Transforming Senior Care: Beyond Eliminating Profit

By Peter Clutterbuck **September 8, 2021**

The unprecedented tragedy of more than 14,000 deaths from Covid-19 in Long Term Care (LTC) facilities across Canada has generated calls for "reform" of the LTC system with better quality care and protection, stronger accountability, and "bed expansion" to meet growing demand.

The most significant proposed structural change is to remove or reduce profit-making care from the delivery system. For the most part, the fundamental flaw of the large congregative service model is given scant attention even among progressive voices.

If there were ever a time to adopt a truly transformative strategy for a pressing human need such as the housing and care of our aging population surely this is it, as thousands of families have suffered the havoc wreaked on the lives of their beloved elders in the facility-based LTC system. Yet, discussions of reform continue to centre on approaches such as establishing national standards of care, which accept the seriously flawed large institutional model as the foundation of the LTC system.

Fixation on Expansion of Beds

The report of the Ontario Long Term Care COVID-19 Commission documents well the devastation of the pandemic among LTC residents in Ontario. More than 60% of Covid deaths in Ontario in 2020 were LTC residents, totaling 4,000 by the spring of 2021. The Commission proposes major changes in how LTC facilities operate and are held accountable.

Its main concern, however, is the failure to plan on the supply side over the last 20 years for adequate "bed expansion", noting the population 75 and older increased by 20% between 2011 and 2018 while only 611 beds were added to a system that requires 55,000 more beds by 2033 to meet the current 38,000 waitlist and its anticipated growth.

Even looking 20 years into the future, The Commission remains fixated on expanding a failing system:

> *If Ontario **continues to care for its seniors as it does currently**, by some credible estimates the province will require an additional 96,000 to 115,000 long-term care beds by 2041 to accommodate the increased demand. While other solutions need to be explored, including better home care support, **it is clear that more and newer beds will need to be built.*** (p. 12)

Rather than challenging how senior care is "currently" delivered, the Commission accepts the facility-based model as the basis for meeting future demand, while essentially dismissing "other solutions" and "better home care support" for exploration only. Elsewhere in its report, The Commission gives only passing reference to existing community care and support models in other jurisdictions that successfully demonstrate proven alternatives.

Focus on Removing For-Profit Care

Recognizing the public attention drawn to the higher death and infection toll in profit-making facilities, the Commission's most serious proposal for systems change is to remove commercial providers from most operational LTC management ("mission-driven" operators the exception, however that is determined), while still drawing on private capital, of course, for facility expansion.

Many progressive voices on the issue have also focused primarily on the for-profit delivery issue. The recent report of the Canadian Centre for Policy Alternatives (CCPA), *Investing in care not profit*, exposes the exceedingly poor pandemic outcomes in commercial providers compared to non-profit and municipal LTC facility operators. The report is properly critical of the Ontario Commission for its proposed retention of private capital in the LTC system.

The CCPA's recommendations, however, focus on limiting bed expansion to non-profit and municipal providers, an independent agency to oversee and expedite new facility development, and increased federal funding for LTC as a critical health service. The limitations and failings of congregative care models are not seriously addressed.

The Different Path Not Taken

Probably the saddest thing about the state we are in is that thirty years ago we had the opportunity to take an entirely different path in Ontario. In the early months of the pandemic, Dr. Ernie Lightman, professor emeritus of social policy at the University of Toronto, wrote a reflection on his appointment by the Ontario Government in 1991-92 to do a systematic inquiry into elder care settings. Dr. Lightman recalls:

> *I recoiled in horror at what I saw in the nursing home system and explicitly recommended that this approach should not be expanded more widely. Though outside my precise mandate, I nevertheless advocated that the nursing home sector itself should be reduced over time, with more emphasis placed on community-based services that would allow people to stay in their homes for longer periods of time, with adequate support from the state.*

Acknowledging growing service demands in the new millennium from aging demographics and longer life spans for the most fragile and vulnerable, Dr. Lightman continues:

> *Offsetting this, however, has been the development of new technologies that enable people to live outside institutions. It was not so long ago that people in need of oxygen had to reside in institutions to be hooked up to machines to help them breathe; today, by contrast, we see people walking along the street pulling a small mobile oxygen system, much like they'd pull a shopping*

cart. Human services such as nursing can be delivered anywhere in the community, and need not be within institutions.

Dr. Lightman concludes that much stronger oversight of LTC facilities is needed but:

First, we must dramatically turn our focus to the community, supporting agencies that can deliver services to people in their homes, keeping them out of long-term care beds in the first place.

Knowledge and Experience with Other Solutions

The bottom line. The warehousing of our elders in larger institutions is a policy of last resort and indicative of a systems failure. Recalling the Ontario Commission's acknowledgment that "other solutions" and "better home care support" should be explored, it is remarkable how little recognition is given in the policy and professional community to what we already know about what is possible in community-based care as the compelling alternative to the institutional model.

- Seniors for Social Action in Ontario (SSAO) is probably the strongest voice for transformative change away from congregative care models to home- and community-based support. Linda Till, SSAO policy advisor, makes the case in policy and on-the-ground practice across multiple jurisdictions for community over institutional care.
- A recent article in the *Ontario Medical Review* describes the Geriatric Assessment and Integration Network (GAIN), a rural in-home care model in Central East Ontario made up of 12 hospitals contributing to mobile inter-professional teams supporting 6,000 medically fragile seniors in their own homes with 25,000 unique visits. Dr. Jennifer Ingram, a leader in GAIN, asserts, "*It is time to divorce long-term care from the buildings and focus on the care*."
- Denmark with an older population than Ontario's has an institutionalization rate of 1.2% compared to Ontario's 3.2% rising to 4.3% with the additional proposed 30,000 bed expansion. Since the 1980s Danish law has focused on preventing institutionalization by supporting seniors in their communities in their own homes, with their families, or in small-scale community based settings. SSAO reports that "*This resulted in Denmark having fewer older adults living in long term care institutions than any other European country, and no new long term care facilities having been constructed since 1987*."
- In a recent article in *Next City*, Priti Salian suggests that Arnberg in central Germany is the world's most age-friendly city, noting that more than 200 projects co-designed with seniors, including those with dementia, not only provide essential care to seniors but also support their active engagement in community life.

This is just a sampling of what we know about community care models. What more is needed to think transformatively about to our current system of care for Ontario's seniors and vulnerable populations?

Critical Components of a Transformational Approach to Senior Care

Although seniors in their sixties and seventies are healthier than generations past, Linda Till cites 2011 Statistics Canada data that almost one-third of Canadians 85 years and older (31.1%) were living in special care facilities. One of the most illuminating statements released in the Ontario Long-term Care Commission Report reads:

The average age of long-term care residents . . . is 84. The Commission heard that residents typically enter a long-term care home in the last two years of their life, and that approximately 22,000 long-term care residents die every year. (p. 41)

Since a recent survey found that nine out of ten Canadian respondents prefer to live in their homes as long as possible, one wonders why society cannot manage its resources so that wish could happen for all to the end of life. When we know so much about home and community-based alternatives that work, why concede that the

last years of life should unfold for so many in an environment as foreign to home, family and community as imaginable? Not only the quality of life but perhaps even the years of life may increase when people can remain in their local communities with the necessary levels of support.

Home, family, neighbours, and community constitute so much of our identity as we journey through life. Social Commons thinking holds that when individuals require support, society and community provide the means necessary for their dignity, stability and security. There should be no age limit or special condition that dismisses individuals from home and community life when they can no longer function on their own. This is becoming increasingly recognized as not just a preferred option but as a matter of human rights as HelpAge International asserts:

> *Age is a social construct as much as it is a numerical category. Stereotypes and negative attitudes can manifest themselves through exclusion, marginalisation, isolation, and abuse in many forms. Structural barriers and legal barriers to older people's enjoyment of equal rights are reinforced by these patterns. The discrimination and mistreatment older people face is something that affects every aspect of their lives and requires greater clarification in international human rights standards.* (p. 8)

Ploughing capital into large, special facilities to house people with complex needs of whatever age is a bad investment with life-limiting and even detrimental outcomes for residents as the pandemic has shown. Upgrading or building new congregative facilities with more "beds", however, is the easy solution and frequently the only option for families with aging parents. This contains the issue, until, of course, a pandemic exposes its failings and infection and death counts arouse public outrage.

The alternative is challenging to implement but doable and requires that we redirect our investment of both financial and social capital by:

- Supporting individuals in the identification of their own needs and how they may be met within their community of choice;
- Engaging families and friends where possible in this individualized planning and implementation process;
- Arranging the appropriate array of service supports, including highly specialized modes, for delivery in home and/or community; and
- Creating and implementing individualized plans that extend beyond care and maintenance to include personal fulfillment and community engagement where desired.

The main ingredients of this approach are people - family, friends, service personnel – and access to highly individualized financial resources to meet the cost of daily living as well as the extraordinary costs of living that people with complex needs require. Stable home bases are critically important, and they can be in a family home, independent living, or at a very small scale community residence. The "residence", however, should not be the life-defining aspect of the individual's experience regardless of age, health status, or physical or mental limitations. This fundamental understanding of genuine community living has shifted resources in the last fifty years or so from institutional to community support models for persons with physical, developmental and mental health challenges. Our approach to the care and support of our elders lags far behind and, in fact, is tracking in the other direction.

Conclusion

There is no question that profit must be removed from the future of long-term care for our senior population. But, a truly transformative strategy would also plan for an aging demographic differently than just expanding and reinforcing the current institutional infrastructure. True, it may not be possible to reverse course for most of the 78,000 residents now residing in long-term care facilities. But, it requires

political courage to invest in an alternative approach to the waiting list and to plan for the development of a community-based system that aims to eliminate admissions to LTC facilities over a five to fifteen year period.

This model of care and support has worked for seniors in other nations and, at home, for those persons with physical and developmental challenges. Political will, progressive policy frameworks, and public investment in partnership with community could make it universal to all vulnerable people now in long-term care facilities and at risk of placement in same.

This article is adapted and expanded from this author's contribution to the e-booklet titled Essays in Aging in Place *soon to be released by Seniors for Social Action in Ontario. The author drew on the extensive research and resources collected at the SSAO web site for this article.*