between the Ontario Ministry of Housing which pays the rent subsidies (no more than 25 percent of the resident's income goes to rent) and the Ontario Ministry of Community and Social Services which pays for the personal-care staff who serve the residents. As is the case with group homes, SSLUs are managed by community boards. Unlike the group homes, however, SSLUs are individual apartments within an apartment building. Tenants rent their own apartments and on-call attendant staff are available in the building on a 24-hour basis. A minimum level of accessibility is generally provided in the units thereby enabling tenants to achieve a certain level of independence. The individuals living in these units tend to be mobility-impaired but otherwise are able to function well in the community - many are employed or going

to school. An interesting example of this type of arrangement is Daly Co-op. Daly differs slightly form the model described as it is a housing cooperative and therefore requires that tenants be members and share in the management and maintenance responsibilities. Daly is somewhat unique in that it was created by a group of people who are disabled and had a particular vision. Rather than building an apartment building with a number of accessible units, they preferred to design and build an apartment building that was entirely accessible. Members living in the SSLU units are provided attendant care by staff who have an office on the first floor of the building. Staff carry a pager and can be reached at all times for regular assistance or emergency help.

Recently, Carleton University secured funding to provide this service to students living in residence on the campus. Students who are disabled and require attendant care can now live in the SSLUs on campus.

Domiciliary hostels are supervised boarding homes owned and operated by the private sector.[21] In 1988, there were 35 such hostels in Ottawa-Carleton providing accommodation for approximately 1300 individuals. Hostel owners are paid a per diem rate by the Regional Municipality of Ottawa-Carleton for tenants who are on income-maintenance programmes. Residents receive a shared room, housekeeping services, meals, 24-hour supervision, assistance with activities of daily living and a comfort allowance paid out monthly. Though originally designed to serve the frail elderly population, currently the majority of residents are psychiatrically, developmentally or mull-disabled.

Another model for supportive living has recently surfaced and it is designed to serve people who have been homeless and who have mental-health support needs. Options Bytown is an apartment building in which tenants live independently in their own apartments and have access to support staff located on the ground floor. 1t is intended to provide a stepping stone for individuals unable to make the step from the street into totally independent living in the community. Once again, this service is funded by the province and managed by a community board.
The Ottawa-Carleton Branch of the Canadian Mental Health Association (CMHA) houses a housing access service, the Supportive Housing Registry which provides information to the general public on supportive housing resources and vacancies for individuals with a psychiatric disability and also provides direct assistance to individuals attempting to access this type of housing. An advisory committee comprised of individuals from the community, service providers and government representatives oversees the service development and reports to the CMHA board.

An outreach component of the service focuses on emergency shelters which are visited regularly by the outreach worker. While on location in the shelters, the worker assists individuals by providing information about the availability of accommodation and helping to fill out application forms for accommodation.

In addition to the locally-sponsored housing programmes, there are a number of government assistance programmes at the Federal and Provincial governments that improve the quality of life for elderly people in the City of Ottawa. These include:

- The Ontario Home Renewal Program which offers loans of up to $Can 7500 to help homeowners with low incomes to bring their houses up to municipal standards. Depending on income, some of the loan may not have to be repaid. The loans help improve such things as structural and sanitary conditions, and plumbing, insulation, heating and electrical work.

- The Ontario Home Renewal Program also offers loans of up to $15,000 to families with low incomes to make their homes more suitable for disabled persons or elderly persons with mobility problems who live in the home. Depending on how long one remains in the home, some or the entire loan may not have to be repaid. Forgiveness of the loan is earned through continued ownership and occupancy. Loans will not be

[21] Social Planning Council of Ottawa-Carleton, *Services for Adults with Physical Disabilities in Ottawa-Carleton* (1988) p.15.

given for work that has not received prior approval. The programme is administered by the Municipality and financed by through the Ontario Ministry of Housing.

- The Residential Rehabilitation Assistance Program (RRAP) gives financial help to low-income homeowners who must make major repairs to homes in which they live. The amount of help is based on the cost of allowed repairs in the area in which they live and the total income of the owner. Under RRAP for the Disabled a companion programme, people who have, or will have, a disabled person living in their home (or rental units) may be able to get financial help to cover the cost of improving their home to make it easier for disabled persons to live there. Both RRAP programmes are offered by the Federal Government through the Canada Mortgage and Housing Corporation. The availability of the financial help depends on the amount of money put into the program by the federal government.

Social services

The array of social services available in the City of Ottawa falls within four general categories as follows: (a) services which support independent living; (b) employment-related services; (c) day programmes; and, (d) information and/or advocacy services.

Services which support independent living are generally available to individual regardless of where they reside as opposed to being attached to a specific location as is the case in the special-needs housing programmes described above. These are often referred to as portable services delivered in-home.

Outreach Attendant Care is a service funded by the Ontario Ministry of Community and Social Services and provided by several volunteer-sector agencies in Ottawa. Attendant Care is non-medical in nature and refers to assistance with personal care and hygiene such as bathing, dressing, toileting etc... The service is available in an individual's home and is provided daily between the hours of 6 am. and midnight. Limited to 90 hours a month, the average consumer of this service receives 3 hours of care per day, usually including one visit in the morning and another in the evening. Attendants are provided by the agency or can be hired by the individual and paid by the agency. The people being served by Outreach are most often very independent, employed and living in their own homes. Currently resources are insufficient to meet the demand for Outreach Attendant Care and the waiting list is quite long. Potential clients of the service are concerned about the programme's lack of flexibility and emergency back-up. Clients are expected to develop their own back-up support system which for most people tends to be family and friends.

Public health units in Ontario have Public Health services throughout the province. The health units are part of the regional department of health and offer numerous health related services aimed at different target groups in the population. One of these programmes is "Healthy Neighbourhoods". This is a seniors' health promotion programme that is offered free to seniors wishing to work together to make their neighbourhood a healthier place for its older residents. The services offered by the programme include group health education classes, health counseling and advice to families on a number of concerns such as caring for an elderly resident. These services are delivered by a variety of health professionals such as nurses, dental professionals and nutritionists.

The Home Care/Integrated Homemaker Program is a provincial programme delivered to the elderly in the Ottawa-Carleton Region by the Regional Health Department. The Program is a coordinated service that offers both professional health care and home-making assistance with some of the activities of daily living such as light housekeeping and laundry to eligible clients. The Program is covered by the provincial health insurance plan and there are no user fees.

Typically, clients are referred to the Program by their physician after discharge from a hospital; however, individuals can make self-referrals. Clients may require short-term help to recover from an illness or a fall, or longer-term assistance for a more chronic condition. The Program offers both types of assistance. A home-care case manager decides if the referred client should receive home care and the level of service required. Clients and their families help decide the best care

plan. The case -manager also has the responsibility for referring people who do not qualify for home care to other sources of assistance.

The health-care portion of the service includes professional help from nurses, physiotherapists, occupational therapists and speech therapy. Help can also be made available for counseling and visiting homemakers services, hospital and sick-room equipment, transport and home-delivered meals. The Regional Health Department contracts non-profit and for-profit agencies in the community for both the professional and homemaking services delivered through the Program. The Program consumes 55 per cent of the budget spent by the Region for health services for elderly people.

Training in Community Living Skills is offered by a variety of community agencies as well as by Home Support Services (BMOC). Among the community agencies offering this service is the Ottawa and District Association for the Mentally Retarded and Ottawa-Carleton Lifeskills Inc. The Region's home-support services are located in community service centres throughout the region. Home-management counselors work on a one-to-one basis to teach people home management and life-coping skills in their homes. Skills taught include cooking, budgeting, shopping, banking, use of community resources, and any other day-to-day skills required to live in the community. Persons who are disabled and/or elderly appreciate the neighbourhood-based, individualized approach of the Home Support programme.

Respite Care Services help families who care for relatives in their own homes. This allows those who give care to have some time off. A trained respite provider makes planned home visits of several hours or emergency visits. As well as looking after the person, some respite providers do light housework, prepare meals, do laundry, and offer personal care. There are a number of such services offered in Ottawa-Carleton through institutions such as Chronic Care Hospitals and Homes for the Aged as well as community agencies such as Daly Support Services Inc.

Primarily designed to assist persons who are psychiatrically or developmentally disabled, Case Management serves to connect individuals with the supports they need in the community. The case manager helps the clients identity their own needs, develop a plan for addressing their needs and link up with the appropriate agencies to receive support. Most importantly, the case manager follows up with the individual providing support to the client when needed. Currently, in Ottawa, this type of service is offered by the Regional Municipality, as well as by several community agencies such as the local branch of the Canadian Mental Health Association, the Ottawa and District Association of the Mentally Retarded and the Catholic Family Service Centre. Unfortunately, resources are insufficient to provide adequate service to meet the need in the City and many individuals who would benefit from such a service are left to their own resources. Funding is provided by the Province and the Regional. Government for Case Management services.

St. John Ambulance is a voluntary agency that offers a course to help seniors learn how to keep their good health and stay independent. It also offers a course to help people handle the emotional changes of ageing, and lifestyle changes of retirement. They give a 21-hour course to caregivers that provides knowledge and skills needed to care for an older person. The agency receives 15.5 per cent of its funding from the United Way. User fees, donations and sales of supplies make up the rest of its budget. It involves 360 volunteers.

The Addiction Research Foundation is an Ontario Government-funded agency that deals with drug and alcohol abuse. It has an Information Line that can be accessed without charge seven days a week from 9 a.m. to 9 p.m. The Foundation offers more than 60 short audiotapes about alcohol and other drug subjects. Tapes are available in five different languages. It has been acknowledged that drug and alcohol abuse is a problem among some elderly people. .

There are many different social service programmes for the elderly funded in a variety of ways through government grants, fund-raising and the collection of user fees. Some of the more effective programmes including a description of local examples are provided.

The City of Ottawa has 14 elderly persons' centres including some focusing on cultural or French-language groups. A number of different non-profit groups with assistance from local and other

levels of government operate the centres. These centres have social programmes that help seniors deal with ageing and retirement. The programmes may include physical fitness classes, educational courses, craft classes of all kinds, choirs, bands, cards and other games, poetry, history and religious studies, languages including English as a second language, garden clubs, and parties to celebrate holidays and birthdays of the month. The centres may also arrange transport for disabled people, professional counseling and referrals concerning financial, legal, housing and family matters, general health screening clinics, foot care, hair care and other personal care services. Many also offer home support such as light housekeeping and meal services including services at the centre (wheels-to-meals) and the provision of home-delivered meals (meals-on-wheels) that are delivered by volunteers. One of the most positive aspects of the elderly persons' centres is that they are based on a principle of seniors helping seniors and voluntarism.

Two examples of elderly persons' centres in the City of Ottawa are: The Good Companions Centre and Centre de Jour Polyvalent des Aires Francophones d'Ottawa-Carleton.

The Good Companions Club was formed in 1955 and was housed in a church basement. At that time the Club was Canada's first facility dedicated to meeting a recognized need by people over the age of sixty for a place to enjoy companionship and social activities with their peers. The Kinsmen Club of Ottawa built the first Good Companions Centre a few years later in 1959, and approximately 500 seniors participated in activities that first year. The Good Companions Centre has grown steadily to over 2000 members today and is just completing a $3.5 million major expansion of its facilities.

Today the Centre offers opportunities to participate not only in social activities but in recreational and educational programmes, both at the Centre and away, as well as derive the benefits available from extensive nutritional, health and social services available to them. The Centre's services and programmes fall into five groups. They are: food services, volunteer services, day support (care) program, recreation services, and home-support services.

Examples of some of the home-support services offered include:

- Providing information and assistance in contacting available community services;
- Linking seniors to home helpers who provide assistance with light or heavy housecleaning on a regular or occasional basis;
- Providing relief to the caregiver by linking seniors to home helpers who provide companionship and light care;
- Linking seniors to workers who provide assistance with yard-work, snow shoveling and other odd jobs - this also includes a volunteer minor repair programme;
- Low-cost nutritious lunches and dinners served weekdays at a nearby restaurant;
- Volunteers are linked with lonely or isolated seniors to provide social contact, friendship and support;
- A weekly telephone call is made at a pre-arranged time by volunteers to seniors living alone to ensure their safety and well-being;
- Weekly escorted grocery bus service for seniors in designated areas of the city;
- Meals delivered by volunteers to elderly people who are shut-ins and are not able to prepare their own meals.

In addition to the many home-support programmes offered by Good Companions, there are also a number of supportive services located at the Centre for seniors. These include a supervised social programme for the frail elderly, foot care, hair care, an osteoporosis self-help group, and a health-promotion clinic. As well, there are numerous social and recreational group activities offered at

the Centre such as crafts, musical groups, fitness classes, a travel club, dancing, and social teas. There were over 600 volunteers associated with the Centre's various programmes in 1991/'92.

The Good Companions Centre receives its revenue from three sources - grants (United Way, Province of Ontario and City of Ottawa), user fees and other sources such as individual endowments. In 1991/92, grants made up 85 per cent of the funding, user fees 11 per cent and other sources 4 per cent.

The Centre de Jour Polyvalent des Aines Francophones d'Ottawa-Carleton is an agency like Good Companions, however, it serves the Francophone community. The Centre provides a day centre for elderly Francophones where participants can receive a main meal and take part in a variety of recreational activities. There is also a respite programme for frail elderly people who need assistance with daily living. Participants are transported to the centre for a day and take part in a variety of social activities including a main meal. The social milieu enhances the seniors' quality of life. There are 225 volunteers involved in the programmes. The United Way provides 33.5 per cent of the budget. Other sources of funding include the Government of Ontario, City of Ottawa, special fund-raising events, donations and memberships.

The Homemakers and Nurses Services Program serves elderly, physically disabled people or people recovering from illnesses. The services provided through the Program help avoid unnecessary institutionalization by assisting elderly people who can no longer function on their own with some of their activities of daily living. Homemakers may prepare meals, for example, shop, or do laundry, light housekeeping or personal care. Nurses make sure that the medical plan of care (changing bandages, checking the effect of medicine etc) is followed. Nurses also help with such things as bathing, skin care and toileting. Organizations may hire their own nurses or homemakers, or contract the services of other nursing and homemaking agencies such as the St. Elizabeth Order of Nurses, the Victorian Order of Nurse, 'the Red Cross, or the Ontario Association of Visiting Homemakers. The fee is calculated according to the person's ability to pay. In order to qualify for the service, the person must live in the area where he or she applies for the service.

Unlike the Home Care Program, the services are not covered by the provincial insurance plan. There is currently a move in the government to combine the various programmes offering home nursing and homemaking services under one umbrella programme. This is part of the long-term care reform and is expected to result in a more efficient and effective delivery of services. Consumers as well as providers have expressed a great deal of confusion over the years about eligibility criteria, accessibility and availability of the different in home-nursing and homemaking' services. One example of a local homemakers' organization in the City of Ottawa is described below.

The Visiting Homemakers Association of Ottawa (VHA) is a non-profit, voluntary health and social service agency which was founded in 1955. VHA delivers in-home services to families with children under the age of 18 who have a serious handicap, as well as to the adult population - the frail elderly clients and younger adults with disabilities. The adult service programmes and their target populations include:

- The provision of services to the frail elderly with diminished capacity to manage independently; caregiver relief focusing on Alzheimer's patient care;

- The provision of medical/surgical short-term service to expedite recovery, Assist in crisis or provide on-going service to chronically ill persons;

- The provision of on-going services to adults with physical disabilities with the objective of facilitating rehabilitation or reintegration into the community;

- The provision of services to those with psychiatric problems or limited intellectual functioning including monitoring and teaching or coping skills;

- The provision of palliative care including personal care and caregiver relief to enhance the quality of life of the terminally ill persons; and

- The provision of respite care on a part-time basis or 24-hour relief for the caregiver of a handicapped person designed to prevent family breakdown.

The specific services offered to the adult population under each of these programmes include meal preparation, food shopping, special diets, light housekeeping, laundry, personal care, simple bedside care, and training and instruction in household management. These services are part of a plan-of-care designed to meet the physical and emotional needs of daily living of adults so that they can function in their own homes.

In addition to the homemaking staff who deliver the in-home services, there are a number of area supervisors. The role of each supervisor is twofold. First, in relation to the homemaker, the supervisor is in charge of selecting the homemaker to ensure that the skills of the homemaker meet the needs of the case. The supervisor is also responsible for the on-going supervision, evaluation and training of the homemaking staff. Secondly, in relation to the client, the supervisor assesses each case, designs the care plan, monitors the case and coordinates with other service agencies who may be involved with the case.

The only source of funding for the VHA is through client fees based on hours of homemaker service provided to the client. The client may pay the full fee directly or may be subsidized by either the regional government social services department (using a means test where the client may contribute to the total cost), by the provincial government through health insurance if the client is eligible for the Home Care Program, through United Way of Ottawa-Carleton (subject to the success of fundraising, an annual allocation is made to assist middle-income families with costs) or through other sources such as the Canadian Cancer Society.

The Home Support Program is offered by non-profit agencies, some homes for the aged (institutions), some local governments and Native bands. These services help senior citizens stay in their own homes. They include: meals-on-wheels, diner's club (wheels-to-meals), nutrition classes, respite care services, senior day-care programmes, home help, home repair, transport (to shopping and doctor appointments), friendly visiting, security checks - which may be a daily telephone call. The following programmes illustrate the variety of different home support programs available to elderly residents living in the city of Ottawa.

An important home support service for seniors living in their own homes in the city of Ottawa is home help. Home-help services are offered by a variety of neighbourhood-based agencies as well as through a number of employment centres. The services usually include assistance with minor repairs to the exterior as well as interior of the home, grass cutting, snow shoveling in the winter and odd jobs in general. Services offered by agencies (such as the Good Companion's Centre described above) that are funded through the provincial Home Support Program may charge a small user fee that is often based on the person's ability to pay. Home-help assistance for the elderly can also be arranged in Ottawa by contacting employment centres such as the Canada Employment Centre for students or the Seniors' Employment Bureau of Ottawa-Carleton.

The "Food for One is Fun" project is jointly conducted by the Health and Social Services Departments of the Regional Municipality of Ottawa-Carleton. Seniors are an invaluable part of the planning process and are active on a community advisory committee to the project. The project is targeted to senior adults, specifically those living alone on low income and has four objectives. They are:

- To increase socialization using interest in food as the focus for group interaction;

- To increase. skills in choosing, preparing and cooking healthy food,

- To increase awareness about the need to limit fat, sugar and salt intake and to increase fibre intake;

- To provide a vehicle through which participants can identify other health and social issues for which leaders can supply leadership, education or advocacy.

The project is multi-disciplinary and consists of workshop each involving six sessions covering different topics related to food preparation. Each session is co-facilitated by a public health nurse and a dietician from the Health Department as well as a home management counselor from Home Support Services of the Social Services Department. The workshops require kitchen facilities and an area large enough to accommodate about 20 people, ideally with a locked area to store equipment. In addition to the lecture and demonstration, participants are involved in preparation of the food and provided with a light lunch. As well as receiving information on nutrition and food preparation, participants are exposed to related concepts of health care. Using self-care as the basis, participants are introduced to exercise, stress management, medication awareness and home safety. One session is devoted to each topic. There sessions are offered free of cost to participants. The project is funded by the regional government.

The King's Daughters Dinner Wagon, The Meals on Wheels Program, is a voluntary community service providing one hot nutritious noon meal, delivered to the person's home Monday to Friday. The Program has served elderly residents in Ottawa since 1968 and helps the frail elderly, disabled and convalescent maintain independence at home by providing:

- Sound nutritional support;
- An interested daily visitor,
- A daily check on well-being.

The meals are supplied by hospitals, Nursing Homes and Homes for the Aged throughout the city and delivered by volunteers with a car who devote two hours of their time either once a week or several times a month to the Program. Recently, the Program added frozen meals to their service. This provides more flexibility for the volunteers as well as the clients and also insures that extra meals are available for the week-end if the client is in need.

In 1991/92, the Meals on Wheels Program provided by the King's Daughters Dinner Wagon served over 1500 clients utilizing almost 800 volunteers. There are also three full-time drivers who are paid for their services. The programme was funded through several sources. More than two thirds (68 per cent) of the total revenue was derived from client payments for the meals - meals cost about $4 each. Just over one quarter of the revenue came from government grants and the remaining was collected through charitable donations.

The Telephone Assurance Program (TAP) was initiated by the Council on Aging of Ottawa-Carleton in 1978. The objectives of TAP are:

- To provide a regular contact by means of a daily phone call to senior citizens and shut-in persons living alone;
- To ensure the security of the client by providing appropriate emergency back-up services if the client is unable to answer the phone; and
- To provide social contact for isolated seniors.

TAP is sponsored by residential institutions for the elderly and by community or social-service organizations such as seniors' centres (e.g., Good Companions operates a neighbourhood TAP program). Residents of the institutions constitute a good source of volunteers who gain satisfaction from contributing to the security of those seniors living in the community. For the most part, TAP is a neighbourhood-based programme with well-defined boundaries so that clients can be served by those living close by. However, in some cases, the programme may be delivered across a wider geographical catchment area such as "Teleshalom", a programme which serves Jewish clients on a regional basis.

There are 13 TAP centres in Ottawa-Carleton. Each of the centres has a coordinator who may or may not receive payment for that role. Typically the coordinator works about two hours per day, five days a week, and is responsible for matching callers with clients and on-going training. The number of clients served by the TAP centres ranges from less than 10 to 35. The number of

volunteers making the calls also varies - in one centre one person makes all the calls - in the larger centres there may be several volunteers. A shortage of volunteers has been identified as a problem by a recent evaluation of the program.
Start up funding for many of the centres came from a Federal Government grant. Once established, operational costs are minimal and are usually absorbed by the sponsoring organization.

Employment-related Services[22] available in the City of Ottawa include a continuum from vocational assessment and counseling through to employment preparation and placement. The service network includes provincial government agencies such as Vocational Rehabilitation Services (VRS) at the Ontario !Ministry of Community and Social Services, Regional Government agencies such as Employment Services at the Regional Municipality of Ottawa-Carleton, and community agencies such as Line 1000.

Case management of employment services is provided by VRS, the Workers Compensation Board (Province of Ontario) and Canada Employment Centres (Federal Government). Job seekers who are disabled are generally served by the VRS or the Workers Compensation Board. These agencies will help an individual develop a plan of action and then refer them to the appropriate services.

Disabled job-seekers are referred for to the Vocational Evaluation Unit (VEU) at the Regional Rehabilitation Centre or the Ontario March of Dimes for assessment and employment preparation. The VEU provides a three-part assessment of vocational potential. A Micro-computer Evaluation and Screening Assessment (MESA) and standardized work samples are used to assess interests, skills and aptitudes. Work sites within the Centre are then used to facilitate the development of work habits and finally, evaluations are conducted at real job sites in the community. This process can be completed in as little as eight weeks; however the average client stays with the programme for about 14 weeks. The Ontario March of Dimes (MOD) offers a similar service having recently adopted standardized work samples as assessment tools. MOD has two training programmes; a 16-week microfilming course and a six-month computer-training programme.

Funded by the Federal Government through the Canada Employment and Immigration Commission's Outreach Program, Line 1000 provides job-placement services to people who are disabled or employment-disadvantaged. A community agency, Line 1000 meets with employers to identify positions for its clientele, matches clients to jobs, facilitates the process of making accommodations to jobs and accessing assistive devices and provides support to workers and employers. Recently, Line 1000 has created a databank of positions and job candidates which has proved to be a useful tool for employers and job seekers alike.

The Seniors Employment Bureau is a voluntary organization that has been in operation since 1981. The Bureau serves people aged 55 and over who are retired from their full-time or life's work but wish to continue employment on either a full-time or part-time basis. Since its beginning, nearly 4000 older adults have registered with the Bureau. The Bureau's objectives are:

- To provide employers in both public and private sectors with a source of reliable, experienced personnel who, because they are retirees, can remain a relatively untapped economic resource in the community;

- To assist people 55 years of age and over to obtain gainful employment when additional income is required to sustain appropriate standards of living;

- To give retirees who encounter problems in adjusting to complete retirement an opportunity to continue in the work force.

The Bureau places over 600 people a year in paid positions. In doing so it has provided over 100 people with very worthwhile and rewarding volunteer work assisting older adults to re-enter the workforce. Volunteers work on average one day a week and are trained to carry out interviews and

[22] Social Planning Council of Ottawa-Carleton, *Services for Adults with Physical Disabilities in Ottawa-Carleton* (1988).

job placements as well as serve as job-finders. Some also provide clerical and stenographic support and assistance with financing, public relations, training etc.
The Seniors Employment Bureau receives funding primarily from three sources. Federal and regional government grants form the highest contribution, followed by the United Way and some donation from the public at large.

Several agencies offer alternatives to competitive employment including sheltered workshops, affirmative industries and volunteer work. The Ottawa and District Association for the Mentally Retarded and Y's Owl Co-op, both community agencies, provide sheltered workshops for persons who are developmentally disabled. In these workshops, individuals are given work that is within their assessed capabilities and have no contact with the general public. Workers do not receive a wage but in most cases are provided with some form of allowance.

The Recycle Store is an example of an affirmative industry. A non-profit corporation, the Recycle Store started with a grant from the Canada Employment and Immigration Commission in 1978 and has been self-supporting since 1981. Employment is provided at the warehouse where appliances, bicycles and wheelchairs are repaired or overhauled and at a retail outlet which provides jobs in sales, marketing, display and bookkeeping. The majority of employees are disabled or experience various barriers to being competitively employed.

The Central Volunteer Bureau and Partage Work are two community agencies which facilitate the attainment of volunteer work for individuals who are disabled. The Central Volunteer Bureau matches individuals to positions with non-profit agencies. Its "Pathways to integration Program" is specifically designed to serve individuals who are psychiatrically disabled, providing the extra support and follow-up required. A similar programme geared towards individuals who are physically disabled, Supported Volunteering, recently lost the funding it was receiving from the Province; however, the agency continues to serve these individuals as resources allow. Partage Work differs from the CVB programme in that it provides a subsidy to volunteers to offset the costs of volunteering. In addition, Partage Work runs a computer-training course, Computerwise, for individuals who require adaptive aids in order to use a computer.

A relatively new type of employment support has been introduced to the City in recent years. Supported Employment is currently being promoted by the Province as a means of facilitating access to competitive employment for individuals who otherwise would likely remain in sheltered workshops. Supported Employment's programmes are provided by several community agencies; however the general concept is similar in each programme. Basically, the service includes the provision of a job coach who works with an individual to identify potential jobs and provides support to the individual and the employer after placement in a position. Typically, the job coach will go on-site and actually do the job for a day or two in order to become familiar with the task involved and the general environment and then will train the employee to do the job. The job coach may stay on-site with the employee for a period until the employee is comfortable and will remain available to the employee and employer should any problems arise. Supported Employment's programmes are offered by the Ottawa and District Association for the Mentally Retarded, Causeway (a community agency serving individuals who are psychiatrically disabled), Y's Owl Co-op (serving individuals who are developmentally disabled) and Maclure Habilitation Centre.

Day Programmes take place during normal working hours and are located outside of a place of residence. They are designed to provide an alternative to staying at home for people who are unable to be employed and also to prevent the premature placement of individuals in institutions. The absence of day programmes would in many cases necessitate moving people out of their homes in order for them to receive the daily support required. The programmes usually take place in community centres or health centres. Many offer group activities that are designed to help people to use their existing abilities as much as they can. The programme may offer advice and education to family care givers. Day programmes usually fall within three categories: municipal programmes, formal day programmes and social programmes nut by self-help organizations.

Municipal day programmes are run by municipal departments of recreation and take place in community centres throughout the City. These tend to be recreation- or leisure-oriented.

Formal day-care programmes are distinguished from the type of programme offered by the self-help groups by the fact that they tend to be funded by the Province or Municipality and to be more formally structured with regularly scheduled activities. One example of this type of day programme is the St. Vincent's Day Hospital. St. Vincent's Hospital is a chronic care institution funded by the Ministry of Health. The Day Hospital offers individualized programmes designed by an interdisciplinary team to assist clients to regain or learn new skills. Another example is the Capital Region Centre for the Hearing Impaired which is a non-profit, community agency set up to provide a focal point for hearing-impaired people. Activities include crafts and games, and educational activities such as literacy training and sign language.

Social and recreational activities are also offered by self-help groups such as the Ottawa Handicapped Association and the Ottawa Quadriplegic Society. Many of these receive little or no funding and have no formally incorporated structure. They survive as a result of the dedication of volunteer members and usually organize social and recreational activities for people who otherwise are homebound.

Information and/or advocacy services are provided by numerous organizations which have been formed to assist people with a particular disability including many local chapters of national and provincial non-profit associations such as: the Canadian Hearing Society, the Canadian National Institute of the Blind, the Canadian Paraplegic and Quadriplegic Association, the Canadian Mental Health Association, the Multiple Sclerosis Society and the Muscular Dystrophy Association. Added to these are the more generic agencies which serve all people regardless of the type of disability. Some of these are described below.

Citizen Advocacy recruits volunteers from the community and matches them with individuals who require emotional support and/or companionship in order to enhance their quality of life. The agency serves people who have a wide range of disabilities including individuals who are physically, developmentally and/or psychiatrically disabled. Often Citizen Advocacy is the place of last resort for people who are typically hard-to-serve. Volunteers are trained and supported by a team of professional social workers and a volunteer coordinator. Often the relationships created by the programme last for many years becoming true friendships.

Resource, Education and Advocacy for the Handicapped (REACH) is an organization that was formed by a group of lawyers and community members interested in providing legal services and support to individuals who are disabled. The organization provides public education services as well as targeting law students for sensitization to the needs of clients who are disabled. One of the organization's earliest successes was winning the right for individuals who are unable to sign their own name as the result of cerebral palsy to open a bank account. The bank agreed to allow such clients who previously could only open a joint account to use a stamp in place of the signature.

A third type of agency or organization providing information and/or advocacy is the consumer-driven agency. These are organizations which have been created and are managed by individuals who are disabled and in Ottawa; The Ottawa-Carleton Independent Living Centre (OCILC) is one example. OCILC is one in a network of centres across the county. The Centre's bye-laws explicitly state that two thirds of the membership on the Board of Directors be individuals who are disabled. Built on a philosophy which promotes the independence of individuals who are disabled, the Centre strives to empower individuals providing them with the supports and information required to make decisions for them, thereby taking control of their own lives. One example of a programme offered by the Centre is its peer-support programme which is similar to the citizen advocacy concept with an important difference. Individuals who are disabled and enjoy an independent lifestyle are recruited and matched with other individuals who can learn from the experience of a peer supporter.

All of these agencies provide information and referral services, some level of advocacy while some also provide a level of counseling.

The Community Information Centre (CIC) of Ottawa-Carleton is a bilingual, non-political, non-profit community organization. Serving all citizens, the Centre exists to help people find answers to their questions or problems by providing information about and making referrals to all human services in the Regional Municipality of Ottawa-Carleton. The Centre has a computerized

database of information on resources and supplies answers to immediate problems in the areas of financial assistance, legal or consumer concerns, education or leisure programmes, housing or counseling resources, self-help groups etc. If the answer sought is not available in the database, the Centre's staff will do special searches or direct the enquirer to other resources.

CIC publishes a directory of community services Ottawa-Carleton which is used primarily by professionals who need a guide to key services in the community. The book is sold on a cost-recovery basis.

In 1991, CIC responded to over 11,000 calls for information and referral. The Centre has four full-time staff and a few volunteers. The single largest source of the Centre's funding is the United Way (39 per cent), followed by the provincial government (23 per cent), regional government (21 per cent), directory sales (15 per cent) and miscellaneous sources.

Income support/replacement

A cornerstone of the social safety net in Canada, income-maintenance programmes are administered by the provinces and 50 percent cost-shared by the Federal Government according to the terms of the Canada Assistance Plan. Under Us Plan, assistance may be provided to any individual or family deemed to be "in need". Provinces have formulated extensive rules to determine the fact and extent of the need.

In Ontario, General Welfare Assistance (GWA) provides basic income support to people in short-tern or emergency need to ease the impact of unemployment, family breakdown, temporary illness or disability. To be eligible for GWA, employable persons must demonstrate a willingness to work.

Family Benefits Assistance (FBA) provides long-term income support to disabled adults and their dependents, disabled children, single-parent families with little or no wage income, older adults under 65, and to children in foster care.

The regional government provides supplementary aid and special assistance to senior citizens and persons who are disabled for expenses such as eye glasses and hearing aids, and assistance with moving and other expenses when the need is determined and other programmes do not cover these items.

A variety of other income-support or income-replacement programmes are also available and include:

The Canada Pension Plan (CPP) to which most working Canadians and their employers must contribute is available as a retirement pension. A lump-sum-survivor's benefit is paid to one's estate upon death. In the event of a severe and prolonged disability, as a result of which an individual is incapable of pursuing gainful employment, a disability pension can be drawn from the CPP.

Workers' Compensation is a provincial programme, which provides retraining and salary-replacement benefits to individuals who have been injured while in the workplace. Employees continue to receive benefits until they are back on the job or it is determined that they are no longer employable in which case income support is provided through either Family Benefits or the Canada Pension Plan.

An unemployment insurance plan is available from the Federal Government to persons who have been employed and find themselves out of work. Eligibility for benefits is dependent on the amount of weeks a person has been employed and whether that person is actively seeking work.
Veterans Affairs Canada provides, a War Veterans Allowance/Civilian War Allowance and health care assistance to war veterans and certain civilians (or their dependents or survivors). They may also be eligible for financial help with home and health services.

The Soldiers' Aid Commission offers emergency and special help to eligible war veterans and/or their families.

The Old Age Security Program is a Federal Government programme. It includes:

- Old Age Security (OAS) pensions, for which one must apply. Pensions are available to Canadian citizens or landed immigrants 65 years of age or older who have lived in Canada for at least 10 years after reaching the age of 18;

- The Guaranteed Income Supplement (GIS) available each month to those who have little or no income besides the OAS;

- Spouse's allowance is paid to couples with limited income where one spouse is receiving the OAS and the other is between the ages of 60 and 65;

- Widowed spouses' allowance allows the pension to continue if the person qualifies.

The province of Ontario provides an income-supplement programme to seniors called the Guaranteed Annual Income Supplement (GAINS) which is available to those who receive the Guaranteed Income Supplement (G IS) from the Federal Government and whose incomes are still below Ontario's guaranteed income level.

Pension programmes account for 75 per cent of Federal Government spending on seniors. Another 15 percent of Federal spending goes to the provincial government to help with the cost of health care. The remaining 10 percent of federal contribution to the province covers such things as veterans' programmes, Old Age Income Tax Credits and the Federal Refundable Sales Tax Credit; and the Canada Assistance Plan (CAP).

Tax grants and exemptions

Elderly citizens in Ottawa can qualify for several tax grants. The provincial government offers qualified seniors - those with Old Age Security - an annual $50 sales tax grant. As well, a property tax grant is paid to all qualifying senior households who own or rent their homes to offset municipal and school- taxes. The grant is equal to actual property taxes or 20 per cent of yearly rent up to $600.

There is also a tax exemption for disabled persons including seniors. Improvements to the home may not increase property taxes if they help disabled persons to live there. This tax plan is aimed at having seniors and disabled persons stay in their homes and is provided as long as the building is the principal residence of the elderly or disabled person.

Health programmes funded by the province

Spending on health care accounts for about 65 per cent of the total budget allocated to the elderly by the Ontario Provincial Government This translates into several major programmes including universal health insurance coverage and extra benefits for the elderly. A great deal of effort has gone into a discussion of long-term cane reform in an attempt by the Provincial Government to redirect funds in the health-care system away from institutional care and allocate larger sums to community support services. At this time (1992), however, these efforts are at a very early stage.

The Ontario Health Insurance Program (OHIP) is administered by the Ministry of Health in Ontario on a province-wide basis. For those under 65 with a Health Card or those over 65 with a Health 65 Card, OHIP pays most medical costs, including visits to family doctors or specialists and hospital treatments. To obtain a Health 65 Card, one must be legally allowed to stay in Canada and have a home in Ontario. Seniors who travel outside the province must spend four consecutive months in Ontario to be covered by OHIP while abroad.

Ontario's Drug Benefit Program for Senior Citizens allows the elderly to have most prescriptions filled at no charge. The medication must be ordered by a person licensed to practice medicine in Ontario. The medication must also be on the list of drugs approved by the provincial Ministry of Health. People 65-years-old or older can receive drug benefits if they are legally allowed to stay in Canada and live in Ontario.

Approved persons will be given an Ontario Health 65 Card. No person may use another's Health 65 Card. This card is used as identification for physician, hospital and other health services including the Ontario Drug Benefit Program. It can also be used to obtain free or reduced rates or admission to all provincial parks and many historical and cultural sites in Ontario. Some municipal transit systems, as well as some business firms, also offer special rates to senior citizens.

The Assistive devices Program (ADP) gives financial help to people who live in Ontario and who have long-term physical problems. It helps pay for certain necessary equipment and services. ADP will pay up to 75 per cent of the cost of. manual and powered wheelchairs; specialized seating inserts for wheelchairs; some specialized mobility aids such as walkers; ostomy supplies and related accessories; prosthetic devices including artificial limbs, eyes, and breasts; respiratory equipment, such as compressors, suction machines, and tracheotomy tubes; and hearing aids.

A number of volunteer groups (e.g., Ontario March of Dimes, Cancer Society, Easter Seal Society) or city social-service departments also provide some assistance with the 25 per cent of the cost not covered, or the cost of equipment not allowed under ADP.

Institutional programmes and services

Ottawa-Carleton operates three Homes for the Aged. These offer long-term care to elderly people who are no longer able to look after themselves in their own homes. Although the homes are administered by local governments or charitable groups, the funding comes from provincial government sources. The amount of funding is related to how much care an individual may need. All homes offer live-in care for residents who need less than 90 minutes of nursing and personal care each day. Homes for the Aged also have a designated number of extended care services for those who require more than 90 minutes of care each day.

Most of the homes also have special programmes that allow seniors to stay for a short time. In this way, seniors get to know the home before they move in. Short stays may be used at other times for seniors who need to be looked after while families or caregivers are on holiday. Day programmes and other support services such as meals-on-wheels, and telephone assurance are also offered by the Homes for the Aged in Ottawa-Carleton.

There are two provincial government programmes responsible for the funding of most of the heavier care institutional services offered to the elderly in Ottawa-Carleton. They are the Extended Health Care Program and the Chronic Health Care Program.

The Extended Health Care Program provides a person in a nursing home or a home for the aged part payment for the cost of room and board. The person's cost is adjusted every three months. This help is available to those who are covered by Ontario Health Insurance and who need at least 90 minutes of skilled nursing and personal care each day. A doctor must fill out an application for a patient.

Chronic Care Program addresses both a short-term illness or a long-term disorder or chronic illness. People needing long-term in-hospital care usually get "chronic care". They need regular care provided by skilled professionals. After 60 days of receiving chronic care, patients pay part of the cost of their room and board. Health-care costs are paid for by Ontario Health Insurance. The patient's part of the cost for room and board is adjusted every four months. Some exemptions to this form of cost sharing are spelled out in the book *Sharing the Cost of Chronic Care.*

Nursing homes may be owned and run by small or large businesses or by charitable agencies. All are licensed by the Ontario Ministry of Health. Nursing homes are for people who do not need hospital care and whose nursing needs cannot be met by relatives, friends or other caregivers at home. Most people in nursing homes receive extended care as offered through the Ministry of Health's Extended Care Program. It offers care for those who need at least 90 minutes of nursing and personal care each day.

There have been instances of nursing homes being operated by business people who used them as a vehicle to make money and failed to give a high-quality service. It is critically important for

seniors' advocacy groups to maintain a close watch on what goes on in these facilities since the population in them is often too frail and their families too frightened to advocate on their behalf. Unfortunately some of the worst offences are committed when the residents are poor. This raises the question as to the appropriateness of having private enterprise involved in this type of service. When the burden of care is heavy and financial resources limited there are relatively few choices for those in search of nursing-home service.

Rest and retirement homes provide accommodation and services for seniors. Most are run by private groups. Some are small, supervised homes. Others are large luxury buildings that offer many recreational and personal-care services. Costs can cover meals, housekeeping, supervision and personal care. Residents generally pay the full cost of living in rest and retirement homes. These facilities are not covered by provincial regulations or guidelines. They are, however, subject to public health standards for fire and building safety. They serve two income groups – very-low-income and very-high-income seniors. The government has in the past provided funding to developers - non-profit and for-profit - on a per bed basis to provide residential care for low-income seniors. The provision of housing with some services has been profitable for private-sector developers but usually only when they are able to target higher-income senior citizens. A combination of higher land costs, building costs and the costs of providing on-site amenities to an ageing population contributes to the higher individual unit costs for these developments.

The Placement Coordination Service (PCS) started in 1979 and is funded by the Ministry of Health. PCS provides information about long-term care options and assists people who need long-term care find a place that meets their needs. Most applications for nursing homes or homes for the aged are referred to this agency. PCS screens the applications and makes recommendations as to the most, appropriate placement of the applicant. The recommendations are based on the level of care needed, the urgency of the placement and the preferred location of the client. Some latitude is given to people who have a religious, language or cultural reason for preferring a specific setting.

Civic affairs

In 1981 the City of Ottawa formed a Disabled Citizens Advisory Committee (DCAC) in response to the International Year of Disabled Persons. The Committee's mandate "to recommend the development of policies to City Council and to monitor their implementation."[23] It was also given responsibility for communicating the concerns of disabled citizens to City Council and coordinating the dissemination of information to the disabled community and the public at large concerning City Council decisions regarding issues having an impact on citizens who are disabled. The Committee was specifically instructed to: examine the City's employment system in order to identify barriers for persons with disabilities and make recommendations for changes to the system which ensure that such persons have equal access to employment opportunities at the City; to recommend methods for keeping elected representatives, staff and citizens of Ottawa aware of the requirements of disabled persons and of existing programmes; monitor the disbursement of funds approved by City Council for employment-related accommodations designed to facilitate the hiring, promotion and career development of disabled persons; monitor development and implementation of bye-laws and regulations which have an impact on disabled persons; monitor services to disabled persons; examine the City's Accessibility Housing Program; and, recommend formats to ensure information is accessible for the print- and hearing-disabled citizens. Comprised of 13 citizens, at least 50 per cent of whom are chosen from a variety of disability groups, one city councilor, the Committee is assigned a member of staff who attends each meeting and acts as a resource.[24]

The Disabled Citizens Advisory Committee has been active for more than 10 years and has played a pivotal role in the improvement of the City's capacity to serve citizens who are disabled.

The impact of the DCAC is immediately evident in the City Hall which has a number of access features and innovations. Access to the building is facilitated for individuals in wheelchairs by automated doors and wheelchair-accessible washrooms and. public areas. A mechanized ramp is

[23] City of Ottawa *Department of the City Clerk Procedures Manual* (1992)
[24] Ibid.

available for accessing raised areas of Council chambers and an infra-red loop system is installed for hearing-impaired individuals. A portable loop system is available for meetings outside of the Council chambers. Telephone devices for the deaf (TDDs) are located at the general information area as well as in departments providing service to the public.

Activities of non governmental and/or community-based organizations

Non-governmental or community-based organizations makeup a sector referred to as the volunteer sector within this document and these play a primary role in the delivery of social services in the City of Ottawa as has been illustrated in the paragraphs on social services. In addition to these direct services, another layer of service is provided by agencies such as the Social Planning Council of Ottawa-Carleton, the Council on ageing, the Canadian Mental Health Association, Disabled Persons Community Resources and others. These organizations provide the indirect services which support the service-delivery system such as planning, service coordination, advocacy (individual and systemic), provision of information, and referral.

The Social Planning Council of Ottawa-Carleton is a private, non-profit organization directed by a voluntary board of 33 directors, elected from a membership of individuals and agencies who share its mission and values. The Council receives the greater portion of its funding from the United Way of Ottawa-Carleton and the Regional Municipality of Ottawa-Carleton while some funding is also provided by the Province of Ontario and private foundations for specific activities.

The Social Planning Council plays a coordinating role in the development of social services, conducts research into questions relevant to social needs and social services, and informs its membership and the public at large of issues affecting social well-being, advocates' improvements in the quality of social services and public policy which contributes to the quality of life in our communities.

Close ties with the community and on-going grass-roots involvement in Council activities, ate the strengths of the Social Planning Council. An integral component of the Council which ensures this connection and subsequently validates the work of the Council are Forums.

Forums are groups of volunteers, chaired by a board member of the Council, who share a common area of interest. A modest level of staff support is provided to Forums, for their on-going work. Forums are encouraged to develop specific action projects, for which additional staff time can be allocated following Board approval. Most of these action projects take the form of SPC task forces. At present, the Council maintains the following forums: the Housing Forum, Income and Employment Forum, Social Assistance Reform Forum, French Language Services Forum, Special Needs Forum and the Forum on Ethnic and Visible Minorities.

The Council on Aging of Ottawa-Carleton is a multi-purpose organization that coordinates the planning and development of services for seniors. The Council works to improve the quality of life of the elderly population by focusing on health, home-support services, income, housing, education, transport, recreation and French-language services. Over the years, different Council advisory committees have initiated and conducted research projects that have identified gaps in services for the elderly clients. The Council, through its programme development activities, has worked to ensure that services are developed or enhanced to cover these gaps.

The Council employs a number of full- and part-time staff and involves 330 volunteers who give almost 5000 hours of service. Seniors work closely with professionals who serve seniors in a truly unique partnership Funding comes from local and regional government as well as the United Way and programme service fees.

The Ottawa-Carleton Branch of the Canadian Mental Health Association (CMHA) plays a major role in the planning and development of a service network for individuals who are psychiatrically disabled. Managed by a community board, CMHA strives to include consumers in all of its decision-making processes and carries out its work thorough volunteer committees and task forces.

Disabled Persons Community Resources (DPCR) serves a similar purpose concentrating its efforts on planning services for persons who are physically disabled. As with the other planning bodies, DPCR involves consumers in the management of the agency as well as in its everyday activities.

V. CONCLUSIONS

General

Relatively speaking, the City of Ottawa is a progressive community demonstrating a real effort to serve all of its citizens equally well. An impressive array of services exists in the City which enables people who are frail or disabled to enjoy a quality of life which approaches that of the able-bodied population. There is a concerted effort evident to provide the supports necessary for citizens who require them to live independently in the City. Housing is developed to meet specific needs and the personal-support programmes and services are made available through a partnership between the government and a vibrant voluntary sector of community agencies. Employment-related services and support assist employment-disadvantaged citizens to enter the labour market. Accommodations to people who experience difficulty with public transport are increasingly evident and the City is gradually becoming more accessible to people in wheelchairs and people with visual or hearing impairments. It is no longer uncommon to see individuals who use wheelchairs or who have seeing-eye dogs on the sidewalks, in shopping malls and theatres, and in the workplace.

A close look at the support network in the City of Ottawa reveals a number of critical factors which together contribute to the relative strength of the network. Based on the Ottawa experience, a number of general recommendations are put forth to other municipalities who may be striving to meet the needs of their disabled and elderly population through an urban planning process.

The foundation upon which the Ottawa support network is built is the funding contribution by both the federal and provincial governments. What has become clear to planners of local programmes is that in order for support programmes to become successful in meeting the needs of their target groups, shared funding responsibility between different levels of government must be accepted as fundamental. Municipal governments typically do not have the resources to fund programmes on their own. Thus a real commitment by funding partners to provide adequate financing to essential support programmes is critical to their long-term success.

1.	It is recommended that: funding be shared among different levels of government.

The support network owes the greater portion of its strength to the dedication of the many volunteers and staff in community-based organizations. Ottawa has a phenomenal voluntary sector which is able to stretch the funding it receives over an impressive list of services. Hundreds of hours of voluntary time are put into the identification of community needs and the development of services to meet those needs. Staff in agencies work long hours at salary levels significantly less than they would earn in the public or private sectors. Unfortunately, the onus remains on the voluntary sector to provide for people in need.

A high level of coordination and cooperation among the actors in the delivery of social services is a significant factor contributing to their relative success in the Ottawa area. On a variety of levels - between and among levels of government, public and voluntary sectors, social and health sectors - planners, policy-makers, funders and service deliverers formally and informally meet on a regular basis to compare notes and collaborate. In the past three years a project designed to establish a process which would formally incorporate the coordinated planning of social and health services has been underway. The Ottawa-Carleton Social Services Planning Project perhaps best illustrates the character of this particular region and the determination to serve its citizens better. The very fact that all of the major funders and planners are willing to work together and establish formal links is evidence of their level of commitment. Entering into a demonstration phase in the New Year, the project will begin to implement local planners, service deliverers model built upon principles identified by the community. Among these principles is a commitment to involve in a meaningful fashion all the stakeholders including funders, planners, service deliverers and consumers of services. The proposed model will establish an on-going consultation process with the community and will take a global approach to community needs by facilitating inter-sectoral consultations, that is, consultations between and among representatives from different age groups such as children, adults and seniors.

2.	It is recommended that: local planners form inter-departmental and inter-sectorial partnerships from the outset.

The problems of a wide variety of citizens requires the recognition that concerns must be addressed according to the needs of specific groups such as elderly or, disabled persons, children and others with specific health and social-support difficulties. Through the active involvement of the ultimate users of services and the front-line workers (including volunteers) who provide services in the planning process, the chances of maximizing the effectiveness of the programmes will be enhanced.

3.	It is recommended that the ultimate users of the service and front-line providers of the service be included in the planning process.

To avoid discouragement and "burn out" by those who become involved in the planning of programmes, it is useful to develop a sound philosophical approach to planning that accepts the notion that there will always be- room for improvement. The existence of a political will on the part of government, combined with willingness on the part of local planners to constantly analyze and reorder ways in which problems can be addressed, leads to innovation and creative thinking.

4.	It is recommended that: a sound philosophical approach to planning be adopted based on the premise that there is always room for improvement

.Service-specific recommendations

In addition to the general recommendations related to urban planning, a number of service specific recommendations are made. These recommendations are related to the provision of transport services, housing and neighbourhood design, social and health services, income support and civic affairs.

(a) Transport

The importance of an accessible means of transport for the elderly and disabled persons cannot be underestimated. Public transport should be accessible to people in wheelchairs and those who have mobility problems for physical and/or psychological reasons.

The wider a group that can be served, the better is the chance for economic viability. This approach allows for coalitions of groups who are concerned with the problem of accessible transport from slightly different perspectives: those who are interested in traveling safely on buses at night and want extra stops by the driver to bring them closer to their destination; those who require wheelchair access to public buses; those who need a bus designed with a lower step to allow easier access etc.

5.	It is therefore recommended that: a coalition of consumers, service providers and funders be formed to work on the planning and implementation of public transport services.

(b) Housing and neighbourhood design

Housing takes on a high priority in Canada as a fundamental need in order to survive. Aside from providing shelter however, housing also is a major factor contributing to the general quality of life enjoyed by individuals and families. The trend away from institutionalizing individuals who are disabled and/or elderly has had a marked influence on the design of housing and neighbourhoods which now must serve everyone regardless of physical ability. Planners are aware that older people are happiest if they can perpetuate a lifestyle to which they are accustomed and are

beginning to realize that it is possible to design housing that will be appropriate for any age group and at the same time address design issues that make it possible for elderly and disabled people to live in a barrier-free and integrated environment.

6.	For communities that are in the early stages of developing their housing, it is recommended that: universal design principles be incorporated in the development of all new housing options to ensure a barrier-free existence for all citizens.

Neighbourhood design should acknowledge that in cities of all sizes - particularly in large cities - people spend the larger part of their lives in their neighbourhood. In addition to physical design considerations therefore, social planning is also critical. The provision of housing for a mix of income and age groups as well as the integration of persons with disabilities are important social planning principles that can help cities from under-developed and developing countries avoid the current social disintegration faced by some of the largest urban centres in developed countries such as the United States.

7.	It is therefore recommended that: neighbourhoods be planned to create mixed communities with a maximum opportunity for sharing recreation time in safe and pleasant places.

(c) Social and health services

The trend today in North American cities, driven by a redirection of government policy at higher levels of government, is to integrate health and social services in such a way as to recognize the importance of health promotion as an integral part of the health-care delivery system. Ottawa-Carleton is a leader in this area and is actively involved in programmes (such as Food for One is Fun) designed to educate older consumers to take control of their own well-being.

8.	It is therefore recommended that: emphasis be given to the creation of programs and services that help older people and those with disabilities maximize their own health through on-going health related education

(d) Income support replacement

Income support/replacement is the responsibility of the provinces in partnership with the Federal Government. Weaknesses are evident in the system, particularly as it serves persons who are disabled: however improvements require legislative change at the provincial level, which is beyond the purview of municipalities. Essentially though, these weaknesses are due to the fact that the system is designed to serve people who are temporarily unemployed as the result of illness or lack of training. Longer-teen assistance is available for those deemed to be unemployable and this is generally the route that an individual who is disabled must take in order to receive on-going assistance. Unfortunately many such individuals are forced to choose between acceptance of the unemployable label in order to have costs associated with their disability covered by the State or living in poverty as a result of having to pay these costs out of their own pocket. The fact is that a person who is disabled must make substantially more money than an able-bodied individual in order to maintain an equal standard of living.

9.	In order to provide equity to individuals who are disabled it is recommended that: a Disability Benefit to cover the costs resulting from a disability be created separate and distinct from the social assistance system

This benefit would cover the costs of special-needs items required by persons who are disabled regardless of their employment status. This measure would also provide greater parity between

individuals with a work history who are the recipients of an income-replacement pension and individuals who have never worked and therefore are dependent on social assistance.

(e) Civic affairs

The City of Ottawa has recognized its responsibility to address the special needs of citizens who are disabled by creating an advisory committee; however, advisory committees generally have less power to affect change than standing committees which are directly accountable to the City Council.

10.	It is recommended that: municipalities create standing committees of council members which are mandated to review and evaluate the performance of the corporation as it serves more vulnerable or marginalized citizens.

Rather than creating several committees each responsible for a particular group of citizens such as the Disabled Citizens Advisory Committee, we recommend the creation of one committee responsible for all special needs. Advisory committees to this standing committee could be established which address the specific needs of a particular group

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Summary

Coordinated community needs assessment and service development is critical to the development of a global plan in which services are integrated and a minimum of duplication occurs. Adequate funding tied to a local decision-making process for funding allocation and a strong commitment on the part of the community-at-large complete the list of requirements for the development of an effective social-service delivery system. The City of Ottawa has made an admirable effort to meet these criteria, as is demonstrated by the strong social-support network currently in place.

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PART TWO

CITY OF MADRAS: A CASE STUDY*

*'This case study has been prepared at the request of the United Nations Centre for Human Settlements (Habitat). The views expressed are those of the authors.

A study conducted for UNCHS (Habitat) by V. Swarup

PREFACE

With the improvements in the delivery of health services during the previous three decades in India the average life expectancy had risen to 57 years in 1981. Consequently, the age structure in the country has changed and the number of aged persons aged 60 and over has increased substantially and will increase further. A major portion of the welfare budget of the Government of Tamil Nadu is targeted for mothers and children and socially- and economically-disadvantaged groups. Excepting old age pensions, introduced in Tamil Nadu in 1962, no serious concern has been shown for the increasing number of old persons.

The net increase in population in Madras city between 1961 and 1991 was about 220 per cent and aged persons as a percentage of the population increased from 4.3 per cent to a little more than 6 per cent in the same period.

Care of aged persons has traditionally been in the voluntary sector. For want of resources the services for aged persons have not increased corresponding to their-increase in the population, though new concepts such as day centres are promoted. The aged poor in the city are the most hit - shelter, food, health care and leisure time activities become a problem. In this context, any attempt to improve the living conditions of aged persons requires a comprehensive understanding of the problems that aged people face.

Disabled/handicapped persons constitute 2 per cent of the total population. The definition for disability ranges from mild impairments, such as hard of hearing to more serious ones, such as the loss of limbs, covering a wide spectrum. Society has recognized its responsibility for the care of disabled persons and the need for their rehabilitation. The Government of India has extended a number of concessions to the disabled population and provides liberal financial assistance to voluntary agencies for the care of disabled persons. The effectiveness of these efforts and the accessibility of rehabilitation services to the urban poor are, however, not adequate.

Madras city is a major metropolitan city with good infrastructure. Voluntary agencies are active and are willing to experiment and to improve. The general response from the individuals, officials and agencies in the city to the problems of aged and disabled people is positive. Promoting interaction between various groups should lead to a spurt in programmes especially for aged residents in the city. This is the need of the hour.

V. Swarup

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V. Swarup

Note: At current exchange rates (March 1993), $US 1 =Rs 30.

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भारत
INDIA
बड़ों के प्रति आदर और स्नेह
LOVE AND CARE FOR ELDERS
1988

I. AN OVERVIEW OF MADRAS CITY

Background

Urbanization has always been an important aspect in economic development. The experience of most countries has indicated that the urbanization process is a reflection of the mature and speed of economic development. It is the shift in employment from predominantly agricultural to non-agricultural activities which sets in motion the urbanization process. By international comparison, the level of urbanization reached in India is low. However, in absolute terms, the size of the urban population in India is huge and the annual increment is also so large that planning for the livelihood, income, occupation, shelter, health and other essential public services for urban residents proves to be a stupendous task.

The rate of urbanization among the various states in the country has mot been even. Maharashtra is the most urbanized state in India, followed by Tamil Nadu, constituting 35 per cent and 33 per cent respectively of total population, as per 1991 census.

Madras Metropolitan Area (MMA)

Madras is the capital city of Tamil Nadu and a cents; of important administrative, commercial and industrial establishments, in the southern part of the country.

MMA area

Madras City occupies 172 sq km after a change in boundaries in 1976. The Madras Metropolitan Area (MMA) is comprised of the city and Madras Urban Agglomeration. The population of the city was 3,280,000 in 1981 and 3,795,000 in 1991.

The growth rate of the urban population in India and Tamil Nadu was found to be faster than the total population. Between 1961 and 1981, the urban population in the country increased by 3.58 per cent annually against the growth rate of 2.24 per cent of the total population. The corresponding figures for Tamil Nadu are 2.90 per cent and 1.82 per cent. Within MMA, it is the urban agglomeration excluding the city proper, which registered the highest growth rate of 5 per cent.

The figures indicate that the population of Madras City tended to increase at a faster rate, i.e., 3.25 per cent than the overall growth rate for the urban population in the state, i.e., 2.90 per cent, confirming the all-India phenomenon of bigger cities growing faster than smaller towns.
The growth of population in Madras Metropolitan Area is given in Table I.

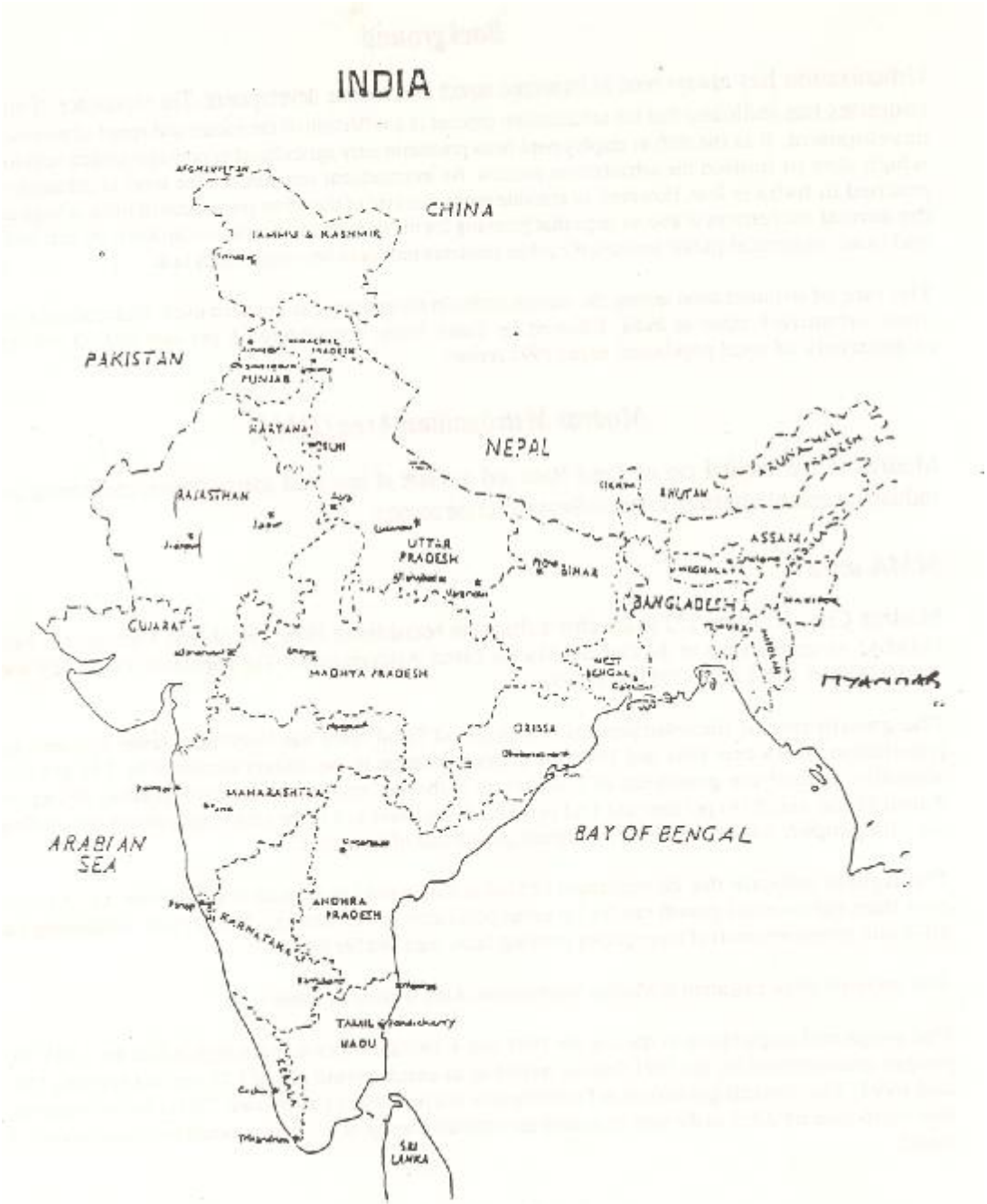
The projected population of the city for 1991 was 4,340,000 which is much higher than the 3,795,000 people enumerated by the 1991 Census, recording an annual growth rate of 1.58 per cent between 1981 and 1991. The overall growth rate in Tamil Nadu for this period was 1.49 percent. This is due to a relatively low birth rate of 23.5 in the state as against the national average of 31.2. This should be seen as a positive trend.

Demographic Features

Age composition of population in Madras City

The age structure of a given population has its influence on the pattern of demand for various goods and services. Changes in particular age groups can create pressure on school facilities, employment opportunities and for housing, among others.

Figure 1. Political map of India



The boundaries shown on this map do not imply official endorsement or acceptance by the United Nations.

Figure 2. Madras Metropolitan Area

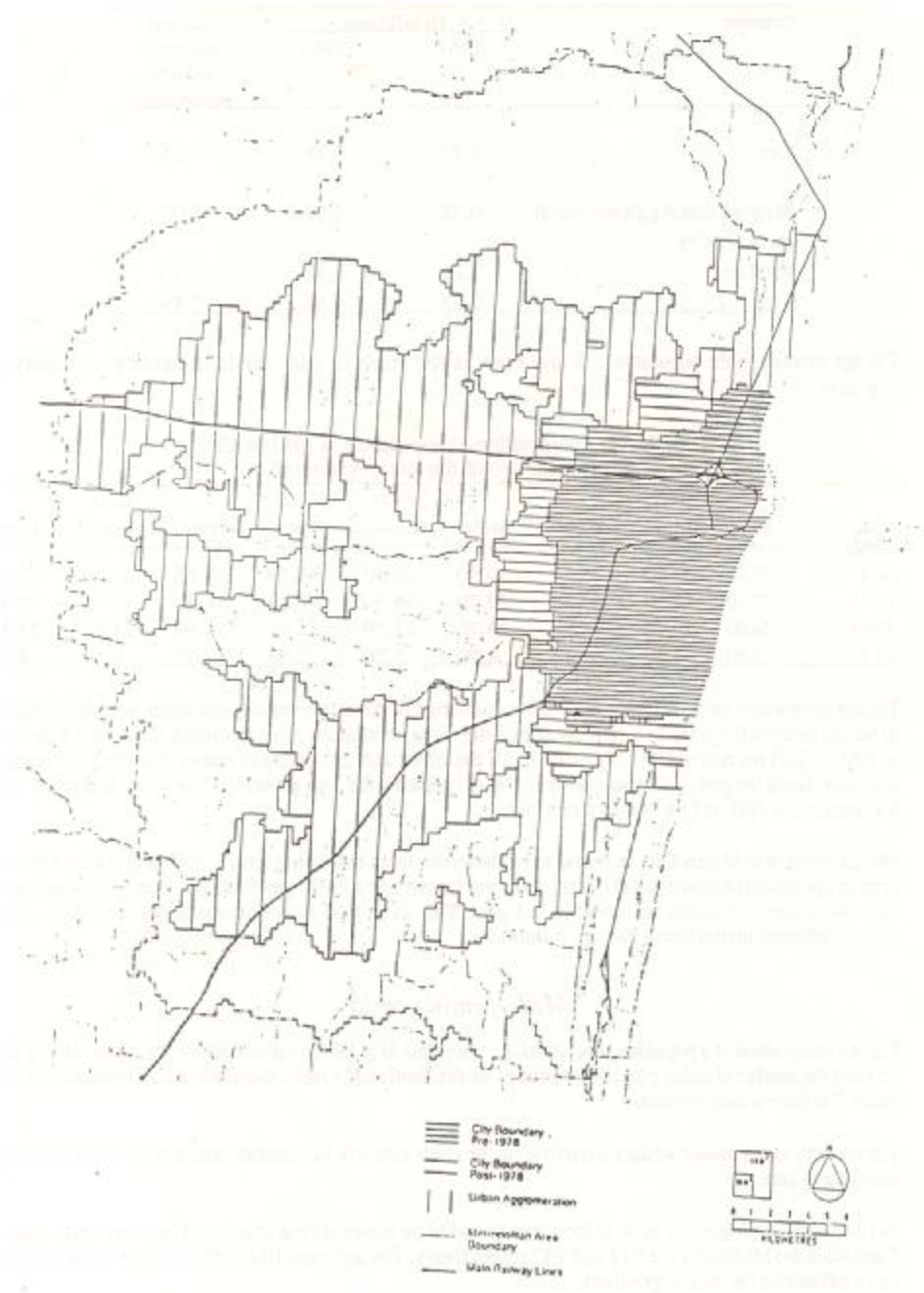


Table 1. Population Growth in MMA

Segment	In millions		Annual average growth (percentage)
	1961	1981	
City	1.73	3.28	3.25
Madras Urban Agglomeration excluding City	0.38	1.01	5.00
Rural area	0.22	0.34	2.20
Total	2.33	4.63	3.49

The age structure of the population, at any time, is the result of past trends in natality, mortality and migration.

Table 2. Age composition of population in Madras City
(percentages within the total population)

Age Group	1961			1971			1981		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-14	35.00	37.50	36.23	33.90	36.40	34.70	32.56	33.30,	32.75
15-34	37.10	38.10	37.58	37.70	36.90	37.50	38.00	38.70	38.36
35-59	24.00	20.10	22.08	23.70.	21.20	22.40	24.40	21.90	23.15
60+	3.90	4.30	4.11	4.70	5.50	5.40	5.04	6.10	5.74

The age composition has undergone a significant change in the city over the last three decades. Children in the age group of 0-9 years as a percentage of the total population have declined from 36.23 per cent, in 1961 to 32.75 per cent in 198 l. Persons in all the other age groups have either declined or remained stationary during the period. Conspicuous is the increase in the age group of "60 years and over" from 4. l1 per cent, in 1961, to 5.74 per cent in 1981.

The age structure in Madras City is found to be different from the state picture, in that children below 15 years of age and old persons aged 60 years and over constitute a lower percentage. As a consequence, the dependency ratio is found to be lower in the city. The migration factor seems to have played a more decisive influence in structuring the age pyramid.

Male female ratio

Tile sex composition of a population is usually expressed as a ratio - called either the masculinity ratio, denoting the number of males per 1000 females or the femininity ratio, the number of females per 1000 males. The latter is used in India.

The sex ratio varies usually within a narrow range from country to country and within a given country from time to time.

In Tamil Nadu, the femininity ratio is low. It is found to be lower still in Madras. The femininity ratios in Tamil Nadu and Madras city are 972 and 930 respectively. The age-specific mortality rate is the important factor influencing the sex composition.

Employment situation in Madras

In 1981, the total number of main workers in Madras city was 914,000. Employment in the organized sector constituted 31.6 per cent of the total employment. In 1981, the workforce under the category of organized sector was 370,000 which rose to 402,000 in 1989 (EMIP)*. The employment share of public-sector establishments, state, central, local and government was 319,000. This is 79.35 per cent of the total employment in the organized sector. Employment in the organized private sector constituted only 20.65 per cent.

Table 3. Growth in organized-sector employment in Madras City
(in thousands)

Years	Public	Private	Total
1984	311	87	398
1985	315	87	402
1986	305	80	385
1987	311	80	391
1988	313	80	393
1989	319	83	402

Source: Director of Employment and Training

* Employment Market Information Programme

Table 4. Employment by occupational categories in Madras City

Occupational categories	Total workers (1981 census)	EMIP[a] (1981)	Unorganized sector (1981)	Unorganized (percentage)
Agriculture, forestry and Fishing	12,060 (1.3)	125 (0.03)	11,935 (2.23)	98.9
Mining and Quarrying	134 (0.01)	-	134 (0.03)	100
Manufacturing	274,215 (30.00)	52,836	221,379	80.7
Construction	51,656 (5.66)	12,703 (3.35)	38,953 (7.29)	75.4
Electricity, gas and water	7,111 (0.78)	9,214 (2.43)	-	0.0
Trade and Commerce	177,247 (19.40)	27,306 (7.19)	239,114 (26.0)	78.4
Transport, storage and communication	105,882 (11.58)	114,576 (30.19)	-	0.0
Financial Services	57,969 (6.35)	35,588 (9.38)	22,381 (4.19)	38.6
Other Services	227,839 (24.92	127,231 (33.52)	100,608 (18.81)	44.2
Total	914,113 (100.00)	379,579 (100.00	534,534 (100.00)	

Source: Madras 2011 - Policy Imperatives, an Agenda for Action
a/ Employment Market Information Programme
Figures indicated in the brackets are percentages column-wise

In 1984 398,00 persons were employed in the organized sector, 311,000 were in the public sector and 87,000 in the private sector and the situation remained more or less the same in 1989. There has been virtual stagnation of public-sector employment from 1984. The relative shares of central, state, local and quasi government employment remained unchanged at 35 per cent, 24 per cent, 5.5 per cent and 35.5 per cent during the period 1984-1988. There is no indication that labour absorption in the organized sector will take place in a substantial way in the future. Going by this trend, avenues for future employment can only be in (a) an unorganized sector within the city; and (b) the organized sector outside the city in the suburban towns.

The unorganized sector, by definition, is the residual component of total employment in the organized sector. It is characterized by low wages and lack of employment security. The estimate and size of the unorganized sector in 1981 was 535,000 which represented 58.5 percent of the workforce in Madras City. Manufacturing (41.4 percent), trade and commerce (26.0 percent) and services other than financial (18.8 per cent) accounted for 86.2 per cent of the employment in the unorganized sector.

Males constituted 87.43 per cent of the total labour force and females constituted only 12.57 per cent.

Work participation rate by age group and Sex

Work participation (including casual employment and self-employment) among people aged 60 years and over constitutes 17.28 per cent. Fully 31.85 per cent of the males aged 60 and over still continue to work, which perhaps reflects the dire need to earn their livelihood.

Table 5. Distribution of workers by age and sex in Madras City
(percentage)

Age	Male	Female	Total
0-14	1.10	2.10	1.30
15-59	95.30	94.90	95.10
60+	3.60	3.00	3.60

Source: Census 1981

Workers in the age group of 60 years and over constituted 3.60 per cent of the total workforce. Aged male workers constitute a slightly higher percentage than the female workers.

Housing

Urban housing has great economic significance. Though essentially housing is viewed as an indicator of improvement in the quality of life, its relevance has to be appreciated in a broader perspective of employment and income generation, savings and investment.

Factors like the unabated increase of the population in the MMA have changed the attitude of people towards investment in real estate as a hedge against inflation. The recent trend towards nuclearization of families and the easy availability of institutional finance for housing have together created a spurt in the demand for houses, which strains the housing supply system.

Residential housing had increased from 147,694 units in 1961 to 620,241 units in 1981 - nearly a fourfold increase. During the corresponding period the increase in residential housing in MMA was from 506,456 units to 891,214 units.

This indicates that the housing units grew faster than the increase in the number of households. As a result of the faster increase in the housing stock, the concentration ratio had steeply increased over the years and stood at 757 units per sq km in the MMA in 1981. But the intensity of congestion is more in the city proper for which the corresponding figure is 3648 units per sq km.

As of today, the ratio could be roughly reckoned at more than 5 000 units per sq km, taking into account the current tempo of house building activities in the city.

Contributions to the housing sector are made by different agencies like Tamil Nadu Housing Board, Tamil Nadu Slum Clearance Board, and the private sector and individuals. It is estimated that the annual addition to the housing stock between 1981 and 1991, including the formal-sector housing, was around 27,531 units. The share of the private sector in meeting the housing demand is constantly increasing.

Quality of Housing

Housing problems should be considered from qualitative as well as quantitative angles. The rate of increase in housing stock is important by itself. However, equally important is the quality of housing, especially with reference to basic amenities like water supply, sewerage, electricity, roads, hygienic environment etc.

Nearly 46 per cent of the households were accommodated in housing stock found to be single-room houses in 1981; 22.5 per cent had only mud flooring and 23.4 per cent of the houses had walls built with materials like grass, leaves, reeds, bamboos and mud. The roofing materials used in about 29 per cent of the houses were grass, leaves, reeds, wood, mud and unburnt bricks (Census 1981).

The quality of housing when analyzed with reference to basic facilities like toilet, drinking water and electricity is very unsatisfactory. About 35 percent of the households did not have electricity connections and 30 per cent of the households did not have toilet facilities. Only 61 per cent of the households had either a well or tap or hand pumps/tubewell within their premises (Census 1981).

Disabled and aged population in the City

The percentage of aged persons, 60 years and over, in India, rose from 5 per cent in 1931 to 6.49 per cent in 1981. In absolute terms, from 12 million in 1901 the aged population increased to 43 million in 1981 and in 1991 this is expected to increase to about 61 million (Geriatric India, 1990).

The age of entry into the geriatric group is undefined. For practical purposes in India it is defined as the age of retirement. Since the age of retirement in India varies from 55 years to 60 years, persons who are 60 years and above are classified as belonging to the geriatric group in medical parlance and for academic purposes.

In Madras, persons aged 60 years and over constituted 5.74 per cent of the total population in 1981 and were estimated to be around 6 percent in 1991. In absolute terms this amounts to a total number of 190,000 in 1981 and 225,000 in 1991.

The World Health Organization (WHO) has estimated that one in 10 of the world's population has some form of disability from the mildest impairment, such as being hard of hearing to the most severe forms, such as the loss of limbs, requiring a high degree of assistance.

The National Sample Survey (NSS) conducted a comprehensive survey on disabled persons in 1981, the International Year of the Disabled Person (IYDP). This survey covered three types of disabilities; visual disabilities, communication disabilities and locomotor disabilities. Mental disability was specifically excluded from the survey. In respect of communication disability, children in the age group of 0 - 4 years were also excluded. The survey arrived at an estimate of 12 million persons having at least some disability, which constituted about 1.8 percent of the total population of 680 million (1981 Census).

Accurate details of the population with disabilities for Madras City are not available. The Directorate for the Welfare of Handicapped, Government of Tamil Nadu (separated from the Directorate of Social Welfare in September 1992), has estimated that approximately 2 per cent of the total population is disabled, mainly based on the NSS surveys 1981. Major categories of disability include visual (blind); hearing (deaf); locomotor (orthopaedically handicapped); mental retardation and multiple disabilities.

II. SOCIO-ECONOMIC CONDITIONS OF ELDERLY PEOPLE IN MADRAS

The family is a prime determinant of the integration of aged persons in the community. The family structure, nature of interpersonal relationships amongst members, patterns of mutual help, money and other related structural and functional features of this established social system throws light on the life situation of aged people. Analysis of the family situation is essential to understand the nature and extent of services received by the aged person, to assess the gaps in services and to determine supplementary community services needed for their well being.

Marital status of elderly persons

Table 6. Marital status of elderly persons in Madras City
(percentage)

Marital Status Men	Men	Women	Total
Never married	2	1	
Married	71	13	39
Widowed	25	85	59
Divorced or separated	2	1	

Source: Old People in Madras

It can be seen from table 6 that a high percentage of women are widowed. This is mainly because of the high age disparity between husband and wife, which is normal all over the country.

Living arrangements of elderly persons in Madras

Table 7. Living arrangements of elderly persons in Madras City

Living arrangements	Men	Women	Total
Living alone	2	3	3
Living with spouse only	10	1	5
Living with children	76	74	75
Living with relatives	11	20	16
Living with non-relatives	1	2	1

Source: Old People in Madras

Among all aged persons, 25 percent of the men and 7 percent of the women live with unmarried children, while 51 per cent of the men and 67 per cent of the women live with married children. Also, l 1 per cent of the men and 20 per cent of the women live with relatives, including siblings and grandchildren. The number of old persons living separately from their children is growing. Only 5 per cent favoured institutionalization, and 25 percent preferred to live separately with their spouses.

Though some old persons prefer to live separately, they like to live within walking distance of their children. Staying close not only helps them to visit their children often, but also builds their relationship with their grandchildren. It is not unusual for grandchildren to accompany the aged to hospitals when the children are busy.

Figure 3. An elderly person employed as a watchman

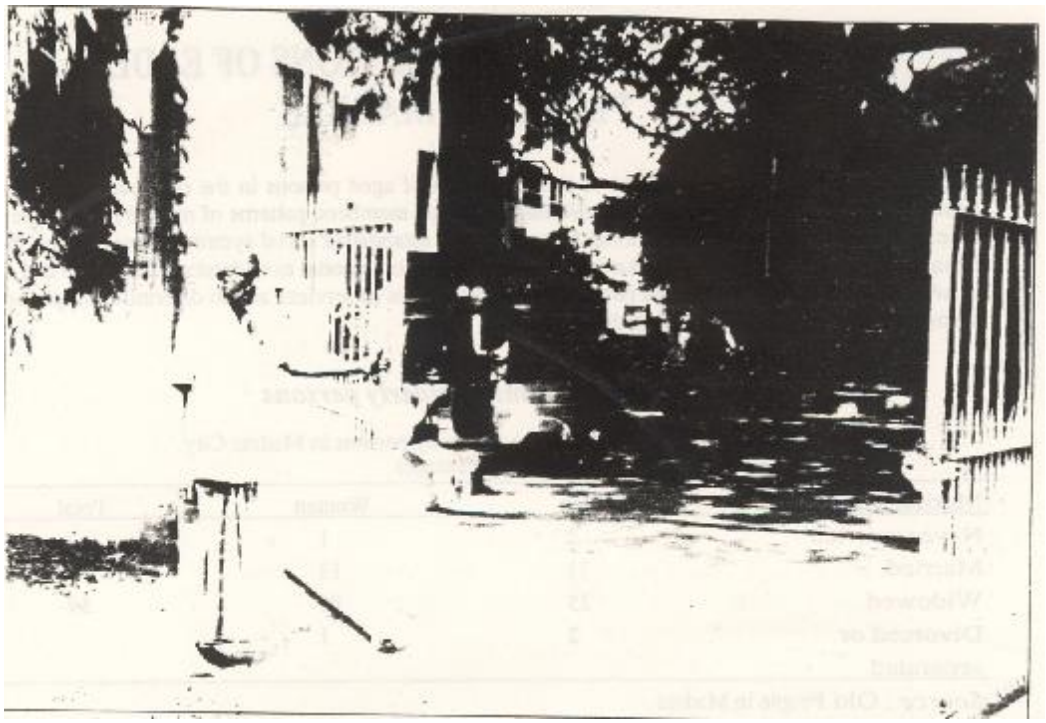
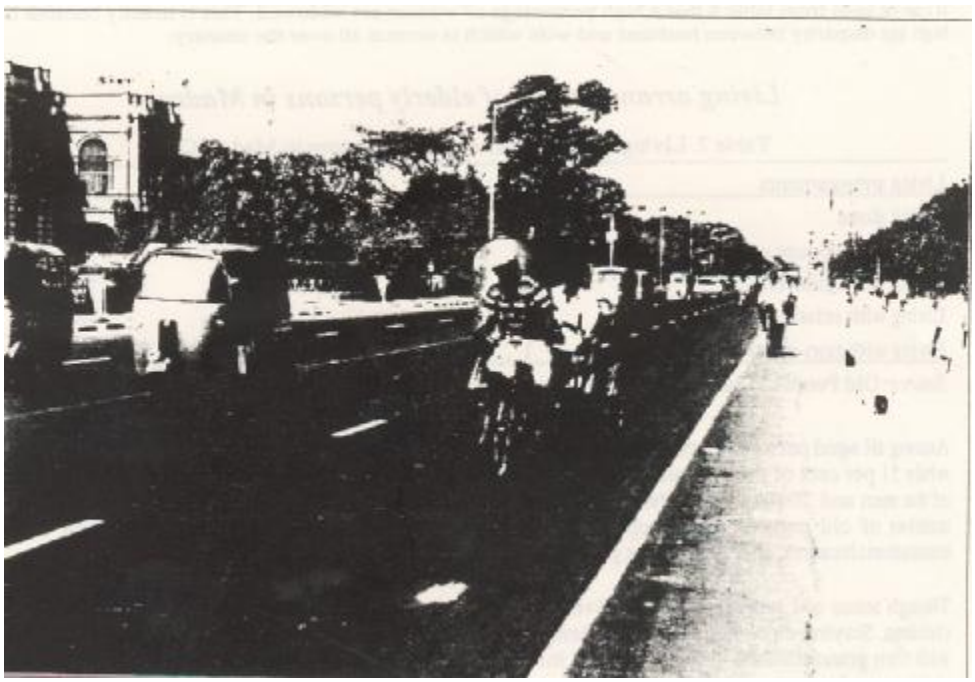


Figure 4. An elderly person peddling a cycle rickshaw



Employment and retirement among aged persons

A survey conducted in the Out Patient Department of the Geriatric Ward, Government General Hospital, indicated that 28 percent of aged persons are still found to be working. Of the 72 per cent retired, 22 per cent had the benefit of pension and 50 per cent had no source of their own income including old age pension. It is interesting to find that aged male workers from the lower economic classes prefer to work as watchmen at construction sites. It provides them a place to stay and also helps them to earn a sizable income to meet their needs. Few aged women from the lower economic classes continue to work. Those who still continue to work are housemaids or vendors. Female retirees from the organized sector who have the benefit of their pensions do not prefer not to take up employment again.

About 16 per cent of aged persons still working were looking forward to not working, while 60 per cent were not pleased with the possibility of not working at all. The major reason was the loss of income. Other reasons include the loss of respect from others and the feeling of being not useful.

The economic situation of aged persons

On retirement, government employees receive pension, gratuity and provident fund as terminal benefits The major retirement income of factory employees and employees of the organized private sector is the contributory provident fund (employer contributes 8.33 percent of the monthly income) and gratuity. But those who retire from the organized sector are a very small percentage. Even among those who are in receipt of pensions or provident funds and gratuity, only a small percentage is in occupations that provide reasonable amounts of retirement benefits. Pension payments vary from job to job. Regardless of the job held, pension payments are far less than earned income at the time of retirement.

Not only is the gap between employment income and pension very wide, but there are other losses as well. The pensioner is not entitled to current dearness allowance (cost of living allowance), house rent allowance and city compensatory allowance. Subsidized housing is provided by some establishments to its employees (central/state governments and a few big industrial establishments in the city) and after retirement. The employee loses access to such subsidized housing.

In a substantial percentage of retired households, family responsibilities such as the education and marriages of their children (in India the marriages of daughters are a major responsibility) drain away much of their retirement benefits, leaving little for their sustenance in old age.

Housing Conditions among aged persons

About 22 per cent of aged persons live in houses, which have thatched roofs while 35 per cent of the dwellings have tiled roofs, and 41 I per cent have concrete roofs. Of the homes occupied by aged people, 45 per cent (if the dwellings have only one room each. and 25 percent are two-roomed dwellings. Around 30 per cent of the dwelling units where aged persons lived have exclusive well or tap connection More than 25 per cent depend on a public tap or well.

More than 20 per cent of the dwelling units have no lavatories. They use public lavatories or open spaces. Only 35 per cent have exclusive toilets and 44 per cent share toilets with their co-tenants. (*Source: Old People in Madras)*

Geriatric health

Health care of aged people has not been given its due importance in the country. As the number of persons above the age of 60 is on tile rise, there is an increasing necessity to improve the functional independence and quality of life of the aged population.

Geriatric care, a fairly new discipline in India, is defined as a branch of general medicine concerned with the clinical, preventive, medical and social aspects of illness among elderly persons.

Diagnostic problems: Aged patients differ in many ways from the young, because of diagnostic or therapeutic problems. There are certain difficulties in making an accurate diagnosis of problems experienced by elderly persons. History: taking in the elderly presents many special features and difficulties in comparison with younger adults. Mental impairments and deafness are the main communication barriers. Presentation of illness may be obscure or misleading or florid or dramatic. These factors contribute to diagnostic and management problems.

Multiple Diseases: A striking feature of disease in elderly persons is their multiple occurrence. Aged persons commonly show evidence of several different pathological processes, some active, other inactive, but nevertheless contributing to the total disability, e.g., dementia, hypothyroidism, cancer, diabetes, cataract, depression etc., An unfortunate consequence of multiple disease is that symptoms and signs of new disease may be wrongly attributed to an old disease which is already diagnosed.

It is also not always easy to distinguish between changes, which are attributable to age and those which are attributable to disease, e.g., osteoporosis, atherosclerosis, impairment of the control of the body, temperature, maintenance of blood pressure on change of posture etc. Hence, caution is required in the critical interpretation of signs which are usually of critical importance in young patients. Among elderly patients, some changes are completely innocent and occur in the absence of a disease. Therefore, allowances must be made for these changes in the clinical examination.

Problems with investigations: It is difficult to distinguish between normal and abnormal symptoms in clinical investigations. Should the standards be the same for young and old patients or should some departure from the usual standards be accepted for the impacts of age? Many such questions are yet to be answered particularly regarding laboratory tests. For example, constipation can affect results of laboratory tests during investigations. The white cell count in older persons is lower than in younger persons. Leucocytosis in response to infection is poor and tends to fall with age.

Therapeutic problems: The purpose of treatment is usually the amelioration of disease to the point where the elderly person can return to a normal way of life in reasonable comfort. However, alternatives to drug treatment may be required, mainly due to: (a) higher incidence of side effects; (b) multiple therapy; and (c) drug interactions. Drug side-effects rise both with age and with the number of drugs prescribed. The reasons being:

(a) Active body mass tends to diminish in old age, hence it is relatively easy to "over-do".
(b) Renal function declines with age. As many drugs are excreted by the kidneys, they become toxic affecting renal functions.
(c) Body systems appear to be more vulnerable to drugs in old age. The brain shows susceptibility and drug induced confusion occurs, far more commonly in old age.

A number of studies have been conducted on health and nutrition issues affecting children. Very few studies have been initiated into the health issues of old persons. The Geriatrics Unit, Government General Hospital, Madras, assessed the nutritional aspects of health affecting old persons. The findings were not definitive, because there is little research or literature on the subject. Also the diseases of old persons are interrelated according to the study. The general complaints of elderly persons include fatigue (51.4 per cent), alteration in appetite (10 per cent), alteration in weight (20 per cent), shortness of breath (24 per cent), giddiness (24 per cent), joint pains and stiffness (26 per cent) (Natarajan). Though ailments are common and wide-spread, diagnosis and treatment has to be related to economic conditions.

Profile of the aged

Ms. Krishnaveni - she is aged 65. Her husband is 75 years old. She was married at the age of 15 and she does not have children. Her husband was a sales worker in a provision shop but he stopped working eight years ago after an operation for cataract. They do not have a house of their own or, any means of livelihood. This has forced her husband to stay with his brother-and

Krishnaveni stays with friends. TV day-care centre is l km away from her residence. She walks to the day-care centre at 9 a.m. every morning. She cooks the meal along with other elderly women in the day-care centre. After lunch, she takes a nap and goes back to her residence around 4 p.m.

Every Sunday she goes to meet her husband as he cannot travel.

She has no idea if they are eligible for an old age pension and hence she has not approached anybody.

Mr. Jayaraman - he is aged 68 years. He looks very weak and frail. He was never married as he has epilepsy. He worked as a tailor for wages. He never went to school but started working at the age of 10 and continued to work until two years ago.

He has close relatives, but they cannot afford to look after him. He stays with the son of his former employer, who has a small apartment allotted by the Slum Clearance Board. As the living space is limited, he prefers to sleep in the corridor in front of the apartment. When it rains or when it is too cold, the apartment owner calls him in. He uses their toilets and bathrooms after everybody else in the house.

His eyesight is poor and in an eye camp conducted by the Rotary Club he was given spectacles. He has no difficulty in moving around but finds it difficult to cross roads or junctions.

His place of residence is close to the day-care centre and he is at the centre around 11 am. After lunch he goes to the nearby temple to rest. His former employer helped him to get the old age pension of Rs.75.00 per month, which he uses for his morning breakfast and night meal. In addition to his old age pension he gets l kg of rice, which he gives to his relatives. On Sundays he visits his relatives when the day-care centre is closed and shares some meals with them. He has no complaints or any regrets. He is grateful to God for the shelter that has been provided.

Mr. James: he is 72 years old. He retired as an audit officer from a central government department. His wife is 70 years old and she is a retired school teacher. They have a house of their own in the heart of the city. Both have pension income.

Mr. James is relatively healthy for his age. He used to go for walks every day until two years ago. Now he is intimidated by the busy traffic and avoids going out. Mrs. James has a heart condition. Though confined to the bedroom most of the time, she is still mobile and performs her daily tasks without much difficulty. Their pastimes are to watch T.V. and to listen to radio programmes. For social occasions they are accompanied by their youngest son.

They have five children - three daughters and two sons. All their daughters are married. One daughter lives in Canada, another in Delhi and the last daughter in Hyderabad. Both the sons stay with them. The elder son is married and has a separate kitchen. The younger son, who is 35 years old, is not married yet. Mrs. James does not want him to get married. She is frightened at the prospect of her last son moving to a home of his own if he marries. He complains about emotional blackmailing by his aged mother and says that he is destined to stay unmarried though he wants to have a family of his own.

III. PROBLEMS EXPERIENCED BY ELDERLY AND DISABLED PERSONS AND CITY SYSTEMS TO ADDRESS THEM

Physical planning norms

The Madras Metropolitan Development Authority (MMDA) prepared a Master Plan for the Madras Metropolitan Area in 1975, which was approved by the Government of Tamil Nadu in 1976. The Master Plan lays down policies and programmes for the overall development of the Madras Metropolitan Area, taking a long-term view of requirements. The emphasis of the plan is on regulation of land and building use. The plan has allocated land for uses such as industries, commerce, housing, playgrounds and other types of major urban land uses in appropriate locations and to promote orderly development and smooth functioning of city systems. For this purpose all the lands have been categorized into the following use zones:

(a) Primary residential use zone;
(b) Mixed residential use zone;
(c) Commercial use zone;
(d) Light industrial use zone;
(e) General industrial use zone;
(f) Special and hazardous industrial use zone;
(g) Institutional use zone;
(h) Open-space and recreational use zone;
(i) Agricultural use zone;
(j) Non-urban use zone.

In each zone certain uses are normally permitted. Other uses may be permitted on appeal to MMDA and all other uses are strictly prohibited.

Planning permissions within the MMA regulated area are granted in accordance with the development control rules. For each of the land-use categories, the height of the building, space index, plot coverage, minimum setback and such other regulations are specified for different units of the Madras Metropolitan Area (MMA).

Layouts are assessed in isolation looking for blind compliance of individual bye-laws such as road widths, lengths etc., instead of taking an integrated or overall assessment of the layout from a functional point of view.

The hierarchy of the circulation system does not take into consideration pedestrian access ways that are important for aged and disabled persons thus resulting in a major portion of all layouts being devoted to circulation, at the cost of open spaces in the layout.

The open spaces are enforced mainly for detached type of buildings at present, but mandatory plot open-space requirements would have to undergo a major change to be more useful. Side open spaces required on both the sides of buildings on the plot are said to be negative spaces. Clustered condominiums with an aggregation of useful space for communal use can improve the residential environment and these are not normally permitted. Such space could he used for community-based services, including those for aged and disabled persons.

To make city planning dynamic and be useful to user groups, continuous interaction with different user groups is required without which citizen needs are overwhelmed by control. Such debates are normally restricted to town planners, architects and property developers.

In a recent budget speech, the Minister for Social Welfare, of the Government of Tamil Nadu, made a statement that disabled people have difficulty climbing steps and, therefore, public buildings must have special designs for easy movement by disabled persons. The matter was referred to MMDA, the planning body for Madras City and following recommendations have been made:

(a) A ramp with a slope not exceeding 1.12 from the ground level or open space or road level to the entrance door of the lift or staircase;
(b) A lift of sufficient size to accommodate the physically-disabled person with the wheelchair,
(c) A 90-cm high hand-rail and an additional one at a height of 75 cm. above the finished level of the steps for staircases and for steps to the ground-floor plinth even if they are enclosed on the sides by walls;
(d) There shall be sufficient number of special toilets provided in the building depending upon the plinth area and units, preferably locating them on the ground floor.

The Chief Urban Planner, MMDA agreed that though building control rules were not framed keeping the needs of disabled and old persons in view, a liberalized approach is required in interpreting the building rules.

Only single flight staircases leading to the first floor in residential buildings are permitted from the side open space. On representation by aged owners, double-flight staircases with landings were permitted on compassionate grounds. This is more as an exception than as a rule. When new rules are framed, the needs of disabled persons should be systematically considered.

There are not many shelter designs available in India for aged and disabled residents. Old-age homes, which have been set up recently, are residential houses converted into old-age homes (hostels). The development authority could definitely insist upon certain design requirements under the building rules.

Building control rules for the city are separate from the municipalities and village councils. It is likely that more shelter for aged and disabled persons will be built in the periphery of the city, as more land is available at cheaper cost. Amendments to regulations have to be made not only in the Municipal Corporation of Madras City Act (MCMC Act), but also the acts covering the *panchayats* and municipalities within MMA to make facilities for aged and disabled persons obligatory.

Interaction with the NGOs running old-age homes in the city has revealed that strict enforcement regulations make it difficult to run such institutions. The old-age homes are classified under the institutional category. The levy on electricity for such institutions is at commercial rates which is twice the domestic rates and so are the charges for cooking gas. Some institutions have appealed to the higher authorities for a reduction of the tariff successfully. Due to a lack of proper rules for concessions provided to the disadvantaged such as aged and disabled persons, decisions are made arbitrarily. It would be desirable to frame uniform rules for old-age homes and homes for disabled persons, including concessions at the outset.

Problems in planning for improving the living conditions of aged and disabled residents

At the city level, social planning is given limited importance. The emphasis is on major sectors like transport and shelter. Social services are considered supplementary activities w id hence planning and coordination of major urban programmes is limited to physical programmes. The structure plan for Madras City (1980) has drawn attention to the importance and development of social services. With physical planners dominating the planning scene, the social sector is given the least importance and hence, the problems of different target groups do not get the attention required.

Shelter planning has failed to include aged persons with other marginal groups like disabled persons, women and destitutes. Shelter planning in the city is limited a to single target group - the economically weaker sections living in the slum areas in the city. The slum-improvement and sites-and-services programmes under the Madras Urban Development Project initiated in 1977 include environmental upgrading, title to the plot, and loans for improving the shelter.

In addition to these elements, social inputs such as an integrated child development scheme, income generation, community health components etc. are also incorporated.

Other housing programmes for vulnerable groups promoted by the State are for the scheduled-castes* population. Very little has been achieved under this category in Madras City. However, in all the housing programmes implemented by State agencies, 12 per cent is reserved for the scheduled castes. Such reservations extend to ex-servicemen as well.

Some government departments like Railways and the Delhi Development Authority have floated housing schemes for their retired personnel. Such programmes have not been introduced in Madras so far.

The National Housing Policy, which was first released in 1989, recognized the need to promote housing programmes for specially-disadvantaged groups including physically-disabled and aged persons, who have special requirements. For such people, housing schemes will incorporate appropriate designs, formulated to meet their specialized requirements.

This policy statement should help initiate programmes for aged and disabled residents in Madras City. Because of a limited appreciation of the problems of these-special categories and because of a lack of pressure groups in the city promoting shelter options for old residents, very little has been initiated in Madras.

Roads

Arterial roads have been widened to cope with the increased volume of traffic, and in the process, platforms/sidewalks which are used by pedestrians have shrunk. In addition, in the central business district, petty vendors occupy the platforms forcing the pedestrians to spill over on to the roads.

The network of storm water drains runs under the platforms. Service points are covered by concrete slabs, which are often missing or broken. When street lights do not function, it is not uncommon for accidents to occur. This is a general problem for all pedestrians.

Another hazard on the platform/sidewalks is commercial hoardings. For better visibility hoardings are put across the platforms. Even some government departments, e.g., the Family Planning Department, display slogans on specially erected concrete posts at a height of 6 feet which impede pedestrians. These factors contribute to virtual disuse of platforms which are mainly meant for pedestrian traffic. In the residential areas, the volume of vehicular traffic is low and roads are conveniently used by pedestrians including aged persons, but the latter still face problems in high-traffic areas and at road crossings.

Though ambulatory a majority of aged persons prefer to remain indoors as they are intimidated by the traffic on the roads. Among disabled persons, the deaf, whose other faculties function normally, do not face these problems.

Transport

Public bus transport in the city is run by the state-owned Pallavan Transport Corporation (PTC). Bus transport run by PTC is supposed to be the best of all metropolitan bus services in the country. With World Bank assistance under the Madras Urban Development Project, a new fleet is added from time to time. Passenger comfort is given maximum importance. Buses also run punctually and fares are nominal. It is estimated that about 3.3 million commuters use the city bus services every day.

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*In caste-hound Indian society certain castes were treated as untouchables. These castes were socially, educationally and economically deprived. Government of India has listed them as scheduled castes and extended a variety of benefits in the form of job reservation, grant of house sites etc.

Each bus has a seat capacity of 45 persons, and 15 standees are permitted. Two seats are arranged on the either side, and standees occupy the space in the middle. Seats on the left, except the two seats in the front near the exit and the back row, are reserved for women.

Two seats near the exit in the front are reserved for physically disabled and aged passengers.

It is difficult for aged and disabled passengers to compete during the peak hour rush. Though entry into " the bus from the front exit is not generally permitted, conductors of the bus allow disabled and aged passengers to board the bus from the front and so they can occupy the seats reserved for them easily without having to squeeze through the crowd from the rear. Conductors also ensure that reserved seats are occupied by those passengers for whom they are meant. These gestures may not he enough when the boarding points are hospitals or special schools, where the number of aged and disabled passengers getting into the bus are much higher.

Free travel concession in all Pallavan Transport buses, including city and suburban services, is extended to blind, deaf, orthopaedically-disabled and mentally-retarded persons to travel to hospitals, schools, training centres, colleges and work centres and back home. Persons accompanying mentally-retarded person are also permitted to travel free. Concessions for deaf and orthopaedically-disabled persons are restricted to persons below the age of 20 years.

Free bus passes are provided by the transport authorities on the basis of medical certificates issued by medical practitioners. The certification of disability needed to be renewed every year. In order to make the procedures simple, the Government issued an order on 20 August 1991 that free travel concession should be extended on the basis of identity cards issued by the Social Welfare Department provided the holders fulfill the required conditions or eligibility criteria for free travel.

Free travel concessions are extended to only those aged persons who are disabled.

Transport authorities also run special buses for women during the peak hours. Only females and male children below the age of 12 years are permitted to travel in these special buses. No such specials are run for aged and the disabled persons at present.

Transport is a major problem for aged and disabled people that must be solved before, among other problems, such as employment can be attacked in order to integrate disabled persons successfully into society.

Officials of Pallavan Transport admitted that the reservation of two seats for aged and disabled riders is only symbolic. As the systems are designed for the majority, as one traffic planner from MMDA has put it, the requirements of minority groups such as aged and disabled persons are bound to be overlooked. With the magnitude of the problems with which the transport authorities have to deal it is difficult to focus on issues affecting a minority group.

Representatives of NGOs with whom discussions were held felt that aged people could be allowed to travel at the subsidized rates during non-peak hours. This would encourage the people to travel during non-peak hours utilizing the services better without competing with office-goers. They also have suggested that specially designed buses should be introduced to service disabled school children.

Figure 5. Platforms are for pedestrians

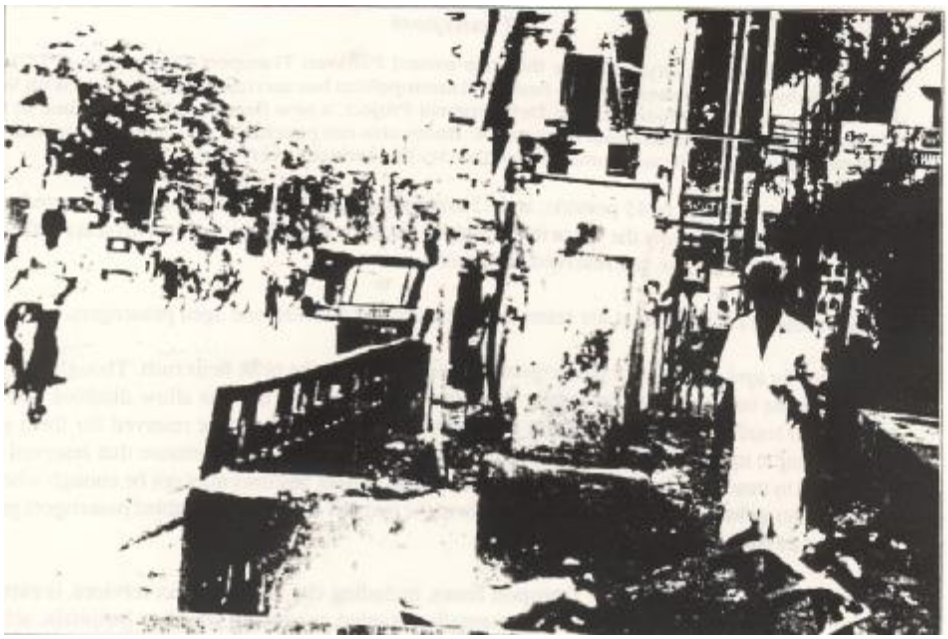


Figure 6. Encroachment on pedestrian space

Foot boards

Because the steps of the buses are fairly high the aged and disabled passengers have a great deal of difficulty in getting into them. A hand bar is provided only on the left though it is ideal to have hand bars on both sides of the steps.

The foot board level should be at the level of the footpath for easy entry into the bus, but lowering the foot board will have other sin-off effects. The city roads are narrow with a number of steep turns. When the bus takes a turn, if the foot board level is too low, it could hit the ground causing damage. Though foot board travel is discouraged, during peak hours, commuters stand on the foot boards and they are likely to get hurt if the foot board is lowered. So foot boards are designed to minimize potential casualties. An appropriate design for the level of the foot board and for easy boarding for all age groups will have to be studied.

Bus stops

One of the old-age homes situated at the outskirts of the city has a bus stop half a kilometre away. Provisions of a bus stop at the entrance of the home would be useful for the aged and disabled residents living in institutions. However, the bus stop cannot be moved close to the home, merely by representation on behalf of the residents. The number of stops on a particular route is fixed in consultation with the trade unions. The travel time to cover a particular route and the number of operations the driver has to perform while driving (i.e., reduce speed, apply the brakes for coming to a halt, restart after waiting time at the stops including signals) are taken into consideration for arriving at the number of stops during consultation with the trade unions. Any change in the specified number of stops must also be discussed with the trade unions before a decision can be taken. Trade unions cannot be excluded from any negotiation to improve the existing travel conditions for aged or disabled persons.

Railways

Senior citizens aged 65 years and over are granted 25 per cent rebate in second class or Mail/Express trains for circular journey routes and for the travel beyond 500 km. No age proof is required and self-declaration on the reservation slip is enough and the concession is automatically extended.

For visually and orthopaedically-disabled passengers a 75 per cent concession is granted for travel in first or second class on the basic fare, the same rebate is also extended to the escort/attendant as well.

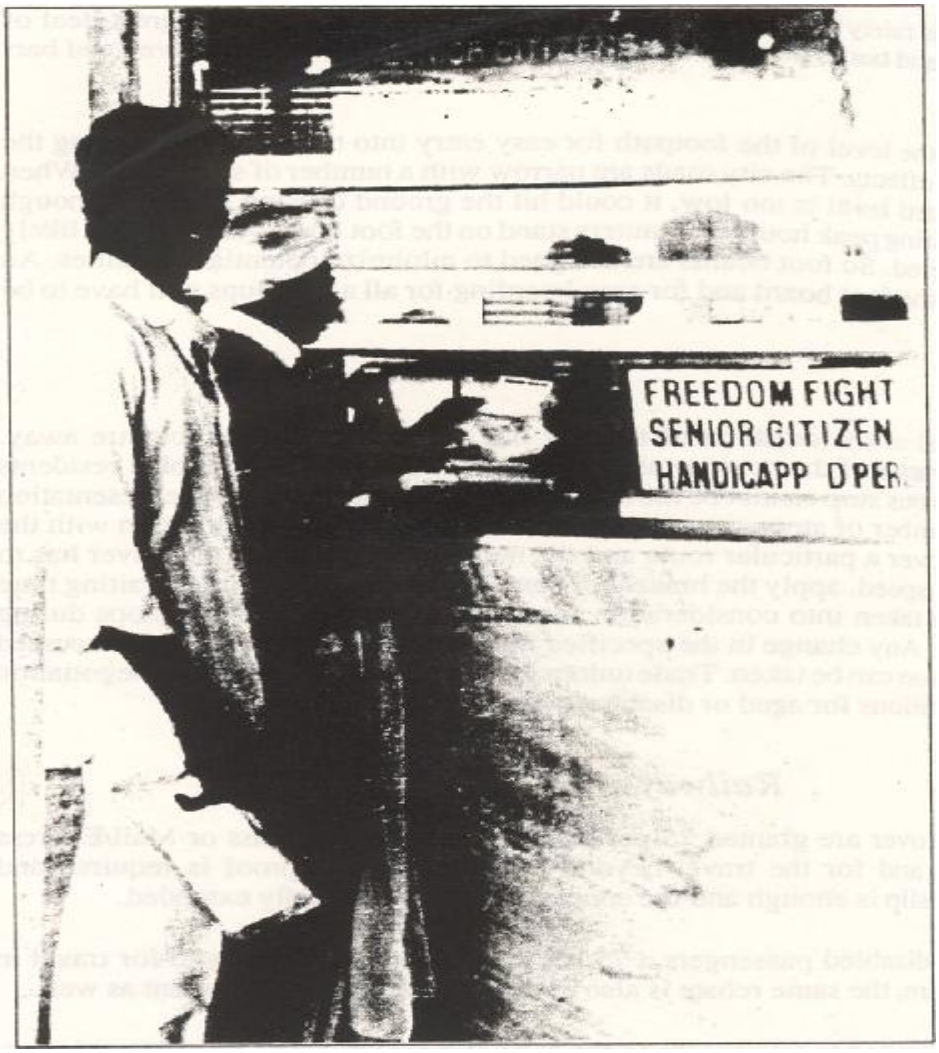
For deaf persons the concession is limited to 50 percent on the basic fare for travel in first or second class. No concession is extended to the escort.

Certificates proving disability are essential in order to obtain railway fare concessions. To obtain a fare concession, the visually-handicapped traveler is required to produce a copy of a certificate, issued by a registered medical practitioner or head of the institution for the blind recognized by the social welfare department or a government doctor, duly attested by a senior government officer, a magistrate or a Member of Parliament or Legislative Assembly. For the orthopaedically-disabled passenger, a certificate, either from a government doctor or an orthopaedic surgeon, should be produced. Only certificates issued by a government doctor are valid for mentally-retarded or deaf travelers. These medical certificates are valid for a period of three years. Collapsible and non-collapsible invalid chairs, children's' push chairs, wheel chairs, perambulators etc. are permitted to be carried in the compartment by the disabled passengers free of cost. If they cannot be accommodated in the train compartment, they are carried free of cost in the brake van (carriage in long-distance trains utilized for carrying the goods of traveling passengers).

Long-distance trains have sleeper facilities in second-class compartments. All such compartments have lower, middle and upper berths. Lower berths are at the sitting level which is used as seats in the day time. Middle berths are kept folded during the day (from 6 am. to 9 p.m.) and unfolded during the night. Utilization of the middle and upper berth requires climbing, which is a difficult task for aged and disabled travelers. Preference for the lower berth can be stated in the reservation

slip and generally senior citizens and the disabled persons are given priority in the allotment of lower berths.

Figure 7. Reservation counters for elderly travelers at Central Railway Station, Madras



Reservation for long-distance journeys can be made 30 days in advance. A multi-storeyed computerized booking office was recently built next to the Central Railway Station in Madras. Normally reservations are done on the second and third floors. A separate counter on the ground floor has been opened for the use of aged and disabled travelers as well as ex-service men.

All railway compartments (except suburban trains) have Indian model toilets in the second class and both the Western and Indian models in the first class compartment. The Indian model toilet is at the floor level and requires a squatting position which is difficult for aged passengers, even though handles are provided at the sitting level. The Western model toilet is easier for aged passengers to use as the seat -is at a higher level. Though the Western model appears to be more convenient, not many aged travelers have indicated their preference for it. They said they could manage with the Indian toilet as the duration spent in the train is normally short. Toilets in the train are a problem for disabled passengers.

Wheelchairs are available in the major stations of the city for the use of aged or disabled people. But the rules for procuring a wheelchair are tiresome. Passengers alighting at the station who require a wheelchair depend on the porters to fetch them, paying the amount demanded by porters.

At the airports help is available at points which prominently display the "May I help you" sign. In the Central Railway Station of Madras City only a police booth has been set up for assisting passengers. A prominent voluntary organization in Madras City contacted the railway authorities about setting up an exclusive booth to serve disabled travelers, but gave up the effort for lack of response from the railway authorities. It is better that the public relations departments of the railways should set up "May I Help You" counters rather than depending on police staff to handle such jobs.

Suburban railway services

Suburban train services extend to a distance of 100 km or less from Madras. There are three major rail corridors, north, south and west, and suburban train services (in the local parlance such services are referred to as locals) are operated in all the three directions.

The suburban trains have seating capacity and provision for standees. Suburban train services start early in the morning and operate until midnight. Office rush hours are considered to be peak hours lasting from 8 a.m. to 10.30 a.m. in the morning and 4 p.m. to 7 p.m. in the evening.

Separate compartments are provided for vendors who can't' their loads to the city and also for women. However, no compartments are reserved for aged or disabled passengers. Suburban trains stop for just half a minute within which boarding and alighting of passengers has to be completed. Separate reserved compartments for aged and disabled passengers are, however, not practicable. With their reduced agility the aged traveler may find it difficult to locate the reserved compartment and to board the train.

A few seats near the entry may be reserved for their use. Alternatively these services need not be provided in all trains, but, in the trains which run at certain intervals, and aged persons may be encouraged to travel only in such trains.

No specific studies have been conducted on the age pattern of the traveling public. Aged or disabled persons who travel by suburban trains may form a small minority and special facilities for a small group may not be cost-effective.

Visually- and orthopaedically-disabled persons as well as mentally-retarded and deaf persons are permitted 50 per cent fare concessions on monthly season first- and second-class tickets on suburban and non-suburban sections of railways. A combined monthly season ticket at 50 per cent concession for the visually-, or orthopaedically-disabled or mentally-retarded passenger and the escort is issued. A medical certificate is required for fare concessions as in the case of tickets for long-distance journeys.

Air

Indian Airlines offers a 50-per cent concessional fare to blind persons on a single journey or single fare for a round trip journey on all domestic flights. Application for the reduced fare should be accompanied by a certificate from a registered medical practitioner. No concessions on the fare are granted to orthopaedically-disabled persons. However, they are permitted to carry a pair of braces or any other prosthetic device, free of charge, provided the disabled persons traveling are dependent on them.

Flight attendants look after accompanied blind passengers during the flight. Public relations officers or the traffic officer in charge of the airport provides the necessary assistance to disabled travelers.

Postal services

Literature for the blind is exempted from postage and registration fees for surface, domestic and foreign mail. Plates bearing characters of writing, sound records, discs, films, tapes and wires on which spoken messages for the blind have been recorded, sent by or addressed to an officially recognized institution for the blind is treated as blind literature. The maximum permissible weight of a blind literature packet is 7.0 kg.

Customs

The Customs Department of the Government of India exempts certain goods, specified by a disabled person for his personal use, from all customs duty, on production of a disability certificate from the civil surgeon of the district medical office, or medical officer of the Directorate of Medical Services of the state or the concerned specialist of the government hospital attached to a medical college, to the effect that the applicant suffers from a particular disability and requires the import of certain goods. Different types of Braille equipment, electric aids, optical aids and environmental sensors, mathematical aids for the use of blind, orthopaedic appliances, wheelchairs for the use of orthopaedically-disabled persons, specially adapted clocks, watches etc. are exempted from import duty.

Institutions for disabled persons are exempted from duty for the import of equipment such as: (a) tangible appliances for the blind; (b) hearing aids and other audio-visual aids for the education of the deaf; (c) vocational aids for the blind and deaf; and (d) articles including machinery, apparatus, appliances etc. for the purpose of providing training to the blind and deaf.

IV. RESPONSIBILITIES OF THE MUNICIPAL CORPORATION OF MADRAS

Madras is the major metropolitan city in the southern region of India. The city is governed by a local self-government institution - Municipal Corporation. The Madras Corporation, the oldest local body in the country, was established in 1689.

The Madras Municipal Corporation has an elected council and executives. The city is divided into 150 divisions and each division is represented by a councilor. Councilors are elected through secret ballot by voters aged 18 and over. The council elects the Mayor from amongst the councilors. The term of the Mayor is one year and a person can be re-elected as the Mayor for another two years.

Madras City has no elected council at present. The city council was superceded in 1972 and, under Section 44-B of the MCMC. Act, a Special Officer has been appointed to discharge the functions of the Mayor. The Special Officer normally belongs to Indian Administrative Service (IAS)*.

The Chief Executive of the Municipal Corporation is the Commissioner who is also drawn from the Indian Administrative Service.

The organizational structure of the Municipal Corporation of Madras is shown in Figure 9.

Major responsibilities of the Madras Municipal Corporation are the upkeep of the city and public health. In order to fulfill these objectives, the Madras Municipal Corporation organizes a number of services such as public health, maternity and child welfare, family welfare, education and maintenance of the city. In addition to the primary functions listed above, the Municipal Corporation also looks after the maintenance of the roads, bridges and storm water drains etc. The Municipal Corporation maintains the stadiums, parks etc. existing in the city.

Until 1978, the Madras Municipal Corporation also looked after the water supply and sewage disposal. In 1978, a separate body, the Madras Metropolitan Water Supply and Sewerage Board (MMWSSB), was constituted and those responsibilities were transferred to this Board.

Works

The Works Department is in charge of the town-planning schemes of the Corporation, i.e., sanctioning of building applications for construction of multistoreyed buildings, sanctioning of layouts and subdivision of plots. The Department is also in charge of planning and execution of traffic improvements in the city and all other construction in general and maintenance.

Maintenance of roads and storm water drains: City roads, other than state high and national ways are maintained by the Municipal Corporation. The construction of bridges across waterways and on the road network, and storm water drains along the road network are constructed and maintained by the Municipal Corporation.

Construction of off-site drains is done by the Public Works Department of the state government and is handed over to the Municipal Corporation for maintenance.

Conservancy** (garbage collection): In order to improve the conservancy services, night conservancy has been introduced to service the main roads. In addition to conservancy in the city, the Madras Corporation also maintains the public toilets.

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* Officers of the Indian Administrative Services are at the top rung of Indian bureaucracy and are selected through the Union Public Service Commission. After undergoing mandatory training, the officers are allotted to state cadres. The Special Officer and the Commissioner of Municipal Corporation belong to the Tamil Nadu cadre of IAS.

** Conservancy refers to the cleaning of roads, collection and transfer of garbage to the dumping yards.

Figure 8. Organizational structure of the Municipal Corporation of Madras

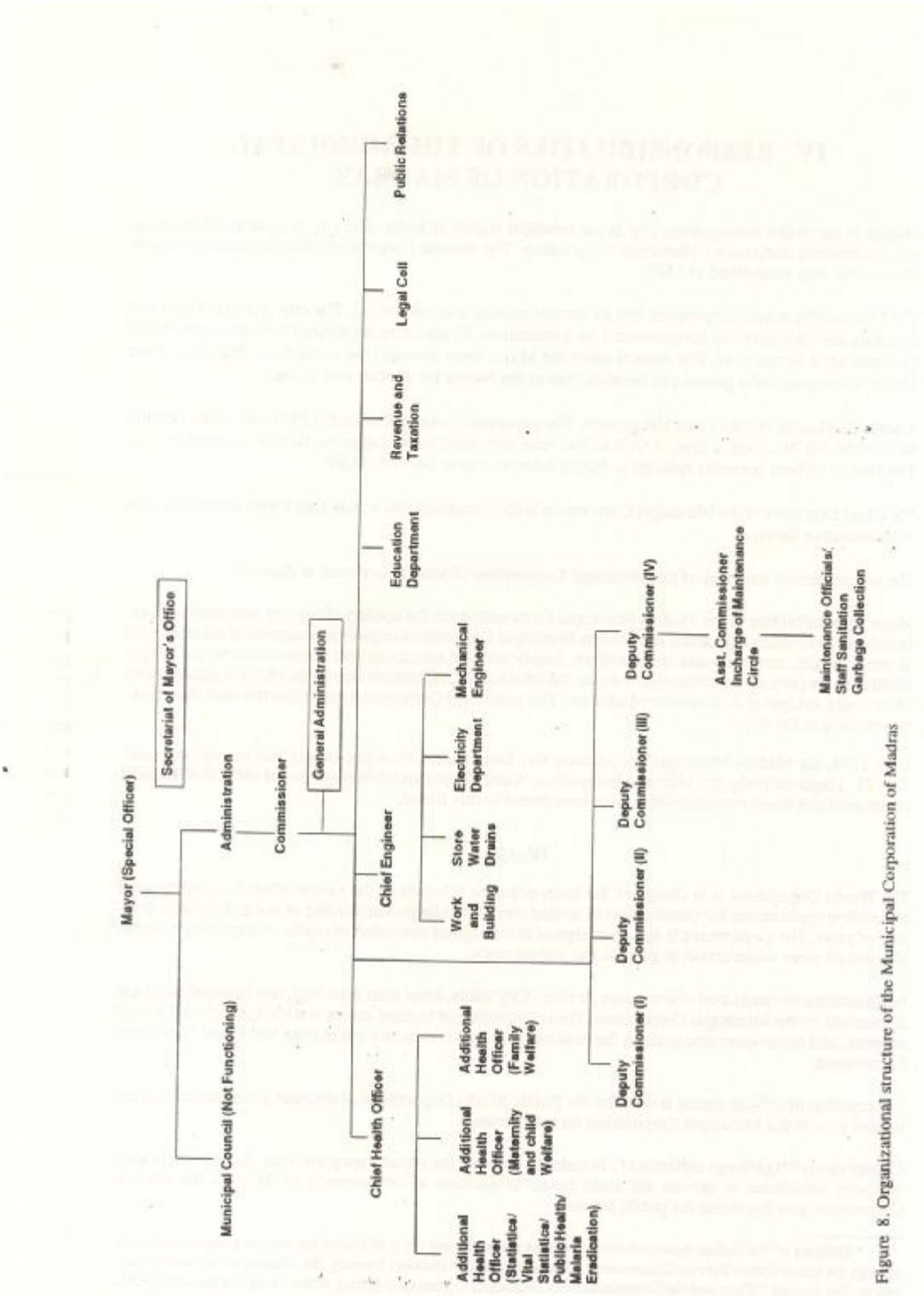

Figure 8. Organizational structure of the Municipal Corporation of Madras

Street lighting: All the street lights within the municipal limits are erected and maintained by the Municipal Corporation.

Public health

The Health Department of the Municipal Corporation of Madras is entrusted with both regulatory and service functions.

Under the regulatory function, it is involved in the control and regulation of dangerous and offensive trades licensed in the city. Those whose trades contravene the conditions of license are prosecuted under the provision of the MC Act and the Public Health Act.

Service functions include running 71 dispensaries, 44 maternity and child-health centres, 32 family welfare centres and a communicable diseases hospital.

The dispensaries and clinics are located close to slum areas and the main clientele are the urban poor. Average attendance per dispensary per day is about 100-150 out-patients. Common ailments like diarrhoea, fever, skin disease, and minor injuries are treated in these dispensaries. For specialized treatment and investigations, referrals are made to major hospitals. Maternity and child-health centres provide medical relief, immunization and counseling services to pregnant or lactating mothers of children. Immunization against polio is an important preventive step against disability.

Family Welfare Scheme - Family planning programmes were introduced in India in 1951-forpopulation control. These programmes are run through the local bodies. Exactly 49 urban family welfare centres are functioning in the city, of which 32 are managed by the Corporation of Madras, 13 by voluntary organizations and 4 are attached to government hospitals. Each centre covers about 50,000 people.

Under the Family Welfare Programme, emphasis is given to maternal and child welfare. Under the maternal and child-health activities, folic acid and folifer tablets are issued to mothers and children suffering from anaemia. Vitamin A solution is given to children to prevent night blindness and these services serve as an entry point to family welfare programmes. The centres distribute condoms, IUDs etc. and insertions are done. Sterilization cases are referred to the government hospitals and other surgical units. Family welfare schemes are promoted through group talks and mass education.

School Medical Inspector: At Corporation schools, medical examinations of the children are conducted for common ailments such as nutritional deficiencies. Eye diseases, skin diseases, worms etc., are treated. Where expert opinions are needed, they are referred to major hospitals.
Urban Malaria Scheme: At present, 16 malaria clinics are functioning under the umbrella of the Municipal Corporation. These clinics undertake the responsibilities for the eradication of malaria. Stephensi control measures are also adopted in about 56,000 cisterns; and about 43,000 overhead tanks. In addition, health education campaigns are also conducted through leaflets and by utilizing the mass media like television and radio.

Education

The Madras Corporation runs primary and middle schools, mainly to cater to the economically weaker sections of the city. Of the total of 369 schools, 225 are primary schools and 144 are middle schools. Besides the primary and middle schools the Corporation of Madras also runs 25 high schools and 10 higher secondary schools.

Revenue

The major resources of the Municipal Corporation are raised through taxes: property tax, profession tax, advertisement tax, company tax and assigned revenue from duty on transfer of property, entertainment tax, surcharge on sales tax and other miscellaneous income.

In addition, the Municipal Corporation also receives a grant/loan under head capital receipts. Total estimated income for 1992/93 is Rs. 1393 million.

Expenditure: Rs. 806 million was the expenditure for the year 1990/91 and estimated expenditure for the year 1992/93 is Rs. 1393 million. During the period 1990/91, nearly 57percent was spent on personnel, and expenditure on programmes was only 0.75 per cent of its budget. .

Administrative control

The Madras Municipal Corporation functions under the overall control of the Municipal Administration Department of the Government of Tamil Nadu. The Department is headed by the Secretary to Government supported by the secretariat department.

Being the capital city of Tamil Nadu, Madras is a nerve centre of the administrative system of the state. The secretariat of the Government and directorates of the various state departments as well as different Madras district offices are located in the city. In addition to the Municipal Corporation, other city level organizations in the city are the Madras Metropolitan Development Authority (MMDA), the Madras Metropolitan Water Supply and Sewerage Board (MMWSSB), the District Collectorate and the Commissioner of Police.

Though initially the civic body was run by the Government through elected representatives, the authority of the Madras Municipal Corporation has been consistently eroded and some of the major functions have been taken over by MMDA and MMWSSB.

The Municipal Corporation handled the planning approvals for new construction in the city. With the establishment of MMDA this control has been taken over by MMDA. Madras Municipal Corporation has been delegated powers to approve the plans for certain categories of buildings under the development control rules framed by MMDA.

Water supply and sewage disposal have traditionally been a local-body function, but it was felt that the Madras Municipal Corporation with its multifarious functions could not cope with increasing demands, for improved infrastructure and maintenance systems. These functions are now handled by MMWSSB, an autonomous body. MMWSSB is not only in charge of water supply and sewage disposal in the city but it is also responsible for augmenting the water supply in the MMA. Besides this functional aspect, the new body was created because it would be in a better position to improve revenue and become self-sufficient.

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It can be seen from the programmes of the Madras Municipal Corporation and its budget that there are no programmes for elderly and disabled people. It would be too much to expect that the local body would implement programmes for aged or disabled citizens without adequate funds and direction.

The Special Officer, Municipal Corporation of Madras, has agreed that the public health of the citizens in Madras City was the responsibility of the municipal body. The municipal body, in addition to its maintenance and control functions, is implementing service programmes. Specific programmes for aged persons, though not on its agenda, could be considered and a portion of its budget could be allocated for them. The Special Officer felt that the Municipal Corporation through its family, and maternal and child welfare centres is already involved in preventive care against disability in children. Organizing rehabilitation services may require additional funds and specialized personnel and hence, the Municipal Corporation may not be able to handle this task.

The Special Officer agreed to the suggestion that medical officers in the Corporation's clinics could be oriented to geriatric medicine and sent a letter to geriatric department of the hospital requesting an in-service training programme for the medical officers.

The Chief Ministers' noon meal scheme is implemented by the Social Welfare Department. The number of pre-schools for children below 5 years of age that were functioning in Madras City, mostly in the improved slums and slum tenements, was around 300. The Government of Tamil

Nadu sanctioned 1000 more pre-schools in 1984 to give further impetus to mother and childcare programmes in the city slums.

The Municipal Corporation was given the task of identifying suitable places sand constructing pre-schools. So far, 1000 pre-school buildings have been constructed-in the slums or near slums to service the target population.

The Municipal Corporation assessed the use of these pre-schools in 1989 and nearly 50 per cent of them were not in use as they were not able to attract a sufficient number of children. The Special Officer indicated that he would consider specific proposals from voluntary groups for more of these unused buildings for programmes serving aged and disabled persons.

The Municipal Corporation performs a variety of functions for the upkeep of the city. Constant complaints or demands for conservancy, sanitation, and road maintenance keep the top management on its toes. Being the capital city there is added pressure. This pre-occupation with current demands leaves little time for the city management to evolve new programmes. At the present juncture, new programmes are introduced only on the basis of state government directions. In the absence of a policy on ageing at the state level, the Municipal Corporation may not be eager to launch municipal programmes for aged people, but it does not bar the municipal body from facilitating voluntary agencies which run programmes for aged or disabled persons.

V. WELFARE PROGRAMMES FOR ELDERLY AND DISABLED PERSONS IN MADRAS CITY

.The Social Welfare and Nutritious Meal Programme Department, Government of Tamil Nadu looks after the welfare programmes for disadvantaged groups, classified below:

* Women's' welfare

  - Vocational training and income generation for women
  - Marriage assistance
  - Service homes for destitute and deserted women

* Child welfare

  - Integrated child-development services and Tamil Nadu integrated nutrition project
  - Nutritious noon meal for pre-school and school children

* Welfare of handicapped persons

  - Education/training
  - Employment –assistance
  - Free supply of aids

* General

  - Financial assistance to voluntary agencies for implementing various programmes

* Welfare of aged persons

  - Old-age pension
  - Noon meal
  - Free supply of *dhoties/sarees* and clothes

The major portion of the state welfare budget is earmarked for children and women. The nutritious noon meal scheme covers the children in the age group, 3-15 years. The budget allocation for the noon meal scheme for 1992/93 is Rs. 2560 million, which is more than 50 per cent of the social welfare budget. This expenditure is viewed as an investment in children.

Old age pension scheme

The introduction of the old age pension scheme by the state government appears to be based on the societal acceptance of the inadequacy or the inability of the modem nuclear family to take care of aged members. Workers from the organized sector, including workers in factories, mines and government employees, are covered under various social security schemes enacted by legislation. The large population falling outside the spectrum of the organized sector does not have the advantage of social security programmes and the government pension scheme services such categories. Tamil Nadu is one of the few states in India which has an old age pension scheme, which commenced in 1962.

The old age pension (OAP) scheme is being implemented in the state under the following categories for grant of pension to destitute persons, who have no subsistence or relative bound by custom or usage to support them.

(a) Old age pension (normal) scheme (w.e.f I April 1962)

(b) Old age pension for destitute physically handicapped scheme (w.e.f. 1 November 1974)

(c) Old age pension for destitute widows scheme (w.e.f. 1 June 1975)

(d) Old age pension for destitute agricultural labourers scheme (w.e.f. 21 August 1981)

(e) Old age pension scheme for deserted wives (w.e.f. 25 April 1984)

The payment of pension has been revised from time to time as indicated below:

1 April 1962 to 31 March 1979	-	Rs. 20 per month
1 April 1979 to 31 March 1982	-	Rs. 25 per month
1 April 1982 to 31 April 1989	-	Rs. 35 per month
l May 1989 to 31 January 1992	-	Rs. 50 per month
1 February 1992 onwards	-	Rs. 75 per month

For the entire state of Tamil Nadu, the total number of beneficiaries by December 1991 was 554,174. Around 16,000 aged persons belonging to Madras City receive the old age pensions.

Earlier, the quota for each district was fixed depending on the population. A new applicant for the old age pension was not entertained unless some recipient died. From March 1989, the Government of Tamil Nadu has introduced a new system sanctioning pensions to all wait-listed persons in the state.

Other features of the old age pension scheme

Nutritious noon meal schemes: All old age pensioners are eligible for a meal from the noon meal centres. They are given daily a cooked meal consisting of 200 gm of rice, 15 gm of dhaH (lentils), 1 gm of oil, and 50 gm of vegetable. They are allowed to carry the food back to their homes so that they do not disturb the pre-school education of the children. In addition 500g of rice per person per week is also supplied. Those who do not take meals from the noon meal centre, are provided 1 kg of rice per week.

Clothing for old age pensioners: Handloom dhoties for men and sarees for women are supplied to old age pensioners twice a year.

Procedures for obtaining the old age pension: Persons seeking the old age pensions apply to revenue officials. Revenue officials visit the place of stay of the applicant to verify that he/she has nobody to look after them and recommend payments of the old age pension to the applicant if he/she has nobody to look after them. Recommendations have been made in various forums that the old age pension scheme should be directly administered by the Social Welfare Department which implements the programme. Verification of eligibility conditions is still carried out by the officials of revenue department with its vast network which reaches the village level.

Some of the shortcomings in administering OAP schemes are summarized as follows

(a) The time schedule according to which certain steps are to be taken and completed is not being followed at different levels of the administration of the scheme. Applications received by *tahsildars* [*taluk* (sub-district) revenue heads] are not forwarded in time. The time-lag between the date of application and the start of payments was found to be more than six months.

(b) Problems have been noted in the selection of beneficiaries. While some ineligible aged persons receive pensions, many who are eligible, do not. Some of the old age pensioners have a very good economic status with sufficient land and housing properties. Either enquiries are not made or if they are made, the rules are not followed. This is more so in the case of enquiries pertaining to the verification of age and economic status. In a few cases the age of the pensioners could not be accepted as eligible.

(c) It is generally agreed that benefits are not reaching the proper persons. Officials do not do anything to ensure eligible persons receive pensions nor do they bring to the

notice of the authorities cases of pensioners who are not entitled to receive such benefits.

(d) The practice of keeping records at different levels of the administration of the scheme was found to be inadequate. The relevant records are seldom available.

The Government of Tamil Nadu has recognized that aged persons in families below the poverty line do not have adequate food, shelter and clothing. No old-age homes have been established by the government as it is felt that such homes should be run by voluntary agencies. The government in its policy note of 1992/93 recommended the establishment of old-age homes to be run by voluntary agencies. During 1991/ 92live old-age homes were established by voluntary agencies with government assistance and in tile coming years old age homes will be established in all the 21 districts of the state in a phased manner. So far no old age home has been set up by the government in Madras City.

Care of elderly persons in the voluntary section

Old age pensions from the State Government is the major support for indigent elderly people. The public-assistance scheme benefits only about 6 per cent of aged persons and in times of an escalating cost of living the quantum of assistance is quite insufficient to meet even basic necessities. Some voluntary organizations (non-governmental organizations) are engaged in the care of the elderly persons in the city. They also cater to a very small proportion of aged persons.

Services provided by voluntary agencies for the aged are:

(a) Homes for the aged, exclusively for- aged residents. Homes for the aged provide residential care including meals and medical care when needed. Some agencies also combine income-generation activities and the residents are paid for their work.

(b) Institutions which extend residential care to other disadvantaged groups in addition to aged persons.

(c) Day-care centres

(d) Financial assistance to aged persons

Old age homes in Madras City

Monegar and Rajah of Venkatagiri Choultries: Monegar and Rajah of Venkatagiri Choultries, in Madras, was the first institution for the care of elderly persons in India. It had its beginnings in the early eighteenth century, though records about the *choultry* are available only from 1782. Both males and females who are destitute and aged above 60 years are admitted. About 90 inmates are staying in the *choultry*

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Anbaham: The institution is run by the Church of South India. Destitute people aged 60 and over are admitted. Residents number around 40 and both men and women are eligible. Old persons who have income pay actual costs but those who are destitute receive services free of charges.

The Friend in Need Society: The institution was established in 1883 mainly for Anglo-Indians aged 60 and over. Persons seeking admission should have resided in Madras city for a minimum of one year. The Society provides shelter to 45 aged persons. Services are provided free of cost to destitute persons and others, whose income does not exceed Rs. 200 per month, pay 30 per cent of their income.

Little Sisters of the Poor: This home for the aged is run by Roman Catholic nuns of the Order of Little Sisters of the Poor, whose headquarters is in Paris. This home was established in 1934. Poor persons aged 60 and over are admitted. Services provided are free of charge. Both males and females are eligible. At present, 200 elderly persons, both male and female, live in the home. An additional block which will accommodate 50 more destitute aged persons is under construction. The Little Sisters specialize in the care of old persons and the home in Madras is a part of a world-

wide network. Nuns who join the order undergo training in Paris. The home provides excellent all round care for its aged residents.

Mercy Home: This is also run by Roman Catholic nuns. Admission is open to not only destitute aged persons but also to abandoned sick persons of other age groups. Services are provided free of cost. A maximum of 206 residents, men and women, are housed.

Muslim Leprosy, T.B. and Old Age Patients Rehabilitation Association: This home was established in 1981 and it is open to a maximum of seven aged Muslims. Services are provided free of cost.

The Patients Divine Mission: This home for the aged was established in 1947. Admission is open to both males and females aged 60 years and over. Services are provided free of cost and 50 aged residents live in the home.

The Rani Meyammal Home for the Aged: This was established in 1986 for 16 residents. Admission is_ open only to elderly women requiring help. Services are provided free of charge.

St. George's Cathedral Home for the Aged: This home was established in 1865 and is run by the Church of South India. Admission is open to poor elderly women, 60 years and over, who are medically fit. The maximum number of people accommodated in the home is only 17. Services are provided free of cost to the poor and others pay according to their ability ranging Rs. 50 to 100 per month.

Stree Seva Mandir, Home for the Aged: This was established in 1949. It is open only to women aged 55 cued over and a maximum of 60 women live there. Services are provided free of charge to destitute women and others pay according to their ability.
St. Thomas Home for the Aged: This is run by the Salesians, a Roman Catholic order. It was established in 1965. Eighty aged men and women who are destitute and infirm are housed. Services are provided free of charge.

St. Thomas Home for the Aged: Run by the Hospitaller Order of St. John of God Society, this home was established in 1980. Space is available for 25 aged men. Services are provided free of charge.

Vishranti Charitable Trust: This home for the aged for destitute women aged 65 and over was established in 1978. Services are provided free of cost. The maximum intake capacity is 100.
Missionaries of Charity: This home for the aged and destitutes provides institutional care to all age groups including aged women. Services are provided free of charge.

Paid homes for aged persons in Madras

Association of Senior Citizens' Resorts: This institution for 200 elderly persons was established in 1983. Single-room and double-mom accommodation is provided to retired men and women who are vegetarian. A one-time payment of Rs. 25,000 for a single room arid Rs. 45,000 for a double room (for a couple) is charged. Charges for board are derived by dividing the costs among residents.

K.J. Home for the Aged: This was established in 1986. It is open to 20 retired men and women who are physically and mentally fit. An initial deposit of Rs. 12W is collected and Rs. 400 per month is charged for boarding mid lodging.

Mary Club Walla Jadhav Home for the Aged: This is run by the Tamil Nadu branch of the National Council of Women in India. The home was established in 1976 for nine male and female residents aged 60 and over. Only lodging is provided and Rs. 225 per month is charged as rent towards a cottage. Residents have to make their own arrangements for meals.

Prembal's Live in Comfort Home for the Aged: This was established in 1988 for middle- and upper-class elderly persons. An initial refundable interest free deposit of Rs. 5000 is made and Rs. 600 per month is charged for food and accommodation.

Sai Charan Senior Citizens Homes: Two homes accommodating 30 persons are run under the same names in two different locations. Male and females aged 55 and over are eligible. Rs. 400-600 is charged for food and accommodation.

Santhi Illam: This home for the aged is located in a suburb of Madras City. Admission is open to 60 men and women aged 60 and over who are mobile. Dormitory accommodation is provided. Rs. 300-325 is charged for food and accommodation.

Sathyalok Ideal Home for Senior Citizens: This was established in 1987 for42 elderly men and women. Dormitory accommodation and cottages are available. Rs. 400-550 per month is charged for food and lodging depending on the type of accommodation.

YWCA: A home for the aged was established in 1982. Women aged 60 years and over are eligible. An initial deposit of Rs. 11,000 is collected and Rs. 250-300 per month is charged for accommodation. Accommodation is available for only six persons.

There are a total of 22 homes for the aged in Madras at present of which 14 provide free services and eight are paid homes. All the homes providing free services except one were started before 1980. All the paid homes, on the other hand, were started after 1980.

This trend is indicative of the need among elderly people belonging to middle- and upper-income groups who are increasingly left to fend for themselves. Their children are either unable to care for them or have left the city for better job prospects. Promoters of these homes, belonging to the middle class, have shown increasing concern for the people belonging to their class. As they are paid homes, the organizers do not have to raise operating funds elsewhere. It appears that this trend will increase.

It should be conceded that paid homes provide accommodation and food, but they do not provide medical care which is an important aspect of care for this group. It is desirable that all the homes meant for aged persons should have certain standards of service.

Unfortunately, old-age homes providing free services have not increased in number in the last two decades. Free homes are just not "lodge and board" homes, unlike paid homes. They provide total care including medical aid and nursing care.

Fully 54 per cent of the households living in Madras City are considered to be poor and 35 per cent five in slums. Within this group, elderly persons have no secure income while employed nor do they have security for their old age.

There is a tremendous need to increase old-age homes that serve elderly people who are poor, destitute, ill or disabled.

The operation of free homes requires a great deal of organizational skill, dedication and fund raising. These organizations depend mostly on private charity. If such services are to be increased, the government has to step in providing land, buildings and running costs.

Other services for elderly persons

Day Centres

A simple definition of a day centre is a place where elderly people get together to meet their mutual needs. They can he run by elderly persons themselves or by voluntary agencies. When health-care programmes are included they are called day-care centres.

In addition, these centres provide a forum for the old to come together and organize income-generation programmes to raise additional funds. Every year Elders Day is celebrated with fanfare providing an opportunity for the elderly to have fun.

CEWA: The Centre for the Welfare of the Aged runs three day-care centres in slums, supported by HelpAge. Elderly persons from the slums come to the centre at 10 a.m. and have a meal in the

afternoon. The agency also organizes income-generation programmes like paper-bag making and *agarbathi*-making to keep the old persons active and to provide them out-of-pocket expenses. Other services of the Centre include: eye examinations, supply of aids, counseling, and liaison with the Geriatric Ward at the General Hospital for health care required by clients.

Mr. Nair of CEWA has observed that day-care centres would not be successful in areas where people are economically independent. They are popular in low-income areas.

Guild of Service: The Guild of Service, a leading voluntary agency in the city, nuns homes for children and women. It also runs Nutrition-on-Wheels programmes for children. Meals-on-Wheels has been started to deliver food in the afternoons to elderly residents in Sivashanmugapuram, a slum close to a graveyard. About 100 elderly women are served food.

About 250 women are provided financial support at the rate of Rs. 150 per month. This sponsorship scheme is supported by HelpAge under the "Adopt a Granny/Grandpa" scheme.
Meals-on-Wheels also runs a day centre under the name "Centre for Economic Development of the Aged". About 27 elderly men and women are provided a meal in the afternoon. The old women cook the meal themselves.

The space for running the day centre is hired from another voluntary agency which has a large property in the city. For a two-room space which accommodates the kitchen and working space, Rs. 1000 per month is paid as rent.

Expenditure incurred in this day centre is as follows:

Food articles (coffee/rice/wheat/gram etc.)	Rs. 1000
Rent	Rs. 1000
Salary for the supervisor	Rs. 1000
Medical care (Consultation and medicines)	Rs. 500
Total	Rs. 3500

This does not include the cost of fuel and milk which are donated to the centre.

Figure 9. Dormitory at Home for the Aged, Little Sisters of the Poor

Figure 10. Dining hall, Home for the Aged, Little Sisters of the Poor

Figure 11. Help the needy

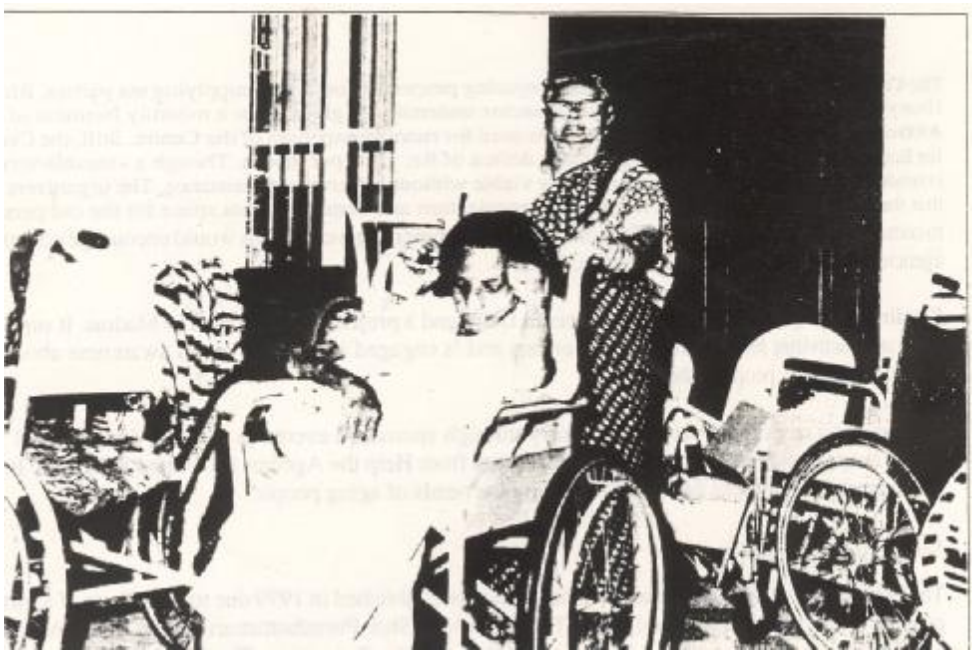


Figure 12. Income-generation project

The Centre undertakes economic activities, preparing processed foods and supplying tea parties. Bharat Heavy Electricals Limited (BHEL), a public-sector undertaking, gives them a monthly business of Rs. 4000 of which 50 per cent is net profit, which is used for running expenses of the Centre. Still, the Centre for Economic Development of the Aged has a deficit of Rs. 1500 per month. Though a valuable service is rendered, the Centre cannot be economically viable without government assistance. The organizers felt that the rent was too high for a social service organization and demanded that space for the old persons to come together should be provided free of cost by government agencies. This would encourage voluntary agencies to run more centres for the aged clients.

Funding: HelpAge India has its headquarters in Delhi and a project office located in Madras. It supports innovative activities for the care of aged persons and is engaged in creating social awareness about the problems of elderly people in the country.

HelpAge India raises funds within the country through sponsored events in schools, direct appeal and special events besides receiving a substantial amount from Help the Aged in the United Kingdom. It is a model agency raising social awareness regarding the needs of aging people.

Senior citizens' lobbying

The Federation of All India Pensioners Association was established in 1979 due to the efforts of a former member of the Legislative Assembly of Tamil Nadu - Shri Purushottaman. Now 256 pensioners' organizations in the state of Tamil Nadu are affiliated to the Federation. The Federation caters to die needs of retired persons from state, and. central government organizations and undertakings. The federation conducts workshops and seminars to sensitize the public and the government about the problems of the aged.

A monthly newsletter for retirees, *Pensioners' Advocate* which advises on retirement benefits and grievance redressals, is published. The Federation also conducts counseling sessions in different government undertakings for would-be retirees. Their efforts in counseling the retired employees are likely to become a permanent feature in government undertakings.

Tile Standing Committee of Voluntary Agencies (SCOVA) is a statutory body of pensioners of the Pay Commission constituted by the government. SCOVA meets on every first Monday of the month and discuss the problems of senior citizens. As the members of SCOVA are mostly drawn from pensioners associations, die major focus of the meetings is on retirement benefits - monetary and non-monetary, to he extended to retired personnel.

Geriatric Unit, Government General Hospital, Madras

The Geriatric Out-Patient Department (OPD) was commenced in the Government General Hospital, Madras, attached to the Madras Medical College, in early 1978 for the care of the health of aged persons. The unit is open three days a week from 10 a.m. to 12 noon. Every day the unit attends to 20 aged sick patients and also reviews about 100 (out-patient department) cases. The unit has catered to about 15,000 elderly patients since its establishment.

The Government General Hospital also runs a geriatric ward with 12 beds. In addition, in the three peripheral hospitals in the city, six-bed geriatric wards have been set up.

The Geriatric Unit of Government General Hospital is the first of its kind in India. It extends comprehensive medical services to elderly patients.

The Geriatric Department of Madras Medical College runs post-graduate courses in geriatrics. Besides handling teaching sessions for the post-graduate and graduate medical students, health education for the general public and research activities are also undertaken by the Department. In addition, it also conducts health camps social counseling and rehabilitation.

The Centre for Welfare of the Aged, a voluntary agency, associates itself with the Geriatric Department in its activities, contributing social workers to the professional team which consists of medical officers, nursing staff and physiotherapists.

Health schemes available to elderly persons

All central-government employees are covered under the Central Government Health Scheme (CGHS). Even after retirement, the retirees can avail themselves of health-care facilities. Under CGHS, dispensary facilities are available around the country, but the general complaint about CGHS is that the dispensaries are not within easy reach in all the metropolitan cities. Aged and disabled people have to travel 10-15 km to reach the CGHS dispensaries. Also the treatment facilities in the CGHS dispensaries are found to be inadequate. They do not have laboratory facilities and, hence, the clients are forced to get tests done elsewhere forcing them to spend considerable amounts from their reduced income. It has been generally agreed that for smaller ailments one may visit the family doctor and pay a nominal consultation fee. Major health problems affecting aged persons include heart attacks and fractures from falls. CGHS dispensaries are ill-equipped to handle such cases. Central-government departments such as Railways and Defense run their own hospitals and retirees from those departments are taken care of by these hospitals. Other central-government retirees are not covered by this scheme.

Employees retired from state government departments and undertakings can use the services of hospitals run by the state government. Madras being a major metropolitan city has a well-developed health infrastructure. There are four major hospitals and three peripheral hospitals run by the government. All the major hospitals have laboratory and operating-theatre facilities. However, bed strength has not increased in recent years. In order to cope with the increasing demand in the major hospitals, the government has started peripheral hospitals. The general complaint about peripheral hospitals is that these hospitals are neither well equipped nor do the doctors show adequate concern. Geriatric health facilities are available only in the Government General Hospital and the peripheral hospitals.

The rest of the population, especially economically weaker sections, have to depend on the government hospitals for services. For the poor, no charges are levied for medical care and in-patients in these government hospitals are also provided food (people from the middle class may not desire to be admitted to the general hospitals because of the lack of privacy in the general wards and also the unsatisfactory hygienic conditions). There are a number of nursing homes run on a commercial basis and also hospitals run by the voluntary/charitable trusts whose charges are nominal.

A few insurance companies, such as General Insurance Company and National Insurance Company have started a health scheme/Mediclaim policy which also includes the Personal Accident Scheme. This Scheme includes hospitalization facilities for the age group ranging from 5 - 70 years. For people who are above the age of 70, the Mediclaim policy is extended subject to medical examination.

Under the Mediclaim Insurance Scheme, the medical expenses incurred for treatment in hospital are reimbursed by the insurance company on payment of a yearly premium ranging from Rs. 200 to Rs. 1300 depending upon the extent of medical benefit the beneficiary chooses. There are six categories to suit different pockets. However, the Scheme suffers from two limitations. One is that only hospitalization treatment is covered at present. Though initially the Scheme covered domiciliary treatment for minor illness like coughs, colds, and fevers under doctor's advice, this benefit was subsequently withdrawn due to large-scale abuse. Secondly, hospitalization treatment is available only up to the age of 70 years.

This Mediclaim policy is tax deductible. A tax rebate up to Rs. 3000 is offered to income-tax filers.

Retirees have been demanding a national health insurance scheme that would cover the costs of treatment in private nursing homes too. The pensioners claim that the annual premium is too high for a pensioner to bear and that the government should share 50 per cent of the cost of the insurance premium.

The Pensioners' Association has demanded that the General Insurance Corporation (GIC) should work out a separate scheme for the senior citizens of India which will provide the following:

(a) Health insurance to cover all senior citizens of India including the spouse until the death of either.

(b) The insurance may include hospitalization and treatment of senior citizens as in-patients, one annual health check-up and domiciliary treatment.

(c) Beneficiaries should register with GIC as a cardholder for health insurance and pay the prescribed insurance premium, either in one lump-sum as done by Railway Pensioners under the Railway Health Scheme or in yearly premiums. They should not be asked to pay in advance to the hospital at the time of admission or at the time of treatment at home or for the annual check-up. The hospitals should claim treatment charges from GIC.

(d) GIC may introduce a scheme of family doctors for all senior citizens entering the Health Insurance Scheme. Under this scheme, family doctors can treat senior citizens at home and claim payment from GIC.

(e) Participating hospitals and nursing homes, as well as the doctors enlisted for domiciliary treatment of senior citizens, must register with GIC and should be subject to annual certification with the Medical Council of India and the state government health regulations as per law.

(f) GIC should try through suitable incentives to promote the opening of new hospitals and nursing homes in all district towns and *taluk* towns, by missionaries, societies of doctors, civic institutions etc.

(g) The existing machinery of GIC for running health insurance can be suitably modified to cover senior citizens.

(h) GIC may provide for domiciliary treatment of senior citizens and losses incurred may be quantified and reported to the Health Ministry, which may make restitution to GIC for the losses.

(i) Clinics-on-wheels (mobile medical vans) should bring health-care facilities to residential localities thus reducing the hazards to elderly and disabled persons of traveling long distances for medical relief.

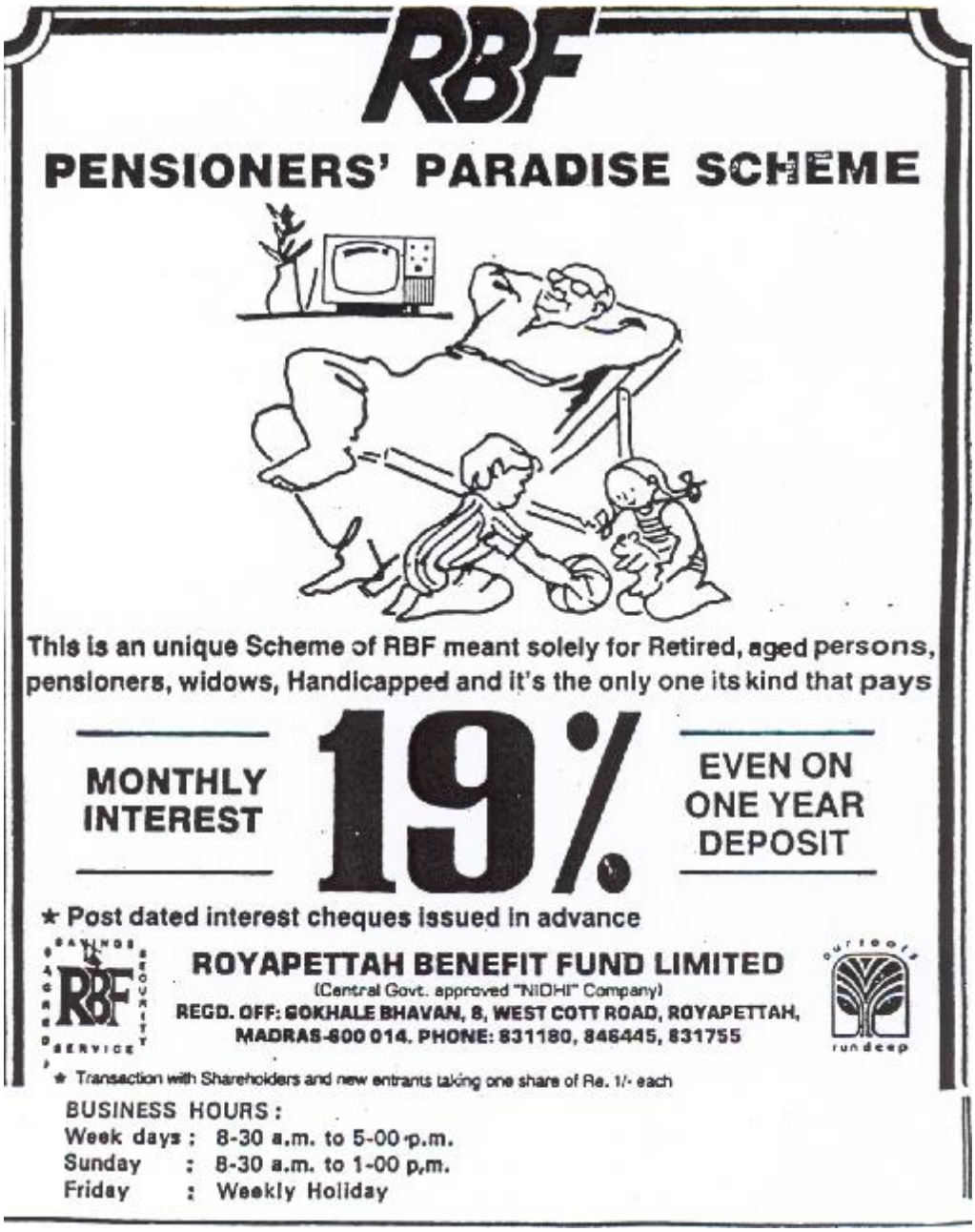
(j) Cooperative drug stores and mobile pharmacies for the elderly should be organized to provide subsidized drugs and appliances on medical advice.

Social security

Retired persons at the age of superannuation receive three benefits: pension, gratuity and provident fund if they were government employees. Others retiring from establishments in the organized sector, receive gratuity and contributory provident fund from the employers.
Some financial institutions such as the Life Insurance Corporation and Unit Trust of India have saving schemes which are normally adjusted to mature at the age of retirement. The Postal Department operates a Public Provident Fund Scheme. Anyone can open an account in the vast network of post offices across the country. Nationalized banks and private financial institutions have also floated pension schemes. A person who contributes a certain amount on a monthly cumulative basis, for a particular duration, later receives a fixed amount every month depending on the total savings accrued with interest.

Banks and financial institutions have realized that aged persons can be valuable customers providing long-term deposits. Attractive saving schemes and fixed-deposit schemes have been designed and guarantee a fixed monthly income for aged depositors, while the capital remains intact. These schemes are, however, not free from monetary erosion.

Figure 13. Pensioners' Paradise Scheme



Banking services

Pension payments for retired employees from the government are routed through nationalized banks. Leading banks like the State Bank of India conduct periodic workshops for their officials who are highly involved in pension payments. Pension procedures are explained and difficult cases are clarified by government officials who also accept input on changes to the systems and procedures for rendering better service to pensioners. Informative handbooks on pension payments have been published for the use of branch officials.

The Bank holds special sessions for pensioners at important centres whenever it launches new issues of mutual funds. Special features such as higher rate of return, value appreciation, incentives and tax concessions are explained.

The State Bank offers an interest-free loan of Rs. 3000 for medical expenses which must be repaid in 12 installments.

The Standard Chartered Bank has introduced the Platinum Club which is exclusive to people 50 and above. Members of the Club have benefits such as free banking, medical discounts from reputable medical clinics and payment of water, electricity and telephone bills.

Tax Relief

Incomes of individuals and companies are taxable under the Income Tax Act. An individual's income up to Rs. 28,000 per annum is not taxed and a standard deduction of Rs. 12,000 is permitted under the Act. Pensioners are permitted a maximum income deduction of Rs. 15000 provided taxable income is below Rs. 100,000.

Civic affairs

Voting

All adults above the age of 18 years are eligible to vote. General elections are conducted through secret ballot once every five years for both the Parliament and State Assembly. Local self-government is another institution where the electorate exercises the franchise. As the corporation council of Madras is superceded elections to the local body have not been held in the last 20 years.

Arrangements for voting is done in schools, colleges and other public buildings. Separate queues are maintained for men and women. No separate arrangements are made for the aged or disabled voters. In order not to lose a vote, political parties arrange transport for elderly or disabled voters who cannot make it to the voting booth. Jumping the queue for infirm and aged voters is accommodated by the supervising election officials.

It is generally agreed that aged citizens with their vast experience can help institutions with their wisdom. But in a political democracy, unless senior citizens are active members of a political party, their participation in the government is not possible. At present, Tamil Nadu is ruled by the All India Anna Dravida Munnetra Kaghagam (AIADMK), which has only one senior member aged above 60. All other ministers are below the age of 50.

In the present political context, it is difficult to predict when the next elections for the local body will be held and whether senior citizens will be willing to participate in the electoral process, though their expertise would be useful for running the city smoothly.

Government programmes for disabled persons

In 1950, for the first time, the Indian Government recognized that disabled persons have an equal right to participate in the social and economic activities of the community. This basic right was guaranteed by the Indian Constitution adopted in 1950.

The Department of Social Welfare of the Government of Tamil Nadu is the nodal agency for managing programmes for disabled people. Departmental programmes include education/

vocational training, employment assistance and the free supply of aids. The Department of Health organizes a medical rehabilitation programme for the handicapped in the city. The Ministry of Welfare of the Government of India provides generous assistance to voluntary agencies which run programmes for disabled persons in the state.

Education for the handicapped

The Government of Tamil Nadu runs 23 schools for disabled persons in the state. It also funds voluntary agencies that educate disabled persons.

Of the 23 state schools, three are located in Madras City, one each for visually-impaired (at Poonamallee close to the city), for hearing-impaired and for mentally-retarded persons.

Training programme for teachers of disabled persons

A Regional Training Centre for the teachers of visually-impaired students at Poonamallee has been established by the Government. About 35 teachers are trained every year. Part of the assistance comes from the Ministry of Welfare, Government of India.

The state government does rot run any institution separately for training teachers of hearing-impaired students, but, sponsors candidates for training at Little Flower Convent Higher Secondary School for the deaf, located in Madras. Teachers from regular government schools and schools aided by the government are also nominated for the training.

The government supports the training programmes for teachers of mentally-retarded children at Balavihar, a voluntary organization specializing in the training of the mentally retarded children.

Vocational training

The following vocational courses for disabled persons are run by the state government in Madras city:

Nature of disability	Institute	Trade	Number of beneficiaries
Hearing -impaired	Government Industrial Training Institute	Fitter	10
Visually-impaired	Government Industrial Training Centre for the Blind	Fitter-cum-basic machine operator Book binder Welder	30

Hostel facilities are available for the trainees and services are provided free of cost. In addition, two sets of uniform are provided free of cost to trainees.

Government efforts in the area of vocational rehabilitation is without a purpose. The Government share of disabled persons who are rehabilitated (40 persons in a year) is grossly inadequate.

Intervention of the government in the area of vocational rehabilitation is not satisfactory. However, medical rehabilitation facilities provided by government institutions are very good. These institutions are staffed by well-trained professionals, both medical and paramedical. These institutions also refer their disabled clients to voluntary agencies for the supply of aids and appliances. These voluntary organizations are adept at managing the welfare programmes but their ability to organize meaningful economic development programmes is doubtful. Hence their

activities are focused on the education of the disabled children, vocational training and counseling. Mere vocational training cannot be equated with vocational rehabilitation.

The government focused its efforts on the prevention of disability, training of professionals in the specialized field, development of service models and research. Another concern was the production of requisite educational materials and rehabilitation aids. However, service activities were still predominantly left to the voluntary sector. Government is largely involved only in training workers and conducting small service centres.

At present, the state government conducts a number of programmes for the prevention of disability throughout the state. These programmes include tetanus-immunization for expectant mothers, DPT (diphtheria, tetanus toxoid and pertussis vaccine), DT (diphtheria toxoid) immunization for-children, prophylaxis against nutritional anaemia and blindness due to vitamin A deficiency, and vaccination against polio and typhoid. Further, there are national programmes for the prevention and control of blindness, nutritional supplements, and programmes to educate mothers on appropriate health and nutritional practices.

In the National Health Policy of the country, medical rehabilitation of disabled persons did not find any significant place. Immunization programmes were introduced primarily to prevent early childhood diseases and to reduce infant mortality. They were incidentally expected to prevent disabilities in early childhood as well.

Disabled children can be broadly classified into two groups: (a) those who do not have teaming defects and can benefit from normal schools; and (b) those who have learning defects and require special measures.

Education for children with no learning defects but with mild locomotor or hearing disabilities are able to attend normal schools with adequate aids. But most handicapped children even without learning defects find it difficult to attend normal schools. They find insurmountable difficulties in reaching the institution and acquiring aids and appliances. School premises are not accessible because of architectural barriers.

Scholarship

Scholarships from the Ministry of Welfare, Government of India, are awarded to students wanting to pursue academic and technical education beyond standard IX .

The state government funds scholarships for the purchase of books and notebooks for disabled children studying in classes I to VIII. Assistance per child ranges from Rs. 10 to Rs. 84 per annum. About 1000 children in the city benefit under this scheme every year.

Reservation of jobs for disabled workers

The Government of India and the Government of Tamil Nadu have reserved 3 percent of C* grade (clerks, typists, telephone operators etc.) and D* grade (unskilled workers, messengers, attendants etc.) job vacancies for physically-disabled workers in all government departments and undertakings.

A committee set up by the Ministry of Welfare, Government of India, made an in-depth study in government offices and government undertakings (referred to as Public Sector Undertakings) and identified 1100 posts out of 3000 posts listed in the National Classification of Occupations as suitable for disabled persons. The recommendations of the committee have not been fully accepted, thus restricting the scope of employment of disabled persons in government departments.

Unemployed persons register themselves in employment exchanges. It is mandatory on the part of all government departments that vacancies in C and D categories (excluding banking services) are filled through employment exchanges. The number of persons registered in the city has exceeded 100,000.

To service physically-disabled workers a Special Employment Exchange functions separately from the regular employment exchange in Madras. The Special Employment Exchange registers disabled persons and sponsors them for employment in both government and private institutions. It also monitors the reservation of jobs made for physically-disabled workers.

* Government jobs (referred to as posts) are categorized in four 4 classes - A, B, C and D. A and B categories cover executive cadre. Category C and D categories cover non-executive cadre including skilled and secretarial and unskilled jobs. For entry into government departments in C and D categories, the upper age limit ranges from 25 to 30 years. Physically-disabled workers are entitled to a relaxation in the upper age limit, up to 10 years.

Because the number of jobs open to disabled workers is limited and because of general resistance from employers, the task of the Special Employment Exchange is difficult. About 8 per cent of the disabled persons registered find jobs every year.

Vocational Rehabilitation Centre (VRC)

The Government of India has set up a Vocational Rehabilitation Centre for physically-disabled clients at Madras. The VRC evaluates the residual capacity of physically-disabled persons and recommends occupations most suited to their qualifications and abilities. The physically-disabled persons who approach the Vocational Rehabilitation Centre are medically examined by a special board and they are not required to undergo medical examination again at the time of their employment.

On the pattern of this Vocational Rehabilitation Centre, the Government of Tamil Nadu has set up five regional rehabilitation centres (RRCs) in different districts including one at Madras. The regional rehabilitation centre, work in liaison with the Special Employment Exchange and also private enterprise for placement of disabled workers:

Employment assistance to persons with disabilities

Visually-impaired and hearing-impaired persons, trained in government industrial training institutes, are placed as apprentices in government undertakings and private enterprises. A stipend of Rs. 400 per month is paid to each apprentice. These establishments are encouraged to absorb the disabled apprentices after completing their apprenticeship.

Unemployment allowance is provided to unemployed blind persons between 18 and 40 years of age after one year of registration in the employment exchange. The amount of unemployment relief varies from Rs. 100 to Rs. 200 depending on the academic qualification of the disabled person. The unemployment relief is paid for a maximum period of five years or until the person gets employment.

Disabled persons are encouraged to set up self-employment ventures

The nationalized banks assist disabled persons with loan assistance on easy terms. Disabled persons who belong to the lower-income group whose family income does not exceed Rs. 7200 per annum, are extended a loan of up to Rs. 6500 for working capital and a term loan of Rs. 5500 for small ventures. A differential rate of interest, 4 per cent per annum, is charged on these loans.

The state government helps persons with disabilities to set up kiosks selling refreshments and snacks. They are also provided a subsidy of Rs. 250-500. Around 20 such kiosks have been set up near hospitals and are managed mostly by orthopaedically-disabled vendors.

Medical rehabilitation

The Directorate of Medical Services runs specialized hospitals for the medical rehabilitation of mentally retarded and orthopaedically-disabled persons. All major hospitals have rehabilitation services for persons with other disabilities.

Care of persons with disabilities in the voluntary sector

The joint family system has always provided security to its disabled members. Christian missionaries have established many hospitals and schools in the city. As an extension of these activities, schools for the blind and deaf were also started. Older voluntary agencies in the city, particularly the Guild of Service, have started organizing activities for destitute children and extended their activities to disabled children as well. The first institutions in the city were mostly for blind and deaf children and the activities of these institutions included special education and vocational training. The intensity of the voluntary action in the city has increased considerably in the last two decades mainly because of the generous financial aid from the government as well as international funding agencies.

There are around 70 voluntary agencies in the city of Madras, working with disabled citizens, some of which deal exclusively with a particular category of disabled client (mentally-retarded, orthopaedically disabled, blind or deaf). Other institutions combine their activities for different types of disabled clients.

Institutions for visually-impaired persons number 23, out of which only nine agencies cater exclusively to blind persons and others extend their activities also to orthopaedically-disabled and deaf clients. Services provided by five agencies are limited to the provision of aids and appliances for all categories of disabled persons. About 11 institutions provide vocational training in addition to special education. Only four NGOs have some kind of employment assistance which consists of referral to the government vocational rehabilitation centres.

There are I 1 agencies organizing programmes exclusively for deaf persons. Of these, five agencies offer special education and vocational training. Two agencies also provide hostel facilities for disabled children. Three agencies cater to only deaf adults and these services include vocational training, placement and marriage counseling.

There are 12 agencies working for the welfare of orthopaedically-disabled persons, mainly catering to children. Three agencies restrict themselves to the provision of aids and appliances, seven agencies have vocational training programmes and two organizations combine general education and vocational training besides health services. Educating orthopaedically-disabled children is not as difficult as in the case of other disabilities. The majority of orthopaedically-disabled children, especially polio victims, are admitted to normal schools. Hence, the majority of agencies under this category specialize in vocational training.

Nineteen organizations deal mainly with mentally retarded children. All these institutions provide special education and vocational training for mentally-retarded children.

The voluntary agencies pursue a traditional approach. Nearly 25 per cent of the voluntary NGOs have no programme to offer. They merely supply aids to disabled persons utilizing government grants, and they are rooted in charity. Others, who are concerned about rehabilitation, organize special education programmes and vocational training programmes. The vocation training imparted is also traditional, confined to trades like tailoring, carpentry, fitter and book-binding. Only one agency, the Interchurch Service Agency, organizes training programmes in electronics, communications and software development for orthopaedically-disabled adults. The training programmes are run without adequately-trained personnel or curriculum. Thus, the training provided is not good enough for disabled youth to secure employment. None of the institutes have regular evaluation programmes to ascertain the efficacy of their programme. The reservation of jobs and the economic assistance programme have mostly benefited orthopaedically-disabled persons. Vocational rehabilitation centres and special employment exchanges do liaise with government offices and industries for placement. Disabled persons trained in light engineering trades find employment in the private sector. But only 8 per cent of the disabled registered with special employment exchanges are able to find employment. The major share of employment in the city is in the unorganized sector. Therefore, placing emphasis on the organized sector for securing employment for disabled workers is misplaced. Greater emphasis must be laid upon training and equipping them for jobs in the disorganized sector.

The World Health Organization (WHO) considers that the present variety of services based on the establishment of state institutions is exclusively for disabled persons. Community-based rehabilitation programmes rely on utilizing existing mainstream institutions and integrating disabled persons into society.

A couple of voluntary agencies with the assistance of the Government of India have started community-based rehabilitation programmes. Though the effort is laudable, the programmes are simplistic. They are merely day centres for handicapped children in the community and rehabilitation aspects have not been really considered.

VI. CONCLUSIONS

Studies have indicated that, in Madras, the majority of aged people are still living with their children or intending to stay close to the children, thus retaining their emotional bond intact. It has been estimated that only 5 per cent of aged people are in favour of institutionalization. Voluntary agencies and leading social workers in the field of gerontology feel strongly about the need to integrate aged members with their families. This is not to say, that the concept of institutional care should altogether be given up. Aged persons, who are infirm or destitute, do require institutional care.

According to the employment statistics, 31.6 percent of the earners were employed in the organized sector (25 per cent were employed in the public sector and 6.6 per cent were employed in the private sector). Employment in the organized private sector also includes small-scale industries where work compensation is not comparable with big industries.

The retirees from the public-sector undertakings have the benefit of a pension, however small, and other benefits like gratuity and the provident fund. They have also formed their own lobby - the Pensioners' Association at the state and national level - and lobby the government authorities to improve their pension benefits. These organizations have also been conducting rallies, workshops and seminars to focus on the problems of pensioners. In addition to the old age pension benefits, they have access to health facilities at the former employers' cost, which, however, are inadequate. They are prepared to struggle to increase and safeguard the rights of the pensioners.

Other aged persons retiring from the private sector have the benefit of gratuity and the contributory provident fund and if they make sound investments, their income in retirement is secure.

According to the 1981 census, Madras City had 160,000 aged people. This number has now risen to 220,000. Considering that 54 percent of all households belong to low-income groups, a formidable number of aged households are poor.

The problems of low-income aged persons tend to be overlooked as they do not have an effective lobby. The majority of these aged poor persons still continue to work. The employment data indicate that 17.5 per cent of aged workers belonging to low-income groups in Madras City still continued to work even after the age of 60 years (male aged workers constitute 30 per cent). As they mostly work in the informal and unorganized sector, they continue to work for as long as their health permits. They do not have the ability to save during their productive period; hence they suffer most during their old age.

Generally, people from the organized sector who have better education and access to information are in a position to better plan their retirement. Aged workers in the informal unorganized sector are illiterate or semi-literate with little awareness or access to information.

Many are not covered by any social security scheme, not even an old age pension. The old age pension, according to the figures made available, is paid to only about 16,000 aged people in Madras City, whereas the estimated number of aged people who belong to the low-income groups in the city is about 132,000.

Housing conditions affect the family care of members. Older persons, who do not have their own homes, rely on relatives and non-relatives for shelter. When housing is small and unhygienic, it is difficult to accommodate the needs of three-generational families.

The Ministry of Urban Development Government of India is considering special housing schemes for aged people and some ministries like Defence and Railways have already floated housing schemes for the benefit of their retired employees. These housing schemes would cater to a very small minority and they are open to only those who are willing to invest their savings.

Such housing schemes are unaffordable to poor aged persons who will have to continue to stay with their families. Hence family care becomes altogether important for those with low income.

The day-care centres can provide a forum for aged people to meet and to receive a variety of services. The health of low-income clients is improved through nutritious warm meals and health care provided at such centres.

Mother and child welfare programmes are implemented through mother and child welfare centres run by the Municipal Corporation. Integrated child-development schemes are run through state social departments. Older residents of the city do not receive similar special attention. Welfare programmes for elderly persons have not had the same impetus as the programmes for mothers and children except a few programmes run by voluntary agencies which are far from inadequate.

Geriatric care is still in its infancy in the country. Madras has the privilege of having the first Geriatric Unit in the country as well as an institution that grants a post-graduate medical degree in geriatrics. Health care for the elderly is a separate discipline dealing with the multiple diseases and deficits associated with age. The Geriatric Department and the Centre for the Welfare of the Aged (CEWA) have been collaborating to build multi-disciplinary teams (the geriatric team consists of social workers, physiotherapists and medical professionals) to deal with the health problems of elderly patients. CEWA also organizes the training programmes for health workers who are already in the system to improve their appreciation of geriatric problems. However their efforts have a limited impact among the large aged population in Madras City.

In the last two decades, there has been a virtual stagnation of spaces in old age homes providing free services. On the contrary, the numbers of paid homes are on the increase as these homes are self-supporting. Persons preferring to join paid homes are those who have pensions and those who want to retain their independence. It must be admitted that conditions of up-keep of the paid homes is far from satisfactory. The personnel employed at the homes have great commitment but few skills to provide quality care to ageing residents.

On the other hand, charitable homes are run by voluntary agencies, which have had long experience in this area. Every facet of living - food, stay, health care etc. - is dealt with, as the agencies have taken a moral commitment to care for their poor aged residents.

In a world which has become increasingly development-oriented, funds for welfare measures are limited. Voluntary agencies cannot mobilize all the resources required (land, buildings, skills, running expenses). Since governments do not provide these important services themselves, they must evolve policies to facilitate voluntary agencies to procure assistance from various departments of government.

Whether paid or unpaid homes, minimum standards for buildings, services and care should be enforced by governments.

The government response to problems of aged people was mixed. It was felt that expenditure on children was an investment for the future, while any expenditure on the old is purely welfare. Besides, the officials of State Social Welfare and the Madras Corporation are limited by economic constraints and cannot consider any additional programme for aged people. However, some have responded positively. "We have not thought about it earlier, but we can consider looking into the problems of the old."

Workshops and seminars should be organized for various government departments (Madras Municipal Corporation, Social Welfare Department, Madras Metropolitan Development Authority and Transport Authority etc.) in order to identify the problems of the aged people to stimulate various policies and to initiate appropriate remedial action by the departments concerned. Joint or coordinated action plans for the future must be initiated to make living conditions of the aged in Madras City better.

Though the basic rights of disabled persons to participate in social and economic activities in the community are assured, the programmes to facilitate their participation have been sketchy. The Government of India contributes to the welfare of the disabled people by providing generous assistance to the voluntary agencies serving them. But governments have not been able to go beyond welfare to full integration of disabled persons into society.

The voluntary sector is comfortable organizing welfare programmes for the disabled persons. Though the government has great faith in voluntary agencies their rehabilitation programmes have failed to a large extent.

The key organization for the welfare of disabled people, The Directorate of Social Welfare, does not even have reliable data on the disabled population in the state and the city.

The staff employed in the Directorate do not have a professional approach to the problems of disabled people. As administrators, they allocate the yearly budget based on existing programmes and forward the applications of voluntary organizations for financial assistance from the Ministry of Welfare, Government of India.

The Directorate for Welfare of Disabled Persons was carved out of the Directorate of Social Welfare in September 1992. But the same officials continue to manage the department. It is doubtful whether this department could view the problems of disabled people in a comprehensive manner and develop meaningful programmes for the rehabilitation of disabled persons.

The interests of the voluntary agencies also vary depending on the category of disabled persons they are dealing with. Hence, collective pressure for rehabilitation measures of disabled persons has not been possible.

Voluntary agencies, without adequate support from the government, would not be able to snake a dent in the required rehabilitation programmes for disabled persons. Madras City is a major metropolitan city with good infrastructure. With interdepartmental coordination between social welfare, industries, health, employment and training, existing measures can be strengthened to cover a larger disabled population especially from the poorer sections of the society, and give new directions for economic rehabilitation of disabled people.

Community-based rehabilitation has not got the right kind of impetus in the country so far. As institutional care cannot be expanded for want of resources, community-based rehabilitation is considered as an appropriate alternative for a developing country. In a city like Madras, where expectations are high, community-based rehabilitation can be utilized at best for primary education. Communities with disabled children may have supportive voluntary organizations but they lack the right kind of expertise for vocational and economic rehabilitation.

Community-based rehabilitation requires thorough understanding of the role of community organizations and has to be backed by extensive training of those involved. This is unfortunately lacking as seen from the limited community-based rehabilitation experiments in the city. Voluntary agencies preparing to operate, seeking community-based rehabilitation programmes, should arrange for adequate training of their personnel by regional rehabilitation centres.

Recommendations

General

1. A national policy on ageing should be developed. Improving the living conditions of aged persons cannot be dealt at the city level alone. The city is governed by state and central legislations and also receives substantial aid from the state and central governments to implement a variety of programmes. In the absence of a national policy on ageing the agencies at the city level may not be inclined to incorporate programmes for aged people in their agenda.

2. Elderly people, between the ages of 60 and 75, though retired, are still active in body, spirit and mind. Only those who are elderly in the age group of 75 and above who are disadvantaged and physically infirm need to be targeted for care and attention.

3. Intradisciplinary studies should be conducted to assess the needs of the diverse elderly population with respect to specific shelter needs, social services and health services, in order to develop policies and identify specific programmes at city level.

Very few studies have been conducted on the vocational and economic rehabilitation of disabled persons. The Ministry of Welfare has identified certain jobs listed in the National Classification of Occupations as suitable for disabled persons. Further studies should be conducted to develop a good database for vocational and economic rehabilitation.

4. State level policies should clearly identify the role of various departments in the holistic approach to welfare of aged and disabled persons rather than restricting action to the Social Welfare Department and its few programmes.

5. There should be a separate allocation in the state budget for programmes for aged people. The budgetary allocation of the state for the welfare of disabled people should be increased.

6. The welfare of aged persons should be the responsibility of the municipal body. Intradepartmental coordination within the Municipal Corporation is better organized to mobilize different resources. Other state-level departments do not have the same reach.

Planning

7. There is a great deal of emphasis on physical planning, and the planning authority, the Madras Metropolitan Development Authority, should also he encouraged to emphasis social planning.

Housing - planning and building rules

8. Buildings designed for the housing of aged residents should not have more, than l+ 1 floors. They should have ramps with side railings on both sides.

   While sanctioning plans for public buildings and residential houses, these facilities should he mandatory.

9. Required amendments in the building rules should be incorporated to ensure minimum facilities for aged citizens in the various buildings not only in the city but also municipalities, townships and *panchayats* (local bodies governing rural areas) failing within the Madras Metropolitan Area.

   One of the major constraints for disabled children to attend schools is the architectural barriers in these institutions. The planning authority should study these problems in depth and suitably alter the building bye-laws to benefit the disabled.

10. Sites should be reserved for the housing of aged persons and for establishing institutions for disabled persons in all housing layouts and land banks. Such reserved land should be close to parks, community, open spaces, institutional areas and away from vehicular traffic.

11. Through cross-subsidies, land reserved for housing for aged persons and institutions for disabled persons should be made available free of cost or subsidized on par to organizations serving low-income groups.

12. Housing agencies, being commercial organizations, are tempted to speculate on land. Hence, land should be kept under the custody of the Municipal Corporation or the Madras Metropolitan Development -Authority or Directorate of Physically Handicapped for allotment to voluntary agencies or old peoples' associations.

Day-care centres

13. Noon meal centres under the control of Municipal Corporation, which are not in use, should be allotted to voluntary agencies for running day-care centres for elderly persons and community based rehabilitation centres for disabled clients.

14. The Municipal Corporation and the Social Welfare Department should also consider running day centres for aged persons in low-income areas, if a sufficient number of voluntary agencies do not come forward to run such centres under the Integrated Geriatric Welfare Scheme (IGWS).

Health

15. The work carried out by the Geriatric Unit of the Government General Hospital is commendable. However, a single unit in a large city cannot cover all the needy population. Out-patient geriatric services should be introduced by the Municipal Corporation in their clinics and dispensaries spread all over the city.

16. Geriatricians should be appointed in the Municipal Corporation clinics in some zones. All medical officers from other clinics should undergo an orientation course in geriatric health care under the guidance of the Geriatric Unit, Government General Hospital.

17. Geriatric units should be started in all major hospitals and the bed strength in the existing geriatric units should be increased.

18. Geriatric health workers should be appointed in these clinics, on the lines of health visitors in the mother and child care programmes, to visit geriatric patients at home to provide health counseling.

19. Suitable self-care health packages for elderly persons should be developed.

20. A suitable low-cost health-care insurance scheme for aged persons should be worked out and the premium for low-income clients should be paid by the government.

    Training packages on community-based rehabilitation for the disabled should be developed and training programmes should be conducted by the regional rehabilitation centres for disabled persons.

21. Aged and disabled poor requiring hearing aids, wheelchairs and other such aids should be identified and be provided with such aid on a regular basis rather than administering such programmes on an ad hoc basis.

Social security

22. Persons receiving an old age pension are very few in the city. The number of pensioners covered under the scheme should be increased to cover all the destitute and poor aged persons.

23. The amount paid as old age pension is not adequate. This amount should be increased based on the cost-of-living index.

24. At present the Revenue Departments are responsible for recommending old age pensions to the needy, though the programme is implemented by the Social Welfare Department. As the Municipal Corporation has wide infrastructure and personnel, the responsibility should be transferred to the Municipal Corporation.

25. The unemployment allowance is the only social-security programme for disabled persons and it is restricted to visually-handicapped persons who have registered with die Special Employment Exchange. The Social Welfare Department should register all visually-

handicapped and mentally retarded persons and provide them an unemployment allowance:

Safety

26. Attacks on elderly persons living alone are common. Security schemes should be evolved in conjunction with the police and voluntary agencies to ensure the safety of vulnerable groups of the aged population.

27. Encourage families to care for their elders and encourage the adoption of poorer elders by the affluent by providing suitable income tax exemptions to individuals and organizations.

Transport and travel

28. Priority should be accorded to aged travelers through separate counters and queues at hospitals, supermarkets, fair-price shops and ticket counters at railway/bus stations, cinema hails, etc.

29. Provide ticket fare concessions for elderly and disabled passengers in the suburban train services as is done for students and children.

    At present, a 25 per cent fare concession is extended to senior citizens aged 65 and over traveling beyond 500 Ian. The age limit should be brought down to 60 and the clause on 500 km and beyond should be deleted. The fare concession should be increased to 50 per cent.

30. Permit the aged to travel free of charge in the city bus service during non-peak hours.

31. If the homes/day centres are on vehicular routes, the bus stops should be located close to these services.

    The State Transport Department should run specially-designed buses for the benefit of disabled persons from their homes to institutions or workplaces and back. .

Other services

32. Voluntary agencies should organize a door-step bill-payment service (electricity, water, telephone etc." for elderly women and aged persons living alone.

33. Organize/encourage voluntary agencies to deliver food at the homes of those affluent aged who stay alone.

34. Arrangements should be made to extend counseling services to all retiring individuals to ensure better adjustment to the changing relationships within the family and community.

35. The Centre for Gerontology/service to the aged should act as an interface between government agencies and voluntary agencies to facilitate the expansion of programmes for the welfare of aged persons.

36. A city-level forum consisting of representatives of voluntary agencies should be established to monitor and implement programmes conceived both for aged and disabled citizens as a part of national-, state- and city-level policies.

37. The mass media may be encouraged and mobilized to create public awareness on the problems of aged and disabled persons to enlist public cooperation for their rehabilitation and to promote civic responsibility towards these marginal groups.

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