To meet the health care demands of an aging population, more consideration needs to be given to the built infrastructure that can address the situation without straining the system.

HOUSING FOR HEALTH

Infrastructure Lessons from Canada's Coronavirus Pandemic.

By Michael Fenn

In February, the Residential and Civil Construction Alliance of Ontario (RCCAO) published *Rx to Cure Hallway Medicine: Building Targeted Housing for Ontario's Seniors*, a research report into the problem of overcrowding in Ontario's hospitals. It warned that aging baby boomers could overwhelm the hospital and long-term care system without a more sophisticated infrastructure response to housing for seniors. Tragically, we recently saw a demonstration of what could happen as COVID-19 patients overwhelmed hospital ERs and ICUs from New York to Montreal. Long-term care homes were also impacted as COVID swept through them.

Even before the coronavirus crisis, our hospitals were already crowded. In normal times, many patients in ERs and/or admitted to hospital have long-term or chronic illness. After treatment, patients can be discharged—but only if they can find suitable (and safe) accommodation, where their recovery and their chronic diseases can be monitored and managed. The post-World War Two generation is healthier, wealthier, longer-living, more diverse and certainly more numerous than all the generations before them. That has implications for both health care and residential infrastructure. Unlike past generations, 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, or those requiring palliative care.

The RCCAO report suggests that part of the solution lies in producing housing options that simultaneously reduce the volume of patients seeking admission to hospitals (and long-term care) and that provide accommodation better suited to the needs of patients ready to leave hospitals. Canada must apply the efficacy test: the right treatment, at the right time, in the right setting, by the right healthcare provider, at the lowest cost to the taxpayer.

Building ever-expanding hospitals, long-term care homes, palliative care wards in hospitals, and similar infrastructure for a whole generation of baby boomers appears fiscally unsustainable.

In response, the RCCAO report recommends building more targeted infrastructure: by offering more seniors' housing options and, as much as possible, by treating chronic disease (including mental illness and mild dementia) in the home and the community.

Our infrastructure investments and funding policies should anticipate, facilitate, and support those right choices. It may mean re-engineering and retrofitting suburbia, from accessible mobility to rezoning and redevelopment. It will mean more contemporary digital support in the home and in the community for diagnostics and condition-monitoring, managing prescribed therapies and social-services interventions, adhering to medication protocols and medical-appointment schedules, and with recent developments, more infrastructure to test for and to track disease.

Part of the solution to the alternate level of care (ALC) or 'bed blocker' issue might be building a network of step-down accommodation outside the hospital environment.

We will always need hospitals to provide complex care and surgery, and to do medical research and education. With the exception of rural and small-town Canada, however, hospitals should not find themselves the primary, front-line providers of healthcare services for patients dealing with chronic disease, minor or recurrent medical episodes, or recuperating from hospital-based medical or surgical procedures.

We will also need to fundamentally rethink our approach to long-term care, for everything from the design of those facilities and their staffing models, through to the criteria for admission and the financial support to their residents. Both hospitals and long-term care homes have long struggled with outbreaks like scabies and Norwalk virus, but the COVID-19 experience has demonstrated the bigger

contagion risks, like drug-resistant MRSA. Keeping seniors out of crowded institutional settings wherever medically appropriate should be a goal.

Making an integrated system out of Ontario's healthcare services may 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 infrastructure to facilitate this difficult transition, beginning with transitional housing and a range of residential options designed for seniors who can care for themselves. Both private-sector and public-sector involvement will be needed to make such a niche housing market viable.

For those who design, build, and finance Ontario's (and Canada's) infrastructure, the report asks four key questions:

1. How should provincial governments adjust their public investment focus to build more types of seniors' accommodation, with the goal of avoiding hospital admissions, reducing the length of hospital stays, and forestalling admission to long-term care homes as long as possible?

2. What infrastructure would allow us to treat chronic disease, wherever practical and medically sound, in the home and in the community, rather than in hospitals and long-term care homes?

3. How can municipal, provincial and hospital authorities free-up suitable land assets for a range of seniors' housing and adjust land-use planning objectives to produce that housing?

4. Are there ways that we can use our tax and pension policies to generate more seniors' housing?

There are many sobering lessons from the pandemic, one being that COVID-19 has accelerated the need to find more creative ways to deal with 21st century accommodation needs.

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