**Notes for the panel presentation by Hugh Armstrong**

**Ontario Health Coalition Conference**

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My assignment is to discuss long-term residential care, and to suggest how it can be better integrated with other health care sectors.

Let me start with long-term residential care itself, and more specifically with what are usually called nursing homes. These are facilities that in Ontario and elsewhere across the country are heavily regulated, receive most but not all their revenue from the provincial government, and have residents who are in need of considerable nursing and personal support care. This means that I’m not focusing on retirement homes, although heaven knows they need our critical attention.

Nursing homes are typically viewed as signs of failure: failure of the individual to remain ‘independent’, failure of the individual’s family to provide needed care, and indeed failure of the medical system to provide cure. Nursing homes have their origins in the poor house, and often have the feel of junior, under-resourced hospitals. They are regarded as the last resort, as the warehouse or refuge where people go to die.

But why can’t we see nursing homes as a positive option that treats people with dignity and respect in safe, caring settings where seniors can escape the unhealthy isolation that so many experience in private homes?

Notwithstanding the dedication of those who work in nursing homes – they put in even more unpaid overtime than do hospital workers, who themselves put in more unpaid overtime than other workers – we know that under current circumstances nursing homes are not the option of choice for most seniors and their families. The *Toronto Star* campaign now underway highlights a couple of the most dramatic reasons: soiled diapers and abuse.

In our research interviews, nursing home workers have talked about the disposable paper diapers that are made available to them only grudgingly, perhaps one per resident per shift. The workers report that they try to ‘steal’ and hide extra diapers, but face ‘diaper police’ who search out and repossess the hidden supplies. One of the glorious achievements of capitalist production is the innovation contained in these disposable diapers: a line indicating when the saturation level has reached 75%. The workers are firmly instructed not to change the diapers until this level is reached.

A second reason nursing homes are considered no better than a last resort is abuse. It is directed at residents, to be sure. The 125 cases reported last year against the 77,000 residents in Ontario nursing homes is 125 too many. But the *Star* is not reporting the whole story. There are also high levels of abuse or violence directed against nursing home workers. Our research revealed that fully 43% of these workers experience violence from residents and their families on a daily or almost daily basis.

These two situations, diapers and abuse, are of course linked. As one personal support workers put it to us, commenting on the 75% saturation rule, “I’d hit out too if you put me in that”. If frustration is widespread, workers and residents alike may lash out.

A central assumption informing our research, and one I was pleased to hear mentioned during yesterday’s meeting, is that the conditions of work are the conditions of care. And our nursing home conditions don’t have to be as they now are. Contrast the 43% daily violence rate in Canada with the 6.6% rate reported in Nordic Europe. Our rate is over six times greater, and the composition of the resident populations is similar in terms of age, sex and levels of cognitive impairment. The explanation for the vast difference must lie elsewhere.

The most obvious factor is of course staffing levels. We lack sufficient staff to provide care, as distinct from carrying out specific tasks in rushed fashion. This situation is exacerbated by widespread short staffing.

Another factor is control. Nordic workers enjoy more autonomy. They can more readily exercise their judgement about which residents need what kinds of care when. A third factor is the effective size of the unit in which residents live, eat and socialize. In smaller, more home-like settings, where residents and workers get to know each other better, violence is reduced.

Our research, along with that of others, also indicates that the care tends to be better where the profit motive is absent. For-profit homes tend to have fewer staff, more complaints and shorter wait lists than their non-profit counterparts. Preliminary indications are that they are less likely to participate in even modest improvement initiatives like “Residents First”, which is now being introduced in Ontario.

Let me now turn to the continuum of care, to how nursing homes and their residents fit within the broader range of health care services.

The first thing to acknowledge is the Alternate Level of Care or ALC issue. Many hospital patients would be better served, and at less public expense, elsewhere.

The simplistic solution would be to build more nursing home places. More are and will be needed, given population growth and aging, but for ALC purposes this is at best a short-term solution. The reason, just as with super highways if not baseball parks, is that if you build it, they will come. The current system requires nursing home operators, for-profit and non-profit alike, to fill each available space in order to get paid for it.

It would be better to make the hospitals, now overly focused on treating discrete body parts, more senior-friendly. Then more patients can be discharged to their private homes rather than waiting in hospital beds for spaces to open up in nursing homes. Why is there so much hospital malnutrition? Why do so many hospital patients lose the capacity to move around? Why do so many become infected or confused?

For all the rhetoric about home care and community care to keep people out of institutions, the reality is that it continues to be health care’s poor cousin, as Doug Allen demonstrated here yesterday. But more than money is needed. To take one modest example, the Aging in Place initiative in Ottawa, which locates public health nurses in apartment complexes where lots of seniors live, has been shown to reduce repeat trips to the ER, easing pressure on the public purse as well as on the seniors themselves.

But these are all only partial solutions. The public health nurses, for example, are paid out of a different budget than the ERs. They are usually outside the jurisdiction of the LHINs, which in my view should be democratized, strengthened and given more responsibility, not eliminated.

In the spirit of the Occupy movement, we need to change the agenda. Generations ago, this was the conclusion reached by the Conservative judge appointed by Prime Minister Diefenbaker to make recommendations on health care. Justice Emmett Hall concluded, for reasons of efficiency and fairness, that universal, public health care should be introduced, and that it should cover all health care services, not just those provided in hospitals and doctors’ offices. As Hugh Mackenzie argued yesterday, we need to fight for more consumption in common.

In other words, our position should be that medicare must include nursing home care, rehab care, home care, respite care, palliative care, pharmacare and so on. Only then can we build an integrated system. Only then will we achieve the fairness, quality and, yes, efficiency we seek for health care.

Thank you.