

Proposed National Standards for Long-Term Residential Care

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Introduction

We have been asked for our opinion about federal authority with respect to long-term residential care (LTC),¹ and in particular that we address:

- the nature and extent of federal authority to ensure that all Canadians have access to quality care in LTC homes based on their needs, not their ability to pay;
- the national standards required to ensure access to necessary comprehensive and high-quality long-term residential care; and
- the federal government's options for reducing the role of for-profit LTC service providers.

For decades, health care advocates have called for a more robust and effective federal role to ensure that we meet the needs of the elderly as Canada's population ages. The emergency caused by the pandemic has catapulted this issue to the top of the public agenda. Canada has had the highest number of long-term care home deaths attributable to the pandemic when compared with other OECD nations.

COVID-19 has laid bare the endemic and longstanding failure of many long-term care homes to provide residents with a safe and healthful environment, and with essential and high-quality care.

While some provinces, notably those in Atlantic Canada, acted quickly to protect the vulnerable in congregate care settings, other provinces have failed to do so. Canadians have been horrified by accounts from the military, families, residents and staff,² of the horrendous circumstances in which thousands of seniors were forced to live, and far too often, die. These dramatic and systemic failures have prompted calls from across Canada, for the federal government to increase funding and establish national standards for long-term care.

The Trudeau government has now responded to these calls by committing to establish national standards for long-term care. Announced last year in the throne speech, a supplemental mandate letter to the Minister of Health, issued on January 2021 by the Prime Minister, directs the Minister to:

¹ Various terms are used across the country to refer to these services, including continuing, extended, special care, nursing or residential care homes. The term as used in this opinion does not apply to retirement homes, or assisted living facilities, but only to publicly funded residential facilities that provide 24/7 access to required nursing care.

² Staff, deemed essential workers, and often left poorly protected in unsafe working environments also suffered serious harm.

“Work with the Minister of Seniors, work with the provinces and territories to set new, national standards for long-term care so that seniors get the best support possible.”

The Minister’s mandate does not specify the form such standards are to take and the government might choose either to house them within a federal, provincial and territorial agreement, or under federal legislation. In our view LTC standards should be established in federal legislation, and we discuss below whether to amend the *Canada Health Act* for that purpose, or enact a stand-alone statute.

However, the specific standards we propose could, with two important exceptions, be established under a federal, provincial and territorial agreement. The first of these is that such an agreement would have no permanence, and would not, as a matter of law, establish any ongoing obligation for the federal government to take responsibility for these essential health care services. Neither would it hold the provinces, territories or indigenous peoples’ organizations³ to any obligation for compliance.

The other important exception is accountability. Below, we propose standards that would establish a legally binding framework of transparency and accountability for both LTC service providers, and for the governments responsible for overseeing them. These include a public right-to-know about the performance of both LTC service providers, and the public officials responsible for the ensuring their compliance. The accountability measures we propose would also establish remedies and rights for residents and their families, and for staff and their representatives, to ensure that rules are complied with, and these rights would include the right to participate in the licensing process for LTC homes, including the right of appeal.

If implemented, proposed reforms described below would bring long-term residential care into the mainstream of the Canadian health care system. Federal legislation would, for the first time, establish a statutory obligation for the federal government to fund, and take some measure of ongoing responsibility and accountability for the sector. As has been true for the *Canada Health Act*, federal legislation on LTC can also help shift societal expectations so that long-term care becomes understood as a necessary element of Canada’s commitment to providing health care to all Canadians, regardless of the setting in which such care is provided.

Finally we must acknowledge that many of the problems that plague long-term residential care also apply in respect of policies and programs that exist to allow people in need of care to remain in their homes. Isolating the two issues is far from ideal, but the desperate need to implement reforms for the long-term residential care sector has so elevated this particular issue that the federal government has committed to establishing standards for the sector.

³ The Minister’s mandate in respect of long-term care does not refer to working with indigenous peoples, nevertheless in the interest of being inclusive we have included them in our draft proposals.

Unfortunately, it has made no such commitment in respect of home care. Rather the mandate letter to the Minister only directs her to “Work with the Minister of Seniors to take additional action to help seniors age in place and stay in their homes longer.” However regrettable the limits of the Prime Minister’s direction, because of the express commitment to national standards for long-term residential care, we have been asked for our opinion about what those standards should be.

Jurisdiction and the *Canada Health Act*

Canada’s medicare system is founded on one central and organizing principle, which is that all Canadian residents are entitled to needed medical care based on their needs, not on their ability to pay. That principle is given expression by the *Canada Health Act (CHA)* and embodied by provincial health care insurance plans that, for the most part, implement the specific principles set out in the *CHA*.

Many Canadians regard medicare as a defining characteristic of our country, and very few would doubt the essential role of the federal government in sustaining this fundamental social service.

Yet under the division of powers under Canada’s constitution, it is the provinces that have jurisdiction over health care services, the regulation of health professionals, hospitals and clinics, and most long-term residential care.⁴

While the federal government has some specific jurisdiction over health-related matters, including food and drugs, and public health, the provision and regulation of LTC in provinces and territories, is not an area of policy and law with respect to which it has direct authority.⁵ The federal government does, however, have important spending power authority under the Constitution which it can use to require compliance by provinces, territories and indigenous peoples’ organizations as condition for access to federal cash transfers. It is this authority that underpins the *CHA* and its requirement that the provinces establish public health care insurance programs in accordance with the criteria and conditions of the *Act*.

The extent of federal funding for health care is negotiated from time to time with the provinces and is then set out in Part V.1 of the *Federal-Provincial Fiscal Arrangements Act*, which deals with the *Canada Health Transfer* and related transfers.

Thus, the *CHA* has been instrumental in establishing a needs-based and publicly funded health care system across the country that provides all Canadian with access to necessary hospital care, and required physician services. Unfortunately, there is a very significant

⁴ Power over these areas is granted by sections 92(7) (hospitals), 92(13) (property and civil rights) and 92(16) (matters of a merely local or private nature) of the *Constitution Act, 1867*.

⁵ The federal government does have some limited direct jurisdiction for LTC, as for example in respect of the armed forces and veterans.

domain of Canadian health care needs that are not covered by the *Act*, including pharmacare, most dental care, home care, and long-term residential care.

Extended Health Care Services under the *CHA*

While the *CHA* defines “extended health care services” to include “nursing home intermediate care service, adult residential care service, and home care service,” it does not require provinces to provide such services to fully qualify for cash transfers (funding) under the *Act*. Thus, while the Minister of Health has some, albeit very limited, authority to regulate LTC services under the *Act*, unless the *Act* itself is amended, compliance would not be a condition for federal funding.

The principles of the *CHA* do however provide a useful starting point for crafting federal standards for LTC - but only a starting point, because there are fundamental differences between the systems of care provided by hospitals and MDs on the one hand, and those required to provide LTC.

Hospitals, Physicians and LTC

To begin with, long-term residential care homes are not hospitals, and while residents may need to see a physician from time to time, the care they need every day is provided by nurses and other health professionals, but mostly by personal support or care workers. Dietary, laundry and cleaning staff are also essential to the care and well-being of LTC residents.

Most Canadian hospitals are large, public and non-profit organizations controlled by a regional health authority, or a board of directors accountable to the province or territory and to the communities it serves. By comparison, Canadian LTC homes are a mix of publicly owned, non-profit, and for-profit facilities that range in size from homes that accommodate dozens of residents to those that accommodate many hundreds.

The presence of for-profit LTC homes poses particular regulatory challenges, and in some provinces such homes have a large footprint. For example, in Ontario, the majority of LTC homes are operated on a for-profit basis, and are often part of large chains of homes that may be organized as real estate trusts that trade on the stock market. For these ownership regimes, the fiduciary obligation to maximize shareholder value is the paramount obligation.

Another unique and related feature of the LTC sector is that responsibility for operating the home may be entirely or partially contracted to out to third party and for-profit service providers.

In addition to the very different nature and economic environment of the LTC sector, LTC homes lack the controlling influence that physicians and nurses have in hospitals,

where the chief of medicine typically reports directly to the Board. MDs and nurses⁶ are regulated health care professionals governed under provincial law, and licensed by statutory professional colleges. While the specific formulation may change from jurisdiction to jurisdiction,⁷ members of both professions are sworn to treat patient needs as their first and paramount obligation.

In contrast, most of the daily care LTC residents require is provided by personal support or care workers (PSWs). The vital care PSWs provide is essential to the well-being of LTC residents, and their work requires considerable skill and dedication. However, PSWs have little influence over decision-making at LTC homes.

Also unlike hospitals, LTC must provide long-term *residential* accommodation to those in need of care. The need to create homelike environments, with necessary recreational and social amenities, creates its own unique demands for capital funding and rents.

For these reasons, the unique challenges posed by LTC require federal standards that go well beyond those established under the *CHA*. As described in some detail below, these include standards relating to: the quality of care provided in LTC homes; transparency and accountability for LTC homes and program administrators; and to the need to provide dedicated support to not-for-profit and publicly owned LTC homes.

As the following opinion illustrates, if the regulatory regime for LTC were to be incorporated into the *CHA*, the *Act* would require substantial amendment and likely new sections to deal with quality of LTC care, accountability, and non-profit care.

In choosing whether to amend the *CHA* or enact a stand-alone health LTC statute, it is important to be aware of the risks posed by the former course. As many will know, there is a well-organized and determined campaign by for-profit private clinics and certain physicians to weaken the essential underpinnings of Canada's medicare model. This campaign includes advocacy, lobbying and very well-funded litigation.⁸ The supporters

⁶ The term "nurses" is used to include licensed or registered practical nurses as they are variously described across Canada.

⁷ For example the Ontario Medical Association OMA, set out "FUNDAMENTAL COMMITMENTS OF THE MEDICAL PROFESSION" to include the: Commitment to the well-being of the patient Consider first the well-being of the patient; always act to benefit the patient and promote the good of the patient. Provide appropriate care and management across the care continuum. Take all reasonable steps to prevent or minimize harm to the patient; disclose to the patient if there is a risk of harm or if harm has occurred. Recognize the balance of potential benefits and harms associated with any medical act; act to bring about a positive balance of benefits over harms, and the Commitment to professional integrity and competence. Practise medicine competently, safely, and with integrity; avoid any influence that could undermine your professional integrity. Develop and advance your professional knowledge, skills, and competencies through lifelong learning.

⁸ We are more than familiar with the threat posed by this litigation having represented the Canadian Labour Congress in the *Chaoulli* case before the Supreme Court of Canada, *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35 (CanLII), [2005] 1 SCR 791. We also serve as co-counsel to the BC Health Coalition and Canadian Doctors for Medicare in the challenge to B.C.'s health care insurance plan by Dr.

of these efforts would relish the prospect of the *CHA* being open for amendment in order to weaken it, and would be able to dedicate significant resources to that effort.

The following provides our opinion as to how the federal government can fill the funding and regulatory void that now exists at the federal level in respect of LTC.

Guiding Principles and Purpose

We believe it would be helpful for a federal standards regime for LTC to set out the following guiding principles:

Guiding Principles

Long-term residential care is an essential component of the Canadian health care system, and requires proper federal funding and conditionality (standards) to improve the availability and quality of care.

The operation of provincial LTC programs must be overseen by a publicly funded, transparent and accountable public body that ensures adherence to the criteria and conditions for federal funding for such services;

Publicly funded LTC services must be accessible and available to all Canadian residents who require such care, and be provided according to their need, not ability to pay.⁹

Publicly funded LTC services must be of an appropriate and high quality.

Organizations and other entities that receive public funding to provide LTC must be accountable to: residents and their families, their staff, administrators of the LTC program, and to the public. This requires routine public financial and performance reporting that is audited and verified.

The fiduciary obligation of for-profit corporations to maximize shareholder value and investor returns is incompatible with the need to treat the well-being of residents in long-term care homes as the first priority. Therefore public funding should be used in priority to support not-for-profit LTC homes with the goal of reducing the role of for-profit providers.

Brian Day, *Cambie Surgeries Corp. v. British Columbia (Medical Services Commission)*, 2010 BCCA 396. The case is now under appeal.

⁹ Subsidized residents are typically expected to contribute to the cost of their care in LTC homes. Such co-pays are consistent with principle of accessibility so long as they do not create a financial barrier to necessary care for anyone who requires it.

Purpose and Objective

The purpose of the following legislative and regulatory reforms is to establish criteria and conditions that must be met by the provinces in order to qualify for LTC federal funding, and to establish a LTC Council to advise the Minister of Health on such matters.

Defining Key Terms

For the purposes of regulating LTC homes, certain terms will need to be defined, including the following:

Long-Term Residential Care Services means any of the following services provided to residents at a long-term residential care home if the services are necessary for the purpose of supporting health, and promoting the well being of residents, namely,

(a) accommodation and meals

(b) nursing and personal care services,

(c) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,

(d) drugs, biologicals and related preparations when administered in the LTC home, and

(e) the use of the common areas within and on the grounds of the LTC home; as well as the home's dining, recreational, exercise, physiotherapy, and other facilities and amenities.

Long-Term Residential Care Home means a home funded under the LTC program of a province, territory or indigenous peoples' organization that provides residents with round the clock access to required nursing and other care, and that accords them the right live with dignity and in security, safety and comfort, and to have their physical, psychological, social, spiritual and cultural needs met.

LTC program means, in relation to a province, a program established by the law of the province, territory, or indigenous peoples' organization to provide for LTC services;

Resident means a person admitted to and living in long-term residential care.

LTC Transfer Payments

The following provisions essentially replicate those of the *CHA*.

The Minister of Finance may make an LTC transfer payment directly to a province, territory or indigenous peoples' organization to support the LTC program of the province, territory or indigenous peoples' organization if:

(a) the operator of the program is accountable to the government of the province, territory or indigenous peoples' organization for the administration and operation of the program;

(b) the program provides LTC services that meet the requirements of this Act and establishes a plan for providing universal, accessible and comprehensive LTC that comply with applicable quality and accountability standards.

In order to satisfy the criterion relating to accountability, the LTC program of a province, territory or indigenous peoples' organization must be directly administered by an organization or institution that is operated on a not-for-profit basis and that:

(a) is appointed by that government or organization;

(b) reports to that government or organization in respect of the administration and operation of the program; and

(c) is subject to a public audit of its accounts and financial transactions by the authority that is responsible under provincial or territorial law for auditing the accounts of that government or organization.

The Criteria for Entitlement to Federal Funding, (5 plus 3)

The *CHA* requires that provincial governments meet five criteria in order to qualify for federal funding: public administration, accessibility, comprehensiveness, universality and portability.

For reasons already noted, the unique character of LTC homes and services warrant adding three criteria to those mandated by the *CHA*. These concern the need for: i) LTC programs to establish and enforce defined standards of quality care that must be met by LTC service providers; and for ii) accountability to be an essential feature at every level of LTC system, from local care homes and program administrators, to the federal Minister: and iii) a commitment to dedicate federal funding to the provision of services in not-for-profit and publicly owned LTC homes.

Statutory language that could be used to establish these standards is described next.

Program criteria

*In order that a province, territory or indigenous peoples' organization may qualify for a full cash contribution referred to in section *, the LTC program of the province must satisfy the criteria described in section * to * respecting:*

- (a) public administration;*
- (b) comprehensiveness;*
- (c) universality;*
- (d) accessibility;*
- (e) portability*
- (f) quality;*
- (g) accountability.*
- (h) public/non-profit delivery.*

Public Administration

In order to satisfy the criterion respecting public administration,

- (a) the LTC program of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the province, territory or indigenous peoples' organization;*
- (b) the public authority must be responsible to that government or organization for its administration and operations; and*
- (c) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.*

Comprehensiveness

In order to satisfy the criterion respecting comprehensiveness, the LTC program of a province, territory or indigenous peoples' organization must provide public funding for all necessary LTC services as defined above.

Universality

In order to satisfy the criterion respecting universality, the LTC program of a province, territory or indigenous peoples' organization must entitle all residents to the publicly funded services provided for under the LTC program services on uniform terms and conditions.

Accessibility

In order to satisfy the criterion respecting accessibility, the LTC program of a province

(a) must provide LTC services on uniform terms and conditions and on a basis that does not impede or preclude reasonable access to such services;

(b) must provide public funding for the operation of LTC homes in accordance with a system of payment authorized by the law of the province, territory or indigenous peoples' organization; and

(c) must provide for reasonable compensation for all LTC insured health services rendered by all professional and non-professional staff responsible for such care such as to maintain a stable and qualified workforce in LTC homes.

Portability

In order to satisfy the criterion respecting portability, the LTC program of a province

(a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;

(b) must provide for the payment, during any minimum period of residence, or any waiting period, imposed by the LTC program of another province, of the cost of publicly funded LTC services provided to persons who have ceased to be covered by the LTC program of the province by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

Quality

As noted, LTC services are different than those provided by hospitals and physicians under the *Canada Health Act*. Many of the institutional and professional safeguards that exist in respect of hospital and physician care are either missing or muted in the LTC environment. The substantial presence of for-profit companies operating in the sector only exacerbates the problem of ensuring that high quality medical and social care is provided to LTC residents.

National standards for long-term residential care must of course take into account the reality that care needs vary greatly across the country. Nevertheless the essential elements of necessary and quality care need to be part of the LTC programs of every province, territory and indigenous community. The following provision would require the provinces, territories and indigenous peoples' organizations ensure that certain standards are part of their LTC programs.

In order to satisfy the criterion relating to quality, the LTC program of a province, territory or indigenous peoples' organization must establish standards:

- (a) that specify an appropriate, evidence-informed staff mix, including registered and non-registered staff, sufficient to meet the care needs of the resident population;*
- (b) that specify, and where necessary establish, professional qualifications and certification requirements for persons employed in LTC homes, including personal support and care aides, and dietary, housekeeping, laundry and security staff; and must as well provide for the recruitment, training, support, compensation and retention of those persons;*
- (c) that specify minimum requirements for resident care including to:*
 - (i) specify resident-to-caregiver ratios or required minimum hours of direct daily care that are necessary and sufficient to meet the care needs of the residents;*
 - (ii) require that a specified minimum of staff work be carried out by full-time staff at a single site, complimented by part-time staff only when it is necessary to do so.*
- (c) that relate to the environment in which LTC services are provided, including standards that:*
 - (i) require the built environment of LTC homes to provide a home-like environment, that is safe and secure, and that facilitates social support for residents, staff, family, friends and volunteers;*
 - ii) require facilities for on-site food preparation, and for proper dietary, sanitation and laundry services; and*
 - iii) require semi-private or private rooms sufficient to accommodate all residents;*
- (d) that ensure that LTC services support the cognitive, physical, emotional, cultural and social well being of LTC residents; and*
- (e) with respect to the provision of LTC services in First Nations, Inuit and Métis communities, standards that reflect the unique values and traditions of those communities.*

Accountability by LTC service providers and program administrators

There is a significant accountability deficit in respect of LTC services and programs. What is a long-standing problem has now been brought into sharp relief by the COVID crisis.

In fact, the failure of governments to dedicate adequate resources to enforcement in the health care sector is endemic, and transcends most political administration. This has also been true of the federal government's anemic efforts to enforce the *CHA*. In our view there are three important ways to address current compliance issues:

- by increasing the transparency of LTC programs and the operation of service providers;
- by providing independent oversight of the LTC programs; and
- by providing residents and their families, staff, and interested third parties with participatory rights in respect of licensing decisions and compliance matters.

Therefore, to ensure that goals of any new LTC standards are actually met, there are four levels of accountability that must be addressed:

- i) accountability by service providers to residents, their families, staff, and to LTC program administrators;
- ii) accountability by LTC program administrators to the public, and the provincial government;
- iii) accountability by the provinces to the federal government in respect of LTC; and
- iv) accountability by the federal government to the public and to Parliament.

*In order to satisfy the criterion of accountability, and in addition to requirements of Public Administration set out in section **, the LTC program of the province must:*

- (a) *entitle LTC residents and their family members, and staff or their union representatives to effective recourse where they believe the needs of LTC residents are not being adequately met, or provincial LTC standards not being complied with or properly observed;*
- (b) *require quarterly financial, staffing and performance reporting by LTC service providers which must include an account of all LTC expenditures made with program funding, together with the purposes for which those expenditures were made;*

- (c) *make the reports of LTC service providers available on-line and in accordance with relevant privacy protections;*
- (d) *publish quarterly reports providing a record of LTCR home inspections, which at minimum will include an annual and unannounced inspection, together with a record of any citations, enforcement actions, and indicating the current status of such measures;*
- (e) *make the licensing and all other agreements entered into with LTC service providers available on-line;*
- (f) *provide for timely public notice of all applications for licenses or permits concerning the establishment or operation of LTC homes;*
- (g) *provide residents and their families, staff or their union representatives, and members of the public with a direct interest, the right to notice of and participatory rights in respect of the issuance, renewal, or revocation of LTC home licenses or permits, including the same rights of appeal provided to the applicants for, or recipients of such licensees or permits; and*
- (h) *provide the Minister with such information, as the Minister may reasonably require for the purposes of this Act.*

Accountability and the federal Minister of Health

Under s. 13 of the CHA, to qualify for federal funding provinces must provide the Minister with “such information, of a type prescribed by the regulations, as the Minister may reasonably require for the purposes of this Act.” There is no such regulation and so the provinces are free to provide, or to not provide, whatever information they choose concerning their compliance with the requirements of the *CHA*.¹⁰ Moreover when provinces submit reports that misrepresent or fail to disclose serious compliance issues, they have been included, without comment, in the Minister’s annual report to Parliament.

A related problem is the cumbersome and opaque compliance provisions of the *CHA*, and the indifferent commitment of the federal government to enforcement. Together these problems of reporting and enforcement have contributed to the creeping growth of various practices that offend the principles and conditions of the *CHA*, whether to allow queue jumping or other forms of preferential treatment.

¹⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5088068/>

The problem is that the *Canada Health Act* has no bite. It will come as no surprise that those doing the extra billing don’t report their violations. And provinces only voluntarily report violations to Health Canada. No one has to do anything, so most do nothing.

Increased funding may strengthen the resolve of the federal government to take its enforcement and reporting obligations more seriously. However, an important answer to the deficiencies of its current approach can be found in providing more transparency and public oversight of the LTC system.

Accordingly, we recommend that the enforcement regime of *CHA* apply in respect to LTC with the following modifications, and one important addition - an advisory council.

Annual Report by the Minister

The Minister shall, within 4 months of the termination of each fiscal year, prepare and make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial Long-Term Care programs have satisfied the criteria and conditions for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed.

Advisory Council

In order to ensure transparency and accountability of the Minister for LTC:

The Governor in Council shall appoint a long-term care Advisory Council consisting of 18 members who support the purposes of this Act, and who represent non-governmental organizations and institutions that have established records of commitment and expertise, in respect of LTC. The majority of Advisory Council members must be comprised of representatives of the non-profit and publicly owned LTC sector, LTC staff, residents and their families.

The members of the Advisory Council shall be chosen from a list of candidates prepared through a public and transparent process and submitted by the standing committee of the House of Commons that normally considers matters related to human resources and social development.

The Advisory Council may, as it considers appropriate, make a report to any standing committee of either House of Parliament, or provide advice to the Minister in respect of any matter that relates to the administration, operation and effectiveness of this Act, including the extent to which the objectives of this Act are being achieved.

The Advisory Council shall submit an annual report to Parliament that is to include recommendations to address any failure to achieve the stated purposes of the Act.

The Advisory Council shall be accorded access to all provincial reporting records under the Act.

The Advisory Council shall submit a report to the relevant Parliamentary Committee(s) concerning the budget it requires in any fiscal year to fulfil its mandate, including the compensation that may be needed to ensure informed participation by Council members.

Not-For-Profit Care¹¹

The presence of for-profit providers in the LTC sector varies considerably across the country. They have little or no presence in several provinces or territories, but represent approximately 57% of the sector in Ontario, 47% in PEI; 45% in N.S., 34% in BC; 25% in Alberta 13% in Manitoba; and 12% in N.B. Many of these homes are in chain ownership, and some chains are organized as real estate investment trusts that are publicly traded on the stock market. In Ontario this has occurred in spite of the fact that the *Long Term Care Home Act* stipulates that the province is “committed to the promotion of the delivery of long-term care home services by not-for-profit organizations.”

The resources of public and not-for-profit owned homes are, as a rule, dedicated exclusively to the care and well-being of residents. Indeed it is not uncommon for such homes to seek out supplementary funding to augment the care provided to residents. In for-profit homes, public funding becomes a source of revenue to support the corporation’s fiduciary obligation to maximize shareholder returns. Yet the subsidies provided to support care for low-income residents are barely adequate to consistently meet basic standards of care.

The competing demand on scarce resources in for-profit homes represents a quintessential zero sum game in which the investors’ gain is the residents’ loss. The awful recent human toll that can result of this conflict has become all too apparent during the current pandemic.

The basic rationale for privatization – that competition will improve levels of service, has no relevance for essential public services, particularly where there is no competitive market - only wait lists to get into any home. Moreover, when given the choice, evidence from wait lists shows a large preference for not-for-profit homes. Neither is there any meaningful potential for improved efficiency in respect of the day-to-day, one-on-one care personal care that is the essential work of long-term residential care. Care givers are either properly trained, compensated and given enough time to provide needed care, or they are not.

¹¹ Including non-profits, municipal and public sector homes.

The need to police the profit taking proclivities of private LTC homes has led to the proliferation of detailed and extensive regulations. However, no matter how well fashioned, the imperative to take profits creates a strong incentive for private companies to find ways finesse or game the rules, as a report of the BC Seniors Advocate documents.¹²

The collateral damage of this regulatory cat and mouse game is to impose overly burdensome regulations on non-profit and publicly owned LTC homes, depriving them of the flexibility required to ensure that all available funding is most effectively used to meet residents' needs.

Non-profit LTC service providers also suffer from having much more limited access to the capital financing required to build or modernize LTC homes than do for-profit providers who can often access private equity capital. This explains the substantial growth in equity investment in the LTC sector.¹³

In other words, the current regulatory and financial playing field is tilted decidedly in favour of for-profit ownership. Unless that imbalance is corrected, the endemic problems associated with for-profit ownership will persist, and worsen as current patterns persist.

We agree with the stated commitment of Ontario's *Long Term Care Home Act*, namely "to the promotion of the delivery of long-term care home services by not-for-profit organizations." To ensure that objective, (as Ontario has failed to do by allowing for-profit care to dominate the sector), it is essential that federal funding for LTC homes be entirely dedicated to not-for-profit and publicly owned service providers. Therefore we recommend the federal LTC standards so stipulate.

In order to satisfy the criterion of non-profit delivery, in addition to requirements of Public Administration, the LTC program of the province must:

- i) promote the delivery of long-term care home services by not-for-profit or public sector organizations, including by providing necessary technical and capacity building support, and preferential funding;*
- ii) provide adequate capital funding support for LTC projects and infrastructure to public and non-profit owned LTC homes; and*
- iii) ensure that public funding for all new or rebuilt LTC homes be dedicated to not-for-profit on public sector homes.*

¹² See "A billion reasons to care" <https://www.seniorsadvocatebc.ca/osa-reports/a-billion-reasons-to-care/>

¹³ National Bureau Of Economic Research; "Does Private Equity Investment In Healthcare Benefit Patients? Evidence From Nursing Homes." Feb. 2021. <https://www.nber.org/papers/w28474>

Regulations

The Governor in Council may make regulations for the purpose of carrying out the administration of this Act and for carrying its purposes and provisions into effect, including regulations respecting the information the Minister may require for the purpose of reporting to Parliament under this Act.

We hope that this will be of some assistance in aiding efforts to encourage the government of Canada to establish meaningful and effective standards for long-term residential care.

Sincerely,



Steven Shrybman