



March 10, 2021

Ena Chadha
Chief Commissioner
Ontario Human Rights Commission
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180 Dundas Street West
Toronto, Ontario M7A 2G5

Via email: cco@ohrc.on.ca

Dear Chief Commissioner:

We are writing to request that the Human Rights Commission use its public inquiry powers under section 31 of the *Human Rights Code* to investigate systemic discrimination based upon age against the elderly in the provision of health care in Ontario.

In particular, we submit that Ontario's long-standing policy of "de-hospitalizing" the health care system by cutting the number of public hospital beds to levels far below population need – and especially, complex-continuing care beds needed by predominantly elderly patients –, while at the same time under-resourcing long-term care homes, has had, and continues to have, a disproportionately negative effect on the province's elderly. The effect of this policy is that elderly patients are denied appropriate hospital care and discharged into circumstances in which there is inadequate provincially-funded care, thereby jeopardizing their health.

We believe that an inquiry would advance the Commission's mandate, and in particular, further the objectives of its *Policy on discrimination against older people because of age*.¹ Given the reluctance of the Ontario Human Rights Tribunal and the Courts to address systemic discrimination claims, and the scarcity of jurisprudence dealing with seniors and

¹ Ontario Human Rights Commission, [Policy on discrimination against older people because of age](#) (Approved 26 March, 2002; Revised by OHRC 1 February 2007).

the health care system, we submit that the Commission has a critical role to play in shining a spotlight on this pervasive form of discrimination, which affects the elderly and their families throughout Ontario.

As set out in detail below, age discrimination in the provision of health care has been an issue of grave and growing concern for several decades. Over the past several months, these chronic concerns have become tragically acute. The COVID-19 pandemic has made all too apparent inequities in access to health care, which already existed for elderly Ontarians.

According to provincial epidemiological data, as of February 27, 2021, 3,869 residents of long-term care homes in the province had died of COVID-19. This represents 55% of the total of 7,014 COVID-19 related deaths across Ontario.² Significant numbers of residents who succumbed to COVID-19 died in the facilities where they lived, without having been transferred to hospital. For example, Toronto Public Health found that as of April 17, 2020, only 22 of 899 residents of retirement and long-term care homes with confirmed cases of COVID-19 were being treated in hospital – or approximately 2.5%. By May 1, 2020, when there were 1,691 cases in Toronto seniors' facilities, 95 residents – or 5.6% – had been hospitalized. An investigative report by the *Ottawa Citizen* also found that the vast majority of long-term care home residents who had died since the pandemic began did not go to hospital. Using provincial data, they found that as of mid-May, only 13% of long-term care home residents over the age of 70 with COVID-19 were treated in hospital, compared with 36% of the same age group who live in the community.³

A new study by researchers at the University of Toronto and Public Health Ontario looks at hospitalization rates for long-term care residents with COVID-19 through the peak of the first wave and into the second wave of the pandemic. They found that in the peak months of Wave I, March and April, only 15.5% of long-term care residents with the virus were hospitalized before they died. This reached a high of 41.2% in June and July when the first wave was ending. Looking at the pandemic as a whole, and into the second wave from March to October, the study finds that the hospitalization rate for long-term care residents with COVID-19 was just 22.4%. This compares to 81.4% of people who lived in the community.⁴

² Public Health Ontario, [Weekly Epidemiological Summary](#) (27 February 2021).

³ Elizabeth Payne, "[Only 13% of Ontario's long-term care COVID patients went to hospital; advocates want to know why](#)", *Ottawa Citizen* (8 June 2020).

⁴ Kenyon Wallace, "[Only a fraction of long-term-care residents killed by COVID-19 were taken to hospital](#)", *Toronto Star* (6 December 2020).

This raises the very troubling possibility that elderly residents were not hospitalized despite clear medical appropriateness/need. It may well be that in individual cases, proper considerations effectively precluded transfer. There are, however, compelling reports that even where family members, who were the residents' substitute decision-makers, requested that their loved ones be hospitalized, they had their requests denied and were told – sometimes incorrectly – that hospitals were not accepting transfers from long-term care homes.⁵ Families also have reported instances where long-term care homes could not provide safe and adequate care and yet residents were not transferred to hospitals or were transferred only after grave suffering.⁶ Lawyers from the Advocacy Centre for the Elderly report that they received numerous calls from families who had to compel long-term care homes to call an ambulance to transfer their loved ones to hospital during the first wave of the pandemic; that long-term care homes had used blanket no-hospitalization policies or dissuasion in contravention of residents' rights to informed consent in health care pursuant to the *Health Care Consent Act*; and that provincial policies have created

⁵ Katie Pedersen, Melissa Mancini, David Common, "[Nursing home told families hospital wouldn't accept sick residents during pandemic. That wasn't true](#)", *CBC News* (17 June 2020).

See also:

Elizabeth Payne, Andrew Duffy, "[No-transfer practice at some long-term care homes denies residents rights during pandemic, say advocates](#)", *Ottawa Citizen* (14 April 2020);

Terry Reith, "['No benefit' to sending seniors ill with COVID-19 to hospital, some nursing homes tell loved ones](#)", *CBC News* (3 April 2020)

Elizabeth Payne, "[Only 13% of Ontario's long-term care COVID patients went to hospital; advocates want to know why](#)", *Ottawa Citizen* (8 June 2020)

Liam Casey, "[Families accuse Ontario long-term care home of denying loved ones hospital trips](#)", *Canadian Press* (18 June 2020)

⁶ Chris Glover, "[Family reeling as senior dies of malnutrition, not COVID-19, inside long-term care home](#)", *CBC News* (9 June 2020).

Jill Mahoney, "[What happened when families were blocked from Canada's long-term care homes](#)", *The Globe and Mail* (3 June 2020).

Sue-Ann Levy, "[\\$20M class-action suit filed against Schlegel Villages](#)", *Toronto Sun* (26 Jun 2020).

Kim Zarzour, "[Families sue Woodbridge Vista alleging long-term care home put profit ahead of residents](#)" *Vaughan Citizen* (16 June 2020).

Muriel Draaisma, "[Canadian military to help long-term care home struggling with COVID-19 in Vaughan](#)", *CBC News* (7 June 2020).

a culture of “hospital avoidance”, leaving the elderly with “minimal care” while they were dying.⁷

In fact, long-term care home operators have now testified before the Ontario Long-Term Care COVID-19 Commission that they were told not to send residents to hospitals. Dr. Allan Bell, Chief and Director of Emergency Medicine at Quinte Health Care, sent a letter to regional long-term care homes informing them that hospital visits were not recommended. Fraser Wilson, Vice-President of Ontario Long-Term Care for Chartwell, a for-profit chain company, testified to the Commission that hospitals denied transfers of sick residents or returned them within hours of being sent. Maria Elias, CEO of Belmont House, a non-profit long-term care home, told the Commission that the homes were instructed not to send seniors with COVID-19 to hospital.⁸

In addition, many seniors were in fact transferred *out* of hospital care in anticipation of a wave of COVID-19 related admissions. According to a recent report from *The Globe and Mail*, between March 2 and May 3, 2020, hospitals transferred out nearly 2,200 Alternate Level of Care (“ALC”) patients, sending 1,589 to long-term care homes and 605 to retirement homes.⁹ In fact, we have found that ALC patients across Ontario, the vast majority of them elderly, were transferred from public hospitals not just to long-term care but also to hotels, private for-profit retirement homes, unlicensed facilities, or even home without adequate care – in some cases in clear violation of their right to informed consent.¹⁰ While not all of those transfers were COVID-19 related, it is clear that the cost of shoring up hospitals fell disproportionately on the elderly.

⁷ Elizabeth Payne, "[Only 13% of Ontario's long-term care COVID patients went to hospital; advocates want to know why](#)", *Ottawa Citizen* (8 June 2020)

⁸ Kenyon Wallace, "[Only a fraction of long-term-care residents killed by COVID-19 were taken to hospital](#)", *Toronto Star* (6 December 2020)

⁹ Kelly Grant & Tu Thanh Ha, "[How shoring up hospitals for COVID-19 contributed to Canada's long-term care crisis](#)", *The Globe and Mail* (20 May 2020)

¹⁰ Media reports detail these transfers across the province. For example:

- **Sudbury** – 95 patients were moved out to the Clarion Hotel: Barbara Sibbald, "[What happened to the hospital patients who had 'nowhere else to go'?](#)", *CMAJ News* (15 May 2020).
- **North Bay** – 16 patients were transferred from hospital to LTC or retirement homes before the province stopped the transfers late-April. At least 7 of them were transferred to one private for-profit retirement home: Jennifer Hamilton-McCharles, "[Plug pulled on hospital patient transfers](#)", *North Bay Nugget* (22 April 2020).
- **Lindsay/Kawartha Lakes** – Hospital reports it transferred many patients out of hospital to LTC, retirement homes or home waiting for care to clear out beds. Family reports it

Public reporting in recent months has brought much needed attention to the issue of elderly patients' access to health care services. It must be noted, however, that the provincial policy to de-hospitalize ALC patients during the first wave of the pandemic¹¹ simply accelerated the existing discriminatory policy of de-hospitalizing the health system by limiting hospital bed availability to levels far below population need, and discharging elderly patients regardless of medical need, appropriateness and safety.

From 1990 to 2014, more than 6,100 complex continuing care (also known as chronic care) hospital beds were closed down, thereby eliminating 54% of Ontario's chronic care hospital bed capacity.¹² At the same time, Ontario's population grew from 10.3 million in 1990 to 13.62 million in 2014 (32%) – and had grown by a further 700,000 to a total of 14.32 million by 2018. In addition, population aging has accelerated, which means that the proportion of the population that is elderly has increased. According to the most recent data, Ontario now has the fewest hospital beds per capita of any province in the country and ranks third last in number of hospital beds among all countries in the OECD.¹³ Ontario's policy of cutting health care costs through de-hospitalization has been not only radical, but a profound departure from the public policy norms of peer jurisdictions.

In order to accommodate the most extreme hospital downsizing policy in the developed world, successive Ontario governments have implemented strategies to re-categorize patients with ever-increasing acuity (complexity of care needs) as being ready for discharge. The standardized designation of "Alternate Level of Care" or ALC was adopted

felt like they were "feeding" their loved one to the virus: Roderick Bennis, "[RMH attempting to move more patients out of hospital to manage expected surge](#)", *Lindsay Advocate* (4 April 2020).

- **Ottawa** - In the end, the hospitals have indeed moved patients out to this hotel and also to retirement homes: Elizabeth Payne, "[Province tells hospital not to move patients into long-term care homes](#)", *Ottawa Citizen* (17 April 2020).
- **Niagara** – Half of their 150 ALC patients were moved out in two weeks: "[In It Together: Everyone is coming with solutions](#)", *News & Updates from Niagara Health* (9 June 2020).

¹¹ Ministry of Health, Ministry of Long-Term Care, Ontario Health, "[COVID-19 Guidance: Use of Hotels and Retirement Homes](#)" (2 April 2020).

¹² Ontario Health Coalition, "[Beds in Ontario Public Hospitals 1990 to 2014](#)".

¹³ Ontario Health Coalition, "[Fast Facts: Hospital Beds per 1000 population by province in 2017-2018](#)".

Ontario Health Coalition, "[Fast Facts: OECD Hospital Beds Per 1000 Population in 2017](#)".

in 2009,¹⁴ following widening use of the designation over the prior decade. ALC patients are not a homogeneous group but rather have unique and varied care needs. They are nevertheless routinely treated as “bed blockers” who do not require hospital care – despite provincial and hospital data showing that a significant proportion are actually in hospital waiting for another appropriate level of care in hospital, including rehabilitation, complex continuing care, and others.¹⁵

The drive to de-hospitalize has been facilitated by the failure of successive governments to set clear standards to protect patients who require hospital care – including complex continuing care, rehabilitative care and palliative care – and the failure to provide resources for that care. Instead, patients with these care needs have been offloaded from hospitals to an array of facilities outside of the *Public Hospitals Act*. This offloading also has the effect of removing patients from the protections of public insurance without user fees and extra billing in the *Canada Health Act*. These patients, who are predominantly and disproportionately elderly, have been sent to their own homes, retirement homes, transitional care units and hotels, sidestepping the protections that provincial and federal legislation are supposed to afford them.¹⁶ Legal advocates for the elderly report that coercive practices to offload these patients from hospitals are among the most frequent complaints they receive.¹⁷

¹⁴ Cancer Care Ontario, “[Alternate Level of Care Reference Manual, Vol 2](#)” (January 2017) at p 13; see also Peter Nord, “[Alternate level of care: Ontario addresses the long waits](#)” (August 2009) 55(8) *Canadian Family Physician* 786

¹⁵ Ontario Hospital Association, ALC Update (20 June 2016).

¹⁶ These protections include the quality of care and levels of care standards, public governance, public funding of care, access to information, accreditation and accountability regimes for public hospitals under Ontario legislative and regulatory regimes. They also include the right to publicly funded care provided on equitable terms and conditions without financial barriers and the terms and conditions of public health care under the *Canada Health Act*.

¹⁷ Advocacy Centre for the Elderly, “[Discharge from Hospital to Long-Term Care: Issues in Ontario](#)” (July 2013).

Advocacy Centre for the Elderly, “[Discharge from Hospital to Long-Term Care: Issues in Ontario](#)” (February 2014).

Carmela Fragomeni, “[No law forcing you to take elderly patients home from hospital](#)”, *Hamilton Spectator* (8 April 2019).

Theresa Boyle, “[Pay \\$1,800 a day or get out: Hospital](#)”, *Toronto Star* (22 February 2011).

Ontario Patient Ombudsman, [Year Three Results](#), 2019.

At the same time, successive Ontario governments have under-resourced long-term care. The acuity of residents admitted to long-term care homes has increased dramatically¹⁸ while hands-on care levels have decreased¹⁹ – and there is no legislated ceiling as to what a long-term care home can provide. In fact, long-term care residents are funded at one-third of the rate of complex continuing care hospital patients despite equivalent levels of acuity.²⁰ At the same time, governments have rationed access to long-term care homes by keeping provincial bed numbers far below population need. Other ALC patients who are actually waiting for long-term care home beds cannot access appropriate care because long-term care homes are full and current wait lists number more than 38,000 people.²¹ Our research has revealed that Ontario ranks second last among all provinces in the number of long-term care beds per capita.²² Not only is Ontario's policy of de-hospitalization an outlier among peer jurisdictions, so too is the province's policy of rationing access to long-term care. As a result of these policies, ALC patients waiting for long-term care admissions have been redirected to transitional care units, retirement homes, home with inadequate home care, and to hotels which do not have the same

¹⁸ One way to look at the difficulty in accessing needed care is to look at the measures of acuity (complexity of care needed) on admission to long-term care. Ontario has extraordinarily high MAPLe scores on admission and they have increased significantly as follows:

The data also shows that acuity has increased at the point of admission, meaning that residents are entering long-term care with greater needs. The MAPLe score (Method for Assigning Priority Levels) is used by care coordinators to classify clients according to their level of care needs. The MAPLe score of residents was 76% in 2010. By 2016 it had increased by 8% to 84%, a very significant leap in 6 years alone. (see file:///C:/Users/brown/Downloads/OANHSS_2016-17_Pre-Budget_Submission.pdf) Today, the vast majority (84%) of those currently admitted to long-term care homes are assessed as having high and very high needs. People with significant care needs who are not ranked as highly are unable to access long-term care.

¹⁹ Ontario Health Coalition, [Situation Critical: Planning, Access, Levels of Care and Violence in Ontario's Long-Term Care](#) (21 January 2019).

Ontario Health Coalition, [Caring in Crisis: Ontario's Long-Term Care PSW Shortage](#) (9 December 2019).

Ontario Health Coalition, ["95% of Ontario's Long-Term Care Homes Report Staffing Shortages Leaving Basic Care Needs Unmet"](#) (22 July 2020).

²⁰ Ontario Health Coalition, [Situation Critical: Planning, Access, Levels of Care and Violence in Ontario's Long-Term Care](#) (21 January 2019).

²¹ Office of the Premier, News Release, ["Ontario Launches Independent Long-Term Care COVID-19 Commission"](#) (29 July 2020).

²² Ontario Health Coalition, ["Fast Facts: Long-Term Care Beds Per 1,000 Population"](#).

protections afforded by the legislative, inspection and regulatory regime for long-term care in Ontario.

The COVID-19 crisis has brought much-needed public attention to the deeply disturbing conditions within long-term care homes which Ontario's seniors have endured for far too long. While we think a formal public inquiry would be more suited to addressing the scope of the issue, we welcome the formation of Ontario's Long-Term Care COVID-19 Commission and look forward to its final report on the effects of COVID-19 on the province's long-term care home sector. However, this limited review of long-term care homes is only a small part of a much broader issue, which includes excessive and inappropriate de-hospitalization and rationing of long-term care.

Ontario's Long-Term Care COVID-19 Commission is intended to provide immediate answers to a relative narrow – albeit urgent – set of questions that do not include issues of systemic discrimination over the longer term. We note that the Ford government has denied the Commission's request for an extension of time to complete its work, which underscores the exigent and circumscribed nature of the review it is undertaking.

Furthermore, the fact that inappropriate de-hospitalization and rationing of long-term care disproportionately affect elderly Ontarians must not be overlooked. The factors that underlie the deplorable conditions within some long-term care homes cannot be fully or meaningfully resolved without also naming and addressing systemic, age-based discrimination in the provision of health care throughout the province. The Commission's particular expertise in relation to discrimination and equality rights is urgently needed.

1. Overview

Since the early 1990s, the Ontario Government has sought to control the rising costs of health care by downsizing its public hospitals. Using policy and funding levers, the Government has promoted "de-hospitalization": reducing the number of public hospitals and cutting 14,815 acute care and 6,109 complex continuing care beds within public hospitals. Given the resulting scarcity of hospital beds, patients with higher and higher acuity levels have had to be discharged to resolve the problem. In the initial round of hospital restructuring in the 1990s, the belief was that the health care system would adjust to these cuts by reducing hospital length of stay on one hand and by increasing reliance on home, community and long-term care on the other. Home care rolls were expanded slowly and 20,000 new long-term care beds were built from the late 1990s to the early years of this century. However, health system planning and resources never kept pace with hospital downsizing and population aging, leaving home care severely rationed. Wait lists for long-term care have numbered from 20,000-38,000 since the turn of the century.

Furthermore, hospital downsizing has continued despite significant population growth, leaving Ontario with the most radical hospital cuts in Canada and among developed nations. To accommodate extremely low levels of hospitalization, Ontario has tolerated a level of hospital overcrowding that is unheard of among our peer jurisdictions,²³ and has adopted a policy approach to offload patients into settings that are under-resourced or inappropriate to care for them. These policies have disproportionately impacted the elderly, eroding their rights to care under the *Canada Health Act* and provincial legislation.

The *Canada Health Act* expressly defines hospital care as including chronic and rehabilitative care.²⁴ Under the *Canada Health Act*, patients have the right to reasonable access to care on equitable terms and conditions without extra user fees and extra billing. Ontario's *Public Hospitals Act* also designates public hospitals as providing specific types of care, including chronic/complex continuing, rehabilitative, and convalescent care.²⁵ Under Ontario's *Health Insurance Act*, patients are covered by public health insurance in hospitals providing this full range of care²⁶ and under the *Public Hospitals Act*, patients in public hospitals are supposed to be protected by public governance, access to information, quality of care and public insurance regimes, as well as other public protections set out in these statutes. The policy of de-hospitalization and the adoption of measures to designate patients as ALC earlier and earlier in their hospital stays have significantly eroded patients' statutory rights.

The emergence of a new designation of certain hospital patients as "Alternate Level of Care" or ALC dates back to policy shifts in the 1990s. The definition of ALC became formalized in the 2000s and health care planners pushed for patients to be designated ALC earlier in their hospital stays in a bid to reduce patient length of stay. Today, policy makers and hospital executives routinely refer to hospitals as being "acute care facilities" despite being required to provide other levels of care, and to ALC patients as though they can and should be discharged to other settings, whether or not appropriate care is available. ALC patients, which include individuals waiting for appropriate public hospital care – including rehabilitative, complex continuing, convalescent and palliative care – are considered an undue financial drain and are routinely treated as "bed blockers". These patients and their families are subjected to pressure, coercion, and in the context of the

²³ Financial Accountability Office of Ontario, [Ontario Health Sector: A Preliminary Review of the Impact of the COVID-19 Outbreak on Hospital Capacity](#) (28 April 2020).

²⁴ [Canada Health Act, RSC 1985, c C-6.](#)

²⁵ [RRO 1990, Reg 964: Classification of Hospitals](#)

²⁶ [RRO 1990, Reg 552: General](#)

current pandemic, measures to actively move them out of hospitals without consideration of their right to consent and without due regard to their care needs.

The formal definition of ALC is: “When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care [CCC], Mental Health or Rehabilitation) the patient must be designated as ALC.”²⁷

The discharge destinations for ALC patients include the following²⁸:

- Home (with/without services/programs)
- Rehabilitation (facility/bed, internal or external)
- Complex Continuing Care (facility/bed, internal or external)
- Transitional Care Bed (internal or external)
- Long-Term Care Home
- Group Home
- Convalescent Care Bed
- Palliative Care Bed
- Retirement Home
- Shelter
- Supportive Housing

Rehabilitation, complex continuing care, transitional care, convalescent care and palliative care beds refer to care normally provided by public hospitals (despite the systematic dismantling, transfer and privatization of these services). As such, many patients designated as ALC are in fact waiting for another type of hospital care, equally legitimate as acute care, but resourced at a different level. Most others are waiting for long-term care. However, in the last 15 years, though the formal definition has remained the same, use of the ALC designation has been contorted to be treated as tantamount to meaning that the patient no longer requires hospital care and should be immediately discharged.²⁹

²⁷ Cancer Care Ontario, “[Alternate Level of Care Reference Manual, Vol 2](#)” (January 2017) at p 13.

²⁸ Cancer Care Ontario, “[Alternate Level of Care Reference Manual, Vol 2](#)” (January 2017) at p 13.

²⁹ See, for example:

Sabrina Jonas, “[Ontario emergency rooms fill up again as COVID-19 fears ebb, patients with other illnesses return](#)”, *CBC News* (14 July 2020).

The continued push for more patients to be designated as ALC earlier in their hospital stays led to an increase in the number of patients designated as ALC. In the last 10-15 years, ALC has been described as the primary hospital “inefficiency” seized upon by policy makers in a bid to reduce hospitalization and hospital length of stay. Consequently, the Government instituted initiatives intended to reduce the numbers of so-called ALC patients, and “divert” them into community care. Since seniors account for 85% of ALC patients,³⁰ this has been, in effect, a plan to remove elderly patients from hospitals and to discharge them to long-term care homes, retirement homes, transitional care, other private sector settings or to their own homes, rather than allowing them to recover in hospital. Often, these premature discharges in effect do not allow elderly patients access to the health care system, giving up on their care and recovery.

The purpose of the “diversion” of ALC patients was to replace expensive forms of care (hospitals) with less expensive forms of care (home care, long-term care): to move patients to modes of care that have fewer staff, fewer services, and fewer medical resources instead of caring for them in parts of the health care system with more highly skilled staff, more services, and access to more medical resources. Since public hospitals are covered by the *Canada Health Act* and public health insurance, shrinking the scope of public hospitals effectively reduces the scope of public coverage, limiting the scope of public medicare, and primarily and disproportionately impacts the elderly.

In order to “solve” the ALC problem, hospitals and Local Health Integration Networks (“LHINs”) have implemented a variety of “transitional care” programs to download patients from their roster. While this has been attempted to varying degrees over the years, only recently has it received official support from the Ontario government. These programs use retirement homes, supportive housing, and unlicensed care facilities as alternatives to the appropriate, publicly-funded health care that patients need and to which they are

Elizabeth Payne, “[Years of restraint straining Ontario’s hospital system: report](#)”, *Ottawa Citizen* (20 December 2019).

Theresa Boyle, “[Worst June on record for ‘hallway medicine’ at Ontario hospitals](#)”, *Toronto Star* (4 September 2019).

Mike Crawley, “[Why Doug Ford’s hospital funding will not end hallway healthcare](#)”, *CBC News* (6 October 2018).

Theresa Boyle, “[Number of seniors waiting to move into long-term care homes in Ontario hits record high](#)”, *Toronto Star* (16 September 2019).

³⁰ See, e.g. Canadian Institute for Health Information: [Health Care in Canada, 2011: A Focus on Seniors and Aging](#), (Ottawa: CIHI, 2011) at 115 “On any given day, more than 5,200 acute care beds across Canada are occupied by ALC patients. Nearly 85% of ALC patients are age 65 or older; many (35%) are older than 85.”

entitled. While these patients typically require high levels of care, usually long-term care and above, they are forced into these other types of care, which are neither resourced nor regulated in the same manner as hospitals or long-term care. For example, while long-term care homes must have at least one registered nurse on staff, none of these other facilities have that requirement, leaving residents without access to appropriate care. While patients and their families often attempt to resist transfer to these inappropriate care destinations, they are often led to believe that they have no choice but to accept, despite there being no requirement to do so.

Hospitals and LHINs use several strategies to require patients to move into these facilities. Patients and their families are not fully informed of the difference between retirement homes and long-term care homes, and are often told that they must go to a retirement home in order to apply to long-term care, as long-term care applications cannot be taken in hospital. This is untrue. They may be told that if they do not agree to go to these facilities, that they will be “discharged” on paper, and charged the “uninsured rate”, which can be thousands of dollars per day. Such pressure on patients and their families at these difficult times is overwhelming, and without proper information they often believe that they have no option but to accept transfer.³¹

In the more than two decades that these strategies have been in place, an unacceptable and disproportionate strain has been placed on seniors and their families. In the absence of sufficient hospital beds, elderly patients are mislabelled or prematurely labelled as ALC patients and pushed out of hospital before their medical condition warrants discharge or before they have had a chance to rehabilitate. And even in respect of those who could properly be termed ALC patients, the critical component of the “de-hospitalization” equation is still missing: there simply are not enough long-term care beds or home-care options available to serve the growing population of seniors for whom there are no longer hospital beds. The waitlists for long-term care and home care are wildly out-of-step with the idea that these services can compensate for shrinking hospital resources. At the same time, long-term care nurses, personal support workers and staff are dealing with increasingly complex patient care, as hospitals juggle shrinking resources and the steady growth of demand.

The end result is that seniors and their families are disproportionately paying the price for these practices and policies. They are suffering health set-backs requiring re-admission to hospital after being sent home prematurely when their medical condition requires continued hospitalization and where no adequate alternative care and accommodation is

³¹ Advocacy Centre for the Elderly, "[Discharge from Hospital to Long-Term Care: Issues in Ontario](#)" (February 2014).

available given their health condition. They are not receiving the care they need while they wait for a long-term care bed, and they are often not getting the amount or type of care their medical condition warrants once they are admitted to long-term care. They and their families are struggling to maintain their dignity as their choices – and their quality of life – diminish and their physical health deteriorates.

In the end, while it is undoubtedly the government's prerogative to design the health care system according to its priorities and its assessment of the best policies and approaches, it must do so in accordance with the legal principles enshrined in the Human Rights Code. We submit that the numerical data, the policies and the attitudes within the health care system establish systemic discrimination against the elderly. This was cast into sharp focus by the COVID-19 pandemic but is a problem of much longer standing and deeper roots. It demands further investigation by the Commission.

2. Background

The Strategy: De-Hospitalization, Alternative Level of Care, and Long-Term Care

- (a) **De-hospitalization:** In the 1990s, the Ontario Health Services Restructuring Commission (HSRC) proposed, and the province executed, dramatic cuts to hospitals and hospital beds.³² According to the Physician Hospital Care Committee, a tripartite committee of the Ontario Hospital Association, the Ontario Medical Association and the Ontario Ministry of Health and Long-Term Care, “[t]he number of acute care beds in Ontario fell by 22% as part of a hospital restructuring process during the mid to late 1990s.”³³ By the end of its mandate in March 2000, the HSRC had issued final directions to 22 communities affecting 110 hospitals, amalgamated 45 hospitals into 13, and closed 29 hospital sites.³⁴

The Province opened some new hospital beds in the early 2000s, but by 2006 acute and chronic bed closures had resumed and Ontario's hospital bed total sunk to a new low. From 1990-2014, Ontario closed 6,109 chronic (complex continuing care) hospital beds and 14,815 acute care hospital

³² Ontario Health Coalition, [No Vacancy: Hospital Overcrowding in Ontario, Impact on Patient Safety and Access to Care](#), 21 July 2011, “Part 1: Failure to Plan”

³³ Physician Hospital Care Committee: Improving Access to Emergency Care: Addressing System Issues, (Ontario, 2006) at p. 44

³⁴ Lorraine Luski, “[Hospital Restructuring in Ontario](#)” (Toronto: Legislative Assembly of Ontario, Legislative Research Services, June 2000, updated October 2000)

beds. This represented a reduction in hospital capacity of 53% of chronic (complex continuing care) beds and 44% of acute care beds.³⁵

Data from the Canadian Institute for Health Information, a Crown corporation that reports government health data, reveal that Ontario has only 2.2 hospital beds per 1,000 residents, the fewest in Canada. The average in the rest of the provinces is 3.2 per 1,000 residents, a very significant difference.³⁶ The OECD average number of hospital beds per 1,000 population among developed nations is 4.7 per 1,000 residents. Only two countries in the OECD – Chile and Mexico - have fewer beds *per capita* than Ontario.³⁷

- (b) Reliance on addressing hospital efficiencies to absorb effects of cuts: ALC, lengths of stay.** The prevailing thinking is that hospitals and the health care system can compensate in part for these shrinking resources in part by using hospital resources more efficiently. The two primary means of increasing “efficiency” have been 1) reducing the length of stays in hospital; and 2) reducing ALC days.

Reduction of ALC utilization has been a high priority for health systems. Dealing with the consequences has not.³⁸

As described in the previous section, an ALC patient is a person who occupies a health care bed and does not require the intensity of resources/services that come with that type of hospital bed. The definition of ALC was formalized in 2009 after being in practice for approximately a decade. Provincial policy has shifted from offloading hospital patients to long-term care and home care (1990s); to designating hospital patients as ALC (first decade of the 2000s); to pushing hospital administrators and physicians to designate more patients as ALC and to do so earlier in their length of stay (2006/7 on); and finally, to reducing the number of ALC days (approximately 2010-current).

³⁵ Ontario Health Coalition, “[Hospital Beds Staffed and In Operation Ontario 1990-2014](#)”

³⁶ Ontario Health Coalition, “[Hospital Beds per 1000 population by Province in 2017-2018](#)”

³⁷ Ontario Health Coalition, “[OECD Hospital Beds per 100 population in 2017](#)”

³⁸ Jason M. Sutherland, PhD and R. Trafford Crump, PhD, “Exploring Alternative Level of Care (ALC) and the Role of Funding Policies: An Evolving Evidence Base for Canada”, *Canadian Health Services Research Foundation*, September 2011, p. 2

In addition to reducing ALC days, reducing lengths of stay in hospital has also been an important strategy for managing shrinking hospital resources. Jane Meadus, counsel with the Advocacy Centre for the Elderly (ACE) has encountered many patients who have been instructed that the hospital only allows a certain number of days' stay for particular procedures. The result is that some individuals – disproportionately elderly – are pressured to leave hospitals before they are ready, and must seek out the services of ACE to help them navigate the system.

A 2010 report on “Senior Friendly Care in Hamilton Niagara Haldimand Brant LHIN Hospitals”, created by the Regional Geriatric Program of Toronto of the Toronto Central LHIN, acknowledged:

increasing costs of hospital care have created pressures to further reduce lengths of stay, increasing the tensions between hospital care and the needs of older patients, particularly those with more complex and chronic conditions.³⁹

- (c) **Reliance on Long-Term Care and Home Care:** A core strategy hospitals are using to reduce ALC days, and to reduce lengths of stay in hospital, is to move more people, more quickly, from hospital into long-term care and home-care irrespective of whether their medical condition permits it. As then-Health Minister Deb Matthews put it in 2013, even after Ontario had cut more hospital beds than anywhere else in Canada and internationally, “We are moving services from hospitals to communities.”⁴⁰

3. Applicable Legal Principles

We submit that this de-hospitalization strategy and its implementation have resulted in multiple, significant adverse effects on seniors in the province, in violation of the bar on discrimination in the provision of services in the Ontario Human Rights Code. Section 1 of the Ontario Human Rights Code provides:

³⁹ Regional Geriatric Program of Toronto, “[Background Document: Senior Friendly Care in Hamilton Niagara Haldimand Brant LHIN Hospitals](#)” (9 July 2010), p. 7

⁴⁰ Richard J. Brennan, “[Closing hospital beds not the answer to reforming health care, critics say](#)”, *Toronto Star* (26 February 2013)

Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.⁴¹

(a) Definition of Service

An analysis of discrimination under this section begins with an analysis of what constitutes the “service”.

The precise scope and definition of the “service” at issue was a central debate in *Moore v British Columbia (Education)*, 2012 SCC 61 (“*Moore*”). The applicant in that case sought to define the service as “the provision of education”, whereas the government argued in favour of “the provision of special education”. Ultimately, Justice Abella of the Supreme Court of Canada reasoned:

The answer, to me, is that the “service” is education generally. Defining the service only as “special education” would relieve the Province and District of their duty to ensure that no student is excluded from the benefit of the education system by virtue of their disability . . . If Jeffery [Moore] is compared only to other special needs students, full consideration cannot be given to whether he had genuine access to the education that all students in British Columbia are entitled to (paras 29-31).

Likewise, the Government of Ontario, and specifically, the Ministry of Health and Ministry of Long-Term Care, provide the funding and set the policy for the health care system in Ontario. The service in issue here is health care generally. To define the service more narrowly, for instance as the provision of hospital care, or the provision of long-term care or home care, would, in the words of Justice Abella “descend into the kind of ‘separate but equal’ approach which was majestically discarded in *Brown v. Board of Education of Topeka*, 347 US 483 (1954)” (*Moore*, para 30).

The scope of health care services for the purposes of this analysis can be defined with reference to the applicable provincial and federal legislation. Under the *Canada Health Act*, R.S.C., 1985, c. C-6, the primary objective of health care policy is defined in s. 3:

It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of

⁴¹ [R.S.O. 1990, c. H.19, s. 1.](#)

Canada and to facilitate reasonable access to health services without financial or other barriers.

The governing principles are set out in s. 7:

In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

- (a) public administration;
- (b) comprehensiveness;
- (c) universality;
- (d) portability; and
- (e) accessibility.

Section 10 specifies what must be achieved in order to meet the requirement of universality:

In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

Ontario has incorporated these principles into provincial law. The *Commitment to the Future of Medicare Act*, 2004, S.O. 2004, c. 5, for example, includes the following reference in the preamble:

Confirm their enduring commitment to the principles of public administration, comprehensiveness, universality, portability and accessibility as provided in the Canada Health Act

(b) Prima Facie Case of Discrimination

In order to establish a *prima facie* case of discrimination in the provision of a service, a complainant must show that they have a characteristic protected from discrimination under the Code; that they experienced an adverse impact with respect to the service; and that the protected characteristic was a factor in the adverse impact (*Moore*, para 33).

In cases assessing systemic discrimination claims against the government in its provision of services, the Courts have adopted the following legal principles, of relevance to the case at hand:

- In *Moore*, Justice Abella wrote, “. . . if the evidence demonstrates that the government failed to deliver the mandate and objectives of public education such that a given student was denied meaningful access to the services based on a protected ground, this will justify a finding of *prima facie* discrimination” (para 36). [Emphasis added.]
- The BC Human Rights Tribunal in *Moore* (2005 BCHRT 580) (“*Moore*, BCHRT”) recognized that it owed deference to the respondent District in delivering educational services. The District was motivated to close the Diagnostic Centre, on which Jeffery Moore and other severely disabled children like him relied, by financial constraints. At the same time, the Tribunal found that the District’s failure to consider the consequences or plan for alternate accommodations together with Jeffery’s need for intervention, and the fact that the Moores were told the services could not otherwise be provided by the District, constituted *prima facie* discrimination. The Supreme Court adopted this reasoning (*Moore*, para 46).
- Furthermore, the BC Human Rights Tribunal’s in *Moore* found that the Government failed to adequately monitor the implementation of programs for Severely Learning Disabled students, to ensure adequacy of services and not just financial accountability. Moreover, the Government “knowingly underfunded the District . . . and refused to address this shortfall, even when it knew of the District’s increasingly dire financial circumstances and that it was cutting specialized programs”, based on a high-profile report detailing these problems. Both the Government’s failure to properly monitor the services, and its underfunding of services for vulnerable students despite clear evidence of a problem, were critical components of the Tribunal’s finding of a *prima facie* case of systemic discrimination (*Moore*, BCHRT, para 887).
- In *Eldridge v. Attorney General of British Columbia*, [1997] 3 S.C.R. 624 (“*Eldridge*”), the Supreme Court ruled: “This Court has consistently held . . . that discrimination can arise both from the adverse effects of rules of general application as well as from express distinctions flowing from the distribution of benefits” (paras 77-80).
- The Supreme Court went on in *Eldridge* to state that those who are responsible for the provision of services to the public must take positive steps to ensure

that disadvantaged persons benefit equally from those services. “The principle that discrimination can accrue from a failure to take positive steps to ensure that disadvantaged groups benefit equally from services offered to the general public is widely accepted in the human rights field . . .”(paras 77-80).

- In *First Nations Child and Family Caring Society v. AG Canada (Minister of Indian Affairs and Northern Development Canada)* 2016 CHRT 2, (“*First Nations Child and Family Caring Society*”) the Canadian Human Rights Tribunal found that the funding formula used by First Nations Child and Family Services adversely impacted, and in some cases denied, adequate child welfare services to First Nations (para 383). In particular, the funding formula made assumptions based on population thresholds and children in care, assumptions which “ignore the real child welfare situation in many First Nations’ communities on reserve” (para 384). Funding levels were “not based on provincial/ territorial legislation or service standards”, but were instead “based on funding levels and formulas that can be inconsistent with the applicable legislation and standards” (para 388). The Tribunal found that the funding formulas “provide insufficient funding to many FNCFS [First Nations Child and Family Caring Society] Agencies to address the needs of their clientele” (para 389). This problem is exacerbated by a “lack of coordination between different programs . . . [a practice which] results in service gaps, delays or denials and, overall, adverse impacts on First Nations children and families on reserves” (para 391). The fact that the Government was aware of shortcomings in the funding formula, based on numerous reports, and had not followed the recommendations was further evidence of continued adverse impacts on the First Nations community (para 386).
- Together, these findings led to a ruling by the Tribunal that “First Nations people living on reserve and in the Yukon are *prima facie* adversely differentiated and/or denied services because of their race and/or national or ethnic origin in the provision of child and family services” (para 396). Perhaps most importantly, the Tribunal roundly rejected the government’s argument that the question of sufficiency of funding is beyond the scope of an investigation into discrimination under the *Canada Human Rights Code*. That question, in the Tribunal’s reasoning “addresses the issue of substantive equality” (para 398).

(c) Justification

The next phase of the analysis is the question of justification. The case law points to the need to have investigated alternative approaches (*British Columbia (Public Service*

Employee Relations Commission) v BCGSEU, [1999] 3 SCR 3 (“*Meiorin*”, at para 65). The discriminatory conduct must be reasonably necessary to achieve a broader objective (*Moore*, SCC, para 49, citing *Ontario Human Rights Commission v Borough of Etobicoke*, [1982] 1 SCR 202, p. 208, and *Central Okanagan School District No. 23 v Renaud*, [1992] 2 SCR 970, at p. 984). In *Meiorin*, the Court described this as the employer or service provider showing “that it could not have done anything else reasonable or practical to avoid the negative impact on the individual”.

4. Indicators and Aspects of Systemic Discrimination against Seniors in De-Hospitalization

Turning to the specifics of this case, in our analysis of systemic discrimination against seniors in the de-hospitalization policy, we have relied on the definition of systemic discrimination used by the Commission in its *Fact Sheet: Racism and Racial Discrimination: Systemic Discrimination*:

Systemic discrimination can be described as patterns of behaviour, policies or practices that are part of the structures of an organization, and which create or perpetuate disadvantage (for racialized persons).

The Commission is very concerned about systemic discrimination. Assessing and tackling systemic discrimination can be complex . . . ⁴²

In its *Policy and Guidelines on Racism and Racial Discrimination*, the Commission lists three considerations for use in “identifying and addressing systemic discrimination”:

1. Numerical data;
2. Policies, practices and decision-making processes; and
3. Organizational culture.⁴³

The *Policy* specifies:

The OHRC expects organizations and institutions to use these three considerations as a basis for proactively monitoring for and, if found to exist, addressing systemic discrimination internally, i.e. with regard to human resources

⁴² Ontario Human Rights Commission, “[Racism and racial discrimination: Systemic discrimination \(fact sheet\)](#)”.

⁴³ Ontario Human Rights Commission, “[Policy and Guidelines on Racism and Racial Discrimination](#)”, June 2005.

and employment or externally, for example in their service delivery. In addition, if an application is filed with the Tribunal, the Commission's position is that these considerations should guide the Tribunal in its assessment of whether systemic discrimination exists within an organization or institution.

While the analysis of racial discrimination does not map precisely on to the analysis of age-based discrimination against seniors, we submit that the three indicators employed by the Commission in that analysis assist in structuring an analysis of systemic discrimination against seniors in the "de-hospitalization" policy.

Using the three indicators from the *Policy and Guidelines on Racism and Racial Discrimination*, and with reference to the case law cited above, we submit that the following analysis demonstrates the need for the Human Rights Commission to exercise its powers under s. 31 to initiate an investigation into systemic discrimination against the elderly in the provision of health services:

- (a) **Numerical Data:** Statistics, on their own, establish the significant stresses that the health care system is under and which may lead to systemic victimization of the elderly in an attempt to cope with chronic shortages and underfunding. Taken together, and when combined with the policies and organizational culture, these statistics point to the existence of systemic discrimination.
- (i) *High Hospital Bed Occupancy:* Ontario's hospital bed occupancy rate stands at 97.9%, the highest among industrialized countries.⁴⁴ This creates a tremendous pressure on hospitals to move people out of beds, and in particular, to move persons perceived to be ALC patients into inappropriate settings.
 - (ii) *Persons labelled ALC patients are mostly seniors:* In practice, targeting ALC patients for discharge from hospital amounts to targeting seniors for hospital removals. The majority of patients in ALC status are elderly, and indeed ALC patients "tend to be the most elderly in the population – age in excess of 80 years".⁴⁵ According to

⁴⁴ Richard J. Brennan, "[Closing hospital beds not the answer to reforming health care, critics say](#)", *Toronto Star* (26 February 2013).

⁴⁵ Jason M. Sutherland, PhD and R. Trafford Crump, PhD, "Exploring Alternative Level of Care (ALC) and the Role of Funding Policies: An Evolving Evidence Base for Canada", Canadian Health Services Research Foundation, September 2011, p. 7; see also Canadian Association of Emergency Physicians (CAEP) Position Statement, "Emergency department overcrowding and access block", published in the CJEM, 2013; 15 (6), p. 363: "The majority of

the Ontario Hospital Association, “nearly 85% of all ALC patients are age 65 or older and many (35%) are age 85 and older.”

The experience of OCHU and the OHC has been that elderly patients too often are placed in an ALC category with little or no justification for this designation and based upon stereotypical views of the aged. Often, and as detailed more fully below, the patient’s age is itself a complicating factor which warrants a higher level of care than might otherwise be the case for the particular condition. As set out above, designating these patients as ALC and seeking to discharge them to increasingly inappropriate settings that are not subject to the standards and patient protections enshrined in both federal and provincial statutes erodes their rights and shrinks the scope of medicare.

- (iii) *Inadequate numbers of long-term care beds:* The evidence is clear that Ontario has failed to plan to meet population need for long-term care and that rationing of access to care is planned. Currently, Ontario has the second fewest long-term care beds per capita among all provinces in Canada.⁴⁶ Despite repeated announcements of capacity expansion, in fact, the growth of long-term care beds has been just a trickle for more than 15 years, since the early 2000s. Prior to that, there was a substantial expansion of long-term care beds, with approximately 20,000 new beds added between 1998 and 2003. However, thousands of hospital beds were cut in that same period, long-term care wait lists already numbered approximately 20,000 in the late 1990s, and Ontario has experienced both population growth and a dramatic increase in the percentage of the population that is elderly.

In its 2012 report, the Auditor General noted that the number of long-term care beds in Ontario grew by only 3% over the seven years from 2004-05 to 2011-12. That means an annual average growth rate of 0.42% or 319 beds per year, which falls well short of population growth. But much more importantly, it falls far short of the growth of the relevant population – the elderly. As the Auditor General stated,

patients in ALC status are elderly; with life expectancy increasing and the population aging this bottleneck will escalate if the problems are not addressed.”

⁴⁶ Ontario Health Coalition, “[Long Term Care Beds per 1000 Population](#)”.

“[a]n increase in the number of LTC home beds of 3% during that period has not kept pace with the rising demand from an aging population.”⁴⁷

In the next period for which data is available, between 2011 and 2018, the number of long-term care beds in Ontario increased by only 0.8% while the population of Ontarians aged 75 and over grew by 20%, according to the Financial Accountability Office, an office of the Ontario Legislature.⁴⁸

We can conclude, based on the evidence, that Ontario’s health care capacity in long-term care has both fallen far behind hospital cuts and population demographic shifts; is based on a planned rationing of access to care; and is not in keeping with peer jurisdictions as our stock of long-term care beds per population has dropped to almost the bottom of the country.

- (iv) *Waitlists:* As of March 2020, there were more than 38,000 Ontarians on the waitlist to access one of Ontario’s approximately 78,000 beds in 630 long-term care homes.⁴⁹ According to Ministry of Health and Long-Term Care statistics, this is an increase of 18,700 Ontarians on the waitlist since May 2014.⁵⁰
- (v) *Wait times:* Ontario government data shows significant wait times for both long term care homes and home care, and these wait times have persisted at high levels for at least a decade.

The Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) [now AdvantAge Ontario] reported that in 2014 “[t]he overall average wait time to placement in a home is three

⁴⁷ Auditor General of Ontario, [2012 Annual Report, Ch. 3.08](#), p 200.

⁴⁸ Financial Accountability Office of Ontario, “[Long-Term Care Homes Program: A Review of the Plan to Create 15,000 New Long-Term Care Beds in Ontario](#)” (Ontario: Queen’s Printer, 2019), p 1.

⁴⁹ Office of the Premier, News Release, “[Ontario Launches Independent Long-Term Care COVID-19 Commission](#)” (29 July 2020).

⁵⁰ Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS), “[The Need is Now: Addressing Understaffing in Long Term Care](#)”, 2015 Provincial Budget Submission (December 2014).

months (89 days). Depending on priority, average wait time range from 64 days for crisis referrals (Priority 1) to 553 days for referrals to lower priority, ethno-cultural or religion-specific homes (Priority 3B).⁵¹

In her 2012 report, the Auditor General reported that “the median wait times have almost tripled from 36 days in the 2004/05 fiscal year to 98 days in the 2011/12 fiscal year”, and nearly one in six people on the wait list for long-term care has died while waiting.⁵² As the Auditor General also noted, “Applicants in some areas of the province get into LTC homes more quickly than others. At one CCAC [Community Care Access Centre], 90% of clients were placed within 317 days, whereas at another, it took 1,100 days.”⁵³

From 2012/13 to 2018/19 (the most recent period for which data is available) median wait times increased again, from 133 to 147 days, according to government data.⁵⁴ Thus, the median wait time is five months, and half of the people on the wait list are waiting longer than that. In its most recent survey of long-term care wait times, conducted this summer, the Ontario Health Coalition found wait times that stretched to more than five years in some regions of the province.

While the wait time for the elderly looking for a bed in any Ontario long-term care home is lengthy, those requiring culturally specific homes often experience even longer wait times, putting additional stress on patients and their families. As an example, in February 2018 the median wait time for a bed in a long-term care facility in Ontario was 160 days; however, those waiting for a place in an ethno-culturally specific care home were faced with an average wait up to six months longer than the mainstream wait times. For some homes such as Mon Sheong Centre, Hellenic Home for the Aged and

⁵¹ Ontario Association of Non-Profit Homes and Services for Seniors, OANHSS 2015 Provincial Budget Submission “[The Need is Now: Addressing Understaffing in Long Term Care](#)”, 2015 Provincial Budget Submission (December 2014) p. 5.

⁵² Auditor General of Ontario, [2012 Annual Report, Ch. 3.08](#), p. 191.

⁵³ Auditor General of Ontario, [2012 Annual Report, Ch. 1](#), p. 21.

⁵⁴ Health Quality Ontario, “[Wait Times for Long-Term Care Homes](#)”.

Yee Hong Centre for Geriatric Care, applicants may have waits upwards of 2,400 days. That calculates to a period greater than six years. The long-term care homes operated by Mon Sheong and Yee Hong together have over 4,000 residents on their wait lists.

- (vi) *Inadequate care within long-term care homes:* In addition to shortages in the number of long-term care homes and the number of beds in long-term care homes, there is a formidable body of evidence showing long-term care homes have care levels that are inadequate to meet resident need, and severe staffing shortages that threaten the safety of residents and staff alike.

In fact, Ontario government data shows that as the complexity and heaviness of the care needs of the residents in long-term care homes have risen dramatically, the amounts of care provided have actually declined.

By all measures, levels of resident acuity have steadily risen and continue to escalate in Ontario's long-term care homes. Today, long-term care residents (really patients) are medically complex and frail – they require many medications, they have comorbidities, and they require complex nursing care. For example, residents today require peritoneal dialysis, wound treatments, palliative care, post-operative care, pain management, suctioning, and so on, all of which require complex nursing care. This care is being provided in environments that are neither physically designed for such care nor staffed with appropriate nursing staff and personal support staff in sufficient numbers to provide that care.⁵⁵

Today, the Ontario government uses the Case Mix Index (“CMI”) to assign a relative value of acuity to patients in long term care. Patients are classified into groups based on condition, complexity and needs. A relative value is then calculated to indicate the amount of resources that the resident needs.

The CMI replaced the previous resident assessment system – the Case Management Mix or “CMM” – in 2009, and no tool was developed to enable researchers to create a consistent data set

⁵⁵ Ontario Health Coalition, [Situation Critical: Planning, Access, Levels of Care and Violence in Ontario's Long-Term Care](#) (21 January 2019).

across these two systems. It is therefore challenging to fully assess rising acuity among long-term care residents. It is clear, however, that acuity levels have increased dramatically on either scale. Provincial government data shows that the CMM increased by 12.2% overall from 2004-2009 and the CMI increased by 7.63% from 2009-2016.⁵⁶ The data corroborates the accounts of those who work in long-term care, who report that rising acuity levels have created an impossible workload for front-line care staff.

The data also shows that acuity has increased at the point of admission, meaning that residents are entering long-term care with greater needs. The MAPLe score (Method for Assigning Priority Levels) is used by LHIN care coordinators to classify clients according to their level of care needs. Between 2010 and 2016, the proportion of new admissions to long-term care homes with high to very high MAPLe scores increased from 76% to 84%.⁵⁷

The Continuing Care Reporting System (CCRS), which contains information on individuals who receive continuing care services in long-term care homes in Ontario, shows an increase in the number of long-term care residents with either “extensive” or “total” dependence on staff in order to perform activities of daily living such as bathing, dressing, toileting or eating. This data also shows a dramatic escalation of the percentage of residents whose care needs rate at the highest levels.⁵⁸

The majority of residents in long-term care homes have a diagnosis of dementia. Dementia is associated with a decline in memory and other thinking skills. Government data reveals that 81% of individuals in long term care have some form of cognitive impairment with nearly

⁵⁶ Statistics Canada, “[Residential Care Facilities](#)”, Table 5.7 and LTC Home Level Master Sheet 2015-16, 2017-18, 2018-19 reporting from 2013-2016. Reported as fiscal year, SR Limited CMI

⁵⁷ Ontario Association of Non-Profit Homes and Services for Seniors, “[Ensuring the Care is There](#)” (January 2016).

⁵⁸ Canadian Institute for Health Information (“CIHI”), Continuing Care Reporting System Data 2012-2017 ([Continuing Care Reporting System Metadata](#)).

one-third displaying severe cognitive impairment.⁵⁹ The number of residents with dementia has been increasing at a steady rate of 1% per annum in recent years.

As many as 86% of individuals diagnosed with dementia will experience displays of aggression as the disease progresses.⁶⁰ Nearly half of residents in long-term care display aggressive behaviours,⁶¹ and as the proportion of patients with dementia in long-term care continues to rise we can expect to see increased levels of aggressive behaviour. As psychogeriatric services in hospitals have been cut, more residents with psychogeriatric needs have been offloaded into long-term care where staffing levels are much lower and staff are not trained or equipped to manage psychogeriatric crises.

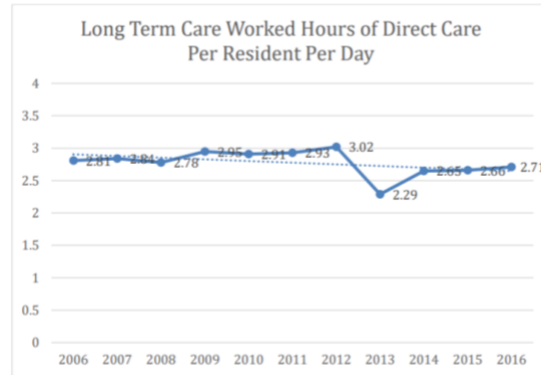
At the same time as the acuity of residents in long-term care has risen, real staffing levels, which determine the amount of care available for residents, have declined. In 2008, Ontario's long-term care staffing was an average of 2.84 worked hours per resident per day. The most recent government data showing worked hours of care shows that staffing by hands-on care staff (RNs, RPNs and PSWs) has dropped to 2.71 worked hours per resident per day, as shown in the graph below.⁶²

⁵⁹ CIHI: Continuing Care Reporting System Data 2016-2017 ([Continuing Care Reporting System Metadata](#)).

⁶⁰ Talerico, K, Evans, L, & Strumpf, N, 2002. "[Mental Health Correlates of Aggression in Nursing Home Residents with Dementia](#)", *The Gerontologist*, Volume 42, Issue 2, 1 April 2002, pp169–177.

⁶¹ CIHI: Continuing Care Reporting System Data 2016-2017 ([Continuing Care Reporting System Metadata](#)).

⁶² Ontario Health Coalition's calculation based on Ministry of Health and Long-Term Care Staffing Database: Ontario Long-Term Care Homes Staffing Data 2009-2016.



- (vii) *Reliance on LTC for increasingly complex cases:* As hospital resources shrink and the health care system relies increasingly on LTC homes, LTC homes are housing increasingly complex cases; however, they are unable to adequately care for them. Policy has been developed to facilitate the offloading of ever more complex patients to long-term care but the resources have not been provided to ensure that they have adequate and safe care.

The average complex continuing care bed is funded by the Ontario Government at \$450-500 per day.⁶³ Patients who require ever more care – who, in fact, have the same acuity as psychogeriatric and complex continuing care hospital patients -- are being shifted to long-term care homes that receive significantly less funding: an average of only \$170.14 per day.⁶⁴

- (viii) *Inadequate long-term care and home care:* The institutions intended to receive the ALC patients are not sufficiently resourced to accommodate the health care system's increasing reliance on their services to handle individuals with complex and serious health care needs.

Consistent with the facts found in the Canadian Human Rights' Tribunal's ruling in *First Nations Child and Family Caring Society*,

⁶³ Rehabilitative Care Alliance, "[Financial and Clinical Implications of Re-Classification](#)" (22 January 2015).

⁶⁴ Registered Nurses Association of Ontario, "[Transforming long-term care to keep residents healthy and safe](#)" (2018).

resourcing of long-term care and home-care is “not based on provincial/ territorial legislation or service standards” (para 388), and is insufficient “to address the needs of their clientele” (para 389). As was the case in *Moore*, the Government has been aware of these significant shortfalls, through multiple reports over decades. Using the language of the Supreme Court in *Moore*, the Government has failed to adequately “plan for alternate accommodations” for a vulnerable population – in this case seniors - after shrinking the available hospital resources. Taken together with the fact that seniors are the primary users of long-term care and home-care, these numbers suggest that the province has under-resourced both hospital and long-term care services which are primarily relied upon by a vulnerable, often marginalized sector of the population, on a ground prohibited under the Human Rights Code.

(ix) *High hospital re-admission rates*: Hospital re-admission rates are generally seen as an indicator of the appropriateness of care, and the appropriateness of hospital discharge policies (discussed further below). According to a study conducted by the Canadian Institute for Health Information (CIHI), the percentage of patients re-admitted to hospital has been rising steadily since 2009: 8.3, 8.6, 8.7, 8.9, 9.1.⁶⁵

(b) **Policies, practices and decision-making processes**: In addition to these numerical indicators of disproportionate impacts on seniors flowing from the de-hospitalization strategy, there are various policies and practices which demonstrate the discriminatory impact of the province’s approach.

(i) *Failure to accommodate the needs of seniors when restructuring the health care system*: When the de-hospitalization process began in the 1990s, the notion was that these changes would benefit both seniors and the sustainability of the health care system. The HSRC was clear, however, that reductions in hospital investments would need to be matched with significant investments in long-term care and community care. The HSRC repeatedly emphasized that restructuring and hospital cuts must be accompanied by substantial reinvestments in other sectors of the health system, like LTC homes. In the words of the Commission, “the HSRC recommended that reinvestment in new LTC beds be linked directly to changes in acute

⁶⁵ Canadian Institute for Health Information (CIHI), [“Trend over time: All patients readmitted to hospital \(%age\), 2013-14”](#).

and complex continuing care hospitals.”⁶⁶ Further, the Commission recommended that the Ministry “reconcile the appropriateness of its current planned reinvestments against the HSRC’s recommendations and the experiences of stakeholder and provider groups who were directly impacted by the changes unfolding in hospitals across the province.”⁶⁷

When the government set about implementing the Commission’s recommendations, however, the focus was on hospital cuts, and the investments in community care were woefully inadequate. In our submission, this is precisely the type of service cut *coupled with* a failure to adequately plan for the needs of a vulnerable population that is at the heart of the Supreme Court’s finding of systemic discrimination in *Moore*. As the Supreme Court ruled in *Eldridge*, the government is under a positive duty to ensure that disadvantaged populations benefit equally from the provision of services, and in no case is that principle more important than cases in which services to vulnerable populations are being cut.

In its review of the implementation of its recommendations the HSRC harshly criticized the insufficient investments in long-term and home care, and flagged a number of key “implementation issues”.⁶⁸ Among them:

- (1) Complex Continuing Care: Lack of joint planning between the Ministry of Health and Long-Term Care, CCACs and affected chronic care hospitals to help re-balance services from chronic to long-term care facilities.

⁶⁶ Health Services Restructuring Commission, “[Looking Back, Looking Forward: The Ontario Health Services Restructuring Commission \(1996-2000\) A Legacy Report](#)”, March 2000, p. 65.

⁶⁷ Health Services Restructuring Commission, “[Looking Back, Looking Forward: The Ontario Health Services Restructuring Commission \(1996-2000\) A Legacy Report](#)”, March 2000, p. 126.

⁶⁸ Health Services Restructuring Commission, “[Looking Back, Looking Forward: The Ontario Health Services Restructuring Commission \(1996-2000\) A Legacy Report](#)”, March 2000, p. 126.

(2) Long-term Care and Home Care reinvestments: Concerns about:

- Lack of investment of operating dollars in long-term care facilities to cope with increased acuity of residents;
- Delays in building of 'new' facility-based beds
- Lack of availability of home care. In particular, there are problems relating to quality, access, and the appropriate level of care and services required in each community to meet local needs.

Contrary to the recommendations of the Commission, the focus of the health care re-structuring was budget cuts, and not the needs of vulnerable, Code-protected populations – specifically the elderly – who rely on the services. Instead, the government re-structured the health care system without adequate regard to, and planning for, the needs of its most vulnerable users, namely seniors. As in the *First Nations Child and Family Caring Society* case, the Government has been repeatedly made aware of these shortfalls and of the impacts on seniors, but has not remedied the situation.

- (ii) *Failure to assess the needs of seniors in the allocation of resources:* Successive restructuring processes have focused on achieving budget targets rather than understanding and meeting community need, and in particular the needs of seniors.
- (iii) *Failure to track effects of new approach to senior care:* When the Government started out on the de-hospitalization track, it was warned by the HSRC, by independent health care advocates and by patient advocates, that hospital cuts would have significant impacts on patient care in the province, and specifically on the province's seniors. In fact, inefficiencies in the handling of senior's care in hospitals were a primary target for the transformation.

Still, the government put no measures in place to track, assess, or receive complaints about the effects of the new structure on seniors.

There has been no capacity study to guide planning for hospital beds in Ontario since the early 1990s, almost 30 years ago. Similarly,

there has been no Ministry study (at least none that has been publicly released) to guide the planning for long-term care bed capacity since the late 1990s. An FAO report released in October 2019 shows that planned LTC bed development falls far short of population need for decades to come, if policy does not change.⁶⁹ There is no publicly available tracking of the number of people who die waiting for long-term care year over year, though advocates hear of this situation fairly frequently.

Since the adoption of the designation of ALC, the Ontario Health Coalition, the Patient Ombudsman⁷⁰ and the Ontario Ombudsman⁷¹ have reported that hospital discharges are among the most common reason for the complaints they receive from patients. Media reports commonly reveal coercive tactics being used to compel elderly patients to move out of hospitals to places where care is inadequate. Yet the province has not measured, assessed or mitigated the impact of its ALC policy on patients.

The Auditor General noted in her 2012 report that key health care outcomes from earlier discharges, such as re-admission to hospitals, are not measured.⁷² Though this measure is now reported both by individual hospitals and by the province, there has been no policy change to address troubling readmission rates. There has been a systemic failure to monitor and assess the adequacy of services for a vulnerable and Code-protected group – the elderly.

As noted above, the BC Human Rights Tribunal in *Moore* made multiple adverse findings against the Government for its failure to monitor the implementation of adequate programming for Severely Learning Disabled students. The duty to monitor the adequacy of services and accommodations for vulnerable populations is in many ways the corollary to the duty, affirmed by the Supreme Court in

⁶⁹ Financial Accountability Office of Ontario, “[Long-Term Care Homes Program: A Review of the Plan to Create 15,000 New Long-Term Care Beds in Ontario](#)” (Ontario: Queen’s Printer, 2019).

⁷⁰ Patient Ombudsman, “[Listening, Learning, Leading: Year Three Highlights](#)”.

⁷¹ Kelly Grant, “[Bad hospital discharges among top complaints, Ontario watchdog finds](#)”, *The Globe and Mail* (11 May 2017).

⁷² Auditor General of Ontario, “[2012 Annual Report, ch. 4.02](#)”.

Eldridge, of the Government to take positive steps to ensure the disadvantaged benefit equally from services.

- (iv) *Impacts of Hospital Efforts at ALC reduction*: The Government has put in place a range of policies and incentives to encourage ALC reduction in hospitals.

In this context, most hospitals have their own ALC reduction goals, strategies and policies. While the policies are not, by and large, available to the public, hospital administrators often reference 'hospital policies' when enforcing these policies with patients deemed 'ALC'. It is our submission that many of these policies target seniors for differential treatment in ways that would be unfathomable for other Code protected groups, and are virtually unrelated to their actual needs and circumstances. Indeed, it appears to us that many of these policies – for example, the requirement that patients “choose” from a certain number of homes, or that bar patients from applying for long-term care in hospital at all – contravene either the *Long-Term Care Homes Act, 2007*,⁷³ or the *Health Care Consent Act, 1996*,⁷⁴ or both.

- (1) Strongly encouraging seniors to leave hospital, despite concerns of patients, loved-ones:

The ACE reports that they receive frequent complaints from patients who are subject to pressure tactics to discharge them to inappropriate facilities, or simply send them home without adequate care. Many people approach their office because a hospital wished to discharge an elderly patient in a manner, or on a timeframe, which concerned them and caused them to fear for the welfare of the elderly patient. Further, the number of people approaching their office has risen significantly in recent years.

⁷³ [S.O. 2007, c. 8.](#)

⁷⁴ [S.O. 1996, c. 2, Sched. A.](#)

The Ontario Health Coalition receives frequent complaints about people forced to be discharged from hospital when they are very frail, due to shortages of hospital beds.⁷⁵

The Ontario Association of Speech Language Pathologists and Audiologists (OSLA), the Ontario Council of Hospital Unions (OCHU), and CUPE Ontario set up a 1-800 patient hotline, and monitored it for the period of a year.,. The report from the Hotline, “Pushed Out of Hospital, Abandoned at Home: After Twenty Years of Budget Cuts, Ontario’s Health System is Failing Patients” chronicles the anecdotal experiences of hundreds of patients from over 30 Ontario communities.⁷⁶ The report is replete with stories of people who were themselves or had their loved ones pushed out of hospital earlier than they believed appropriate, and ended up with significant adverse health effects as a result. One particularly poignant vignette tells the story of a patient who had a hip replacement, and was sent home from hospital before adequate physiotherapy or instructions on how to handle the resulting limitations:

“I was to be discharged at 10 am on Monday. At 9 am, two physiotherapists came. They rushed me through, how to use the bath and . . . Everything was a blur. The nurse in the background kept saying ‘You have to be outta here by 10 o’clock.’ She was quite adamant; she said it more than once . . . I was out of there at the prescribed time, very foggy about what I was supposed to do. The very next day I ended up in emergency.”⁷⁷

⁷⁵ Ontario Health Coalition, Release: “[Hundreds of Millions in Home Care Funding Going to Profit, Duplicate Administration and ‘Impossibly Complex and Bureaucratic’ Home Care System: Auditor’s CCAC Home Care Report](#)”, September 23, 2015.

⁷⁶ Ontario Association of Speech Language Pathologists and Audiologists (OSLA), the Ontario Council of Hospital Unions (OCHU), and CUPE Ontario “[Pushed Out of Hospital, Abandoned at Home: After Twenty Years of Budget Cuts, Ontario’s Health System is Failing Patients](#)”.

⁷⁷ Ontario Association of Speech Language Pathologists and Audiologists (OSLA), the Ontario Council of Hospital Unions (OCHU), and CUPE Ontario “[Pushed Out of Hospital,](#)

- (2) Pressure on seniors to accept a long-term care bed that is not of their choosing:

Many ALC patients require a spot in a long-term care home, and the absence of space in an appropriate home can significantly stall their discharge from hospital. Because delays in hospital discharges can interfere with a hospital's efforts to reduce ALC numbers, patients are often subjected to coercive tactics to move them out of hospital to care facilities that are not of their choosing, sometimes far away from their home communities. The Ontario Health Coalition has received numerous complaints to that effect, and documented them in their report "No Vacancy: Hospital Overcrowding in Ontario, Impact on Patient Safety and Access to Care".⁷⁸

The ACE reports that they are frequently approached by individuals who have been told by hospital administrators that if the individual refuses to comply with hospital policy, such as choosing a long-term care home that is not on a short list provided or refusing to take the first available bed, they will be charge a substantial *per diem* at uninsured rates ranging from \$600 to many thousands of dollars.

- (c) **Organizational Culture:** There are, without a doubt, scores of individuals, institutions and networks attempting to care for seniors with dignity and compassion. Still, at the highest levels, in policy-making and resource allocation, we submit that there is a pattern of approaching seniors as a drain on the system, and a burden to be managed.

This is most clearly seen in the discourse around "bed blocking". In the prevailing thinking, seniors are conceived of as "bed blockers", interrupting the efficient flow of patients through the system. This is typified by the comment of Dr. Chris Simpson, President of the Canadian Medical Association who remarked to a Toronto Star reporter: "Hospitals are congested because there are too many seniors occupying beds while

[Abandoned at Home: After Twenty Years of Budget Cuts, Ontario's Health System is Failing Patients](#)", p. 9.

⁷⁸ Ontario Health Coalition, "[No Vacancy: Hospital Overcrowding in Ontario, Impact on Patient Safety and Access to Care](#)", Jul 21, 2011, Introduction.

waiting for long-term care or home care, both of which are in short supply.”⁷⁹ He later warned: “Seniors currently eat up half of health-care costs. If nothing changes in the health system, they will account for 59% of health costs by 2031 because of their increasing numbers”.⁸⁰

This stereotypical and stigmatizing view is reflected in an article in *The Globe and Mail*, which reports, “Seniors are another problem: Sunnybrook has them stuck in more than five per cent of its beds while they wait for a spot in rehab, nursing homes or community hospitals. And Sunnybrook is not unique. There are more than 2,500 patients, known as bed-blockers, clogging up hospitals across Ontario.”⁸¹

In recent months, a host of media reports have echoed similar sentiments, misunderstanding or having been misled about the actual meaning of the designation of ALC, and following the now routine characterization of patients occupying hospital beds as unduly using public resources.⁸²

5. The Commission’s Priorities and Policies: The inquiry requested here would advance key priorities in the Commission’s *Litigation and Inquiry Strategy*.

The inquiry we are requesting is consistent with the Commission’s statutory powers to “look into programs, policy and practices made under statute for consistency with the Code; and to “look into . . . conditions of tension or conflict in a . . . sector of the economy and to make recommendations, and encourage and co-ordinate plans, programs and activities to reduce or prevent such incidents or sources of tension or conflict”

⁷⁹ Richard J. Brennan, “[Closing hospital beds not the answer to reforming health care, critics say](#)”, *Toronto Star* (26 February 2013), quote from Dr. Chris Simpson, CMA President.

⁸⁰ Richard J. Brennan, “[Closing hospital beds not the answer to reforming health care, critics say](#)”, *Toronto Star* (26 February 2013).

⁸¹ Sandra Martin, “[The Hospital: How one hospital is dealing with Canada's aging population](#)”, *The Globe and Mail* (24 January 2014).

⁸² See: Laurie Fagan, “[Blocked beds costing Ottawa hospitals millions](#)”, *CBC News* (9 December 2019).

Gary Chalk, “[Seeking to move hospital care out of the hallways](#)”, *The Brantford Expositor* (5 February 2020).

Mike Crawley, “[Some of Ontario's biggest hospitals are filled beyond capacity nearly every day, new data reveals](#)”, *CBC News* (22 January 2020).

In its *Litigation and Inquiry Strategy*, the Commission identifies the issues it considers when deciding whether to get involved in any particular case or inquiry. The issues of relevance to the inquiry requested here include:

1. Broad, systemic impact;
2. Significant issues of public policy;
3. Benefit vulnerable or marginalized people protected by the Code;
4. Shape, clarify or advance human rights law in Ontario; and,
5. Commission involvement is required because of the complexity of issue.

We submit that the human rights obligations of government with respect to health care remain under-analyzed. An inquiry into the human rights impacts of de-hospitalization and inadequate alternative care would infuse health care debates, currently focused on efficiency and cost-saving, with a human rights perspective. This, in turn, could influence funding decisions at the highest levels; focus attention on respect for dignity when individuals are moved from one form of care to another; and lead to recognition of the need for significant new investments in hospital, long-term care and home care. All of this would be of tremendous benefit to the province's growing population of the elderly, which is highly vulnerable and often neglected.

Perhaps most importantly, this is the type of discrimination that is almost certain to go un- or under-reported: the population is vulnerable, and often isolated. The fact of being shifted home, or into long-term care, exacerbates both conditions. Furthermore, they continue to rely on the public health system, and are often fearful of complaining. And the people caring for them are struggling to keep their heads above water, not often poised to litigate. Hardly anyone who is being treated in the system has a large enough perspective on the workings of the health care system to know how to challenge it. The Advocacy Centre for the Elderly reports that this type of consideration has been a concern for their organization for years, but they are so busy fielding the unmanageable number of complaints, and helping individuals navigate the system, that they simply do not have the resources to put towards this type of systemic complaint on their own. The Commission's involvement would be particularly important because the issues are so complex, and the evidence so far-reaching as to be nearly impossible for an individual claimant, or group of claimants, to raise.

6. The Time is Right

As you know, the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System recently released its final report, which sheds considerable light on the shortcomings of the existing long-term and home care systems and the pressing need for reform. The report issued by the Canadian military in May 2020, after it was called in to assist with the COVID-19 crisis, is a further indictment of policies and practices at a number of long-term care homes across the province. Other reviews will no doubt identify additional challenges and areas for improvement and reform.

While we agree that changes to the long-term and home care systems are urgently required, it is equally essential to critically examine the forces that drive vulnerable patients out of hospital and into those systems.

Despite the stated commitment of the current provincial government to end hallway medicine, the problem has only deepened. Ontario Hospital Association data show that June of 2019 was the worst month on record for hospital overcrowding since the province began collecting data in 2008. The average wait time to be admitted to a hospital from an ER was 16.3 hours, while at the same time the number of ALC patients in that month was more than 4,500 – an increase of 450 compared to June 2018.⁸³ Even before the current crisis emerged and COVID placed increasing demands on all aspects of the healthcare systems, hospitals were struggling to operate at or beyond 100% capacity.

The pressure to de-hospitalize ALC patients – mostly seniors – is intensifying. At the same time, the number of seniors waiting for LTC beds has climbed to a record high of 36,245 in July 2019 – an increase of 2,460 from the previous year.⁸⁴ And while the government pledged to increase the number of LTC beds by 30,000 over 10 years, progress has been effectively stalled: the number of long-stay beds grew by only 0.2% between July 2018 and July 2019, and is projected to grow by only 0.1% (a total increase of a mere 77 beds) by July 2021.⁸⁵

7. The Path Forward

⁸³ Theresa Boyle, "[Number of seniors waiting to move into long term care homes in Ontario hits record high](#)", *Toronto Star* (16 September 2019).

⁸⁴ Theresa Boyle, "[Number of seniors waiting to move into long term care homes in Ontario hits record high](#)", *Toronto Star* (16 September 2019).

⁸⁵ Theresa Boyle, "[Number of seniors waiting to move into long term care homes in Ontario hits record high](#)", *Toronto Star* (16 September 2019).

We believe an investigation into this situation, pursuant to your powers under s. 31 of the *Code*, is warranted.

In addition to the information we have provided here, we would welcome the opportunity to provide more complete submissions, should your office decide to investigate further.


Sincerely,



Michael Hurley
President
Ontario Council of Hospital Unions-CUPE



Natalie Mehra
Executive Director
Ontario Health Coalition



Graham Webb
Executive Director
Advocacy Centre for the Elderly