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## COVID-19 Crisis Public Health and Emergency Measures Working Group

### Communique #4: A Tale of Two Epidemics: Why Seniors' Care in Canada was So Hard Hit

The C.D. Howe Institute has initiated a special project to provide rapid expert insights to help Canadians and Canadian policymakers navigate the COVID-19 crisis. The Working Group on Public Health and Emergency Measures is Co-Chaired by Janet Davidson, Chair of the Board of the Canadian Institute for Health Information and former Deputy Minister of Health (AB) and Tom Closson, Co-Chair of the C.D. Howe Institute Health Policy Council. The membership of the group includes health academics, professionals and business leaders. Meeting weekly, this group discusses policy ideas for addressing various aspects of the COVID-19 crisis, and publicly communicates the results of its discussions via Communiqués.

The most recent meetings of the Public Health and Emergency Measures Working Group have focussed on healthcare for the elderly population in the context of COVID-19. In particular, the group discussed high mortality rates in institutional care settings and some of the underlying causes. Provinces have implemented different policies related to long-term care and retirement homes which has resulted in some faring much better than others. In general, however, Canada has not done well at protecting the elderly population living in an institutional care setting from COVID-19 infection and mortality compared to many other countries.

### Canada: A Tale of Two Epidemics

Working group members noted that, overall, Canada has been successful in flattening the curve with physical distancing and other public-health measures. Quick action, relatively consistent messaging from politicians reaffirming evidence-based recommendations from subject-matter experts and scientists, and generally broad public cooperation with restrictions have resulted in many regions of Canada achieving better outcomes than the US, Italy, the UK. As a result, COVID-related mortality in the community has been limited to about 1,000 deaths (of which about 600 were senior citizens). By contrast, in the institutional settings of long-term care and retirement homes, there have been about 5,000 deaths.



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Members observed that long-term care and retirement homes are [the center of the epidemic in Canada](#). About 80 percent of deaths have occurred in residential care facilities; a poorer outcome than most other nations. Residential care facility outbreaks of COVID-19 have been centered in five provinces: Nova Scotia, where [one home experienced a particularly severe outbreak](#), and the four most populous provinces (BC, AB, ON, QC). The outcomes are particularly bad in Quebec, where [60 percent of Canada's COVID-19 deaths have occurred](#). Ontario continues to struggle to manage institutional outbreaks as well; more than 25 percent of facilities are experiencing or have experienced an outbreak. British Columbia, the first province to experience a COVID-19 outbreak in a residential care facility, has since controlled outbreaks sufficiently enough [for possible reopening to visitors beginning in June](#).<sup>1</sup> Abroad, Hong Kong is an example of successful containment and prevention, noted some members. Hong Kong has achieved zero deaths in care homes by [employing rapid and rigid isolation protocols](#). In addition, every care home has trained infection control staff that regularly conduct simulation drills of an infectious outbreak. This practice is common in Canadian hospitals, but not in residential care facilities.

Residential care facilities are not included in the *Canada Health Act* and systems, subsidies and policies vary significantly across the country, as do the structures governing funding, ownership, and staffing. Members noted that regional variation results in the quality of care, price of accommodation and access to facilities also varying. There are also significant variations in testing and tracing strategies across provinces. Initial access to testing for staff and residents was deployed under different accessibility criteria and varying comprehensiveness, thereby affecting the speed at which new outbreaks in residential care facilities could be identified and contained.

## Funding and Wages

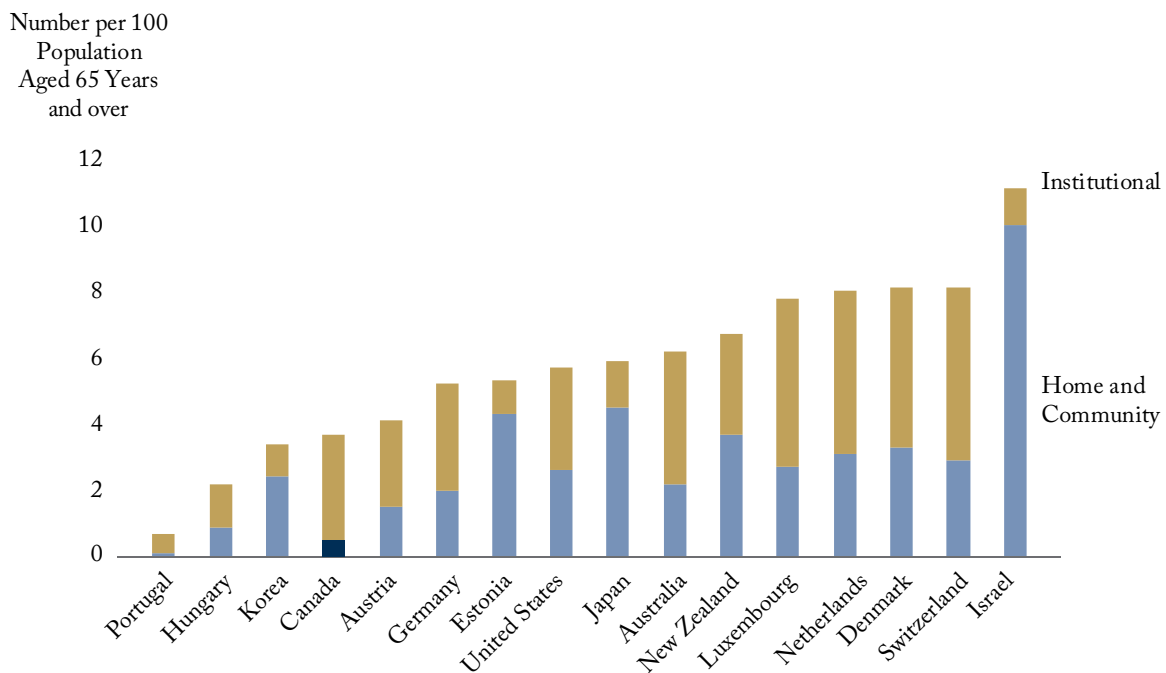
The working group discussed the issue of funding and wages, noting that all provinces fund long-term care residences (nursing homes) at a lower rate per diem than they fund hospitals to provide care to a person with similar needs who is awaiting transfer to a long-term care residence. Differences in funding between hospitals and long-term care residences for serving post-acute patients are due to differences in hours of care provided per diem, staffing mix and wage and benefit levels for each staff type (RNs,

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1 To prevent and address outbreaks in residential care facilities, every day matters. British Columbia has achieved better containment in community COVID-19 spread and generally has better outcomes than other provinces. The more positive results from residential care homes should be considered within the context of better outcomes throughout the population.

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Figure 1: Nurses and Personal Care Workers by Setting



Source: OECD Long-Term Care Utilization and Resources, 2016 or most recent available year.

RPNs and personal support workers and other staff). Members believed this makes staff recruitment and retention a challenge for long-term care residences. For example, [in a 2018 survey of Ontario's long-term care homes](#), 80 percent of respondents said they had difficulty filling shifts, and 90 percent experienced challenges recruiting staff. In addition, long-term care residences often use more part-time labour to reduce costs. Significant reliance on part-time workers, however, means that many work at multiple facilities and do not have sick leave or other health benefits.

Group members suggested that an appropriate comparison of staffing levels and wages would be international examples. Among OECD countries for which recent data are available, Canada has fewer nurses and personal support workers per senior citizen than most (Figure 1). In addition, the proportion of workers in the institutional setting, as opposed to the community or home-care settings,

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is much higher in Canada than most other countries. This suggests, members noted, that there is a relative shortage of personal support workers and nursing staff providing care to Canadian seniors, particularly in the community and home-care setting.

The current system creates a perfect petri dish to spread uncontrolled infection, in the view of some members. The working group noted the system depends on relatively low-paid workers, many without sick leave benefits, possibly with limited access to personal protective equipment, working in multiple facilities with immunocompromised and vulnerable populations. Group members also noted that limited job security, retirement benefits and other factors contribute to the generally lower quality of employment in the residential care sector, relative to hospitals. Rather than blame long-term care residence operators, group members noted that contract rates paid to these providers by government have not kept pace with increases in case complexity and inflation. Group members pointed out that long-term care operators have been unable to increase staffing levels and augment staff mix sufficiently given the limited funding increases they have received. Addressing the needs of the residents of long-term care facilities needs to be done as a partnership between operators and government. Some group members argued, however, that there is little incentive for for-profit providers to pass funding increases on to staff through wage increases or to invest in facility improvements to improve quality of life and care for residents when they are successful in keeping beds occupied without such changes. Neither the government nor the operators are entirely faultless for the current situation in these residential care facilities. Both government and operators have a significant role to play in addressing the problems that resulted in the spread of infection in some residential care facilities, in the view of working group members.

They observed that staff working at multiple facilities are more likely to be exposed to and to expose others to infection simply due to a higher volume of close contacts with both residents and other staff. There is a need to limit foot traffic in residential care facilities and especially limit staff contact between facilities. A critical step is to provide low-wage and part-time workers, currently without sick-leave benefits, the support they need to be able to take time off work if they have been exposed. British Columbia has done just that, said members.

The British Columbia government took over as the employer of [all long-term care staff for six months as of April 1, 2020 to ensure that they are made full-time employees and are paid at standardized rates which are the same as the health authority rates.](#) This move, costing the province about \$10 million per month, has many benefits in the context of controlling the spread of COVID-19, noted some members. In particular, it helps maintain a stable workforce and it streamlines communication of infection control procedures and education among staff. Since all staff are public employees, the government can directly communicate new or changed infection control guidelines and other procedures with all of them at the

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same time. One aspect of the policy that remains unclear is how the new wage arrangements affect sick leave and other benefits for newly publicized residential care staff. Increases in the wage rate encourage staff to continue to work. Access to paid sick leave would encourage them not to work following possible exposure or infection.

Other provinces have also increased wages but many have yet to make sick pay available for workers who are part-time or have multiple employers. The federal government [reached a cost-sharing arrangement with most provinces for temporary increases in wages for front-line workers](#) in early May. Quebec increased hourly wages for workers in private long-term care homes by \$4 and offered a \$24.28-per-hour salary to attract new workers to fill in as attendants at the facilities. [Ontario](#), British Columbia and Saskatchewan have since followed suit with similar programs.

Unfortunately, the extent of residential care outbreaks in Ontario and Quebec have exceeded the level where providing benefits and additional pay is sufficient to address the ongoing staffing crisis situation, in the view of members. In Quebec, for example, [9,500 health workers were absent from work in late April](#) (about 4,000 were diagnosed with COVID). Since many workers and facilities have been exposed, and many staff are off sick, hospitals and the military have been compelled to make up the shortfall. However, the extent of the outbreaks has many hospital staff not wanting to work on COVID floors or go to residential care homes. Health workers are losing faith in the system and its capacity to protect them, noted some members. There is a need to rebuild the trust and capacity.

Overall, underfunding of residential care facilities and the sector's resultant reliance on part-time and low-wage staff has been an ongoing problem across the country for many years, in the view of the working group. These pressures existed in British Columbia as well; however early action by public health authorities and better outcomes with regard to community spread and containment contributed to less severe or widespread outbreaks in residential care facilities compared to other provinces. Challenges in seniors' care existed before COVID-19, but the crisis is highlighting the ongoing issues related to care for elderly people.

## **Private Ownership: Not as Simple As It Seems**

Early analysis has shown that the severity and mortality of COVID-19 outbreaks are higher at privately run, for-profit facilities than in non-profit or publicly operated facilities. In Ontario, [for-profit nursing homes have four times as many deaths as municipally run homes](#). In British Columbia, about 2.7 percent of publicly managed homes experienced an outbreak, compared to about 12 percent of contracted (privately run) facilities and about 6 times as many patients were infected in privately run

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facilities. Worse outcomes at privately operated facilities are not particularly surprising, as pre-crisis research across many countries and populations consistently finds that private, for-profit providers generally perform worse than not-for-profit providers. Privately operated facilities receive the same funding envelope as non-profits and are required to provide a similar level of care, said working group members, meaning that they are subject to all the same pressures as non-profit facilities plus the additional pressure of generating profit.

The situation is more complicated than simply concluding public administration equals better outcomes, however, and there is a need to understand the underlying reasons for worse outcomes at privately run facilities in relation to COVID-19. The working group agreed there is a need to research the differences in privately run (for-profit and non-profit) and publicly funded, privately run and privately funded, and publicly run and publicly funded residential care facilities. Factors that could have significant effects on the severity of outbreaks include:

- Staffing levels, their disciplines and working conditions: patterns in ratios of professionals, the effects of particular employment arrangements, and appropriate staffing levels (staff: patients).
- Size and configuration of rooms and facility layout: the majority of rooms in BC are single occupancy, but publicly operated homes have a higher proportion of shared occupancy. Single occupancy is likely to reduce the spread of infection, but privately operated homes have had more frequent and severe outbreaks. The reasons for these differences and the effects of the physical layout of facilities needs to be better understood.
- Patient complexity: residents of long-term care facilities, by definition, have pre-existing health conditions that require significant personal care. Facilities with particularly complex resident populations have more difficulty controlling an outbreak and are also more likely to have high mortality in the event of an outbreak, due to the vulnerability of their resident population. The relationship between outbreak severity and the case mix index of facilities is not well understood in the context of infectious disease.

While privately managed long-term care and retirement facilities have had more outbreaks and higher mortality when outbreaks occur, it is likely that a better understanding of some of the underlying patterns would explain a significant portion of the worse results, members cautioned. There are significant challenges in the effective management of residential care facilities regardless of the type of ownership. Better understanding of which factors play the most important role in reducing the spread of infection would inform policies to improve outcomes at all facilities. Addressing the issues that resulted in 4 out of 5 COVID-19 deaths occurring in residential care facilities is not as simple as shifting ownership or management. It will require significant change to the funding and management structures currently in place to determine: appropriate funding levels; best practices for delivery of care to minimize the potential for infectious disease outbreaks; and ways of addressing perverse incentives to improve health outcomes for Canadian seniors in residential care.



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## Where to Care: Keeping People in the Community

The elderly population receiving care in the community is at a much lower risk of infection than those in residential care facilities. However, they are also generally less medically complex cases than long-term care residents. That said, the severity of outbreaks at residential care facilities varies across provinces, as does the proportion of seniors living in residential care facilities. Each province has different policies and funding mechanisms that create varying incentives and affect where seniors receive care and how much it costs.

An important factor affecting the severity of COVID-19 in the senior population is simply the proportion of elderly people living in residential care facilities and the proportion living in the community, in the view of working group members.

In Canada, about 12.7 percent of the population over 65 years of age receives ongoing care and more than two-thirds is delivered at home or in the community – similar to many peer countries.<sup>2</sup> Those over 80 years of age, however, are more likely to be receiving care in an institutional setting, like a nursing home or hospital than at home, relative to other countries. About 42 percent of those requiring ongoing care and over 80 years of age in Canada reside in a care facility, compared to about 30 percent in Switzerland, the US, New Zealand, Norway, Germany and Denmark, for example. The differences in the proportion of the institutionalized elderly population across countries and the relatively high utilization of long-term care relative to home and community care in Canada suggest that some of the people residing in institutional care facilities could receive effective care in a non-institutional setting, observed members.

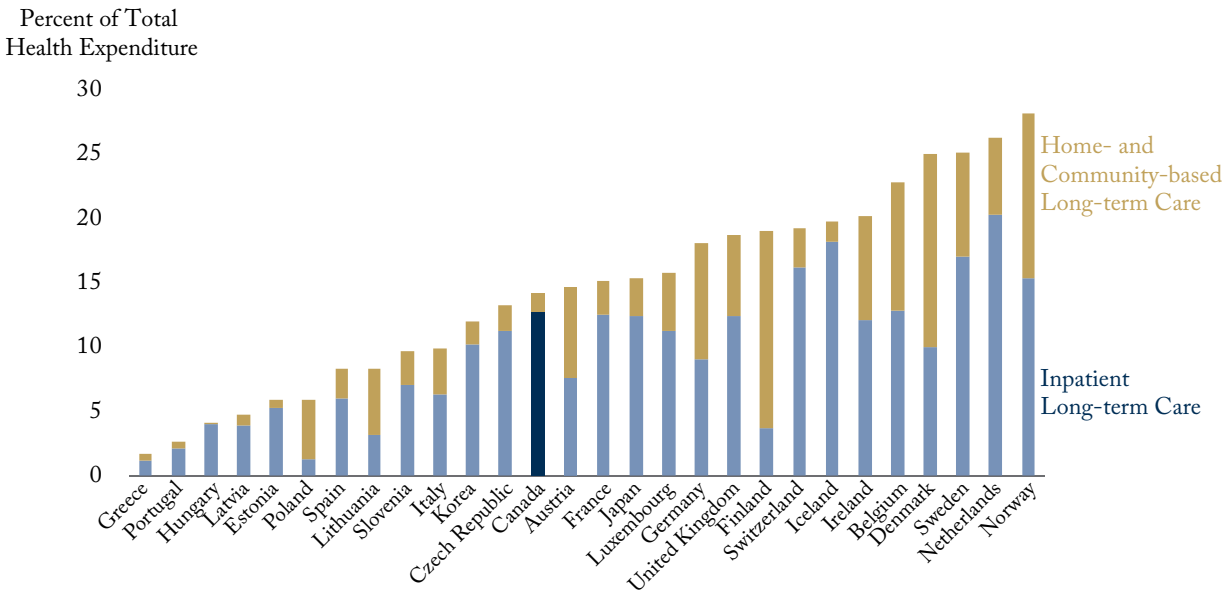
Significant changes to the location of care delivery for the elderly population are not likely to occur during the current crisis situation in residential care facilities. Canada has not performed well relative to other countries, however, in protecting the senior population from COVID-19 exposure and high mortality rates. The results might have been more favourable if a lower proportion of seniors were living in residential care facilities prior to the crisis.

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2 OECD Long-Term Care Utilization Database, 2017 or most recent available year.

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Figure 2: Long Term Care Funding by Country (2017)



Source: OECD Health Expenditure Database.

About 90 percent of funding for seniors' care in Canada is directed to institutional care with only 10 percent directed to home- and community-based long-term care (Figure 2).<sup>3</sup> Canada falls well below the OECD average of 35 percent of long-term care expenditures being directed to home and community care. Generally, the countries that have a higher proportion of seniors receiving care at home are also the ones that direct a higher proportion of long-term care expenditure to such care and also spend a larger proportion of all health expenditures on seniors' care.

To understand the current crisis scenario presented by severe outbreaks in residential care facilities across the country, and why many other countries have so far have fared better than Canada in

<sup>3</sup> Among OECD countries (for which data are available) only Hungary, Estonia and Iceland direct a larger proportion of long term care expenditures to inpatient settings than Canada.



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protecting their senior populations, it is important to understand the differences in setting and funding pre-crisis, in the view of the working group. Canada invested in residential long-term care at similar levels to other countries. But, comparatively under-invests in elderly care overall and particularly in home- and community-based care. To address the ongoing challenges in Canada's residential care sector and prevent such disastrous outcomes from infectious disease outbreaks in the future, significant investment will be needed.

Across provinces, the investment in institutional or community-based care significantly varies; as does the proportion of the senior population residing in institutional settings. Overall, Canada underinvests in seniors care relative to other countries, meaning that all provinces likely have significant room for improvement. But some are much closer to the international average than others. In particular, Ontario is the only province to invest more in home and community care than residential care: there are about 90,000 people eligible for nursing home care but are still at home (up from about 40,000 ten years ago). Those 90,000 people are less likely to be exposed to COVID-19 simply because they don't live in an institutional setting, said members. They are also less physically restricted, as they aren't subject to entry and exit restrictions that have been necessary to prevent and control facility outbreaks. Quebec, by comparison, has the largest proportion of its senior population living in a residential care facility.

Members believed each province should revisit their seniors' healthcare policies and evaluate how incentives affect where people receive care, as well as the role clinical thresholds can play in admission to institutional care settings. Those requiring 24-hour, intensive-care services undoubtedly need to be accommodated in long-term care facilities but many others are best and more happily accommodated at home and in their own communities with home care and other appropriate service supports. The former are also at a higher risk of exposure to infectious disease than they would be if living elsewhere. Addressing underinvestment in home and community care along with reforming subsidy and funding mechanisms to improve the allocation of health services would likely prevent future waves of COVID-19 or other infectious diseases from having such negative consequences for Canada's senior population.

## **Policy Discussion**

Overall, Canada has been successful in flattening the curve with physical distancing and other public health measures, in the view of the working group. In the institutional settings of long-term care and retirement homes, however, there have been about 5,000 deaths. About 80 percent of deaths have occurred in residential care facilities; a poorer outcome than most other nations. Residential long-term care is [the center of the epidemic in Canada](#).

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Since each province is at different stages of infection control and the loosening of restrictions, there is not a “one size fits all” solution to dealing with COVID-19 outbreaks in residential care facilities. There are, however, common challenges in providing residential care across the country that should be addressed over the long term: the dependence on part-time workers, lower wage rates, and other factors.

Some provinces, Ontario and Quebec in particular, are still struggling to control active outbreaks at residential care facilities. They are implementing emergency policies to address the spread of infection and the shortage of staff resulting from work/location restrictions and exposure/infection of residential care staff. Hospitals and local health authorities are being compelled to help address outbreaks in residential care facilities in their regions. A lack of agreement persists, however, about joint management between long-term care facilities and hospitals. For the duration of the epidemic, joint management protocols should be formalized. Given differential funding arrangements, staff compensation rates, protocols regarding use of PPE and many other details, between hospitals and individual residential care facilities, the lack of a formalized arrangement can delay effective action as details are negotiated and sorted out.

British Columbia provides an example of quick action and a combination of measures that has resulted in better outcomes than other provinces, in the view of working group members. One of the major factors in the success of BC in containing residential care facility outbreaks was making all staff of such facilities public employees. Providing full time jobs, sick leave benefits and comparative pay rates prevents sick workers from choosing between income and protecting residents. In addition, it streamlines communication of public health information and procedures.

Once the initial crisis has passed, all provincial governments must work to address the ongoing challenges in the residential care sector. Consistent under-investment in home and community care has resulted in a higher proportion of Canadians living in an institutional care setting than in many other nations. Seniors living in the community are at much lower risk of exposure, infection and death from COVID-19 than those in institutional settings. Provinces should increase investment in home and community care and develop policies that increase the freedom of choice for senior Canadians with respect to where and how they receive care services. Incentives should be designed to encourage those who can receive appropriate care in a non-institutional setting to do so. France, Germany and Australia, for example, have implemented self-directed models of care delivery that support greater independence among the elderly while improving patient satisfaction ([Blomqvist and Busby 2014](#)).

The working group concluded there are many challenges to providing high quality and accessible elderly care services. From effective primary care and access to expertise in managing chronic

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conditions, to adult day programs and recreational physical activities to maintain health, caring for an elderly individual takes a team. While not directly related to the current crisis in residential care facilities, addressing underlying challenges and improving coordination of health and other care services would reduce the baseline risk to the senior population in the event of a COVID-19 second wave or a different infectious disease in the future.

## Members of the Public Health and Emergency Measures Working Group

**Dr. R. Sacha Bahtia**, Director of Institute for Health Systems Solutions and Virtual Care, Women's College Hospital.

**Åke Blomqvist**, Health Fellow-in-residence, C.D. Howe Institute; Adjunct Research Professor, Carleton University.

**Tom Closson (Co-Chair)**, Health Policy Council, C.D. Howe Institute.

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**Perry Kendall**, Co-Interim Executive Director at the BC Centre on Substance Use; BC Provincial Health Officer (former).

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**Duncan Sinclair**, Emeritus Professor, Queens University.

**Colleen Flood**, Professor & Director, uOttawa Centre for Health Law, Policy & Ethics University Research Chair in Health Law & Policy.

**Catharine Whiteside**, Executive Director, SPOR Network in Diabetes, Emerita Professor and Former Dean of Medicine, University of Toronto.

**Rosalie Wyonch**, Policy Analyst and Research Lead, Health Policy Council, C.D. Howe Institute.

## Special Guests

**Dr. Samir Sinha**, Director of Geriatrics, Sinai Health System and the University Health Network; Associate Professor of Medicine, Health Policy, Management and Evaluation, University of Toronto and Assistant Professor of Medicine Johns Hopkins University School of Medicine.

**Isobel Mackenzie**, Seniors' Advocate, British Columbia.

**Vivek Goel**, Vice-President, Research and Innovation, and Strategic Initiatives at the University of Toronto and a Professor in the Institute of Health Policy, Management and Evaluation at the Dalla Lana School of Public Health.

**Christian Ouellette**, Head of Government Relations and Public Affairs, Novartis Canada.