DISCUSSION PAPER

A Higher Standard

Setting federal standards in long-term care and continuing care

Pat Armstrong and Marcy Cohen

Introduction

The COVID-19 pandemic has highlighted the critical importance of federal government leadership in health care. The pandemic's impact has been particularly dramatic in long-term care homes, exposing a fragmented and under-resourced system that is heavily reliant on for-profit delivery.

There can be no question that federal leadership is urgently needed in the development of a coordinated approach to long-term care, along with the broader system of home and community-based health services for seniors and people with disabilities (i.e. continuing care). Both the 1964 Hall Royal Commission on Health Services[1] and the 2002 Romanow Commission on the Future of Health Care in Canada[2], as well as a host of other research, have called for such leadership.

This document begins by proposing foundational principles for pan-Canadian continuing care services: principles that recognize the need for a shared, equitable

CCPA
CANADIAN CENTRE
for POLICY ALTERNATIVES
CENTRE CANADIEN
de POLITIQUES ALTERNATIVES

approach that allows for diversity in practices across jurisdictions, communities, groups and individuals to address local contexts and needs in evidence-informed ways.

In the September 2020 Speech from the Throne, the federal government indicated it will introduce national standards for long-term care homes. For this reason, the second section of this discussion paper proposes federal standards and assumes that federal funding will be dependent on evidence of compliance with these standards. These standards reflect the foundational principles and are understood as only one step in the development of a more equitable pan-Canadian continuing care system.

The third section looks specifically at the need for a federal labour force strategy. Both the Hall and Romanow commissions called for such a strategy, and in recent years various international organizations have warned of a critical shortage of care workers unless there are fundamental changes in the conditions of work in the long-term care sector.

1. Foundational principles for a pan-Canadian system of continuing care

Continuing care services include a range of programs, from home care and community social supports, to long-term and palliative care. The objective of these services is to support the health, wellbeing and functional abilities of older adults and people with disabilities, and to ensure they are able to age and die with dignity.

Historically the provinces and territories have developed these continuing care services on an ad hoc basis, in response to specific gaps that came to the public's attention and could not be ignored. As a result, access to such services, the quality of care and the conditions of work vary considerably across the country.

The foundational principles outlined below focus on transforming this fragmented and underfunded system of care and creating, for the first time, a pan-Canadian approach to continuing care. These principles prioritize the importance of improving care and support for the many marginalized populations that use these services, their unpaid family and friend care providers, and the undervalued workforce in the sector, which is primarily female and often racialized and/or immigrant.

This project is more important today than ever, as the ongoing global pandemic and climate emergency disproportionately have a negative impact on marginalized populations that use and work in the continuing care sector.

Foundational principles

1. Accountability and Transparency

"As owners, funders and users" of continuing care services, Canadians have a right to know how these services "are being administered, financed and delivered."[3] We also have a right to learn about the strategies that will be most effective in transforming the system to increase access, improve quality and cost-effectiveness, and enhance the capacity of the system to respond to the evolving needs of seniors and people with disabilities, and to those who provide paid and unpaid care. While this accountability framework is pan-Canadian in scope, it will be designed in ways that recognize the need for flexibility, given the diversity of our country and the unique circumstances of different groups, including Indigenous, racialized, LGBTQ2, and rural communities.

2. Evidence-informed policy development

First and foremost, evidence-informed policy development requires the provinces and territories to provide quality, comprehensive, verified and comparable data in a number of key areas (including staffing, quality of care, infection control measures, health and well-being process and outcome indicators, and ownership status, among others). This information must then be contextualized, put into useable formats, and fed back to the provinces and territories, health system managers, staff and the public to support innovation and system-wide improvement.[4]

The goal of this accountability process is not only to ensure transparency as to whether the conditions set by the federal government are being met, but also to create the opportunity for learning about the effectiveness of different approaches. Such evidence would provide the basis for working collaboratively with others—at the provincial, regional and local levels—in order to drive systems change. This is often referred to as a "*learning health systems*" approach, where transparent sharing of information, research evidence, and input from those who deliver and receive the services is used to support continuous learning and systemic change.[5] There is a broad and growing consensus among health policy experts internationally that this is the most promising way to optimize health system performance in our rapidly changing and increasingly complex health care environment.[6]

3. A focus on health promotion and the social determinants of health

There is a growing recognition of the positive health and wellness benefits of supporting vulnerable populations, not only with medical services, but also with access to affordable living spaces, nutritious and culturally appropriate food, and services that support people to be as socially, physically and mentally active as possible.

A health promotion approach focuses attention on strategies to improve the health and wellbeing of everyone involved in continuing care services. In contrast, a

social determinants of health perspective highlights factors such as racism, sexism, colonialism, working conditions and poverty that shape socio-economic disparities and emphasizes the need to address the factors that contribute to health inequities. There is a growing body of evidence to show that these two combined strategies not only improve health and wellness, they can also reduce health care utilization and costs.[7]

4. Relational care and support

Relational care recognizes the value of supporting reciprocal and interdependent relations among everyone involved in the care experience, including the person receiving services, their family and friendship network, volunteers, and staff in continuing care.

Putting relationships at the centre of public policy planning focuses attention on how work is designed and organized to ensure that the care providers can, in fact, have meaningful connections with the people they support. This includes, but is not limited to, ensuring job security, employment benefits, higher staffing levels, improved working conditions and compensation levels, and respectful workplace and injury prevention policies. It also means providing initial and ongoing training and education for all staff, with an emphasis on team work, so that they are better able to support the autonomy, dignity, and well-being of people with care needs, even as their health deteriorates.

Relationship-based care attends to individual needs but also focuses on the social, economic and political context of care provision, hence the importance of strategies to address power imbalances. This includes, for example, the implementation of culturally safe and sensitive care practices to support residents and the right to union protection for all staff. It also speaks to the importance of mechanisms to ensure that those receiving care, their family and friendship network, and staff have opportunities for regular and effective input into decision-making structures within service-providing organizations.

5. Comprehensive, integrated, community/neighbourhood-based delivery

Ongoing concerns about fragmentation and silos within our health care system are legendary. This includes the lack of coordination and communication across different parts of the health system—primary, continuing (long-term, home and community based) and hospital care. Effective coordination is essential to facilitate effective transitions and communication. There is also fragmentation within continuing care itself, where a more comprehensive approach is needed that includes health promotion, prevention, medical and social care, rehabilitation, and palliation.[8]

The idea of working locally in neighbourhoods and/or small communities to support a more integrated and comprehensive approach—including linkages with primary

and specialized care, community social supports and affordable housing—is one that has caught the imagination of many who work in or receive continuing care services. Developing, supporting and scaling-up innovative models for service integration and improving connectivity across the health and social support sectors are of paramount importance for the health and well-being of seniors and people with disabilities.

6. Access based on need and not on ability to pay

An increasing number of the services that older adults and people with disabilities require to maintain their health and wellbeing are not available through the public system and must be paid for through the private market. Many of the people who require continuing care services, however, cannot afford to pay for them privately and some have difficulty in even covering their basic monthly expenses for food and accommodation. Access must be based on need and not ability to pay, as is the case for physician and hospital services.

7. Not-for-profit delivery

There is a body of accumulated research demonstrating a pattern of lower quality care in for-profit services.[9] At the same time, there is little justification for profit making in this sector, in which the human right to basic care should be paramount. There is no evidence that for-profit services or a managed market competition in the provision of care services lowers cost, improves quality, access or choice. It is, however, more difficult to ensure health-focused governance, given the responsibility of for-profit firms to their shareholders. Policy and funding at the federal and provincial levels should be developed with a view to eliminating profit taking in publicly funded continuing care.

2. National standards for long-term care homes

According to the Canadian Institute for Health Information, "countries with centralized regulation and organization of [long-term care]," such as Australia, "generally had lower numbers of COVID-19 cases and deaths."[10] National standards have helped, but as a recent Royal Commission report from Australia acknowledges, they would be more effective if they provided "incentives to improve," [11] which would require standards that are transparent, specific and measurable.

We already have an extensive body of research demonstrating what needs to be done to address the crisis in long-term care homes with standards that are, in fact, transparent, specific, and measurable. We do not need more studies or commissions before we act. The time is now.

Federal funding for long-term care homes must be dependent on demonstrated compliance with the following standards:

Access based on assessed care needs, not ability to pay.
This means providing a sufficient number of publicly funded beds to ensure maximum wait times for admission to a long-term care home and addressing any financial barriers to admission.

The establishment and enforcement of minimum staffing levels, based on current research, verified data and an assessment of social, emotional, and clinical needs.[12]
An appropriate number and mix of staff are essential components in quality care and need to be accompanied by decent working conditions, as well as by recruitment strategies that attract and retain staff.

A plan to ensure that a minimum of 70% of staff work full-time in a single site, with the remaining 30% being permanent, part-time staff to provide needed flexibility. This plan will also ensure that all staff have benefits and pay based on equity principles.
Staff or contractors that move from home to home take infections with them while undermining team work and continuity of care, which is especially vital to effective dementia care.

A plan for physical environments that ensure safety and social support for residents, staff, family, friends and volunteers, including surge capacity to address infections.
Physical environments include components ranging from PPE and methods for effectively dealing with laundry and waste, to room size and ventilation.

Education and training standards that support the existing staff as well as new hires, and are developed in partnership with public post-secondary institutions and organizations representing the relevant occupations. Education and training plans would also be developed to ensure that all those family, friends and volunteers who enter care homes are educated in infection control.
Long-term care requires team work and appropriate specialized skills to address the physical, mental, and social health of residents. Given that relatives and volunteers provide care, they, too, require education and training, especially in infection control.

Policies requiring transparent, verified reporting to ensure accountability to the public and compliance with the above standards in the operation of the home.
Public accountability means accessible information based on data that is verified as accurate, and regular public reporting on inspections that includes enforced penalties for failure to comply with the standards. Public reporting makes it possible to learn about the effectiveness of different approaches, improve the standard setting process over time and increase compliance.

A plan to ensure that all public money goes to public or non-profit organizations, including any sub-contracted services.
Research clearly demonstrates a pattern of lower quality care in for-profit homes while there is little, if any, research demonstrating benefits from providing public funds to for-profit homes. Sub-contracting services also undermines continuity, quality, and team work.

3. The basis for a labour force development strategy

As the World Health Organization makes clear: "Before the COVID-19 pandemic, workforce shortages, poor pay and working conditions, and low proportions of professionally qualified staff were already a major concern in long-term care systems. The workforce supporting people with long-term care needs is predominantly female and in many countries migrant care workers make up a large proportion of the long-term care workforce."[13] Pre-pandemic, the Organization for Economic Co-operation and Development (OECD) and the International Labour Organization (ILO) also warned that there would be a crisis in recruitment and retention unless working conditions, values and training were improved.[14]

Many of the standards for long-term care homes outlined in this discussion paper depend on the the federal government introducing a national long-term care labour force strategy for Canada as a central plank of this standard setting process, and as a condition of federal funding, based on the following principles and an understanding that:

This is skilled labour. The skills required are both clinical and social, informed by an understanding of aging, culture, gender, and other intersections of identity. The skills require continual renewal to address new developments and populations. They also require learning to work collaboratively in, and through, teams.

The conditions of work are the conditions of care. Addressing the quality of care requires addressing the quality of the conditions under which care is provided. This includes ensuring, at a minimum, decent and equitable pay, benefits, sick leave, job security, breaks, the right to union protection, access to appropriate supplies (including PPE), safe physical and social environments, and appropriate staffing levels, beginning with clear minimum standards.

Care is a relationship. Especially in long-term care, it is important to create the conditions that support care relationships through continuity, full-time employment or permanent part-time employment, with benefits in a single workplace, time to meaningfully attend to the individual needs of care residents, and sufficient autonomy for staff to apply their knowledge.

All staff members are part of the care team. Appropriate care requires the inclusion of the entire range of staff who work in long-term care: all nursing and medical staff, personal support workers/care aides, dietary, food, housekeeping, and laundry staff, recreation and therapy staff, and security, maintenance and teaching staff.

Enforcement is essential. Standards for health, safety and care must be clear and enforced through unannounced inspections, assistance with compliance and significant penalties for non-compliance.

4. Accountability and transparency

The 2002 Royal Commission on the Future of Health Care in Canada (the Romanow report) recommended both sustainable federal funding and specific strategies for using the federal spending powers laid out in the constitution to set conditions for improving health services over time.[15] In 2004, the federal government signed a 10-year Accord with the provinces and territories that stabilized funding and the sustainability of our Medicare system by guaranteeing 6 per cent annual increases for 10 years. The Accord process did not, however, succeed in incentivizing the needed changes in the health system. The failure to secure system change was, in large part, because the recommendations for transparency and public accountability in the Romanow report were ignored. In negotiations with the provinces on the specific conditions to be included in the Accord, such as access to primary care 24/7 and access to home care after a hospital stay, there was no requirement for transparency and public reporting on how the money was spent and most provinces refused to voluntarily provide this information.[16] This not only limited the federal government's ability to hold the provinces accountable, it also made it impossible to learn how, and if, the Accord

funding contributed to service improvements and to decide what could be done more effectively in the future.

It is essential that we learn from this history of health care development in Canada if we are to successfully transform continuing care from a fragmented and underfunded patchwork of services into an effective, equitable system that supports the health and wellbeing of seniors and people with disabilities and recognizes the vital role of care staff. We all deserve and have a right to such care—regardless of where we live in Canada, and regardless of socio-economic circumstance such as age, race and gender or sexual identity.

Notes

1 *Royal Commission on Health Services: 1964, Volume I*, tabled in the House of Commons on June 19, 1964, and the *Royal Commission on Health Services: 1965, Volume II*, issued on December 7, 1964.

2 Commission on the Future of Health Care in Canada, 2002. *Building on Values: The Future of Health Care in Canada*, tabled in the House of Commons on November 28, 2020.

3 Romanow, page 63.

4 Royal Society of Canada, June 2020, page 13, https://rsc-src.ca/en/restoring-trust-covid-19-and-future-long-term-care.

5 Royal Society of Canada, June 2020, page 13.

6 Donald Berwick, April 5, 2016. Institute of Healthcare Improvement (IHI), *Era 3 for Medicine and Health Care,* Journal of the America Medical Association, pages 1329–1330; M. Dayan and N. Edwards, 2017, *Learning from Scotland's NHS,* London: Nuffield Trust, https://www.nuffieldtrust.org.uk/files/2017-07/learning-from-scotland-s-nhs-final.pdf.

7 Laura Kadowaki and Marcy Cohen, March 2017. *Raising the Profile of the Community Based Seniors Services Sector in BC***:** http://www.seniorsraisingtheprofile.ca/wp-content/uploads/2017/06/RPP-Literature-Review.pdf.

8 The World Health Organization, July 24, 2020, page 17.

9 See, for example, Peter Tanuseputro, et al., 2015. Hospitalization and mortality rates in long-term care facilities: Does for-profit status matter? *Journal of the American Medical Directors Association*, *16*(10): 874–883; Margaret J. McGregor et al., 2011. Complaints in for-profit, non-profit and public nursing homes in two Canadian provinces. *Open Medicine*, *5*(4), E183-E192. Devereaux, P.J. et al., "A Comparison of Mortality between Private For-Profit and Private Not-for-Profit Hemodialysis Centers: A Systematic Review and Meta Analysis." *Journal of the American Medical Association* 288.19, 2002: 2449–57.

10 CIHI, June 2020. *Pandemic Experience in the Long-Term Care Sector How Does Canada Compare With Other Countries?* https://www.cihi.ca/sites/default/files/document/covid-19-rapid-response-long-term-care-snapshot-en.pdf, p.4.

11 The Royal Commission into Aged Care Quality and Safety, October 31, 2019. *Aged Care in Australia: A Shocking Tale of Neglect.* https://agedcare.royalcommission.gov.au/news-and-media/royal-commission-aged-care-quality-and-safety-interim-report-released.

12 Research almost two decades ago set 4 hours per resident per day of worked nursing hours. More recent research indicates that minimum care hours should be even higher. See Harrington et al., 2016. "The Need for

Higher Minimum Staffing Standards in U.S. nursing Homes", *Health Services Insights,* 9: 13–19 doi:10.4137/HSi.S38994; Harrington, Charlene et al., 2020. *Appropriate Staffing Levels for US Nursing Homes,* Health Serv Insights; 13: 1178632920934785. Published online 2020 Jun 29. doi: 10.1177/1178632920934785.

13 World Health Organization, 2020. *Preventing and Managing COVID-19 Across Long-Term care Services*, p.12. file:///C:/Users/patarmst/Downloads/WHO-2019-nCoV-Policy_Brief-Long-term_Care-2020.1-eng.pdf.

14 OECD, 2020. *Who Cares? Attracting and Retaining Care Workers for the Elderly*. OECD Health Policy Studies, OECD Publishing, Paris. https://doi.org/10.1787/92c0ef68-en. OECD & ILO. 2019. *New Job Opportunities for an Aging Society.* https://www.oecd.org/g20/summits/osaka (accessed May 2020).

15 Roy Romanow, November 2002. *Building on Values: The Future of Health Care in Canada*, Final Report of the Commission on the Future of Health Care in Canada, pages 3–4 and 46–48.

16 Healthy Debate, April 25, 2011*, Federal health spending without accountability*. https://healthydebate.ca/2011/04/topic/cost-of-care/part-2-lessons-from-the-2004-health-accord-for-2014

CCPA
CANADIAN CENTRE
for POLICY ALTERNATIVES
CENTRE CANADIEN
de POLITIQUES ALTERNATIVES

www.policyalternatives.ca