

NATIONAL STANDARDS FOR LONG-TERM CARE: THE ART OF THE POSSIBLE?



INTRODUCTION

The COVID-19 pandemic has provided a tragic wake-up call to the shortcomings of Canada's long-neglected long-term care (LTC) sector. The Canadian Institute for Health Information (CIHI) reported in late June that as of May 25, 2020, LTC residents accounted for 81% of COVID-19 deaths in Canada, more than double the average of 38% across 17 countries of the Organisation for Economic Co-operation and Development (OECD).¹ Sadly, lockdown policies in LTC facilities meant that some family members were unable to be with their relatives as they passed away.² COVID-19 has also taken a toll on health care workers. CIHI reported that as of July 23, health care workers accounted for almost one in five COVID-19 cases (19.4%), although a breakdown of the work location of these cases (e.g., LTC facilities and elsewhere) is not available.³

It should be stressed that the majority of LTC is provided outside LTC facilities in recipients' homes, and this has received little attention since the pandemic began. According to the 2016 Census, there were 425,755 Canadians residing in nursing homes, residences for senior citizens and facilities that combined both.⁴ In comparison, according to the 2019 Canadian Community Health Survey, 1.8 million Canadians aged 12 years and older reported that they or someone in their household had received home care services in the previous 12 months and that nursing care was the most frequently reported service, by 870,000 Canadians. Moreover, an additional 733,500 Canadians reported that there had been a need for home care services for themselves or a household member in the previous 12 months that had not been filled.⁵

THE FEDERAL GOVERNMENT CALL FOR NATIONAL LTC STANDARDS

Reacting to the June CIHI report about the 81% of COVID-19 deaths in LTC facilities, Prime Minister Justin Trudeau made the following statement: “We will continue to work with the premiers on ensuring that our long-term care centres are properly supported, whether that’s by bringing in national standards, whether that’s by extra funding, whether that’s by looking at the *Canada Health Act*.”⁶

LTC standards were also highlighted in the Speech from the Throne (SFT) on Sept. 23, 2020.

“The Government will also:

- Work with the provinces and territories to set new, national standards for long-term care so that seniors get the best support possible;
- And take additional action to help people stay in their homes longer.”⁷

Before a teleconference with the provincial and territorial (PT) premiers on Oct. 15, 2020, Trudeau indicated that he would push the premiers on “harmonized norms” or standardized rules for the level of care in LTC homes.⁸

In its Nov. 30 Economic Statement, the government announced up to \$1 billion for a Safe Long-Term Care Fund to support the provinces and territories in infection prevention and control in LTC facilities and \$9.8 million for related initiatives. The statement also repeats the commitment to work with the provinces and territories to set new national standards for LTC.⁹

THE PROVINCIAL-TERRITORIAL PREMIERS CALL FOR MORE FUNDING

The premiers have not publicly collectively engaged with the prime minister’s call for national LTC standards and have focused on a demand for more funding with no strings attached. Quebec Premier François Legault was quoted in late May as saying, “We’re telling Mr. Trudeau if you really want to help us in long-term care facilities, please increase your transfers in health to all provinces. Then we’ll be able to hire, pay better and have more staff in our long-term care facilities.”¹⁰

In advance of the Sept. 23 SFT, the premiers upped the ante: in the past several years they had called for a 25% federal share of PT government health spending but they increased this to 35%, which would represent an increase in the Canada Health Transfer (CHT) of \$28 billion annually to start.¹¹ In their response to the SFT, the premiers demanded an “immediate and unconditional injection to the CHT to bring the federal share from 22% to 35%.”¹²

On Oct. 30, 2020, the premiers released a report from the Conference Board of Canada to buttress their demand that the federal government contribute a 35% share of PT government health spending. The report noted that between Jan. 1 and June 5, 2020, the PTs incurred nearly \$11.5 billion in spending that was attributed directly to dealing with the COVID-19 pandemic. The report presented three scenarios that suggest that the additional health costs due to COVID-19 will range from \$20.1 to \$26.9 billion in 2020–21 and the total amount between 2020/21 and 2030/31 will range from \$80 billion to \$161 billion.¹³ In releasing the report the premiers called on the prime minister to confirm the date for a meeting to talk about the CHT.¹⁴ One example of these increased costs is the 2020 Ontario budget, which includes \$15.2 billion in funding to support the health care system and the LTC sector.¹⁵

Suffice it to say that there is unlikely to be any concerted national action on LTC standards without a further infusion of federal funding, and it is unlikely that there will be an unconditional increase in the CHT on the basis of the evolving experience of targeted federal health funding over the past two decades.

THE EVOLUTION OF TARGETED FUNDING

The *Canada Health Act* explicitly addresses only insured hospital and medical–dental services, and although it is permissive about adding other services it continues to be interpreted as applying only to hospital and medical services. Moreover, the only criterion that has ever been enforced is the accessibility principle that bars private payment for insured services.

It is noted, however, that when 50:50 cost sharing was replaced by Established Programs Financing (EPF) in 1977, an Extended Health Care Program was introduced. This was intended to cover nursing home intermediate care, adult residential care, converted mental hospitals, home care and ambulatory care. The initial payment under this program was set at \$20 per capita in 1977–78, to be increased thereafter by the EPF escalator.¹⁶ This notional program allocation has been lost in the evolving fiscal machinations on transfers over the decades since EPF was implemented.

Since that time the federal government has used its spending power to incentivize the provinces to experiment with and adopt new programs in exchange for reporting commitments, with mixed success.

The 1995 federal budget announced the consolidation of health and social transfers into the Canada Health and Social Transfer (CHST) and the reduction in the cash transfer of \$6 billion over two years beginning in 1996–97. This precipitated long wait times for care that continue to this day. The PT governments put great pressure on the federal government to restore transfers, which it began to do modestly in the 1999 budget. Significant targeted funding was introduced in the 2000 First Ministers' Health Accord. The total increase of \$21.2 billion in the CHST included an \$800 million Primary Health Care Transition Fund, and \$500 million each for health information technology and diagnostic and medical equipment. In exchange the PTs agreed to report to their citizens on jointly agreed-upon common indicators beginning in 2002.¹⁷ This approach was extended in the 2003 Accord on Health Care Renewal, at which time the PTs agreed to the establishment of the Health Council of Canada to monitor and report on the Accord commitments.

The First Ministers' 2004 10-Year Plan to Strengthen Health Care (the 2004 accord) took a more aggressive approach to targeted funding and accountability. The \$41.3 billion deal included a \$5.5 billion Wait Times Reduction Fund that called for the development of evidence-based benchmarks for medically acceptable wait times for five priority procedures by Dec. 31, 2005, and multi-year targets to achieve them by Dec. 31, 2007.¹⁸ The 2004 accord also introduced "asymmetrical federalism" by which Quebec agreed to support the overall objectives and principles set out in the accord but would develop its own wait time reduction plan and other measures.¹⁹ The provinces and territories were successful in agreeing to common wait-time benchmarks for scheduled procedures in the priority areas, which were announced on Dec. 12, 2005.²⁰

The next step was announced by the Harper government in the 2007 budget. The budget committed \$612 million to a Patient Wait Times Guarantee Trust, funding that would be made available to those jurisdictions agreeing to implement a patient wait-time guarantee in at least one of the five priority areas. All jurisdictions signed on almost immediately.²¹

The most recent development in targeted funding was the series of bilateral agreements signed between the federal and PT governments in 2017–18 whereby they were to receive \$11 billion over a 10-year period for home and community care and mental health and addictions. The foundation for the bilateral agreements is *A Common Statement of Principles on Shared Priorities*. The specific points for home and community care include:

- spreading and scaling evidence-based models of home and community care;
- enhancing access to palliative and end-of-life care;
- increasing support for caregivers; and
- enhancing home care infrastructure.²²

In keeping with the principle of asymmetrical federalism, Quebec did not sign onto the statement of shared principles, but like the other jurisdictions it signed a funding agreement with its proposed actions set out in an annex. It also indicated that it would use comparable indicators to compare health and social services with other jurisdictions and would observe the Canadian Institute for Health Information's (CIHI) work to develop them.²³

CIHI has led the development of a set of 12 common indicators in the two areas. The six home care indicators are as follows:

- hospital stay extended until home care services or supports ready;
- caregiver distress;
- new LTC residents who potentially could have been cared for at home;
- wait times for home care services;
- home care services helped the recipient stay at home; and
- death at home / not in hospital.

Results have been reported for the first three, and the plan is to report on the remaining three in 2021–22.²⁴

To date there has been some success with targeted funding. For example, the funding for health information technology has greatly increased the uptake of electronic medical records and the Primary Health Care Transition Fund led to significant uptake of team-based models of care in Alberta, Ontario and Quebec. There has been mixed success with the Wait Times Reduction Fund — jurisdictions measure wait times in the priority areas but few have expanded beyond those and it would appear that the wait-time guarantees have not been sustained. Moreover, CIHI has reported that many jurisdictions have seen increases in wait times for joint replacement and cataract surgery since 2017.²⁵

In general, the PT governments have resisted any sort of individual or collective accountability to the federal government for health transfers.

OPTIONS FOR TARGETED FUNDING LINKED TO LTC

Since the prime minister's initial comments, reports have addressed the LTC standards issue. A report by the Royal Society of Canada on LTC set out a series of principles, including this one: "the federal government must take a major role and develop a mechanism for supporting provincial and territorial governments to achieve high standards in LTC across Canada. This could be achieved through a similar framework to the *Canada Health Act*, where core standards are articulated. Provincial and territorial governments who meet those standards receive additional federal transfers."²⁶ Similarly, the CanAge advocacy organization has proposed national quality standards that would link federal funding to their implementation.²⁷

Carolyn Tuohy has proposed a joint-decision model for LTC built on a social insurance approach with a joint federal, provincial and territorial governance mechanism modelled after the Canada Pension Plan and the Quebec Pension Plan.²⁸

Another possibility would be for the federal government to use its spending power to adopt legislation that would establish criteria for federal funding for LTC. An example was the tabling of Bill C-213 in February 2020 by the New Democratic Party to establish a national pharmacare program. The bill includes four of the *Canada Health Act* principles — comprehensiveness, universality, portability and accessibility — but leaves the determination of the program details up to each jurisdiction.²⁹ The bill was debated for the first time on Nov. 18.³⁰

It would be useful to review international experience in the funding and regulation of LTC. Unlike Canada, Australia has divided jurisdiction between the commonwealth and state governments. Medical insurance and pharmacare are federal programs while hospitals fall mainly under the jurisdiction of the state governments. The federal *Aged Care Act 1997* provides for funding and standards for aged care homes. There are eight national aged care quality standards:

- consumer dignity and choice;
- ongoing assessment and planning;
- personal care and clinical care;
- services and supports for daily living;
- organisation's service environment;
- feedback and complaints;
- human resources; and
- organisational governance.³¹

Each aged care home is assessed against the quality standards and their performance is rated using four bars, which range from 1 (few requirements met) to 4 (all requirements met). Accreditation by the Aged Care Quality and Safety Commission is required to receive the Australian government subsidies. The government funds aged care service providers through subsidies and supplements, capital grants for residential aged care and program funding.³²

Countries such as Germany, the Netherlands and Japan have social insurance schemes for LTC and one could look at their experience with regulation of quality and standards.

In terms of spending on LTC, according to the OECD, in 2017 Canada spent 1.3% of gross domestic product (GDP) on LTC. Although Canada is tied with France and Ireland for 10th place out of 36, Nordic countries such as Denmark (2.3%), Norway (2.6%) and Sweden (2.7%) spend double what Canada does.³³

CONSIDERATIONS FOR NATIONAL STANDARDS FOR LTC

Every Canadian province and territory except Nunavut has legislation in place for long-term residential care. The recent Royal Society study has a useful tabulation of the pertinent legislation.²⁶ Accreditation Canada/Health Standards Organization has a standard for the accreditation of LTC services³⁴ and also has standards for retirement homes and home care. LTC homes, retirement homes and home care programs can be accredited against these standards by Accreditation Canada's Qmentum Accreditation Program.³⁵ CIHI reports data on 14 indicators for more than 1,600 LTC facilities across Canada, and data collection and reporting have started for the common indicators agreed to in the 2017 bilateral accords as noted above.

In 2013 the Canadian Home Care Association carried out an extensive national consultation process to develop six principles and descriptors for home care. These included:

- patient- and family-centred care;
- accessible care;
- accountable care;
- evidence-informed care;
- integrated care; and
- sustainable care.³⁶

These principles then served as the foundation for a framework for the development of home care standards.³⁷ This is an interesting approach that could have wider applicability on the LTC continuum.

Since the start of the COVID-19 pandemic, several reports have put forward recommendations to address the LTC sector and many more will ensue from the commissions and inquiries yet to be struck. These include the following:

- The Canadian Nurses Association has called for a federal commission of inquiry on aging and increased investments in community, home and residential care.³⁸
- In May the Canadian Armed Forces released findings on the shocking conditions in LTC facilities in Ontario where they were called in to assist.
- The Royal Society policy briefing sets out 16 guiding principles and nine recommended actions to address the workforce crisis in LTC facilities.²⁶
- Ryerson University's National Institute on Ageing has set out guiding principles and draft policies for families and general visitors to LTC facilities³⁹ as well as other resources.

- The Canadian Foundation for Healthcare Improvement and the Canadian Patient Safety Institute have reported on a stakeholder consultation that identifies six areas of promising practices.⁴⁰
- CanAge has put forward 135 recommendations as a road map to an age-inclusive Canada.²⁷
- Ontario's Long-Term Care COVID-19 Commission has put forward 11 recommendations that address the LTC workforce, linkages between LTC and hospitals and infection prevention and control.⁴¹ The commission's recommendation of a minimum daily average of four hours of direct care per resident has been accepted by the government and is included in the 2020 Ontario budget (although not costed).¹⁵

It is clear that achieving any national standard with respect to the quality of life of residents of Canada's LTC facilities is going to take more than agreeing on common indicators. There is also a need to build a functioning quality improvement process into care processes, for which there is currently little or no capacity.

On Sept. 3, 2020, representatives from 10 national health organizations held a preliminary discussion on national standards for LTC. Several key points emerged from this discussion:

- LTC must encompass the full continuum ranging from home care to long-term residential care to palliative care.
- There is wide variability in medical staff engagement in LTC homes across Canada.
- Standards must be based on resident outcomes and evidence-informed practices that provide safe and reliable care.
- There is a need to recognize that there are multiple standards that exist at different levels and vary across Canada.

Reflecting on the previous experience with targeted funding of the CHT, one could imagine a range of measurable commitments that could be built into a supplementary LTC transfer or a piece of legislation modelled on the *Canada Health Act*. This could include conditions such as:

- a requirement for LTC services across the continuum to be accredited;
- provision for a mechanism for a meaningful voice for residents and family members in LTC;
- adoption of a risk-based policy for family/caregiver visits;
- adoption of a health human resource competency framework(s) for LTC;
- adoption of national recipient/resident quality-of-life and outcome indicators and public reporting;
- adoption of targets to move to single-bedroom LTC facilities;

- adoption of employment standards that support high-quality care and the safety of both providers and receivers of care;
- standards for nursing homes that ensure (a) training and resources for infectious disease control, including optimal use of personal protective equipment, and (b) protocols for expanding staff and restricting visitors during outbreaks;
- mental health supports for staff providing LTC; and
- a requirement that residents be immunized for influenza, pneumonia and shingles and that the immunization information be captured using a digitized record.

CONCLUSION

The COVID-19 pandemic has underscored the urgent need to address the capacity of the LTC sector and the quality of care it provides across the continuum of care. One indication of the challenge ahead is a 2017 report by the Conference Board of Canada that projected the need for an additional 199,000 LTC beds by 2035, almost double the existing stock of 255,000 beds, at an estimated cost of \$64 billion to build and \$7 billion per year to operate.⁴² Staffing these beds will be an even bigger challenge.

RECOMMENDATION

On the basis of the foregoing it is recommended that the upcoming discussions on the CHT between the prime minister and the PT premiers include a specific focus on the LTC sector with a view to including specific measurable commitments as a condition of increased federal transfers.

Nov. 30, 2020

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