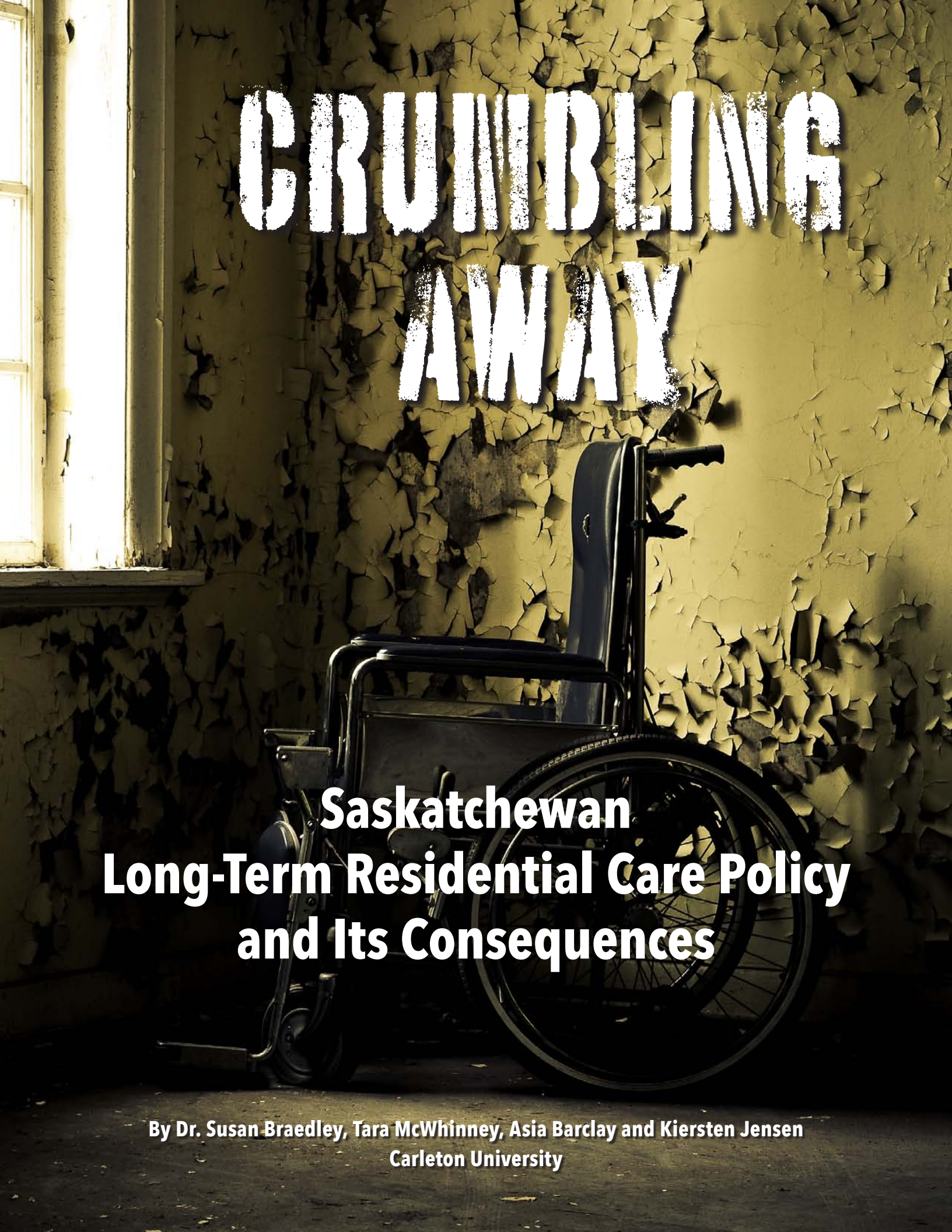

CRUMBLING AWAY

Saskatchewan Long-Term Residential Care Policy and Its Consequences

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Executive Summary

Spurred by bed closures at both Grenfell and District Pioneer Home and Regina's Pioneer Village special care homes, followed by Saskatchewan Health Authority's plan to replace long-term care beds at both locations, this report was commissioned to answer the following questions:

1. Who is caring for Saskatchewan's seniors (and others) with frailty or complex medical conditions that require 24/7 personal care and/or medical supervision?
2. What are the projected needs for residential care for Saskatchewan's aging population, in terms of both numbers and geographic distributions?
3. What is the policy plan for seniors' residential care in Saskatchewan?
4. How does this plan meet the projected needs?
5. How does it compare to promising practices identified in other jurisdictions?

To answer these questions, we reviewed available academic literature, policy documents, and the statistical data. We talked to and corresponded with sources in government, unions, and long-term care sector organizations to ensure our data was as current and complete as possible.

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Our Findings

Saskatchewan residents' substantial investments to ensure their long-term care security are *crumbling away*. However, it is not too late to retain, restore and update this significant legacy and public resource.

1 Policy shifts have eroded both the care and physical infrastructure in publicly funded long-term residential care, which are called special care homes in Saskatchewan, seriously compromising supply for the large numbers of next generation seniors.

Our analysis shows that over the last decade, despite demographic trends that predict needs for more capacity, Saskatchewan long-term care policies have both reduced the number of beds available and eroded service provision by removing staffing requirements that allow for dedicated care hours per resident. Failures to plan for and dedicate sufficient funding to replacing, renovating, repairing, and maintaining the physical infrastructure of publicly owned and operated special care homes have left the sector in disrepair and literally crumbling away.

Despite these problems, Saskatchewan has one of the most promising bases for long-term residential care in Canada, with a mostly publicly owned and operated sector. As this ownership structure has been consistently correlated with the highest quality care if adequately funded, strategic investment in special care homes in Saskatchewan can reverse this course. However, failures to anticipate and plan for current and future needs threaten Saskatchewan seniors' care security.

2 Policy choices aim to involve *private sector actors — and especially for-profit corporations* — in long-term residential care service delivery. These choices ignore research evidence on quality and effectively decrease provincial government responsibility and accountability for long-term care.

Since the election of the Saskatchewan Party in 2007, the provincial government has pursued a marketization and privatization agenda across public services. For long-term residential care, this involves opening a market for private actors, including for-profit corporations, through public — private partnerships (P3) and other means. There is significant high-quality evidence that for-profit provision leads to lower-quality care, lower staffing ratios, higher rates of hospitalization and mortality, escalating costs and lower accountability and financial transparency. There is also significant evidence that public-private partnerships cost more in the long-run than traditional public procurement.

3 Policy has promoted the development of the *privately owned, private pay care sector personal care homes*, including admission of very frail and medically fragile residents to these homes. However, this policy is being pursued without requirements for the staffing or standards that safeguard these vulnerable residents' safety and wellbeing.

Developing a continuum of care is an important policy shift that can more adequately serve people with frailties that include physical disabilities, complex illnesses, and dementias. Home care,

short-term respite and rehabilitation care, and retirement homes are important. However, it is dangerous to promote care options for very frail, vulnerable people that are not designed, regulated, or staffed to meet their needs. Through recent policy developments that allow personal care homes to offer the higher levels of care typically served by special care homes, Saskatchewan is developing a private pay alternative of questionable quality.

Saskatchewan owns and operates most special care homes in the province. Investing in this system is still possible, to preserve the infrastructure legacy and improve staffing. Research shows that a well-run publicly owned and operated system produces higher quality care than for-profit long-term residential care, offering accountability, financial transparency, and cost effectiveness.

Introduction

In May 2018 the Saskatchewan Health Authority closed 94 beds at Regina's Pioneer Village, a 390-bed special care home and extended care facility that had been identified as requiring urgent repairs in 2014. Repair costs were estimated at $59.3 million or a replacement cost of $118 million.[1] This was the second time beds had been closed, as 10% of the beds were closed in 2017. Pioneer Village was crumbling due to continual failures to adequately address major plumbing, electrical, roofing, asbestos, and mould problems. The government did not make replacement plans, allowing it to fall into deeper disrepair.

In August 2018 Grenfell and District Pioneer Home, a 32-bed special care home not far from Regina, was closed due to similar kinds of infrastructure problems identified at least two years earlier and left inadequately addressed by the Ministry of Health.

In February 2019 a plan for replacement was announced. Three request for proposals were released: one for the long-term care beds in the town of Grenfell,[2] one for Pioneer Village in Regina, and one to address the short-term, current shortfall of beds in Regina. The Saskatchewan Health Authority call asked for "an innovative approach" to "community-based long-term care delivery" that can provide the high levels of care offered by special care homes. Consistent with the Saskatchewan Party's decision to open publicly funded health care to for-profit providers, these requests aim to transfer publicly owned and operated long-term care beds to private, and very likely for-profit, corporations. Yet research evidence shows that private, for-profit long-term care is of lower quality and less cost effective than publicly provided long-term care.

Access to long-term care services has become an increasing concern across Canada, including Saskatchewan. More of us are living longer than ever before. For the most part, Canadians look after themselves and their family members, including those in late life who are living with complex disabilities and frailty. However, when care needs and safety concerns exceed what we and our families can look after, we look to governments to take their share in organizing, funding, regulating and providing care.

Long-term care in Canada is not covered by the federal *Canada Health Act*. This means that unlike hospital or physician care, provincial governments have considerable policy power to determine whether and how long-term care services will be provided. Increasingly, hospitals provide only acute care services. When people experience high health and social care needs that are chronic, rather than acute, their care security depends on long-term care.

While all Canadian provinces and territories have long-term care services, they vary in scope, extent, funding arrangements, and regulation.[3] Canadians count on their provincial health ministries and are asking tough questions about how these governments are organizing, funding, and regulating long-term care to ensure there will be services available when and where Canadians need them.

This research report focuses on residential long-term care in Saskatchewan — the special care home program. This program exists within the context of health care and long-term care policies and programs that fall within the jurisdiction of the recently formed Saskatchewan Health Authority and the Ministry of Health. Over many years, Saskatchewan developed one of the most promising long-term residential care programs in the country.

However, in the last decade this program has been undermined by government policy. It is crumbling away, due to neglect of its physical infrastructure, legislative changes that reduce staffing requirements, failures to recruit, train, and fund adequate staffing, and insufficient responses to meet the increasingly complex medical and social care required by changing resident populations.

In what follows we describe Saskatchewan's special care home program and highlight its excellent potential to meet the needs of the province's aging population. Next, we show how government policy shifts have undermined publicly operated care homes and opened doors to private for-profit involvement in the sector. We also describe increasing policy support for the private sector, private-pay personal care home sector, including shifts that allow personal care homes to support high care need residents without qualified medical and social care staff. We also show that personal care home distribution does little to meet the needs of rural Saskatchewan. Finally, we draw on the extensive literature on quality long-term residential care provision to reveal the many problems associated with for-profit provision. We conclude by asking, why does a government squander a legacy, built by generations of Saskatchewan residents, that can offer reliable, accessible, high quality long-term residential care to those who need it?

Saskatchewan's Long-Term Residential Care Legacy:

Special Care Homes

Special care homes (SCH), sometimes called "nursing homes", are the backbone of Saskatchewan's long-term care system. These homes offer 24/7 nursing care for Saskatchewan's most vulnerable adults who live with extreme frailty, dementias and/or complex care needs. Special care home residents require regular medical monitoring and support with the tasks of everyday life, such as bathing, dressing, eating, and toileting. Meeting these needs goes beyond what families, communities and home health care aides can offer. Special care homes have both long-term care (LTC) beds and short-term respite or emergency beds. Access to a special care home is approved and processed by the Saskatchewan Health Authority.[4]

Who Lives in Special Care Homes?

In 2017-18 there were 21,886 residents living in Saskatchewan's special care homes, and 54.5% of these residents were over 85 years of age.[5] Women make up 61.9% of all residents and the highest proportion of the oldest residents.

To be admitted residents need to be assessed as needing the higher levels of care offered by special care homes, known as either Level 3 care (intensive personal support such as that required by a person with advancing dementia) or Level 4 care (continuous medical support such as that required by a person with complex medical fragilities). Most residents in Saskatchewan's special care homes are assessed as Level 4.[6]

Data submitted by the portion of Saskatchewan special care homes participating in a recent national continuing care survey (accounting for about half of SCH residents in the province) confirm the high care needs of their residents. The survey showed that 68.2% of residents have a neurological disease, such as dementia. Sixty percent have heart disease or other circulatory condition, 43.8% have a musculoskeletal disease, and 26.9% have a psychiatric or mood disease, as the most common diagnoses. The majority of residents experience some bladder incontinence, and 41.3% have some bowel incontinence. Residents who show aggressive behaviour make up 30% of the resident population.[7]

In addition, we know that special care home residents are mostly women and that most of the residents have lost a life partner and were living alone prior to admission. We know they are more likely to have low to average incomes. Recent immigrants are among the least likely to use nursing home care and more likely to live with family.[8]

According to both our key informants in Saskatchewan and the research literature,[9] contemporary special care home residents require higher levels of care in terms of both quantity and skill than in the past. The resident population is now much frailer, with more complex and advanced illnesses. They need much more help with the activities of daily life, such as dressing, bathing, toileting, eating, moving, or participating in recreational or physical activity. Because of their frailty on admission, many residents die within months, so there are always new residents who

need assessment and support to adjust to their new surroundings, creating greater work intensity for care staff.

What is the Predicted Demand/Need for Special Care Homes?

There are many concerns about meeting the health care, housing and social care needs of an aging population. A recent analysis identified factors associated with nursing home (special care home) and senior residence (personal care home) admissions in Canada for those aged 60 and over.[10] The authors report that nursing home admission depends primarily on health status and whether a person lives alone. People who were unmarried or widowed, in poor health, diagnosed with dementia, and born in Canada were more likely to be living in a nursing home. The odds of requiring a nursing home is significantly higher for women living alone.

Research on the Canadian publicly funded nursing home bed supply shows that LTC bed supply across Canadian provinces has no correlation to population demographics, provincial wealth, or investments in home care as an alternative,[11] yet, there are no significant interprovincial differences in the admission profile of those who transition to long-term residential care.[12]

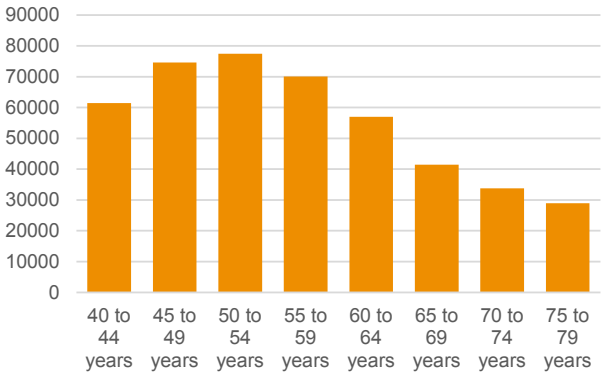
Experts agree that long-term residential care is required for very frail seniors and others who require both medical and social care,[13] offering a more home-like and cost-efficient alternative to both hospital admission or 24/7 professional home care. Age is a strong predictor of admission to long-term residential care.[14] According to the 2016 Census, 6.8% of Canadians 65 years or older and 30% of Canadians 80 years or older lived in either a long-term residential care home or a retirement residence of some kind.[15]

There is evidence that a lower long-term residential care bed supply increases the number of emergency room visits and hospital stays.[16] A lack of long-term residential care also increases family caregiving strain, with negative impacts on caregivers' employment, physical health, and mental health.[17]

Research has also shown that as the LTC bed supply across Canada has declined relative to the older frail population, admission requirements have adjusted upward, requiring higher levels of illness and frailty for entry to a home.[18] As a result, the average length of stay in Canadian long-term residential care has been declining, with a reported 18 months average stay, and some jurisdictions reporting 12-13 months.[19] Increasingly, long-term residential care focuses on end-of-life care.

In light of this information, Saskatchewan's population projections indicate that while many people will never need this kind of care, special care home need will continue to increase. Saskatchewan's citizens are living longer than ever before, and the percentage of people over 65 will continue to increase. Like other provinces in Canada, those 45 to 59 years of age make up the largest portion of the population (see Figure 1). Combined with declining birth rates, this means that the proportion of Saskatchewan residents who are over 65 is growing rapidly. At present Saskatchewan has a resident senior population of 15.5%, similar to Manitoba (15.6%), and higher than Alberta (12.3%), while slightly below the Canadian average (16.9%).[20]

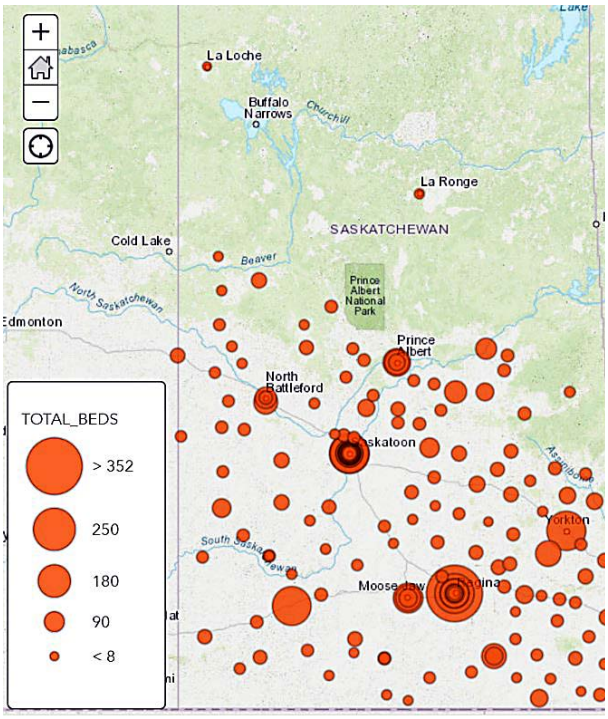
Figure 1: Saskatchewan Population by Age[21]



Saskatchewan seniors are more likely to live alone and less likely to live with extended family than those in many other provinces, likely due to children's migration to cities and other jurisdictions.[22] As noted above, living alone is an important factor shaping admission to special care homes. Compounding this factor is Saskatchewan's large rural population, with 35.6% living outside of a metropolitan area. Living alone in a rural area means less access to home care and other health care supports. Publicly funded special care homes are more likely to be closer to home for many, as they are located throughout most of the province (see Figure 2 below). While not offering convenience for every rural community, publicly funded homes have been located according to community needs rather than other market-related considerations.

In addition, Saskatoon and Regina have had one of the highest rates of population growth in Canada.[23]

Figure 2: Special Care Home Locations and Bed Distributions 2018



These increasing urban populations include a high proportion of seniors, some who have moved due to concerns about health care accessibility. It is also important to ensure sufficient special care home capacity in these growing cities.

Low income is a factor affecting special care home need and a reality for many seniors in Saskatchewan: 15.7% of seniors are poor, which is slightly higher than the national average.[24] This rate jumps to 36.3% for seniors who live alone or with non-family members. Women are more likely to live alone and in poverty in later life, due to longer life spans and lower lifetime earnings. In 2016 29.7% of seniors living in private dwellings in Saskatchewan lived alone, and approximately two-thirds were women.[25]

Growing population diversity is also an important consideration in planning for special care home needs. The LGBTQI2S+ senior population is growing across Canada, with many LGBTQI2S+ adults over 80 years of age living alone, shaping needs for nursing homes and seniors' residences that can offer these seniors knowledgeable care that offers dignity and respect.[26] Saskatchewan has a significant Indigenous population, making up 16.3% of the population in 2016,[27] and this population is living longer. Indigenous seniors' care must take into account both cultural needs and histories of trauma. Immigrant populations are also growing, and while new immigrants are less likely to use special care homes, experience in other jurisdictions indicates that future generations will access this care, shaping needs for care that respond to culture and language differences.

These population trends will affect not only the number of special care home beds needed, but changes in service delivery necessary to address the needs of Saskatchewan's increasingly diverse population.

Despite all of these factors, Saskatchewan's supply of LTC beds relative to the population most likely to need it — those 85 years and older — has been on the decline. In 2010-11, Saskatchewan's ration was slightly higher than the Canadian average in 2010-11.[28] By 2017-18, Saskatchewan's LTC bed supply had declined to 8,517 beds, according to our calculations.

As government health programs work to treat more patients in their homes and to shift people from facilities into the community, it is reasonable to assume that the need for nursing home care will grow at a slower rate than demographics alone might suggest.[29] For example, a Conference Board of Canada report takes the development of home care and other programs designed to decrease reliance on special care homes into account when predicting bed supply needs.[30] It projects new bed demand in Saskatchewan by 2035 at .4% of the total current provincial population. However, this formula ignores the many younger people with complex disabilities and illnesses who make up about 10% of special care home residents.[31] It also ignores the factors associated with increasing demand noted in the discussion above.

Even conservative estimates like those proposed by the Conference Board of Canada still suggest that 4,648 new beds need to be constructed in Saskatchewan by 2035 in order to address demographic aging, while all existing beds must be maintained or replaced. With no building plan to increase capacity in place, this bed deficit is growing and unaddressed by current policy.

Who Owns Special Care Homes?

In 2018 there were 152 special care homes in Saskatchewan, and 113 of these facilities were publicly owned and operated. Thirty-four special care homes were owned by private non-profit corporations, often associated with religious or other charitable groups. There were also five private for-profit facilities. The number of beds has declined significantly over time. Changing bed numbers, distribution, and ownership are shown below.

The question marks in Figure 3 signal questions about the process involved in replacing publicly owned and operated beds in Grenfell and Regina. As noted in the introduction, requests for proposals have been released to replace these beds through "community-based delivery," a phrase used to signal privatization. Likely, these publicly funded beds will move from public ownership to private for-profit corporations, where public tax dollars will be used to expand private profit margins, rather than care provision.

Figure 3: SCH Ownership by Bed Count

Year	2001	2009	2014	2018	Since closures
Public beds			5,427	5,421	4,099
Private non-profit beds			2,442	2,447	2,447?
Private for-profit beds			666	649	649?
Total beds	9,240	8,700	8,535	8,517	7,195

Saskatchewan Health Authority personal communication

Who Pays for Special Care Homes?

Eighty percent of special care home costs are paid by the Saskatchewan Health Authority, including all medical care, whether provided by public, non-profit, or for-profit organizations. Residents pay for accommodation based on a provincially established fee schedule. As of January 1, 2019, a standard room costs $1,128 per month, plus 57.5% of a resident's personal monthly income between $1,550 and $4,457.[32]

Who Works in Special Care Homes?

Staffing includes a wide variety of highly qualified medical and social care staff. Continuing care assistants (CCA), who provide most of the bedside, body care, and social care, must complete intensive training. They work together with registered nurses (RN), registered psychiatric nurses (RPN), licensed practical nurses (LPN), and recreation workers to provide medical and personal care in special care homes. Nursing oversight of all care is mandatory. Maintenance, laundry, and housekeeping staff ensure that the home is maintained and properly cleaned to ensure resident health and guard against infection and disease outbreak. Food services staff prepare specialized menus, meals, and snacks, including specialized food items and textures needed by frail residents. Many of these workers interact regularly with residents as they do their work, contributing both directly and indirectly to care quality and care relationships.

In national and international studies, long-term care staffing levels are measured in a number of ways. One method is to assess the number of staff relative to the number of residents as a measure of quality care. This method has been deemed problematic, as it includes staff who have no direct contact with residents, including data entry clerks, managers, and others.

Another measure is to assess the numbers of direct care staff to the number of residents. This is more useful, but it depends on the mix of tasks assigned to the direct care staff. In some cases, for example, some nursing staff spend significant hours entering care-related data into a computer data base, and others do primarily management tasks. In some homes, food services and cleaning staff spend significant time interacting with residents. These are just a few of the complicating factors involved in assessing and comparing staffing levels and their relationship to care quality.

A preferred method to assess staffing is to measure the number of hours of direct care per day per resident available. According to experts, a benchmark of 4.1 care hours per day is considered reasonable, if not optimal, for quality care.[33] This level takes into account varying levels of care required due to higher resident acuity or issues related to differences in assigned duties or staff mix and is a useful guide and noteworthy policy direction. It offers a reasonable level of direct care hours that can improve and support residents' experiences of well-being and quality of care.[34]

Direct care involvement from registered nurses and licensed practical nurses has been associated with many measures of quality of life and health for residents.[35] These include fewer physical restraints, fewer urinary tract infections, less decline in a resident's ability to perform activities of daily living (ADL), fewer pressure ulcers, and fewer hospitalizations. Increases in continuing care assistant time with residents is associated with improvements such as less decline in participating in the activities of daily life, fewer pressure ulcers, decreased infections, and less physical restraint use.[36] Finally, higher numbers of direct care hours are associated with lower levels of interpersonal violence, lower worker burnout and stress, and higher staff retention rates.[37]

Unfortunately, there is little consistency in how staffing levels are counted, and reliable data is not always available.[38] There are studies that offer

insight into staffing levels in some jurisdictions. A campaign to increase Ontario's ratio of care aides per resident to 1:8 over each 24-hour period is one indication. A 1:5 care aide to resident ratio for dementia care has been implemented in nursing homes using one care model.[39] Internationally, most countries do not have required staffing ratios, but many jurisdictions have recommended ones. For example, Sweden has a recommended staffing ratio of 1:2 that includes all staff. It was widely criticized as inadequate when introduced in 2012.[40]

To gain insight into staffing ratios in Saskatchewan, we asked about scheduled staffing at different publicly owned and operated special care homes. In an urban public special care home with 233 beds, the scheduled ratio of CCAs to residents is approximately 1:7 during the day when care needs are highest. Each unit has both a licensed practical nurse and a registered nurse for day shifts. In the evening and overnight, three units have either a registered nurse or licensed practical nurse on staff, while the others have both on staff.

The CCA to resident ratio in the evening was 1:12 and 1:30 for overnight shifts. The overall staffing ratio is 120 staff to 230 residents, or a 1:2 ratio. The chart below outlines all staff positions in this special care home.

A smaller rural public special care home with 35 beds had similar staffing ratios, with a CCA-to-resident ratio of 1:7 during the day, 1:8 in the evening, and 1:35 overnight. A licensed practical nurse or registered nurse is always working during the day and evenings. There is also a full-time recreation worker.

These staffing ratios, while good on paper, are misleading. They do not reflect times when staff are on leave, including sick time, and vacations. Nursing homes are hard pressed to replace CCAs and nurses who are absent from work for any reason. This is due to a severe shortage of qualified staff. It is also a way to trim budgets. The result is that in special care homes across Saskatchewan and many other

Figure 4: Typical Staffing in a Public Special Care Home

Front line staff	# staff per 233 beds	Home maintenance	# staff per 233 beds
Day CCA	33	Housekeeping	9
Day LPN	5	Food Service	18
Day RN	5	Maintenance	5
Evening CCA	14	Laundry	3
Evening LPN	3		
Evening RN	0		
Night CCA	14		
Night LPN	2		
Night RN	4		
Rec. Worker	5		

provinces, staff are regularly "working short" with higher ratios of residents per CCAs.

There is a staffing crisis nationally, across the sector. In New Brunswick, for example, staffing shortages have become so severe that a new nursing home wing has not been able to accept residents in 60 new beds due to staffing shortages.[41] In British Columbia 50% of home care providers and 60% of long-term care operators reported continuous staff shortages.[42] A Conference Board of Canada webinar report estimated that the Canadian nursing workforce needed to grow at 3.4% annually to keep up with demand but is growing at only 1% per year.[43] In Saskatchewan long-term care staffing shortages have been noted across the province and are particularly acute in rural and remote regions.[44]

This small sample of scheduled staffing indicates that while special care home staffing has been undermined by removing requirements, the skill mix and nursing oversight offered at these homes provide the basis for high quality resident care. Work is needed to ensure that: a) direct care hours are sufficient; and b) sufficient human resources are in place to provide appropriate coverage when staff are absent.

How are Special Care Homes Regulated?

The special care home sector is highly regulated through legislation, including the *Provincial Health Authority Act*,[45] the *Facility Designation Regulations*,[46] the *Housing and Special-care Homes Regulations*,[47] the *Housing and Special-care Homes Rates Regulations*,[48] and through required accreditation with Accreditation Canada. These homes must also follow the *Program Guidelines for Special-care Homes*[49] and *Facility Designation Regulations*.[50] The *Program Guidelines* are highly detailed and cover a wide range of policy areas, such as facility operation, care standards, service provision, health and safety requirements, incident reporting, resident rights and responsibilities, resident costs, and staffing requirements.

Special care homes are required to hire regulated health care providers to provide nursing and personal care, such as registered nurses, registered psychiatric nurses, licensed practical nurses, and continuing care assistants. All nursing and personal care staff must be trained and registered with the appropriate governing body.[51] Special care homes are required to employ at least one full-time registered nurse or registered psychiatric nurse. As well, special care homes must have a registered nurse or registered psychiatric nurse available on-site or on call 24 hours per day. All resident nursing care must be carried out by or under the direction of an RN or RPN, and under the supervision of a resident's personal physician or a nurse practitioner.[52] All residents must have access to care provided by a physician or both a registered nurse practitioner and a physician. As well, each facility must have a physician or registered nurse practitioner on call at all times, in case of emergency.[53]

Policy Shifts
Affecting Special Care Homes

Citizens expect their policy makers to:

- consult with them about what they need and want;
- assess the research and policy implementation evidence to consider not only what has worked well in other jurisdictions but what approaches may be promising for their specific context;
- bring these ideas to stakeholders and the public for feedback; and
- make public a coherent policy plan.

In this section, we review Saskatchewan's long-term care policy direction from 2009 to 2019. We show that Saskatchewan governments have not consulted widely with the general public about long-term residential care. They have failed to assess the evidence on promising approaches that offer quality and reliability, and they have not brought forward a plan to stakeholders and the public for democratic input. There is no publicly available, coherent policy plan. The policy plan for long-term residential care must be deduced from the policy history.

In brief this plan has been to undermine publicly owned and operated long-term residential care through marketization and privatization, using policy shifts common to governments pursuing privatization in Canada and internationally.[54]

During the 10-year period under review, the Saskatchewan Party formed the government, first under Premier Brad Wall, and subsequently under Premier Scott Moe. This centre-right party platform includes prioritizing free market economic approaches, making provincial tax cuts, supporting for-profit medical care systems, privatizing public assets, and opposing the federal carbon tax.[55] Their approach to long-term residential care aligns with their overall ideological perspective.

Reducing Staffing Requirements Reduces Quality of Care

In 2004 under the previous government, the *Housing and Special-Care Regulations*[56] were instituted, requiring that residents receive at least two hours of personal or nursing care per day, with a required ratio of one registered nurse or registered psychiatric nurse to seven ancillary nursing staff. This requirement offered a care guarantee, although one below the generally accepted benchmark of 4.1 hours a day of personal and nursing care per resident. Residents were guaranteed 45 minutes of personal care and 20 minutes of care carried out by a staff person who had, or was supervised by someone with, practical nursing experience.

It appears that the policy plan aims to:

- reduce staffing requirements at the exact moment that resident needs are becoming more acute;
- undermine public confidence in the public system by allowing public infrastructure to crumble and fall into deeper disrepair;
- remove or dismantle structural barriers to privatization, such as local control over finances or decision-making; and
- privatize incrementally and ignore costs, even when provincial auditors point out that privatization costs taxpayers more.

In 2011 the Government of Saskatchewan eliminated these legislated requirements for care and staffing in special care homes. They were not replaced by any guaranteed or recommended care time or staffing ratio.[57]

Since that time special care homes have seen resident populations change, with increasingly higher levels of frailty, due to more health care system emphasis on care at home and in the community, and fewer special care home beds. Residents began to have more complex needs, medical conditions, and higher requirements for personal support. This changing resident population made care work more demanding and strained organizational capacity. Yet, pressures to do more with less continued.

In 2012 the drive to find efficiencies within the Ministry of Health began with the introduction of a "Lean" management process.[58] Following its implementation in the province's hospital sector, this initiative was taken to the offices of the province's regional health authorities. Saskatchewan is the only jurisdiction to attempt this process and method across an entire health care system, with the promise that it would produce "patient-centred care." According to Tom McIntosh,[59] "Lean" in Saskatchewan was initiated with the direct involvement of American consultant John Black, who adapted the Toyota manufacturing process to focus on: continuous quality improvement; setting strategic priorities; eliminating waste; and employee engagement. However, this initiative proved to be an expensive mistake. Given that "Lean" was designed for manufacturing environments, the complexity of the health care system environment, including the professional autonomy and regulation of health care professions, was not a good fit. Further, patients vary in their presenting problems and conditions and do not respond uniformly to intervention. These central aspects of health care do not fit with the "Lean" method's reliance on systematic consistency to achieve effectiveness and efficiency.

Not surprisingly, provincial auditor reports indicate that the "Lean" initiative resulted in some improvements in coordination and efficiency, but there was no evidence of improvements in quality or value for money. A systematic review of this initiative concluded that the exercise had cost much more than it had saved, did not improve outcomes for hospital patients, and negatively impacted morale among nurses.[60] The study also found that "Lean" did not help patient satisfaction, health outcomes, or worker satisfaction. For every $1,511 spent by the provincial government on "Lean," only $1 in savings was recovered.[61]

Given reductions in staffing and the drive to do more with less, it is not surprising that while Saskatchewan continuing care assistants report high levels of professional efficacy and feel their work matters in the lives of residents and families, they report very high rates of burnout. [62] Related to these changing working conditions, they report time pressures, excessive workloads, high job demands, and few decision-making opportunities.

Burnout leads to higher levels of staff turnover and absenteeism.[63] These workplace realities undermine continuing care assistants' capacities to provide relational and interpersonal care, reduces the quality of care residents receive, and undermines resident and worker safety.[64]

The results of severe system strain became heartbreakingly evident in an Ombudsman Report investigating the tragic death of a resident at Santa Maria Seniors Home.[65] The report noted that the conditions of work and care in the Santa Maria Seniors Home were not unique to this home but were shared in many special care homes across Saskatchewan and that these conditions contributed to the death that occurred. These issues were: higher resident needs; insufficient staffing, including nurses, allied health professionals, and care aides; problems with recruiting and retaining care aides; insufficient funding and the lack of a clear funding structure; and erosions in public trust that result from all of the above conditions.

The report concluded with recommendations that the Ministry of Health consult widely to identify present and future long-term care needs, identify factors involved in providing quality care, and develop and implement a strategy to meet these needs.

To date, these recommendations have been ignored.

Infrastructure Has Crumbled to the Point that It Is No Longer Repairable or Livable

Publicly owned special care home buildings across Saskatchewan have been deteriorating for a long time. In the 1990s a formula that provided consistent, predictable capital funding was dropped. Since then special care homes must apply and compete for capital funding to maintain their infrastructure, and often get either nothing or a fraction of their needs.[66] Problems with mould, mildew, plumbing, electrical, and more have been reported repeatedly in special care homes across the province. In 2013, in response to complaints, the Minister of Health instructed health regions to inspect and report on their special care home facilities. Inspections revealed major problems, with infrastructure issues as a major area for improvement. However, funds allotted were insufficient for the many homes needing repair or replacement. An estimate provided by a facility assessment company, Vanderweil Facility Assessors, indicated that $2.2 billion was necessary to replace and/or repair the 270 healthcare facilities across Saskatchewan, including special care homes. The government responded by dedicating only 1% of this funding in the 2015 provincial budget.

Insight into specific challenges faced by Saskatchewan's special care home sector emerge from the subsequent annual CEO inspections from a CEO tour of facilities across the province.[67] A review of the inspection reports shows the most frequently mentioned challenges in two areas. The first is around staffing and includes recruitment and retention, staffing levels, workload, and education.

Associated with staffing issues are other concerns difficult to address when there is inadequate staffing and funds, such as a lack of resident activities and food quality. The second area is building-related, including consistent mention of the need for repairs, maintenance, capital improvements, renovation, and renewal.

The disrepair of the Grenfell and District Pioneer Home and Regina's Pioneer Village made them top contenders for replacement. With 2014 estimated costs of replacement of $118 million for just one of these homes, investment has been needed for some time. The bed closures and relocation of residents affecting both these homes, and discussed earlier in this report, were long predicted. The government decision to look for private providers in 2019 reveals the connection between the neglected building infrastructure and privatization policies, detailed below.

According to these and other government reports, many public special care homes across the province require urgent repairs, renovations and replacements. The situation remains critical. These buildings and the land on which they sit are publicly owned. These are public assets that are being allowed to deteriorate, in what appears to be a deliberate move to make space for private for-profit providers.

Finding 1

Policy shifts have eroded both the care and physical infrastructure in publicly funded Special care homes in Saskatchewan.

Marketize and Privatize

The Saskatchewan provincial government has made a series of policy shifts that prepare for long-term residential care divestments and privatization, while also shoring up privately owned, private pay alternatives to long-term residential care. Across Canada and internationally, government initiatives to encourage public sector involvement in public services vary. Some are marketizing policies that "encourage and enforce competitive markets with buyers and sellers within the private or public sectors".[68] Others are privatization shifts that transfer ownership from public government owners to private for-profit and non-profit corporations. Another privatization shift is when governments contract out with private actors for a specific service, such as laundry or cleaning, or for leasing, managing, staffing, maintaining, financing, or other services, rather than providing these services from within the public sector. Both marketization and privatization are happening in Saskatchewan's long-term residential care sector.

Marketization and privatization change the structures and basis for decision making in the provision of public services. Public services become more vulnerable to the financial volatility of markets and the problems associated with bankruptcies and poor business practices. Future innovation is hampered by long contractual arrangements running from 10 to 30 years. Decisions are made based on market factors rather than democratic process and community need. Research has shown that these contracts allow companies to charge high fees for any related services not specified, while also ensuring that public services are prevented from acting unilaterally. Further, risk is usually unevenly shared. When crisis hits, it is still the public who must provide the services and pay the costs when things go wrong. [69]

The Saskatchewan Party announced their intention to marketize and privatize health care in the province in 2009, in its *Patients First Review Commissioner's Report*.[70] Long-term care facilities were identified as ideal for "leasing or alternative funding mechanisms," with the suggestion that Saskatchewan should follow the example of the disastrous privatization policies in the United Kingdom.[71] This was despite mounting data on long-term care privatization in the U.K. and elsewhere showing that marketization and privatization have led to higher costs, less accountability, government bail outs for bankrupt nursing homes and questionable quality of care.[72] Privatization ensued with a pilot project launched in 2010 with Amicus Health Care, a large for-profit chain, to build a 100-bed special care home in Saskatoon. The project bore a striking resemblance to a private-public partnership (P3). Amicus financed all of the capital costs, and in return receives monthly capital and operating lease payments from the province for a seven-year payment agreement. In keeping with findings on privatization in the research literature, this project has been a financial disaster.

The provincial auditor criticized the absence of a cost benefit analysis, noting that the proposed daily capital rate was higher than other affiliates (privately owned nursing homes) because Amicus had borrowed 100% of the capital required for construction. Further, although Amicus was responsible for building the facility, it is the Saskatoon Health Region that "assumes the risk over debt repayment and the operation of the new facility."[73] When the deal was reviewed by economist John Loxley,[74] he estimated this private financing cost $11 to $20 million more than if the province had built the facility.

The Long-Term Care Initiative was also launched in 2009, consisting of public consultations on five restricted topics that completely curtailed any discussion of special care homes. A policy outline was released in the report, *Focus on the Future*.[75] This report repeatedly pointed out Saskatchewan's high per capita special care home bed ratio as a problem, and focused on the development of "aging-in-place," not only calling for much-needed investments in home care but in privately owned and operated personal care homes that, as of that

date, were restricted to providing care to those with low to medium care needs. The recommendations included expanding possibilities for people to stay in their personal care home when their care needs became high and to offer a subsidy for personal care home accommodation. These recommendations became realities by 2012.

In April 2013 the *Program Guidelines* require that special care homes be accredited through Accreditation Canada, a process that had been optional up until that time. Accreditation Canada is a private non-profit corporation that accredits about 1,200 health care organizations across the country. By requiring special care homes to be accredited through this private body, the government of Saskatchewan removed itself from one layer of regulatory responsibility for the sector.[76] Typically, Accreditation Canada establishes regulation through a negotiation process within the specific industry, thus creating a self-regulation system where industries are able to exert pressure on health systems to meet their accreditation goals. While Accreditation Canada's *client-and family-centred care* approach to long-term care standards is adapted from the Institute for Patient and Family-Centred Care and the Saskatchewan Ministry of Health,[77] it is based on agreement from the organizations that participate in self-regulating. As the number of for-profit long-term care homes across Canada are swelling and dominate service delivery in some provinces, industry self-regulation is unlikely to lead to the most promising practices for care.

Saskatchewan policy shifts that required participation in this private accreditation system privatize some regulatory aspects to the industry itself, taking them out of government hands where democratic engagement can occur. Accreditation is "market-facilitating," in that it shifts power to the industry actors and away from governments.[78] "While some studies have looked at the link between accreditation and resident outcomes, the role accreditation plays in structuring frontline LTC work is under-explored."[79] We agree, seeing reason to pay attention to developments in accreditation and its influence on special care homes quality of care and working conditions.

In July 2013 a so-called "first" public-private partnership (P3) contract was announced, this time for a special care home in Swift Current. "The Meadows"[80] replaced three special care homes with a 225-bed facility that opened in 2016. The private partner was Plenary Health, a U.S. based for-profit company that invests, designs, and operates public health care facilities in North America and Australia. This project came in on budget and has won many prizes for P3 construction. While estimates of what a fully public sector build would have cost show this was a cost-effective option,[81] these analyses do not consider benefits that accrue to the province when profits from the build and 30 years of maintenance remain in Saskatchewan. While the province owns and operates this facility, thus providing the conditions for high quality care, Plenary Care financed and built the facility, and is now responsible for maintaining it. In exchange, it will receive average monthly payments of $776,000 for 30 years, plus the costs of construction. This contract constrains any major renovation or innovation at this facility, despite changing care needs or practice guidelines.

In 2017 the government announced that the 12 regional health authorities were being dissolved to make way for a single Saskatchewan Health Authority. While expected to save money, the 2019-20 budget dedicated significant funding to supporting this change.[82] This shift is consistent with policies of other right-wing governments who aim to marketize and privatize.

A single health authority centralizes decision making and contracting, facilitating outsourcing, and privatization by being able to contract across many sites and services. This move was made, despite evidence that decentralization has positive impacts on public health.[83]

Privatization is Incompatible with High Quality Long-Term Care

The Problems with Marketization and Privatization

Problems emerging from marketized and privatized long-term care are now well documented in a growing international literature.[84] While proponents of privatization often complain about the pressures from labour that influence public services provision, they stay quiet on the tremendous, unrelenting, well-funded pressure and lobbying from investors, shareholders, and capital market actors who perceive public services as a potential business opportunity and wield increasing influence over public policy.

Canadian evidence on for-profit health care and long-term care provision has been definitive, showing clear correlations to lower care quality. For-profit long-term residential care has been shown to have lower quality care overall than public and non-profit provision.[85] Researchers evaluated observational evidence on quality of long-term care using the scrupulous Bradford Hill guidelines for causation.[86] Their study confirms that publicly funded long-term care delivered by for-profit nursing homes provides poorer care quality than care delivered in non-profit or fully public nursing homes.[87] In another analysis[88] researchers found that in Ontario, where privatization has been the policy of choice in long-term residential care for many years, for-profit provision was correlated with *significantly higher rates of hospitalization and mortality*, suggesting that for-profit providers transfer residents to hospital when they require more care. Hospital care is more expensive than long-term residential care, thus creating both more health care costs and more pressures on already strained hospital bed capacity. Further, for-profit care was correlated to higher rates of death, a troubling finding. The *overall lower staffing levels* in for-profit long-term care homes, especially those operated by chains, may be a factor, as revealed in an assessment of for-profit staffing levels.[89]

There are other problems with marketization and privatization, apparent in a series of comparative international analyses that include Canada. Financial transparency and accountability are issues that have been well-identified. Government oversight and financial transparency were problems in jurisdictions with private for-profit provision, with little to no accountability from providers to government on how public dollars were spent.[90] Consistent with this analysis, problems of accountability related to the relationship between the province and the 20 privately owned special care homes under the Saskatoon Regional Health Authority were identified in the *Provincial Auditors 2017 Report*.

Concerns include a poorly articulated accountability relationship, the quality of care expected, and compliance with regulation. The report indicated that these "homes are not consistently achieving the ministry's quality of care targets."[91] Clearly, Accreditation Canada involvement was not helping to ensure quality of care.

In a comparative analysis of long-term care marketization in five countries,[92] researchers found more problems with accountability and transparency. The largest for-profit chains are not publicly traded,

and several have private equity shareholders. The goal of a private equity firm is to buy companies, increase their profit, and sell them when the profit is high.[93] "If companies fail to maximize returns, they may experience falling share prices, hostile takeovers, reductions in executive earnings and stock, and a loss of executive positions."[94] Under this system, shareholders' profits are prioritized over the needs and lives of residents, families, and staff.

Privately held companies are not required to publicly report their financial operations or profit, and in some cases, it is difficult to determine who actually owns the companies. Further, some nursing homes have developed limited liability structures to limit the risk of financial losses, thus providing an incentive for corporate risk-taking. These factors were implicated in the collapse of nursing home providers in Sweden and the United Kingdom.

In addition, evidence on revenues and expenditures showed increasing costs across jurisdictions, at an annual rate that varied from 3.5 to 5.5%. Jurisdictions contained cost increases by various rate-setting systems. Those jurisdictions with higher levels of for-profit and chain ownership spent less on direct care, but not less overall, due in part to high administrative costs. Profit margins are difficult to calculate, given the private ownership of so many homes and chains, but three publicly traded nursing home chains in Canada reported 10 to 13% profits in 2013.[95]

A review of 82 health care aide workforce studies points to troubling trends in long-term care. "Globally, health systems are called upon to do more with less — less space, less staff, less money. In high-income countries, current LTC costs and funding models have been characterized as unsustainable."[96] Fueled by governments' platforms of lower taxes and less debt, there has been a growing policy preference for privatization as an answer to this situation, despite evidence that it costs more.

In light of this research, Saskatchewan's high proportion of publicly owned homes is important to Saskatchewan's capacity to provide high quality care. The evidence is clear: private for-profit ownership is associated with poor quality care, lower staffing, and problems with accountability and financial transparency.

Finding 2

Policy choices that aim to involve private sector actors — and especially for-profit corporations — in long-term residential care service delivery, ignores research evidence on quality and effectively decreases provincial government responsibility and account-ability for long-term care.

Figure 5: Undermining and Privatizing – A Timeline

2009

- The Long-Term Care Initiative aims to increase accessibility to a continuum of care, including private pay/private sector Personal Care Homes, home care supports, and to add a seniors' secretariat and falls prevention program.
- The Saskatchewan Party introduces its “Patient First Review”, advocating for greater private sector involvement in health care delivery.
- A plan to renovate or replace 13 long-term care facilities is announced.

2010

- A pilot project is announced for a new Special Care Home in Saskatoon, to be built, owned and operated by Amicus Health Care, a large for-profit chain. The funding arrangement is a public-private type contract that ends up costing much more than a publicly-built facility.
- Focus on the Future: Long-Term Care Initiative report is released. It recommends personal care home subsidies for people with low incomes and assessed needs, and advocates for extending private-pay Personal Care Home services for those with high levels of care need, usually provided by Special Care Homes.

2011

Special Care Home Regulations are amended to remove required hours of daily personal or nursing care and any prescribed Registered Nurse to Care Aide ratio.

2012

- A Lean consultant, John Black, is hired from the USA to introduce this cost-reduction strategy. It ends up as an expensive failure.
- The Personal Care Home Benefit is implemented, in keeping with the 2010 report recommendations. Seniors with lower incomes receive the benefit to help cover costs of living in Personal Care Homes.

2013

- Following complaints at Special Care Homes, the Ministry of Health instructs health regions to inspect their long-term care facilities. Inspections reveal major problems with staffing levels and old and unrepaired infrastructure, as well as other issues.
- $10 million is allocated to address the most pressing structural issues determined during inspections—this proves to be insufficient as some facilities need replacing altogether.
- In July, a new long-term care facility is announced for Swift Current. It is to be built using a $108.5 million 30-year public-private partnership (P3) contract.

2014

- Vanderweil Facility Assessors report that $2.2 billion of infrastructure repairs and replacements are needed for 270 healthcare facilities across Saskatchewan. The government responds with only 1% of the needed funding in the 2015 provincial budget.
- The Provincial Auditor reports that from 2009 to 2014, provincial ministries increased spending on private consultants by 228%. Much of this spending was in health care, including long-term care.
- The Leader Capital Project is announced, providing renovations to one integrated hospital and one long-term care facility that do not commence until 2017.

2015

The Ombudsman Report investigates a resident's death at the Santa Maria Senior Citizens Home. The Special Care Home system is deemed “under strain”, with overworked/rushed staff, understaffed roles, and funding problems. Public funding is recommended.

2016

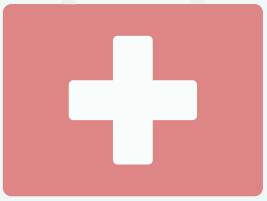
The closure of the northwest wing of Grenfell and District Pioneer Home is announced, due to disrepair, moving 8 residents.

2017

The provincial government announces that the twelve regional health authorities will be dissolved into the singular Saskatchewan Health Authority. This move allows for centralized decision-making and contracting, making it easier to outsource and privatize services.

2018

- The budget reports on long-term residential care repairs and replacements, indicating that $329 million has been spent over the past 4 years to replace or renovate the Meadows (P3), the Leaders Integrated Care Facility, and 11 others.
- Beds are closed in an entire wing of a 390-bed Special Care Home, Pioneer Village in Regina, due to disrepair.
- Grenfell and District Pioneer Home is closed permanently due to disrepair, with 22 residents moved and 33 staff laid off.



2019

- The Saskatchewan Health Authority opens up requests for proposals to replace closed beds at Grenfell Pioneer Home and Regina Pioneer Village. Publicly-owned and operated beds are being replaced by opening a market to private for-profit and non-profit sectors. The Saskatchewan Health Authority makes no move to own or operate these beds.
- Despite its failures, the Lean strategy continues through "Lean Champions" who implement it across workplaces and healthcare service delivery.

Personal Care Homes:
The Privately Owned, Private Pay Alternative to Special Care Homes

In addition to policy shifts that have undermined, marketized and privatized the special care home sector, government initiatives have aimed to support developments in the personal care home sector as an alternative to special care homes.

This aim has been part of government direction to expand the continuum of care: a long overdue and much needed development for Saskatchewan residents. For example, home care resources are being developed and strengthened, allowing people who need support, but do not need 24/7 specialized care, to remain in their current living environments. Personal care homes are an important contributor to care, providing a residential option for those who need low to moderate levels of personal support for daily activities. The development of subsidies for low income people to access this care is a positive development, as well.

Problems emerge, however, when government policy aims to support these homes to care for those needing high levels of care, exceeding the type of care that personal care homes were designed to provide. Personal care homes are not a replacement for special care homes, as our analysis shows. Personal care homes are the only category of *regulated* facilities in Saskatchewan other than special care homes that provides a residential option, including lodging, meals, and assistance with, or supervision of, the activities of daily living. Yet, these homes are very different from special care homes.

Who Lives in Personal Care Homes?

Although licensed and monitored by government, there is no systematic data collection to monitor who is living in personal care homes. Personal care homes tend to accommodate individuals with lighter care needs (often termed as Level 1 or 2 needs),[97] but some personal care homes in Saskatchewan now accept those with high levels of care need (Levels 3 and 4). These care needs include intensive personal care and/or continuous medical monitoring, such as people with advanced dementias, little mobility, or complex chronic illnesses. Using the rationale that allowing seniors to stay in their personal care home supports "aging in place," policy shifts allowing for this higher intensity care in personal care homes occurred, beginning with pilot projects that have quickly spread.[98]

Who Owns Personal Care Homes?

In 2018 there were 255 personal care homes in Saskatchewan, and all of them were privately owned and operated. The number of beds in personal care homes has risen significantly from 2,655 in 2004 to 4,399 in 2018.[99]

Most personal care homes are for-profit businesses often owned by individuals, while 31 are private

non-profit corporations. Out of 4,399 beds in Saskatchewan's personal care homes, only 688 beds are in non-profit homes.[100]

The Ministry of Health, Community Care Branch, indicated to us that there is no data available on the number of Level 3 and 4 care beds in personal care homes. *Carehomes*, a Saskatchewan association of personal care homes, maintains a website that advertises personal care homes. It showed at least 17 homes offering Levels 1, 2, and 3 care and 19 homes with Levels 1-4 care,[101] but it was unclear if all personal care homes in the province are represented on the website. Most of the personal care homes that offered higher levels of care were located in or near metropolitan areas.

Who Pays for Personal Care Homes?

Residents pay for accommodation and care, with resident charges set by each facility without government oversight. These charges ranged from $1,000-4,000 per month according to a 2012 provincial auditors report.[102] Currently, there are personal care homes with rates as high as $6,000 per month.[103] Nursing and other specialized care, medications, personal care supplies, and more are typically additional charges.

These homes do not receive direct government subsidy, but residents are often subsidized as individuals. Publicly funded support for personal care homes was initiated in 2012 through a program that offers eligible low-income residents a personal care home benefit to subsidize costs.[104] Further, when personal care homes are unable to meet the care needs of their residents, publicly subsidized home care services are provided to residents. This home care use is becoming common in personal care homes due to their limited care service capacity and increasing resident frailty. Thus, the home care sector offers a second public subsidy to this form of residential care, substantially increasing the public costs involved. No estimate of the total public subsidies to personal care home services are publicly available.

How Does Staffing in Personal Care Homes Compare to Special Care Homes?

There are significant differences between the staff training and oversight required in personal care homes and special care homes. Personal care home jobs require significantly less training for care staff, and there is no requirement for nursing oversight, either on-site or on-call. This means that personal care home residents assessed at high care need levels (Level 3 or 4) are not guaranteed this critical type of medical oversight.

These conditions increase transfers to emergency rooms and hospitals for these very frail residents, further imperiling resident well-being while creating more costs elsewhere in the health care system. A detailed comparison of staffing requirements is noted in the Figure on the next page.

Figure 6: Staffing Comparison of Special Care Homes versus Personal Care Homes 2018[105]

Requirements	Special Care Homes	Personal Care Homes
Staffing for Nursing and Personal Care	• Must be regulated health care providers, such as registered nurses and psychiatric nurses, licensed practical nurses, and continuing care assistants*. **Continuing care assistants must complete 760 hours of training from a provincially approved curriculum.* • All nursing care must be carried out by, or provided under the direction of, a registered nurse, or psychiatric nurse, and under the supervision of the resident's personal physician or a nurse practitioner.	• Staff must have a personal care worker course of at least 16 hours or equivalent. Staff giving care must be certified in standard first aid, and staff handling food must be certified in basic food sanitation. Staff are required to take training every two years that they believe would be helpful to their work. • Personal care homes must arrange for nursing care to be provided by a regulated health care provider. Some specialized care can be provided by an unregulated staff person if they are trained by a regulated health care provider.
Nurses	• A registered nurse or registered psychiatric nurse must be on site or on call 24/7.	• There are no requirements for a nurse to be on site or on call outside of special arrangements.
Doctors and Nurse Practitioners	• A doctor or nurse practitioner must be on call 24/7 in case of an emergency.	• There are no requirements for a doctor or nurse practitioner to be on call outside of special arrangements.

How are Personal Care Homes Regulated?

Personal care homes are licensed and monitored by the Ministry of Health. They are regulated through the *Personal Care Homes Act*[106] and *Personal Care Homes Regulations*.[107] Personal care homes are required to operate in accordance with the *Licensees' Handbook*,[108] providing suggestions as well as requirements that range from staffing and administration to food guides and care plans. The Ministry of Health is responsible for monitoring personal care homes and issuing annual licenses. The Ministry of Health inspects personal care homes at one to two-year intervals.[109] There are no regulations requiring personal care homes to be accredited. In 2018, the Ministry of Health conducted 248 licensing inspections in personal care homes.[110]

Do Personal Care Homes Offer Quality Care to Frail Residents Deemed Levels 3 and 4?

When residents require Level 3 or 4 care in a personal care home, it is the responsibility of the home to ensure appropriate health care professionals are caring for these residents' specialized needs. Section 10 of the personal care homes *Licensees' Handbook*[111] provides instructions for offering "care in special cases" — specialized care that can only be provided by a registered health care professional, or in some cases by an employee who has received special training by a health care professional. Staff at personal care homes are trained by health care professionals to take on "specialized care" procedures also referred to as "controlled acts." These are procedures typically carried out by a health care professional that could cause harm if performed incorrectly.

Staff are required to be trained in each specific procedure for each specific resident and are prohibited from performing that procedure on another resident without again being trained by a health care professional. Under the *Licensee's Handbook*, these procedures can include, but are not limited to, diabetes management, oxygen use, physiotherapy, colostomy care, catheter care, application of anti-embolic stockings, use of physical restraints, blood pressure and pulse monitoring, enemas, and care of skin ulcers and wounds.[112] However, there is no required on-site or on-call nursing oversight of this care. As a 2011 report points out, "there is no lack of research indicating that nursing care is strongly correlated to better patient outcomes as well as balanced budgets."[113] In personal care homes workers are trained, but nursing care is absent.

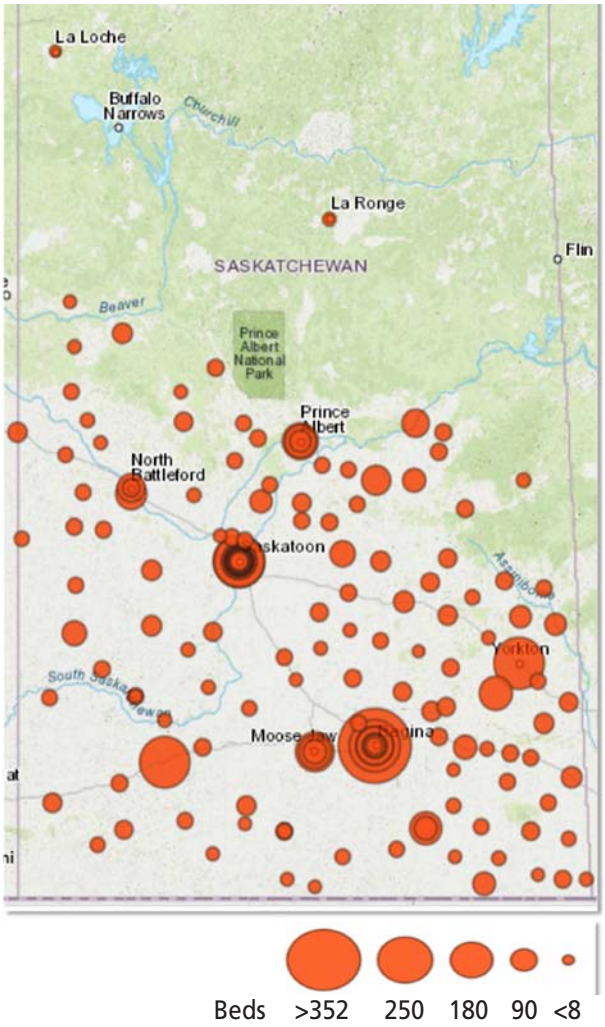
Personal care home staffing is a major concern. Unlicensed staff who lack formal training are now responsible for complex health care procedures without on-site medical supervision. These conditions increase the risk that procedures will be performed incorrectly, causing harm to residents and/or that staff will not recognize or correctly evaluate a resident's changing health condition. This increases the likelihood that a change in condition could go unnoticed, putting the resident at risk.[114]

Accessing Personal Care Homes

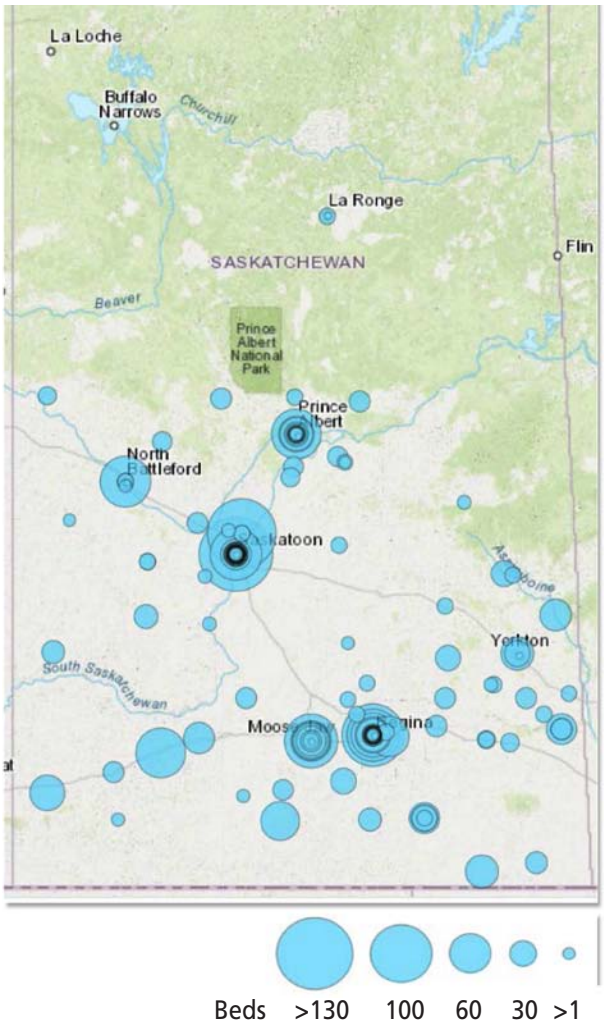
One of Saskatchewan's long-term care challenges is to ensure care close to home. Given the relatively small population of the province and the high number of rural dwellers, options for care in small towns and rural areas are welcome. We wondered if personal care homes provided care to under-served areas of the province. Our research, illustrated in the maps on the next page, shows that personal care homes do not serve areas unserved by special care homes, and indeed, the opposite is true. Personal care homes are clustered in more populated areas. Personal care homes, while more available than special care home beds that have long waiting lists, are not as affordable, do not offer highly qualified care, and do not offer care closer to home for those in rural and remote communities.

Figure 7: Comparing Locations of Special Care Home and Personal Care Home Beds in Saskatchewan

Special Care Homes, 2018



Personal Care Homes, 2019



Finding 3

Policy has promoted the development of the *privately owned, private pay care sector, personal care homes*, supporting their admission of very frail and medically fragile residents, but without the staffing or standards that ensure these vulnerable residents' safety and wellbeing.

Summary and Conclusions

Although crumbling from a decade of undermining, marketization and privatization shifts, special care homes in Saskatchewan are ready to be restored and revitalized. Offering one of the most promising bases for long-term residential care services in Canada, this mostly publicly owned and operated sector is the legacy of generations of Saskatchewan residents who supported accessible, affordable high quality public long-term residential care provision offered as close to home as possible.

In the last decade, this promising system has been pummeled by policy shifts that seem designed to undermine public trust in special care homes. Public consultations on seniors' care explicitly left out special care homes. Attention to the sector has been activated mostly in the aftermath of scandals, such as a death, a broken waterline, or mould discovery. Otherwise, an unarticulated policy plan aims to marketize and privatize the sector despite significant, high-quality research evidence that shows private for-profit provision is associated with lower staffing, lower quality of care, and problems with accountability, financial transparency, and costs.

To take advantage of Saskatchewan's special care home strengths, some policy adjustments are needed. First, staffing levels and staff mix need to be addressed across the sector to improve quality of care, as some other provinces are doing successfully. In New Brunswick, for example, a pilot project to ensure an average of 3.5 hours of personal care per day per resident had important positive impact, leading to policy targets that are incrementally increasing care hours.[115]

Many buildings are in a state of disrepair, but can be repaired, renovated or replaced to better serve present and future residents. The ratio of beds-to-seniors in Saskatchewan has been declining and this too must be assessed and reversed. While the development of a continuum of care for those experiencing frailties, complex illnesses, dementias, and end-of-life health concerns is a welcome and overdue development, long-term residential care is appropriate and necessary for those who need 24/7 care.

Given the weight and quality of the evidence against private for-profit long-term care provision, which shows overall lower quality, lower staffing, inadequate accountability, and lack of financial transparency, privatizing long-term care makes sense *only* to those who will profit from the new business opportunities. From the perspective of most residents of Saskatchewan, who aim to ensure that quality long-term care is available when needed for their family members, their neighbours, and themselves, investments in publicly owned and operated long-term residential care is the best way forward. Publicly owned and operated long-term care has the greatest potential to ensure quality of care, accountability, financial transparency, and value for dollar.

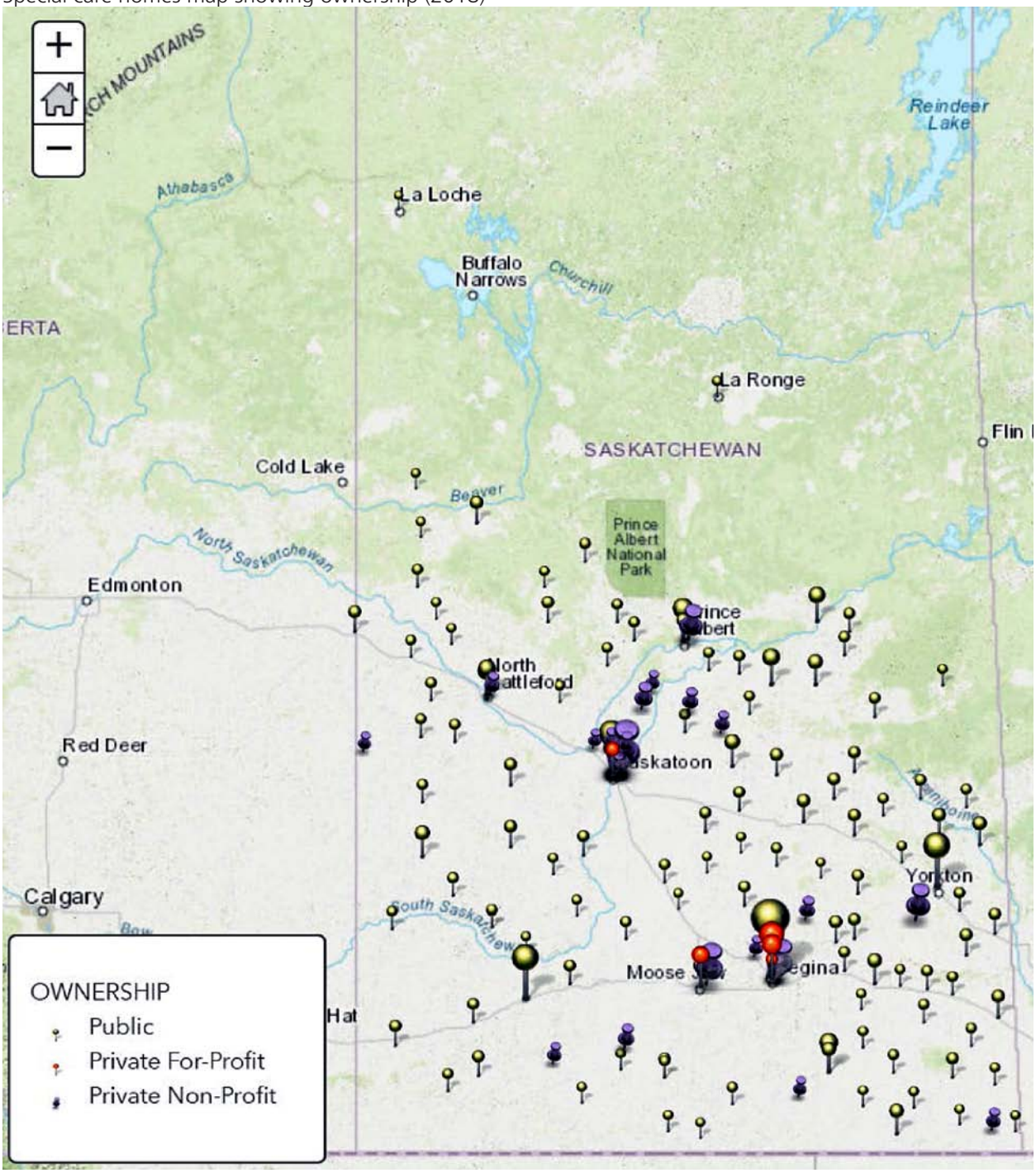
The potential benefits of publicly financed, owned, and operated special care homes for Saskatchewan's aging population are tremendous. Public long-term residential care not only offers quality care that improves the quality of vulnerable residents' lives and deaths, it also relieves caregiver burden, protecting them from care-related health problems, work absences, and more. Further, public long-term care is a source of quality employment and an important economic stimulus in communities. Public long-term care services offer care security, so that citizens know that if and when they are at their most vulnerable, they will receive compassionate, qualified care in homes that can be both a public trust and a source of public pride.

The Government of Saskatchewan should continue to build on the province's legacy of investing in the public provision of long-term care. Privatization will not ensure that seniors and others who require chronic care live with dignity and respect as they age. The evidence is undeniable. The best, most affordable way to ensure residents receive high quality care they deserve is through a special care home system that is fully publicly owned and operated.

Appendix

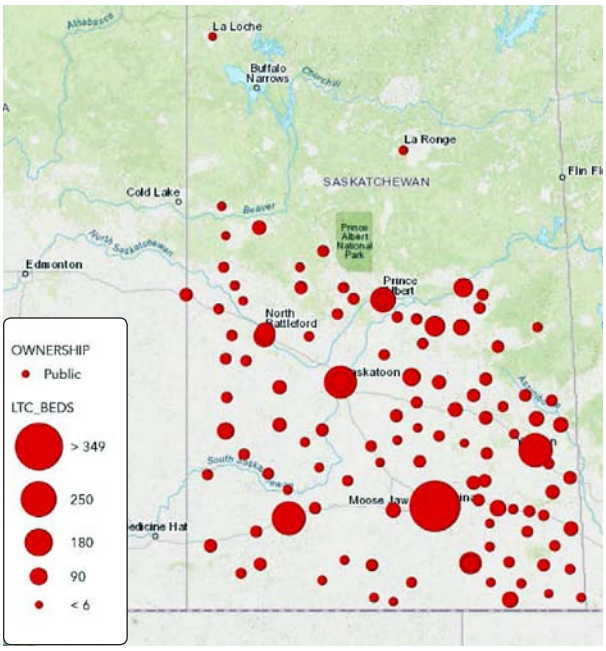
Special Care Home: Maps

Special care homes map showing ownership (2018)



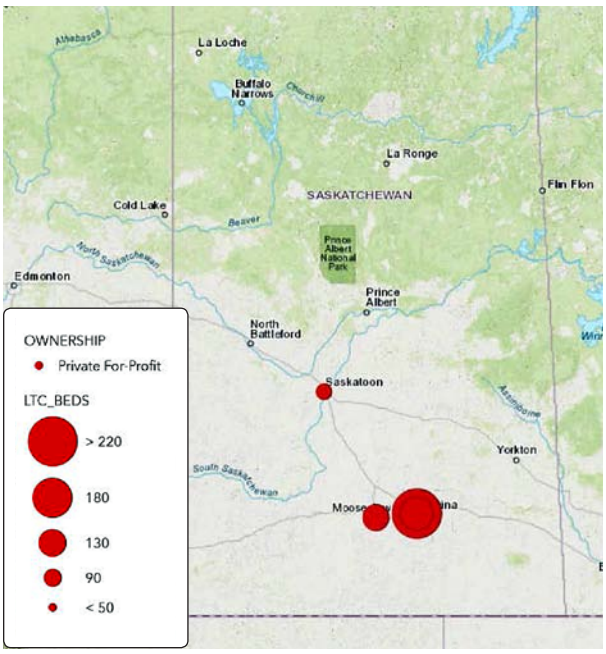
Special Care Homes: Public Map

(The map shows the distribution of beds in publicly owned special care homes)



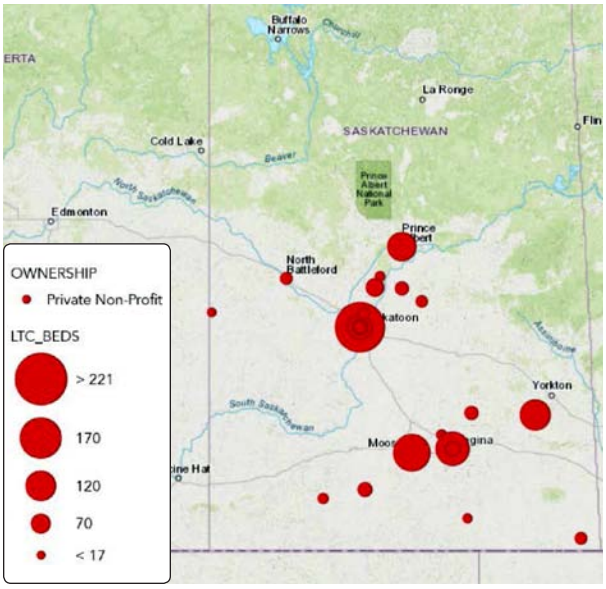
Special Care Homes: For-Profit Map

(The map shows the distribution of beds in privately owned for-profit special care homes)



Special Care Homes: Not-For-Profit Map

(The map shows the distribution of beds in privately owned non-profit special care homes)



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- *SALTY: Adding Life to Years* (CIHR 2016-2020) *https://www.msvu.ca/en/home/research/chairs/centresandinstitutes/centreonaging/projects/current/SALTY/default.aspx*
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