



DIGNITY DENIED 2012

LONG-TERM CARE AND CANADA'S ELDERLY



National Union of Public
and General Employees



Who

we

are

The **National Union of Public and General Employees (NUPGE)** is a family of 11 Component unions that represents provincial public sector workers and a growing number of workers in the private sector.

NUPGE Components

- British Columbia Government and Service Employees' Union
- Health Sciences Association of British Columbia
- Health Sciences Association of Alberta
- Saskatchewan Government and General Employees' Union
- Manitoba Government and General Employees' Union
- Ontario Public Service Employees Union
- Canadian Union of Brewery and General Workers
- New Brunswick Union of Public and Private Employees
- Nova Scotia Government and General Employees Union
- Prince Edward Island Union of Public Sector Employees
- Newfoundland & Labrador Association of Public & Private Employees



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Foreword

CANADIANS CHERISH our public health care system. In repeated surveys and opinion polls, support for universal health care is reaffirmed as a fundamental value. Indeed, for the vast majority of Canadians, Medicare is an identifying mark of the Canadian character. Our system, for the most part, provides universal access to quality care for all, regardless of wealth, social status or other barriers. Sadly, this universality ends for too many seniors at the doors of long-term care (LTC) facilities. Too often LTC is not available for the seniors who need it. When available, it is frequently unaffordable and, in some cases, the quality of care is not the best that could be provided.

Long-term care is not included in the *Canada Health Act* (CHA), and it is not a fully insured health service in any Canadian province or territory. Ironically, if a frail and elderly person receives medically necessary services in a hospital, those treatments are provided from the public purse. Yet the same person receiving similar services in a LTC facility must often pay for it out-of-pocket. Our system is failing to provide tens of thousands of Canadians with the affordable care they deserve.

There are profound demographic changes just around the corner. To be clear, these demographic changes will not bankrupt our health care system. The fact is our system is financially sustainable.¹ But we do need to make the system more comprehensive. We need a cogent, national strategy to meet the health care needs of seniors, which are becoming ever more pressing. Here are some salient facts:

- People 80-years-old and over are the fastest growing age group in the country. Many seniors will enjoy healthy and active lives long into retirement, but most will experience disability near the end of their lives;
- In 2008, there were 193,858 beds in LTC facilities across Canada. Estimates are that between 560,000 and 740,000 seniors will need a LTC facility by the year 2031. This is an incredible gap and it requires governments to get serious about planning;

An 86-year-old Alberta woman went on a hunger strike in 2005 to protest the poor care she was getting

- Almost 30% of Canada's seniors in 2006 were people who arrived as immigrants. Providing appropriate care for these seniors is a new challenge. Many worked in low wage industries and are now doubly disadvantaged by a LTC system that favours the wealthy;
- Income from Old Age Security (OAS) and the Guaranteed Income Security (GIS) totals \$1,267.41 per month;
- Charges for basic accommodation in publicly supported LTC institutions range from \$918 to \$2,800 per month. Private accommodation costs are much higher; and
- In 2005, 35.5% of unattached seniors fell below the low income cut-off. Another 19% of seniors had incomes barely above the cut-off. For these seniors, existing LTC facilities present a costly and often inaccessible option.

Most LTC residents are required to pay for far more than the costs of accommodation. They are forced to empty their pockets to pay for medical and personal care and, in some jurisdictions, they are forced to spend their assets in order to make those payments.

In some facilities there are also issues with the quality of care residents receive. Workers are often run off their feet and there are just not enough of them. The media reported on a hunger strike in 2005 by an 86-year-old Alberta woman to protest against the lack of staff to provide adequate care. Other stories report poor food, substandard facilities and rip-offs by for-profit owners.

Ottawa has a responsibility to provide adequate and targeted funding toward cost sharing LTC programs. It is the responsibility of provincial governments and territories to bear their share of the costs, to establish clear standards and guidelines governing LTC, and to provide adequate oversight and inspection. Many of these governments have failed in their responsibilities. These failures have had a devastating impact on residents and the workers attempting to provide quality and compassionate care.

The financing and delivery of LTC requires sweeping reforms. This is a matter of urgent concern to all Canadians and certainly to NUPGE and its members. Most of our 340,000 members deliver public services to the citizens of their home provinces and many of these members work in the LTC sector. We can offer some lessons based on our experience and solutions based on common sense. There are better ways to help the elderly and their families.

In this paper we discuss the issues confronting LTC in Canada, including the lack of access to adequate and affordable care. We

speak to the stress endured by families that have to make difficult choices regarding their parents and grandparents. We also consider the circumstances of the women and men who work in LTC facilities, providing care to our nation’s seniors. Too often those workers are undervalued, underpaid and burned out.

It is time for bold and fundamental change. Long-term care is excluded from the *Canada Health Act* and, as a result, our parents and grandparents are largely left to fend for themselves at a time of life when they most need support.

Our key proposal is that provisions for LTC should be integrated into the *Canada Health Act* to ensure it is a medically necessary service available to every citizen, regardless of income. This is an essential step in the evolution of Canada’s public Medicare system. This will require vision from political leaders and we insist they exercise their responsibility. We also propose targeted and increased funding for public, not-for-profit LTC.

Our plan would reform the fragmented, inadequate and inefficient delivery of LTC that currently exists. Our proposals would improve the quality of care and the enforcement of optimal care standards. We propose enhancing the role of public, not-for-profit, LTC which has been proven to provide better services at less overall cost.

We want to see improved working conditions and wages for people working in the LTC system. The dignity and respect we wish for our parents and grandparents should be extended to those who provide care to them.

Our proposals would also allow for more public accountability and scrutiny.

Finally, the availability of timely and complete information on the sector is lacking. To build and maintain an effective long-term care system, reliable national information is required. We are calling on all levels of government to do a much better job of gathering and providing systematic information about the sector.

This is a struggle about demonstrating our enduring commitment to human dignity. NUPGE is committed to working tirelessly toward that goal.



James Clancy
National President

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Overview

Definitions Involving LTC Facilities

There is a complex system in Canada to provide continuing care to seniors. It has been called a “patchwork quilt” which contains many inconsistencies and inequities for the elderly people it is intended to serve. The system includes:

Home Care

Refers to a range of programs designed to maintain or improve the health and functioning of frail seniors and people with disabilities. Programs include: home support, assisted living, residential care and other community-based services. In many cases, these services receive public funding.

Retirement Homes

Offer meals, housekeeping and basic care services, usually for an expensive monthly rent. They are almost all privately-owned and are not required by governments to provide a minimum level of medical care. They receive no public funding.

Assisted Living Centres

Offer supportive housing and home care services. The intent is to provide the frail elderly with a safe and affordable home-like setting that gives them more control over private space and enables them to maintain their capacity for self-care as much as possible. Residents usually choose from a menu of services, including meals, housekeeping and personal support services. Public home care programs may insure some of the services but others must be purchased out-of-pocket from the private sector. These centres often operate as unlicensed and unregulated LTC facilities that offer expensive services.

LTC Facilities

These are known by various names in different Canadian provinces and territories. They may be called nursing homes, residential care facilities, special care homes, continuing care centres or personal care homes. They provide accommodation and meals, but

We are
fast
approaching
a major
tipping
point

they also offer on-site personal support and health care services. Most often a person enters a LTC facility on the recommendation of a doctor or social service agency. The facilities are provincially regulated, receive some government funding and, in many instances, act as chronic-care hospitals.

This paper identifies them as long-term care (LTC) facilities. They continue to be the focus of our attention because, in spite of the burden of evidence and the overwhelming outcry for action, significant change has yet to come. As the need grows, work will have to be done to LTC facilities to maintain the dignity of seniors.

The Demographic Challenge

Population aging is one of the most striking demographic trends in the world today and Canada is no exception. We are approaching a major tipping point that will have profound effects on our country and on us as individuals.

- Baby boomers (people born between 1946 and 1964) are the most populous generation in Canadian history. Those born in 1946 will officially become seniors in 2011 and many of them are already moving into retirement. Between 2001 and 2006, those over 65 years increased by 11.5%;
- Seniors comprised 7% of the population when hospitalization was introduced in Canada in the 1950s. In 2006, those over 65 years were 13.7%. It is estimated in 2031 the same group will rise to approximately 25%;²
- Canadians are living longer. Near the beginning of the 20th century, the life expectancy of the average 65-year-old was another 13.3 years. By 2003, the average 65-year-old was expected to have an additional 19.2 years of life.³ People aged 80 and over are the fastest growing age group in the country;
- In 2006, there were 1,167,310 Canadians aged 80 years or over. Between 2001 and 2006, this group increased by 25.2%;⁴
- The percentage of older Canadians who live in LTC institutions has been declining, yet the absolute number is growing. In 2008, there were 193,858 beds in LTC facilities throughout Canada;⁵
- As the absolute number of seniors grows, estimates are that between 560,000 and 740,000 seniors will live in LTC facilities by the year 2031;⁶

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Overview

- The health care needs of the frail elderly are becoming more complex. Alzheimer's disease and related dementias affect 500,000 Canadians over the age of 65. By 2038, this number will grow to 1,125,200 or 2.8% of the Canadian population;⁷
- More than 25% of Canada's seniors in 2006 were people with neither French nor English as their mother tongue. Almost 30% of seniors in 2006 were immigrants to Canada;⁸ and
- In 2007, 2.7 million Canadians over the age of 45 provided unpaid care to seniors over 65 who had long-term health care needs. Most of these caregivers were women. In addition, about 43% of these caregivers between the age of 45 and 54 still had children living at home.⁹ This demographic makes up the "sandwich generation" and places a great burden on families.

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Accessibility & Affordability

CANADA'S HEALTH care system is admired throughout the world. The original legislation attempted to ensure that every Canadian had access to medically necessary services regardless of ability to pay. But we are abandoning this vaunted commitment when it comes to LTC for seniors.

LTC & Public Health Care

Canadian provinces and territories are responsible for the administration and delivery of most health care services, but universal access is a federal concern. For that reason, Ottawa agreed, historically, to return to provinces and territories an amount equal to one-half of the costs of publicly administered health care.¹⁰

Saskatchewan Premier, Tommy Douglas, whose government first introduced public hospitals and medical care insurance, saw those as the first steps toward improving the general health of the population. Emmett Hall, the judge whose royal commission recommended Saskatchewan's Medicare model for the nation, conceived of public health care in broad terms that included, for example, public pharmacare and optometry programs.

In the 1970s, the federal government introduced the *Canada Health Act* (CHA) with five main principles:

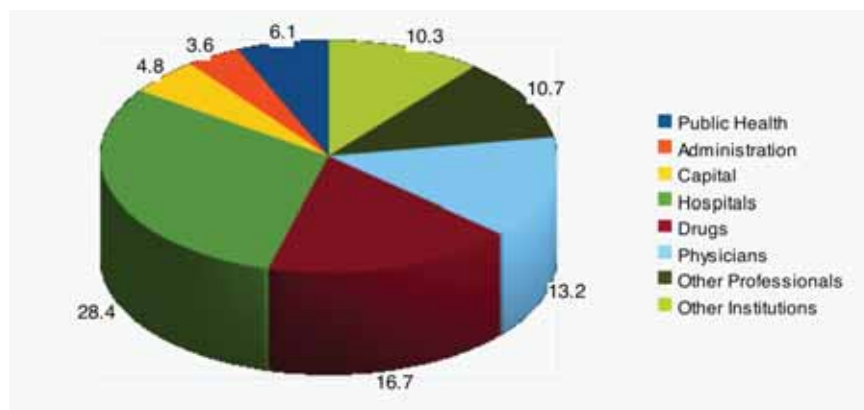
1. Public administration: each provincial health care insurance plan must be administered on a not-for-profit basis by a public authority which is accountable to the provincial government for its financial transactions;
2. Comprehensiveness: provincial health care insurance plans must cover all "insured health services" (hospital care, physician services and medically required surgical dental procedures which can be properly carried out only in a hospital);
3. Universality: all residents in the province must have access to public health care insurance and insured health services on uniform terms and conditions;
4. Portability: provinces and territories must cover insured health services provided to their citizens while they are temporarily absent from their province of residence or from Canada; and

Times have changed and health care finances and delivery must also change

5. Accessibility: insured persons must have reasonable and uniform access to insured health services, free of financial or other barriers. This condition is emphasized by two provisions of the Act which specifically discourage financial contributions by patients, either through user charges or extra-billing, for services covered under provincial health care insurance plans.

Total Health Expenditure by Use of Funds in Canada, 2006
(% OF HEALTH CARE BUDGET)

Source: Canadian Institute for Health Information (CIHI), National Health Expenditure Trends, 1975-2008 (Ottawa, ON: CIHI, 2008) p. 15, figure 10.



Over the years, the definition of health has been broadened to include health promotion and disease prevention as well as treatment but few people realize how narrowly the principles outlined in the *Canada Health Act* are applied. The Act's most serious limitation is that it covers only physician and hospital services. In the pie chart above this makes up almost 30% of health expenditures. But, many services today are provided outside of hospitals and doctors' offices such as, home care, long-term care and pharmacare. These services are not covered under the Act. Provinces and territories are free to develop their own systems and insurance for these services, yet no government has fully insured them.¹¹

Times have changed and health care finances and delivery must also keep up. The principles of the CHA must apply to the needs of the patient rather than the building in which that need is met.

Regional Disparities in Accessibility

Sadly, the LTC system that has developed is a bewildering patchwork of plans and policies, with wide variations in the number of spaces available, the length of time people have to wait to gain entry and the range of fees attached. This means that the availability, cost

and quality of LTC depends, to a great extent, upon where people live in Canada.

Our long-term care system is a bewildering patchwork of plans and policies

TABLE I							
RESIDENTIAL CARE BED RATE BY PROVINCE, 2001 AND 2008							
(BEDS PER 1,000 POPULATION AGED 75+)							
	2001 beds	2001 Beds per 1,000 age 75+	2008 beds	2008 Beds per 1,000 age 75+	% change from 2001 to 2008		
					In Pop'n aged 75+	In Bed numbers	In Beds per 1,000 age 75+
BC	25420	102.3	24616	81.3	21.8%	-3.2%	-20.5%
Alberta	14486	106.0	14654	83.9	27.7%	1.2%	-20.8%
Saskatchewan	9240	123.4	8944	112.8	5.9%	-3.2%	-8.6%
Manitoba	9733	124.5	9833	116.1	8.4%	1.0%	-6.8%
Ontario	58403	88.2	75958	91.5	25.3%	30.1%	3.8%
Quebec	43491	104.8	46091	88.3	25.8%	6.0%	-15.7%
New Brunswick	4227	89.6	4175	78.5	12.7%	-1.2%	-12.4%
Newfoundland	2818	101.3	2643	84.2	12.8%	-6.2%	-16.8%
Nova Scotia	5806	96.3	5986	89.4	11.0%	3.1%	-7.1%
PEI	950	106.5	978	100.1	9.5%	-2.9%	-9.3%
Canada	174574	99.2	193858	90.0	22.4%	11.0%	-9.3%
Source: Cohen et al., 2009b.							

Table 1 shows us that between 2001 and 2008 the availability of beds decreased in every province except Ontario, while the number of seniors rose across the board. Clearly, the availability of beds in LTC facilities is not keeping pace with the demographics. But more importantly, as Canadians, why should access to needed care vary depending on where you live?

Beyond that regional question, there is the question of individual means. There are significant differences between publicly-funded

Spending
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level lower
than 1951

services in LTC facilities and those for which individuals are forced to pay out-of-pocket. Those costs are a barrier to citizens of low or even modest incomes.

Budget Cuts

Throughout the 1990s, governments across Canada slashed funding on a wide range of social programs. In the 1995 budget, the federal finance minister reduced cash transfers to the provinces by 40% over the following two years. The minister announced that by 1996-97, program spending would be lower (relative to the size of the economy) than at any time since 1951 - an era in which public, universal health care did not even exist¹²

Some provinces, notably Ontario, Alberta and later British Columbia, seized on the public's concern about deficits as an excuse not only to cut back on health and social spending but also to privatize services, including LTC facilities.

Provinces shifted delivery away from acute and chronic care hospitals and into community settings. Patients were allowed less time to recover in hospital on the expectation they would receive home care services. Disappointingly though, some of those programs were also cut back while other promised programs were never created.

Assisted Living Model

During this period, a few provinces, such as Alberta and BC, started talking soothingly about emulating the American assisted living model. These provinces began partnering with developers and realtors to promote assisted living as a residential option that falls between independent living and care in a long-term care facility. The original model represented a new and progressive approach to meet the needs of special populations with limited abilities. It advocated for a home-like setting that would give residents control over their private space, offering a combination of safe and secure housing, nursing care and help with personal care as well as hotel-type services such as regular meals and housekeeping. Both the housing and health care supports would be heavily subsidized by public funding in order to ensure it would be an affordable and accessible option for as many as possible.

However, since its inception, assisted living has branched out in many less-than-authentic directions in the US and Canada. The term is now applied to housing situations and care models that do not embody the original philosophy. Regrettably, some provinces, like

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Alberta, while talking about investments in assisted living centres, surreptitiously withdrew funding and cut direct care staffing levels from long-term residential care. Today, assisted living is more likely to refer to multi-unit apartments with varying amounts of on-site personal supports and care available 24-hours-a-day, all of which must be purchased by the resident at a hefty price.

The original vision of the assisted living model has been largely co-opted by private for-profit developers, looking for a high return on investments, as they take advantage of the lack of accessible, publicly-funded accommodations and services. According to the Alberta Chapter of the Consumers' Association of Canada, the reality of assisted living in Alberta is a crisis in access, costs, funding and accountability. In 2006, in Alberta, there were approximately 14,500 people living in long-term care facilities within the continuing care system. Like everywhere else in Canada, this number will grow dramatically as Alberta's population ages. Currently, 51% of the long-term care residents are over the age of 85 and 31% are over the age of 90.

The original vision of the Assisted Living model has been largely co-opted by private for-profit developers

LTC Ignored

The 1995 federal budget also changed the manner in which Ottawa transferred health care money to provinces and territories. The *Canada Health and Social Transfer* (CHST) replaced the separate, targeted transfers that had existed for health, post-secondary education and social programs.¹³

After making deep cuts to health transfers in the 1990s, Ottawa was convinced to use some of its burgeoning surpluses to restore funding. In the 2002 report, the Romanow Commission called on the federal government to increase its funding to the equivalent of 25% of total provincial-territorial spending, a minimum amount long demanded by health care advocates. We must remember that when the system was first created, it was based on the federal government paying 50% of the costs. Federal-provincial agreements have resulted in federal funding increases that have met the 25% target. But as the pie chart of total health expenditures shows, the discussion of public health care by various government commissions has been dominated by the needs of the acute care system. Reform of the LTC sector has largely been neglected. Regrettably, the Romanow Report, and the Kirby Report before it, said little and recommended less regarding LTC.

The 2004 funding accord also returned to the practice of a dedicated transfer payment for health care but made no announcements regarding LTC. Ottawa's health care dollars have been flowing to the provinces without any targeting to LTC or any commitment that

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provinces will use new money to improve the accessibility and quality of LTC.¹⁴ In addition, there was nothing in the agreement to prevent for-profit companies from making further incursions into LTC and the health care sector in general.¹⁵

Publicly-delivered care has proven to be more affordable than private care but even this option has become too costly for many seniors. The issues of affordability and accessibility are closely related. There are not enough LTC spaces available and the spaces that do exist come at a price that limits access for many people.

The lack of affordable LTC erodes the values of equality and fairness that are entrenched in both the *Canada Health Act* and the *Charter of Rights and Freedoms*. Canadians have a right to health care as an extension of two sections of the Charter. Section 7 guarantees “the right to life, liberty and security of the person”. Section 15 guarantees that “every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability”.

Despite attempts made to prevent and forestall illness, and efforts to maintain elderly people in their own homes for as long as possible, a percentage of seniors will always need more support than their families or home care services can provide.

When the elderly need LTC facilities, it is crucial that the services are available to them and that all Canadians share the expenses through our public health care system.

Personal Costs of LTC

There is a broad consensus that residents should, finances permitting, contribute a portion of the cost of their LTC by paying a monthly fee. In addition, provincial governments and territories provide licensed LTC facilities with a per diem subsidy for each resident. There are several policy models used by provinces and territories concerning monthly charges to residents.¹⁶

Per Diem-based Model (Alberta, Yukon Territory, Nunavut Territory)

A per diem rate is set based on public pension incomes available to individuals. Residents are not subject to a means test.

Income-based Model (BC, Saskatchewan, Manitoba, PEI, Newfoundland & Labrador, Ontario, Nova Scotia, New Brunswick)

Individuals pay a per diem rate which is adjusted to actual income. There is a means test but it does not apply to family assets.

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Accessibility & Affordability

Income/Asset-based Model (Quebec)

In this case, charges to individuals are based not only on income but also on assets. Before being admitted, an individual must liquidate a percentage of the family's assets including savings and investments. In some cases this includes some or all of the value of the family home. This policy can impoverish families with modest incomes often leaving a spouse who may not be in a LTC facility with very few resources.¹⁷

Charges to individuals are based not only on income but also on assets

Affordability Varies Across Canada

The charges to residents for standard accommodation in publicly-supported LTC facilities as of October 2009 ranged from around \$918 per month in Manitoba to \$2,800 per month in Newfoundland/Labrador.¹⁸ These are charges applied to the minimum level of accommodation and services as defined by each province. Simple dollar comparison can be deceiving because of extra charges and variability in service across provinces.

Table 2 (page 17) shows that LTC is expensive and the financial burden a senior and/or their families will bare depends on the province in which they reside.

For-Profit Costs More

The rates in publicly-supported LTC facilities are always lower than those charged in private for-profit facilities when comparing within provinces. In British Columbia, for example, the cost of care in a private for-profit facility averages \$4,718 per month. In Ontario, the average rate for a space in 2009 was \$3,437 per month.¹⁹

Table 3 (page 18) shows that some beds are available but there are not enough people who can afford those private sector spaces. Private homes are simply out of financial reach for too many families.

Once living in a long-term care facility, seniors are faced with a long and costly list of supplies and services they are expected to pay for out-of-pocket. The list can include things like personal care and incontinence products, non-prescription drugs, and special equipment like walkers or wheelchairs. However, seniors usually do not have much, if any, disposable income for these supplies and services. They typically receive a paltry personal care allowance which varies by province, from a low amount of just \$103 per month in PEI, to just over \$265 per month in Alberta.

TABLE 2
Range of costs for Government funded long-term
care facilities, by province

	Accommodation charges for LTC residents (per day)	Charges per month	Annual charges
British Columbia	\$44.50 – 54.50	\$927 – 2,229	\$16,242 – 19,892
	Range based on income		
Alberta	\$30.90 – 74.30	\$1,335 – 1,627	\$11,278 – 27,119
	Range based on per diem and standard, semi-private or private accommodation		
Saskatchewan	\$32.70 – 62.20	\$982 – 1,866	\$11,935 – 22,703
	Range based on income		
Manitoba	\$30.60 – 71.80	\$918 – 2,154	\$11,169 – 25,848
	Ranged based on income		
Ontario	\$52.70 – 69.73	\$1,614 – 2,161	\$19,368 – 25,932
	Range based on income and standard, semi-private or private accommodation		
Quebec	\$33.77 – 54.36	\$1,013 – 1,631	\$12,156 – 19,572
	Range based on standard, semi-private or private accommodation		
New Brunswick	\$83.00 max.	\$2,525	\$30,295
	Range based on standard, semi-private or private accommodation		
Nova Scotia	\$86.50 max.	\$2,631	\$31,527
	Range based on income		
Prince Edward Island	\$69.30	\$2,108	\$25,294
	Range based on income		
Newfoundland and Labrador	\$93.00 max.	\$2,800	\$33,600
	Range based on income		

NOTES: Many facilities have additional charges for personal care products, incontinence products, non-prescription drugs, special equipment like walkers and wheelchairs and other products and services.
Some facilities will be not-for-profit and others will be for-profit government subsidized facilities.
Source: Manulife Financial working with TAKINGCARE INC. Report for each province. October 2009.

TABLE 3			
Vacancy Rates and Average Rents for Private For-Profit Long-term Care Spaces			
Province	Vacancy Rate	Average Rent/month	Number of spaces
British Columbia	11.8%	\$4,718	1264
Alberta	8.6%	\$3,403	371
Saskatchewan	4.2%	\$2,686	Data not available
Manitoba	Data not available	Data not available	Data not available
Ontario	9.8%	\$3,437	1392
Quebec	11.7%	\$2,563	2599
New Brunswick	Data not available	Data not available	Data not available
Nova Scotia	Data not available	Data not available	Data not available
Prince Edward Island	6.3%	\$2,867	113
Newfoundland and Labrador	Data not available	Data not available	Data not available
Source: Seniors Housing Report: Canada Highlights 2009, CMHC			

TABLE 4	
Minimum Disposable Income per Month for LTC Resident	
Province	\$ allowance/month
British Columbia	\$236
Alberta	\$265
Saskatchewan	\$200
Manitoba	\$254
Ontario	\$122
Quebec	\$179
New Brunswick	\$200
Nova Scotia	\$115
Prince Edward Island	\$103
Newfoundland and Labrador	\$125
Source: CBC News web interactives. <i>Canada's nursing homes: national statistics. 2007.</i> ²¹	

Nineteen percent of seniors lived in near poverty—but few could qualify for income-tested aid programs

Accessibility & Low Income

Almost all Canadians over the age of 65 receive an Old Age Security (OAS) benefit. The maximum OAS per month is \$537.97 as of October 2011. In addition, seniors with low incomes are eligible for a Guaranteed Income Supplement (GIS). It is means-tested and the maximum payable is \$729.44 per month for a single senior.²²

The combined income from OAS and GIS is \$1,267.41 per month or about \$15,200 per year. Some provinces and territories use this amount as a basis for their per diem or monthly charges to LTC residents. As of October 2009, the lowest charges to residents for standard accommodation in government funded LTC facilities start at \$918 per month in the province of Manitoba (see Table 2). For seniors who rely on public pensions of \$1,180 per month, these are costly and often inaccessible options.

In 2005, about 35.5% of unattached seniors were below the before-tax Low Income Cut Off (LICO), an indicator of economic vulnerability. In fact, 14.4% of all seniors fell into this category. In numerical terms, 572,315 seniors were living below the after-tax LICO and 404,340 of them were women.²³

	Both sexes	% of Men	% of Women
All seniors	14.4%	9.4%	18.3%
	35.5%	28.1%	38.3%

Source: Statistics Canada 2006 Census.

Consider that between 2001-2004, 19% of seniors had pre-tax incomes just slightly above the LICO. They lived in near poverty but most could not gain access to the benefits of various income-tested programs and had to get by on extremely tight budgets.²⁴

Out of Pocket Expenses

As mentioned, the charges to individuals vary greatly depending upon where they live. Some provinces and territories pay for the cost of prescription drugs. Other provinces have an income tested drug plan which can dramatically increase the residents' out-of-pocket costs. Some jurisdictions also charge for a variety of medical sup-

plies, wheelchairs, prosthetic devices, incontinence supplies, not to mention laundry, housekeeping, personal care and transportation.

In some cases, the out-of-pocket contribution goes far beyond that. In 2003, the *Toronto Star* reported an increasing number of families were hiring private attendants to supplement the care their family member was receiving in a LTC facility. *The Star* reported examples of families spending \$25,000 to \$30,000 a year for a bed and another \$40,000 a year for a private care attendant to perform tasks the facility would not or did not perform adequately including walking, feeding, bathing and helping frail seniors go to the toilet.²⁵

What financial burden should we expect the elderly to bear? They do not choose to enter a LTC facility on a whim. All applicants are assessed and LTC is allocated based on a need for that level of care. Yet the out-of-pocket charges in place across Canada add up and can be prohibitive for seniors, especially low income seniors.

The irony and the injustice is that services under the *Canada Health Act* are **not** subject to means or asset tests. If an elderly person receives medically necessary services in a hospital, those are provided from the public purse. Yet the same person receiving essentially the same services in a LTC facility is often expected to pay for it out-of-pocket. This discriminates against the elderly based on the building in which they are receiving health care services.

What financial burden should we expect the elderly to bear

Funding Formula Inadequate

Costs of care are rising, as are the costs for basic elements within accommodation, food and supplies. As seniors' care needs become more complex, health care costs rise. Licensed LTC facilities, both not-for-profit and for-profit, receive a per diem subsidy from provincial governments or territories for each resident. In July 2008, the Ontario government provided a per diem of \$136.21 comprised of the following components:

TABLE 6	
PER DIEM RATES FOR ONTARIO RESIDENTS, JULY 1, 2008	
Nursing and Personal Care	\$75.07
Programming and Support Services	\$7.25
Accommodation	\$46.74
Raw food funding	\$7.15
Total	\$136.21
Source: North East LHIN and MOHLTC. 2008 LTC Bed Allocation for the City of Timmins – Application Guidelines. July 2008. pg.17	

Governments, through under-funding, have shifted costs to residents and their families

This Ontario per diem would appear to be far too low to actually operate a bed when compared to other provinces. In the seven years between 2001 and 2008, the raw food per diem increased over 60% and would still seem to be too low to provide three healthy meals a day.

A 2007-2008 annual audit of costs associated with operating a Saskatchewan LTC bed was estimated to be approximately \$179.57 per day. Similarly, a LTC bed in Newfoundland was calculated at roughly \$167 per day in 2001.²⁶

LTC facilities often attempt to make up the difference between the provincial subsidy and their expenses by increasing accommodation

Province	Not-for-profit	For-profit	Total beds	% not-for-profit beds	% for-profit beds
British Columbia	17,028	7,588	24,616	69%	31%
Alberta	10,230	4,424	14,654	70%	30%
Saskatchewan	8,273	671	8,944	92%	8%
Manitoba	7,280	2,553	9,833	74%	26%
Ontario	35,748	40,210	75,958	47%	53%
Quebec	35,638	10,453	46,091	77%	23%
New Brunswick	4,175	216	4,391	95%	5%
Nova Scotia	4,190	1,796	5,986	70%	30%
Prince Edward Island	578	400	978	59%	41%
Newfoundland and Labrador	2,747	0	2,747	100%	0%
Canada	125,887	68,311	194,178	65%	35%

Source: Residential Long-Term Care in Canada: Our Vision for Better Seniors' Care, CUPE publication, 2009. See Table 8 and Appendix B.

rates. Governments, through under-funding, have shifted costs to residents and their families.

Furthermore, provincial-territorial funding formulas do not adequately take into account unique and changing care needs. The number of residents with dementia and Alzheimer's, for example, is not sufficiently considered when determining funding levels. Residents with dementia-related illnesses make up a growing part of the LTC population and require higher staffing levels, more intensive care and specially trained staff.

The current
system
embraces
yesterday's
thinking

For-profit versus not-for-profit

This is especially a problem in provinces where for-profit facilities dominate the sector. For example, in Ontario 53% of publicly funded LTC facilities are for-profit, as compared with 8% in Saskatchewan.²⁷ If for-profit and not-for-profit facilities receive the same provincial government subsidy, corporate profits must be squeezed out of the monies intended for accommodation, food and care. This is due to the very nature of for-profit care: draining money out of resident care to satisfy the profits of owners and shareholders (see Table 7).

Some for-profit facilities have also been permitted to set aside a number of private spaces for wealthier residents who can afford to pay higher fees for private accommodation. This practice reinforces a system in which accessibility is based on ability to pay rather than need. When spaces are reserved for wealthier clients, the waiting lists grow for those seniors who can't afford private accommodation rates. In fact, while many seniors wait in line for a bed, most for-profit facilities have vacancies but they are waiting for the wealthiest to move in (see Table 3).

Long Wait Times

Government cutbacks and the reduction of LTC spaces, especially in the mid-to-late 1990s, occurred at a time when waiting lists were already a problem and a large number of baby boomers were moving toward retirement. The current system embraces yesterday's thinking. As the country's demographics shift, seniors make up more than 30% of Canada's population and wait lists are growing faster.

In 2010, it was reported that 4,977 Ontarians were waiting in hospital beds for a long-term care bed.²⁸ The Ontario government announced long awaited funding to rebuild or re-develop facilities for 4,183 beds across the province to be completed by 2012. These are not new beds but improved beds to ease the backlog in hospitals. Since seniors waiting for long-term care beds don't pick

A 92-year-old Ottawa woman died after being transferred to a privately-run retirement home unequipped to deal with her needs

older homes, the hope is that these retrofits will fill these once overlooked LTC facilities.²⁹

During that same year, a 92-year-old Ottawa woman died after being transferred to a privately-run retirement home unequipped to deal with her needs.

In response to the crisis, an Ontario retirement home, not a LTC facility, opened 74 interim long-term care beds in an effort to relieve the pressure to move seniors who no longer needed acute care out of hospitals. It is questionable whether a retirement home can meet the needs of LTC patients but the strategy was merely a short term fix. The region has the longest waiting list for LTC.

Ontario needs more services that allow people to spend their final days in more humane and less costly settings such as hospices and nursing homes. “Compared to a space in hospital, which costs more than \$1000 per day, a retirement home bed, even subsidized, is far more affordable at between \$150 and \$250 per day,” said Dr. Robert Cushman, chief executive of the Champlain Local Health Integrated Network (LHIN).³⁰ Despite the recent injection of cash, no new nursing homes will be built.

Public Interest Alberta notes the provincial government is aiming to reduce the ratio of LTC beds while 800 seniors are still in hospitals on waiting lists. In addition, about only half of the existing LTC homes are compliant with standards. Some homes still do not meet standards, even months after being told they must comply.³¹

In Nova Scotia, the provincial government is putting out requests for proposals in areas of the province where more LTC facilities are needed. This tactic has led to the opening of private long-term care facilities to fill the gap.

In New Brunswick, there are still seniors waiting in hospitals for nursing home beds. Since 2007, 90 new enhanced special-care home beds have been approved and 64 existing special-care home beds have been converted to admit clients with Alzheimer’s and dementia. The enhanced special-care home beds help reduce waiting lists in nursing homes and, as demand increases, more of these enhanced beds will become available as part of newly constructed facilities but the progress is slow.

It is difficult to gather precise and current information on waiting lists in provinces and territories. However, given that on average, across Canada there are only 90 beds per 1,000 seniors (as listed in Table 1), it is clear there are still waitlists for space in long-term care facilities. Those numbers will inevitably grow as the absolute number of seniors increases in the coming years.

Difficult Decisions

When LTC spaces do become available, families are forced to make an immediate decision out of fear the bed will go to someone else in a few hours. In some jurisdictions, if a family refuses a space in a specific facility, they are moved to the bottom of the wait list and it may take months, possibly years, before another space becomes available.

Some families are forced to borrow money to pay for the care their loved ones need. Those who can't afford to borrow are forced to provide the care themselves. While their love and commitment are to be praised, the consequences can be devastating. It can result in stress and lost work time, income and future pension benefits on the part of the provider. In some cases, family members, most often women, are forced to leave their jobs to care for loved ones.

Those seniors who can't afford access to a LTC facility and who don't have informal family support will, most often, experience deteriorating health. They will require more expensive interventions down the road, leading to higher overall costs for the health care system.

The federal
government
must expand
Medicare to
include long-
term care

A Better Way

Canadians view our universal, public health care system with pride. We should apply it beyond hospitals and doctors' offices to include the services provided to vulnerable seniors in LTC facilities as well. There is a clear and urgent need for increased public funding for LTC in every province in order to improve accessibility and affordability. Governments must also take steps, through existing funding and licensing levers, to privilege public, not-for-profit facilities and phase out corporately owned LTC facilities.

The federal government must expand the coverage under the *Canada Health Act* to include LTC. It is a medically necessary service for thousands of seniors and including it under the Act is an essential step in the evolution of Canada's public Medicare system.

Ottawa must introduce a targeted transfer to provincial and territorial governments for LTC to be linked to the principles of the *Canada Health Act*.

Provincial and territorial governments must increase public funding for LTC to a level that ensures universal access.

Wait times are unacceptably long. Provinces and territories must provide the funds to create more public, not-for-profit facilities and spaces.

These steps will ensure that accessible and affordable LTC is equally available to everyone who needs it. Our parents, our grandparents, our aging friends and neighbours deserve no less.



Quality of Life, Quality of Care

IN APRIL 2005, 86-year-old Marie Geddes launched a hunger strike to protest the staffing shortages in her LTC facility in Camrose, Alberta. She said that seniors there had to wait too long for help with everything from going to the bathroom to getting bathed to going to bed.

Ms. Geddes, who was a diabetic, refused food for four days. She became ill after breaking her fast and was placed in hospital, where she died.³²

Canaries in the Mine

Marie Geddes was like a canary in a coal mine. Her death was a warning that life in long-term care is not healthy. It's time we all paid attention.

Lynda Johnson is someone who has. She visited 100 of Alberta's LTC facilities. Her conclusion was that staff didn't have enough time to give patients the care they need.³³ She presented a petition with 5,000 names to the provincial legislature calling for higher staffing standards. Marie Geddes died just a few days later.

In 2008, a 92-year-old Ottawa woman was transferred from the Queensway Carleton Hospital to a privately run retirement home. She died, in part, because of inadequate care at the retirement home which was not licensed to provide the same level of care as a LTC facility.³⁴

Numerous other news investigations have chronicled a LTC system in which many elderly residents live in desperate straits while their families remain silent for fear of retribution.³⁵

The findings revealed: seniors who were ill or had broken bones and inadequate food and fluid intake for residents at risk of nutritional deficiencies. Substandard dietary practices included: the use of synthetic crystals instead of real fruit juices, powdered potatoes and processed vegetables instead of fresh ones, smaller portions and, in some cases, micro-waved leftover airplane food.³⁶

A team Government & Academic Reports

dedicated The various media investigations have been validated by a number of important reports, including:

solely to

nursing home

PricewaterhouseCoopers

inspections

PricewaterhouseCoopers completed a report in 2001 paid for by the Ontario government. The project compared LTC in 11 jurisdictions across North America and Europe. The report included assessments of care in Ontario, Saskatchewan, Manitoba, Michigan, Maine, South Dakota, Mississippi, the Netherlands and Scandinavian countries. The study concluded that Ontario offered the lowest levels of professional nursing care and therapy levels among the jurisdictions reviewed.

had actually

been

disbanded

The study found, for example, that Ontario's LTC facilities provided 2.04 nursing hours per resident per day, the lowest among the jurisdictions studied. Saskatchewan, by contrast, provided 3.06 hours per day and the state of Maine, 4.40 hours per day.³⁷

In addition, Ontario's poor record of care extended to a lack of programs for exercise, physical rehabilitation services and counseling for depression and other mental health problems.

This neglect takes its toll on the quality of life and health of LTC residents. There is a convincing body of research indicating that higher staffing levels and the provision of appropriate therapies allow older citizens to be more active, more independent and to remain healthier.

Provincial Auditor of Ontario

Ontario's Provincial Auditor reported on LTC facilities in 2002. The report found there was no evidence that the government had addressed the results of the 2001 PricewaterhouseCoopers study. In fact, the Auditor General found that a team dedicated solely to nursing home inspections had actually been disbanded and that annual inspections of homes had dropped dramatically. The report also found there was no way to identify that provincial monies promised for seniors' care were actually being allocated as intended.

The Auditor's report concluded that 68 nursing homes, with more than 7,000 beds, needed to be entirely retrofitted because they were decrepit. Facilities with a further 9,000 beds were found to need substantial renovations.³⁸

Dignity Denied

Quality of Life / Quality of Care

As of 2010, the Ontario government has retrofitted a number of homes across the province but without an increase in beds.

Clinical Nutrition Studies

A 2003 study, in Saskatoon, showed that over half of LTC residents assessed were at least moderately malnourished.³⁹ This result is similar to other international studies that show dehydration and malnutrition are becoming endemic in the LTC sector, especially in for-profit facilities.⁴⁰

CBC Exposé - L'épicerie

In April 2010, this French language CBC documentary revealed long-term care residents in Quebec suffering from malnutrition, primarily due to under-funding, staffing shortages, turnover and mismanagement.⁴¹

Not-for-profit
facilities

provide

better LTC

than those

facilities run

to make a

profit

Ownership Matters

Dr. Michael Rachlis, a respected Canadian health care researcher, is one of a growing number of academics to find that not-for-profit facilities provide better LTC than for-profit businesses. Rachlis observed in 2001 that there was “much recent rhetoric” claiming that introducing more private markets in health care finance and delivery would lead to more efficient health care. “The reality,” Rachlis concluded, “is exactly the opposite.”⁴²

Rachlis performed an extensive examination of the performance of for-profit and not-for-profit continuing care organizations. Within his study, Rachlis reviewed the literature for 39 LTC facilities. The following are some of his conclusions:

Rachlis' finding for not-for-profit LTC providers:

- Not-for-profit LTC institutions provided higher or equal quality of care and lower hospitalization rates;
- Studies of infrastructure and environmental characteristics all found in favour of not-for-profits;
- Not-for-profits had more staff and provided higher salaries and benefits;
- Not-for-profits had lower staff turnover rates;
- Not-for-profits were less likely to be cited for deficiencies than for-profits;
- Not-for-profits were much less likely to use physical restraints on residents;

Moldy food, excessive use of restraints and errors in administering medications were documented while profits skyrocketed

- Ontario not-for-profits had higher expenditures per resident per day than for-profit homes, spending more on nursing care but less on overall administration; and
- Not-for-profits attracted more volunteers, played the major role in planning community networks of services and provided more support for research and education.

Rachlis' findings for for-profit LTC providers

TABLE 8	
Impact of for-profit services on continuing care	
Long-term Care Institutions	Home Care Services
Health care costs <ul style="list-style-type: none"> • Government costs reduced initially then may well increase • Overall costs increased 	Health care costs <ul style="list-style-type: none"> • Government costs likely to be increased • Overall costs increased
Quality of care <ul style="list-style-type: none"> • Patient outcomes worse • Staff turnover increased 	Quality of care <ul style="list-style-type: none"> • Patient outcomes worse • Patient/family satisfaction worse • Staff turnover increased
Intangibles <ul style="list-style-type: none"> • Continuing education decreased • Volunteers decreased • Civil society decreased 	Intangibles <ul style="list-style-type: none"> • Continuing education decreased • Volunteers decreased • Civil society decreased

New York Times Investigation

In 2007, an investigation by the *New York Times* documented extensive and disturbing violations of care standards at investor-owned private nursing homes in the United States. Among the short-comings was the level of nursing staff which fell below regulated standards. Quality of care scoring showed there was an increase in bed sores, injuries, and preventable infections. The serving of moldy food, excessive use of restraints on patients and errors in administering medications were documented while profits skyrocketed.⁴³

BC Study on Care Outcomes

In addition, in 2006, Dr. M. J. McGregor and his team looked at the care outcomes for LTC facilities in BC comparing not-for-profit ownership with for-profit owned

facilities. Specifically, they examined whether ownership of facilities resulted in a difference in hospitalization rates for six diagnoses (falls, pneumonia, anemia, dehydration, urinary tract infection and decubitus ulcers and/or gangrene) which are considered to be reflective of facility quality of care.

The study found that for-profit facilities had higher rates of hospitalization for pneumonia, anemia, and dehydration but no difference for falls, urinary tract infections, or decubitus ulcers and/or gangrene. Further distinctions were made among the two ownership types and, in the final analysis, the superior performance by the not-for-profit sector was driven by those facilities connected to a hospital or health authority.⁴⁴

Residents
living in
for-profit
facilities had
significantly
higher risk
requiring
hospital care

Manitoba Long-term Study

In 1995, the *Canadian Journal on Aging* released a study comparing the care performance of both for-profit LTC facilities and not-for-profit LTC facilities in Manitoba. The four year study found that, of the more than 15,000 residents affected, those living in for-profit facilities had significantly higher risk of hospitalization for dehydration, pneumonia, falls and fractures.⁴⁵

British Medical Journal 2009 Study

The Journal presented an overview of all studies of not-for-profit and for-profit care facilities. Of the 82 studies, 40 demonstrated that not-for-profit facilities ranked significantly higher in quality of care than the for-profit facilities. Only three studies showed for-profits achieving similar quality rankings.⁴⁶

US Studies of Long-term Care Facilities and Ownership

A US study looking at 815 homes across the country found the rate of hospitalization for residents with pneumonia was two times higher for those in for-profit facilities.⁴⁷ Another study looking at 527 homes in Massachusetts showed that not-for-profit homes had a 9% lower hospitalization rate compared to for-profit homes.⁴⁸ A much larger study of 14,423 long-term care facilities concluded, using similar indicators, that for-profit nursing homes have a significantly lower care quality than not-for-profit homes.⁴⁹

A study, comparing risk of death for residents in not-for-profit versus for-profit long-term care facilities, found



that not-for-profit homes provided residents with a 6.2% lower risk. The study also found that these same residents had a 6.3% lower risk of infection.⁵⁰

Other US studies have shown, using a variety of indicators, that not-for-profits provide a higher quality of care than for-profit facilities.^{51,52} In addition, there is clear evidence in terms of inspection reports and complaints data that for-profit LTC facilities have more violations of care standards and deficiencies.⁵³

Canadian Medical Association Journal

In 2005, a group of five researchers from the University of Toronto conducted an extensive literature review of nursing homes in North America. They concluded that:

- Empirical research in the past 12 years has found that systematic differences exist between for-profit and not-for-profit nursing homes; and
- For-profit nursing homes appear to provide lower quality of care in many important areas of process and outcome.⁵⁴

Michael Hillmer, the lead author on the study, stated the reason not-for-profit homes perform better may be because they put any profits back into care.⁵⁵

In a second study, published in the *Canadian Medical Association Journal* in March 2005, researchers obtained staffing data for 167 LTC facilities in British Columbia and linked that information to the type of facility and its ownership. The study found that:

- The number of hours provided per resident per day was higher in not-for-profit than in the for-profit facilities for both direct-care and support staff; and
- Not-for-profit ownership was associated with an estimated 0.34 more hours per resident per day provided by direct-care staff and 0.23 more hours per resident per day provided by support staff.

The study concluded that “public money used to provide care to frail elderly people purchases significantly fewer direct care and support staff hours per resident per day in for-profit LTC facilities than in not-for-profit facilities”.⁵⁶

American Journal of Public Health

A study published in the *American Journal of Public Health* in 2001 analyzed data from state inspections of almost 14,000 nursing facilities, both investor-owned and not-

There is clear evidence that for-profit LTC facilities have more violations of care standards and deficiencies

Profit-seeking
diverts funds
and focus
from clinical
care

for-profit. The researchers, drawn from the University of California, Harvard and other educational institutions, concluded that:

- Investor-owned nursing homes provide worse care and less nursing care than not-for-profit or public homes;
- Chain ownership of homes is associated with a further deterioration in quality;
- Skimping on staffing by for-profit homes may explain their lower quality; and
- Profit-seeking diverts funds and focus from clinical care.⁵⁷

The Aspen Institute

The Aspen Institute in Washington, D.C. published a study in 2005 titled *Why Nonprofits Matter in American Medicine*. The authors examined over 250 empirical studies, covering a dozen types of health services, including hospitals and nursing homes, and compared the performance of for-profit and not-for-profit organizations. They reported that:

- Not-for-profit nursing homes have lower costs and greater efficiency;
- Not-for-profits have marked patterns of higher quality care than their for-profit counterparts;
- Not-for-profits are less likely to make misleading claims, have complaints lodged against them by patients and less likely to treat less-empowered patients in a manner different from other clientele; and
- The presence of not-for-profit competitors in a community is associated with increased quality of care in for-profit nursing homes.⁵⁸

There is always room for more research but it can safely be determined that not-for-profit LTC facilities provide better care to the frail elderly and do so more efficiently than for-profit homes.

The privatization of LTC leads to the neglect of our most frail elderly citizens. The profit-seeking behaviour of private facilities diverts funds and focus from providing care and leads to cutting corners in staffing. For-profit facilities pursue profit by cutting staff or reducing spending on services and care. Every dollar in shareholders' dividends represents money that is not being spent on care

Dignity Denied

Quality of Life / Quality of Care

for elderly residents. It is our most vulnerable citizens who pay the price.

The public and not-for-profit sectors have demonstrated a marked resilience in the face of the distress caused by government cutbacks and the move to privatization. Governments must, in the public interest, invest more in public and not-for-profit facilities while using public policy levers to phase out for-profit facilities over time.

It can be easier to purchase a quality car or kitchen appliance than a room for a loved one in a LTC facility

Inspections, Monitoring and Quality Care

It is easier in some Canadian provinces and territories to reliably purchase a quality car or kitchen appliance than a room for a loved one in a LTC facility. Families often have no way of knowing whether a facility has a history of substandard care. Policies for regulation, oversight and inspection are inconsistent and weak. Often there are no clear standards and guidelines on what constitutes adequate quality of care.

Residents, families, workers, unions and community advocacy groups are forced to play a watchdog role. Residents, in particular, are often afraid to raise concerns about questionable practices or to report serious incidents and violations for fear of repercussions. This is clearly unacceptable.

In April 2005, *CBC News* used the *Right to Information Act* to obtain copies of inspection reports between January and November 2004 for all 61 nursing homes in New Brunswick.

The news investigation found that, on average, nursing homes in the province had four health and security violations in the previous year even with inspectors giving them advance notice they were coming. Findings from the inspection report included:

- 19 homes broke the rules on storing or serving food at proper temperatures;
- 13 homes didn't follow the procedures on fire drills; and
- 17 homes did not properly document how they were storing medication, hazardous materials and electrical appliances.⁵⁹

The Minister of Health promised to put an end to advance notice of inspections and to change the licensing system so that homes with violations receive only a temporary license.⁶⁰ Since then, the New Brunswick government has developed a detailed strategy for senior care with provisions for improved quality monitoring and inspection.⁶¹ In 2010, the government released improved building standards for new nursing homes.⁶² Unfortunately the growing trend in New Brunswick has been to privatize long-term care facilities.

There has
been no
significant
legislation
to enforce
minimum
staffing
levels

In Ontario, the media exposed a for-profit chain, called Royal Crest, which had a record of bankruptcies, financial negligence and fraud against vulnerable residents in Canada and the US. The Royal Crest facilities were shut down after their owners declared bankruptcy and vanished. The company owed the provincial workers' insurance program \$3.2 million and money was also reported missing from residents' bank accounts.⁶³ Ontario, as well as Alberta, have since committed to increasing the number of surprise inspections of facilities but these commitments came only after increased public pressure and media scrutiny.

In Manitoba, the government created a *Bill of Rights* for LTC residents containing a long list of standards for care, personal attention and privacy rights but again only after intense public pressure.⁶⁴

These examples all demonstrate the importance of placing continued pressure on politicians and policy makers. It required the courageous actions of individuals, media scrutiny or grassroots mobilization by community-based organizations in each of these cases to prod governments into action. But residents, their families, workers and the community have only a limited amount of time and energy to devote to such vigilance.

A Better Way

Numerous reports reveal the quality of care in many LTC facilities across the country must be improved.

Governments have a responsibility to legislatively enforce optimal staff ratios and LTC standards to ensure the frail elderly receive good care and that they do not become the victims of neglect. The Center for Medicaid and Medicare Services (CMS) in the US found that the minimum staffing level of 4.1 worked hours per resident day (hprd) is required for quality care standards to be met.⁶⁵ This minimum standard includes a combination of nursing assistant and registered nurse hours of care. It does not include additional staff, such as dietitians, occupational therapists, music therapists, recreational therapists, physiotherapists and support staff that work with patients. Numerous other studies since the CMS report have confirmed the minimum 4.1 hprd.

Despite this, there has been no significant legislation to enforce minimum staffing levels to ensure quality care. Provinces with "targeted levels" are not able to enforce the implementation of these targets and Saskatchewan, the only province with a legislated level, is at 2 hprd, less than half the recommended hours. Other provincial staffing rates (on average) are far below where they should be at 2.6-2.7 hprd in BC and 2.6 hprd in Ontario.

The research is also compelling when it comes to the interplay between working conditions and caring conditions. The number of staff is by far the most significant factor in the quality of care. For example, high turnover rates, high workload levels and poor working conditions, low pay and benefits and high injury rates are also the key factors in the quality of care.

The next section of this report further explores the relationship between healthy and positive environments for workers and the quality of care for residents.

Numerous studies reveal that not-for-profit ownership and delivery are essential for improving the quality of care. There is convincing evidence that for-profit ownership means:

- Lower quality of care;
- Lower staffing levels;
- Poorer working conditions; and
- Higher costs.

All governments must take the necessary steps to increase not-for-profit ownership and operation of LTC facilities and phase out public funding to for-profit providers.

There must be thorough background checks on owners and operators before awarding them a license. Residents must rest assured they will not lose their personal savings if a facility goes bankrupt. Governments must monitor facilities and enforce tough measures against those that do not comply with optimal standards. Governments must provide the tools necessary to prevent financial abuse and mismanagement and ensure fiscal integrity at facilities.

All of these measures are important but they are not enough. Ultimately the answer to Canada's crisis in LTC must be the recognition that it is an essential part of our health care system. LTC must become an ensured service under the umbrella of the *Canada Health Act*. It is time for Canada to provide its most vulnerable citizens with the quality of life and care they need and deserve.

The number
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Workers Who Care for the Elderly

THOUSANDS OF women and men work in Canada's long-term care system and are trying to provide high quality care in an environment of respect and dignity. Today, these people are working harder than ever before under incredibly stressful conditions. There can be no doubt about it: staff is the backbone of quality long-term care. Every occupational category, not just doctors and nurses, is critical to care, including therapists, pharmacists, social workers, dietitians, health care aides, personal support workers, cleaners, food service workers and administrative staff. Building a first-class long-term care system depends on an adequate supply of all types of skilled workers.

It takes a special kind of person to work in LTC and the vast majority of workers do it because they are dedicated to caring for the elderly. Due to the very frail nature of many residents, high rates of dementia and the increasing prevalence of Alzheimer's disease, the job demands more than just patience and compassion. It also takes special training and a high degree of skill and commitment. But, most importantly, it takes time. Sadly, there are not enough workers and not enough time.

LTC workers know there is a gap between the care they want to provide and the care they can give. Low levels of funding, staff shortages, poor working conditions, pay inequities and profit-taking have created a human resources crisis in the LTC sector.

Privatization & Contracting Out

One might expect the workers who care for the elderly to be valued and compensated accordingly but this is not the case. Wages and benefits in LTC facilities lag behind those in other health institutions. For example, governments have decided that more health services should be delivered in LTC establishments but nurses and other health care professionals in those facilities earn less than they would in hospitals.⁶⁶

Some governments have sought illusory savings by shifting resources to the for-profit sector. These facilities chase profits by reducing staffing levels, pushing down wages and compromising the quality of care. Rehabilitation services such as music and rec-

Emotional
exhaustion
leads staff to
look for work
elsewhere

reation therapy are often viewed as frills and, as a consequence, services are reduced and eliminated. These cuts hurt residents' quality of life and increase the risk of injury and illness including depression. There is also a growing trend to contract out ancillary services such as cleaning, maintenance, food preparation, security and laundry to large multinational companies such as Aramark, Sodexo and Compass Group.

Once jobs are contracted out to these companies, previous collective agreements are scrapped, wages and benefits reduced, staffing levels lowered, training programs gutted and service levels minimized. Contracting out also lowers the continuity and quality of care. Residents receive meals delivered by trucks. Cleaning, security and other staff may work for a myriad of different companies, rather than from a cohesive workforce united in the common goal of providing quality care and services. The cutbacks and fragmentation are distressing for residents but are also difficult for LTC workers.⁶⁷

Stress, Burnout & Turnover

The average number of days of work that Canadians in health occupations lost due to illness or disability since 1987 has been at least 1.5 times greater than that for all workers. In 2004, full-time workers in health occupations across Canada missed an average of 12.8 days of work due to illness or disability.

Dr. Margaret Ross, a professor at the University of Ottawa School of Nursing, led a research team studying stress and burnout among staff in nine LTC facilities in the Ottawa-Carleton Region. The results were reported in *Geriatrics Today* in September 2002.⁶⁸

The team polled 275 registered nurses (RNs), registered practical nurses (RPNs) and health care aides (HCAs). They found significant levels of "emotional exhaustion", particularly among health care aides. They concluded that emotional exhaustion could negatively affect the quality of care. The team concluded that emotional exhaustion leads staff to look for work elsewhere.

"Such considerations," Dr. Ross wrote, "do not auger well for residents of LTC facilities, who are dependent upon health professionals for many aspects of their care and well-being."

High rates of turnover can have negative effects on working conditions, staff morale and the quality of care. There is a definite impact on residents since they develop a comfort level with the staff who assist them with their health care and personal tasks which are very private matters.

Changing complex needs of residents

Health Canada reports that seniors are living longer and healthier than those of a generation ago. However, those who must enter a LTC facility are more likely to have multiple health concerns. Eighty-three per cent of LTC residents reported having two or more chronic conditions.⁶⁹ The profile of LTC residents has changed yet the staffing and organization of LTC facilities has not changed in step with this new reality.

The data in Table 9 (below) illustrates the array of health concerns facing seniors in LTC facilities and the challenges to their care providers. As the 4.2 million Canadians over the age of 65 years balloons to 9.8 million by 2038, there will be at least a doubling of the demand for long-term care beds and a need for ongoing education and training for health care providers to equip them for this new complexity of care.

Seniors who must enter a LTC facility are more likely to have multiple health concerns

TABLE 9								
Prevalence of various health concerns among LTC residents								
	ON CANADA	SK CANADA	MB CANADA	MI USA	ME USA	SD USA	Fin-land	Hol-land
Dementia/Alzheimer's	53%	62%	41%	47%	50%	44%	65%	34%
Diabetes	19%	12%	17%	24%	20%	18%	6%	9%
Chronic Heart Failure	11%	18%	13%	27%	21%	30%	8%	22%
Stroke	22%	18%	16%	24%	22%	21%	23%	13%
Arthritis	30%	32%	26%	32%	26%	39%	4%	17%
End Stage Disease	1%	0.20%	0.20%	1%	1%	0.80%	22%	0.80%
Parkinson's	6%	6%	7%	6%	7%	7%	3%	4%
Cancer	9%	11%	3%	11%	9%	11%	2%	6%
Peripheral Vascular Disease	4%	3%	2%	12%	10%	6%	1%	3%
Osteoporosis	7%	13%	5%	14%	11%	11%	2%	5%
Chronic Obstructive Pulmonary Disease	1%	4%	2%	19%	19%	13%	3%	7%
Atherosclerotic-Heart-Disease	12%	7%	4%	19%	18%	17%	7%	11%
Source: from PricewaterhouseCoopers (2001) in Ontario Health Coalition, 2002.								

Without job satisfaction, the loop of staff turnover results in the remaining staff experiencing even more work overload

The Canadian Nurses Association (CNA) identifies mental illness, medication management and safety/security among the most critical challenges facing seniors. The CNA recommends additional educational emphasis in these areas.⁷⁰

A 2009 study by the Alzheimer's Society of Canada estimates 1.1 million Canadians will have Alzheimer's disease, or a related dementia by 2038. This alone will create a tenfold increase in the demand for LTC beds. The alarming statistic that "257,000 Canadians a year will be diagnosed with dementia by 2038, or about one every two minutes" means their care will be an enormous challenge for our society.⁷¹

In 2008, Statistics Canada reported that "the prevalence of chronic pain was highest in health care institutions, where 38% of seniors were affected by it". Spin-off effects of chronic pain include higher odds of being unhappy, having a negative impression of overall health and reducing physical and mental activities. The management of chronic pain is a central feature to providing quality care.

Improving Management and Organizational Practices

Research around effective management practices can bring new approaches to managing and organizing LTC facilities with the aim to improve the quality of care.

As we have observed, staff members play a key role in the quality of care residents receive. A survey of LPNs, care aides and RNs in 61 LTC facilities across BC found that workers felt they could give better care if they had support, access to information, resources and additional education.⁷²

A recent report outlines six different studies that all demonstrate that workers do their "best work" and provide demonstrably higher quality care when they are:

- Engaged in teamwork;
- Managed with open communication;
- Provided with clear policies and procedures;
- Provided with orientation;
- Active in committees and have more influence in resident care decisions; and
- Given access to training.⁷³

Employee Satisfaction

Without job satisfaction, the loop of staff turnover results in the remaining staff experiencing even more work overload which leads to more staff turnover. It becomes a never-ending cycle.

In addition, high turnover rates have been shown to correlate with lower quality of care. When continuity of care is disrupted, it can be upsetting for residents, especially those who suffer from dementia and Alzheimer's.

A large US study demonstrated that stable staffing produced lower catheterization, less use of restraints and lower rates of pressure sores - all commonly used indicators when considering quality of care. In facilities where there were higher turnover rates, the quality of care was generally lower as measured by state deficiency citations.^{74,75}

Another key factor in reducing worker turnover is wages. Workers in LTC facilities earn less than their counterparts in hospitals.⁷⁶ A US study surveyed workers to find that one in three would consider their rate of pay as a reason to leave their job. Among a variety of factors considered in the study, both intrinsic and extrinsic to the job, the study concluded that "wages, fringe benefits, job security, and alternative choices of employment are important determinants of job tenure that should be addressed, in addition to training and organizational culture".⁷⁷

The
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Education and Training

The education and training of health care staff has significant and measurable impacts on the quality of care given to residents in long-term care facilities. Improved education and training also increases staff morale and confidence in possessing the latest knowledge of care techniques. This training has been found to translate into improved staff retention.⁷⁸

A three-year study in Pennsylvania demonstrated that training reduced the rate of new pressure ulcers.⁷⁹ Alternatively, a survey of Saskatchewan LTC workers felt their formal training had ill equipped them to care for residents with dementia.⁸⁰ In both cases, training was basic to improving the quality of care.

Research into dementia and Alzheimer's disease is an expanding field that will continue to inform care practices for years to come. It only makes sense that workers should be given opportunities to expand and update their knowledge of best care practices for this growing population of residents.⁸¹

More broadly, provincial standards need to be established for resident care aide education programs. This is of particular importance where there is a mix of public and private institutions. Working with colleges, LTC facilities could be sure of a knowledge baseline for aides and could design relevant and effective continuing education for workers.

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Hearing from the Workers

In 2009, the Canadian Centre for Policy Alternatives (CCPA) published a comparison of workers' experience in long-term care in Canada and Scandinavia.⁸² The key findings are set out below:

Canadian direct care worker's number one concern:

- 58.6% heavy workloads;
- 57.3% staffing levels;
- 34% policy change that resulted in more difficult work;
- 32.3% violence; and
- 29.6% wages.

Most workers felt that workload and staffing levels were of greater concern than wages even though wages are comparatively low. Rather, they were more concerned about issues that had a direct impact on not only themselves but the care they are able to provide.

Working Alone:

- 34.8% of direct care workers in Canada “strongly agree” they are too often left alone to care for residents; and
- 5.8% of direct care workers in Scandinavia “strongly agree” they are too often left alone to care for residents.

Working “Short”:

- Almost half of the survey respondents across Canada worked short on a daily basis; and
- Over one-third reported working short on a weekly basis.

Work simply cannot be done well when the same amount of work is required with fewer staff.

Work Loads and Work Pace:

Direct care workers have too much to do all or most of the time, comparison between provinces:

- 49.4% in Manitoba;
- 41.5% in Nova Scotia; and
- 62.5% in Ontario.

These numbers correspond to the difference in staffing hours per patient per day between the provinces.

Dignity Denied

Workers Who Care for the Elderly

Direct care workers have too much to do all or most of the time, comparison between Canada and Scandinavia:

- 57.8% in Canada; and
- 40.2% in Scandinavia.

Both sets of respondents agreed they required more time to talk with and to listen to their patients in order to build real human relationships with those they are caring for. This connects back to Ontario's very definition of quality of care where the necessary elements of security, happiness, pleasure, fun, individuality, self-worth and trust can only be built on a foundation of meaningful personal relationships.

Few Swedish direct care workers felt they needed more time for personal care of residents, such as feeding and toileting. However, Canadian workers repeatedly made comments such as:

- "Getting residents ready for the day—bathing and feeding them all. There is not enough time in the day."; and
- "45 minutes to get 12 residents (ready) for breakfast!!! How do you think that works?"

"Forty-five
minutes

to get 12
residents
(ready) for
breakfast!

How do you
think that
works?"

Ontario Public Service Employees Union (OPSEU/NUPGE)

OPSEU/NUPGE represented approximately 1,000 members working in LTC facilities in Ontario in 2002. Surveys were sent to union members, most of them front-line workers, asking about pressures they faced on the job, especially in the areas of health and safety.⁸³

Some of the results are:

- 84% work alone always or often;
- 65% work always or often with clients who may become aggressive;
- 78% came into contact with body fluids, many on a daily basis;
- 62% work in facilities with poor air quality;
- 19% lost time at work due to a work related injury within the past year;
- 84% felt increased levels of stress at work due to workload; and
- 14.2% would feel comfortable reporting such occurrences to the Ministry of Health.

Quotes from OPSEU Survey Respondents:

- "Our workload has almost doubled."
- "We are short of staff. Two people have to do the work of three people."
- "Morale is down."
- "People's bodies are getting sore and tired as well as sick."

The presence
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- “Our workload has almost doubled. [We are] short of staff. Two people have to do the work of three people.”
- “New clients come in every day. [The employer doesn’t] tell us their disabilities.”
- “We would like to have better communications in advance regarding residents who are ill or contagious – better precautionary measures.”

The Union Advantage

There is a better way to recruit and retain LTC workers. Those who care for Canada’s elderly can, by working collectively, improve the workplace and the care they are able to provide.

Studies in the health care sector have demonstrated that the presence of a union reduces staff turnover and increases staff retention. For example, unionized members in home care settings remain employed in the sector one to three years longer than non-union workers.⁸⁴

Workers are more satisfied and remain in their jobs longer if they have an influence over the quality of their workplace. A union provides workers with a voice in these matters. The result is a stable workforce with more experience, greater skills and broader knowledge of the needs of patients and residents.

Canada’s LTC system can become a source of comfort to residents and of pride to workers. Respect and dignity must form the basis of the relationship between the elderly, the workers who care for them and the administration in LTC facilities.

A Better Way

Research clearly demonstrates that better working conditions for staff lead to higher quality of care.

All governments must take the necessary steps to reach optimal staff levels and the right mix of staff. There must be investment in education and training of LTC workers. The provinces must ensure safer and healthier work environments and provide fair compensation to all staff. These steps are needed to produce a stable and excellent workforce and provide high quality care.



Conclusion

WE MUST ACT NOW if we are to strengthen and expand Canada's public and not-for-profit LTC sector.

It took years of under-funding and privatization for our LTC system to be driven into such a shabby state of disrepair.

It will require a bold response to repair all the damage. We have a long way to go and only a short time to get there.

The good news is the system can be repaired and improved - provided that our governments, at every level, act with courage and choose the right path.

Each of us can do our part to make that happen. We can make it a personal priority to make it clear that care of our frail elderly is a Canadian priority.

It is no more than they deserve. It is no less than we should give.

Recommendations

[1] CANADA HEALTH ACT

- The definition of medically necessary services covered under the *Canada Health Act* should be expanded to include long-term, facility-based care.

[2] ACCESSIBILITY AND AFFORDABILITY

Federal Funding

- The federal government should introduce targeted transfers to provincial and territorial governments for LTC linked to the principles, criteria and conditions of the *Canada Health Act*.

Provincial and Territorial Funding

- Per diem rates provided to not-for-profit LTC facilities need to increase to reflect the true costs of care.
- Provincial and territorial governments should provide new funding to not just renovate existing facilities but to build more facilities and spaces needed to ensure adequate LTC spaces for our growing senior population.
- Monthly allowances for residents need to be increased with consideration to additional charges for supplies and services.

Resident Fees

- Accommodation charges to LTC residents should not exceed those for current market rates in the local community for similar lodging and food services. Any increase in accommodation rates and resident user fees should not be more than the cost of living adjustment for seniors' income support programs.
- Provincial and territorial governments should conduct reviews to determine those LTC costs that should be funded publicly and those that will be paid out-of-pocket by residents. This consideration should include: prescription fees, lab test fees and on-site visits for dental, hearing, therapy and prescription glasses.

Off-Loading from Hospitals

- Provincial and territorial governments should establish guidelines to prevent off-loading of patients from acute and chronic-care hospitals to retirement residents and assisted living programs that may be inadequate to provide appropriate care.

[3] QUALITY OF LIFE AND STANDARDS OF CARE

A National Long-term Care Commission

- There should be a federal-provincial-territorial Long-term Care Commission established to study and recommend optimal staff-resident ratios and standards and hours of care.

Provincial and Territorial Strategy

- Provincial and territorial governments must develop an integrated and comprehensive strategy to provide public LTC, home and community care services that meet the needs of Canadian seniors today and for the future.

A Public and Not-for-profit System

- Governments should award new facility licenses and provide public funding for public and not-for-profit facilities only. Funding to for-profit facilities should be phased out.

Inspection and Compliance System

- Provincial and territorial governments should create dedicated inspection teams consisting of a range of specialists, including health care, food, hygiene and safety experts.
- Provincial and territorial governments should establish a system of multiple, random, surprise inspections of LTC facilities.
- Inspection teams with enforcement powers and the ability to recommend interventions must also have the power to issue mandatory compliance orders and impose sanctions for non-compliance.
- Provincial and territorial governments should post all inspection reports, including disclosure of any violations, on their website to allow families to make comparisons and fully informed decisions before choosing a facility.

[4] THE LONG-TERM CARE WORKFORCE

Sufficient Staffing

- Governments must provide more money to increase staffing (both direct care and support staff) in LTC facilities in order to provide the highest level of care possible.

Management and Organization

- Facilities must improve their managerial and organizational practices in order to provide safe and healthy work environments that support high quality care.

Recruitment and Retention

- Governments must make a financial commitment to improve the wages, benefits and working conditions of currently employed LTC workers.

Education and Training

- In order to reduce turnover and recruit new workers, employers must provide continuing education training for staff to deal with the increasingly complex needs of LTC residents.

Health and Safety

- Governments and employers must continue to take measures to reduce injury.

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