

**Protecting the Public Interest in
Toronto's Long-Term Care Homes:
A Review of the Evidence on Privatization**

**By: the Introduction to Health Policy Class at the University of Toronto
in partnership with the Ontario Health Coalition**

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Introduction to the Current Situation in Toronto

The municipality of Toronto's long-term care homes and services department provides a wide array of healthcare services for the city's residents. There are community clients that live in their own residences and receive in-home care, clients who attend adult day programs, and clients who reside in designated long-term care supportive housing.

Under Mayor Rob Ford, the City of Toronto is undertaking a series of initiatives to cut public services and contain costs. Currently, Toronto is reviewing the possibility of privatizing publicly-owned long-term care homes in Toronto based on the findings of consulting group KPMG's report reviewing city services last year.

In its report, KPMG identified the publicly owned (municipally-owned) long-term care homes as a service which the city could divest itself of ownership. The Ontario Long-Term Care Homes Act of 2007 mandates that municipalities have at least one publically funded long-term care home under their jurisdiction, regardless of the size of the municipality in question. Pro-privatization forces see this mandate as an opportunity to privatize 9 out of 10 Toronto long-term care homes.

The City of Toronto owns 10 long-term care homes housing more than 2,300 beds. The long-term services and homes current operating budget is \$224.2 million.¹ Background information on different types of residential care services such as retirement homes and supportive housing can be found in the Appendix to this report. In addition to the publicly owned (municipal) long-term care homes, there are non-profit and for-profit long-term care homes in Toronto.

The privatization of 9 out of 10 of these essential long-term care homes will be significant in the assessment of Toronto's next budget (for 2013), for which the budget process has already begun. The issue is subject to a review by a to-date unnamed consultant this spring. The Standing Committee on Community Development and Recreation is overseeing the consultant's review and the recommendations produced by the review will have to be passed by this committee prior to going to the municipal council.

Last year's KPMG report, commissioned by the City, did not look at quality of care issues in making its assessment about which services can be privatized. In fact the evidence shows that public, not-for-profit long-term care homes provide a greater amount of care than private care homes and accept a larger variety of aged residents who need more extensive care. Public and non-profit homes provide more hours of care and show better health outcomes in general. This report aims to present the evidence that compares the quality of care provided to seniors in public, non-profit and private (for-profit) long term care homes based on data from a variety of different jurisdictions. The body of evidence shows that there is a distinct difference in the quality of care provided in the public and non-profit long-term care homes when compared to private for-profit care homes, even though both receive the same government subsidy per resident per day.

¹ City of Toronto. (2011). Core services review public consultation report. Appendix B to the City Manager's Report on the Core Service Review. Retrieved from <http://www.toronto.ca/ltc/>

Evaluating the Quality of Private vs. Public Long-term Care Homes: The Evidence

There are three factors that are considered when measuring the quality of a long-term care (LTC) home: structure, process and outcome.² Structural elements are institutional characteristics such as the amount and ratio of staffing types. Process refers to the quality of care provided to residents (excluding medically related issues) including the inappropriate use of restraints, catheters and psychoactive drugs. Outcome indicators measure how quality of care impacts residents, including the development of pressure ulcers, frequency of falls and mortality rates.³ There are eight primary outcome indicators that are used to determine the quality of care provided by a LTC home: mortality, infections, pressure ulcers, hospitalizations, functional ability, incontinence, dehydration, accidents, weight change and contractures.⁴ The evidence addresses each of these indicators as a comparison between for-profit (FP) and non-profit (NP) long term care homes.

Quality of Care: Medical Indicators

An array of studies, literature reviews and meta-analyses have compared outcome indicators between non-profit and for-profit long-term care homes. The evidence is clear that for-profit homes show higher rates of adverse outcomes including pressure ulcers (bed sores), dehydration, pneumonia, falls and fractures. The higher care needs in public/non-profit homes results in higher mortality rates in non-profit homes versus for-profit homes; however, in preventable adverse outcomes, the for-profit homes show worse results on every measure for which there is a difference.

A 2009 literature review of 82 studies focused on the relationship between ownership status (for-profit vs. non-profit) and quality of care in LTC homes between 1965 and 2003. One of the primary variables used to measure quality of care was pressure ulcers. Pressure ulcers occurrence was significantly lower among residents of NP homes.⁵ The development of pressure ulcers is a telling outcome indicator because their occurrence is completely preventable with proper care.⁶ As such, it serves as a surrogate measure of the higher quality of care that is provided in NP nursing homes. The higher rate of pressure ulcers in FP homes is linked to poorer overall care and attention and is thus associated with increased overall likeliness of morbidity and mortality.⁷

Data from the Manitoba nursing home files for the years 1988 to 1991 also indicated that NP long term care homes had statistically significant lower rates of dehydration and pneumonia in

² Hillmer M.P. et al. (2005). Nursing home profit status and quality of care: is there any evidence of an association? *Medicare Care Research and Review*. 62(2):139-66.

³ Ibid.

⁴ Ibid.

⁵ Comondore V.R., Devereaux P.J., Zhou Q., et al. (2009) Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis. *BMJ*. 339:b2732.

⁶ Hillmer M.P. et al. (2005). Nursing home profit status and quality of care: is there any evidence of an association? *Medicare Care Research and Review*. 62(2):139-66

⁷ Ibid.

comparison to FP homes in their residents.⁸ Rates of anemia and urinary tract infections did not significantly differ between both ownership statuses. The rate of serious falls and fractures was also significantly higher in FP homes where 7.7% of hospitalizations reported in a four year period were related to a fall.⁹ The high rate of falls reported in FP homes suggests inadequate care and a lack of supervision, likely indicative of the fact that these institutions tend to maintain lower staffing ratios and are more limited in the services they provide.^{10,11} The lack of staffing and services in FP nursing homes has been directly linked with higher rates of adverse outcomes among residents such as the development of pressure ulcers and the increased use of restraints.¹²

Although FP homes tend to have lower mortality rates, this is not a direct indicator of good quality of care due to differences in case mix (or the complexity of resident needs).¹³ Publicly-owned nursing homes provide most of the care for residents with chronic illnesses and those requiring higher levels of care.¹⁴ Not surprisingly, these individuals are generally older and sicker than those in FP homes. Indicators such as the rate of falls, fractures, dehydration, pressure ulcers and pneumonia are considered better indicators of care than mortality rates because they are partially or wholly preventable with proper nursing care.

Putting these factors together, McGregor et al conducted two major literature reviews that showed that NP homes generally had higher staffing ratios, lower rates of pressure ulcers and use of restraints as well as fewer issues as reported by inspectors.¹⁵ As a result, they conclude that there is a higher quality of care delivered in NP homes when compared to FP homes.

Quality of Care: Other Indicators

In addition to outcome measures, particularly medically diagnosed conditions such as pressure ulcers and infections, it is important to consider the treatment of residents and approaches to care. Several Canadian research studies show that NP long-term care provides a higher quality of care because these homes were less likely to engage in the inappropriate use of restraints, over-usage of catheterization or tube feeding or the inappropriate use of psychoactive drugs. These negative practices can lead to an increase in both morbidity and mortality, greater susceptibility to urinary tract infections, and heighten the probability of falling and hip fractures. These factors all contribute to a decrease in the quality of life for residents.

⁸ Shapiro E., Tate R.B. (1995). Monitoring the outcomes of quality of care in nursing homes using administrative data. *Can J Aging*. 14: 755-68.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Berta W., LaPorte A., Valdemanis V. (2005). Observations on institutional long-term care in Ontario: 1996-2002. *Can J Aging*. 24: 70-84.

¹² Ibid

¹³ Ibid.

¹⁴ Berta W., LaPorte A., Valdemanis V. (2005). Observations on institutional long-term care in Ontario: 1996-2002. *Can J Aging*. 24: 70-84.

¹⁵ McGregor M.J., Ronald L.A. (2011). Residential Long-Term Care for Canadian Seniors Nonprofit, For-profit or Does it Matter? IRPP Study.

In the Comondore et al literature review of 82 studies, quality of care was measured and compared in terms of not only pressure ulcers, but also the number of staff per resident, physical restraints, and regulatory deficiencies. Of these, 40 studies showed statistical significant variables that all favoring NP LTC care and only 3 favored FP care. While the remaining studies did not show statistically significant differences between the two ownership types or mixed results, NP long-term care generally showed higher quality when such a difference existed.¹⁶

Similarly, a 12-year research study by Hillmer et al found that systematic differences exist between FP and NP nursing homes. Statistical significance was reported between each quality of care indicator showing consistently higher quality of care in NP long-term care. These indicators were process-based measures such as inappropriate use of restraints, federal audit deficiencies for the use of restraints, rate of catheterization, rate of tube feeding, inappropriate use of psychoactive medications, percentage of residents who are not toileted, and the percentage of residents with advance directives. Positive patient outcomes and resident satisfaction was greater in NP long-term care when compared to FP care.¹⁷ NP homes provide residents with more direct resident care per individual, more independence, and a greater voice in daily decision-making.¹⁸ Even though it is common for private homes to claim to differentiate themselves by providing luxurious environments and improved care and services, residents of NP homes were significantly more satisfied with the environmental comfort.¹⁹

Health issues are less likely to occur when the same support and care team is treating and caring for an individual. Inadequate staffing levels can increase the use of in-person care substitutes, such as medications, use of catheters and restraints. Many of these issues associated with FP LTC homes could be a result of an attempt to cut employment costs and other expenses in order to maximize profits.

Sadly, rates of mortality, infections and dehydration were higher in FP homes than in NP care if residents had no family visits within a month of admission. This means that residents who receive regular visitors may experience higher qualities of life and have greater self-satisfaction. This raises inequality issues in the care being offered to seniors in these homes.

¹⁶ Comondore V.R., Devereaux P.J., Zhou Q., et al. (2009) Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis. *BMJ*. 339:b2732.

¹⁷ McGrail K.M. et al. (2007). For-profit versus non-for-profit delivery of long-term care. *Canadian Medical Association*. 175(1).

¹⁸ Gamble B. (2007). Canadian stakeholders' views about the boundaries of publicly funded health care: What are the consequences for women caregivers?. (Master's thesis, University of Toronto).

¹⁹ Walker K. R. (2012). Assessing the determinants of quality in Ontario's long-term care homes: Relationships between staff and resident satisfaction. (Master's thesis, University of Toronto).

Staffing and Care Levels

The ability of long-term care to provide the necessary quality of life for residents depends directly on staffing levels and the direct care they provide daily for each resident. Lower staffing levels reduce care workers' abilities to provide an appropriate standard of care. Lack of sufficient staff numbers means less time spent with residents, increased responsibility for each worker, increased worker injuries and greater overall costs for care.

Many studies show a lower quality of care in FP long-term care homes. The evidence from these studies and analyses consistently shows systematic difference in staffing with greater per resident hours in NP homes. In his research, Walker notes 'greater demands are placed on staff in for-profit facilities due to staffing and working conditions'.²⁰ The limited nursing staff is overwhelmed with more residents and the services that they must provide. Hillmer et al also state that the higher quality of care found in NP nursing homes is due to more staff and availability of information as to what should be done to care for specific residents.²¹ McGregor and Ronald found overall staffing levels to be lower in FP nursing homes and a larger number of registered nurses per resident in NP homes, both of which the researchers link to an improved quality of care in NP care.²² Like their colleagues, McGrail et al provide further evidence that the amount of direct-care and activity aid staff is consistently higher in NP rather than in FP homes.²³

Statistics Canada data shows that Ontario has the lowest overall staff hours of care of all provinces at an average of 2.04 hours per resident per day.²⁴ This limited amount of times is even lower in FP homes than NP homes, leading inevitably to a lower quality of care and life for residents. In overall comparisons conducted by Comondore et al, it was found that NP LTC homes were providing 0.42 hours of care per resident per day more than FP homes, which amounted to 42 000 hours more care in NP versus FP care in total.²⁵ Hillmer et al note that not-for-profit homes had increased numbers of more highly skilled staff and lower rates of nursing aide turnover when compared to for-profit nursing homes.²⁶

It is not just the residents who suffer from staff shortages. Care workers are put under stress when trying to care for more residents than they are able to. Limitations in funding imposed more frequently in FP facilities to increase profits mean that staff must also deal with fewer services and medical necessities required to supply quality care. Additionally, McGregor and

²⁰ Walker K. R. (2012). Assessing the determinants of quality in Ontario's long-term care homes: Relationships between staff and resident satisfaction. (Master's thesis, University of Toronto).

²¹ Hillmer M.P. et al. (2005). Nursing home profit status and quality of care: is there any evidence of an association? *Medicare Care Research and Review*. 62(2):139-66.

²² McGregor M.J, Ronald L.A. (2011). Residential Long-Term Care for Canadian Seniors Nonprofit, For-profit or Does it Matter? IRPP Study.

²³ McGregor M.J., Cohen M., McGrail K.M. et al. (2005). Staffing levels in not-for-profit and for-profit long-term care facilities: Does type of ownership matter? *CMAJ*. 172:645-9

²⁴ National Union of Public and General Employees. (2012). "Dignity Denied". Accessed from http://nupge.ca/files/publications/Dignity_Denied_2012_web_version.pdf

²⁵ Comondore V.R., Devereaux P.J., Zhou Q., et al. (2009). Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis. *BMJ*. 339:b2732.

²⁶ Hillmer M.P. et al. (2005). Nursing home profit status and quality of care: is there any evidence of an association? *Medicare Care Research and Review*. 62(2):139-66.

Ronald discovered a correlation between higher staffing levels and reduced worker injury.²⁷ Trinkoff et al also reveal a similar correlation in their studies of American nursing homes where they linked total nursing hours per resident with worker injury rates, showing that lower staffing levels were associated with more injuries.²⁸

Establishing a relationship between the staff and residents is beneficial to both parties as it creates a level of trust. It results in more resident-centered care and enhanced knowledge of each resident's health issues. This relationship decreases the 'social inequalities affecting the relationship between recipients and providers of care'.²⁹ However, the time needed to establish such relationships is not available to long-term care homes with too few staff.

Recommendations have continuously been made to avoid the effects of staff shortages by implementing policy and resources that would serve to guarantee consistent and regulated staffing levels across all nursing homes.³⁰ Based on the fact that FP homes show consistently lower staffing levels, private for-profit ownership of LTC homes works counter to this goal.

Organization Structure

Ownership (for-profit, non-profit and public) of LTC homes is characterized by different organizational structures and business models. For-profit organizations answer to private owners or shareholders whose goals generally include profit maximization and growth opportunities. Non-profits usually have a charitable or community mission and are usually governed by elected volunteer boards. Non-profits do not have share capital and are run without the profit motive. Public long-term care homes are owned by municipal governments with a public mission. They are accountable through their elected municipal councils.

All types of homes in Ontario receive the same provincial government subsidy as well as regulated user fees paid by residents for their accommodation.³¹ Currently, the per diem subsidy in Ontario amounts to a total of \$132.21 per resident per day and the additional amount each individual must pay for their room is adjusted relative to their income.³² The key question in terms of for-profit private homes is how profit taking correlates with quality of care. It has been shown that FP nursing homes make different spending decisions and these are often not the interest of their residents.³³ Since the goal of FP homes is to provide return to their investors, it is

²⁷ McGregor M.J., Ronald L.A. (2011). Residential Long-Term Care for Canadian Seniors Nonprofit, For-profit or Does it Matter? IRPP Study.

²⁸ Trinkoff A.P., Johantgen M., Mutaner C., Le R. (2005). Staffing and Worker Injury in Nursing Homes. *American Journal of Public Health*. 7:1220-1225.

²⁹ Cranford C. J. (2010). Negotiating quality care and quality work: The organization of care-work and the care-work relationship in Ontario. (Master's thesis, University of Toronto).

³⁰ Trinkoff A.P., Johantgen M., Mutaner C., Le R. (2005). Staffing and Worker Injury in Nursing Homes. *American Journal of Public Health*. 7:1220-1225.

³¹ Walker K. R. (2012). Assessing the determinants of quality in Ontario's long-term care homes: Relationships between staff and resident satisfaction. (Master's thesis, University of Toronto).

³² National Union of Public and General Employees. (2012). "Dignity Denied". Accessed from http://nupge.ca/files/publications/Dignity_Denied_2012_web_version.pdf

³³ McGrail K.M. et al. (2007). For-profit versus non-for-profit delivery of long-term care. *Canadian Medical Association*. 175(1).

the managerial and profit outcomes that are prioritized, and this is thought to result in a lower standard of care.³⁴ This is particularly a problem when the residents are frail and elderly and usually lack the resources or abilities to advocate for their own needs.³⁵ While NP homes will re-invest their profits or extra funds into care and facility improvement, FP homes will try to improve efficiency to pass profits onto their shareholders.³⁶ The research shows that market pressures, rather than compliance to standards and improvement of care, govern for-profit nursing home decision making.³⁷ As a result, government regulation must focus on active deterrence (rather than support) which involves monitoring, sanctions and is more costly.³⁸

For-profit, multi-unit chain-operators have flourished in Ontario's regulatory environment, where their ability to reap economies of scale gives them an advantage over smaller independent NP homes.³⁹ There is a clear risk for "corner cutting" with this approach.⁴⁰ In fact, whether LTC care is delivered as single site homes or part of chains or networks has been more important for NP homes. A study of LTC nursing homes in British Columbia showed comparable risk ratios of hospitalization of residents (a care indicator) for FP nursing homes regardless of whether they were chain owned or single site homes.⁴¹ However, in the case of NP, hospital admissions were significantly lower if the nursing homes was associated with a bigger structure such as a health authority or multi-site center compared to a single site facility.⁴² Compared to the FP LTC homes, the single center NP homes showed no advantage, whereas NP homes that were part of bigger structures had lower hospitalization rates, suggesting better care.⁴³ While the chain operators may have the means of making the process more efficient, they are guided by their self-interest of increasing profits and are less accountable to the public than NP nursing homes.

The Ontario Long-Term Care Association contends that for-profit LTC homes do not make money from the provincial subsidy.⁴⁴ Instead, profits come from the extra charges for semi-private and private rooms, but also, as the evidence suggests, from lower staff wages or ratios.⁴⁵ Extra charges promote inequality of services and increase waitlists while staffing has a crucial impact on quality of care. Although the government subsidy is in place to set staffing and programming levels rather than leaving these decisions to the operator of the nursing home, FP

³⁴ Hillmer M.P. et al. (2005). Nursing home profit status and quality of care: is there any evidence of an association? *Medicare Care Research and Review*. 62(2):139-66.

³⁵ Ibid.

³⁶ Berta W., LaPorte A., Valdemanis V. (2005). Observations on institutional long-term care in Ontario: 1996-2002. *Can J Aging*. 24: 70-84.

³⁷ McGregor M.J, Ronald L.A. (2011). Residential Long-Term Care for Canadian Seniors Nonprofit, For-profit or Does it Matter? IRPP Study.

³⁸ Ibid.

³⁹ Berta W., LaPorte A., Valdemanis V. (2005). Observations on institutional long-term care in Ontario: 1996-2002. *Can J Aging*. 24: 70-84.

⁴⁰ Walker K.R. (2012). Assessing the determinants of quality in Ontario's long-term care homes: Relationships between staff and resident satisfaction. (Masters thesis, University of Toronto)

⁴¹ McGregor M.J., Cohen M., McGrail K.M. et al. (2005). Staffing levels in not-for-profit and for-profit long-term care facilities: Does type of ownership matter? *CMAJ*. 172:645-9

⁴² Ibid.

⁴³ Ibid.

⁴⁴ McKay, Paul. (2003). Ontario's Nursing Home Crisis- Part 1: Cut-Rate Care. *The Ottawa Citizen*.

⁴⁵ Ibid.

owners attempt to lower operating costs and this can including altering these “set” factors.⁴⁶ Adding to this, for-profit homes will generally not accept residents with complex health needs, leaving them to the NP homes so that they do not have to absorb the extra costs associated with their care.⁴⁷ Similarly, more user fees (such as those for premium rooms) increase revenues for the nursing home but serve to increase the total cost of healthcare.⁴⁸ A 2001 study in the American Journal of Public Health and the 2005 Aspen Institute study have both shown that FP homes in the US show less efficiency and have higher costs than NP homes.⁴⁹ While the operations of FP may be advantageous to their owners, the benefits and profits are not passed on to residents or the public.

Recommendations for the Future

The need for long-term care will only become greater as the Canadian senior population grows. Canadians – and Torontonians - deserve appropriate health services, but already many face high costs, lack of resources, and limited availability.⁵⁰ While Canada prides itself on its public healthcare system, inadequate long-term care is a major challenge to the core values of the Canada Health Act. In attempts to minimize public expenditure, the government has increasingly turned to privatization in the hopes of reducing costs. However, the evidence shows the opposite is true. Private long-term care companies have higher costs in order to maximize business profits.⁵¹ They maximize fees to residents and prioritize profit-taking over the public interest. Additionally, these for-profit homes provide lower quality of care than that offered in the public and not-for-profit nursing homes. It is important to develop and protect public long-term care in order to ensure compassionate and equitable care for senior citizens.

⁴⁶ Berta W., LaPorte A., Valdemanis V. (2005). Observations on institutional long-term care in Ontario: 1996-2002. *Can J Aging*. 24: 70-84.

⁴⁷ Ibid.

⁴⁸ Baranek P.M. (2000). Long-term care reform in Ontario: The influence of ideas, institutions and interests on the public/private mix. (PhD Thesis, University of Toronto)

⁴⁹ National Union of Public and General Employees. (2012). “Dignity Denied”. Accessed from http://nupge.ca/files/publications/Dignity_Denied_2012_web_version.pdf

⁵⁰ National Union of Public and General Employees, (2010). Iq private delivery. Accessed from www.nupge.ca/files/./IQ_2_Private_Delivery.pdf

⁵¹ Baranek P.M. (2000). Long-term care reform in Ontario: The influence of ideas, institutions and interests on the public/private mix. (PhD Thesis, University of Toronto)

Conclusion

In conclusion, a review of the evidence reveals that the privatization of Toronto's long-term care homes is not in the interests of Toronto's elderly population and their families. Numerous studies demonstrate that private long term care homes work to maximize profitability by cutting costs and reducing the quality of their staff, their services and their amenities. For-profit homes have been demonstrated to select more independent residents, to spend less time and give fewer services to those residents, hire less staff members, and have poorer health outcomes. The for profit system decreases the accountability of long-term care homes, forcing a focus on deterrence and enforcement of government regulations and standards, and as a result, both medically and socially defined measures of care quality are under evaluated. Residents in for-profit homes suffer from more frequent infections, falls and hospitalizations, and receive fewer visitors than do residents in not-for-profit and public homes. The most vulnerable of long term care residents are routinely denied space in for-profit homes, adding to the burden of increasingly overcrowded hospitals and non-profit long term care homes.

Given the evidence, the privatization of 9 of Toronto's 10 long term care homes would have an adverse effect on the health of long-term care home residents across the city. The City of Toronto should consider the ample evidence regarding quality of care. Simply the fact that the City could possibly, with the approval of the province of Ontario, divest its long-term care homes, does not mean that it should pursue this course. It is imperative that Toronto Councillors eschew the influence of the private for-profit sector and their lobbyists and act to protect and support the public interest in municipally-run, publically-funded care homes that are such a vital part of our public health system.

Appendix

Background on Residential Care in Ontario

There are three major types of residential care for the elderly in Ontario: supportive housing, retirement homes, and long-term care (also known as nursing) homes.⁵² Supportive housing is provided in designated buildings across the city and is designed for seniors who need very minimal assistance with daily living and wish to live independently. Retirement homes are also intended for seniors with more independence and requiring minimal care but specifically include accommodation and other services. However, the cost for a spot in a retirement home comes entirely from the resident and they are not city-operated or funded. Seniors in need of long-term care homes require higher levels of assistance and personal care, and these residents are often older with more difficult personal needs that require specialized training.

Long-term care homes in Ontario provide the following:

- Nursing and personal care
- Regular and emergency medical care by an on-call physician
- Treatment and medication administration
- Assistance with activities of daily living
- 24-hour supervision
- Room and board, including laundry services (special diets are also accommodated)
- Pastoral services
- Social and recreational programs⁵³

Long-term care homes throughout Ontario are funded by the Ministry of Health and Long-Term Care and all provide the above-mentioned services.⁵⁴ They are also regulated by the Ministry and evaluated annually.⁵⁵ In addition to provincial funding, there are monthly costs to the resident that are regarded as co-payments; these rates are also set by the Ministry to cover the costs of accommodation and food. These rates vary based on length of stay (long versus short) as well as type of accommodation (basic accommodation, semi-private and private).⁵⁶

⁵² Home, Community and Residential Care Services for Seniors- Public Information. (n.d.). *Ministry of Health and Long-Term Care*. Accessed from http://www.health.gov.on.ca/en/public/programs/ltc/3_overview.aspx

⁵³ Long-term Care Options. (n.d.). *Community Care Access Centre*. Accessed from <http://www.ccac-ont.ca>

⁵⁴ Seniors' Care: Home, Community and Residential Care Services for Seniors- Public Information. (n.d.). *Ministry of Health and Long-Term Care*. Accessed from http://www.health.gov.on.ca/en/public/programs/ltc/15_facilities.aspx

⁵⁵ Service Ontario. (n.d.). *Proposed Amendments to O. Reg. 79/10 under the Long-Term Care Homes Act, 2007*. Accessed from http://www.e-laws.gov.on.ca/html/source/regs/english/2010elaws_src_regs_r10079_e.htm#BK181

⁵⁶ Seniors' Care: Home, Community and Residential Care Services for Seniors- Public Information. (n.d.). *Ministry of Health and Long-Term Care*. Accessed from http://www.health.gov.on.ca/en/public/programs/ltc/15_facilities.aspx

There are ten long-term care homes operated by the city of Toronto⁵⁷ and nineteen not-for-profit homes in Toronto.⁵⁸ Applications for long-term care homes are completed through the Community Care Access Centre (CCAC)⁵⁹ and admission is based on eligibility standards set by the Ministry of Health and Long-Term Care. Assessments of abilities include: functional capacity, requirements for personal care, current behavior and behavior during the year preceding the assessment.⁶⁰ After an individual has been deemed eligible, they are able to apply to three nursing homes.⁶¹

The CCAC is a provincial wide organization that works with the elderly to help navigate through the available resources offered by the province of Ontario; they essentially act as a liaison between the elderly and the province. There are fourteen CCAC offices in Ontario, placed strategically based on population density. They are also funded through the Ministry of Health and Long-Term Care as well as the Local Health Integration Networks. The CCAC provides the elderly with individual consultation to manage personal health concerns; their aim is to allow individuals to live independently as long as possible through the following services:

- Meal delivery and dining programs
- Caregiver relief
- Transportation services
- Community dining
- Friendly visiting
- Supportive housing
- Adult Day Programs

When it becomes exceedingly difficult for a senior to manage independently even with these supports, the CCAC acts as the access point to long term care services.

⁵⁷ Long-Term Care Homes and Services. (n.d.). *Official website for the City of Toronto*. Accessed from <http://www.toronto.ca/ltc/>

⁵⁸ Toronto Non-Profit Long-Term Care Homes/Nursing Homes. (n.d.). *Canada's Long-Term Care Services* Accessed from <http://www.torontonursinghomes.com/>

⁵⁹ Seniors' Care: Home, Community and Residential Care Services for Seniors- Public Information. (n.d.). *Ministry of Health and Long-Term Care*. Accessed from http://www.health.gov.on.ca/en/public/programs/ltc/15_facilities.aspx

⁶⁰ Service Ontario. (n.d.). *Proposed Amendments to O. Reg. 79/10 under the Long-Term Care Homes Act, 2007*. Accessed from http://www.e-laws.gov.on.ca/html/source/regs/english/2010elaws_src_regs_r10079_e.htm#BK181

⁶¹ Ibid