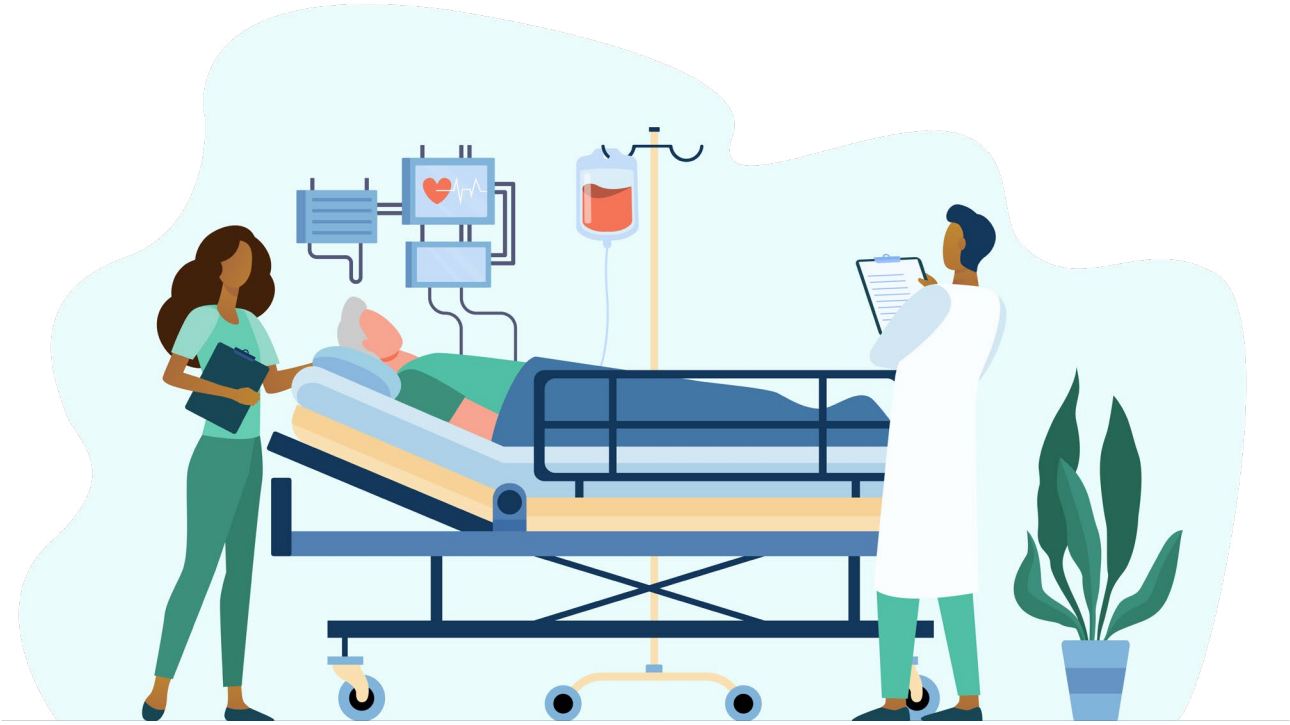
This issue snapshot is excerpted from Unmasking the Future (2021), a scan of major current socio-economic trends and developments, at local, provincial, national and international scales, authored by James Stauch of the Institute for Community Prosperity, commissioned by the Calgary Foundation.



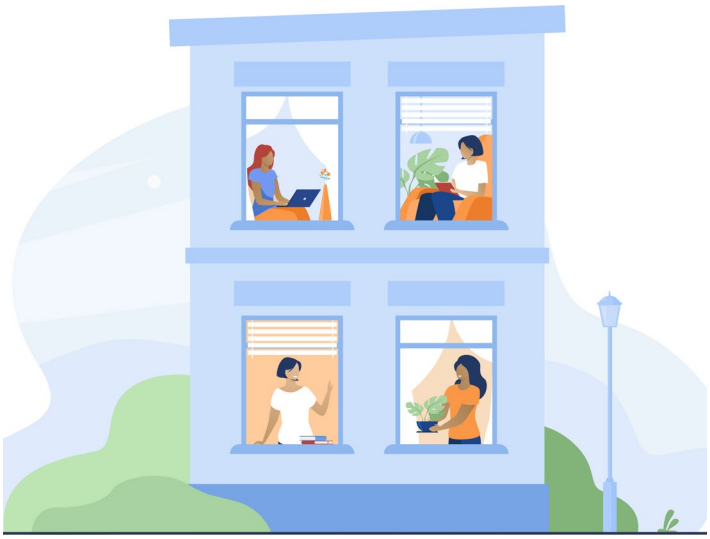
OLD CANADA:

Do We Stand on Guard for Thee?

COVID-19 has revealed much about our attitudes toward, and public policy choices regarding, the eldest members of our community. It was clear early on, that the pandemic was ravaging the elderly: For those who contract the virus, mortality rates are 1.3% at age 65, 4.2% at age 75, and 14% at age 85.[205] Even at age 55, one's changes of dying from the coronavirus are 50 times greater than dying in a car accident. Even more important than chronological age is having multiple chronic diseases and/or general frailty.

The residential context in which elder members of the community are living is also an important factor. Among the heightened risk factors, according to a study just published in *The Lancet* looking a country-wide data in Sweden, "living in a care home was associated with an increased risk of COVID-19 mortality compared with living in independent housing." Living in close proximity to younger relatives, or in high density situations, was also associated with higher mortality.

Arguably more than any other social issue, the pandemic has shined a light on the state of long-term care in Canada. What it has revealed is not pretty: Over 80% of all COVID deaths in Canada have been in long-term care facilities, the highest rate of any country in the OECD.[206] As health writer Andre Picard notes, "those living in these group settings were 77 times more likely to die than their counterparts still living in homes and apartments."[207] Starting in late March, news stories abounded at the numbers of dead emerging in single facilities where outbreaks had occurred: The Langley outbreak in Vancouver (24 lives lost) and The Pinecrest outbreak in Bobcaygeon (29 deaths) were the first to shock Canadians. But they were surpassed by so many others in the ensuing weeks and months. Among them, Northwood in Halifax (41 of Nova Scotia's 47 deaths); Sainte-Dorothée in Laval (95 deaths); Notre-Dame-de-la Merci in Montreal (93 deaths); Altamont in Toronto (59 deaths), and Orchard Villa Pickering (78).[208] While Alberta has not had mortality counts this high in individual facilities, it has spread through a greater number of facilities, with over one hundred continuing care facilities experiencing active outbreaks in December



"This is a strategy that may protect business but the cost of doing business is a bunch of dead seniors. If that's a formula that works for people in Alberta, well, then there you go. But… these are human beings that basically need our support and protection."

Dr. Samir Sinha, Director of Geriatrics at the Sinai Health System[225]

"Unfortunately, I don't think it's explicit; it's implicit systemic ageism. I find that to be very unfortunate… We know who the most vulnerable in our society are, based on the learning from the first wave of the pandemic and I think we could've done more to prevent the vulnerability of those in continuing care centers."

Mike Conroy, CEO, Brenda Strafford Foundation[226]

alone. Alberta also has the highest percentage of seniors living in long-term care of any province other than Quebec.[209] Among the many shocking revelations that have accompanied this crisis is a failure of governments to track (or make public) COVID-19 cases in care facilities: What we know of the numbers is largely the work of activists, researchers, clinical workers and other citizens connected to the system.[210]

The impact of COVID-19's spread through seniors' residences in Canada has been nothing short of horrific, and has revealed what Picard describes as "shocking systemic neglect towards our elders."[211] When the military were called in to provide emergency care in Ontario and Quebec, they reported on appalling conditions – overmedication, abuse, unattended hygiene, undernourishment – and yet these have been reported on in previous investigations going back many years.[212] The ripple effects on the 425,000 Canadians living in continuing care are vast (loneliness and isolation at the top of the list), not to mention their families or the backlog of seniors waiting to get into these residences. Wait times for admission to Alberta's 355 long-term care and supportive living facilities now stands at 79 days, up 61% from 2019.[213]

So why is this almost uniquely Canadian epidemic-within-a-pandemic happening? And what are the prospects for change? Certainly, there have been differences in preparedness, with well-staffed facilities with plenty of personal protective equipment (PPE), able to nimbly implement protocols and isolation measures to avoid serious outbreaks.[214] PPE was also prioritized for hospitals, often at the expense of care facilities.[215] But there are financial and public policy factors at play too: While $1 billion in emergency funding pledged from the federal government will help in the short term, Canada spends less than 30% than OECD average for long-term care, resulting in little capacity or resilience in the system for responding effectively to outbreaks.

The system is a mix of private for-profit, nonprofit and public providers, a patchwork of provincial regulatory regimes, with lax oversight and spotty inspection, and chronic issues with overcrowded residents, understaffed facilities, and over-worked, poorly-paid employees.[216] While more research needs to be done on private vs. public vs. nonprofit facilities, there is an emerging pattern of the public sector stepping in to support the safe operation of private facilities. Some private facilities in Ontario lost up to 80% of their staff, relying on emergency redeployment from the military and the public health care system.

A deeper analysis reveals that implicit ageism may well play a part, all the more so with respect to seniors experiencing dementia.[217] On the face of it, our collective choices to permit community circulation as a consequence of keeping the economy running, means that we've tacitly made the choice to jeopardize seniors' health, as community circulation inevitably spreads into care settings. A meta-analysis of ageing and cultural factors, conducted by researchers at Princeton and NYU, revealed that ageism globally is less a function of Eastern vs. Western cultures, but rather is associated more with highly industrialized societies.[218] However, a 2018 paper in the Journal *Nature* reporting on a multi-year experiment conducted by MIT's Media Lab involving millions of participants from 233 countries making ethical judgements for autonomous vehicles in fictionalized crash scenarios, revealed that participants in collectivist cultures, "which emphasize the respect that is due to older members of the community" – Taiwan, Japan, China and South Korea in particular - were less likely to make decisions that would harm elders.[219] Participants from Canada were near the opposite end of the spectrum, with participants from France being the least likely to make ethical decisions that favoured saving elders. Gerontologist Dr. Samir Sinha adds that there is intersectionality at play as well, between marginalized seniors and racialized, immigrant workers: "If we

don't really value the old, we aren't going to fund their care adequately, and won't pay the people who care for them properly. The entire long-term care system exists in the shadows, largely built on the backs of racialized immigrant women."[220] Relatedly, structural violence in long-term care is well-document (it is 6 times higher in Canada than in Scandinavia), and is directly connected to low-quality working conditions.[221]

As the influential baby boom generation reaches the age at which long-term care may be necessary, the political prioritization of this issue will change dramatically. Will we continue to embrace mass institutionalization? Can we learn from de-institutionalization in other settings, such as mental health?

How can this system be fundamentally reformed, even revolutionized? What role is there for a universal home care program, or for age-friendly communities, or for housing and supported living innovations from elsewhere (co-housing, dementia villages, and naturally occurring retirement committees, or NORCs, for example). How can we build for unprecedented plurality and diversity of cultures, preferences and lifestyles? And most of all, how can listen – really listen - to the needs and desires of seniors themselves?

We will also require better ways of valuing family and kinship care in Canada, which we tend to undervalue, both culturally and through Canada's tax and benefit regimes. According to one recent study, 93% of seniors preferred to stay at home if given the choice, and none envision long-term care in their future housing plans.[222] On November 19, 2020, Petro-Canada announced the creation of the *CareMakers Foundation*, noting in its media release that 1 in 4 Canadians are caregivers. Shirly Sharkey, CEO of SE Health, notes that only 10% of health care resources are dedicated to the 90% of seniors living in their homes.[223] Dianne Roussin of the Winnipeg Boldness project, urges those in elder care to incorporate Indigenous knowledge systems and methodologies. As she frames it, "we have to stop placing 'independence' over 'interdependence'" as well as "thriving over surviving", noting as well that Indigenous cultures are more likely to value seniors living with extended family for as long as feasible.[224]