

# IMPROVING LONG TERM CARE IN CANADA

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## **Abstract**

Within the next 20 years we will see a drastic increase in the number of seniors, which will make up more than 25% of our population (Statistics Canada projection 2014). This will lead to a significant pressure for improved geriatric health care needs. Although the Canadian Government faces many challenges in trying to balance budgets amongst infrastructure, other social welfares the government needs as well as healthcare, this incoming societal change requires us to subsidize elder care.

Beyond health care, reduction of income upon retirement also interferes with the basic needs of life. We need stronger social welfare services for the elderly in Canada. We must expand income assistance for seniors beyond OAS (Tridelta Financial 2014), the CPP (Government of Canada 2017), and guaranteed income supplement. Although these assistance programs are extremely beneficial to niche senior groups, in the future, we will be seeing a rise in number of seniors in every economic class which will require broader infrastructural improvements.

This article will outline how the Canadian Government should expand their social welfare program and medical coverage for the health of seniors to: improve long term care insurance availability, expand at home care funding, and make specialty, palliative and primary care more accessible/affordable.

**Keywords:** long term care, home care, insurance, palliative care, seniors

## **Résumé**

Il y a actuellement une augmentation radicale du nombre de seniors qui représenteront plus de 25% de notre population dans les deux prochaines décennies (Statistiques du Canada; 2014). Cela entraînera une croissance significative des besoins en soins gériatriques. Bien que nous sommes confrontés à de nombreux défis en essayant d'équilibrer nos budgets pour les besoins en soins médicaux et qu'on alloue aussi des fonds aux infrastructures, d'autres protections sociales doivent être soutenues par le gouvernement pour subventionner les soins apportés aux anciens, parce que leur financement est extrêmement désavantageux.

Au delà des soins médicaux, les besoins courants de la vie sont perturbés également par la réduction des revenus tirés de la retraite. Nous avons besoin de meilleurs services de protection sociale pour les personnes âgées au Canada. Le Canada doit étendre l'aide aux revenus des seniors à travers l'OAS (Tridelta Financial; 2014), le CPP (gouvernement du Canada; 2017) et les garantis de suppléments de revenus. Bien que ces aides bénéficient surtout à une poignée de seniors, on constate qu'une hausse du nombre de seniors dans chaque classe économique nécessitera de nettes améliorations en infrastructures.

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Cet article exposera brièvement comment le gouvernement canadien doit étendre le programme de protection sociale et la couverture médicale pour les soins des seniors, afin d'assurer, sur le long terme, la disponibilité des soins; d'étendre au domicile le financement des soins ; et rendre les soins spécialisés, palliatifs et primaires plus accessibles/abordables.

**Mots-clés:** soins long terme, soins à domicile, assurance, soins palliatifs, seniors

### **Rezumat**

În curând vom vedea o creștere drastică a numărului de persoane în vârstă care va ajunge la aproape 25% din populația Canadei în următoarele 2 decade (Statistics Canada, 2014). Aceasta va determina o creștere masivă a serviciilor de geriatrie. Asistența medicală, reducerea veniturilor după pensionare se vor adăuga la celelalte nevoi ale vieții de zi cu zi. Avem nevoie de un sistem mai puternic de servicii de asistentă medicală pentru cei în vârstă în Canada. Canada are nevoie să-și extindă bugetul de asistentă medicală pentru cei în vârstă peste OASIS (Tridelta Financial 2014), Canadian Pension Plan (Guvernul Canadei 2017) și suplimentul garantat de venit pentru cei în vârstă. Chiar dacă acestea sunt bune pentru o parte din grupul celor în vârstă, pe viitor vom vedea o creștere a numărului seniorilor din fiecare clasă economică ceea ce va solicita o îmbunătățire a infrastructurii sociale și economice.

Acest articol va prezenta în linii generale cum Guvernul Canadian ar trebui să își extindă programul de asistentă socială și medicală ca să acopere pentru persoanele în vârstă asigurările de lungă durată, fondurile pentru îngrijirea la domiciliu și cum să facă serviciile de bază, paleative și de specialitate mai ușor de beneficiat de cât mai multă lume.

**Cuvinte-cheie:** îngrijire de lungă durată, îngrijire la domiciliu, asigurare de sănătate, pensionari, îngrijire paleativă, paleație

## **1. Introduction**

There is a significant lack of resources supporting LTCI's in Canada. Even those who can afford them often experience ridiculous wait times before they can make it in. We see this in our own facilities here in Toronto, take Baycrest for example (1,868 days) for basic level of long term care.

Ontario Long Term Care Association Actions for Seniors (2016) mentioned that most facilities, are outdated from when they were built, and don't have the funds to support necessary renovations to support residents' medical needs due to rising resident acuity (Ministry of Health and Long Term Care 2010). This is surprising due to the significant regulation that these facilities experience in the forms of standards and guidelines by agencies and inspectors (Friends of Medicare 2016). This entails confusing oversight because more than one legislative piece and more than one agency can be involved in long term care regulation. Transparency (CLHIA 2015) of this oversight is virtually non existent.

Many of these standards are not made public without explicit request and there is not much information available for seniors trying to evaluate and compare the quality of different long term care facilities.

Furthermore, there are many problems with how the current eligibility system is run (Matsuda and Yamamoto 2001). Determining eligibility for long term care and what people have to care is variable around the country. There is little transparency in formulas and procedures which are very complex and hard for lay people to evaluate the different options. Income is taken into account and those who can afford minimum rates can apply for exemptions, but most long care funding comes from public sources (Matsuda and Yamamoto 2001).

As predicted by the Report by the Canadian Life and Health Insurance Association we're approaching a future with a large funding gap for long term care. Current levels of Government care covers 595 billion and the estimated cost will raise to 1.2 trillion dollars. This calls for radical change of future policy standards that need to be introduced and have capacity to be continually improved as need be (based on need of populations).

In many systems without proper long term care support, there is a unreasonably high amount of "social hospitalization" (Federal Government of Canada 1984). This refers to family members who function as caregivers and often don't have the resources to properly care for them. Because hospital care is covered, this leads to over-admittance to hospitals by these seniors who do not require acute or emergency care.

This both creates large inefficiencies in hospitals and puts seniors who should be in long term care facilities in a demeaning situation. Seniors who require more intensive care s and looked after in a place with integrity and is fit to their needs. Although it is not the fault of the family caregivers, the government needs to support both the family members and the senior in providing financial assistance and access to proper facilities should be supported.

However Canada should not despair. Because we do not cover long term care in the Canadian health act (Ogawa and Retherford 1993), there is a lot of room for experimentation and expansion. Canada should look at long term care on a social insurance platform, funded by mandatory payments and government subsidies for those with low incomes.

## **2. Improve Long Term Care insurance (LTCI)**

Many are looking to how Japan has been approaching long term care since 2000 in their LTCI Model. Despite Japanese social norms (Ministry of

Health, Labour and Welfare 2016) that insist that the family to care of their elders, a new generation of long living seniors with complex health problems makes this increasingly difficult for families. It also increases social hospitalization of elders. Hence the need of government intervention in funding LTCI's. Japan's long term care program separates itself from health care insurance (Canadian Medical Association 2015). Eligible people for Japan's LTCI include people over 65 or are already insured by health insurance and although there is an out of pocket payment at a fixed rate, there is an upper limit for these payments. There is also a lower upper limit set for seniors with low incomes.

As a result of this new policy, they have seen an increase in number of home service enterprises, a 67.5% increase in people who already use LTC and an increased in 52% and 82% increase in home care and long term care (respectively) in under a year. This is drastically different to their previous system where pensions were too low relative to long term care costs. In this new system, 16% are pension deductions, 33% are premiums from those with health care insurance and 50% is from government revenues/municipal funds.

In Canada, each province should also look for achieving efficiencies in running the long term care system by possibly developing a unified way to access the LTC services ("single-point of contact model"). While there could be multiple agencies and service providers competing for providing the services, a common, clear, flexible and regulated framework should ensure the services are provided uniformly and at the lowest costs possible.

There are a lot of efficiencies and waste reduction that can be achieved by eliminating bureaucratic processes that are different between different areas, similar to how a common curriculum requirement is successfully applied across a system of private/public/catholic school board system to drive standardized levels of learning and performance measurement.

### **3. Expand at home care**

Daily fees for at home care through a nurse or allied health professional is 42\$/day, a long term care bed fee is 126\$/day and costs of a hospital bed its 842\$/day (Canadian Medical Association 2013). You can see how care cost can add up. Beyond the potential savings of home care, 9/10 seniors report that they would prefer to remain living at home as long as possible. This is an important statistic that the government should consider as they continue to support home care. Although home care is usually covered by public

insurance, this does not mean that appropriate at home care is coordinated without complications (Coyte and McKeever 2016). Most homes that elders have spent their entire lives in are unfit for them once they're aged. This entails necessary renovations of bathrooms, installations of stair lifts, and implementing means to control infection which together tend to add up. To seniors who choose at home care and are economically disadvantaged, these home improvements can be quite costly.

The government should look to subsidize companies that create affordable and quality products that address accessibility and safety concerns for at home seniors. In some cases, the government might have to fully provide these goods and services for seniors under a certain income level. These home care environments can become further dangerous if without appropriate and knowledgeable assistance from trained caregivers.

The possible implications of this can be seen in possible improper medication management and preventing substance abuse. Although the costs of these caregivers are typically covered by public insurance (Turcotte 2014), many Canadians still don't have their home care needs met (Canadian Medical Association 2013) due to a lack of funding. 1.6-6.4% of total public health expenditure in recent years is devoted to at home care (Canadian Institute for Health Information 2016). In some provinces the proportion of funding for home care has dropped further in recent years, despite a rise in use and demand for home care (Canadian Medical Association 2013).

Another large flaw with current home care provision is that insured home care is highly unregulated. Only four provinces have at home care standards. These standards are nowhere near equitable around Canada (Nova Scotia Department of Health and Wellness 2016). We need policy that equalizes and sets standards for what is appropriate care. We also need to instruct home care providers to create home care plans which are appropriate and comfortable for the individual receiving it.

Another important consideration when we evaluate the current state of home care is the number of unpaid caregivers in Canada. As estimated by the Conference Board of Canada (Ontario Government of Health 2016), unpaid caregivers provide 10 times more hours in home care than paid workers in 2007. There is very limited support for family caregivers who are often older themselves. This puts a lot of pressure on their physical health and can induce high levels of stress as they care for their loved ones.

In the past, all provinces have offered unpaid compassionate care leave between 8-12 weeks and the federal EI Compassionate Care Benefit program provided financial support for individuals caring for a family

member. However, these benefits were only for six weeks and are intended to cover end of life care of the family member who is sick. More recently, this has seen a six month extension in coverage in the Federal budget. However there are still very limited tax credits to support caregivers. Nova Scotia gives direct grants but a very limited 1,700 people have accessed the Direct Family Support program (Canadian Medical Association 2015). More tax credits and return support is needed for caregivers as well as direct grants to provide financial support for family members. Although we are seeing some changes in how Home care is approached through bureaucracy with the Patients First Act (Canadian Medical Association 2015) passed by Ontario Legislature, we still have to wait some time to see if switching CCAC responsibility to LHIN's will change financing and allocating funds to home care and its impact on caregivers.

#### **4. Make Primary Care, Specialty Care, and Palliative Care more accessible**

Often in *primary care*, profound attention from a regular medical doctor is limited and leads many seniors to fill up space at hospitals/ hospital beds as they lack access in the regular system. This leads to seniors receiving care from people overqualified over a family physician who would be better suited to help with their condition. This leads to longer wait times for other patients who need emergency help, possibly for acute care or other kinds of immediate medical attention. This leads to large inefficiencies in the health system. We see invites aimed at changing this in Ontario's "Patients First Act" which is aimed at patients gaining more immediate care from doctors and nurses. Even with this, in Ontario, 16% of hospital beds are filled up by seniors awaiting discharge (Béland et al. 2006). When these seniors remain in hospitals any longer than they need to, they can become infected or contract viruses which could be extremely detrimental to their health and is easily preventable. There are efforts by Health Links by the Ontario Government which outlines ways to decrease the likelihood of seniors readmission to hospitals. Winnipeg is also piloting a hospital health team to follow up for 60 days after the use of a Hospital emergency department. Its main aim is how to keep these people out of the hospital and as healthy as possible.

Seniors can experience waits for *specialist access* of about 2 months on average. This is extremely problematic as seniors have some of the most complicated illnesses and immediate needs for specialists to help diagnose,

manage and develop specific treatment plans for. In order to fix this mis-saturation of hospital beds and a systematic lack of specialist availability, we need the government to guide the de-hospitalization of specialist care. We need to shift from a hospital based care system to a community based system. Where specialists work in the community and along with long term care systems to care for seniors with complex health problems outside of hospitals. This shift needs to be subsidized and needs further support from the government to incentive more geriatric care. We see efforts made in this direction by Halifax with creating specialized geriatric paramedics. This shift is necessary because the geriatric field is currently not very profitable in comparison to other specialties that tailor to niche patients with a lot of disposable income. Elders as a group do not usually have dispensable income to purchase extra health resources so the government needs to encourage the training of geriatric specialists.

We also see other initiatives like the Sinai Health Geriatric Psychiatry Outpatient Program as well which gives offers comprehensive outpatient care to patients with dementia through a geriatric specialist team lead by a geriatric psychiatrist.

Lastly, Palliative care needs to be adopted earlier than at the end of the patient-care journey. Care needs to be interdisciplinary and we need more teaching institutions to emphasize the importance of its integration. We need better delivery models like those suggested by the CMA's National Call to Actions Examples of Innovative Care delivery Modes, where there is more training and opportunities of physician leaders in palliative care.

Another significant challenge is the lack of advanced care planning. Most health care professionals don't discuss long term health plans in advance. This denies patients some important informed choices that they can explore and understand in advance. This is troublesome because treatments for senior are highly complex. 1/4 of seniors have at least one chronic condition and report no daily treatment plan. 1/2 of those with a daily treatment plan take 5 drugs or more from different classes and 20% of which report that it hadn't been revised by any health professionals for over 12 months (Government of British Columbia 2016).

This leaves room for many adverse drug reactions among seniors which require expensive treatment. This is easily preventable with more comprehensive palliative care encouraged and coordinated by the government. A good example of a program moving in this direction is the best PATH program however its implementation and reach is still limited. Simply put, there is not enough affordable palliative care in Canada, especially in

rural areas or available to those with disabilities. Currently, only BC (Banks 2004), Alberta and Yukon have coordinated palliative care that is fully covered or mostly subsidized. Most other provinces only supply a patchwork of palliative care.

This palliative care should include subsidized medication for the elderly. We need to integrate primary, specialist care and advanced training via government support programs to encourage deeper involvement and use of available medical technologies.

The Taber Clinic model in Alberta is piloting this where integrated multidisciplinary teams are provided with physician payment methods. An important step to adequate coverage of palliative care involves coordinating a drug assistance plan for elderly around the nation. Most recently, in August 1st 2016, Ontario has introduced newly eligible low-income Seniors in the Co-Payment program under the Ontario Drug Benefit (ODB) Program. Although this is expected to bring great results, it only covers Seniors in Ontario who are of a specific low income class and are enrolled in either home care, Ontario Works, the Trillium Drug Program or live in a long term care facility. In order to be eligible for the copayment program, you must have an income of less than \$19,300. This program at the moment only covers about 4,300 prescription drugs (Battersby 2005), none of which can be bought outside of Ontario and must be listed in the Exceptional Access Program. Savings from this plan on average come to \$130 (Canadian Medical Association 2013) on per year on out of pocket drug costs which seems to take some of the burden off of seniors but at a great expense to the government.

## **5. Conclusions**

We have seen Canadian society demonstrate preference for individual choice in health care needs based on the principles and implementation of the Canadian Health Act. We should follow this social gradient in how we plan to amend our social welfare and health provision for senior care in the future. However its development towards coverage of long term care, home care, other necessary medical services are still inadequately supported and will only create greater discrepancies as senior population rises. The implementation of adequate medical and social policies, means investing in the ability of people to develop and to face the risks (Şoitu 2015; Medeleanu 2013; Mihalache 2010).



For LTC, a model like Japan's LTCI definitely provides some profound insight into what is effective and what falls short. This is something that could be used as inspiration in how we approach a similar problem. For Canada, the main goal should be not to blindly adopt a foreign mode or to scrap the services that currently exist to create new ones, but rather to evolve the current system by creating a common framework that can be used to assess the level of service provided and to integrate flexibility into existing policies to administer the proper level of income support for all Canadian seniors.

In the future, the federal government will have an increasingly important role in highlighting, equalizing and enforcing provincial standards and expenditures in senior care. Such standards will include many of the same principles that currently dominate basic health care, but should also introduce and outline the terms and conditions for public LTCI and home care insurance, including eligibility conditions, service plans, and cost-sharing arrangements. A careful balance of federal action between new programs is necessary for Canada to achieve the same national standards in which normal (non geriatric) medical care currently experiences.

Moreover, there is a need to develop consensus with respect to medically necessary services, irrespective of the health care route in which such services are sought or received. Extension of the current health insurance to cover to a larger group of health settings and care providers ensures that it will be relevant to the upcoming health system needs. While a range of policy options exist to address; financing of LTCs services, tax-based incentive schemes for the provision of home care and future considerations for medicine coverage, there are concerns as to if their adoption is likely. Only through devoting a portion of national infrastructure to funding primary and palliative care, by providing elders with adequate income support for relevant home care solutions and by adequately funding long term care services can we provide older Canadians with adequate access to income supports for a healthy and fulfilling life.

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