

Home, Hotel, Hospital, Hospice

Conflicting Images of Long-Term Residential Care in Ontario, Canada

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"A client's 'home' is wherever that person resides. It can be a private residence, supportive housing, retirement home, or just about anywhere except a hospital."
ONTARIO, BRINGING 1

"It's been quite disturbing for us because everything here is set-up to create a home-like environment ... but ... a large number of our residents are admitted ... on the verge of palliative ... We're not really set up for a palliative population."

INTERVIEW WITH CARE HOME SPIRITUAL HEALTH MANAGER, 2014¹

Few institutions have been surrounded by as much confusion, such gendered contradictions, and so many cultural anxieties as care homes for older adults, which bear the weight of cultural and economic uncertainties around population aging, changing perceptions of frailty and family ties, the meaning of dependence and independence, and fears of mortality. As one former care aide observes, "finding no one to blame for old age, why not blame those who house it?" (Tisdale xii). In their recent study *Residential Care Transformed: Revisiting the Last Refuge*, British gerontologists Julia Johnson, Sheena Rolph, and Randall Smith agree that "what people fear most is not residential care per se but ageing and the challenges of deep old age" (216).

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In this chapter I will explore a series of recurring narratives about care homes that featured prominently in policy discourse and in the media in Ontario, Canada's largest province, primarily during the post-World War II era. During these years, the modern old-age home emerged out of the shadows of its poorhouse origins as both a companion institution to the postwar hospital and an alternative to the family home as an appropriate site for the care of vulnerable older adults living out the final years of their lives. Neither purely medical settings nor "homes," long-term residential-care facilities continue to exist in the "somewhere between," which complicates their efforts to attract both broad public support and the sufficient funding required to provide a good quality of life for their residents and a rewarding working environment for their staff. How these competing stories first emerged within Ontario and how they continue to intersect will form the core of my discussion below. I will conclude by looking at the ambiguities and contradictions contained in some of the Ontario government's most recent policy documents on the future of long-term care.

"SELFISH CHILDREN"

Old age and the institutional care of aging adults emerged as a policy problem in Ontario, as in the United States, in the last quarter of the nineteenth century (Montigny; Haber; Haber and Gratton). Several trends converged, by the 1890s, to create the perception of an old-age crisis. The first was population aging. Due to declining fertility rates and increased life expectancy, the percentage of Ontarians over the age of 60 rose from 4.6 in 1871 to 8.4 by 1901. The growing visibility of an aging population was also made more evident by the increasing proportion of all adults over 20 in Ontario who were also over 60. As Edgar-André Montigny observes, "one was more than twice as likely to encounter elderly people among the population as forty years earlier" (35–36).

As the numbers of adults over 60 grew, economic conditions for their working-age children also deteriorated, due to a sharp recession in the early 1890s. The result was an upsurge in demand, both from the aged without kin and from those whose families could no longer support them, to gain admission into Ontario's county poorhouses, which grew from only 9 in 1889 to 34 by 1912, in addition to 40 charitable city refuges also subsidized by the province (Williams 55). Increasingly, other categories of the dependent poor such as widows, the disabled, and children were also being rehoused in special institutions or programs of foster care. By default, the aged became the "leftovers" of the poorhouse, comprising 80 per cent of inmates in Ontario's Houses of Refuge and 70 per cent of inmates in its Houses of Industry. These were the elderly now most visible to the state. And due to the rigid admission policies

mandated for these facilities, they were seen as a population that was overwhelmingly decrepit, unproductive, and helpless (Montigny 98–99).

Why did so many of the poor now seem to be old?² And why were they demanding entry into refuges? The responsibility, according to provincial officials, lay with families, not the state. Old people, they argued, were being “foisted upon the government” in order to shift the burden of their care “from the home to the state.” Building more institutional care would simply “take away ... the filial obligations for the support of aged parents which is the main bond of family solidarity” (Montigny 32, 103). After 1912, the construction of new houses of industry or refuge virtually ground to a halt, despite a 218-percent increase in the proportion of the population over 60. By the mid-1940s, 10,000 needy aged were crammed into structures originally designed to house fewer than 5,000 (Williams 56–57). Creating a narrative of selfish families, however, allowed the government to justify policies designed to avoid spending more money on the problem.

“REFUGEES”

From the 1890s until the 1940s, the fate of aging inmates in Ontario’s Houses of Refuge was bleak. Admitting to any “friends or family” able to provide care denied them the right to be admitted (Montigny 102). Since Houses of Refuge were located on working farmland outside towns and cities, they also physically segregated the aged from the majority of the population. Inmates lost their right to vote as well as their right to leave the institution without the permission of its superintendent. Living in dormitories of 10 to 18 beds, they also lost their right to privacy (Snell 39, 47; Struthers, *Limits* 56–57).

If physically able to work, they were required to do so, without pay, in order to help defray the costs of running the refuge. If they could no longer work, which became increasingly the case as the average age and frailty of residents rose over time, they were segregated within the oldest and most unattractive areas of the buildings, often basements or attics, which were renamed the “Old Persons’ Home” or “Old Persons’ Section” (DesRoches 64–65). If they misbehaved, or became “gravely disturbed mentally,” they could be confined to a locked and barred cell in the basement (Struthers, *Limits* 57). Married couples were not allowed to live together, nor were residents allowed to marry (58). The labels “decrepit” and “helpless” were used to describe older inmates in order to “justify [their] segregation” and to appeal to public sympathy and support. Due

2 | In fact this was an illusion. As Montigny notes, “contrary to common assumptions the vast majority of elderly people in late-nineteenth century Ontario lived independently and were capable of maintaining themselves” (52).

to their perceived maternal instincts, women took over the administration of these parts of the refuges whose residents were increasingly seen as “childlike” (DesRoches 64–65; Snell 46).

By the early twentieth century, many Houses of Refuge were given new names such as “Home for the Aged, Friendless, and Infirm” (Snell 47), but this rebranding, Cheryl DesRoches argues, “awarded neither additional status nor additional comfort.” It only acknowledged that these were places where “the old people are not expected to work if sick, or unable to work” (DesRoches 70). Before World War II, these homes never lost the stigma of their poorhouse origins. As one 75-year-old retired Ontario schoolteacher put it in 1925, when pleading to the federal government for an old-age pension scheme,

I do not want to beg ... Often the only resource for men who have lived useful lives ... is to go to one of ... those horrible, abominable institutions, the county poor houses ... those PLAGUESPOTS of the universe.... They may do for some of the feeble-minded and for sots, but certainly are not places for decent citizens. (qtd. in Struthers, *Limits* 50)

“A NICE HOMELIKE ATMOSPHERE”

By 1945, demographic changes within Ontario and new conceptions of social citizenship emerging out of the Depression and war years intensified the demand for different approaches to the care of vulnerable older adults as the percentage of the population aged 65 or older ballooned from 5.5 to over 9.0 between 1901 and 1951. The answer to their needs could no longer be the poorhouse. Inspectors’ reports in 1946 revealed more than 500 frail elderly crammed into “temporary” beds in the attics, basements, and hallways of the province’s houses of refuges, all of which had long waiting lists for admission. “Upon entering these [homes],” one complained, “the first impression was an overpowering odour ... of human excrement, body odours, boiled cabbages and strong disinfectant. With the wooden floors, cloth upholstery on the furniture, poor plumbing and lack of ventilation it was almost impossible to keep down odours” (Struthers, “Nice” 337). In Toronto, municipal officials noted that while the city’s population had quintupled since 1900, institutional shelter for the elderly had only doubled. Out of this crisis had emerged the “rise of unsupervised, commercialized accommodation” for those with “minor and serious illnesses common to aged people.” Public-health officers reported growing numbers of the elderly “lying sometimes in filth and squalor in a rooming house with no one to feed or attend them, sometimes in rooms so cold that they cannot be bathed by a visiting nurse and no hospital will accept them” (Struthers, “Reluctant” 172–73).

Other changes also heightened the search for institutional alternatives to either poorhouses or family care of the aged. By the 1940s, over 40 per cent of the Ontarians aged 70 and over would be collecting means-tested provincial old-age pensions, first made available in 1929. In 1951, their numbers more than doubled when a universal old-age pension of \$40 a month became available for all Canadians aged 70 and over, a change that greatly expanded the market for sheltering older adults. A housing crisis in larger cities such as Toronto also reduced the ability of families to take in bedridden aging parents (Struthers, "Reluctant" 172–73). As a result, by the 1940s, government officials were no longer blaming "selfish and ungrateful children" for abandoning their familial responsibilities. "With the best of intentions," they conceded, "younger members of families are finding it increasingly difficult to maintain the older members who have not been able ... to look after themselves" (Ontario, *Caring for the Aged*; Davies, *Into the House* 102). The increasing employment of married women throughout the 1950s also complicated the situation. As newspapers pointed out, coping with the chronic illnesses of the aged "requires almost constant attention and care which the busy housewife of today feels she cannot provide while looking after her own children or working at the same time" (Struthers, "Reluctant" 173).

Over the next three decades, two new policy narratives around the shelter and care needs of Ontario's vulnerable older citizens took shape. The first focused on the growing backlog of hospital "bed-blockers" and the greed of private nursing homes. This was a policy discourse shaped by a search for regulation, safety, cost savings, and efficiency. The second centred on the creation of a new welfare state, a visible symbol of which was abolition of the poorhouse and its replacement by a rapidly expanding provincial network of public and charitably owned and operated Homes for the Aged. This was a narrative shaped by images of comfort, dignity, happiness, and "home."

"Home dreams" of privacy and comfort for nuclear families were extremely compelling for the generation of Canadians emerging out of the years of Depression and war, and they fuelled the rapid expansion of the suburban experience (Strong-Boag). One of the by-products of these "dreams" for postwar politicians and social planners was the desire to eradicate the old Victorian poorhouse and replace it with a "reformed old age home ... fit for the newly minted 'senior citizen.'" It would be a modern, single story complex, decorated inside with light paint rather than dark stained wood. Communal areas would bring together residents for social events rather than merely for meals. All of this suggests a middle-class family home" (Davies, "Renovating" 162).

As Canada's wealthiest and most urbanized province, Ontario was at the forefront of this campaign. In the two decades following the passage of its "Homes for the Aged" Act in 1949, the province and its municipalities spent \$110 million constructing 89 modern homes for the aged, to care for more than

15,000 residents. Churches, ethnic communities, and other charitable organizations accommodated another 12,000 within 92 non-profit institutions. Over the 1960s alone, the annual cost of institutional care for the aged would jump from \$70 million to \$455 million, and with 8.9 per cent of its 65-and-over population living within institutional care by the mid-1970s, Ontario's rate of institutionalized elderly was 75 per cent higher than that of Great Britain and 41 per cent greater than that of the United States (Struthers, "Nice" 335; Forbes et al. 43-44).

The key significance of the province's Homes for the Aged initiative lay in its recognition that medical and social barriers to independent living rather than destitution should form the principal criterion governing admission. The intended clients were older Ontarians from all walks of life, not simply the poor. Once admitted, all "residents," as they were now called, would be treated equally as "paying guests", whether their care was subsidized by a local welfare department or came out of their own, or their children's income. The province's Conservative welfare ministers explicitly underscored the symbolism of this change at ribbon-cutting events held to celebrate the opening of the new facilities across the province during the 1950s and 1960s. "This ... is not a poor-house where unwanted people of the community are placed," W.A. Goodfellow pointed out at one such event in 1954. Instead, he and his successor Louis Cecile likened Ontario's new "ultramodern" homes for the aged either as dwellings that "match the finest of hotels" or as places where aged citizens could "enjoy all the physical comforts of a family home." In the new world of the postwar welfare state, families should no longer feel shame in seeing their aging parents in care homes. "The attitudes today are entirely different," Cecile proclaimed in 1962. "When an aged person cannot live in a private household, the family recognizes the Home for the Aged as a public service available to everyone ... The elderly person accepts the Homes as the best place in the community for his care and comfort." Or as the president of Ontario's Association of Homes for the Aged boasted in 1967, "twelve years ago it was unusual for families to place a relative in a home ... Today it seems to be a status symbol" (Struthers, "Nice" 337-38). Built mostly as 100- to 300-bed single-storey facilities, with three or four wings radiating out from a central core, they were located most frequently on the suburban fringe, often on farmland formerly occupied by older Houses of Refuge. Sleeping two or four to a room, they were still clearly institutions, not homes or hotels. But their open style, attractive colour and lighting schemes, spacious reading and television areas, tuck shops and beauty parlours, restaurant-like dining rooms, and new emphasis on recreational and physical activity provided a fitting architectural symbol of the entitlement of Ontario's pensioned citizens. Unlike the Houses of Refuge they replaced, the aim of these Homes for the Aged, according to government spokesmen, "was not to preserve a mere existence but to promote happiness" (Struthers, "Nice"

338). Gone were the “Superintendents” and “Matrons” of the older poorhouse, to be replaced by a new cadre of female professionals working as nurses, social workers, nutritionists, and physiotherapists, as well as occupational therapists whose goal was to “add life to years rather than years to life.” As Megan Davies points out, “with their special nurturing qualities and their cultural connection with ‘the home,’ women were seen as essential in a modern, compassionate institution for the aged.” At the same time, the emphasis on their maternal “nurturing” skills, combined with the absence of male employees, also underscored “the secondary status of these facilities and the ageist equation of the elderly with children” (Davies, *Into the House* 93–94).

For the first thirty years after the war, Ontario’s homes for the aged also struggled over the question of how much medical as opposed to “social” care they should or could provide. Throughout the 1940s, Ontario’s hospital infrastructure, which had not grown since the 1920s, struggled to find beds for “even urgent [acute care] cases ... because there are so many elderly, helpless, sick, occupying beds, living and boarding in these expensive institutions and for whom no place is available when they are ready for discharge,” Toronto health officials and physicians complained in 1947. “They just remain in hospital and keep patients out for whom something could be done.” The solution was to build “a low cost home for the aged.” In response, the Ontario government mentioned the need for accommodating a small proportion of so-called “bed-care” patients in its 1949 “Homes for the Aged” Act. “We feel this will be a great saving to the taxpayer,” its welfare minister argued. “These chronically-ill, bed-ridden persons need only bed-care, not the active valuable bed-space they have been taking in general hospitals” (Struthers, ““Nice”” 338–39). But the number of beds and the degree of medical care to be provided was never clearly defined. Homes for the Aged were specifically intended as “social care” rather than as “medical” facilities, which is why they were placed within the jurisdiction of the Department of Public Welfare rather than the Department of Health. Few issues would become more blurry over the next 30 years than determining the precise medical boundaries separating Homes for the Aged, on the one hand, from local hospitals and/or private nursing homes, on the other.

The principal criterion for admission to a home was proof that applicants were “incapable of looking after themselves in the community and require care.” However, the definitions of “incapable” and “care” could be elastic, ranging from frailness, physical disability, mental confusion, incontinence, or the inability to shop, cook, clean or climb stairs, to simply difficulties in finding an affordable place to live. The starting assumption, however, was that most clients would be able to walk through the front door. The 1952 brochure advertising one new home, for example, described a “home for elderly citizens designed to accommodate ... those who are self-reliant and active.” Out of

this home's 110 beds, only 17 were set aside for "special care due to physical or other infirmities." Similarly, when Toronto's first 700-bed Home for the Aged, renovated from a former veterans' hospital, opened in 1949 on a supposedly temporary basis, in order to help the city cope with an acute-care hospital-bed shortage, its director nonetheless protested that to devote more than one-third of its capacity to the care of the bedridden "would be in effect to change [its] character ... from predominance of ambulatory residents to that of the infirm" (Struthers, "'Nice'" 340). Seven years later, the city built a new 625-bed special-purpose home for the aged, on farmland 60 kilometres away from the downtown core, so that senile and bedridden residents from its other six municipal homes could be relocated in order to avoid compromising the "homelike atmosphere" of these other homes (CUPE). More than 200 of its first residents came from the original downtown Home for the Aged (which remained operating until 1981). Segregation of the senile, either in small separate wings in newer homes or in a 625-bed "special care" home, government officials maintained, was necessary in order to "shield ... from the sights and sounds of sickness and senility those who were in a better state to appreciate their surroundings and use the recreational areas, the craft and hobby rooms, gardens and chapel" (Williams 60). New semi-professional female staff in these homes also preferred to deal with "ideal" residents who were "willing and able to participate in therapeutic and recreational activities." Those perceived as "not treatable" were thought better fitted for life "in a custodial institution" (Davies, "Renovating" 172–73).

The new Homes for the Aged program did have its critics. Some argued that "the old folk have been placed in the beautiful glass and brick tombs outside our cities, their precious privacy invaded, and their right to make their own plans taken from them" (Gillen). Social workers specializing in the problems of old age also argued that "communal care rather than institutional care ... located in the actual neighbourhoods where these folk have always lived" was a more humane approach. Citing European examples, Toronto's Welfare Council in 1948 called for the construction of "co-operative homes to accommodate couples as well as single people, apartments for old people as part of public housing projects, [and] apartments specially designed for the convenience of older people," to be located not on the outskirts of the city but "close to centres of activity which include shopping sections, churches, transportation, and theatres," so that the elderly could feel they "belonged to the community and had responsibilities" (Struthers, "Nice" 342–43). These criticisms and alternatives, although prescient, would not be taken up by local and provincial governments in Ontario until the late 1960s and early 1970s, when federal government funding for seniors' housing became available on a sustained basis (Bacher; McMahon).

Homecare was also suggested as a better alternative. As Toronto's largest newspaper argued in 1951, the province's Homes for the Aged program "promote[d] huge and costly institutions which before long may become obsolete" and which too often were "being put up in the country, far from familiar interests." Why not look to British examples as an alternative and build "self-contained apartments or co-operative houses" for the aged combined with "community social services – home nursing, domestic aide, and personal case work and recreation to ensure comfortable and secure independence of aged persons living in their own apartments, flats, or lodgings" (Struthers, "Nice" 343)? At Ontario's first Conference on Aging, held in 1957, such concerns were voiced repeatedly, but they fell by the wayside due to major changes in provincial and federal shared-cost programs that same year. In 1957, Canada launched a universal hospital-insurance program that excluded federal funding for homecare as an insured service. The next year, the federal government also allowed older adults institutionalized in special care homes to be included, as "unemployables," for a cost-shared subsidy claimed by provinces under the new Unemployment Assistance Act, which provided relief to the jobless not eligible for unemployment insurance. By 1962, 21 per cent of Ontario's funding received through this legislation went toward supporting the care of the elderly and disabled in such homes. These decisions intensified the biases in favour of institutional rather than community-based approaches to caring for vulnerable older adults (Taylor 129–31; Struthers, *Limits* 190–91, 353). Homecare and assisted-living alternatives, first put forward in the 1940s and 1950s, would return as significant policy responses to the emerging fiscal crisis in hospital and long-term residential care only from the mid-1980s onwards (Baranek et al.; Struthers, "No Place").

Despite these criticisms and shortcomings, the construction and expansion of Ontario's Homes for the Aged during the 1950s and 1960s represented a high-water mark of "positivist" public perceptions of the old-age home as an innovative and progressive development within the postwar welfare state (Davies, "Renovating" 156). As one civil servant long engaged with the program wrote, in looking back on this era decades later, these "well-built, almost luxurious group homes ... each a local showplace in civic services ... [were] expressive of the most up-to-date and benign ideas concerning the quality of group living" (Williams 65). To Ontario's provincial treasurer, in 1964, the program also symbolized "the tribute which the present pays to the past. It is a *concrete* expression of the younger generations of citizens honouring their fathers and mothers" (Struthers, "Nice" 346; emphasis added).

“RELUCTANT PARTNERS: NURSING HOMES AND HOSPITALS IN ONTARIO”

A year after the passage of the Homes for the Aged Act, a report released by Ontario's Health Survey Committee revealed that there was “a shortage of 10,500 acute treatment hospital beds across the province,” a situation that government officials deemed was “nothing short of a tragedy” (Struthers, “No Place” 392). A major cause was the growing number of indigent “older men and women, disproportionately elderly, and unable to receive convalescent care at home,” who were suffering from chronic cardiovascular, respiratory, and digestive problems. Their long-term “bed-blocking” was keeping self-paying patients out of local hospitals, thus eroding their fiscal integrity (Gagan and Gagan 83–86).

During the previous decade, Toronto, where the problem was most severe, had begun improvising its own solution. Starting in 1941, the city started to subsidize the discharge of elderly patients, at the rate of \$40 a month, about half the cost of their hospital care, from hospital indigent wards to selected private nursing homes. By 1947, this “temporary” program, which started with only 30 patients, was now paying for the care of over 600 aged in private homes (Struthers, “Reluctant” 174). But what kind of care were they getting? No one really knew. “[S]ome of them provide satisfactory care and some doubtful care, but under present circumstances adequate or effective supervision is impossible,” city officials confessed in 1946. A major scandal that same year, uncovered by Ontario's Old Age Pension Commission (OAP), forced the city into action. In one Toronto home, the OAP reported, 36 pensioners had died over a two-year period, a mortality rate double that of the city's Hospital for Incurables. When a suspicious pension official visited the home to find out what was going on, he discovered a disturbing scene: “Practically everyone in the house had severe colds, all the old people were coughing and one ... was very ill in bed with pneumonia. A slim, frightened looking person had two black eyes and a badly swollen face.” Another elderly lady had a “bad bruise on the left temple” and “blood ... oozing [from her] stocking from the knee to the ankle.” Further investigation revealed a home swarming with cockroaches and packed with 35 sick, elderly patients, locked in, seven to a room, where door-knobs had been removed so doors could not be opened from the inside. Six men were sleeping in the basement, five more in the attic. In response, Toronto's city council passed Ontario's first by-law requiring the registration, licensing, and inspection of private nursing homes. Lacking enforcement, it was largely a symbolic gesture. Unlicensed homes continued to operate and even to receive per diem stipends from the city welfare department for the care of indigent, elderly patients. Since hospitals and municipal homes for the aged already had

long waiting lists, Toronto officials confessed, there was little else they could do (Struthers, "Reluctant" 175–76).

Ten years later, not much had changed. Only a dozen cities had enacted nursing-home by-laws, which, health officials agreed, were "not in accordance with any real standards." Few homes provided much more than room and board, "with practically no nursing care of a skilled type." Local Medical Officers of Health seemed "generally [to] show little or no interest in a Nursing Home," provincial officials conceded by the end of the 1950s. Their hands were tied. "We know very little about the exact number or kind of nursing homes which exist," nor was there any commonly accepted definition of what they were. Most were unlicensed, but they could hardly be closed. "What would we do with the patients if it were decided to close them?" a public health officer asked (Struthers, "Reluctant" 177).

Ontario's 1957 Conference on Aging provided a forum for action. Over 150 private nursing home proprietors attended and two years later organized themselves into the Associated Nursing Homes Incorporated of Ontario (ANHIO), the first provincial lobby group for their sector. Over the next six years the ANHIO would take the lead in successfully pressuring a reluctant provincial government to license, regulate, and publicly fund for-profit care homes across the province. Three changes were crucial to their victory. The first was the province's entry into Canada's new national hospital-insurance scheme in 1959, which provided Ontarians with insured access to hospital beds on a universal basis, a major new entitlement that only exacerbated the problem of aging hospital "bed-blockers." As Ontario's Health Minister asked, "When do they stop being a patient who is chronically ill and in need of ... hospital care, and when do they become a patient who is essentially a ... custodial care? ... I cannot see how these can ever be brought into such a hospital care insurance plan." In response, the Ontario Hospital Insurance Commission contracted with 48 private nursing homes to outsource the care of chronic and aged hospital patients. The more provincial health officials began to learn about private nursing homes from this new partnership, however, the less they liked them. "Conditions in the majority of them [are] dreadful," the health minister warned Ontario's premier in 1959 (Struthers, "Reluctant" 178).

The second change was the previously mentioned extension of federal funding, under the Unemployment Assistance Act, for the social care of unemployable elderly welfare patients in private nursing homes. This development, an Ontario government study revealed, created a major stimulus "to the opening of many ... homes with the proprietors, sometimes with no previous experience and few qualifications, applying for licensing" (Struthers, "Reluctant" 177). The third was the impact of the Ontario Legislature's Select Committee on Aging hearings in 1964–65, which shone a spotlight on atrocious conditions within private care homes. As the president of the newly formed ANHIO testified,

some operators were making “profits as high as 30 % to 40 % in homes where blind patients were served the scrapings off the plates of others.” In others, record keeping was so poor that the proprietors “[didn’t] even know how long some patients [had] been there.” As for medication, “in most cases there is little or no control” (179).

In Ottawa, witnesses from Ontario’s non-profit care-home sector, testifying before the Senate of Canada’s Special Committee on Aging, said that these new government subsidies for private nursing homes were only “financing public psychological slums” in which people “sit ... and rot by the thousands” (Struthers, “Reluctant” 180). The impact of this damning testimony created a firestorm of negative newspaper coverage that pushed the provincial government into passing the Ontario Nursing Homes Act of 1966, creating a provincial licensing, inspection, and regulatory regime through the Department of Health for all nursing homes in the province. For the largest private operators within the ANHIO, this was a key policy victory. Regulation promised to bring order to a chaotically expanding sector. It also cemented an uneasy partnership between private enterprise and the provincial state to ensure that their profitability could be reconciled with the government’s fiscal priorities as well as with the long-term care needs of the aged.

Once safely under the umbrella of state licensing and regulation, private care home entrepreneurs launched a long-term strategy to place themselves on a level playing field with the charitable non-profit and public homes for the aged sector by demanding ever higher per diem patient subsidies, to the growing exasperation of Ontario’s health minister. “[S]ince the province got into the business of regulating nursing homes they have constituted themselves a pressure group to beat the Government over the head,” he complained to the premier in 1967. Two years later he was even more disgusted: “I have learned to my bitter sorrow that they are concerned about one thing only, making as much money as possible and giving as little as possible in return to the patients ... [T]he sooner this is gotten into on a public basis, the sooner we will be able to provide good quality health care for this segment of our population” (Struthers, “Reluctant” 181).

The confrontation came to a boil at the end of the 1960s, after a period in which the number of private care-home beds leaped from 8,500 to 18,200 following the passage of the province’s nursing-home legislation. The industry was simply growing “without rhyme or reason” as new operators rushed into the sector and began building homes “before we know anything about it,” Ontario’s deputy health minister complained. Half had been in business less than six years, and the health officials charged with overseeing them confessed that their own quality of knowledge about the sector was little more than an educated guess (Struthers, “Reluctant” 181). In the summer of 1968, private-sector care-home owners in Toronto threatened to evict all their subsidized welfare patients unless the city agreed to a 47-per-cent increase in the per

diem patient subsidy from the existing \$8.50 to \$12.50, as recommended by a private consulting-firm report commissioned by the ANHIO. City officials, in response, threatened to move them all to care homes outside the city which would accept the existing \$8.50 rate. Outraged residents refused to be moved away from their families, friends and familiar surroundings and their resistance attracted widespread public and media support. Toronto would be “ill-advised to consider ... shipping the old folks out of town,” a leading newspaper commented. Repeating a widespread exaggeration, the editors argued, “This does not seem too far removed from the traditional Eskimo [*sic*] ceremony of placing the old and infirm on a small ice-floe and leaving them to drift away” (qtd. in Struthers, “Reluctant” 183). Eventually a compromise was reached over a new per diem rate, but the ugliness of the incident was a harbinger of the difficulties of reconciling caring with profit.

Over the next four years, demands grew for bringing nursing-home care into Canada’s new universal Medicare legislation, which Ontario’s Conservative government only reluctantly joined in 1969. For three years Ontario resisted the idea, arguing that it would let families off the hook for the care of their own parents. Why should taxpayers underwrite “by grant or insurance ... the maintenance of the aged in facilities of some sort, when the families cannot, or will not, any longer maintain them?” Ontario’s health minister asked. “Too often, it is concluded, since an old person has to spend much time in bed and have his personal wants and needs attended to by others, he should be kept in hospital. This is wrong.” Here lay the crux of the matter. The need for hospital care was a medical issue, decided by doctors, so it should be an “insured” benefit. However, care in nursing homes, deemed mostly “custodial,” seemed to make it a means-tested welfare benefit, not an insured right. But in practice were the boundaries that clear-cut? Not according to Ontario’s care-home operators. As they argued, in a brief to the Senate Committee on Aging, the difference between “chronically ill care” covered by health insurance and “ordinary chronic care” within nursing homes was “so indistinguishable as to be hardly discernible by the experts, let alone the uninformed public” (Struthers, “Reluctant” 184).

By 1972 their view prevailed when, prior to an election, the government agreed that nursing-home care would be included within the province’s medical-insurance scheme through a separate Extended Care Plan subsidizing medical, but not residential costs. With its inclusion under public health insurance, the private nursing-home sector achieved its most important victory. Under this new umbrella the industry grew by leaps and bounds after 1972, transforming itself, within five years, from mostly small, single-operator homes of less than twenty beds into highly profitable 100- to 200-bed facilities, owned by corporate chains. By 2004, the for-profit sector would be responsible for 60 per cent of the homes and 54 per cent of the beds in Ontario’s long-term residential-care sector (Ontario, *Commitment* 90).

“BUILDING A CULTURE OF COMPLIANCE”

From the mid-1970s until the late 1990s, the rapid rate of expansion in Ontario's long-term residential-care sector slowed dramatically. Faced with growing budgetary deficits and capital shortages as economic conditions worsened throughout much of this period, Ontario's Conservative politicians, who governed the province until 1985, were content to let the private sector finance the costs of building most new nursing-home beds. During these years, policy narratives about long-term care centred on more efficient and intensive care-home regulation as well as the impact of increasing longevity, frailty, and population aging on the culture and costs of care homes. Problems with inadequate nursing-home inspection, staffing, and management also loomed large, as periodic scandals rocked the public's trust in this sector. In 1977, Daniel Baum's bestselling book *Warehouses for Death: The Nursing Home Industry* provided a bleak portrait of Canadian nursing home life:

People are there to die. Once they walk through the nursing home door and take their rooms, they will not walk out again. They are stripped of their assets, given a small personal allowance, promised minimal nursing care, regulated severely in their routine and medicated to institutional compliance. In a very real sense they are encapsulated and warehoused for death. They are removed from the community and the community does not have to see either old age or death. (3)

This was a far cry from the celebratory descriptions of Ontario's Homes for Aged program in its first two decades. Newspaper exposés added to these images. In 1981, the union local representing 300 staff in Greenacres, Ontario's largest care home, which, as mentioned previously, was opened in 1956 specifically to house senile residents from other nearby homes for the aged, revealed degrading conditions of work and care for its almost 600 residents. Residents were being fed, toileted, and bathed in “factory-like” conditions; staff experienced the highest rates of injury of any home in Toronto. Equipment was “broken down”; there were such inadequate supplies of clothes, blankets, shoes, and socks for residents that “staff had to raid closets at home for shirts for the men and dresses for the ladies.” The home was grossly understaffed. Although its name “evokes images of a small and tranquil estate in the country,” the report concluded, “Greenacres is a large and far from peaceful place. It is not a ‘Home.’ It is an institution,” and one that was “in a state of crisis” (CUPE 2, 6, 8–9). The ensuing media publicity that followed the release of this report resulted in a major public enquiry. Three years later, 19 residents in a London, Ontario care home died from a serious outbreak of bacterial food poisoning, due to substandard conditions for food preparation. This prompted another explosion of negative media coverage of Ontario's long-term residential-care

sector, leading to growing public and political demands for an end to for-profit ownership. Concerned Friends, a new advocacy organization dedicated to long-term care reform, described long-term residential-care facilities in 1982 not as “homes” but as “sterile, friendless [places] ... lacking humanness and warmth, where old people sit and rock, stare at walls for most of their day or are led around by the hand like small children.” In 1984, a Canadian Medical Association Task Force argued that care homes should be “run on a principle of loving care, not tender loving greed,” and recommended that governments “move as quickly as possible towards the elimination of care for-profit institutions and establish non-profit facilities” (Tarman 76–83).

The Ontario government response was more bureaucratic consolidation and intensive regulation of the sector. Rather than address issues of who owned care homes, the province instead focused on more aggressively enforcing a culture of “compliance.” Annual inspections of care homes were mandated, and the reports were made public. Resident councils were promoted. A Residents’ Bill of Rights was introduced, which included “freedom from mental and physical abuse” and “privacy.” Complaint-reporting mechanisms were expanded and made more transparent. Nursing-home owners were required to identify their directors and owners and to release their financial statements so that the public could see how much revenue was spent on residents rather than in dividends for shareholders. A new category of “compliance officers” was created to advise care homes on how best to meet new and more intrusive Ministry of Health standards. But the question of private ownership of care homes itself was left unaddressed by both Conservative and Liberal governments of that decade (Tarman 82–88).

Instead, in response to a court challenge and more aggressive lobbying from the private care-home sector, in 1993 per diem government funding for privately owned, charitable non-profit, and public care homes was made identical by Ontario’s left of centre New Democratic Party government, the unexpected winners of the 1990 provincial election. Since all homes now had to meet the same, more highly medicalized requirements, their level of per-patient government funding should also be equal, the NDP acknowledged. At the same time, the government also transferred all responsibility for care homes to the Ministry of Health, marking an end to separate oversight of municipal Homes for the Aged and non-profit charitable homes by the Ministry of Community and Social Services. This was another major victory for the for-profit sector, (Tarman, 87, Daly, 44)

Care-home policy narratives from the early 1990s to the present have increasingly focused on fears around the costs of population aging as the baby-boom generation matures into old age. A major 2012 Ontario government report on aging makes no mention of private care-home ownership whatsoever, but instead it frankly warns that “our demographic challenge could bankrupt

the province,” in arguing for a moratorium on building new care homes. A new “Seniors Strategy” should “focus on helping older Ontarians to stay healthy and stay at home longer” through concentrating on homecare as the most fiscally responsible solution to population aging (Ontario, *Living* 5–6). Another report, from 2011, argues that Ontario is still relying “too heavily on acute care hospital resources and a culture that emphasizes ‘permanent’ placement of seniors in Long-Term Care Homes without appropriate consideration of the patient’s potential to improve or recover and be cared for at home with support.” As in the 1940s, aging “bed-blockers” clogging up provincial hospitals are seen as the most urgent problem facing long-term care (Ontario, *Caring for Our Aging* 6–7).

An intensified focus on implementing an “audit” culture in nursing-home management has also emerged, in which “hard” quantifiable measurements such as pressure ulcers, blood-sugar levels, incidence of falls, fluid intake, and incontinence are viewed as the key inputs for measuring the “quality of life” in Ontario care homes and for determining their level of funding. Reduced emphasis is placed on the “softer” and less quantifiable variables of relational and social care performed by staff, whose numbers, since 1996, are no longer regulated by any minimum standard (Banerjee and Armstrong, Daly). The extent to which care homes should be allowed discretion to imagine different approaches for delivering good quality care in a “home-like” atmosphere remains subject to debate. While one report argues for “tougher enforcement and swift compliance” as well as “clear, measurable, enforceable, resident-focused standards with enforceability ... being key” (Ontario, *Commitment* 5), another decries the impact of such a “compliance culture” on the ability of these facilities to be “homes”:

Many stakeholders told us that often this results in situations where staff focus on compliance-related administrative and process activities instead of on providing care. In addition, they indicated that time dedicated to resident care is diverted to compliance-related functions, many of which are related to documentation and other paper work. (Ontario, *People* 11)

The first narrative has care homes facing outwards to concentrate on provincial standards. The second looks inwards in arguing for more locally based decision making “building on the knowledge, passion, and commitment of staff, LTC home operators, residents, and families to the provision of quality care. They set the stage for a change in how LTC homes plan to use their staff resources to meet resident needs” (Ontario, *People* 29; Banerjee and Armstrong).

CONCLUSION

From 1949 to 1972, the Ontario government believed it had a coherent story to tell about care homes for the aged during the only era in which long-term residential care was portrayed in a mostly positive light. It was an uplifting and gendered narrative about the virtues of social care in delivering comfort, dignity, and “successful” aging within a communal context that officials insisted was “homelike” and “luxurious.” This was also a story about Ontario’s postwar affluence, the earned entitlement of its “senior citizens,” and burgeoning municipal and provincial pride.

To make this “homelike” story work, however, the numbers of vulnerable older adults who were senile, bed-ridden, or in other ways profoundly “helpless” had to be kept to a minimum through being segregated either within or between institutions. It was also a story about care homes as legitimate sites for an enjoyable and non-stigmatized middle-class life pursued by “active” individuals getting along together within a “quiet and intimate” setting, with some paid female care help from the state (Williams; Davies, *Into the House*). The trade-off, within the setting of new postwar suburbs, was an architecture facing mostly inwards as a “haven” looking away from the “busy” community outside, echoing in a smaller way the broader postwar suburban “home dreams” also being pursued by the children of the care homes’ new residents (Davies, *Into the House*; Strong-Boag).

In contrast and in tension with this positive story was the rise of Ontario’s nursing-home industry during the same era, which was a more incoherent, unexpected, contested, and increasingly medicalized development. This was a narrative of unintended consequences, grudging regulation and inspection, and recurring scandal. And the end result was anything but “homelike.” Within these buildings, the type and quality of care remained in service to the overarching needs of Ontario hospitals to free up scarce beds, and to the dividends of a mostly profit-seeking industry. At bottom, this was also largely a story of “facilities,” not “homes.”

By the 1990s, these two parallel stories of homes for the aged and nursing homes had converged, symbolized by the takeover of the entire field by Ontario’s Ministry of Health (Daly, 44–47). It has increasingly become a narrative dominated by the themes of medical more than social care, in which relentlessly rising costs, overcrowded hospitals, and rising panic over population aging continue to be the dominant actors. Once existing on the margins, a new emphasis on “community” care has also been in steady ascent since the 1990s and now dominates state-centred conversations about “home” and “care” within the province’s policy discourse on how best to meet the needs of Ontario’s vulnerable older adults. A century after worried provincial officials first shone a spotlight on the growing “burdens” of old age within Ontario’s Houses of Refuge, family care and family obligations are once again back at the centre of a new government story called “Bringing Care Home” (Ontario, *Bringing*).

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