Presentation to the Standing Committtee on the Legislative Assembly
Ontario Legislature in regards to
Bill 37, Providing More Care, Protecting Seniors, and Building More Beds Act, 2021

Matthew Gventer, Co-chair Kingston Health Coalition
on behalf of the Kingston Health Coalition
93 Hillcrest Avenue
Kingston ON K7K 4L7
613-542-5843

The Kingston Health Coalition has been diligently defending public medical care for over 30 years. We have wide support in the community with over 200 people who follow our activities. In the past three years we have put much energy into addressing concerns about long term care. Two years ago, prior to the pandemic, we reported on the critical state of long term care and the steps needed to correct its failings. The parts of the Long Term Care Act being amended by Bill 37 reflect these concerns in part. However, the changes are not adequate to meet the need. In fact, in some ways they are inhumane.

We owe you an explanation for the assertion that they are inhumane. The reforms needed in long term care comprise elements of essential care. People working in long term care or family of residents in long term care in Kingston have observed conditions of care that harm residents. For example, people on hydration protocols being given drinks, but not monitored for consuming the drinks and the drinks being removed before they have been consumed. Or people needing to get to a washroom and on a fall protocol being forced to wait beyond reason. Staff report they have no time to communicate with the residents who need such support and who have no family visiting. The bill has finally recognized the legitimacy of our call for a standard for 4 hours hands on care a day. This government has proclaimed its concern with minimizing budget deficits, so it wouldn't have included such a change unless it recognized that such a care standard is vitally important. If that standard is essential to the well-being of residents, it is essential now, not 4 years from now. We urge the government to amend the act to put a deadline for accomplishing this change within a year and to make it a requirement, not a target.

We also note that we need a capacity to measure this target. This measurement should be public so that it is visible to all. Operators need to be open to public scrutiny as to their meeting this essential target. The most immediate measure of the effort to meet the target is staff ratios. The act should provide for absolute standards of staffing. Mantaining and reporting staff ratios should be in the act.

We also expressed concern that annual surprise inspections were cancelled when the government took office. In fact, our experience in Kingston reinforced the importance of inspections. It was the proactive intervention of the Kingston, Frontenac, Lennox and Addington Public Health Unit in the long term care sector at the start of the pandemic that helped Kingston avoid the tragedy other facilities experienced. This was the case even though we had facilities with four bedded rooms. The intervention was inspections and direction on infection control procedures that paid off so well. However, we also warned that inspections without consequences were ineffective. Unfortunately, the inspection regime promised in the Act is years in the offing.

While we are underlining many of the recommendation that you will find in the Ontario Health Coalition (OHC) submission, these comments are based on our observations in Kingston. We agree with the OHC's concern that the inclusion of mission driven operations in the preamble undercuts the emphasis on not for profit delivery of long term care. However, we don't expect to get far with that

criticism given the governing party's bias toward for profit care. We would alert you to the motion passed by Kingston City Council to look into more municipal beds. The Provincial Government should take steps to encourage a city like Kingston. The Fairmount Homes, a municipal facility, moved to porovide 4 hours care per patient before the pandemic. Rideaucrest was built 30 years ago with individual rooms because City Council believed seniors deserved humane care. The pay of City PSW's is higher than the private sector pays which helps encourage PSW's to stay in the field. The City found the means to provide good benefits and good pay as a matter of principle. We believe the Act should provide for a program of capital assistance to municipalities wishing to provide more beds.

We want to put on the record our expectation that for profit facilities be driven by a mission of care over profit be put into practice. We note that the Commission of Inquiry into Long Term Care commented on the question of profit and long term care. It was very critical of the extent to which current operators were under the control of corporate interests that used long term care as an investment opportunity (such as in the case of real estate trusts or investment funds). To include an expectation that a mission of care should be what drives management requires a change from the current ownership pattern. It requires commitment to change. For that to happen the act needs to mandate clear standards for content of missions and inclusion of evaluation procedures with prompt correction of diversions from the mission. We note that the government has rewarded some of the worst performing operators during the pandemic (and before) with new and expanded contracts. Not including provisions in the act for a requirement for mission standards and assessment protocols reinforces our concerns.

While we could present many more suggestions and comments, we are confining our comments to a few key concerns. There is one final observation we wish to present to assist in the deliberations of the Committee. We recognize that this final observation will receive scant attention. We present it to begin to advance the conversation about just provision of health care to address its underlying failing. Throughout health care system there is a systemic failing. What is a systemic failing? It is a bias in the structure of the system that generates undesirable outcomes that is not just the consequence of individual decision making. The bias we want you to take to heart is the built in bias based on wealth.

When Tommy Douglas wrote about his life experiences in health care he emphasized that health care is a human right that must be equitably available to all and delivered as justice is supposed to be delivered, without looking at the wealth, race, persuasion, or gender of the person being served. We have many components of our health care with this bias against the less affluent. Dental care, prescription drugs for people under 65, accessibility to cpap treatment in the case of the homeless, basic physiotherapy services, access to Optometry are examples. In those examples, the bias is clear. The less affluent may not even be able to get such care.

In our long term care facilities we start out housing people into basic, semi-private and private rooms based on ability to pay. The implications of this were stark during the pandemic. The people in multi bedded rooms were most exposed to the virus. Of course, the inability to isolate people and the failure to institute access to PPE's meant the virus spread quickly beyond those rooms.

We understand that the new facilities being built will have people living in individual rooms, but sharing bathrooms when not classified as private. This may soften the impact in the case of a pandemic, but won't change the basic differentiation of people. Theoretically, only the size of the rooms and certain benefits would be affected. It is claimed that health care services will be covered by the government and will be available equally to all.

The United States Supreme Court considered a similar argument in the case of Brown versus the Department of Education. It was claimed that providing separate but equal facilities did not violate the rights of children. A considerable body of evidence was brought to the court showing that it didn't work that way. One study showed how black children responded to dolls of different skin hues. It was found that, not only did the black children prefer the white skinned dolls, but that in cases they denied their own skin colour. Thus the decision, SEPARATE CANNOT BE EQUAL!

We see bias against the less affluent in many situations. In schools, studies have found that children who were identified as being poor were graded lower than children who were identified as more affluent although the labels were randomly assigned. Do we not see examples of this reported in emergency rooms?

You might argue that residents in long term care are "residents" and not "patients". Their rooms are like their homes. Hence, differentiation of living arrangements are justified and reflect the right to private wealth. These arguments are spurious. Residents of long term care are dependent individuals. Their life prospects are diminished. (The mean survival length is about 1 year 8 months, is it not?)

Unconscious judgments about the merit of care of individuals are likely. Also, management of facilities have reason to prefer to house higher paying "guests". These folk generate more profit.

We want to be clear. We are not suggesting that front line staff are prejudiced or blaming them for systemic effects. In fact, reports by PSW's of the dynamics in the current reality are very different. Being so short staffed, front line staff are desperately occupied with reacting to the demands of those residents most disturbed and most in need of attention. In fact they have talked about the effort they make to meet the needs of ALL the residents.

Nevertheless, separate is not equal and differentiating people by their wealth works against equal care. By its very nature, distinguishing people by the rooms they can afford reinforces the primacy of the profit motive in long term care. If care is the mission, making money from how people are housed militates against the mission of care taking priority over profit.