Ontario Long Term Care facilities: What incentives facilitate quality care?

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I begin by explaining what (Ontario) LTC is, how it is delivered and to whom. I describe competing incentives in care delivery, arguing that a profit motive may compromise care quality – particularly where effective regulation is absent. I conclude by suggesting regulatory and enforcement procedures that will maximize care outcomes.

There are 577 long term care (LTC) facilities in Ontario, providing care for 70,000 residents.[1] Older[2] adults[3], and particularly older women, are by far the heaviest users of the LTC system. As the population ages, the demands on LTC will increase commensurately. This is particularly true because the older population is itself aging and the very old tend to accumulate chronic, non-fatal conditions to the point where daily medical attention is required. Dementia, another common trigger for institutionalization, is also highly correlated with very old age – the 1992 Canadian Study of Health and Aging reported that 28.5% of people over 85 had some sort of dementia, as compared with 4-6% of people between the ages of sixty-five and eighty-four.[4] By 2041, 16.3% of the older population (and 4% of the general population) will be over 85, as compared with 10.2% in 1998 and 5.1% in 1901.

Moreover, population aging may indirectly affect the incidence of informal caregiving - the main alternative to LTC - particularly for women, who already make up

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[1] Monique Smith, "Commitment to Care: A Plan for Long-Term Care in Ontario", Spring 2004 at 9. Online at http://www.health.gov.on.ca/english/public/pub/ministry_reports/ltc_04/mohltc_report04.pdf.
[2] A brief note on terminology: I will use "old" and similar adjectives to refer to people over 65 years of age. I will use the term "very old" to refer to people over 85. This distinction is necessary because grouping together everybody over 65 can sometimes be extremely misleading due to the vast differences in health and function between the 65-85 and 85+ cohorts.
[3] Mark Novak and Lori Campbell *Aging & Society* (2001). Older adults make up over 80% of the institutionalized population.
[4] *Ibid.* 102.

76.6% of the institutionalized population.[5] Men rely on their wives – who are typically both younger and destined to live longer – for informal care, but widowed wives usually receive informal care from their daughters and daughters-in-law.[6] Informal caregiving already strains daughters who feel "sandwiched" between demands from their jobs, children and aging parents. But as the population ages, the situation will worsen as older women in their mid-sixties, who often already have myriad chronic conditions themselves, must care for their 90+ year old mothers. For all these reasons, the number and percentages of institutionalized persons will almost certainly increase as the population ages.

It is therefore important to reflect on the way in which we have structured our formal care system. I begin this paper by outlining the four different types of residential care available in Ontario, focusing primarily on long-term care. I then distinguish between the three different mechanisms of delivering LTC, noting the unique nature of LTC as a residential facility in which the residents are primarily conceived of as care receivers. Next, I explain the way in which the LTC system functions and attempt to describe the competing incentives that animate the delivery of care. In particular, I highlight ways that for-profit care outcomes may differ from not-for-profit care outcomes, arguing that a profit motive creates some extra risk of poorer care. That risk can be alleviated, but not eliminated, through effective regulation. I conclude by offering suggestions as to what that effective regulation might look like and how it ought to be enforced to ensure maximal care outcomes.

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[5] PriceWaterhouse There is also homecare, but homecare relies heavily on informal care and so it is difficult to truly separate them.

[6] Novak *supra* note 3 at 257.

What is long-term care?

There are four classes of residential facility that are designed for people who, because of physical or cognitive impairment(s), are not able to live alone without assistance. In this section I describe each of them, highlighting the differences between long-term care facilities and the other types of residential facilities.

Retirement Homes and Supportive Housing

The first class of residence is the retirement home.[7] Retirement homes assist people who need "minimal to moderate support for their daily activities" to live on their own in an apartment style setting.[8] Typically, retirement homes provide residents with light housekeeping, basic personal care, full-time access to staff members and optional extra services, such as meal plans. Private corporations, most of which are for-profit, own and manage all retirement homes. There are no government subsidies for those who cannot afford the rent.[9]

The second alternative, designed for people who require moderate levels of care, is supportive housing.[10] Like retirement homes do, supportive housing helps people to retain their independence by providing personal care, meal preparation and homemaking services. Supportive housing contrasts with retirement homes in that the services are geared towards a slightly more impaired population, they are solely non-profit and are

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[7] "Retirement homes" are also known as retirement residences, care homes, assisted living facilities and rest homes.
[8] Government of Ontario. "Seniors Care Retirement Homes" online at http://www.health.gov.on.ca/english/public/program/ltc/14_retirement.html.
[9] Seniors' Care: Comparing Residential Options online at www.health.gov.on.ca/english/public/program/ltc/16_options.html.
[10] Supportive housing is also referred to as non-profit housing, social housing and seniors' housing.

significantly cheaper.[11] The government assists low-income people to pay for supportive housing.[12]

Long Term Care

Long term care (LTC) contrasts with both retirement home and supportive housing in that it exclusively serves among the frailest, most impaired segment of the population. In fact, an applicant cannot enter an LTC institution without first satisfying the local Community Care Access Centre, which is the non-profit, provincially funded agency that oversees nursing home admissions, of serious health care needs.[13] Residents in LTC facilities are, because of their poor cognitive and physical health status, extremely vulnerable to and dependent on their caregivers. That vulnerability is exacerbated by the fact that the majority of the LTC population is old[14] and female, a combination that is very highly correlated with disadvantage.[15] Other factors that heighten the vulnerability are language barriers and cognitive impairments, both of which can interfere with the residents' ability to communicate their experiences or care or any problems that they may have. The power imbalance between residents and caregivers is especially heightened for

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[11] Options *supra* note 8. The rental rate for retirement residences ranges from $1500-$1500 per month. In contrast, the rental cost for supportive housing ranges from $600 - $1200.
[12] *Ibid*.
[13] Specifically, an applicant is eligible only if she can satisfy one of the following criteria: requires 24-hour nursing care, requires daily assistance with her ADLs, requires regular supervision in order to secure her well being, risks of financial, physical or emotional harm if she remains in her current residence, or risks harming another person if she remains at her current residence. Advocates's Manual 3.16.
[14] In Ontario, the average age of residents in LTC institutions was 82.1. PriceWaterhouseCooper *Report of a study to review levels of service and responses to need in a sample of Ontario Long Term Care Facilities and Selected Comparators* (2001) at 31 [PriceWaterhouse]. This is especially high when one considers that anyone over 18 is eligible to enter an LTC facility.
[15] See for instance Eleanor Palo Stoller and Rose Campbell Gibson *Worlds of difference: inequality in the aging experience* Pine Forge Press, Thousand Oaks CA 1997 and Sarah Irwin, Later Life, inequality an sociological theory (1999) Aging and Society 19:6 691.

demented persons, who comprise 53% of Ontario's LTC care receiving population. That is because their complaints, when made, are easily dismissed as "senile" and unreliable.[16]

In recognition of the unique character and the complex needs of the LTC population, the provincial government heavily regulates[17] and heavily subsidizes the LTC industry. The LTC statutes differ markedly from the *Tenant Protection Act*, which is the default legislation that binds retirement homes and supportive housing. Most of the substantive differences between these two statutes can be traced to a conceptual difference that is evident from the language we use to discuss them: supportive and retirement housing residents are primarily *tenants* whereas LTC residents are principally *care receivers.*[18] The construction of resident as care receiver informs both the duties assigned to LTC facilities and the rights granted to care receivers.

Perhaps the most striking manifestation of this difference between the TPA and the LTC Acts is that LTC facilities are obliged to house all applicants that pass the CCAC's 'care needs' threshold". That is, LTC institutions are not allowed to evict or to deny a bed to any person based on inability to pay, refusal to sign an admission contract, propensity to cause a nuisance, or requirement of abnormally high[19] levels of care. A facility cannot reject CCAC approved applicants unless it can demonstrate an inability to meet the person's needs, either because the staff does not have the necessary

[16] To clarify, some complaints would be unreliable products of dementia. My point is simply that it becomes easy to draw the invalid conclusion that all complaints are false from the true premise that some of them are.
[17] *Nursing Homes Act* R.S.O. 1990, Chapter N.7 [NHA]; *Homes for the Aged and Rest Homes Act* [HFA] R.S.O. 1990, Chapter H.13.The *NHA*, *HARH* and *CIA* govern nursing homes, homes for the aged and charitable institutions respectively. They are discussed individually and in further detail below.
[18] To clarify, the care received is not "medically necessary" in the sense of being an insured service under the *CHA*. The CHA is very clear on this; it classes nursing home care as an extended service.
[19] The government tries to mitigate the burden of high-needs patients on the facilities by indexing funding to the level of care required. However, this is done categorically rather than on a case-by-case basis and so it is possible for a resident's actual needs to exceed the set amount for a person in the highest care bracket.

qualifications to provide appropriate care or because the physical facilities are inadequate.[20] It cannot discharge a resident unless the resident consents, dies, is absent for a prolonged time or has care needs that exceed the facility's ability to meet.

The conceptual difference between tenants and care receivers is also reflected in the kind of care that the residential facilities are required to provide. Retirement homes and supportive housing are obliged to provide a place to live and physical assistance with certain tasks. The services provided are not set out in any law; they are determined by private contract between the resident and the facility in question. In contrast, long term care facilities are statutorily required to provide 'whole person' care. The fundamental principle in the interpretation of each act is that:

> (Each long term care facility) is primarily the home of its residents and as such it is to be operated in such a way that the physical, psychological, social cultural and spiritual needs of each of its residents are adequately met and that its residents are given the opportunity to contribute in accordance with their ability to the physical, psychological, social cultural and spiritual needs of others.[21]

In practice, this means that all facilities provide pastoral services, social programs and recreational activities in addition to the care they provide to maintain the body, such as assistance with ADLs, full-time nursing care, meal preparation, full-time supervision and access to health workers. As well, every facility must publicize and promote the 19 rights enumerated in the Residents' Bill of Rights.[22] To be clear, these rights are legal, contractual, enforceable ones that exist in addition to and independently of other rights under the *Charter* and human rights codes. The acts state explicitly that "A licensee of a

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[20] CIA 9.6(14); HFA 18(14), NHA (20.1)(14).
[21] *Nursing Homes Act* R.S.O. 1990, Chapter N.7 at para 2(1). [NHA]; *Homes for the Aged and Rest Homes* [HFA] *Act* R.S.O. 1990, Chapter H.13 at para 1.1(1).
[22]See CIA s.3.1(2); HFA s.1.1(2); NHA, s.2.2

nursing home shall be deemed to have entered into a contract with each resident of the home, agreeing to respect and promote the [residents' bill of rights]."[23]

LTC staff members are expected to monitor and respond to residents' changing care needs – although they are encouraged to participate, there is no duty on residents to caregivers to inform their caregivers of their medical status.[24] This places a higher than usual burden on caregivers to care proactively. That said, residents or their substitute decision makers can (in theory) consent to undertake risks – to forego restraints, or to eat solid foods against medical recommendations – if that consent is informed.

Chronic Care Hospitals

Chronic care hospitals (CCHs) provide "complex continuing care" for people whose impairments – often stemming from chronic conditions – are so severe that they are beyond the abilities of long-term care facilities to treat adequately. A person is classified as receiving chronic care if her needs are so severe that her physician foresees she will become a permanent resident in the hospital. Even more than LTC residents, CCH residents are primarily viewed as care receivers. That said, because the hospital is their home – and not a temporary way station in the way that acute hospitals theoretically are -- residents who have the means must still contribute towards the cost of their accommodation.

Different Models of Long Term Care

Long term care in Ontario is delivered by three kinds of institutions. As of 2004, of a total of 577 LTC facilities in Ontario at that time 343 were nursing homes, 102 were

[23] NHA s.4; HFA; CIA
[24] LTCF Advocate's Manual: ACE- February 2001.

municipal homes for the aged and 132 were charitable or non-profit homes for the aged.[25] The previous section focused on the features that LTC facilities share. Many of the similarities noted are relatively new; in particular, the statutorily defined per resident rates and equitable funding are as a result of 1993 amendments. This section identifies the ways in which the three types of facility still differ.

Nursing homes (NHs) are all privately owned, typically by for-profit operations. NHs emerged as in the early 1900s as unregulated, family operations. The first version of the *Nursing Home Act*, which is the law that governs NHs, was enacted in 1966 in response to public concern over varying standards of care. The legislated standards were high, and many of the smaller nursing homes closed because they could not afford to comply with the laws. This left the larger corporations to dominate the market largely unchallenged, which facilitated the shift to the kind of nursing home corporations that we see today. An NH must be licensed by the Ministry of Health and, in theory, that license must be renewed annually.[26]

Municipal Homes for the Aged (MHAs), which are governed by the *Homes for the Aged and Rest Homes Act*, are publicly run, non-profit entities. Municipal homes are descended from "houses of refuge", which were shelters built to house the destitute "inmates". Today, the homes aim to provide quality care for the impaired "residents" who cannot care adequately for themselves. Each municipality must establish and maintain a home for the aged, either on its own or in conjunction with a nearby

[25] Smith *supra* note 1 at 9.
[26] The annual licensing is set out in ss4(1) and 5(8) of the NHA. But see p.11 for a discussion of the chasm separating theory and practice.

municipality.[27] Charitable homes for the aged (CHAGs) are also non-profit, but they are established and managed by religious or charitable groups. The government will approve charitable home applications where the corporate applicant demonstrates that it can provide "competent management (operating) in good faith for charitable purposes."[28] CHAGs are also governed by the *Charitable Institutions Act.*

The question of which differences matter for quality of care in Ontario is a difficult one to answer in any legitimate way, largely because comparative, objective information about the quality of care in long term care facilities is scarce. The Ministry website does not publicize compliance reports, complaints, unusual occurrences,[29] or any quality of ratings of quality of care. That said, it *is* possible to get all these data through a Freedom of Information or to obtain an individual facility's compliance review by asking either the Ministry of Health or the facility. There are, however, nearly 600 facilities in the system and so it is almost ludicrous to expect an average person to meaningfully compare relative quality of care among different kinds of institutions. It is partly because of the difficulty in obtaining this data that I do not empirically review it in this paper. Instead, I focus on two of the obvious differences between the institutions: profit and legislation, using secondary sources, case law and government reports to evaluate whether these factors affect quality of care.

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[27] See HARHA ss.3-4,8-12 and Regulation 637 ss.5,8,59-61 for details on the way in which the homes are publicly run. Briefly, the municipal council appoints a management committee from among its members. The committee appoints a board of management, which, along with the council, is empowered to appoint an administrator, a doctor and all the necessary staff. The administrator that they appoint does the daily work of running the nursing home.
[28] Charitable Institutions Act at s.2.
[29] "Unusual occurrence" is a Ministry term that means "an occurrence that poses a potential or actual risk to the safety, security, welfare and/or health of a resident, or to the safety and security of the facility which requires action by staff."

Different statutes, similar standards

Initially, I was struck by the fact that each LTC was governed by a different statute and speculated that this might affect quality of care. This hypothesis turned out to be largely incorrect, but I think it is worthwhile to briefly discuss it and draw out the few differences that do exist between the kinds of LTC institution. That the facilities are each governed by separate statutes is largely a relic of their different historical origins. As I mentioned earlier, there *were* significant differences among LTC statutes prior to 1993, but amendments at that time effectively homogenized them. Another step towards standardizing LTC guidelines was the introduction of the *Long-Term Care Facility Program Manual*, which sets out government's expectations from LTC facilities. The Manual is available to the public on request and for a small fee. The Manual is easier to update than regulations, and updates do occur occasionally. However, because they are not regulations, the expectations set out in the *Manual* are not binding on LTC facilities. Given this, I will outline in this section the legal differences between facilities.

Licensing

Nursing homes require licenses and municipal and charitable homes do not. Licenses must be renewed annually, giving nursing home operators a strong incentive to maintain standards. Charitable homes, in contrast, once granted permission to operate retain that permission until it is revoked. Municipalities must maintain homes and that obligation is not revocable. However, as with charitable and nursing homes, Ministry officials may take over operations if residents are at risk.

Ostensibly, this holds nursing homes to the highest standard of care by ensuring that they adhere to compliance procedures from year to year. This has not been the case

in practice. At the time of the Auditor General's audit, *none* of the nursing homes in Ontario had a valid license. As well, the signed service agreements – the contracts that are meant to govern the transfer of provincial funds to nursing homes -- were typically signed at the end of the year automatically, without any reference to whether that facility conformed to ministry standards.[30] Despite *de jure* differences all facilities are held to the same *de facto* licensing standards. I will revisit some of these issues in the section on government enforcement.

Other Quality of Care Requirements

The regulations to the NHA require that residents receive "proper and sufficient care of their bodies", that those who are incontinent receive daily baths and that other residents are "bathed at least once a week".[31] The NHA also has more detailed (and protective) provision about the use of restraints.[32] That the remaining differences between the acts se a higher standard for NHAs is perhaps in recognition of the increased incentives in for-profit care providers (discussed below) to shirk care duties, though that may be giving parliament too much credit. Regardless, the differences are mysterious because there is no compelling reason not to set a minimum standard of quality care that is consistent across all types of LTC institution.

Profit versus not-for profit

Statutes aside, perhaps the most obvious difference between the models of LTC is that some operate for-profit and some operate not-for-profit. For-profit provision of LTC is marginally more common than non-profit provision; the CBC reported in 2001 that

[30] Auditor at 124.
[31] NHA Reg s.56(8)
[32] NHA Reg s. 5.5.6

51% of Ontario LTC beds are for-profit, whereas 49% are not-for-profit.[33] Many of the for-profit facilities are part of larger nursing home chains.[34] Profitability – much more so than privatization, although the two concepts are often conflated – is a divisive issue, both among academics and among the general public. In a recent Ipsos Reid survey, for instance, 39% of respondents felt that for-profit ownership ought not to exist in the LTC sector and 56% preferred a mix of non-profit and for-profit LTC providers. The literature on for-profit delivery of health care services is also divided.

General Literature on for-profit versus not-for profit delivery of health care

There have been several very striking recent studies indicating that US style for-profit delivery is correlated with lower quality of care. These include an investigation by Devereaux and colleagues, a Canadian team, who conducted a "meta-analysis" of 15 studies (to create a combined samples size of 38 million patients) comparing mortality rates in for-profit and not-for-profit American hospitals. They found that death rates were 2% higher in private for-profit hospitals than in private-non-profit hospitals. [35] Two other studies that specifically looked at nursing homes found a significantly higher incidence of pressure sores[36] and quality of care, quality of life and administrative "deficiencies" at

[33] http://www.cbc.ca/consumers/market/files/health/nursinghomes/facts.html. This is a relatively shift from the previous situation in which not-for-profit firms were in the majority. Ontario devoted $1.2 billion to LTC to adding 20 000 beds, most of which were granted to the for-profit sector. John Lorinc "OLD" Globe and Mail (2003) September 5, 2003 at 75

[34] The three largest companies in Ontario are Central Park Lodge, which is a publicly traded company that operates in Canada and the US and owns 62 homes in Ontario; Extendicare, which is a publicly traded company that operates in Canada and the US and owns 51 homes in Ontario; and Leisureworld, which is a privately owned Canadian company that owns 19 homes in Ontario.

[35] P.J. Devereaux *et al.* "A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals" (2002) 166 CMAJ 1399 at 1402. See also

[36] Aaronson *et al.* "Do for-profit and not-for-profit nursing homes behave differently? 24 *G*erontologist (1994) 775.

for-profit facilities than at their non-profit and publicly owned counterparts.[37] Low levels of staffing at homes were also associated with for-profit care.[38]

Another, though less dominant, strand of literature argues that for-profit care is more efficient and that quality is not compromised.[39] One might attribute this efficiency in nursing home chains to economies of scale that are not available to municipal and charitable institutions. Some policy makers and commentators tread a middle ground, (at least implicitly) admitting the possibility that unregulated provision of private care services may compromise quality, but arguing that these problems can be legislated away through stringent enforcement mechanisms and public accountability. Senator Michael Kirby, who chaired the Senate Social Affairs Committee Commission on health, wrote:

> The combination of a single funder/insurer, service-based funding and the separation of funder and provider means that *the funder is neutral on the issue of who owns a hospital*…the patient and the funder/insurer will be served equally no matter what the corporate ownership of a health care institution may be, as long as the two following conditions are met: 1) all institutions in a province are paid the same amount for performing any given medical procedure or service; 2) all institutions, no matter their ownership, are subjected to the same rigorous, independent quality control and evaluation system. The Committee emphasizes that it is not pushing for the creation of private, for-profit, facilities. But we do not believe that they should be prohibited…[40] [emphasis added].

Flood and Choudhry advanced a similar position in their submission to the Romanow Commission, although the recommendation was not taken up in the final report.[41]

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[37] Charlene Harrington *et al.* Does Investor Ownership of Nursing Homes Compromise the Quality of Care. American Journal of Public Health 91 (2001) 1452 at 14.
[38] Aaronson *supra* note 36.
[39] See Spector and Takada. Risk-adjusted outcome measures and quality of care in nursing homes. Med Care. 1997 Apr;35(4):367-85.
[40] Senator Michael Kirby. The Standing Senate committee on social affairs, science and technology "The Health of Canadians – The Federal Role." Volume Six (October 2002) at chapter 2. Online http://www.parl.gc.ca/37/2/parlbus/commbus/senate/Com-e/SOCI-E/rep-e/repoct02vol6-e.htm
[41] Colleen Flood and Sujit Choudhry. Strengthening the Foundations: Modernizing the Canada Health Act. Discussion paper no.13 Commission on the Future of Health Care in Canada August 2002; Romanow *supra* at 6.

This debate clearly has some applicability to the long-term care arrangements in Ontario. Though nursing home care is not an insured service under the CHA, the caregiver-care receiver relationship is very similar to traditional hospital care and, moreover, the residents of LTC are more dependent and vulnerable (and therefore more likely to be affected by fluctuations in care) than most of the patients in acute hospital wards. Precisely how it is applicable, however, is influenced by the idiosyncrasies of the Ontario system following the legislative amendments that revamped LTC in 1993. To clarify what I mean by this, to put the literature in proper context for discussion and to ground the policy recommendations I make in the final section of this paper, I will outline the way in which long term care financing works in Ontario.

Long-Term Care Financing in Ontario

For all facilities, both profit and not-for-profit, operating revenue is divided into four streams. The first two streams, Nursing and Personal Care (NPC) and Program and Support Services (PSS), come solely from the provincial government provided that the resident is covered by OHIP. The money allocated towards these services must, at least in theory, be either spent on NPC and PSS or returned to the government at the end of the fiscal year.

The third funding stream, which accounts for approximately 40% of the total revenue, is dedicated to accommodation costs. "Accommodation" is defined by statute as including lodging, housekeeping, maintenance, dietary services, laundry services, administrative services and "raw food".[42] The government and the resident together pay the resident's accommodation costs, and it is only from this revenue stream that facilities are permitted to 'keep' surplus dollars. The one exception to this rule is the raw food

[42] NHA reg s.1; CIA reg s.1; HFA reg s.1.

category, for which any money unspent must be returned. There is a legislated maximum to the number of residents (60%) who can be charged for "preferred" private and semi-private rooms[43], as well as a maximum accommodation rate, so the amount of surplus it is possible to generate is inherently limited.[44] The government payment for the basic accommodation is flexible and means driven; the government will pay the full cost of accommodation if the resident cannot afford it. No subsidies beyond the standard co-payment are available for either type of preferred accommodation. Finally, LTC facilities may charge for extra services such as dry-cleaning, hairdressing and finance management. This is a very minor source of revenue.

Earlier I suggested that the main difference between the LTC acts and the Landlord Tenant Act lay in different conceptions of the resident; that the *LTA* viewed residents as primarily tenants and that the LTC statutes mainly viewed residents as primarily care receivers. Another way of formulating that statement is to say that the LTC acts view LTC facilities as caregiving institutions first and landlords second, and that the reverse is true of the *LTA*. This profit structure is consistent with this formulation. The LTC system allows private operators to deliver publicly financed health care services but not to profit from the provision of those services. LTC facilities are open to everyone who can demonstrate health care needs regardless of income, because the government will pay the whole ward rate if necessary and because non-payment of rent cannot be a ground for eviction. Thus, insofar as LTC facilities function as caregivers, they are not-

[43] CIA reg s.40.1, HFA reg,. s.39.01, NHA reg., s.113.1. If more than 60% of the beds are private or semi-private the institution must develop a system to designate some of them as "basic" and charge the ward rate.

[44] As of 2003, the maximum rate for a four-person "basic" ward room was $101.39/day ($48.69 from the resident and $44.70 from the government), the maximum rate for a "preferred" semi-private was $109.39/day ($56.69 from the resident and $44.70 from the government) and the rate for a "preferred" private room was $119.39/day ($66.69 from the resident and $44.70 from the government).

for-profit. In this sense, they are like Canadian hospitals. Where they diverge is that unlike (acute care) hospitals, LTC institutions are partially landlords. In that capacity, institutions are allowed to derive profit even from the use of ward rooms and other administrative type services.[45]

The reason that I am hesitant to generalize from the data on for-profit hospitals and nursing homes in other jurisdictions, then, is that Ontario law forbids LTC facilities to derive a profit from caregiving. That said, it would be simplistic to suppose that the mere fact of this statutory scheme can rid us of all concerns about for-profit care, without first examining how the facilities operate in practice.

Economic incentives to skimp on care

Two sets of incentives flow from these financing policies. The negative incentives are to attempt to "game the system" by budgeting creatively and attempting to shift costs to the NPC and PSS streams in order to maximize profits. This gaming occurs, for instance, when facilities classify accommodation equipment, such as medical supplies, as an NPC cost.[46] These cost-shifting tactics negate the factor – non-profit provision of medical care that is rigidly separated from for-profit provision of accommodation services -- that in theory separates Ontario nursing homes from for-profit hospitals.

As well, there is a financial incentive to provide 'accommodations services' – of such low quality as to affect quality of life. There is, moreover, very little motivation to supplement the government funded NPC and PSS in order to hire more or better trained staff, so the subsidy may act as a cap on quality. This is especially true since 1996, when the government of Ontario removed the requirement that nursing homes provide a

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[45] The Canada health Act funds ward rooms, but hospitals are also allowed to charge consumers extra for "non-medically necessary" private rooms.
[46] Auditor General *supra.*

minimum of 2.25 hours of personal care per resident per day. This deregulation has had empirical effects: the amount of care per resident per day has dropped to an average of 2.04 hours.[47] This is markedly lower than other jurisdictions, despite the fact that Ontarian LTC residents tend to be older, more cognitively impaired and suffer deeper depression than their counterparts in other provinces.[48]

As well, there are three tactics that LTC facilities – typically nursing homes who, again, must be parsimonious – use to generate revenues. The first is to "vertically integrate" by including retirement housing, home care subsidiaries and pharmacies among the corporate housing. LTC facility operators thus have an incentive, not just to shift costs within the home, but to shift costs between facilities and to subsidize their higher profit-margin retirement homes with public dollars earmarked for resident care.[49] The second is to contract out accommodations like cleaning and meal preparation. Finally, nursing homes rigidly restrict wages and deal harshly with labour groups. Entering the names of the three major Ontario nursing home chains into Quicklaw yields massive amounts of litigation, the overwhelming majority of which derives not from residents but from unions. The other side of this coin is that long term care facilities often hire untrained staff and nurses' aides over registered nurses in order to keep labour costs low. This is problematic because care outcomes suffer when staff morale is low.[50]

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[47] PriceWaterhouseCooper *supra* note 13 at 65.
[48] *Ibid.*
[49] *Ibid.* Once resources are shared in this way it is difficult for facility managers to withdraw them. In one recent instance, residents at a Manitoba facility successfully launched a rent strike to protest the withdrawal of nursing services to which they had not been entitled to begin with under the terms of their contract. Graeme Smith. Manitoba seniors win dispute over emergency alarms. Globe and Mail. Wednesday March 3.
[50] See, for instance, JF Marr. Poor wages and overwork can precipitate abuse. Elder Care. 1995 Oct-Nov;7(5):41.

I do not want to romanticize not-for profits, or to suggest that only for-profit facilities would have any incentive to manipulate the system. Certainly non-profit facilities also have an interest in budget surpluses – and not only because they may want to funnel extra money into patient care. Accommodation surpluses can allow higher salaries and better benefits. Higher caregiving staff salaries, of course, are correlated (to a point) with better patient care, but doubtless corporate officers also receive high salaries that translate less directly into increased quality. However, the risk of creative bookkeeping that is present across all institutions is heightened in for-profit facilities. Devereaux *et al.* convincingly advance this position, noting that for-profit institutions simply have more financial pressures on them than not-for-profit facilities do. That is, for-profits begin with the same 'pot' of money as their non-profit counterparts do, but the for-profit investors expect a 10%-18% return on their investments,[51] nursing home administrative officers expect performance based rewards and for-profit facilities have to pay taxes that do not apply to not-for-profit institutions. The heightened risk can be alleviated, but not eliminated through effective legislation. The question becomes one of values; the policy maker must decide whether she feels that *any* risk is problematic – particularly in residential facilities where the resident is a vulnerable care receiver – and if not, how much is too much. Below, I examine structures that mitigate the risk for homes in general and highlight how these incentives may play out differently in for-profit versus not-for-profit care.

[51] Devereaux *supra;* Lorinc *supra.* Whether for-profit corporations are even permitted to pursue ends that are not profit, such as the interests of the community, is an unresolved question in Canadian law. Section 122(1)(a) of the Canadian Business Corporations Act requires directors to act "with a view to the best interests of the corporation." This is somewhat ambiguous and the best interest of the corporation is often interpreted to mean maximizing profits for shareholders. But the *obiter* in *Teck v Millar* coupled with the fact that non-shareholders can apply for oppression remedies under s.241(2) of the CBCA indicate that corporations may have some legal responsibilities to non-shareholders.

Incentives to Care Conscientiously

On the other side of the incentive scale are the threats of resident litigation (criminal or civil), government sanctions and loss of market share all of which theoretically motivate facilities to adhere to their statutory obligations and to maintain a 'decent minimum' in terms of quality of care. However the force that these incentives have will depend on the degree to which they are true threats and on whether the money saved through cutting costs on staffing can outstrip the potential loss from government intervention or the occasional law suit.

Incentive to Care #1: The Threat of Government Sanctions

The Ministry of Health subscribes to a cooperative, 'benign big gun' type policy that conforms to the pyramid of enforcement schemes suggested by Ayres and Braithwaite.[52] That is, the government has access to harsh punishments but uses them rarely (if at all), and only after a range of milder measures and attempts to persuade have failed to induce compliance. In Ontario, the official procedure is as follows: If there are concerns about the institution's compliance, the administrator of the institution will receive a warning letter. If that is unsuccessful, a statement of unmet standards will follow. If that fails to produce a change in behaviour, then the Ministry will send a written notice of non-compliance. Only after these steps are taken can sanctions be applied. Sanctions include: suspension of admissions, financial sanctions and, as mentioned, revocation of the license or approval.[53]

Since 1998, the government has applied the first level of sanctions, suspension of admission to seven nursing homes. License revocation is also live threat, recently

[52] Ian Aryes and John Braithwaite. Responsive Regulation: Transcending the deregulation debate. Oxford University Press, 1992 at chapter 2.
[53] Advocate's Manual 6.24-6.25. NHA 13-17; CIA 11(1); HFA s.30.12-30.15.

invoked by the government to shut down the Royal Crest Lifecare group due to severe neglect of the residents. Remedies, however, are slow to come by and the vulnerable population can endure prolonged suffering before a resolution is reached. For this reason, I argue in the policy recommendations section that a benign big gun of regulatory regime may not be appropriate for care of this kind of population.

Although ministry officials do usually[54] perform facility compliance checks, they do not apply compliance standards consistently across facilities and regions. The Auditor General reported that "some compliance advisors told us that they might give an operator a warning while another advisor might give a citation for the same standard." Part of the reason for this may be that despite ministry policy requiring compliance "advisors" on particular subject areas (e.g., environmental health, diet, medical services, financial), many regions lacked these sources. Furthermore, from the fact that regions with specific advisors were more likely to initiate inspections and to report infractions, we can infer that the dearth of inspectors led to the underreporting of non-compliance with best practices. Further diluting the value of the inspections is the fact that compliance officers notified facilities up to a week in advance of their visits.[55] The facilities with the lowest everyday standards of care therefore had the incentive and opportunity to prepare for the official visit.

The Ministry of Health does not regularly review lists of facility purchases under each funding stream. In 2002, the Auditor General confirmed that "there was insufficient

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[54] At least since 2001; The Auditor General reports that provincial inspectors visited less than half of the ministry facilities between 1997 and 1999. Auditor at 119.
[55] *Ibid.* at 120. George Smitherman, the Ontario health minister, has indicated that he intends to implement surprise compliance checks during his tenure. As I note below, this would be a very positive change, but it is one that will be very contingent on government policy (and hence ephemeral) unless it is made into law rather than mere practice.

information to determine whether funds within each [funding] envelope were used for their intended purposes."[56] The between-facility subsidization also almost certainly occurs, said the Auditor General. While it is very common to have retirement homes adjacent to nursing homes, it is not standard practice for the ministry to require separate audited statements with lists of segregated costs. Again, if administrators know that the government is not even monitoring their conduct in a certain area, it is difficult to believe that financial sleight of hand will not occur.

All these problems are compounded by the fact that for-profit companies often have very close relationships with provincial politicians; this is far less common among non-profit homes for the aged. This takes the form of donations – for-profit LTC companies donated $336,545 to the Conservatives between 1995 and 1999, $72,918 to the Liberals and $2,000 to the NDP - but also of other forms of goodwill. Paul Tuttle, for instance, moved from his job as the overseer of Ontario's long term care division to become VP-Operations at Extendicare.[57] Though it is impossible to definitively identify cause and effect, there are policies that are either the products of soft lobbying or make no sense (I am not certain which of these is the more charitable explanation). For instance, the government recently halved the "structural compliance per diem premiums"[58] for non-profit homes who used government funds to help finance facility construction but *not* for their for-profit counterparts. This is especially inexplicable given that when the government subsidizes capital costs for a for-profit chain, that person owns the product and can sell it to anyone at any time – taking that money outside of the LTC

[56] *Ibid.* at 129.
[57] Lorinc *supra* note 33. Paul McKay. Taxpayers finance construction boom. Ottawa citizen (April 29, 2003).
[58] These premiums are paid to institutions whose facilities comply with the 1998 design standards for nursing homes.

sector. Money given to municipalities and charitable institutions for capital costs, in contrast, is much more likely to stay in the LTC system. Another inequity is that for similarly rated nursing homes and homes for the aged, nursing homes arbitrarily received premiums that were 30%-50% higher than those received by homes for the aged.[59]

Incentive to Care #2: The Threat of Litigation

Another incentive for LTC facilities to care adequately is the threat of litigation. Although it is possible to raise criminal charges against LTC facilities, this happens quite rarely because the government tends to either (a) charge individual perpetrators or (b) rely on administrative protocol for physical abuses. Fraud charges are common in the US but appear to be less so in Canada. I speculate this is because monitoring is so lacking that it is difficult to obtain evidence that satisfies a criminal standard.

Tort law seems real sword of Damocles in litigation, though it is not yet the industry in Canada that it has become in the US for two reasons.[60] First, US juries are more likely to award (almost unreasonably) massive damages than Canadian juries are. In *McCorkle v. Extendicare*[61], for instance, a Florida plaintiff was awarded nearly $3 million in compensatory damages and $17 million in punitive damages from a US Extendicare site for negligence in care. Another Arkansas case involving a defendant nursing home that had holdings in Ontario was *Advocat Inc. and Diversicare Leasing, et al v. Sauer*[62]*,* in which the jury set a state record by awarding damages totaling $78.4 million against the owner of Diversicare Canada Management Services. Plaintiff-side

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[59] Auditor General at 137.
[60] Interestingly, most litigation involving the major nursing homes was precipitated by unions rather than residents. Whether this is because of power asymmetries between labour and residents or whether it is because staff are treated more poorly than residents are (or whether both factors are at work) is unclear.
[61] *McCorkle v Extendicare Health Facilites* No. 99-00815-CIV-011.
[62] 111 S.W.3d 346 http://courts.state.ar.us/opinions/2003a/20030501/02-189.html

nursing home litigation is an emerging and lucrative market in the US, particularly in Florida because of the high numbers of older adults. Older adults make sympathetic plaintiffs and juries often reward damages in the millions of dollars. [63]

Secondly, the majority of the frail elderly who live in LTC do not have the resources or the stamina to launch a legal battle outside of small claims court. The fact that contingency fees were prohibited in Ontario until *McIntyre* was decided in 2002 may have diminished the number of claims against homes.[64] Contingency fees are the backbone of the US litigation in this area, and so it will be interesting to see how this affects the case law in Ontario. Other provinces all allowed contingency fees long previously without seeing a similar rise in US style claims, but Ontario has larger and more vulnerable population of older adults than other provinces[65] and so may be the jurisdiction from which this trend will emerge in Canada. That said, there are restrictions on contingency fees in Canada that do not exist in the US and these could dissuade lawyers from launching long-shot lawsuits.

Another emerging phenomenon in Ontario - the class action - might be a preferable means of resolving issues, and nursing home residents in a particular facility could potentially qualify as a class under the test laid out in the *Class Proceedings Act*.[66] Class action cases have been successful in the US[67] and they would empower those

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[63] Profits & Patients. Stephen Nohlgren. St. Petersburg Times. March 18:2001. See also Paul Mackay "Mining Florida's Seniors for Gold" The Ottawa Citizen April 28, 2003.

[64] *McIntyre v. Attorney General of Ontario* Osborne J.A. ruled that a widow could pay by contingency fee in her case against Big Tobacco, was decided in 2002

[65] PriceWaterHouse *supra* note 46.

[66] See ss.5-6 of the *Class Proceedings Act*. See also *Anderson v. Wilson* in which the Court of Appeal affirms a liberal interpretation of s.5. Class actions, however, are lengthy and so it may be difficult to find a representative plaintiff who could be guaranteed to live through the proceeding.

[67] See, for instance, *Troutman v. Cohen* a case in which nursing home patients successfully sued to restore care when the state tried to reduce services.

numerous patients who are extremely vulnerable but do not have family members nearby (or at all) to advocate on their behalf.

These sorts of changes may also mitigate the David and Goliath aspects of litigants attempting to make cases against LTC facilities, particularly for-profit institutions owned by large national and international chains with vast resources. Nursing homes until now could exert a chilling effect on complaints by launching preemptive litigation. In one example of this phenomenon, Leisureworld filed a $2.5 million libel suit (which was later reduced to $25 000) against a resident's sister, who had attended a residents' council meeting at her sister's request and had complained about the quality of the food, the quantity of the staff and about the bathing regime at the home. The judge dismissed that case, and even commented that "some of the improvements which have taken place were influenced by Tina's insistence that things could and should be further improved."[68] Nevertheless, the threat of litigation may have made others reconsider complaints.

Incentive to Care #3: The Invisible Hand

One might argue that because for-profit institutions compete in the same market as not-for-profit ones, charging approximately[69] the same price for admission, that if for-profit homes did provide substandard care than the demand for them would not be commensurate with the demand for non-profits. The force of this argument is diminished because of the high demand for beds everywhere and because of informational asymmetries that are especially potent in the nursing home industry. Human services are

[68] *Creedan Valley Nursing Home Ltd. v. Van Klaveren* [1996] O.J. No. 4475 [QL].

[69] Sometimes not-for-profit institutions actually charge less than the provincially legislated maximum, and so their rates will actually be slightly lower than the rates of for-profit facilities. The Apotex Centre, Jewish Home for the Aged is one example of this. http://www.baycrest.org/directory_housing_apotex.htm.

not fungible goods and so market failure is inevitable if (a) reliable information about the product is unavailable or (b) if information is available but impossible to act on because beds are so scarce. In contrast to some US states, Ontario has no system for ranking quality of care, does not disclose infringements etc. Peter McKay, a reporter, aptly said that "in Ontario, it is easier to reliably choose a quality sofa…than a nursing home."[70]

Policy Recommendations

I have argued that for-profit delivery increases the risk of poor quality care. This is true across health care sectors, but particularly so in the context of residential systems in which the residents are primarily care receivers. That is because those facilities create a long term dependent relationship that is rife for exploitation. This is true even if we try to separate the 'care' the 'landlord' functions because those categories are too amorphous to sustain a clear distinction. In the LTC context, the people receiving the care are extremely dependent and often cognitively impaired, which means that the information and power asymmetries that permeate all care relationships are uniquely heightened. Exposing these people to unnecessary risks, particularly risks to which we do not presently expose other kinds of care receivers (e.g., those in acute care hospitals), seems unfair and if there were not already for-profit facilities in this province I would strongly support maintaining the status quo.

That said, policy recommendations cannot be made in a vacuum. For-profit LTC facilities have too much money and too much political clout – not to mention control of a majority of the LTC beds – for eliminating them to be a real possibility in this province for the foreseeable future. I therefore devote the bulk of this section to policies that presuppose for-profits but work to foster quality care.

[70] Mckay *supra*

Treat all LTC facilities equally: Consolidated LTC legislation and policy

If LTC is going to rely on a market model, then the government ought to provide all facilities with the same benefits so that they can compete equally. One aspect of that is bringing the subsidies of capital and maintenance costs for not-for-profits up to the level of subsidy available to for-profit institutions. Another is to standardize licensing requirements, perhaps staggering them and allowing them to be renewed once every few years if it is too onerous to require all homes in the province to re-apply for licensing every year. As I mentioned earlier, regulations surrounding bathing and restraints ought to be amended to match the NHA, which has the most rigid safeguards for residents' rights.

Furthermore, there ought to be a unifying statute for all long-term care, binding every institution in law to the exactly the same legislative standards. It is laudable that the resident's bill of rights is standard and that it gives residents and their families a broad view of the kind of services they are entitled to expect from an institution. However, the current fragmented legislation makes it more difficult for residents, and particularly those who move between types of facilities, to be apprised of precisely what their rights are. As well, while it is useful to articulate standards, placing guidelines that are not legally binding into a *Program Manual* (that one can only acquire by writing the ministry of health and that is not available online) is not effective enough at ensuring quality care. Another benefit of well-publicized standards is that they will also heighten the perceived threat of litigation on behalf of residents. Although remedies in Canadian courts are not as large as American ones, they are still big enough to significantly alter the risk/benefit analysis of knowingly understaffing a facility or under-supervising a resident.

Another mechanism for facilitating this would be the establishment of conflict of interest guidelines for health officials who deal with nursing home owners and, perhaps, caps on the amount that owners of for-profit care facilities can donate to political parties or to individual political campaigns.

Penalties: Moving to a Stronger Enforcement Mechanism

Again, the reason that 'guidelines' are insufficient and that the risks associated with for-profit service delivery are particularly problematic is that this population is uniformly vulnerable, often very sick and – particularly for those with cognitive impairments and without family – unable to effectively advocate on their own behalf. While not unique – this feature is shared by other residential facilities where the resident is a care recipient – this vulnerability demands an increased state role in ensuring that quality of care reaches a minimum standard.

Cooperative models of regulation like benign big gun may be more appropriate to dealing with the regulation of financial services than of human services for disadvantaged populations.[71] That the Royal Crest Care facilities were not shut down until (long) *after* a resident was found with "feces and live maggots in her shoes"[72] indicates that requiring the government to issue a series of polite warnings before intervening may create too long a wait for the people living in LTC facilities. Penalties for violations of compliance protocols should be clearly spelled out and strictly enforced, with the burden on the LTC facility to show why a penalty (e.g., suspension of admissions) is not warranted. Moreover, when one nursing home in a chain is clearly and egregiously not performing adequately others in the chain ought have admissions suspended until they can be re-

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[71] See Smith and Lipskey for a discussion of the unique character of human services.
[72] Paul McKay. "The Missing Millions of a nursing home empire: the family behind two decades of retirement home bankruptcies in Ontario, Florida and Kansas go for broke –literally." (April 27, 2003).

inspected. This is a precautionary protocol aimed to curb similar abuses in other homes. It is consistent with the evidence from the Royal Crest debacle that negligently poor care, where it exists, is not usually anomalous.

As well, the ministry should adhere to its commitment to stop announcing their nursing home compliance inspections in advance. This will increase inspectors' chances of seeing the true living conditions at any given home. Finally, provinces withhold subsidies for construction and retro-fitting from nursing homes who have had poor previous compliance reports.

More Stringent Care Standards

Without stringent care standards to enforce, however, increased monitoring will not yield substantive results to generate quality of care. The Ontario government may not have liked having a one-size-fits-all standard number of personal care hours per resident per day, but the Program Manual's requirement that nursing care staffing be "sufficient" is not adequate either. There ought to be some minimum standard, perhaps calibrated to match the resident's care rating. This process would automatically tailor the personal care to the amount of government funding received by homes for personal care.

Requiring a certain number of registered nurses on staff and reinstating the rule that they be available on site (as opposed to on-call) 24-hours a day could also help to elevate the quality of care, depending on the nature of the residents' health problems.

Adequately Fund PSS and NPC

As I mentioned earlier, one effect of the separation of the 'care' budget from the 'tenant' budget is that, even if there is no cost-shifting, there is little incentive to supplement the government budget with accommodation dollars. If the government is

going to require proper physical and social care and if it is going to say that it covers all the costs of care it ought to follow that it provide an adequate budget. The facility ought to be able to afford to hire registered nurses from its PSS budget, for instance. Moreover, the food budget ought to be sufficient to meet nutritional needs of residents. The $5/meal for food (which is the one accommodation cost from which facilities are not allowed to derive profit) does not meet this very minimal standard.[73]

Alleviate Market Failure: Publicize Ratings and Rankings of LTC facilities

One of the most damning criticisms against using the market to distribute human services, and particularly health care is the massive information asymmetry between the people delivering the care and the people receiving it. Part of this could be alleviated with an online database, of the sort that is available in numerous American jurisdictions, ranking quality of care in nursing homes.[74] This could be assembled either by government or by another independent body from two already existing sources. First, consolidating the compliance and infringement reports could provide evidence about whether the homes adhere to guidelines. This is the only practical way in which those reports can be useful to the average person. A second indicator, complementary to the first, would be patient outcomes as indicated by the MDS (Minimum Data Set) which document the resident's condition upon entry and is updated annually. The MDS is on its way to being consolidated for internal use, and it would be a relatively simple matter to anonymize the data and make it publicly available.[75]

[73] McKay. "How to fix the system" *The Ottawa Chronicle* May 1, 2003.
[74] See, for instance, Nursing Home Inspector online http://www.carepathways.com/nhg-state-FL.cfm.
[75] There could be exceptions or consent forms when dealing with small homes where there might be privacy issues with releasing even anonymous data, if it will be obvious which data belongs to which resident.

Conclusion

The population is aging, as people are living longer and having fewer children. This is a significant demographic shift, and it is affecting the shape of the life cycle, the family and the ways in which we experience end-of-life. One significant change that is occurring is a shift in care needs; incidence of acute illnesses in Canada is rapidly decreasing, while chronic, degenerative illnesses are on the rise. These factors all portend that formal care is going to be very important in the 21st century, and that the incentives we create will strongly influence the way in which most people (particularly women) experience very old age. The LTC population is, by its nature, vulnerable and disempowered and so it is particularly important to fashion legislation and regulations that will increase the odds of high quality of care outcomes in LTC facilities.