An Independent Study Commissioned by

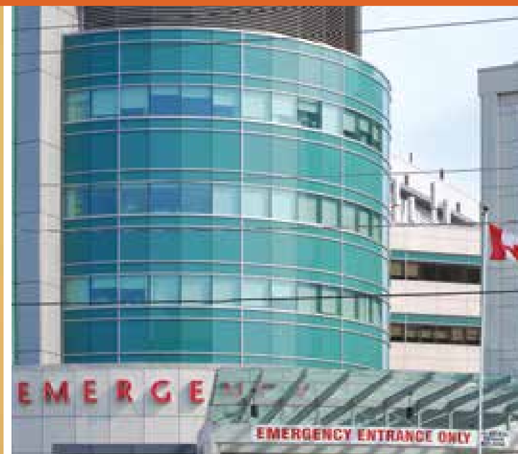
RESIDENTIAL AND CIVIL CONSTRUCTION ALLIANCE OF ONTARIO

Constructing Ontario's Future

℞ TO CURE HALLWAY MEDICINE:

Building Targeted Housing for Ontario's Seniors

FEBRUARY 2020



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An investigative study commissioned by the
Residential and Civil Construction Alliance of Ontario (RCCAO)

BY:

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The Residential and Civil Construction Alliance of Ontario (RCCAO) is composed of management and labour groups that represent a wide spectrum of the Ontario construction industry.

RCCAO's goal is to work in cooperation with governments and related stakeholders to offer realistic solutions to a variety of challenges facing the construction industry and which also have wider societal benefits.

RCCAO has independently commissioned 53 reports on planning, procuring, financing and building infrastructure, and we have submitted position papers to politicians and staff to help influence government decisions.

For more information on RCCAO or to view copies of other studies and submissions, please visit **rccao.com**

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- Carpenters' District Council of Ontario
- Greater Toronto Sewer and Watermain Contractors Association
- Heavy Construction Association of Toronto
- International Union of Operating Engineers, Local 793
- Joint Residential Construction Association
- LiUNA, Local 183
- Ontario Formwork Association
- Toronto and Area Road Builders Association

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(The opinions expressed are those of the author and may not represent the views of any organizations with which he is associated.)

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EXECUTIVE SUMMARY

Photos: Infrastructure Ontario

Ontario faces a grey tsunami, as those born after the Second World War retire and increasingly seek to access the social safety net and the public healthcare system. We also know that the boomer generation is healthier, wealthier, longer-living, more diverse and certainly more numerous than all the generations before them.

Our hospitals are crowded. A major contributor to this overcrowding (and in some instances, overcapacity) is patients with long-term or chronic disease who are being treated in emergency rooms (ERs), some of whom are admitted to hospital. After critical incidents in those long-term diseases are addressed in hospitals, patients can be discharged – but where can they be housed, while their chronic diseases are monitored and managed? The traditional home-supports and at-home family members who cared for our grandparents' generation are rarely available now. There are retirement-home or assisted-living options, but will their numbers keep meeting the growing demand and will their cost prove prohibitive for some? In particular, will demand for "niche" forms of assisted living be available for those with specific needs?

Most Ontarians now look to government-subsidized long-term care as the accommodation of choice for the frail elderly or those suffering with severe, often multiple chronic illnesses. But admission to those facilities can be very limited. (Placement in hospices for palliative care patients is equally constrained.) Scarcity also makes eligibility criteria tighter: already, healthy seniors in their late-eighties and nineties are ineligible for long-term care if their level of physical and mental acuity remains too high.

In Ontario, the cost of publicly-funded healthcare already consumes nearly half the annual operating budget of the Provincial Government. It is arguably a major contributor to Ontario's deficit and debt levels over time. With the impact of demographic trends and emerging medical

technology, these healthcare costs will continue to rise. Ontario needs to take targeted action to meet the evidence-based test of "right treatment, by the right provider, in the right place, at the right time, for the lowest cost to the taxpayer."

In the fields of social and health infrastructure policy, our current trajectory will overwhelm Ontario's healthcare system. Despite significant commitments to increase supply of long-term care beds by 15,000, the prospect of governments building long-term care homes, palliative care wards in hospitals, and similar infrastructure for a whole generation of Baby Boomers would be unaffordable under the present fiscal circumstances. Continued investment in home and community care, supportive housing and assisted living accommodation, will be required to address future demands.

This paper seeks to answer a few fundamental questions. Are we developing healthcare policies well suited to the needs of these anticipated patients? Are we ignoring some important demographic signals? Are there measures that we can take now to cushion the impact of the boomer generation on our healthcare and housing systems – and on Ontario's fiscal outlook? These are issues that the new Ontario Health Agency and the Ontario Government will need to tackle.

Serving a growing and aging clientele in their homes and in community settings has been shown to achieve better health outcomes, as well as being far less expensive and more time-responsive than the costly institutional alternatives. "Good medicine" represents good fiscal policy. As the new Ontario Health Agency has pointed-out, better integration of healthcare delivery is the key. Our infrastructure investments and funding policies should anticipate, facilitate and support those right choices.

Technological, medical and social-support measures to maintain the elderly in their own homes, in retirement residences and in transitional accommodation (both to avoid hospital admissions and after hospital discharge) will need to expand dramatically.

One of the best ways to address the "alternate level of care" (ALC) or "bed blocker" issue might be to build a network of "step-down" accommodation outside the hospital environment, for those awaiting longer-term housing or other care solutions (e.g., long-term care beds). The healthcare sector describes this as the "transitional care setting" or "reactivation care". The cost of a "step-down" residence would be a fraction of the cost of conventional hospital accommodation, while still affording the protection of easier hospital access for residents at risk of re-admission.

We will always need hospitals to provide complex care and surgery, and to do medical research and education. But hospitals should not be the primary, front-line providers of healthcare services for those dealing with chronic disease, for patients recuperating from hospital-based medical or surgical procedures, or for those who have minor medical episodes. Hospitals must join in the broader collaboration/partnership approach of the comprehensive health and social care system, to achieve real change in efficient and efficacious use of resources. That is the quickest route to patient-centred care.

Making an integrated system out of Ontario's healthcare services will mean less emphasis on hospitals, and more attention to community health facilities of various kinds, both public and private, and related social services. But it also requires housing options to facilitate this transition.

RECOMMENDATIONS

Recommendation #1: Ontario's public investment focus should be on building seniors' accommodation to avoid hospital admissions and to reduce the length of hospital stays

Ontario should focus on building or expanding hospitals for advanced treatment, complex surgery and medical research and education, where the demand warrants it.

It would be prudent to begin that transition with the construction and retrofitting of accommodation outside hospitals to house and care for those dealing with chronic health conditions and those ready to be discharged from hospital.

Recommendation #2: Wherever practical and medically sound, chronic disease should be treated in the home and in the community, rather than in hospitals

The key to "bending the curve" in healthcare may prove to be more creativity in three related areas:

A. Transferring chronic-disease patients and their treatment programs out of acute-care facilities, complemented by housing where seniors can access the healthcare system remotely, in-community and on an out-patient basis;
B. Facilitating healthcare system transition by building ample, reasonably-priced, short-term and medium-term accommodation for those being discharged from hospital and/or requiring on-going, in-community medical and social supports; and,
C. Focusing hospitals on those things that hospitals do best, and building fewer new and expanded hospitals as a consequence.

Recommendation #3: Free-up suitable land assets for seniors' housing and adjust land-use planning objectives to produce a range of seniors' housing

Our current land-use planning and tax policies promote a real estate market that makes it hard to produce suitable and economical housing for seniors. We need to re-think our planning and land-assets policies, with the goal of producing a range of seniors' housing.

If some portion of our public and private land assets could be leveraged, it would lessen the challenge of producing reasonably-priced seniors' housing in a timely fashion, in an otherwise overheated residential market. It would also lower the direct and indirect taxpayer cost of these land and building portfolios.

Ontario's land-use policies at the provincial and municipal levels also need to look beyond density and intensification considerations to target types of housing that meet the needs of various categories of seniors.

Recommendation #4: Use our tax and pension policies to generate more seniors' housing

We should modify our fiscal and pension policies to create incentives to favour building a range of seniors' housing.

Retirees legitimately worry about paying for expensive supportive accommodation and healthcare costs late in life. Governments and innovative pension administrators might be able to restructure public and private pension plans to mesh realistic retirement income needs over time (income replacement) with insurance against the cost of chronic or catastrophic illness. Properly structured, such reforms are bound to generate social and financial benefits for contributors, pension sponsors and taxpayers.

Funding organizations could aid the transition of chronic-care services from hospitals by helping to finance more affordable short-to-medium-term accommodation options for those ready for hospital discharge or to forestall frequent or premature hospital admissions and ER visits.

Could the tax system encourage the building or retrofitting of suburban homes for safer mobility, bathing and cooking, and installing the digital connectivity to support healthcare monitoring? Could the tax system ultimately encourage seniors to transfer the value of their traditional family home to fund more suitable accommodation? A suite of tax credits and tax deductions will encourage seniors to relocate to more appropriate, eligible housing options, thereby creating a market incentive both to build and to buy housing units that offer the benefits outlined above. The historic experience of the MURB (multi-unit residential building) tax credit is a model to consider.

An aging society

Ontario faces a grey tsunami, as those born after the Second World War retire and increasingly seek to access the social safety net and the public healthcare system. We also know that the boomer generation is healthier, wealthier, longer-living, more diverse and certainly more numerous than all the generations before them.

With these facts in mind, are we developing healthcare policies well suited to the needs of these anticipated patients? Are we ignoring some important demographic signals? Are there measures that we can take now to cushion the impact of the boomer generation on our healthcare and housing systems – and on Ontario's fiscal outlook? These are issues that the new Ontario Health Agency and the Ontario Government will need to address.

We should begin by recognizing the full sweep of the boomer-generation's impact.[1] Given increasing longevity, we should think of the boomer generation as a four-decade-long phenomenon. For those in their sixties and seventies, the impacts of post-retirement employment, access to transportation, and re-engineering suburbia, will be significant issues, as will fiscal policies related to pensions and taxation of retirement income. Above all, throughout that full 40-year period, healthcare and related accommodation needs will predominate as public issues. As the boomers age, healthcare and housing issues for aging seniors will drive the public and fiscal agendas. Do our investments – more acute-care hospitals, more long-term care home beds – reflect future needs, or just traditional approaches?

Our predecessors lived shorter lives: age 65 was selected as the retirement age for government pension plans in Europe and America because that was the average life expectancy of the era. In the early 20th century, the majority of North Americans ultimately succumbed to infectious disease, heart attacks, injuries and related infections, complications from childbirth, and cancers (as the 1940s' cancer survival rate was barely 25%, while exceeding 60% today). Diseases of the very old were uncommon, since people typically did not live that long. The majority of our grandparents' claim on the healthcare system came in the last six months of their lives. As a result, our hospitals were designed to deal with acute health episodes – indeed, hospitals are still referred to as "acute care facilities" by those in the field.

Hospital crowding

Our hospitals are crowded – from two streams. ERs are treating an array of patients – and among admitted patients, short-term medical-surgical beds are occupied by those awaiting or recovering from surgery and diagnosis/treatment. Much of the crowding in ERs and among patients awaiting admission to hospital is caused by those with long-term or chronic diseases. These chronic conditions include treatable cancer, chronic-obstructive pulmonary disorder (COPD), chronic heart failure (CHF), type-2 diabetes, kidney failure, Alzheimer's disease and other forms of dementia, recurring episodes related to opioids and other addictions, degenerative skeletal and muscular conditions, and debilitating mental illness. Some are afflicted with more than one chronic disease (so-called "co-morbidities").

As critical incidents in those long-term diseases are addressed in hospitals, patients can be discharged – but where can they be housed, while their chronic diseases are monitored and managed? The traditional home-supports and at-home family members who cared for our grandparents' generation are rarely available now. Retirement-home or assisted-living facilities provide important options, but these spaces are unlikely to meet the growing demand and will prove to be cost prohibitive for some. Although some 17,000 new retirement-home beds are being produced across Ontario over the next five years, and some locales (e.g., Ottawa) may even face an over-supply, demand will overwhelm supply in many market areas. Meeting the demand for "niche" forms of assisted living for those with specific needs will also prove to be challenging.

Most Ontarians now look to government-subsidized long-term care as the accommodation of choice for the frail elderly or those suffering with severe, chronic illness. But admission to those facilities can be very limited. (Placement in hospices for palliative-care patients is equally constrained.) Local Health Integration Networks (LHINs) presently match eligible patients with available long-term care beds, a process that will continue in some fashion after LHINs are dissolved in the near future. This process is a challenge, as families can be very discriminating in the long-term care homes that they will accept. Some local commercial long-term care homes may not have reputations that recommend them, despite government regulation and oversight. Scarcity also makes eligibility criteria tighter: already, healthy seniors in their late-eighties and nineties may not be eligible for long-term care, if their level of physical and mental acuity remains too high.

Hospitals strain to discharge patients with a very limited supply of acceptable after-care residential accommodation options, while ERs, primary-care and specialist physicians, and hospital clinics continue to generate urgent demands for those same hospital beds. Hallways fill with patients on stretchers, emergency-room wait-times increase, and ambulance backlogs lengthen. Hospital funding is increasingly tied to dealing more effectively with "alternate level of care" (ALC) patients or so-called "bed blockers" – those whose continuing stay in hospital is solely related to an inability to discharge them to an acceptable home or care setting.

Additional pressures on hospitals

Since many Ontarians cannot find a family physician or find the ER more readily accessible, especially after-hours and on weekends, hospitals see an ever-increasing volume of admissions that might have been avoided with more preventative care or with alternative treatment facilities. There is, in particular, a small sub-set of hospital patients who generate a disproportionate number of ER cases and subsequent hospital admissions. Patients afflicted with addictions and / or mental illnesses, like schizophrenia, are often unable or unwilling to manage their complex cocktail of pharmaceutical therapies and may be neglected by the social services system. They may also suffer from related or consequential illnesses or medical episodes, a.k.a. 'co-morbidities'.

On September 16, 2019, the Globe and Mail summarized the issue facing a typical hospital:

> "In 2018-19, there were 61 patients from midwest Toronto – an area that includes Parkdale – who visited the emergency departments at Toronto General or Toronto Western 20 times or more. They accounted for 2,096 visits, or an average of 34 visits each.
>
> "Patients who go to the emergency room every 11 days, on average, are more likely to need a social worker than a doctor."[2]

Hospitals are by far the most expensive place to treat illness, and in some cases, they are not the most medically efficacious. Despite this, an indicator of the changing nature of illness in our society is the fact that most acute-care hospitals host a number of essentially chronic-care facilities.

Even after they are discharged, many patients are readmitted to hospital. In January 2020, when Health Quality Ontario (HQO) announced new guidelines for patients in transition from hospital to home care, it highlighted the problem with follow-up care:

> "In terms of follow-up care, as many as 44 per cent of patients in Ontario do not attend suggested post-discharge appointments for medical care because of issues such as mobility limitations, low health literacy, financial concerns and a lack of social supports."[3]

It does not have to be this way. Some routine surgeries, like ophthalmology, can be much more efficiently and effectively handled by specialized facilities, like the Kensington Eye Institute in Toronto. As technologies advance, the prospect of so-called "virtual care" can be realized, combining in-person consultations with remote monitoring and other supports. Effective therapies and disease-monitoring could increasingly be done in lightly-supervised home, community or primary-care (family practice) settings.

With some process redesign, supported by appropriate capital investments, many of these hospital-based chronic-care services could be relocated into the community – such as cardiac rehabilitation, kidney dialysis, physiotherapy, palliative care, diagnostic imaging, out-patient psychiatric services, and a range of clinics that hospitals support for patient-consultations with 'specialist' physicians.

Proposed improvements in public pharma-care coverage across Canada reflect a recognition that new medications and targeted treatments can prolong life, improve the quality of life and forestall the need for hospitalization and long-term care. Effective and technologically-enabled medication-management and condition-monitoring, in the home and in the community, could dramatically reduce the severity and frequency of disease episodes and the need for hospital visits.

Recommendation #1: Ontario's investment focus should be on building seniors' accommodation to avoid hospital admissions and to reduce the length of hospital stays.

Recommendation #2: Wherever practical and medically sound, chronic disease should be treated in the home and in the community, rather than in hospitals.

The key to "bending the curve" in healthcare may prove to be more creativity in three related areas:

- **A** By moving more chronic-disease patients and their treatment programs out of acute-care facilities, complemented by housing where seniors can access the healthcare system remotely, in-community and on an out-patient basis; (when realized, integrated, community-based care is far more efficient than having an array of agencies and their staff in institutional settings, like hospitals);
- **B** By facilitating healthcare system transition by building ample, reasonably-priced, short-term and medium-term accommodation for those being discharged from hospital and/or requiring on-going, in-community medical and social supports, some of which can be supplied on a short-term basis through rehabilitation programs currently delivered within retirement homes; and,
- **C** By focusing hospitals, particularly major (academic health sciences) hospitals, on those things that hospitals do best, and building fewer new and expanded hospitals as a consequence.

At various stages in the aging process, moving to an appropriate form of housing is an important dimension of healthcare.

Among 'younger' seniors (those in their sixties and early seventies), we need to reconsider our assumptions about their accommodation options and preferences. In Ontario, our land-use planning policies are focusing on increased densities and intensification, which some assume will address the needs of seniors downsizing from suburban family homes. These policies may generate increased numbers of small residential units. But simply relying on new mid-rise and high-rise, urban-centre condominiums and apartment buildings may misread the true preferences of younger seniors, particularly if they are given real choice in the marketplace.

Are the seniors among the three million suburban residents of the GTA (beyond the Toronto core) likely to embrace the urban lifestyle of downtown or mid-town Toronto or the 'Square One' precinct in Mississauga? For these life-long suburbanites, the answer is likely: only if they have no lifestyle or market choice. In fact, recent evidence suggests that the other primary market for new 600-square-foot urban high-rise condominiums and apartments may also erode, as young couples move into the family-formation phase and seek more child-friendly types of accommodation, notably ground-related housing.

For seniors, an emerging indicator of market preference may be the popularity of small-lot, condominium bungalows and bungalofts, for which there is market scarcity and high demand. Homes in established smaller-lot, urban-bungalow subdivisions and land-based condominiums often sell rapidly and even informally, with considerable price-elasticity.

Another option that is attracting interest from younger seniors is the aging-in-place retirement residence, where the level of care increases as their level of acuity inevitably declines. This type of housing is often structured as a life-lease, funded from the sale of the family home. This model can appeal to the asset-rich but income-poor senior.

Finally, for those suffering from chronic disease but not yet requiring the full suite of long-term care's personal care and medical supports, or who have lost the support of a spouse, there is a market for retirement homes. This accommodation serves those with declining acuity, and in particular, those recently released from hospital or to forestall premature or recurring admission to hospital.

In this latter category, consider the discharged hospital patient who needs some additional time and supports to return to independent functioning. There are some very successful short-to-medium-term rehabilitation programs ("transitional care" or "reactivation") presently operating in retirement-home settings, where seniors stay until they regain enough function to return home safely.

Currently, too many seniors are being kept in acute-care hospitals because, although medically stable, they are not yet functionally able to return home. In addition, rehabilitation beds are both scarce and expensive. This kind of transitional assistance can definitely be done more cheaply and effectively outside of a hospital setting.

All three of these options – the bungaloft condominium, the aging-in-place retirement residence and the conventional commercial or non-profit retirement home – lend themselves to the introduction of technologically-supported healthcare, to address the needs of aging seniors.

There is, however, also a need for transitional, "step down" or short-to-medium-term accommodation for patients being discharged from hospital to cope with ongoing chronic illness,

physical disability or rehabilitation needs (i.e., "transitional-care setting" or "reactivation care").

Each of these four types of housing could be designed to provide a mix of in-home technology and telecommunications, and neighbourhood-based healthcare facilities and services (e.g., fitness, rehab, dialysis, social worker, nutritionist, senior day-care or transportation).

Given the growing local political resistance to neighbourhood intensification and high-rise density, it might be observed that the most politically acceptable forms of urban and suburban redevelopment tend to be those aimed at building low-density or medium-density seniors' residential accommodation.

How can housing choice help the healthcare system?

The housing options outlined above would appear to reduce the pressure on healthcare facilities and the public healthcare system overall. How might the supply of this kind of housing choice be expanded in-synch with the growth and aging of the boomer demographic? It would require mutually supporting initiatives, in these three areas:

- land-use planning and land-disposition policies;
- fiscal and pension policies; and,
- reforming healthcare system incentives, to promote a patient-centred integration of both health and social services.

Recommendation #3: Free-up suitable land assets for seniors' housing and adjust land-use planning objectives to produce a range of seniors' housing.

Making land available for seniors' housing

Our current land-use planning and tax policies promote a real estate market that makes it hard to produce suitable and economical housing for seniors.

It begins with the way we treat space-extensive lands for various public uses:

- Despite the smart-growth policies underlying Ontario's Growth Plan, suburban healthcare facilities, along with post-secondary institutions and other public institutions, still favour the suburban-campus format, with a large geographic footprint and ample paid surface parking.
- Ontario's tax policies confer favourable property-assessment taxation treatment on places of worship and other community facilities, which tend to promote a sizable allocation of land for weekly or periodic surface parking. Property tax deferrals for golf courses have a similar effect.
- There are inventories of Ontario Government lands in the hands of Infrastructure Ontario, held for past plans for social and affordable housing and other public purposes.
- Many school boards, notably in Toronto and Ottawa, are sitting on inventories of real estate and decaying buildings, against the hope that public-school enrolments may someday rebound due to immigration or intensification (as well as being used for staff parking and informal neighbourhood parks). Regulations now require health agencies to be notified when surplus school properties are available.

If some portion of these land assets could be leveraged for other public objectives, or to produce identified "community benefits", it would lessen the challenge of producing reasonably-priced seniors' housing in a timely fashion, in an otherwise overheated residential market. It would also lower the direct and indirect taxpayer cost of maintaining these lands and building portfolios.

Ontario's land-use policies at the provincial and municipal levels also need to look beyond density and intensification considerations to target types of housing that meet the needs of various categories of seniors.

Housing options to support hospitals and healthcare

A promising option would be to use these properties to create subdivisions of bungalows and aging-in-place homes to accommodate those facing diminishing physical acuity and chronic illness. To enhance effectiveness, these types of projects could be designed to host "step-down", transitional accommodation for those ready to be discharged from hospital.

While serving as a safety-valve for hospitals and other parts of the healthcare system, these residential developments need not be adjacent to healthcare facilities, but could be located convenient to community amenities, supported by dedicated transit services, ride-sharing and automated vehicles, and by subsidized fare media. Linking good seniors' accommodation with convenient, accessible transportation would certainly facilitate the difficult decisions faced by physicians and families when the time comes to revoke or restrict driver's licences, with practical, emotional and social isolation consequences for seniors. It would also address the persistent problem of missed medical appointments. Transportation options could include subsidized transit passes and ride-sharing options, and in the relatively near future, access to automated vehicles or shuttles equipped for seniors' needs.

Removing those who should not be driving from our highways and local streets would also reduce the risk of death and injury to motorists, cyclists and pedestrians due to motor vehicle collisions. These accidents will otherwise continue to grow as a major contributor to increasing healthcare costs, particularly for hospital-based trauma centres, and the cost of litigious motor vehicle insurance coverage.

These housing options also open-up opportunities for community voluntarism, including seniors-supporting-seniors, as they cope with the daily challenges of life in a modern world and with their ongoing health needs.

Recommendation #4: Use our tax and pension policies to generate more seniors' housing

Pension plans, healthcare and housing

Governments across Canada have cooperated to increase public pensions and tax plans (RRSPs, RRIFs, TFSAs, pension-income splitting) to meet the needs of seniors facing health and housing costs in retirement. Hundreds of thousands of Ontarians enjoy pensions or contribute to pension plans that promise a high percentage of pre-retirement annual income as an annual pension.

How might our fiscal and pension policies be modified to create incentives to favour the housing options outlined above?

Part of the reason that defined-benefit pension plans are structured to be generous is the pensioner's reasonable worry about paying for expensive supportive accommodation and healthcare costs late in life. If the quality of late-in-life housing and chronic-illness healthcare could be more assured (and insured), many seniors might be willing to accept a modified monthly pension entitlement. Innovative pension administrators might be willing to restructure public and private pension plans to mesh realistic retirement income needs over time (income replacement) with insurance against the cost of chronic or catastrophic illness. Such reforms will generate social and financial benefits for contributors, pension sponsors and taxpayers.

At the same time, pension plans face increasing challenges to produce investment returns that will meet their large and longer-lived pension obligations. As an investment asset class, residential accommodation for seniors has the potential to pay steady, long-term returns, given the size and financial profile of retiring seniors.

Charitable and fiscal options to support seniors' housing

For their part, hospital fundraising foundations and other health-specific charities could be encouraged and enabled to widen their charitable objects. Hospital foundations' first priority is to hospital facilities, notably those items like technology that are not subsidized by government. Yet some hospital foundations may see step-down housing as a way to leverage land assets, or to ease the burden on hospital operations, in a way that does not create the ongoing operational costs the way that direct hospital capital investments inevitably do. Either as donations or investments, funding organizations could aid the transition of chronic-care services from hospitals, by helping to finance more affordable short-to-medium-term accommodation options for those ready for hospital discharge or to forestall frequent or premature hospital admissions and ER visits.

Could the tax system encourage the building or retrofitting of suburban homes for safer mobility, bathing and cooking, and installing the digital connectivity to support healthcare monitoring? The answer is an emphatic "yes". In fact, the tax system could be adapted to encourage seniors to transfer the asset-value of their traditional family home to fund more suitable accommodation. A suite of tax credits and tax deductions could provide the necessary incentive for seniors to relocate to more appropriate, eligible housing options, thereby creating a market signal both to build and to buy housing units that offer the benefits outlined above. The historic experience of the MURB (multi-unit residential building) tax credit might be a model to consider.

Housing as a partial solution to hospital over-crowding

The last element of the three-part strategy to relieve pressure on the healthcare system may prove the most daunting. Moving healthcare funding from the hospital sector to the community health sector, much less to the housing sector, has never been easy. In fact, some would argue that any reduction in hospital funding can lead to closing acute-care beds. Hospital priorities typically have a prior claim on any money saved in their own operations. Savings in the hospital sector can also be intimately related to the compensation regimes for physicians, nurses and hospital workers, so there may be resistance to funding being diverted to other worthwhile purposes.

The justification of reduced cost or cost-avoidance measures in healthcare rarely gains much support in either the medical community or with the broader public, including the media. It would require a whole-of-government approach to budget allocations, and incentives for those whose cost reductions and procedural reforms generate the opportunities and the benefits. It would also require champions in the medical community and among civil society organizations.

There is no reason why hospital corporations should not be active partners in this effort, as some already are. For example, some community hospitals operate long-term care facilities with medical supports. Hospitals themselves use so-called "step-down" units, which are wards for patients whose post-operation conditions have stabilized, or who are awaiting discharge to a more appropriate care and accommodation setting.[4]

One of the best ways to address the ALC or "bed blocker" issue would be to build a network of "step-down" accommodation outside the hospital environment, for those awaiting longer-term housing or other care solutions (e.g., long-term care beds).[5] Many hospitals have the land (and the charitable foundations) to support such ventures. The cost of a "step-down" residence would be a fraction of the cost of conventional hospital accommodation, while still affording the protection of easier hospital access for residents still at risk of re-admission.

If the "step-down" residence was operationally divorced from the operation of the hospital, it would also likely benefit from a lower cost structure than prevails in the complex and heavily-regulated hospital environment and its workforce. To make the system work better, these facilities may also need to become eligible for government-funded home and community care services. (These Home and Community Programs, currently provided by LHINs, now primarily serve the own-home needs of the chronically ill, or those in rehabilitation and recovery.) To balance the ebb-and-flow of hospital discharges, these residential facilities might also be made available for short-term respite for family care-givers, including spouses, thus reducing the incentive for seeking admission to long-term care or hospital.

More suitable accommodation of the chronically ill and those with declining acuity may also require a more realistic contribution by beneficiaries of the healthcare and housing systems, particularly from those who do not require open-ended taxpayer support. Just as transportation and utility infrastructure should be funded, in part, by its users over its useful life, so too should universal public medicare tolerate some cost-recovery for accommodation across the spectrum of seniors' housing and supplementary healthcare.

Focusing hospitals on their primary role

In the fields of social and health infrastructure policy, the current trends will overwhelm Ontario's existing approaches to healthcare delivery. The prospect of governments building long-term care homes, palliative care wards in hospitals, and similar infrastructure for a whole generation of Baby Boomers appears unsustainable under the present fiscal circumstances. Technological, medical and social-support measures to maintain the elderly in their own homes, in retirement residences and in transitional accommodation (both to avoid hospital admissions and after hospital discharge) will need to expand dramatically.

In Ontario, the cost of publicly funded healthcare already consumes nearly half the annual operating budget of the Provincial Government and is arguably a major contributor to Ontario's deficit and debt levels over time. With the impact of demographic trends and emerging medical technology, these healthcare costs will continue to rise. Ontario needs to take targeted action to meet the evidence-based test of "right treatment, by the right provider, in the right place, at the right time, for the lowest cost to the taxpayer."

Despite our investments and progress in areas like diagnostic imaging and laboratory testing, we still do not have easily transferrable electronic medical records and electronic health records. Adding to the complexity, personal health data is neither intelligible nor conveniently available to the patient and family caregiver, for those trying to manage chronic disease. In Ontario, it has been observed, we all have more electronic information about our

cars and our pets than we do about our personal health.

Serving a growing and aging clientele in their homes and in community settings often achieves better health results, as well as being far less expensive and more time-responsive than the costly institutional alternatives. The right kind of housing also encourages continued social interaction by seniors. There is compelling evidence to suggest significant negative health effects from loneliness and social isolation on the health and well-being of seniors.

"Good medicine" represents good fiscal policy. As the new Ontario Health Agency points-out, better integration of healthcare delivery is the key. Our infrastructure investments and funding policies should anticipate, facilitate and support those right choices.

We will always need hospitals to provide complex care and surgery, and to do medical research and education. But they should not be primary, front-line providers of healthcare services to those dealing with chronic disease, patients recuperating from hospital-based medical or surgical procedures, or those dealing with minor medical episodes. Hospitals must join in the broader collaboration/partnership approach of the comprehensive health and social care system, to achieve real change in efficient and efficacious use of resources. That is the quickest route to patient-centred care. Along with transitional housing, it is also part of the prescription for curing hallway medicine.

CONCLUSION

An integrated system means a greater focus on community health facilities, coordinated with the provision of appropriate seniors housing

Making an integrated system out of Ontario's healthcare services will mean less emphasis on hospitals, and more attention to community health facilities of various kinds, both public and private, and related social services. But it also requires housing options to facilitate this transition.

In the future, outside of under-serviced areas, Ontario should only need to build or expand hospitals for advanced treatment, complex surgery and medical research and education.

We should begin that transition with the construction and retrofitting of accommodation outside hospitals to house and care for those dealing with chronic health conditions and those ready to be discharged from hospital.

ENDNOTES

1. John Ibbitson, "Older, longer: The super-aging of Canadians has taken everyone by surprise", *The Globe and Mail* (Toronto: January 26, 2020)

2. Kelly Grant, "Toronto-based hospital network commits land to building affordable housing", *The Globe and Mail* (Toronto: September 16, 2019); found at: https://www.theglobeandmail.com/canada/toronto/article-toronto-based-academic-hospital-commits-land-to-building-affordable/

3. Nicholas Sokic, "New standards for patients leaving hospital to go home", *healthing.ca*, January 17, 2020; found at: https://www.healthing.ca/news/new-standards-for-patients-leaving-hospital-to-go-home

4. It should be noted, however, that hospital "step down" units are frequently related to the intensive care unit (ICU) or cardiac care unit. They are, by design, an intensive, short-term use of costly hospital space, staffing and services.

5. For example, the old Humber hospital in Toronto was recommissioned as a transitional care facility – mostly ALC patients; other hospitals have partnered with retirement homes for the same purpose. Another approach is the recent University Health Network / City of Toronto initiative, referenced in footnote #2.

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