

Ownership Matters

Lessons from Ontario's Long-Term Care Facilities

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Introduction

Forty three years after Saskatchewan Premier Tommy Douglas had the vision, the compassion and the courage to create a universal system of public health care, the very foundations of Medicare are under attack as never before. At a time when rampant restructuring of provincial health care systems demand that we consider an expansion of the services protected under the Canada Health Act - such as home care and long term care - the fundamental principles of the Act are being undermined. “Public-private partnerships” are offered as a panacea for the challenges facing Canada’s most cherished social program. But what does it mean to involve the for-profit sector in the delivery of health care? How does it affect levels of care? How does it affect the quality of that care? What is the relationship between elected policy makers and the corporations who make donations to their campaigns and at the same time compete for contracts to deliver public services?

We can look south of the border to the United States for myriad examples of how private, for-profit operation of long-term care facilities impacts the delivery of care. Or we can look within our own borders, to Ontario and its long-term care facilities, for our very own cautionary tale about the dangers of having the health and well-being of some of our most vulnerable citizens in the hands of private-sector.

Ownership matters. In Ontario, more than half of all long-term care facilities are owned and operated by for-profit enterprises, far and away the highest proportion of private sector involvement in the country. And yet studies show that care levels in Ontario nursing homes and homes for the aged are among the lowest.

With the final awarding of contracts for the construction of 20,000 desperately needed new long-term care beds in Ontario, more than two-thirds have been handed over to the private sector. For the first time, the public is paying for the construction of long term care facilities that will be owned and operated by corporations for profit.

Sophisticated lobbying has resulted in the diminishment of care standards in the largely for profit nursing homes. Residents in these homes can no longer expect to receive a minimum number of hours of care each day – the regulation requiring enough staff to provide to provide 2.25 hours of care has been eliminated, leaving levels of care at the discretion of facility operators.

Until recently, the inspection process for facilities has been questionable at best and unconscionable at worst. The available evidence shows that staffing conditions are worsening.

Ontario’s facility-based long-term sector is more than ever a two-tiered system - 60% of beds are now reserved for those who can afford to pay an additional daily fee for “preferred” accommodation. Yet provincial waiting lists for admission to a long-term care facility are at their highest levels ever while the effect of new government regulations aimed at reducing these numbers remains to be seen.

As the population ages and competition for lucrative long-term care dollars increases, Ontario's seniors must not become commodities. Most of the long-term care policies introduced since 1995 appear to promote profit-making for owners, rather than improved resident care. Ontario's seniors deserve better. Ownership matters.

Where we've been...

To understand how Ontario's system of institutional care for its disabled and frail elderly citizens has evolved into the most privatized in the country, it is important to go back. Until the late 1960's, two pieces of legislation governed long-term care facilities: the Homes for the Aged and Rest Homes Act (1949) and the Charitable Institutions Act (1951). Homes for the Aged were, and still are, operated by municipalities. Charitable Homes were operated by charities, which is still the case today. Both operate as not-for-profit enterprises. They were not the only ones offering long-term care however. Private "nursing homes" were typically houses that had been renovated to accommodate 25 to 50 beds and were usually operated by a retired nurse.¹ These were run on a for-profit basis and were unregulated. Through the 1960's, the number of these "homes" increased rapidly, with no consistency in services or standards.

Public pressure forced the provincial government to introduce the first Nursing Homes Act in 1966 which required nursing homes to be licensed, however there was little enforcement of the provincial regulations.² Continued concern for the welfare of those living in Ontario's nursing homes resulted in further public outcry and finally, in 1972, the government responded with amendments to the Nursing Homes Act. These changes standardized care across the province, gave the Ministry of Health responsibility for enforcement and extended OHIP coverage to nursing home residents. Following the introduction of this legislation, many of the small, independent nursing homes found it more difficult to operate under the stricter guidelines and by the mid-1970's many of them disappeared or were swallowed up by larger corporations. Still, long-term care in Ontario remained highly privatized.

Even after many of the smaller operators had disappeared, Ontario still had significantly more privately-run facilities than any other province in the country. In fact, by 1983, 41% of the beds in Ontario were owned by the ten largest nursing home companies in the province.³ Of those ten, the three companies with the largest market share in the mid-80's - Extendicare, Leisureworld and Central Park Lodges – continue to dominate the market today. To say that the system of care during that period was fragmented is an understatement, although it would still be years before any kind of rationalization or reform of the sector was undertaken.

¹ Sullivan et al, 1999. *Compassionate Journey: 40 Years of ONHA*, page 33.

² Advocacy Centre for the Elderly, July 1998. *Long-Term Care Facilities in Ontario: The Advocate's Manual*, page 2.10.

³ Sullivan et al, 1999. *Compassionate Journey: 40 Years of ONHA*, page 35.

The Seeds of Reform

Shortly after their election in 1990, Ontario's first NDP government began the process of change. First, they froze the number of beds receiving provincial funding. Next, they passed Bill 101 to replace the 1972 *Nursing Homes Act* and brought all three types of facilities – nursing homes, homes for the aged and charitable homes – under the umbrella of one ministry, the Ministry of Health, and under one administrative system. Bill 101 was the starting point. For example, under this new legislation, residents of nursing homes were to receive a minimum of 2.25 hours of nursing care per day. The NDP's plan was to bring consistency to what had been a rather disparate system and improve the care standards for residents of long-term care facilities through comprehensive changes to funding structures, levels of service, methods of referral, admission practices, regulation and accountability.

In 1994, Bill 173, the *Long-Term Care Act*, was passed, outlining the framework for this new system. The result of years of organizing and lobbying by seniors groups and disability advocacy groups, Bill 101, along with Bill 173, finally put into place stricter oversight of nursing homes and offered Ontarians a choice between facility-based care and community-based services that would allow them to age in place.

One of the most important features of the new *Nursing Homes Act* was the Residents' Bill of Rights and the mandatory establishment of Residents' Councils in all long-term care facilities. These Councils had the power to advise residents of their rights, file complaints, monitor the operation of the facility, review inspection reports and financial statements including the allocation of government funds. This was progress.

Where We Are...

The Conservatives swept to power in 1995 on a platform of tax cuts, slashing public services and privatization. One of their first initiatives was Bill 26, the "Omnibus Bill", which brought about sweeping changes to literally dozens of pieces of legislation across numerous sectors, including health care. The most significant aspects of the "Omnibus Bill" affecting long-term care facilities were: the establishment of the Health Services Restructuring Commission (HSRC); the empowerment of the Minister of Health to unilaterally close hospitals; and, the introduction of a daily fee for hospital patients waiting for a bed in a long term care facility.

The mandate of the HSRC was to restructure Ontario's hospitals. This was an enormous undertaking and one that had a lot of people nervous. By the time the HSRC completed its work, 39 hospitals were ordered closed (33 public, six private); six psychiatric hospitals were ordered closed; 44 other hospitals were amalgamated into 14 multi-site hospitals and it was proposed that 100 more hospitals be combined into 18 networks or clusters.⁴ Altogether, just under 9000 hospital beds (acute, chronic,

⁴ Canadian Centre for Policy Alternatives, 2000. *Public Pain, Private Gain*, page 12.

psychiatric and rehab combined)⁵ were eliminated through this restructuring exercise. More than 5000 of these were chronic care beds and would have the greatest impact on long-term care facilities.

Where did all these people go? Were Ontarians suddenly healthier? No. Faced with increasing demand for the remaining beds, the newly restructured hospitals simply discharged patients “quicker and sicker” into both the community and facility-based care sectors, neither of which was prepared for the onslaught. In 1996/97, Statistic Canada determined that Ontario’s average length of stay in hospital had dropped to just 8.1 days, one of the lowest in the country.⁶ And while the Conservatives were quick to act upon the HSRC’s recommendations regarding hospital closures, they were not so quick to act upon the Commission’s concurrent recommendation that there be an infusion of resources into home care and long-term care facilities to handle this downloading of patients. As a result, both of these sectors found themselves not only dealing with an overwhelming number of patients but also with acuity levels that were higher than they were prepared for or mandated to deal with.

To make matters even worse for residents in nursing homes, in June 1996, following an intensive lobby by the nursing home industry, the Conservatives removed the standard established by the NDP requiring that residents receive at least 2.25 hours of personal care per day. In addition, the government removed the requirement that a registered nurse be on duty 24 hours per day, seven days per week. To this day, there is no regulated minimum level of care required in Ontario’s nursing homes. Since then, care levels have spiralled downward and are now among the lowest in Canada and the U.S.⁷

Who pays and how much

Along with the other reforms introduced in 1993, the NDP instituted a classification system upon which funding for all long-term care facilities would be based. Modelled after the Alberta Resident Classification System, this system continues to be used to determine the nursing and personal care needs of residents in facilities and, consequently, the level of funding the province will provide for these services. The system is based on seven categories ranging from “A” (lightest care) to “G” (heaviest care). Each fall, the Ministry of Health hires registered nurses as “classifiers” to undertake assessments of the facilities. Their task is to review residents’ records from the previous three months and categorize them based on their “care requirements”.⁸

These “requirements” are determined by assessing a set of criteria which include indicators for four activities of daily living (eating, toileting, transferring and dressing),

⁵ Ontario Hospital Association.

⁶ For 1999/2000, the Canadian Institute for Health Information reports this number had dropped to 6.4 days. <http://www.cihi.ca>

⁷ PriceWaterhouseCoopers, January 2001. *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators*, page 65. Ontario residents in long-term care receive, on average, 2.04 hours of nursing care per day.

⁸ Ministry of Health and Long-Term Care, June 2000. *The Long-Term Care Facility System in Ontario*.

two behaviours of daily living (potential for injury to self or others and ineffective coping) and two for continence (urinary and bowel continence).⁹ The data is then grouped together to determine the Case Mix Measure (CMM), or total care requirements, of all residents in each facility. CMMs for all facilities across the province are averaged and used in a formula to establish the Case Mix Index (CMI). This is the value used to calculate how much funding each facility will receive from the province for nursing and personal care services. A Case Mix Index value of “100” represents the average of all long-term care facilities across the province and serves as the base value. Therefore, the funds provided to each individual facility will be proportionately higher or lower depending on their residents’ care requirements relative to this average.¹⁰

For the current year, 2001/02, the base amount facilities receive per resident per day is \$102.32. This amount is made up of three separate funding envelopes – nursing and personal care; program and support services; and accommodation. Table 1 shows the breakdown for each of these envelopes.

As outlined above, nursing and personal care is based on the Case Mix Index. These funds are provided solely by the provincial government and are to be used to pay for nursing and personal care staff wages as well as to purchase the supplies and equipment used by the nursing department. Surpluses from this envelope must be returned to the province.

Programming and support services are funded on a per diem basis, also by the province, and all long-term care facilities receive the same amount per resident regardless of their CMI. These funds are to be used to provide recreational programs, therapies and other resident support services including staff wages, equipment and supplies. Again, surplus funds must be returned to the province.

Funding for accommodation is set by the province but paid for by the resident, whether they live in a ward, semi-private or private room. The fee includes a mandatory, nominal amount for “raw food” while the remainder is used to pay for administrative costs, dietary, housekeeping, laundry and maintenance services, equipment and supplies. This is the only envelope from which the facility operator is allowed to keep surplus funds.¹¹

⁹ OCHU/CUPE Fact Sheet, January 2000. *Patient Classification and Funding in Chronic Care Hospitals and Long Term Care Facilities.*

¹⁰ Ministry of Health and Long-Term Care, June 2000. *The Long-Term Care Facility System in Ontario.*

¹¹ Ibid.

Table 1: Per diem rates per resident, as at October 1, 2001¹²

Nursing and Personal Care (Based on a CMI of 100)	\$52.38
Programming and Support Services	\$5.24
Accommodation (Including the “raw food” amount of \$4.49 per day)	\$44.70*
Total	\$102.32

*This is the amount charged for basic accommodation in a ward room (more than two beds per room). “Preferred” accommodation rates are \$52.70 per day for a semi-private room and \$62.70 per day for a private room.

How do Ontario’s rates compare to the rest of the country? Table 2 outlines the amounts charged for basic accommodation in each of the ten provinces. Clearly from this information, gathered by the Government of Alberta, residents of Ontario’s long-term care facilities are paying among the highest rates in the country.

Table 2: Basic accommodation rates of provinces, as at November 2001¹³

Province	Minimum Daily Accommodation Rates	Minimum Monthly Accommodation Rates
British Columbia	\$27.20	\$816.00
Alberta	\$28.22	\$858.21
Saskatchewan	\$27.23	\$817.00
Manitoba	\$25.80	\$774.00
Ontario	\$44.21	\$1326.30
Quebec	\$27.76	\$832.80

*Comparable data is not available for New Brunswick, Nova Scotia, P.E.I. and Newfoundland where amounts paid by residents are on sliding scale up to the full daily rate charged by the facility, including accommodation, nursing, programming, etc. Payments are based on ability to pay.

From 1993 to 2001, CMM rates, or the “care requirements” of residents in all three types of facilities, increased an average of 13.7%.¹⁴ In other words, residents today require much more care and much heavier care than they did nine years ago.

The most dramatic increase has been in Charitable Homes for the Aged where acuity levels rose by an alarming 30.8%. In Municipal Homes for the Aged, the increase was 15.0%, slightly more than the provincial average. Nursing homes, on the other hand, have seen a lower than average increase in the acuity of their residents – only 9.9% over the eight-year period.

Has there been a proportionate increase in staffing and funding as acuity levels rose from 1993 to 2001? According to the Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS), government funding including subsidies for care levels, debt servicing and capital compliance were approximately \$90 per resident per day in

¹² Ministry of Health and Long-Term Care, Public Inquiries Branch, Long-Term Care Division.

¹³ Government of Alberta News Release, November 16, 2001.

¹⁴ OANHSS Analysis, March 2002. *Levels of Care Trends in Long-Term Care Facilities.*

1993. Based on this information, government funding for long-term care facilities has risen 13.6% to 2001. According to Statistics Canada, the rate of inflation in Ontario for this eight-year period was 16.5%. In other words, funding has *not* kept pace with care needs. Nor is the situation expected to improve. In fact, given the expected increase in demands for services through the continued “downloading” of chronic care patients and the increasing number of seniors who will require long-term care beds as the population ages, OANHSS estimates that the sector needs an extra \$558 million per year just to keep up.¹⁵

In the context of a highly privatized industry, it is important to understand how the provincial funding system works for one very simple reason. Private sector corporations have very basic and fundamental imperatives – to seek profit and growth. Because much of the funding to nursing homes comes from the provincial government and is therefore tightly controlled, profit margins must be found elsewhere. The alternatives are fairly limited: quality of the facilities; staffing levels and/or wages and working conditions; quality of patient care; and the imposition of new user fees. Since coming to power in 1995, the Conservative government has systematically de-regulated the long-term care facility sector and, in almost every instance, the changes have facilitated the profit imperative.

Faster, better, cheaper...for whom?

The story from the front-line is worrisome. Unfortunately, there is no statistical information available regarding the actual number of staff working in facilities over this eight-year period. In part, that’s because nursing homes are no longer required to submit staffing schedules to the Ministry as part of their annual service agreements. In 1993, the NDP made this submission a requirement in order to get an accurate picture of staffing levels in homes and to ensure that they were adequate. In 1997, the Conservatives removed this requirement in response to pressure from the nursing home sector. Nonetheless, anecdotal evidence gathered at a series of public forums on long-term care held in 2001, as well as the findings of a 1997 survey of nearly 2800 front-line workers in nursing homes, reveal a startling picture of intense workloads and staffing levels that border on neglect and abuse.

In February and March 2001, an ad-hoc coalition of seniors’ organizations, unions and health advocacy groups held seven public forums in cities across Ontario. More than 800 people participated in these forums and provided the material for the coalition’s report *Long-Term Care – In Limbo or Worse?* In city after city, workers, family members and advocates for those living in long-term care facilities expressed their concern about inadequate staffing levels, especially in the face of increasingly complex care needs.

The Thunder Bay Family Caregivers Action Network expressed concern that the time-factors involved in performing various “tasks” have become more important than the tasks themselves, not to mention the people who need the help. By way of example,

¹⁵ OANHSS, February 2002. *OANHSS Submission to the Standing Committee on Finance and Economic Affairs.*

they say that food is often pureed, mixed all together and served cold in heaping tablespoons to residents so that meals can be completed in the fifteen minutes allocated for staff to complete this particular “task”. In Brampton, a registered nurse said that residents in her facility often become incontinent simply because there are not enough staff to answer their calls for assistance when they need to go to the bathroom. The Kingston Council on Aging quoted figures gathered by OANHSS indicating that registered nurses in long-term care facilities now look after an average of 60 residents each during a day shift and 100 residents each during a night shift. The Ontario Council of Hospital Unions (OCHU) reported that in a survey of its members working in chronic care hospitals and converted nursing homes, many cannot bathe residents more than once per week and are lucky if they can take them outdoors once per month. Staff say they are working more unpaid overtime hours than ever before: coming in early, leaving late and working through breaks and lunches. Ninety-six percent of health care aides surveyed by OCHU thought the increased workload was affecting their health.

These stories of increased workloads and lowered levels of care were in evidence as early as 1997 - two years after the Conservatives began implementing their changes. At that time, Armstrong et al¹⁶ surveyed front-line long-term care providers on a range of issues including quality of care, levels of care, needs of residents, workload, staff injuries, incidents of error, and the use of physical and chemical restraints. The results were staggering:

- 94% reported a significant decline in the quality of care after the government removed the minimum care requirement.
- 86% said workloads had increased and staffing levels were inadequate.
- 80% said they did not have enough time to do their jobs.
- 79% overall reported working in short-staffed units, 89% of workers in privately-owned, chain-operated facilities reported working short-staffed compared to 74% of those in publicly-owned facilities

The current Minister of Health, Tony Clement, is fond of using the phrase “faster, better, cheaper” when he attempts to justify why Ontario should increase the involvement of the private sector in the delivery of health care. Statistically and anecdotally, there is simply no basis for this assertion. And while the phrase makes for a nice sound bite from a media-savvy politician, it takes on a fundamentally different meaning when considered in the context of the daily reality faced by those on the front-line.

Staff in private nursing homes are working faster because there are fewer and fewer of them to do the work. Ontario’s seniors and citizens with disabilities certainly deserve better when it comes to the levels of care they receive. And if the private sector does things so much more cheaply, why are the residents of Ontario long-term care facilities paying more than just about anywhere else in the country? Faster, better, cheaper – the question is for whom?

¹⁶ Armstrong et al, July 1997. *The Consequences of Government Policy Changes in Long-Term Care in Ontario: A Survey of Care Providers*, page 7-8.

Lowest Levels in the Country

In January 2001, the results of a massive study conducted by PriceWaterhouseCoopers of Ontario's long-term care facilities were released. Commissioned by OANHSS and the Ontario Long-Term Care Association (OLTCA) - the organization representing mostly for-profit facility operators – and paid for by the provincial government, the study had three main objectives:¹⁷

- to evaluate the acuity of residents;
- to review the provision of services in facilities;
- to compare the acuity and services received in Ontario Long-Term Care (LTC) facilities to those of Ontario Complex Continuing Care (CCC) settings as well as long-term care facilities in other provinces, the United States and Europe.

Researchers looked at the staffing levels and financial data of long-term care facilities as well as information about the care of almost 150,000 frail elderly people in Ontario, Manitoba, Saskatchewan, Maine, Michigan, Mississippi, South Dakota, Sweden, Finland and the Netherlands from data collected over a five-year period. They compared the experiences of Ontario long-term care residents against those of residents in each jurisdiction and what they found was startling.

Ontarians living in long-term care facilities exhibited among the highest levels of Dementia/Alzheimer's Disease and depression across all jurisdictions in the study, yet they received the lowest levels of service when it came to nursing, rehabilitation and therapy. They were also among the oldest. The average age of an Ontario LTC resident is 82.1 years, exceeded only by Saskatchewan, South Dakota and Finland.

Table 3 is an amalgam of several graph tables found in the report and details the prevalence of various diagnoses among the populations studied. In almost every instance, Dementia and Alzheimer's Disease combined were far and away the most widespread of the conditions diagnosed in residents. The report's authors note that this finding has "significant implications for the care and treatment of these individuals" for several reasons. Clearly, they assert, in order to offer adequate care for people with dementias, there must be sufficient numbers of staff. And, in order to ensure safe, appropriate and quality care, staff must be specially trained so they will have the necessary expertise required to meet the needs of these residents. Failure to ensure these fundamentals may inevitably result in a diminished quality of life for residents, excessive acute care hospital and increased strain on staff in long-term care facilities.¹⁸

¹⁷ PriceWaterhouseCoopers, January 2001. *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators*, page 6

¹⁸ PriceWaterhouseCoopers, January 2001. *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators*, pages 36-37.

Table 3: Prevalence of Dementia and Alzheimer’s Disease, Physical Problems and Other Diagnoses¹⁹

	Ontario LTC	Ontario CCC	Saskatchewan	Manitoba	Michigan	Maine	Mississippi	South Dakota	Sweden	Finland	Netherlands
Dementia/Alzheimer’s	53%	24%	62%	41%	47%	50%	57%	44%	19%	65%	34%
Diabetes	19%	18%	12%	17%	24%	20%	22%	18%	9%	6%	9%
CHF	11%	12%	18%	13%	27%	21%	24%	30%	19%	8%	22%
Stroke	22%	29%	18%	16%	24%	22%	25%	21%	4%	23%	13%
Arthritis	30%	17%	32%	28%	32%	26%	34%	39%	7%	4%	17%
End Stage Disease	1%	6%	0.2%	0.2%	1%	1%	0.4%	0.8%	0.6%	22%	0.8%
Parkinson’s	6%	5%	6%	7%	6%	7%	6%	7%	5%	3%	4%
Cancer	9%	18%	11%	3%	11%	9%	6%	11%	6%	2%	6%
PVD	4%	6%	3%	2%	12%	10%	9%	6%	2%	1%	3%
Osteoporosis	7%	7%	13%	5%	14%	11%	10%	11%	4%	2%	5%
COPD	1%	14%	4%	2%	19%	19%	14%	13%	3%	3%	7%
AHD	12%	11%	7%	4%	19%	18%	19%	17%	7%	7%	11%

As the table shows, more than half of the residents in Ontario LTC facilities have a diagnosis of Dementia and/or Alzheimer’s and a substantial number have diagnoses of serious physical impairment such as arthritis, stroke and diabetes. The next logical question is, what does this mean in terms of the actual needs of residents in long-term care facilities and are those needs being met? Having determined the kind of health impairments occurring in long-term care facilities, researchers next compared the degrees of impairment by evaluating the results of four clinical assessment scales: the Cognitive Performance Scale, the Activities of Daily Living Hierarchy Scale, the Health Instability Profile and the Depression Rating Scale. The findings are as follows:²⁰

- On the Cognitive Performance Scale, 44.8% of residents in Ontario LTC facilities had the highest levels of impairment. Only Sweden and Finland had higher levels, at 48.3% and 51% respectively.
- On the Activities of Daily Living Hierarchy Scale, 47.9% of Ontario LTC residents had high impairment. This is greater than Saskatchewan (46.5%) and Manitoba (38.3%) and lower than Maine (58.2%), Sweden (58.1%), Finland (62.4%) and, not surprisingly, Ontario Complex Continuing Care – or chronic care - (67.3%).
- The outcomes of the Health Instability Profile scores, a relatively new measuring tool, are comparable for Ontario LTC, Saskatchewan and Manitoba.
- The rates of depression in Ontario LTC facilities were higher than all other comparator groups except the Netherlands. The scores showed that 30.5% of Ontario LTC residents experienced minor or major depression as compared to 24.9% in Saskatchewan and 15.4% in Manitoba.

¹⁹ Ibid. Taken from graphs on pages 34, 39 and 41.

²⁰ PriceWaterhouseCoopers, January 2001. *Executive Summary*, page 6-7.

And while none of these tools specifically measure need, they do give a clear picture of the issues faced by the residents of facilities and the intense challenges facing the staff charged with their care. In fact, the report's authors point out that one of the study's limitations is that the available data only provides information about the services residents have actually received, rather than information about the services they need.²¹ This point is particularly important in the context of the continued "downloading" of Ontario's chronic care patients into long-term care.

Finally, researchers identified the range of services available to residents and measured levels of service for comparison. As can be seen in Table 4, the mean Case Mix Index – or acuity levels - across all jurisdictions is very similar, however Ontario LTC residents clearly receive fewer nursing, therapy and rehabilitation services compared to everywhere else. In fact, Ontario LTC has the lowest level of nursing care, at only 2.04 hours per resident per day, as well as the lowest level of rehabilitation services of all jurisdictions surveyed. Only 10% of residents who have the potential for rehab actually receive it. And, despite the fact that 61% of the residents in Ontario LTC facilities present with behavioural issues²² - the highest of all the populations – they receive among the lowest levels of therapy²³ only slightly more than 10 minutes per person per day.

Table 4: Summary of Levels of Service against Selected Clinical Indicators²⁴

	Ontario LTC	Ontario CCC	Saskatchewan	Manitoba	Michigan	Maine	Mississippi	South Dakota	Sweden	Finland	Netherlands
Mean CMI	0.75	1.31	0.85	0.80	0.79	0.97	0.81	0.84	0.79	0.93	n/a
% of residents with Rehab Potential	14%	15%	10%	5%	17%	20%	10%	13%	12%	11%	16%
% with Rehab Potential who receive Rehab	10%	79%	38%	13%	84%	55%	55%	41%	50%	25%	19%
Total Therapy Hrs/resident/day	0.17	0.86	0.13	0.41	n/a	n/a	n/a	n/a	n/a	n/a	0.70
% who receive Nursing Rehab	32%	55%	10%	16%	14%	61%	26%	42%	32%	36%	20%
% with Behaviour Problems	61%	38%	42%	40%	31%	44%	27%	34%	32%	51%	45%
Total Nursing hrs/resident/day (RN, RPN, Aide)	2.04	3.25	3.06	2.44	3.40	4.40	4.20	3.00	n/a	n/a	3.3

²¹ PriceWaterhouseCoopers, January 2001. *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators*, page 14.

²² The report's authors define behaviour disturbances as verbal or physical abuse, socially inappropriate behaviour and wandering or resisting care.

²³ Fewer than 6% of Ontario LTC residents received "talk" therapies which may involve treatments with psychologists, mental health professionals, behaviour symptom evaluation and/or behaviour management programs according to the PriceWaterhouseCoopers study. In fact it was more likely that residents with behavioural issues would be given drugs (34%) or restrained (31%).

²⁴ PriceWaterhouseCoopers, January 2001. *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators*, page 92.

One thing the PriceWaterhouseCoopers report does not evaluate is quality of life. Given the report's comprehensive examination of the physical and mental health conditions experienced across jurisdictions and the treatments residents do, or do not, receive, it is obvious that a very serious deficit exists between the needs of Ontario's long-term care residents and levels of service. Even in the absence of quantitative data to support conclusions on this issue, the impact these discrepancies are having on the quality of life for those living in Ontario's long-term care facilities must not be overlooked.

Chronic Care and Long-Term Care are NOT the same

Many believe that one of the biggest contributors to this gap between need and service has been the increasing acuity of long-term care residents as a result of the downloading of chronic care patients into nursing homes and homes for the aged.

Included in the 39 hospitals ordered closed by the HSRC were four chronic care hospitals.²⁵ The Commission also recommended that thousands of chronic care beds in acute care hospitals be replaced by long-term care beds. Following the release of the Chronic Care Role Study in 1993, chronic care hospitals and chronic care units in acute hospitals changed their admission policies to accept only patients whose medical needs are complex – primarily those who depend on high-tech medical equipment to keep them alive. But, patients whose care needs do not meet these criteria may still be in need of chronic care. In fact, many patients who are no longer being admitted to chronic care hospitals still have very heavy care needs. They may be unable to get out of bed, dress or feed themselves and they may be totally incontinent. And now they live in long-term care facilities. All these years later, it's become clear that the closure of these hospitals and downloading of beds has had, and continues to have, a devastating effect on both patients and workers in long term care facilities.

The Armstrong et al survey and the PriceWaterhouseCoopers report, as well as reports by the Ontario Hospital Association²⁶, and the Canadian Union of Public Employees²⁷ identify this shifting of patients as a key factor in the reduced care levels being seen in Ontario's long-term care facilities.

Another significant distinction between the two types of care is the funding differential. Chronic care hospitals are funded at a rate of approximately \$200 per person per day. Long-term care facilities are funded at just over \$100 per resident per day. The downloading of chronic care patients into long-term care facilities means that care for

²⁵ Responding to public pressure and the fact that there were more chronic care patients requiring hospital based care than anticipated, the government reversed its decision to close all four chronic care hospitals. Two of the four will now remain open.

²⁶ Ontario Hospital Association, December 2001. *Managing Change, Implications of Current Health Reforms on the Hospital Sector*, page 10-11.

²⁷ Canadian Union of Public Employees, February 2001. *Submission by CUPE, Ontario Division to the Ontario Government's Standing Committee on Finance and Economic Affairs*, page 10.

the very same individuals is now being funded at half the rate. Increasingly, many families feel they have no alternative but to pay out of pocket for private attendants to ensure that their loved ones receive the one-on-one care facility staff are simply unable to provide.

In 1996, the government-appointed “Red Tape Commission” recommended that the legislation governing long-term care facilities be amended. Bill 101 currently requires that, “A plan of care is developed for each resident to meet the resident’s requirements.” The Commission proposed this be changed to, “A plan of care is developed for each resident based on the resident’s assessed needs and available resources.” This is extremely important because it would limit, through legislation, a person’s entitlement to receive the care they need and instead receive the care that there is enough money for. There’s a big difference. The government has not yet acted on this recommendation although they are expected to. And while no one would claim that residents’ needs are currently being met, this subtle change in language has the potential to make what is already a bad situation for many, that much worse.

Waiting and Waiting and Waiting...

As Bill 26 was being implemented and the HSRC was ordering acute and chronic care bed closures, more than 16,000 people were on the provincial waiting list for facility-based long-term care. According to the most recent figures available from the Ministry of Health, this number has now ballooned to more than 20,000²⁸, the highest levels ever.

In an effort to address this very serious issue, the government recently introduced a new regulation aimed at reducing waiting times, and potentially options, for Ontarians. Less than a month old at the time of this writing, the full implications of the new regulation have yet to be seen but the key objective is clear – to reduce the size of waiting lists. The first significant change is the reduction in the number of facilities individuals are allowed to apply to. Previously, seniors could have their names placed on the waiting list for up to five facilities. This has been reduced to three. More significant is the elimination of a person’s ability to defer an offer of placement. Under the old rules, when a bed became available it was offered to the person at the top of the waiting list, who then had the option to accept the bed or reject it and remain on the waiting list. They were allowed to “defer” twice before being forced to accept a placement offer or be removed from the list. Deferrals can happen for any number of reasons: a health condition improves, personal circumstances change, or an individual is just not ready to give up their independence yet. Given that waiting times for some facilities can be measured in years, it is understandable that many seniors want to plan for their future and have their name placed on the list for the facility of their choice early. The problem is that having people on waiting lists who don’t actually need a long-term care bed yet can lead to even longer waiting periods for those who need one right away.

²⁸ Ministry of Health, Placement Coordination Service Statistics, June 2001. The total number of individuals on the 2001 provincial waiting list is 29,613 however 8,962 of them are already in a long-term care facility waiting for transfer to another facility.

Under the new rules, deferrals simply will not be permitted. Should a person refuse an offer, not only will they be taken off all lists, they will also not be allowed to re-apply for six months. When and if they do re-apply, it's back to square one at the bottom of the list.

Provincial waiting lists also include patients in hospital who cannot be discharged to their home because of failing health. Most of these people are seniors. As a result, and through no fault of their own, they are now forced to wait this inappropriate setting until a long-term care bed becomes available. To add insult to injury, under Bill 26 patients are now charged a daily fee²⁹ while they wait. What's worse is the actual care these patients receive, or don't receive, while they wait in hospital. Designated as "ALC" (or alternative level of care), these patients do not require acute care but rather some other form of care such as rehabilitative care, chronic care or facility-based long-term care. As a result, already overburdened hospital staff focus their attention and energy on patients with acute care needs, often leaving ALC patients virtually ignored. At its best, this situation is lonely and isolating. At its worst, it can lead to a vicious cycle of deteriorating health and the recurrence of more serious health problems. What's needed is appropriate services in appropriate settings.

"Improving Long-Term Care Facility Bed Placement in Toronto" is an interim report of the Long-Term Care Bed Placement Task Force and was released by the Toronto District Health Council (TDHC) in December 2001. It is a comprehensive examination of waiting lists, placement co-ordination, criteria for priority placement, special needs, waiting times and the impending crisis of bed shortages for the Toronto area. The report says that not only has the size of the waiting lists in Toronto grown but the length of time people are spending on these lists has grown enormously too:³⁰

- In 1997, the average wait for placement from hospital was 56 days. The average wait in the community was 86 days.
- In August 2001, the average wait for those in an acute care setting who were assessed as having a "normal" priority was 98 days. In the same month, people in the community with the same assessment waited an average of 290 days.

It seems obvious that these increases in waiting time for facility placement would have serious implications for the rest of the health care system. The TDHC indicates that between 39% and 53% of ALC patients in Toronto's hospitals are awaiting placement in a long-term care facility.³¹ For those waiting in the community, it means that in-home care arrangements have a far greater chance of deterioration, especially because under-funded Community Care Access Centre cannot provide adequate home care to fill the gap. This, in turn, can lead to an increase in the number of crisis admissions to

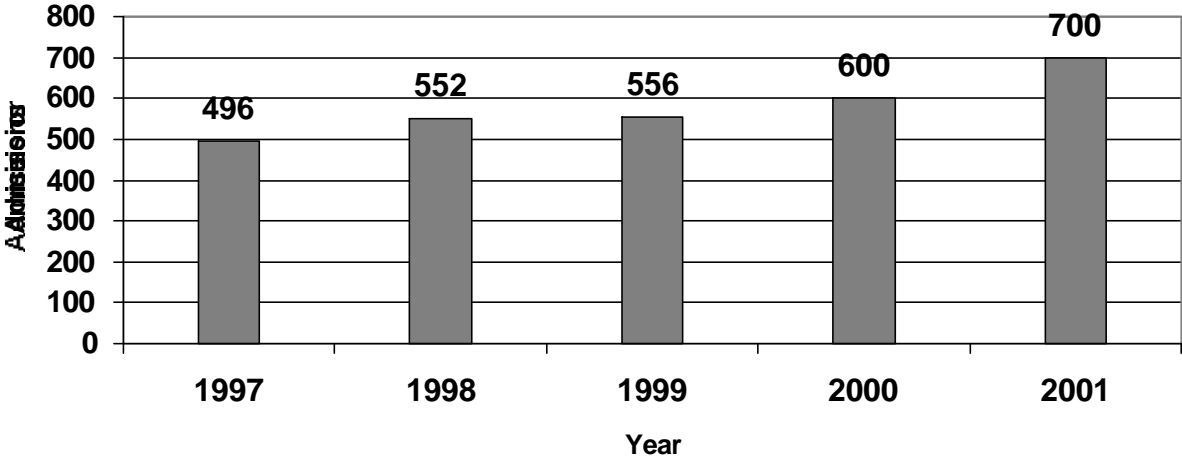
²⁹ This fee is equivalent to the daily basic accommodation rate charged in long-term care facilities and is adjusted annually.

³⁰ Toronto District Health Council, December 2001. *Improving LTCF Bed Placement in Toronto, Interim Report*, page 14.

³¹ Ibid.

long-term care facilities. Table 5 shows that there has been a steady increase in the number of crisis admissions to long-term care facilities in Toronto over the past four years. Similar Ontario-wide figures are not available, however it is reasonable to surmise that the same pattern exists across the province.

Table 5: Number of Crisis Admissions to LTC Facilities in Toronto, 1997-2001³²



Policies Strengthen Profits

Ontario’s system of facility-based long-term care has always had a second tier in that those who can afford to pay more have access to better accommodation over those who cannot. Policy changes in recent years have only expanded the second tier.

The 1972 Nursing Home Act provided for three types of accommodation: private (one bed per room); semi-private (two beds per room); and ward (more than two beds per room). At the time the legislation was enacted, a minimum of 60% of the licensed beds in nursing homes had to be set aside and classed as ward accommodation. In the mid-’90s, the proportions were reversed. Today, only 40% of beds must be classed as ward and up to 60% may be offered as “preferred” accommodation.³³ This change in policy was particularly worrisome because an individual’s ability to pay for “preferred” accommodation was, and still is, an important factor in accessing long-term care beds. Common sense says that the diminishment of the number of affordable beds available would result in even longer waiting lists. The TDHC Task Force report categorizes individuals needing a ward bed as having special needs because of the Task Force’s perception that there is a “supply-demand mismatch in this area”.³⁴ In fact, the report’s authors go on to say that anecdotally there is a much higher proportion of people waiting for ward accommodation than there are ward beds available.

³² Ibid, page 15.

³³ Ministry of Health and Long-Term Care, May 1999. *Long-Term Care Facility Design Manual*, page 13.

³⁴ Toronto District Health Council, December 2001. *Improving LTCF Bed Placement in Toronto, Interim Report*, page 32.

In November 2000, the Minister of Health announced that long-term care facility operators would be allowed to keep 100% of the surcharges paid by residents living in “preferred” accommodation (an additional \$8.00 per day for semi-private rooms and \$18.00 per day for private rooms). Historically, this amount had been split 50/50 between the operators and the government. Intensive industry lobbying brought about this rather lucrative change. Coupled with the increase in the proportion of “preferred” beds, the new initiative was said to have resulted in a \$47 million annual windfall for facility operators industry-wide.³⁵ And, with no strings attached. Facilities were not required to use the additional resources to improve or increase nursing care, dietary services or programming. By their very nature as not-for-profit enterprises, the municipal and charitable homes would invariably turn these additional funds into increased services for residents. However, there was absolutely nothing to stop for-profit nursing homes from putting this money directly into their own pocketbooks. Immediately following the Minister’s announcement, Extendicare, one of the largest nursing home operators in Canada, reported to shareholders that it was projecting an approximately \$2 million increase in revenues for the year 2000 as a result of this rollback.³⁶

Building Bonanza for the Private Sector

The marketplace is ruled by a fundamental principle of supply and demand. Control the supply and the demand will be created. Demand for long-term care before the Conservatives came to power had already been quite high, although once they began their exercise of restructuring the health care system, demand for facility-based long term care reached unprecedented levels. Inadequate home care budgets, diminished community services and contributed to the increasing desperation felt by seniors and their families with each passing year of so-called “reform”. The corporations that helped to bring the Conservatives to power were eager to capitalize on that desperation. It now seems they’ll been given their chance - at the taxpayer’s expense.

In April 1998, the government announced it was making a major investment in long-term care. More than \$1 billion would be spent to create 20,000 new long-term care beds across the province. Contracts were to be awarded through a Request For Proposal (RFP) process in three stages beginning in 1998, and construction was to be completed by 2006. This completion date has since been moved up, to 2004. In addition to new bed construction, the Conservatives also announced their plans to upgrade approximately 16,000 existing beds in older facilities, referred to as “D” sites and mostly operated by public and not-for-profit organizations, so that they could meet new ministry standards.

According the government’s media releases about this initiative the new standards are intended to offer residents a more home-like environment with greater privacy. No more

³⁵ Concerned Friends of Ontario Citizens in Care Facilities, March 2001 Newsletter.

³⁶ Extendicare, Inc., November 2000. *Shareholders’ Report for the Three and Nine Months Ended September 30, 2000*. <http://www.extendicare.com/investor/qreports.html>.

than 32 people can live in any “home area”. Bedrooms can house only one or two residents and must have adjoining washrooms with dining, bathing and leisure areas close by. Facilities are required to install security systems to protect people with dementia and ensure that buildings are fully accessible for people with disabilities.³⁷ And while new beds and new standards were certainly welcomed by advocates, they were quick to point out that close to 20,000 people were already on the waiting list for long-term care beds at the time of the announcement. Chances were, and are, that by the time construction is completed in 2004, long-term care beds will still be hard to come by.

The RFP process wrapped up in May 2001 with the final awarding of contracts. More than two-thirds (67.7%) of the new beds went to for-profit operators, and those three long-time market dominators – Extendicare, Leisureworld and Central Park Lodges – received 39.5% of them.³⁸ The outcome was not unexpected, in large part because of the RFP process itself. Interested parties were required to submit lengthy, detailed proposals to the Ministry of Health and Long-Term Care, proposals which demand hours and hours of dedicated staff time to prepare. For many not-for-profit organizations, putting together an RFP of this magnitude is simply outside their area of expertise, not to mention their budgets. By contrast, private sector operators, particularly large, multi-national corporations, have the money as well as the time and the staff to put together comprehensive proposal packages. Most importantly, they have access to much needed start-up capital, an absolutely crucial element of any proposal. For example, Borealis Long-Term Care Facilities Inc. is a wholly-owned subsidiary of the Ontario Municipal Employees Retirement System (OMERS), one of the richest pension plans in the province. Borealis is bankrolling Extendicare, to the tune of \$125 million in construction costs, so it can build the 1,189 beds it was awarded through the tendering process.³⁹ Not-for-profits, by their very nature, simply do not have this kind of access to resources because they cannot offer a return on investment, the way Extendicare can. Consequently, banks are less likely to lend them money. Fundraising initiatives to raise the necessary cash, are a daunting task at the best of times and one that is particularly difficult given the current climate of “donor burnout”.

Obviously, once construction is complete, all of the new facilities and upgraded “D” sites will be eligible to receive the provincial per diem funding for all the beds in operation, just like every other facility operator in Ontario. Unlike other facility operators, they will also be eligible to receive a subsidy of up to \$10.35 per bed per day, payable for the next twenty years, to offset borrowing and construction costs. This amounts to up to \$75,555.00 of taxpayer money per bed over a twenty-year period. Construction costs for facilities of this type are indeed quite high, however government subsidy of the actual bricks and mortar for private, for profit enterprises is unprecedented. And while the amount may not cover the full cost of constructing a long-term care facility, it

³⁷ Ministry of Health and Long-Term Care, May 2001. *Media Release: Ontario announces final phase of 20,000 long-term care bed expansion. Backgrounder.*

³⁸ Ministry of Health and Long-Term Care.

³⁹ Extendicare Inc., August 2001. *Shareholders Quarterly Report – Six Months Ended June 30, 2001.* <http://www.extendicare.com/investor/qreports.html>.

certainly goes a long way towards helping pay for it. At the end of the twenty years, facility operators – again, most of whom are for-profit - will have full ownership of a relatively new building subsidized by taxpayers. For the not-for-profit operators, payout of this subsidy upon completion of the construction still doesn't solve the dilemma of finding the capital to get started.

Some potential not-for-profit organizations may have been shut out of the competition right from the start. The Ministry of Health and Long-Term Care clearly stipulated in its selection criteria that new facilities were to be built in “preferred locations” identified by the province.⁴⁰ Applications proposing construction outside of these locations would be considered only if they included a detailed market analysis and a compelling rationale for why the ministry should support building in a non-“preferred location”. In other words, don't hold your breath. And so, if the resource challenges of trying to put together a successful bid weren't overwhelming enough, where you live might just do it instead. For communities in Northern Ontario this is exactly what happened. At the public forums held to look at the future of long-term care, the mayors of two small northern towns – the Municipality of Red Lake and the Township of Schreiber – expressed their frustration at being left out of the competition. The Mayor of Red Lake, Duncan Wilson, told the forum, “The RFP process and the criteria for awarding long-term care beds in the North is definitely unfair as long as it is based on population and not on the needs of communities...”.⁴¹ Mayor Wilson went on to say that there is currently a significant waiting list for long-term care in Red Lake and the options available to families are: to go to Dryden, which has no bus or plane service from Red Lake; or, to go to Kenora, which has no direct plane service. Of course, one could always drive, but the trip can take upwards of three-and-a-half hours, making visits to loved ones difficult at best. Most people would agree these hardly seem like options. One final note. Of the 20,000 new beds to be created over the next several years, only about 2% of them are north of Sudbury.

Who's Who in Ontario LTC

With the awarding of the final round of beds in 2001, overall ownership of Ontario's long-term care facility sector basically reversed itself and shifted in favour of the for-profit operators. The private sector now represents 51.6% of the market according to OANHSS and the Seniors Secretariat of the Ministry of Citizenship, Culture and Recreation. As Table 6 shows, Ontario now has, by far, the highest proportion of private, for-profit long-term care facilities in the country.

⁴⁰ Ministry of Health and Long-Term Care, August 2001. *2001 Bed Allocations, Frequently Asked Questions*. http://www.gov.on.ca/health/program/ltc/redev/redev_qa.html.

⁴¹ Group of Organizations Concerned with the Future of Long-Term Care, May 2001. *Long-Term Care – In Limbo or Worse? A report on seven public forums*.

Table 6: For-Profit and Not-For-Profit Ownership: LTC Comparison Across Jurisdictions⁴²

Province	Public/Not-for-profit*	Private for-profit
British Columbia	68.3%	31.7%
Saskatchewan	96.2%	5.8%
Manitoba	84%	15%
Ontario	48.4%	51.6%
New Brunswick	100%	0%
Nova Scotia	72%	28%

*Public/not-for-profit include provincial and municipal government LTC facilities and LTC facilities seen by not-for-profit societies.

What do we know about the private sector players in Ontario’s long-term care facility sector? The biggest winner, CPL REIT (Central Park Lodge Real Estate Investment Trust), is Canada’s largest owner/operator of nursing home facilities. Based in Ontario, CPL REIT was established in 1997 by the Reichmann family and quickly became a leading force in the Canadian and U.S. markets.⁴³ In fact, CPL REIT was awarded over 12% of the new beds and will build 20 new facilities to house 2,387 long-term care residents. The second biggest winner in the long-term care bed bonanza was Leisureworld. Very little is known about Leisureworld because they are not a public company and, therefore, not required to disclose much information about who they are and what they do. What is known is that Leisureworld was awarded a total of 1,536 new beds in the three rounds of tendering, or approximately 8% of the total beds. In third place is Extencicare. One of the oldest operators of nursing homes in Ontario, Extencicare opened its doors in 1968. Today, it is a multi-national corporation with 276 facilities worldwide, “home” for more than 27,000 people. With its headquarters in Ontario, Extencicare keeps itself close to the largest component of its business, one that got even larger with the awarding of 1,189 beds in ten new facilities.

The relationship between the Conservative government and private, for-profit long-term care companies is a cozy one indeed. Campaign contributions, unparalleled access to government officials and a shared ideology have facilitated a highly successful lobby to change the policies governing long-term care facilities in Ontario over the past seven years. The fact that the Conservatives increased the legal limits on campaign contributions during their first term in office didn’t hurt either.

Robert MacDermid is a political science professor at York University and last year the CBC Television show *Marketplace* asked him to do research into donations made to the

⁴² Hospital Employees’ Union, April 2002. Statistics collected from the Ministry of Health in British Columbia, Saskatchewan and Manitoba. CUPE in New Brunswick and Nova Scotia. The Seniors Secretariat at the Ministry of Citizenship Culture and Recreation in Ontario.

⁴³ CPL REIT owns many subsidiaries in the long-term care sector including: CPL Delaware LLC, CPL Subacute, Huronia Nursing Home Ltd, Preferred Care Corp, Versa-Care Ltd and, most notably, Central Care Corporation, a name that appears frequently on the list of Ontario’s successful tenders.

Ontario Conservative Party by nursing home companies. The program aired on March 20, 2001 at which time MacDermid was quoted as saying, "The companies that received the most beds, they also seemed to be the companies that gave the most money."⁴⁴ His research is perhaps the most comprehensive of its kind, although he cautions that it has some limitations. Campaign contributions made by corporations are fairly easily traced. For marketing purposes their names are usually quite unique. Even the donations made by a company's subsidiaries, while a much bigger job, can also be traced. Individuals, such as company owners and members of a corporation's board of directors, often make political donations in order to further the company's interest, however it is very difficult to identify these people even if the information is available which, often, it is not. Having said that, MacDermid still uncovered some very interesting results. Table 7 shows the contributions made to both the Federal and Ontario parties by long-term care companies. Election finance laws at both the Federal and the Ontario level require the disclosure of the donor's name if they are contributing more than \$100 in any given year.

Table 7: Contributions greater than \$100 by LTC companies to Federal and Ontario parties.⁴⁵

	1995 – 1999 Number of Contributions	1995 – 1999 Sum of Contributions	1997 – 1999 Number of Contributions	1997 – 1999 Sum of Contributions
Federal Parties				
Liberals	n/a	n/a	68	\$59,798
Conservatives	n/a	n/a	43	\$31,470
Reform/Alliance	n/a	n/a	12	\$12,474
NDP	n/a	n/a	2	\$4,675
Total				\$108,417
Ontario Parties				
Conservatives	542	\$336,545	409	\$269,672
Liberals	87	\$72,918	33	\$34,049
NDP	3	\$2,000	1	\$500
Total		\$411,463		\$304,221

MacDermid points out that donations by long-term care companies to the governing party provincially are more than four times higher than those made to the governing party federally. Not so surprising given that long-term care is a provincial responsibility. Another point worth noting is that the majority of the donations made to the Ontario Conservatives were in the period 1997-1999, right around the time the government was getting ready to announce the tendering of 20,000 new long-term care beds. It is

⁴⁴ Canadian Broadcasting Corporation, March 2001. *Marketplace: Relationship between nursing homes, Ontario government questioned.* <http://www.cbc.ca>

⁴⁵ MacDermid, Robert, March 2001. From the unpublished files of the author. Reproduced with permission.

estimated that as much as 80% of the total contributions made to the party by the industry were donated during this period.⁴⁶ What may be even less surprising is that the three largest companies operating nursing homes in Ontario, in addition to being recipients of the highest number of new bed contracts, were also the biggest LTC contributors to the Ontario Conservatives: CPL REIT donated \$22,865.00, Extendicare donated \$36,378.00 and Leisureworld gave \$44,370.00. Certainly not the biggest corporate donations the Conservatives have received during their tenure, but not inconsequential either.

Inspection process appalling

Turning over the care of a loved one to strangers demands a huge leap of faith. Deciding to give up independent living because of failing health is difficult. One of the things that can help to make these decisions easier is the idea that somebody is watching. Somebody with the authority to intervene and protect the safety and best interests of vulnerable people. Somebody who will ensure standards are being met and do something if they are not.

Quite rightly, this responsibility lies with the government through legislation. The *Nursing Homes Act*, the *Homes for the Aged and Rest Homes Act* and the *Charitable Institutions Act* hold long-term care facility operators accountable to the Ministry of Health and Long-Term Care who, in turn, must ensure that programs and services meet the standards set out by the province. To do this, the Ministry has developed detailed guidelines for the inspection and enforcement processes, including the use of sanctions, which are contained in the *Long-Term Care Facility Program Manual*.⁴⁷ In a nutshell, the *Manual* states that comprehensive reviews of facilities must be carried out at least once a year. “Compliance advisors” are to visit a facility to observe, audit resident files, compare delivery of care and services with the relevant legislation, policies and directives and then prepare a written report of their findings. The report outlines any issues identified during the inspections including a statement of “unmet standards”. What the report does not include is input from facility staff. Inspectors are not mandated to consult with front-line staff nor is there a mechanism available to staff if they have concerns about findings in the report. Inspection reports must be posted in an easily accessible location in the facility and made available to the public upon request. At least that’s what *should* happen.

In the spring of 2000, former NDP Health Minister Frances Lankin began a very personal and very public crusade to expose the appalling record of inspections by the Ministry of Health and Long-Term Care. At the time, Lankin’s mother was a resident of a long-term care facility and she was concerned about the care her mother was receiving. After looking into the matter, Lankin and her staff discovered that many nursing homes hadn’t been inspected in two years, even though their licenses were

⁴⁶ Ibid.

⁴⁷ Advocacy Centre for the Elderly, July 1998. *Long-Term Care Facilities in Ontario: The Advocates Manual*, page 6.18.

renewed.⁴⁸ For months, Lankin hammered the government in the Legislature and in the media to explain the gap in inspections and to do something about it.

By the fall of 2000, the story had taken on a life of its own and in October, the Canadian Press made a startling report. Documents obtained through a Freedom of Information request revealed that regular inspections had dropped close to 40% between 1996 and 1999.⁴⁹ In some instances, facilities were not inspected for three years, a clear violation of government policy. The NDP claimed that this abysmal record was due in large part to shortages of inspection staff. Apparently, inspectors had been reassigned to work on evaluating bids for new long-term care beds and had no time to carry out inspections. When inspections did actually take place they were not the three- to seven-day examinations mandated by the Ministry. Instead they were quick and often cursory reviews. The government responded quickly to this public embarrassment by hiring new inspectors and returning the old ones to their jobs, however the damage had been done. The Canadian Press quoted one official as saying, "This cannot be turned into a good-news story".

Almost a year later *The Toronto Sun* published a 16-page special report on long-term care entitled "Elderly Care Crisis". A moving and disturbing expose of life in a long-term care facility, the report made it pretty clear that not much had changed. Indeed, University of Toronto professor Ernie Lightman, who is quoted in the story, calls the provincial licensing and inspection of nursing homes a "fraud". He says the fact that there are no sanctions placed against operators who do not meet the provincially set standards leaves residents virtually unprotected.⁵⁰ Consider these numbers:

- In 1984, there were 497 charges brought under the Nursing Homes Act.
- In 1988, there were 12.
- Since 1989, there have been none.

One explanation for these figures is the ministry's approach to the process. Ministry practice is for inspection dates and times are booked in advance with facility operators. Surprise inspections are not common but are conducted when a formal complaint has been filed. Ministry staff attempt to deal with problems in a consultative and co-operative manner. Sanctions are a last resort and may be applied only after "enforcement officers" have worked with facility operators and issued warnings to no avail.⁵¹ In fact, the Ministry of Health is currently conducting a complete review of the compliance system and, in particular, the use of sanctions. This is good news to Concerned Friends of Ontario Citizens in Care Facilities, an advocacy group that closely monitors the conditions in long-term care facilities. They say that the biggest problem with the inspection process is an effective method of enforcement.

⁴⁸ Ontario New Democratic Party, April 11, 2000. *Media Release: Government Failed Elderly in Nursing Homes, Says Lankin.*

⁴⁹ Canadian Press, October 23, 2000. *'Dangerous' gaps in Ontario nursing home checks.*

⁵⁰ The Toronto Sun, June 10, 2001. *Elderly Care Crisis.*

⁵¹ Advocacy Centre for the Elderly, July 1998. *Long-Term Care Facilities in Ontario: The Advocates Manual*, page 6.20.

Despite this, it's hard to believe there hasn't been a need for sanctions in over twelve years. Or is it? With waiting lists of over 20,000 is it realistic to think that inspectors would be allowed to actually close down a nursing home, no matter how bad they are?

Dr. Patricia Spindel offers another explanation. She says that large nursing homes have learned how to 'play the system'.⁵² They bring their facility into compliance long enough to avoid sanctions only to let things slide again, be cited again, then they bring the home back into compliance. Round and round it goes.

Where we're going...

Statistics Canada predicts that the number of Canadians 65 and over will double in the next 50 years. Twenty percent of the population – one in five people – will be a senior citizen by the year 2026. The fastest growing age group in this country is people aged 80 years and older. As Canadians continue to live longer and longer, the demand for facility-based long-term care, as well as other forms of long-term care, will make today's worries seem like a piece of cake. What we see as our collective priorities will play an integral role in how we respond.

To date, the long-term care lobby has achieved many successes in Ontario since the Conservatives came to power in 1995. Consider the following:

- ELIMINATED – Requirement to provide a minimum 2.25 hours of care per resident per day in nursing homes.
- ELIMINATED – Requirement to have a registered nurse on duty 24 hours per day, seven days per week in nursing homes.
- ELIMINATED - Requirement for nursing homes to submit staffing schedules annually to the Ministry of Health.
- ELIMINATED – Requirement to return 50% of surcharges for “preferred” accommodation to the Ministry.

And, they most certainly look after their own. In April 2000, Shelly Jamieson was appointed as president of Extendicare⁵³ following a stint as the Executive Director of the Ontario Long Term Care Association, the organization representing mostly for-profit nursing homes, and as a member of the government-appointed Health Services Restructuring Commission that recommended the closure of thousands of chronic care hospital beds. Premier Ernie Eves sat on the Board of Trustees for the retirement division of CPL REIT until he returned to politics in recent months. There is no reason to expect the power of this well organized lobby will diminish in the years to come.

Where are we going? There is no question that the shift in government policies and practices will move the province further down the road of privatization and closer to a

⁵² Spindel, Patricia, March 2001. *The Problem of Regulation and Enforcement in LTCF: Lessons from U.S. Jurisdictions*, page 2.

⁵³ Extendicare, Inc., April 2001. <http://www.extendicare.com/news>.

U.S. model of care, where litigation is rampant and care levels are negligently deficient. Over 65% of long-term care facilities in the U.S. are privately run. And in September 2001, a study published in the American Journal of Public Health concluded that private, investor-owned nursing homes provide less, and worse, care than not-for-profit or public homes.⁵⁴ Recently Extendicare disposed of its operations in Florida following a record-breaking law suit in which the multi-national was ordered to pay \$20 million (US) to the family of a resident with Alzheimer's who died hungry, dehydrated and unkempt in one of their subsidiary facilities.⁵⁵

Ontario will have 20,000 new long-term care beds by the year 2004. Still, they will not be enough to keep pace with our aging population. Already, unregulated facilities such as retirement homes have emerged to meet the demand. In no way are they a suitable alternative to a long-term care facility. To begin, the only pieces of legislation that apply to retirement homes are the Tenant Protection Act and the Corporations Act. As a result there are no controls on the fees being charged, the provision of services, standards of care or even the amount of rent new residents can be charged.⁵⁶ Nor do retirement homes have the medical staff on hand to provide the care needed by many frail elderly people. At least they're not supposed to. The *Nursing Homes Act* defines nursing homes as, "Any premises maintained and operated for persons requiring nursing care." Facilities matching this definition must be licensed as a nursing home and are subject to regulatory standards as well as annual inspections. Given that frail seniors are increasingly turning to retirement homes when they cannot access a long-term care bed, the government has an obligation to ensure that these homes do not cross the line. Regulation of retirement homes is overdue.

Many retirement homes may not even be an option for Ontario's low-income seniors, especially if they are living on a fixed income. The Toronto Star reports that 1.5 million Canadians receive assistance under the Old Age Security program and, in Toronto, 38,000 live on OAS alone.⁵⁷ Including all federal and provincial pension programs, this translates to a maximum annual income of \$12,648.00. In Ontario, a person with this level of income would qualify for a government subsidy of the daily accommodation charged in a long-term care facility. Such is not the case in retirement homes where the average rental fee is \$2,200 per month⁵⁸.

Something drastic must be done to avoid a crisis in long-term care in the coming years. Private sector corporations are already gearing up to cash in on the worsening long-term care bed shortage by developing new business strategies and retirement homes are the new frontier. After all, it's where the big money is. CPL REIT has developed a strategy they call a "Continuum of Care" model. The concept is to offer increasing levels of assistance with the activities of daily living initially as a home care

⁵⁴ Harrington et al, American Journal of Public Health, September 2001. *Does Investor Ownership of Nursing Homes Compromise the Quality of Care?*

⁵⁵ The Toronto Sun, June 10, 2001. *Elderly Care Crisis.*

⁵⁶ Service Employees International Union, November 2001. *Retirement Homes: People or Profit?*

⁵⁷ The Toronto Star, April 13, 2002. *Moving Down in the World.*

⁵⁸ SEIU, November 2001.

provider, then with their assisted living centres or retirement homes and finally as the operator of a long-term care facility.⁵⁹ CPL REIT currently owns 74 retirement homes, a number that just keeps growing.

Government funding for long-term care facilities in Ontario is inadequate. Everybody, except the government, says so. In the absence of increased funds, long-term care facilities have to find the money somewhere and as we've seen, it often ends up coming from a reduction in staffing levels, diminished wages and working conditions and, consequently, lowered levels of care for residents. In private facilities, profit margins only exacerbate the situation. That's why wage rates and staffing levels in these facilities are lower than in their public and not-for-profit counterparts. Given that the majority of long-term care facilities in Ontario are now private, is the answer to simply put more money into long-term care facilities and therefore into the pockets of the private sector? There must be more money but increased funding must not mean increased profits. Provincial policies must work towards eliminating the disparities in the system that have led to two-tiered levels of access and affordability. Ontario's long-term care facilities are one part of a comprehensive system which includes hospitals and home care. Perhaps long-term care, both in facilities and in the community, more properly belong enshrined in the Canada Health Act so that they may be protected from further erosion and privatization. Vulnerable Ontarians must be protected from neglect and abuse.

An Ipsos-Reid poll released in April 2001 indicated that the majority of Ontarians were worried about the affordability (60%) and the availability (57%) of long-term care. They have good reason to be worried. Ownership does matter.

⁵⁹ CPL REIT, 2001. *Retirement Residences Real Estate Investment Trust Prospectus*, page 5.