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POSITION PAPER

ONTARIO'S LONG TERM CARE CRISIS

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INTRODUCTION

Ontario's long-term care (LTC) system provides adults with healthcare and assisted living services when they require access to 24-hour nursing and personal care services. These long-term care facilities are often identified under various names across the province, and can be referred to as nursing homes, continuing care facilities and residential care homes. It has been well established that for many decades now, the LTC system in Ontario has been overburdened, and this has only been further exacerbated by the COVID-19 pandemic (1). As the Canadian population continues to age, and more demand is placed on already limited resources, a robust and sustainable remodeling of LTC facilities in Ontario is needed to improve health outcomes for Ontario' present and future LTC residents.

OPTIONS FOR INCREASED MEDICAL NEEDS IN ONTARIO:

When an adult resident of Ontario has medical needs requiring more intense care, there are a few options available to them. These options include staying in a long-term care facility, which can provide 24/7 care, accommodation, meals, and support with activities of daily living; staying at home with home care support, where healthcare workers visit and provide medical and non-medical supports; or a long-term hospital stay when the person requires active medical management or if a bed in other spaces is unavailable (2). Out of all options, home care is the least expensive in terms of government resources, costing around $100/day, while long term care and hospitals cost around $200 and $1000 a day respectively (2). Home care is also the preference of most Ontario seniors, with research conducted by Home Care Ontario showing that 93% of Ontario seniors prefer home care supports over moving into long term care facilities (2), and in a survey conducted by the National Institute on Ageing, 97% of respondents aged 65 years and older report that they will do everything they can to avoid moving into an LTC home (3).

HOME CARE IN ONTARIO:

While home care is the least expensive and most preferred method of increased support in the community, it too suffers from a number of challenges. Home care was not spared from the impact of the COVID-19 pandemic, with home care assessments and intakes noticeably decreasing during the first wave of the pandemic (4). Prior to the COVID-19 pandemic, shortages in personal support workers (PSW) and nursing staff were known to exist in both home care and LTC, and the pandemic served to further exacerbate these shortages, to the point where the Canadian military had to be called to staff care facilities (5). Staffing difficulties were heavily impacted by poor working conditions, such as hazardous environments, inadequate and unsafe staffing ratios, poor remuneration and limited full time-job opportunities, especially for PSWs. It is estimated that half of new PSW graduates will leave the field within a year (6). Despite the challenges associated with home care in Canada, countries around the world have achieved better outcomes with prioritizing funding for home care models over long term care models (2). Denmark prioritized funding home care in the 1980s and found that access to care increased greatly, with an 185% increase in the percentage of people receiving less than 4 hours of home care a week, while also reducing the number of LTC beds for those 80 and over by 45% (2). The financial benefits of home care were also further emphasised, as research in the United States showed that the cost of one person receiving care in a nursing home was equivalent to three people receiving home care (2). Taken together, while the home care industry is also experiencing difficulties, the fact remains that home care is preferred by the

vast majority of Canadian seniors, and also shows greater economic and social benefits compared to long term care homes. It is important to keep this in mind when discussing the present and future of the long-term care system in Ontario.

STRUCTURE OF LONG-TERM CARE IN ONTARIO:

While Canada's healthcare system is based on the *Canada Health Act*, the inclusion of LTC services is not outlined under any specific sections of the *Canada Health Act*. LTC is considered as an extended health care service by Health Canada (7) and is independently administered by provinces. In Ontario, LTC is overseen by the *Long-Term Care Homes Act*, wherein details about regulation and funding of LTC facilities are specified. Ontario currently has 627 LTC facilities, which can be organized by type of ownership and administration type. LTC facilities can be privately or publicly owned, and the majority (54%) of LTC homes in Canada are privately owned (8). Of privately owned LTC homes, they can be classified as for-profit or non-for-profit organizations. In Ontario, the majority of LTC homes are private, for-profit organizations (57%), with 27% being private, non-for-profit organizations and 16% being publicly owned and administered (8). All LTC facilities, despite the ownership model, are regulated and inspected by the Ministry of Health and Long-Term Care annually. Not-for profit homes are also regulated by their respective governing bodies (9). Funding for LTC is divided into health services and accommodation services, where health services costs are borne by the government (9). Health services costs include services such as nursing and personal care staff, as well as supporting food, social and recreation program costs (10). Accommodation costs, funding non-care staff, utilities and housing related expenses, are expected to be fulfilled by the resident, but government subsidies also exist for those who are not able to supplement the full cost on their own (9). While both private and publicly owned LTC homes receive government funding to cover health services expenses, profits are made through accommodation costs.

Residents must meet specific requirements to access LTC, which include being 18 years or older, being part of the Ontario Health Insurance Program, and requiring health care needs such as 24/7 nursing care and on-site supervision that cannot be met through community-based services (10). These applications are assessed and filtered through case managers through local community care access centers. Importantly, individuals may apply to a maximum of five LTC facilities, which can then accept, reject, or place prospective residents on a waitlist. Waitlists can be lengthy, with the median number of days Ontario community members waited to move into a long-term home being 118 from home and 114 from hospital (10). Waitlist times

are also influenced by the type of bed requested for care. In Ontario and certain other provinces, residents of LTC facilities can opt for different bed tiers depending on their personal resources (11). Three tiers of beds exist: basic beds, semi-private and private beds, and can be found in both private and publicly owned LTC facilities. Basic care beds house 3-4 individuals per room, whereas semi-private host 2 and private are individual rooms, with the cost of each type of room proportional to the amount of privacy provided. Basic beds however are the only beds that qualify for the Long-Term Care Home Rate Reduction, a governmental program to help offset the accommodation costs associated with LTC (11).

As per governmental policy, LTC facilities are required to set aside a minimum of 40% of rooms for basic care, which also includes short-stay and certain specialized care beds (11). Basic beds are also the bed type with the longest waitlist, such as in Ottawa, where 64% of those waiting for a LTC bed are waiting for a basic bed (11). This can result in wait times nearly a year longer than for private or semi-private beds (12). Once off the waitlist, however, a prospective resident's application is once again re-evaluated by the facility and if accepted, the resident may choose to either accept or reject the offer (10). It is important to note that while the demands of aging and chronic disease often pre-dispose Ontario's senior population to access LTC, many individuals require LTC throughout their life span, and it is not solely limited to those 65 and older.

STATE OF LONG-TERM CARE: PRIOR TO COVID-19

While the pandemic has shone a spotlight on LTC homes, the conditions that precipitated the tragedies therein did not appear overnight, but rather progressed for decades on the backdrop of insufficient funding and support. The issues facing LTC facilities prior to the pandemic included shortages of healthcare staff, especially those with adequate training, physical capacity limitations that fell short of existing design standards, and the ever-growing wait list and access to care for Ontario residents who are presenting with increasing medical complexity and reflect the cultural diversity of the aging population.

Adequate staffing of LTC facilities is an ongoing challenge, exacerbated by the limitations in funding in Ontario and COVID-19 crisis. Currently, provincial remuneration models fund only direct healthcare staff in LTC facilities, which include physicians, nursing and PSW staff (14). Funding is often limited, and as a result, staffing is often far below recommended levels (14). A 2020 public inquiry showed that of all LTC staff, PSWs make up the majority of LTC staff at 58%, and 25% are registered nurses, but with only 40% of nursing staff working full

time, this means most cannot access benefits and other securities associated with full time employment (15). In addition, 50% of newly graduated PSWs leave the field within a year (5), and 25% of PSWs also leave the field within two or more years of experience (15). It is also important to note the gender and racialized backgrounds of those working in LTC. As of 2018, 90% of the PSW workforce in Ontario is female (15), with 41% of PSWs also identifying as a visible minority (15). Immigrant and racialized women are known to be overrepresented in Canada's healthcare workforce (16), with most performing the most underpaid roles (16).

It is no surprise to see the high staff turnover when reports of mismanagement, neglect, abuse, and violence are rampant within Ontario LTC facilities. A CIHI investigation into PSW experiences showed that PSWs often felt overlooked and reported multiple incidences of bullying, racism, stigma, and discrimination in their roles (17). Reports also showed unsafe work environments both physically and emotionally (17). These findings are exacerbated by the high pressures of a low staff-to-patient ratio, increasing biopsychosocial complexity of patients, and limited time allotments per patient (17,18). Care workers are overworked beyond their capacity and unable to provide safe patient care. Ontario currently has no legislated minimum staff-to-resident ratio requirement for long-term care facilities (17).

In addition, poor working environments for staff translate into poor living conditions for residents. 85% of LTC homes in Ontario have routinely violated healthcare standards for decades with near-total impunity (18). An investigation by CBC Marketplace reviewed 10,000 inspection reports and found over 30,000 "written notices," or violations of the Long-Term Care Homes Act and Regulations (LTCHA), between 2015 and 2019 inclusive. The LTCHA sets out minimum safety standards that every care home in Ontario must meet. Violations included abuse, inadequate infection control, unsafe medication storage practices, inadequate hydration of patients, and improperly managed skin and wound care. Furthermore, of the 632 homes in the Ontario database, 538 (85%) were repeat violators of these regulations. In 2018, the Progressive Conservative government under Doug Ford scaled back comprehensive, annual inspections of Ontario nursing homes, which may have further contributed to the problem by removing protective oversight mechanisms that could have caught issues within LTC facilities earlier. A joint CBC Marketplace and The National investigation analysed thousands of long-term care violations from 2019 to 2020 and found the new system identified 68% fewer infection control violations (18).

High staff turnover and lack of hours are not the only staffing challenges facing LTC facilities. Over the past decade, more seniors were entering LTC homes at later stages in life and with more chronic health conditions, requiring complex levels of care that LTC homes were unable to accommodate. From 2000 to 2015, the number of newly admitted residents living with five or more comorbidities increased from 41.8% to 56.4%, and those living with seven or more conditions increased from 14.1% to 22.1% (19). These residents require comprehensive care including assistance with daily activities, which require staff who need specialized training skills- for example, staff caring for residents with dementia require specialized training in behavioral management skills. As of 2019, there was an estimated shortage of 9,000 healthcare staff (20). Yet, limited funding for hiring, long hours and patient overload for existing staff, and insufficient training support have created a healthcare staffing crisis. A survey of LTC homes in 2018 reported that approximately 80% of homes had difficulty filling shifts and 90% had difficulty hiring staff (20). While staffing issues became worse in the decade leading up to the pandemic, little was done to alleviate this crisis. From 2011 to 2019, funding for LTC nursing and personal care increased at an average annual rate of 2.3%, marginally above the 1.7% rate of inflation during the same period (21).

In addition, while the demand for LTC facilities continued to rise, LTC facilities lacked the physical capacity to keep up with demand. From 2011 to 2019, the waitlist increased by 178% from 19,615 to 34,862, and the wait time by 154% from a median of 99 to 152 days (21). During their wait, most seniors resided at home or in hospitals, the latter of which further exacerbated hospital overload and financial resources. Of all LTC facilities in Ontario, 235 or 38% only met or even fell below the 1972 Nursing Home Act design standards (22). Of the 235 older-design homes, 82% were under for-profit ownerships despite their better access to financial resources for renovation projects compared to non-profit and municipal homes (22). In fact, of all for-profit LTC homes in Ontario, 53.6% do not meet the current design standard compared to 18.5% and 11.9% of non-profit and municipal facilities, respectively (22). While the government pledged funding for construction of new LTC facilities or renovation of prior beds, for a goal of 30,000 beds in 2017, this was hampered by insufficient construction funding, excessive bureaucratic processes, and increasingly rising land costs in certain parts of Ontario (20). The approval process for construction lasted 18 to 24 months due to coordination with multiple governmental bodies instead of a centralized office. Furthermore, LTC homes, particularly in the Greater Toronto Area, were challenged by land costs priced in the millions which disproportionately disadvantaged non-profit homes with fewer financial resources. These development challenges

directly impacted the health and safety of seniors residing in these homes. During the first wave of the pandemic, older design standards and chain ownership that predominated for-profit LTC homes were the most significant factors contributing to the extent of COVID-19 outbreaks and resident death (22). Similar to the staffing shortage crisis, bed capacity shortages in the decades prior were met with insufficient legislation and funding, leading to the current state of LTC facilities.

While the current state of LTC homes has continued to negatively impact all Ontarians, it is important to remember that some groups have been impacted far more than others. Research has shown that immigrant seniors in Ontario experience cultural and language barriers when accessing LTC facilities, and these barriers are only increased in those who are racialized and/or have a non-English first language (23). In addition, Canadians with ethno-culturally specific care needs have been seen to experience wait times as much as six months longer than the average individual (12). An Ontario-wide study confirmed that those who were immigrants and requested an ethno-specific LTC facility were more likely to have increased wait times than those who did not (24). These delays in culturally specific accommodation can have a wide array of consequences on one's health, ranging from malnutrition to depression (25). One of the major contributing factors to longer wait times for culturally sensitive services is the dearth of LTC facilities that offer such services, in addition to contributing factors such as socioeconomic status, which is a known predictor for longer wait times. While much is known of the delays to accessing LTC in Ontario, it is also important to recognize and work towards ending the further disparity in accessing culturally sensitive care.

COVID-19 AND LONG-TERM CARE

The already tenuous LTC system in Ontario was devastated by the COVID-19 pandemic, with LTC residents paying much of the price. Not only were residents impacted by reduced quality of life and social isolation, but LTC facilities in Ontario had some of the highest rates worldwide for COVID-19 infection and death (3,26). While LTC residents make up 0.5% of Ontario's population, they accounted for 64% of the total COVID deaths (26). COVID-related deaths added up to a 28% increase in LTC deaths compared to the pre-COVID 5-year average (26). Multiple factors are thought to have contributed to this increase in infection and death rates. By nature of admission to LTC, LTC residents are already at higher risk of serious complications of COVID-19 infection due to factors such as advanced age and complex medical needs. However, the disparities in infection rates between LTC residents and the rest of Ontario

is not simply explained by these factors, and other factors impacted COVID-19 infection rates in Ontario's LTC facilities.

As previously mentioned, the staffing crisis in LTC facilities was known prior to the pandemic and further exacerbated. In July 2021, 53% of LTC facilities were experiencing daily staff shortages (27). As a result of the staffing crisis, the quality of healthcare provided to residents suffered during the pandemic as residents' existing health needs went unmet. LTC staff were also at risk of contracting COVID-19, especially prior to vaccination and arrival of adequate PPE. In addition, many LTC staff work at other health care facilities or other positions. A BC-based study assessing care-aid work arrangements showed that out of 3700 care-aids surveyed, 24% reported working in multiple LTC homes and 15% worked other additional jobs (28). 73% of care-aids reported the reason for working these additional jobs as financial, and 17% because of the inability to get a full-time position (28). Working at other LTC homes or other positions not only increased one's risk of infection, but also contributed to COVID-19 transmission between facilities. Staffing shortages were further exacerbated with required quarantines due to COVID-19 infection. Severe understaffing led to the Canadian military being deployed to assist in LTC homes (5). In addition, during the COVID-19 pandemic, physician visits to LTC facilities decreased by 16% (29). There were also significantly fewer transfers to hospitals for frequent health issues such as urinary tract infections, chronic obstructive pulmonary disease, heart failure, and pneumonia which led to delays in timely and adequate care (29). Due to social distancing policies, LTC residents also had less visits from unpaid caregivers, family and friends (29). Altogether, the limitations in staff inevitably compromised the quantity and quality of care delivered to LTC residents.

A key observation of the data of infection rates showed a few surprising covariates associated with COVID-19 infection and death rates in LTC facilities. Out of all OECD countries, Canada has had the highest rate of COVID-19 infection in LTC facilities (22), with 1 in 3 Canadian LTC facilities experiencing an outbreak (29). The fatality rate of infected cases in LTC homes was also much higher than the population average, with 37% in the first wave and 17% in the second wave from September 2020 to February 2021 (22). Interestingly, deaths were more prevalent in homes with chain ownership and outdated designs which are mostly found in for-profit facilities (22). American literature using data from 2020 demonstrated that for-profit nursing facilities were associated with higher COVID-19 infection and death rates in six different studies (30). They also looked at the association of demographic data and COVID-19 rates and demonstrated that facilities with higher ethnic minority populations were more likely to have

higher COVID-19 case and death counts compared to facilities with lower minority populations (30). The Ontario LTC COVID-19 Commission reported that oftentimes LTC facilities did not always recognize, acknowledge or value the diverse needs of residents, which caused some residents from diverse ethno-cultural backgrounds to feel disproportionally isolated and alienated (25). While these disparities already existed prior to the pandemic, the pandemic further elucidated the repercussions and highlighted the crucial need to address these disparities.

CURRENT GOVERNMENTAL APPROACH:

According to the 2021 Ontario Budget, of Ontario's $186.1 billion annual expense for 2021-22, the health sector makes up 37.5% ($69.8 billion), and Long-Term Care spending makes up 3.1% ($5.8 billion). $2.6 billion of this is planned to support the building of 30,000 new LTC beds, set to occur over the next ten years. In addition to building new beds, $246 million will be used to improve living conditions in existing homes. The projects undertaken with these funds seek to eliminate three- and four-bedrooms, add spaces to high need areas, address the growing needs of diverse groups and promote the specialized care needs of residents (32).

As of October 2021, the province has stated 60 percent of the promised 30,000 beds are in the planning, construction and completed stages of the development process (33). The projects span the entire province, taking place in northern (e.g., North Bay), eastern (e.g., Cornwall), southwestern (e.g., Owen Sound) and central regions (e.g., North York). According to the budget, this includes adding capacity for high need areas like Francophone and Indigenous communities. To fast-track for some of the current needs, Ontario is building four new LTC homes at an accelerated pace as part of the Accelerated Build Pilot Program, which will provide 1,280 LTC beds. One of these LTC homes in Ajax has just been completed and construction of the other three is already underway (34).

On top of funding new beds, additional investment into LTC was needed to support the operation of facilities during the COVID-19 pandemic. According to the Government of Ontario, since the start of the pandemic, over $2 billion has been invested in an attempt to increase staffing and improve infection prevention and control practices in LTC homes. This includes upgrades to support physical distancing, plumbing or water supply cleaning, updating heating, ventilation and air conditioning systems. The pandemic has also prompted conversations concerning staff shortages and hours of direct care per day received by LTC residents. In response to this, Ontario is investing $4.9 billion over four years to increase the average direct

daily care to four hours per resident per day in LTC and hiring more than 27,000 new positions, including personal support workers (PSWs) and nurses.

The budget further explains that this investment is not only meant to hire additional registered nurses, registered practical nurses and personal support workers, but it is also meant to support continued professional development, improved working conditions and the improvement of staff retention. $121 million of the $4.9 billion is to support accelerated training—a 6-month, tuition-free, college training program—of almost 9,000 PSWs, which is the largest recruitment of PSWs in Ontario's history. Additionally, $4.1 million is being invested into eight PSW training projects for regions with a high prevalence of COVID-19 cases (33).

LTC structure and funding was a hot topic during the 2022 provincial election, where numerous parties offered different approaches to tackling the LTC crisis. The Ontario NDP, Green and Liberal parties proposed ending for-profit long term care systems (35), in different methods. The NDP suggested changing all new LTC projects to be run via a non-for-profit or by the municipality, and proposed funding for these institutions to purchase for-profit homes (35). The Liberal Party would stop renewing licenses of for-profit homes and transfer them to non-for-profit and municipal organizations, while the Green Party proposed increasing funding for long term care by 10 percent (35). All three parties also pledged to build new beds, but with the caveat of being managed by not-for-profit and municipal institutions (36). The elected Progressive Conservative Party did not pledge to remove private for-profit homes and continued their previous pledge to build 30,000 new beds by 2028 (35).

In the fall of 2022, the Ontario Progressive Conservative government proposed and passed a new bill regarding patients awaiting transfer to LTC facilities. Bill 7, the *More Beds, Better Care Act*, targets patients who are deemed "alternative level of care" or ALC who are admitted to hospital but discharged from active medical care, and are instead awaiting a spot at a LTC facility (36). As of September 2022, approximately 6,000 patients in Ontario are designated ALC, of which 2,400 are awaiting LTC (37) Previously, patients and their decision makers had the opportunity to select their preferred LTC facility; which can be based on finances, location, availability of specific ethno-cultural, care or language needs, or other reasons. This new bill allows hospitals to send ALC patients to LTC facilities not of their choosing, on a temporary basis, while still awaiting permanent placement at their desired facility. These facilities can be up to 70 km away if the patient is residing in Southern Ontario or up to 150 km away if in Northern Ontario. It is important to note that these facilities can be

private or public facilities and can be facilities without their specific care needs or outside of their financial resources (37). If patients do not accept the transfer, they can be charged up to $400 a day. The intention behind the bill is to increase the number of acute beds in hospitals to ease the burden on the healthcare system (36). This bill was passed with no public consultation (37). The public outcry to this bill has been focused on the devastating effects it has on both patients and their families. Family members, many of whom provide unpaid caregiving services in already overburdened LTC facilities, may have to drive hours further away; which can be incredibly difficult in places like Northern Ontario in the winter (36,37). Both the cost and lack of appropriate services can serve as huge detriments to patients, on top of the potential decrease in visits from family and friends, who are now farther away. Lack of specific ethno-cultural services, language or care will further deepen health inequities in vulnerable populations and will decrease the quality of healthcare provided to Ontario's LTC residents.

PRINCIPLES

The Ontario Medical Students Association makes its recommendations using the following guiding principles:

1. All adults deserve timely access to appropriate and culturally competent long-term support and care services in Ontario in line with their specific wishes and treatment goals.
2. All employees of long-term care facilities deserve a safe workplace that provides adequate financial, occupational, and emotional support.
3. All efforts should be made to maximize home care services, which research supports as the most popular and cost-effective model of serving increased care needs.
4. Publicly administered and non-for-profit LTC facilities have been shown to have better outcomes in regards to resident and staff wellbeing.
5. The population of adults who will be requiring long-term and increased services will only be increasing in the future, and current LTC models are not equipped to handle current demands nor the increased future predicted demand.

RECOMMENDATIONS

The Ontario Medical Students Association recommends the following:

1. **That Home Care Services be provided with increased funding and staffing to service more individuals and lessen the strain on LTC facilities, including providing living wages to staff, improving staff working conditions, increasing the amount of funding to home care, and increasing the proportion of funding going to Home Care services.**

Close to 1.2 million people in Canada relied on Home Care in 2019, and the demand is only expected to increase, to around 1.8 million people by 2031 (38). Home care, which tends to be generally overlooked in the discussion regarding long term care models, is the clear solution for reducing dependence on acute care services and keeping our population healthier for longer. During the COVID-19 pandemic especially, home care has played a key role in minimizing the exposure to the virus by helping to keep vulnerable adults at home where they are less likely to encounter it. Home care is also the clear preference of most seniors in Ontario, with 93% of seniors preferring home care over other care options and 96% of older Canadians stating they would do anything possible to avoid LTC facilities (2). Home care is patient-centered, personalized, and engages the individual as well as their family at every step of the care planning process. By keeping seniors in home care, they can engage and continue to be active members of their local communities and independently socialize with their friends and family. Compared to other care settings, home care is the most cost-effective and flexible method of providing care (2). The flexibility of home care also allows families to specify the time, frequency, and level of care they require based on their specific needs, rather than having to commit full-time to a LTC facility or retirement home. Unfortunately, home care in Ontario has been suffering similar changes to the LTC system, including staffing and funding crises. Therefore, we call on the Ontario government to provide living wages to staff, improve staff working conditions, increase funding towards home care, and increase the proportion of funding that is provided to home care.

1.1 Provide Living Wages to Staff

Similar to LTC facilities, home care providers have also experienced a staffing crisis. According to Home Care Ontario, care requests were filled 95% of the time prior to the COVID-19 pandemic (39). As of December 31, 2021, only 56% of home care requests were

able to be filled (39), with around 4,000 nurses leaving in addition. The lack of staff was further compounded by high staff absences related to COVID-19 infection (39). Primary reasons why staff leave the home care sector include poor wages. While nurses and PSWs perform similar work in the home care and acute (hospital, LTC) setting, they receive $5 an hour less when working in the home care sector as per Home Care Ontario (39). Better wages is a primary driver of PSWs leaving the field (40). It is also important to recognize that PSWs in particular tend to be overwhelmingly racial and gender minorities, who are already more likely to experience poor treatment and already likely to be receiving less pay for equal work (41).While the Ontario government introduced a temporary wage increase and measures to recruit and train more PSWs, it is imperative to continue these measures by addition of a living wage to retain and attract staff (41). It is also imperative to pay equally for equal work (i.e., between LTC/hospital and home care settings) to ensure adequate staffing and attract more staff as the demand for home care services only further increases.

1.2 Improve Home Care Working Conditions

Improving working conditions at home care services goes beyond providing a living wage. Improving job security, work burdens and providing funding for work related expenses will also help decrease staff burnout and increase retention rates. Job security concerns include adequate hours, stable employment contracts, but also specific concerns about COVID-19 impacts, including infection (41). Many PSWs described reduced hours during the pandemic, including refusal of homecare and decrease in number of clients (41), as well as COVID-19 related including sick and isolation periods. Poor working conditions, including inadequate sick days, inadequate staffing and hours, as well as increased tasks contributed to an increased work burden on PSWs in the homecare setting (41). With a shortage of staff, more PSWs were expected to take on more duties without increases in pay (41). Increased tasks, including working with less-experienced temporary colleagues (who often received more pay), as well as strict infection control protocols, were also noted by PSWs (41). Taken together, these experiences indicate the dire state of home care, and the need for improved working conditions to attract and promote staff retention. It also further underscores the need for equal pay for equal work (i.e., when temporary PSWs made more money than permanent PSWs). The government must ensure that personal support workers and other workers in the home care system are paid fairly for their work and are working in equitable conditions which includes appropriate patient workloads and adequate time per patient. The home care

system cannot be expanded and made robust if the workers powering the system are paid less compared to their counterparts in acute care and LTC facilities

1.3 Increase Home Care Funding to Address Current Issues

While all sectors of Ontario's chronic care system need more funding, the home care system is a prime example. More funding is needed not only to assist with current home care challenges, such as inadequate staffing and poor working conditions, but also to provide a solution to Ontario's burgeoning elder care crisis. Home care is the clear preference for most Ontario's seniors, and also provides sound financial sense compared to other methods of long-term care (2). A report carried out by the Canadian Medical Association demonstrates that while care costs will continue to rise as more Canadians age and require more intensive services, a way to limit healthcare costs is by utilizing home care services more (38). By increasing the number of patients treated at home, the report predicts that $794 million can be saved by 2031 (38). However, funding is needed now to not only fix current home care inequalities but to begin planning ahead. Home care Ontario estimates $460 million is needed to stabilize the home care sector now (42). While the Ontario government has pledged $1 million to expand home care services, it is imperative for the government to first address current issues.

1.4 Increase Proportion of Home Care Funding

Other countries around the world including Denmark, Australia, and the US have successfully reduced the number of long-term care patients by investing into home care services. In 2019, Ontario invested $1.88 billion on direct home care services, compared to $4.3 billion in long-term care. It is important to note that direct-home care services provided care to 730,000 patients compared to 100,000 in long term care. Ontario, and Canada as a whole, must increase the proportion of funding going towards home care. In Denmark, approximately 65% of long-term care funding is spent on home care, compared to 13% in Canada (2). With increasing funding and support to home care services, Denmark was able to increase the percentage of seniors receiving less than 4 hours of care a week by 185% (2). Similar cost reductions in services were found in the United States and Australia (2). As Ontario – and Canada's – population continues to grow, promoting home care services provides the greatest value for the greatest number of people. Home care is the least expensive method of healthcare administration, while also being the most reliable and effective form of care for individuals compared to acute care and LTC

facilities (2). By investing in a robust home and community care system, the healthcare system will reduce burden on acute care visits and congregate settings like LTC facilities.

2. That the Ontario government commit to urgently address unsafe working conditions in LTC by increasing and promoting equal pay, improving working conditions and providing better oversight over LTC staff.

2.1 Equal Pay for Equal Work

LTC facilities suffered from a mass exodus of staff during the COVID-19 pandemic, which made it clear they are not an attractive workplace for several reasons. One such reason is the clear pay difference between LTC staff and other healthcare facilities. Dr. Samir Sinha, Chair of the National LTC Services Standard Committee, argues that the first step towards better working conditions is “wage parity”, which involves paying LTC staff the same amount they would be paid at hospitals (43). By failing to equalize pay, we promote the loss of qualified staff in the LTC system, exacerbating staffing shortages. When staffing shortages are too dire to function, additional staff must be called in, usually through temporary agency workers. Similar to hospital workers, agency workers often receive more pay than permanent LTC staff- sometimes by more than double. Agency workers have reaped other benefits as well: at one point in the pandemic, agency workers were exempt from having to remain at one facility (31). This not only increased the risk of COVID-19 transmission but also disrupted the continuity of care provided to residents as new workers were unfamiliar with the preferences and safety considerations of specific residents. It is inequitable and unsustainable for workers to be paid differing amounts for the same vital work. The government must formulate a clear plan to achieve equal pay for equal work across the province’s healthcare sector to adequately tackle the staffing shortage in LTC.

2.2 Implement a Living Wage for LTC staff

On top of reduced wages in the LTC system, LTC employees often do not make enough or have enough hours to earn a decent income. The lack of a suitable living wage is another reason LTC facilities are suffering from major staffing crises, and lead to poor resident outcomes. LTC facilities PSWs make an average of $22.69 (44) throughout Ontario. While the living wage in Ontario can vary depending on location (45), it is assumed to be based on working 40 hours a week, which many PSWs are not given. When given a $3 an hour raise

by the government in the midst of the COVID-19 pandemic, many PSWs employed by private institutions did not receive their pay until months later (46). It is also important to recognize the intersectionality of many PSWs and the overall labor force in LTC facilities; there is an overrepresentation of gender and ethnic minorities (16). These groups are more likely to face the burden of racism and sexism and exercise less political power (16). Therefore, it is crucial to provide PSWs and other staff in LTC facilities a living wage. We call on the Ontario government to provide a living wage to all PSWs employed in public and private LTC systems, and to make this wage equivalent to PSWs employed in home care and hospital settings. By not doing so, we fail to recruit and retain qualified workers in LTC homes and thereby exacerbate staffing shortages, unsafe work environments and ultimately negatively impact patient care.

2.3 Implement a Governmental Staffing Oversight Agency

The LTC system in Ontario is a hodgepodge of publicly and privately owned and operated facilities. While all facilities are overseen by the *Long Term Care Act,* there exists no legislation regarding staffing oversight of LTC. This became a major issue during the COVID-19 pandemic when due to poor wages and job security, many PSWs and other healthcare support workers worked at a number of facilities, thus contributing to the spread of COVID-19 (28). In addition, labor shortages were so dire that the Canadian military had to be called in to staff LTC facilities (2). As a solution to combating spread of infections between facilities, the BC provincial government created a registry of care workers (47). While this tool was developed to prevent staff from working at multiple sites, it also created a centralized registry of all staff, including demographic data, educational levels, employment trends and staffing levels. Ontario had plans to create such a registry in 2018 (48); however, it appears that this registry never came to fruition, as the linked website now provides information about gambling (49). We call on the Ontario government to develop a centralized, province wide PSW and health care aide staffing registry. This registry will provide information about staffing challenges, demographic data and employment trends of PSWs and other health care aids throughout Ontario and is the first step in improving working conditions.

3. **That the Ontario government mandates comprehensive socio-demographic data collection as it pertains to waitlists/wait times across LTC.**

As outlined, many of the current issues that plague the LTC system in Ontario need to be examined and addressed with EDI considerations. A barrier to this, and perhaps a reason why the government has failed to address these shortcomings thus far, is the lack of robust data collection and research examining these issues. Although there is currently plenty of COVID data collection in LTC, the government has failed to collect data related to EDI in LTC. Currently, we can hypothesize where EDI plays a role in LTC issues, but it is difficult to make direct recommendations to address issues that are poorly quantified and researched. The first step to addressing these problems is gathering the data to better tailor solutions.

Comprehensive data collection would clarify the makeup of the population currently residing in LTC and on the wait lists. This will allow for tailored EDI staff training to best suit the needs of the population. This data and related research will also be able to verify the positive impacts of ethno-cultural specific homes on outcomes and quality of life. Additionally, further down the line this data collection will allow for the building of appropriate numbers of ethno-cultural specific homes/beds. Ideally, this would also help address the inequality in wait times that people waiting for specific care experience. This initiative will also increase our understanding of the ratio of patients waiting for basic beds, and to plan accordingly.

Ultimately, mandating the collection of socio-demographic data with respect to wait times, care, and outcomes is the first step towards addressing the complex issues involving these factors, and increasing the awareness of equity, diversity, and inclusion in LTC in Ontario.

4. **That the Ontario government improve LTC access by increasing the percentage of beds for basic care above the 40% minimum.**

Long term care is a costly matter, and its expenses are borne between the government and individual residents. The cost of accommodation at all long-term care homes are set by the Ministry of Long-Term Care and reviewed every year (50). As of October 2022, the basic daily rate for a long-term care resident was $63.73, or almost $2000 monthly (50). For comparison, a private room costs $91.04 daily, or around $2800 monthly (50). These rates, even for basic beds, can be cost-prohibitive for many, especially those with increased health needs, as they are more likely to be older or have limited incomes. While the Ontario government does offer a subsidy for beds, it does not cover the full cost of care. Long-term care homes, both for-profit and nonprofit, are allowed to designate up to 60% of their rooms as “preferred accommodation” (51). With the introduction of Bill 7, patients may be forced to

go to a more expensive LTC room in order to free up beds (52). To improve access to long term care facilities, and reduce waitlists, we call on the Ontario government to increase the percentage of basic care beds above the current 40% minimum. By increasing more financially affordable beds, more patients can access the care they need and reduce time spent on waitlists.

5. **That the Ontario Government improve LTC resident quality of care by legalizing adequate staffing ratios and providing access for ethno-culturally specific avenues of care in all LTC facilities.**

5.1 Legalizing Adequate Staffing Ratios

Currently, there is no legalized minimum staffing ratio for LTC facilities. Current regulations require enough staff to "meet the assessed needs of residents" and at minimum, "one registered nurse on duty at all times" (53). There is also no legally mandated number of hours of care per resident either (53). The Ontario government promised in 2020 to provide four fours of care per resident each day (54) with Bill 37, which is scheduled to be implemented by March 25, 2025. However, while 4 hours of care per patient is a step in the right direction, this step is too late and too little to sufficiently manage appropriate care in the long-term care sector. According to the Ontario Nurses' Association (ONA) and the Registered Nurses' Association of Ontario (RNAO), a formula consisting of 20% registered nurses, 25% registered practical nurses and no more than 55% personal support workers should be implemented in LTC facilities (55). In addition to expediting the implementation of Bill 37 to earlier than two years from now, we call on the Ontario government to legalize adequate professional staffing ratios in accordance with the ONA and RNAO's recommendations. Not only will legalizing adequate staffing ratios improve patient care, but they will also improve staff morale, turnover and burnout rates.

5.2 Providing ethnoculturally specific care in all LTC facilities

As per the *Fixing Long Term Care Act*, the long-term care center is "primarily he home of its residents" and must be operated in a way where residents have their "physical, psychological, social, spiritual and cultural needs adequately met". While the COVID-19 pandemic showed quite clearly the lack of physical, psychological, and social care services in LTC homes, it is important to draw attention to the spiritual and cultural needs of residents.

Homes that have resources for specific religious or cultural communities are few and far between and often have lengthy waitlists and are in major centers, limiting accessibility to those who do not live near those centers (38). While the government commits to increase staffing levels and physical long term care home availability, it is also imperative to increase the provision of ethnoculturally specific services in LTC facilities across the province. Residents and their families should not have to wait excess periods of time to receive adequate culturally specific care, and this should be available in all LTC facilities across the province. Therefore, we call on the Ontario government to commit to funding upgrades for all current and pending LTC facilities to provide a variety of ethnoculturally specific care services, including translational staff and specific cultural and religious programming.

6. **That the Ontario government and Ministry of Health and Long-Term Care aim to increase the amount of publicly funded and administered long-term care facilities due to the better evidence surrounding publicly administered LTCs with the aim of removing all privately administered long term care homes.**

Ontario is currently in the process of awarding 30-year funding deals and operational licenses to replace 31,000 LTC bed licenses that will expire in July 2025. Currently, for-profit, non-profit, and municipal-run organizations can apply for these licenses. We urge for new legislation to stop renewing and approving new licenses of for-profit homes and instead, diverting the funding and licenses to non-profit organizations and municipalities.

For-profit organizations have a poor history of managing LTC homes and ensuring resident health and safety. Regulations exist but are not implemented appropriately. There is a lack of strict penalizations and immediate action to correct the poor standards that are being provided by for-profit organizations. Since Doug Ford has led the PC Government, only 9 out of 626 LTC homes in Ontario underwent quality inspections, and no LTC home has been fined, lost its license, or had its license revoked (18).

Studies show that for-profit LTC management is considerably worse than publicly run facilities across a range of outcomes (57). This impacts mortality and morbidity as evidenced by the 6.3 deaths per 100 residents that occur in for-profit LTC facilities as compared to 2.8 deaths per 100 residents in non-profits, and 1.4 deaths per 100 in publicly owned LTCs (58). Despite this, the majority of new LTC bed licenses have been tentatively awarded to the same for-profit

organizations responsible for the worst pandemic death rates (58). For example, UniversalCare Canada Inc, a private company known for dozens of citations for violating the Long-Term Care Homes Act and involvement in a $35-million lawsuit over dozens of deaths at one of its LTCs, was chosen to manage an LTC home in Etobicoke, Ontario (59).

Much of the problem with how these licenses are afforded is due to the newly legislated Bill 37. The *Providing More Care, Protecting Seniors, and Building More Beds Act, 2021*, otherwise known as Bill 37, was passed towards the end of 2021, and serves to overhaul the Long-Term Care sector in Ontario. Bill 37 uses ambiguous wording that may make it easier for more for-profit organizations to gain contracts to build future LTC homes. The *Long-Term Care Homes Act, 2007* states that the government must be “committed to promotion of the delivery of long-term-care home services by not-for-profit organizations” (60). Bill 37 changes this to “committed to the promotion of the delivery of long-term care home services by not-for-profit and mission- driven organizations". “Mission-driven” is not given a specific definition or rationale; it is a term that may be applied to for-profit LTCs to be given additional contracts based on intangible vision statements. Under its “Limitations on eligibility for license” section, Bill 37 does not provide sufficiently specific standards to prevent those with poor records from being eligible for licenses. The past conduct of a corporation operating an LTC home only needs to meet “reasonable grounds to believe that the home will be operated in accordance with the law and with honesty and integrity”. Furthermore, the corporation only needs to demonstrate that it is “competent to operate a long-term care home in a responsible manner”. The lack of concrete definition leaves room for subjective interpretation; more quantifiable clauses are needed. In addition to this, towards the beginning of the pandemic in 2020, Bill 218 was passed which provides liability protection to various businesses, nonprofits and workers against COVID-19 related lawsuits. Essentially, any entity acting in “good faith” or in “honest effort” is offered protection from being held liable for harms related to COVID-19. Unfortunately, this provides a higher threshold for families of residents to bring action against bad actors. Advocates for LTC residents like the Ontario Health Coalition, are pushing for LTCs to be cut out from this bill (61). Long-term care needs to be integrated into our public health care system via legislation that ensures that care in this sector is universal, accessible, and adequately funded. As future providers, invested in the health and well-being of our patients and communities, we call on policy makers and elected officials to achieve this goal by issuing LTC bed licenses to non- profit organizations.

7. **That the Ontario government repeal Bill 7.**

Bill 7, which was passed without any input from health care staff, community members or citizens of Ontario, intended to reduce the backlog of ALC patients in hospital. However, this Bill causes more harm to patients and their families than good, by effectively forcing patients to accept any LTC facilities, including those that may be further away from supports and home or not provide the specific care they need. If patients refuse their placement, they are penalized $400 a day, which is prohibitively expensive to those who require long term care, who are more likely to be financially vulnerable. We call on the Ontario government to repeal Bill 7 and focus on investing more long-term support to the LTC sector rather than implementing this harmful short-term measure.

8. **That all undergraduate medical schools provide mandatory curricula about the administration and functioning of LTC facilities in their region, and call for mandatory pre-clerkship LTC medical student involvement, whether that be in the form of shadowing or longitudinal clinical exposures.**

Our own experiences as medical students have shown us the importance of long-term care. Unless one is granted the opportunity through specific rotations – and those may not be consistently available, such as family medicine, palliative or geriatric medicine, medical students may never encounter the inside of a long-term care home. While many of the patients we see live full time at such facilities, it is an environment we are entirely unfamiliar with. Therefore, we call all Ontario medical schools to include more curricula and exposures within long-term care settings. This can include pre-clerkship longitudinal experiences, where we can shadow or participate in supervised clinical encounters. These encounters can range from socialization to supervised medical activities. In addition, medical schools should also offer formal pre-clerkship training about long-term care homes and options in their respective communities. This can be done through didactic or interactive teaching options. In our opinions, this teaching will greatly increase our knowledge of social determinants of health, but also help us better understand the constraints of the healthcare system.

Implementation Strategy

The long-term care system in Ontario has been deteriorating in the past decades, and of note, a solution to our current crisis will require extensive overhauling over multiple years and enormous amounts of advocacy work. We recognize that as a student organization, our role in this crisis may be limited to advocacy. As such, our implementation strategy includes the following:

1. **Home Care:**

A clear solution for addressing the LTC crisis is by investing in Home Care, including increasing funds to salaries of Home Care workers and improving accessibility. As medical students, we recommend that OMSA be involved in advocacy work such as Equal Pay for Equal Work campaigns.

2. **Improving LTC working conditions:**

Working conditions for LTC facilities have been poor for many years for a number of reasons. As a starting point, we recommend that OMSA be involved in currently existing campaigns such as Equal Pay for Equal Work. We also recommend that OMSA advocate for improved working conditions through speaking directly with policy makers at the provincial and federal levels. In addition, OMSA can continue to raise awareness about the poor working conditions at student events such as the Day of Action.

3. **Improving LTC oversight:**

Standards of care and policies that guide LTC function are in place. However, the varying organizational structures for different LTC facilities across Ontario act as barriers to meeting these standards within LTC care homes. Improving the level of oversight for these LTC facilities will help to address the varying levels of adherence by these facilities to the standards of care set out for these programs. We recommend that OMSA be involved in advocacy efforts to the government at the provincial level in order to advocate for greater LTC oversight and raise awareness of the differing standards of care across LTC facilities.

4. **Mandating Ethnocultural data collection:**

It is known that seniors in Ontario that come from marginalized and racialized communities and/or have a non-English first language face cultural and language barriers when accessing LTC facilities. In order to address the health care inequity and longer wait times faced by Canadians with ethno-culturally specific care needs, we call upon the LTC administration in

Ontario to begin a comprehensive data collection program in order to create an up-to-date database of the current population of seniors in LTC facilities, and their specific ethno-cultural needs. This is the first step towards addressing the lack of specific ethno-cultural services, language or care for the diverse populations of Canadians in LTC. OMSA can help advocate for this by raising public awareness, such as through social media campaigns, as well as utilizing their relationship with decision makers in CMA, OMA, and Ministry of Health to advocate for such programs.

5. **Increase number of publicly administered LTC facilities:**

Research has shown that publicly administered LTC facilities lead to better outcomes than alternative approaches to administration. We recommend OMSA to be involved in advocating for new LTC facilities to be publicly administered. This can be done through social media campaigns and advocating directly with policy makers such as members of municipal and provincial government.

6. **Increasing the number of basic LTC beds:**

In order to improve access to LTC and reduce the length of the waitlists, we call on the Ontario government to increase the percentage of basic care beds above the current 40% minimum. By increasing more financially affordable beds, more patients can access the care they need and reduce time spent on waitlists. This can be done through social media campaigns, public letter writing and advocating directly with policy makers.

7. **Repeal of Bill 7**

OMSA and other healthcare organization partners such as the Ontario Long Term Coalition, CMA and OMA, need to advocate for a repeal of Bill 7. With the introduction of Bill 7, patients may be forced to go to a more expensive LTC room in order to free up beds. Advocacy to repeal Bill 7 can include direct advocacy with policy makers and public relations campaigns.

8. **Increase LTC Education in Medical School Curricula:**

As medical students, our most effective and quickest form of advocacy is likely in the change of our own program. We call on OMSA and its respective partners- the six medical schools across Canada- to advocate for the initiation of curricula surrounding LTC in pre-clerkship. This can be

done by first carrying out a survey of current education practices, and then developing curriculum material and opportunities for clinical encounters from there.

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