Submission to the Standing Committee on General Government

Regarding Bill 160, An Act to amend, repeal and enact various Acts in the interest of strengthening quality and accountability for patients

Draft

November 13, 2017

General Overview

Public media messaging about this legislation has focused on the elements of the Bill relating to transparency. However, in actuality Bill 160 is an Omnibus Bill with far-reaching implications. The legislation repeals four existing Acts, enacts three new Acts, and makes significant amendments to seven Acts and other amendments to more than thirty Acts in total. Most of its Bill 160's key sections have not received any public consultation prior to their introduction in legislation.

The process by which this Bill has been introduced is unacceptable. It is a massive piece of legislation impacting dozens of existing laws without proper public consultation and without appropriate time for the public to analyse and respond. There are four days of public hearings in Toronto only, though the Act impacts the liability of municipalities and ambulance services across Ontario, lifts the ban on private hospitals across the province, enables the introduction of an array of private clinics, changes conditions of care and work in all of Ontario's long-term care homes impacting more than 77,000 Ontarians who reside in those homes and their families as well as tens of thousands of care workers, and enables private retirement homes to legally restrain or lock up residents, among many other provisions.

As a matter of top urgency, we are calling for the repeal of Schedule 9 of this Act. This Schedule repeals the Private Hospitals Act , the Independent Health Facilities Act and the Healing Arts Radiation Act. By repealing the Private Hospitals Act, this Schedule removes the ban on private hospitals. It also dramatically widens the ability for cabinet or for an appointee of the Minister, without going back to the Legislature, to usher in a whole array of private for-profit hospitals and clinics. There is no preference for non-profit ownership and no prevention of foreign ownership. There is no improvement to the safety regimes in the new Act as it is proposed here. Almost every meaningful item regarding quality of care, safety, monitoring and enforcement is left to regulations that can be decided by cabinet and changed easily with little public notice and input.

Schedule 10 must also be repealed. It enables private for-profit retirement homes to legally confine residents.

Schedule 1, which enables the Minister of Health to order all ambulance services in Ontario to transfer patients to non-hospital facilities (including the new array of private hospitals and clinics described above) and to treat patients in ambulances without taking them to public hospitals must be amended.

We support Schedule 4 which provides the Minister of Health with new powers to obtain information about financial relationships in the health care sector.

We also support Schedule 5 which limits the confining (including use of restraints and locked units) of residents in long-term care homes. However, this Schedule does not recognize in any way that the requirement to minimize confining must be accompanied with a level of care that is adequate to meet the needs of residents. While the acuity of residents (that is, the complexity and care needs) has increased dramatically with the cuts to psychogeriatric and chronic care hospital beds and population aging, the level of care in Ontario's long-term care homes has lagged far behind the increased need. As a result, the level of violence has increased. Homes are increasingly unsafe for residents, families and staff alike. This Schedule must be amended to include a minimum average care standard of 4 hours of hands-on daily care for residents, proper provisions for specialized care for those with behavioural issues, better monitoring and reporting, a reduction of temporary agency staff, and an increase in hospital beds for patients with care needs that are too heavy for long-term care.

Schedule I: Ambulance Act

This Schedule amends the Ambulance Act to do the following:

1. *Enables the Minister of Health to direct all ambulance services to take patients to non-hospital destinations.*
2. *Enables the Minister to expand the role of land ambulance operators to cover more than pre-hospital services and to treat patients without taking them to hospitals, enables an expanding array of services, and gives expanded powers for inspectors to access more facilities, vehicles and records.*
3. *Forbids anyone from holding themselves out as a paramedic except for paramedics.*
4. *Enables Cabinet, by regulation, to exempt anyone from any part of this Act.*

There has been no public consultation on these amendments.

<u>Analysis</u>

As written, these amendments appear to be geared to facilitating existing cuts to public hospitals, facilitating privatization of public hospital services, and enabling more cuts to public hospital services. Already Ontario has engaged in the most radical cuts to our public hospital services of anywhere in Canada. Ontario has the fewest hospital beds left in the country. In fact, among OECD nations, only Chile and Mexico have fewer hospital beds than Ontario. As a result, Ontario's hospitals are now experiencing rates of overcrowding that are unparalleled and unsafe. This is a direct result of cuts to public hospital beds and services. As hospital wards are full, patients are treated in beds that are inappropriate for their levels of acuity. When all beds are full, as is the situation in the majority of Ontario's hospitals, patients are held on stretchers in hallways waiting for a bed to become available, sometimes for days. Emergency departments back up and ambulances are taken off the road in offload delays as they cannot transfer their patients to hospital.

The solution for this situation is not to privatize public hospital services to an array of private providers with lesser-regulated care standards, no triage, inadequate personnel and training to assess and care for patients. One part of the solution is to restore public hospital capacity to levels that are safe, according to internationally recognized benchmarks. The other part of the solution is to improve funding and support for public ambulance services to meet population need.

There are few, if any, appropriate places to which ambulance services could redirect patients and the safety and liability issues raised by these amendments are serious. In recent years, for example, private walk-in clinics have begun to rename themselves as Urgent Care Centres. There is no legislation defining or regulating Urgent Care Centres. These are private walk in clinics with a varying array of staff and equipment. They do not have emergency room physicians, Registered Nurses trained in triage, the array of diagnostics and other supporting services that are available in public hospitals. In fact, there is no triage. A patient in a waiting room at a walk in clinic (or urgent care centre) is not under anyone's care. As such, walk-in clinics and so-called urgent care centres are not safe places for transfer of ambulance patients. In addition, most community-based non-profit providers have rosters or admissions processes that would make them inappropriate -- or indeed impossible -- venues for transfer of ambulance patients. We are concerned that these amendments open the door to inappropriate, unsafe and privatized clinics being used to take patients. Further, we are concerned that paramedics and municipalities will be left with more liability as a result of pressure to treat patients without taking them to a public hospital or to take patients to inappropriate and unsafe settings.

Recommendations

Support:

We support the clarifying amendment 20.01 which states that no person other than a paramedic acting in the course of or in relation to his or her duties as a paramedic for an ambulance service shall hold himself or herself out as a paramedic or emergency medical attendant, and; 20.1 which extends the prohibition on fees to cover not only ambulance services but any class or kind of service provided by the operator of an ambulance service. These amendments clarify that private patient transfer services cannot erroneously hold themselves out to be providers of paramedical services and cannot charge fees for ambulance services.

Amendments:

Clauses 7.0.1 (1) (2) and (3) expand the ability for the Minister to make operational or policy directives to operators of land ambulance services where the Minister considers it in the public interest to do so. This includes the ability for the Minister to: give a directive to convey persons by ambulance to destinations other than hospitals; to expand the provision of treatment by paramedics without taking patients to hospitals; to prescribe a standard of care; to make other directives to facilitate the "adoption of treatment models for persons with lower acuity conditions".

These clauses should be amended to clarify that the Minister may direct ambulance services to convey persons by ambulance to non-profit and public facilities only in specifically defined instances including:

- That the patient consents without coercion or pressure.
- That the paramedic is certain the patient is low acuity.
- That the facilities to which ambulances may transfer patients are specifically designated, that the Minister holds liability for so ordering these transfers, and such transfers can include only public and non-profit facilities including: public hospitals and psychiatric hospitals; public non-profit mental health and additions facilities, or; non-profit community health centres, aboriginal health centres and nurse-practitioner clinics.
- That any such transfer accords with evidence-based practices that result in better outcomes for patients.

And, that any expansion of treatment by paramedics outside of hospitals:

- Must be clearly defined in legislation.
- That the Minister holds liability for so ordering the expansion of treatment in non-hospital settings.
- That such expansion of treatment can only occur after broad public consultation, and;
- That such treatment accords with evidence-based practices that result in improvement to patient outcomes.

Deletions:

The amendment to s. 22.1 whereby the Lieutenant Governor in Council may make regulations:

> (f) exempting any class of persons, services, conveyances, vehicles or equipment from any provision of this Act or the regulations and attaching any conditions to any such exemption, including exemptions for the purpose of pilot projects.

This gives wide ability for Cabinet, acting alone with minimal consultation, to exempt anyone from the Act's provisions that protect the public and set standards and conditions for the safe provision of ambulance services. These new powers are sweeping, poorly defined and dangerous and they undermine the entire Act. This amendment should be deleted.

Schedule 4: Health Sector Payment Transparency Act

This Schedule enacts a new Act to do the following:

1. *Require the reporting about financial relationships in Ontario's health care system.*
2. *Intermediaries or affiliates involved in a transaction may also be required to report transfers of value according to prescribed thresholds.*
3. *Provides for the disclosure of the information collected, or analysis of it, on a website or other such place.*
4. *Provides for considerable inspection powers for inspectors to gain access to records.*
5. *Provides for compliance orders from the Minister or inspectors.*

Recommendations

Support:

We support this Schedule as it will provide for greater transparency regarding financial relationships in Ontario's health care system in the public interest.

Schedule 5: Long-Term Care Homes Act

This Schedule amends the Long-Term Care Homes Act to do the following:

1. *Repeal references to secure units and restraints, and to bring them together under one system with a new definition of "confinement". Confinement is not defined in the Schedule, it is left to a regulation to be passed by Cabinet.*

2. *Clarify and limit the use of confinement. In summary: A resident may be confined, if this is included in the residents plan of care and certain conditions are met including:*
    a. *There is risk of significant harm*
    b. *Alternatives have been considered and tried as appropriate*
    c. *Method and degree of confining are reasonable, least restrictive*
    d. *Physician/RN/prescribed person has recommended the confining*
    e. *Consent is obtained from the resident or substitute decision-maker*
    f. *Resident's condition is reassessed as per regulations*
    g. *Resident is confined only as long as there is risk*
    h. *Resident is given written notice*
    i. *Resident is provided with verbal explanation in keeping with regulations*
    j. *Resident is given option to meet with rights advisor promptly*
    k. *Resident can seek legal services and make an application to the Consent and Capacity Board*
3. *Require reports from Rights Advisors, the right to legal counsel, written notice with specific contents, and placement coordinators' considerations when making a recommendation to confine.*

4. *Provide for new regulations for confining residents under the common law duty.*

5. *Enable Long-Term Care Homes to refuse admission to residents if the homes lack the physical facilities staff training, other circumstances pertaining to the regulations.*

6. *Enact new penalties for Long-Term Care Home licensees for non-compliance with a maximum penalty of $100,000.*

7. *Provide for an additional level of compliance such that the Minister or Director (appointed by the Minister) may order the suspension of a license and may appoint an interim manager under certain conditions. These orders are backed with enforcement provisions and provisions for reviews and appeals, including the admissibility of documents etc.*

8. *Enable the Minister to issue operational or policy directives in the public interest.*

9. *Increase the penalties for individuals who commit an Offense under the Act, including fines up to $100,000 and up to 12 months imprisonment for a first offense and $200,000/12 months imprisonment for subsequent offense. For corporations, fines range from $200,000 for a first offense to $500,000 for a subsequent offense.*

This Schedule also amends the Health Care Consent Act to do the following:

1. *Replace references to secure units and restraints with the new concept of confinement.*

2. *Enable those who are confined to access the Tribunal and have a representative.*

3. *Provide guidelines for substitute decision-makers to make decisions in accordance with the person's wishes or in their best interests.*

4. *Provides that consent shall not be given for confining unless it is "essential to prevent bodily harm" to the person or others, or unless it allows the incapable person greater freedom or enjoyment.*

5. *Provides for the role of the Board and evaluators in determinations regarding confining.*

There are ensuing amendments to the Personal Health and Protection Act to include confining in a care facility.

Analysis

For persons with dementia and behavioural issues the issue of restraining and locked units is one that impacts fundamental human rights. For years concerns over the use of restraints, including chemical (drug) restraints, as a practice of convenience or to facilitate care with too few resources, has been raised by advocates as a critical issue. It is a matter of principle that restraining or locking up vulnerable people -- often with severely diminished capacity -- sometimes for the remainder of their lives, must be undertaken only as a last resort.

On the other hand, issues of safety for residents and staff are also critical. Ontario's long-term care homes house residents with very high levels of acuity. As Ontario's complex continuing care hospital bed capacity has been cut in half, patients have been offloaded to long-term care homes without adequate resources and support to provide for their care. Complex continuing hospital beds in Ontario numbered 11,435 in 1990. By 2015 they had been cut to 5,329. Psychogeriatric beds have also been subject to severe cuts. As a result of these cuts and population aging, the number of new admissions to long-term care homes with a high to very high MAPLe scores (the measure of acuity) has grown from 76% in 2010 to 84% by 2016 with an annual increase of 1.8% per year. Today, the vast majority (84%) of those currently admitted to long-term care homes are assessed as having high and very high needs.

The result has been an undeniable increase in violence in Ontario's long-term care homes. In its extreme this violence has resulted in death. In fact, Ontario has a high rate of resident-on-resident homicide in long-term care that must be addressed as an issue of the utmost urgency. Reports from the Office of the Chief Coroner of Ontario's Geriatric and Long-Term Care Review Committee show that there have been 25 homicides in the four years up to and including 2015 in Ontario's long-term care homes. This is an extremely high rate of homicide compared to the general population. In addition, incidents of accident and injury are extremely high. The evidence is irrefutable that Ontario's long-term care home residents and staff have been put at risk by offloading of high-needs patients from Ontario's psychiatric and public hospitals combined with population aging.

The Coroner's jury in the Casa Verde Inquest into the homicides of two residents in a long-term care home noted:

> "…the Jury recognizes that as a consequence of health care restructuring, LTC facilities have become the "new Mental Health institutions" in Ontario. The Jury also notes that these changes have occurred with neither the funding and resources necessary nor recognition of the anticipated needs given demographic changes and the projected increases in numbers of older adults with cognitive impairments."

The Chief Coroner of Ontario's Geriatric and Long-Term Care Review Committee in 2015 reported:

> "Over the last several years, the GLTCRC has reviewed a number of resident–to-resident violent interactions in long term care settings which have resulted in the death of one of the residents. The committee calls upon the Chief Coroner to urgently bring the issue of homicide in long term care homes to the attention of the MOHLTC and the Attorney General."

It recommended that the Ministry of Health and Long-Term Care develop a concrete action plan to address resident-to- resident violence in long-term care homes noting that the current investments in Behavioural Support Teams and training are not a replacement for sufficient numbers of caring staff who have time to spend with residents.

In long-term care homes, the conditions of care for residents and their families are also the conditions of work. Repeated reports note that the current approach to behavioural supports and training are inadequate to provide for the acuity of residents in Ontario's long-term care homes. The amendments to the Long-Term Care Homes Act to limit confinement comprise important recognition of – and protection of – the fundamental human rights of residents. However, the amendments do not recognize in any way the additional resources needed to provide for the safe care of residents with very high needs.

In 2015, the Auditor General concluded that Ontario legislation does not require a minimum front-line-staff-to- resident ratio at long-term- care homes. Home administrators identified insufficient staffing and training as the main reasons for their failure to achieve compliance.

Further, the limitations on long-term care homes' ability to provide for the needs of very high acuity patients must be recognized and addressed. As recommended by the Office of the Chief Coroner of Ontario's Geriatric and Long-Term Care Review Committee:

> "A provincial strategy and implementation plan to improve access to specialized senior's mental health should be developed. It is too difficult to access crisis mental health support for seniors. There are a minority of seniors who require urgent access to specialized geriatric psychiatry in-patient beds. The current level of geriatric psychiatry in-patient beds is insufficient to meet the demand."

In addition, the amendments repeal and replace references to secure units and restraints with the new concept of confinement. But "confine" is not defined in the amendments. Instead it is left to be defined in regulation. Since the entire body of amendments provided in Schedule 5 regarding restaints and locked units follow from this definition, the failure to define confinement in the legislation is a glaring omission.

Recommendations

Support:

Amendments regarding the minimizing of confinement, rights advisors, notice given to residents regarding confinement and their rights to consent, rights advice and other protections.

Amendments regarding the increases in penalties for committing an offense under this Act.

Amendments pertaining to the ability for the Minister or Director to suspend a license and appoint an interim manager.

Amendments:

Confining should be clearly defined in legislation.

A minimum care standard of an average of 4-hours per resident per day including daily worked hours of RN, RPN and PSW daily hands-on care must be required. This average minimum care standard should be contoured to the acuity of the residents. Appropriate resources must be provided to long-term care homes to provide for this minimum care standard. The Ministry must monitor and enforce this minimum care standard.

Eligibility and admissions regulations and policies must be amended to ensure that individuals exhibiting or prone to aggression be assessed prior to the eligibility decision and only be placed in specialized long-term care homes or homes with appropriate specialty units. These homes and units must be sufficiently staffed with appropriate skilled regulated health care professionals who have expertise in managing these behaviours and staffed at a level that these behaviours can be managed without risk of harm to self and others.

The Ministry of Health and Long-Term Care must monitor and decrease significantly the use of agency nurses in long-term care homes.

The Office of the Chief Coroner should be asked provide a comprehensive report covering all the cases of resident-related homicide in Ontario's long-term care homes in the past 15 years to provide added perspective regarding the magnitude and urgency of the problem. This summary report should be shared publicly.

Annual unannounced inspections of all Ontario long-term care homes must be undertaken by the Ministry of Health and Long-Term Care.

Schedule 9: Oversight of Health Facilities and Devices Act

This Schedule enacts a new Act. It repeals the Private Hospitals Act, the Independent Health Facilities Act, and the Healing Arts Radiation Act.

There has been no public consultation on these very significant changes.

In the new Act, private hospitals and private clinics (Independent Health Facilities – IHFs) are rolled into one Act. They are renamed euphemistically "Community Health Facilities" and under section 4 (1) Any person may apply for a licence to operate a community health facility, subject to any prescribed conditions or prohibitions, whether or not the executive officer has requested applications, but the executive officer is under no obligation to accept or consider an application".

Every meaningful definition is left to regulation including the definition of "community health facilities" which is framed so broadly that it could include any health care facility or even non-health care facilities:

> A "community health facility" means (a) a place or a collection of places where one or more services prescribed in regulations made by the Minister are provided, and includes any part of such a place; and (b) a place or collection of places prescribed in regulations made by the Minister."

All meaningful issues regarding quality regimes, standards, safety, inspection bodies and enforcement are left to discretion or regulations.

Analysis

This Schedule is deeply problematic and should be repealed. We consider this to be an urgent and priority issue.

Repeal of the Private Hospitals Act:

The Private Hospitals Act is a limiting Act. It grandfathers in private hospitals that existed prior to 1973 and bans any more licenses for private hospitals from being issued. It gives the Minister to the power to require annual license renewals and to charge fees for them. The Minister can in the public interest, refuse to renew a license, revoke a license, and decide whether a license can be transferred. It also provides for enforcement and fines for non-compliance.

The repeal of the Private Hospitals Act is extremely serious. It removes the ban on private hospitals and the Minister's powers under that Act to control the transfer and renewal of licenses. The provisions of the new Act do not provide for a ban on private hospitals. On the contrary, the new Act delegates authority to an unelected executive officer with wide powers to expand private clinics and hospitals.

The relatively wide discretion of the Minister to control existing private hospitals' licenses is revoked and replaced with weaker provisions that enable private clinics and hospitals to challenge the Minister's decisions.

Moreover, the approach of rolling private hospitals (which allow for a patient to be admitted to an overnight bed) and private clinics (which do not) into one regime is dangerous. The new definition for so-called "Community Health Facilities" that will replace the Private Hospitals Act

will have to allow for admission of patients. As such, this new Act is essentially a new private hospitals and clinics act. Even worse, it has almost no public interest protections, no limits on the introduction of new private for-profit hospitals and clinics, no preference for non-profit ownership, no limits on foreign ownership, no quality or safety regime remotely comparable to public hospitals, and no clear enforcement provisions.

We consider it a top priority that the repeal of the Private Hospitals Act be stopped.

Repeal of the Independent Health Facilities Act:

This new "Oversight of Health Facilities and Devices Act" also repeals the existing Independent Health Facilities Act. The Independent Health Facilities Act was passed in 1989 over the opposition of both Opposition Parties and a wide range of public interest organizations. It governs private clinics, the vast majority of which are for-profit. In fact, in 2012, Ontario's Auditor General reported that less than 3 percent of these clinics were non-profit.

The Independent Health Facilities Act (IHFA) was always problematic and continues to be so. However, the new Act, enacted here, is worse. We consider it an urgent and top priority that the repeal of the Independent Health Facilities Act and its replacement with this Act be stopped.

The new Act renames Independent Health Facilities (IHFs) even more euphemistically as "Community Health Facilities" and the definition of these is left to regulations. In fact, the definition, as noted above, is so widely framed that it does not contain reference to health care at all.

Under the new Act, the ability to introduce a whole range of new private clinics is widened. Cabinet can, at any time, change the definition of the so-called "Community Health Facilities" which are really private hospitals and clinics. As noted above, by rolling the two former Acts into one, the Community Health Facilities definition would have to include admission of patients, thereby opening up the ability for the government, without having to go back to the Legislature, to bring in private hospitals and clinics at any time.

Under the Independent Health Facilities Act Section 3 (3.1) expressly prohibits the charging of facility fees to patients. This provision is missing in the new Act. Currently facility fees can only be charged to the LHINs or Cancer Care Ontario. In the new Act, cabinet can, by regulation, enable facility fees to be charged to anyone.

The new Act does not ban membership fees, or other ancillary fees. Instead it seems to envision these fees being allowed as it simply requires private clinics not to discriminate against patients for refusing to pay them. Our research shows that patients are afraid to refuse to pay fees to clinics and are generally unaware of their right not to pay. This provision is too permissive, very difficult to monitor and enforce, and does not solve the problem of private clinics charging patients for care.

We consider it a top priority that the repeal of the Independent Health Facilities Act be stopped.

Additional General Provisions:

The new Act sets up an executive officer whose powers will be set in regulations. The officer may request applications at any time for more private clinics. Any person may apply for a license at any time. The form of the license is open. The executive officer may approve a license as long as the applicant

pays a fee if applicable and the application complies with a requirement that the license is in a form that is acceptable to the executive officer and contains information that the executive officer considers necessary or advisable. (One wonders why there is any legislation at all, given the paucity of details here.) In general, if the executive officer simply believes that applicant to be honest and law abiding, he or she can approve a license.

There is no limit on private for-profit ownership and foreign ownership of the private clinics that can be introduced under this Act.

For energy applying and detecting medical devices the executive officer has to believe the applicate is competent and responsible. The executive officer also must consider the need for the service now and in the future, the projected cost and availability of funds, and anything else they deem relevant. The legislation gives discretion to the executive officer to decide not to issue a license. The executive officer may amend a license under certain conditions. The executive officer can consent to the transfer of a license. Quality and safety standards are left to be provided for in regulations.

Like the IHF Act there must be a quality advisor. In addition there must be a quality committee. Requirements for these are left to the regulations. The licensee (ie. private clinic owner) can be the quality advisor with the written approval of the executive officer. In an energy applying and detecting clinic, an additional safety officer is required. All details are to be in the regulations. There may or may not be regulations regarding monitoring of services. All other safety issues, such as reporting of incidents will be as per regulations.

Inspecting bodies will be designated by regulations. Those bodies will set standards etc. as per regulations. The inspecting body shall keep confidential all information that comes into their possession in the course of carrying out their function except where required to make the information public as listed. The inspectors can enter and inspect without warrant. An inspector or the executive officer can order a licensee to cease operating or cease providing a service for a time, only for functions under this Act. Penalties for non-compliance are not set. They will be prescribed. The executive officer can suspend, revoke or refuse to renew a license under a set of conditions listed. These decisions can be appealed first to the Board then to Court. One can imagine that any attempt to limit private clinics and hospitals under these provisions would end up tied up in expensive legal proceedings for years. (Note: In the Private Hospitals Act the Minister may revoke a license if he/she deems it in the public interest to do so and there are no appeals.)

All existing IHFs are transferred to the new Act.

At least 34 Acts are amended by this new Act.

Recommendation

Schedule 9 must be repealed.

Schedule 10: Retirement Homes Act

This Schedule allows for the legal "confining" of residents in Retirement Homes. The definition of confining is left to the regulations. There are provisions for rights advisors.

Analysis:

The Retirement Homes Act (2010) is already a deeply problematic piece of legislation, made more so by the amendments enacted in Schedule 10. The Ontario Health Coalition opposed the Retirement Homes Act and called for its repeal. This Schedule is even more problematic as it would allow private for-profit, self-regulating retirement homes to confine residents. There is nowhere in our society where we allow such a situation to exist.

Retirement Homes are not health care facilities. They are governed under the Tenant Protection Act, like any apartment building. The industry is overwhelmingly private and for-profit and the Retirement Homes Act sets up a self-regulating model for the homes.

The role of retirement homes should be limited so that they cannot become de facto long term care homes or chronic care hospitals which are privately owned and operated and are subject to much less legislation and regulation than long term care homes. This would entail limiting the types of services that retirement homes can provide. The consequences of not limiting their role to something more akin to supportive housing are serious. There are no provisions for adequate staffing, including directors of care and physicians as well as nurses and adequate personal support to meet the needs of the residents. There is no facility design manual to ensure the built environment is safe and appropriate. Everything about the regulatory regime for Retirement Homes is less than long term care homes' requirements. Further, because retirement homes pay less and have many fewer legal requirements they are cheaper to operate. The for-profit chains, in particular, may well close their long term care beds, making shortages worse, in favour of opening high-cost privately funded and privately operated (and, according to this legislation, self-regulated) retirement homes.

With the amendments in Schedule 10, it appears that the government will enact Section 70 of the Retirement Homes Act. In so doing, the government will legally enable Retirement Homes to confine residents.

We strongly oppose this Schedule. Retirement homes should not be allowed to confine residents. People with care needs that are so high as to require confining should not be in retirement homes.

Recommendation

Schedule 10 must be repealed.