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POLICY BRIEF

Ensuring Quality Care For All Seniors

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Overview

Most Canadians will rely on seniors care (home, long-term or palliative care) at some point in their lives. Canadians deserve equitable access to a full continuum of care that enables them to age with dignity, respect and independence. Unfortunately, our public health care system is currently ill-equipped to address the health care needs of the aging population.

The federal government is responsible for ensuring access to public health care. Seniors care often falls outside the scope of the public health care system, which primarily covers hospital and physician services. The level and scope of seniors care available through the public system differ dramatically between provinces and territories. Eligibility criteria and wait times also vary considerably. Much seniors care has been privatized to

fill in the gaps in the public system. This has led to significant out-of-pocket expenses for seniors. Without a pan-Canadian strategy to ensure a consistent continuum of care, many seniors are falling through the cracks. A recent international survey found that Canadian seniors were less satisfied with their health care than their counterparts in several OECD countries; only 67% said they were satisfied with the quality of their health care.[1]

The consequences of this patchwork of care have been documented in academic research and reports from national roundtables, parliamentary and departmental committees, stakeholder conferences, health care worker organizations and community advocates. Without proactive strategies at all levels of government, a crisis in our public health care system will affect the health and well-being of families across the country.

Canadians know there is a problem and they want the government to act. Over 9 in 10 Canadians believe the federal government should work in partnership with the provinces and territories to ensure equitable access and quality in long-term care across the country. Nearly 9 in 10 believe a national long-term care strategy is the way to go about this.[2]

The challenge is not insurmountable. There are innovative, effective and affordable solutions. We just need the political will and leadership to put them in place. We must take action now to ensure we have the proper resources and capacity before it's too late.

The provision of seniors care should be subject to the principles and criteria in the *Canada Health Act* to ensure an inclusive and integrated approach to seniors care across Canada.

Seniors care involves several components of our health care system. This paper focuses primarily on long-term and home care, while acknowledging the important role of palliative care and pharmacare.

1. SENIORS CARE: THE NUMBERS

Between 2011 and 2016, the proportion of seniors in Canada grew more than it has in over 100 years. Those aged 65 and older now account for 16.9% of the overall population. Eastern Canada has the highest proportion of seniors, while Western and Northern Canada have a comparatively younger population (Table 1).[3]

We tend to require more health care as we age. Decreases in functional capacity are common among seniors, and multiple chronic conditions and frailty are more prevalent with age.[4] As the population of seniors increases, we need more resources to properly address their complex health needs.

Table 1: Proportion of the population aged 65 and older within the total population, Canada, provinces and territories, 2016 [5]

Provinces/Territories	**%**
Nova Scotia	19.9
New Brunswick	19.9
Newfoundland and Labrador	19.4
Prince Edward Island	19.4
British Columbia	18.3
Quebec	18.3
Ontario	16.7
Canada	16.9
Manitoba	15.6
Saskatchewan	15.5
Alberta	12.3
Yukon	11.9
Northwest Territories	7.7
Nunavut	3.8

Many seniors still lack access to adequate health care. This can be explained in two ways. First, while health care spending on seniors has been increasing alongside seniors' population growth (roughly 2.8%), this increase doesn't account for inflation or funding cuts to the health care system as a whole. These cuts have placed additional burdens on sectors in the system most used by seniors. For instance, the sharp decline in the number of hospital beds (from 6.8 per 1,000 people in 1985 to 2.7 in 2010)[6] and reductions in long-term care bed capacity[7] have created significant barriers to adequate care for seniors. Second, overall expenditures don't tell

us where money is being spent (in the public or private sectors) and whether resources are equitably distributed to those who need them. That data is difficult to find.

Many seniors' health care needs aren't currently covered by the public health care system. The *Canada Health Act* primarily covers in-hospital and physician services. As soon as people leave the hospital, the services they need may not be covered by the public system.

According to the Canadian Life and Health Insurance Association, only one-quarter of Canadians have included long-term care costs in their financial planning for retirement.[8] The median retirement savings of those between the ages of 55 and 64 who don't have employer-based pensions is only $3,000. For those with an annual income of $25,000 to $50,000, it is only $250.[9] Making the situation worse, Old Age Security and Guaranteed Income Supplement levels have not kept pace with median income levels, and the proportion of seniors with a pension is on the decline.[10] With an overall median income of $27,353, it's clear the vast majority of seniors do not have the financial resources to access suitable health care as they age.[11]

The overall cost of caring for seniors may seem daunting, but with proactive measures, planning and sufficient up-front resourcing, we can put in place a cost-effective public system that enables all seniors to access adequate and appropriate care.

Social Inequities in Seniors Care

Accessing quality seniors care is particularly burdensome for low-income, racialized, Indigenous and LGBTQ+ seniors. According to Statistics Canada, the rate of low-income seniors has steadily increased since 1995, reaching 12.5% in 2014.[12] Single and immigrant seniors are particularly vulnerable to financial stress.[13]

Certain groups of seniors are also more likely to experience greater health issues and require increased health care services. As noted by the Health Council of Canada, "In comparison to the larger Canadian population, a significantly larger proportion of Aboriginal seniors live on low incomes and in poor health, with multiple chronic conditions and disabilities."[14] Recent research by the Wellesley Institute also highlights significant health disparities between immigrant (especially racialized) and non-immigrant seniors in the Greater Toronto Area.[15] In addition, research shows that socio-economic status impacts the ability to engage in healthy lifestyle choices, which leads to lower health outcomes and greater health care needs.[16]

Seniors who are Indigenous, immigrants and/or racialized also face barriers in accessing care, in particular culturally appropriate care.[17] In addition, seniors living in rural or remote communities must often travel extremely long distances to access care, separating them from their loved

ones, friends and community. Without coordinated government action on seniors care, these groups will suffer the most since they lack the financial resources to access private, for-profit continuing care.

Inequities also exist within the health care labour force. Women account for most of this labour force. The lower they are on the workplace hierarchy, the more likely they are to be racialized and/or immigrants with limited employment options.[18]

2. LONG-TERM CARE

Long-term care facilities provide both medical and personal support to individuals who are no longer able to live in their own homes or within the community. Commonly referred to as nursing homes, they provide round-the-clock medical and social support for those with more complex health care needs. Admission to a long-term care facility is generally approved and processed by regional public health authorities.

What distinguishes long-term care homes from other seniors' residences such as retirement homes is the level of care provided and the extent of government financial support. Retirement homes are usually privately run (for-profit or non-profit), with few direct government subsidies and with costs borne mainly by seniors. They may provide a basic level of care, such as assistance with taking medication or visits from personal support workers

Long-term care is provided through both public and private (for-profit and non-profit) entities.[19] Just under half of all long-term care facilities are private for-profit entities (44%), while 29% are private non-profit entities and 27% are public entities.[20]

Funding and Affordability

Internationally, funding models for long-term care range from fully funded public systems to entirely private systems. Most OECD countries require some level of cost-sharing by residents.

Canada's long-term residential care funding is described as a "mixed-model," where some costs are covered by the state and others are privatized.[21] In 2012, the total cost of long-term care in Canada was $9.8 billion; today that number likely exceeds $10 billion.[22] Just under three-quarters of this amount is paid for by public sources, which include various provincial and municipal sources of funding. The remaining 23% is paid for by residents through private

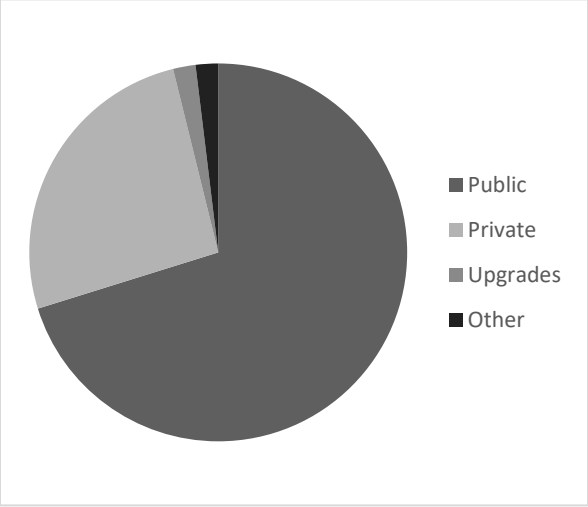
insurance or direct payments, mainly for accommodation fees that cover room and board.[23] More and more seniors are paying out of pocket for their residential long-term care and the costs of care keep rising.

This mixed funding model makes it even more challenging to navigate the regulations and financial eligibility requirements for long-term care. Until 1996, the federal government provided targeted funding for long-term care to provinces and territories through the Extended Health Care Services program. This program was abolished following the creation of the Canada Health and Social Transfer, and in theory funding for long-term care was rolled into this larger funding program.[24] Outside the Federal Provincial Territorial transfer payments, the federal government continues to provide direct funding for long-term care through its subsidy program for veterans seeking long-term care and through the First Nations and Inuit Home and Community Care program.

Several broad principles shape long-term care funding across Canada:

- health care costs are covered by the state;
- residents bear some responsibility for accommodation costs;
- public subsidies of accommodation costs are targeted based on residents' ability to pay;
- residents' payments should not take all of their income; and
- residents' payments should take into account the needs of other family members.[25]

Figure 1: Sources of funding for long-term care in Canada



The implementation of these principles varies considerably across the country, which has important consequences for accessibility and equity. For instance, the percentage of public

health care dollars directed towards long-term residential care varies significantly. British Columbia falls at the lowest end of the spectrum at 5.1% of public health spending, while Nova Scotia reports the highest percentage at 15.8%.[26] In most jurisdictions, both public and private facilities receive funding for costs related to medical and personal care. However, in some jurisdictions, government funding is only provided to public facilities. In setting co-payments for accommodation, some jurisdictions mandate sliding scale costs based on income. Others have a flat maximum rate depending on accommodation type, with subsidy programs available to those who qualify for support for accommodation fees.

Provinces set different income thresholds and use different mechanisms to assess residents' ability to pay (gross, net or after-tax income). They also have different regulations about what deductions can be applied and whether assets are included.[27] Residents may also be charged additional fees for things such as cable, telephones, internet and recreational programming. Ontario, Quebec, Manitoba and Alberta allow facilities to charge different rates for semi-private or private rooms.[28] As a result, seniors are faced with a variety of charges and they receive starkly different levels of government funding depending on where they live. With co-pays ranging from $1,000 to $3,400, the affordability of long-term care is a serious concern in both public and private facilities across Canada. This is particularly concerning for low-income seniors.

Table 2: Accommodation co-pay in selected provinces

Province	**Accommodation co-pay (per month)**	**Variation based on**	**Subsidy/Rate reduction**
Ontario	$1,848.73 for basic accommodation $2,640.78 for a private room[29]	Accommodation type	Low-income residents can apply for a subsidy through the Long-Term Care Home Rate Reduction Program for the cost of basic accommodation
Alberta	Between $1,673 and $2,036[30]	Accommodation type	Seniors on social assistance may have their charges partially or fully covered
British Columbia	Between $1,130.60 and $3,278.80	Income	Additional subsidy for eligible residents[31]

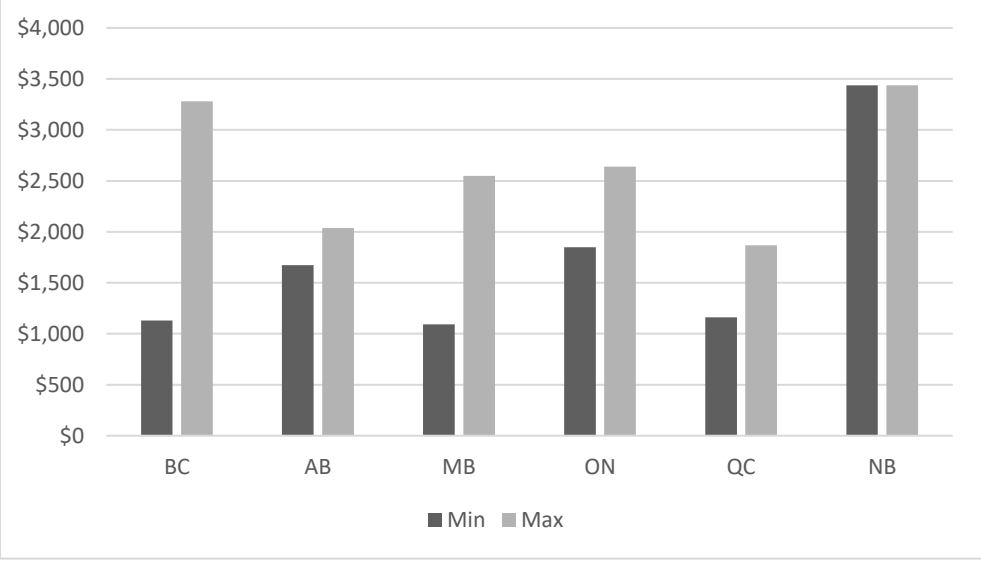
Province	Accommodation co-pay (per month)	Variation based on	Subsidy/Rate reduction
New Brunswick	Maximum rate of $3,437[32]	Accommodation type	Residents unable to afford the co-pay can apply for a subsidy based on monthly income
Manitoba	$1,092 to $2,550	Income[33]	

*Note: This includes public and private facilities, except in British Columbia, where only public facilities receive government funding. In long-term care facilities in British Columbia without public subsidies (which are usually called "licensed beds"), residents bear the full cost of care and accommodation, at an average of $6,000 a month.

Many argue these accommodation and other additional fees are reasonable given that everyone is financially responsible for their primary residence. Nonetheless, these fees represent a significant burden for many seniors. Co-payments can be especially difficult when one spouse enters long-term care while the other remains at home, as not all provinces and territories take this type of living arrangement into account in determining co-payments.[34]

Not surprisingly, long-term care is a growing industry. Private, for-profit facilities are lucrative business endeavours. Revenue from nursing and residential care facilities topped $25 billion in 2015. These facilities had an overall profit margin of 9% that year.[35] Several of Canada's largest private nursing home chains have posted profits considerably higher than that.[36]

Figure 2: Long-term care monthly co-payments in selected provinces



(Ontario and Quebec figures based on type of accommodation, not income-based. BC only includes public facilities)

Access and Wait Times

While there are currently close to 200,000 long-term care beds in Canada, the actual demand is estimated at closer to 263,000.[37] Tens of thousands of seniors are currently on waitlists for long-term care, often occupying acute care beds in hospitals while they wait. This causes further backlogs and increased wait times in other areas of Canada's health care system. Other seniors are receiving home or community-based care without having all their needs met.

Despite the growth in the population of seniors and the resulting increased need for long-term care, the number of beds and long-term care facilities across Canada decreased between 2005 and 2014.[38] In Ontario, there are 34,000 people on the waitlist for long-term care, with an average wait time of 143 days (i.e. almost 5 months). Wait times in Nova Scotia vary widely depending on the region, ranging from 29 days to a year and a half for nursing homes and between 9 days and two and a half years for residential care facilities.[39]

Table 3: Long-term care facilities in Canada

	2005	**2014**
Number of Facilities	1630	1334
Number of Beds	173,376	147,926
Number of beds per 1,000 aged 65+	41.2	26.5

(Reproduced from Harrington et al. - 2017)

While the overall number of long-term care beds has decreased in Canada, the number of beds per facility and the number of corporate chains (where one company operates multiple facilities) has increased. This means that the long-term beds that are available are increasingly in larger corporate-style for-profit facilities.[40] For instance, Ontario has seen a dramatic jump in for-profit chain facilities, compared to public, private non-profit and private for-profit independent facilities.[41]

Due to the shortage of long-term care beds, seniors are expected to take the first available bed, which could be hours away from their families and communities. While some provinces impose limits on the distance a resident can be expected to move, others have no such restrictions or designate wide geographical areas within which a senior can be moved into a long-term care home. In New Brunswick, seniors must accept an available bed if the facility is within 100 km from their community, as long as services are available in their primarily language (French or English).[42] "First available bed" policies can be particularly difficult for seniors living in rural and remote areas who may come from a particularly large geographical catchment area. For

example, in 2017 a woman in Newfoundland was placed in a nursing home over 200 km from her home.[43]

Research funded by the Canadian Medical Association projects that Canada will need to add 199,000 long-term care beds to meet the demand by 2035, nearly doubling existing capacity. While this will require a significant financial investment, the spending will ultimately have a positive economic impact by creating jobs and contributing to a growth in GDP.[44] Expanded public investment in long-term care would also have a positive ripple effect by easing the burden on hospitals, freeing up beds for patients with more acute care needs.

Quality of Care and Care Work

In addition to issues with access and affordability, concerns have been raised about the quality of long-term care. In a 2015 survey, over 90% of respondents said they were concerned or somewhat concerned about wait times and inadequate staffing levels in long-term care homes.[45] Concerns have also been raised about the overuse of medication. According to the Canadian Foundation for Healthcare Improvement, over 25% of seniors in long-term care take antipsychotic medication without a corresponding diagnosis.[46] This medication is often used as a quick way to reduce challenging behaviours. However, it can cause serious harm, such as falls and unnecessary hospital visits.[47]

Quality care requires quality working conditions for care workers.[48] It requires adequate staffing levels, proper training and supports and workforce stability. Funding cuts, contracting-out, privatization, inadequate staffing levels and reduced care services negatively impact both the quality of care and working conditions. Inadequate staffing levels are often addressed through short-term measures such as hiring temporary workers. This negatively affects the continuity of care residents receive. It also prevents care workers from familiarizing themselves with residents and work environments. The prevalence of casual, part-time and contract staff erodes and limits the development of meaningful relationships between care workers and seniors.

Care workers are acutely aware of the impact of working conditions on the quality of care. In a recent survey of Manitoba nurses working in long-term care, only 26% rated the quality of care provided in their facility as "excellent"; 58% said they didn't have enough time to properly care for their patients and 56% said the staffing levels at their workplaces were inadequate.[49] The workload of care workers in both long-term and home care has increased alongside an overall increase in patients' needs, meaning workers have less time to adequately address more complex situations. Long-term care workers also face disturbing levels of workplace violence and harassment. According to the Canadian Institute for Health Information (CIHI), nearly 50% of nurses working in long-term facilities have been abused by a patient.[50]

The commonly cited benchmark for quality long-term care is 4.1 hours of direct care per resident per day.[51] However, many provincial and territorial guidelines fall below that standard or they lack specific standards altogether. For example, Manitoba staff guidelines are set at 3.6 hours, but they aren't limited to direct care; they cover paid hours of care, which include staff meetings, training, administrative duties and paid breaks, and they don't take work absences (vacation, injury, illness or maternity leave) into account.[52] The New Brunswick guidelines stipulate 3.1 hours of care per resident per day divided among nurses, attendants and rehabilitation staff. A pilot project in New Brunswick found that raising the hours of care to 3.5 enabled small daily changes in the care relationship that had significant impacts: "Staff members [got] to know the residents better, provide greater choice and dignity to residents and develop meaningful relationships with the residents."[53]

In its analysis of long-term care homes across Canada, CIHI found considerable variation in the quality of care between and within jurisdictions, highlighting the importance of pan-Canadian standards to ensure a more consistent level of care.[54]

Research suggests there are important differences in the quality of care between public and private facilities.[55] Citing research in Ontario and British Columbia, Armstrong et al. noted that non-profit and publicly owned long-term care facilities tend to have higher staffing levels, fewer verified complaints and fewer transfers to emergency departments.[56] A recent study of long-term care facilities in Ontario also suggests that the level of care at non-profit facilities is superior. Researchers found that hospitalization and mortality rates were lower at non-profit facilities than for-profit ones.[57] Research in Manitoba found that on average, for-profit facilities had lower staffing levels and higher dispensing of antipsychotic medications.[58] Research in Alberta found that public facilities reported higher hours of direct care per resident than private for-profit or private non-profit facilities. A higher proportion of those hours are delivered by a registered nurse, as opposed to a practical nurse or care aid (personal support worker).[59]

In both public and private long-term care facilities, the quality of care and of working conditions are two sides of the same coin. We need to ensure that both residents and care workers are treated with dignity and respect,[60] based on an understanding that care is a relationship between those receiving and providing care. An effective and progressive approach to seniors care would allow seniors and care workers to build meaningful and sustainable relationships. While the quality of care isn't solely attributable to staffing ratios and hours of care, pan-Canadian benchmarks would help achieve equity across jurisdictions.

3. **HOME CARE**

Home care includes a range of health and personal care services provided within an individual's home, including nursing, physiotherapy, occupational therapy, assistance with daily living needs (bathing, grooming, toileting and transferring) and homemaking support (cleaning, laundry and meal preparation). It can include short-term (acute) care or long-term care for those with a chronic illness or recovering from significant medical treatment. It can also include care that enables individuals to maintain a stable level of health.[61]

Over 2 million Canadians receive some form of home care, either formally from a paid professional or informally from family or friends. Home care is not solely a service for seniors. In fact, in Ontario seniors accounted for only 58% of home care clients in 2016-17.[62] However, research suggests seniors are more likely than those under age 65 to receive home care through publicly-funded services.[63]

Where appropriate, home and community-based care is often preferable to long-term facility- or hospital-based care, as it can enable individuals to maintain independence, dignity, familial and social relationships and power over their own care needs. Eighty-six percent of seniors receiving home care said the services helped prevent them from having to move to a residential care facility.[64] However, it's important that home care not be treated as a Band-Aid solution for shrinking hospital and long-term care capacity. Individuals who require institutional care should not be pushed out due to a lack of space or resources. Access to home care should be based on the kind of care that will best meet people's medical needs.

The majority of those receiving home care do so informally through family or friends, most of whom are women. While roughly a quarter of seniors receive some form of home care, only 6% receive formal, publicly-funded care. This amounted to over 350,000 individuals in 2016-17, 71% of whom were aged 75 or older.[65] Although most home care is informal, the total spending on formal home care remains significant; it amounted to $3.7 billion in 2014, of which $3.4 billion was publicly funded.[66] This doesn't account for the economic value of informal care provided on a volunteer basis.

All the provinces and territories offer a limited amount of publicly-funded home care services performed by both public and private agencies. As illustrated in Table 4, there is great variation in the level and scope of home care available across the country. Interestingly, most provincial and territorial guidelines set maximum – but not minimum – limits for the amount of home care people can receive.

Table 4: Maximum hours of service in selected provinces and territories

Province/Territory	Maximum Hours of Service and Funding
Ontario	120 hours in the first 30 days of service and 90 hours a month for personal support services
Manitoba	55 hours per week of home care attendant services
Quebec	15 hours per week
New Brunswick	215 hours per month for home support
Nova Scotia	100 hours of home support every 28 days
Prince Edward Island	28 hours a week, or 3 visits
Newfoundland and Labrador	$3,490 per month for home support to pay for: • 4 hours a day of personal care and/or behavioural support; • Up to 1 hour a day for meal preparation and 2 hours a week for homemaking when a caregiver doesn't live with the client; • 2 hours a week of homemaking when a caregiver lives with the client and there are additional homemaking requirements; • Respite services for caregivers living with someone who needs 24-hour care or supervision.
Nunavut	5 hours per week for homemaking services and 2 hours per day for personal care services
Northwest Territories	4 hours per month for housekeeping services
Yukon	35 hours per week for homemaking, personal care and respite care

(Data from Levels of Care Expert Panel - 2017)

There can also be differences in care within provinces and territories. For example, in 2015, the Ontario Auditor General found inequities and discrepancies in home care services available across the province due to variations in staff workloads and benchmarks used to add clients to waitlists. In a 2017 follow-up report, the Auditor General noted progress in several areas, but found the Ontario government had "made little progress on centralizing wait lists for community support services and on tracking rescheduled and late home-care visits in addition to missed care."[67]

Given these varying levels of service and lack of minimum guarantees, it's not surprising that individuals face challenges in accessing the care they need. While Canadian governments have increased public funding for home care over recent decades, access remains an issue, particularly for those with complex health conditions.[68] Research from Statistics Canada found that in 2012, 15% of the 2.2 million Canadians who received home care did not receive adequate care. An additional 461,000 required home care but did not receive it. This means 1 in

6 individuals who needed home care didn't get it, and a significant number of them were seniors. Those with lower incomes, immigrants, refugees or non-permanent residents were more likely to have unmet care needs.[69]

With scarce resources, home care is increasingly only available for acute, short-term medical needs, leaving less urgent – but no less important – chronic and daily health needs to informal caregivers. These challenges are compounded by cuts to hospitals and acute care, which are pushing more and more people into an already under-resourced sector of our health care system. A recent CIHI report found more than 20% of seniors admitted to residential care facilities likely could have remained at home if additional supports and services were available within the community.[70] At the same time, there are many who are still at home who need the more complex care provided in long-term care facilities, but who can't move there because there are no beds available.

Limits on the availability of publicly-funded home care services place additional burdens on friends and family, especially women. While informal care may be a choice for some seniors and their families, in other cases it's the only option. Informal home care by friends and family is not a minor commitment. On average, these caregivers provide 20 hours of care per week.[71] A recent study revealed that 35% of informal caregivers show signs of distress, including being unable to continue caring activities and exhibiting anger or depression.[72] As care needs become increasingly complex, home care becomes even more challenging for family and friends who lack formal training. Investments in home care must therefore include adequate supports for informal caregivers.

In a recent report, the Levels of Care Expert Panel recommended that the Ontario Ministry of Health and Long-term Care adopt a "levels of care" framework to guide home and community care service delivery. The framework should include specific benchmarks of support hours for different functional needs (ranging from 12 to over 120 hours per month). The Expert Panel also noted the importance of an integrated approach to seniors care. In addition to support hours, they identified other key components of effective home and community care, including a care coordinator, access to appropriate community support services and programs, regular primary care, comprehensive and specialized geriatric assessment and dementia supports, assistive devices, access to the appropriate rehabilitative programs, and coaching and educational programs for caregivers.[73]

A further challenge is that home care work tends to be low-paid and precarious, making it difficult to establish meaningful caring relationships.[74] Much home care is performed by Personal Support Workers (PSWs), which are also referred to as health aides, personal care aides and health care assistants. As an unregulated profession, PSWs face chronic underemployment and often lack specialized training and education to handle complex care needs. Nurses working in home care also face challenges. In a 2017 survey of home and long-term care nurses, nearly

90% said their workload had increased over the past 3 years, with 60% saying it increased considerably. Overtime is also an issue, with 63% saying they worked overtime at least once a week or almost every week when they would have preferred not to.[75] It's estimated that British Columbia alone will need an additional 2800 care workers to meet the demand for seniors care over the next five years.[76]

Technology

Several reports and studies identify increased use of technology as one means to improve the availability and delivery of home care. In a survey of health care professionals and the general public, over 75% of respondents saw "connected care technology" as an important tool to improve home care services.[77] These technologies usually refer to the sharing of health care data among health care professionals and agencies as part of a move towards more integrated health services. The College of Family Physicians of Canada, the Canadian Nurses Association and the Canadian Home Care Association advocate for increased investment in technology-based home care (e.g. virtual care, tele-homecare, home care using electronic records).

While technology can play a role in improving the coordination and integration of health care services, it should not be seen as a solution to the core challenges faced in home care. Virtual support is not a substitute for meaningful in-person care relationships. Technology can't overcome the need for additional education and training for care work, and for improved working conditions for care workers.

Federal Funding

In the most recent bilateral Health Transfer Agreements between the federal and provincial-territorial governments, the federal government committed to funding $2.8 billion over 4 years for home and community care.[78] However, this funding is back-ended, with the largest amount pegged for after the next federal election (Table 5). There is a significant risk that the funding might not be made available at all if a new government is elected in 2019. In addition, this funding doesn't make-up for the overall reduction in federal health care funding that resulted from the new bilateral health agreements.[79]

Table 5: Federal home care funding - 2018

Fiscal Year (beginning April 1)	Amount
2018-19	$600 million
2019-20	$650 million
2020-21	$650 million
2021-22	$900 million

Ultimately, Canada must recognize home care's increasingly central role in meeting patients' health care needs. We must connect home care services to primary and acute care so that patients experience integrated, consistent and continuing care.

4. ADDITIONAL CONSIDERATIONS

Pharmacare

A National Public Drug Plan would be particularly beneficial for seniors, many of whom live on fixed incomes. Seniors account for 55.3% of total public spending on pharmaceuticals.[80] In 2017, the top ten drug classes for seniors cost public plans just under $1.8 billion.[81] While most provinces and territories have some form of public drug plan for seniors, there are discrepancies in eligibility criteria, available drugs and required co-payments (Table 6). A national public drug plan that is accessible, affordable, comprehensive and universal would ensure seniors have access to the drugs they need to continue living healthy lives, no matter where they live in Canada. The Canadian Health Coalition has focused on pharmacare in separate policy papers.[82]

Table 6: Seniors public drug plans - provinces and territories[83]

Province/ Territory	Name	Eligibility Requirement	Co-pay or Premium
Alberta	Coverage for Seniors	65 years or older	30% co-pay, maximum of $25 per prescription
British Columbia	Fair Pharmacare	Born before 1939 Others are eligible for population-wide income-based pharmacare plan	Born before 1939: Deductibles from $0 to $10,000 based on income. Plan covers 75% of costs after deductible reached

Province/ Territory	Name	Eligibility Requirement	Co-pay or Premium
			Born in 1939 or after: Income-based deductible (0-2%), plus 25% co-pay
Saskatchewan	Seniors' Drug Plan	65 years or older	Maximum co-payment of $25 per prescription. Exemptions for recipients of Guaranteed Income Supplement and Seniors Income Plan. Other policies (Maximum Allowable Cost and Low Cost Alternative) may apply
Manitoba	N/A	Eligible for population-wide income-based pharmacare plan.	Minimum deductible of $100, increases based on income
Ontario	Ontario Drug Benefit program[84]	65 years or older or living in a long-term care facility or enrolled in a home care program No existing drug coverage	$100 deductible and up to $6.11 co-pays. Seniors with incomes below $19,300 can enroll in Low-Income Seniors Co-Payment Drug Program to eliminate deductible and limit co-pay to $2
Quebec	N/A	65 years or older: automatically enrolled in population-wide Provincial Public Plan	Income-based premium between $0 to $667 per year Full and partial reductions if receiving Guaranteed Income Supplement 34.8% co-pay, exemption if receiving 94-100% of Guaranteed Income Supplement
Nova Scotia	Seniors Pharmacare Program	65 years and older No existing drug coverage	30% co-pay, maximum premium of $424/year Premium reduced for incomes between $22,986 and $35,000 and eliminated for incomes below $22,986

Province/ Territory	Name	Eligibility Requirement	Co-pay or Premium
New Brunswick	Drug Plans for Seniors	65 years or older Enrolled in Federal Guaranteed Income Supplement Other low-income seniors without other insurance coverage may be eligible Others can enroll in the population-wide income-based pharmacare program (New Brunswick Drug Plan)	$9.05 co-pay up to annual maximum of $500 per person New Brunswick Drug Plan: income-based premium between $16.67 and $166.67 per month, 30% co-pay
Prince Edward Island	Seniors' Drug Program	65 years or older	Maximum co-pay $8.25 per prescription, plus a dispensing fee of $7.69
Newfoundland and Labrador	65 Plus Plan	65 years or older Enrolled in Old Age Security Benefits and the Guaranteed Income Supplement	Up to $6 dispensing fee
Nunavut	Extended Health Benefits	65 years or older Non-Indigenous	Unknown
Northwest Territories	Extended Health Benefits Seniors' Program	60 years and older Non-Indigenous	None
Yukon	Pharmacare and Extended Health Benefits	65 years or older (or 60 and married to someone 65 years or older)	None, but only covers cost of lowest generic

Palliative Care

There have also been calls for a National Palliative Care Strategy. While palliative care may rely on long-term care, home care and pharmacare, it has its own unique considerations and priorities.

In 2014, the World Health Organization called on member states to develop strategies to ensure palliative care is integrated into national public health care to guarantee equitable access to a full continuum of services. Without provincial or national guidelines and strategies, access to palliative care in Canada remains inconsistent and incomplete, relying on community-level service providers.[85] In 2011, the Parliamentary Committee on Palliative and Compassionate Care released its report "Not to be Forgotten: Care of Vulnerable Canadians." The Committee affirmed that a national palliative care strategy is desperately needed, noting that only 16 to 30% of Canadians requiring palliative care were able to access it.[86]

Bill C-277, *An Act providing for the development of a framework on palliative care in Canada,* may help change this. The bill, which was passed in December 2017, requires Health Canada to develop a national framework within five years. Health Canada is currently conducting consultations with Canadians on the development of a framework. We hope Health Canada's recommendations will ensure that we adequately meet the needs of individuals requiring end-of-life care.

5. RECOMMENDATIONS

To ensure seniors in Canada have equitable access to the full continuum of care they require to live with health and dignity, the Canadian Health Coalition recommends the following actions:

A National Seniors Care Strategy

First and foremost, Canada needs a National Seniors Care Strategy to establish consistent funding, standards of care and staffing levels across federal, provincial and territorial jurisdictions. Many of the health issues faced by seniors are treated in hospitals or through long-term care and home care. This care is funded and administered through a mix of private, municipal, provincial-territorial and federal entities. To fully understand the current state of health care for seniors in Canada and to effectively address its shortcomings, we need an integrated approach that will cut across relevant sectors and jurisdictions. While health care is a multi-jurisdictional issue, there is much the federal government can do to show leadership. It

should initiate a plan with the provinces and territories to ensure equitable access to seniors care across the country.

There have also been calls for a broader National Seniors Strategy, which would include seniors care.[87] A March 2018 report by the Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities recommended the development of a Pan-Canadian Seniors Strategy. A key objective of this strategy would be ensuring that "all Canadians can age with dignity."[88] The strategy should include pan-Canadian guidelines for home care services to address the wide variation in levels of service available through public programs. It should also include training to improve the quality and supply of home care workers, as well as action on long-term care and support for informal caregivers.[89] National standards of care are desperately needed, either as a stand-alone instrument or as part of a broader seniors strategy. We also need increased funding and a human resources strategy to reform the existing patchwork of public and private care and to ensure seniors from coast to coast to coast can access adequate and equitable care.

A National Seniors Care Strategy should include the following:

A) Dedicated federal funding to the provinces and territories as part of the Canada Health Transfer.

- Maintain the current targeted funding increase for home care ($2.8 billion over 4 years), but equalize the dispersal of funds over the 4 years instead of back-loading to later years. (Proposed schedule: $600 million in 2018, $725 million in 2019, $725 million in 2020, $750 million in 2021). In addition, commit to working towards a goal of 10% of total public health care spending on home care, recognizing that most patients prefer to receive care within their community, whenever possible.
- Commit to a funding floor of 2% of GDP for long-term care. Public spending on long-term care is currently 1.2% of GDP, requiring an investment of $1.65 billion in federal contributions (representing 25% of the total cost).[90]
- Prioritize this funding to create more public non-profit long-term care facilities and public home care services, recognizing that they provide a higher quality of care than private for-profit facilities and services.
- Explore public financing options to improve access to quality home and long-term care for all seniors. Some have argued that a public insurance plan would be a more equitable and efficient way to finance long-term care.
- Provide additional resources to the Canadian Institute for Health Information (CIHI) to enhance and expand the Home Care and Long-Term Care Reporting Systems for staffing

ratios and home care funding across jurisdictions. Also provide funding to pilot promising innovative practices in seniors care.

B) National Standards, developed in consultation with the provinces, territories and Indigenous governments, as a condition of federal funding to ensure consistent levels of seniors care across Canada, including:

- Adequate staffing levels and ratios within long-term care facilities, with a minimum of 4.1 direct hours of care per resident per day.
- A minimum floor for public home care services, based on the "levels-of-care" approach developed by the Ontario Levels of Care Expert Panel.
- Benchmarks for best practices in integrated (primary, home and long-term care), culturally appropriate and patient and family-centred care.[91] This should include specific standards of care and best practices for rural and remote areas, as well as jointly developed standards for seniors care within Indigenous communities.

C) A Human Resources Strategy to guarantee a skilled seniors care workforce as well as decent working conditions for care workers, including:

- Enhanced education and training for care workers, including in rural and remote communities, and addressing barriers faced by internationally-trained care workers.
- Strategies to increase staff retention and the development of more consistent and equitable compensation frameworks.
- Capacity-building services and supports for family and unpaid care workers, including tax credits, training programs, respite services and supportive workplace policies.
- Mechanisms to document and monitor workload and staffing shortages in seniors care as a basis for program and policy interventions to ensure sustainable workload and staffing levels across long-term care and home care.

This strategy should be implemented and monitored through a framework that extends the principles and criteria of the *Canada Health Act* to long-term care and home care. The federal government should work with First Nations, Inuit and Metis governments and representative bodies to ensure equal levels of resources and services are provided for Indigenous seniors' care that are sensitive to community, cultural, familial and spiritual needs.

Related Recommendations

To be most effective, these recommendations should be accompanied by:

- An increase to the overall Canada Health Transfer payments through the establishment of a minimum 5.2% escalator in order to eliminate the projected shortfall of $31 billion over the next 10 years under current funding levels. Without a broader re-investment in our public health care system as a whole, targeted investments in seniors care will merely serve as a stop-gap to compensate for other cuts, rather than improving and increasing the capacity for seniors care as part of a universal continuum of care.
- The creation of a National Public Drug Plan to ensure seniors, along with all people living in Canada, can access the medication they need to lead healthy lives.
- Enhancements to Guaranteed Income Supplement/Old Age Security benefits levels to ensure seniors do not fall below the poverty line, as well as investments in affordable housing for seniors.
- The development of a National Palliative Care Strategy to establish pan-Canadian standards of care for hospice and end-of-life care as well as targeted investments to ensure all residents of Canada are treated with care and dignity in their final days.
- A requirement that for-profit long-term care facilities and home care services direct public money towards care, rather than towards profit.

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