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AGEING WELL

Don Drummond
Stauffer-Dunning Fellow,
Queen's University

Duncan Sinclair, C.M.
Distinguished Fellow,
Queen's University

Rebekah Bergen
Queen's University M.P.A

COVID-19 Health Policy Working Group
School of Policy Studies, Queen's University

COVID-19 Health Policy Working Group

Queen's University's School of Policy Studies established a working group early in the COVID-19 pandemic tasked with analyzing its implications for the long-term care dimensions of the health sector. Special thanks are due to the research assistants and members of the working group for their contributions to this report:

- **Ishita Aggarwa**l, Medical Student, Queen's University
- **Sam Buttemer**, Senior Resident, Public Health and Preventative Medicine, Faculty of Health Sciences, Queen's University
- **Helen Cooper**, Distinguished Fellow, School of Policy Studies, Queen's University, and retired Ontario Public Servant
- **Vincent DePaul**, Assistant Professor, School of Rehabilitation Therapy, Faculty of Health Sciences, Queen's University
- **Catherine Donnelly**, Associate Professor, School of Rehabilitation Therapy, Faculty of Health Sciences, Queen's University
- **Marcia Finlayson**, Professor and Head, School of Rehabilitation Therapy, and Vice-Dean, Faculty of Health Sciences, Queen's University
- **Luc Martin**, Associate Professor, Associate Director and Graduate Coordinator, School of Kinesiology and Health Studies, Queen's University
- **Chris McGlory**, Assistant Professor, School of Kinesiology and Health Studies, Queen's University
- **John Muscadere**, Associate Professor, Department of Critical Care Medicine, Faculty of Health Sciences, Queen's University and Scientific Director, Canadian Frailty Network
- **David O'Toole**, President and C.E.O., Canadian Institute of Health Information
- **Donna Segal**, retired Ontario Public Servant
- **Cathy Szabo**, President and C.E.O., Providence Care Hospital
- **Tracy Trothen**, Professor, School of Religion and School of Rehabilitation Therapy, Queen's University
- **David Walker**, Professor, Departments of Emergency Medicine and Family Medicine, Faculty of Health Sciences and School of Policy Studies, Queen's University

Research Assistants:

- **Nicholas Agius**, Research Assistant, Queen's School of Policy Studies
- **Ravneet Dhesi**, Research Assistant, Queen's School of Policy Studies
- **Ngina Kibathi**, Research Assistant, Queen's School of Policy Studies
- **Fizza Mirza**, Research Assistant, Queen's School of Policy Studies

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SUMMARY

What Seniors Want

The great majority of seniors want to age well and in place, in homes and communities they can call their own. They want to be able to choose where they live and the structure of their living arrangements.

You Should Get What You Want More Often

Far too many Canadian seniors get placed where they do not want to be and do not age well. Many remain in alternative level of care beds in hospitals for long periods and are then placed in long-term care homes (LTC-homes). Between one-in-nine and one-in-five seniors in LTC facilities could do well with home care, a living arrangement that would suit them better and be a lot less expensive for them and society.

Post-pandemic Reviews of Long-Term Care Facilities Need to Consider a Broader Context

They must embrace and deliver on what seniors want.
They must recognize the coming surge in seniors, especially of older cohorts.
The number of seniors increased by 4.2 million over the past 38 years. Over the next 22 years Canada will need to accommodate the needs of another 4.2 million, of whom 82 percent will be 75 years of age and older, sharply increasing the median age and with it the complexity and cost of seniors' care.

If the current propensity to place them in LTC-homes continues, the number of beds needed will double between now and 2041, adding another 250,000 beds. Current plans would only supply a fraction of that – the train is moving with a lot of momentum on a straight track that no government seems to see. There is a valid need to upgrade LTC, but nobody is talking about it in the context of the pending surge in the number of older seniors.

Our guess is that the improvements that will flow from the numerous LTC reviews will increase costs about 67 percent. They will include recommendations for LTC-homes like more and better qualified workers, better infrastructure, more sanitary protocols, and greater safety. This would put Canada's cost, as a share of GDP, just a bit above the average for the Organization for Economic Co-operation and Development (OECD). But given the demographics, that elevated cost will double. The current 1.3 percent of GDP spent on LTC will surge to 4.2 percent by 2041. Nobody can afford it—individuals, families, nor governments—and few want to be in LTC-homes in the first place.

In addition to being the least desired, continuing care hospitals and alternative levels of care in hospitals are the most expensive care options available for seniors, ringing in at almost $1,000 per day. LTC-homes are less expensive at about $142 a day. Communal housing is much less expensive still and formal home care can provide a lot of the services needed to support 'Ageing Well' for around $45 per day.

Canada is an International Outlier with Little Emphasis on Home Care

The 1.3 percent of GDP Canada now allocates to LTC falls well short of the OECD average of 1.7 percent. Worse, our spending relative to GDP has barely increased despite the surge in the number of seniors. Worse still, the measly 0.2 percent of GDP Canada spends on home care is one of the lowest allocations to home care in the OECD. And even worse than that, the ratio of more than 6 dollars spent on institutional care for every dollar spent on home care is one of the most imbalanced resource allocations in the developed world. Many countries spend equally on institutions and home care and some that are renowned for the life satisfaction of seniors, Denmark being a good example, spend more on home than institutional care.

Only 6 percent of Canadians receive publicly funded home care services for which rationing has driven long and lengthening wait lists.

Challenges to Independent Living Must be Addressed

As people age, they are more likely to develop conditions that impinge upon their ability to live as they wish – frailty, chronic conditions or morbidities, and dementia become especially prevalent as of age 85. Strategies to lower the prevalence and acuity of these limitations exist but they require a major shift in the approach to continuing care to support Ageing Well.

Transformation Needed in Supporting the Elderly

Seniors require 4 primary types of support. The current model gives predominance to care to alleviate physical and mental limitations; housing, lifestyle and social needs lie many tiers down. The new approach must recognize that the four are interrelated and must be advanced together if seniors are to age well.

Housing or Living Arrangements

The book ends of living arrangements for seniors may be the family home at one end and an LTC facility or continuing care hospital at the other. Many options should be available in-between that seniors can choose in a flexible way as their state of health changes. Some options revolve around the family home through the offer of day programs in the community or services provided in the home. That home could be that of a relative, in the same premise or in a "granny flat." Then there are communal living models, co-operative housing, and home sharing. Moving further along the continuum are seniors' residences and senior-friendly villages. Many of these housing options can be supplemented with an array of services on or off site.

There are many examples of interesting and promising living arrangements. For example, in Kingston Ontario, Oasis serves about 60 seniors who live independently with some supports in place such as communal meals, exercise programs, skills training, and entertainment. In the United Kingdom, there is the growing popularity of senior-friendly villages which feature the availability of care and of social and leisure activities.

Lifestyle and Socialization

Regular physical activity and socialization are two lifestyle changes that greatly improve health conditions and support independent living. Unfortunately, society is going the opposite direction, especially with a trend toward less activity. If this continues, it may drive up the incidence of frailty, dementia, and morbidity. Many of the factors such as physical activity and education that ward off frailty also help ward off dementia.

Care of the Elderly

As with most aspects of healthcare in Canada, the propensity is to address seniors' problems after they have arisen rather than promoting health to reduce their incidence and severity. This approach and the attitude of all providers of healthcare must change. The shift toward healthcare teams in many places can help in this regard, provided those teams have diverse representation including doctors, nurses, physiotherapists, nutritionists, pharmacists, counsellors, social workers, and "coaches" to help seniors navigate the options available to them for matters like living arrangements and programs, as well as their care needs. The importance of diversity is reinforced by observations such as the lessening of frailty when medical prescriptions are managed and how hearing aids modulate dementia for those whose hearing challenges drive them to social isolation.

Many of the services seniors need could be offered by communities, including frailty screening at pharmacies and the frailty and dementia prevention services provided by entities such as Canadian Frailty Network centres.

More generally, society and governments should have paid greater attention to the wise counsel of the Canadian Senate when in a report in 2009, it concluded that 50 percent of the health of a population is determined by socio-economic factors such as education and income. A fragmented approach to policy, built on silos, prevents the promotion of health through combining such means.

Many Partners Need to Drive the Transformations

Health is not a federal responsibility per se but many of the socio-economic determinants of health are heavily influenced by federal policy. Moreover, the federal government is a major funder of health. Its current restrictive funding formula for the Canada Health Transfer is going to squeeze provinces as they struggle to deal with their ageing populations.

Provincial and territorial governments are at the front line of managing health and healthcare, including the care of seniors. They need to look beyond the immediate problem of substandard LTC and realize that the current model is not the right one from either a life satisfaction or financial perspective.

All health professionals must be at the forefront of shifting equal emphasis to the promotion of health as is now given to fixing things after something goes wrong. The formation of diverse health teams offers hope for this more holistic approach to health.

Many needs of the elderly are best delivered within and by communities, the members of which can often self-coordinate their activities. Shaping supports by local interests ensures the needs of seniors are met optimally in the many diverse parts in which seniors live in the vast country of Canada.

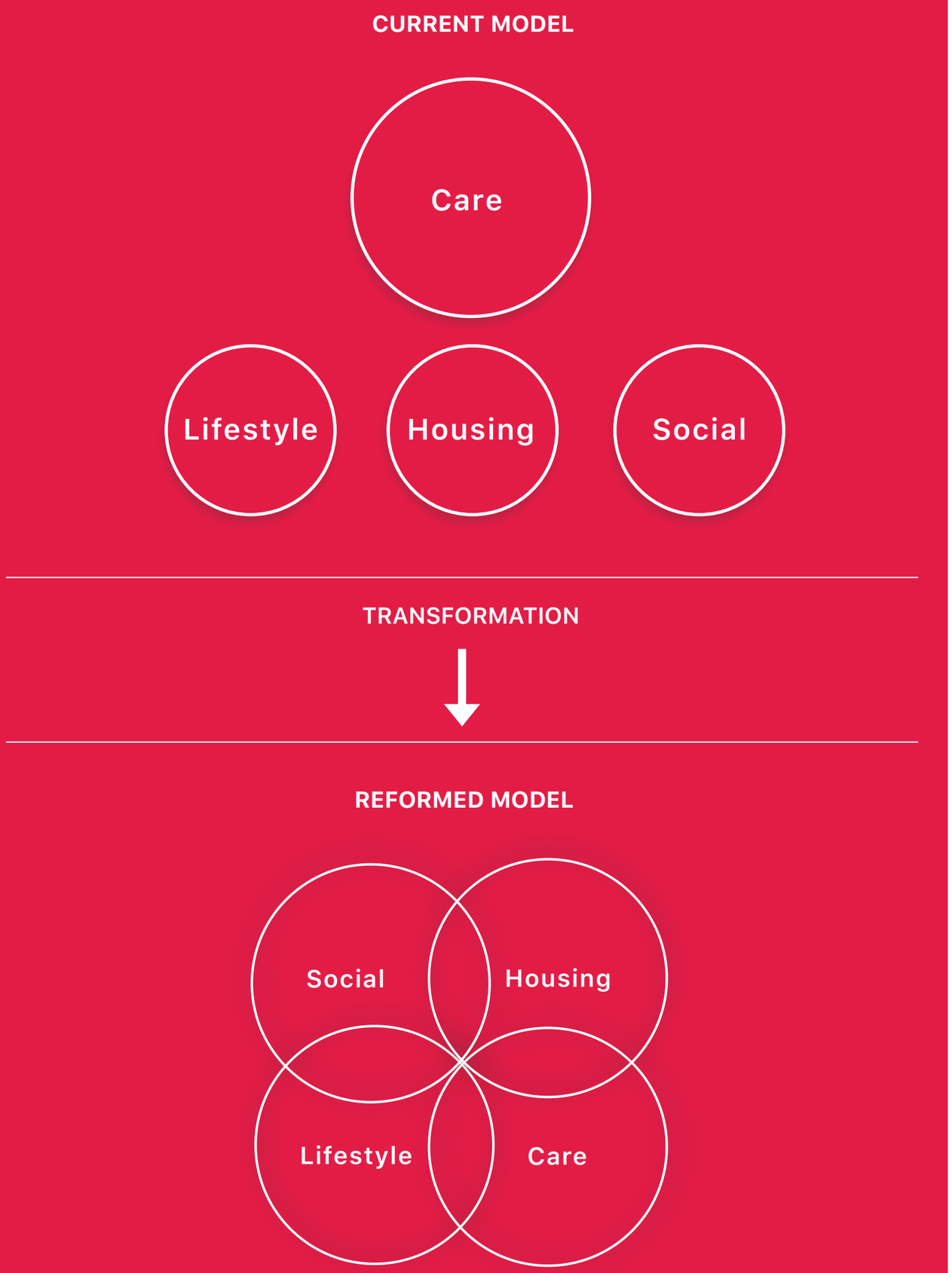
INTRODUCTION

The central goal of Canadian society is surely to meet as best it can the needs and wants of its population. With this in mind, we ask what Canadian seniors—already numerous and soon to become much more so—want as they age? The great majority want to age well and in place, in homes and communities they can call their own. They want to enjoy healthy lives of high quality in the midst of familiar physical and social surroundings well into their golden years. They want to be able to choose, not just be told, where they will live and the nature of their living arrangements.

For the great majority of people—poor, rich, and middle-class—satisfaction of those wants is distinctly achievable provided that the following four key categories of need are met, an objective surely possible in our affluent country. Each is different but interrelated. All are essential to support healthy ageing:

- Housing needs to ensure seniors have options that are flexible and adjustable as their other needs change with age;
- Lifestyle needs such as good nutrition, regular rest and recreation, and the maintenance of healthy habits;
- Social needs that reinforce confidence in the continuing support of family, friends, neighbours, and communities;
- Care needs to alleviate physical and mental limitations often brought on by progressive failure of ageing bodily systems and/or chronic disease.

Meeting these needs will require a major policy change, a shift in the status quo, putting emphasis on the housing, lifestyle, and social needs of the elderly equal to that now given to meeting their care needs.



FUTURE NEED FOR LONG-TERM CARE

Seniors (65+) currently make up 17.5 percent of the population, more than one in six Canadians, almost 6.6 million people.[1] Soon there will be many more and on average they will be older than they are now. If the propensity to 'warehouse' them in LTC-homes does not change, Canada is going to be overwhelmed. The senior population is expected to reach nearly 25 percent (10.8 million) by 2041, 4.2 million more, equivalent to a 63.6 percent increase.[2] Accommodating their needs in only 22 years will constitute a tremendous challenge.

As shown in Figure 1, while 65 to 74-year-olds are anticipated to remain the largest of all their age cohorts, the burden of caring for seniors will shift to caring for the new majority (58 percent), those 75 and older, who account statistically for the highest average healthcare spending per capita.[3]

One of the main drivers of growth among seniors is the ageing baby boomer generation, those born between 1946 and 1965.[4] Today they account for 51 percent of the senior population which will grow at a rapid pace, only slowing after 2031, when the last baby boomer will have surpassed age 65. By then, seniors will constitute 22.7 percent of Canadians, numbering approximately 9.6 million.[5]

Around 60 years ago, when Medicare was first being implemented, seniors made up 7.6 percent of the population (1.4 million); those under 20 constituted 41.8 percent.[6] Logically, the policy foundation of healthcare was structured to meet primarily the needs of the young population; but the emphasis on acute care remains to this day. Currently, that emphasis is out of touch with the reality that the majority of seniors require healthcare services focused on chronic illnesses and/or frailty; conditions that require ongoing care and long-term management.[7]

Figure 1

Projected Demographic Breakdown of Seniors in 2041				
	Canada		Ontario	
	Total Population	% Of Senior Population	Total Population	% Of Senior Population
65 to 74 years	4,569,800	42.16	1,790,700	42.37
75 to 84 years	4,217,000	38.90	1,643,900	38.90
85 to 94 years	1,863,600	17.19	714,600	16.91
95 years and over	188,900	1.74	77,000	1.82

Source: Statistics Canada. Table 17-10-0057-01 Projected population, by projection scenario, age and sex, as of July 1 (x 1,000).

Ontario

Seniors constitute the fastest-growing demographic in Ontario; their 2.5 million accounted in 2016 for a larger share of the population (17.2 percent) than children (aged 0-14) for the first time in the province's history.[8] This population is expected to increase by approximately 1.7 million, reaching almost 24 percent of the total by 2041.[9] Figure 2 shows much of the growth is due to the increase in the total number of seniors in the middle two deciles. The senior population is not only burgeoning, but its members are also living longer.

Figure 2

Breakdown of Projected Increase in Seniors from 2019-2041 by Decile						
	Canada			Ontario		
Age Cohort	Total Additional Seniors from 2019-2041	% of 4.2 Million Increase in Seniors	% Increase from 2019-2041	Total Additional Seniors from 2019-2041	% of 1.7 Million Increase in Seniors	% Increase from 2019-2041
65 to 74 75 to 84 85 to 94 95+	766,433 2,266,019 1,110,218 104,019	18.05% 53.36% 26.14% 2.45%	20.15% 116.15% 147.36% 122.55%	367,628 888,444 416,629 43,537	21.42% 51.77% 24.28% 2.54%	25.83% 117.60% 139.82% 130.10%
Total	4,246,689	100%		1,716,238	100%	

Source: Statistics Canada, Table 17-10-0057-01 Projected population, by projection scenario, age and sex, as of July 1 (x 1,000) and Statistics Canada, "Population Estimates on July 1st, by Age and Sex."

Over the past 10 years, the 95+ cohort has grown at an average annual rate of 11.3 percent, more than double that of the other senior cohorts.[10] Over the next 22 years, the fastest-growing cohort is projected to be 85 to 94-year-olds, growing at an average of 6.4 percent annually, with the 95+ cohort close behind at 5.9 percent.[11] The increase in seniors, particularly those aged 75 and older, will put unprecedented pressure on long-term and healthcare services in Ontario. The need for alternative, expanded, and more cost-effective approaches to continuing care of the elderly is obvious.

ECONOMIC & FISCAL IMPLICATIONS OF THE AGEING POPULATION

As seniors age, many seek help with independent living and maintaining a household. They gradually transition toward some form of alternative living arrangement. These can take many forms, from an LTC-home, an assisted living facility, living independently at home with assistance, to a retirement community or other variants of communal living. The number of seniors in some form of communal living is heavily influenced by age with those 75 and older being much more likely to live communally.

Eighty-five to 94-year-olds make up 30 percent of residents in hospital-based continuing care and 43 percent of those in LTC residential care.[12] Unfortunately too many seniors remain in hospitals for prolonged periods in alternative level of care (ALC) beds waiting to be placed elsewhere.[13] ALC is a term used to describe patients who remain in hospital but no longer require the intensity of hospital services.[14] Across Canada, approximately 13 percent of all hospital days are ALC; in Ontario on any given day they are 15.5 percent, the equivalent of 4,500 beds.[15]

While their profiles vary, the median age of ALC patients is 80 years.[16] They are predominantly frail, have cognitive or behavioural conditions; many are neurological or stroke patients.[17] It is common for more than half to have dementia and for these patients to remain ALC for an average of 380 days. [18]Long stays in hospital cause seniors to lose mobility and/or develop hospital-acquired delirium and deconditioning which makes the transition back to their homes after discharge difficult.[19] In 2016, there were approximately 255,000 LTC-home beds in Canada; 263,000 were then urgently needed, the shortfall (8,400) being ALC patients alone, excluding seniors on the extensive waitlists in some provinces, more than 40,200 in Ontario alone.[20]

A variety of projections have been made of the number of LTC-home beds needed to accommodate the ageing baby boomers. As shown in Figure 3, between now and 2041 they range from 250,000 to almost 300,000.

ONTARIO'S PLAN FOR 15,000 ADDITIONAL LTC-HOME BEDS

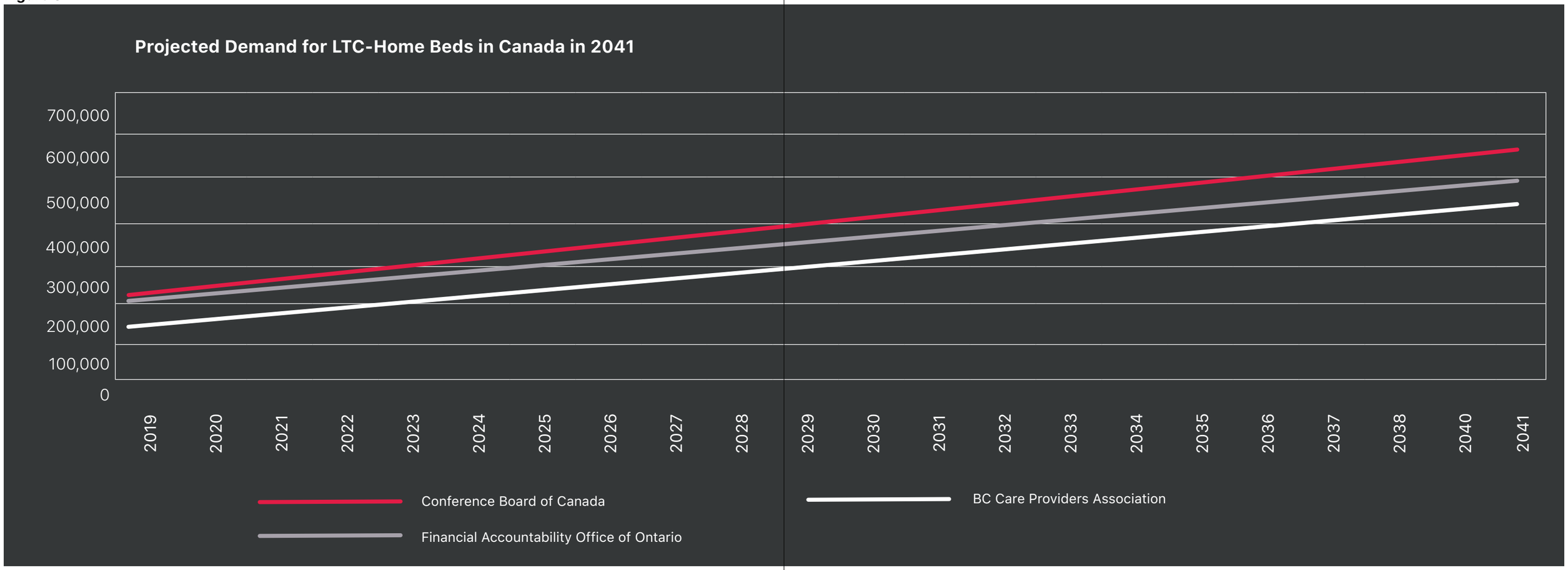
Existing provincial plans to build LTC-beds are nowhere near enough to satisfy the suggested needs. In 2018, the Ontario Government announced a five-year commitment to build 15,000 new LTC-home beds—adding beds to existing homes and building new ones. To date, the province has distributed just over half of the new beds.*

It is unclear how the province settled on 15,000 as the number of beds required. The Ontario Financial Accountability Office suggests that even with this addition, the waitlist for LTC-home beds in Ontario will continue to grow** especially given the decommissioning of beds in the shared rooms of older LTC-homes post COVID-19.

In the grand scheme, an additional 15,000 beds seems like little more than a rounding error if the province continues its current policy of housing seniors in LTC-homes over other alternatives.

** Ministry of Health and Ministry of Long-term Care. "Long-Term Care Homes: Apply to build new or redevelop existing long-term care beds," Government of Ontario, (2020).*
***Financial Accountability Office of Ontario. "Long-Term Care Homes Program: A Review of the Plan to Create 15,000 New Long-Term Care Beds in Ontario." Financial Accountability Office of Ontario (2019). 17.*

Figure 3



Source: Conference Board of Canada 2016, BC Care Providers Association 2019, and the Financial Accountability Office of Ontario 2019.

**The BCCPA and FAO projections were made provincially. These were converted to Canada-wide projections by calculating the percentage of the 75+ population residing in BC and Ontario in 2019 and scaled up. Each projection had different end dates, so the average of their annual growth rates was used to standardize the demand projection in 2041. This projection was made on the assumption that the growth rate stays constant over time and that trends in BC and Ontario are reflective of those Canada-wide.*

The argument that Canada needs primarily to expand the capacity of LTC-homes misses the mark on several points. It is based on the current policy of "warehousing" seniors, among whom there is actually little demand for such homes. Rather, the problem is a paucity of alternatives from which seniors can choose, coupled with chronic underfunding of preferred alternatives such as home care and community services. Surveys have shown that seniors want to stay and age in their homes and communities. While some LTC-home expansion will be required to accommodate the fast-growing number of ageing seniors, the real need is for promotion and investment in home and community services and other alternatives to provide seniors with choices that enable them to maintain the highest possible quality of life as they age.

Two economic shocks are expected to generate a crisis in LTC. The first is that residences are going to be more expensive as a result of the reforms taking place in existing LTC-homes following the COVID-19 pandemic. The second is that the total cost of LTC will rise enormously as the baby boomers surpass 80; under the current policy, accommodating them in LTC-homes will be prohibitively expensive for both individuals and governments.

Canadians are facing record-high personal debt-loads with debt-to-income ratios over 175 percent.[21] As a result, individuals will have a hard time finding the extra money to fund their own care, let alone that of their relatives. Governments face similar financial problems with massive debt loads in the wake of the pandemic.

Also, the working-age population is shrinking in relation to the growing number of ageing Canadians and economic growth rates are falling; the incomes of the working-age population are not likely to grow high enough to counteract the cost of caring for the elderly.[22] Support for higher taxes to raise revenue to fund the existing "warehousing" policy is unlikely, especially as LTC costs will likely grow faster than the economy.[23]

Figure 4

Government Health Expenditures by Age in Millions of Dollars in 2017		
Age Groups	Ontario	Canada
<1	$ 1,753.67	$ 4,647.29
1-9	$ 2,176.89	$ 6,212.06
10-19	$ 2,791.93	$ 7,519.65
20-29	$ 4,010.17	$ 11,252.25
30-39	$ 4,887.21	$ 13,613.67
40-49	$ 4,989.60	$ 13,414.75
50-59	$ 7,569.41	$ 20,237.64
60-69	$ 9,268.46	$ 25,251.71
70-79	$ 9,225.09	$ 24,958.28
80-89	$ 8,439.29	$ 23,041.41
90+	$ 3,047.34	$ 9,175.10
Total	**$ 58,159.05**	**$ 159,323.82**

Source: Canadian Institute for Health Information, National Health Expenditure Trends 1975 to 2019.
Data table E.1.20.2.

Healthcare Spending Influenced by Age

Currently, governments in Canada spend the most overall on healthcare services for the senior cohort aged 60-79.[24] This is because the population size of seniors dwindles after the age of 79.

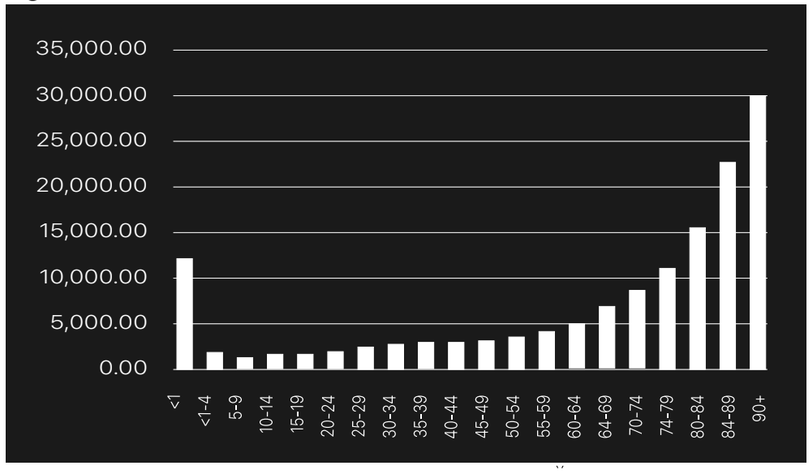
The average per capita healthcare spending in Canada is $6,448.[25] As shown in Figure 5, after the age of 1, healthcare costs are low and relatively constant until the age of 60 when the average is pulled upwards as the spending per senior reaches an average of $15,693 for those 80 to 84, $22,783 for those 85 to 89, and upward of $30,000 for those 90 years and older.[26]

The increased use of healthcare services is also associated with the incidence of chronic diseases. Seniors with chronic conditions use hospital or home care services more frequently than seniors with none; those with two chronic conditions (17 percent) stay in hospital almost four times as long as the 31 percent with none and consume far more healthcare services.[27]

In 2019, Canada spent a total of $264 billion on healthcare, 11.6 percent of GDP.[28] Seniors account for 44 percent of the total, about $17,600 each, or 5.1 percent of GDP. Given the expected rise in the senior population, if continued at the same per capita cost in 2019 dollars, Canada would be spending upward of $190 billion annually by 2041. Population ageing has added 0.8 to 0.9 percentage points to the growth rate of total public-sector healthcare spending, which has been increasing at around 3.5 percent per annum over the past 8 years.[29] Overall, while ageing is not the largest driver of the growth in healthcare spending, it remains a substantial factor, adding approximately $2 billion to health spending each year, around a 1 percentage point increase in total annual health expenditure.[30]

Figure 5

Annual Per Capita Health Spending in Canada by Age



Source: Canadian Institute for Health Information, National Health Expenditure Trends 1975 to 2019. Data table E.1.20.2.

Cost Variation Between Alternative Forms of LTC

There are currently seven types of continuing care available to seniors in Canada: ALC hospital beds; complex continuing care hospitals; LTC-home beds; formal home care; communal home care; informal home care; and community services. Hospital beds are the most expensive; each day in ALC or complex continuing care costs upwards of $842 to $949 per patient.[31] LTC-home beds cost around $142.[32] Communal home care varies but is normally much cheaper than hospitals or LTC-homes; Oasis, a communal living home in Kingston, Ontario, costs $10 each weekday in addition to each senior's living expenses. Formal home care in Ontario costs around $45 per day, while informal care is usually free in financial terms but has other economic costs such as lost wages and additional forms of productivity loss for caregivers.[33]

With the exception of some public funding for community services, the highly variable, but low and rarely recorded cost of informal care is borne entirely by its recipients and their families. Community care can supplement formal and informal home care with services like senior day programs, transportation, or respite services, which are usually funded in small part by provincial and municipal grants, and largely through not-for-profit fundraising. Such is often sparse and precarious, making difficult the establishment of reliable networks of community care services on which seniors can depend.

While still much cheaper than LTC-home alternatives, the cost of home care will rise if a fuller range of its services becomes available in the future. The average cost of institutional care in 2014 was around $60,200 per person, with formal home care at $18,000 and informal care at $21,900.[34] These estimates will have gone up with inflation but it remains that home care is around one third the price of institutional LTC.

The operating costs of LTC-homes in Canada can be funded privately, publicly through provincial governments, or through some combination of both.[35] Each province and territory differs in the extent to which it subsidizes LTC for seniors, but they all share a similar basic model in which governments usually cover around three-quarters of institutional costs, while individuals cover the rest out-of-pocket or through private insurance.[36]

That private cost can be considerable, enough to deplete the finances even of wealthy families; co-payments, private services, and the unpaid work of caregivers were estimated to cost $44 billion in 2014.[37] The length of most institutional stays for seniors ranges from 2 to 4 years, but can be longer, particularly for people with dementia.[38]

In 2014, subsidized provincial programs for institutional senior care were estimated to cost $24 billion across Canada, making up about 10 percent of healthcare spending as a whole.[39] On average, 4 percent of health spending was spent on home care; Ontario budgeted $2.7 billion in 2018 (5 percent).[40] In 2016, more than 730,000 Ontarians received publicly-funded home care; an estimated 150,000 purchased it privately.[41] Between 2008 and 2012 the number of patients discharged from hospitals to home care increased by 42 percent, exemplifying growing demand.[42] Despite that, home care budgets in Ontario have remained relatively stagnant over the past decade, never surpassing 5 percent of the provincial healthcare budget.[43]

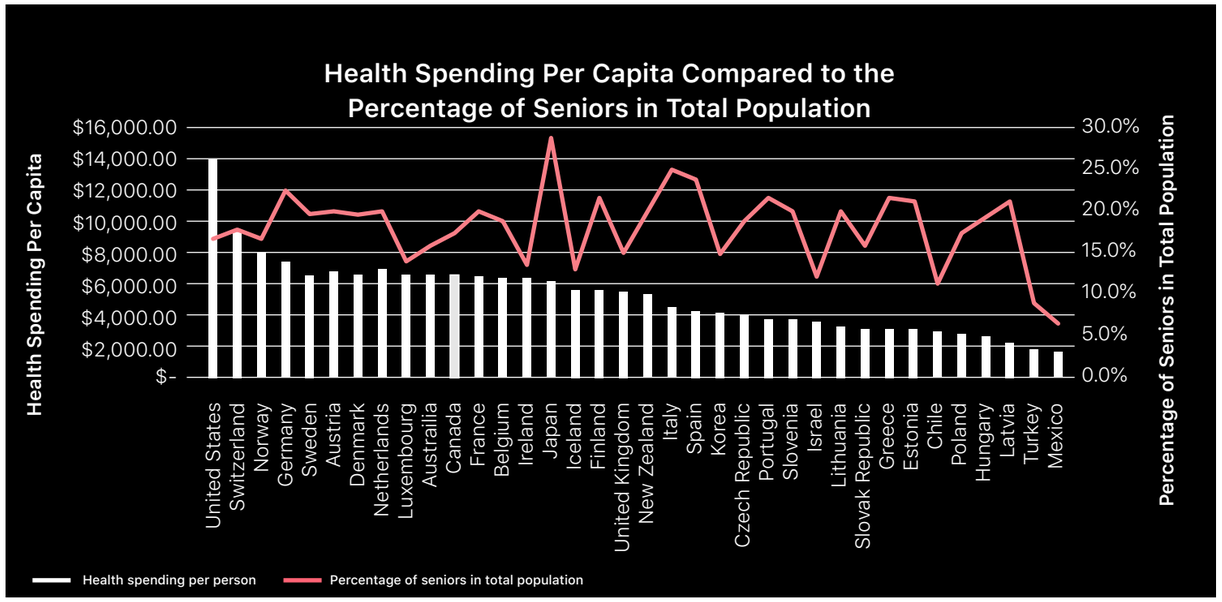
Roughly 6 to 8 percent of seniors receive publicly funded home care, and of these services received, the top three are nursing care (51 percent), medical equipment or supplies (43 percent), and personal or home support such as help with bathing or housekeeping (41 percent).[44] More than four out of five recipients (86 percent) claimed those

services helped them remain in their homes.[45] The limited funding has resulted in rationing of these services with waitlists growing ever-longer.[46] Seniors with private financial resources are usually able to patch together the housing and support services they require to meet their needs as they age, but the majority with modest means are left behind, resulting in a large and enduring impact on the aggregate health and wellbeing of Canadian seniors.[47]

PROJECT LONG-TERM CARE COSTS IN THE FUTURE

Canada's per capita spending on healthcare is one of the highest among developed countries.[48] In 2018, Canada spent $6,448; the OECD average is $5,175.[49] As illustrated in Figure 6, it is notable that Japan, Italy, Finland, and Portugal all have a higher proportion of seniors than Canada but still spend less per capita on healthcare.

Figure 6



Source: Canadian Institute for Health Information. How Canada Compares Internationally: A Health Spending Perspective—International Chartbook, 2019.

In 2017, Canada spent 1.3 percent of GDP on public LTC services , less than the OECD average of 1.7 percent.[50] Canada's proportion of spending has barely changed since 2006 whereas it has grown significantly in other countries (Figure 7).[51]

Public LTC expenditure is defined according to the System of Health Accounts classification, as the sum of publicly financed items including services of long-term nursing care which encompasses the medical component of LTC and social services of LTC which includes the administration and provision of social services to assist those living with disease and impairment. Public LTC expenditure is further defined in the European Commission 2009 Ageing Report.

Figure 7

PERCENT OF GDP SPENT ON PUBLIC LTC			
COUNTRY	2006/07	2017	10-YEAR CHANGE
BELGIUM	1.5	2.1	0.6
CANADA	**1.2**	**1.3**	**0.1**
DENMARK	1.7	2.5	0.8
FINLAND	1.8	2.2	0.4
FRANCE	1.4	1.9	0.5
IRELAND	0.8	1.3	0.5
JAPAN	1.4	1.8	0.4
SPAIN	0.5	0.7	0.2
SWEDEN	3.5	3.2	-0.3
NETHERLANDS	3.4	3.7	0.3
UNITED KINGDOM	0.8	1.4	0.6

Source: OECD Health Division, "Long-Term Care" 2020 and OECD "Help Wanted? Providing and Paying for Long-Term Care" 2011.

Most other OECD countries spend a much larger proportion of their healthcare budgets on home care.[52] In sharp contrast to the current Canadian model—where seniors have little control or choice over the services offered to them—the majority give their seniors more options about the types of services available and where to receive them.[53]

Future LTC Cost Estimate

The cost of expanding the capacity of LTC-homes is made up of three components. The first is the non-recurring capital cost of revamping presently outdated capital stock, eliminating shared bedrooms and washrooms and installing better air-filtration systems; prior to COVID-19 there were around 300 outdated LTC-homes in Ontario encompassing more than 30,000 LTC beds.[54] The second is the recurrent operating cost associated with higher staffing standards, additional staff training, and related items. The third component is that referred to above, the capital and recurrent operating costs associated with expansion to accommodate more and older seniors.

Canada has one of the lowest ratios of LTC workers to seniors in the OECD; 3.5 workers for every 100 seniors.[55] The international standard of care workers is 8.2.[56] The Canadian Medical Association estimates that the total annual cost of expanding the LTC workforce could range from $9 billion to $14 billion depending on wage rates.[57]

It will be expensive to recruit and improve the training of home care providers needed to expand and raise the quality of home and community care programs but that expansion in the supply of personnel will be essential for all alternatives. Technology holds some promise, but we remain a long way from substituting technology for empathetic care and support workers.

In 2018, Canada spent approximately $28.4 billion on LTC, 1.26 percent of total GDP.[58] It is estimated that it will cost at least $9 billion annually for Canada to meet the international standard of care workers of 8.2 caregivers per 100 seniors.[59] This is the equivalent of a 33 percent increase, to which another 33 percent increase in spending will be needed to incorporate improvements into LTC-homes. While daunting, a 66 percent increase in current spending would put Canada just a bit above the OECD average. Then if we also scale up for demographics, there will be a doubling of bed demand by 2041. When this is all combined, it means that Canada could be spending around 4.2 percent of GDP on LTC by 2041 without a significant change in policy.

INCREASING NUMBER OF VULNERABLE SENIORS

Seniors in Canada are living longer but not necessarily healthier lives as a result of many problems associated with ageing, including diminished health status, social isolation, a reduced capacity to care for themselves, and limited access to home care services.[60] More attention must be directed toward the maintenance of a high quality of life in seniors' later years.

Age increases the susceptibility to frailty, a condition of reduced function and health that puts individuals at a higher risk for health deterioration and death than is expected based solely on age.[61] Frailty is a central health indicator for seniors that focuses attention on a holistic view of individual wellbeing and quality of life. The shift to assessing the health of seniors through the lens of frailty is complex and poses a challenge to healthcare's predominant focus on single diagnoses and the treatment of specific chronic conditions. Frailty is a helpful measure of increased aggregate vulnerability in seniors given that it encompasses both the effect of chronic conditions and a measure of functional capacity.

Functional capacity measures a person's independent ability to carry out everyday tasks, including the ability to perform the activities of daily living (ADL), feeding oneself, bathing, dressing, toileting and transferring.[63] Canadian seniors exhibit a wide range of functional capacities, with an inflection point at age 85 after which the majority report at least mild limitations.[64] One of the main drivers of this loss of capacity is the onset of dementia. The most common limitation reported by all seniors was the inability to perform housework (14 percent), whereas among seniors 85 or older, the most frequent were inability to bathe or shower without help (15 percent), walk (11 percent), or use the washroom (10 percent).[65]

Another major factor contributing to frailty in seniors are chronic conditions, those defined as those that are expected to last a year or longer, limit what one can do, and/or may require ongoing care.[66] These conditions increase the overall vulnerability of seniors to functional decline.[67]

As noted above, the use of healthcare services is strongly correlated with age and the incidence of chronic conditions leading often to disabilities, hospitalizations, and a poorer quality of life. In 2011, the Canadian Institute for Health Information (CIHI) found that in seniors 75 and older, primary healthcare use is driven by an increasing number of chronic diseases, rather than age alone.[68] This study also found that the more chronic conditions a senior has, the less likely s/he is to report being in good health.[69]

Lifestyle factors are also integral to the health of seniors. A survey of senior Canadians found that three quarters engage in active pursuits like exercising, socializing, and using technology, and that 9 in 10 Canadians engage in passive leisure activities like reading or watching television.[70] It also revealed that those who reported being in poor or fair health were less likely to participate in such activities.[71]

There has been a decline in the participation rates of senior women in activities from 77 percent to 69 percent between 1986 and 2015 and a decline in the average amount of time spent daily by both men and women on active pursuits by 35 and 40 minutes respectively since 1986.[72] Another survey found that more than 90 percent of seniors 60 years or older are sedentary for at least 8 hours per day.[73] Extended inactivity can have a big impact on the health of all, but particularly older Canadians.[74] Lifestyle factors play a critical role in affecting the onset of chronic conditions and frailty.

WHAT SENIORS WANT

Surveys show that an overwhelming majority of seniors want to live independently in their own homes for as long as possible where they feel confident, comfortable, safe, and able to maintain social connections with their friends and families.[75]

While remaining independent and socially connected in their own homes is ideal, it is not always possible. When it is not, seniors want to maintain control of their lives by having choices of where to reside and in what type of community. Few seniors would willingly choose to live in an LTC-home where the primary focus is on their residential and care needs to the detriment of their social and lifestyle needs.

Currently, many seniors have no choice, having been transferred to an LTC-home directly from hospitals. Seniors whose needs are assessed in hospitals are over 6 times more likely to be placed in residential care than those assessed elsewhere, perhaps as a result of the hospital's staff being more concerned with clearing a bed than meeting the preferences of seniors.[76] Anywhere from one-in-nine to one-in-five residents of LTC-homes are estimated to be capable of returning home with adequate support.[77]

WHY DO SENIORS WANT TO AGE IN PLACE?*

- **72% - FEEL THEIR HOME IS CONVENIENTLY LOCATED**
- **66% - EMOTIONAL ATTACHMENT**
- **60% - FAMILIARITY WITH THE NEIGHBOURHOOD**
- **59% - FEEL INDEPENDENT IN THEIR HOME**
- **56% - FEEL SAFE IN THEIR HOME**

* Bayshore Healthcare, "Aging in place: Helping seniors live at home for as long as possible," 2018.

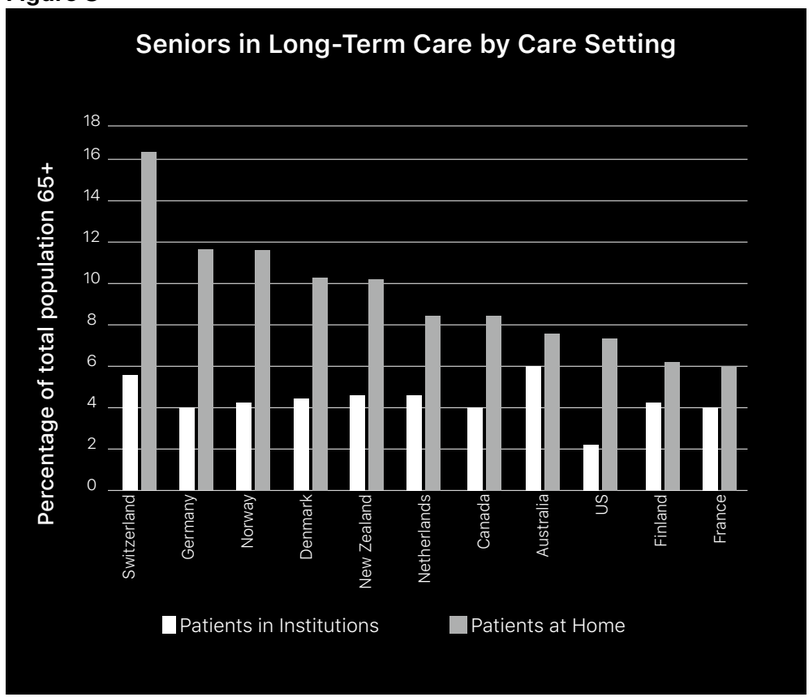
INTERNATIONAL APPROACHES TO AGEING POPULATIONS

Developed countries around the world are facing ever-larger senior populations and most, if not all, have insufficient LTC-home beds to accommodate them.[78] In response, a trend has emerged, particularly in Nordic countries and Continental Europe to shift toward home care, based on the sound premise that enabling seniors to age at home for as long as possible helps keep them physically, mentally, and socially active.[79] It is also much cheaper than the alternatives; one week of hospital care is 20 times more expensive than providing the same services through home care.[80] Throughout the OECD the proportion of LTC recipients receiving home care rose from 64 percent in 2007 to 68 percent in 2017, reflecting this growing preference.[81]

While most OECD countries house about 4 or 5 percent of seniors in institutions, the rate of home care provision varies greatly (Figure 8) with Switzerland, Germany, and the Nordic countries in the lead.[82]

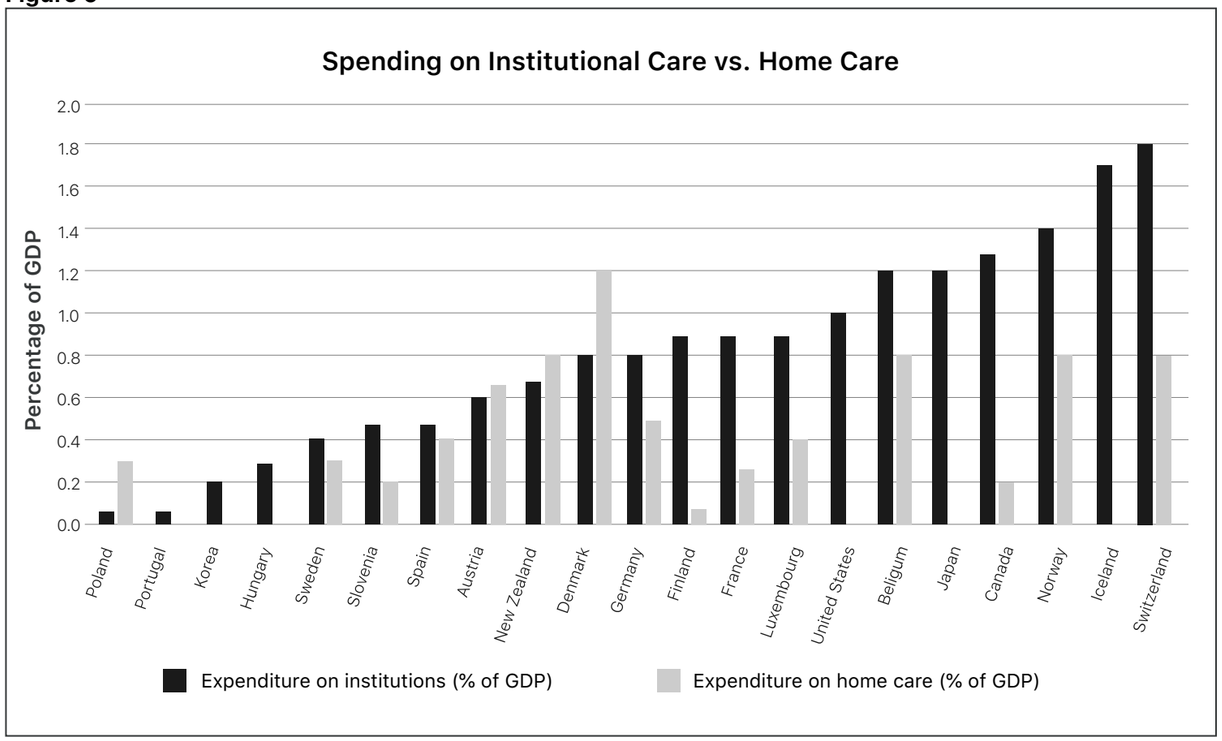
Japan also has a strong policy favouring home care, having established a community-based integrated care system in 2012 to provide an array of healthcare resources to all seniors.[83] Canada has close to the average in institutional care but just over 8 percent of seniors in receipt of home care, slightly increased in recent years, but not nearly sufficiently to shift the burden away from LTC-homes.[84]

Figure 8



Source: OECD Statistics for 2017, extracted on May 20, 2020.

Figure 9



Source: OECD Health Data, 2010. "Help Wanted? Providing and Paying for Long-Term Care," 2011.

** Note: Home care includes day care expenditure. Data for Denmark, Japan and Switzerland refer to 2007; data for Portugal refer to 2006; and data for Luxembourg refer to 2005. Data for Poland exclude infrastructure expenditure, amounting to 0.25% GDP (2007).*

Although seniors prefer home over institutional care, this does not necessarily translate to higher spending on these services. Throughout the OECD, Canada is an outlier, having one of the lowest levels of spending on home care (Figure 9).[85] As of 2008, only Denmark, New Zealand, Austria, and Poland spent more on home care than on institutions. Led by Denmark, Germany, and Japan, other developed countries are far ahead of Canada in terms of establishing home care as the primary service for the support of their ageing populations. They have implemented innovative and effective strategies to do so.

Denmark

Key Features & Home Care Policies

Senior Friendly System Orientation: principles of self-reliance, dignity, and self-respect are entrenched in all health service transactions – patients expect to return home in the event of hospitalization.

Policy & Governance Framework: National strategy to maintain people in their homes, implemented and funded by municipalities.

- Legislated against the development of new institutional LTC spaces in 1980's.

Financial Incentives/Disincentives: Housing costs are paid by the individual while health service costs are paid by the government.

- Home nursing is fully covered by universal health insurance once referred by a physician.
- Permanent home care is free of charge; temporary care cost is shared.
- In institutional care setting, patient pays housing portion of expenses (including utilities) based on size and location of dwelling.

Caregiver support: Relatives of seriously ill individuals allowed to take paid leaves of absence from their jobs for up to nine months. These can be incremental and may be divided among several relatives.

All patient outcomes tracked: "cradle to grave" approach to patient data sharing, providing a unique identifier for all health records.

Available home care services include:

- preventive home visits to elderly citizens.
- 24-hour assistance from a nurse, meals, the possibility to adapt the home, day care centers, financial assistance, and transport facilities.

Results

No new institutional LTC beds since 1987.

- 30% decline in LTC spaces overall (spaces not re-populated over time).
- High satisfaction rates of health services amongst elderly population.
- 2007 there were 9.5 formal LTC workers per 1000 population over the age 65, above the OECD average of 6.1 workers.
- In 2007, 14.5 LTC-home beds per 1,000 population aged 65 years old and over, substantially lower than OECD-average of 44.5 beds.
- Performance data, including patient outcomes, show strength of Denmark's system.

Japan

Key Features & Home Care Policies

Shift to Community-Based Services: Japan has begun to try to shift the balance away from institutionalization and toward home and community-based services.

- Japan has decreased the proportion of room-and-board costs paid by LTC insurance.

Comprehensive Health System: In general, they have a comprehensive system rather than a collection of fragmented programs, which facilitates effective policymaking in home and community-based care.

As Per Need Basis: Consists of LTC Insurance, designed to cover those aged 65+, according to their needs.

- A care manager advises on how these needs may best be met, based on the budget allocated and a knowledge of local service providers.

LTC Insurance System: Everyone age 40 and older pays premiums. Everyone age 65 and older is eligible for benefits based strictly on physical and mental disability in six categories of need. Benefits are all services covering 90 percent of need.

Services Provided: Services are provided via a range of organizations in the public, not-for-profit, and private sector and are selected based on specific needs.

Results

- Japan ranks first in the health domain with a life expectancy of 26 additional years at the age of 60, with over 20 years of those years expected to be healthy according to Global AgeWatch Index.
- Older adults in Japan report high satisfaction with social connectedness, safety, and civic freedom.
- Number of Japanese people aged 100 or older has risen to a record high of over 70,000—many of whom are independent and healthy.

Germany

Key Features & Home Care Policies

LTC Insurance System: Similar to that of the Japanese system, Germany has developed public universal LTC insurance systems.

- Everyone contributes to a dedicated fund proportional to income and everyone is covered.

Policy Objectives:

- Support family caregivers, contain spending to within the premium level set by law, create sickness funds separate from health insurance.
- Germany has decreased the gap in benefits between home care and institutional care.

Supporting Family Caregivers: Germany's LTC insurance system seeks to recognize and encourage family caregiving. Beneficiaries may choose to receive direct services or a cash allowance.

As Per Need Basis: Assigned doctors and nurses certify applicants and assign a level of need specific to that individual.

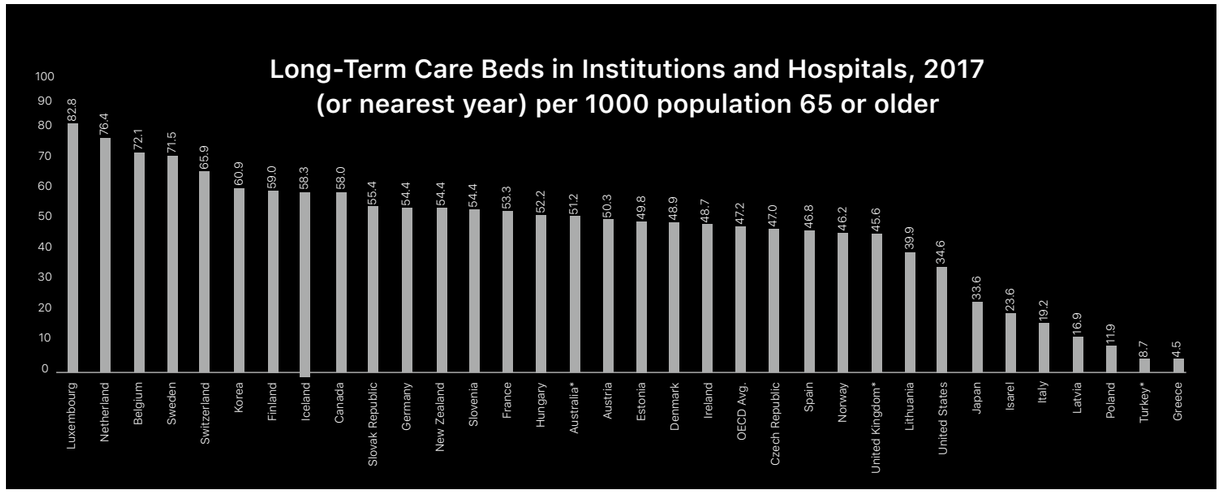
Social Insurance Framework: German LTC insurance covers people of all ages (21 percent of beneficiaries are under age 65).

Results

- Germany ranks high in the capability domain of the Global AgeWatch Index, with the second-highest educational attainment rate among older adults, as well as in social connectedness, elder satisfaction, and civic freedom.
- Life expectancy and healthy life expectancy are strong as well.

With 58 care beds per 1000 seniors Canada has one of the highest number of LTC-home beds proportional to its population (Figure 10); the OECD average is 47.2.[86] In some ways, this ranking constitutes a snapshot of each countries' approach to comprehensive care for seniors. Japan's low number of LTC-home beds, for example, reflects a culture and policies oriented toward enabling the elderly to age at home.[87]

Figure 10



*Source: Health at a Glance 2019: OECD Indicators *The numbers of long-term care beds in hospitals are not available for Australia, Turkey, and the United Kingdom.*

While Canadians are quite satisfied with their primary healthcare services, seniors are less so with the care they receive relative to seniors in other countries.[88] Seniors in Switzerland (84 percent), Norway (83 percent), New Zealand (82 percent), and Sweden (80 percent) are most satisfied whereas in Canada only 67 percent of seniors report satisfaction with the quality of healthcare they receive.[89]

Canada also falls short in other key indicators. One third of Canadian seniors report having three or more chronic conditions, more than most other countries, apart from the United States.[90] Although ranked close to the international average, hospital discharge planning and the communication of these plans to seniors remain issues; one-in-five seniors had no follow-up care arranged and no written information on what to do following discharge from hospital.[91]

Canada also falls below the international average on the issue of timely access to primary healthcare; the majority of seniors (59 percent) are unable to get a same- or next-day appointment.[92] This often results in their greater use of emergency departments than in other countries. Almost one third of Canadian seniors reported that their most recent visit to the emergency department was for a condition which could have been treated by their regular provider of primary care.[93]

Caregiver Support

According to the Conference Board, between 2019 and 2035, the cost of caring for seniors will increase 1.5 times the rate of disposable household incomes.[94] Support for caregivers is provided through federal tax credits, primarily in the form of the Canada Caregiver Credit (CCC) and the Disability Amount Credit Transfer (DTC). The CCC is a tax refund, designed to reimburse families a portion of the costs associated with caring for a family member with a physical or mental disability.[95] The DTC allows caregivers to claim the remaining balance if the entire amount has not been claimed by the recipient.[96] These tax credits reimburse only 18 percent of expenses related to care-giving and are underutilized, claimed by only 4.5 percent of caregivers.[97] They exclude many who for cultural and other reasons want to age at home with their families. Equity is another challenge; the current model excludes families with low taxable incomes.[98] A formal caregiving structure modeled on those in other parts of the world would be beneficial in Canada.

JURISDICTIONAL SCAN OF CAREGIVER SUPPORTS

Sweden – Family Caregiver Wage

In Sweden the law entitles caregivers to a certain amount of allowance and social security equivalent to what caregivers in the formal sector receive.[99]Caregivers looking after seniors are reimbursed by the municipality at a salary equal to what the municipal formal home care worker receives; this salary is taxed as income.[100] In addition, if the caregiver is a family member, s/he is compensated in untaxed cash with what is called an Attendance Allowance.[101] This amount is approximately 550 Euros per month.[102]The municipality decides how this is assigned and no federal or provincial regulation has authority over it.[103]

Australia – Care Allowances

Australia has one of the most established and comprehensive caregiver policies in the world.[104] The Australian caregiver support is available to both low-income and high-income caregivers through different streams.[105] Some of these supports look like the Carer Pension which offers a bi-weekly benefit to caregivers.[106] This benefit is means tested and aims to reach caregivers in the low-income bracket; the caregiver receives AUD $569.80 each and AUD $475.90 to each spouse of a couple participating in constant caregiving (this is equal to how much it costs to purchase six weeks groceries in Sydney for a family of three).[107] There is also a Carer Allowance (also known as the Carer Payment) that is available on a bi-weekly basis for caregivers working in care for up to 20 hours a week; the amount is AUD $105.10 and is not means tested.[108] Additionally, those caregivers who receive the Carer Allowance are eligible for a yearly Carer Supplement of AUD $600. Australia also recognizes that there are caregivers who might be in more financial need who receive both benefits; they are entitled to AUD $1,200.[109] These payments to caregivers of approximately AUD $1,450 per month include annual bonuses to those caregivers in extreme financial need. They illustrate Australia's commitment to support caregivers and make it one of the most generous policies in the world in terms of the significant compensation offered.[110]

United Kingdom – Carer's Allowance

This comprehensive program provides a weekly benefit of £67.25 to caregivers with an income of £128 per week or less after tax and expenses who provide a minimum of 35 hours of care.[111] The carer need not be related to the person receiving support nor live with the individual, but the care-recipient must already be receiving a certain type of benefit (disability, war disablement pension, etc.) when the carer's allowance is claimed.[112] The person being cared for may lose those benefits.[113]

CONTINUUM OF LIVING ARRANGEMENTS

The needs of the elderly change over time, sometimes incrementally, other times suddenly, and often not linearly. Many seniors go through short periods when they require additional care but then recover the capacity to return to some level of independent living.

Seniors are highly capable of living fulfilling and vibrant lives well into old age when they are given the freedom and the support needed to do so. It is not hard to understand why most seniors do not want to live in LTC-homes. These facilities remove them from their families and friends, making it more difficult to maintain the strong social relationships that give them a certain sense of independence and the freedom to interact regularly with their communities.

Seniors should be afforded autonomy over how they age and given a variety of options from which to choose where and how they grow old. Although their capabilities may change over time, maintaining control over what is meaningful in their lives is important to preserve their dignity.

A senior's health should not be viewed solely through a healthcare lens. As mentioned at the beginning of this report, seniors have four key categories of need: housing, lifestyle, social, and care. They are all critical to a senior's health. Their housing determines in many ways to what level they are able to satisfy these other categories of need, especially their social and lifestyle needs.

INDEPENDENT LIVING IN FAMILY HOME

Independent living is when the senior is able to remain in his or her own home while remaining self-sufficient. For many seniors, it is preferable to age at home, in their own communities, for as long as possible.

ADULT DAY PROGRAMS IN FAMILY HOME

Adult day programs are designed to engage socially isolated seniors, and seniors experiencing cognitive and physical impairments in a variety of physical and recreational activities.[114] These programs enable seniors to build new relationships and strengthen ties with their peers through participation in organized activities. They destigmatize ageing and give families peace of mind that their loved one is in a safe and supportive environment, allowing the caregiver to complete daily tasks.[115]

Hospice Kingston offers free of charge an adult day program specifically targeted to families coping with cognitive impairment with special wellness programming, recreational activities and social events.[116]Examples include singalong and piano therapy, yoga, reiki, holiday parties, and pampering days.[117]They also offer special programming with Parkinson's Canada and the Alzheimer's Society.[118]

Serving Kingston, Southern Frontenac Community Services offers an adult day program led by a personal support worker (PSW) at a daily fee of $20.[119] This program allows vulnerable seniors to age within their own homes though programming designed to maximize functional capacity in seniors and eliminate stigma associated with cognitive and physical impairment.[120]

The Region of Peel organizes its adult day programs through the Mississauga Halton Local Health Integration Network (LHINs) and for a daily fee of $23.50 offers a variety of activities and services.[121] Included is access to health services such as physiotherapy, dietician services or consultations with healthcare professionals, in addition to social and recreational activities.[122]The program also books medical and personal appointments for participating seniors.[123]

REMAIN IN FAMILY HOME WITH SUPPORTS

Some supports for families who care for the elderly: (note most of these require care recipients to be critically ill/ have a mental or physical impairment)

Canada Caregiver Credit (CCC) and Other Federal Benefits:

There are a number of benefits that support caregivers including the Compassionate Care and Family Caregiver Benefits (described previously) and Family Medical Leave.[124] All require those receiving care to be critically ill or injured or have a physical or mental impairment.[125]

Nova Scotia – Caregiver Benefit Program:

This program provides financial support to loved ones and friends who take on the role of care giver to adults with very high care needs. A home care assessment is carried out to determine the level of need, and if the caregiver and care recipient qualify they receive $400 per month.[126]

The Home Accessibility Tax Credit (HATC):

HATC is a tax credit for those over the age of 65 for renovations to improve the functionality and accessibility of their residence.[127] It applies to the "total qualifying expenses up to $10,000 per year, resulting in a maximum non-refundable tax credit of $1,500" and would allow seniors to remain in their homes while maximizing functioning.[128]

GRANNY FLATS

Granny flats are often the result of informal arrangements between parents and their children.[129] These housing arrangements can include the parents occupying a room in the child's house, residing in an attached suite, or living in a tiny house in the backyard. Often the parent will help cover the cost of housing renovations or additions.

The benefit of this arrangement is that the senior retains the sense of family and feels supported because their family is close as they age and in case of emergency (ie. falls, heart attack, etc.). It can also benefit the child, particularly those with small children when the senior is capable of child-care. There is a risk that such arrangements can deteriorate if there is a breakdown of the parent-child relationship, however, many of these arrangements are successful for both parties.

COMMUNAL LIVING – OASIS COMMUNAL LIVING IN KINGSTON, ONTARIO

A successful example of communal living exists in Kingston, Ontario, in a pilot program known as Oasis. Oasis serves about 60 seniors who live independently, with some supports in place such as catered and communal meals three times a week, exercise programs, social events, on-site support workers, movies and art classes, skill sharing, and projects to support the broader community. An on-site coordinator supports Oasis programs and helps members navigate community supports to meet changing needs and abilities.[130] According to a case study report by the University Health Network, residents have testified that "the program has been instrumental in helping manage their own personal chronic illness, as well as providing invaluable support for caregivers managing their loved one with dementia."[131] In fact, the 12 original Oasis residents eligible for an LTC-home refused to enter these homes and stayed in Oasis as a direct result of the program's benefits to their health and lives. The program hopes to continue expanding to other Ontario communities.[132]

INTERGENERATIONAL/MIXED HOUSING

Intergenerational living is when seniors and young people live together in exchange for low rent or the performance of services. These arrangements are mutually beneficial for both parties involved.[133] This type of living arrangement connects seniors with the outside world, reduces social isolation, and allows the senior to remain engaged in the community. Some seniors prefer intergenerational living as it can reduce the social isolation sometimes associated with exclusively senior living arrangements.[134]

Homesharing between seniors and university students is the primary form of intergenerational living in Ontario. Based in Hamilton, the McMaster Symbiosis Homesharing Program matches compatible senior residents in the Hamilton community with university students to reduce financial costs and social isolation for all parties involved.[135] In addition to fostering budding friendships and providing companionship, students can also assist the senior with household chores and other tasks.[136]

In Toronto, the Toronto Homeshare Program connects university students with participating seniors in exchange for affordable rent (typically between $400-$600/month).[137]In exchange, students agree to provide up to seven hours of assistance or companionship to the senior.[138]This program is led by a series of social workers to ensure safety and mitigate any potential conflicts or tension between the senior and young person.[139]Routine safety checks are conducted to ensure the residence is safe for all parties.[140]

The Humanitas Retirement Home in the Netherlands is an intergenerational living environment connecting students with older residents within the community. The program is financially beneficial for students who would otherwise have limited student rental housing options.[141] In exchange for accommodations, students are expected to spend time with the senior residents. The students may help seniors navigate social media, share entertainment experiences, and offer companionship.[142]The student-senior relationship is typically based on mutual respect and trust since all residents are expected to co-exist within a shared space.[143] Regular interactions with students help keep seniors engaged in the outside world.

HOME-SHARING PROGRAM

New York Foundation for Senior Citizens (NYFSC's) Home Sharing Program
This home sharing program links adult "hosts" who have a space in their home or apartment with adult "guests".[144] One of either the host or guest has to be 60 years or older; however hosts from age 55 are permitted if they are looking to support an adult guest with developmental challenges who is capable of living independently.[145] In an article by the New York Times this method is reported to increase housing options for seniors and also appeal to individuals wanting to avoid the high cost and institutional nature of assisted-living and nursing homes.[146] This option also supports a senior's independence without having the element of isolation that comes with staying in a place over a long period of time.[147]

SENIORS' RESIDENCES

Seniors' residences bring together various required supports and are a form of housing where the senior pays both for accommodation and care services; there is no government funding received.[148] The services included in these living arrangements include but are not limited to meals, dementia care, administration of medication, etc. [149] For admission to these residences there are no specific criteria to be met and for the seniors who pursue this option a tenancy relationship is entered into with the residence or home and then the decision on what services and care to purchase is made.

SENIOR-FRIENDLY VILLAGES

Retirement villages in the UK refer to large developments consisting of around 100 units and are a fairly new type of housing for seniors with growing popularity. [150] These villages offer an array of services that include social facilities as well as sports and leisure activities for village residents. Additionally, some offer a high level of care and support as per residents' needs, all with the goal of offering independent housing through flats or bungalow-style living arrangements.[151]

Retirement villages provide seniors with more housing options while also meeting their care needs and providing social connection, engagement, and security.[152] An example of a major retirement village company is Audley Villages which has 20 different villages around the UK.[153] Audley Villages recently entered a joint venture to develop four cutting-edge retirement villages which cost upwards of £400 million with more than 500 units and extensive facilities.[154] This is one example of how private companies are recognizing the opportunity and scale of the demand for additional retirement communities and housing options designed for the elderly.[155]

In this instance owners purchase these homes on long leases and have access to Audley Club that offers a range of facilities such as libraries, health and fitness clubs, among other services.[156] Additionally, all the seniors care needs at the village are met by Audley Care, a registered care provider.[157] These villages are responding to seniors' desires to live independent and healthy lives in their own homes with whatever supports needed being made easily and readily available.

An in-depth study by the Associated Retirement Community Operators (ARCO) in the UK showed that seniors living in retirement communities compared to those not yet moved in stayed healthier for longer, enjoyed life and privacy, and felt more secure.[158] The study also showed that the residents of these communities felt more in control of their lives.[159]

INTERIM PLACEMENT AT A CARE FACILITY

Interim care facilities function as temporary housing for seniors and act as a bridge between hospitals and other types of housing arrangements. Interim placement caters to seniors who require temporary care following a hospital stay; it allows them to recover before returning to their homes.

These beds are beneficial because they free up capacity in hospitals by removing seniors from ALC beds and provide an option for seniors to receive care but avoid permanently entering an LTC-home. Interim placement beds can be provided through LTC-homes or in their own facility. A short stay at an interim care facility is considered to be anytime up to 120 days for the first stay.[160]

Some interim care facilities exist in Ontario; however, placement is contingent on being on a waitlist for an LTC-home.[161] These facilities should be used as a place for seniors to recuperate before returning to their housing arrangements—whatever they may be.

LTC-HOME

LTC-homes are classified as locations where individuals requiring LTC can live and receive help with a majority of all daily activities, as well as have access to 24-hour nursing and personal care supports.[162] Eligibility includes the necessity for these services, as well as demonstration that they cannot be safely met in the community through publicly funded community-based services and other care-giving supports. These places are better equipped for the ageing population and provide more nursing and personal care supports than retirement homes or supportive housing residences. The following services are available in LTC-homes:

- shared dining room, TV rooms and other living areas
- nursing and personal care on a 24-hour basis
- access to health professionals
- individual care plan (reviewed every 3 months)
- furnishings (e.g., bed and chair)
- meals (including special diets)
- bed linens and laundry
- personal hygiene supplies
- medical/clinical supplies (e.g., walkers and wheelchairs for occasional use)
- housekeeping
- individualized religious and spiritual services
- social and recreational programs
- medical services
- assistance with ADL

The personal and nursing care available in these homes are often funded by the government, as is the case in Alberta, British Columbia and Ontario, however accommodation charges are paid by the resident.[163]

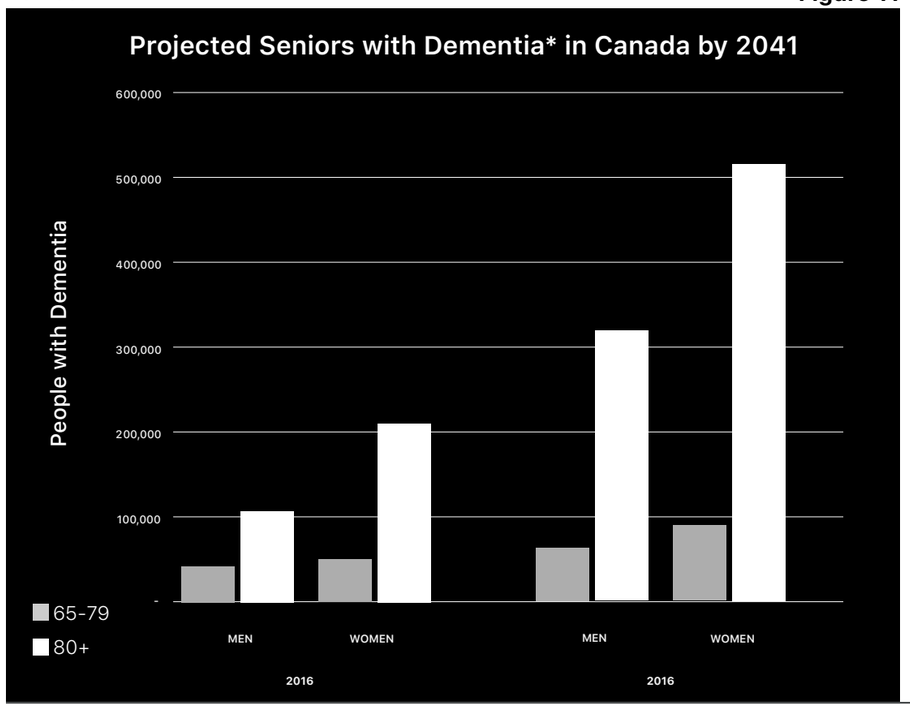
COMPLEX CONTINUING CARE HOSPITAL

Complex continuing care hospitals—also known as extended care, chronic care, or hospital-based continuing care—constitute a form of hospital care that provides ongoing professional services to individuals with complex health needs; serves patients who no longer need acute care, but are not fully prepared to be discharged from a hospital; and contains facilities that may be free-standing or co-located with acute and/or rehabilitation services within a hospital. This type of living arrangement is for seniors with who have long-term illnesses or disabilities that require skilled, technology-intense care not available at home or in LTC-homes.[164] In addition to medical care, patients are provided with room, board, and other necessities. This form of care a not designed for permanent or long-term stays.

FACTORS DRIVING SENIORS INTO LONG-TERM CARE HOMES

The principal factors driving people into LTC-homes are frailty and dementia. Dementia increases in prevalence with age and is more common in women than men. Its prevalence in seniors more than doubles[165] every five years, from less than 1 percent for 65 to 69 year-olds to approximately 25 percent for seniors 85 and older.[166] The coming boom in the elderly population and its skew toward older age cohorts is expected to increase sharply the total number of seniors with dementia (Figure 11) whose particular care requirements are currently thought to require their housing in LTC-homes.

Figure 11



**Dementia, including Alzheimer's disease. Canadians are identified as having diagnosed dementia if they have one or more hospitalizations; or three or more physician claims within two years, with at least 30 days between each claim; or one drug prescription or more" with an ICD code for dementia. Saskatchewan data not included in this analysis as they were unavailable. Source: The Canadian Chronic Disease Surveillance System, Dementia Data Tool, Statistics Canada, Table 17-10-0057-01 and Table 17-10-0005-01.*

Figure 12 shows that in Ontario, almost 80 percent of all those in residential care facilities have a neurological disease, 63.5 percent have dementia.[167] It is estimated that there are approximately 482,000 seniors currently living with dementia in Canada, a number expected to jump to over a million by 2041.[168] Barring any major breakthrough in dementia prevention, treatment, or changes in the ways and sites in which those affected are provided with continuing care, more and more seniors will be heavily reliant upon residential care and healthcare services going forward.[169]

Figure 12

Disease diagnosis	**Hospital-based continuing care***				**Residential care****			
	Ontario		Total		Ontario		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Neurological diseases	**9,283**	**46.6%**	**9,414**	**46.7%**	**83,225**	**79.9%**	**141,613**	78.6%
Dementia	4,090	20.5%	4,117	20.4%	66,103	63.5%	111,024	61.6%
Alzheimer's disease	715	3.6%	714	3.5%	16,138	15.5%	25,048	13.9%
Dementia other than Alzheimer's disease	3,565	17.9%	3,590	17.8%	55,015	52.8%	93,937	52.1%

** Based on complex continuing care hospitals/units in Ontario and chronic care facilities in Manitoba.*

*** Based on submitting residential-based continuing care facilities in Newfoundland and Labrador, Ontario, Manitoba (Winnipeg Regional Health Authority), Saskatchewan, Alberta, British Columbia and Yukon. Percentages do not add to 100%, as many residents had multiple health conditions recorded.*

Source: Canadian Institute for Health Information, Profile of Residents in Residential and Hospital-Based Continuing Care, 2018-2019.

Frailty also increases the likelihood of seniors going into residential care.[170] They are 3.3 times more likely to do so if they require extensive assistance with toileting or maintaining personal hygiene.[171] Falls, caregiver distress, and medical instability are other common reasons.[172]

Seniors who are assessed in hospital are much more likely (60 percent) to be admitted into an LTC-home than if assessed in a community setting (10 percent).[173] While it is possible that hospital ALC patients could have higher needs, there may be an institutional bias at work.[174] In Ontario, the standard wait time for seniors in ALC for a bed in an LTC-home is 28 days as opposed to 36.5 days to be set up with home care.[175]

From hospital, seniors face a high risk of never returning to independent living. The lack of same- or next-day access to primary healthcare services drives too many seniors into emergency departments and thence into acute care hospitals where many seniors stay in ALC far too long, thus making difficult their return to independent living.

To address ageing well successfully, the promotion of healthy ageing and meeting seniors' preferences must be accommodated through the provision of a wider range of living arrangements for seniors.

FACTORS DRIVING SENIORS INTO LONG-TERM CARE HOMES

NATURALLY OCCURRING RETIREMENT COMMUNITIES (NORCS)

Naturally Occurring Retirement Communities (NORCs) were first identified by Michael Hunt and Gail Gunter-Hunt in a 1986 article in the Journal of Housing for the Elderly. They are defined as "housing developments that are not planned or designed for older people, but which over time come to house largely older people."[176] These locations can vary from neighborhoods of apartments, condominiums, to single-family houses, and are typically developed over time from multiple factors including adults ageing in place, the out migration of younger households, and the in migration of older households.[177] Supportive neighborhoods with integrated services appear to be the common denominator in the successful use of NORC's in elder care. Communities specifically with these integrated services and supports are known as Naturally Occurring Retirement Communities – Supportive Services Program (NORC-SSP). These are defined as "a partnership between a housing development or neighborhood, its residents, and health and social service organizations collaborating to help older adults age in place."[178] Partners, both public and private, work collaboratively to reduce social isolation, create opportunities for seniors to remain active, increase community involvement, and provide accessible social services and health support.living arrangement is for seniors with who have long-term illnesses or disabilities that require skilled, technology-intense care not available at home or in LTC-homes. In addition to medical care, patients are provided with room, board, and other necessities. This form of care a not designed for permanent or long-term stays.

COMMUNITY PARAMEDICINE PROGRAMS

Community paramedicine programs are programs in which "community paramedics provide community-centred healthcare services that bridge emergency care and primary care and undertake expanded roles such as health promotion and disease/injury prevention."[179] An analysis of these programs found that community paramedicine programs can be effective in improving health outcomes for some populations, reduce use of emergency services, and may lower costs to the healthcare system.[180] In Ontario, community paramedicine programs work with teams of health professionals, including Health Links, to co-ordinate care for individual patients with complex chronic conditions.[181] Currently, more than half of Ontarians have access to these programs which help the elderly and other patients receive care at home, while reducing unnecessary emergency room visits and hospital admissions. Expanding these programs in Ontario is a key component to the overall health and wellbeing of our ageing population. [182]

DEMENTIA-FRIENDLY COMMUNITIES

The number of people diagnosed with dementia has increased as a result of population ageing. Initiatives have been developed by the World Health Organization (WHO) and Alzheimer's Disease International to promote social inclusion and better care for the elderly and those with dementia (Ontario is included in the development of these communities through such initiatives). The term "dementia-friendly communities" has been coined by these groups and defined as "communities where people with dementia are able to remain socially included." These communities allow people with dementia to remain at home as members of a community which is educated and trained to support and respect them while also allowing them to confidently contribute to community life. People with dementia are at the center of dementia-friendly initiatives, which fosters their social inclusion and boosts their overall wellbeing. These communities include the following dementia-friendly aspects:

- Care services
- Hospitals
- Community environments
- Transportation
- Stores and shops
- People
- Information
- Opportunities for people with dementia

The understanding, involvement, inclusion, and respect of people with dementia is incredibly important—especially with an ageing population. Developing and enhancing these communities is an important way to promote health and wellbeing in the growing segment of the population living with dementia.

BLUE UMBRELLA PROGRAM IN ONTARIO

Implemented in jurisdictions across Ontario, the Blue Umbrella Program includes training sessions led by an Alzheimer Society representative and a person living with dementia so that organizations and businesses can be better equipped to support, include, and welcome customers and community members with dementia.[183] These organizations and businesses are awarded a blue umbrella decal to showcase on the front of their businesses to indicate to the community that they are trained and dementia-friendly. Since its inception in 2017, thousands of Ontarians and organizations have received this training which continues to educate Ontarians on how to develop their own dementia-friendly communities.[184]

PROMOTING HEALTHY AGEING

The WHO defines healthy ageing as "the process of developing and maintaining the functional ability that enables wellbeing in older age."[185] Refocusing services in Canada for seniors to support their healthy ageing requires a paradigm shift, a rebalancing of meeting the now predominant care needs in institutional housing with social and lifestyle needs delivered through home and community care and for healthcare's more wholehearted adoption of its dual purpose "to prevent illness when possible and treat it when necessary." [186]

There are many ways to help seniors continue to live engaged and fulfilled lives long past their first needing support when living independently in their golden years. Among those ways, one of the most effective is to reduce or reverse risk factors associated with functional decline through exercise.[187]Providing regular access to interaction and socialization is another way to prevent loneliness, isolation, and decline. [188]

Both are changes that can easily be incorporated into an individual's lifestyle that can greatly improve health outcomes including diminishing the effects of dementia.[189] Dementia's prevention or delay is a lifelong pursuit through 12 modifiable risk factors which include:[190]

(percentage reduction in dementia prevalence if this risk factor is eliminated)

- Hearing impairment (8%)
- Low education (7%)
- Smoking (5%)
- Social isolation (4%)
- Depression (4%)
- Traumatic brain injury (3%)
- Physical inactivity (2%)
- Hypertension (2%)
- Air pollution (2%)
- Obesity (1%)
- Diabetes (1%)
- Alcohol consumption (1%)

Eliminating them all could prevent 40 percent of all dementia cases while also alleviating frailty.[191] Healthy ageing is about incorporating and sustaining healthy habits into every person's daily routines, not only those of seniors.

What is Required

Focusing on health and its maintenance widens the discussion to include the social determinants of health. In 2009, the Senate Subcommittee on Population Health showed that healthcare accounts for but 25 percent of health outcomes.[192] The other 75 percent is determined by other factors, of which an individual's socio-economic environment is the most powerful.[193]These socio-economic factors include housing, early childhood development, education, income, employment, culture, and gender, and span the entire lifetime of every individual including his or her ageing years. A broad policy focus is essential in achieving for Canadians the goal of enabling their healthy ageing and ensuring their continued engagement as productive and valued members of society.

Implementing Healthy Ageing

There are three key areas of reform to implement healthy ageing successfully.

I. Primary Care

The first is for primary care to focus on health, especially of the elderly, as well as healthcare. Every aspect of primary care should be aligned with the goal of promoting health including reform of the existing pay-for-service fee structure for physicians, nurses, and other providers and incorporating coordinating health coaches into primary care practice teams. Implementing Ontario **Health Teams** would support this goal by coordinating the work of doctors with that of nurses, physiotherapists, nutritionists, pharmacists, counsellors, health coaches, and social workers.

II. Community Services

Many valuable supports could be delivered through community services, including frailty screening in local pharmacies to identify proactively individuals at risk for frailty, potentially pre-empting the development of their functional decline.[194] Other innovative services could include the "Adopt a Grandparent" program as implemented in the United Kingdom or the Trent University Eldercare Village proposal. Another could be through centres spearheaded by the Canadian Frailty Network to reduce frailty and promote healthy ageing by implementing a framework that includes **AVOID**:[195]

- Incorporating **A**ctivity and exercise
- Prioritizing **V**accination
- **O**ptimizing medications
- Promoting **I**nteraction and socialization
- Incorporating proper **D**iet and nutrition

TRAINING PHYSICIANS AND OTHER HEALTH PROFESSIONALS IN CONTINUING CARE OF THE ELDERLY

As healthcare generally remains slow in adjusting to the demographic reality of a much larger and older population, so also are the curricula and training programs of the health professionals who will provide their care. Medicine is an example. A survey of Canada's 16 medical schools in 2008 revealed that Canadian undergraduate students received some 300 hours of instruction in paediatrics and but 82 in geriatrics; the latter is not a mandatory rotation during clerkship whereas 4 weeks in paediatrics are required. It is no wonder that there are only 300 or so geriatricians in the country, one third of them already 55 or older, against an anticipated need for at least 700. It is true that in their clinical training, doctors, nurses, physiotherapists, and other health professionals all gain experience from working and communicating with increasing numbers of elderly patients but that experience is usually focused on the patient's manifestation of the teacher's particular clinical specialty, not on the geriatrician's broader concern with the ageing person's holistic wellbeing. Adaptation of the educational/training programs is urgently required.

The caregivers of the population today, and especially of the populations of tomorrow, will have responsibility for the healthcare needs of a preponderance of elderly people. They will look to their caregivers for help and advice in addition to the hands-on services they will need to age well in all the residential environments in which they will live. All those caregivers, doctors, nurses, and the personal support workers and housekeepers who anchor LTC wherever it is provided, need education and training appropriate to the challenges they will face throughout their practice lives. The time to make the requisite changes is short!

ADOPT A GRANDPARENT

In October 2019 CHD Living, a UK based group offering services to seniors, launched the 'Adopt a Grandparent' program.[196] It was created with the hope that members of the community would visit care facilities to socialize with the residents - the idea was to encourage an exchange where people also had an opportunity to learn from seniors who have plenty of life experience.[197] Initially, the program started with 130 locals signing up as volunteers, however with COVID the program moved to a virtual platform and CHD Living received 67,000 volunteers signing up for the virtual Adopt a Grandparent program and there is currently a waitlist of volunteers.[198] The adopted grandparent and grandchild matches are selected from many places around the world and are paired based on shared interests.[199] CHD Living's head of communications notes that while the program's initial goal was to benefit the senior, they are noticing that it is beneficial for all parties involved.[200] This program is building strong relationships as individuals from different generations come together to support each other.[201] Due to the success of the program, CHD Living is reaching out to other facilities potentially to expand the program elsewhere.[202]

TRENT UNIVERSITY ELDERCARE VILLAGE

Trent University has been pursuing plans to establish a university-integrated seniors community. It is planned to include an LTC-home, with retirement homes and potentially student housing as well.[203] The website notes that having this village for seniors will support experiential learning for students and will inform innovation in teaching to further the practices of LTC that support quality of life and care for seniors.[204] This initiative will also create opportunities for more students to become interested in careers in geriatric care. The University states "the Eldercare Village aims to create a lifelong learning environment where older people can stay engaged in intergenerational learning, social engagement, the arts, research opportunities, and the life of the University."[205]

III. Socio-Economic Factors to Health

Given that 50 percent of the health of a population is determined by socio-economic factors, there are many changes outside the healthcare system which can contribute significantly to ageing well, education being one particularly effective in reducing the risk of dementia.[206] Education, of course, begins in early childhood when cognitive stimulation is particularly important but it continues to help people later in life too. [207]

Providing Services Where It Suits the Senior

The lack of a range of accessible continuing care services is a major source of seniors' dependency on hospitals and LTC-homes. It is one of the main obstacles that must be overcome to enable older people to age well and remain capable of living independent and fulfilling lives in their homes and communities.

The rural-urban divide factors into the issue of accessibility in Canada; it can severely limit care options available to rural seniors who often have financial and accessibility challenges – fewer supports, services, and available caregivers. Two others are ensuring access to quality healthcare services and the services of home care providers given the lack of rural transportation systems.[208]

WHO IS RESPONSIBLE FOR THIS CHANGE?

While the specific needs of seniors vary by community, there are important roles for all stakeholders in implementing the shift of focus to incorporate health as well as healthcare and ending the current reliance on LTC-homes as the primary site of caring for the ageing population

Federal Government

The federal government can provide the provinces and territories with additional funding for health as opposed to healthcare initiatives. It can also address some of the socio-economic determinants of health such as housing initiatives, early childhood education, and opportunities for employment.

Provincial Government

Provincial and territorial governments have a vital role to play in adopting and communicating a new vision and managing the measurement and accountability aspects of its implementation. In Ontario, the government will have to determine the path forward and charge Ontario Health Teams with figuring out how to best execute its vision of health and healthcare throughout Ontario's regions.

Health Professionals

Ontario Health Teams are best suited to fulfill the 'Ageing Well' initiative as they incorporate the providers of both home and community care services as well as primary, secondary, and tertiary healthcare. Such teams are essential to deliver a holistic approach to health and ensure the appropriate balance among the four categories of seniors' needs – housing, lifestyle, social, and care.

Communities

Because the needs of seniors vary depending on the communities in which they live, the organization of supports for seniors is best coordinated locally. Seniors themselves and community volunteers provide invaluable contributions to the design and provision of the services that best meet the needs of seniors in the many diverse areas in which they live in the vast country of Canada.

CONCLUSION

The preponderance of COVID-19 deaths in LTC-homes has focused attention on the inadequacies of many institutions. The plethora of reviews across the country may lead to much needed improvements to their infrastructure, personnel, regulation, and protocols. But the reviews will miss the broader picture. If current practices continue, the need for beds will double over the next twenty-one years and current expansion plans will do little more than replace beds that will be decommissioned. Demographics and institutional improvements will more than triple spending. All for something few seniors would choose.

Most wish to age well and in place, in homes and communities they call their own. Canada is an international outlier in spending much more on institutional care of seniors than on home care. We need to develop housing options that are flexible and adjustable as needs change with age. Factors such as frailty and dementia that compromise independent living must be addressed through changes to lifestyle and approaches to care. Social needs must be satisfied. The best time to change course to address better the wellbeing of seniors was many years ago. The second-best time is right now.

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