

Residential Long-Term Care in Canada

Our Vision for Better Seniors' Care



Canadian Union of Public Employees

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CUPE

Residential Long-Term Care in Canada: Our Vision for Better Seniors' Care

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This full research report and a 12-page popular summary can be downloaded from cupe.ca/long-term-care-tour

La version intégrale de ce rapport et un résumé de 12 pages peuvent être téléchargés à l'adresse scfp.ca/tournee-soins-de-longue-duree

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Summary

Equal access to health care is a bedrock value held by most Canadians. We consider universal access to health care a fundamental right, one that should not be affected by a person's social status or financial means.

Caring for our elders and treating them with dignity and respect is another principle we hold dear as Canadians. We struggle with how best to help our parents and other aging loved ones in ways that maximize their independence and choices, and that struggle is complicated by family resources and other conditions. Nonetheless, the desire to treat elders with respect is deeply felt in our society.

Our attitudes and actions towards seniors and others living in LTC facilities are a reflection of our values and practices as a society. As the World Health Organization puts it, "A society that treats its most vulnerable members with compassion is a more just and caring society for all."¹

If we consider health care a fundamental right and we want our parents and neighbours to age with dignity, we need to change the way we approach seniors' care – in particular, the care of seniors who live in residential long-term care facilities, the most vulnerable group. Most urgently, we need to address the two-fold problem of limited access and poor quality of residential long-term care (LTC). Funding and regulatory regimes of Canadian governments fall far short of meeting our society's values and principles when it comes to residential long-term care.

If equal access to health care is a core Canadian value, we should provide health care free of charge at the point of use no matter the setting. The arrested development of medicare (limited at present to hospital and physician services) made little sense 50 years ago, when federal health care programs came together. It makes even less sense today, when our society is rapidly aging and more seniors need high-level, complex care. Paying for residential long-term care as a society and guaranteeing equal access to that care is smart from an economic standpoint and fair from a social standpoint. Wiser yet would be to cut profit-making from the system, putting all of our available resources into care.

Our attitudes and actions towards seniors and others living in long-term care facilities are a reflection of our values and practices as a society.

Not only do we want equal access, we want better quality of care in our LTC facilities, which principally means better staffing levels. Residential LTC in Canada is usually seen as a grim place of last resort for ailing seniors and, increasingly, younger people with disabilities who cannot get health care elsewhere. Caregivers are rushed and social isolation is the norm. For-profit facilities and ones that contract out tend to be the worst. The consequences of understaffing and privatization for residents are clear, documented by decades of research: poor health and lower quality of life. Reversing the downward spiral of funding cuts and privatization is the first step to improving quality; the next is to create environments that foster good health and enjoyment of life.

This report addresses what we see as two of the most urgent problems in the residential long-term care system: barriers to access and poor quality of care. It does this by examining two of the driving factors: understaffing and privatization. There is a great deal of literature on these issues, and there are a number of strong policy statements. Our contribution is to shed light on the connection between working and caring conditions and to propose ways to improve both. Our recommendations can be summed up as this: That governments develop, finance, regulate and, to the fullest extent possible, deliver public programs that will guarantee seniors universal, equitable, and high-quality residential long-term care that is adapted to their needs, free from commercial exploitation, and conducive to maximum health and enjoyment of life.

CUPE represents 67,000 residential long-term care workers, and 590,000 workers across Canada – many of whom are caring for aging relatives, all of whom worry about what their own life will be like when they grow old.

The Canadian Union of Public Employees engages in the struggle for better residential long-term care from several standpoints. CUPE represents 67,000 workers in long-term care facilities across Canada. Our members, with some differences between provinces, provide everything from direct care (like rehabilitation and nursing) to support services (like cleaning, food and laundry). We represent a total membership of 590,000 workers – many of whom are caring for aging relatives, all of whom worry about what their own life will be like when they grow old. Part of a movement, we see the issues of long-term care from the perspective of a partner with other unions, seniors' organizations and citizens' coalitions who have long fought for universal, single-tier, good quality residential long-term care in Canada.

Long-term care facilities are the places where almost a quarter of a million people live and another quarter of a million people work.² By this fact alone, they deserve our close attention.

What do we mean by residential long-term care?

By residential long-term care, we mean government-funded and regulated long-term care (LTC) facilities that provide 24-hour nursing care, primarily to frail seniors. We touch on private-pay and unregulated facilities, but our focus is primarily on publicly funded and regulated facilities that provide high-level care to seniors and others with multiple chronic conditions involving physical and/or mental disability. Different terms are used across Canada: nursing homes, residential care facilities, complex care facilities, special care homes, auxiliary hospitals, personal care homes, charitable homes, homes for the aged, and manors. In this paper, we use the terms “long-term care facility” and “residential long-term care” interchangeably to refer to this group of facilities. See Appendix A for definitions and terminology.

Residential LTC coverage is inadequate and uneven

The first part of this paper looks at the exclusion of residential LTC from medicare and its consequences, concluding that a pan-Canadian residential LTC program with legislated standards is needed.

Residential long-term care is, for all meaningful purposes, excluded from medicare. The *Canada Health Act*, the federal law that substantially defines medicare, requires that provincial and territorial insurance plans for *medically necessary physician and hospital services* be publicly administered, universal, comprehensive, accessible, and portable, with no extra billing or user charges allowed. While the *Act* refers to “extended health care services,” which include LTC facilities, the federal government failed to promulgate regulations that would define those services, and it has never enforced these or other LTC standards as a condition of funding.

In the absence of federal standards, there are enormous variations across provinces in the availability of services, level of public funding, eligibility criteria, and out-of-pocket costs borne by residents. Seniors with the same clinical profile and needs face disparities in access to beds and access to equipment, supplies and devices, depending on where they live and what financial resources they have. Inequality is widespread.

Residential long-term care in Canada is a two-tiered system. While all provinces regulate and subsidize LTC facility fees, eligibility criteria and means-testing methods vary widely. After paying monthly facility fees in publicly-subsidized facilities, many residents (a majority in some provinces) are left with a small “income allowance” ranging from \$103 to \$265 per month. From this, they have to pay for medical and personal expenses that can include (depending on public subsidies): dentures, hearing aids, specialized wheelchairs and cushions, therapeutic mattresses, diagnostic tests, over-the-counter drugs, personal hygiene products, personal laundry, telephone, physiotherapy, foot care, and personal expenses like gifts and clothing. People who can afford to pay privately get a richer package of goods and services in publicly-subsidized facilities.

This is even more true of entirely private-pay LTC facilities, which are beyond the reach of most Canadians. In 2009, the average cost of a bed in British Columbia private-pay residential care facilities was \$4,718 per month or \$56,616 per year. As of 2005, in the same province, less than 5 per cent of unattached women over 65 and just over 11 per cent of unattached men over age 65 had incomes over \$60,000 and therefore could afford a private-pay facility. Private-pay facility fees and income levels vary by province, but the picture is similar across the country: only a small minority can afford to live in wholly private-pay residential care facilities.

Private long-term care insurance is certainly not the answer. It is expensive, high-risk, and difficult to get. A 2006 review of Canadian LTC insurance products documented high and rising premiums, frequent rejection of applicants, caps on benefits and insufficient coverage, misleading advertising, difficulties with claims, and a confusing array of products, fees and rules. As a way of paying for residential long-term care as a society, it is inefficient as well as unfair. Not surprisingly, only 1 per cent of Canadian seniors have private LTC insurance.

In the absence of federal standards, there are enormous variations across provinces in the availability of services, level of public funding, eligibility criteria, and out-of-pocket costs borne by residents.

The population is rapidly aging, and many seniors need residential long-term care, yet most provinces are reducing rather than expanding access to LTC beds.

In addition to uneven services and two-tier access rooted in residential long-term care’s exclusion from medicare, another pressing challenge is rising demand with an aging population. In 2005, 13 per cent of the population was over 65. In 2031, almost one quarter of the population is projected to be over 65. The number and proportion of *older seniors* in particular (persons aged 80 years and over) is projected to increase sharply over the next few decades. By 2056, the proportion of older seniors will triple to about one in 10, compared to about one in 30 in 2005. This cohort is most relevant to residential LTC, where the average age at admission was 86 in 2002 (up from 75 in 1977). While demand for LTC beds is driven by many factors, an aging population is certainly a critical one.

The population is rapidly aging, and many seniors need residential long-term care, yet most provinces are reducing rather than expanding access to LTC beds. As shown in the table below, the number of LTC beds relative to seniors over 75 has been cut in all provinces except Ontario – by 7 per cent in Manitoba and Nova Scotia all the way up to 21 per cent in BC and Alberta. The expansion in Ontario, this paper shows, has been almost entirely in the for-profit sector, where lower staffing is common and (with the elimination of legislated staffing levels in 1996) more money is diverted from direct care to company profits.

Residential care bed rate (beds per 1,000 population aged 75+), by province, 2001 and 2008							
	2001		2008		% change 2001 to 2008		
	beds	beds per 1,000 aged 75+	beds	beds per 1,000 aged 75+	pop'n 75+	bed number	bed rate
BC	25,420	102.3	24,616	81.3	21.8%	-3.2%	-20.5%
Alberta	14,486	106.0	14,654	83.9	27.7%	1.2%	-20.8%
Saskatchewan	9,240	123.4	8,944	112.8	5.9%	-3.2%	-8.6%
Manitoba	9,733	124.5	9,833	116.1	8.4%	1.0%	-6.8%
Ontario	58,403	88.2	75,958	91.5	25.3%	30.1%	3.8%
Quebec	43,491	104.8	46,091	88.3	25.8%	6.0%	-15.7%
New Brunswick	4,227	89.6	4,175	78.5	12.7%	-1.2%	-12.4%
Newfoundland	2,818	101.3	2,643	84.2	12.8%	-6.2%	-16.8%
Nova Scotia	5,806	96.3	5,986	89.4	11.0%	3.1%	-7.1%
PEI	950	106.5	978	100.1	9.5%	-2.9%	-9.3%
Canada	174,574	99.2	193,858	90.0	22.4%	11.0%	-9.3%

Source: Cohen et al., 2009b.

Cuts to LTC facility capacity have not been compensated by expansion in other parts of the health care system. In fact, hospital downsizing continued during this period in most provinces. Despite new investments in home and community care services in some provinces, non-residential long-term care services remain severely underfunded. Even with properly-resourced services in other parts of the health care system, the demand for LTC beds will continue to outpace capacity if current trends continue.

Waits for LTC beds have become longer, and elders are forced to make difficult choices. Some must accept the first available bed, often at a facility they would not choose. This is especially the case for elders with specific cultural needs and those living in rural and remote communities. Couples are often separated, unable to get beds in the same facility or, in some cases, the same community. In some provinces, a person who refuses an offered space is moved to the bottom of the wait-list, forced to wait months, possibly years, for another opening.

The solution to the accessibility crisis in residential long-term care is two-fold:

1. Extend medicare to residential long-term care, with increased federal funding tied to legislated standards, including *Canada Health Act* criteria and conditions.

The federal government should substantially increase funding transfers to provincial and territorial governments for residential LTC and make those transfers conditional on compliance with legislated standards. New federal residential LTC legislation should incorporate the criteria and conditions in the *Canada Health Act*, namely:

- Public administration (administered on a not-for-profit basis);
- Universality (covering all insured persons on uniform terms and conditions);
- Comprehensiveness (covering all medically necessary services);
- Accessibility (reasonable access on uniform terms and conditions, unimpeded by extra charges or discrimination);
- Portability (coverage while absent from home province); and
- No extra billing or user charges.

The federal government should substantially increase funding transfers to provincial and territorial governments for residential LTC and make those transfers conditional on compliance with legislated standards.

In the implementation of this new fiscal arrangement and legislation, the federal government should recognize the distinctness of Quebec. Quebec should have primacy in its jurisdiction over social policy and should have the right to opt out of this proposed joint federal-provincial residential LTC program and receive the full transfer payment under the program.

2. Expand residential long-term care, home and community care services to meet the needs of Canadian seniors, as part of a comprehensive and integrated system.

Our call for an extension of medicare to residential long-term care – with regulation and increased funding – is part of our vision of a comprehensive medicare system that would also include pharmacare, home care, primary health care, dental and vision care. Expansion in these areas should not be at the expense of hospital services, already stretched too thin across Canada.

Special mention is due home care. Seniors and others who need long-term care should have the choice of receiving that care in their own homes or in long-term care facilities, and be given the proper resources whichever setting is chosen. We know that many people on LTC wait-lists could be cared for at home if appropriate home and community supports were available and that these supports remain severely underfunded. The costs are borne by patients/clients, foremost, but also by underpaid home and community workers and unpaid caregivers, the majority of whom are women.

Proper resourcing of both home and residential long-term care means more than funding. It requires changes to how the long-term care system is governed, managed and even conceptualized. Instead of pitting ‘home’ against ‘institution’ in a simplistic dichotomy that is used to justify rationing and privatization, policy-makers should improve both and—as a minimum—remove exploitation (of patients/clients/residents and caregivers, paid and unpaid) from the choice of setting.

Extending medicare to residential long-term care would help over-burdened families, in particular the women in those families, and would provide a much-needed boost to the economy—both by freeing up unpaid caregivers to participate more fully in the labour force and by creating new jobs.

Residential long-term care has particular significance for women, who make up the majority of residents and caregivers. Nearly two thirds of all residents and three quarters of residents 85 and older are women. Women are also disproportionately represented among caregivers: nine out of ten workers in LTC facilities are women, and the majority of unpaid caregivers are women.

Working conditions and caring conditions are inter-connected, the foundation of quality

Staffing is the most important determinant of quality in long-term care facilities, and better working conditions for staff are also better caring conditions for residents.

Staffing is the most important determinant of quality in long-term care facilities, and better working conditions for staff are also better caring conditions for residents. Decades of research show that the foremost determinant of quality is the level of staffing, and this holds true whether considering medically-oriented “quality of care” measures or more comprehensive “quality of life”³ measures. In addition to the number of workers on staff, their education/training and their work environment have proven impacts on residents’ health and well-being.

The staffing and organization of LTC facilities have not kept up with the increasing needs of the residents. The number and mix of staff, their training, equipment, and care models—none of these have evolved in step with the changing profile and needs of residents.

Residents living in long-term care facilities today have significantly greater needs than residents 15 years ago. The vast majority is over the age of 75, has multiple medical diagnoses, can’t move independently, suffers serious cognitive and physical impairments, and has unstable, complex health needs. A small but growing minority are younger adults with disabilities and chronic conditions who have distinct needs. Sub-acute and palliative care admissions have also grown in recent years. Overall, residents’ physical and psychosocial care needs have become so complex that some experts characterize residential care facilities as “mini-hospitals.”

Yet staffing, equipment, infrastructure, policies and care models have not kept pace with residents’ needs. Governments are not increasing funding enough to pay for the number of staff, their education and training, or the specialized equipment needed in residential long-term care. Looking at palliative care in British Columbia as an example, the rate of deaths in

residential care increased by 81 per cent over five years, yet residential care appears to get only half of the funding that hospitals get for palliative care. This and other evidence points to downloading from hospitals to residential long-term care as primarily a cost-cutting exercise. The consequences for residents are devastating.

The research is unequivocal: staffing levels are the most important factor in quality, and higher levels mean better health outcomes for residents. Controlling for other factors (like facility size and resident acuity), researchers consistently find that higher staffing is associated with fewer “adverse outcomes” such as falls, fractures, infections, weight loss, dehydration, pressure ulcers, incontinence, agitated behaviour, and hospitalizations. Below is a sample of the evidence presented in this report:

- Residents who received 45 minutes or more of direct care per day from licensed practical nurses were 42 per cent less likely to develop pressure ulcers than residents who received less care.
- Residents who received three or more care aide hours per resident day (hprd⁴) had a 17 per cent lower risk of weight loss compared to residents who received less care.
- Residents living in higher-staffed facilities spent less time in bed, experienced more social engagement, and consumed more food and fluids than residents living in lower-staffed facilities.
- Residents living in facilities with higher care aide staffing levels were more likely to be involved in a scheduled toileting program, receive active or passive range of motion training, and receive rehabilitative training for such things as walking, getting out of bed, and moving around.
- Residents had better nutrition and hydration when care aides could focus on helping to feed or assist no more than two or three residents at mealtime. With less care, residents were more likely to cough and choke during meals and lose weight due to insufficient food intake.
- Care aide staffing below two hours per resident day was associated with roughly a four-fold increase in the likelihood of high hospitalization rates for a range of avoidable health problems, including urinary tract infections, electrolyte imbalances, and sepsis. When care aide time fell below 2 hprd, 32 per cent of residents developed pressure ulcers.
- The social-emotional aspects of care are the first to be cut when workloads are heavy, and residents’ quality of life suffers. Meaningful activities and positive relationships are particularly important for residents with dementia.

The research is unequivocal: staffing levels are the most important factor in quality, and higher levels mean better health outcomes for residents.

The most extensive research to date is a large national study commissioned by the United States Congress and carried out by the Center for Medicaid and Medicare Services (CMS). The CMS study, reported in 2002, found that a minimum staffing level of 4.1 worked hours per resident day (hprd) is required to avoid jeopardizing the health and safety of LTC residents. The 4.1 hprd includes 2.4 to 3.1 nursing assistant hours and 0.95 to 1.55 licensed nurse (RN and LPN) hours, each with different health outcome improvements.

It is important to point out that the CMS-recommended minimum of 4.1 hprd:

- Refers to worked hours, not paid hours. Paid hours include benefits, holidays, vacation, sick time, and other compensation beyond hours actually worked. *Paid hours* represent anywhere from 15 to 30 percent more than *worked hours*. Minimum staffing levels must specify *worked hours*.
- Includes only hands-on nursing (RNs and LPNs) and personal support (care aides). Higher minimum staffing levels are needed to cover the full range of work done in LTC facilities.
- Refers to the level needed to “avoid jeopardizing the health and safety of residents.” Additional hours are needed to actually improve quality of care beyond this essential minimum. The minimum level required to improve care was identified as 4.55 worked hprd in a 2000 study and somewhere between 4.5 to 4.8 worked hprd in a 2004 study.

The CMS study is widely recognized as the most comprehensive and academically sound research to date on the subject. The study was conducted by nationally recognized experts in long-term care, nursing, economics, and research. It included logistic regression analysis of empirical data from 10 states with over 5,000 facilities. Time motion studies were used to identify which specific staffing levels (to the hour and minute, for each direct care classification) lead to better health outcomes. The level of 4.1 hprd has been supported by numerous studies published since the CMS report.

No Canadian province has meaningful legislated minimum staffing levels; provinces have either “target levels,” which are unenforceable, or their regulated levels are so out of date they are virtually meaningless.

There is no reliable Canada-level data on staffing in long-term care facilities, but available provincial data indicate serious deficiencies—staffing levels well below the CMS-recommended minimum. In British Columbia, LTC facilities provide on average 2.6 to 2.7 worked hours of direct care per resident per day. Ontario, the only other province with available information on worked hours, provides an average of 2.6 worked hours of direct care to its long-term care residents daily.

No Canadian province has meaningful legislated minimum staffing levels; provinces have either “target levels,” which are unenforceable, or their regulated levels are so out of date they are virtually meaningless. For example, in Saskatchewan, the only province with a legislated minimum staffing standard, the standard is 2 hprd of personal and nursing care—that is, less than half the 4.1 level recommended to “avoid jeopardizing the health and safety of residents.”

Several provinces have promised to increase funding for front-line staffing, but there is no guarantee this money will go to staffing unless there are legislated minimum staffing levels and strong monitoring and enforcement systems. As a case in point, the Ontario government has reported steady funding increases for residential LTC over the past five years, but the money has not translated into higher staffing levels. In fact, evidence suggests fewer care hours delivered even while funding increased.

Canadian LTC facility staffing levels likely fall below levels in the US, where regulated staffing standards have resulted in more care for residents. Most LTC facilities in the US also fail to meet the CMS-recommended minimum, but where there is a set standard in policy or law, progress is evident. Thirty-six states have minimum nurse and personal care staffing standards, and the remaining 14 states use either the federal staffing requirements or state licens-

ing rules for professional staff coverage. Research shows that states with minimum staffing standards have higher staffing levels. Across states, the average LTC facility has 3.7 paid hrpd of combined nurse and personal care staffing.

While the focus of research and regulation around LTC facility staffing has been direct care (nursing and care aide) staffing, support services are equally important and need to be reflected in staffing standards. Research shows that support workers (food, cleaning, laundry, maintenance, clerical and others) play a vital role in residential long-term care. For example, clinical studies and audits have linked healthcare-associated infection outbreaks with understaffing, increased workload, and high turnover of cleaning staff. Studies of nutrition and disease in seniors and investigations of outbreaks of food-borne illnesses in LTC facilities likewise demonstrate the importance of well-staffed and supplied food service departments.

While the number of staff is by the far the most significant factor in the quality of care, other aspects of staffing and working conditions also play a major role. The degree of staff empowerment, shared decision-making, open communication, relationship-oriented leadership—these and other aspects of “work environment” have a proven effect on residents’ health and well-being. This effect holds true whether researchers looked at medical indicators (e.g. rates of pressure ulcers, fractures, and immobility complications) or broader measures of quality (e.g. social engagement or self-reported quality of life).

Turnover is central to the workload/work environment and quality relationship. It is both a cause and effect of poor working and caring conditions in LTC facilities. High workload and poor working conditions (including low pay and benefits, high injury rates, and workplace violence) lead to higher turnover, and higher turnover exacerbates those very problems. Workers are seriously harmed, and residents are also caught in this damaging cycle, their physical, emotional and mental health undermined. Here again, the research is specific and convincing: higher turnover disrupts continuity of care, which leads to worse quality (higher restraint use, rates of pressure sores, use of catheters, lower “satisfied with care” scores, and other measures).

The interplay between working conditions and caring conditions is also evident in the research on violence. There is a growing recognition of the structural conditions that contribute to high rates of violence against both residents and workers in LTC facilities. While the issue is certainly complex, understaffing and poor working conditions have been cited as key factors in the abuse and neglect of residents and the physical and psychological violence against staff.

Another aspect of the “staffing and quality” relationship is staff education and training. As with other causal relationships identified in this paper, the links between education/training and quality of care are both direct and indirect, and the evidence is both specific (quantitative and medical) and broad (qualitative and social). Solutions include education program standards, more professional development opportunities, and increased resources for students.

Improving quality of care in LTC facilities also requires proactive approaches to cultural and racial diversity. Residents and workers in long-term care facilities are more culturally diverse and more likely to be racialized than 20 years ago, and new strategies are needed to address discrimination and provide culturally competent services. The interests of workers and residents, here as elsewhere, are intricately connected.

High workload and poor working conditions lead to higher turnover. Workers are harmed and residents’ physical, emotional and mental health are undermined.

What all of this evidence points to is that in order to create healthy and positive environments for residents, LTC facilities need to create healthy and positive environments for workers. This means providing safe and healthy working conditions, where hazards are minimized and injuries and harm are prevented. It also means providing a work environment where there is open communication and access to information, support for problem solving and conflict resolution, equal participation in decision-making, and opportunities for professional development. All of these conditions lead to better health and well-being for residents, through direct and indirect effects.

Non-profit ownership and delivery are essential to improving both access and quality

There is convincing research evidence that for-profit ownership leads to lower staffing levels, poorer quality of care, and higher costs for residents.

Just as staffing issues have multiple and strong effects on the health and well-being of workers and residents, so too is privatization of residential long-term care a shared concern with many dimensions. With few exceptions, privatization of residential LTC infrastructure, ownership, and delivery is happening at an increasing pace across Canada. There is convincing research evidence that for-profit ownership leads to lower staffing levels, poorer quality of care, and higher costs for residents. The evidence is also strong that contracting-out undermines working and caring conditions. Assisted living and other deregulated models represent a newer form of privatization, and the results so far are troubling. At an industry-wide level, privatization is risky because it weakens public policy options and makes residential LTC even less transparent and accountable to residents and the public—changes we can ill-afford.

In Canada, long-term care facility ownership can be categorized as non-profit or for-profit. Non-profit covers two groups of facilities: those owned by government, either federal, provincial, or municipal; and those owned by voluntary lay or religious organizations such as the Lions Clubs and religious orders. (Sometimes, the first group is called “public” and the second “non-profit” or “voluntary.”) For-profit facilities are owned by a corporation, private organization, or individual and are run on a for-profit basis.

Residential long-term care is a mix of non-profit and for-profit operators in Canada, and the ratio varies widely between provinces. The proportion of LTC beds owned by for-profits ranges from zero in Newfoundland and Labrador to 53 per cent in Ontario. Of all LTC beds in Canada, 35 per cent are owned by for-profit organizations.

The ratio of for-profit to non-profit beds has increased over the years in most provinces, and signs point to a continuation of this trend. In BC, between 2000 and 2008, the number of for-profit beds increased by 22 per cent while the number of non-profit beds decreased by 12 per cent. In Alberta, for-profit beds as a ratio of total beds increased by 6 per cent between 2000 and 2007. In Ontario, almost two thirds of new long-term care beds since 1998 have gone to for-profit companies. New Brunswick is a newcomer to residential care privatization, last year contracting with an eastern chain to build the first for-profit LTC facilities in the province. Prince Edward Island is among the few provinces not relying on the private sector for renovation and replacement beds, deciding last year to redevelop its public LTC facilities using conventional financing rather than public-private partnerships.

The method of privatizing residential long-term care infrastructure varies across Canada. It takes the form of untendered contracting, public-private partnerships, capital funding grants, and replacement of licensed residential care with assisted living, supportive housing, and other forms of deregulated, defunded, and largely for-profit residential care.

While the pace and method of privatization vary, the impacts are the same. For-profit ownership and delivery of residential long-term care means lower quality, higher costs, more risks, and less transparency and accountability.

A growing body of empirical evidence has established that for-profit long-term care facilities are associated with lower quality of care and poorer resident health outcomes. Below is a selection of the evidence presented in this report.

- A four-year Manitoba study of LTC facilities' performance (covering all residential care beds and 15,501 residents) found that residents living in for-profit facilities, compared to those in non-profit facilities, had significantly higher adjusted risk of being hospitalized for dehydration, pneumonia, falls, and fractures.
- A study of eight British Columbia LTC facilities between 1996 and 2000 found that, compared to non-profit facilities, for-profit facilities had higher hospitalization rates for pneumonia, anaemia, and dehydration (9, 18 and 24 per cent higher, respectively).
- A systematic review and meta-analysis of observational studies and randomised controlled trials spanning four decades, published in the *British Medical Journal* in August 2009, found a trend towards higher quality care in non-profit facilities compared to for-profit facilities. In 40 of the 82 top-level studies, non-profits ranked higher on all statistically significant quality measures; in only three studies did for-profits achieve this ranking. Based on their findings, the researchers estimated that 600 of 7,000 incidences of pressure ulcers in Canadian LTC residents are attributable to for-profit ownership and that residents in Canada would receive roughly 42,000 more hours of nursing care a day if all long-term care facilities were non-profit.
- In a groundbreaking study that analyzed data on 14,423 facilities across the US, controlling for time-, location-, and provider-related effects, researchers concluded that for-profit nursing homes have significantly lower care quality compared to public and non-profit nursing homes.
- In a study of eight years of data covering 96 per cent of all nursing homes in the US, non-profit ownership compared to for-profit ownership was found to be significantly associated with high-quality care (measured by incidence of pressure ulcers and use of physical restraints, feeding tubes, and catheters).
- State inspection surveys of 13,693 LTC facilities across all states found that for-profit facilities averaged 46.5 per cent more deficiencies (violations of care standards) per home than non-profit facilities.
- In a five-year national study of 302,351 complaints filed against nursing homes, US researchers found that for-profit facilities were almost twice as likely to receive a complaint during a given year as non-profit facilities.

The ratio of for-profit to non-profit beds has increased over the years in most provinces, and signs point to a continuation of this trend.

The main reason for the pattern of lower quality of care at for-profit facilities is lower staffing levels. Again here, the evidence is strong and specific. Taking two examples from the paper:

- In a major Canadian study, after adjusting for facility level of care, not-for-profit ownership was associated with an estimated 0.34 more hprd of direct care services (RN, LPN, care aide) and 0.23 more hprd of support services (dietary, housekeeping, laundry, and other).
- In one of many US studies with similar findings, researchers examining 2007 data found that total nurse and personal care staffing hours were 14 per cent lower in for-profit than non-profit LTC facilities.

In addition to suffering worse health outcomes and receiving less care, residents in for-profit LTC facilities in most provinces have to pay more out of pocket for services and products. The extra costs range from relatively small expenses, such as off-the-menu dessert options and specialty incontinence products, to substantial expenses such as wheelchairs, therapeutic mattresses, non-prescription medication, rehabilitation therapy, and palliative care. With more privatization, residents will see more fees.

Contracting out is another form of privatization that hurts residents. Whether support services or direct care services are involved, contracting out is associated with inadequate training and high turnover, which undermines continuity and quality of care.

Contracting out is another form of privatization that hurts residents, and it happens in both non-profit and for-profit facilities. Whether support services or direct care services are involved, contracting out is associated with inadequate training and high turnover, which undermine continuity and quality of care. Residents are particularly vulnerable where governments allow operators to “flip” subcontractors—that is, terminate a contract with one third-party provider and hire another provider, often with an entirely new workforce.

The impacts of cleaning, food and direct care outsourcing are relatively well-documented and offer disturbing examples of the risks to residents’ health and safety. Contracted-out cleaning is associated with serious hygiene problems and spiking infection rates in health care facilities. Growing reliance on ready-to-eat products such as cold-cuts increases the risk of food-borne illnesses, as shown by the recent listeriosis outbreak. And over-reliance on nurse and care aide agency staff is associated with disrupted continuity of care and higher resident psychological distress. As with other forms of contracting out, it is the *use* of contracted staff and their working conditions that are problematic, not the workers themselves.

A relatively new form of privatization in this sector is the replacement of licensed residential care with lower-funded, deregulated models that are more likely to be for-profit. They go by different names: assisted living, supportive housing, retirement residences, personal care homes, lodges, and other titles. What these facilities have in common is that they receive less government money, face fewer government rules, and tend to be for-profit. What they also have in common is lower levels of care, fragmentation of services, and greater burdens on residents and their families. Canada certainly needs a range of housing options for seniors, but those should be non-profit and not used as a replacement for licensed, publicly-funded beds.

All of these forms of long-term care privatization represent new public subsidies to for-profits, from public funding for private sector capital acquisitions and profit-taking to the extra costs borne by hospitals when residents are admitted for avoidable health problems. This paper focuses on the impacts of privatization directly on residents and workers, but these broader society-wide costs must be kept in mind.

Privatization, whether of entire facilities or component services, is a risky undertaking. It is difficult to reverse, weakens transparency and accountability, and opens seniors' care to instability and displacements that are costly and harmful for residents, workers, and the health care system. The growing clout of the residential LTC industry and the movement back and forth between senior government and industry officials calls into question the very integrity of public policy making in this sector.

Recommendations

Residential long-term care in Canada is characterized by two-tier access and uneven, often unsafe, quality of care. Privatization is making the problems worse. Even with changes elsewhere in the health care system, an aging population will only increase pressure and widen the quality and access gaps. What we need is government action at the federal and provincial levels to improve access and quality of residential long-term care across the country, taking into account the complex interplay between working and caring conditions.

In this paper, we offer many concrete recommendations for creating a strong system of universal, equitable, cost-effective, and high-quality services in residential long-term care. The top seven are:

- Extend medicare to residential long-term care, with increased federal funding tied to legislated standards, including *Canada Health Act* criteria (public administration, universality, comprehensiveness, accessibility, and portability) and conditions (no user fees or extra billing). Quebec should have the right to opt out without penalty.
- Expand residential long-term care, home and community care services to meet the needs of Canadian seniors, as part of a comprehensive and integrated system.
- Establish non-profit ownership and operation of long-term care facilities by phasing out public funding to for-profit providers and ending contracting out.
- Establish provincially-legislated quality of care standards for residential long-term care facilities, including minimum staffing levels.
- Increase staffing (direct care and support staff) in residential long-term care facilities.
- Provide safe and healthy work environments that support high quality care.
- Support education and professional development of residential long-term care workers.

What we need is government action at the federal and provincial levels to improve access and quality of residential long-term care across the country, taking into account the complex interplay between working and caring conditions.

Introduction

The accessibility and quality of care for seniors living in long-term care facilities is a pressing concern for the Canadian Union of Public Employees, as it is for Canadian society as a whole. CUPE members are touched by this issue as health care workers, as family members of aging relatives, and as future users of the residential long-term care system.

This paper examines Canadian residential long-term care (LTC) programs from the perspective of accessibility and quality of care, drawing links to three fundamental issues: public funding and regulation, staffing (levels, education, and work environments), and privatization.

CUPE represents roughly 67,000 workers in long-term care facilities and another 115,000 workers in hospitals and community health agencies across the country, providing everything from direct care such as rehabilitation and nursing to support services such as cleaning, food and laundry. Our members also care for aging loved ones and anticipate the time when they will need support themselves. Experiencing the health system from all of these angles, CUPE members place a priority on seniors' care and want to see accessible, high-quality care across the country.

This paper examines Canadian residential long-term care (LTC) programs from the perspective of accessibility and quality of care, drawing links to three fundamental issues: public funding and regulation, staffing (levels, education, and work environments), and privatization. First, it considers the exclusion of residential LTC from medicare coverage and the impacts on seniors, families, and society as a whole. Second, it presents research evidence, with an emphasis on empirical research published in academic journals, showing the connection between conditions of work and care and the concrete impacts on residents' health and well-being. Third, it studies the impacts of privatization on both the quality and accessibility of residential LTC, again drawing from a substantial body of research. Finally, it considers funding and legislative strategies that would improve the quality and accessibility of residential long-term care.

By residential long-term care, we are referring to government-funded and regulated long-term care (LTC) facilities that provide 24-hour nursing care, primarily to frail seniors. We touch on private-pay and unregulated facilities, but our focus is primarily on publicly-funded and regulated facilities that provide high-level care to seniors and others with complex,

multiple, chronic conditions. Different terms are used across Canada: nursing homes, residential care facilities, complex care facilities, special care homes, auxiliary hospitals, personal care homes, charitable homes, homes for the aged, manors, and other titles. In this paper, we use the terms “long-term care facility” and “residential long-term care” interchangeably to refer to this group of facilities. See Appendix A for definitions and terminology.

In this paper, “long-term care” (as opposed to “residential long-term care”) refers to a broader category that includes home and community-based care as well as residential care provided in a long-term care facility. Some provinces use the term “continuing care” to describe this category of services.

Extend medicare to residential long-term care

Introduction and summary

Residential long-term care in Canada is highly privatized, fragmented, and uneven across the country. Unlike medically necessary hospital care, it is not fully covered by public insurance or by the *Canada Health Act*. There is a nominal federal funding allocation to long-term care, but it is not tied to standards or program requirements. Provincial government funding, eligibility rules, and standards vary widely, leaving residents to pay privately for many important goods and services or do without. Fully private-pay facilities are beyond the financial means of the vast majority.

In Canada, medicare (universal public health insurance) covers medically necessary hospital and physician services, but does not cover medically necessary long-term care services, either in home or in residential care.

Demand for long-term care beds is increasing due largely to hospital downsizing, inadequate home and community care services, and population aging, yet most provinces are reducing rather than expanding bed capacity relative to the seniors' population. Long waits are the norm, and choice is limited or non-existent.

This section concludes with proposals for eliminating two-tier access and properly resourcing residential long-term care as part of a broader strategy for meeting seniors' health care needs.

Excluded from medicare, residential LTC coverage is inadequate and uneven

In Canada, medicare (universal public health insurance) covers medically necessary hospital and physician services, but does not cover medically necessary long-term care services, either in home or in residential care. Neither the five criteria nor the two conditions in the *Canada Health Act* (criteria and conditions that must be met for provinces and territories⁵ to get full

federal health transfers)⁶ apply to residential LTC. The *Act* refers to “adult residential care service” and “nursing home intermediate care service” as part of “extended health care services,” but the federal government failed to promulgate regulations that would define those services, and it never attached strings to its funding for those services.⁷

Federal funding has assisted elderly persons in residential care since 1966 and been nominally allocated for long-term care more broadly since 1977, but it has never been tied to any delivery standards or program requirements.⁸ The federal government issued “guidelines” for institutional health care in 1973, but those guidelines were general and unenforceable.⁹ When the Established Program Financing (EPF) formula was put in place in 1977 (combining funding for health and post-secondary education), it included a small fund for “extended health care” called the Extended Health Care Services program, but again, there were no binding conditions. The EHCS transfer started at \$20 per capita (out of a total EPF transfer of \$186.79 per capita that year),¹⁰ and by the early 1990s had risen to \$51.51 per capita for a total of \$1.5 billion.¹¹ The EHCS program lost profile in 1996 when federal transfers to the provinces for health, postsecondary education, and welfare were collapsed in the Canada Health and Social Transfer (CHST). The current Canada Health Transfer covers extended health care services, but there are still no program delivery criteria.

The federal government provided a substantial boost to the construction of many non-profit LTC facilities developed after WWII, particularly in the 1960s and 1970s. Under the *National Housing Act*, the Canada Mortgage and Housing Corporation (CMHC) assisted non-hospital LTC facilities to cover capital costs, usually through loans, loan insurance or subsidized mortgage rates. Between 1946 and 1979, CMHC contributed financially to an estimated 43,028 institutional beds for the elderly, representing about one third of all beds assisted under the *National Housing Act*.¹² None of this funding was tied to standards, for example to ensure access or minimum levels of care.

Even at the level of information, the federal system is weak. The Canadian Institute for Health Information, which is spearheading a project to establish key Canada-wide indicators for residential LTC, notes in its recent report that “very little data is currently available at a national level on the types and adequacy of services provided, the service providers and the service recipients, program effectiveness and client outcomes.”¹³

In the absence of legislated federal standards, or even common terminology, residential LTC became a patchwork of provincial systems with different ownership patterns, levels of public funding, eligibility rules, and standards. While all provinces regulate and subsidize LTC facility fees, there is wide variation across the country. Eligibility criteria and means-testing methods differ from province to province.¹⁴ Table 1 (on page 22) presents the accommodation fees that residents can be charged in each province. Means-testing methods vary; some provinces include residents’ liquid assets such as Registered Retirement Savings Plans (RRSPs), while others do not. There are also differences in allowances made for personal expenses, spouses’ and dependents’ needs, and other expenses. Further, the accommodation charge covers different items in each province; for example, it may or may not include incontinence supplies. Differences in prescription drug plans, subsidies for medical supplies, and other government programs exacerbate the inequalities between provinces in terms of the financial burden borne by long-term care residents.

In the absence of legislated federal standards, or even common terminology, residential LTC became a patchwork of provincial systems with different ownership patterns, levels of public funding, eligibility rules, and standards.

Table 1: Resident charges for long-term care facilities, by province		
	Accommodation charges for LTC residents (per month)	Cost as of
British Columbia	\$882 minimum; \$2,118 maximum	Sept. 2007
Alberta ^a	\$1,354 standard room; \$1,650 private room	Nov. 2008
Saskatchewan	\$956 minimum; \$1,815 maximum	Jan. 2008
Manitoba	\$903 minimum; \$2,120 maximum	Aug. 2008
Ontario	\$1,578.02 standard room (four beds); \$1,821.35 semi-private room; \$2,125.52 private room	July 2008
Quebec	\$988.50 standard room (three or more beds); \$1,329.00 semi-private room (two beds); \$1,590.90 private room	Jan. 2008
Newfoundland and Labrador	\$2,800 maximum	Jan. 2008
New Brunswick	\$2,129 maximum	Jan. 2007
Nova Scotia	\$2,403; LTC facilities are prohibited from charging extra for private or semi-private rooms	Nov. 2007
Prince Edward Island	In public facilities, maximum: \$1,977 standard room; \$2,561 semi-private room; \$3,011 private room	Nov. 2007
Notes:	Most facilities charge additional fees for incontinence products, uninsured prescription drugs and health services, hairdressing, and many other products and services.	
	^a Alberta has been converting standard rooms to private and semi-private rooms since the early 1990s, and subsidies for low-income residents are based on semi-private rooms. Upgrades to private rooms must be paid out of the income allowance.	
Sources:	Banerjee, 2008; for Alberta, email communication with Wendy Armstrong, August 4, 2009.	

Table 2: Minimum disposable income allowance, by province	
	Minimum disposable income allowance (per month)
British Columbia	\$236
Alberta	\$265
Saskatchewan	\$200
Manitoba	\$254
Ontario	\$122
Quebec	\$179
Newfoundland and Labrador	\$125
New Brunswick	\$200
Nova Scotia	\$115
Prince Edward Island	\$103
Source:	Alberta Seniors and Community Supports (2007) in Banerjee, 2008, 21. The minimum disposable income allowance is the amount the provincial government allows subsidized residents to retain for personal expenses.

Low-income residents receive government subsidies to cover monthly facility fees, but the amount left over is not enough to pay for additional services and products they need. After paying LTC facility fees, seniors who receive only Old Age Security (OAS) and Guaranteed Income Supplement (GIS) benefits are left with a personal allowance ranging from \$103 to \$265 per month (Table 2). In BC, 63 per cent of LTC residents fall into this category.¹⁵ Further, the “disposable income allowance” generally increases slower than inflation; a report in 2002 indicated that many provinces had not increased the rate for over a decade.¹⁶

The income allowance has to cover a wide range of residents’ expenses not covered by the facility fee, and while this varies by province, the expenses may include such things as: dentures, hearing aids, specialized wheelchairs and cushions, therapeutic mattresses, diagnostic tests, over-the-counter drugs, personal hygiene products, personal laundry, telephone, physiotherapy, foot care, and personal expenses like gifts and clothing. Some provinces offer additional subsidies for medical products, but nowhere are these fully insured. In Alberta, for example, residents can apply to the income-tested Aids to Daily Living program for assistance with the costs of some health care supplies, like wheelchairs, but there are limits to what is covered and how often assistance is available.¹⁷ Veterans’ costs for medical supplies are subsidized by the federal government, but again, this is not universal coverage.

Low-income residents receive government subsidies to cover monthly facility fees, but the amount left over is not enough to pay for additional services and products they need.

An aging population

The ratio of older to younger Canadians is increasing rapidly, and demand for LTC beds will rise with it. By one estimate, the number of beds required in LTC facilities could range from 565,000 to 746,000 by 2031.¹⁸ (Currently, Canada has roughly 194,000 beds. See Table 4 on page 25.) Certainly, LTC bed projections are determined by more than simply age trends—they consider changes in life expectancy, health status, technology, supply in other parts of the health care system, and many other factors. Population age patterns do, though, have a significant impact.

The aging pattern is indisputable. In 2005, 13.1 per cent of the population was over 65. In 2031, almost one quarter (23.4 per cent) of the population is projected to be over 65. The number of *older seniors* in particular and their share of the total population are projected to increase sharply over the next few decades. By 2056, the proportion of Canadians 80 years and over will triple to about 1 in 10, compared with about 1 in 30 in 2005.¹⁹ This cohort is most relevant to residential LTC, where the average age at admission was 86 in 2002 (up from 75 in 1977).²⁰ This increase by 11 years of the average entry-level age of residents over 25 years is likely due more to insufficient capacity and narrowed access than to health improvements in the seniors’ population or expansion of services elsewhere, as the next section addresses.

The population is not aging at the same rate across Canada. The population of eastern provinces is older and aging faster than the population of western provinces due to differential immigration/migration trends and birth rates. The population of Newfoundland and Labrador is the oldest with a median age of 41.1 in 2006; Alberta has the youngest population (median age 35.8). The gap between the east and west is expected to widen. Table 3 (on page 24) presents “middle of the road” population projections for 2031 (i.e. using medium assumptions on fertility, mortality, immigration, and interprovincial migration).

Table 3: Median age and percentage of population 75+ by province, 2006 and 2031

	Median age		Percentage of population 75 and older	
	2006	2031	2006	2031
British Columbia	39.8	45.1	6.74	11.57
Alberta	35.8	42.5	4.93	9.88
Saskatchewan	37.6	44.2	7.84	11.98
Manitoba	37.3	41.8	6.93	10.30
Ontario	38.2	43.4	6.11	10.14
Quebec	40.4	46.0	6.44	12.09
Newfoundland & Labrador	41.1	49.9	5.93	14.26
New Brunswick	40.7	47.7	6.75	13.88
Nova Scotia	40.8	48.1	8.42	13.41
Prince Edward Island	39.6	46.3	6.64	12.77
Canada	38.8	44.3	6.27	10.99

Source: Statistics Canada, 2005.

Long waits and difficult decisions

Long waits for acceptance into a LTC facility, already a problem before this decade, have worsened with hospital downsizing, an aging population, reduced LTC bed levels in all but one province, and persistent shortages in home and community supports.

The population is rapidly aging, and many seniors need residential long-term care,²¹ yet most provinces are reducing rather than expanding access to LTC beds. Long waits for acceptance into a LTC facility, already a problem before this decade, have worsened with hospital downsizing, an aging population, reduced LTC bed levels in all but one province, and persistent shortages in home and community supports.

Access to licensed residential care for people aged 75 and over has narrowed in all but one province since 2001. As indicated in Table 4 (on page 25), the number of beds relative to seniors over 75 has been cut in all provinces except Ontario—by 7 per cent in Manitoba and Nova Scotia all the way up to 21 per cent in BC and Alberta. New Brunswick has the lowest capacity, by this measure. Even just looking at absolute bed numbers across the country, five provinces cut LTC beds between 2001 and 2008, and three others had negligible increases. Ontario is the exception, but as shown in a later section of this paper, the expansion of LTC beds in Ontario has been largely in the for-profit sector, where lower staffing is common and (with the elimination of legislated staffing levels in 1996) more money is diverted from direct care to company profits.

The general pattern of cuts to residential long-term care beds relative to the population began earlier. Between 1990/91 and 2000/01, the number of residential LTC beds per 1,000 population in Canada was reduced by 9.9 per cent. Alberta downsized its LTC facilities during the 1990s more than any other province, by just over 40 per cent.²²

Table 4: Residential care bed rate (beds per 1,000 population aged 75+), by province, 2001 and 2008

	2001		2008		% change 2001 to 2008		
	beds	beds per 1,000 aged 75+	beds	beds per 1,000 aged 75+	pop'n 75+	bed number	bed rate
BC	25,420	102.3	24,616	81.3	21.8%	-3.2%	-20.5%
Alberta	14,486	106.0	14,654	83.9	27.7%	1.2%	-20.8%
Saskatchewan	9,240	123.4	8,944	112.8	5.9%	-3.2%	-8.6%
Manitoba	9,733	124.5	9,833	116.1	8.4%	1.0%	-6.8%
Ontario	58,403	88.2	75,958	91.5	25.3%	30.1%	3.8%
Quebec	43,491	104.8	46,091	88.3	25.8%	6.0%	-15.7%
New Brunswick	4,227	89.6	4,175	78.5	12.7%	-1.2%	-12.4%
Newfoundland	2,818	101.3	2,643	84.2	12.8%	-6.2%	-16.8%
Nova Scotia	5,806	96.3	5,986	89.4	11.0%	3.1%	-7.1%
PEI	950	106.5	978	100.1	9.5%	-2.9%	-9.3%
Canada	174,574	99.2	193,858	90.0	22.4%	11.0%	-9.3%

Source: Cohen et al., 2009b.

Cuts in residential long-term care across Canada over the past two decades have not been matched by an expansion in home and community care, and hospital downsizing continues. While hospital closures and cutbacks were most pronounced across Canada in the 1990s, including radical downsizing of extended and chronic care hospitals,²³ a number of provinces have continued to close small and rural hospitals and reduce length-of-stay in all types of hospitals.²⁴ In terms of health care services provided in the home and by community agencies, there have been new investments in all provinces,²⁵ but progress is uneven,²⁶ and nowhere is the investment sufficient.²⁷ Despite government rhetoric about restructuring health care to provide services “closer to home”²⁸ and despite decades of studies and commissions calling for investment in home and community care, these services remain severely underfunded across Canada. Private payment is high and on the rise,²⁹ and an increasing share of public home care funding is going toward profits in at least one province, Ontario.³⁰ Even with an end to hospital cuts and with better-resourced services in home and community settings, the demand for LTC beds will continue to outpace capacity if current trends continue.

Given the shortage of LTC beds, elders needing residential care placement are forced to make difficult choices. Some must accept the first available bed, often at a facility they would not choose.³¹ This is especially the case for elders with specific cultural needs and those living in rural and remote communities. Couples are often separated, unable to find beds in the same facility or, in some cases, the same community. In some provinces, a person who refuses an offered space is moved to the bottom of the wait-list, forced to wait months, possibly years, for another opening.³² Few can afford to move to a fully private-pay facility.

Despite government rhetoric about restructuring health care to provide services “closer to home” and despite decades of studies and commissions calling for investment in home and community care, these services remain severely underfunded across Canada.

Private-pay residential care is unaffordable

Private-pay residential care facilities are beyond the reach of most Canadians. In 2009, the average cost of a bed in British Columbia private-pay residential care facilities was \$4,718 per month or \$56,616 per year.³³ As of 2005, in the same province, less than 5 per cent of unattached women over 65 and just over 11 per cent of unattached men over age 65 had incomes over \$60,000 and therefore could afford a private-pay facility.³⁴

Private-pay residential care facilities are beyond the reach of most Canadians. In 2009, the average cost of a bed in BC private-pay residential care facilities was \$4,718 per month or \$56,616 per year. As of 2005, in the same province, less than 5 per cent of unattached women over 65 and just over 11 per cent of unattached men over age 65 had incomes over \$60,000 and therefore could afford a private-pay facility.

Private-pay residential care facilities are also beyond the means of seniors in other provinces. Fees vary widely between and even within provinces, but rent for private-pay facilities runs anywhere from \$30,000 to \$60,000 per year.³⁵ Table 5 presents data from the Canadian Mortgage and Housing Corporation on rents for “heavy care” seniors housing—that is, housing units that provide 1.5 or more hours of health care per day. Note that these rents cover only low levels of care (below the levels received in most licensed facilities) and exclude many fees.³⁶

Table 5: Average rent for private-pay facilities, and relevant income levels, selected provinces, 2009

	Average rent	
	monthly	annual
British Columbia	\$4,718	\$56,616
Alberta	\$3,403	\$40,836
Saskatchewan	\$2,686	\$32,232
Ontario	\$3,437	\$41,244
Quebec	\$2,563	\$30,756
Prince Edward Island	\$2,867	\$34,404

Note: CMHC does not provide data for Manitoba or for Atlantic provinces outside of PEI, citing “data suppressed to protect confidentiality or data is not statistically reliable.”
Source: Canada Mortgage and Housing Corporation, 2009, 9, (Table 1.3).

Consider that the 2007 median income for single elderly women in Canada was \$21,800, for single elderly men, \$25,100, and for elderly families, \$47,900. Median after-tax income was \$21,300, \$23,400, and \$44,900 for each group, respectively.³⁷ The vast majority of seniors simply cannot afford private-pay facilities.

Private long-term care insurance is also beyond the reach of most Canadians. A 2006 review of the private health insurance industry in Canada and in-depth analysis of selected offerings concluded that “long-term care insurance is a complex, expensive and high-risk product.”³⁸ The study documented high and rising premiums, frequent rejection of applicants, caps on benefits and insufficient coverage, misleading advertising, difficulties with claims, and a confusing array of products, fees and rules. The authors conclude that “Increased reliance on private long-term care insurance does not appear to be a viable alternative to protect

Canadian families and communities from the high costs of unpredictable care needs or effectively influence the price and quality of suppliers.”³⁹ This might explain why only some 54,000 Canadians (1 per cent of the seniors population) own long-term care insurance.⁴⁰

The way forward

SOLUTION: Extend medicare to residential long-term care, with increased federal funding tied to legislated standards, including *Canada Health Act* criteria (public administration, universality, comprehensiveness, accessibility, and portability) and conditions (no user fees or extra billing).

Expanding federal funding and extending the regulation of medicare to residential long-term care would reduce wait times and end two-tier access. The federal government should substantially increase funding transfers to provincial and territorial governments for residential LTC and make those transfers conditional on compliance with legislated standards. New federal residential LTC legislation should incorporate the criteria and conditions contained in the *Canada Health Act*,⁴¹ namely:

- Public administration (administered on a not-for-profit basis);
- Universality (covering all insured persons on uniform terms and conditions);
- Comprehensiveness (covering all medically necessary services);
- Accessibility (reasonable access on uniform terms and conditions, unimpeded by extra charges or discrimination);
- Portability (coverage while absent from home province); and
- No extra billing or user charges for such insured services.

See Part 5 on page 63 for additional details on federal legislation.

In the implementation of this new fiscal arrangement and legislation, the federal government should recognize the distinctness of Quebec. Quebec should have primacy in its jurisdiction over social policy and should have the right to opt out of this proposed joint federal-provincial residential LTC program and receive the full transfer payment under the program. For the rest of Canada, joint federal-provincial responsibility applies, with a federal leadership role in funding this residential long-term care program, as well as in setting and enforcing national standards.

In addition to being universal,⁴² the federal LTC program should be single-payer and funded through general tax revenues. Single-payer, tax-based programs have a number of advantages: equitable access; administrative simplicity and efficiency; progressivity in the sharing of costs; large risk pooling; and controlling service costs through single-payer buying power.⁴³ Tax-based health systems typically cost two to three percentage points less of Gross Domestic Product than do social insurance models,⁴⁴ which are funded by mandatory contributions (usually a percentage of income contributed by employers and employees).

Expanding federal funding and extending the regulation of medicare to residential long-term care would reduce wait times and end two-tier access.

Part of a larger vision

SOLUTION: Expand residential long-term care, home and community care services to meet the needs of Canadian seniors, as part of a comprehensive and integrated system.

Our call for an extension of medicare to residential long-term care—with regulation and increased funding—is part of our vision of a comprehensive medicare system that would also include pharmacare,⁴⁵ home care, primary health care, dental and vision care.⁴⁶ Expansion in any of these areas should not be at the expense of hospital services, already stretched too thin across Canada. The entire continuum of health care is important.

Our call for an extension of medicare to residential long-term care is part of our vision of a comprehensive medicare system that would also include pharmacare, home care, primary health care, dental and vision care—and not be at the expense of hospitals, already stretched too thin.

Improving the accessibility and quality of non-residential long-term care, in particular home care, is urgently needed. We know that many people on LTC wait-lists could be cared for at home if appropriate home and community supports were available⁴⁷ and that these supports remain severely underfunded across Canada. Our focus in this paper is on residential LTC because we have particular expertise in this area, with one in ten CUPE members employed in residential LTC—and because residential LTC policy on its own is complex. We believe governments should improve the quality and accessibility of LTC facilities as part of a broader strategy to improve programs for seniors and others who need long-term care.

The key is a comprehensive strategy, not one that uses ‘closer to home’ rhetoric to camouflage cuts or to pit ‘home’ against ‘institution.’ Instead of increased support for seniors, health care restructuring has on the whole meant increased burdens—a shifting of responsibility and costs to underpaid workers, unpaid caregivers, and seniors themselves. There has been inappropriate downloading of patients from hospitals and mental health facilities to LTC facilities. With rationing of residential LTC, there has been a further downloading onto already-strained home and community health programs. At every step, the burden on unpaid caregivers increases,⁴⁸ and the wages and working conditions of paid caregivers deteriorate.

Relocation of care⁴⁹ from institutional to home care is often premised on a simplistic dichotomy that characterizes institutional care as ‘cold, unfeeling, regimented and without free choice’⁵⁰ and home as ‘warm places of love, with lots of freedom and no schedules.’⁵¹ As sociologist and health care researcher Pat Armstrong explains,⁵² the options are not so dichotomous:

- Home is not always a safe haven where loved ones offer care spontaneously or with adequate support themselves;
- Paid home care also enforces a schedule, and it offers less continuity of providers;
- Care at home as the only option promotes a private notion of care that favours people with more resources (financial and support); and
- Institutions allow for teamwork and employ providers with different skill sets.

Equally important, the dichotomy writes off institutions rather than finding ways to promote residents’ autonomy, make facilities less rigid and medical-dominated, and in myriad other ways make facilities better places to live. The solution is to properly resource and genuinely reform both home and residential care, not to pit one against the other.

Hospital-based extended and chronic care, for seniors and others with complex conditions, also has an important place in the continuum of care. While this paper focuses on residential long-term care, it does in the next section address the rationing of hospital services as part of a deregulation and privatization strategy that has serious negative consequences.

Services for seniors need to be integrated between hospital, LTC facility and home / community as well as with external programs like housing and social services. Integration between health services and social services varies province to province, as does integration across government programs more broadly. The federal government should play a larger role in supporting innovative governance and delivery models that integrate care for seniors and others who suffer from chronic, multiple, complex conditions. Provincial governments have a clear responsibility to implement successful models system-wide, and a recent study of pilot projects in British Columbia identifies concrete strategies for “scaling-up” such innovations.⁵³ The World Health Organization offers a useful framework for integration:

A long-term care system is comprised of a comprehensive range of services, some based in the home, others based in the community, in health care institutions, and elsewhere. In an optimal and rational model, all of the services and structures that form a system will be designed to allow individuals to lead lives of dignity and, where possible, independence, without placing intolerable burdens on their families.⁵⁴

Good for families, good for the economy

Extending medicare to residential long-term care would help overburdened families, in particular the women in those families, and would provide a much-needed boost to the economy—both by freeing up unpaid caregivers to participate more fully in the labour force and by creating new jobs.

Residential long-term care has particular significance for women, who make up the majority of residents and caregivers.

The majority of long-term care residents are women. Women make up nearly two thirds of the residential care population overall and three quarters of residents 85 and older.⁵⁵ Looking at it another way, the likelihood of being in a long-term care facility is roughly equal for men and women between the ages of 65 and 74; however, the pattern changes around age 75. By the age of 85, women are almost twice as likely as men to be in a LTC facility. (See Table 6.)

Extending medicare to residential long-term care would help overburdened families, in particular the women in those families.

Table 6: Percent of population in LTC facilities by age and gender, Canada, 1995		
age	% in this age group in a LTC facility	
	women	men
65–74	2	2
75–84	10	7
85+	38	24

Source: Pitters, 2002.

Women are overrepresented among LTC residents primarily because they live longer and have fewer resources to stay at home. Life expectancy was 82.5 years for women and 77.7 years for men in 2006.⁵⁶ The ratio of women to men in the over-74 age group is roughly six to four (61 per cent versus 39 per cent).⁵⁷ Elderly women have less income than elderly men,⁵⁸ and they are also less likely to have someone to care for them at home.⁵⁹

Caregivers, both paid and unpaid, are also disproportionately women. On the paid side, using data from three provinces, women account for as much as 95 per cent of workers in LTC facilities.⁶⁰ On the unpaid side, women are more likely than men to put in unpaid overtime to compensate for care deficits⁶¹ and to provide unpaid care to family and friends who live in facilities.⁶² This unpaid care can be significant, particularly in for-profit facilities where staffing is (on average) lower. A 2007 Statistics Canada survey found that nearly 30 per cent of seniors living in care facilities received assistance from unpaid caregivers with meal preparation, cleaning and laundry; one half received help with care management; and one in 10 received personal care (such as bathing and dressing) from family and friends.⁶³

The general pattern of underfunding, deregulation and privatization of residential long-term care in Canada means that already-burdened families are being asked to take on more responsibility for their loved one's care. These extra responsibilities have a ripple effect on families, communities and society at large.⁶⁴ Families are strained as a result of lost income (including pensions) for unpaid caregivers and the impacts of stress on relationships and the health of family members.⁶⁵ Employers are affected by lost work time and the consequences of stressed-out employees. The impacts on society more generally includes lost tax revenues, higher poverty rates, family bankruptcies and increased demands on social programs.

Creating a universal public residential long-term care program would also be a smart investment from the perspective of job creation and economic stimulus. Often this effect is measured as a choice between public investment and tax cuts. Recent research shows that \$1 billion of public investment in health care would create three times as many jobs as the same amount in personal income tax cuts. The boost to the economy (measured as GDP increase) would also be stronger.⁶⁶

Conclusion

A pan-Canadian residential long-term care program with dedicated federal funding and legislated standards is long overdue. As Canadians, we pride ourselves on the universality of medicare, reflecting our belief that access to health care should be based on need, not ability to pay or place of residency. The values of fairness and equality reflected in medicare should be applied to health care goods and services regardless of where they are provided, whether in a hospital, a long-term care facility, a doctor's office, a community agency, or at home.

The next section addresses staffing as a critical part of that residential long-term care program, illustrating the link between working and caring conditions and the urgent need to improve both.

Families are strained as a result of lost income for unpaid caregivers and the impacts of stress on relationships and the health of family members. Employers are affected by lost work time and the consequences of stressed-out employees. The impacts on society more generally includes lost tax revenues, higher poverty rates, family bankruptcies and increased demands on social programs.

Staffing and quality of care

Introduction and summary

Good working conditions are a prerequisite for good caring conditions. Decades of research show that the number of staff is directly and positively related to quality of care and that there is an urgent need to increase staffing in LTC facilities.⁶⁷ The relationship of LTC staffing to quality of care and quality of life goes beyond numbers of staff.⁶⁸ Continuity of care, organizational practices, and management approaches play a major role,⁶⁹ as do education and training of LTC staff. Continuity of care—primarily determined by turnover—is in turn a complex issue, with staffing levels, compensation, and work environment having decisive influence.

Decades of research show that the number of staff is directly and positively related to quality of care and that there is an urgent need to increase staffing in long-term care facilities.

Our framework on staffing

Measuring quality of care and quality of life

Staffing emerges as the critical determinant in quality whether “quality of care” or “quality of life” measures are used. In residential LTC, discussions about quality usually focus on the health and safety of residents and on care outcomes such as pressure sores (ulcers), weight loss, or falls. Sometimes they also measure care process, such as the use of physical and pharmaceutical restraints or the number of staff to assist at meal times.⁷⁰

Quality of life is a broader concept.⁷¹ It captures aspects of well-being such as residents’ opportunities for choice, autonomy, and meaningful relationships. A recent report published by the Ontario Ministry of Health defines quality of life as:

*living with dignity, respect, comfort, choice, security, happiness, pleasure, fun, individuality, self-worth, trust, security, safety, pride, reduced stress, autonomy, independence, and the resident's preferred culture, beliefs and language.*⁷²

The evidence linking staffing and quality is strong in both the *quality of care* and *quality of life* literature. The data and research on *quality of care* in long-term care facilities offers convincing evidence that staffing lies at the heart of quality, as this section shows. Research on *quality of life* is more recent and less abundant, but it underscores the importance of staffing—in particular, the value of social-emotional care and residents' relations with staff. One Ontario study of residents relocated from an outdated LTC facility to a new “state of the art” facility found that relations with staff appeared to be central to residents' assessment of quality of care and life—more important by far than the change to a new, bright, high-tech environment and diversified programming.⁷³

In this section and this paper more generally, we use the term *quality of care* because it represents the bulk of research evidence and is the more commonly-used term. However, we support the broader framework of *quality of life* and draw on that research literature where possible.

Direct care and support staff—both critical to quality

Support workers play a vital role in residential long-term care. They provide nutritious food. They ensure a safe and healthy environment for residents. They make sure that records are properly maintained. They also provide personal care to residents.

Research on residential long-term care is biased in another way: it tends to focus on direct care workers (nurses and care aides) and under-represent support workers (food, cleaning, laundry, maintenance, clerical and others).

From our perspective, the two types of work are equally important, and we draw on evidence around support services where we can.

Nursing, care aide, dietary, recreational, rehabilitation, clerical, laundry, housekeeping, maintenance and other staff in LTC facilities are all critical to care quality.⁷⁴ Most of the research on staffing and quality of care has examined nurse⁷⁵ and personal care staff⁷⁶: registered nurses, licensed practical nurses, and resident care aides. Registered nurses have received the most attention. Research is sorely needed on staffing in other areas: food, cleaning, laundry, maintenance, clerical and other support services.

Support workers play a vital role in residential long-term care. They provide nutritious food. They ensure a safe and healthy environment for residents. They make sure that records are properly maintained. Support workers also provide personal care to residents: assisting them with their meal trays and with eating and drinking, portering residents to activities, and providing social interaction while doing work like cleaning and delivering laundry and meals. When any of these roles are short-staffed, nurses are spread thin trying to cover gaps, taking valuable time away from nursing care.

Food service workers and cleaners are two groups of support workers in LTC whose contribution is researched more than other support workers, though still far less than nurses. The demonstrated link between their work and residents' health outcomes is an indication of the valuable role of support staff as a whole.

Food service workers support good nutrition, which many studies show is critical in maintaining health and preventing disease, particularly for frail seniors. Whereas well-nourished seniors have “fewer medical complications and diseases, faster wound healing, and fewer infections,” malnourished seniors experience “decreased quality of life, decreased independence, and deterioration in overall health status, increased use of health care resources, and increased morbidity and mortality.”⁷⁷ Substitution of processed foods for fresh items prepared on-site and the importance of food safety for seniors gained attention recently with the listeriosis outbreak in long-term care facilities.⁷⁸

Hygiene is also critical to quality of care. Laundry, housekeeping, food handling and other staff play a vital role in protecting residents from healthcare-associated infections (HAIs).⁷⁹ A number of clinical studies and audits have linked outbreaks of HAIs with understaffing, increased workload, high levels of absence and high turnover of cleaning staff.⁸⁰ Government investigations, including a recent coroner’s inquest in Quebec, have confirmed the central role of cleaning in prevention and control of HAIs.⁸¹ LTC residents are at elevated risk of getting infections,⁸² and yet infection control staffing, policies and practices, education, and surveillance in LTC are dramatically under-resourced.⁸³

Knowing that good nutrition, hygiene, and other outcomes of support services are a vital part of good health, it is safe to theorize that our findings below regarding direct care staffing levels, education, stability, continuity, and work environments also apply to support staff.

Increase staffing in long-term care facilities

SOLUTION: Increase staffing (direct care and support staff) in residential long-term care facilities.

Staffing and policies have not kept pace with changes in residents’ needs

The staffing and organization of LTC facilities have not kept up with changes in the profile and care needs of residents.⁸⁴ The number and mix of staff, their training, and the way care is provided—none of these have evolved in step with the changing profile and needs of residents.

Residents living in LTC facilities today have significantly greater needs than residents 15 years ago.⁸⁵ The vast majority is over the age of 75, has multiple medical diagnoses, can’t move independently, suffers serious cognitive and physical impairments, and has unstable, complex health needs.⁸⁶ According to one recent profile, 75 per cent of residents have serious dementia; more than 90 per cent need assistance with mobility, eating, toileting and dressing; and residents average five serious chronic medical diagnoses.⁸⁷ Table 7 (on page 34) presents another, earlier snapshot. Residents’ physical and psychosocial care needs have become so complex that some experts have characterized residential care facilities as “mini-hospitals.”⁸⁸

Adding to the complexity of residents’ health profile and care needs is that more younger adults with disabilities and chronic conditions are entering long-term care facilities. This is largely due to rationing of other facility-based care and inadequate supply in other parts of the health and social services system. These residents too have complex health problems

The staffing and organization of LTC facilities have not kept up with changes in the profile and care needs of residents. Residents living in LTC facilities today have significantly greater needs than residents 15 years ago.

Table 7: Prevalence of dementia and Alzheimer's disease, physical problems and other diagnoses among LTC residents

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

Source: Adapted from PriceWaterhouseCoopers (2001) in Ontario Health Coalition, 2002.

Looking at palliative care in BC as an example, the rate of deaths in residential care increased by 81 per cent over five years, from 14.6 per cent of all clients to 26.4 per cent of all clients between 2001 and 2006. Resources and policies, however, have not kept pace.

requiring a high level and broad range of services, and they have distinct needs and experiences. For example, many of the new, younger residents have no psychological impairment but are in facilities where a large number of residents have dementia.

More people with sub-acute and palliative care needs are admitted into residential long-term care, and funding gaps are evident here too. Governments are not increasing funding enough to pay for the specialized staff and equipment needed to properly care for these residents. Looking at palliative care (care for people who are dying) in British Columbia as an example, the rate of deaths in residential care increased by 81 per cent over five years, from 14.6 per cent of all clients to 26.4 per cent of all clients between 2001 and 2006.⁸⁹ Resources and policies, however, have not kept pace. Research carried out in one region of the province, in 2007, found that average daily spending on residential care was roughly half the amount spent on hospice care (hospital-based palliative care).⁹⁰ Staffing and policies for sub-acute care have likewise failed to keep up with the changes in residents' needs.⁹¹

Increased staffing improves residents' health and well-being

The first solution to this crisis in quality is to increase staffing. The research is unequivocal. Study after study demonstrates that staffing levels are directly and positively related to residents' health outcomes:⁹²

- Residents (1,376) from 82 LTC facilities in 19 US states who received 45 minutes or more of direct care per day from LPNs were 42 per cent less likely to develop pressure ulcers compared to those who received less.⁹³

- In a study including 363,895 residents living in 2,951 LTC facilities in six US states, residents receiving three or more resident care aide (RCA) hours per resident day (hprd⁹⁴) had a 17 per cent lower risk of weight loss compared to those who received less.⁹⁵
- A California study of 882 residents in 34 LTC facilities found that the residents living in higher-staffed facilities (six facilities, 136 residents) spent less time in bed, experienced more social engagement, and consumed more food and fluids than residents living in the lower-staffed facilities (28 facilities, 746 residents).⁹⁶
- In a US study including 5,314 residents living in 105 LTC facilities, those residents living in facilities with higher care aide staffing levels were more likely to be involved in a scheduled toileting program, receive active or passive range of motion training, and receive rehabilitative training for such activities as walking or getting out of bed. Residents were also more likely to be involved in a scheduled toileting program in facilities with higher recreational aide staffing.⁹⁷
- In a four-year study of quality of care at mealtime in two northwest US LTC facilities, researchers found that residents had better nutrition and hydration when care aides could focus on helping to feed or assist no more than two or three residents at mealtime.⁹⁸ However, on the whole, the quality of care at mealtime was poor as each care aide typically had to care for seven to nine residents at lunch and 12 to 15 residents at dinner. The researchers observed some residents lost a great deal of weight, and many were coughing and choking during mealtimes.
- In a study of 91 residents living in LTC facilities, researchers observed that residents who need only supervision and verbal cuing require just as much staff time as residents who are physically dependent on staff for eating. To improve fluid and food consumption, residents needed 35 to 40 minutes of staff time per meal.⁹⁹
- In a large study involving 5,294 long-stay residential care facilities in 10 US states, residents who received 4.1 total nurse and patient care hours per resident per day improved their activities of daily living skills and had fewer incidences of weight loss and pressure ulcers.¹⁰⁰
- Among 21 California LTC facilities, those with one care aide for every 7.6 residents (six facilities) performed better on 13 out of 16 care process measures than facilities with one care aide for 9 to 10 residents (15 facilities).¹⁰¹
- In a simulation study based on a data sample of 674 New York LTC facilities and 972 Ohio facilities, researchers showed that in order for care aides to provide optimal levels of feeding, toileting, exercise and personal care assistance, 3.2 care aide hprd are needed for high-workload residential care facilities.¹⁰²
- Using data from five sources, including the 2005 and 2006 national survey of US nursing home administrators and government nursing home databases over two years (2004 to 2006), researchers found that higher care aide staffing levels were associated with lower restraint use, rates of pressure sores, and use of catheters.¹⁰³

The first solution to this crisis in quality is to increase staffing. The research is unequivocal. Study after study demonstrates that staffing levels are directly and positively related to residents' health outcomes.

There is evidence of a clear link between inadequate staffing levels and higher rates of adverse outcomes for residents, such as falls, fractures, infections, weight loss, dehydration, pressure ulcers, incontinence, agitated behaviour, and hospitalizations.

- Comparing LTC facilities in Norway with high staff-to-resident ratios (120 facilities) to facilities with low staff-to-resident ratios (125), residents in higher staffed facilities were more likely able to:
 - Get up and go to bed when they wanted to;
 - Go to the toilet when they needed/wanted to; and
 - Go for a walk (with a companion if needed) when they wanted to.¹⁰⁴
- An analysis of all licensed, freestanding nursing homes in California that received state inspections between 1999 and 2003 (1,099 facilities) revealed that facilities with higher than average nurse and care aide staffing had significantly lower total deficiencies, quality of care deficiencies, and serious deficiencies.¹⁰⁵
- Looking at 302,000 complaints received on 19,893 facilities between 1998 and 2002, researchers found that facilities with higher staffing levels had fewer complaints about care quality.¹⁰⁶

Just as proper staffing levels support good health, they also avoid bad health. There is evidence of a clear link between inadequate staffing levels and higher rates of adverse outcomes for residents, such as falls, fractures, infections, weight loss, dehydration, pressure ulcers, incontinence, agitated behaviour, and hospitalizations.

- In a study covering 1,768 LTC facilities in New York, Ohio and Texas, care aide staffing below two hours per resident day was associated with roughly a four-fold increase in the likelihood of high hospitalization rates for a range of avoidable health problems. Specifically, facilities with care aide staffing below 2.04 hours per resident day were 4.77 times more likely to be in the worst 10 per cent of facilities with respect to hospitalization of people with urinary tract infections. Facilities with care aide staffing below 2.06 hprd were 4.46 times more likely to be worst performers regarding hospitalization related to electrolyte imbalance and 3.45 times more likely regarding hospitalization for sepsis. At 2.05 hprd, the likelihood of ranking “worst 10 per cent” regarding hospitalization for sepsis was 4.4 times greater.¹⁰⁷
- In the above-mentioned study of 82 LTC facilities in 19 US states, when care aide time was less than 2 hprd, 32 per cent of residents developed pressure ulcers.¹⁰⁸
- Among 519 New York LTC facilities and 728 Ohio LTC facilities, those with less than 0.77 hours of LPN staffing per resident per day were almost five times more likely to be among the “worst 10 per cent” in terms of pressure ulcer rates.¹⁰⁹
- In Missouri LTC facilities with poor resident health outcomes (92 facilities), staff fed more than two residents at a time, and in many cases, more than five or six at a time.¹¹⁰
- In the above-mentioned study of quality of care at mealtime in two northwest LTC facilities, researchers found that because of inadequate staffing, residents with inadequate care before and during meals were more likely to choke and cough during meals and lose weight due to insufficient food intake.¹¹¹

The crisis of short-staffing is also now recognized by “patient safety” specialists. A recent report by the Canadian Patient Safety Institute pointed out that “progress in resident safety

in Canadian LTC settings is imperative to improve the safety of frail elders in this setting”¹¹² and identifies staff to patient ratios as a critical element in this regard.¹¹³

The social-emotional aspects of care are the first to be cut when workloads are heavy, and residents’ quality of life suffers.

- A Saskatchewan study of job strain among staff of seven rural LTC facilities found that heavy workload prevented care aides from spending time socializing with residents and providing opportunities for meaningful activities. “Much of the strain ... resulted from inability to offer the quality of care that they thought residents deserved.”¹¹⁴
- An Ontario survey completed by 917 LTC workers at 18 facilities found these tasks most frequently cut short by the rush to care: chatting with residents (left undone 69 per cent of the time) and providing emotional support to residents (left undone 60 per cent of the time). Keeping in touch with families was another part of the job frequently overlooked (30 per cent of the time) because of workload pressure.¹¹⁵
- In a survey completed by 948 workers in 71 LTC facilities in three provinces (Ontario, Manitoba and Nova Scotia), one third of the workers reported that they often do not have time to chat with residents or take them out of their confined spaces.¹¹⁶ The situation was well summed up by this comment: “[I want] to be more social and not rushed while caring for residents. Don’t like the feeling of assembly line care.”
- In a two-year observation/interview study of 38 care aides working in six Midwest US LTC facilities, researchers found that inadequate staffing prevented care aides from developing relationships with residents, which are necessary for quality care that is done individually or affectionately.¹¹⁷

The social environment is particularly important in the care of nursing home residents with dementia.¹¹⁸ Practice guidelines for dementia care developed by a national team of experts in Alzheimer’s care in the United States highlight the importance of social engagement:

*Meaningful activities and positive relationships are the cornerstone of dementia care because they help residents retain functional abilities and can enhance the quality of life... Every encounter or exchange between residents and staff is a potentially meaningful activity. For example, dining is an important opportunity to engage in socialization, eliciting enjoyment, satisfaction, and self-fulfillment.*¹¹⁹

The rationing of social-emotional care is rooted in part in the devaluing of women’s work. Social-emotional caring skills are among the many skills that are assumed to be women’s ‘natural, inherent’ skills which, by their very association with women, are often given low status.¹²⁰

Rationing of social-emotional care is also related to the dominant work organization model in health care that approaches care as a set of distinct and measurable tasks, some less visible and valued than others. Pat Armstrong describes the consequences of task-focused work measurement systems in this way: “a bath is reduced to a quick application of water to skin, and the way nurses and care aides use the bath to comfort, support, educate and assess disappears, as do the varied skills involved in getting the patients to cooperate and in lifting them without injury. Time not spent directly on tasks is defined as wasted, not productive.”¹²¹

Wherever the rationing of care happens, short-staffing leads to workers feeling tremendous frustration, knowing that despite their best efforts, they do not have enough time to meet residents’ needs.

Wherever the rationing of care happens, short-staffing leads to workers feeling tremendous frustration, knowing that despite their best efforts, they do not have enough time to meet residents' needs. An Ontario survey of 227 nurses and care aides found that LTC workers have a high level of commitment to their jobs, but feel that the press of work and time urgency dominate their work.¹²² Over one third of workers in a survey of 948 nurses and care aides in three provinces reported feeling inadequate "all or most of the time" because they were too rushed to meet residents' needs, and a larger number still reported "thinking about work so much it keeps them awake" and "going home mentally and physically exhausted."¹²³ A comparison of these findings with results of a parallel survey of 1,625 care workers in four Nordic European countries (where staffing is higher) depicted Canadian workers struggling more with the strain of poor working and caring conditions.¹²⁴ A separate two-year qualitative study of turnover in three nursing homes in Sweden documented the high level of frustration among staff who wanted to provide personalized care for residents, but were prevented by staff cuts and organizational upheaval.¹²⁵

Residents are likewise torn, in their case between the need for attention and feeling guilty about increasing the pressure on staff. A qualitative study in Ontario found that residents' reluctance to request help from overworked staff "increased anxiety and feelings of helplessness in residents."¹²⁶

Increased staffing is necessary to reduce abuse and neglect

While much of the abuse prevention work that has been done in LTC facilities has focused on the actions of individual workers, there has been a move more recently to "consider abuse and neglect in the context of systemic issues such as staffing levels and types of training staff are receiving."

Neglect and abuse of residents rightly receives a lot of attention in the media, but the coverage usually fails to acknowledge the role of short-staffing. Research and policy development are likewise blinkered, but there is some evidence of progress. While much of the abuse prevention work that has been done in LTC facilities has focused on the actions of individual workers, there has been a move more recently to "consider abuse and neglect in the context of systemic issues such as staffing levels and types of training staff are receiving."¹²⁷ In the research, understaffing along with poor working conditions and lack of staff training have been cited as factors contributing to abuse and neglect.¹²⁸

At regional forums on preventing abuse and neglect held across Canada, participants identified "a care gap in the long-term care system where the number of residents and the complexity of their needs is increasing while the number of appropriately trained care providers is decreasing."¹²⁹ Residents currently living in LTC facilities have significantly greater needs than residents 15 years ago,¹³⁰ but staffing levels, mix and training have not kept pace. In a recent BC study, key informants made the following suggestions on how to handle aggressive behaviour in LTC facilities:

The ratio of staff to residents must be increased, especially on evening and nights, if aggression is to be prevented...It was suggested that greater use of recreation and activity staff to provide appropriate activities for residents on evening and weekend could reduce resident boredom and frustration, increase well-being and prevent aggression.¹³¹

There is also growing recognition of the link between violence against residents and violence against workers in residential long-term care, and the role of short-staffing. In a large-scale survey of LTC workers in three provinces, part of an international research project comparing

Canadian and Nordic care workers' experiences, researchers at York University found that Canadian direct care workers are well over six times more likely to experience physical violence on a daily basis than workers in Nordic countries. In Canada, 38 per cent of direct care workers experience physical violence daily; the average among Nordic countries is below 7 per cent. The research also documented high levels of unwanted sexual attention and verbal abuse.¹³²

The researchers identified “chronic short-staffing as a key contributor to workplace violence” and concluded that “governments need to address short-staffing by legislating adequate care standards and by providing the funding to meet these standards.”¹³³

Recommended minimum staffing levels

Not only is there an abundance of strong evidence linking staffing to quality measures, including violence, but the evidence is very specific—suggesting how much staff time is needed to avoid harming residents and how much would allow quality improvements. The levels are specific with respect to nurse and care aide time only, but it provides a useful starting point.

A very large national study commissioned by the United States Congress and carried out by the Center for Medicaid and Medicare Services (CMS) found that a minimum staffing level of 4.1 worked hours per resident day (hprd) is required to avoid jeopardizing the health and safety of LTC residents.¹³⁴ The 4.1 hprd includes 2.4 to 3.1 nursing assistant hours and 0.95 to 1.55 licensed nurse (RN and LPN) hours, each with different health outcome improvements.¹³⁵ This study was conducted by nationally recognized experts in long-term care, nursing, economics, and research. It included logistic regression analysis of empirical data from 10 states with over 5,000 facilities. Time motion studies were used to identify which specific staffing levels (to the hour and minute, for each direct care classification) lead to better health outcomes.¹³⁶

Not only is there an abundance of strong evidence linking staffing to quality measures, including violence, but the evidence is very specific—suggesting how much staff time is needed to avoid harming residents and how much would allow quality improvements.

It is important to point out that the CMS-recommended minimum of 4.1 hprd:

- Refers to worked hours, not paid hours. Paid hours include benefits, holidays, vacation, sick time, and other compensation beyond hours actually worked. In BC, it was determined that “paid hours” represent anywhere from 15 to 30 per cent more than “worked hours.”¹³⁷
- Includes only hands-on nursing (RNs and LPNs) and personal support (care aides). Higher minimum staffing levels are needed to cover the full range of work done in LTC facilities.
- Refers to the level needed to “avoid jeopardizing the health and safety of residents.” Additional hours are needed to actually improve quality of care beyond this essential minimum. A 2000 study recommended that to improve the quality of care in residential long-term care facilities, staffing levels should be 4.55 worked hprd, which includes 1.15 RN hprd, 0.70 LPN hprd, and 2.70 care aide hprd.¹³⁸ This expert recommendation was based on the time study data and a review of previous studies on staffing and quality of care. A 2004 study found that staffing levels of 4.5 to 4.8 worked hprd of direct care staffing significantly improved the quality of care.¹³⁹

The level of 4.1 hprd has been supported by numerous studies published since the CMS report.¹⁴⁰

Most LTC facilities in the US fall below the recommended minimum, but where there is a set standard in policy or law, progress is evident. The implementation of minimum staffing standards in the US has resulted in higher staffing in LTC facilities.¹⁴¹ Thirty-six states have minimum nurse and personal care standards, some adjusting for the different types of facilities, and the remaining 14 states use either the federal staffing requirements or a state professional coverage standard for nursing home licensure.¹⁴² For example, since January 2007, Florida has had legislated minimum direct care/nurse assistant staffing levels of 2.9 hprd plus 1.0 hours of licensed nursing per day, for a total of 3.9 hprd.¹⁴³ Across states, with these varying standards, the average LTC facility has 3.7 paid hprd of total nurse and personal care.¹⁴⁴

Current staffing levels in Canada

In Saskatchewan, the only province with a legislated minimum staffing standard, the standard is 2 hprd of personal and nursing care—that is, less than half the 4.1 level recommended in a US government study to “avoid jeopardizing the health and safety of residents.”

No Canadian province has meaningful legislated minimum staffing levels; provinces have either “target levels,” which are unenforceable, or their regulated levels are so out of date they are virtually meaningless. For example, in Saskatchewan, the only province with a legislated minimum staffing standard, the standard is 2 hprd of personal and nursing care—that is, less than half the 4.1 level recommended in the US government study to “avoid jeopardizing the health and safety of residents.”

There is no reliable Canada-level data on staffing in Canadian long-term care facilities, but available provincial data indicate serious deficiencies. In British Columbia, LTC facilities provide on average 2.6 to 2.7 worked hours of direct care per resident per day.¹⁴⁵ Ontario, the only other province with available information on worked hours, provides an average of 2.6 hours of direct care to its long-term care residents daily.¹⁴⁶

Several provinces have promised to increase funding for front-line staffing,¹⁴⁷ but there is no guarantee this money will go to staffing unless there are legislated minimum staffing levels and strong monitoring and enforcement systems. Most provinces express staffing levels as hours paid, not hours worked. This approach makes governments look better, padding the levels by 15 to 30 per cent, and it relieves employers of responsibility for unsafe workplaces.

Ontario is a case in point. The Ontario government has reported steady funding increases for residential LTC over the past five years, but the money has not translated into higher staffing levels. From a Freedom of Information request,¹⁴⁸ CUPE learned that average staffing levels fell from July to December 2007 even though funding had increased. Funding over this period was 2.25 per cent higher than over the previous six months, but hours of care delivered were 1.13 per cent lower. Between March 2006 and December 2007, hours of care fell by 0.58 per cent though funding increased by 8.07 per cent.¹⁴⁹

While some provinces have minimum requirements for care functions, for example minimum number of baths per week or limits on the use of restraints, these are meaningless without adequate staffing levels to provide the care. Bathing, repositioning, wound care, reduction of restraints and other vital care functions rely on adequate staffing levels.

Safe and healthy environments

SOLUTION: Provide safe and healthy work environments that support high quality care.

Improve managerial and organizational practices

While staffing level is by far the most significant factor in the quality of care, other conditions play an important role. Foremost among them are managerial and organizational practices (i.e. patterns of management and overall running of the facility), which influence residents' health and well-being in myriad ways.¹⁵⁰

Management and organizational practices of open communication, staff empowerment, and relationship-oriented leadership have been associated with improved quality of care for LTC residents.¹⁵¹ There are many examples from the research literature of managerial and organizational practices influencing care outcomes.

- A survey of LTC workers (care aides, LPNs, and RNs) from over 61 facilities in British Columbia found that workers were better able to provide the individualized care that residents needed if they were provided with support, and access to information, resources, and education.¹⁵²
- Another BC study of LTC workers identified these organizational characteristics as key to helping front-line staff do their “best work”: an engaged environment (one that supports teamwork, open and honest communication, full skill utilization, and management follow-up on problems), a substantive philosophy of care (modelled by managers, in a climate of mutual respect, trust and fairness, with clear and realistic expectations) and concrete policies, procedures, and training to support this philosophy of care.¹⁵³
- In a study involving 156 LTC facilities in five US states, researchers found:
 - A lower incidence of pressure ulcers when care aides were given more opportunities—for example, access to advanced care aide positions, participation on committees, access to training, and orientation for new staff.¹⁵⁴
 - More social engagement (residents spending more time with others, participating more in social, religious, occupational or other preferred activities) when care aides had more influence in resident care decisions.¹⁵⁵
- In a study of turnover in 164 Texas LTC facilities, which included survey data from 244 RNs, 964 LPNs and 2,317 care aides:
 - Increased nurse participation in decision-making was linked to lower rates of aggressive or disruptive behaviours among residents.¹⁵⁶
 - More open communication explained lower use of resident restraints in LTC facilities.¹⁵⁷
 - Relationship-oriented leadership (e.g. that generates trust and helps staff resolve conflicts) was associated with better outcomes for residents: fewer fractures, immobility complications, pressure ulcers, poor circulation, constipation, and depression. By contrast, work procedures that were more formalized, including

Management and organizational practices of open communication, staff empowerment, and relationship-oriented leadership have been associated with improved quality of care for LTC residents.

surveillance of work performance, were associated with a higher rate of immobility complications among residents.¹⁵⁸

- A study of the quality of life of 421 residents with dementia living in 45 facilities in 10 US states found that involving nurses, activity workers, and resident care aides in care planning improved residents' quality of life (measured by observations as well as resident and caregiver surveys).¹⁵⁹
- In a study of 20 LTC facilities in California and Pennsylvania, "high-quality" LTC facilities (those with more gerontological training for all staff, more teamwork, and greater information sharing) had, compared to "low-quality" homes, measurable improvements in resident outcomes: lower incidence of pressure ulcers, fewer hospitalizations, fewer infections, and fewer falls.¹⁶⁰

Managerial and organizational practices impact quality of care in significant part by influencing workers' job satisfaction and turnover rates, which affect continuity of care and workload.¹⁶¹ The next section explores turnover more specifically.

Reduce turnover

When there is high staff turnover, residents have different caregivers, undermining continuity of care and contributing to residents' psychological distress, and worse health outcomes.

Personnel turnover is both a cause and an effect of many structural conditions that characterize the residential long-term care sector. The interplay between turnover and workload is one example. Heavy workloads lead to high turnover, which in turn exacerbates workloads.

Research has documented that high turnover of LTC staff results in poor resident outcomes,¹⁶² including higher rates of infection and hospitalization.¹⁶³ As the health department in the government of California put it:

*High turnover disrupts continuity of patient care, undermines employee morale, increases demands on remaining staff, and increases facility costs for employee recruitment and training.*¹⁶⁴

When there is high staff turnover, residents have different caregivers, undermining continuity of care¹⁶⁵ and contributing to residents' psychological distress.¹⁶⁶ Continuity of care is particularly important to residents with dementia. When frail, memory-impaired persons with dementia are constantly receiving care from different persons, it adds to their disorientation.¹⁶⁷

High turnover undermines health promotion and illness prevention efforts for all residents. Over time, caregivers get to know residents, monitor changes in their health, and help prevent crises.¹⁶⁸ When this relationship is disrupted, quality of care suffers. In a study of the health of Canadian seniors, Statistics Canada reported that "seniors in institutions who were close to at least one staff member and those with at least one close friend in the institution tended to have positive self-perceived health."¹⁶⁹ Residents who have developed a relationship with their caregiver are also less likely to resist care and either sustain or inflict injuries.

Staff turnover also affects quality by diverting resources away from direct care. The costs of high turnover include costs for recruitment, supervision of new personnel, overtime pay for staff covering shortages, and personnel training.¹⁷⁰ Finally, high turnover increases the workload of remaining staff who must care for more residents.¹⁷¹

When organizations emphasize employee job satisfaction, residents have better health outcomes, in large measure because job satisfaction reduces staff turnover and improves the continuity of care.¹⁷² Highlights of the research evidence include:

- A large US study (8,023 nursing homes) revealed that in facilities with more stable staffing (i.e. more staff stay in their jobs five years or longer), there was lower restraint use, rates of pressure sores, and use of catheters.¹⁷³
- A second study involving the same 8,023 facilities examined both turnover rates and staffing levels as they impact quality of care. It found that high turnover (RN, LPN or care aide) was in general associated with poor quality as measured by higher numbers of deficiency citations. Furthermore, staffing levels were inversely related to turnover (higher staffing, less turnover, and the reverse).¹⁷⁴
- In a survey of 156 LTC facilities in four US states, researchers found that the facilities with low care aide turnover had lower rates of pressure ulcers compared to facilities with high turnover.¹⁷⁵
- In 95 facilities participating in the National US Pressure Ulcer Long-Term Care Study, when LPN turnover was less than 25 per cent, fewer residents developed pressure sores.¹⁷⁶
- A Canadian study of human resource management practices and employee satisfaction and retention in 283 LTC facilities found that better-performing facilities (53 out of 283) were those with more open communication, team-based programs, validation of employees' work, and a supportive workplace climate that valued employee participation, empowerment, and accountability. Those facilities had higher scores on employee morale, resident satisfaction, operating efficiency, and other indicators of success.¹⁷⁷
- A survey study of 255 care aides working in 15 LTC facilities in Massachusetts found that after accounting for wages, benefits and opportunities for advancement, good supervision (defined as supervisors being respectful and providing positive feedback and support for problem solving) was the most important factor influencing care aides' commitment and intent to stay in their jobs. In turn, when care aides were more committed to their jobs, residents were more satisfied with their care.¹⁷⁸

When organizations emphasize employee job satisfaction, residents have better health outcomes, in large measure because job satisfaction reduces staff turnover and improves the continuity of care.

Appendix C presents further evidence from the research literature on turnover in residential long-term care, exploring the impacts of different managerial and organizational practices.

Compensation is, not surprisingly, a key factor in residential LTC workers' turnover, and pay equity is in the interests of both workers and residents. Residential long-term care workers in the majority of provinces receive lower wages and lesser benefits than do their counterparts in hospitals.¹⁷⁹ Below is a sample of the research linking compensation to recruitment and retention.

- A recent survey of care aides suggests that among those likely to leave their jobs in the next year, one in three workers cited pay as a reason to leave.¹⁸⁰
- In a rare study of the effects of wage increases, a near doubling of wages of home care workers in San Francisco County, California, increased the retention rate over the 52-month period from 39 per cent to 74 per cent.¹⁸¹

- In the first national US study focusing on care aides' working conditions and job satisfaction, a survey of 2,252 care aides found that a \$1.00 increase in the mean hourly wage (a 9.7 per cent increase) is predicted to decrease by 7.8 per cent the probability that a care aide is dissatisfied. Paid sick leave also had a major impact on job satisfaction.¹⁸²

While LTC workers as a group earn less than their counterparts in hospitals, part-time, casual and temporary workers fare the worst. Part-time, casual and temporary work is more common in this sector than in other sectors,¹⁸³ and many of these employees have to patch together jobs at different LTC facilities in order to get enough hours.¹⁸⁴ Part-time and temporary work is less likely to come with extended health and pension benefits. This gives employers an economic incentive to increase precarious employment, further contributing to employee stress, higher turnover and compromised quality.

Governments must make a financial commitment to improve the wages, benefits and working conditions of LTC workers, equalizing compensation across the health care system. Part-time, casual and temporary workers must be brought to the same per-worked-hour total compensation level as regular full-time workers.

As with injury rates, compensation inequity should be eliminated in the first instance as a matter of fairness and justice. Since this paper focuses on quality of care in nursing homes, however, we raise the issue of compensation inequity to show that the interests of workers and the interests of residents are tightly linked.

Governments must make a financial commitment to improve the wages, benefits and working conditions of LTC workers, equalizing compensation across the health care system. Part-time, casual and temporary workers must be brought to the same per-worked-hour total compensation level as regular full-time workers.

Pay equity must also extend to home care workers, who fare even worse in terms of total compensation comparisons and collective agreement rights in most provinces. In the majority of provinces, home care workers get less pay and fewer benefits, are less likely to be unionized, and are more isolated than their institutional counterparts.¹⁸⁵ Even more than residential long-term care, home care is a low-wage sector where racialized people and immigrant women are overrepresented.

Reduce injuries

Injury rates in long-term care facilities are another illustration of the relationship between staffing levels, working conditions and quality of care for residents. Long-term care facilities are a dangerous place to work, and under-staffing is the main reason.

- In a BC study, resident-to-staff (care aide/LPN) ratios differed substantially between high and low injury rate facilities. High injury rate facilities averaged 16:1 residents-to-staff compared with 12:1 residents-to-staff at lower injury rate facilities (using average day shift across all units).¹⁸⁶
- US researchers studying worker injury data from 1,076 LTC facilities in three states found that total nurse and personal care staffing hours (RN, LPN and care aide) per resident day were significantly associated with worker injury rates. Each additional hour of direct nursing (i.e. patient care) and personal care staff decreased the injury rate by nearly 16 per cent.¹⁸⁷

Organizational and managerial factors also have a proven role in workplace injury rates. BC researchers found that, in contrast to staff in facilities with high injury rates, workers in lower injury rate facilities reported more supportive and trusting relationships between managers and front-line staff, meaning more information sharing, problem solving, policy dissemination and monitoring, and follow-up on staff concerns.¹⁸⁸

Informed by these and other findings, injury-prevention programs are showing positive results. One study of a “best practices” musculoskeletal injury prevention program reduced full- and part-time nursing personnel’s injury rates, workers’ compensation costs, lost work day injury rates, and incidence of resident assault on caregivers in six nursing homes over a six-year study period.¹⁸⁹

Privatization of residential long-term care, the focus of Part 4 of this paper, plays a role in occupational health and safety. An Ontario survey found that for-profit nursing homes are particularly hazardous, with higher reported rates of disability and time off work due to musculoskeletal injuries, more cases needing medical attention, and more fear of job repercussions for reporting a work-related injury or accident.¹⁹⁰

The foremost reason to prevent workplace injuries is to protect workers’ health, but injury reduction is important to residents as well. Injuries drain already-scarce resources out of resident care budgets. The costs of injuries include training costs, new hire costs, agency staff costs, compensation claims,¹⁹¹ and fines levied by regulatory authorities. Worker turnover resulting from injuries also affects the quality of care and residents’ health outcomes beyond wasting resources, as the previous section illustrated.

Eliminate discrimination and guarantee culturally safe care

Healthy working and caring environments demand the elimination of discrimination and a guarantee of culturally competent services. The interests of workers and residents, here as elsewhere, are intricately connected.

Residents and workers in long-term care facilities are more ethnically diverse and more likely to be racialized than 20 years ago, and proactive approaches are needed to address discrimination and provide culturally competent services. Post-1960 immigrants (from a broader range of countries and more likely to be racialized than earlier immigrants)¹⁹² are now reaching old age, and more Aboriginal people are surviving into old age.¹⁹³ Considering Canada as a whole, racialized workers are overrepresented in the long-term care workforce,¹⁹⁴ and this pattern is becoming more pronounced as employers (particularly for-profits) recruit international migrant workers from countries where the majority of the population is racialized.¹⁹⁵ LTC facilities, historically geared to residents of western European heritage, now rightfully face more pressure to meet the cultural needs of a more diverse population. They also need to deal better with racism.

Racism impacts residents indirectly through the domino effect that it has on workers, turnover, and continuity of care. Workers subjected to prolonged racial harassment suffer from psychophysiological illnesses, such as ulcers, depression and insomnia.¹⁹⁶ Though research on racism as an occupational health issue is sorely inadequate (and inquiries specific to the health sector few), it is likely that racism has similar effects on job satisfaction and turnover as

The foremost reason to prevent workplace injuries is to protect workers’ health, but injury reduction is important to residents as well. Injuries drain already-scarce resources out of resident care budgets. Worker turnover resulting from injuries also affects the quality of care and residents’ health outcomes.

Confronting racism and ensuring culturally-safe and culturally competent care for residents requires a broad strategy that includes safe staffing levels, effective education and training programs, democratic governance, services that meet residents' cultural needs, and anti-oppression policies and practices.

do other forms of harassment. Interviews with 644 direct care workers in 46 continuing care organizations in Ohio found that perceived racism was a significant predictor of job satisfaction.¹⁹⁷ As shown earlier in this paper, low job satisfaction is associated with higher turnover and lower quality of care, so a poisoned environment for workers translates to poorer care for residents.

Residents are also affected directly by racism and by the related problem of culturally unsafe policies and practices—those that “diminish, demean or disempower the cultural identity and well-being of an individual.”¹⁹⁸ Cultural competence, by contrast, is “a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.”¹⁹⁹ Confronting racism and ensuring culturally safe and culturally competent care for residents requires a broad strategy that includes safe staffing levels, effective education and training programs, democratic governance, services that meet residents’ cultural needs, and anti-oppression policies and practices.²⁰⁰ Reducing conflict created by unsafe working conditions must be a core part of the strategy.

Eliminating discrimination and delivering culturally competent care is also a concern for workers and residents who are gay, lesbian, bisexual or transgender (GLBT) and their allies. As with other forms of oppression, heterosexism and homophobia affect residents both directly²⁰¹ (most immediately, as GLBT residents) and indirectly (through the effect that poisoned work environments have on quality of care). Solutions must aim for the full protection of workers’ and residents’ rights and provision of services that respect the diverse experiences and realities of residents’ lives.

Education and training

SOLUTION: Support education and professional development of residential long-term care workers, first by establishing provincial standards for resident care aide education programs and increasing resources for continuing education for all staff.

Education and training of staff have measurable impacts on the quality of care for residents and merit attention across Canada. As with other causal relationships identified in this paper, the links between education/training and quality of care are both direct and indirect. An example of the direct relationship is an education program properly preparing a caregiver to support good hydration and nutrition for residents. An indirect relationship might be the favourable effect that training has on recruitment and retention, which translates to better staffing and better care. Below are some examples:

- A three-year study of quality improvement initiatives in a Pennsylvania not-for-profit LTC facility found that enhancing staff abilities through training, combined with real-time feedback, resulted in a significant reduction in the rate of new pressure ulcers.²⁰²
- A literature review on the impacts of training on recruitment and retention found that additional training helped employers attract and, even more so, keep care aides.²⁰³

- Training has been identified as a strategy for reducing burnout in staff caring for nursing home residents with dementia.²⁰⁴ A survey of 110 direct care staff in seven Saskatchewan LTC facilities found that half felt their current training had not adequately prepared them to care for residents with dementia. Focus group participants in the same study said training would improve their confidence in handling difficult behaviours.²⁰⁵

CUPE National recommends that provincial governments establish standards for resident care aide education programs. British Columbia is doing this by establishing provincial standards (covering curriculum and instruction time, with other standards under discussion) and an educational approval process for health care assistant (home support/resident care attendant) programs.

Provincial standards are particularly urgent in provinces with a mix of public and private education programs for health care workers.²⁰⁶ A recent project in BC called attention to concerns about some private training programs being too short, having “no fail” policies, graduating students with inadequate English language skills, and having poorly qualified instructors.²⁰⁷ An advisory committee including health authorities, employers and unions²⁰⁸ worked with educators to develop “care aide competencies” and a new provincial curriculum and standards for care attendant/community health worker (RCA/CHW) education programs.²⁰⁹ The advisory committee is currently working on a mechanism for ensuring a common training standard for graduates of RCA/CHW educational programs, whether delivered by public or private training institutions.

Current employees should be grandparented from any increased entry-level education standard (with wage protection) and offered upgrading opportunities. Upgrading should be fully funded, on-the-job where appropriate, and incorporate Prior Learning Assessment and Recognition (PLAR).

Credit for competencies learned outside of the formal education system should be part of assessment of qualifications across job classifications, not only for care aides, and financial barriers to formal education should be reduced across the board. New entry-level education standards and high tuition create serious barriers to would-be employees, worsening an already severe labour shortage. The new food services course requirement in Ontario is just one example.

Equally important is continuing education, and this also applies across occupations. As noted earlier, the level and complexity of residents’ care needs are on the rise. Increasingly, workers are expected to care for people who are very frail, have complex physical and emotional health problems, and are in the final stages of their life. When the new RCA/CHW curriculum was developed in BC, the advisory committee recommended a new post-basic certificate program in mental health and palliative care. As another example, cleaning and laundry staff need regular upgrading on new techniques and products for dealing with rapidly-spreading healthcare-associated infections. Laddering programs, like care aide to nursing, and recognition of international credentials should also be supported.

To develop and deliver these education and training programs, additional targeted funding will be required. The cost of tuition and lost wages are a major barrier to education, and the likelihood of students recovering the costs are limited given low wages and benefits in this sector.

CUPE National recommends that provincial governments establish standards for resident care aide education programs. Current employees should be grandparented and offered paid upgrading.

There is a chronic shortage of health care workers, especially in long-term care. Access to education and training with financial support may be an effective recruitment tool to begin to address this shortage.

Conclusion

Proper staffing in LTC facilities – encompassing the right number and mix of staff, well-educated and working in healthy environments with fair compensation – is necessary to achieve high-quality care for residents.

This section has shown that better working conditions for staff are also better caring conditions for residents. Proper staffing in LTC facilities—encompassing the right number and mix of staff, well-educated and working in healthy environments with fair compensation—is necessary to achieve high-quality care for residents. The next section addresses the link between quality and non-profit delivery, another shared concern for workers and residents.

Non-profit ownership and delivery

Introduction and summary

Just as staffing issues have multiple and strong effects on the health and well-being of workers and residents, so too is privatization of residential long-term care a shared concern with many dimensions. With few exceptions, privatization of residential LTC infrastructure, ownership, and delivery is happening at an increasing pace across Canada. There is strong evidence that for-profit ownership leads to lower staffing levels, poorer quality of care, and higher costs for residents. There is also abundant evidence that contracting out undermines working and caring conditions. Assisted living and other deregulated models represent a newer form of privatization, and the results so far are troubling. At an industry-wide level, privatization is risky because it weakens public policy options and makes residential LTC even less transparent and accountable to residents and the public.

SOLUTION: Establish non-profit ownership and operation of residential long-term care facilities.

To implement this solution, governments must:

- Phase out public funding to for-profit operators. New facility approvals should go to non-profit operators only. Where a publicly-funded for-profit facility is up for sale, the government responsible should acquire the facility at market value and convert it to a public, non-profit facility. Employees should have their job security, seniority rights, and collective agreements fully protected in the process.
- Declare a moratorium on reclassification of long-term care facilities to assisted living facilities, and end the substitution of assisted living for residential long-term care.
- Stop contracting out and grant LTC workers successor rights.

With few exceptions, privatization of residential LTC infrastructure, ownership, and delivery is happening at an increasing pace across Canada. There is strong evidence that for-profit ownership leads to lower staffing levels, poorer quality of care, and higher costs for residents.

- Require for-profit operators to follow the same regulatory standards as non-profits. Until for-profits are completely phased out of residential long-term care, laws should be amended to subject for-profit operators to the same standards and disclosure requirements as non-profit operators. As one example, the *Ontario Public Sector Salary Disclosure Act*—the law that requires disclosure of salary for employees earning more than \$100,000—does not apply to for-profits and their parent corporations. Salary perks collected in the private sector are therefore hidden from public view.

Public-private mix in residential LTC: The for-profit sector is large and growing

In Canada, long-term care facility ownership can be categorized as non-profit or for-profit. Non-profit covers two groups of facilities: those owned by government, either federal, provincial, or municipal; and those owned by voluntary lay or religious organizations, such as the Lions Clubs and religious orders. (Sometimes, the first group is called “public” and the second “non-profit” or “voluntary.”) For-profit facilities are owned by a corporation, private organization, or individual and are run on a for-profit basis.

Residential long-term care is a mix of non-profit and for-profit operators in Canada, and the ratio varies widely between provinces.

Residential long-term care is a mix of non-profit and for-profit operators in Canada, and the ratio varies widely between provinces. At the one end is Ontario, which has the highest concentration of for-profit LTC beds (see Table 8). Newfoundland and Labrador is currently the only province that has no for-profit LTC facilities funded by government. Keep in mind that, for this paper, LTC beds include publicly-funded beds only. There are thousands of privately-funded LTC beds that fall beyond the scope of this research; in fact, there is not even pan-Canadian data on the number or distribution of privately-funded beds in Canada.

The ratio of for-profit to non-profit beds has increased over the years in most provinces, and signs point to a continuation of this trend. In BC, between 2000 and 2008, the number of for-

Table 8: LTC beds (publicly-funded) by province and by ownership status, 2008

	non-profit	for-profit	total beds	% non-profit	% for-profit
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 ^a	4,175	216	4,391	95%	5%
NFLD & Labrador	2,747	0	2,747	100%	0%
Nova Scotia ^b	4,190	1,796	5,986	70%	30%
Prince Edward Island	578	400	978	59%	41%
Canada	125,887	68,311	194,178	65%	35%

Notes: ^a For-profit bed number is a projection for 2010. ^b Estimates.
Sources: See Appendix B.

profit beds increased by 22 per cent while the number of non-profit beds decreased by 12 per cent.²¹⁰ In Alberta, for-profit beds as a ratio of total beds increased by 6 per cent between 2000 and 2007.²¹¹ In Ontario, almost two thirds of new long-term care beds since 1998 have gone to for-profit companies.²¹² New Brunswick is a newcomer to the LTC privatization bandwagon, last year handing contracts for three new LTC facilities to Shannex, a for-profit chain based in Nova Scotia. Prince Edward Island is among the few provinces not relying on the private sector for renovation and replacement beds, deciding last year to redevelop its public LTC facilities (called “manors”) using conventional financing rather than public-private partnerships.

Governments are using different strategies to privatize residential LTC delivery. The BC government, beginning in the late 1990s, withdrew direct capital funding grants in favour of private capital financing and, as of 2001, uses a Request for Proposal (RFP) process to approve new publicly-funded residential care facilities. Only large organizations, primarily corporations, have the infrastructure capacity to participate in the RFP process. Non-profit societies have also lost technical support from the government to design and build new facilities.²¹³

Ontario is also using the RFP process and is funding new development through a capital per diem. For-profit LTC facility operators in Ontario have always had “licensed beds” that they can buy and sell as commodities in the open market, but funding for capital development takes the commodification of seniors’ care to a new level. Under the funding for new beds, first announced in 1997, for-profits receive a per diem over 20 years to fund construction and equipment expenses. The per diem started at \$10.35 per bed and now ranges from \$13.30 to \$15.80, depending on the size and other features of the project. After paying \$75,000 and upwards per bed, the public has no equity stake in the for-profit facilities; they are owned entirely by the private sector, increasingly by multinational corporations.²¹⁴ In other words, the public is paying for-profit corporations to build beds that they run on a profit-seeking basis for 20 years, at the end of which the for-profit corporation owns the beds and the public, which has paid for them, has no equity.

In New Brunswick, the government signed an untendered contract with Shannex to build three new facilities, without even going through an RFP process. The contract is currently being investigated by the Auditor General, and it bolstered the Ombudsman’s campaign to secure oversight powers for nursing homes and their residents.²¹⁵

In Quebec, the government is closing beds in public institutions and investing in for-profit institutions—both residential LTC facilities built as public-private partnerships (P3s) and less regulated facilities.²¹⁶ The government cut 7,632 beds from the public system (a loss of 14 per cent) over 15 years,²¹⁷ and is now funding renovations and new construction of LTC facilities as public-private partnerships, using 25-year deals that include contracting out services. Unlike typical P3s where the public sector ultimately owns the infrastructure, these LTC facilities (the building, furnishings and equipment) will be owned by the private sector when the contracts expire. Another dimension of LTC privatization in Quebec, as elsewhere, is the narrowing of eligibility for residential LTC; people with lower care needs (in this case, between 3.5 and 4 hprd) are now being placed in lesser-regulated and -funded private facilities.

A pioneer of LTC privatization, Alberta has been closing long-term care facilities for many years, with assisted living facilities springing up in their place.²¹⁸ In a more recent move, the government is converting LTC facilities to assisted living facilities, with no change in the residents.²¹⁹

The ratio of for-profit to non-profit beds has increased over the years in most provinces, and signs point to a continuation of this trend. Governments are using different strategies to privatize residential LTC delivery.

The substitution of LTC beds with assisted living, private retirement lodges, and other de-regulated and defunded residential long-term care models is happening across the country. In the three years following the Saskatchewan government's 1996 decision to quadruple their bed limit (from 10 to 40 beds), personal care homes (mainly for-profit) grew by 28 per cent.²²⁰ After the cap on bed numbers was removed completely in 2002, large for-profit homes emerged.²²¹ New Brunswick has a large and growing number of special care homes serving seniors, prompting the Auditor General already in 2005 to call for licensing of this sector.²²²

All of these forms of LTC privatization represent new public subsidies to for-profits, from public funding for private sector capital acquisitions and profit-taking to the extra costs borne by hospitals when residents are admitted for avoidable health problems. This paper focuses on the impacts of privatization directly on residents and workers, but these broader society-wide costs must be kept in mind.

For-profit ownership means lower quality of care

New forms of long-term care privatization represent new public subsidies to for-profits, from public funding for private sector capital acquisitions and profit-taking to the extra costs borne by hospitals when residents are admitted for avoidable health problems.

Concern over quality of care in long-term care facilities has led to increased research on the factors impacting quality, including ownership. Repeatedly, studies have established that for-profit nursing homes are associated with lower quality of services and poorer resident health outcomes, including an increased risk of hospitalization.²²³ Hospitalization rates are an important measure of quality; seniors often develop iatrogenic (resulting from medical treatment or advice) complications and nosocomial (hospital-acquired) infections in the hospital setting and return to the LTC facility functionally and cognitively more impaired.²²⁴

- A four-year Manitoba study of LTC facilities' performance (covering all residential care beds and 15,501 residents) found that residents living in for-profit facilities, compared to those in non-profit facilities, had significantly higher adjusted risk of being hospitalized for dehydration, pneumonia, falls, and fractures.²²⁵
- A study of eight British Columbia LTC facilities between 1996 and 2000 found that, compared to non-profit facilities, for-profit facilities had demonstrably higher hospitalization rates for anaemia (18 per cent higher), pneumonia (9 per cent higher), and dehydration (24 per cent higher).²²⁶ Non-profit LTC facilities attached to hospitals had dramatically lower adjusted hospitalization rates for all outcomes, perhaps because they have better access to diagnostic services, nursing and physician services, and other specialized services.²²⁷
- A systematic review and meta-analysis of observational studies and randomised controlled trials spanning four decades, published in the *British Medical Journal* in August 2009, found a trend toward higher quality care in non-profit LTC facilities compared to for-profit facilities. In 40 of the 82 top-level studies, non-profits ranked higher on all statistically significant quality measures; in only three studies did for-profits achieve this ranking. Based on their findings, the researchers estimated that 600 of 7,000 incidences of pressure ulcers in Canadian LTC residents are attributable to for-profit ownership and that LTC residents in Canada would receive roughly 42,000 more hours of nursing care a day if all long-term care facilities were non-profit.²²⁸

- In a national study of 815 LTC facilities in the US, the rate of hospitalization for residents with suspected pneumonia varied dramatically by ownership status: residents in for-profit facilities were twice as likely to be hospitalized with suspected pneumonia as residents in not-for-profit facilities (29 per cent versus 15 per cent, respectively).²²⁹
- A study of hospitalization rates for residents in 527 LTC facilities in Massachusetts found that:²³⁰
 - Residents in non-profit LTC facilities were 9 per cent less likely to be hospitalized than residents in for-profit facilities.
 - Residents living in a LTC facility operated by a management company or chain had 7 per cent greater odds of being hospitalized than residents living in an independently managed facility.
- In a groundbreaking study that analyzed data on 14,423 facilities across the US, controlling for time-, location-, and provider-related effects, researchers concluded that for-profit nursing homes have significantly lower care quality compared to non-profit nursing homes. The study also found that government-run facilities, relative to the others, tend more to serve the traditional safety-net role, providing greater access to low-income people (Medicaid recipients).²³¹
- According to an analysis of government data on over 15,000 nursing homes in the US, 1,200 of them purchased by large private investment groups between 2000 and 2006, “at facilities owned by private investment firms, residents on average have fared more poorly than occupants of other homes in common problems like depression, loss of mobility and loss of ability to dress and bathe themselves.”²³²
- In a longitudinal study (1991 to 1999) using data from approximately 96 per cent of all nursing homes in the US, non-profit ownership compared to for-profit ownership was found to be significantly associated with persistent high-quality care (measured by incidence of pressure ulcers, use of physical restraints, feeding tubes, and catheters).²³³
- Using data on 2,230 US nursing home residents, researchers found that private-pay residents in non-profit homes had a 6.2 per cent lower risk of death and a 6.3 per cent lower risk of infection than private-pay residents in for-profit homes.²³⁴

Repeatedly, studies have established that for-profit nursing homes are associated with lower quality of services and poorer resident health outcomes, including an increased risk of hospitalization.

In addition to studies that explicitly examine the role of ownership on quality, there is strong evidence from inspection reports and complaints data. In the US, where all LTC facilities are inspected annually, researchers have shown that for-profit LTC facilities have more violations of care standards, also called deficiencies. Deficiencies indicate failure to meet Medicare or Medicaid funding requirements (related to care, staffing, operations, administration, and physical plant).²³⁵

- US researchers examining state inspection surveys conducted during 1998 in 13,693 LTC facilities across all states found that:
 - For-profit facilities averaged 46.5 per cent more deficiencies per home than non-profit facilities and 43 per cent more deficiencies than public (government) facilities.²³⁶

- Severe deficiencies (which make up one quarter of all deficiencies) occurred at a rate 40.5 per cent higher at for-profit facilities than non-profit facilities and 35.8 per cent higher than at public (government) facilities.²³⁷
- A study of 1,098 California LTC facilities found that for-profit facilities had significantly more total deficiencies and serious deficiencies than non-profit facilities.²³⁸
- A national study of 4,830 US LTC facilities found that privatized facilities (ones that county governments sold to for-profit companies) had 46 per cent more regulatory violations on the “total quality” score as well as more deficiencies pertaining to quality of life than non-divested facilities.²³⁹
- A recent investigation into rates of serious health deficiencies at LTC facilities owned by large investment companies found that they were almost 19 per cent higher than the national average.²⁴⁰
- A study examining ownership and quality in 105 Minnesota LTC facilities found that non-profit and government facilities provided higher quality care than their for-profit counterparts. They also had better resident satisfaction, both in terms of relationships with caregivers and overall satisfaction.²⁴¹
- Evidence from a review of 38 studies looking at the relationship between ownership and quality in residential care across North America found lower levels of staffing, higher staff turnover, and more quality deficiencies in for-profit than non-profit facilities.²⁴²
- In a five-year national study of 302,351 complaints filed against nursing homes, US researchers found that for-profit facilities were almost twice as likely to receive a complaint during a given year as not-for-profit facilities (1.88), and chain facilities were 1.48 times more likely to receive a complaint as non-chain facilities.²⁴³

The main reason for the pattern of lower quality of care at for-profit facilities is lower staffing levels. Researchers in Canada and the US have documented that staffing levels are, on average, lower in for-profit LTC facilities compared to non-profit facilities.

Though most of the research using data from inspections and complaints comes from the US, this type of inquiry is beginning to take place in Canada and elsewhere. A recent pilot study of licensing complaints in one region in British Columbia over a five year period (2003 to 2008) found significantly higher substantiated complaints in for-profit than in non-profit facilities.²⁴⁴ An examination of government inspection reports covering three quarters of Israel’s nursing homes found that, on average, staffing levels and quality of care were better in the 48 non-profit homes compared to the 79 for-profit homes.²⁴⁵

For-profit ownership means lower staffing levels

The main reason for the pattern of lower quality of care at for-profit facilities is lower staffing levels. Researchers in Canada and the US have documented that staffing levels are, on average, lower in for-profit LTC facilities compared to non-profit facilities.²⁴⁶

- In Ontario, for-profit LTC facilities were found to provide significantly lower nurse and personal care staffing levels than non-profits (either government or lay/religious group-owned).²⁴⁷

- British Columbia researchers similarly found that staffing levels were considerably lower in for-profit facilities, despite the fact that both for-profit and not-for-profit facilities fall under the same government funding system.²⁴⁸
 - Considering all facilities and adjusting for level of care, not-for-profit ownership was associated with an estimated 0.34 more hprd of direct care services (RN, LPN, care aide) and 0.23 more hprd of support services (dietary, house-keeping, laundry, and other). In other words, residents in not-for-profit facilities received 0.57 more hours of staffing each day than residents in similar for-profit facilities. Looking at the different types of facilities, the staffing advantage of non-profits over for-profits was largest (0.91 hprd) for intermediate/extended care facilities.
 - The pattern held for activity and recreation care as well. Not-for-profit intermediate care facilities provided 33 per cent more recreation activity staff (0.21 hprd versus 0.14 hprd), and not-for-profit multilevel care facilities provided 65 per cent more recreation activity staff (0.31 hprd vs. 0.11 hprd).²⁴⁹
- In the study of 1,098 California nursing homes mentioned above, the average total hprd in for-profit homes was 3.11, compared with 3.91 in non-profit homes.²⁵⁰
- In 2001, US researchers found that RN and LPN staffing at for-profit facilities was 31.7 per cent lower than at non-profit facilities, and care aide hours were 11.9 per cent lower.²⁵¹
- A 2007 analysis of data for nursing homes across the US concluded that for-profit LTC facilities' total nurse and personal care staffing hours (RN, LPN, and care aide) were 3.54 hprd, or 15 per cent lower than in government LTC facilities (4.15 hprd) and 14 per cent lower than in other non-profit LTC facilities (4.13 hprd).²⁵²

For-profit residential LTC chains, in general, perform the worst. For-profit chains have on average lower staffing than independent for-profit facilities and non-profit chains.²⁵³ In 2006, US for-profit LTC facility chains had an average total of 3.77 nurse and personal care hprd, compared to 3.85 hprd in for-profit independent facilities, and 4.8 hprd in non-profit facilities.²⁵⁴

So how do for-profit nursing homes stay in business, if they tend to have lower staffing levels and poorer quality of care? The main reason is that governments continue to subsidize them, often knowing the consequences. In a rare expression of candidness, the Ontario Minister of Health in the mid-1960s, facing pressure from for-profit operators to increase payments, told his cabinet:

I have learned to my bitter sorrow that they are concerned about one thing only, making as much money as possible and giving as little as possible in return to the patients...[The] sooner this is gotten into on a public basis, the sooner we will be able to provide good quality care for this segment of the population.²⁵⁵

In spite of this recognition, the Ontario government continued to subsidize for-profit operators, and the current government—like the majority in Canada—is expanding their role.

The bankruptcy of Royal Crest Group, operator of 17 nursing and retirement homes in Ontario until 2003, is one case of many where government turned a blind eye. When creditors

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put Royal Crest facilities under receivership, significant abuse of public funds and neglect of residents came to light. Ministry officials who approved the purchase of these facilities and annual license renewals failed to meet their duty to ensure that the facilities were operated satisfactorily.²⁵⁶

Because consumers have incomplete information on LTC facilities²⁵⁷ and are vulnerable due to their physical and cognitive health, and due to urgent need for services and lack of alternatives, few residents use either exit²⁵⁸ or voice²⁵⁹ in response to poor quality. Combined with governments neglecting their oversight duties and, increasingly, carving out an easy market for the private sector, this means for-profit homes have little incentive to provide better care; in fact, cutting costs generally improves their profit margins.

The business model of seniors care is well illustrated by a profile of the US nursing home and assisted living industry²⁶⁰ that pegged its worth at \$130 billion in annual revenue and “revenue per employee” of \$45,000 per year.

Revenue per employee is a measure of how efficiently a particular company is utilizing its employees. In general, rising revenue per employee is a positive sign that suggests the company is finding ways to squeeze more sales/revenue out of each of its workers.²⁶¹

For-profit ownership means higher costs for residents

In addition to suffering worse health outcomes and getting less care, residents in for-profit long-term care facilities in a number of provinces have to pay more out of pocket for services and products.

In addition to suffering worse health outcomes and getting less care, residents in for-profit long-term care facilities in a number of provinces have to pay more out of pocket for services and products. User fees²⁶² exacerbate a two-tier system wherein residents with no private pension or retirement savings (mainly women) get a lower level and quality of care.

A recent comparison of fees in two LTC facilities in BC—one non-profit, the other for-profit—revealed higher costs for residents in the for-profit facility.²⁶³ For example, at the non-profit LTC facility, all of the rooms were private (single occupancy), whereas at the for-profit facility, residents paid an additional daily charge for private and semi-private accommodation. Whereas all residents had access to rehabilitation services at the non-profit facility, residents at the for-profit facility had to pay additional fees for this service.

In another example from BC, residents who were moved from a non-profit LTC facility (Cowichan Lodge) to a new for-profit replacement facility (Sunridge Place) were billed for hundreds of dollars in extra charges. The fees were for over-the-counter medications, cable-tv, and other expenses that were provided free by the former non-profit owner.²⁶⁴

For-profit operators are driven by pressure to increase revenue, and private-pay fees are an important source of revenue. The differences in fees between facilities range from relatively small expenses, such as off-the-menu dessert options, cable, and specialty incontinence products, to substantial expenses such as wheelchairs, therapeutic mattresses, non-prescription medication, rehabilitation therapy, and palliative care. With more privatization, residents will see higher fees.

As with many privatization schemes, increased user fees are couched in the language of “choice.” As part of a larger privatization plan announced last year, the Alberta government

promises LTC residents and families “more choice to buy additional services and amenities.”²⁶⁵ What this means, in fact, is more fees to buy additional services and amenities as government restricts coverage and operators carve up services and apply new fees.

The move from Cowichan to Sunridge illustrates not only fee hikes, but also the inefficiencies of for-profit delivery. The regional health board manager in charge of P3 homes acknowledged that drug costs at Cowichan Lodge might have been lower because medications were supplied in bulk through the local hospital, an acute care pharmacy, whereas Sunridge, like other for-profit operators, uses a retail pharmacy.²⁶⁶ Bulk purchasing is an important advantage of public health systems—one that would be maximized by expanding non-profit residential long-term care and bringing it into medicare.

Contracting out means poor care and working conditions

Contracting out is another form of privatization that concerns both workers and residents. Many LTC facilities, both non-profit and for-profit, contract out support services and, in some cases, direct care services.²⁶⁷ Drawing from research on contracting out in different areas of the health care system, we know the negative consequences for workers and residents.

Contracting out is frequently associated with poor working conditions (most notably, lower wages and benefits), inadequate training, job insecurity, and high turnover.²⁶⁸ Contracted-out employees receive fewer hours of training and orientation than do in-house employees, and, with higher turnover rates, new hires have fewer experienced staff to mentor them. As described earlier in this paper, high turnover rates and inadequate training undermine continuity and quality of care.

High staff turnover caused by contracting out is worse in provinces where workers lack successor rights (the right to keep their job, union, seniority and collective agreement when the facility owner or contractor changes). A number of private for-profit LTC operators in British Columbia have taken advantage of provincial legislation that allows them to “flip” sub-contractors—that is, terminate a contract with one third party provider (with 60 days notice) and hire another provider, often with an entirely new workforce. They typically do this to avoid paying negotiated wage and benefit improvements.²⁶⁹ In a particularly egregious example, one for-profit operator on Vancouver Island caused the layoff of staff twice in three years, each time it switched contractors. Roughly 165 workers were affected each time; not all were hired back by the new contractor, and the workers had to start from scratch and unionize all over again.²⁷⁰ This scenario has been repeated at for-profit LTC facilities across BC, disrupting the lives of many frail seniors.²⁷¹

Governments should legislate successor rights for workers when the facility either changes sub-contractors (terminating a commercial contract with one third-party provider and signing a contract with another), is sold to another corporation, or has its license transferred to another operator.

Healthcare-associated infections are one of the best examples of a quality of care problem compounded by contracting out. One in every nine hospital patients contracts an HAI,²⁷² and 8,500 to 12,000 Canadians die of HAIs every year.²⁷³ Many are LTC residents. Contracting

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out plays a role because it leads to cuts in staff, higher turnover rates, less training, and a rift between clinical and support staff—all of which contribute to HAI outbreaks.²⁷⁴

- When health care facilities in BC (many of them LTC) contracted out 8,500 health care jobs over two years, turnover skyrocketed and team-based care broke down.²⁷⁵
- In the United Kingdom, cuts to health care cleaning staff by almost 50 per cent over 15 years of contracting out have been associated with severe hygiene problems and spiking infection rates.²⁷⁶
- The Auditor General of Scotland found that hospitals with contracted-out cleaning, compared to those with in-house cleaning, had fewer cleaning hours, less monitoring and supervision, greater use of relief staff, and lower scores on cleanliness.²⁷⁷
- The UK Department of Health found that 15 of the 20 “worst” National Health Service trusts for cleanliness had outsourced cleaning.²⁷⁸

Increasing reliance on ready-to-eat products, in particular processed foods, is another form of privatization that has deadly consequences. Of the 57 people who contracted listeriosis from contaminated deli meat during the 2008 outbreak, 54 were elderly people in hospitals and long-term care facilities—40 per cent of those who fell sick died.²⁷⁹ Long-term care facilities frequently serve cold-cuts ordered in bulk from factory processing plants. In addition to ensuring better food safety practices, governments should tie funding to on-site food preparation, with penalties for misspent funds. In Ontario, for example, there is a protected budget for “raw food” that must be prepared in the facility, but the money is often used to buy pre-prepared food.²⁸⁰

Using temporary agency staff²⁸¹ is yet another form of privatization that can affect quality of care. Recent studies reveal that high use of care aide agency staff is associated with lower quality care.²⁸² Disruption of continuity of care, unfamiliarity with care practices, and higher resident psychological distress are likely consequences of heavy reliance on agency staff. As with other forms of contracting out, it is the *use* of agency staff and their working conditions that are problematic, not the agency workers themselves.

Privatization— a risky business

Privatization of long-term care, either entire facilities or services therein, weakens transparency and accountability and opens seniors’ care to instability and displacements that are costly and harmful for residents, workers and the health care system. It is also difficult to reverse, not least because the private sector wields a growing influence over policy makers.

Monitoring for-profit providers, much less holding them accountable, is difficult. LTC facilities are owned by a complex web of investors and companies, and often they contract out management and services to another layer of companies.

In the US, investors have created a web of complex management structures and contracts to obscure responsibility for care and avoid liability, particularly in high litigation states. Government agencies have a harder time overseeing the care provided in these homes, and individuals have a harder time sorting out who is responsible for the care of their family member.²⁸³

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Oversight is also hampered by the private sector's lobbying influence. In a comparison of LTC regulatory systems in the US, researchers concluded: "Some states have better-organized and active stakeholder groups that seek to influence the survey and inspection process."²⁸⁴ Various studies looking at the correlation between inspection and enforcement patterns and political environments have shown that nursing home lobbies tend to be more uniformly powerful players than elder groups and other advocacy organizations.²⁸⁵

Lack of transparency is characteristic of public-private partnership and sole-source arrangements—current models for LTC infrastructure redevelopment in a number of provinces. As noted, New Brunswick is using sole-source contracting to build three new facilities, and the P3 model is favoured by Ontario and Quebec.

Privatization is also risky because the market is extremely volatile. Already in 2000, five of largest chains in the US (representing 1,800 facilities) operated under bankruptcy protection.²⁸⁶ In the current economic climate, even more private investors in LTC are filing for bankruptcy and closing facilities.²⁸⁷

Bankruptcies can be devastating for residents and workers and costly for creditors and governments. When Royal Crest Group, the operator of 17 nursing and retirement homes in Ontario, went bankrupt in 2003, residents and their families went through the stress and uncertainty of the facility transferring to government trusteeship and then to a new for-profit operator. The unions representing 1,400 workers had to fight several years for payment of long-owed vacation wages and pension contributions and are still owed millions in unpaid dues. As of March 2009, the provincial government was still trying to recover \$4.1 million owed to it.²⁸⁸

Once LTC facilities are turned over to for-profit providers, it is hard to reverse because of the significant capital costs involved²⁸⁹ and potential challenges under international trade rules.²⁹⁰ It is also hard to reverse because the private sector begins to wield considerable influence over policy makers, making them more likely to further privatize.

For-profit chains' growing influence on policy-makers is troubling. Chains actively recruit former government officials, best shown by recent moves from high-level positions in Ontario to for-profit LTC management or lobbyist roles.²⁹¹ As just one example, the former head of the LTC section of the Ontario health ministry went to Extendicare, a for-profit chain that has been one of the main recipients of new LTC beds.²⁹² The door also revolves. For example, the former head of Ontario's association of for-profit nursing homes is now the senior civil servant in Ontario.²⁹³ The Ontario government's refusal to enact staffing levels, despite election promises, is seen by many to be a consequence of the industry's growing influence.

The industry's clout is most visible in the US, where research attributed New York's generous reimbursement rates to its politically well-connected nursing home industry.²⁹⁴

For-profit chains' growing influence on policy-makers is troubling. The Ontario government's refusal to enact staffing levels, despite election promises, is seen by many to be a consequence of the industry's growing influence.

Privatizing by shifting to assisted living and other forms of deregulation

A number of provinces are privatizing long-term care by moving away from higher-funded and -regulated facilities that are more likely to be non-profit (with variation across the country) to lesser-subsidized and -regulated facilities that are more likely to be for-profit. These deregulated and privatized facilities go by different names: assisted living, supportive housing, retirement residences, personal care homes, lodges, and other titles. What they have in common is that they get less government money, face fewer government rules, and tend to be for-profit. What they also have in common is lower levels of care and higher costs for residents.

Deregulated and privatized facilities go by different names: assisted living, supportive housing, retirement residences, personal care homes, lodges, and other titles. What they have in common is that they get less government money, face fewer government rules, and tend to be for-profit. What they also have in common is lower levels of care and higher costs for residents.

Many provinces have narrowed eligibility criteria for admission to a long-term care facility, admitting only those people who need high-level complex care, claiming that others are better supported in “homelike” settings through the provision of assisted living and home support services.²⁹⁵ As noted earlier in this report, the promise of additional home support has not been fulfilled. There are certainly many new assisted living facilities,²⁹⁶ but they are unaffordable for most, and are not an appropriate substitute for licensed residential care. Seniors’ care expert Evelyn Shapiro describes the change as “the development of residential ‘ghettos’ where residents are housed in line with their financial status rather than being served in line with their care needs.”²⁹⁷

Assisted living is intended for people with low to moderate disabilities and those with sufficient mental capacity to direct their own care (see Appendix A for definitions). It includes hospitality services and personal assistance to adults who can live independently, but require some help (e.g. assistance with activities of daily living or medication management). Assisted living facilities do not have registered nurses on site, and most do not have any care staff available overnight.

What is intended and what is happening are two different things. In Alberta, for example, the government is expressly using assisted living as a substitute for residential long-term care.²⁹⁸ In the words of Wendy Armstrong, who has closely monitored and analyzed this trend:

By recasting health care facilities as “housing” and health care benefits as “income subsidies” within a larger context of continuing care reform, a remarkable range of medically necessary health care goods and services have been unbundled, de-regulated and de-listed.²⁹⁹

Reports are beginning to call into question the adequacy of assisted living in meeting population needs. A 2004 study of 41 assisted living facilities in BC found that many residents entering assisted living had care needs too high or too diverse to be accommodated within the assisted living model. Neither the staffing levels nor the physical environments were appropriate for people with dementia or significant mobility limitations. Administrators reported that tenants entering assisted living tended to move to a higher level of care quickly.³⁰⁰ In Ontario this past summer, the death of a hospital patient placed in a private retirement home prompted the Chief Coroner to remind hospitals that only “clinically stable patients with minimal care and supervision needs” are appropriate for placement in private care homes.³⁰¹

Recent research indicates that assisted living is a form of deregulation and that it leads to higher costs, fragmentation of services, and greater burdens on unpaid caregivers. A case study of the conversion of an Alberta nursing home to a designated assisted living program found increasing fragmentation of services, deregulation of price and quality controls, unexpected and unpredictable costs, stress for residents and their families, and a shift in provincial policy from a “health needs” entitlement for public health care benefits to a subsidy model based on demonstrated “financial need.”³⁰²

There is certainly a need for more seniors’ housing, but it should not be a substitute for residential long-term care. Likewise, there is a need for residential LTC improvements that reflect the original philosophy and aims of the assisted/supportive living model, but deregulating and privatizing only hinders progress. Aspects of the “philosophy” of assisted living could certainly be applied to residential LTC: creating a more home-like environment, with more privacy and greater emphasis on social care and maximizing residents’ independence. Even among facilities that market themselves as “assisted living,” however, reality veers far from the philosophy; in fact, the term is often used by facilities that do not even subscribe to the model.³⁰³

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The ideology and methods used to privatize residential long-term care resemble the ideology and methods used to privatize health care in other settings. Wendy Armstrong makes this observation of Alberta’s policy of “unbundling” residential long-term care services and shrinking the “health care” bundle: “The more a service can be broken down into its component parts, the more opportunities for reducing the basic health care package and offloading costs.”³⁰⁴ The same process happens with privatization of hospital services. Governments and employers draw an artificial distinction between clinical services (like nursing and therapy) and support services (like food and cleaning), claiming that support services are “hotel” services and not “health care” services and steadily narrowing the scope of clinical services. They do this to rationalize contracting out of support services and payment of lower wages and benefits to support workers.³⁰⁵

Privatization of policy development

The movement of personnel from government to the for-profit residential long-term care sector and vice-versa represents a privatization of policy development. There is a high level of consultation in policy development between government and the for-profit sector. There is also consultation between government and the operators of non-profit LTC facilities. Sometimes there is consultation between government and seniors’ advocacy groups. However, there is very little if any consultation by government with front-line workers and their unions.

The policy development process needs to be made more equitable and transparent. Governments should commit to full consultation with long-term care facility workers and their unions, and with seniors and their representatives. In particular, governments should commit to equal degrees of consultation with these groups as governments provide to operators of LTC facilities and their representatives. As much as possible, such consultation should be done in one forum, so each stakeholder can know and comment on the input of other stakeholders.

Conclusion

This section has shown the devastating consequences of Canada's historical and accelerated reliance on for-profit ownership and delivery of residential long-term care services. Whether privatization is in the form of infrastructure development, government subsidies to for-profit care providers, for-profit assisted living, contracting out or any other form, it is clear from the research evidence that accessibility and quality suffer. Considering broader impacts like greater hospital usage and public funding for capital acquisitions and profits, the costs to society are even greater. The next section turns to legislative strategies needed to improve residential long-term care.

Legislation to protect seniors

SOLUTION: Increase federal funding and establish federal legislated standards for residential long-term care, including *Canada Health Act* criteria (public administration, universality, comprehensiveness, accessibility, and portability) and conditions (no user fees or extra billing).

Federal funding and regulation of medicare should be extended to residential long-term care. The federal government should substantially increase funding transfers to provincial and territorial governments for residential LTC and make those transfers conditional on compliance with legislated standards. New federal residential LTC legislation should incorporate the criteria and conditions contained in the *Canada Health Act*,³⁰⁶ namely:

- Public administration (administered on a not-for-profit basis);
- Universality (covering all insured persons on uniform terms and conditions);
- Comprehensiveness (covering all medically necessary services);
- Accessibility (reasonable access on uniform terms and conditions, unimpeded by extra charges or discrimination);
- Portability (coverage while absent from home province); and
- No extra billing or user charges for such insured services.

To meet new federal standards for residential LTC, provincial and territorial governments would need to fully insure medically necessary services and carefully regulate accommodation charges. Accommodation charges must not apply to medically-necessary services, exceed current local rental market rates, or increase more than the cost of living adjustment for seniors' income support programs. Provinces and territories should also regulate the out-of-pocket fees that facilities can charge for uninsured services.

Decisions about what gets listed and delisted from public residential LTC plans—in contrast to how medicare coverage gets decided now³⁰⁷—should be based on evidence, using a process that is transparent, accountable, and involves all key stakeholders: government health officials, administrators, workers, and advocates of residents. There should be an effective

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mechanism for complaints and appeals, and activities and reports of decision-making committees should be public and readily accessible.

In the implementation of this new fiscal arrangement and legislation, the federal government should recognize the distinctness of Quebec. Quebec should have primacy in its jurisdiction over social policy and should have the right to opt out of this proposed joint federal-provincial residential LTC program and receive the full transfer payment under the program. For the rest of Canada, joint federal-provincial responsibility applies, with a federal leadership role in funding this residential long-term care program, as well as in setting and enforcing national standards.

SOLUTION: Establish provincially-legislated quality of care standards for residential long-term care facilities, including minimum staffing levels.

The federal and provincial governments should jointly undertake an evidence-based study, supervised by a multi-stakeholder group, to evaluate current assessment tools and determine the staffing level and mix required to meet the needs of residents. The research should consider all LTC staffing needs: direct care and support staff. It should look at “quality of life” as well as “quality of care” indicators.

The staffing standard that is implemented must be:

- The minimum and not the average;
- Fully funded and mandated in regulations;
- For worked hours, not funded hours; and
- Indexed to rise with resident care needs, assessed on a regular basis.

The joint government-commissioned study should also look at exemplary models of residential long-term care governance, management and delivery. Again here, the framework should be a social model of care rather than a strictly medical model. It would identify success stories in residential long-term care proper, but also in coordination and integration of seniors’ programs more broadly. The recommended models identified by the study should be promoted by the federal government through the proposed residential long-term care transfer and advanced by provincial governments on a system-wide basis.

Both the federal and provincial regulatory regimes must include robust accountability and enforcement mechanisms, including public reporting on staffing by facility, unannounced inspections, whistleblower protection, and swift and progressive penalties for violations of standards. Long-term care residents are among the most vulnerable in society because of their deteriorated mental and physical condition and, often, their lack of family to support and monitor their care. Strong accountability systems are necessary.

The inspection and reporting system should include:

- Random, unannounced inspections, at least once a year for each facility;
- Inspection teams that include front-line workers from different departments, chosen by their union, as well as representatives of the residents and families, chosen by their respective councils;

Both the federal and provincial regulatory regimes must include robust accountability and enforcement mechanisms, including public reporting on staffing by facility, unannounced inspections, whistleblower protection, and swift and progressive penalties for violations of standards.

- Solicitation of input from staff and from family and resident councils through a confidential process, as part of inspections;
- Inspection teams with clear investigative and enforcement powers to ensure swift and effective interventions, including the power to issue mandatory compliance orders and impose progressive sanctions for non-compliance;
- Right of appeal (for representatives of the union and the resident and family councils) to a neutral adjudicator where the inspection does not lead to adequate remedial orders, including these representatives being parties to any appeals from the facility owner;
- Annual reporting of inspection results at the facility and on the Internet, including the nature of violations, remedial orders, sanctions, and remedies undertaken; and
- Regular inspection of staffing levels to ensure compliance with the legislated staff-to-resident ratio.

The oversight system must provide for independent scrutiny from Ombudsmen and Auditors General, and it must empower residents, families and staff at all stages of the process.

The majority of residents in LTC are low-income women, and many residents do not have family or friends to advocate on their behalf. It is critical that residents and families have a way to reflect on their experiences and advocate for their interests as a group.

Governments should require, in legislation, the establishment of autonomous resident councils and family councils with authority to advocate for residents. Facilities should be required to inform the residents and their families about the existence and role of such councils. Councils should have the right to the necessary information and public funding to carry out their role effectively.

In addition to government inspections, there should be an effective complaints process in every province and federally. Information must be made readily available to residents and their family members, upon admission, on how to engage in the complaints process. There should be public reporting of complaints data.

LTC workers should be encouraged to report on incidents or conditions that negatively affect residents' care. Provincial and territorial governments should establish statutory whistleblower protection preventing employers from disciplining for any reason someone who has engaged in whistleblowing, unless the employer has first proven to a labour tribunal that it was not in any way motivated by retaliation and that there is just cause for the discipline and the penalty. The law should provide a mechanism for immediate reinstatement should the employer impose discipline without first proving its case. Without such protections, workers are held back from advocating for safe care.

Ombudsman and Auditor General offices in every province should have full legal authority and sufficient resources to scrutinize long-term care facilities and other health care organizations. Independent oversight is an important part of accountability, yet many provinces restrict Ombudsman's powers, and everywhere their resources are insufficient. The New Brunswick Ombudsman cannot receive complaints, make unannounced visits or otherwise investigate nursing homes. Even in Ontario, where complaints about hospitals and long-term care have almost doubled in the past year, the Ombudsman characterized his current inves-

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tigation of the government’s monitoring of long-term care homes as “dancing on the edge of our jurisdiction.”³⁰⁸

Canada should consider the model of ombudsman programs in the United States. There, the *Older Americans Act* sets conditions for financial assistance to states for LTC ombudsman programs (LTCOPs). Under the *Act*, state LTCOPs have an extremely broad mandate to promote the health, safety, well-being, and rights of residents of nursing homes and other long-term care facilities. Most state-enabling statutes state that LTCOPs shall engage in individual advocacy, systemic advocacy, and the development of citizens’ organizations, family and resident councils, and educational activities.³⁰⁹

Public reporting is another critical aspect of transparency and accountability. Facilities should be compelled by the government to report publicly on: number of beds in the facility, inspection results, enforcement orders, staffing levels (all types of care, by shift), staff mix, staff retention and turnover rates, culturally competent care, revenues and expenditures, and out-of-pocket fees charged to residents. This information should be posted in the facility and online.

Governments should be obliged to report publicly on residential long-term care programs, in a timely fashion and using a standardized format that includes at minimum: number of beds by type, revenue by source, expenditures, waiting lists, staffing levels and mix, ownership (non-profit, for-profit), and health human resources planning data. The federal government should establish a database on residential long-term care, with public reporting on provincial and federal programs and on provinces’ compliance with federal standards (including actions taken to remedy non-compliance).

The majority of residents in long-term care are low-income women, and many residents do not have family or friends to advocate on their behalf. It is critical that residents and families have a way to reflect on their experiences and advocate for their interests as a group.

Conclusion

This report addresses the two most pressing shortcomings of residential long-term care: limited access and poor quality. It shows that access is restricted because of underfunding and a highly privatized system, and the for-profit share is growing at residents' and workers' expense. With respect to quality, it shows that working conditions and caring conditions are tightly interwoven; reducing work overload, improving training, and addressing work environment problems lead to better health outcomes and a higher quality of life for residents.

This report documents the two-tier character of residential long-term care, where personal wealth and support networks secure a better standard of care. It also sheds light on the unfair distinction between medically necessary services delivered in hospital and medically necessary services delivered in LTC facilities, the former considered a universal right, the latter a case of charity.

Our population is rapidly aging. Even with better home and community care, both urgently needed, the demand for residential long-term care will continue to grow. Families are buckling under the strain of added responsibilities, and the impacts reverberate into communities and the economy. Extending medicare to residential long-term care is a matter of fairness, equity and economic good sense.

The narrow scope of medicare is out of step with the needs and aspirations of Canadians, and a critical mass of seniors and their allies will make the issue unavoidable. As our population ages and more of us become privy to the inequalities within and between provincial long-term care systems (home and residential), federal inaction on seniors' care becomes more visible and less palatable—ultimately, a political liability. Provincial governments also neglect or actively ration and privatize residential long-term care at their peril. Our leaders can correct the ill-conceived narrow definition of medicare. Retiring baby-boomers will certainly demand it.

In tandem with removing barriers to access, governments must address the quality of care problems that have become the mark of residential long-term care. This obligation is clearly

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shared with LTC facility operators. Certainly front-line workers, in CUPE and in other unions, have been calling for this for decades—alongside residents and their advocates—and we are eager to see the resources and system-wide changes that would make progress possible. In one study of many that come to the same conclusion, front-line workers were most concerned about “the gap between the care they want to give and the care they can give. They are committed to providing the best care possible and suffer when the patients suffer because they can see the care deficit that continues in spite of all the providers’ efforts to ensure care is there.”³¹⁰

As the weight of research evidence in this paper shows, improving care in LTC facilities requires foremost improving the number of staff, their education opportunities, and their working conditions. Quality of work is closely tied to quality of care. The relationship is strongest with respect to the number of staff; study after study concludes that higher staffing leads to better health outcomes, whether it be fewer ulcers, less incontinence or other outcomes. The interplay between working and caring conditions extends to the conditions of work, not only the hours worked. Places that are good to work are also places that are good to live, and this is borne out by evidence of specific and strong effects of managerial approaches, education programs, and staff injury rates and turnover levels on residents’ health status and well-being.

As the weight of research evidence in this paper shows, improving care in LTC facilities requires foremost improving the number of staff, their education opportunities, and their working conditions. Quality of work is closely tied to quality of care.

Improving quality also requires removing the profit-motive from residential long-term care. This would improve access as well. There is considerable evidence linking for-profit ownership to lower staffing and hence lower levels of care. The evidence of higher costs in for-profit facilities is also abundant. Other forms of privatization—contracting out, public-private partnerships, and for-profit assisted living—create the same problems. The case against contracting out is clear whether examining over-reliance on temporary agencies for nurse and care aide staffing, contracted-out cleaning and the environmental transmission of healthcare-associated infections, or increasing reliance on pre-prepared food and the associated impacts on nutrition and risk of food-borne pathogens. The risks are likewise high when we allow governments to, either by stealth or large-scale transfer, move residents to assisted living facilities and other models of deregulated and privatized residential care.

This paper presents a number of concrete recommendations that would address the two-fold challenge of access and quality.

- Extend medicare to residential long-term care, with increased federal funding and legislated federal standards, including *Canada Health Act* criteria (public administration, universality, comprehensiveness, accessibility, and portability) and conditions (no user fees or extra billing).
- Expand residential long-term care, home and community care services to meet the needs of Canadian seniors, as part of a comprehensive and integrated system.
- Establish non-profit ownership and operation of long-term care facilities by phasing out public funding to for-profit operators and ending contracting out.
- Establish provincially-legislated quality of care standards for residential long-term care facilities, including minimum staffing levels.
- Increase staffing (direct care and support staff) in residential long-term care facilities.

- Provide safe and healthy work environments that support high quality care: improve managerial and organizational practices, reduce turnover, pay long-term care workers the same wages and benefits as their hospital counterparts, reduce injuries, eliminate discrimination, and guarantee culturally safe care.
- Support education and professional development of residential long-term care workers, first by establishing provincial standards for resident care aide education programs and increasing resources for continuing education for all staff.
- Ensure robust accountability and enforcement mechanisms in both the federal and provincial regulatory regimes, including public reporting on compliance with staffing and other standards, unannounced inspections, whistleblower protection, swift and progressive penalties for violations of standards, independent scrutiny from Ombudsmen and Auditors General, and empowered autonomous resident and family councils.

Our goal is that, through these and other necessary changes, long-term care facilities would be transformed from places people dread to places people trust—homes where workers and residents both are treated with dignity and respect, working and living in safe and healthy environments. Further yet, we want facilities that give residents choice, autonomy, independence, pleasure, joy, and pride—where each resident’s culture, beliefs, and language are respected. We want seniors in Canada to have equal access to residential long-term care no matter where they live or what their income, and we want that care to be of the highest quality possible, enabling a good quality of life as well as a good quality of care.

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Types of residential services

Long-term care facilities

The focus of this paper is government-licensed long-term care (LTC) facilities that provide 24-hour nursing care, primarily to seniors. Different terms are used in each province (see the table below). To avoid confusion and for the purposes of this paper, we use the term *long-term care facilities* to mean facilities that are government-licensed and are intended for persons (mainly seniors) with high levels of physical and/or mental disabilities who require 24-hour nursing supervision, continuous care, and specialized care.

Terms used for long-term care facilities, by province	
	LTC facilities are known as:
British Columbia	Residential care facilities and complex care facilities. (Previously called long-term care, which included different levels of care from personal care, intermediate care to multi-level and extended care.)
Alberta	Long-term care facilities, nursing homes or auxiliary hospitals.
Saskatchewan	Special care homes or nursing homes.
Manitoba	Personal care homes. Personal care homes are defined as proprietary (for-profit) and non-proprietary (not-for-profit). Non-proprietary facilities are further defined as “free standing” or “juxtaposed” to another health care facility.
Ontario	Long-term care facilities. There are three types: nursing homes (mainly for-profit), charitable homes (non-profit), and homes for the aged (mainly owned and operated by municipal governments).
Quebec	LTC facilities in Quebec are referred to in English as “residential and long-term care centres” and in French as Centres d’hébergement et de soins de longue durée (CHSLDs). Private facilities are further distinguished by those that are registered (privés conventionnés) and those that are not (privés non conventionnés).
Newfoundland & Labrador	Nursing homes.
New Brunswick	Nursing homes.
Nova Scotia	Nursing homes; homes for the aged.
Prince Edward Island	Private facilities are called “nursing homes” and public facilities are called “manors” or “government manors.”

There are both publicly-funded LTC facilities, which are subsidized by the government, and private-pay facilities, in which residents or their families pay the full cost. Publicly-funded facilities can be owned by either non-profit or for-profit organizations. In most provinces, eligibility for publicly-funded facilities is determined by regional health agencies.

Governments regulate the fees that LTC facilities can charge residents and the scope of services they provide.

What most distinguishes LTC facilities from other forms of seniors' residences is the level of regulation and the provision of 24-hour nursing care.

Assisted living

Assisted living is promoted as a form of housing for people with low to moderate levels of disability who require daily personal assistance to live independently. It includes hospitality services (i.e. meals, housekeeping, laundry, social and recreational opportunities, and a 24-hour emergency response system) and low levels of personal assistance³¹¹ with such things as "activities of daily living," monitoring of therapeutic diets, or physical rehabilitation. Assisted living is not suited for persons with mental/cognitive disabilities unable to make decisions on their own behalf.

Resident rooms are like apartment suites: they include bathrooms, kitchenettes (or a small fridge and microwave) and are lockable. There is usually no registered nursing care on-site. Depending on the province, residents apply directly to the facility or through a regional health agency.

There are both publicly-funded and private-pay assisted living facilities. Public funding typically includes subsidies for personal assistance through the health care system and subsidies for housing and hospitality (e.g. meals, housekeeping, laundry) through the provincial housing department. Subsidies vary between provinces; in BC, for example, individuals pay 70 per cent of their after-tax income in assisted living.

Publicly-subsidized assisted living facilities can be owned by either non-profit or for-profit entities. Most assisted living facilities are for-profit.

Government regulation varies. In Alberta, for example, accommodation fees are capped only if the operator has received a capital grant under a provincial housing program, or has an operating contract that controls access. Assisted living units are regulated under the Supportive Living Accommodation Standards, which specifically excludes tenancy protection provisions.³¹² In most provinces, assisted living units are regulated as apartments under tenant protection law and/or general fire and safety regulations.

Supportive housing

Supportive housing is a form of housing for low-income seniors who are either independent or have minor disabilities, but need some assistance to continue living independently. Supportive housing also differs between provinces, but it usually includes a daily meal, weekly housekeeping and laundry, social and recreational opportunities, and a 24-hour emergency response system. No personal care or prescribed service is available on-site, except where individual residents arrange to receive home support from external home support agencies. Supportive housing varies from small group homes to large congregate living settings. Again, subsidies vary; tenants in BC supportive housing pay 50 per cent of gross household income.

Supportive housing units are typically regulated as apartments under tenant protection law and/or general fire and safety regulations.

IT IS CHALLENGING TO DEFINE THE CATEGORIES OF RESIDENTIAL CARE because different terms are used across Canada, and the same term may have a different meaning in each province. For example, in some provinces, supportive housing provides a higher level of services than assisted living. “Special care homes” means one thing in one province and an entirely different thing in another.

Differences in terminology and definitions make data collection and comparisons difficult as well. As the Canadian Institute for Health Information states: “the lack of standardized terminology, definitions, and data collection processes make comparisons from one jurisdiction to another and even across facilities within the same jurisdiction challenging.”³¹³

It should also be noted that the distinctions between the three facility types are becoming increasingly blurred. For instance, assisted living facilities are offering higher levels of personal and nursing care, and governments are shifting public funds away from long-term care facilities toward assisted living and supportive housing.

LTC beds (publicly-funded) in 2008, by province and ownership status

	Non-profit	for-profit	total beds	% non-profit	% for-profit
British Columbia ^a	17,028	7,588	24,616	69%	31%
Alberta ^b	10,230	4,424	14,654	45%	30%
Saskatchewan ^c	8,273	671	8,944	92%	8%
Manitoba ^d	7,280	2,553	9,833	74%	26%
Ontario ^e	35,748	40,210	75,958	47%	53%
Quebec ^f	35,638	10,453	46,091	77%	23%
New Brunswick ^g	4,175	216	4,391	95%	5%
NFLD & Labrador ^h	2,747	0	2,747	100%	0%
Nova Scotia ⁱ	4,190	1,796	5,986	70%	30%
Prince Edward Island ^j	578	400	978	59%	41%
Canada	125,887	68,311	194,178	65%	35%

This data, with the exception of the Newfoundland and Labrador data, was gathered by Janice Murphy, Research Consultant, for the Canadian Union of Public Employees. Ministry representatives were asked to identify the number of licensed, government-funded, residential long-term care beds in the province (with a breakdown by for-profit and non-profit), not including fully private-pay or assisted living beds.

- ^a British Columbia bed numbers came from the Canadian Centre for Policy Alternatives 2009 report *An Uncertain Future for Seniors* (Cohen et al., 2009b). Sources include Hospital Employees' Union freedom of information requests of the regional health authorities in August 2008, cross-referenced with a long-term care site tracking spreadsheet with information from the Canadian Healthcare Association Guide and health authority websites. The numbers for Vancouver Island Health Authority (VIHA) were updated to December 2008 based on information provided by VIHA on recent openings and closures.
- ^b Alberta bed numbers came from correspondence with Thuy Nguyen, Strategic Issues and Continuing Care, Alberta Health and Wellness. The number of LTC beds is as of March 31, 2008. Information on the ownership status of residential care facilities came from www.ab-cca.ca/about-our-members/

- c Saskatchewan bed numbers came from correspondence from Gaye Holliday, Special Care Home Consultant, Saskatchewan Health, on October 1, 2008. Information on ownership status also from Gaye Holliday: 671 or 7.5 per cent of residential care beds are private-for-profit (and the privates do not have any respite beds).
- d Manitoba bed numbers are as of March 31, 2008 and include a limited number of respite beds. At a maximum, a facility may have two respite beds. Not all facilities have respite beds. There are also an additional 150 non-licensed interim beds in Manitoba that are being phased out. These non-licensed beds are not included in the number 9,833. Information on LTC beds and ownership status came from Lorene Mahoney, Long Term Care Consultant, Manitoba Health.
- e Information on Ontario LTC beds came from Health System Information Management and Investment (HSIMI), July 31, 2008, Health Data Branch, Ministry of Health and Long Term Care.
- f Quebec bed numbers came from the table “Capacités: Lits ou Places autorisés au permis. Sommaire provincial selon les mission-classe-type” (a provincial summary of licensed beds according to class types) retrieved January 5, 2009 from wpp01.msss.gouv.qc.ca/appl/M02/M02SommLitsPlacesProv.asp, last updated December 20, 2008.
- g The non-profit bed number for New Brunswick came from Mike Leger, Manager of Nursing Home Services, and applies to 2008. Of the 61 non-profit facilities currently operating in New Brunswick, 56 are run by non-profit organizations and five are run by regional health authorities. The for-profit bed number is drawn from a New Brunswick government news release dated April 15, 2008 and is a projection. The New Brunswick government at that time entered an arrangement with Shannex, a nursing home chain based in Nova Scotia, to build three new LTC facilities as public-private partnerships over a period of two years. Joyce Alberta, consultant with New Brunswick Nursing Home and Residential Services, reported in a conversation August 31, 2009 that the first Shannex nursing home, including 72 beds, is expected to open in January 2010. The remaining two nursing homes, with 72 beds each, are expected to open by June 2010.
- h The Newfoundland and Labrador bed numbers and public-private ratio were provided by the Department of Health and Community Services to CUPE on August 17, 2009.
- i Nova Scotia LTC bed numbers came from correspondence with Annette Fougere, Supervisor, Intake and Placement in Long-term Facilities, Continuing Care, Nova Scotia Department of Health. The number of “nursing home” beds is as of August 1, 2008. The estimated ratio of for-profit to not-for-profit beds is based on a Nova Scotia Department of Health bulletin that identifies 70 LTC facilities with this ownership mix: 20 private-for-profit (30 per cent); 21 private-non-profit, 22 municipal owned, and seven based in hospitals (total 70 per cent non-profit), accessed at www.careerbeacon.com/corpprof/ns_dept_of_health/nove_scotia_long_term.htm
- j PEI bed numbers were obtained from Calvin Joudrie, LTC Subsidization Manager. As of February 19, 2009 there were 578 public LTC beds and 400 permanent licensed private nursing home beds. In addition, there were 44 temporary licensed private nursing home beds. If these 44 beds are included, the total LTC bed count increases to 1,022 and the for-profit share to 43 per cent.

Job satisfaction and turnover in LTC facilities

Part 3 of this paper presented evidence of the impacts that high turnover have on residents' health and well-being. This appendix summarizes the literature on factors behind high turnover in residential long-term care.

Organizational factors such as leadership and workload influence employees' commitment to the job and job satisfaction, and both commitment and satisfaction are related to staff retention.³¹⁴

- Care aides and nurses working in 12 Ontario LTC facilities reported that the relationships between supervisors (nurse managers and RNs) and care providers (care aides and LPNs) were improved by considerate listening, recognition, positive reinforcement, respect and trust (“managerial communication behaviours”) and by more overt behaviours such as helping, teaching, and advocating (“role-modelling practical behaviours”).³¹⁵
- An Ontario survey of LTC facility workers' views on quality of work life found that the most important predictors of job satisfaction at a combined residential care/ community hospital site (124 beds) were: open communication between staff; good decision authority; supervisor social support; organization keeping staff informed; and staff being satisfied with their pay level. At the other residential care site surveyed (389 beds), the most important predictors of job satisfaction were: belief that the organization carries out its mission statement, supervisor social support, good decision latitude, and “often or always given enough time to get the job done.”³¹⁶
- Interviews and data analysis on turnover in 250 LTC facilities in 10 US states revealed that care aide turnover rates were one third lower in facilities where care aides were consulted about care plans or had their suggestions accepted by nursing staff, in comparison to facilities where care aides had no involvement in care planning. Where care aides were actually involved in care planning meetings, their turnover rates were 50 per cent lower.³¹⁷
- In a survey of care aides at 24 Illinois and Indiana LTC facilities, personal growth and development, job security, and job challenge were significantly related to job satisfaction.³¹⁸
- A state-wide survey of 550 care aides in 70 Louisiana LTC facilities found that care aides had less turnover and more job satisfaction when they had supportive and fair supervision, participation in work-related decisions, opportunities for professional growth, and an environment of open communication.³¹⁹

- Care aides working in 50 LTC facilities in five US states who positively rated their supervisor (on communication, feedback, support and other measures) were less likely to quit their job.³²⁰
- A study of 854 nursing homes in six states found an interesting relationship between care aide staffing levels and turnover: higher care aide staffing was linked to lower voluntary and involuntary turnover for all categories of nurses, suggesting that care aide staffing is vital to retention efforts for the entire nursing staff.³²¹
- A survey of 2,900 nursing home administrators across the US found that consensus managers (leaders who solicit, and act upon, input from their staff) had the lowest turnover levels, even when the effects of organizational and local economic conditions are held constant.³²²
- A study involving 6,354 LTC workers from 76 Midwest US facilities reported that the quality of the organization's environment was the strongest predictor of job satisfaction and intention to stay in their jobs. "Quality of the environment" measures included the extent to which the organization rewarded quality, provided time for improvement and training, exhibited cooperation and teamwork, and followed up on ideas.³²³
- In the first national US study focusing on care aides' working conditions and job satisfaction, a survey of 2,252 care aides found that significant predictors of job satisfaction included workload, good relationships with supervisors, feeling respected and valued, finding the work challenging, and being encouraged to discuss resident care with residents' families. In terms of job demands, an increase in care aide hours per resident day of 0.5 hr decreased the probability of job dissatisfaction by 8.5 per cent.³²⁴

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Notes

- 1 World Health Organization, 2002.
- 2 According to Statistics Canada (2007b), there were 206,170 approved residential care beds in Canada in 2005/06. The Statistics Canada survey captures some assisted living/supported housing beds and excludes some hospital-attached beds. Our research identifies just under 200,000 LTC beds, excluding assisted living and likely some hospital-attached beds (see Appendix B).

Armstrong et al. (2009) explain that Statistics Canada identifies 212,474 full-time equivalent positions in Canada outside of Quebec, but that many residential LTC employees are part-time, so this number significantly underestimates the actual number of people working in the sector. Elsewhere, through its Labour Statistics Division, Statistics Canada identifies a much higher number of employees – 325,700 – for the residential long term care sector in 2008 (Statistics Canada, 2008, special tabulation based on 2008 Labour Force Survey).
- 3 “Quality of care” measures include such things as the rate of pressure sores, weight loss, falls, and hospitalization. “Quality of life” is a broader concept, encompassing residents’ opportunities for choice, autonomy, meaningful relationships, and other things that make life worth living.
- 4 Hours per resident day (hprd) refers to the average daily hours worked by the staff in question (usually nurses and care aides) divided by the total number of residents. Sometimes it reflects “paid hours” and not “worked hours,” but it rarely includes administrative hours. It is the most commonly used measure of staff intensity in residential long-term care.
- 5 Reference to “provinces” in the remainder of the paper should be interpreted as “provinces and territories.”
- 6 Canadian Union of Public Employees, 2008a.
- 7 The *Canada Health Act*, with respect to extended health care services, requires only that provinces and territories provide information (section 13(a)) and give recognition to the federal cash contribution (section 13(b)). The information, included in annual reports on the *Act*, is incomplete and difficult to interpret given the lack of standardized terminology, definitions and detailed reporting requirements.
- 8 Alexander, 2002, 19. The federal government began subsidizing residential care for the elderly through the 1966 Canada Assistance Plan (CAP). There was a drop in CAP funding for extended health care as the Extended Health Care Services Program came on stream, and CAP was eliminated entirely in 1996.
- 9 Tarman, 1990, 35. The federal guidelines issued in 1973 identified five levels of institutional health care: residential, extended care, chronic care, rehabilitation, and acute care.
- 10 Deber, 2000, 25. Deber explains that the federal government, in its EPF spending reports, assigned a portion to health care and a portion to post-secondary education, but those were “notional” allocations since the EPF transfer itself was not tied to specific spending requirements.
- 11 Alexander, 2002, 18.
- 12 Fletcher (1987) in Alexander, 2002.
- 13 Canadian Institute for Health Information, 2000, 3.
- 14 Stadnyk, 2002.
- 15 BC Government (2009), in Cohen et al., 2009b, 36.
- 16 Stadnyk, 2002, 12.

- 17 Wodak, 2007.
- 18 Pitters, 2002, 164.
- 19 Statistics Canada, 2005. The rapid increase between 2026 and 2046 is attributed to both the large baby-boom cohorts reaching age 80 and an increase in the average length of life (as life expectancy is projected to rise by an average of approximately seven years during that period).
- 20 Pitters, 2002, 176.
- 21 34 per cent of Canadians aged 85 years or older resided in LTC facilities in 2002 (Pitters, 2002). Using another measure, this one province-specific, in Quebec, 28.9 per cent of seniors not living in their homes live in LTC facilities (CHSLDs) (Confédération des syndicats nationaux, 2007).
- 22 Ostry, 2006, 219.
- 23 Ostry, 2006, 208-216. Looking at concurrent LTC and hospital bed trends in one province, between 1992 and 1998, 436 new personal care home beds were constructed in Manitoba, while 1,200 acute care hospital beds were closed (Leach, 2006).
- 24 Ontario Health Coalition, 2009; Friends of Medicare Alberta, 2009; Hospital Employees' Union, 2009.
- 25 Cohen et al., 2009a, 40.
- 26 Health Council of Canada, 2008, 28-33.
- 27 The federal government's home care study reported in 2003 that "although home care programs are receiving more funding, the funding levels are not enough to address the care needs of the home care recipients" (Human Resources Development Canada, 2003). The gaps identified in this and numerous other reports continue to exist. The April 2009 final report of the Special Senate Committee on Aging confirms that home care services are uneven and inadequate in Canada (Senate Special Committee on Aging, 2009, 54-55).
- 28 Armstrong, 1994, 95-110.
- 29 Human Resources Development Canada, 2003; Kushner et al., 2008; Cohen et al., 2009a.
- 30 Kushner et al., 2008, 41.
- 31 Cohen et al., 2009b, 31.
- 32 National Union of Public and General Employees, 2007.
- 33 Canada Mortgage and Housing Corporation, "Seniors' Housing Report—British Columbia," 2009, p. 10-11, retrieved August 26, 2009 at https://www03.cmhc-schl.gc.ca/b2c/b2c/init.do?language=en&z_category=0/0000000160
- 34 Canada Revenue Agency, "Basic Table 6 – All returns by age, sex, total income class, and major source of income, British Columbia: Income Statistics 2008 – 2006 tax year," retrieved August 28, 2009 at www.cra-arc.gc.ca/gncy/stts/gb06/pst/fnl/pdf/bc/tbl6-eng.pdf
 Statistics Canada describes individuals living on their own as "unattached individuals," defined as "a person living either alone or with others to whom he or she is unrelated, such as roommates or a lodger" (Statistics Canada, 2003, "A Guide to Statistics Canada Pension and Wealth Surveys" retrieved at www.statcan.gc.ca/bsolc/olc-cel/olc-cel?catno=13F0026M2003001&lang=eng)
- 35 Canada Mortgage and Housing Corporation, supra note 33, Seniors' Housing Reports for British Columbia (p. 10-11), Alberta (p. 9), Saskatchewan (p. 9), Ontario (p. 13), and Quebec (p. 18), all retrieved August 26, 2009 at https://www03.cmhc-schl.gc.ca/b2c/b2c/init.do?language=en&z_category=0/0000000160
- 36 The rent figures pertain to rent and mandatory services only. For the purpose of the survey, CMHC defines mandatory services as those services that must be paid for by the resident without option. Charges for any health care, meal plan, housekeeping or other services that

are optional are not included in the rental figure. Email correspondence to Janice Murphy from David Europe-Finner, Market Analyst, BC Market Analysis Centre, CMHC, August 31, 2009.

- 37 Statistics Canada, 2009.
- 38 Armstrong and Deber, 2006b, 5.
- 39 Ibid.
- 40 LIMRA International Inc., Canadian Individual Long Term Care Insurance Sales, in Baker, 2009. Hurley and Guindon (2008, 20) put the number at 52,000 at the end of 2005.
- 41 Canadian Union of Public Employees, 2008b.
- 42 According to the World Health Organization, “universal coverage requires that everyone within a country can access the same range of (good quality) services according to needs and preferences, regardless of income level, social status, or residency, and that people are empowered to use these services” (World Health Organization Commission on Social Determinants of Health, 2008, 8).
- 43 World Health Organization, 2000.
- 44 Fuller, 1998.
- 45 Canadian Health Coalition, 2007.
- 46 Canadian Union of Public Employees, 2008b.
- 47 Williams et al., 2009.
- 48 Grant (2004) in Armstrong et al., 2009.
- 49 Armstrong, 2007, 528-553.
- 50 Guberman (2004) in Armstrong, 2007, 537.
- 51 Armstrong, 2007, 537.
- 52 Armstrong, 2007, 537-541.
- 53 Cohen et al., 2009a.
- 54 World Health Organization, 2002.
- 55 Armstrong et al., 2009.
- 56 Statistics Canada, 2007a.
- 57 Statistics Canada, 2008a. In 2005, women accounted for almost 75 per cent of persons aged 90 or older (Turcotte and Schellenberg, 2007, 13).
- 58 Statistics Canada, 2009; Townson, 2009, 29-31.
- 59 Cranswick and Thomas, 2005. According to the 2002 General Social Survey, two thirds of non-institutionalized senior men lived in a two-person household with a spouse, while only a little over one third of women did. Women most often lived alone (43 per cent) while it was the least common arrangement among men (16 per cent) (p. 13). Seniors receive more formal care as they age because they are losing their social networks (p. 12).
- 60 Armstrong et al., 2009, 43.
- 61 Baines, 2004.
- 62 Grant et al., 2004.
- 63 Statistics Canada, 2008a.
- 64 Armstrong and Deber, 2006a, 20.
- 65 This is even more true today than 30 years ago, given that more women are in the paid labour force and families are more dispersed geographically. Declining birth rates may mean fewer family social supports available to baby boomers when they get older and need help. (Human Resources Development Canada, 2003; Special Senate Committee on Aging, 2009, 118.)

- 66 Informetrica Ltd. in Canadian Union of Public Employees, 2008c.
- 67 Murphy, 2006.
- 68 Kane, 2004.
- 69 McGillis Hall et al., 2005.
- 70 Murphy, 2006.
- 71 Wiener et al., 2007.
- 72 Ontario Ministry of Health and Long-Term Care, 2008, 4.
- 73 Coughlan and Ward, 2007.
- 74 Armstrong and Daly, 2004; Armstrong et al., 2008.
- 75 “Nurse” staff includes licensed practical nurses (LPNs, also called registered practical nurses or RPNs) and registered nurses (RNs).
- 76 “Personal care” staff includes resident care aides (care aides), personal care aides (PCAs), nurses aides (NAs), nursing assistants, and other titles. In the US, continuing care assistant is a common job title. For the purposes of this paper, “care aide” and “resident care aide” are used in reference to personal care staff. Care aides provide the bulk of hands-on care in LTC facilities.
- 77 Dewolfe and Millan (2003) in Cohen et al., 2009b.
- 78 Weatherill, 2009.
- 79 Canadian Union of Public Employees, 2009.
- 80 Andersen et al. (2002), Archibald et al. (1997), Denton et al. (2004), Griffiths et al. (2008), and Hugonnet et al. (2007) in Canadian Union of Public Employees, 2009.
- 81 Canadian Union of Public Employees, 2009.
- 82 Smith and Rusnak, 1997; Smith et al., 2008.
- 83 Zoutman et al., 2009; Van Iersel, 2007, 2-3, 15-16.
- 84 Armstrong and Daly, 2004; CAW Canada, 2007.
- 85 Spencer et al., 2008a, 4; Spencer et al., 2008b.
- 86 Wodak, 2007.
- 87 Staples and Wodak, 2008.
- 88 Dr. R.J. (Dick) Raymond of the Family Practice Residency Program in Prince George, BC, in Cohen et al., 2009a.
- 89 Cohen et al., 2009b.
- 90 Gallager and Drance (2007) in Cohen et al., 2009b.
- 91 Ontario Health Coalition, 2009, 12.
- 92 Murphy, 2006.
- 93 Horn et al. (2005) in Murphy, 2006, 22.
- 94 Hours per resident day (hprd) refers to the average daily hours worked by the staff in question (usually nurses and/or care aides) divided by the total number of residents. Sometimes it reflects “paid hours” and not “worked hours,” but it rarely includes administrative hours. It is the most commonly used measure of staff intensity in residential long-term care.
- 95 Dyck (2004) in Murphy, 2006, 23.
- 96 Bates-Jensen et al. (2004) in Murphy, 2006, 25.
- 97 Arling et al., 2007.
- 98 Kayser-Jones and Schell (1997) in Murphy, 2006, 29.
- 99 Simmons and Schnelle, 2006.

- 100 Kramer and Fish (2001) in Murphy, 2006, 23.
- 101 Schnelle et al. (2004) in Murphy, 2006, 26.
- 102 Schnelle and Simmons (2001) in Murphy, 2006, 27.
- 103 Castle and Engberg, 2008.
- 104 Kirkevold and Engedal, 2006.
- 105 Kim et al., 2009.
- 106 Stevenson, 2006.
- 107 Kramer et al. (2000) in Health Care Financing Administration, 2000, 9.1-9.22. As Kramer et al. note, care aides can play a major role in preventing hospitalizations by: providing hydration and assistance with eating (reducing the risk of electrolyte imbalance), supporting proper positioning and feeding (preventing aspiration pneumonia), keeping residents with chronic pulmonary disease warm (preventing respiratory infections), providing hydration and careful hygiene, including regular bathing (preventing urinary tract infections), and providing assistance with prevention of primary infections and recognizing signs and symptoms of infection (preventing sepsis, including bloodstream infections).
- 108 Horn et al. (2005) in Murphy, 2006, 22.
- 109 Hutt et al. (2000) in Murphy, 2006, 21.
- 110 Rantz et al. (2004) in Murphy, 2006, 27.
- 111 Kayser-Jones and Schell (1997) in Murphy, 2006, 28. On the day shift, each care aide typically cared for seven to nine residents, and in the evening they were assigned 12 to 15 residents. However, if someone called in sick, they had an even greater workload.
- 112 Wagner and Rust, 2008, 6.
- 113 Ibid., 20.
- 114 Morgan et al., 2002.
- 115 Armstrong and Daly, 2004.
- 116 Armstrong et al., 2009, 105.
- 117 Bowers et al., 2000.
- 118 Morgan et al., 2002.
- 119 Reed and Tilly, 2008, 39.
- 120 Armstrong et al., 2008, 88-103.
- 121 Armstrong, 2001, 136.
- 122 Ross et al., 2002.
- 123 Armstrong et al., 2009.
- 124 Ibid.
- 125 Flackman et al., 2008.
- 126 Coughlan and Ward, 2007.
- 127 Howes et al. (2008, 7) in Hospital Employees' Union, 2009b, 11.
- 128 Hawes, 2002, 7; Hirst et al., 2008; Spencer et al., 2008.
- 129 Howes et al., (2008, 7) in Hospital Employees' Union, 2009b, 11.
- 130 Spencer et al., (2008) in Hospital Employees' Union, 2009b, 12.
- 131 McCourt (2004, 46) in Murphy, 2006, 30.
- 132 Armstrong et al., 2009, 131-132.
- 133 Banerjee et al., 2008, v.
- 134 Kramer and Fish (2001) in Health Care Financing Administration, 2002, Chapter 2, 1-26.

- 135 For example, 3.1 care aide hprd were needed for improvements in weight loss, 2.8 care aide hprd were needed for improvements in the incidence of skin trauma and pressure ulcers, and 2.4 care aide hprd were needed for residents to achieve functional improvements. Likewise, 1.55 licensed nurse hprd impacted improvements in functional abilities, 0.95 licensed nurse hprd were needed to prevent weight loss, and 1.15 licensed nurse hprd were needed for improvements in skin trauma.
- 136 Feuerberg (2002) in Health Care Financing Administration, 2002, Vol. 1, 1-22.
- 137 Hospital Employees' Union, 2009b.
- 138 Harrington et al., 2000.
- 139 Schnelle et al., 2004. Highest-staffed homes performed significantly better on 13 of 16 care processes implemented by care aides compared to lower-staffed homes. In general, participants in the highest-staffed homes spent more time out of bed during the day, were engaged more frequently, received better feeding and toileting assistance, were repositioned more frequently, and showed more physical movement patterns during the day that could reflect exercise.
- 140 Collier and Harrington, 2008, 164.
- 141 Harrington et al., 2006; Harrington et al., 2007.
- 142 Tilly and Harvell, 2003; Harrington, 2008a.
- 143 Harrington, 2008a, 13.
- 144 Harrington et al., 2008.
- 145 Hospital Employees' Union, 2009b, 35.
- 146 Ibid.
- 147 As one example, a recent government-commissioned report in Ontario recommended a target of four hours of paid care per resident per day. The goal is a "target" only, and it refers to paid, not worked, hours (Sharkey, 2008).
- 148 Unlike in the United States, which posts staffing levels on a public web site, data on staffing in each facility in Ontario is considered confidential.
- 149 Canadian Union of Public Employees, News Release, "*Liberal MPPs get cookies, long-term care residents get crumbs. More money going into long-term care isn't translating into more care,*" June 30, 2009.
- 150 Collier and Harrington, 2008.
- 151 Anderson et al. (2003) in Murphy, 2006; Rosen et al., 2005.
- 152 Boothman, 2007.
- 153 Yassi et al., 2004.
- 154 Barry et al. (2005) in Murphy, 2006, 35.
- 155 Ibid.
- 156 Anderson et al. (2003) in Murphy, 2006, 34.
- 157 Ibid.
- 158 Ibid.
- 159 Zimmerman et al., 2005.
- 160 Eaton, 2000.
- 161 Collier and Harrington, 2008.
- 162 Harrington et al., 2006.
- 163 Donoghue and Castle, 2009.
- 164 California Department of Health Services, 2001, 19.

- 165 Castle (2005) in Murphy, 2006, 36. Continuity of care requires good information flow, interpersonal skills, and coordination of care (Reid et al., 2002). Consistency of care staff is an important element of continuity (Human Resources Development Canada, 2003, Appendix B).
- 166 Castle and Engberg (2005) in Murphy, 2006, 36.
- 167 Gruss et al., 2004.
- 168 Cohen et al., 2006.
- 169 Ramage-Morin, 2005, 52.
- 170 Gruss et al., 2004.
- 171 Castle (2005) in Murphy, 2006, 36.
- 172 Murphy, 2006.
- 173 Castle and Engberg, 2008.
- 174 Castle, 2008.
- 175 Barry et al., 2005.
- 176 Horn et al. (2004) in Murphy, 2006, 37.
- 177 Rondeau and Wagar, 2001.
- 178 Bishop et al., 2008.
- 179 Armstrong et al., 2008, 42.
- 180 Squillace et al. (2009) in Wiener et al., 2009.
- 181 Howes (2005) in Wiener et al., 2009.
- 182 Bishop et al., 2009.
- 183 Certified General Accountants Association of Canada (2005) in Leach et al., 2006, 23; Armstrong et al. 2008, 41; Armstrong et al. (2009, 84) found a high level of involuntary part-time work in Canada compared to Nordic countries.
- 184 Armstrong and Daly, 2004.
- 185 Aronson and Neysmith, 1997; Kushner et al., 2008, 151.
- 186 Yassi et al. (2003) in Murphy, 2006, 42.
- 187 Trinkoff et al., 2005.
- 188 Yassi et al. (2003) in Murphy, 2006, 42.
- 189 Collins et al., 2004.
- 190 Occupational Health Clinics for Ontario Workers Inc. (1998) in Armstrong and Armstrong (2002).
- 191 Stone and Gershon (2006) in Castle et al., 2009.
- 192 Pendukar, 2002; Statistics Canada, 2008b.
- 193 Statistics Canada, 2008c, 14; Health Canada, 2002, 6.
- 194 Das Gupta, 2009, 81. Das Gupta's research addresses nursing employment. Knowing that racialized workers are overrepresented in low-paid jobs (Galabuzi, 2001), we can expect racial segregation in the long-term care workforce to be even more pronounced among care aides and support staff.
- 195 Flecker, 2006b; Flecker, 2006a, 9; Sullivan, 2009.
- 196 Das Gupta, 2009, 10.
- 197 Ejaz et al., 2008. In the study, a majority of the staff were racialized minorities, and 70 per cent of the workers reported hearing residents and clients making racist remarks. Another study (Berdes and Eckert, 2001) found that direct care workers are more likely to condone racist remarks from residents because they believed that the elders were too impaired to be

- maliciously racist. Certainly, workers are often told to accept violence as “just part of the job” (see Banerjee et al., 2008).
- 198 “Cultural safety” in contrast to “cultural sensitivity” recognizes socio-economic power imbalances rooted in institutions and social relations (Nursing Council of New Zealand, 2005, 4). Culture includes personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social groups (US Department of Health and Human Services Administration on Aging, 2009).
 - 199 US Department of Health and Human Services Office of Minority Health, 2009; see also Roberts, 2008.
 - 200 On anti-racist organizational change, see Lopes and Thomas, 2006. On achieving cultural competency in human service organizations, see Ngo, 2000.
 - 201 Cahill, 2002.
 - 202 Rosen et al., 2005.
 - 203 Leon et al., 2001; Noel et al., 2000.
 - 204 Frazier and Sherlock, 1994.
 - 205 Morgan et al., 2002.
 - 206 Private care aide programs represent 60 per cent of grads and 67 per cent of all care aide colleges in BC; 55 per cent of colleges in Alberta, and 73 per cent of colleges in Ontario. Email communication from Marcy Cohen, Research Director, Hospital Employees’ Union, August 31, 2009.
 - 207 Hospital Employees’ Union, 2009b, 18-19.
 - 208 Facility Bargaining Association Joint Policy Committee, 2008.
 - 209 BC Ministry of Health, 2008.
 - 210 Cohen et al., 2009b, 27.
 - 211 Wodak, 2008.
 - 212 Ontario Health Coalition, 2008.
 - 213 Cohen et al., 2009b.
 - 214 Email communication from Corey Vermey, National Representative, Canadian Auto Workers, August 10, 2009.
 - 215 D. McHardie, “Watchdogs keying in on nursing homes,” *New Brunswick Telegraph-Journal*, September 9, 2008, A3.
 - 216 Fédération interprofessionnelle de la santé du Québec, 2007.
 - 217 Confédération des syndicats nationaux, 2007.
 - 218 Armstrong and Deber, 2006a.
 - 219 The 10-year Strategic Continuing Care Services Plan of the Chinook Region in Alberta calls for reductions of 80 per cent of traditional long term care beds (in auxiliary hospitals and nursing homes) and replacement of these spaces with assisted living and enhanced service programs in private congregate housing and public lodges (Chinook Regional Health Authority, 2003, 90).
 - 220 Canadian Union of Public Employees (1999) in Wilson and Howard, 2000. The 28 per cent growth refers to bed numbers.
 - 221 Canadian Union of Public Employees Saskatchewan Health Care Council, 2009. The number of personal care homes increased by 8.2 per cent from 1996 to 2009. The most dramatic growth since 2002 has been in personal care homes with more than 40 beds.
 - 222 Canadian Union of Public Employees New Brunswick Council of Nursing Home Unions, 2007, 8.

- 223 In the vast majority of these studies, researchers took into account differences in resident and facility characteristics, such as resident acuity and facility size.
- 224 Ouslander et al. (2000) in Grabowski et al., 2008.
- 225 Shapiro and Tate, 1995.
- 226 McGregor et al., 2006.
- 227 Ibid.
- 228 Commodore et al., 2009. The mixed results in 37 of the studies could, the researchers hypothesized, be explained by differences within ownership categories, for example non-profit homes managed by for-profit companies may function differently from those with in-house management, and investor-owned corporations may have different motivations, management styles and organizational behaviour than single proprietors.
- 229 Konetzka et al., 2004.
- 230 Carter et al., 2003.
- 231 Amirkhanyan et al., 2008.
- 232 C. Duhigg, "At Many Homes, More Profit and Less Nursing," *New York Times*, September 23, 2007, retrieved January 27, 2009 at www.nytimes.com/2007/09/23/business/23nursing.html
- 233 Grabowski and Castle, 2004.
- 234 Spector et al., 1998.
- 235 Harrington, 2007, 13; Mitchell et al., 2003.
- 236 Harrington et al., 2001.
- 237 Ibid.
- 238 O'Neill et al., 2003.
- 239 Amirkhanyan, 2008.
- 240 Duhigg, supra note 232.
- 241 Ben-Ner and Ren, 2008.
- 242 Hillmer et al., 2005.
- 243 Stevenson, 2006. Over the five-year period there were 302,351 complaints filed concerning 19,893 facilities. Residents or family members reported 39 per cent of the complaints; staff 23 per cent; anonymous 16 per cent; other 16 per cent; Ombudsman 6 per cent.
- 244 McGregor (2008) in Cohen et al., 2009b.
- 245 Clarfield et al., 2009.
- 246 Harrington, 2007, 13; Mitchell et al., 2003.
- 247 Berta et al., 2005.
- 248 McGregor et al., 2005.
- 249 Ibid., 647.
- 250 O'Neill et al., 2003.
- 251 Harrington et al., 2001.
- 252 Harrington, 2008b.
- 253 Harrington, 2007; Banaszak-Holl et al., 2002.
- 254 Harrington and Carrillo (2007) in Harrington, 2007, 4.
- 255 Ontario Minister of Health, quoted in Struthers, 1997.
- 256 Email communications with Shalom Schachter, Research Representative, Canadian Union of Public Employees, July 22, 2009.
- 257 Chou, 2002.

- 258 Hirth et al., 2000.
- 259 Stevenson, 2005.
- 260 Hoovers, *Industry Overview: Nursing Homes and Assisted Living*, retrieved at www.hoovers.com/nursing-homes-and-assisted-living/ – ID__48 – /free-ind-fr-profile-basic.xhtml
- 261 Street Authority, “Revenue Per Employee,” retrieved at www.streetauthority.com/terms/r/revenue-per-employee.asp
- 262 By user fees, we mean fees charged directly to residents – in other words, fees that are not covered by the government subsidy.
- 263 Baumbusch, 2008.
- 264 B. Clarke, “Private-care home is costing more, seniors say; Residents of new ‘P3’ facility say they are paying more than at public home, despite health authority’s assurances to the contrary,” *The Globe and Mail*, December 10, 2008, Page S1, Section: British Columbia News.
- 265 Alberta Health and Wellness, 2008.
- 266 Clarke, supra note 264.
- 267 In BC, hands-on care of residents is contracted out in 39 facilities (14 per cent of all facilities), and support services are contracted out in 107 facilities (37 per cent) (Cohen et al., 2009b).
- 268 Stinson et al., 2005; Jaffe et al., 2008; Cohen and Cohen, 2004; UNISON, 2005; Office for Public Management, 2008; Davies, 2005; Aronson et al., 2004; Aronson et al., 2006; Burchell, 2002.
- 269 Hospital Employees’ Union, 2009b, 24.
- 270 British Columbia Legislative Assembly (2007) in Hospital Employees’ Union, 2009b, 25.
- 271 Hospital Employees’ Union, 2009b, 25.
- 272 Zoutman et al., 2003.
- 273 Van Iersel, 2007.
- 274 Jansen and Murphy, 2009.
- 275 Stinson et al., 2005.
- 276 Davies, 2009.
- 277 Auditor General of Scotland (2003) in Canadian Union of Public Employees, 2009.
- 278 Davies, 2009.
- 279 Weatherill, 2009, 44.
- 280 Email communication with Shalom Schachter, supra note 256.
- 281 Agency staff are employed by private contractors, known generally as agencies, that are contracted to fill vacancies on a temporary basis.
- 282 Castle et al., 2008.
- 283 Harrington, 2007.
- 284 Miller and More, 2008.
- 285 Ibid.
- 286 Harrington, 2007.
- 287 Kitchener et al., 2008; Harrington, 2007.
- 288 CBC.CA News, “Advocates demand inquiry into Ontario’s costly handling of Royal Crest nursing-home failure,” March 23, 2009.
- 289 Amirkhanyan, 2008.
- 290 Grieshaber-Otto and Sinclair, 2004; Shrybman, 2008.
- 291 Ontario Health Coalition, 2009, 4.
- 292 Ibid.

- 293 Office of the Premier of Ontario, "Premier Names New Secretary of the Cabinet," News release, December 6, 2007, retrieved August 14, 2009 at http://ogov.newswire.ca/ontario/GPOE/2007/12/06/c8556.html?lmatch=&lang=_e.html
- 294 Miller and More, 2008, 258.
- 295 Cohen et al., 2005; Fédération interprofessionnelle de la santé du Québec, 2007.
- 296 Cohen et al., 2009b; Armstrong and Deber, 2006a.
- 297 Shapiro, 2009, 7.
- 298 Armstrong and Deber, 2006a.
- 299 Ibid.
- 300 Araki (2004) in Cohen et al., 2009b.
- 301 Letter from Andrew L. McCallum, Chief Coroner for Ontario, to Greg Shaw, Vice President, Ontario Hospital Association, June 25, 2009.
- 302 Armstrong and Deber, 2006a.
- 303 Hawes et al. (1999) in Zimmerman, 2003.
- 304 Armstrong, 2002.
- 305 Jansen and Murphy, 2009.
- 306 Canadian Union of Public Employees, 2008a.
- 307 Flood et al., 2006.
- 308 André Marin quoted by Karen Howlett, "Ombudsman reports mixed results on closed-door meetings," *The Globe and Mail*, June 23, 2009. The investigation is focused on two issues – "the effectiveness of the Ministry's monitoring of the facilities to ensure compliance with statutory requirements and policy standards, and whether the Ministry standards are unrealistic, trivial or onerous to the extent that they detract from effective compliance monitoring and patient care" (Ombudsman Ontario, 2009, 39).
- 309 Gittler, 2008.
- 310 Armstrong and Daly, 2004, 14.
- 311 In BC, for example, assisted living is restricted to persons who require a minimum of one, but not more than two, of six prescribed personal assistance services: activities of daily living; central storage, distribution, administering or monitoring of medication; maintenance or management of resident cash, resources or property; monitoring of food intake or therapeutic diets; structured behavioural programs; and psychosocial rehabilitation or intensive physical rehabilitation.
- 312 Email communication with Wendy Armstrong, health care researcher, September 1, 2009.
- 313 Canadian Institute for Health Information, 2000, 3.
- 314 Karsh et al., 2005.
- 315 Hall et al., 2005.
- 316 Krueger et al. (2002) in Murphy, 2006, 42-43.
- 317 Banaszak-Holl and Hines (1996) in Murphy, 2006, 39.
- 318 Atchison (1998) in Murphy, 2006, 43.
- 319 Parsons et al. (2003) in Murphy, 2006, 43.
- 320 Brannon et al., 2007.
- 321 Donoghue and Castle, 2007.
- 322 Donoghue and Castle, 2009.
- 323 Karsh et al., 2005, 1276.
- 324 Bishop et al., 2009.



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