Enabling a More Promising Future for Long-Term Care in Canada

June 2023

AGEING IN THE *RIGHT* PLACE

NIA NATIONAL INSTITUTE ON AGEING

National Institute on Ageing

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The NIA is focused on leading cross-disciplinary, evidence-based, and actionable research to provide a blueprint for better public policy and practices needed to address the multiple challenges and opportunities presented by Canada's ageing population.

The NIA is committed to providing national leadership and public education to work with all levels of government, private and public sector partners, academic institutions, ageing related organizations, and Canadians productively and collaboratively.

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Acronyms

ADLs	Activities of Daily Living
AHS	Alberta Health Services
AIRP	Ageing in the *Right* Place
ALC	Alternate-Level of Care
CALTC	Canadian Association for Long-Term Care
CAs	Care Aides or Attendants
CCRS	Continuing Care Reporting System
CIHI	Canadian Institute for Health Information
CISSS	Centre Intégré de Santé et Services Sociaux
CIUSSS	Centre Intégré Universitaire de Santé et Services Sociaux
CLHIA	Canadian Life and Health Insurance Association
CLRI	Centres for Learning, Research and Innovation in Long-Term Care
CMA	Canadian Medical Association
CNO	College of Nurses of Ontario
CPP	Canada Pension Plan
DP	Dynamic Pension
GDP	Gross Domestic Product
GIS	Guaranteed Income Supplement
HCAs	Health Care Aides
HELOC	Home-Equity Line of Credit
HSO	Health Standards Organization
iADLS	Instrumental Activities of Daily Living
interRAI LTCF	interRAI LTC Facilities
LPNs	Licensed Practical Nurses
LTC	Long-Term Care
LTCI	Long-Term Care Insurance
MDAs	Maisons Des Aînés
NIA	National Institute on Ageing

NIC	NORC Innovation Centre
NORCs	Naturally Occurring Retirement Communities
NPs	Nurse Practitioners
OAS	Old Age Security
OCSA	Ontario Community Support Association
OECD	Organisation for Economic Co-operation and Development
OHTs	Ontario Health Teams
OTs	Occupational Therapists
PERS	Personal Emergency Response Systems
PHAC	Public Health Agency of Canada
PICS	Progressive Intercultural Community Services Society
PPE	Personal Protective Equipment
PSWs	Personal Support Workers
PTs	Physiotherapists
QPP	Quebec Pension Plan
REI	Race, Ethnicity and Indigeneity
RIA	Research Institute for Aging
RDs	Registered Dieticians
RNs	Registered Nurses
RPhs	Registered Pharmacists
RPNs	Registered Practical Nurses
SLPs	Speech Language Pathologists
TFPPs	Tax-Free Pension Plans
THE	Total Health Care Expenditures
VPLA	Variable Payout Life Annuities
WHO	World Health Organization

Executive Summary

For decades, older adults and their families, advocates and researchers have been calling attention to fundamental challenges in the way that long-term care (LTC) services have been traditionally conceptualized, funded, organized, and delivered across Canada.

Then, in early 2020, came the COVID-19 pandemic, which disproportionately affected those living and working in LTC homes, as well as receiving and providing home care — further highlighting the long-standing and inherent issues in Canada's LTC systems. With what we have learned over the last three years, this third — and final — report in our *Future of Long-Term Care Policy Series* helps to now re-establish what Canada needs to do to ensure that it can adequately meet the current and future LTC needs of its rapidly ageing population.

The report begins by building on the key challenges, opportunities, and enablers — outlined in the first two papers of this series — to further contextualize how we can facilitate a paradigm shift in the financing, organization and delivery of LTC services in Canada. In particular, we summarize the current challenges facing Canada's LTC systems:

- Canada's rapidly changing demographic profile to that of a super-aged nation;
- A long-standing legacy of government underfunding of LTC services across Canada;
- A mounting financial burden of out-of-pocket LTC expenses for Canadians;
- Canada's chronic and problematic predilection to provide care for older people in institutionalized settings;
- Rapidly expanding waitlists for publicly-funded LTC services;
- Ongoing staffing shortages due to long-standing LTC sector recruitment and retention issues;
- Canada's perilous overreliance on unpaid caregivers amidst a lack of support for them; and
- Growing quality inconsistencies of LTC services due to variations in legislation, regulations, policies and their enforcement.

Although there are many challenges currently facing Canada's LTC systems (as outlined above), there also exist significant opportunities to support much-needed changes that reflect the current LTC priorities of Canadians. The noted necessary changes relate to increased funding, support with navigating LTC systems, embracing models of care that align with the Canada's new national LTC standards, and improving access to home and community-based care that adequately supports older Canadians to age in their own homes and communities for as long as possible.

With this in mind, the remainder of the report presents a number of strategies — or emerging enablers and opportunities — that form the foundation of an evidence-informed road map for governments and policymakers to drive much-needed reforms in the delivery of LTC in Canada. Specifically, the roadmap includes strategies for:

- Changing the game: Transforming the delivery of LTC services across Canada;
- Preserving the lifeline: Increasing the recruitment and retention of Canada's LTC workforce;
- Building a strong foundation: Improving the affordability and sustainability of LTC systems in Canada; and
- Enabling data-driven excellence: Enhancing the quality and outcomes of Canadian LTC services through data collection and monitoring.

When it comes to *improving the delivery of LTC services*, we start by presenting a number of strategies for *enabling integrated and holistic LTC that is primarily community-based, and institutional by exception*. This includes adopting a reablement approach to the provision of LTC, providing care that is coordinated, integrated and responsive, and expanding options for supportive housing. Next, we present strategies for *enabling evidence-informed person-centered care that is equitable, accessible and aims to not just meet needs, but people's actual goals of care*. This includes *organizing care around individual needs and goals*, as well as *supporting inclusion, diversity, equity and accessibility* in the provision of LTC services. The final component for improving the delivery of LTC services focuses on *enabling technologies to support ageing in the right place* — such as technologies that enable reaching/serving more people, utilizing technologies that allow for greater assisted living and integrating technologies that connect people to knowledge and each other.

When it comes to *improving workforce recruitment and retention*, we present strategies for *enabling an LTC workforce that is appropriately supported and recognized*. In particular, we focus our attention on strategies for investing more in Canada's LTC workforce (e.g., appropriate staffing, increasing full-time employment opportunities and establishing wage parity) alongside efforts to balance the supply (e.g., number of care providers) and demand (e.g., number of people requiring LTC services).

When it comes to *improving the affordability and sustainability of Canada's LTC systems*, we outline a number of strategies for *enabling system sustainability and stewardship through more effective, efficient and sustainable financing arrangements*. In particular, improvements to the financing arrangements can be thought of in the following three major ways: what can be done by individuals (e.g., enhancing understandings of public pension programs, exploring options to mitigate risk of financial insecurity); the financial service industry (e.g., developing products to support payment of out-of-pocket LTC expenses); and policymakers

(e.g., re-allocating funding towards home and community-based care, creating a public LTC insurance program, introducing workplace tax-free pension plans).

Finally, when it comes to strategies for *improving data collection and monitoring*, we present strategies for *enabling evidence-based decision making through appropriate data collection and utilization*. These strategies include adopting a standardized data collection tool and an enhanced commitment to the collection and utilization of socio-demographic data to drive decision-making and facilitate better access to high-quality care across LTC systems.

As we move forward along this roadmap, using policy to facilitate Canada's journey along this road — or paradigm shift — will be integral in creating the necessary changes to improving the way that LTC services are funded and provided. We also acknowledge that the organization and delivery of LTC services is complex and that there are no easy solutions, but it is clear that without a paradigm shift in the way Canada finances, organizes and delivers LTC services, the challenges will only continue to prevent (or block the road to) the sustainable and fiscally responsible provision of high-quality LTC services.

Therefore, there is no time like the present to move forward with a balanced approach towards enabling a more promising future for the provision of LTC in Canada.

Introduction

For decades, older adults and their families, advocates and researchers have been calling attention to fundamental challenges in the way that LTC services have been traditionally conceptualized, funded and delivered across Canada.

In 2019, the National Institute on Ageing (NIA) launched its ground-breaking *Future of LTC Policy Series* to, for the first time, comprehensively examine both the current and future state of LTC services in Canada.

The NIA's first two reports were published in the fall of 2019 and clearly outlined that if nothing changed, Canada's LTC systems were on an untenable and unsustainable path.

The NIA's inaugural paper, *Enabling the Future Provision of Long-Term Care in Canada,* explored the pre-COVID-19 pandemic landscape of LTC services across Canada. This report highlighted that Canada was already struggling to meet the rapidly growing needs of its ageing population, which became even more widely apparent after the COVID-19 pandemic began to more broadly expose the long-standing short comings of Canada's LTC systems in early 2020.

The NIA's second paper, *The Future Co$t of Long-Term Care in Canada,* reported on its analysis using Statistics Canada's complex population microsimulation model to comprehensively project, for the first time, Canada's future LTC costs, both through public funding and care support that is provided to older Canadians by their families between now and 2050. It not only predicted that public LTC costs will more than triple over the coming three decades, but the availability of family caregivers to provide unpaid care to older Canadians would also likely decrease by one-third. Without that support, retiring Canadians will need to finance a longer retirement time horizon with less money and higher expenses. Should the projected unpaid hours of family care be paid publicly, this would lead to a quadrupling of the projected costs — representing more than one-quarter of all projected provincial and federal personal income tax revenue at that time.

Then, in early 2020, came the COVID-19 pandemic, which disproportionately affected those living and working in LTC homes, as well as receiving and providing home care — further highlighting the long-standing and inherent issues in Canada's LTC systems. Over the last three years, the NIA used its substantive knowledge of LTC services in Canada to examine the impact of COVID-19 in Canada's LTC homes, call for the collection of enhanced sociodemographic data in LTC settings, lead the development of new National LTC Standards, raise awareness about a number of chronic conditions impacting older Canadians and examine new ways to finance, organize and deliver future LTC services for Canada's ageing population.

With what we have learned over the last three years, this third — and final — report in our *Future of LTC Policy Series* helps to re-establish what Canada needs to do now to ensure that it can adequately meet the LTC needs of its rapidly ageing population.

This report brings together expertise in financial and health policy to present options and recommendations for a feasible and fiscally responsible set of policy strategies, to enable access to high-quality LTC services for all older Canadians.

A Summary of the Current State of Long-Term Care in Canada

The first and second policy papers in the NIA's *Future of Long-Term Care Policy Series* set the pre-COVID-19 context for an important evidence-informed conversation that has long needed to take place around the future provision of long-term care in Canada. Since these two reports were released, the COVID-19 pandemic further highlighted the need to provide the right mix of publicly desired, clinically appropriate and cost-effective LTC services that are delivered across a variety of settings and to a population with an increasing diversity of needs, abilities and challenges. At the same time, there is a growing demand and necessity to provide more high-quality LTC to Canadians within the confines of strained health care budgets and limited household means.

To get a better sense of what is needed to enable the future provision of LTC in Canada, we begin this final report by building on the key challenges, opportunities, and enablers — outlined in the first two papers of this series — to further contextualize how we can facilitate a paradigm shift in the financing, organization and delivery of LTC services in Canada.

In what follows, we summarize eight specific challenges (listed to reflect the interconnected and influential nature of each area) currently facing Canadian LTC systems:

- Canada's rapidly changing demographic profile to that of a super-aged nation;
- A long-standing legacy of government underfunding of LTC services across Canada;
- A mounting financial burden of out-of-pocket LTC expenses for Canadians;
- Canada's chronic and problematic predilection to provide care for older people in institutionalized settings;
- Rapidly expanding waitlists for publicly-funded LTC services;
- Ongoing staffing shortages due to long-standing LTC sector recruitment and retention issues;
- Canada's perilous overreliance on unpaid caregivers amidst a lack of support for them; and
- Growing quality inconsistencies of LTC services due to variations in legislation, regulations, policies and their enforcement.

Following the discussion of each of these specific eight challenges, we conclude with an acknowledgement of the overarching impact of societal and systemic ageism on the care of older Canadians. Taken together, this summary of the current state of LTC in Canada sets the stage for our proposed road map for enabling a more promising future for LTC in Canada.

Challenge #1: Canada's Rapidly Changing Demographic Profile to that of a Super-Aged Nation

It is now widely known that Canada's demographic profile is rapidly changing. Life expectancy in Canada has increased from around 60 years in 1920[1] to almost 82 years in 2020, which is among one of the highest in the world.[2] For example, between 2016 and 2021, the number of Canadians aged 65 years and older rose by over 18%, which is the second-largest increase in 75 years.

In fact, within the next few years, Canada will join the ranks of other super-aged nations, where at least 21% of our population becomes aged 65 and older.[3]

Further, some projections show that by 2031, nearly one-quarter of Canadians (23%) could be aged 65 years or older.[4] More recent projections suggest that by 2051, 24.9% of Canadians could be aged 65 years and older.[5] It is also expected that by 2046, the population aged 85 years and older could almost triple.[6]

As Canadians continue living longer, the number of people living with complex social and medical needs and, subsequently, in need of LTC services will also increase.[7] For example, of community-dwelling older adults who are living with newly identified dementia in Ontario, 48.4% were admitted to an LTC home within five years of diagnosis.[8] The Canadian Institute for Health Information (CIHI) also found that around 70% of those living in an LTC home are living with a formal diagnosis of dementia.[9] However, the vast majority of Canada's LTC homes have not been appropriately funded to have enough staff to provide adequate care to their residents. Nor do they have adequate access to specialized services, such as physical, occupational, speech or recreational therapists, and social workers, needed to provide resident-centred dementia care.[10]

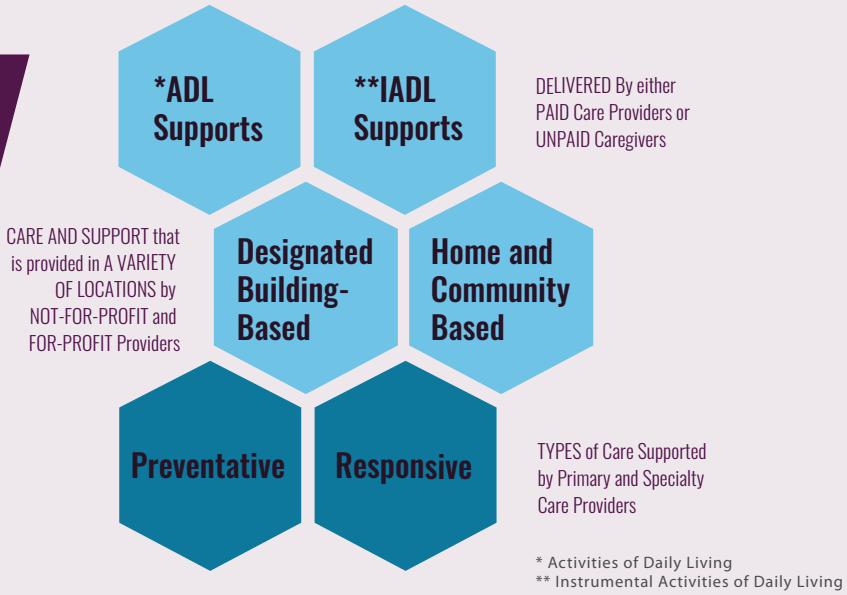
As a result, it is clear to see there is a mismatch between Canada's ageing population and shifting demographics and the provision of appropriate funding and care for older adults in Canada.

Key Terms

NIA Definition of Long-Term Care (LTC): To support its analyses, the NIA specifically adopted a broader definition of LTC than is traditionally considered in Canada. The NIA's definition, in line with other common international definitions, encompasses a continuum of care and support ranging from home care and community support services to those being providing in designated care settings like LTC homes, nursing homes or retirement homes (See Figure 1).

The NIA defines *long-term care* as a range of preventive and responsive care and supports, primarily for older adults, that may include assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (iADLs) provided by either not-for-profit and for-profit providers, or unpaid caregivers in settings that are not location specific and thus include designated buildings, or in home and community-based settings.

Figure 1: NIA Visual of the Components Inherent to the International Provision of Long-Term Care



***Activities of Daily Living (ADLs)*:** The World Health Organization (WHO) defines these as "the basic activities necessary for daily life, such as bathing or showering, dressing, eating, getting in or out of beds or chairs, using the toilet and getting around inside the home."[11]

***Instrumental Activities of Daily Living (iADLs)*:** The WHO defines these as "activities that facilitate independent living, such as using the telephone, taking medications, managing money, shopping for groceries, preparing meals and using a map."[12]

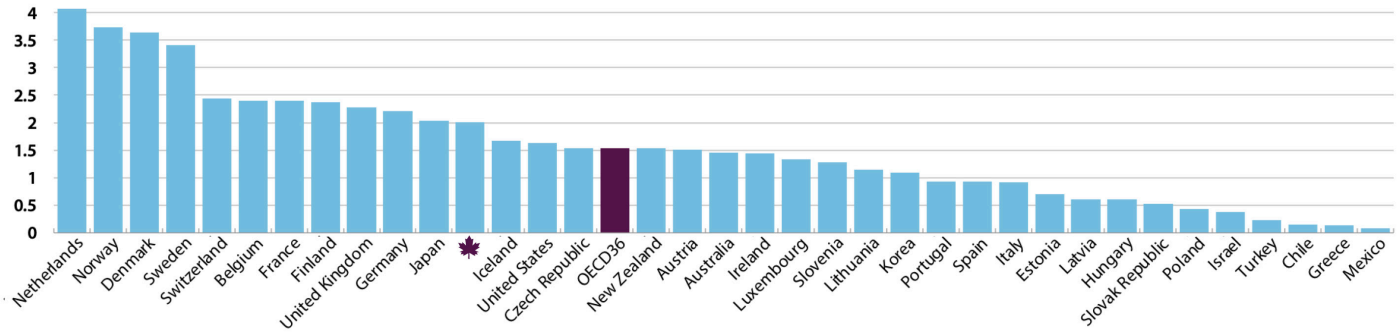
***Home Care and Community Support Services*:** This term refers to care that is provided in home-based settings rather than in a hospital or an LTC home, and which allows individuals to remain independent in the community.[13] Home care can be grouped into two types: home care services and home support services. The former principally focuses on the provision of health care services by trained professionals, whereas home support services focus on facilitating ADLs and include non-medical services (e.g. personal care).[14] Home care may be supplemented with community-based support services (e.g. adult day programs) to help older adults engage with their social and physical environments.[15]

Challenge #2: A Long-Standing Legacy of Government Underfunding of LTC Services Across Canada

Currently, there is growing demand and necessity to provide improved LTC services to Canadians within the confines of increasingly strained health care budgets and limited household means, as Canadians are living longer with more complex health, social and functional issues than previous generations. In fact, Canadians aged 65 years and older make up 19% of the population,[16] however, in 2017, this age group already represented 47% of Canada's total health care spending.[17] It is estimated that LTC health expenditures accounted for 19.4% of Canada's total health care expenditures (THE) in 2019, which was lower than several other Organisation for Economic Co-operation and Development (OECD) countries including Norway (29.7%), the Netherlands (28%), Sweden (26.4%), Belgium (22.9%) and Denmark (21.3%).[18]

When it also comes to spending on LTC services, Canada spent 2.0% of its Gross Domestic Product (GDP) on LTC services in 2019, which is almost 25% above the OECD average of 1.5% but still behind at least 10 other countries including Denmark, Germany, Japan, the Netherlands and the United Kingdom (see Figure 2).[19]

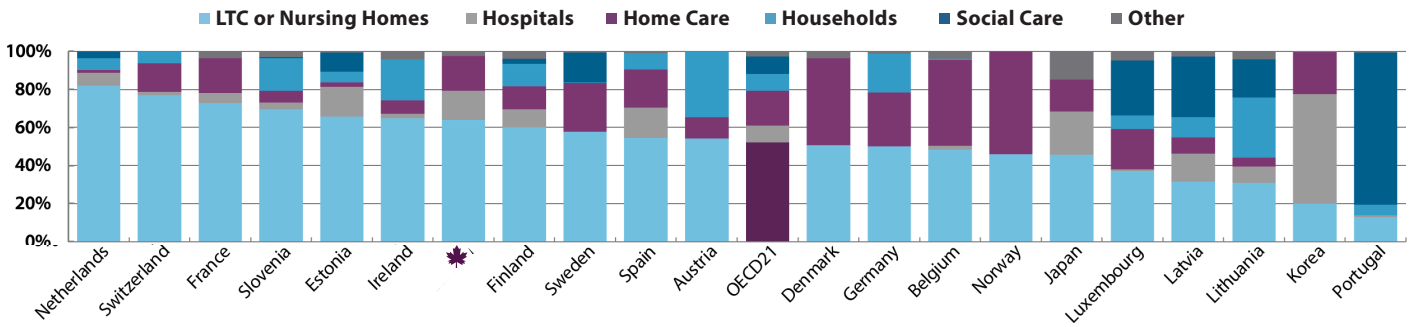
Figure 2. Canada Spends Less on Average of its GDP on the Provision of LTC[20]

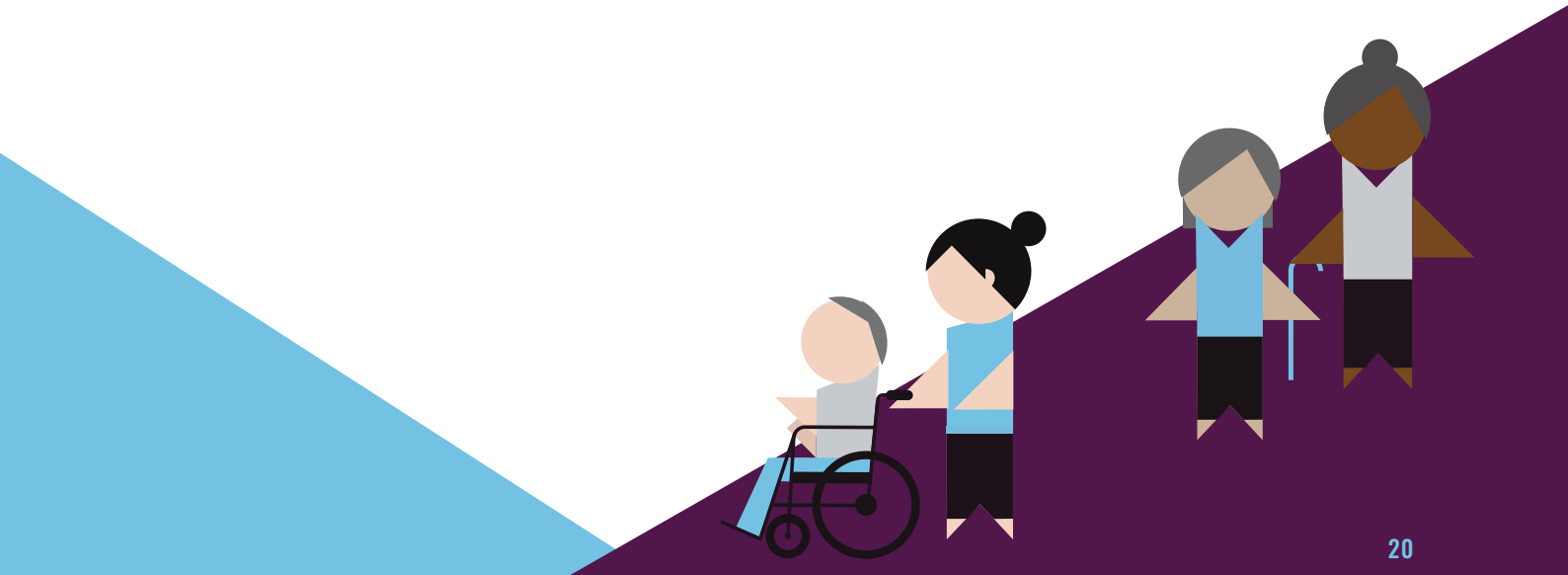


Further, the most recent available estimates from the OECD found that, in 2019, 64% of Canada's LTC expenditures were allocated to care in LTC settings including nursing or LTC homes (OECD average was 52%); 15% on providing this type of care in hospital (OECD average was 9%); and 18% on providing home and community-based care (OECD average was 36%) — as illustrated in Figure 3.[21] It is clear to see that government spending on LTC services continues to lag.

With respect to expenditures on providing home and community-based LTC, Canada continues to fall below that of other OECD countries. For example, Norway, Sweden, Denmark, Belgium and Germany spend a much higher proportion of their LTC expenditures on home and community-based care.[23] In 2019, Germany and Denmark both allocated 50% of their LTC expenditures toward home and community-based care.[24] The disparity in spending on home and community-based care is particularly salient given that approximately 14% of hospital beds, or around 7,500 beds, across Canada are occupied by "Alternate-Level of Care (ALC)" designated patients.[25]

Figure 3. Canada Spends far Less on Home and Community Care than on Care in LTC Homes[22]





Key Term

Alternate-Level of Care (ALC) refers to when a patient is occupying a bed in a care setting (e.g., hospital) and does not require the intensity of resources/services provided (e.g., acute, chronic or complex continuing care, mental health or rehabilitation). For example, a patient deemed ALC in an acute care setting may be discharged/transferred to one of the following destinations:

- home (with/without services);
- acute designated/specialized mental health treatment facilities;
- chronic or complex continuing care (facility/bed within or outside reporting facility); and/or
- LTC home.[26]

The Canadian Association for Long-Term Care (CALTC) notes that an average day of ALC designated care in a hospital continues to cost multiples of what delivering equivalent care in an LTC home or at home with home and community-based care, which ends up tying up thousands of expensively resourced hospital beds daily across Canada.[27] This strain is related to the inability of people to leave the hospital with publicly-funded home care or to go to an LTC home because the resources/beds are not available — despite being eligible to access — due to the complex interplay of staff shortages, limited funding, lack of housing options and mental health supports in the sector.[28,29]

While spending on the provision of LTC is increasing across Canada, it has not kept pace with the spending of most other Organization for Economic Co-Operation and Development (OECD) nations.

In fact, despite increases in spending on LTC services over the past 10 years, Canada continues to devote most funding to providing care in LTC homes, and deprioritizes home and community-based care and supportive housing with expenditures varying depending on the province or territory. For example, in 2020-21, some provinces spent an average of $300 per capita on home and community-based care, with Newfoundland and Labrador spending the most at $624 per capita and Quebec spending the least at $237 per capita.[30]

To further highlight the imbalance in LTC services expenditures across Canadian provinces and territories, Table 1 illustrates the percentage of growth (on the right) for home and community-based care spending for jurisdictions working to close the gap in funding on these services (i.e., spending on home and community-based care is increasing faster than other institutional care spending) over the period. While there has been rapid growth (almost doubled) of overall spending on home

and community-based care over the past decade, there are several jurisdictions that continue to lag behind (i.e., ON, MB, NWT, NU).

unpaid care for older Canadians — with the average unpaid caregiver increasing their efforts by 40% and the number of Canadians requiring their support projected to rise by 120%. If the public

Table 1. Spending Growth for LTC Settings and Home and Community Care by Canadian Jurisdiction*[31]

	Spending (Current $M) - Other Institutions			Spending (Current $M) - Home and Community Care		
PT	2012-13	2022-23 (forecasted)	% growth	2012-13	2022-23 (forecasted)	% growth
ON	4867.3	8863.0	82%	3058.4	4956.5	62%
QC	5718.7*	9653.8	69%	1335.6*	2648.6	98%
NB	412.9	501.1	21%	139.3	208.2	48%
NS	644.4	1007.1	56%	222.2	392.9	77%
PEI	83.4	135.2	62%	31.2	68.2	118%
NL	387.3	510.0	32%	219.6	399.1	82%
MB	788.4	1050.1	33%	357.7	431.4	21%
SK	684.0	879.6	29%	269.4	428.5	59%
AB	1502.1	2141.4	43%	740.2	1141.1	54%
BC	2195.6	3562.7	62%	1296.5	2399.2	85%
YK	29.9	73.1	144%	5.1	13.7	170%
NWT	44.4	83.9	89%	5.3	8.8	67%
NU	39.5	68.4	73%	3.7	4.8	29%
CANADA	15879.7	28529.2	80%	6348.5	13101.0	106%

In 2019, the OECD estimated that Canada's governments spent $38 billion on publicly-funded LTC health services.[32] MacDonald and colleagues have noted that specifically for older Canadians, the costs associated with public sector LTC will more than triple by 2050 — increasing from $22 billion to $71 billion, in constant dollars. However, this increase will not occur in isolation. The authors also project significant increases in pressure on

sector were to absorb these unpaid service costs, the cost of public LTC for older Canadians would instead quadruple from $22 billion to $98 billion between 2019 and 2050.[33]

It is clear that more funding is required to better support the future provision of LTC in Canada.

* Notes: 1) The % change for Quebec is between 2015-16 and 2022-23 (versus 2012-13 and 2022-23); 2) CIHI data on spending in "Other Institutions" also includes care provided in non-LTC settings, such as detox centres, and for younger persons living in LTC settings; 3) Spending is not deflated to account for increased system costs.

Challenge #3: A Mounting Financial Burden of Out-of-Pocket LTC Expenses for Too Many Canadians

Despite the fact that Canada is currently spending more on health, social and community services than ever before, many Canadians are often shocked when faced with navigating the many gaps within current publicly-funded LTC systems when they, or their family members, require care. In fact, the out-of-pocket health care costs often come as a surprise for some older adults, even though many older adults will experience a decline in their health as they age.[34] As a result, older Canadians (along with their families and/or caregivers) still have difficulty accessing the right care and supports at the right time.

Since the financing of LTC services is primarily the responsibility of provincial and territorial governments, the levels of funding and the subsequent range of public LTC services vary across Canada. As a result, the publicly-funded services must often be complemented with privately-paid services in order to keep more older Canadians at home (e.g., out-of-pocket, private LTC insurance plans or workplace health plans) and, mostly commonly, with unpaid care provided by family members and/or friends.[35]

For example, Canadian households spent an additional $9.4 billion out of their own pockets to access LTC health services — despite Canada's governments spending $38 billion in providing LTC health services in 2019.[36]

This, as MacDonald and colleagues noted, has "led to a fragmented patchwork of services where cost, access and provision of care varies across the country. Long-term care in Canada is best characterized as a 'targeted,' means-tested collection of programs and regulations."[37]

If the need for LTC services arises, the associated ongoing costs may indeed be out of reach for the average Canadian. In a 2019 national survey conducted for the Canadian Medical Association (CMA), Ipsos found that 88% of respondents were worried about the growing health care costs due to the ageing population, with 58% reporting that they will delay their retirement in order to afford the health care they need to remain healthy and independent in their own communities.[38]

In fact, about half of Canadians aged 60 and over were still working because they needed to.[39] Further, many Canadians will not have enough money to cover the full costs of LTC, or at least not sustainably — especially as Canadians are increasingly reporting difficulties with being able to save for retirement.[40,41] For example, almost half of Canadians are nearing

retirement without a pension plan from a workplace, and they have only $3,500 in median retirement savings.[42]

Despite people being concerned about the availability, quality and affordability of LTC, a Canadian Institute of Actuaries report found that less than half of Canadians had financially planned for retirement, and 27% of current retirees reported not thinking about or getting around to building a financial plan for retirement.[43]

Moreover, 67% of Canadians reported that they did not do anything when it comes to planning for LTC.[44] In its 2012 survey, the Canadian Life and Health Insurance Association (CLHIA) found that around 75% of Canadians have no financial plan in place to pay for LTC if they need it.[45]

When it comes to government support for later life financial security, one third of older Canadians receive the Guaranteed Income Supplement (GIS), which is meant for older Canadians with low incomes.[46] Of Canadians aged 55 years and older, 79% believe that current government-run and regulated retirement savings plans, such as Registered Retirement Savings Plans, Canada Pension Plan/Quebec Pension Plan (CPP/QPP), and Old Age Security (OAS) do not provide adequate savings to prepare for a comfortable retirement.[47] It is also important to note that public programs (GIS, OAS, CPP/QPP) are not meant to cover unanticipated expenses often associated with ageing. A recent report by the Conference Board of Canada (2019) found that while a number of older adults and their caregivers can take advantage of existing federal non-refundable tax credits to help offset some out-of-pocket expenses, these mechanisms have remained of little or no value to low or no-income individuals. The tax credits continue to remain underutilized, with only 4.6% of unpaid caregivers receiving money through these sources which still often provide insufficient coverage of their out-of-pocket expenses.[48]

Financial situations also play a role on the LTC options that are available to older Canadians. In particular, Canada's provincial and territorial LTC systems do not provide enough financial incentives and supports to be able to reduce barriers and costs associated with ageing in place — resulting in an increased reliance on unpaid caregivers and/or out-of-pocket expenses. For example, of Canadian households receiving home care services, only around 52% of them have their home care services funded solely by public sources, while around 27% of Canadian households paid for home care services using their own money.[49] Further, for households receiving home support services only, 44% of households pay out of pocket, compared to 39% who receive government funded services. For 12% of households, the costs of personal or home support can amount to $400 or more per month. However, out-of-pocket home care costs can be larger depending on the province. For example, in British Columbia, only older adults receiving GIS have their publicly-funded income-

based home care fees waived.[50] All other older adults have their home care costs calculated based on their income.[51]

Further, a 2015 national survey reported that 63% of respondents said that their family was not in a good position (financially or otherwise) to care for older family members if they needed long-term health care and it worried them greatly.[52]

In particular, although 42% aged 45 years and older say they may be expected to help cover living expenses for loved ones in the next five to 10 years, 47% say they do not have adequate financial resources to help cover living expenses for their ageing parents in the next five to ten years.[53] The NIA/Telus Health survey also reported that while 28% of Canadians said they already have unpaid caregiving responsibilities for an ageing parent or loved one, only 43% say that, if needed, they are personally and financially prepared to become a caregiver for an ageing family member.[54] As a result, 37% of Canadians aged 45 years and older say they would consider borrowing money to cover the costs of receiving in-home care for themselves or their loved ones.[55]

The COVID-19 pandemic has also had a significant impact on the financial realities of ageing. For example, the 2021 NIA/HomeEquity Bank survey that found 75% of Canadians aged 45 years and older say that the COVID-19 pandemic has made them more concerned about their family's financial security and well-being.[56] Further, recent research by the Canadian Institute of Actuaries indicates that the COVID-19 pandemic has exacerbated concerns about financial security in retirement. Nearly a quarter of Canadians reported that COVID-19 impacted their (or their spouse's) timeline for retirement — and that they will likely have to work longer in order to address these shortfalls.[57] Overall, greater awareness of the out-of-pocket costs associated with LTC alongside effective solutions are needed to augment the long-term financial security of Canada's ageing population by helping Canadians plan, save and pay for the financial costs associated with LTC.

Challenge #4: Canada's Chronic and Problematic Predilection to Provide Care for Older Adults in Institutionalized Settings

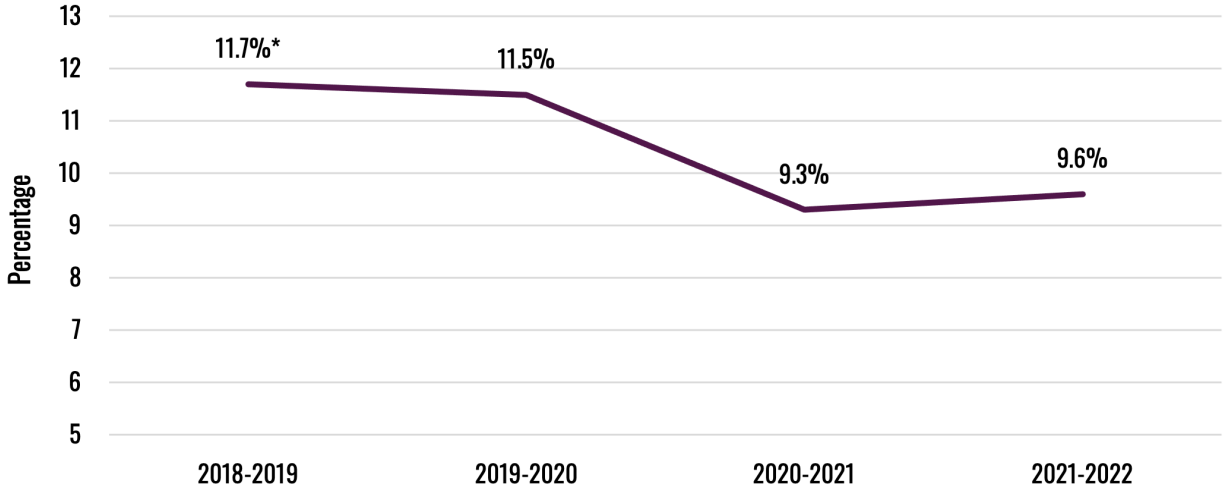
When it comes to the delivery of LTC services for older Canadians, the focus to date has been on the provision of care within LTC homes, rather than enabling ageing in the *right* place by providing more options to receive care at or closer to home. Despite the general predilection to provide care for older people within institutionalized settings (e.g., promises to "build more LTC beds"), still only a small percentage (12%, 709,500) of Canadians aged 65 and older received some form of LTC services in any setting in 2016—whether that is in LTC homes

(3.3%, 198,000)[†,58] or in their own homes with home and community-based care support (8.6%, 511,500).[59,60] However, more recent estimates based on 2021 census data state that an estimated 205,000 Canadians aged 65 years and older were receiving care in LTC homes.[‡,61] Further, among those aged 85 and over, almost 120,000 were living in LTC homes, representing 13.8% of Canadians in this oldest age group.[62,63]

The reality is that not all adults with complex care needs require the level of care provided in LTC homes. However, for many, an admission to an LTC home is considered the default rather than one of multiple options for care along a care continuum, ranging from low to high intensity LTC services that can be offered in a variety of settings.

Recent estimates from CIHI state that approximately 10% of older adults newly admitted to LTC homes across Canada could potentially have remained at home and in their communities if adequate home care and community-based supports were available (see Figure 6).[64]

Figure 6. Newly Admitted LTC Residents Who Could Potentially Have Remained at Home[§,65]



† Those receiving care in designated LTC buildings includes: LTC homes and half those reported as receiving care in facilities that are a mix of both an LTC home and a residence for older adults.

‡ Those receiving care in designated LTC buildings includes: LTC homes and half those reported as receiving care in facilities that are a mix of both an LTC home and a residence for older adults.

§ Only value entirely based on the Continuing Care Reporting System (CCRS), the other values had data collected from either CCRS or Integrated interRAI Reporting System.

CIHI researchers have noted that greater reliance on physical assistance (i.e., personal care, toileting, mobility, and eating) increases one's likelihood of being admitted to an LTC home — when compared to Canadians who are independent. For older Canadians, the availability of specialized services like nursing, physiotherapy, occupational therapy, home maintenance and personal support (hygiene care, support with dressing, meal preparation and housekeeping), financial barriers and difficulty navigating the health care system can mean the difference between being able to remain at home and having to seek care and support in a retirement or LTC home with the associated public and private expenses.[66]

Unfortunately, it is more difficult to find recent estimates of older Canadians who are receiving care in their own homes. However, in 2022 the NIA estimated that approximately 6.6 million Canadians aged 65 years and older (93.9% of this demographic) are living in their own private residence. Provincial figures from 2021-22 also shed some light as approximately 450,000 older adults were estimated to be receiving home care in Ontario alone — which means that the number of older adults across Canada receiving services is much higher.[67] Home and community-based care has been found to prevent adverse events as well as acute and chronic conditions, resulting in lower health care costs and fewer institutional admissions over the long-term, which in turn frees up additional costs that can be reallocated to patients with more complex care needs.[68] For example, delaying placement in an LTC home for people who do not need that level of service by providing them with appropriate support in the community — even for just one month — would have profound implications for increasing the overall capacity of the health care system, especially when multiplied across an entire service population. Likewise, eliminating time spent waiting in hospitals for home and community-based care would help reduce over-crowding and strain on the hospital system, and in turn help lower demands for budget increases from hospitals.[69]

Improved access to targeted home and community-based care, thus, not only has the potential to greatly improve the overall efficiency and quality of care available to older Canadians who require LTC services, it could also enable more older Canadians to age in their own homes and communities.

Ultimately, if adequate home and community-based supports (including supportive housing options) are not available in the future, older adults may continue to be prematurely institutionalized, further straining Canada's already overburdened LTC homes.

Challenge #5: Rapidly Expanding Waitlists for Publicly-funded LTC Services

Despite the relatively small proportion of older adults receiving LTC services, Canada's provinces and territories are already struggling to meet the growing demand for publicly-funded LTC — both in LTC homes, and home and community-based settings. In turn, older Canadians, their families and their caregivers often find it challenging to access the right care and supports when they need it.[70]

For individuals who require LTC services, waitlists have become a serious issue.

Unfortunately, this is not a new issue when it comes to accessing the right care, in the right place, at the right time, by the right provider. Looking back to 2012, the Ontario Long-Term Care Innovation Expert Panel noted then that "lack of integrated systems, poor coordination of admissions to long term care and overly complex rules related to eligibility and choice are resulting in bottlenecks, duplication, longer wait times and negative resident and family experience."[71] This statement remains true over a decade later as LTC homes across the country have reduced their capacity (without a comparable shift in home and community-based care) due to staffing shortages — contributing to increased wait times for LTC services. For example, waitlists have grown to as long as five years in some parts of Ontario, while wait times increased by 10-12% in Nova Scotia and 61% in Alberta since the beginning of the COVID-19 pandemic.[72] In Quebec, the waitlist for CHSLD (the French acronym for LTC homes) has nearly doubled since 2019 — rising from 2,477 in April 2019 to 4,067 people waiting for a bed in an LTC home in February 2023.[73] Further compounding the issue of access to LTC services, the emphasis placed on the provision of home and community-based care has not kept pace with demand. Before the COVID-19 pandemic began, Ontario home care providers reported being able to fulfill requests for care 95% of the time. This number, unfortunately, decreased to just 56% by the end of 2021 — in part, the result of the exodus of 4,000 nurses to other parts of the health care system since the beginning of the COVID-19 pandemic.[74,75]

In fact, in 2021, 6% of Canadian households reported using formal home care services in the previous year, with 48% of them receiving only home health care, 32% receiving only home support care and 20% receiving both.[76]

Further, it was estimated that in 2021, more than 52,000 Canadians were on waiting lists for placement in an LTC home,[77] while more than 430,000 Canadian adults were estimated to have unmet home care needs, with around 167,000 of them aged 65 years and older.[78]

Key Terms

Home Health Care: According to Statistics Canada, home health care includes "nursing care (e.g., dressing changes, preparing medications, [in-home nursing] visits), other health care services (e.g., physiotherapy, occupational or speech therapy, nutrition counselling), help with medical equipment or supplies (e.g., wheelchair, pads for incontinence, help with using a ventilator or oxygen equipment) and palliative or end of life care."[79]

Home Support Care: According to Statistics Canada, home support care includes supporting personal needs (such as bathing, housekeeping, meal preparation) and other services (such as transportation, meals on wheels)."[80]

Unmet home care needs, or households that felt there were times when they needed home care and the services were not received, was reported by 2.8% of Canadian households in 2021.[81] In particular, higher unmet care needs were reported in households in lower socioeconomic status (SES) areas (4%) compared to other neighbourhoods (3%) — which could be a reflection of the limited resources available in these neighbourhoods.[82] Interestingly, unmet care needs in neighbourhoods with a higher number of older adults were not significantly different when compared to other neighbourhoods.[83] Statistics Canada noted that this may be due to more home care being more readily available for older adults, or the fact that they may choose — or be forced to choose — living in an LTC home or other care options when home care is unavailable.[84] This is pertinent because older adults with higher and/or more stable incomes often have more options (e.g., private home care, assisted living and retirement housing) to expedite access to needed supports, while it is often lower income older adults who are prematurely and disproportionately admitted to LTC homes as they end up providing an affordable housing option — due to many jurisdictions offering subsidies to help cover their co-payments.[85,86,87]

As a result, older Canadians who cannot access timely and appropriate supports to remain in their own homes will likely need to be prematurely institutionalized in a publicly-funded LTC home.

In Ontario, home support services are particularly inaccessible for older adults who require lower levels of assistance (e.g., housekeeping, laundry and meal preparation) — which often results in rapid deterioration due to the lack of needed support, and subsequently, becoming ineligible to be cared for at home by the time they eventually qualify for more intensive home care supports. Indeed, it is clear that even small levels of home support services — especially early on — is important to ensuring older Canadians receive the right care, at the right time and in the right place.

When it comes to accessing LTC, it is clear that the most frequent barrier older Canadians face has been the overall availability of LTC services. However, there are also a number of additional barriers that further impact the accessibility of LTC services in Canada, including language, not knowing where to get care, the cost of care or being ineligible for care.[88] In fact, wait times are especially long for basic rooms — which are typically shared and more affordable — leaving lower income older Canadians at a disadvantage. Geographic location also creates disparities in access to LTC services, particularly impacting older adults living in rural and remote communities.[89] For example, Ontarians have different access to care depending on where they live due to the lack of both funding and available staff.[90]

Further barriers exist in accessing culturally safe and appropriate care. For example, in 2017-18, Wellesley Institute found that the median wait time for those waiting for a religious, ethnic or cultural LTC home in the GTA was 246 days or longer than those waiting for a mainstream home with the same level of needs.[91]

When looking at the 20 homes with the longest wait times, approximately 60% of them were for ethno-specific or religious LTC homes, while these homes represent only 6% of all LTC homes more generally.[92]

Further, older adults who reported neither English nor French as their first language waited longer than those whose first language was English or French. These barriers and challenges to accessing culturally safe and appropriate care in ethno-specific LTC homes have only increased in recent years due to the ongoing impact of the COVID-19 pandemic and the more recent introduction of the Government of Ontario's Bill 7 — which have further constrained access as new admissions to LTC homes are now almost exclusively "crisis" and/or hospital transfer admissions.

Key Term

Ethno-Cultural LTC homes are LTC homes that typically provide culturally appropriate services such as having staff speak the same language as residents, serving ethno-specific meals and delivering cultural or religious programs.[93]

For many people, simply making the decision to move their loved one into an LTC home is difficult and there is often anxiety about whether they had done enough to remain at home alongside concerns about the level of care they would receive.[94] These feelings may be amplified by the wait times for culturally appropriate homes — leaving many caregivers with feelings of guilt, worsening mental health without support, increased care load, lack of self-care and burnout. These impacts also have implications beyond the immediate caring relationship, extending to the rest of the

caregiver's support network as they may be absent, tired or overwhelmed. Further implications could also include caregivers reducing their hours at work, missing work or leaving temporarily or completely to provide care.[95]

These barriers to accessing LTC services also result in increased strain placed on the hospital system in Ontario and across the country. As many older Canadians report having unmet home care needs and others remain on waitlists for admission to an LTC home, the imbalance of care provision across LTC systems has resulted in thousands of Canadians waiting in expensive hospital settings as ALC designated patients until their long-term care needs can be met.[96] As a result, individuals in need of care, their families, and care providers from across Canada have all reported being pressured to choose less than ideal care options in the interest of alleviating ALC pressures.

While LTC home beds will continue to be needed in the future, there is also a clear need to target efforts to improve the availability of home and community-based care for older Canadians.[97] If there are not more adequate services available to older Canadians in their own home, there may continue to be older adults prematurely entering LTC homes, which will further increase the strain on the long-term care sector.[98]

Further, when older Canadians require the level of care that is provided in LTC homes, jurisdictions across Canada must also ensure protections are in place that enable timely access to culturally safe and appropriate care — especially during times of prolonged crisis, such as the COVID-19 pandemic.

Challenge #6: Ongoing Staffing Shortages due to Long-standing LTC Sector Recruitment and Retention Issues

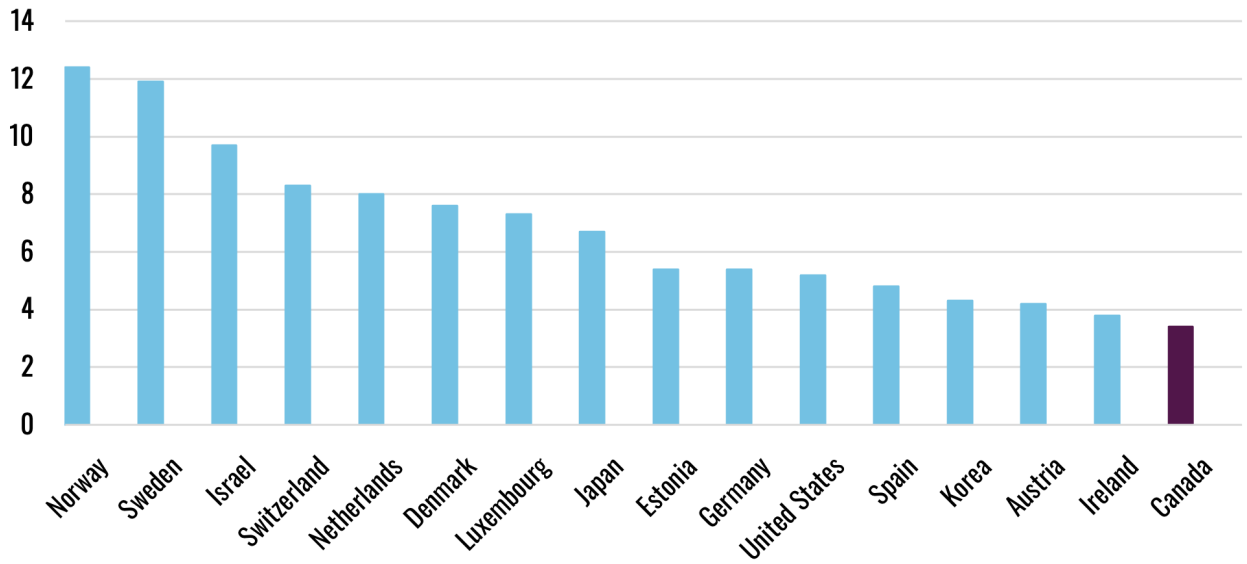
Providers of LTC services in Canada are facing mounting challenges in finding and retaining a qualified workforce** to support the growing and complex health and social care needs of an ageing population. As highlighted in *Enabling the Future Provision of LTC*, many of these challenges stem from the systemic over-prioritization of the provision of both primary and hospital-based care at the expense of those working in the LTC sector. Front-line care providers across Canada's LTC sector have generally been underappreciated, overworked and underpaid, despite being the teams and individuals who care for some of the most frail, vulnerable and complex amongst us. Indeed, the COVID-19 pandemic has only exacerbated these long-standing staffing challenges (e.g., increased hours worked by direct care employees,

** The LTC workforce in Canada is made up of hundreds of thousands of dedicated professional and non-professional care providers including: registered nurses (RNs); registered or licensed practical nurses (RPNs, LPNs); nurse practitioners (NPs); health care aides(HCAs), care aides or attendants(CAs), or personal support workers(PSWs); therapists including physiotherapists (PTs), occupational therapists (OTs), and Speech Language Pathologists (SLPs); registered pharmacists (RPhs); registered dieticians (RDs); recreation therapists; and other workers such as housekeepers and food services staff.

increased overtime hours, stagnated wages and heightened absenteeism, increased challenges to mental health) in ways that can no longer be ignored.[99] For example, nurses in Manitoba have identified their number one complaint was chronic understaffing — which, then, leads to an inability to spend adequate time with residents, delays in care, and rushing many aspects of care, which is not ideal when providing care.[100]

It has become more challenging to attract and retain individuals in careers caring for older Canadians with increasingly complex care needs.[101] For example, between 2020 and 2021, the number of registered nurses (RNs) and licensed practical nurses (LPNs) decreased in LTC and community health agencies—despite an overall increase in the number of people working in health care as a whole.[102] In fact, there was a 2.2% decline in RNs providing direct care in LTC homes and a 0.8% decline in licensed or registered practical nurses (L/RPNs) providing direct care in community health agencies. Further, there were increases in those providing direct patient care in private nursing agencies, occupational health centres, and self-employment.[103] As this decline relates to staffing shortages, the job vacancy rate for all industries in the second quarter of 2022 was 5.9%, with the rate in LTC homes and retirement homes being 6.8%.[104] In comparison, in the second quarter of 2015, the total job vacancy rate was 2.9%, with LTC homes and retirement homes being 1.9%.[105] When compared to other OECD countries, Canada continues to lag behind when it comes to health human resources (e.g., number of nurses and PSWs) working in LTC—as illustrated in Figure 4.[106]

Figure 4. Total LTC Nurses and Personal Care Providers per 100 Population Aged 65 Years Old and Over - 2019†† [107]



†† Netherlands, Luxembourg, Japan and Canada data points are estimated.

One of the most significant driving forces behind challenges to recruit and retain LTC care providers is the need for wage parity across health care sectors.[108] In fact, there are clear and marked differences in wages for PSWs, RPNs and RNs across different care settings — as shown in Figure 5.[109] For example, the average hourly wage for PSWs working in Ontario's home and community-based care sector (who have the same level of education as PSWs working in other sectors) is on average 26% less than those working in Ontario's publicly-funded LTC homes.[110] RNs also make less including an average of $11 less per hour, equating to 32% less than those in hospitals.[111]

As a direct result of these long-standing wage disparities, many integral frontline LTC staff have sought out better paying employment opportunities in other parts of the health care system (i.e., higher wages offered by staffing agencies) and beyond — especially during the COVID-19 pandemic.[112]

Further contributing to wage disparities, and subsequent staffing challenges, the majority of staff providing LTC services in Canada are unregulated workers such as PSWs — with over 90% of direct care being provided by these workers to LTC home residents.[113]

Figure 5. Wage Rates in Home Care versus LTC Home and Hospital in Ontario

Occupation	LTC Homes (Difference)	Home Care	Hospital (Difference)
PSW (per hour)	$22.69 ($5.39)	$17.30	$23.78 ($6.48)
RPN (per hour)	$29.40 ($4.29)	$25.14	$30.67 ($5.53)
RN (per hour)	$44.14 ($7.16)	$36.98	$47.75 ($10.77)

In fact, there is no Canadian jurisdiction that currently licenses or regulates care aides or PSWs working in LTC homes or home care. However, there are promising examples in two Canadian jurisdictions:

- In British Columbia, the *BC Care Aide & Community Health Worker Registry* is a registry of credentialed or "registered" health care aides (HCA) and community health workers for those wanting to, or working for, publicly-funded employers – including in acute care, assisted living, LTC homes and home and community care settings.[114] To be listed on the *Registry*, care aides and community health workers must submit an online application for review. Once the application is evaluated and approved by the *Registry*, the applicant is then provided with a registration number.[115] All publicly-funded health care employers in British Columbia can then verify and confirm that their prospective HCAs are registered. British Columbia also provides a list of educational institutions that offer HCA curriculum, which must be approved by the Registry before it is included on the list.[116]
- In Ontario, the *Advancing Oversight and Planning in Ontario's Health System Act* included plans for establishing a new legislative framework to support greater uniformity of education and training standards for PSWs; as well as establishing a new oversight authority (called the Health and Supportive Care Providers Oversight Authority) for the registration of PSWs including defining roles, responsibilities and accountabilities — but as of right now, registration in this authority will be voluntary.

Continued increases in critical staffing shortages have a significant impact on both employee safety and quality of resident care — as reported in over half of LTC homes and nearly half of retirement or assisted living facilities.[117]

Specific issues related to staffing shortages include:

- Inability to focus on providing resident-centred care;
- Reduction in critical staffing positions, such as housekeeping, dietary, laundry, clerical and recreation services;
- Increased reliance on temporary agency staff;
- Increased expectations for unpaid labour by staff, families, and volunteers; and
- Lack of recognition that care work is skilled work that requires education and training.[118,119]

Despite the number and variety of roles that are available for professionals in LTC settings, there is low public awareness of the existing career opportunities.[120] A recent Ontario Community Support Association (OCSA) survey highlights the impact of this lack of awareness — and underappreciation of such roles — stating that 17.4% of positions were vacant in 2021 for the top three frontline positions (PSWs, RNs and RPNs) in home and community care, for both full-time and

part-time employment opportunities. This is nearly triple the previous year's results, which had a 6.8% vacancy rate.

To further complicate this issue, Canada does not routinely collect data on the characteristics of its LTC workforce nor do they collect data on standards of their training.[121] As a result, Canada's total number of care aides or PSWs remains unknown, which creates significant challenges for workforce planning.

Therefore, it is clear that enabling the future provision of LTC in Canada must focus on addressing recruitment and retention strategies that include attention to wage parity, training, minimizing travel expectations and ongoing recognition.

Profiling Personal Support Worker (PSW) Perspectives

The Ontario Centres for Learning, Research and Innovation in Long-Term Care (CLRI) at the Schlegel-UW Research Institute for Aging (RIA) partnered with Overlap Associates in 2021, on a project aiming to better understand the experiences of PSWs in Ontario.[122] It became clear through their engagement that, in general, PSWs do not feel valued in their role, and that they feel unacknowledged, undervalued and overlooked. Although most of them take great pride in their work and very much care for the residents, they face many barriers and challenges that they would like to be addressed so they can continue providing high-quality care.[123] They stated the biggest challenge is staffing shortages, which lead to stress and impact their ability to provide the care they believed residents should receive.[124] PSWs similarly noted systemic issues including stigma, lack of prestige (associated with societal ageism) and not being acknowledged for their work, as well as poor communication.[125,126]

Since the COVID-19 pandemic, they have had even greater levels of stress including having to manage and implement protocols from the government, and inadequate access to personal protective equipment (PPE), in addition to their normal daily activities.[127] PSWs also noted that the needs of residents are becoming more complex, with increasing numbers living with more complex health conditions and dementia, and increased diversity of needs related to "language, culture, addictions, aggressive responsive behaviours and mental health needs."[128] They noted that they often felt viewed as "easily replaceable" or dispensable if they made mistakes and they did not feel they were recognized in their work.[129] Speaking specifically about HCAs (also known as PSWs in some jurisdictions), Chamberlain and colleagues noted: "the perception that their work is 'domestic', unskilled and thus as of less importance and value is counterproductive to actions that will improve their working conditions and the quality of care LTC home residents receive."[130]

Challenge #7: Canada's Perilous Overreliance on Unpaid Caregivers Amidst a Lack of Support for Them

Long-term care is provided in different places by different caregivers, depending on a person's needs. In Canada, over 8 million unpaid caregivers — usually friends or family of other Canadians in need — provide far more than the $25 billion annually in care cost savings for publicly-funded health care systems — as estimated over a decade ago.[131]

In *The Future Co$t of Long-Term Care in Canada*, the NIA estimated that, based on data from 2019, approximately 75% of total home care hours that older Canadians received (who were also receiving publicly-funded home care services) were being met by unpaid caregivers.[132]

The NIA reported that the number of Canadians who are going to require the support of unpaid caregivers is projected to increase from 345,000 to 770,000 (or growing by 120%) by 2050, with the cost of in-home care provided by these caregivers would increase the overall cost by a third to public sectors if paid publicly.[133]

Key Term

The NIA has adopted the Change Foundation's definition of caregivers as "the people — family, friends, neighbours — who provide critical and ongoing personal, social, psychological and physical support, assistance and care, without pay, for loved ones in need of support due to frailty, illness, degenerative disease, physical/cognitive/mental disability of end of life circumstances."[134] The NIA also pairs the term "caregiver" with "unpaid" as Stall and colleagues helped to determine that this pairing of words is preferred by those providing unpaid care.[135] The authors further noted that the term "informal" caregiver should be avoided as many unpaid caregivers may find this term insulting and invalidating.[136] While "family caregiver" or "family/friend caregiver" are also preferred terms, "unpaid caregiver" provides more inclusive terminology as it recognizes unpaid caregivers beyond those who are only family and friends.[137] When referring to a caregiver who is paid for their services, the NIA uses the term "care provider."

However, due to declining birth rates, there will be 30% fewer family members and friends to provide unpaid care in 2050 than there are today so those who are available would need to increase their efforts by 40% in order to keep up with the care needs.[138] If nothing changes, the number of caregivers for people living with dementia in particular will increase

to over one million by 2050, which would equate to an 188% increase in the number of caregivers in the next 30 years.[139] Although it is evident that unpaid caregivers have and will likely continue to save the health care system tens of billions of dollars, it takes a significant toll on them.

With approximately 35% of working Canadians balancing paid work with unpaid caregiving duties, these individuals are increasingly finding it a challenge to maintain a balance of work, life, and caregiving duties.[140,141]

In fact, a CIHI report found that 96% of individuals who are receiving long-term home care also have an unpaid caregiver in 2020.[142] The same report found that one-third of unpaid caregivers experience distress, which is an increase from 16% in 2010.[143,144] Further, caregivers who are living in distress spend an average of 37 hours per week providing care, which is two times the number of hours provided by caregivers who are not distressed.[145] Not only are all Canadian unpaid caregivers at an increased risk of burning out, but the added challenges being faced by unpaid caregivers who also work are now being identified as a significant potential threat to Canada's future economic productivity.[146]

Moreover, the COVID-19 pandemic has only enhanced Canadians desire to age in place — with 96% of Canadians aged 65 years and older reporting that they would do everything they can to avoid going into an LTC home — which will have significant implications for the demand for unpaid care.[147]

The NIA and others have also previously highlighted some additional issues facing Canada's unpaid caregivers, including the fact that their role often remains inadequately recognized, there are limited financial supports for unpaid caregivers, especially working unpaid caregivers. The health care system is difficult for unpaid caregivers to navigate because of a lack of integration between service providers, there are significant financial, emotional and physical costs associated with caregiving, and there is a lack of information or formal training for unpaid caregivers.[148]

Looking to the future, the growing care and financial burdens being placed on family members, friends and neighbours acting as unpaid caregivers should not be underestimated, as it could likely threaten the ongoing availability of persons willing to serve in such roles.

The NIA further recognizes that LTC policies need to not only deliberately recognize the presence of non-government funded care providers, including unpaid caregivers, but also the role that government-enabled supports can play in the future delivery of LTC, such as benefits for unpaid caregivers.

Challenge #8: Growing Quality Inconsistencies of LTC Services Due to Variations in Legislation, Regulations, Policies and their Enforcement

The long-standing under-resourcing of LTC across Canada by governments is also reflected in the widespread lack of national and jurisdictional data on the coverage, quality and access to LTC services. For example, there are no standardized Canada-wide data on the costs of accessing home care or LTC homes, nor on the range of LTC services provided within these settings.[149] In fact, all jurisdictions across Canada are facing similar challenges around quality, access, efficiency, financial sustainability, political will and the ability of each government to pay for its LTC services.

With no established federal standards for this type of care across Canada, there exists a patchwork of programs and variations in the availability of services, level of public funding, eligibility criteria and out-of-pocket costs for clients and residents as each jurisdiction has created their own health and reporting systems.[150] The variable and inconsistent utilization of data to inform decision-making then creates a ripple effect that leads to variable standards and enforcement — which, in turn, leads to variable quality of LTC services as leaders and policymakers cannot identify priority areas for political intervention.[151] As a result, the impacts of ongoing deficits in the provision of LTC services that are experienced by older Canadians cannot be properly evaluated and addressed and therefore remain hidden.

Policies to better enable data collection and utilization will be one of the best ways to broaden perspectives on addressing the long-standing challenges facing Canada's LTC sector.

In fact, this is one of the reasons why the federal government made the important decision to revisit and revise Canada's National Long-Term Care Standards, with new standards for LTC recently developed by Health Standards Organization (HSO) and the Canadian Standards Association with the support of the Standards Council of Canada.[152]

In particular, the new HSO standard provides LTC home residents, teams and the workforce, leaders, and governing bodies with guidance on:

- Providing evidence-informed, resident-centred care that values compassion, respect, dignity, trust and a meaningful quality of life.
- Working in a team-based way to deliver high-quality care that is culturally safe and trauma-informed to meet residents' goals, needs and preferences.
- Enabling a healthy and competent LTC home workforce and healthy and safe working conditions.
- Upholding strong governance practices and a culture that is outcome-focused and committed to continuous learning and quality improvement.

The development of these standards has been a collaborative approach rooted in several phases of engagement with residents, families, health care providers and policymakers across Canada.[153] In total, HSO's National Long-Term Care Services Standard Technical Committee heard from over 18,500 people through a variety of engagement activities such as a national survey, consultation workbooks, town halls and public review.[154]

In fact, a key component of the new National Long-Term Care Services Standards is a renewed focus on data collection and promoting quality improvement. However, unless LTC providers receive significantly more resources it may be very challenging for them to implement and meet these new national standards.

Further, the impact of variable standards is perhaps felt most acutely when it comes to recent efforts — spurred by evidence on the inequitable impacts of COVID-19 across Canada — to enhance equity, diversity and inclusion within LTC homes across the country. In 2021, the NIA and Wellesley Institute co-authored a report, *Leaving No One Behind in Long-Term Care: Enhancing Socio-Demographic Data Collection in Long-Term Care Settings*, highlighting the importance of socio-demographic data as a tool for measuring and reducing health disparities among people across different population groups and from different backgrounds. Evidence from Canadian literature clearly demonstrates that health outcomes differ based on social and demographic factors such as sexual orientation, gender identity, language, race, immigration status and ethnicity, as well as access to affordable housing, adequate income, social inclusion and other factors.[155,156]

While current research is limited, the existing evidence sheds light on some of the existing inequities in Canadian LTC settings, highlighting the importance of collecting and analyzing socio-demographic data, as well as the need for better data collection on diverse population groups living in LTC homes.[157]

The limited use of integrated health records is another continuous challenge to the delivery of high-quality care; shared and effective information systems, can improve communication, coordination and make transitions smoother, with fewer errors.[158] In Ontario, for example, care assessment, planning, and resource allocation is often determined using mobile or web-based software, with limited integration between other systems of information technology (i.e. primary care or hospital). This results in greater siloing of care providers, which in turn leads to the further fragmentation of care for care recipients.[159]

It is also important to note that calls for enhanced data collection and standardized regulations within Canadian LTC settings can also create barriers when implemented inappropriately. In practice, regulations have a significant impact on the type of care that is delivered and how it is provided, which ultimately impacts quality of care for residents. For example, the additional burden of regulations within LTC homes can create and reinforce a "culture of compliance" where time is diverted from clinical care toward performing regulated tasks and mandatory documentation — and subsequently, impeding the delivery of emotion-focused care.[160] Nurses in these settings have noted that regulations sometimes placed constraints on their creative thinking and professional judgement and led to a greater level of inflexibility in responding to the individual needs and care preferences of their residents.[161] Excessive documentation burdens often leave little time to develop relationships with LTC home residents.[162]

While it is clear that efforts are being made to address the variable quality of LTC services across Canada, what is increasingly clear is that better collection and utilization of data should be guiding these efforts.

Bringing It All Together: The Overarching Impact of Societal Ageism on the Care of Older Canadians

As we look towards enabling a more promising future for long-term care in Canada, we would be remiss if we did not acknowledge the overarching impact of societal and systemic ageism on the care of older Canadians — especially as it is linked to the eight specific challenges discussed above. Within and beyond Canada in recent years, there has been a growing acknowledgement of the overarching impact of ageism on the LTC experiences of older Canadians — manifesting in varied ways with profound implications for the well-being and quality of life of older adults.[163] In fact, one Canadian survey[164] highlighted that 80% of Canadians agree with the statement, "older adults 75 and older are seen as less important and are more often ignored than younger generations"; while another[165] reported about one in three (31%) Canadians aged 50 years and older reported having experienced ageism.

Key Term

Ageism: Commonly understood to be the pervasive and widespread "stereotyping of, and discrimination against, individuals or groups because of their age" within society.[166] While this broad definition includes those who are young or old, ageism appears to be a more significant issue for older members of society. Indeed, many have come to remark that ageism remains one of the most unchallenged forms of discrimination in our society.[167]

Ageist attitudes and stereotypes contribute to shaping the perceptions and treatment of those who need and provide LTC services.[168] For example, the impact of ageism may lead to:

- Underestimating the capabilities, disregarding the preferences and diminishing the autonomy of older Canadians;
- Undermining the dignity and personhood of older Canadians;
- Feelings of disempowerment, marginalization and social exclusion among LTC residents; and
- Lack of person-centered approaches to care provided by the LTC workforce.

At the systemic level, the ongoing devaluing professions within the LTC sector has led to inadequate staffing levels, less attractive compensation packages to attract and retain staff, and insufficient training in the provision of geriatric care. Furthermore, systemic ageism can influence policy decisions, resource allocation decisions and funding priorities, resulting in limited choices and a lack of investment in alternative models of care that prioritize independence and individualized support.[169] This can impede the availability and accessibility of the right care — that aligns with preferences and needs — in the right place at the right time.

Overcoming the overarching impact of ageism on the long-term care experiences of older Canadians necessitates comprehensive action.

Therefore, the road forward must involve challenging ageist attitudes and systems as we work to promote person-centered care models, enhance training for LTC staff and advocate for policy changes that prioritize the rights, autonomy and well-being of those who live and work in LTC settings across Canada.

Long-Term Care is at a Crossroads in Canada

The COVID-19 pandemic has only exacerbated the long-standing inherent challenges that Canadians already knew existed in our LTC systems, such as underfunding, staffing shortages and long waitlists.

This was amplified as Canada earned the unfortunate position of leading the OECD countries in COVID-related mortality in LTC settings, with LTC home residents accounting for 81% of COVID-19 deaths in Canada in June 2020 — compared with an average of 38% in other OECD countries.[170]

A key contributing factor to the significant number of deaths in Canadian LTC homes is the outdated layout of many Canadian LTC homes, which feature inadequate infection control design and ventilation, large populations, shared rooms and bathrooms, large gathering rooms, lack of access to outside spaces and narrow hallways.[171,172] This not only made strong infection control efforts nearly impossible, but also placed people living with dementia in LTC settings at increased risk of developing COVID-19, a population already vulnerable to infection due to frailty, poor lung health, multiple co-morbidities and an inability to express their symptoms such as pain.[173]

As a result, COVID-19 disrupted traditional care delivery channels and prompted a significant and expedited shift to virtual models of care. This shift, however, highlighted that the delivery of LTC services remains a largely "hands-on" endeavour — further demonstrating the need to address staffing shortages.

On the other hand, countries with smaller, less crowded and more home-like LTC environments were better able to weather the COVID-19 isolation and infection-related issues, and these environments have also been shown to be better for residents overall.[174] For example, Green House LTC homes, which are built in small home formats with 10–12 residents living in a household setting, each with their own private bedroom and bathroom, found that residents were one-fifth as likely to get COVID-19 as those living in typical large LTC homes and one-twentieth as likely to die from COVID-19.[175] In addition to providing care in smaller, more home-like LTC settings, these countries also had specific and mandatory prevention measures targeted to LTC homes and stay-at-home orders with closure of public places, which led to fewer COVID-19 infections and deaths in LTC homes. Some of these measures

included immediate IPAC measures, broad testing and training, isolation wards and support for LTC workers including surge staffing, specialized teams and PPE.[176]

What is perhaps most clear after three years of the COVID-19 pandemic is that Canadians want to stay in their own homes and communities for as long as possible.

In fact, almost all Canadians aged 65 years and older reported that they planned to support themselves to live in their own homes for as long as possible — compared to 83% of Canadian adults as reported in a 2013 RBC survey.[177,178] This survey, conducted by the NIA and the CMA during the second wave of the COVID-19 pandemic, also found that 85% of Canadians and 96% of those aged 65 years and older reported they would do everything they could in order to avoid going into an LTC home.[179]

However, factors such as the inability of Canadians to pay out of pocket, the inadequacy of public home care support, the strains on unpaid caregivers, the already insufficient levels of public LTC spending and staffing shortages do not support this preference and will, ultimately, result in greater unmet care needs in the population, unless something changes.

Where Do We Stand Now?

While the COVI9-19 pandemic shone a bright light on the cracks of Canada's LTC systems, it has also spurred efforts toward system transformation.

The federal, provincial and territorial governments across Canada know that Canadians increasingly want to age at home and in their communities.

Mounting fiscal pressures have led provincial and territorial governments to emphasize providing more care at home rather than in more expensive care settings such as LTC homes.

In the 2021 budget, the federal government announced its intention to improve the provision of LTC, as well as support ageing-in-place initiatives.[180] In particular, the government announced $3 billion over five years to improve the delivery of care in LTC homes by developing and implementing new national LTC standards that were released in January 2023.[181] This move has also prompted several provinces to announce reviews of their own LTC home standards.[182] The government also pledged $90 million over three years for a new Age Well at Home initiative, which would assist community-based organizations in providing support for low-income and vulnerable older Canadians. The Minister of Seniors has also announced that work is underway on establishing an Aging at Home

Benefit informed by recommendations provided by a panel of experts from the National Seniors Council.[183] Further, during the 2021 election campaign, the incoming Liberal Party of Canada pledged to expand its previous $3 billion commitment to $9 billion, with $1.7 billion over five years to raise wages for PSWs to a minimum of $25/hour and $500 million to train up to 50,000 new PSWs.[184] Part of this commitment was included in Budget 2023, which mentioned support for wage increases for PSWs and related professions, but without stating a minimum hourly wage target.[185,186]

At the provincial and/or territorial level, it is clear that many are struggling to find ways to better accommodate the type of LTC services that Canadians are looking for.

In particular, many jurisdictions are pledging more increases to home and community care spending, others — including Alberta, Quebec and Prince Edward Island — are making investments in their models of LTC, still others are working on plans to expand infrastructure, like Ontario's plans to create 30,000 new LTC homes by 2028.[187]

Some specific examples from jurisdictions across Canada include:

- Alberta has made changes including moving away from having multiple people living in the same room, increasing the number of home care hours provided and improving access to palliative care and caregiver support.[188] They have also announced that one of the changes they want to implement to change their continuing care system is to promote the development of smaller scale LTC homes.[189] In August 2021, the government announced that they had made significant progress on reducing the number of multi-resident rooms in publicly-funded facility-based continuing care and there are only five rooms remaining across the province, housing a total of 15 residents.[190] The government of Alberta has also announced that it will make a further investment of $3.2 billion, with $1.7 billion to community care, $1.2 billion for continuing care and $750 million for home care.[191]
- Quebec has pledged to develop small LTC home models of care "Maisons Des Aînés" (MDAs) at an expected cost of $2.8 billion. This initiative will create around 2,600 spaces for older adults through renovating existing beds and creating 46 new LTC homes inspired by the Green House model.[192] The MDAs are areas in the home with 12 residents, each with a separate bedroom and shower and they are designed as an L-shape, with the corner of the "L" representing the kitchen and dining room. While this model is similar

to the Green House model, it has not taken the step of removing nursing stations altogether as is the case in Green Houses, but they have a medical and administrative service provided in a separate wing for two MDAs.[193]

- Prince Edward Island has committed to additional steps to assist older adults – including those who want to continuing living in their own homes. This includes investing over $2.2 million in the expansion of existing ageing-in-place programs, such as the ***Seniors Safe at Home*** and ***Seniors Home Repair*** home renovation programs, as well as its ***Seniors Independence Initiative*** (which is discussed later in this report).[194,195] The PEI government is also beginning work on the Primary Caregiver Grant, which would support families to keep their loved ones at home with up to $1,500 a month.[196]

While these efforts to improve the funding and provision of LTC services in Canada are promising, the need remains for an overall paradigm shift that will create opportunities for LTC that better reflect and support the desires and preferences of Canadians to age in the right place. To date, no truly transformational paradigm shift has emerged.

Given Canada's imminently ageing population and the challenges that LTC is already facing, it is critical to find and implement workable solutions quickly that will transform the organization, delivery and affordability of LTC services while also balancing fiscal responsibilities — and at the same time holding the important goal of enabling older Canadians to age in the right place at the fore.

Where Should We Go from Here? The Need for a Paradigm Shift to Support a More Promising Future for Long-Term Care in Canada.

While it is clear that federal, provincial and territorial governments are now attuned to the untenable situation within Canada's LTC systems, increases in funding alone will not be enough to address long-standing issues and transform the future provision of LTC, especially if allocated to simply doing more of the same. Instead, we need to fundamentally rethink how we finance, organize and deliver LTC services because Canada's current path remains unsustainable.[197]

Although there are many challenges currently facing Canada's LTC systems (as outlined above), there also exist significant opportunities to support much-needed changes that will reflect the current LTC priorities of Canadians, as well as the priorities outlined in the first paper of this series (see Box 1). The noted necessary changes relate to increased funding, improving access to home and community-based care, support with navigating LTC systems, embracing models of care that align with Canada's new national LTC standards, and improving access to home and community-based care that adequately supports older Canadians to age in their own homes and communities for as long as possible.

Box 1. Revisiting the NIA's 2019 Vision Statements[198]

In 2019, the NIA identified emerging enablers and opportunities that could be used to support the comprehensive and positive change that is needed to enable future provision of LTC in Canada. Indeed, a sustainable and successful future will depend on us adopting a strategic approach that is grounded in the following principles:

1. Enabling evidence-informed integrated person-centred systems of LTC, accounting for the expressed needs and desires of Canadians.
2. Supporting system sustainability and stewardship through improved financing arrangements, a strong health care workforce and enabling technologies.
3. Promoting the further adoption of standardized assessments and common metrics to ensure the provision of consistent and high-quality care no matter where Canadians need it.
4. Using policy to enable care by presenting governments with an evidence-informed path toward needed reforms.

These were chosen to be the basis for the continued conversation around creating a sustainable and successful future. Achieving this will require decisive action based on solid evidence, that enables innovation and begins an honest national conversation around what it will truly cost to provide better, more equitable and higher quality care for all Canadians. For the purposes of this paper, the NIA has adapted these vision statements as the foundation for the road map moving forward.

Despite the many possibilities for reimagining the future provision of LTC in Canada, their impact will be dampened if there is not simultaneous work to both address the overarching impact of ageism alongside the development of a common understanding of the direction and overall scope of LTC services in Canada. It is important that Canadians understand what is required to age in the right place — in other words, clearly defining the "social contract" around ageing in Canada. Canadians of all ages also have the right and ability to understand how they can participate in determining the best ways for them to age with independence, dignity and respect in the place of their choice.

While Canada's universal health care system may not be perfect, its principles are a clear point of pride for many Canadians. As a result, Canadians expect their government to provide the essential care they will need and are therefore surprised when faced with an LTC system that is not better funded by the government to meet their needs. Instead, the provision of LTC for many Canadians relies on a mix of public and private funding, and varies in the way it is structured, organized and delivered across every province and territory, and in many cases within individual provinces and territories, creating a literal "postal code lottery" of care.

Governments have a central role to play in providing the right care and support, in the right place, at the right time and by the right provider. It needs to be transparent to Canadians what the government will provide and what older people and their families will need to do for themselves in order to ensure that the options (i.e., LTC services) are better defined and easy to navigate.

However, Canada currently does not have a national framework or plan for enabling the future provision of LTC, largely because the provision of LTC is the individual responsibility of each province or territory.

This remains a significant barrier to improving the quality, safety and availability of long-term care for all Canadians. The proposed new Safe Long-Term Care Act could outline a pan-Canadian vision for the delivery of LTC that reflects the new national standards. Ultimately, in order to move forward, all provincial and territorial governments need to work in partnership with the federal government to develop a road map for enabling a more promising future for LTC in Canada which contemplates a range of policy interventions that touch on innovative models of care, the workforce and funding models.

It is clear, now more than ever, that prioritizing the strengthening of Canada's LTC systems will have widespread benefits for all, including older Canadians, unpaid caregivers, the LTC workforce and employers, the health care system (including hospitals) and all levels of government.

It is time for a paradigm shift to support the future provision of LTC in Canada.

Facilitating a Paradigm Shift to Support a More Promising Future for LTC in Canada: Developing the Roadmap

In 2015, the WHO acknowledged the variations in LTC systems across the globe. In Canada's case, there are some core general principles that should apply to all provincial and territorial systems. The WHO (2015) contends that all LTC systems:

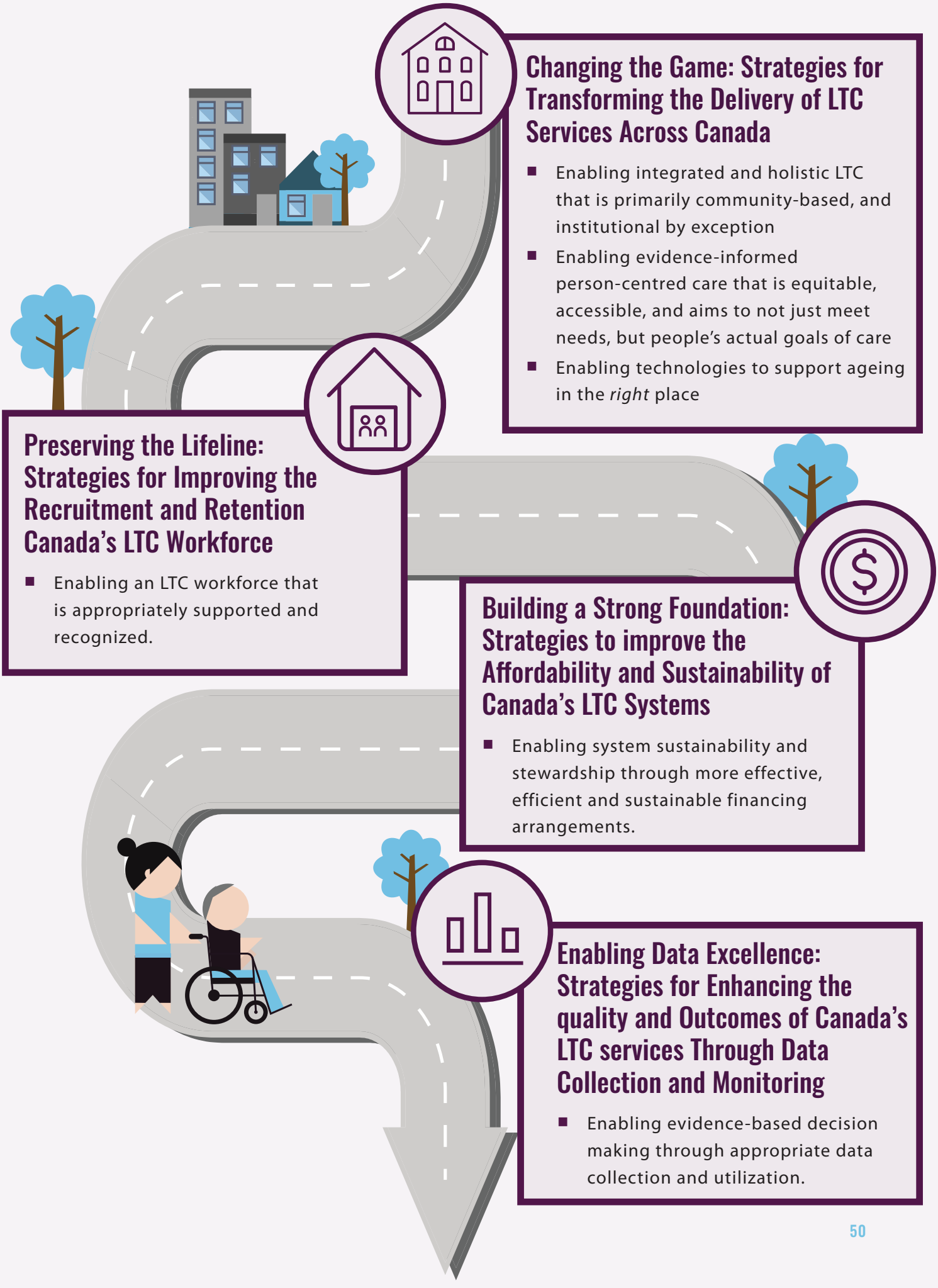
- Must be affordable and accessible;
- Must uphold the human rights of care-dependent older adults;
- Should enhance older people's intrinsic capacities;
- Should be person-centred;
- Should treat the workforce (both paid and unpaid) fairly and give it the social status and recognition it deserves; and
- Must have their national governments take responsibility for the stewardship of LTC systems.

Building from these principles and the vision statements outlined in *Enabling the Future Provision of Long-Term Care in Canada* (see Box 1 above), we present a number of strategies — or emerging enablers and opportunities — for facilitating a paradigm shift to better enable the future provision of LTC in Canada. When taken together, the following sections outline the strategies that form the foundation of an evidence-informed road map for governments and policymakers to drive much-needed reforms in the delivery of LTC in Canada.

Indeed, there has been a growing emphasis on promoting more person-centred, flexible LTC models that prioritize well-being, prevention, engagement and choice. While the policy of de-emphasizing care provided in designated buildings has been motivated by evolving societal care preferences to enable the provision of care closer to home and the need to create a more sustainable health system, it is clear that the right incentives can drive the right change. This final section highlights emerging and leading strategies (i.e., evidence-informed models of care, support and care practices) that the NIA and its stakeholders from across Canada have identified. Specifically, the road map includes strategies for:

- Transforming the delivery of long-term care services across Canada;
- Increasing the recruitment and retention of Canada's long-term care workforce;
- Improving the affordability and sustainability of long-term care systems in Canada; and
- Enhancing the quality and outcomes of Canadian long-term care services through data collection and monitoring.

Each innovative model of care, support, or care practice that is presented could either be introduced into the Canadian context — or, if already present, could be spread across Canadian jurisdictions in an effort to shape an enhanced future for the provision of LTC.



Changing the Game: Strategies for Transforming the Delivery of LTC Services Across Canada

- Enabling integrated and holistic LTC that is primarily community-based, and institutional by exception
- Enabling evidence-informed person-centred care that is equitable, accessible, and aims to not just meet needs, but people's actual goals of care
- Enabling technologies to support ageing in the *right* place

Preserving the Lifeline: Strategies for Improving the Recruitment and Retention Canada's LTC Workforce

- Enabling an LTC workforce that is appropriately supported and recognized.

Building a Strong Foundation: Strategies to improve the Affordability and Sustainability of Canada's LTC Systems

- Enabling system sustainability and stewardship through more effective, efficient and sustainable financing arrangements.

Enabling Data Excellence: Strategies for Enhancing the quality and Outcomes of Canada's LTC services Through Data Collection and Monitoring

- Enabling evidence-based decision making through appropriate data collection and utilization.

Changing the Game: Strategies for Transforming the Delivery of LTC Services Across Canada

Despite the current challenges discussed throughout the earlier sections of this report, providers and jurisdictions across Canada and around the world have been supporting innovation in the LTC sector through the development, spread and adaptation of models of care, support and care practices. The last few decades have seen a host of new innovative policies, models of care and approaches being implemented in the provision of LTC that have evolved based on jurisdictional priorities and societal demand.

Enabling Integrated and Holistic LTC that is Primarily Community-based, and Institutional by Exception

Many older Canadians and their unpaid caregivers note that they are not even sure what options are available, what the associated costs are, if it is publicly funded, how to access it and how to ensure it can be more person-centred, flexible and responsive to their own needs.[199] However, Canada has not kept pace with the evolving needs and preferences of its ageing population. For example, the CIHI recently found that one in 11 hospital patients of all ages have had their hospital stay extended until home care services or supports were ready. This is the equivalent of approximately four large (400-bed) hospitals occupied every day by individuals who do not require hospital care — of which approximately 85% are older adults aged 65 years and older.[200,201]

It has also been suggested that the cost associated with having Canadians receive LTC services in a hospital (versus at home or in an LTC home) is at least $2.3 billion each year.[202] Over the last four years, CIHI estimated that approximately 10% of older adults who are admitted to LTC homes across the country could have potentially stayed at home with the support of home and community-based care.[203] Therefore, Canadians living in LTC settings may not actually require the level of care provided in an LTC home, but may be there because they are not able to access home and community-based care.

A clear solution to better support older Canadians to age in their own homes and communities is to shift away from the default provision of care in institutional settings (e.g., LTC homes) toward more home and community-based care.

However, across all levels of government, the response to ageing has mostly been on care in designated buildings, which has resulted in gaps and shortages in other types of care that would better meet the needs of older adults, including home and community-based care.[204] While it is important to acknowledge that certain parts of the population will still require

the level of care provided in LTC homes, we must, however, begin to redefine what we mean by "long-term care." That is, moving away from institutional care alone and toward more integrated care that is provided in or closer to people's homes and encompassing a variety of living environments.

Adopt a Reablement Approach

Improving care for older adults who are living at home or in the community can also be approached using policies that will make it easier to access LTC services they may need. As recommended in the inaugural paper of this series, Canadian LTC systems should adopt a reablement philosophy, which would provide services to help older adults who are living with physical or mental limitation adapt to their conditions by learning or re-learning skills that are required to function in daily life.[205] A deliberate reablement approach can positively impact health-related quality of life, functional capacity and service utilization.[206] Since the goal of reablement programs is promoting and optimizing independence, integrating these types of services into home care programs would encourage independence of older adults by helping them to manage the acute and gradual declines that may occur with the onset of frailty and ageing.[207] These programs could be delivered through home and community-based care in Canada since the services offered can be delivered by non-professional providers including PSWs or care aides.[208]

Examples of Canadian programs that might allow older adults to remain in their own homes and communities include:

- Remote patient monitoring programs, where vitals are monitored and transmitted to a health care provider, show great promise in being able to improve chronic disease management in community settings.[209]
- Community paramedicine programs have the goal of reducing hospital visits and improving well-being and have been able to provide patients with chronic disease management.[210] A study of paramedic-initiated home care referrals in Toronto found that in a 24-month period there were significant reductions in 911 calls (10%) and ambulance transports to the emergency department (7%).[211] A three-year project by Canada Health Infoway where community paramedics provided chronic disease monitoring supports found that there was a 32% reduction in hospital admissions, a 26% reduction in visits to the emergency department, and a 35-41% reduction in hospital re-admissions.[212]
- Home-based primary care interventions, which are designed to support individuals who are homebound and may be living with multiple chronic health conditions, use an integrated and interprofessional primary care, including geriatricians, nurse practitioners, continence specialists, physiotherapists and general practitioners, to provide care in individual's own homes.[213, 214]

- Community care navigator roles to assess the needs, develop and then adapt care plans, and then find the appropriate providers based on the preferences and needs of the person in need of care.[215] While Canada does have coordinators of various types of care at home and in the community, they do not always provide a holistic view of all available care and support options.[216]
- ***Seniors' Centres Without Walls*** is a free interactive telephone-based program that aims to foster social connectedness and wellbeing for older adults (and adults living with physical disabilities). Specifically, the program offers an inclusive and inviting space to listen, learn and be heard.[217]
- ***Nursing Homes Without Walls*** — a first-of-its-kind program currently underway across New Brunswick — aims to provide services (e.g., groceries, house maintenance, personal care) to support older adults to remain independent in their homes for as long as possible.[218,219]

Promising Programs from Across the World: Examples from Denmark and Taiwan

To supplement inspiration drawn from within Canada, there are a number of promising programs from across that world that could be implemented.

Denmark

Denmark has been actively taking steps to encourage a change and shift away from LTC homes toward more home and community-based care, which is preferable to most older adults. In fact, Denmark was able to avoid building any new LTC homes for around 20 years, while being able to close thousands of hospital beds.[220] Over the first decade of this transition in the care of older adults, Denmark saw a 12% reduction in overall LTC expenditures for the population aged 80 years and older.[221] In the 1990s, Denmark made municipalities responsible for providing LTC services and required them to offer at least one preventive home visit per year by a community-based health care professional (e.g., a nurse for those aged 75 years and older).[222,223]

Denmark has also implemented a "reablement" policy approach, meaning that restorative care becomes a key feature of any ongoing home and community-based care that it provides. In particular, the average length of a hospital stay in Denmark is three days — and if the citizen is not able/ready to return home, they are supported within a rehabilitation center until they become ready to return home. Further, Denmark has made assessing whether a person who is receiving home care services could also benefit from a time-limited reablement scheme a mandatory requirement of providing home care services.[224]

Taiwan

Taiwan has a "community-based integration care system" called the ***ABC System,*** which has three components.[225] The "A" level is for individuals who require long-term care connect with a case manager from the local government, who determines the level of need, benefit amount, then develops a care plan and connects with the service providers.[226] The "B" level is to provide the services and then the "C" level is to promote community care stations and help people find opportunities for social participation and health promotion.[227] This type of care navigator approach has the potential to improve the coordination of care across Canada and including

Provide Care that is Coordinated, Integrated and Responsive

Whether we draw inspiration from specific programs within or beyond Canadian borders, it is clear that, ultimately, the provision of LTC services need to be better coordinated, integrated and responsive. As we work to redefine the provision of LTC, we need to move away from siloed, fragmented care toward integrated and holistic LTC services that are primarily community-based — and institutional by exception.

The first option is to focus attention on implementing integrated care models where care is delivered by teams that include primary care, home and community-based care, community paramedics, etc. To get a better sense of what this could look like, Leatt and colleagues proposed six strategies for integrated care:[229]

1. Focus on the individual
2. Start with primary care
3. Share information and use technology
4. Create virtual coordination networks at local levels
5. Develop practical needs-based funding methods
6. Implement mechanisms to monitor and evaluate

Within Canada, a number of provinces have or are moving toward more integrated care systems, which would enable multiple sectors and providers to work together with more flexibility. Some of the examples of integrated LTC models within and beyond Canada include:

- In Alberta, Alberta Health Services (AHS) "is Canada's first and largest province-wide, fully integrated health system, responsible for delivering health services to nearly 4.4 million Albertans."[230] AHS has responsibilities including promotion and protecting health and prevention; assessing the needs of Albertans; determining priorities and allocating resources; ensuring reasonable access to health services; and promoting the provision of health services in a manner that is responsive to the needs of individuals and communities and supporting the integration of services and facilities.[231] In particular, Alberta's continuing care system which provides services in a wide variety of settings, including individuals' homes, community-based service locations (e.g., adult day programs), supportive living facilities, and facility-based continuing care (e.g., designated supportive living and LTC homes).[232]
- In Prince Edward Island, the ***Seniors Independence Initiative*** provides funding to eligible seniors to help them access services and supports that enable them to live independently in their own homes. The program covers a range of services, including home maintenance, transportation, meal delivery, and housekeeping.[233]

The Home Care Program provides home care services, including personal care, homemaking, nursing care, respite care, and palliative care, to eligible PEI residents who require assistance with activities of daily living. Eligibility criteria are based on assessed needs, and the program is delivered through a mix of public and private providers.[234] ***The Supportive Care Program*** provides additional support to eligible PEI residents who are receiving home care services but require additional help due to complex care needs. The program includes specialized services such as wound care, medication management, and physiotherapy.[235]

Additional examples from Canadian jurisdictions that have great (albeit currently unmet) potential to advance integrated care systems, include Quebec and Ontario.

- In Quebec, the Ministry of Health and Social Services regulates and coordinates the entire health and social services system. The integrated centres – referred to as Centre Intégré de Santé et Services Sociaux (CISSS) or Centre Intégré Universitaire de Santé et Services Sociaux (CIUSSS) – are local service networks responsible for the planning and coordination of the services within their area, putting in place public health measures and ensuring services are available for everyone, specifically those who are most vulnerable.[236] In March 2023, the Quebec government announced its intention to create a new provincial agency, called ***Santé Québec***, to oversee the CISSS/CIUSSS health agencies.[237]
- In Ontario, ***Ontario Health Teams (OHTs)*** were introduced in 2019 with the aim of providing a new way to organize and deliver care that is more connected, including having health care providers work as one coordinated team. Providers and organizations that provide residential care and/or LTC home placement are able to become an OHT. There are currently 54 OHTs across the province, however, they have not yet started fully functioning to their potential scope as of yet.[238]

Beyond Canada, there are more examples of integrated care systems that provide further insight into how this approach to care could function.

- In England, integrated care systems bring together various organizations to be able to plan and deliver both the health and care services in an area.[239] The ultimate goal is for them to integrate care in the area and thereby improve health outcomes for the people living there.[240] As well in 2017, Singapore reorganized their health care system to become three integrated regions, with the goal of delivering more comprehensive and person-centered health.[241]
- In the United States, the ***Program for All-Inclusive Care of the Elderly (PACE)*** provides older adults who are eligible to enter a care home access to a variety of services so that they can remain in the community.[242] It includes an interdisciplinary team that does assessments of the person, care plans, and then coordinates 24-hour care.[243] This program started in San Francisco and now consists of 148

programs in 32 states.[244] Studies have found that this model is able to reduce hospitalizations and admissions to LTC homes, even though these individuals tend to experience increased cognitive and overall impairment.[245,246,247,248] One study noted that after three years, only 15% of participants were ultimately admitted to an LTC home.[249]

- In Australia, ***My Aged Care***, which can be accessed online, on the phone or in person, provides information on the different types of care available, an assessment of needs to identify eligibility and right level of care, referrals and support to find service providers, and information on what patients may need to pay.[250] Health professionals are also able to refer patients to this service. This service is important as the population continues to age, people are able to find all the information they need in one place, including the cost.[251] It was first introduced in 2013, with increased services and functionality being added in 2015. In 2017, the Increasing Choice in Home Care reforms was introduced to the Home Care Package program, which gave consumers the ability to choose a provider that best meets their needs, and government subsidies can be directed to that provider. In 2019, it was found that 72% of participants indicated some degree of satisfaction. Those aged 65 to 74 years were significantly less satisfied with the way it allowed them to access quality care (71%), while those aged 75 years and older were more satisfied (78%).[252] Over two in three carers reported being satisfied with the information received on the website, with 35% being very satisfied in 2019.[253]

Expand Supportive Housing Options

Another potential pathway forward is to explore and promote the role that supportive housing options can play in addressing gaps in the current LTC services continuum of care for semi-independent older adults living in Canada. To date, the options for both housing and support available to older Canadians have traditionally been comprised of a continuum of options tailored to meet the specific and varied needs of older adults — ranging from independent living residences to LTC homes. However, there are many older Canadians who fall between these points for which is there is a gap in the current continuum of LTC services. This gap also includes a lack of access to affordable housing options for older adults and limited access to home care. For example, AdvantAge Ontario has identified several concerns related to the housing needs of older adults, including a lack of supportive housing for frail and vulnerable older adults.[254]

Key Term

Supportive Housing refers to a combination of housing and supports that enables individuals to live as independently as possible in their community and that:

- accommodates individuals of varying abilities who require assistance to maintain independence;
- are appropriate to the housing needs of individuals (e.g., detached home in a supportive community, condominium/apartment building);
- are attainable and flexible in response to emerging enhanced care needs; and
- provide suitable and flexible services that address needs as they may change over time.[255]

Assisted Living refers to more institutional-based housing options. These options are often directed toward older adults with high care support needs.

To address these identified gaps in the housing options for older adults, there are some promising examples of supportive housing models – which include:

Naturally Occurring Retirement Communities (or NORCs): Originally coined in 1986 by Hunt and Gunter-Hunt, the concept of NORCs refers to communities that over time may naturally come to house a high-density of older adults. To this definition, the NIA and NORC Innovation Centre (NIC) recently proposed an additional set of parameters, which state that NORCs may also include communities that were designed to house a large concentration of older adults (e.g. aged 55-plus apartment buildings, rent-geared-to-income housing or other communities for older people) but were not purpose-built to provide care for older adults in the way that retirement homes, assisted living facilities or LTC homes were, as well as existing across housing types (e.g., single-family homes in one geographical area, a multi-residential building or complex, condos or co-ops).[256] Regardless of the building type, a key feature of NORCs is the provision of centralized LTC services that meet older adults where they are — enabling them to age in place; rather than move into a LTC home. Some specific examples include the Cherryhill Health Ageing Program in London, Ontario, and Oasis Senior Supportive Living program in Kingston, Ontario (with expansion sites in Hamilton, Quinte-West, Kingston, London (Ontario), and Vancouver, British Columbia).[257] This model is discussed in more depth in the NIA and NIC report, *It's Time to Unleash the Power of Naturally Occurring Retirement Communities in Canada.*

Collaborative Housing: As a concept, collaborative housing enables older adults to age in place while getting the support they need through mutual support, tailored amenities and sense of community.[258] In practice, cohousing residents offer neighbourly support within an environment designed

for physical accessibility, as well as financial, environmental and social sustainability.[259] This model can take a variety of forms, ranging from long-time friends purchasing a home to live in together (e.g., Harbourside Co-Housing, Sooke, BC[260]) to a non-profit housing developers creating affordable intergenerational cooperative housing (e.g., Urban Green Cohousing[261]).[262] Collaborative housing offers a potential solution to the challenges of housing affordability, access to health services and social isolation that many older adults face.

A final example of supportive housing for older Canadians are Campuses of Care, or Seniors' Villages. This model is discussed in more depth in AdvantAge Ontario's evidence brief, *Campuses of Care: Supporting People, Sustaining Care Systems in Ontario*.[266]

Ultimately, the prioritization of integrated and holistic continuum of LTC services will go a long way to enabling older Canadians to age in the right place, while striving to not only meet but exceed the evolving needs and preferences of its ageing population. However, the implementation of these models will continue to fall short without increased investments and political will.

Key Terms

Cohousing: A type of collaborative housing that is an "intentional community" located in one area (e.g., 10–30 attached or detached homes). These communities combine the autonomy of compact, private dwellings with the benefits of shared community amenities (e.g., recreation spaces, gardens, gathering spaces).[263]

Co-housing: A type of collaborative housing that is a "small cluster community" of co-owners or people living together in a single dwelling unit (e.g., with only one shared kitchen). [264]

Collaborative Housing: An umbrella term referring to a variety of collective forms of housing (and funding sources) that emphasize the relationships between residents and their broader communities.[265]

A Pathway Forward: Adopting the NIA's Ageing in the *Right* Place Framework

In trying to support older Canadians with much more complex health and social care needs to live independently and age in their communities, the ways LTC is organized and delivered in Canada will need to be more responsive, enable greater choice and engage meaningfully with older adults and their caregivers as partners in care. With this in mind, the NIA released a report in October 2022 calling for LTC systems that enable "ageing in the *right* place" (AIRP), which is defined as "the process of enabling healthy ageing in the most appropriate setting based on an older person's personal preferences, circumstances and care needs."[267] Based on this definition, the NIA has identified four "pillars" that are fundamental to enabling people to age where they want to age (whenever possible) with health and independence (see Figure 7):

1. Promoting Preventive Health and Better Chronic Disease Management
2. Strengthening Home and Community-Based Care and Supports for Unpaid Caregivers
3. Developing More Accessible and Safer Living Environments
4. Improving Social Connections to Reduce Loneliness and Social Isolation

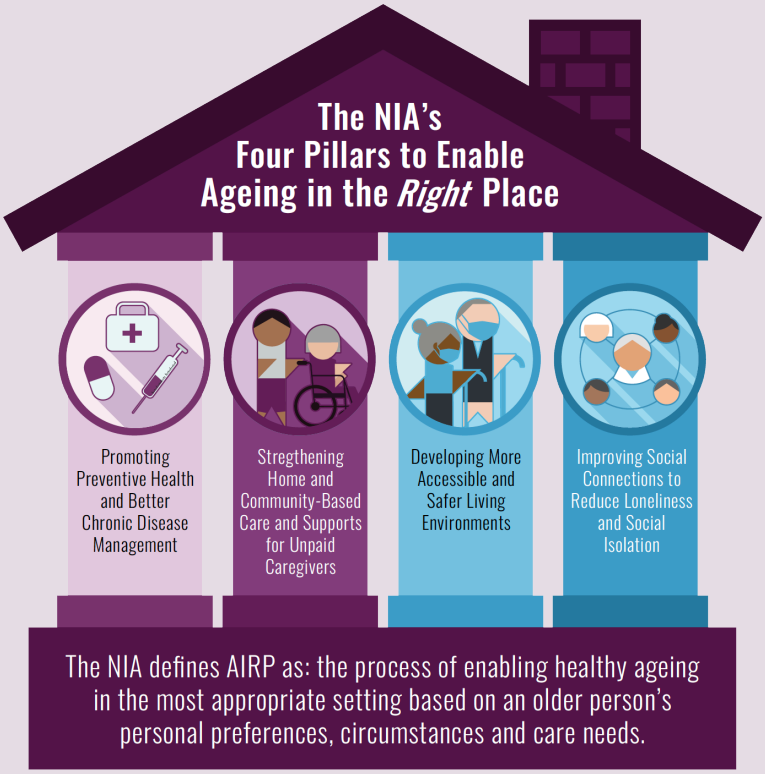


Figure 7. The NIA's Four Pillars to Enable Ageing in the *Right* Place

These four pillars were developed to provide a comprehensive framework to support AIRP approaches at individual, local, regional, and federal levels. This recognizes that AIRP takes place within broader factors including social, economic, political and environmental, with the understanding that none of these pillars exist in isolation.

Enabling Evidence-Informed Person-Centered Care that is Equitable, Accessible and Aims to Not Just Meet Needs, but People's Actual Goals of Care

Meeting the future LTC needs of older Canadians presents an opportunity to re-think our collective approach to meeting the growing and varied needs of an ageing population. This is especially the case as the number of Canadians living with multiple chronic health conditions, including dementia, increases.[268] For example, a 2017 Commonwealth Fund survey found that Canadians receiving publicly-funded home care services have higher needs, with 59% being over age 75, 43% describing their health as fair or poor, 53% having three or more chronic conditions, 59% taking five or more medications and 46% living alone.[269]

As a result, there will be a growing need for care models that are more flexible, adaptable, coordinated, integrated and inclusive of the needs and preferences of older adults and their unpaid caregivers.

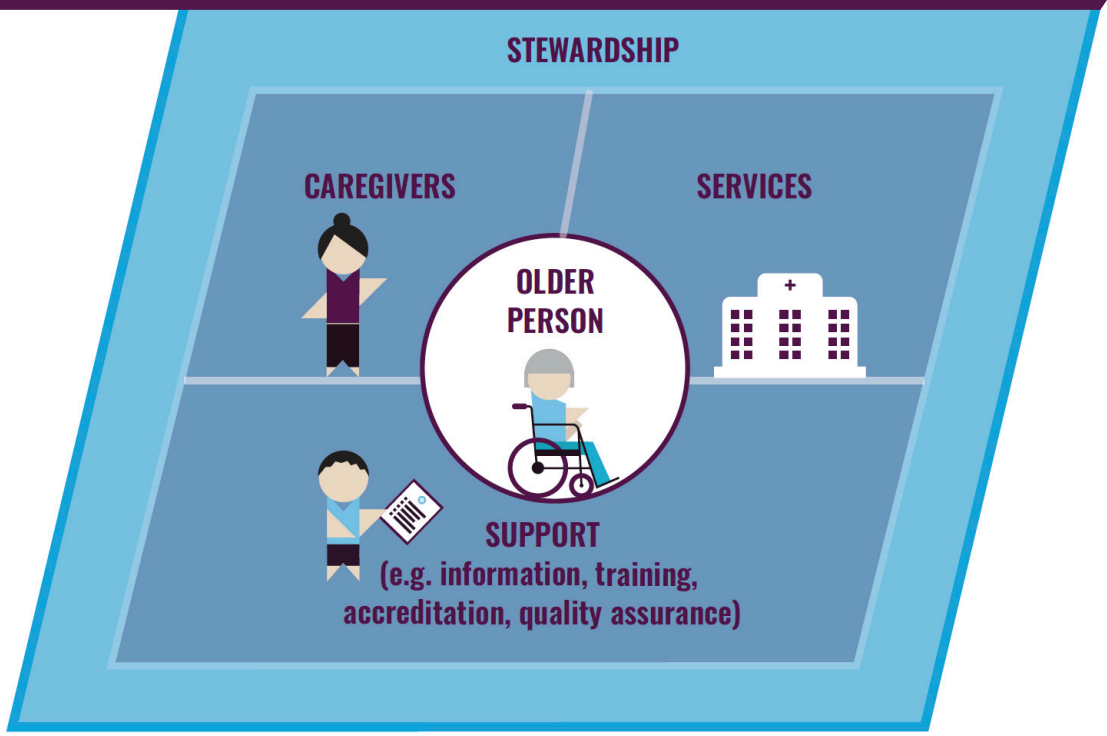
For example, the concept of "ageing in the right place" (as previously introduced) may have different meanings for different people. Indeed, for some, it may mean staying in their own home, while for others it may mean moving to a safer or adapted home where care can be obtained.[270] Ideally, the focus should always remain on the older adult and what is right for them.[271]

Organize Care Around Individual Needs and Goals

Thinking forward to the future of LTC in Canada, LTC services should be organized and coordinated around the needs and goals of care for the care recipient and caregivers (including family members), also known as person- or resident-centred care. However, several stakeholders from across Canada noted an ongoing gap between what people want and need from LTC systems and what is actually offered and delivered. The less Canada's system recognizes the existing diversity of functional, social, financial, ethno-cultural or even behavioural needs of older Canadians, the less able it will be to deliver the appropriate care that will truly empower Canadians to age in place with dignity and respect as we move forward.

Although the concept of person-centred care is not new, it is often overlooked in health care, and long-term care is no exception. A person-centred approach to LTC should be holistic, in order to appropriately understand and respond not only people's physical health and key care needs (e.g., dementia, incontinence, palliative care), but also consider mental health and social determinants of health.

Figure 8. The WHO Elements of an Older Person-Centred LTC Systems



Adapted from the WHO, Figure 8 describes the elements of an older-person-centred system of LTC. At the heart of this figure is the older person whose needs should dictate the support and services provided and the role their unpaid caregivers can play in supporting the provision of care.[272]

For example, mental health issues are common for LTC home residents, with studies showing a prevalence of depression in LTC homes in Canada of around 27%.[273] Even though mental health issues are common, there is often a lack of access to mental health services, with 40% of LTC home residents in Ontario needing psychiatric services, but only 5% receiving them.[274] Therefore, truly person-centered care considers the goals, circumstances and specific health and social needs of each person, to enable more tailored and appropriate services to be provided — which results in better outcomes and also often provides greater value from care delivered. In fact, person-centered care has been found to be associated positively with patient satisfaction of care within a variety of health care settings, including LTC.[275,276]

However, in order to meaningfully integrate a person-centred approach into the future provision of LTC in Canada, consideration must also be paid to the implications for the LTC workforce as well as inclusion, diversity, equity and accessibility. With respect to the LTC workforce, there is a new initiative through Healthcare Excellence Canada, *Reimagining LTC: Enabling a Healthy Workforce to Provide Person-Centred Care,* which will support quality improvement and create a more resilient sector. The program specifically aims to increase capacity for safety and quality improvement; support homes to identify changes and then plan and implement them to create a workforce that

can deliver person-centered care; create opportunities for peer-to-peer sharing and learning among homes in Canada; and help people working in LTC provide more person-centred care.[277] This program will run from January to December 2023, and will provide funding for the home of up to $10,000 and supports such as coaching and monthly webinars.[278]

Support Inclusion, Diversity, Equity and Accessibility

A person-centred approach to the provision of LTC services must also consider supporting inclusion, diversity, equity and accessibility alongside physical care needs — as each has implications for overall well-being and goals of care for older Canadians. The growing diversity of Canada's population is creating a new series of challenges in the provision of LTC — especially as older Canadians are finding it increasingly challenging to access culturally appropriate and safe care. Many care providers also come from increasingly diverse backgrounds that can further create challenges in appreciating the diverse needs and views of care recipients and care providers, especially when caring for individuals with dementia. A diversity of needs and a diversity in providers exists, but matching the two isn't always easy. Unfortunately, data on race and ethnicity are not routinely collected or reported in Canada at any level of government, but other countries such as the UK, Australia and the US now report race and ethnic disparities as a standard practice.[279] For example, the Census of Population in Canada, does not ask all Canadians about race and ethnicity.[280] Gender identity and sexual orientation have also not been routinely collected. However, the 2021 Census became the first to include a gender identity question. Within LTC settings, the lack of standardized collection on residents' sexual orientation and gender identity has led to a significant knowledge gap.[281] Despite the limited understanding of 2SLGBTQIA+ communities who are living in LTC homes, there is evidence of needing to "go back into the closet" and/or their sexual orientation or gender identity leading to a lower quality of care.[282]

Key Term

2SLGBTQIA+: An acronym representing the continually evolving array of sexual and gender identities. This specific acronym refers to the following identities: Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual and so many more.[283]

Within the context of LTC settings, cultural safety flourishes when the values of empathy, respect and collaboration are embedded within all aspects of care — especially pertinent when working with Black, Indigenous and other People of Colour, as well as 2SLGBTQIA+ communities and members of other equity-deserving communities. Cultural safety is an outcome of providing culturally appropriate and sensitive care. In particular, respectful engagement, based on recognizing

and working to address inherent power imbalances in the health system. It results in an environment free of prejudice, discrimination and harassment based on an individual's various interconnecting social identities (e.g., age, race, ethnicity, gender identity, sexual identity, etc.). It is a space where people feel safe when receiving and providing care, and when interacting with the health system.[284]

Promising Examples of Culturally Appropriate Care in Canada

Yee Hong Centre for Geriatric Care (Ontario)

People sometimes wait as long as a decade to enter a Yee Hong facility, which are a group of LTC homes geared toward the Chinese-Canadian population. They have reported lower rates of depression, falls, skin ulcers and hospitalizations when compared to those in mainstream homes. The Director of Care at their Mississauga location says their success is due to looking to other facilities for best practices.

They have had measurable improvements in weight loss, depression and number of falls:

- Weight loss: 6.7% in mainstream homes, compared to 2.6% at Yee Hong locations;
- Worsened mood due to depression: 25.1% in mainstream homes, compared to 3.4% at Yee Hong locations;
- Pain: 11.6% in mainstream homes, compared with 4.4% at Yee Hong locations; and
- Average fall rate in Ontario 13.6%, compared with 8.9% at Yee Hong locations.

The improvements are attributed to having access to culturally appropriate food and programs, language concordant care (e.g., ability to communicate between staff and residents) and an interdisciplinary approach to care.

PICS Diversity Village (British Columbia)

In Surrey, British Columbia, a new facility, which will have 125 publicly-funded LTC beds, is expected to open in 2024. PICS Diversity Village is operated by Progressive Intercultural Community Services Society (PICS) and will provide culturally appropriate services to people who identify as South Asian, although it will be open to all older adults. It will incorporate South Asian cultural values, traditions and beliefs; work with cultural and faith-based organizations to connect residents to services and include South Asian-focused activities; provide traditional South Asian food options; arrange activities that are familiar to South Asians; communicate in their language; and train all staff on cultural competence and cultural safety.[285]

Recognize the Importance of Unpaid Caregivers

Beyond focusing solely on the care recipient, a person-centred approach to LTC must also recognize the importance of the contributions and perspectives of unpaid caregivers, family members and loved ones in the planning and delivery of care, but also acknowledge that there are limits to what they are able and should be expected to do.[286] Similar to those for whom they provide care, unpaid caregivers should be provided with individualized supports, training and respite as needed, and not be financially penalized for the significant contributions they make.

In 2018, the NIA called for formal recognition of caregivers as integral components of the care team. This call for recognition includes adopting a common definition as a first step toward formalizing their role through actions such as assessing their needs separately and allowing them to access training, support services and respite care.[287] This first step is not only an acknowledgement of their important contributions to care, but an intentional effort to support their own needs alongside the needs of their loved one. [288] In fact, the NIA also called for individualized assessments of their own needs separate from care recipients, which would enable them to better access services that reflect the needs of both caregivers and care recipients.[289] Formal recognition of caregivers with a common definition will encourage their inclusion as integral members of the care recipient's care team and, with the care recipient's consent, would encourage inclusion of caregivers in care planning.[290]

When it comes to recognition of caregivers within Canada, Manitoba became the first province to enact legislation, *The Caregiver Recognition Act,* in 2011.[291] Some provinces offer refundable tax credits for unpaid caregivers, while most provinces/territories and the federal government only offer non-refundable tax credits, meaning they are treated as income.[292] In 2017, the federal government introduced the Canada Caregiver Credit, which was meant to be a more accessible tax credit, providing eligible unpaid caregivers in approximately $7,000 in tax relief. However, unpaid caregivers must be employed, or they must earn taxable income through another source to receive this tax credit.[293] It also fails to consider the increasing contributions of non-relative friends and/or neighbours. Additionally, the Ontario Caregiver Organization was created to better support Ontario's four million caregivers who provide physical and emotional support to a family member, partner, friend or neighbour.[294] Ultimately, better recognizing and supporting unpaid caregivers, family members and loved ones would enhance Canada's ability to support its citizens to ageing in the right place.

A Pathway Forward: Implementing Promising Models of Person-Centred and Emotion-Focused Models of Care

While the importance of person-centred care has long been emphasizing within LTC settings, emotion-focused models of care are now being endorsed as a way to drive positive culture change, inspire and retain staff, as well as provide high-quality, person-centred care that underscores individual autonomy. Two of the most commonly cited models of care are the Butterfly Model of Care and the Green House Project.

The Butterfly Model of Care[295]

The Butterfly Model of Care focuses on delivering emotion-focused care that connects with people in a dignified, human way. It addresses the holistic needs of the individuals and supports quality of life for each person across the whole of their lived experience.

The key components of the Butterfly Model of Care are focused upon:

- Small households (with front doors) of eight to 12 people;
- Housekeepers who are at the heart of the home;
- Emphasizing the quality and value of close relationships that focus on real, positive, social and shared connection;
- Mealtime experiences (including food preparation, visual choices) are key opportunities for social interaction in the day;
- Grouping people together who are at a similar point of experience;
- Providing flexibility in routines;
- Opportunities to reminisce, touch, feel, carry objects and be engaged in the daily life of the home; and
- Training on the meanings behind behaviours.

A Canadian example of an LTC home that employs the Butterfly Model of Care is Malton Village's Redstone unit — which was the site of a year-long pilot program before the model was permanently adopted and since expanded to other units in LTC homes operated in Ontario's Region of Peel.[296]

The Green House Project[297]

The Green House Project aims to develop small-scale, self-contained and self-sufficient LTC settings that put residents at the centre of what they do. Each home includes private rooms and bathrooms for each resident, a living room with a fireplace, a kitchen where meals are prepared and outdoor spaces that are easy to access and navigate. Each home is guided by the Green House core values:

- Meaningful Life: Deep knowing, autonomy and control, and purposeful, meaningful engagement are key.
- Empowered Staff: Radical organizational redesign where care teams thrive on collaborative coaching culture and shared decision making.
- Real Home: Intentional communities of belonging that leverage the power of deinstitutionalized living and convivium (the sharing of good food in good company).

Dementia Villages (or the Hogeweyek Care Concept)[298]

The guiding principles of the Hogeweyek Care Concept are to "deinstitutionalize, transform and normalize" care for people with advanced dementia. The six "pillars" of the Hogeweyek Care Concept are:

- Favourable surroundings: houses with front doors, outdoor spaces, daily routines that accommodate personal preferences.
- Life's pleasures and meaning: freedom to wander, social life.
- Health: staff to support quality of life, wellbeing through social relationships.
- Lifestyle: recognizing humanity and dignity, etc.
- Staff and volunteers: team-based care, ongoing training, etc.
- Organization: forefront is "living life as usual," while the provision of LTC is behind the scenes.

The Village Langely in British Columbia is a Canadian example of the Hogeweyek Care Concept.[299]

By embracing and supporting the transition to emotion-focused models of care, LTC home residents and families will view LTC more favourably and some of the sector's staffing challenges will be remedied. Compared to other investments needed to help move the yardsticks in LTC, emotion-focused models of care represent a promising pathway to driving significant improvements, and may, over time, help bring down other costs, such as those associated with staff turnover, resident falls or hospital admissions.

Enabling Technologies to Support Ageing in the Right Place

As the COVID-19 pandemic disrupted existing care delivery channels, it also accelerated the shift to virtual and digital care. This shift provided older adults and care providers with safe and secure options for care as virtual visits are more achievable than ever — even becoming the norm. This shift also enabled people needing LTC to be able to access care more flexibly, from video visits with their primary care provider, to virtual family meetings, to enabling dispersed adult children and other family members to be able to meet and discuss care plans with their loved one's care team. The ability to meet virtually where appropriate can also reduce travel time and sometimes even eliminate the need for certain visits entirely.

With more ways to bring virtual care into people's homes, it is also important to note the increasing number of technological solutions that may be able to support older adults safely in their own homes for a longer time.

Currently, the utilization of technologies is being explored to improve the delivery of LTC in three principal ways:

Implement Technologies that Enable Reaching/Serving More People

Investments in tele-home care (or remote patient monitoring) programs across Canada have aimed to bring health services to individuals in their homes.[300] Telehealth, telemedicine and other similar technologies can connect care providers to patients as well as primary care providers and their patients to specialists, to provide more convenient ways to enable the provision of care especially across significant distances. In fact, the Ontario Telemedicine Network is one of the largest telemedicine networks in the world. These modalities can enable greater communication, multi-disciplinary collaboration and coordination of care, thereby improving outcomes and effectiveness of the care that is delivered.[301]

Another example is Personal Emergency Response Systems (PERS), which are signalling devices that can detect an emergency and then call for help. These can help older adults age in the right place by detecting things such as falls and result in a faster response from family, friends and/or health care professionals. There are various types, but in general, all include three basic components: electronic hardware, a connection to a response centre and the ability to be able to dispatch the needed help.[302] Most PERS are meant to be easy to use and are typically worn on the person in a form of a necklace or a bracelet and

may have a large button to initiate an alert when needed. Some function as a cordless phone that act as a two-way voice interaction if the client is unable to reach the main telephone. They usually require an independent power source, like a battery, and the majority are wirelessly connected to a base unit.[303] While these are not preventive measures, they do help older adults to cope with emergencies and be able to receive support than they may have been able to without one. By getting care faster, they can help prevent complications that may occur after spending a prolonged period of time on the floor including dehydration or hypothermia.[304]

Utilize Technologies that Allow for Greater Assisted Living

In addition to making physical modifications to the built environment, such as ramps and wider doorways that can enable access, the development of technologies or devices can address certain functional challenges to enable more independent living. Canes, walkers, grab bars, stair lifts, hearing aids and many other assistive devices have been in common use in a variety of settings. Research has also found that wearable sensors can support ageing in the right place. It has been found that wearable sensors are able to improve fall-risk assessments when compared to the current standard of care.[305] Although there has been promising evidence on technological interventions on falls or fall-related injuries, it has yet to show whether this would reduce these outcomes in the real world.[306] A survey in 2021 conducted by the NIA and Telus Health found that Canadian health care providers do discuss emergency situations including falls with older adults, but only 11% of these include the use of technologies such as alarms or PERS to be able to support their safety. This is despite the fact that 75% of practitioners are familiar with PERS.[307]

Ambient sensor technologies including things such as infrared motion, video, pressure, sound, floor and radar[308] have been found to be a promising area for improving care for older adults and can delay or prevent admission to LTC homes.[309,310] For example, there are digital technologies for continence support that send notifications to caregivers and care providers indicating that continence product changes are required.

Integrate Technologies that Connect People to Knowledge and Each Other

Numerous websites and apps have been developed to provide individual and caregiver-oriented information to better educate and empower these individuals with the information they need to better engage in their care. Other technologies have been developed to better connect people and their unpaid caregivers to their care teams, education and other resources. For example, Tyze is an online platform that can be used to better connect unpaid caregivers, family members, care providers and others around an individual.[311] The platform also allows for the coordination of appointments

and the sharing of information to enable unpaid caregivers and care providers to more easily communicate with each other and to plan an individual's care collaboratively.[312] Within LTC homes, virtual reality technology is also being used increasingly as part of recreation programming.

Where there are persistent staffing shortages, especially in rural and remote communities, leveraging the use of technology has been helpful to minimize the need to have direct care providers on hand when some monitoring and other communication functions could be virtualized.[313] Further, other available human resources can also be utilized, such as paramedics and community health workers as well as unpaid caregivers and other community members.

However, when discussing the impact of shifts to virtual or digital care (or even technology-enabled ageing), it is always important to consider digital equity. As age increases, internet access and use tend to decrease despite the fact that more older adults are using the internet. In 2007, just under 47% of older adults aged 65 to 69 years reported using the internet, compared with just over 15% for those aged 80 years and older. By 2016, 85% of those aged 65 to 69 years reported using the internet, 62% of those aged 75 to 79 years and just under 41% of those aged 90 years and older. In 2016, around 32% of older adults reported not using the internet in the past month, which was compared to 2.8% of non-use among non-older adults.[314] Finally, during the COVID-19 pandemic, there were increases in internet usage, as around 30% of those aged 65 years and older increased their usage, with 18% reporting that the COVID-19 pandemic was the first time they had used these services.[315] However, notwithstanding the fact that more older adults are using the internet, many older adults or families are not able to access these tools. This needs to be carefully considered when moving forward with virtual care options so that all Canadians have an equal opportunity to access the care and information they need. Access to affordable and high-speed internet is not guaranteed for all Canadians and access can be particularly hard for those in remote areas. These challenges were made more difficult by the pandemic as many public internet access points were closed due to COVID-19 restrictions. Therefore, access to internet needs to be guaranteed for all Canadians to have the option for them to age in place.[316]

Although there are many promising technologies that may enable greater efficiency, improved care outcomes, and quality of life for older adults and their care providers, many of these technologies are not widespread or available at scale and have not yet become established standards of care. However, this will likely change over the coming decades.

A Promising Pathway Forward: Bringing (Virtual) Long-Term Care Home

Those who are living at home, or waiting in a hospital, who are deemed eligible for LTC home placement are at a significant risk for continued functional decline, loss of independence and caregiver distress. More needs to be done to involve clients and their caregivers in the planning and delivery of reliable, continuing and episodic supports so that they can receive LTC in their own home. Often a lack of access to primary care supports, ongoing health monitoring and support, or lack of flexibility or availability of home care and community support services, and caregiver burnout are all factors that often lead to people applying for a place in an LTC home. Being able to provide a comprehensive community-based option for these high-needs individuals and their families could allow for a more cost-effective alternative to LTC homes to be provided.

In 2020, the NIA report *Bringing Long Term Care Home* found that Ontario would be able to save around $240,000 in infrastructure costs for every LTC home bed that it would not need to build or redevelop by allowing the ageing population to age at home with proper supports.[317] According to Ontario's Ministry of Health, the province supported more than 131,180 clients that were eligible for LTC of all ages to remain in their homes in 2021-22, with 97,700 clients being aged 75 years and older.[318]

Criteria to be included in Virtual LTC @ Home program:

- Persons who are eligible for an LTC home placement
- Persons with an interRAI Home CARE (HC), Community Health Assessment (CHA) or LTC Assessment MAPLe Score of 4 or 5
- Persons with complex care — living with multiple comorbidities/chronic conditions
- Persons living in the community or in hospital with an ALC designation or who are on an LTC home waitlist
- The ability to safely live in the community at the time of enrollment, with support of this proposed program

OHTs would work to identify appropriate individuals who are eligible for LTC and who are on a waitlist, but who prefer to stay at home for as long as possible. The team would work to create a coordinated care plan and organize and provide the ideal mix of services in line with the funding they were allotted. A minimum number of weekly huddles would occur with the entire care team to coordinate care, discuss issues and strategize solutions. All clients would be routinely assessed with the same interRAI assessment systems for long-stay home care clients to support care planning and monitoring. All documentation would occur using a shared Electronic Health Record.

It should be acknowledged that, when these clients are no longer able to be supported to remain in their homes with community-based care, they should be supported and prioritized for admission to one of the LTC homes they were on the list for.

Ultimately, this proposed concept is based on care being provided by local primary care, home care, community paramedics and community support services, as available. It is not meant to duplicate or compete with existing services, but work within partnerships to find innovative ways to improve patient access and experience, bridge gaps in care, and increase the overall effectiveness, efficiency and care experiences.

The cost of supporting LTC-eligible clients to be cared for in their own homes (versus in an institutionalized setting) is estimated to be $1.3 billion,[319] this, however, is only a fraction of the projected $6.4 billion the Ministry of Long-Term Care is anticipated to spend on care across nearly 79,000 publicly-funded LTC home beds in 2021-22.[320] In fact, a Virtual LTC @ Home Model for LTC home eligible clients in Ontario was estimated to save significant construction and development related costs between $212,259 and $268,369 for every LTC bed that it may no longer need to build or redevelop while also allowing it to better meet the needs of its ageing population to age-in-place.

Preserving the Lifeline: Strategies for Improving the Recruitment and Retention of Canada's LTC Workforce

Staffing shortages and pay inequities have been featured prominently in media reports outlining human resources challenges in LTC during the COVID-19 pandemic. While these are long-standing issues (as highlighted in the first paper of this series), the COVID-19 pandemic has reinforced the importance of focused policy attention on strategies to improve the recruitment and retention of health care workers.

Enabling an LTC Workforce that is Appropriately Supported and Recognized

Long-term care, like other health and care services, is a human-resource driven sector, and as such, the LTC workforce must be appropriately developed, resourced, supported and recognized if LTC is to be improved for Canadians.

To do this, we must continuously recognize the value and impact of the LTC workforce. Unfortunately, long-standing inaction on reforms that would support a strong workforce and recognize LTC as a specialized care discipline continues.

Some of the reasons contributing to this inaction include the high costs of providing appropriate wages for workers and assumptions that family caregivers are responsible for this type of care. In addition, one cannot ignore the gendered aspects of care and care provision; care is often provided to older women and provided by women (typically, aged 40 years or older), many of whom are also racialized and/or newcomers, often with English as a second language. As a result of this and as is the case for many other female-dominated professions, lesser value is often placed on this work.[321,322]

To address staffing shortages of workers, there are often calls to enhance the "education, training, accreditation/certification issues, and hiring as soon as possible of many more workers, including from overseas."[323] While these are certainly important considerations, there are a few key considerations for enabling a LTC workforce that is appropriately supported and recognized, including increased investments in staffing (including increases in funding in order to accomplish this much-needed shift), addressing wage inequities, and supporting mental health and well-being.[324]

Invest More in Canada's LTC Workforce

The COVID-19 pandemic made it clear that there needs to be greater investment in staffing (e.g., improving staffing ratios and skill mix) if we are to achieve increases to the daily average hours of direct care LTC home residents currently

receive.[325] In Ontario, the College of Nurses of Ontario (CNO) has been trying to assist in registering internationally educated nursing applicants and to make information about competency-based nursing programs more available.[326] In July 2022, CNO had registered 4,728 applicants, an increase from 2021.[327] Continuing to assist internationally trained workers to get registered and be able to practice in Canada is crucial to be able to address the shortage of workers.[328] For example, in 2021, the Nova Scotia Government announced plans to cover college tuition fees for about 2,200 Continuing Care Assistant students over the next two-and-a-half years.[329] In addition, the LTC workforce needs appropriate training in the first instance, as well as access to ongoing training while working, especially given the increasing complexity of the people they are caring for.[330,331]

While it is clear that the number of staff working in LTC needs to increase, there also needs to be more full-time positions in the sector so workers do not need to work multiple jobs — as noted by a CLRI and RIA study.[332] This also means increasing pay and providing benefits, such as supporting the mental health and well-being of the LTC workforce as a whole in order to avoid inequities that can exacerbate health human resources challenges. Furthermore, well-intentioned efforts to adjust the compensation of one type of care provider during the COVID-19 pandemic inadvertently led to the compression or inversion of wages among: 1) the same care providers across different settings and/or 2) different care providers within the same setting, exacerbating ongoing health human resources challenges.[333] The CALTC has received support from the Public Health Agency of Canada (PHAC) to provide mental health and well-being support for LTC staff,[334] with PHAC committing $1.2 million to adapt a program called *Working Minds*, developed by the Mental Health Commission of Canada, to support those working in LTC homes and increase their resiliency skills.[335] Additional strategies for support for the LTC workforce include policy and operational adjustments to support their roles, some of which enable teams to help PSWs with their tasks and include them in decision-making processes, implementing a system for raising concerns and ideas to management, and offering equity, diversity, inclusion and anti-racism training for teams and management, as well as on-the-job training so that newer team members could support learning.[336]

Considerations regarding living wages and wage parity are important as wages have stagnated; while work that is mostly part-time (without any security or benefits) has increased.[337] It is no secret in Canada that LTC providers have lower wages than their acute care colleagues, and this has been seen as one of the long-standing reasons why LTC providers remain in short supply. As a result, workers may need to work extended hours or work at multiple jobs, which affects their quality of life.[338] The new 10-year bilateral health care funding agreements that the federal, provincial and territorial governments are currently negotiating provide the opportunity for significant new funding, as well as resolving the long-standing issue of wage parity in Canadian health care between care providers performing the same roles in different settings.

While improving funding and eliminating sectoral pay gaps is seen as one potential enabler to stabilize the LTC workforce, there are other aspects of labour engagement that may improve recruitment and retention rates. The first avenue would be to ensure that the COVID-19 pandemic pay is permanent.[339] This temporary wage increase was an acknowledgement that the wages were too low for the specialized care provided by PSWs working in LTC homes.[340] If made permanent, these changes must be equitably dispersed across the LTC workforce — and on par with wages for similar roles within hospitals — in order to reduce potential for wage compression as witnessed during the COVID-19 pandemic.

The second would be to ensure a living wage for the LTC workforce. A living wage, which is different than minimum wage, is calculated at a level at which a household would need in order to cover all basic necessities and allow families to have a decent quality of life. A living wage is meant to allow the household to avoid severe financial stress, support the development of any children or dependents and participate in the community.[341] Research suggests that providing living wages is a benefit to both employers and employees and may support a workforce with more commitment and lower turnover.[342] For workers that already have a living wage, training or benefits may also lead to better attitudes and behaviours in the workplace.[343] The OCSA, Home Care Ontario and AdvantAge Ontario each note the importance of acknowledging the wage inequities that exist across different care settings, including setting a fair wage for PSWs and supporting wage increases for critical staff, frontline managers, and office supports.[344,345,346]

Balance the Supply and Demand for LTC Services

Given the increasing complexity of the LTC population, one of the main goals of addressing the health human resources shortage is to ensure that future workforce supply is balanced with the services that will be demanded.[347] The OCSA and Home Care Ontario both note the importance of bringing professionals back into the home care sector.[348, 349] While home care in Canada is a relatively small sector, properly staffing it would lead to better health outcomes, greater satisfaction for older Canadians, and would incur a lower cost compared with investing in other sectors (i.e., institutional care).[350] For example, Home Care Ontario's estimates suggest that if the home care workforce is stabilized, being able to meet an additional 4.6 million hours of care, this would reduce the amount of time older adults wait for LTC by more than 50%, which can save the province almost $500 million yearly.[351] With this in mind, AdvantAge Ontario is calling for a national health human resources strategy (including appropriate funding) that comprehensively addresses working conditions, training and encourages more workers to enter the LTC work force — and the health care sector, more broadly.[352]

However, shifting toward home and community-based care will likely increase the overall need for PSWs, as well as the need for other home support services like meal delivery or transportation.[353] Drummond, Sinclair, & Gratton (2022), using OECD statistics, found that the OECD average of formal LTC workers per 1,000 people aged 65 years and older was 54 workers. Canada is at 34 and would need to add around 140,000 staff to close this gap.[354] It was estimated that around 58% of those working in LTC in Ontario were PSWs, so applying this to the international data, this would mean PSWs would be around 81,200 of the additional workers that would be needed.[355] The COVID-19 pandemic disrupted the labour market in ways that prompted many to switch industries in order to maintain stable employment.[356] As a result, there are now strong demands in certain industries that will likely lead to strong competition as qualified job candidates will have many job openings across the labour market to choose from.[357] Targeted immigration could help to fill workforce shortages, but wage rates would likely need to rise more rapidly than has been assumed to attract and retain more people in this line of work given the current imbalance between the low supply of, and high demand for, trained workers.

Ultimately, innovative or transformative initiatives that are foundational to a paradigm shift in the provision of LTC in Canada need a better health care workforce in all aspects of the LTC sector to be able to succeed.[358] It is clear that adequately supporting and recognizing the invaluable work these dedicated individuals provide in enabling older Canadians to age at home and in their communities through wage parity, living wages and more full-time work and benefits will be crucial to ensuring the future successful provision of LTC in Canada.

Building a Strong Foundation: Strategies to Improve the Affordability and Sustainability of Canada's LTC Systems

There are legitimate concerns around the quality and delivery of LTC in Canada today — but they pale in comparison with concerns about its future sustainability. It is no secret that the overall provision of LTC in its current form is neither affordable nor sustainable for governments and individual Canadians. With Canada on track to join the ranks of other super-aged nations within the next year, one thing is clear: it is time to get serious about improving the affordability and sustainability of LTC services.

Enabling System Sustainability and Stewardship through More Effective, Efficient and Sustainable Financing Arrangements

While some Canadians can and will be in a position to finance all or portions of their own care, many Canadians will have to rely solely on available publicly financed care and the support and care unpaid caregivers may be willing to provide.

If the public system continues to fall short, and unpaid caregivers are unable to fill the gaps, the impact will continually be widespread — affecting the personal lives and financial welfare of more and more Canadians.

Improvements to the financing arrangements can be thought of in the following three major ways — what can be done by individuals, the financial service industry and policymakers.

What Individuals Can Do

When considering what individuals can do, it is important to note that, in general, older Canadians want to remain at home and, subsequently, are increasingly willing to pay to ensure this happens. However, many are also unaware of, or significantly underestimate, the potential costs of ageing in place, including the costs of in-home care.[359] While most Canadians are likely to remain healthy well into older ages, a minority will face care needs that could potentially be expensive and long-lasting.[360] As a result, many Canadians who are nearing or in retirement do not have enough savings to be able to comfortably retire, nor have they engaged in financial planning to achieve it.[361][362]

In fact, Canadians tend to underestimate the costs of remaining and receiving care at home, but home care services can provide considerable cost savings for the public sector, relative to receiving care in a LTC home.[363]

For example, in Ontario, the Ministry of Health estimates that supporting a person in an LTC home costs around $6,000 per month. In comparison, the equivalent level of publicly-funded home care costs the government around $3,000 per month, which is a much lower cost to taxpayers.[364,365]

Enhance Understandings of Public Pension Programs

It is important for Canadians to better understand public pension programs including the CPP/QPP, OAS and GIS, which are administered by the government, provide all Canadians with a base level of retirement income.[366] The public pension income system was designed to help prevent senior poverty while also partially replacing employment earnings — these programs were not, however, intended to act as an insurance and cover the large, unanticipated expenses associated with developing a chronic health condition.[367] Provincial LTC programs may be able to support lower-income Canadians or those living with higher care needs, but those who are not lower-income may need to cover their own LTC costs, which changes the amount of income needed for retirement when compared to other generations.[368] If there is no secure income, paying for these care services will deplete savings, which may require reducing living standards, and potentially being unable to cover costs.[369]

The key starting point for Canadians is to determine how they want to spend their retirement years, where they want to live and receive care, and then take concrete steps to be able to plan for their futures.[370] Promoting financial literacy, and encouraging working Canadians to start planning and saving for their retirement earlier, will also be key to ensuring retirees have greater financial security. Research from Canada, and around the world, shows that retirement planning is strongly associated with financial literacy. In Canada, those with higher levels of financial literacy are 10% more likely to have retirement savings.[371] Financial literacy can be acquired in many ways, by reading books and online resources, through financial education provided by employers, at school or in a community program, and with the assistance of professional financial advisors. For example, the federal government has developed a program called Your Financial Toolkit, which includes sections on retirement planning. The 2019 Financial Consumer Agency of Canada survey found that among individuals who took steps to improve their financial literacy, 80% saw a two-fold increase in their general financial knowledge, and 46% learned about retirement planning.[372]

Explore Options to Mitigate Risk of Financial Insecurity

There are a number of strategies, outlined below, that Canadians may consider to ensure that they have more secure sources of lifetime pension income, so as to mitigate the real risk of running out of money in retirement and secure a steady flow of income that will better enable them to finance their care needs should they arise at advanced ages.

Delay Claiming CPP/QPP

One underused retirement financial strategy to improve retirement income security into later life is to delay the claiming of retirement benefits from the CPP or the QPP. Over the past decade, Canadians have most commonly taken their CPP/QPP benefits as soon as they are eligible at the age of 60.[373] However, for Canadians who are in reasonable health and who can afford the financial implications of waiting, MacDonald (2020) proposed that delaying the start of their CPP/QPP for as long as possible can lead to substantially higher secure, inflation-indexed, lifetime pension income.[374] In practice, CPP/QPP benefits can be taken as early as age 60 and as late as age 70, with the amount of the benefit being adjusted according to the age of the individual when they first receive payments. This solution — and the financial advantages offered — are described in detail in the NIA's report *Get the Most from the Canada & Quebec Pension Plans by Delaying Benefits — The Substantial (and Unrecognized) Value of Waiting to Claim CPP/QPP Benefits)*. Future NIA research will be focused on how to better support Canadians to make an informed decision. Overall, when to claim CPP/QPP benefits is a valuable retirement financial strategy that is currently extremely underutilized.

Leverage Home Equity Assets

Another way that individual Canadians can access additional funding is to leverage their existing home equity assets. In older age, owning a home is often beneficial as it can provide cash income or be turned into an income flow for those who may be struggling to pay for their retirement.[375] One such option is a *home-equity line of credit (HELOC)*. When a HELOC is taken out, it is secured against the value of the person's home equity and can provide flexibility and tax-free retirement income. Funds can be borrowed and repaid without penalty, up to a maximum credit limit.[376] The maximum credit can go as high as 65% of the home's purchase price or market value. The downfall is that one of the requirements for this is a sufficient and stable income, which many people approaching (or in) retirement may not have.[377] They may be helpful for a limited time and/or to supplement additional income sources.[378]

Another way individual Canadians can leverage their homes is through reverse mortgages. These allow Canadian homeowners aged 55 years and older to take out a loan against the equity of their home. People can borrow up to 55% of the current value of the home and they do not need to repay it during their lifetime as long as they remain

living in the house and do not sell it.[379] Some of the advantages are that the homeowners do not have to make regular payments and they may be able to turn some of the value of their home into cash, while being able to remain living in the home.[380] In fact, one of the advantages of a reverse mortgage over HELOCs is that they are specifically meant for those aged 55 years and older — which makes qualifying easier for this population.[381] Another advantage is that this solution is tax free and does not affect OAS or GIS benefits. However, a notable downfall is that reverse mortgages are significantly more expensive, due to higher interest rates, when compared to HELOCs.[382,383]

Purchase LTC Insurance (LTCI)

Last, Canadians approaching retirement can alleviate worrying about the costs of care in later life by purchasing private LTCI from private providers. LTCI provides protection in the event that people become unable to care for themselves and can cover costs including LTC home, other care homes or the services in the home.[384] In general, two types of LTCI exist including one that reimburses you for specific expenses up to a maximum and another that is a pre-determined monthly amount.[385] However, private insurers often struggle to find an affordable premium due to the small number of people who can afford it and the high probability that services will be needed. This, in turn, makes insurers more likely to raise their premiums, making private insurance more unaffordable, which continues to decrease the potential pool of people who can afford it.[386] As a result, private LTCI has been extremely limited historically in Canada and is unlikely to be a meaningful solution in the future without substantial innovation to overcome its challenges.[387]

What the Financial Service Industry Can Do

The financial service industry has the potential to develop private-market financial products that can support Canadians in paying for out-of-pocket LTC costs by expanding the availability of low-cost long-term insurance and pension income programs beyond the current product offerings available to retired Canadians.

For example, a current major innovation in the Canadian eco-system has been a push to provide retirees a financial vehicle that would allow them to pool their retirement savings into collective dynamic pension plans for the purpose of providing them an ongoing, low-cost and secure source of income for life.

Dynamic Pension (DP) pools (also known as Variable Payout Life Annuities, or VPLAs) are designed "to help people optimize their expected lifetime retirement income while ensuring they never run out of money".[388] DP pools operate on a risk-sharing principle: protecting one individual from outliving their savings is often expensive, but the same protection is more affordable when spread across a larger group.

This solution is explained in *Affordable Lifetime Pension income: Strengthening the Canadian Retirement Income System with Dynamic Pension Pools)*.[389] In 2018, led by the NIA with Keith Ambactsheer, a group of retirement income system experts, as well as advocates for older adults and other organizations asked the federal government to amend the Income Tax Act to allow for Dynamic Pensions.[390] In Budget 2019, the government stated their intention to pass federal legislation that would allow for DP Pools (called VPLAs in the legislation)[391], and then in 2021 amendments to the Income Tax Act were introduced through Bill C-30, which then received Royal Assent in June 2021.[392,393]

What Policymakers Can Do

First and foremost, policymakers need to help Canadians better understand and plan for their future finances and care needs.

This requires a clear understanding of what expenses Canadians should expect as they age alongside what is and is not covered by the government — essentially establishing a social contract that allows Canadians to plan and consider their future — both as care recipients and as caregivers.

It will also require endorsing and supporting retirement income system reforms and private industry innovations (e.g., VPLAs, as noted above) that enable individual Canadians to save for their advanced ages.

Re-allocate Funding Toward Home and Community-Based Care

Beyond this, another necessary change is the funding and re-allocation of funding toward more home and community-based care and moving away from providing care in institutional settings. Federal, provincial and territorial governments should look to redistribute their current health expenditures and move away from LTC home-centric care toward home and community care.[394] For example, in the *Financial Realities of Ageing*, one of the overarching suggestions was to shift the provision of publicly-funded LTC away from its current focus on institutional care toward more home and community-based care.[395] There is a need to expand the availability of and access to publicly-funded home and community-based care in order to accommodate the care needs and preferences of ageing Canadians.[396] By re-allocating these funds, it would help to address the current unmet needs of Canadians living in the community.[397]

Of those receiving publicly-funded home care, many also must pay out of pocket for privately paid services to fully meet their care needs. If funding was reallocated from institutional care to home and community-based care, policymakers would better enable the provision of care in the *right* place since home care would become more affordable and accessible

for older Canadians while also increasing the efficiency of the public spending on LTC services.[398] While reallocation of current spending is a good start, there would also need to be an expansion of budgets toward LTC as well. By increasing the amount spent on publicly-funded LTC services, specifically with more emphasis on home and community-based care, it would provide the opportunity to expand the provision of this type of care to Canadians across the country.[399]

Create a Public LTC Insurance Program

Another potential policy option is to consider exploring the creation of a public LTCI program at the national level by setting aside revenue from provincial and national taxes, which is similar to how the existing health care system, Medicare, is financed.[400] The goal would be to provide those who are eligible with either fully funded or reduced in-home or LTC home type services, while matching their care needs and ability to pay out of pocket.[401] This would allow Canadians to contribute to a pooled fund dedicated to covering future LTC costs, which could relieve the burden on older Canadians and the increasingly strained system.[402] This could be integrated into, or complementary to, existing private and public financial systems. For example, it could be financed through an additional and separate contribution from employees and employers, similar to CPP/QPP contributions.[403] Models to provide "universal LTC coverage" have also been implemented in different ways around the world. Other countries — which are also facing similar long-term pressures — have implemented national LTCI models to address the challenges of an ageing population, including the Netherlands (in 1968), Germany (in 1996), Japan (in 2000), South Korea (in 2008) and Taiwan (in 2015). Most recently, Washington State also approved a LTCI program in 2019, which will begin providing benefits in 2025.[404]

However, the Canadian context could pose some potential challenges to the implementation of a public LTCI program. For one, adding additional income-tested benefits to the Canadian senior public programs create even further financial disincentives for workers to save for retirement. In fact, according to research, lower income retired Canadians with savings are among the highest people taxed in the country, being already penalized with an effective tax rate of 50% or more.[405] Second, such a program would require consideration and cooperation between federal, provincial and territorial governments, as well as the political will to enact changes alongside the broader private and public sectors. As a federal system, Canada would not be able to impose the program centrally and rather would have to engage in negotiations with all 13 subnational jurisdictions.[406] Another issue needing careful consideration relates to intergenerational equity, namely that policymakers would need to determine how to meet current needs without unduly burdening younger generations.[407] LTCI programs require a relatively long lead-time to develop and implement and therefore, would be unlikely to be in place in time to meet the needs of the bulk of the baby boom generation.[408] Third, from a public policy perspective, the provision of LTC in Canada has been structured in

such a way that LTC is paid for through a mix of public and private funding. Moving toward a publicly funded system would be a departure from the existing system, which could result in a number of unknown, unanticipated or unforeseen consequences, which may be challenging to navigate. Finally, it's important to keep in mind that LTCI programs are not meant to reduce costs related to LTC, but rather to guarantee a level of LTC service and financial coverage for those services.[409] As such, it would allow for the opportunity to establish a social contract between governments and Canadians that allows for a clearer picture of what an individual may need to contribute to their future LTC needs and what type of benefit and financial level of protection will be available through both public and private funding.[410] There may also be an opportunity to allow for a system whereby incentives could be structured to encourage home and community-based care, rather than care provided in designated buildings. For example, South Korea has co-payments that are lower for a home care option than for care in a LTC home.[411] This solution is further discussed in *Could a National Long-Term Care Insurance Program be a Feasible Solution to Address Canada's Growing Long-Term Care Crisis? Lessons from Six Countries.*[412]

Introduce Workplace Tax-Free Pension Plans

Another possibility for policymakers to obtain more scale and reach more Canadians through the private system is through reforms that more effectively tap into collective groups, particularly workplace-based pension plans and group benefit programs. For example, workplace pensions allow for automatic savings, employer contributions, fee reductions due to the economies of scale associated with a larger group of participants, potentially higher risk-adjusted investment returns and pooling of long-term risk.[413] Workplace pensions help Canadians protect their retirement income security, thereby reducing the reliance on publicly-funded programs for older adults.[414] However, workplace pension plans can be financially unattractive to middle and lower-income Canadians on account of the sub-par (or even negative) financial incentives[‡‡] underlying the current Canadian registered pension plan framework. One approach to fill this gap suggested and explored in the NIA's report *Filling the Cracks in Pension Coverage: Introducing Workplace Tax-Free Pension Plans*[415] is to introduce a new class of "workplace Tax-Free Pension Plans (TFPPs), which would operate in a "tax-free" environment like TFSAs." Contributions to this type of plan

[‡‡] For example, "Conceptually, workplace plans allow workers to defer income — and taxes on that income — to a time when they are not working (i.e., retirement). But these tax deferrals are generally much more valuable to higher earners. Canadians with lower annual income also pay an effective tax rate of 50% or more on each dollar of pension income they receive, due to the income testing underlying the eligibility calculation for senior social benefits like the Guaranteed Income Supplement (GIS)" (pp. 5-6).[‡‡]

would be made using after-tax dollars and would not be associated with a tax deduction. However, once the money is in the plan it would grow free of investment income tax and any withdrawals wouldn't be taxed or added to taxable income.[416] "By improving the attractiveness of workplace plans, and offering better value to both workers and plan sponsors, TFPPs have the potential to raise pension coverage in Canada, and ultimately improve the retirement income adequacy of Canadians and empower employers while protecting the public purse."[417]

Overall, it is clear that the financial security of older Canadians will increasingly become an important public policy issue as Canada's population continues to age. It is of the utmost importance that governments, individuals and workplaces are proactive in supporting Canadians to build long-term financial security as they age. While some of these larger policy options will require timing, coordination, funding and planning, Canadians ought to start developing their own strategies immediately. Doing so will support more older adults to fulfill their desire to age in place and more sustainable health and LTC systems.

Enabling Data-Driven Excellence: Strategies for Enhancing the Quality and Outcomes of Canadian LTC Services through Data Collection and Monitoring

An effective person-centred system needs to encourage the use of available data to understand current utilization patterns and what unmet needs may still exist.

Good data are also integral to inform decision making, promote research, share best practices, and to promote knowledge translation.

Furthermore, the encouragement of continuous research through the creation of a 'learning system' can enable the development of more innovative and effective models of care that are scalable across Canada. It can further establish the basis for resource allocation discussions, innovation strategies, and LTC policy development. Therefore, in order to properly plan for the future of LTC in Canada, it is important that we have access to better and more timely data and data systems (e.g., provinces/territories need to partner with national data organizations, as Statistics Canada, CIHI, and Canada Health Infoway) in order to inform decision making.[418]

Supporting Evidence-Based Decision Making through Appropriate Data Collection and Utilization

It will also be important to adopt a standardized data collection tool, along with a policy mandate to collect this type of data across LTC settings. This collection will begin to shift mindsets and programs toward accountability for outcomes, experiences and costs. It will make the gaps and opportunities clearer. As interRAI is internationally used, it seems like a formal adoption of a common interRAI assessment for all of Canada would lead to comparable data. As of 2019-20, six provinces and territories have committed to submitting data for all LTC homes with 24-hour nursing. These include Newfoundland and Labrador, Ontario, Saskatchewan, Alberta, British Columbia and Yukon.[419] Manitoba has partial commitment and in Nova Scotia it is voluntary.[420] The standard used for collection is the RAI-MDS 2.0. "The RAI-MDS 2.0 is a comprehensive assessment that is used to identify the preferences, needs and strengths of residents of LTC homes and patients in continuing care hospitals; it also provides a snapshot of the services they receive. It includes measures of cognition, communication, vision, mood and behaviour, psychosocial well-being, physical functioning, continence, diseases diagnoses, nutritional status, skin condition, medications, and special treatments and procedures."[421] There is also a new assessment called the interRAI LTC Facilities (interRAI LTCF) that Saskatchewan began implementing in

2019-20, but in a staggered way so there is not full coverage yet.[422] New Brunswick implemented interRAI LTCF in 2017-18.[423]

It is also integral that data collection within LTC across Canada also includes socio-demographic data. The COVID-19 pandemic shone a light on the implications of insufficient data collection when informing public health measures — especially with respect to disparities in health outcomes (e.g., COVID-19 cases and deaths) experienced by vulnerable populations.[424,425]

A report by the NIA and Wellesley Institute (2021) called for enhanced collection of socio-demographic data in both the planning and delivery of care in long-term settings.[426] *Leaving No One Behind in Long-Term Care: Enhancing Socio-Demographic Data Collection in Long-Term Care Settings,* outlines recommendations for moving forward related to data collection and use that can inform efforts to plan and deliver LTC that ensures health equity for older Canadians, including:

1. Ensure clarity exists amongst individuals living and working in LTC settings about the purposes of socio-demographic data collection.
2. Build trust through community engagement design and implementation of socio-demographic data collection initiatives.
3. Ensure standardized socio-demographic data is collected across Canada's LTC settings.
4. Ensure appropriate skills, training and understanding are established for those collecting socio-demographic data.
5. Ensure a commitment is developed to effectively and appropriately use the socio-demographic data being collected.

The data should be used to identify health disparities and promote health equity, with the goal of achieving more responsive care and reducing inequities in treatment.[427]

With targeted and intentional investments being made in the provision of publicly-funded LTC across Canada, measuring and analyzing its impact and utilizing data to drive decision making will facilitate better access to high-quality care across LTC systems. Further improvements in the quality of LTC services for Canadians will come with the broader dissemination of established and innovative best practices and technologies.

Promising Pathways Forward: Enhanced Socio-Demographic Data Collection Initiatives from Across Canada

There are a number of initiatives in Canadian jurisdictions that appear promising for improving data collection and monitoring across the country.

Manitoba

In May 2020, Manitoba became Canada's first province to collect race, ethnicity and Indigeneity (REI) information from people who test positive for COVID-19. The province set the guideline that supports the data collection process in collaboration with an Advisory Working Group, consisting primarily of Black, Indigenous, and People of Colour. Regional public health staff are required to ask every person who tests positive for COVID-19 to self-declare which REI group they belong to (while responding is voluntary).[428] According to the Health and Seniors Care Minister, the REI data will be used to help inform the government determine what needs to be done to address the identified disparities in its future planning.[429]

Ontario

In Ontario, three public health units in Ontario started collecting race-based data in April 2020.[430] That data enhanced the understanding of the varying impacts of COVID-19 on different population groups. For example, Toronto residents who identified as Arab, Middle Eastern, West Asian, Latin American, South East Asian or Black were found to be six to nine times more likely to test positive for COVID-19 when compared to White respondents.[431] Data from Toronto Public Health has shown a connection with income, finding that those with lower-incomes were more likely to test positive versus those with higher-income.[432]

Further, the CLRI has developed the *Embracing Diversity: A Toolkit for Supporting Inclusion in Long-Term Care Homes,* which aims to teach about equity, diversity and inclusion, as well as how to adapt and apply these concepts to LTC.[433] It provides ideas on how to review and modify any existing policies, practices and programs, discusses training initiatives and encourages developing a diversity committee. CLRI acknowledges that diversity is valuable and discussion should include representatives from leadership, direct care team members, residents, families, volunteers and representatives from all departments/areas of the home.[434]

Conclusion and Next Steps

COVID-19 has not only exacerbated problems that were already known to exist within Canada's complex LTC systems, but it has also changed the views of Canadians on living in, and receiving care in an LTC setting. There is now little doubt that, if they have the option and ability, Canadians will want to age in place or in their own communities for as long as possible. However, the demand for LTC services will continue to grow with the ageing population and a full spectrum of services will be required to address the wide range of needs and desires of Canadians.

As a result, there is a need to move from our current disconnected and patchwork approach in the provision of LTC services toward a system that better responds the needs and desires of Canadians.

While we acknowledge that the organization and delivery of LTC services is complex and that there are no easy solutions, it is clear that without a paradigm shift in the way Canada organizes and delivers LTC services, the challenges — as presented in the first section of this paper — will only continue to prevent (or block the road to) the sustainable and fiscally responsible provision of high-quality LTC services. This paradigm shift — or transformational approach — must hold the people who provide and receive this vital care as the central focus. In particular, this will mean that we not only prioritize investing in home and community-based care, which is how Canadians want to receive more of their care, but also acknowledge that care in provided in LTC settings will still be required and can be improved.

With this in mind, this final report in the NIA's Future of LTC Series has mapped a number of innovative strategies that will be integral to ensuring a more promising future for LTC in Canada that will better address the current and future needs of Canada's ageing population, but in a more dignified and sustainable way.

The NIA has laid out the strategies — or sign posts — on the road map toward enabling the future provision of high-quality care include strategies to improve:

- Delivery of LTC services, which are focused on:
  - Enabling integrated and holistic LTC that is primarily community-based, and institutional by exception;
  - Enabling evidence-informed person-centered care that is equitable, accessible and aims to meet not just needs, but goals of care; and
  - Enabling technologies to support ageing in the right place.
- Workforce recruitment and retention, which is focused on enabling a LTC workforce that is appropriately supported and recognized.
- Affordability and sustainability, which is focused on enabling system sustainability and stewardship through more effective, efficient and sustainable financing arrangements.
- Data collection and monitoring, which is focused on enabling evidence-based decision making through data.

As we move forward along this road map, using policy to facilitate Canada's journey along this road — or paradigm shift — will be integral in creating the necessary changes to improving the way that LTC services are funded and provided.

However, the NIA also recognizes that these are policy areas in which significant reforms will be needed and that such reforms will take time. Therefore, the direction that Canadian decision makers take now will be essential to their success.

It is clear that there is no time like the present to move forward with a balanced approach toward enabling a more promising future for LTC in Canada.

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