2020 VISION:

IMPROVING LONG-TERM CARE FOR PEOPLE IN CANADA

May 2020

Summary and Recommendations

1. The rampant outbreaks and tragic deaths COVID-19 has brought to long-term care in Canada are largely due to our continuing neglect of that sector. The average age of residents of long-term care homes has been increasing for decades and their resident population is more medically complex, frail and more likely to suffer cognitive difficulties than ever before. Little, however, has been done to ensure institutions have the number of staff they need, with the appropriate levels of expertise, to provide the quality of care our most vulnerable elders need.

2. The benefits of redesigning how we provide care for older adults (Canada's largest growing demographic) and others with complex continuing care needs will go beyond improving their life and health. A good long-term care system, in tandem with effective, well-organized community support and home care, will ease pressure on the acute-care system and eliminate many of the gaps in the continuum of care that too often result in previously independent seniors landing in the hospital or long-term care.

To address the flaws COVID-19 has revealed in the support and care systems available to Canada's seniors, the Canadian Nurses Association recommends action on three important fronts:

1. **The Government of Canada should immediately appoint a commission of inquiry on aging.**

2. **Federal public health leaders must work with provincial, territorial and Indigenous governments and public health leaders to review the country's COVID-19 response and organize preparations for the next pandemic.**

3. **Federal, provincial and territorial governments must increase investments in community, home and residential care to meet the needs of our aging population.**

2020: A troubled world laid bare

The dreadful toll COVID-19 is taking on Canada's elders is both shocking and shameful. Shocking, because no one foresaw that 80 per cent of coronavirus deaths would befall residents of long-term care. Shameful, because we all knew what conditions are like in some nursing homes but have done very little to improve them, making the death toll almost inevitable.

Now the pandemic has laid bare our lack of preparation for managing infectious diseases anywhere, but least of all in the outdated buildings where so much long-term care is delivered. In those long-term care institutions, the pandemic has further exposed a crippling lack of leadership, funding, standards, basic supplies and equipment for patient care, and safety supplies (especially personal protective equipment). There is not enough staff, including too few professionals, while many of the unregulated care providers who do the bulk of the work lack proper training and support. It's important to remember, too, that a great deal of long-term care is home care, which shares many (though not all) of the problems found in nursing homes — too few staff, those there are rushed and low paid, and often forced to have several jobs to make ends meet.

In light of all that, it is tragic but no surprise that while just 20 per cent of Canada's COVID-19 patients lived in long-term care settings, they have accounted for 80 per cent of deaths across the country — the worst rate of death among care residents in the world.

This situation is not a recent phenomenon. The increasing volume, complexity and pace of care that has been shifted from hospitals to nursing homes and other care settings in recent decades has coincided with pressure to cut costs and a related reduction in the proportion of regulated nurses[1] on the staffs of long-term care organizations. Long-term care facilities have fewer regulated nurses, fewer clinical educators, fewer recreational therapists and aides, fewer social workers, and fewer physical and occupational therapists and fewer professionals in wound care and infection prevention and control than ever before. The same holds true for home care.

As a result, unregulated care providers (the term we use to refer to point-of-care workers whose titles vary across the country, but include personal support workers, nurse's aides and care aides) are responsible for as much as 80 to 90 per cent of all care in long-term care settings. That complex care should be shared with regulated nurses to ensure fragile patients do as well as possible.

Instead, that heavy responsibility is imposed on workers who are primarily female, often racialized and paid low wages. They are often precariously employed, working part time, cobbling together a living by working for multiple employers and putting in extremely long hours.

It's become clear these patchwork arrangements allowed COVID-19 to flourish and spread throughout the long-term care sector. It's equally clear long-term care must be better organized, better funded and more professional, starting now.

1 Unless otherwise specified, the terms nurse and nursing in this report refer collectively to the four regulated categories in Canada: licensed/registered practical nurses, nurse practitioners, registered nurses, and registered psychiatric nurses

It's time for action

COVID-19 has caused upheaval to every corner of health care and, in some instances, given rise to opportunities we should take advantage of:

- Primary care has taken a great leap forward, connecting with and treating patients over the phone and online, letting Canada catch up to where much of the rest of the world is already operating
- Nurses and nurse practitioners are working more fully to their scope of practice: the range of medications nurses can prescribe has been safely expanded, nurse practitioners are managing long-term care as they are educated to do, regulated nurses are running testing centres
- Governments rapidly provided a basic living income for people in Canada and created safe housing for homeless people

All these are system and process improvements we have urged for decades. It's too soon to say what the health outcomes of these changes will be, but it's abundantly clear we not only have the ability to fix longstanding system problems, we can do it in a heartbeat if we want to.

Our first action must be to sustain these changes: going back would be a terrible mistake. But that is not enough. We have to press on, now, while the errors we have made with long-term care are under an unrelenting spotlight, and examine what this country does to support senior citizens, and what needs to be done to reform how we care for our most vulnerable citizens.

Improving the overall lives of seniors in this country, and especially meeting the long-term care needs of people in Canada, including Indigenous people, will require sweeping changes. Part of that is an examination of how we care for older adults and those with complex continuing care needs (including rethinking the way institutions are built and how they function).

But beyond that, we must — in consultation with older people — re-imagine aging in this country. What supports and home care do older people need to stay in their homes and communities? What are their expectations and desires for long-term care and end-of-life care? What can experts and evidence show us about the best options for supporting and looking after the whole range of humanity our older adults represent?

All this will take bold ideas and determined action, but people in Canada have demonstrated both, unflinchingly, in the few short months we have faced this pandemic. We have an opportunity now, with the lessons of COVID-19 still unfolding around us, to bring about an essential overhaul of long-term care. Above all, we have a duty to stop papering over cracks in health care for older people in Canada and create the system they deserve.

The public places more trust in nurses than any other profession in Canada, and they expect us — along with physicians, scientists, health planners and researchers — to redevelop outdated elements of our health systems. This is our response: the Canadian Nurses Association calls on all governments, civil society groups, our fellow health professionals and the people of Canada to act now, collectively, in our shared interest for better care for older people in Canada and the those with complex continuing care needs. Here is our three-part action plan for doing that.

2020 Vision: Improving Long-Term Care for People in Canada

The benefits of redesigning how we provide care for older adults (Canada's largest growing demographic) and others with complex continuing care needs will go beyond improving their lives and health. A good long-term care system, in tandem with effective, well-organized community and home care, will ease pressure on the acute-care system and eliminate many of the gaps in the continuum of care that too often result in previously independent seniors landing in the hospital or long-term care.

The Canadian Nurses Association believes decisions about transforming health systems' structures and services should be guided by evidence, sound principles and Canada's existing commitments. Each of our recommendations is based on foundational principles, with the understanding that meeting Canada's commitments to domestic and international treaties and agreements is an underlying goal of this work (see Appendix A).

To address the lessons of COVID-19 and reset the course for the health of all in Canada, we recommend these three actions.:

1. The Government of Canada should immediately appoint a Commission of Inquiry on Aging in Canada.

The Commission of Inquiry's goal should be:

- To identify the range of integrated health and social services, and the best models for delivering them, that would support safe and dignified aging for every person in Canada.

Some questions to consider:

Seniors:

- Are seniors too segregated?
- Are supports to keep seniors living in their homes equal across the country? Which models work best?
- What special measures are needed for Indigenous, northern, rural and remote seniors?

Long-term care:

- How can long-term care (including community care, home care, residential living, and nursing homes) be redesigned to maximize safety, comfort dignity and health?
- What measures are needed to make long-term care an attractive, stable and rewarding place to work?
- What combination of staff would maximize health and quality of life in long-term care?

2. Federal public health leaders must work with provincial and territorial governments and Indigenous governments and public health leaders to review the country's COVID-19 response and organize preparations for the next pandemic.

3. Federal, provincial, and territorial governments must increase investments in community, home and residential care to meet the needs of our aging population.

Conclusion

Acting on these three recommendations will provide a solid foundation on which to build a safe and dignified future for Canada's elders. Canada is known for its humanitarian work around the world. It's time we brought those values home, to care for the people to whom this country and each one of us owes so much.

Appendix A

Foundational principles and commitments

Decisions about transforming health systems structures and services should be guided by evidence, sound principles and Canada's existing commitments.

The Canadian Nurses Association recommends the following principles and commitments should guide the strategic directions:

1. Principles to Guide Health-Care Transformation in Canada

In 2011, the boards of directors of the Canadian Medical Association and the Canadian Nurses Association suggested principles to guide the transformation of health systems in Canada that still apply well in 2020. The principles were derived to support transformation of the health-care system "toward one that is sustainable and adequately resourced, and provides universal access to quality, patient-centred care delivered along the full continuum of care in a timely and cost-effective manner" (p. 1).[iii]

Enhance the health-care experience

Patient-centred

The patient (or population) must be at the centre of health care. Patient-centred care is seamless access to the continuum of care in a timely manner, based on need and not the ability to pay, that takes into consideration the individual needs and preferences of the patient and his/her family, and treats the patient with respect and dignity.

A strong primary health-care foundation as well as collaboration and communication within and between health professional disciplines along the continuum are essential to achieving patient-centred care.

Quality

Canadians deserve quality services that are appropriate for patient needs, respect individual choice and are delivered in a manner that is timely, safe, effective and according to the most currently available scientific knowledge.

Improve population health

Health promotion and illness prevention

The health system must support Canadians in the prevention of illness and the enhancement of their well-being. The broader social determinants of health (e.g., income, education level, housing, employment status) affect the ability of individuals to assume personal responsibility for adopting and maintaining healthy lifestyles and minimizing exposure to avoidable health risks.

Equitable

The health care system has a duty to Canadians to provide and advocate for equitable access to quality care and multi-sectoral policies to address the social determinants of health. In all societies, good health is directly related to the socio-economic

gradient — the lower a person's social position, the worse his or her health. The relationship is so strong that it is measurable *within* any single socio-economic group, even the most privileged.

Improve value for money

Sustainable

Sustainable health care requires universal access to quality health services that are adequately resourced and delivered along the full continuum in a timely and cost-effective manner. Canada's health-care system must be sustainable in the following areas:

Resourcing: Health services must be properly resourced based upon population needs, with appropriate consideration for the principles of interprovincial and intergenerational equity and pan-Canadian comparability of coverage for and access to appropriate health services.

Financing: The health-care system needs predictability, certainty and transparency of funding within the multi-year fiscal realities of taxpayers and governments, and funding options that promote risk-pooling, inter-provincial and inter-generational equity and administrative simplicity.

Health human resources: Health care will be delivered within collaborative practice models; pan-Canadian standards/licensure will support inter-provincial portability of all health-care providers; health human resource planning will adjust for local needs and conditions.

Infrastructure: Health care in the 21st century demands a fully functional health care information technology system as well as buildings and capital equipment.

Research: Health research in Canada will inform adjustments to health service delivery and to the resourcing of health services.

Measuring and reporting: Outcome data are linked to cost data; comparable and meaningful performance measures are developed and publicly reported; outcomes are benchmarked to high-performing, comparable jurisdictions.

Public support: The health-care system must earn the support and confidence of the users and citizens of Canada, who ultimately pay for the system.

Accountable

All stakeholders — the public/patients/ families, providers and funders — have a responsibility for ensuring the system is effective and accountable. This includes:

Good governance: Clear roles, lines of authority and responsibilities are necessary for the funding, regulation and delivery of health-care services, even where these may be shared between levels of government and among health-care providers. Patients, families and providers must be partners in the governance of the system.

Responsible use: Services should be funded, offered and used responsibly.

Strong public reporting: Timely, transparent reporting at the system level on both processes and outcomes that can be used and understood by stakeholders and the public are necessary.

Enforceability and redress: Mechanisms are in place to enforce accountability and provide redress when the system does not fulfil its obligations.

Leadership/stewardship: Long-term strategic planning and monitoring is necessary to ensure the system will be sustainable.

Responsive/innovative: The system is able to adapt based on reporting results.

2. Achieving the quadruple aim

Application of the principles proposed by the Canadian Medical Association and Canadian Nurses Association was designed to align well with achieving the Institute for Healthcare Improvement's now ubiquitous *triple aim*[iv] — better population health, better health-care experiences and better value (i.e., lower per capita costs). Since those principles were developed, many users of the triple aim have begun to speak of a fourth goal, creating a *quadruple aim*, the fourth being the well-being of the health care team and the obligation to improve the work lives and conditions of the team. Achieving this fourth aim takes on particular meaning in the context of Canada's COVID-19 response.

3. Building value-based health care

Described as an emerging leading approach to improving patient and health system outcomes, the Canadian Foundation for Healthcare Improvement[v] suggests two pillars underpin Value-Based Healthcare:

- Link the dollars spent to outcomes that matter to patients, rather than to the volumes of services, processes or products that may or may not achieve those outcomes, and
- Deliver services that are high value, and scale back or drop those that are not. To meet the goal of better outcomes at the same or lower total cost, a re-balance of the mix of services will be required to improve the ratio of outcomes to overall costs.

4. Commitments to Indigenous Peoples

The Truth and Reconciliation Commission of Canada

To "redress the legacy of residential schools and advance the process of Canadian reconciliation," the Truth and Reconciliation Commission of Canada issued its landmark *Calls to Action* in 2015[vi]. Central to health systems transformation are the following clauses and conditions:

18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23. We call upon all levels of government to:
i. Increase the number of Aboriginal professionals working in the health-care field.
ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
iii. Provide cultural competency training for all health-care professionals.

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism

55. We call upon all levels of government to provide annual reports or any current data requested by the National Council for Reconciliation so that it can report on the progress towards reconciliation. The reports or data would include, but not be limited to: Progress on closing the gaps between Aboriginal and non-Aboriginal communities in a number of health indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services

United Nations Declaration on the Rights of Indigenous Peoples

Canada was one of just four nations to vote against the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), which was adopted by the General Assembly on September 13, 2007[vii]. Canada subsequently signed onto the declaration in 2016, when the Honourable Carolyn Bennett stated, "We intend nothing less than to adopt and implement the declaration in accordance with the Canadian Constitution."[ix]

The United Nations describes the declaration as "the most comprehensive international instrument on the rights of indigenous peoples. It establishes a universal framework of minimum standards for the survival, dignity and well-being of the indigenous peoples of the world and it elaborates on existing human rights standards and fundamental freedoms as they apply to the specific situation of indigenous peoples."

Conditions of particular importance to health systems transformation in Canada are found in Articles 21, 24 and 29 as follows:

Article 21
1. Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.
2. States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities.

Article 24
1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.
2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

Article 29
3. States shall also take effective measures to ensure, as needed, that programmes for monitoring, maintaining and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.

5. The Declaration of Astana

In 2018, Canada signed the *Declaration of Astana*,[x] committing to "strengthen health systems by investing in [primary health care] (p. 6), intended to deliver a comprehensive range of services and care, "including but not limited to:

- Vaccination
- Screenings
- Disease and injury prevention
- Control and management of noncommunicable and communicable diseases
- Care and services that promote, maintain and improve maternal, newborn, child and adolescent health
- Mental health
- Sexual and reproductive health."

The declaration signed by Canada commits to delivering primary health care that is "accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable, and will deliver continuous, integrated services that are people-centred and gender-sensitive." It notes that "We will enhance capacity and infrastructure for primary care — the first contact with health services — prioritizing essential public health functions" and "We will prioritize disease prevention and health promotion and will aim to meet all people's health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care" (p. 6).

Finally the declaration commits Canada to "strive to avoid fragmentation and ensure a functional referral system between primary and other levels of care" and — importantly in the

current context — to **enhance "health systems' resilience to prevent, detect and respond to infectious diseases and outbreaks."**

6. Other pan-Canadian and global obligations

Beyond the principles and commitments noted above, Canada has invested in strategies and plans within the country and committed to engage in initiatives at the global level. Transforming health systems in the wake of COVID-19 will help to meet Canada's commitments to respond to these, including:

- Canada Health Act[xi]
- Changing Directions Changing Lives. The Mental Health Strategy for Canada[xii]
- Framework on Palliative Care in Canada[xiii]
- *A Dementia Strategy for Canada: Together We Aspire*[xiv]
- Global Strategy on Human Resources for Health: Workforce 2030 (World Health Organization)[xv]
- United Nations Sustainable Development Goals[xvi]
- World Health Organization Global Strategic Directions for Strengthening Nursing and Midwifery 2016–2020 (expected to be extended to 2020-2030 by World Health Assembly)[xvii]

7. State of the World's Nursing Report

Tabled in April 2020 by the World Health Organization and International Council of Nurses, the first-ever *State of the World's Nursing* report "provides the latest, most up-to-date evidence on and policy options for the global nursing workforce. It also presents a compelling case for considerable — yet feasible — investment in nursing education, jobs, and leadership."[xviii] The report calls for governments to commit to strengthening nursing globally, through acting on 10 recommendations to achieve three over-arching goals:

1. "Invest in the massive **acceleration of nursing education** — faculty, infrastructure and students — to address global needs, meet domestic demand, and respond to changing technologies and advancing models of integrated health and social care;

2. Create at least 6 million **new nursing jobs by 2030**, primarily in low- and middle-income countries, to offset the projected shortages and redress the inequitable distribution of nurses across the world;

3. **Strengthen nurse leadership** — both current and future leaders — to ensure that nurses have an influential role in health policy formulation and decision-making, and contribute to the effectiveness of health and social care systems."

Resources

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