Envisioning a New Future for Vulnerable Elderly Citizens

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Ageism, defined as the "stereotyping, prejudice and discrimination against people on the basis of age" (https://www.who.int/ageing/ageism/en/), is an insidious, pervasive and unethical practice within our society, triggering widespread policy and practice decisions that are disrespectful at the least and out-right deadly at their worst. This cannot be overstated. These biases broadly influence thinking throughout the world, and can reach such disturbing extents as the opinions expressed by well-known British ethicist, Baroness Mary Warnock, who has proffered the opinion that old people with dementia have a duty to die, as they waste public taxpayer money. (https://www.dailymail.co.uk/news/article-1058404/Old-people-dementia-duty-die-pushed-death-says-Baroness-Warnock.html).

The harmful practices of ageism are particularly evident in our responses to the care needs of our aging population, where an inadequate effort is made to support people in their own homes and communities, while a corresponding and excessively utilized response is institutionalizing our elderly in large, congregate, impersonal facilities. Most often these facilities operate for a profit, creating an unacceptable risk of harm as a result of the driving force of profit-over-care corporate goals.

Dr. Ernie Lightman, professor emeritus of social policy at the University of Toronto, puts it clearly: "My PhD in economics tells me that maximization of profit is the goal of the corporation (or most other businesses), and that profit is the difference between what comes in (revenue or income) and what is paid out (costs or expenses). Maximizing profit means increasing the former and/or decreasing the latter. Incomes for long-term care centres are relatively fixed: The province pays $182 per diem for each licensed bed, with various top-ups and opportunities for user co-payment increasing this figure. With four beds to a room, this is a lucrative daily guaranteed payment for any operator. So, the main avenue to increase profit is to reduce costs: 'Continuity of care' – knowing the patient and working with [him or her] on a daily basis – is less important than reducing labour costs. Hence, staff are employed for limited hours so they are not eligible for benefits which only kick in at a certain hour threshold. High resident-to-staff ratios and inadequate personal protections are the hallmark of the truly marginalized workforce found in most long-term care facilities today. (https://rabble.ca/blogs/bloggers/views-expressed/2020/05/private-long-term-care-facilities-have-been-understaffed-and).

Of particular note is the extent to which exactly this practice of cost-cutting through utilizing significant numbers of part-time staff has been recognized as contributing to the massive crisis that developed in Long Term Care (LTC) settings in the Covid 19 pandemic.

The Law Commission Of Ontario in 2009, provided a detailed illustration of the significant harms that Ageism has engendered in our society. In concluding their report, they identified the need for significant policy and practice changes within our province, stating that "guiding principles for responding to older adults in the context of law and policy, such as independence, participation, security, dignity, and respect for diversity, can be valuable starting points" (https://www.lco-cdo.org/en/our-current-projects/a-framework-for-the-law-as-it-affects-older-adults/older-adults-funded-papers/ageism-and-the-law-emerging-concepts-and-practices-in-housing-and-health/vii-conclusion/).

Relatedly, the Expert Working Group of the United Nations (UN) has issued multiple reports that contain extensive detailed recommendations. These can and should inform us in the development of Best Practices for supporting our elderly citizens, within a context of Human Rights understandings and global innovations.
(https://www.un.org/development/desa/ageing/resources/reports-of-the-expert-meetings-and-workshops.htmlj.

The Ontario Human Rights Commission, the Alliance for Aging, the Ontario Health Coalition, the Canadian Accessibility Standards Development Organization, and the Advocacy Centre for the Elderly all have comprehensive material and documentation that speaks clearly to the need for substantial revision to the system of elder care supports in our province. The existing system is not only 'broken' as Premier Ford has acknowledged, it is shattered. Dr. Spindel is unequivocal on this point "This is a human rights issue, and it is time it was treated as one".
We simply cannot ignore the mountain of evidence and conviction for the need for respectful, human rights-based change that exists.

Ontario has the singular dishonour of having institutionalized elderly citizens at one of the highest rates in the world. According to a United Nations report on Economic and Social Affairs, 4-6 % of the global population aged 65 years and over are in residential aged care. (https://www.un.org/esa/socdev/ageing/documents/papers/guide.pdf). The Organisation for Economic Co-operation and Development (OECD) reports that in Canada, an estimated 238,000 individuals, aged 65 and over, resided in institutions in 2009." (OECD. Help wanted? Providing and paying for long-term care. Paris: Organization for Economic Co-operation and Development; 2011.). From their 2011 data, Stats Canada breaks this down further, detailing that among the age group 65 to 69, about 1% lived in special care facilities; among seniors aged 85 and over, the proportion was 29.6%." **Almost 30%!**
(https://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-312-x/98-312-x2011003_4-eng.cfm).

Numerous studies, critiques, inspection reports, and complaints paint a glaring picture of ageism proliferating within our society, under the guise of providing care. One such study, commissioned by the Institute for Public Research in the UK, in a document entitled "The Financialization of Adult Social Care" bluntly concluded that "large corporate business models [of elder care] are not only financially unsustainable, but are also detrimental to quality". (https://www.ippr.org/files/2019-09/who-cares-financialisation-in-social-care-2-.pdf). The

evidence is in, from an abundance of multiple sources. There is no secret here. The manner in which our society has responded to the needs of our very vulnerable elderly population is appallingly inadequate and thoroughly shameful.

It is not only the elderly that are currently residing in LTCs. A substantial number of younger people, some only recently graduated from High School, have been placed in such settings, most against their will. These people include those with developmental disabilities, and those with physical disabilities and/or medical support needs. Repeatedly, they call for relocation to more normalized alternatives. Jonathan Marchand is one such individual. Marchand uses a ventilator to breathe, and has been unable to obtain the level of support he requires to live in the community, which is his goal. He states "Living in a Long Term Care facility is no life. I've got no future – nothing to look forward to. I need to be able to live like any other Canadian citizen…. – to be able to participate and contribute to society.". (https://www.cbc.ca/news/canada/montreal/quebec-chslds-young-adults-living-with-disabilities-autonomous-1.5538583).

Within our collective memories, society has progressively recognized the harmful effects of institutionalizing people, from orphanages to large facilities for people with disabilities, and has taken action to develop more humane alternatives. But these changes didn't come about on their own accord – they were driven by outrage. They were led by insightful and courageous people, and they were implemented when every-day people created a demand that couldn't be ignored by policymakers of the day.

People in Ontario today are taking such a stand. No more slotting of people into large dehumanizing facilities. No more profiting from the needs of our vulnerable elderly. We must instead build capacity in developing innovative, respectful responses to the needs of this population through thoughtful exploration of creative alternatives, and INVEST in such initiatives immediately, both through policy development and through funding commitments.

Alternatives

Stopping the blatant warehousing of our elderly into institutional settings requires a meaningful grasp of the fact that far more appropriate and respectful alternatives are possible. Additionally, these alternatives are currently in existence and are successfully operating in many jurisdictions. Sadly this is far from the reality in Ontario for our elderly citizens. The models that are in existence in this province exist primarily for another similarly vulnerable population – those with disabilities – but these models can be significantly informative. Not only can we turn to that sector for an understanding of a range of community and home-based supports, but there is a body of knowledge within that community that has direct experience in the deinstitutionalization of thousands of people who had been living in the large facilities that existed in this province up until 2009.

Douglas Cartan, is longtime advocate for deinstitutionalization and the rights of the disabled. He was also a former member of the Minister of Community and Social Services Advisory Group on Developmental Services in the 1990s. He confirms this understanding, stating "With good person-centred planning, flexible and adequate funding, and the engagement of the person along with those who really care about the person, we discovered that there was really no one with a disability that needed congregate care in large facilities. Furthermore, this model of personal planning and the individualized delivery of personal support is widely applicable to any citizen who requires extensive care and assistance regardless of their physical, intellectual and health needs. All across this country people with significant and even challenging support needs have been accommodated in their own home or in small local community-based arrangements that dignify and respect the life of the person. People with disabilities, especially those previously institutionalized in large congregate care facilities, and who are now living in their own homes are demanding that they be enabled to age in place and, if it is their wish, to die at home".
This same sentiment is repeatedly regularly by our elderly citizens.

Linda Till, Policy Advisor for vulnerable elderly and for people with disabilities, expands on this, explaining "the concepts of 'aging in place' and 'homes for life' can provide us essential underpinnings as we shift from institutionalizing people, to ensuring meaningful quality of lives in the settings of people's choice, with the required supports centred around the whole person, including their dreams and goals, whatever their age".

We can also be informed by the practices in other countries where alternatives to institutionalization of the elderly is the norm. Italy, Israel, Sweden and Japan are four such jurisdictions. Israel has a law on the books since 1988 to provide older people with a legislative right to supports to continue living in their own community. More countries are recognizing the necessity of such sifts in elder care responses. A recent article in the Irish Times called for just such change in Ireland, explaining that Israel has had a law on the books since 1988 to provide older people with a legislative right to supports to continue living in their own community, and that the Australian Royal Commission on aged care quality has recently called for submissions on alternatives to institutions. (https://www.irishtimes.com/opinion/nursing-homes-must-be-made-a-thing-of-the-past-1.4257422?mode=amp) ; (https://www.mutualinterest.coop/2020/05/forget-big-business-or-the-state-co-operatives-should-run-care-homes) ; (https://globalhealthaging.org/2014/08/03/sweden-a-role-model-for-elderly-care/)

Of critical importance is the need to assert clearly that the oft-held belief that there will always be some people who require institutional care is simply and blatantly false. Linda Till explains "Extensive evidence exists that people with even the most challenging support needs can be appropriately and safely cared for in their own homes, or in small home-like settings in the community. In so doing, they can be enabled to live more comfortable, healthy, normalized, valued, and meaningful lives than those who have been relegated to large, impersonal congregate settings".

Dr. Ernie Lightman conducted a thorough systematic inquiry into elder care settings in this province under appointment by the Public Inquiries Act in the 1990's. He explicitly recommended even that many years ago that the nursing home approach to elder care should not be expanded more widely. He specifically identified "We must dramatically turn our focus to the community, supporting agencies that can deliver services to people in their homes, keeping them out of long-term care beds in the first place". Dr. Lightman has recently further explained that "The development of new technologies [has] enabled people to live outside institutions. It was not so long ago that people in need of oxygen had to reside in institutions to be hooked up to machines to help them breathe; today, by contrast, we see people walking along the street pulling a small mobile oxygen system, much like they'd pull a shopping cart. Human services such as nursing can be delivered anywhere in the community, and need not be within institutions." (https://rabble.ca/blogs/bloggers/views-expressed/2020/05/private-long-term-care-facilities-have-been-understaffed-and).

Vision

In envisioning a future devoid of institutionalization, the path lies in embracing the concept that every single person can be supported in such alternatives. This requires a revised understanding of how to build sustainable supports that revolve around a full understanding of a person's needs; doing so in a manner which is individualized and inclusive of their own dreams and goals, interests, and capacities. To focus strictly on personal care or medical needs leaves a whole component of the total needs of a person un-addressed.

Current allocation of funding for the elderly and for Long Term Care settings, if redirected into innovative alternatives in homes and communities, would enable such developments. Some jurisdictions have legislated that the funding currently allocated to an individual in an institution must be relinquished and redirected to their care in community, such as the ***Money Follows the Person*** program within Medicaid in the United States. (https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html)
We can do this.

Additional Funding

Long term care settings and their supporters repeatedly call for more funding, claiming that the LTC sector has long been under-funded. If we scrutinize these claims in light of the significant profits and shareholder benefits that the large LTC corporations acknowledge, the argument becomes evidently specious. Definitely, our elderly deserve investment into their care, but it is incumbent upon us to ensure that such additional investment be directed towards the Best Practices of elder care that have been shown to be more effective, more respectful, more appropriate, and more humane. More funding is definitely warranted, but must not be funnelled into settings already proven to be inadequate and harmful.
We can do this.

[i]Person DirectedPlanning

An individualized planning approach has been shown to be most effective in ensuring that the supports provided to a person include all aspects of their needs and preferences. The P4P Planning Network provides an example of such an approach. They offer a wealth of practical strategies, creative tools, and sustainable solutions designed to help families and caregivers. Their program reflects a comprehensive understanding of the need to plan for the whole person, recognizing that "social inclusion, opportunities to contribute in a meaningful way, relationship development, and the right to make choices are key elements of a good life. **Person Directed Planning** is a principle that recognizes a person's right to control and direct their own lives with the support of those closest to them. A key component of the P4P approach is **Independent Facilitation** – "an ongoing process that supports an individual to fulfill these objectives, develop a vision for their future and take the steps necessary to work toward their goals and dreams.". (http://www.partnersforplanning.ca/).

Care in People's Own Homes

One would be hard-pressed to find anyone who has a personal goal of one day living in one of the LTC's in this province. Conversely, the prevailing sentiment is that as people age, they most often state clearly and unequivocally that they want to remain in their own homes. In depth global research from the UN establishes this clearly "People the world over generally prefer to remain at home and maintain their independence for as long as possible. Adequate primary care and community-based service networks are key to the realization of these goals." (https://www.un.org/development/desa/ageing/resources/reports-of-the-expert-meetings-and-workshops.htmlj)
We can do this.

Redirecting both funding and staff to supporting people in their own homes as extensively as individually required, is absolutely feasible, and has been shown to be successful for people with disabilities who have similar support requirements to those of our vulnerable elderly. In Sweden, 94% of the elderly over the age of 65 live at home and are given the opportunity to live an independent life, even if someone is in need of supported assistance. (https://globalhealthaging.org/2014/08/03/sweden-a-role-model-for-elderly-care/).
We can do this.

Currently, existing programs in Ontario that enable people to live in their own homes with support include, but are not restricted to, initiatives such as:

- **Supported Independent Living (SIL)**, whereby an individual receives and manages funds specifically targeted for the provision of the care they require to live independently. The **Centres for Independent Living (CIL)** are an example of such an initiative.
- **Special Services at Home (SSAH)** and **Passport** programs make individualized funds available to families to purchase the supports their family member requires.
- **Family Homes** are settings in which an individual welcomes and essentially fosters a dependent other person into their home, with supports as needed made available

within that setting. An example of this approach is currently in practice in Ontario for people with disabilities, funded under the Ministry of Community and Social Services, and could be effectively established for some elderly.

- **Double duty** initiatives are emerging. A particular demographic, those elderly people who themselves require assistance, but are also providing care for their aging sons/daughters who have disabilities, has been significantly underserved. A recently approved initiative aimed at providing supports to both parties in these situations is under development, and will minimize the likely transfer to LTC's for each. (A Trauma-Informed Social Support Program for Aging Caregivers; Etobicoke Support Services).
- **Local Health Integration Networks (LHIN)** provide nursing and paramedical supports to people with medical support needs living in their own homes. Current funding allocation practices are very often inadequate for the needs of elderly people living in their own homes. A significant investment into this service would greatly enhance the number of people enabled to remain in their own homes, correspondingly diminishing the number of people being shunted into LTCs, most often against their will.
- An innovative development called **E-marketplaces** has emerged in the UK, and is an initiative which gives individuals easier access to adult social care services – "E-marketplaces allow self-funded adult social care users and holders of personal budgets (including direct payment recipients) to search for and purchase products and services, in line with their personal care plans, on Amazon - or eBay - style digital platforms." (Institute for Public Research, https://www.ippr.org/research/publications/next-gen-social-care-the-role-of-e-marketplaces).
- Services such as the **Red Cross** and **March of Dimes**, amongst others, can provide in-home supports to people who qualify for their funded services, or who can purchase such services privately, either from their own financial resources, or through insurance supports they may have access to. Unfortunately, most seniors are not in a position to privately fund such supports.
- **MicroBoards** are small groups of people who work jointly to oversee the allocation of such funds when an individual requires support to do so, or is unable to do so, and does not have a close or capable family member to manage funding on their behalf. As the founder of Microboards Ontario, Brendan Pooran, explains, "Microboards are not-for-profit corporations that formalize support networks for people with disabilities, enhance supported decision making, provide alternatives for managing direct funding, and promote future planning and facilitate connections to the community". (https://pooranlaw.com/brendon-pooran-is-proud-to-be-a-founding-director-of-microboards-ontario/). These organizations also provide accountability mechanisms, as well as safety and efficacy oversight.

Replication and appropriate variations of these and similar models would be completely viable for our elderly.

We can do this.

Families

Many cultures have an established practice and preference for caring for elderly family members within the family unit. Many of our immigrant and indigenous families have this orientation, amongst others. However, most must find employment to meet the financial needs of their families and must work out of the home. Rethinking this dynamic would suggest a logical conclusion: for those who wish to care for an ageing family member who requires support, why not pay them to do so? For what reason did it ever become anathema to pay people to support a family member?
We can do this.

Sharing Care

Multiple versions of **Home-Sharing and/or Care-Sharing initiatives** have emerged over the years. These models often incorporate live-in supports being provided by individuals to a dependent person in exchange for room and board. They may incorporate shared living arrangements with another individual requiring care, but for some reason unable to remain in their own home. The individuals requiring care own or rent their own home, or are assisted to do so.
We can do this.

Intentional Communities.

L'Arche International is one example of the development of Intentional Communities. L'Arche communities exist world-wide, and in Canada alone, have over 31 communities in locations in 9 provinces. In these settings, members with and without intellectual disabilities, share life together. Each member receives support to grow, attain their goals, and contribute their gifts and abilities. As stated by L'Arche "Life-sharing breaks down the barriers in the traditional caregiving relationship. Mutual care, respect and compassion transform these relationships. The persons supported and those who support them help each other reach their full potential." (https://www.larche.ca/).

NABORS is a Toronto based inclusive community, dedicated to the lives and futures of people with support needs. They utilize a concept referred to as Circles of Support, made up of friends and family who freely give their time to assist the dependent member to make informed decisions, act on choices, manage paid supports and feel safe. (http://www.nabors.ca/). Several similar initiatives build capacity for housing in apartments or condos with in-building shared care supports available for those who require them.
Reena Foundation in Vaughan, Ontario offers another model of intentional community, and collaborates with **Circle of Care, March of Dimes** and their local **LHIN** to ensure comprehensive and individualized supports are in place to enable vulnerable people "to live with safety, dignity, and a greater quality of life". (http://www.reena.org/about/reena-community-residence/).

These approaches are not disability specific, and are totally replicable for vulnerable elderly people requiring support.
We can do this.

Cooperative Initiatives

Cooperative Housing initiatives such as the **Prairie Housing Cooperative** in Winnipeg (https://www.communityworks.info/articles/cooperatives.htm) and related **Care Provision** initiatives such as the **L'Avenir Cooperative**, are made-in-Canada examples of person-centred developments enabling people to live in their own homes in community. These two organizations operate inter-dependently to provide homes and the required supports to enable people labelled with intellectual and/or physical disabilities to live with dignity, fulfillment, and security in their communities (https://lavenircoop.ca/). They illustrate another viable approach to ensuring elderly people are enabled to remain in homes within the community, and are appropriately supported to do so.

Jonathan Marchand, in the CBC interview he recently engaged in, described a co-operative called **COOP-Assist** that he has developed, with a goal to recruit their own care-givers and manage their own needs, but notes that the government has not been willing to approve funding for the initiative. (https://www.cbc.ca/news/canada/montreal/quebec-chslds-young-adults-living-with-disabilities-autonomous-1.5538583).

Various cooperative initiatives have been developed in other countries as well and have proven highly effective and sustainable. In Italy, **Social Cooperatives** account for up to 85% of care services for children, the elderly, the poor, the disabled, and other vulnerable people (https://www.mutualinterest.coop/2020/05/forget-big-business-or-the-state-co-operatives-should-run-care-homes).

The success of these initiatives has shown "…that a cooperative may work when composed of people with diverse interests, resources, skills, abilities, and needs: that is, a multi-stakeholder cooperative organization is viable." (https://senscot.net/italian-social-cooperatives/). Cooperative initiatives have been developing in England as well, and a champion of such development, James Murray, MP, asserts "The argument underpinning the model is that it provides a democratic, equitable, staff-led, and community-orientated option to public or private social care provision, allowing for surplus capital to be reinvested into the [organization] to improve quality and reduce costs." (https://parliamentlive.tv/Event/Index/46033adb-3a96-45b1-a096-86c9d5cd91d5).
We can do this.

Other Creative Initiatives

The Ontario Developmental Services (ODS) Housing Task Force of 2018, facilitated and published by the P4P Planning Network, solicited submissions of creative options currently in

practice or proposed for development in this province.
(http://www.planningnetwork.ca/HTF2/viewer/desktop/).

Reviewing and exploring such alternative models can provide an even broader understanding of new ways of approaching the needs of our vulnerable elderly. The work has already been done. We can be guided by such innovative practices as we develop a comprehensive plan towards the deinstitutionalization of the elderly in this province.
We can do this.

Staffing

Most people who are elderly, even those currently in LTC's, do not require 24/7 care. As Dr. Janice Lessard explains, "It is nonsense to think 24/7 "care" is necessary. People usually sleep. What care do they need then? We watch a lot of television and some of us [spend] time on computers. We read, we talk. We just want to keep doing it. In the privacy of our own homes. Getting in and out of bed, dressing, going to the bathroom and eating does not take up 24/7 and that is what is actually meant by "care" in a LTC setting."
Nor do the elderly always require specialized nursing care. Rethinking and restructuring our approach to providing support to people can and should explore innovative staffing models. As Linda Till explains, "Old people are not necessarily sick, and although illness may be more frequent in this population, those needs can often be met through delegation of medical procedures from nursing personnel to other support personnel, as currently enabled through policy in this province, and as supported through the College of Nurses of Ontario.
(https://www.cno.org/fr/exercice-de-la-profession/outils-educatifs/ask-practice/delegation/),

Additionally, nurses – utilizing current technologies – can have immediate access and eyes-on opportunities to assist and/or intervene whenever necessary, but do not need to be physically in an individual's home at all times.".

Shortages of people with certification in care provision such as Personal Support Workers (PSW's), Developmental Service Worker's (DSW's), Registered Practical Nurses (RPN's) or Registered Nurses (RN's) can be addressed with thoughtful consideration of the actual support needs of an individual and a resultant determination of the skill sets required for each person, rather than an across-the-board assumption that all care must be provided by people with specific certification. This would enable those with certification to be assigned according to actual need. Re-deployment of existing LTC staff as the institutionalization proceeded would assist in ensuring access to qualified personnel as needs dictated. It should be noted that there is a sub-set of people with some of these various qualifications who have left the profession out of dismay about the circumstances existing in LTC's, and who might be enticed back into the provision of supports to elderly people if more individualized, respectful, and safer alternatives were in existence.

Exploration of ways, means, and appropriate circumstances for the engagement of currently under-employed and otherwise marginalized people within our society can result in substantial

reciprocal gains. Such initiatives could enable Indigenous people, Immigrants, Street Youth, Abused Women (and Men), and people struggling with poverty to be enabled to step into a meaningful opportunity for skill development, employment and poverty reduction. The pool of certified personnel within care-specific training could be greatly enhanced if the cost of attending a relevant College certification program were offered in exchange for on-site nonspecialized support for those requiring basic assistance: a 'win-win'. Under-employed and marginalized people gaining employment, experience and training, while vulnerable elderly gain support. Colleges could be engaged in dialogue that would ensure flexible programs and relevant curriculum to address the nature of such an initiative. This is not an unheard of concept. The practices of many Cooperative Social Care initiatives have utilized this approach, demonstrating its effectiveness for the multiple groups who are engaged in the process. (https://www.open.edu/openlearn/money-business/business-strategy-studies/how-italy-reinventing-the-co-op).
We can do this.

Group Homes

The Group Home model currently widespread in the disability community provides another option for supports for our elderly. Past practice has shown that groups of no more than three non-related people in one home are the most effective, and offer the best opportunity for a normalized living experience. As Dr. Trish Spindel, Policy Advisor and Systems Change Architect has explained, "Smaller, more humane and better-staffed, community-based non-profit homes are the key to long term care success; they welcome frequent visits by loved ones, they can have fenced garden's with safe areas to wander, and can offer music, the smell of home cooking and the opportunity to introduce introduce trauma-informed care.". These group home settings are operated by nonprofit boards, and the boards serve as transfer payment agencies for funds allocated for the care of the individuals they support.
It must be acknowledged, that even within the disability community, the practice of grouping individuals into homes has begun to shift towards more individualized supports in people's own homes. Thus, replication of a model currently leaning towards re-conceptualizing and re-developing itself into a more innovative, personalized approach should be entered into with the caveat that even these, too, may need to be re-developed.

Nevertheless, the benefits to people currently housed in far less acceptable settings, such as our current LTC institutions, would be comparatively substantial. Often, the development of such options can address an immediacy of need, but building in a time-limited existence option, or a 'self destruct' mechanism can alleviate an over-arching pressing need. Our elderly are nearing their end of life. They don't have decades within which to wait while we create better alternatives for them. Action now is essential.
We can do this.

Retirement Homes

These apartment-like settings are sometimes sought out by people as they age. They have the multiple appeals of Ofer ring opportunities for down-sizing, off-loading of maintenance obligations, opportunities for purchasing meal preparation and meal sharing with others, and access to limited levels of in-apartment supports. They also offer the apparent benefit of transition from this semi-independent living arrangement to more extensive support settings, such as the LTC settings usually affiliated with them. Unfortunately, many of these settings are operated by the same for-profit corporations that are operating the very LTC's that have demonstrated such alarming care inadequacies over many years. While the semi-independent opportunity is seen as desirable, there is often a disturbing outcome of forced placement into a LTC – not necessarily one of choice, nor close to family and friends – when the individual's care support requirements escalate. Re-visiting this type of initiative, and building in aging-in-place provisions, would greatly improve the experiences of the people residing in these settings, especially if/when their care needs increase.
We can do this.

Allocating More Funds to the Current LTC System

One further note is important in this dialogue. As we – both government as well as individuals in society – grapple with the enormity of the crisis impacting our elderly in LTC's, it is imperative that we ensure that funds are not thrown at a broken system in a misguided belief that the problems will then be resolved. The problems of the system permeate right through to its very foundation. To attempt to fix such a structurally unsound system would amount to simple window dressing. It would increase the risks that the additional funds, or portions thereof, would be siphoned off into greater profits for the operating corporations. These corporations have made it clear that they want to continue to exist and in doing so, continue to profit off of the needs of our vulnerable elderly. This is evidenced not the least by the recent hiring and registering of several lobbyists who have established links to the current Ontario conservative government (https://www.huffingtonpost.ca/entry/for-profit-homes-conservative-insiders-coronavirus_ca_5ec5922cc5b63de4aabdd95f).

It is necessary to state unequivocally that any funds directed to the existing LTC settings be earmarked exclusively for resident care, be open to public scrutiny, be required to demonstrate relevant accountability, and be time-limited, because increases allocated to an archaic system are incompatible with the ethical obligation to meet the needs of the very people that system is charged with providing care to. To do otherwise in the face of evidence that these settings are harmful to people would be unethical. Apathy cannot continue. Our elderly can no longer be treated as 'out-of-sight out-of-mind'.

We can do this.
We *must* do this.

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