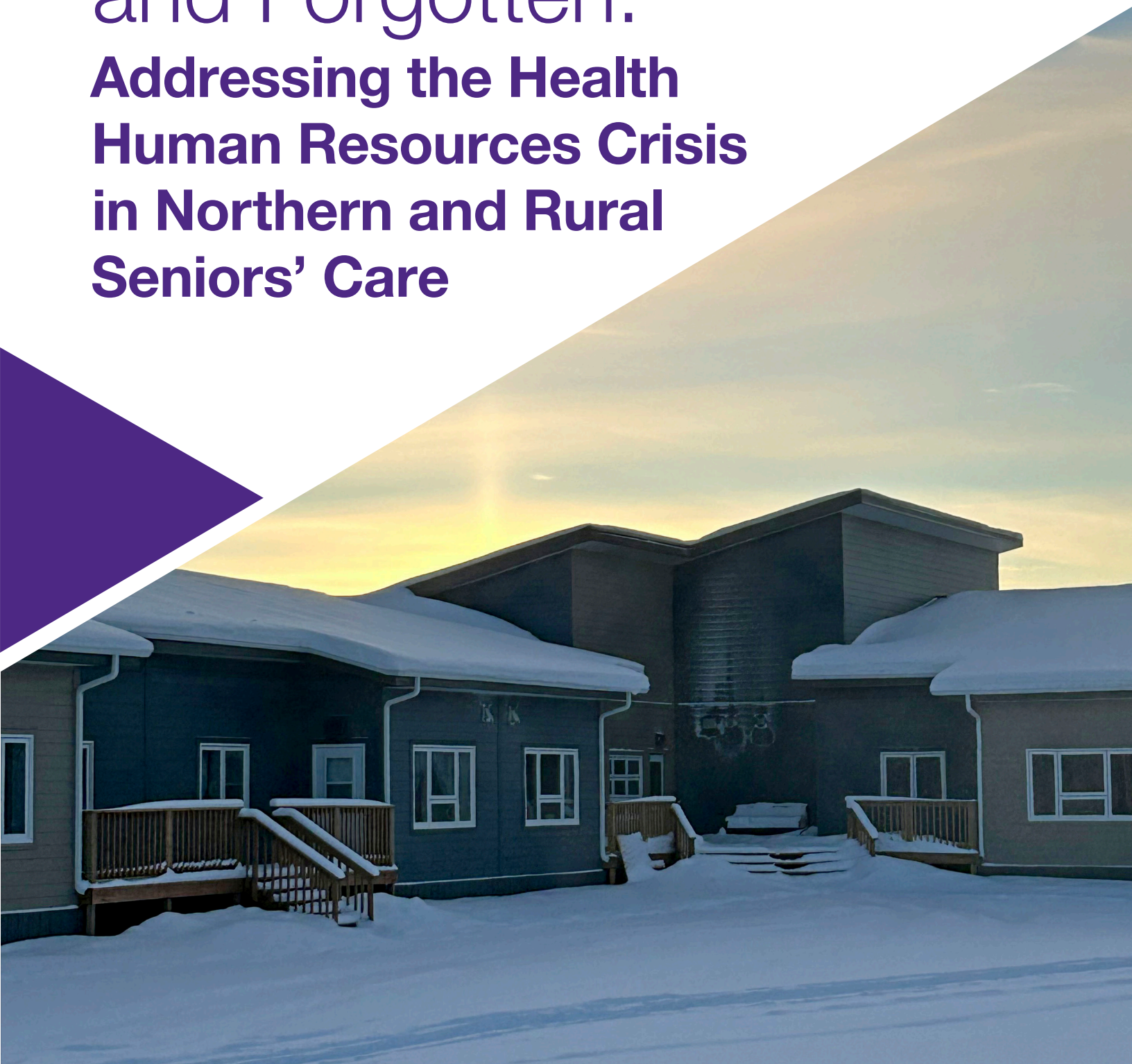
AdvantAge Ontario

Advancing Senior Care

Rural, Remote, and Forgotten:

Addressing the Health Human Resources Crisis in Northern and Rural Seniors' Care



Executive Summary

Northern and rural communities in Ontario have long faced challenges with health human resources (HHR), which escalated during the COVID 19 pandemic. While conditions have improved somewhat since that peak—with some long-term care (LTC) homes reporting reduced reliance on temporary agency staff—serious and persistent shortages remain. These ongoing challenges continue to place pressure on care providers and affect access to services for vulnerable populations. In response, AdvantAge Ontario engaged sector leaders and organizations across rural and northern regions to better understand the scope of the issue and identify practical solutions. This report summarizes the recommendations from these consultations and presents targeted recommendations to the Government of Ontario, with some recommendations for federal collaboration, to help stabilize the workforce and ensure equitable access to care for older adults in rural, remote, and northern communities.

The recommendations made in this report fall under the following six priority pillars:

PILLAR 1 – Establish Wage Parity and Rural Incentives:
Harmonize wages and benefits across care settings and introduce northern/rural pay incentives to level the playing field.

PILLAR 2 – Stabilize Workforce: Reduce Agency Dependence and Improve Immigration Pathways
Limit reliance on costly temporary staffing agencies by leveraging international talent through streamlined immigration processes and retention strategies.

PILLAR 3 – Expand Local Training and Rural Pathways:
Increase satellite training opportunities, rural clinical rotations, and Indigenous-led "grow-your-own" programs to build a sustainable pipeline of health workers.

PILLAR 4 – Tailor Legislation and Funding to Scale:
Adjust regulatory requirements for small LTC homes, provide ELDCAP funding parity in the north, and ensure flexibility without compromising safety.

PILLAR 5 – Support Workforce through Housing, Transportation and Childcare Services:
Address practical barriers to recruitment and retention by improving access to affordable housing, transportation stipends, and childcare options in rural and northern communities. These supports should be available to *all types of public sector workers* in northern and rural communities—including health care—because these are shared structural constraints.

PILLAR 6 – Strengthen Specialized Care Capacity for Complex Residents:
Improve access to specialized mental health and addictions supports, expand referral pathways, and ensure long-term care staff have the training and clinical resources needed to care for increasingly complex resident populations in rural and northern communities.

About Us

For more than 100 years, AdvantAge Ontario has been the voice of not-for-profit seniors' care in Ontario. We represent more than 530 providers of long-term care, seniors' housing, supportive housing, and community service agencies, including 96 per cent of all municipal long-term care homes and 88 per cent of all not-for-profit long-term care homes. We are the only association representing the full continuum of seniors' care in the province.

About this Report

This report examines the drivers behind the HHR crisis in northern and rural communities and proposes solutions that will have immediate and lasting impacts. It was prepared by AdvantAge Ontario following a thorough literature review and extensive consultations with health care and seniors' care providers throughout northern and rural Ontario. The following organizations were among those consulted:

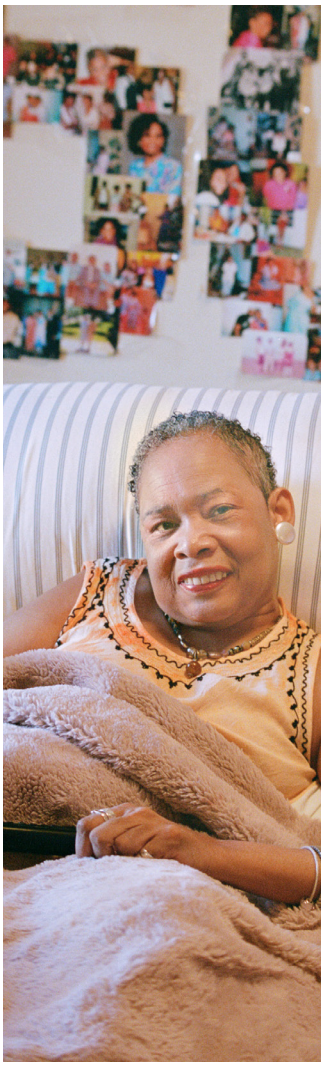
- AdvantAge Ontario's Northern and Rural Advisory Committee (see Appendix A)
- Association of Municipalities of Ontario
- Mohawks of the Bay of Quinte
- North East Specialized Geriatric Centre
- Ontario Aboriginal Housing Services
- Pikangikum Health Authority
- Rural Ontario Institute
- Rural Ontario Medicine Program
- United Way

Northern and Rural Definitions

While a common definition of rural Ontario is communities with a population of less than 30,000 that are greater than 30 minutes away in travel time from a community with a population of more than 30,000, this report does not limit its findings by adhering to a strict or limiting definition of northern or rural. For the purposes of this report—and in order to accurately identify challenges and solutions that will work across the province—any community that identifies as northern or rural and is facing health care staffing challenges is considered relevant to this report. This is because some members could be several kilometres outside of traditional boundaries and consider themselves rural and therefore be in need of a specialized approach. In other words, the report is focused on the HHR and seniors' care challenges facing non-urban communities. While the health care challenges faced by these communities may often be similar, in certain instances where circumstances differ, solutions or approaches may need to be tailored to match each community's unique demographics, geography, and population. The report provides these distinct solutions when necessary.

Introduction

The State of Health Human Resources in Northern and Rural Communities



Large geographies and small populations create natural challenges accessing health care in northern and rural communities. But as stated previously, over the last decade the situation has deteriorated to the point of crisis, which peaked during the COVID-19 pandemic. While labour market pressures have eased somewhat, many employers continue to face significant hiring challenges. Health care providers across northern and rural Ontario are having difficulty attracting and retaining the professionals needed to provide timely and appropriate care to their populations.

Recruitment and retention challenges are impacting health care broadly. However, these challenges are most pronounced in the seniors' care sector. Northern and rural communities have a higher proportion of older adults than urban communities but have less access to health care services. This acute HHR crisis is further exacerbated by the rapid increase in the aging population in Ontario. In 2021, the province had 2,637,709 older adults. This is projected to grow to 3,722,900 by 2030 and over 4 million by 2040. Additionally, the number of older adults living with frailty is expected to climb from 644,384 in 2021 to 932,208 in 2030 and reach well over one million by 2040.[1]

Of the 2.5 million Ontarians who lack a primary care provider, many are older adults and many of these individuals live in northern and rural communities. The government recently announced in June 2025 a historic investment and action plan to connect every person in Ontario to primary care by 2029.[2] Digital tools and targeted recruitment and retention strategies for northern and rural communities will be provided as part of this investment to reduce overall administrative burden. This is a positive step in the right direction, and we will follow closely to ensure the plan is executed in a timely manner and with the unique northern and rural lens.

> Older adults make up **24%** of the population in rural communities and **17%** of the population in urban communities. In 2021, **35%** of households in rural communities were maintained by older adults.
>
> Source: Rural Ontario Institute - Seniors Factsheet

> Rural Ontarians are losing access to primary care at four times the rate of urban residents.
>
> Source: Fill the Gaps Closer to Home: Proposals from Rural Ontario Municipal Association. January 21, 2024

The lack of health care services means that for those living in northern and rural communities, primary care is often received through emergency departments. This approach is costly, inefficient, and inconvenient. Long travel distances, extended wait times, and increasingly frequent emergency department closures mean that older adults in northern and rural communities often experience reduced access to essential health services compared to those living in larger population centres.

> In 2023, there were more than **600** Emergency Department closures in rural Ontario.
>
> Source: Roma Report - Fill the Gaps Closer to Home https://www.roma.on.ca/sites/default/files/assets/IMAGES/Home/ROMA%20Fill%20the%20Gaps%20Closer%20to%20Home%20Backgrounder%202024.pdf

> **670,000** Ontarians live at least **51km** from the closest family doctor, while **130,000** live at least **200km** from the closest family doctor.
>
> Source: https://upstreamlab.org/project/distance-between-patients-and primary-care-providers-and-quality-of-care/

Northern and rural municipalities face competition, both among themselves and with urban centres, to attract and retain physicians, nurses, and other frontline staff. To remain competitive, many offer financial incentives (e.g., signing bonuses), further straining limited budgets. Competition also exists across care settings within a community, including home and community care, hospitals, and long-term care. In response to persistent staffing shortages, many organizations rely on staffing agencies, an expensive solution that diverts resources from hiring permanent staff and further constrains workforce capacity, reducing continuity and quality of care.

Demand for HHR professionals working in older adult care is everywhere across the province and will continue to become increasingly competitive. This will push rural and northern communities further down the list of attractive places to work, if nothing is done to reverse this trend.

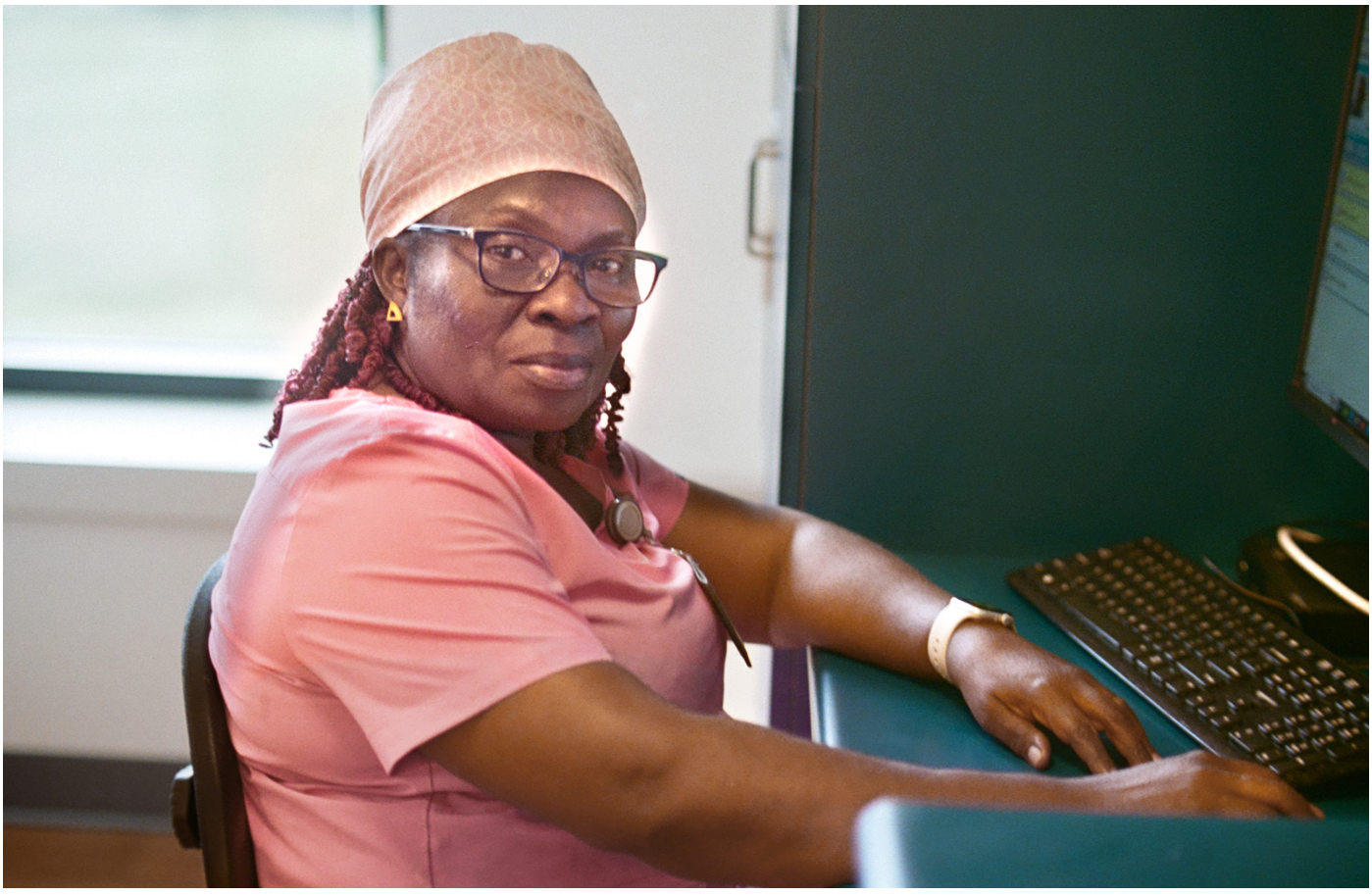
An Opportunity to Lead

The province has the capacity to reverse current workforce challenges and improve access to care for older adults through targeted investments in staff education and training, the development of strategic partnerships, and the implementation of policies aimed at attracting and retaining health care workers in northern and rural communities.

The Ontario government has recently introduced a range of measures to support workforce recruitment, training, and retention in rural and northern communities, including targeted incentives, training investments, and regulatory reforms. These actions represent important progress; however, significant gaps remain that require further targeted action.

A fully funded northern and rural HHR strategy is needed to address the unique challenges faced by these communities and should build off of the six pillars of action identified in this report, which include targeted, short- and long-term solutions.

Those consulted for this report shared different perspectives on health care delivery in northern and rural Ontario. However, there were three key findings we heard repeatedly: the current situation is unsustainable, solutions are available, and provincial leadership is required.



PILLAR 1:
Establish Wage Parity and Rural Incentives

Challenge: Older adult and seniors' care providers in the home and community care sector (long-term care, community support services, home care, community mental health, interprofessional primary care) often cannot compete with other settings (e.g., hospitals) for wages and benefits, resulting in wage disparities and subsequent staffing shortages and high turnover in home and community care. Additionally, urban centres often offer higher pay, more flexible scheduling, and cost-of-living advantages – making northern/rural roles less desirable.

Solution: Address the community health care wage gap – once and for all – by harmonizing wages for like positions across the health care system.

Wage and benefit disparities across the home and community care sector have been a persistent problem, with hospitals typically offering higher wages and generous benefit and retirement savings plans compared to other settings, thus exacerbating workforce imbalances. This inequity was accelerated through the pandemic and continued to place community-based providers, including long-term care, at a competitive disadvantage in recruiting and retaining staff, particularly personal support workers (PSWs) and nurses. As a result, limited capacity in preventative and community-based care leads to increased reliance on hospital services among older adults. AdvantAge Ontario partnered with nine other community health associations in the province in commissioning a compensation study that demonstrated wage gaps across the health care sector and supported advocacy for a harmonized provincial compensation grid and improved workforce funding.[3]

Beyond wage disparities, other financial factors also shape workforce distribution. As Ontario becomes increasingly urbanized, larger centres offer greater perceived desirability due to access to amenities and, in some cases, lower costs for essential goods driven by economies of scale. In health care, urban settings often provide greater scheduling flexibility, improved access to public transit and supportive services such as childcare and housing (see Pillar 5), in addition to higher wages. Collectively, these factors place a relative burden on those working in northern and rural communities, reducing the attractiveness of these positions. While the Ontario government has recently announced incentive programs aimed at attracting and retaining nurses and PSWs in long-term care and home and community care in northern and rural communities (e.g., Ontario Nursing Plan[4], Community Commitment Program for Nurses (CCPN)[5] and the PSW Graduates Incentive Program[6]), these initiatives require ongoing attention to ensure they deliver meaningful, long-term impact.

Recommendations:

A. As recommended by the Ontario Community Health Compensation Market Study, the ministries of Health and Long-Term Care should immediately bring forward a plan to close the wage and benefits gap (e.g., retirement plans) between like positions across different health care settings.

B. The ministries of Health and Long-Term Care should continue to explore and implement northern and rural pay incentives for all staff delivering publicly funded health care in these communities. Incentives could help attract and retain health care professionals in these communities.

PILLAR 2:

Stabilize Workforce: Reduce Agency Dependence and Improve Immigration Pathways

Challenge: The unregulated growth of for-profit temporary staffing agencies, some of whom have charged exorbitant, unsustainable rates, has been depleting scarce health care resources in rural and remote settings, eroding limited organizational budgets and reducing continuity of care. Staff turnover can lead to a reduction in the quality of care of residents and result in increased expenses. Recent federal immigration changes to Temporary Foreign Workers (TFW), international students, and Labour Force Market Impact (LMIA) have noticeably worsened staff shortages and turnover rates.

Solutions: Reduce reliance on temporary staffing agency use and stabilize staffing through agency rate caps, permanent hires, and international talent retention. Additionally, it is imperative that solutions address the root causes of the recruitment and retention challenges facing the seniors' care sector, as outlined elsewhere in this report, to mitigate the reliance on agency staff.

$40.15: Average hourly rate for a registered nurse directly employed by a long-term care home.

$97.33: Average hourly rate for an agency staff nurse contracted to a long-term care home.

Source: Auditor General of Ontario 2023 Report: Long-Term Care Homes: Delivery of Resident-Centred Care

Staffing Agencies

Ontario now has over 3,000 registered health care staffing agencies, which have become a critical interim solution for many northern and rural long-term care homes facing persistent workforce shortages. While agencies can provide necessary *short-term* relief, their growing use as a sustained staffing solution raises significant concerns. Agency staffing is costly and may compromise continuity of care, which is associated with better resident outcomes.[7-10] Evidence also links higher reliance on agency staff in long-term care to increased staff turnover, particularly among RNs, which has been associated with more care deficiencies and higher resident mortality.[11-14] Recent changes to Bill 11, the *More Convenient Care Act, 2025*, introduced mandatory licensing and increased transparency for agencies, including requirements to disclose agency fees. These measures represent important progress toward improving accountability in the sector; however, as they have not yet been fully implemented, uncertainty remains regarding their impact and whether additional action will be required to address workforce challenges in rural and northern communities.

Rural and remote long-term care homes are among the most reliant on agency staff.[15] Relying on agency staff places considerable financial strain on homes, as homes often pay inflated fees. Rural and remote homes face the highest expenses, with many providing additional funding for travel and accommodation costs. As a result, scarce resources are diverted away from building a stable, local workforce and investing in resident care. This dynamic undermines progress toward key policy goals, including the four hours of direct care commitment, effectively eroding the impact of recent investments in staffing. While the government announced that in the first quarter of the 2025-26 fiscal year, residents received an average of four hours and five minutes of PSW and nursing care every day,[16] this data was an average across the entire province. More work is still needed to close this gap in northern and rural regions, where difficulty meeting the four hours of care target is still present and is, in part, due to the increased reliance on costly temporary staffing agencies.[17]

Immigration

International students and temporary residents have been a critical workforce pipeline into PSW, nursing, and allied health roles, especially in northern and rural communities. However, several recent immigration barriers have been introduced by the federal government which have been significantly contributing to staffing shortages. Specifically, TFW permits have been cut from two years to one year and LMIA validity has been shortened from 12 months to six months. These changes not only contribute to worsened staff shortages but also add to administrative burden. Shortened timelines introduce a greater risk of homes losing staff before their staff can achieve permanent residency.

Additionally, the number of new study permits issued is being reduced to control the growth of the International Student Program.[18] Fewer applications and lower-than-projected approval rates led to a sharper decline in study permit approvals, far more than intended, without adequately assessing impacts on labour markets or essential services. Additionally, international students graduating as PSWs and nurses often face increasing residency denials, creating sudden gaps in care. Targeted, workforce critical solutions that recognize the unique and urgent staffing realities of long-term care in northern and rural communities is needed.

Northern Staffing Challenges

A municipal long-term care provider in Northwestern Ontario invested significant financial and operational resources in recruiting approximately 30 internationally trained workers through LMIA pathways to address critical staffing shortages. While a small number of workers have successfully obtained permanent residency, most remain in progress. Recent changes reducing Temporary Foreign Worker (TFW) permits from two years to one year have created significant risk, as the shortened timelines do not allow sufficient time to complete permanent residency applications. As a result, the organization may be required to repeat the LMIA process—an approach that is financially unsustainable and risks destabilizing staffing levels in an already underserved region. Further compounding this issue, some northern communities have been excluded from federal rural immigration programs, limiting access to alternative pathways to permanence. For example, some northern or remote communities do not qualify under current definitions and program criteria for the Rural Community Immigration Pilot, which offers permanent residency to skilled workers in rural communities. Communities beyond these program boundaries are facing rapid LTC expansion without the workforce pipeline needed to staff new beds.

An Unstable Workforce

A municipal long-term care provider in a rural Eastern Ontario community recruited over 50 TFWs to stabilize staffing across two homes following prolonged vacancies and high turnover. These workers have become fully integrated into care teams and have supported compliance with mandated care standards. However, many are now at risk of losing eligibility to remain in their roles, as work permits may expire before they accumulate the required experience for permanent residency through programs such as the Ontario Immigrant Nominee Program (OINP). Policy inconsistencies—including classification changes that prevent the recognition of accumulated work experience—have further complicated pathways to permanence. At the same time, homes have also relied on international students and recent graduates, many of whom face increasing challenges securing permanent residency, creating the risk of sudden workforce losses despite significant investment in recruitment and integration.

Recommendations:

Staffing Agencies:

- **A.** Implement the proposed changes in Bill 11, 2025, related to mandatory licensing and agency charging fee transparency. If needed, the province should mandate set agency rate caps for staff in the same role across health care settings.
- **B.** The government to work with the sector on the further development of best practice guidelines and conversion incentives for turning temporary staff into permanent hires.

Immigration:

- **A.** Government of Canada: Restore longer TFW permits and streamline LMIA processes to allow for healthcare-specific LMIA approaches (one LMIA per facility).
- **B.** Ontario Government: Opt in to the federal measures put in place in a number of other provinces to introduce temporary, time-limited measures for rural employers, allowing participating provinces to retain existing low-wage TFWs or increase the cap from 10% to 15% between April 1, 2026, and March 31, 2027.
- **C.** Ensure equitable access to federal immigration programs for rural and remote communities.
- **D.** Develop streamlined immigration and clear pathways for international students graduating as PSWs and nurses to transition from study to permanent roles in long-term care and home and community care settings to remain and work in those settings.

PILLAR 3:
Expand Local Training and Rural Pathways

Challenge: Northern and rural communities lack local training opportunities for physicians, PSWs, nurses, and allied health roles. Young people who leave their northern and rural community for education and training are at high risk of moving away permanently, worsening staff shortages. Additionally, Indigenous communities face severe gaps, as many rely on fly-in staff and lack "grow-your-own" programs.

Solution: Build a sustainable pipeline of health workers rooted in northern and rural communities, reducing reliance on external recruitment and improving culturally appropriate care.

The Rural Ontario Medicine Program (ROMP) found that when a medical student or recent graduate spends two years in a northern or rural community, there is a 95% likelihood they will remain in that community to practice after their education or placement is complete. However, with only 8% of residency students classifying as rural, many residency programs are concentrated in urban settings, reducing the chance for medical students to be exposed to these areas and choose a career in northern and rural medicine.

To increase residency rotations in both northern and rural communities and in long-term care homes and other seniors' care settings, non-coercive incentives that include both financial (e.g., recruitment grants, relocation support, and student loan forgiveness) and non-financial (e.g., practice support, locum program, and community welcome packages) elements may be most successful in retaining talent in northern and rural communities compared to other types of incentives.[19,20]

> The Government of Ontario classifies **17%** of Ontario's population as rural, but according to the Rural Ontario Medicine Program only **8%** of medical residencies occur in rural areas.
>
> Source: https://www.ontario.ca/page/socioeconomic-facts-and-data-about-rural-ontario, ROMP

It is common for young people to leave their northern/rural community to pursue health care training, such as nursing, with the intention of returning home. However, while away, many establish personal and professional ties and are ultimately retained in urban labour markets.

This trend may be mitigated through improved access to affordable, locally available health care education for northern and rural residents. In addition, rural-focused training pathways that recruit locally and provide education closer to home have been shown to improve long-term workforce retention in these communities.[19,20] Ontario has introduced programs to strengthen local pipelines and reduce outmigration, including the Living Classrooms and Preceptor Resource and Education Program in Long-Term Care (PREP-LTC).[21] These initiatives represent important progress; however, they are not yet at sufficient scale to meet workforce needs across northern and rural communities, and further expansion and sustained evaluation will be required to achieve long-term retention.

The need for locally accessible training opportunities is particularly acute in northern, rural, and Indigenous communities, where HHR are often flown in on a temporary basis. This reliance on short-term staffing contributes to limited and inconsistent access to care, particularly for higher-needs older adults. Many fly-in First Nations communities, for example, have limited or no access to Ontario Health atHome services due to workforce constraints, despite a desire to provide home care for their older adult populations.

Expanding local health care training capacity would support "grow your own" workforce approaches, enabling community members to enrol in and complete health care programs locally. This would help address staffing shortages internally while also creating stable, long-term employment opportunities within these communities.

Recommendations:

Medical Education and Rotations:

- **A.** Incentivize medical schools to increase northern/rural rotations and seniors' care placements.
- **B.** Work with ROMP and the Northern Ontario School of Medicine (NOSM) to expand rural residency programs and preceptor supports.

Expand Local Training:

- **A.** Scale up Living Classrooms and PREP LTC across northern and rural Ontario.
- **B.** Partner with colleges/universities to deliver hybrid programs (virtual and in-person), where internet access allows.
- **C.** Remove financial barriers (e.g., tuition supports) and offer incentives for graduates committing to northern/rural work.

Indigenous-Led Pathways:

- **A.** Fund Indigenous-led "grow-your-own" programs with wraparound supports (housing, childcare, mentorship).
- **B.** Support partnerships like Pikangikum's model with Confederation College for remote PSW and nursing training (Northwest Ontario, 230 km north of Kenora, fly-in-community).

Pikangikum First Nation Case Study

In remote, fly-in Indigenous communities in Northern Ontario, HHR are often flown in for short periods of time and residents are flown out in emergencies or to receive the more complex care available in population centres. While sometimes these transfers are medically necessary, this is extremely costly and uproots individuals from their communities. Building local capacity is essential to reduce reliance on these transfers and support care closer to home.

In the Pikangikum First Nation, in Northwestern Ontario, innovative and homegrown solutions are bringing more locally sourced health care to the fly-in community of approximately 3,000. The community has recently opened a 20-bed assisted living home for elders' care—the Knowledge Keepers Elders' Complex—and is in the process of building a new health centre. In order to increase personal support workers and nursing numbers to staff these facilities—and honour the communities' wishes of keeping elders at home, rather than flying south for care—Pikangikum has had to get creative. The community has invested in its workforce and built its internal capacity up so that they are always served by two registered nurses. Without those investments, nursing care would only be available Monday through Friday from 9 am to 5 pm through the remotely staffed nursing station. If anything happened outside those hours, the person needing care would need to be flown to Sioux Lookout's emergency department for care. Pikangikum's effort to ensure they have 24/7 nursing is not only improving care and quality of life, it is saving the province the expense of flying people to costly emergency care.

In spite of its successes, Pikangikum has still struggled with grow-your-own programs, which in remote First Nations communities require wraparound supports and can take several generations to bear fruit. To staff the new health care facilities, the Pikangikum Health Authority is partnering with the Oshki Campus at Confederation College in Thunder Bay to provide remote, in-community training opportunities in personal support work and nursing care. These kinds of in-community supports are critical to improving access to health care and health outcomes for community members, including seniors. However, they require supports that in turn require planning and funding: dedicated classroom space, human resources and administrative support, and people who can work with the students to keep them on track towards their degrees or diplomas.

Against great odds, Pikangikum is achieving greater health care autonomy and self-sufficiency with a combination of its own resources and a patchwork of federal and provincial health care dollars. This is a rare success. Many remote communities are smaller and lack the support and coordination to build a health system that meets their needs. A coordinated federal-provincial system to support improved health care and seniors' care in remote First Nations, with an emphasis on supporting Indigenous-led care that decreases reliance on outside, costly and unreliable HHR would go a long way to resolving the unacceptable disparities in health outcomes between Indigenous people and the rest of the Canadian population.

PILLAR 4:
Tailor Legislation and Funding to Scale

Challenge: *The Fixing Long-Term Care Act, 2021*, includes several provisions that, while well-intentioned, are exacerbating the unique HHR challenge faced by northern and rural communities. Additionally, the Elder Care Capital Assistance Program (ELDCAP) homes are expected to deliver the same level of care as long-term care homes, but do not receive any dedicated long-term care funding, such as funding for the four hours of care per day mandate.

Solution: Ensure regulations and funding models reflect the realities of small northern and rural homes by introducing flexibility without compromising safety and providing funding parity of ELDCAP beds, so these communities can maintain compliance and deliver quality care.

The Fixing Long-Term Care Act, 2021, and its regulations, include several provisions that, in an HHR scarce environment, are limiting northern and rural homes to provide the best possible care to older adults. Specifically:

> The requirement that an IPAC lead be present for a minimum of 17.5 hours/week is challenging for small homes to comply with (Section 102(15) of O. Reg. 246/22). Finding and retaining staff with these specialized qualifications is an ongoing concern. While a strong IPAC program and dedicated IPAC leadership are essential to maintaining resident safety, preventing outbreaks, and ensuring ongoing compliance with infection prevention and control standards, the prescribed minimum hours can be difficult to sustain in homes with very few beds – in some case less than 20, especially ELDCAP homes. A more flexible approach that recognizes the size, risk profile, and operational realities of small homes could support effective IPAC oversight while addressing significant human resource challenges.

> With limited access to health care professionals in northern and rural communities, the requirement that directors of care be registered nurses, and that a registered nurse must be attending 24 hours a day, 7 days a week, is impractical for small homes. Without flexibility, small homes risk non-compliance and closure, further reducing access for older adults living in rural communities.

ELDCAP options were created to ensure seniors in communities too small to support a long-term care home could still access a long-term care level of care, when necessary. While the number of ELDCAP spaces in the province is small, all of them are in the northwest (147 spaces) and the northeast (137 spaces), making this challenge unique to the north.

ELDCAPs are subject to long-term care legislation, regulations, and program requirements (e.g., four hours of care per resident per day) but are funded through a hospital's global budget and do not receive long-term care funding increases or specialized pots of funding (e.g., four hours of care funding). Unlike regular long-term care beds, ELDCAP funding is not Case Mix Index adjusted under the Ministry of Long-Term Care's funding model to reflect residents' acuity. This unique funding structure has created significant operational and financial challenges for ELDCAPs as they must comply with the same regulatory standards as traditional long-term care homes but receive no additional funding or support.

Additionally, ELDCAPs are excluded from the long-term care Staffing Supplementary Funding Policy, meaning they lack access to funding to provide higher wages and increase direct care hours like other long-term care homes, though they are still required to do so. Excluding ELDCAP homes from the Ministry of Long-Term Care supplementary funding has deepened wage disparities, making it harder for ELDCAP homes to attract and retain permanent staff.

Recommendations:

The following recommended legislative adjustments would allow flexibility to small northern and rural homes facing severe staffing challenges:

- **A.** Maintain the requirement for robust IPAC oversight and leadership in all homes while providing flexibility in how minimum IPAC Lead hours are met in small northern and rural homes. This flexibility should recognize home size, occupancy, and risk factors, while ensuring homes have the capacity to prevent, identify, and respond to infectious disease risks at all times.
- **B.** Put in place a provision that allows small homes to place RPNs in the role of Director of Care and fulfill 24/7 coverage when RN shortages exist.
- **C.** Create supplementary funding streams for ELDCAP homes to meet long-term care requirements, including staffing and wage parity, to support financial needs and reduce the burden on hospital budgets.

PILLAR 5:
Support Workforce through Housing, Transportation and Childcare Services

Challenge: Practical barriers, including affordable and/or available housing, transportation, and childcare in northern and rural communities, place further pressure on HHR recruitment and retention. Limited affordable housing options, lack of public transit, and scarce childcare services add hidden costs and stress for health workers and make relocation less attractive. All are critical enablers for stabilizing the workforce.

Solution: Remove practical barriers that make it difficult to attract and retain health care workers in northern and rural communities by improving access to housing, transportation, and childcare, ensuring these communities can build and sustain a stable workforce. A multisector approach on these shared issues across all public sector workers would be most effective.

Housing

The lack of affordable, available, and/or appropriate housing is cited as a top issue among northern and rural seniors' care providers in both attracting and retaining staff.[22] In some northern communities, the only affordable housing options being built are often bachelor or one-bedroom apartments. To fully address the HHR crisis, available housing needs to reflect the reality that many health care workers have families and require appropriately sized units. Additionally, those health care providers who are building affordable housing and/or paying for affordable housing for their staff tend to be larger for-profit companies who have the means to provide this support. As such, there are fewer options for smaller and non-profit homes. Ontario has introduced initiatives to support housing development, including programs that enable the re-purposing of existing properties for affordable housing through non-profit providers. These efforts represent important progress; however, access to suitable and affordable housing remains limited in rural and northern communities and further coordinated action will be required.

Emerging approaches in Ontario demonstrate potential solutions. For example, programs that support the repurposing of existing properties for affordable housing through grants to non-profit providers—such as initiatives piloted in municipalities like Toronto and Waterloo—have shown how government can accelerate housing supply for public sector workers. However, these models have not yet been implemented at sufficient scale in rural and northern communities, where housing shortages remain most acute.

Transportation

Vehicle ownership in northern and rural communities in Ontario is essential due to low populations and vast geographies, significantly limiting public transit options. Investment in vehicle ownership includes several additional costs on top of the purchase of the vehicle, including fuel, maintenance, and insurance costs. Statistics

Canada found transportation to be the second highest household expense (~16% of purchases),[23] with the average cost of vehicle ownership in Canada to be $1,370 per month, or over $16,000 per year, acting as additional expenses not typically thought of for northern and rural health care staff.[24] High transportation costs of vehicle ownership may be particularly challenging for lower-paid positions such as PSWs, adding to the recruitment and retention challenges for northern and rural seniors' care providers. Whereas, those living in urban cities have greater access to low-cost transit to travel to and from work as a feasible alternative to vehicle ownership, thus reducing their overall transportation costs.

Childcare

While affordable and accessible childcare is a challenge throughout Ontario, the difficulty in finding and affording childcare is most acute in northern and rural communities. Similar to seniors' care, low population densities, long distances, and low wages make it difficult to attract and retain northern and rural childcare workers. One way for both childcare and long-term care sectors to increase recruitment and retention is to co-locate seniors' and childcare services.[25-28] Childcare options co-located with seniors' care services will make these sites more attractive to nurses, PSWs, and other allied health professionals.

> **Urban areas:** spaces for **34%** of children up to three years of age
> **Rural areas:** spaces for **22.8%** of children up to three years of age
> Source: https://www.ruralontarioinstitute.ca/uploads/userfiles/files/RuralOntarioReport-CIW-ACCESSIBLE_FINAL.pdf

Recommendations:

Housing:

- **A.** Provincial leadership to coordinate public sector worker housing development in northern and rural communities.
- **B.** Create grants or subsidies for long-term care and seniors' care providers to offer housing allowances or build staff housing.
- **C.** Explore innovative solutions, such as modular homes and repurposing existing properties.
- **D.** Housing costs currently absorbed through agency contracts could be redirected to permanent workforce housing for increased sustainability.

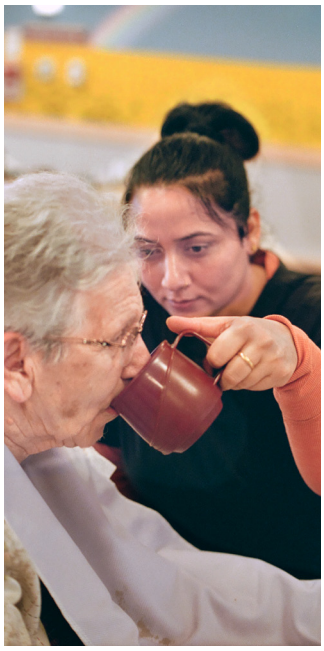
Transportation:

- **A.** Provide government funding for a transportation stipend to offset the costs of vehicle ownership for rural health workers (e.g., fuel, insurance, maintenance).

Childcare:

- **A.** Partner with the Ministry of Children, Community and Social Services to co-locate childcare at or near long-term care homes.

PILLAR 6:
Strengthen Specialized Care Capacity for Complex Residents



Challenge: There are a rising number of residents in long-term care with high clinical complexity, particularly serious mental health conditions and addictions, creating significant safety risks and care challenges for themselves, other residents, and staff. This is compounded by a mismatch between resident needs and workforce capacity, as staff lack specialized training and access to appropriate clinical supports. Rural and northern homes are disproportionately affected due to limited access to specialized services and referral pathways.

Solution: Improve access to specialized mental health supports in rural and northern regions by expanding referral pathways, increasing the availability of specialized providers, and enhancing training and ongoing clinical support for long-term care staff.

While the first five pillars focus on stabilizing the supply of the health workforce, our sector consultations identified a growing and related challenge: the increasing clinical complexity of residents, particularly those with mental health and addiction needs, and the lack of specialized supports in northern and rural communities, to meet these needs.

Long-term care homes are increasingly caring for a more complex resident population, particularly individuals with serious mental health and addictions, as well as younger residents (under the age of 65) and individuals experiencing homelessness. Despite this trend, staff often lack access to specialized training, clinical supports, and referral pathways—gaps that are most acute in northern and rural communities, where access to specialized services is limited.

Compared to other jurisdictions in Canada, Ontario has the highest proportion (58%) of long-term care residents with high and moderate clinical complexity,[29] and this complexity continues to grow, increasing from 27.1% in 2019-2020 to 32.5% in 2024-2025.[30] In recent years, a greater focus on crisis admissions and reduced alternate level of care (ALC) pressures from hospitals have resulted in more individuals with complex mental health needs being admitted directly into long-term care. With a lack of supportive housing and appropriate community-based support for these individuals, long-term care has become a "catch all", placing considerable strain on staff who are not equipped to meet these needs.

This mismatch between resident needs and workforce capacity is creating significant HHR pressures. Long-term care staff lack the specialized training, resources, and clinical supports required to care for residents with serious mental health and addictions. Homes attempt to mitigate these gaps through external supports, such as psychogeriatric specialists, community paramedicine programs, Geriatric Mental Health Outreach Teams (GMHOT), and Behavioural Supports Ontario (BSO). As well,

homes refer residents to behavioural specialized units (BSU) within other long-term care homes or apply for BSU beds within their own home. However, access to these services is inconsistent and heavily concentrated in urban areas. For example, while Toronto represents approximately 18% of Ontario's older adult population, it has over 45% of the province's geriatric psychiatrists,[31] whereas Northern Ontario represents about 6% of the older adult population but has only a handful of specialists.[31] This highlights a significant geographic inequity in access to specialized mental health supports, even when population size is considered, which is further compounded by the vast geographic areas in northern regions. As a result, rural and northern homes face substantial inequities, with limited availability of specialized services and fewer BSUs in their regions due to population and home size restrictions that may exist. In many cases, they are also unable to access referral pathways to urban-based BSUs, as those units are operating at capacity and prioritize residents within their immediate geographic areas. This leaves rural and northern homes without access to specialized expertise or escalation pathways, forcing existing staff to manage highly complex residents beyond their scope of training, raising concerns about both staff and resident safety.

These challenges are compounded by the longstanding staffing shortages in rural and northern communities. Homes already face persistent difficulties in recruiting and retaining staff, particularly those with specialized mental health expertise. The increasing complexity of resident care is further contributing to staff burnout and attrition, with some workers leaving the sector altogether. This creates a cycle of workforce strain, where fewer staff are available to care for residents with increasingly complex needs. While these issues are felt across the long-term care sector, rural and northern homes are disproportionately impacted due to geographic isolation, limited access to external supports, and more constrained labour markets, exacerbating existing HHR challenges and threatening the sustainability of care delivery in these communities.

Recommendations:

- **A.** That the ministries of Health and Long-Term Care work with Ontario Health to further map out the available mental health and addictions services and training across the province to address the disparities in programming in rural and northern areas.
- **B.** Provide a clear referral pathway to allow rural and northern long-term care homes with equitable access to BSU beds, if none exist in their region. Ensure equitable access to BSU beds by removing any population and/or home size barriers, should rural and northern homes be willing and able to provide this unit in their home/region.
- **C.** Expand adequate and affordable housing options for older adults experiencing homelessness and mental health conditions and addictions.

Conclusion

Northern and rural seniors' care in Ontario is facing a persistent and structural health human resources crises – driven by geography, demographic change and systemic inequities – that jeopardizes access, quality, and sustainability of care. Older adults in these communities have less access to primary care, leading to higher emergency use and poorer outcomes, as well as increased strain on long-term care. With Ontario's older adult population aged 65 and over reaching approximately four million as of 2024, which is projected to continue growing, there is an urgent call to action, as without immediate intervention the current system gaps will widen and create further strain on northern and rural communities. There are several key drivers creating these gaps that should be addressed, including wage disparities, agency dependence, immigration challenges, lack of local training, rigid regulations, and practical barriers to housing, transportation, and childcare.

While there have been some recent investments into rural and remote communities to improve the HHR crisis, there are still several calls to action that this report highlights. Specifically, we are recommending the government to develop and fully fund a northern and rural HHR strategy to address the unique challenges faced by these communities. This strategy should include closing wage gaps, reducing agency reliance, improving immigration, expanding local training, adjusting regulations, and removing barriers to housing, transportation, and childcare. It is essential that the province show leadership in these areas and collaborate with municipalities, Indigenous communities, the federal government, and other providers. Ontario has the tools to address these challenges. By implementing the six pillars outlined in this report—focusing on workforce stability, system flexibility, and specialized care capacity—the province can improve equity, strengthen rural health systems, and ensure older adults receive the care they need close to home. Failure to act risks widening existing gaps and placing further strain on already fragile systems.

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Appendix A: Contributors

AdvantAge Ontario's northern and rural advisory committee members who contributed to this report include the following:

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- Eastholme
- Fairview Park Communities – Craigwiel Gardens
- Fairview Manor
- Lakeland Long Term Care
- Maxville Manor
- MICs Group of Health Services
- Mississippi River Health Alliance
- North of Superior Healthcare Group – Wilkes Terrace and Terrace Bay
- Northwood Lodge Home for the Aged – Community Support Services, Red Lake
- Pioneer Ridge Long Term Care Home
- St. Joseph's Care Group – Bethammi Nursing Home
- St. Joseph's Care Group – Hogarth Riverview Manor
- Sun Parlor Home County of Essex
- The Four Seasons Lodge
- Valley Manor Inc.
- West Perry Sound Health Centre

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For more than 100 years, AdvantAge Ontario has been the voice of not-for-profit seniors' care in Ontario. We represent over 530 providers of long-term care, seniors' housing, supportive housing and community service agencies, including 96 per cent of all municipal long-term care homes and 88 per cent of all not-for-profit long-term care homes.

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