

Food in Institutional Settings in Ontario: Health Equity Perspectives

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Wellesley Institute works in research and policy to improve health and health equity in the GTA through action on the social determinants of health.

Food in Institutional Settings| Think Piece
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We would like to acknowledge this sacred land on which the Wellesley Institute operates. It has been a site of human activity for 15,000 years. This land is the territory of the Huron-Wendat and Petun First Nations, the Seneca, and most recently, the Mississaugas of the Credit River. The territory was the subject of the Dish With One Spoon Wampum Belt Covenant, an agreement between the Iroquois Confederacy and Confederacy of the Ojibwe and allied nations to peaceably share and care for the resources around the Great Lakes.

Today, the meeting place of Toronto is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work in the community, on this territory.

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Introduction

No one expects food in public institutions to be gourmet. However, we should expect it to be nutritionally adequate, socially and culturally acceptable, and safe. In many of our public institutions, the food does not consistently meet these basic standards. Malnutrition is common among hospital patients¹ and long-term care home residents;² institutional food often fails to accommodate the cultural needs of diverse ethno-cultural groups;^{3,4} and reports suggest that the low quality food offered by some correctional facilities can lead to food-borne illness as well as malnourishment.⁵ There's a fundamental problem when the food provided to people living in public institutions is so far below the standards that we set for the population as a whole.

According to the World Health Organization's (WHO) International Covenant on Economic, Social and Cultural Rights, which Canada has ratified, the right to health encompasses the right to adequate nutrition and safe food.⁶ These rights should apply to individuals staying in all public institutions — whether for a few nights or many years.

This paper explores food provided in three selected public institutions in Ontario: hospitals, long-term care homes, and prisons and correctional services. These three settings were selected because they are all places in which patients, residents, and inmates spend days and nights, often for an extended number of weeks, months or years, in a restrictive environment. Of course, the level and nature of restrictions vary across the three types of institutions. What and how much people eat for each meal is highly regulated by the relevant governments and is planned and provided by the staff at each institution. We will explore the current situation and the challenges associated with assuring nutritionally adequate, socially and culturally acceptable, and safe food in these settings.

These three public institutions often serve those who are relatively more marginalized members of our society, those who are sick, frail, or disadvantaged. For this reason, we think it is important to pay close attention to how food in these settings can impact existing health and social inequalities. When we consider the right to health, and good food as a fundamental component for ensuring an individual's health, it becomes clear that we aren't affording many residents of these institutions in Ontario the right to adequate food and nutrition and thereby ensuring good health.

Good Food is Central to Good Health

The food provided in our public institutions should meet the basic standards that comply with the right to health. People staying or living in institutions need, and should have, access to nutritionally adequate, socially and culturally acceptable, and safe food — the essentials for everyone to achieve good health and well-being. In hospitals, long term care homes, and correctional settings, residents are in a restricted environment: their access to food options

from outside the institutional environment is limited to varying degrees. Because of the lack of choice for residents, special attention must be paid to ensure equal access to adequate, acceptable, and safe food.

At the most basic level, a nutritionally adequate diet must offer a sufficient amount of energy, macro and micronutrients (fats, proteins, carbohydrates, and vitamins and minerals) for our bodies to function.

Malnutrition has significant effects on the health and well-being of people staying in our public institutions and on Ontario's health care system. Many studies have found that poorly nourished hospital patients experience worse health outcomes including prolonged hospital stays, more frequent readmissions, and a higher likelihood of mortality while in-hospital.^{7,8,9} For long-term care residents the consequences of malnourishment include declines in functional and cognitive abilities, increased risk of falls and hospital admissions, extended hospital stays, and death.¹⁰

But institutional food needs to be more than just nutritionally adequate—what we eat is woven into our cultural fabric. The consumption and preparation of food is a social activity, and while some foods or meals may offer adequate nutrients, they are not considered by many to be a desirable or even acceptable meal. For individuals eating food in institutional settings, having unfamiliar foods and disparate cultural preferences can negatively affect their food intake and nutritional status.¹¹ Culturally appropriate meals can promote food intake, which in turn can reduce the risk of malnutrition and unintended weight loss.¹²

Finally, food that is safe to consume is another important contributor to good health. Foodborne illnesses can occur most commonly when food is processed in a contaminated setting and when food is not properly handled, stored, and cooked. Young children and older adults are at increased risk from serious illness related to foodborne illnesses, and they are more often affected during outbreaks in institutional settings such as hospitals and long-term care homes.¹³ Following established food safety guidelines can hugely reduce the risk of foodborne disease outbreaks in public institutions.¹⁴ Studies on the outbreaks in U.S. prisons recommend food temperature monitoring, effective infection control procedures and training of food handlers as priority measures for outbreak prevention.¹⁵

Hospitals

For hospital patients, a healthy diet is critical to a timely recovery. The average length of stay in hospital for patients in Ontario was 6.8 days in 2011.¹⁶ However, hospital food is often conceptualized as hospitality rather than medical treatment or essential for good health, as indicated by the lack of provincial regulation.¹⁷ As health care costs increase annually, hospital budgets are constantly being squeezed and services like food are not prioritized. At an institutional level, hospitals face the incredible challenge of meeting the dietary needs of patients with a wide range of health complications.

In Ontario's hospital system, patients are fed three meals and two snacks per day. The current budget for food per patient in Ontario is between \$30-\$35 per day, and only \$7-\$8 of that is spent on the raw food.¹⁸ Although the Ministry funds all public hospitals, they are independent corporations run by their board of directors under provisions of the Public Hospitals Act. The Ministry of Health and Long Term Care does not mandate a cost guideline for food services.¹⁹ Hospital food services management is therefore entirely up to each hospital administration.²⁰ As a result, budgets for food provision vary. SickKids, for example, spends 50 percent more than the average hospital on food — \$12 per patient per day.

These budget variances have significant practical impacts. With their larger budget, the kitchen at Sick Kids is able to cook from scratch in their own kitchen rather than relying on pre-prepared packaged foods and provide food using a room service model.²¹ This type of food production within hospitals has been found to lead to higher levels of patient satisfaction among patients and lead to less food waste.²² Due to the limited food budgets, however, it has become a common practice for many hospitals to outsource their food services and reheat pre-packaged foods at patients' meal times.

For patients who spend extended periods in hospitals, hospital food tends to constitute the bulk of their food supply.²³ While patients are provided meals and snacks throughout the day, Canadian reports suggest that they often eat less than half of the food on their meal trays.²⁴ Research in Switzerland supports these reports, and found that despite sufficient food provision (i.e. sufficient number of calories and micronutrients), many hospitalized patients did not meet their estimated nutritional needs.²⁵ Another recent study found that 45 percent of patients in 18 Canadian hospitals were malnourished when they were admitted and malnutrition was significantly associated with longer hospital stays.²⁶ Insufficient food intake affects many hospital patients and may exacerbate the negative health consequences of malnutrition for those who get into hospitals when already malnourished.

Insufficient food intake is often attributed to causes other than disease, including organizational barriers such as frequent disruptions and the lack of preferred foods available.²⁷ While budgetary limitations are one of the factors limiting the foods patients eat, the mealtime experience may have significant impacts on patient food intake. In addition, there is limited research on the impact of providing culturally appropriate foods in hospital settings. Further research in this area may prove fruitful for improving patient food intake.

Individuals of all income levels, ethno-cultural backgrounds, and education levels may get sick and spend time in hospital. However, individuals of lower socioeconomic status are at higher risk of chronic diseases which place them at further likelihood of hospitalization.²⁸ Data in Ontario also show that low-income and immigrant individuals are more likely to have longer hospital stays than those who do not fall into either of those categories.²⁹

When hospitals do not offer patients preferred foods, family or friends often provide home-made favourite foods. Media reports suggest that some hospital staff expect their patients'

family visitors to supplement food to improve patients' appetite.³⁰ There are also other food options available through various food vendors within and around most hospitals in urban cities like Toronto. However, individuals of lower socioeconomic status and who lack social networks that can support them while in hospital have less opportunity to access their preferred foods during their stay.

Food in hospitals in Ontario is adequate and safe, but research and reports suggest that improvements could be made to ensure that it is provided in an appropriate manner. The lack of province-wide oversight for hospital food leads to potential gaps which means that some populations may be left behind. Making improvements to the delivery method and timing of meals, focusing on culturally appropriate food, and to the meal environments, could improve patient dietary intake.

Long-Term Care Homes

Long-term care (LTC) homes are home to about 80,000 Ontario's most frail and vulnerable individuals. These are individuals with support needs that do not require hospital care but cannot be met in the community or in their home. Residents are mostly older adults with complex health needs and most residents stay there until the end of their lives. Ontarians are admitted when they are "older, frailer, and in need of more medical and personal care than ever before."^{31,32} According to a study on newly-placed older adults in Ontario LTC homes between 2010 and 2012, LTC residents were predominantly those older than 80 years (68%), more than half of residents had dementia on admission, and they tended to reside in poorer neighbourhoods than the general population before admission.³³

According to the Long-Term Care Homes Act (LTCHA), 2007, the fundamental principle to be applied in its interpretation is that "a long term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity ... and have their physical, psychological, social, spiritual and cultural needs adequately met."³⁴ This principle must be applied when considering the food prepared for residents. LTC homes should provide not only nutritionally adequate and safe food but also a comfortable, flexible mealtime environment where residents feel at home by having access to the food they are familiar with and that is comforting to them.

Residents have most or all of their meals at their LTC homes, three times a day and 365 days a year. LTC homes' food service management is highly regulated by the Act, which is different from the hospital sector. There are detailed requirements for menu planning and meal service. Meal and snack times are also set by the LTCHA. A full-time cook is required by the Act, and LTC homes typically prepare food in-house while using a small proportion of outsourced products.³⁵

The Ministry of Health and LTC currently funds all LTC homes \$8.33 per resident per day for raw food.³⁶ Labour costs for kitchen staff, including registered dietitians, nutrition managers

and food service workers, are funded by other funding categories, separated from raw food funding.³⁷ Due to funding constraints for raw food and labour, many LTC homes report that they serve cheaper protein foods and fewer fresh fruits and vegetables and they often cannot meet residents' special dietary needs.³⁸ It is common for many homes to rely on frozen or canned vegetables, fruits, and meats.³⁹ The 2017 Ontario Budget announced an increase in LTC food allowance by \$15 million, making it to \$9 per resident per day, starting July 2017.⁴⁰ This additional funding is expected to alleviate LTC homes' financial challenges to provide healthier and fresher foods that meet residents' nutritional and cultural needs.⁴¹

Malnutrition is one of the most common concerns for LTC home residents. Across Canada, malnutrition affects more than half of residents living in LTC homes.⁴² The main cause for LTC malnutrition is poor food and fluid intake as average consumption is about 50 percent of food offered,⁴³ similar to what has been reported for hospital patients' food intake. Most LTC malnutrition is preventable, attributed to not only meal quality, but also to the eating environment and the ability to access to food.⁴⁴ More home-like mealtime experience with enhanced social interactions with staff and other residents, more flexible meal-timing for residents to choose when to eat their main meals and snacks, and more eating support from staff can all improve residents' food intake.

Many LTC residents also require special diets due to their health conditions. Those having difficulties with swallowing and chewing are offered beverages of modified consistency and modified texture foods (i.e., pureed, mashed, chopped, minced) so that it is easier to consume.⁴⁵ While these modified texture foods are provided to increase residents' food and nutrition intake, a study found that Canadian LTC residents who were on a pureed diet had significantly lower macronutrient and energy intakes, compared to those on a regular-textured diet.⁴⁶ Residents often find modified texture foods unappealing in their appearance, texture, and taste. Research suggests that this could be largely due to a lack of quality control and standardization of modified texture foods used in LTC homes.⁴⁷

While meeting religious food requirements such as Halal or Kosher foods is mandatory for LTC homes, it seems that cultural food provision is not. The LTCHA requires that residents' cultural, spiritual and religious preferences be asked upon admission and regularly thereafter and reflected in their plan of care.⁴⁸ Although its importance is widely recognized, many LTC staff describe challenges in accommodating their residents' cultural needs due to lack of sufficient resources.⁴⁹

Although the LTCHA emphasizes the notion of a LTC home as the "home" of its residents, it appears that there is a lack of the implementation of the idea of home in food provision in this setting. Food in LTC homes is reduced to a medicalized task, like food in hospitals, rather than being understood as an important part of resident's daily life and social engagement.⁵⁰

Food in Correctional Settings

Prisons in Ontario are either under the jurisdiction of Corrections Services Canada, or the province's Ministry of Community Safety and Correctional Services. Provincial detention centres house those awaiting trial and those sentenced to less than two years while federal correctional facilities house individuals who have been sentenced to two or more years. Ontario's corrections facilities spend \$14.54 per day to feed inmates, with \$9.17 of that going toward raw food.⁵¹

While there are limited data on food quality in prisons, the Annual Report of the Office of the Correctional Investigator 2015-16 reported ongoing complaints related to portion size and selection of quality meals now being served. The Correctional Investigator further recommended an external audit of meal production services, with "particular emphasis on safe food handling practices, equitable distribution of meals and concordance between the standards outlined in the National Menu and the nutritional value of meals proved to inmates."⁵²

There has recently been pushback regarding the increasingly poor quality of food in Canadian prisons. In Saskatchewan and British Columbia (BC), prisoners have gone on hunger strikes. In BC, there were reports of hundreds of prisoners contracting food-borne illnesses in prisons.⁵³ Other anecdotal accounts reported in the media suggest that this may be widespread across prison systems in Canada and the United States. As one former prisoner cited in a recent *Globe and Mail* investigation on prison and hospital food, "Any jail food, you're going to be on the toilet six times a day because what they're giving you is running through you."⁵⁴

The Office of the Correctional Investigator's call for an audit on food in federal correctional settings highlights the current gaps in research on food in prisons. Data are sparse and much of the findings in this section are from media and anecdotal accounts. More research is needed to fully understand the scope of the problem for this often-overlooked population.

Prison food systems can impact both physical health — including weight loss or gain and nutrient deficiencies — as well as mental health. In the United States and in Europe prisoners are more likely to be overweight than the general population. However, it is still unknown if this is a causal relationship, or if those who are incarcerated are more likely to be overweight or obese prior to incarceration.⁵⁵ Anecdotal evidence suggests that prisoners face routine malnourishment, but in Canada there is limited research to substantiate these claims.⁵⁶

Food in prison can also impact mental health. Research in the United States and Europe suggests that nutritional supplements may decrease the likelihood that prisoners will exhibit aggressive behaviours.⁵⁷ Further, research in the United Kingdom suggests that offering prisoners choice in their foods, and choice to make non-nutritious decisions may enable prisoners to better cope with emotional distress.⁵⁸ It is not only the types of food prisoners

eat, but other aspects of food services, including choice of what, and when to eat, that may impact their mental health and also their dietary intake.

It is well-documented that many marginalized groups across Canada are more likely to be incarcerated than those from non-marginalized groups, having already been exposed to a range of systemic challenges. Individuals identifying as Indigenous are 10 times more likely to be incarcerated than those who are non-Indigenous.⁵⁹ In provincial prisons, 36 percent of women are of Indigenous origin. Similarly, African-Canadians are more than three times as likely to be incarcerated as the general population. Incarcerated individuals are also more likely to be low-income, and are more likely to suffer from mental health challenges.^{60,61}

Like hospitals and LTC homes, Corrections Services Canada must meet inmates' religious food requirements, but there is no similar provision for cultural food either as part of the Food Services or Inmates' Canteen. A study on Black inmates' experiences conducted by the Office of the Correctional Investigator for the Correctional Services Canada found that inmates strongly felt the lack of consistent access to cultural food.⁶²

Prisoners are a population with limited public support. Recently in Canada, some politicians and public servants have pushed back against complaints regarding the quality of food in prisons by suggesting that they do not have right to appropriate, adequate, safe food. Saskatchewan's Premier, Brad Wall, suggested that the "best way to avoid prison food is to avoid prison." In British Columbia, in response to claims that prison food was making prisoners sick, the spokesperson for Public Safety Minister argued that prisoners had too high expectations.

For many inmates, prisons are a place of residence for years and decades. The limited Canadian and Ontario-based research and reports available suggest that while food provided in correctional settings may be adequate, there may be situations in which the food is not safe and not served appropriately. Further research is needed to better understand if these health risks are in fact a systemic problem, and also how to improve the methods of food delivery to improve food consumption. Models in Denmark where inmates prepare their own food, take cooking classes and eat communally have shown promise both in improving inmate satisfaction and also in improving the social climate of the prisons.⁶³ Research is needed to understand what the health impacts of models like this would be, and if models like this are feasible in Ontario.

Conclusion

Considering the number of Ontarians who spend time in institutional settings at various points throughout their lives it is essential that we strive to provide at minimum nutritionally adequate, socially and culturally acceptable, and safe food to everyone in public care.

Examined from a right to health perspective, ensuring that everyone in our public institutions has access to food that meets such basic standards should be a baseline requirement.

Because our public institutions house some of our most vulnerable populations — those who experience health disadvantages due to their lower socio-economic backgrounds and/or current health issues — institutional foods have significant implications on health equity in our society. When food provided in these institutions does not meet the basic standards of healthy food, it can exacerbate existing health inequities. When people in the care of public institutions are fed adequate, acceptable, and safe foods during their stay, it can contribute to improving their health and well-being in long run and therefore to enhancing health equity.

Compared to food in other institutional settings, we found that the discourse around prison food is often strongly punitive — it seems to be an issue beyond budgets. Food in prisons often does not afford prisoners basic food safety, as well as other requirements for healthy food including nutritious and socially acceptable food. When considering the adequacy and safety of food provided to prisoners, these basic principles should be applied. Food safety is — and should be — a minimum quality expectation to meet across all public institutions including prisons.

Rethinking how we approach institutional food requires significant change within some of the largest institutional systems in Ontario. There is a well-documented need to improve people's food intake in institutional settings. Strategies such as improving access to more palatable, culturally appropriate foods and offering more flexible, home-like mealtime environment need to be considered to ensure the well-being of individuals spending time in institutions where they have limited access to other foods. However, there are also major research gaps in understanding the current food environments in each of these institutions — especially in correctional settings. While a range of evidence suggests gaps that may be leaving some individuals more vulnerable to malnutrition and poor health, research is needed to better understand how to make institutional food environments healthy for all residents.

Endnotes

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