

**Ontario's Retirement Homes and Long-Term Care Homes:
Policy Implications for Care Services, Funding and Governance Regimes**

by

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Institute of Health Policy, Management and Evaluation
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Abstract

Purpose: The Province of Ontario is experiencing substantial growth in the seniors' population requiring care, with capacity, cost and regulatory pressures across all settings. This study compares long-term care homes (LTCHs) and retirement homes (RHs), significant residential care alternatives for seniors in Ontario, regarding pricing, levels of care and availability of services, in the context of different government funding and regulatory oversight. Attention is given to the way owners of homes shape their services in response to prevailing policy instruments and other environmental factors.

Methods: The research uses an explanatory sequential mixed methods design, with a first phase involving the analysis of quantitative data regarding LTCHs and RHs, and a second phase involving qualitative (interview) data from key informants. The first phase informs the interview questions for the second phase, with integration occurring after Phase 2.

Results: Substantial overlaps exist in the characteristics of the two resident populations (LTCHs and RHs), which are most evident among the population of seniors requiring high levels of care and support. However, the two sectors are funded and regulated differently, which affect how services are delivered. Most care costs in LTCHs are publicly funded, while residents in RHs generally cover these expenses personally. Equity of access issues arise from shortages of beds in LTCHs and limited government funding for care services in RHs. LTCH owner strategies are

affected by excess demand for beds and by regulatory instruments that limit profit for care and accommodation. With RHs, more flexible owner strategies are evident for care levels, pricing and location. However, without public funding, availability and affordability of RHs to the resident suffer and owner strategies focus on areas of higher income, population density or community infrastructure. The two sectors are also regulated differently in respect of care standards, security and enforcement.

Conclusions: Policy instruments influence the features of residential care service offerings by shaping how the owners of seniors' residential care offer services, with important consequences regarding access to those services. Policy instruments play an important part in determining the availability and affordability of seniors' residential care, and consistency of governance.

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List of Abbreviations and Defined Terms

ADL – Activity of Daily Living, including eating, bathing, dressing, toileting, walking and continence

AL – Assisted Living (RH)

ACE – Advocacy Centre for the Elderly

Care services – all nursing and personal support services, including ADLs

CCAC – Community Care Access Centres

CIHI – Canadian Institute for Health Information

CMHC – Canada Mortgage and Housing

CMHC Ontario Report – 2016 CMHC Seniors’ Housing Report for Ontario

CORE – Collaborative Retirement Econometrics

FP – For-profit

HCC – Home and community care

HDB – Health Data Branch, of the MOHLTC

IL – Independent Living (RH)

ISL – Independent Supported Living (RH)

LTCH – Long-Term Care Home

LHIN – Local Health Integration Networks

LTCHA – Long-Term Care Act, 2007

MAPLe – Method for Assigning Priority Levels

MC – Memory Care (RH)

MOHLTC – Ministry of Health and Long-Term Care

NFP – Not-for-profit

NPC – Nursing and personal care

OA – Other accommodation

OANHSS – Ontario Association of Non-profit Homes and Services for Seniors

OLTCA – Ontario Long-Term Care Association

ONA – Ontario Nursing Association

Owners – Those with an economic interest in a home, including FPs, NFPs and municipalities

ORCA – Ontario Retirement Communities Association

PSS – Programming and support services

PSW – Personal support worker

List of Abbreviations and Defined Terms (cont'd)

RAI-MDS – Residential Assessment Instrument-Minimum Data Set

RF – Raw food

RH – Retirement Home

RHA – Retirement Homes Act, 2010

RHRA – Retirement Homes Regulatory Authority

RNAO – Registered Nursing Association of Ontario

RPN – Registered practical nurses

RTA – Residential Tenancies Act

Service offering – the pricing, array and availability of services

1. Introduction

Similar to other jurisdictions in Canada and throughout the developed world, Ontario is experiencing substantial growth in its seniors' population. This is resulting in increased demand for care and support services, with consequent capacity and cost pressures across institutional and home settings. This research examines how government policy reacts with other factors, such as market forces and the characteristics of home owners and operators, to shape seniors' residential care services and their availability in Ontario.

The focus of the study is on two of the main congregate residential care alternatives for seniors in Ontario, which are long-term care homes (LTCHs) and retirement homes (RHs). This research identifies similarities and differences between the two settings in terms of the pricing, array and availability of services (service offering), in the context of differential government funding and regulatory oversight. Particular attention is given to the way owners and operators of homes develop their services in response to existing regulations governing funding and compliance standards, as well as other industry-related factors, such as consumer demand, competition and profitability. The contrast in funding and governance models of LTCHs and RHs in Ontario make this inquiry an interesting case study of the policy effects on service offerings in seniors' residential care.

The research comprises a first phase involving the collection and analysis of descriptive and quantitative data regarding the LTCH and RH sectors, followed by a second phase involving qualitative data in the form of interviews of key informants on issues informed by the first phase.

Interview questions were posed in the second phase to elicit explanations of data collected in the first phase, but also to explore implications of existing and alternative policy directions in the sector.

1.1 Importance of this Research

LTCHs and RHs in Ontario, together referred to in this study as seniors' residential care, represent an important sector within health care because of the number and proportion of seniors in the population, the vulnerability of this group, the high costs of care and accommodation, and the scarcity in term of availability of beds, particularly in LTCHs. The ability of the province to meet the care and support needs of the expanding seniors' cohort will depend on its ability to regulate, fund and guide the operational and investment practices of a sector that is largely private and at arm's length from government.

- **Numbers affected:** As of 2016, RHs in Ontario have capacity for approximately 72,000 residents¹, excluding those homes that are not regulated (i.e., those providing fewer than two care services). LTCHs have approximately 78,000 residents², with another 27,500 on waiting lists.³
- **Vulnerability of this population:** Both RHs and LTCHs are governed by legislation that highlights the need for protection of our seniors' population, particularly those who are compromised in terms of health, access to daily living supports and decision-making capabilities.
- **Cost of care and accommodation:** As of 2016, the cost to the Ontario government associated with LTCH homes is approximately \$4 billion annually, constituting about 8% of the provincial health budget.⁴ In addition to the government expenditures for care, residents of

LTCHs are normally responsible for co-payment charges for accommodation.⁵ For residents in RHs, accommodation charges vary widely, but are often higher than in LTCHs. Care costs in RHs are not eligible for the same public funding as LTCHs, with the consequence that residents bear greater responsibility for their own care costs in RHs. Aside from operating costs, both LTCHs and RHs consume significant capital costs, given the physical infrastructure associated with land, buildings and equipment.

- ***Availability of LTCH beds:*** Most LTCHs in Ontario have extensive waiting lists of applicants, all of whom have been qualified for LTCH residency on the basis of need.⁶ Growth in the supply of LTCH beds has stagnated in recent years, while the population of seniors' over 85 is expected to quadruple over the 20-year period from 2011 to 2031.⁷

In addition to the importance of seniors' residential care as a sector within health care, the relative roles of LTCHs and RHs appear to be changing. In contrast with LTCHs that have become static in numbers, RHs have become more numerous and many now cater to residents requiring higher acuity of care. As such, they have become a prominent alternative to LTCHs. This calls for the attention of researchers and policy-makers to understand the implications of the significant differences between the funding regimes and regulatory structures of LTCHs, as compared with RHs, especially to the extent that the sectors may be serving similar populations.

Ontario proclaimed its first retirement homes legislation into force in 2010, established a governing authority in 2011 and began licensing RHs in 2012. As such, there is a dearth of research examining effects of the new regime for RHs, the effects of similarities and differences between the RH and LTCH statutory regimes, or comparisons of service offerings supplied by RHs and LTCHs in this context.

It is posited that important issues of equity arise from differential access to residential care service and funding dollars for seniors in Ontario. As noted above, while the provincial government covers the costs of nursing, personal support and food in LTCHs, residents in RHs generally cover much of these expenses from their own resources. In addition, while accommodation charges in LTCHs are effectively rent controlled, these costs in RHs range broadly, depending on location and amenities provided. Given the cost differentials faced by the individual between LTCHs and RHs, seniors may experience financial hardship if faced with the prospect of receiving care in a RH at their own expense, at least until a LTCH bed becomes available.

To the extent equity of access to residential care turns on government funding, there are broader – and unanswered – policy questions at play, including *what* care or support services governments should be responsible for financing, and *who* should receive public dollars for residential care. Here, principals of universal coverage that so often inform the discourse of Canadian health care may conflict with social models based on need, affordability and the differential abilities of individuals to pay. While these issues are not easily solved, policy makers need to weigh the expectations of stakeholders and citizens against the resources of government and individuals.

Regulation of RHs has introduced a different set of rules and care requirements, regulatory body, and inspection regime from that of LTCHs. As RHs continue to serve more high acuity seniors, questions arise as to whether the use of two different regulatory structures can ensure the

necessary clarity and consistency to protect the interests of residents and whether some amalgamation of these structures is prudent or manageable.

Of particular interest in this study is how the various policy instruments that determine funding, care and safety affect the strategies of owners and providers of seniors' residential care regarding the care services offered, costs charged to residents, locations of homes and occupancy levels.

As such, this study focuses on factors that determine the supply of residential care services, rather than the resident-consumer accessing those services. The importance of understanding the supply of services is accentuated in circumstances where the resident-consumer has limited ability to exercise consumer choice and must therefore take what is available. Choice, here, includes both *whether* services are accessed, and *where* they exist. In cases where care services represent needs rather than wants – for example, services related to feeding, dementia, incontinence or wound care – the consumer may have no discretion to forego services.

Furthermore, where the supply of residential care services is capacity constrained as evidenced by waiting lists, or priced beyond one's budget, the consumer is likely to have little choice as to where services can be accessed. Considered from this perspective, the interests of seniors engaging residential care services can be served by understanding those supply factors that are outside their control, yet within the purview of policy makers able to influence the strategies and service offerings of the owners and operators providing these services.

While this research inquiry examines Ontario as a case study, it has relevance for all provincial and territorial jurisdictions in Canada. As distinct from “medically necessary” services provided by physicians and hospitals, the services provided in LTCHs and RHs are not classified as

insured services within the *Canada Health Act* (CHA)⁸. Instead, they fall into the category of “extended health services” which are governed by provincial and territorial legislation, resulting in differences across the country in terms of service offerings and public-versus-private responsibilities for the cost. As such, each jurisdiction within the country faces issues similar to those in Ontario, with corresponding demographic and care issues and increasing demands on publicly and privately paid residential care options.

1.2 Research Objectives

This research study is based on the following query: How does the differential use of policy instruments (such as government funding, licensing, regulatory standards, and compliance) interact with other factors (such as market forces, ownership models and organizations’ characteristics) to shape the service offerings in seniors’ residential care (such as service array, care levels, location, pricing and occupancy/availability)? Three operational research questions are used to address this query and these questions are detailed below.

Ontario’s LTCHs and RHs provide an interesting case study for this research, as the two sectors feature significantly different uses of policy instruments, possibly resulting in different service offerings. The relevance of these differences will depend, in part, on the extent to which LTCHs and RHs serve similar groups of seniors with similar care and support needs. The first question therefore asks:

1. To what extent is there convergence between LTCHs and RHs in Ontario in terms of the care services provided and the people served, with particular attention to the effect of

differences and similarities in the government funding and regulation/inspection regimes as between the two sectors. This question is the subject of Phase 1 of the study.

To answer this question, and to understand the service offerings and regulatory environment in the sector, the study involved gathering descriptive data for both LTCHs and RHs and asking:

- (i) What is the regulatory framework (purposes, funding, governance, residents' rights and remedies, safety and security, care services, staffing)?
- (ii) What are the numbers and locations of homes and residents (geographic dispersion of homes, migration of residents, wealth effects on choice, health indicators by geography)?
- (iii) What are the sectoral characteristics (market concentration, ownership type, barriers to entry, economies of scale, profitability and return on capital, business risks)?
- (iv) What is the prevalence of care services and amenities?
- (v) What are the costs of accommodation and care? and
- (vi) What are the occupancy rates, vacancy rates and waiting lists?

While answers to question 1 provide detailed information of a descriptive nature about the sector, they cannot on their own, explain how the resulting service offerings are a product of antecedent policy instruments or other factors. Phase 2 of the study therefore engaged key informants to ask:

2. How can the Phase 1 findings about service offerings be explained in terms of strategies pursued by the owners of LTCHs and RHs and how, in turn, are those strategies related to antecedent policy instruments or the interaction of policy instruments with other factors?

To address the effect of policy instruments on the strategies and service offerings of owners of homes, interviews were conducted with key informants to understand:

- (i) What are the key risk/return criteria in the seniors' residential care business?
- (ii) How are decisions made around home location and the array of services?
- (i) How do government funding policies (differentially) affect the strategies or service offerings of RHs and LTCHs?

Building on the answers to question 2, the study uses the input from key informants, the integration of information from Phase 1, and background research referenced in this study, to explore answers to the question:

3. What are the implications of current government funding and governance policies regarding seniors' residential care in Ontario, and what are the merits of considering modifications to existing policies instruments or the introduction of new ones? Through interviews with key informants, this question explored issues related to:

- (i) Funding of services in LTCHs on a differential basis than in RHs;
- (ii) Funding directed to the LTCH, rather than to the eligible senior or to a care service or residence that meets the senior's needs;
- (iii) Funding of professional/medical services such as nursing, as compared with personal services such as bathing and dressing;
- (iv) Funding based on a resident's needs, even where they have the means; and
- (v) Differential versus common governance frameworks for the two categories of homes.

1.3. Thesis Outline

In addition to this introductory chapter, this thesis contains the following chapters:

- Chapter 2 provides background on the seniors' residential care sector, including the organization of services in Ontario, the regulatory regime, economic forces and capacity pressures within the sector.
- Chapter 3 outlines the conceptual framework used to guide the inquiry and defines the key concepts related to it.
- Chapter 4 lays out the research design and methods, including the research questions for the study.
- Chapter 5 details the Phase 1 findings and addresses research question 1 by providing information that is descriptive of the service offerings and regulatory environment in the seniors' residential care sector.
- Chapter 6 presents the Phase 2 findings, including summaries and analysis of responses to the interview questions posed and addresses issues raised in research question 2 related to the strategies of owners.
- Chapter 7 provides an analysis of the findings in Chapter 6 to discuss and integrate the findings in the context of Phases 1 and 2, and presents study results in terms of the conceptual framework introduced in Chapter 4. This Chapter addresses issues raised by research question 3.
- Chapter 8 summarizes the conclusions and limitations of the study and comments on the implications for policy and for research.

2. Sector Background

This Chapter provides background information regarding seniors' care and support services in Ontario, including services offered in the home, the community and in congregate settings. It then describes the legislative and regulatory structure in Ontario that governs the provision of seniors' care, including both federal and provincial statutory and regulatory instruments to which seniors' residences are subject. Following these descriptive sections, the Chapter discusses several sectoral issues that have important policy ramifications for governments charged with funding and governing seniors residential care.

2.1. Seniors' Care and Support Services in Ontario

Seniors' care generally comprises both residential care, such as LTCHs and RHs, and home or community care, where seniors receive services in their homes or within their local community. For recent Ontario governments, the provision of home and community care (HCC) has been an important and favoured policy option for the funding and delivery of care and support for seniors.

HCC includes categories of service that are both professional services (e.g., nurses) as well as personal care support.⁹ *Home care services* generally include nursing, therapies, homemaking, and other supports that are provided by personal support workers (PSWs), who visit seniors in their own homes. *Community services* include non-clinical supports such as meals, transportation, supported living, home help and other assistance. In Ontario, HCC services may be purchased privately by consumers using personal funds, or may be provided through support service agencies with funding provided through provincial or municipal government budgets.

Where these services are funded by the provincial government, funding flows from the Ontario Ministry of Health and Long-Term Care (MOHLTC) to one of the 14 Local Health Integration Networks (LHINs) in the province. The LHINs each have a distinct geographic area within the province and are responsible for the planning, integrating and funding of health care within their respective regions. This entails managing a wide range of service providers in HCC, as well as the LTCHs. At the time of undertaking both the Phase 1 and 2 research for this study, the province also maintained 14 Community Care Access Centres (CCACs) with geographic responsibility that aligned with the LHINs, and which were directly responsible for the coordination and delivery of in-home and community-based care at the local level through service agency agreements. To be eligible for services through a CCAC, a person was required to participate in an initial assessment by the CCAC in order to evaluate needs.¹⁰ It should be noted that as of May, 2017, the process was underway to eliminate the CCACs and to transfer HCC services to the LHINs, pursuant to Ontario's Bill 41, *Patients First Act, 2016*.

As distinct from the HCC sector, the senior's residential care sector comprises care options of a live-in nature, of which RHs and LTCHs are two of the main alternatives available. RHs and LTCHs share many similarities, as both (i) cater primarily to seniors, (ii) involve provision of care, (iii) are residential/institutional in nature, and (iv) are regulated by the Ontario government specifically with regard to the care provided. RHs and LTCHs are not direct substitutes – residents of RHs vary widely in terms of their care needs while residents of LTCHs generally require a high level of care. However, they represent positions on the care continuum with considerable overlap, particularly where RHs provide a higher level of care or where seniors default to RH accommodation in response to long waiting lists for LTCHs.

In Ontario, LTCHs and RHs are primarily owned by for-profit corporations (FPs) with the balance owned by not-for-profit firms (NFPs) and municipalities.³ Owners of RHs and LTCHs that have an economic interest in the home (referred to as Owners) are private and public corporations, including both FPs and NFPs, and government entities. In terms of firm characteristics, these companies comprise a mix of small corporations, registered charities and foundations, municipalities, religious and community groups, and large national chains.

In addition to the home, community and residential care alternatives described above, there are numerous supportive housing programs available to seniors in designated residential buildings who require daily personal support and essential homemaking to live independently. According to the Ontario Supportive Housing Policy Framework¹¹ established by the Ministries of Municipal Affairs and Housing, supportive housing includes a combination of housing support and assistance that enables people to live as independently as possible in their community. It includes different forms of housing assistance, such as rent supplements and housing allowances and different housing types, such as individual units and dedicated buildings. Supports also vary in intensity according to people's needs. According to the Ontario Community Support Association, services typically include meal preparation, medical reminders, light housekeeping, personal care, shopping, and exercise support, though the level of service provided in supportive housing varies widely by provider and community. Similarly, the category of individuals eligible for supportive housing will depend on the setting and may include the frail elderly, people with physical disabilities, people with acquired brain injuries and those living with HIV/AIDS, among others.¹²

Aside from the various care settings for Ontario's seniors, numerous alternatives in the form of seniors' apartments exist for those who can live independently but who wish to live in a community designated for seniors. Typically, seniors' apartments provide social or recreational programming. Individual units may have emergency call systems, though normally there are no regular care services provided through management. Seniors apartments are governed by the *Residential Tenancies Act*, as is the case with any domestic rental setting in Ontario.

The various care and support services and modes of accommodation should not be regarded as mutually exclusive. For example, a senior living in a RH or a seniors' apartment may purchase HCC services privately and may also be eligible to receive such services through government-paid channels such as the CCAC or LHIN, provided eligibility is established through the assessment criteria referenced above.

2.2. Legislative Jurisdiction over Seniors' Residential Care

From a constitutional perspective, matters related to health and health care have never been explicitly either federal or provincial jurisdiction. However, exclusive provincial responsibility for the direct delivery of most health services is generally agreed to derive from the powers over property and civil rights (section 92(13)) and matters of a merely local or private nature (section 92(16)) in the *Constitution Act, 1867*.^{13,14} The federal power over matters related to health comes principally from its spending power, which is inferred from Parliament's jurisdiction over public debt (s.91(1A)) and general taxing power (s. 91(3)). As such, Parliament may raise money by taxation and may spend it, grant it to others, or set conditions for the receipt of money.

The federal CHA, therefore, derives its constitutional authority from *financing* of health care, rather than health care directly, and the standards it establishes are the conditions that the provinces must meet to receive federal money.¹⁵

Section 2 of the CHA distinguishes between (i) “insured health services”, which are defined as hospital services and physician services, and are seen to be “medically necessary”, and (ii) “extended health care services”, which are “provided for residents of a province” and include nursing home, adult residential care, home care and ambulatory health care services. The distinction between these categories has important implications. Extended health care services are not required to be insured under the government-run Ontario Health Insurance Plan (OHIP) and are not subject to the provisions in the CHA, which prohibit user charges and extra-billing. In addition, these services are not required to be publicly administered, universal, comprehensive, accessible or portable, which are the five criteria that qualify provincial health insurance plans for the full cash contribution from the federal government (s.7).

LTCHs and RHs fall into the category of extended health services defined above, as do HCC services. Both LTCHs and RHs are subject to provincial legislation that governs their operation and funding. LTCHs are governed by the *Long-Term Care Homes Act, 2007* (LTCHA)¹⁶ and Ontario Regulation 79/10 (O.Reg.79/10)¹⁷. Section 155(1) of O.Reg.79/10 stipulates that LTCHs cater to residents requiring 24-hour nursing care, assistance or supervision. RHs, as examined in this study, are those governed by the *Retirement Homes Act, 2010* (RHA)¹⁸ and Ontario Regulation 166/11 (O.Reg.66/11).¹⁹ The RHA defines RHs in section 2 as those residences occupied primarily by persons over the age of 65 where the operator provides at least

two care services. As defined in subsection 2(1) of the RHA, “care services” are similar to “care and services”, defined in s.8 of the LTCHA. As used in this study, the term care services comprises all nursing and personal support services, and activities of daily living (ADLs), such as eating, bathing, dressing, toileting, transferring/walking and continence.

High-level residential care services of the type offered in Ontario’s LTCHs exist in all provincial and territorial jurisdictions in Canada and are governed by statutory and regulatory regimes similar to Ontario. The LTCH-equivalents in other Canadian jurisdictions are typically government funded in a manner similar to Ontario.

From a regulatory perspective, LTCHs and RHs in Ontario are treated quite differently. The Ontario government funds LTCHs for the cost of nursing, therapies and food on a per-resident basis, while the corresponding costs in RHs are funded principally by residents. Governance also differs between the groups. LTCHs are governed by the MOHLTC and service accountability is to the Local Health Integration Networks (LHIN). RHs are governed by a non-government authority called the Retirement Homes Regulatory Authority (RHRA). The board of the RHRA is made up of representatives from the retirement home industry, business, government and consumers, and is ultimately responsible to the Ontario Seniors Secretariat, which was established by the Ontario government in 1982 to undertake and support policy and program initiatives on behalf of the province’s seniors.

Residential and care services comparable to those of Ontario’s RHs differ significantly by province. From a regulatory perspective, there is no standard form of governance or regulation for such facilities. For example, the *Community Care and Assisted Living Act (2004)*²⁰ sets

licensing, safety, health and staffing requirements of RHs in British Columbia, but facilities of a similar nature in other provinces are not regulated or licensed uniformly across the country.

From a funding perspective, British Columbia publicly subsidizes the cost of assisted living for seniors, which includes the cost of assistance with ADLs due to health-related problems.

Assisted living residences in the province take many forms, including units in an apartment complex, or other congregate settings. Residents pay a monthly rate based on income, subject to minimum and maximum monthly rates. Rates are based on 70% of after-tax income with the minimum rate for a single client receiving assisted living services set at \$931.50 per month for 2017.²¹ The Alberta equivalent of assisted living, which serves the needs of seniors requiring support, is called supportive living. Alberta Health Services (AHS) provides publicly funded continuing care health and support services to residents in supportive living settings. To be admitted to supportive living settings that have a contract with AHS for health and personal care services, individuals must be assessed by an AHS case manager to determine their unmet health needs. There are 28,600 supportive living residents in more than 780 licensed supportive living settings in Alberta.²²

2.3. Emerging Tensions and Trade-offs in Seniors Care

While the previous sections of this chapter describe the sectoral and legislative features of seniors' care in Ontario, there are several issues emerging in the sector that place tensions on governments charged with funding and governing seniors residential care. Five of these are presented in this section. First, as governments look to defray the cost and demand for residential care by diverting seniors to less expensive HCC solutions, there are limits to home and community alternatives that include inefficiencies of delivery and the challenges of serving

seniors with 24-hour needs for care or monitoring. Second, and conversely, the residential care model as offered through LTCHs in Ontario represents an expensive form of care, and efforts by government to restrict the issuance of new home licenses can result in shortages of beds. A third challenge, also in part financial, concerns the trade-off between universality of care programs where the goal is to include all seniors within available budgets, and comprehensiveness aimed at maintaining the breadth of care services offered in the residential setting. Unfortunately, compromises may be necessary to the extent that a greater breadth of services to be funded can result in a smaller group of seniors that the government can afford to fund under the same program. Fourth, in relation to regulatory compliance, efforts of governments to ensure safety and quality of care through strict regulation may negate trust in Owners and restrict choice and flexibility for both the providers and users of residential care. A fifth issue concerns the emergence of self-directed funding models in numerous jurisdictions – which is now being considered in Ontario – and the competing goal of governments to control the costs, uses and quality of the care services purchased. Each of these issues is explored below.

2.3.1. Limits to the HCC Alternative in Ontario

In recent years, numerous Ontario government initiatives have highlighted the role of HCC in catering to the care needs of the province's seniors. In 2012, the MOHLTC issued *Ontario's Action Plan for Health Care (Action Plan)*²³ with broad ambitions to make Ontarians healthier while observing budgetary discipline. The Action Plan called for a seniors' strategy that would focus on seniors staying at home longer. The Action Plan was followed by the Province's *Patients First: Action Plan for Health Care*²⁴, with one of its four pillars being the delivery of

better coordinated and integrated care in the community. In 2015, the MOHLTC released *Patients First: A Roadmap to Strengthen Home and Community Care (Roadmap)*²⁵, which was directed specifically at HCC and was informed by the MOHLTC's expert group on HCC, led by Gail Donner, and its report, *Bringing Care Home*²⁶.

Through these various documents, the MOHLTC has detailed its goal to make HCC central to health policy for seniors in Ontario. This goal is predicated on both the preference of people to remain at home and in the community as long as feasible and the high cost of residential care to government, patients and their families. Indeed, as *Bringing Care Home* points out, there is much that can be done to expand and improve HCC to help meet the demand for seniors' care. These initiatives can ultimately eliminate or postpone the move to LTCHs for many people.

Research studies conducted in Ontario have shown that many seniors could remain at home longer if they were given the right support. Individuals assessed as having sufficiently high needs to qualify for LTCH placement in Toronto were found to have been cared for adequately in their homes through community supports.²⁷ It has also been found that a lack of informal caregivers and community-based care capacity increased the risk that seniors would be admitted to LTCHs despite relatively low impairment in ADLs or cognition.²⁸ Furthermore, this was a greater concern in rural areas that had more limited community supports than in urban areas.

Others argue that, despite efforts to keep seniors in the community longer, there are limits to what can be achieved. An April, 2016 position paper by the Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) points to the increase in the seniors' population in

Ontario while LTCH capacity in Ontario remains “capped” at approximately 78,000 beds²⁹. They reference an internal study done to investigate the level of acuity of seniors entering Ontario’s LTCHs between July 2009 and March 2012, which found that only 1.1 per cent of LTCH residents could have entered supportive housing and that only six per cent could have received care in the community, as an alternative to accommodation in a LTCH. A more recent study in Ontario, looked at the level of need and divertibility of newly admitted LTCH residents between January 1, 2010 and March 1, 2012 and found that the majority had high levels of need and only 5.4% could have been cost-effectively diverted to the community, suggesting that the system is at capacity.³⁰

The debate as to what proportion of seniors’ care can be accommodated by HCC as opposed to residential care turns, in part, on (i) the availability (and attributable cost) of informal caregivers, including family members, to provide care and (ii) the acuity level at which care resources become less efficient or more expensive per person in the home than in a congregate/residential setting.

A shortage of informal caregivers can be expected to arise, not simply because of the increasing numbers of seniors who require care, but by the trend towards smaller families (i.e., fewer children to provide care). This ratio is apparent in Ontario’s dependency ratio, which compares the population aged 0–19 and 65+ (the numerator, which is a gauge of those who are considered dependent) to the population aged 20–64 (the denominator, representing those on whom others are assumed to “depend”). The Ontario Ministry of Finance projects an increase in the dependency ratio through 2041, as follows:³¹

Table 2.1. Ontario Dependency Ratio (%) Projection

	<u>2016</u>	<u>2021</u>	<u>2026</u>	<u>2031</u>	<u>2036</u>	<u>2041</u>
Total dependency ratio, Ontario (%)	61.8	66.4	73.7	80.5	83.7	84.2

The dependency ratio statistic is often used for economic applications, as the 20-64 age group is considered to be of working age. In fact, a 2012 Statscan study calculates the average age of retirement in Canada at 66.³² This working-age group is also a relevant group to consider in terms of providing care to both children and aging parents. In the case of seniors' care, a confluence of factors has been cited for exacerbating the pressure on informal caregivers in OECD countries with aging populations. These include the increase in the proportion of women working, the emergence of social policies that no longer support early retirement, and looser family ties.³³

In addition to the scarcity of informal caregivers is the cost, often not considered, of their time commitment. In examining the costs incurred by families in providing home care, a 2008 study conducted in Ontario concluded that there is a poor understanding of the economic outcomes and determinants of privately financed services.³⁴ Researchers concluded that the mean total cost of home care for a four-week period was \$7,671 (in 2004 \$Cdn), with the majority of these costs (75%) associated with private expenditures, primarily the cost of time spent by informal caregivers. Expenditures increased with age, ADL impairment and the number of chronic conditions. Of note was the estimation of time costs of informal caregivers, which was done by assigning a monetary value to each unit of time spent. These results contrast with those of a 2004 study conducted in Victoria B.C. and Winnipeg, Manitoba that calculated the monthly cost

of community care to be approximately \$2,500 per month, again including hourly costs attributable to informal care.³⁵ This cost was compared with a considerably higher monthly cost of a LTCH and therefore represented the preferred alternative for those able to be accommodated in the community.

Rising acuity levels in LTCHs in recent years suggest that fewer LTCH residents could be cared for safely and economically in the community, even with greater supports. According to the OLTCA's 2015 Pre-Budget Submission to the Ontario Government,³⁶ 85% of 2012 admissions to LTCHs from the community, and 78% from hospitals, had high (4) or very high (5) acuity scores according to the Method for Assigning Priority Levels (MAPLe), while fewer than 1% of new long-term care admissions were low-needs clients with scores of 1 or 2. MAPLe is a decision support tool which assigns individuals to five priority levels, based on their risk of adverse outcomes. Those in the highest priority level show a presence of ADL impairment, cognitive impairment, wandering, or behavior problems, while those in the lowest priority level have no major functional, cognitive, behavioral, or environmental problems and are considered self-reliant.³⁷ The OLTCA submission also points to prevalence rates of endocrine, metabolic, pulmonary and heart/circulatory diseases similar to patients in complex continuing care and notes that the prevalence of serious medical conditions increased steadily in LTCHs between 2008/09 and 2013/14. Conditions such as dementia, and even reliance on assistance for certain ADLs such as feeding and toileting can require residents to seek 24-hour monitoring by a caregiver, which tends to be more efficient in a congregate setting where one nurse or PSW can attend to or check on several seniors in one location. By illustration, the MOHLTC funds nursing and personal care on a 24-hour basis at \$94.37 per person per day in LTCHs (see

Chapter 5.1.2. Government Funding), which can be exceeded by the cost of several hours of home care purchased for an individual.

In addition to issues of capacity and suitability of HCC services to meet the needs of high acuity seniors, there are practical concerns about the inconsistency with which home care services are delivered in the province. One of the initiatives outlined in *Roadmap*, referenced above, was the design of a Levels of Care Framework to achieve greater uniformity in HCC services across the province as well as greater transparency in the way needs of individuals are assessed. It called for a “bold reshaping” of how services are delivered, and significant system-wide improvement to address service and information gaps, which it identified as two of the most commonly heard concerns regarding HCC. The assessment tools used by CCACs to conduct assessments for home care have been observed to lack consistency across the province in terms of the interpretation of the assessment and what services it warrants. There is also variability in the level of publicly-funded home care services that are provided. Individual CCACs receive different per capita budgets without a clear rationale for the differences, with the consequence that the system has been referred to as a “postal code lottery.”³⁸

As noted above, RH residents who are otherwise paying for care support services from their own resources are eligible to receive government-funded services through their local CCAC.

However, a 2015 study examined the use of CCAC services by RH residents and found that RH Owners encouraged their residents to procure publicly-funded services through the CCAC but that, in most cases, residents bore the cost of replacement services if the CCAC services were not

delivered. For the Owners, the poor reliability of CCAC services resulted in disruptions to staff in the home, who had to provide unscheduled care in such cases.³⁹

A 2017 study⁴⁰ conducted in the Hamilton Niagara Haldimand Brant LHIN examined the subset of RH residents serviced by the local CCAC, and particularly how services compared between RH residents and others served in private homes. Despite significantly higher acuity levels among the RH residents (as measured by health conditions, incidence of dementia, use of medication, ADL assistance), RH residents received fewer hours of publicly-funded support service than those in private homes and substantially less nursing time. The study also concluded that seniors in RHs, unlike their counterparts in private homes, were paying privately for a significant portion of their services, particularly nursing, rather than receiving care through the CCAC.

2.3.2. Capacity Constraints in LTCH Beds

As noted in Chapter 1, LTCHs have approximately 78,000 residents, with another 27,500 on waiting lists. Recognizing the limits of the HCC sector to absorb the demand for care among seniors who have high care needs or require regular monitoring, it is worthwhile estimating the trajectory of need for additional LTCH capacity as the seniors' population grows in Ontario.

In a 2014 study commissioned by the Ontario Long-Term Care Association (OLTCA), Preyra Solutions Group (Preyra Report)⁴¹ compared the number of residents placed in LTCHs with an age-standardized rate of admissions of seniors over age 75, using four years of data:

Table 2.2. Rate of Seniors Newly Admitted to LTCHs in Ontario per 75+ Population

Years Ended March 31	2009/10	2010/11	2011/12	2012/13	3Yr +/-
Clients placed in LTCHs	26,367	25,761	26,589	25,890	-2%
Population 75+	992,543	1,023,034	1,065,210	1,102,700	11%
Clients placed per 100,000 75+ Population	2,657	2,518	2,496	2,348	-12%

Source: Adapted from Preyra Report.

As Table 2.2 indicates, client placements fell slightly from 2009/10 to 2012/13. However, given the 11% increase in the 75+ population during the period, the result was a 12% decrease in the rate of placement of seniors in LTCHs.

The Preyra Report considers age standardization as a means to examine the demand for LTCH beds in the future, summarized in Table 2.3. The forecast shown starts with the provincial beds per age group in 2012/13 and projects an increase in beds commensurate with expected population growth by age group in each LHIN. The result is a required increase in beds of 24,962 over the 10-year period, which would represent a significant departure from the apparent stagnation in growth of LTCH beds observed in recent years. In addition to this forecast, the report references a “25th percentile”, which represents the point at which 25% of LHINs have a higher ratio of beds to seniors and 75% have a lower ratio. Under this 25th percentile forecast, LHINs with higher ratios are assumed not to increase the number of beds at the demographic rate until the population of seniors has increased to the point where the ratio is at or below the 25th percentile. Under this scenario, the required increase in beds in the province would be lower, at 18,243.

Table 2.3. Bed Forecast Increase By LHIN With Expected Population Growth

	Actual Beds	New Beds
LHIN	2012/13	2022/23
<i>Erie St. Clair</i>	4,339	1,299
<i>South West</i>	7,161	1,945
<i>Waterloo Wellington</i>	3,839	1,446
<i>Hamilton Niagara Haldimand Brant</i>	10,428	2,721
<i>Central West</i>	3,390	891
<i>Mississauga Halton</i>	4,153	2,103
<i>Toronto Central</i>	5,920	2,387
<i>Central</i>	7,232	3,225
<i>Central East</i>	9,702	2,466
<i>South East</i>	4,125	1,101
<i>Champlain</i>	7,614	1,847
<i>North Simcoe Muskoka</i>	3,055	1,458
<i>North East</i>	4,963	1,755
<i>North West</i>	1,792	318
<i>Province of Ontario</i>	77,713	24,962

Source: Adapted from Preyra Report.

As shown in Table 2.3, only a minimal increase is predicted for the North West LHIN, since population growth is low and there are already relatively high rates of LTCH beds per senior. By contrast, in Mississauga Halton, which has the minimum beds-to-seniors ratio and the population least likely to be admitted to a LTCH, the forecast calls for an increase in beds of greater than 50%.

Understandably, LTCH demand growth is a function of numerous factors beyond age demographics. Many of these factors are examined in Phase 1 of this study and include the availability of informal care, disease prevalence, frailty management, consumer preferences,

income levels, LTCH substitution from hospitals and LTCH substitution to the community. In spite of these many variables, LTCH resources are likely to become increasingly constrained, highlighting the importance of fostering alternatives within the residential care sector. As such, RHs present a viable supplement or substitute for LTCH care and accommodation. Phase 1 of this study includes an examination of the numbers, locations, features, care services offered and costs associated with RHs and will inform an understanding of the capacity of RHs to absorb demand for seniors' residential accommodation. To the extent RHs offer an array of services to seniors across a spectrum of care needs, RHs might also address the desires of many seniors to age in place. Graduated care services may allow seniors to remain "at home" in an RH, while taking advantage of additional services as their care needs increase, and as their personal financial resources permit.

2.3.3. Trade-offs between Universality and Comprehensiveness

Universality implies that all seniors are eligible for the same coverage of government-funded services on the basis of need. While universality answers the question of *who* is covered, comprehensive answers the question of *what* is covered, i.e., what breadth of services is funded by government. Most OECD countries support some form of universal coverage for long-term care benefits, recognizing that pooling the cost of benefits can be an efficient solution where there is uncertainty regarding whether and how long such benefits will be needed by individual seniors. A 2011 OECD study (Colombo Report)³³ makes the observation that universal programs can ensure more equitable access to care than means-tested or social assistance programs – though at a cost – and that there has been a convergence in recent years in OECD countries towards providing a basic floor for coverage. The same study notes, however, that

universality of long-term care benefits does not exclude the concept of *targeted universalism*, where those with the highest needs are targeted for personal care benefits. They cite Germany, Japan, Korea, Sweden and the Netherlands as moving in the direction of targeted universalism. All jurisdictions that attempt to provide some level of universal care for older adults must settle on coverage schemes that are able to balance:

- (i) the eligibility, i.e., the need level that triggers the entitlement to coverage;
- (ii) the breadth of coverage, i.e., the basket of services to be covered; and
- (iii) the depth of coverage, i.e., the extent of public coverage, after which there must be some form of private cost-sharing of long-term care benefits.

With regard to eligibility for coverage, many countries now employ the International Resident Assessment Instrument (interRAI) to assess care needs and devise care plans. InterRAI uses a range of standardized assessment instruments that apply to different care settings, including residential, home care and mental health. Most provinces in Canada are members of interRAI, including Ontario,⁴² where RAI LTCF is used to assess eligibility for the LTCH waiting list.

With respect to the breadth of coverage, jurisdictions vary greatly within the OECD, since long-term care comprises multiple services (e.g., supportive care, nursing care, assistive devices, social work) delivered by different providers (e.g., professional nurses, PSWs) and applied to diverse settings (home, LTCH, community).

Regarding the depth of coverage, the Colombo Report asserts that all public-coverage systems throughout the OECD require users to share part of the cost of personal care, though substantial differences exist between countries. Some countries have used means-tested systems, as evidenced by income or asset thresholds, below which government will set its contribution.

Countries that have used such a system include Slovenia, the U.K. and the U.S. (i.e., Medicaid). Others define the public contribution, with cost sharing applied to the residual. Australia, Austria, Germany and France are in this category. A third group, including Japan, Korea and Belgium, applies flat cost sharing, where a set percentage of the cost is paid by the user.

In Ontario, it is posited that the breadth and depth of public coverage of seniors' care varies markedly depending on the site of care. For those seniors residing in LTCHs, care is quite comprehensive, comprising nursing and support care, food and certain therapies. Furthermore, while there is means testing applied to the accommodation portion in LTCHs for those of low income, there is essentially no assessment of means for the care component. With respect to home and community care, as noted above, comprehensiveness varies across regions of the province and there are limits to the services and time allotments to those of high need. For seniors residing in RHs, public coverage of care services depends on the ability of the resident to access publicly-funded home and community care, with services that are considerably less extensive. Arguably, the universality of the system – the tendency to treat all seniors equitably – is compromised by a system that delivers a different breadth of funded service in different settings.

2.3.4. Stringent Regulation versus Trust, Flexibility and Choice

A recent study by Pat Armstrong⁴³ compares seniors residential care challenges in Norway, Sweden, Germany, the UK, the US and Canada and notes the tendency of governance regimes to impose detailed regulation at the facility level, often as a response to publicly reported scandals or adverse events in the LTCH setting. The study suggests that resort to such strict regulation is

in contrast to the concept of trust, which is understood to assume that homes and their workers have the best interests of residents in mind and are acting on the basis of shared principles or guidelines. In the context of residential care, rules can relate to procedures around dispensing medications, bathing, or where and how seniors take their meals. Armstrong concludes that, particularly in North America, the balance is increasingly tilting towards tighter regulation, reporting, inspection and enforcement. She cites Ontario as an example where many regulations in the LTCH environment have become overly complex, difficult to implement, inaccurately reported and unsuccessful in improving outcomes.

Related to the adverse outcomes to residents from increased regulation, Armstrong points to the unintended consequences of rules aimed at ensuring the safety of residents and the avoidance of risks. Where policies are adopted in response to accidents or complaints, the reaction may be to implement practices that limit unnecessarily the freedom or enjoyment of residents. She cites as examples in Ontario LTCHs, the prevalence of pureed food to avoid choking, wearing bibs to protect clothes and diapers to limit the number of accidents that can result when caregivers are too busy to take residents to the toilet. The greater risk may be that risk avoidance itself takes priority over autonomy and personal fulfillment for the resident. Armstrong's conclusions are consistent with previous research suggesting that quality of life outcomes for seniors in long-term care come second to rules regarding health and safety. In a U.S. study, Kane⁴⁴ found that quality of life domains, which included comfort, meaningful activity, relationships, enjoyment, dignity, autonomy, privacy and individuality, tended to be sacrificed for *technical* quality of care. She concluded that trends in the care of seniors in long-term care, such as the growth in

assisted living, increased attention to physical environments and efforts to foster cultural change in nursing homes may all lead to a more consumer-centered emphasis on quality of life.

2.3.5. Alternative Payment Models versus Controlling Expenditures

There is evidence that consumer choice and flexibility are becoming important features of modern long-term care systems, as a function of growing demand for better-tailored and responsive care requirements. Benefits in the form of personal budgets and cash entitlements have enabled greater autonomy and family choice, with some countries (e.g., Netherlands, Germany, England, Italy) providing both in-cash and in-kind benefits.^{45, 46} A recent examination of self-directed funding models for seniors was undertaken by the Rotman School of Management at the University of Toronto³⁹ and found that jurisdictions outside Canada made extensive use of such models, varying by the level of individual control of funds and the mix of private and public contributions. They noted that the Netherlands, as an example, used personal budgets, managed by the individual, to cover approximately 80 per cent of care requirements for older adults. Such systems necessarily require the establishment of eligibility criteria, which may consider the severity of functional impairment, as well as level of income or assets of the individual. Levels of client involvement vary across different self-directed funding schemes and vary by level of client involvement in the management of the funds. Worldwide, three categories can be ordered according to declining levels of autonomy, including (i) direct payment models, where funds are placed in the hands of the user (ii) financial intermediary models, where oversight of the care expenditure is managed or monitored by a trust or appointed party, and (iii) service provider managed models, where funding is directed to an approved provider.

According to a study by the C.D. Howe Institute⁴⁷, self-directed models have enjoyed considerable success in several European countries, bolstering the satisfaction of seniors and their families by increasing the say they have in their care plans. The authors observed, however, that challenges have been encountered in implementing self-directed plans, which have related to government control over fiscal budgets, approval of the uses to which the funds are committed by individuals, and safeguarding of care quality. They concluded that all countries they studied were able to contend with such challenges to some degree, by restricting the amount of the subsidy given to those with substantial means or available family caregivers, and by careful oversight regarding the use of the cash subsidies.

3. Conceptual Framework and Context of the Study

This research examines how government policy reacts with other factors, such as market forces and the characteristics of home ownership, to shape seniors' residential care services and their availability in Ontario. Figure 3.1 sets out a conceptual framework, which is used to understand how different Owner organizations come to offer different suites of services in residential care for seniors. The framework is derived from SWOT analysis, which considers the internal *strengths, weaknesses* and other characteristics of an organization, as well as the external *opportunities and threats* (or constraints) it faces, which together lead it to the development of strategies to employ in the relevant sector. The theoretical base of SWOT aligns with organizational theory⁴⁸. SWOT analysis is often used in strategic planning, where strengths and weaknesses usually relate to the internal environment of an organization, and opportunities and threats are often associated with the external environment.^{49,50} However, SWOT analysis has been used extensively in other FP and NFP sectors, such as social work⁵¹ and education.⁵² For example, the SWOT model was used to understand the impact of government policy making and funding environment on social work education in Canada.⁵¹

In terms of gerontological theory, the conceptual framework aligns most closely with the *political economy of aging theory*. As McDonald explains, the theory provides a structural perspective on the experience of aging.⁵³ Bengtson, et al. describe the explanatory ability of the theory in terms of interactions of economic and political forces, which determine variations in the treatment and status of older adults.⁵⁴ The political economy of aging theory states that the experience of seniors can be understood by examining public policy and economic forces⁵⁵ and that these factors mold the experience of aging, including the loss of power and autonomy of

older adults. More specifically, the political economy of aging theory has been applied in the health care setting to argue that access to health care for older adults is determined by factors within the political and capital (profit) structure that control their dependencies and access to health care resources.^{56, 57}

Figure 3.1 depicts a process that results in the pricing, array and availability of services provided by LTCHs and RHs. In this framework, it is the Owners who ultimately determine the service offering and the allocation of resources (financial, property and human resources) to be committed to the service offering. For seniors requiring higher levels of care, in particular, it is posited that supply-side factors are critical, since the decisions of seniors to engage care services are dictated more by need than by consumer choice. This lack of choice pertains both to the senior's decision *whether* to obtain the care service and *where* to obtain it. Regarding the former, services such as dementia care, wound care, feeding assistance and even dressing and bathing are generally obtained not because they are desirable or available at a reasonable expense, but because they are necessary for the individual's well-being. Regarding the latter, choice is limited as to where services can be obtained if capacity is constrained, such as the case where waiting lists persist for available or affordable beds. In fact, eligibility of a resident in a LTCH is based on there being no other caregiving or support arrangements available to meet the person's requirements. Subsection 155(1)(d) of O.Reg.79/10 requires that for admission to a LTCH, "the publicly-funded community-based services available to the person and the other caregiving, support or companionship arrangements available to the person are not sufficient, in any combination, to meet the person's requirements."

For both LTCHs and RHs, the decisions around service offering encompass not only what services to provide and at what cost, but whether and how to enter the market, either by way of application for a new license or by purchase of an existing one; whether to upgrade a home; whether to shift the mix to a different level of accommodation or care; or whether to continue offering services at all if the opportunity cost of owning the home exceeds the returns from employing the land in its current use.

With the conceptual framework, the flow is from left to right, beginning with factors that are both internal and external to the organization that can lead to the choice of strategies employed by the organization. In the context of the study, *internal factors* (Box 1 in Figure 3.1) include strengths and weaknesses of the Owner, such as size and scale of the organization, skills and competencies of management and staff and access to financing. Also included are the organizational characteristics of the Owner, such as NFP or FP status.

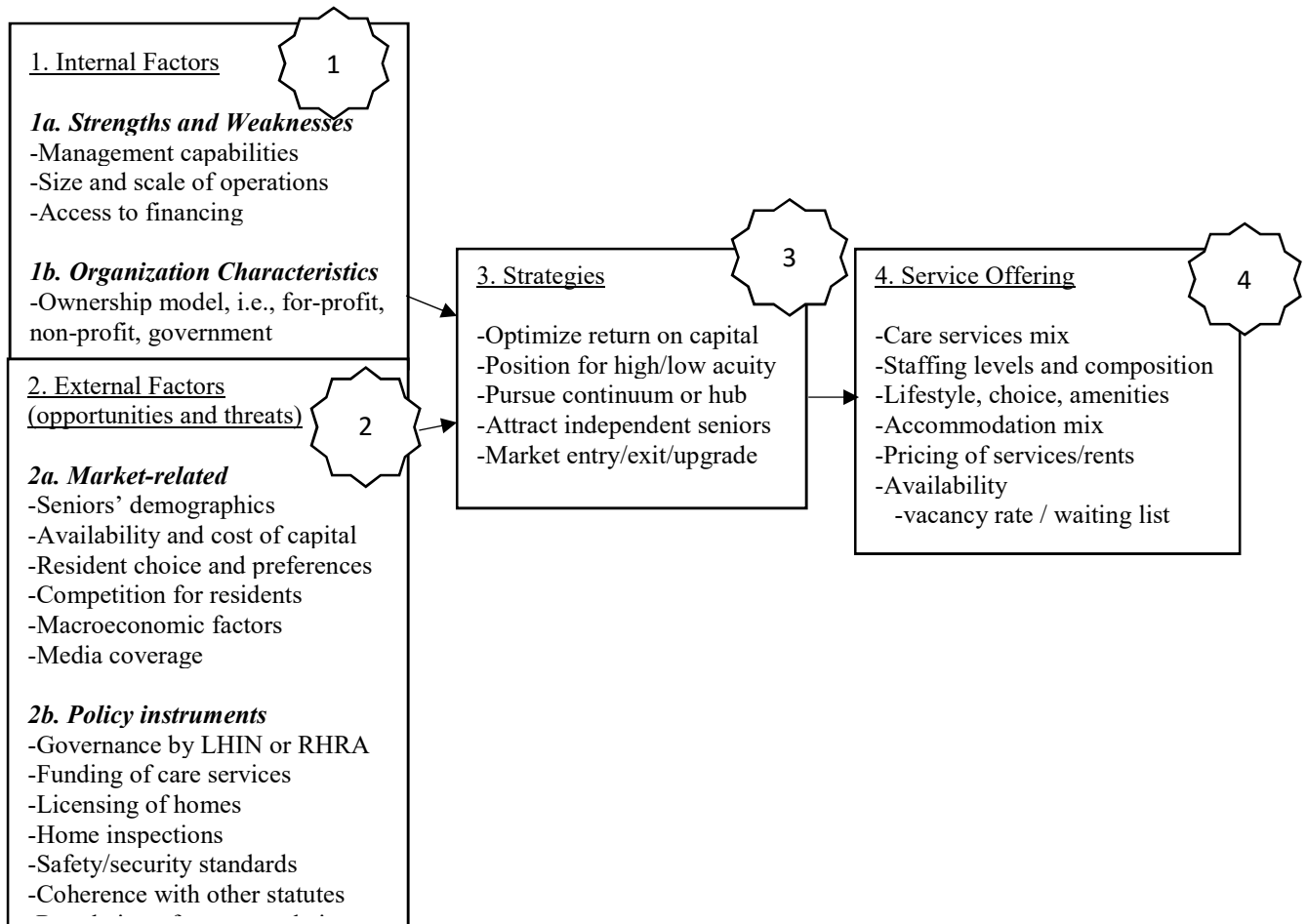
Among the *external factors* (Box 2) are the opportunities and threats affecting Owner strategies, which include consumer preferences, demographics of the resident population and competitive forces within the sector. In addition, and of particular interest in this study, are public policy-related instruments that governments and regulators apply to Owners in the sector. Implicit here is the prospect that market forces, which might otherwise determine the balance of supply and demand between consumers and Owners (as well as the competitive forces among Owners) are altered by governments through policy instruments that include funding envelopes, regulation of accommodation charges and licensing requirements.

In this conceptual model, the strategies of Owners (Box 3) are depicted as following from the internal and external factors. These strategies are represented in decisions of Owners as to which categories of consumers they seek to serve, the levels of care to provide, and how they meet the needs of their own stakeholders, whether shareholders, charities or municipalities.

Finally, while strategies position the Owners within the sector, these strategies lead to more specific decisions around service offerings (Box 4), which include the mix of services and accommodation levels, pricing of services, staffing levels, capacity (which affects occupancy or vacancy rates) and other amenities or lifestyle features that may be critical to attracting and retaining residents in the sector that is of interest to them.

In the context of the study design, the service offering (Box 4 in Figure 3.1) corresponds with Phase 1 of this study, which describes and quantifies the particulars of home locations and numbers, care levels, pricing, occupancy and other sectoral characteristics. Phase 2 provides additional context and examines the qualitative factors that lead to the service offerings. Phase 2 employs interviews with key informants to understand how strategies and decisions are made by Owners (Box 3) and how these strategies are shaped by the internal and external factors, i.e., the strengths, weaknesses, opportunities and threats (Boxes 1 and 2).

Figure 3.1. Conceptual Framework



The balance of this Chapter discusses the more salient categories within the conceptual model that are expected to produce the service offerings described in this study. It also provides an overview of literature that corresponds with factors in the conceptual framework and helps to explain how service offerings emanate from internal and environmental precursors. Among the internal factors of interest in Box 1 are ownership models, especially whether and to what extent an organization's status as a FP or NFP affects strategies and service offerings. In addition, there are numerous strengths and characteristics of individual organizations that may have an impact, such as the scale of operations. Of particular interest is Box 2 of the model, which are the policy

instruments, and which interact with market-related factors, such as demographic forces, competition among Owners, access to and cost of capital, and the evolving demands and tastes of residents.

3.1. Policy Instruments

Christopher Hood developed a taxonomy of policy instruments known as the ‘NATO’ model, which categorizes instruments into four broad resources for governance. These include *nodality*, *authority*, *treasure* and *organization*.⁵⁸ Hood posited that governments utilize these various resources to confront policy problems and manipulate policy actors in order to achieve desired goals. Thus, governments can provide or restrict information (nodality), exercise legal or coercive powers to force others to act in a certain way (authority), apply capital funding for desired purposes (treasure) or step in directly with their own resources and people (organization). A comparison of Ontario’s governance regimes for LTCHs and RHs shows rather different uses of these four categories of instruments, which will be explored further in Phase 1 (see Chapter 5.1.). With respect to the *treasure* category, the MOHLTC funds LTCHs directly in respect of the provision of care services, while this is not the case for RHs. In the exercise of *authority* over LTCHs, the MOHLTC restricts the issue of licenses, defines the purposes to which funding is applied, limits the ability of Owners to earn a profit on care services, implements care and safety standards, and supervises directly the inspection regime over homes. For RHs, authority is exercised through the RHRA, where it is shared among industry, consumer and government representatives. Profitability is not restricted. Though care and safety standards are central to the governance regime, inspection and enforcement are not conducted through a government ministry. In the case of *organization*, government generally does not act directly in the

ownership or delivery of services for RHs or LTCHs, except in the case of municipal ownership of certain LTCHs, which is required by the LTCHA (see Chapter 5.3.2.). However, LTCHs are organized within the purview of the LHINs, whose role, as noted, is to plan, integrate and fund health care within their geographies, on behalf of the MOHLTC. From a *nodality* point of view, information is collected from both LTCHs and RHs with respect to their services and residents and reports regarding compliance and home inspections are made publicly available. However, since RH residents are not required to be assessed by a CCAC care coordinator in order to be admitted, the MOHLTC does not have the same access to the particulars of resident health acuity and care plans that it has with residents of LTCHs. In fact, to carry out this study, information regarding the levels of care provided by RHs had to be gathered from public sources that detail the care services provided by RHs and from accounts of key informants in the sector, rather than from sources that incorporate the acuity levels and needs of the residents themselves.

Within the NATO model described above, the relationship between treasure (i.e., government funding) and authority is perhaps the greatest point of distinction between LTCHs and RHs. Funding to LTCHs for care-related services generally flows through the LHINs according to the contractual terms of accountability agreements with each LTCH. As noted, RHs are not eligible for the same MOHLTC funding. Public policy scholars explain how the willingness and capacity of governments to provide funding go hand-in-hand with the ability to exercise direct authority. Michael Howlett⁵⁹ points out that governments require sufficient financial resources or administrative capacity to justify the use of *first generation* instrument choices, which are those involving direct intervention. Howlett measures the constraints of a state's resources and legitimacy against the nature of the policy target. In doing so, he defines four governance styles,

including, (i) public provision with oversight, (ii) direct subsidization (iii) regulatory corporatism, and (iv) institutionalization of policy networks (see Table 3.1).

Table 3.1. Howlett’s Basic Implementation Styles

<p><u>Low State Constraints re Resources and Legitimacy</u> <i>Public Provision with Oversight</i> Use of governmental organization (personnel and structural) resources to provide goods and services, combined with manipulation of network actors through information release and distribution.</p> <p><i>Directed Subsidization</i> Extensive use of financial instruments to influence market actors coupled with the use of authority to preferentially recognize networks actors.</p> <p><u>High State Constraints re Resources and Legitimacy</u> <i>Regulatory Corporatism</i> Regulation of market actors and financial manipulation of interest articulation systems.</p> <p><i>Institutionalized Voluntarism</i> Exhortation based manipulation of market actors and institutionalization of policy networks.</p>

Source: Adapted from Howlett, *Studying Public Policy*⁶⁰

Governance of LTCHs involves direct funding of operations, control over accommodation charges and, to a limited extent, ownership of municipal homes. With these financial instruments go direct authority over LTCHs to the LHINs, on behalf the MOHLTC.

In the case of RHs, the first three of these governance styles are problematic as they involve some role requiring financial resources, whether by direct government ownership, funding or financial manipulation. Without a willingness to put some form of financing on the table, government is relegated to the fourth model – voluntary institutionalization of policy networks – which cedes a broader role to other players. Some use of regulatory corporatism is also evident in the regulation of market actors through the RHRA, but without financial manipulation, governance of RHs falls within the realm of institutionalized policy networks, where the

complexity of governance is viewed by Howlett as requiring *second generation* instrument choices, defined as those sufficiently flexible as to context and mix. Second generation analysis looks at the complementarities and conflicts within instrument mixes and is more concerned with pragmatism than ideology.

In a similar fashion, Carolyn Tuohy⁶¹ points out that a state's "use of fiscal (as opposed to regulatory or persuasive) instruments simplifies and strengthens lines of accountability" and that "fiscal instruments, then, are not simply inter-changeable with non-fiscal instruments: they provide a clearer identification of responsibility and a relatively stronger set of sanctions" (p. 210). By implication, states that do not bring their financial might to the regulatory arena are more likely to wind up sharing the governance role with others in a loosely coupled network. Such has been the result for RHs, where funding is from private sources, responsibility for observance of care standards is ultimately to the Ontario Seniors Secretariat by negotiated contract, and governance occurs through the RHRA, whose majority is non-government representatives.

The logic offered by Howlett and Tuohy would suggest that, by funding LTCHs, governments are able to exercise greater control over care and accommodation standards, the range of services that can be offered, and issuance of licenses and the frequency of inspection than is the case with RHs. This, in turn, may have differential consequences for LTCHs and RHs in terms of the flexibility they have in choosing their strategies and service offerings.

3.2. Market-Related Factors

Box 2 of the conceptual framework includes factors related to the market for seniors' residential care services. Demographic forces, particularly the aging population and accompanying care needs, are critical market factors that impact Owner strategies and service offerings. Related to demographics are the evolving needs and expectations of residents as consumers of residential services. These are becoming particularly important in the RH sector, where many residents have lower care needs, can exercise greater choice than in LTCHs, and where there is evidence of expanding lifestyle features such as flexible care service options, larger spaces, more activity programs, amenities and services, as well as technological advances (see Chapter 5.3.1.).

Competition among Owners should be an expected feature of an open-market sector. In the RH sector, which is dominated by FPs, and where the ability of Owners to determine services, pricing and location is relatively unfettered, competition is more likely to be the norm. In the case of LTCHs, however, the existence of competition among organizations may be stifled significantly by powerful policy instruments. These include restrictions on the issue of licenses, which has the effect of ensuring near full capacity for all homes, as well as regulations that dictate accommodation charges (see Chapter 5.1.2.) and the suite of care services (see Chapter 5.1.6.), making it difficult for one home to distinguish its services or prices from that of another. Also, to the extent Owners are prevented from earning any margin on the provision of services related to funding envelopes (see Chapter 5.1.2), there may be a reduced incentive to strive for cost-saving efficiencies. In 2012, a Long-Term Care Innovation Expert Panel was convened by the OLTCAs to study and report on the state of the sector and options for renewal. The panel

noted that LTCHs are restricted by the extent of regulation of the sector, making it difficult to innovate or experiment with new models of service delivery.⁶²

A factor that distinguishes the residential care sector from the HCC sector is the substantial requirement for capital in order to fund the cost of land, buildings and equipment. Estimates vary as to the capital costs associated with residential accommodation, but capital costs per bed are likely to average between \$150,000 and \$200,000, including real estate (see Chapters 5.3.6 with regard to return on capital). All Owners in the sector have the same requirement for capital, whether NFPs, FPs or municipalities, though their sources will differ along categories of equity, debt, tax revenues or donor funds. Regardless of the source, all Owners must contend with the cost of capital, often expressed as a capitalization rate, which is the annual percentage return in earnings required to compensate the investor for the time value of money and the risk associated with the business.⁶³ For FPs, the cost of capital is normally returned to the Owner in the form of profits, but for NFPs, the cost of capital employed is represented by opportunity cost, i.e., the return which is foregone by the government, taxpayer or donor that provides the capital without profit.

Issues concerning cost of capital and access to capital have been cited as reasons for the predominant role of FPs in Ontario's LTCH sector. Pat Armstrong⁶⁴ describes the competitive bidding process undertaken by the Ontario government in the late 1990s to build 20,000 new LTCHs as favouring FPs, since FPs – particularly the large chains – had greater access to capital to invest in such project than did charities, municipalities or small family-owned firms. The result was that two-thirds of new nursing home beds were awarded to FPs in the process.

3.3. Internal Strengths: Economies of Scale

One of the more significant strengths that enable Owners to compete in the sector (Box 1) are the size of individual homes and the number of homes in the portfolio. Research has shown that size and scale of operations provide important advantages to organizations from a cost viewpoint. Residential care involves substantial fixed or quasi-fixed costs in the form of land, buildings, equipment, management infrastructure and staff, which are most efficiently spread over larger numbers of residents. In the U.S., for example, it has been shown that lower average costs in nursing homes are associated with a higher number of patients, demonstrating the effect of economies of scale in nursing home care.⁶⁵ A Swiss study reached a similar conclusion, that efficiency gains can be obtained with larger capacities or joint operations in the nursing home sector and that the great majority of the nursing homes in the sample did not fully utilize the benefits of economies of scale.⁶⁶

In the Ontario context, research has also shown that scale of operations is an advantage in contending with the regulatory challenges of operating in the LTCH sector. In studying the rise of chain nursing homes in the province during the 70s, 80s and 90s, Baum observed that strict regulatory conditions, including funding and care standards, have tended to favour FP operators of LTCHs – particularly multi-unit chain operators – for their abilities to realize economies of scale over independent NFP organizations.⁶⁷

In the context of the conceptual framework for this study, the size or scale of a residential care operator may be viewed as a strength or characteristic of the organization (Box 1), but also as a

strategy (Box 3), if the benefits of scale are pursued by means of a growth strategy of the Owner. A growing presence of chains in the seniors' residential care sector could be evidence of a perception by Owners of the advantages of scale.

3.4. Organizational Characteristics: FP versus NFP Ownership

In Ontario, the majority of LTCHs and almost all RHs are owned by FPs (see Chapter 5).

From a legal perspective, the principal distinction between NFPs and FPs in Ontario relates to what NFPs are permitted to do with profits. Ontario's *Not-for-Profit Corporations Act, 2010*⁶⁸ (NCA) received royal assent in 2010. Still awaiting proclamation at the time of writing, it will replace provisions in the *Corporations Act*.⁶⁹ As described by the Ontario Ministry of Government and Consumer Services' Guide to the NCA⁷⁰, a not-for-profit corporation may earn a profit, provided it is used to further the purposes of the corporation and is not paid to its members. The relevant section to be replaced (126) in the *Corporations Act* states that "a corporation, shall be carried on without the purpose of gain for its members and any profits or other accretions to the corporation shall be used in promoting its objects." Thus, under either statute, as long as profits of the NFP are used to advance the provision of long-term care for seniors, the significance of incorporating a LTCH as a NFP versus a FP may not be determinative of its financial management practices.

Considerable research has focused on the differences between FP and NFP organizations and how they approach their markets and service offerings. Research regarding the role of FPs in health service delivery is made more complex by a socio-political debate on the subject. It has been noted that proponents of the profit model often attribute superior health outcomes to

competitive market incentives to innovate, control costs and meet consumer needs.⁷¹ Against this rationale, others assert that FPs are more likely to benefit from – or take advantage of – asymmetrical information, or situations where they know more about market demand, cost, care requirements or quality than care recipients do.⁷²

At the policy level, there are strong views that governments, rather than corporations, should assume the principal role in health care due to the failure of markets to achieve important social goals. An examination of the Canadian perspective highlights the debate⁷³ in view of the Romanow⁷⁴ and Kirby⁷⁵ reports on health care, both released in 2002. While the Kirby report was inclined to consider various delivery models for health services, the Romanow report viewed health care as a moral enterprise rather than a business venture and that direct health care services should therefore be confined to NFPs and public health care facilities. Interestingly, despite the preponderance of FP Owners of LTCHs, the preamble to the LTCHA highlights the importance to “the people of Ontario and their Government” of promoting the delivery of LTCH services by NFP organizations.

In the context of the conceptual framework, the research literature situates FP status not only as a characteristic of organizations in the seniors’ residential care sector, but also in terms of the strategies that FPs are seen to pursue in the market (Boxes 1 and 3 of Figure 3.1). These strategies have been shown to include the propensity of FPs to focus on services and markets where they are more likely to maximize profits.^{76,77,78} As it relates to the conceptual framework, relevant strategies may include pricing decisions, targeted segments of the consumer (resident) markets, and levels of care or preferred geographies. In this regard, FPs have been found to be

more likely to focus on patients who had diagnoses requiring lower-skill requirements or less intensive care.⁷⁹ Other research relates the profit imperative of FPs to incentives to employ fewer staff.⁸⁰ As Deber noted in a paper prepared for the Romanow Commission,⁸¹ the desirability of FP delivery depends on how the profit is made. Net benefits can occur where efficiencies are derived from economies of scale or from better management, but problems can occur if savings are generated at the expense of service quality.

While the current study does not examine service offerings as they relate to resident experience, numerous studies have found evidence of poorer quality of care as a result of FP strategies. FPs have been shown in an American study to score worse than NFPs on the basis of clinical criteria related to “avoidance of hospitalization”.⁸² Similarly, acute care hospital readmission rates in Manitoba were found to be higher among FP long-term care facilities because of quality of care related diagnoses, as compared with NFPs.⁸³ A further study based in British Columbia found that hospital readmission rates for six care-sensitive diagnoses were higher among FP long-term care providers than among NFPs.⁸⁴ Not all research concludes that care quality can be related directly to profit status.⁸⁵ Indeed, literature from jurisdictions outside Ontario may have limited relevance, given (i) the stringent regulatory requirements around care standards in Ontario and (ii) a regime that requires all care funding from public sources to be applied to specific purposes/envelopes or be refunded to the MOHLTC, substantially eliminating the ability or incentive of homes to profit from underfunding care services.

There is a considerable body of literature that examines the strategies and service offerings of LTCHs in terms of staffing decisions. This research, which is mostly in the U.S., links higher

direct-care staffing levels in LTCHs to better care outcomes. For example, staffing information from California nursing home cost reports and onsite interviews showed that the highest-staffed homes had significantly lower resident care loads (patient-to-staff ratio) and performed significantly better on care processes implemented by nursing staff compared to lower-staffed homes.⁸⁶ A 2006 literature review of the research on staffing and care quality in LTCHs⁸⁷ concluded that minimum staffing levels of nursing and care aides are effective in preventing adverse outcomes, such as functional decline and pressure ulcers^{88,89,90,91,92} and that staffing levels of nursing and personal care are associated with outcomes related to activities of daily living, food and fluid intake.^{93, 94, 95,96} Research regarding staffing levels in seniors' residential care is often related to the debate regarding NFP and FP providers. This is because several studies have connected lower staffing levels of FPs with poorer quality. In the U.S., a comparison of FPs with NFPs in the hospice sector concluded that FPs served significantly more patients per health care worker and that the employee-to-patient ratio related directly to quality.⁷⁶ In Canada, a British Columbia study determined that the mean number of hours spent by direct-care and support staff per resident-day was higher among NFP than FP long-term care facilities across all levels of care.⁹⁷ A study conducted in Ontario and Manitoba found a similar relationship in home care agencies between home care quality indicators (HCQIs) and the number of clients per case manager.⁹⁸ Agencies with fewer clients showed better quality on the HCQI basis, though in this case, the relationship was evident in both FP and NFP facilities.

Specifically in Ontario, it has been shown that LTCHs owned by governments (mostly municipalities) tend to have higher levels of nursing intensity and higher levels of direct care staffing than other ownership types, while FP staffing levels are significantly lower.⁸⁵ NFP

operators were found to have higher ratios of administrative staff to care staff than either government-owned or for-profit facilities. Indeed, research in Ontario indicates that there is wide variation in the staffing levels observed in different LTCHs, despite the fact that government funding envelopes for all Owners (NFPs and FPs) are calculated on the same basis. In an independent review of staffing in Ontario LTCHs, it was noted that the average number of paid hours of nursing and personal care per resident per day ranged between 0.9 hours to 5.1 hours depending on the home.⁹⁹ In addition, resident-to-staff ratios can vary considerably throughout the day or week. This variability may be due to the fact that, despite the parity in government funding envelopes, the LTCHA does very little in terms of prescribing minimum staffing levels in LTCHs (see Staffing Levels, Chapter 5.1.7), or that NFP and municipal homes are able to supplement their staff complement from additional funding sources (see Ownership Type, Chapter 5.3.2.).

3.5. Summary

The features and availability of services offered by LTCHs and RHs can be explained in terms of antecedent factors in policy instruments, market dynamics, and characteristics of provider organizations. These factors help to construct, or even distort, the service offerings through regulation, enforcement, financial incentives and disincentives and restrictions of supply. The result can be an uneven pattern of care services and inequities of access between LTCHs and RHs, between geographies and between wealthy and poor. The conceptual framework used in this study is employed to help explain the role of policy instruments in bringing about some of these gaps, many of which may be unintended.

4. Research Design and Methodology

This study is designed to accommodate (i) the collection of descriptive information about the seniors' residential care sector from various government, industry and academic sources, followed by (ii) interviews with key informants to understand the qualitative factors that produced the current service offering in the sector, and the role that policy does and can play in forming or reforming those service offerings. This Chapter begins with the research questions posed in the study and then outlines the design and methods employed to answer the research questions.

4.1. Research Questions

As stated in Chapter 1, this research study is based on the following query: How does the differential use of policy instruments (such as government funding, licensing, regulatory standards, and compliance) interact with other factors (such as market forces, ownership models and organizations' characteristics) to shape the service offerings in seniors' residential care (such as service array, care levels, location, pricing and occupancy/availability)? Three operational research questions are used to address this query. The first question asks:

1. To what extent is there convergence between LTCHs and RHs in Ontario in terms of the care services provided and the people served, with particular attention to the effect of differences and similarities in the government funding and regulation/inspection regimes as between the two sectors? This question is the subject of Phase 1 of the study.

To answer this question, and to understand the service offerings and regulatory environment in the sector, the study involved gathering descriptive data for both LTCHs and RHs and asking:

- (i) What is the regulatory framework (purposes, funding, governance, residents' rights and remedies, safety and security, care services, staffing)?
- (ii) What are the numbers and locations of homes and residents (geographic dispersion of homes, migration of residents, wealth effects on choice, health indicators by geography)?
- (iii) What are the sectoral characteristics (market concentration, ownership type, barriers to entry, economies of scale, profitability and return on capital, business risks)?
- (iv) What is the prevalence of care services and amenities?
- (v) What are the costs of accommodation and care? and
- (vi) What are the occupancy rates, vacancy rates and waiting lists?

While answers to question 1 provide detailed information of a descriptive nature about the sector, they cannot on their own, explain how the resulting service offerings are a product of antecedent policy instruments or other factors. Phase 2 of the study therefore engaged key informants to ask:

- 2. How can the Phase 1 findings about service offerings be explained in terms of strategies pursued by the Owners of LTCHs and RHs and how, in turn, are those strategies related to antecedent policy instruments or the interaction of policy instruments with other factors?

To address the effect of policy instruments on the strategies and service offerings of Owners, interviews were conducted with key informants to understand:

- (i) What are the key risk/return criteria in the seniors' residential care business?
- (ii) How are decisions made around home location and the array of services?
- (ii) How do government policy instruments regarding funding and governance (differentially) affect the strategies or service offerings of RHs and LTCHs?

Building on the answers to question 2, the study uses the input from key informants, the integration of information from Phase 1, and background research referenced in this study, to explore answers to the question:

3. What are the implications of current government funding and governance policies regarding seniors' residential care in Ontario, and what are the merits of considering modifications to existing policies instruments or the introduction of new ones? Through interviews with key informants, this question explored issues related to:
- (i) Funding of services in LTCHs on a differential basis than in RHs;
 - (ii) Funding directed to the LTCH, rather than to the eligible senior or to a care service or residence that meets the senior's needs;
 - (iii) Funding of professional/medical services such as nursing, as compared with personal services such as bathing and dressing;
 - (iv) Funding based on a resident's needs, even where they have the means; and
 - (v) Differential versus common governance frameworks for the two categories of homes.

4.2. Design and Methods

The research employed a *mixed methods sequential explanatory design*, consisting of two distinct phases: quantitative followed by qualitative. In this design, the first phase involved the

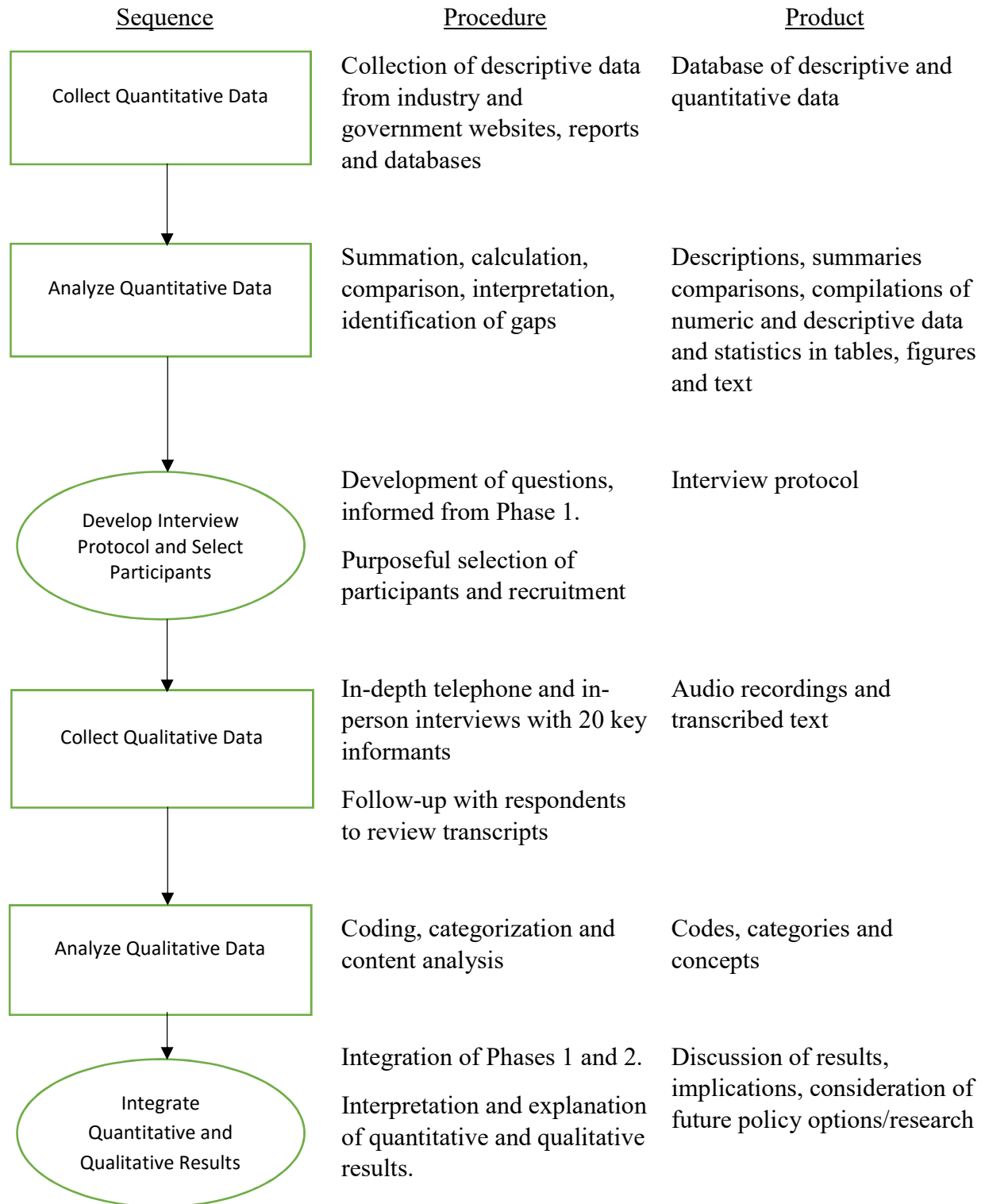
collection of quantitative and descriptive data, followed by the presentation and analysis of the data in summative and statistical form in figures and tables.

The analysis of Phase 1 data revealed either gaps in information or a need for explanatory input from key informants as to the antecedent factors that might explain the service offerings. This led to the development of a list of interview questions and the recruitment of interviewees. The use of an explanatory sequential design permitted Phase 1 data to inform the Phase 2 inquiry by developing the interview questions in order to address issues raised in the quantitative data. The second phase involved the collection and analysis of qualitative, interview data from people considered likely to be familiar with the quantitative results obtained in the first phase and able to explore the health policy issues arising from these data.

Analysis of the Phase 2 interviews was done first, by coding and categorizing the text of the interviews in Chapter 6. Chapter 7 includes an analysis of these findings, interpretation in the context of Phase 1 and 2 results, and a discussion of the results in terms of the research questions posed in Chapter 4.

Figure 4.1 shows the mixed methods sequential explanatory design in flow chart form and is developed from Creswell and Clark's¹⁰⁰ visual model for mixed methods sequential explanatory design procedures.

Figure 4.1. Flow Chart of Mixed Methods (Quant/Qual) Sequential Explanatory Design



4.2.1. Phase 1

The focus of Phase 1 is on how RHs and LTCHs in Ontario compare in terms of their service offerings. The research is cross-sectional as it involves data collection at a specific point in time (July/August 2016) from the population of approximately 730 RHs and 640 LTCHs. It is observational as it draws inferences about the differences between the two groups (RHs and LTCHs). Analysis of the data is conducted to identify patterns of characteristics that distinguish one group from the other, though not causal linkages. All of the data compiled from Phase 1, both descriptive and numerical, are then analyzed quantitatively as they have discrete data characteristics (e.g., location, LTCH versus RH), or are defined by statute (e.g., type of service, regulatory framework, governance models), or can be measured numerically (e.g., numbers of homes/residents, prices, vacancy rates).

Phase 1 data were drawn from public and private databases, comprehensive reports, statutes and regulations. Categorized according to the subject area of the Phase 1 inquiry, these included:

- (i) ***For regulatory framework*** (purposes, funding, governance, residents' rights and remedies, safety and security, care services, staffing), principal sources of information for LTCHs were the LTCHA and O.Reg.79/10. For RHs, the main sources were the RHA and O.Reg.166/11 and 53/12.¹⁰¹ All statutes and regulations are available publicly.
- (ii) ***For the numbers and locations of homes, beds and residents***, the principal source for LTCHs was the MOHLTC's Reports on Long-Term Care Homes, which were available online.² For RHs, these data came primarily from the RHRA public register which is also available online.¹⁰² Geographic comparisons of wealth effects and migration of residents

were obtained from the Preyra Report, and health indicators by LHIN region were available from the MOHLTC's Ontario Health Profiles database.¹⁰³

- (iii) ***Sectoral characteristics of the seniors' residential care industry***, including market concentration, barriers to entry, economies of scale, and risk/return considerations were compiled from public securities industry sources. These included the System for Electronic Document Analysis and Retrieval (sedar)¹⁰⁴, which contains public filings with securities commissions or stock exchanges, including the annual information forms (AIFs) and annual reports of industry competitors. Ownership categories for LTCHs (FP, NFP, municipal) were obtained from the MOHLTC's Reports on Long-Term Care Homes. Data with regard to profitability of LTCHs were derived from the OLTC's 2015 Pre-Budget Submission.³⁶
- (iv) ***Data regarding the prevalence of care services and amenities for RHs*** were sourced from the RHRA public register; from Canada Mortgage and Housing Corporations' 2016 Seniors' Housing Report for Ontario (CMHC Ontario Report)¹⁰⁵ and from the database of Collaborative Retirement Econometrics (CORE database) which contains property, operational and financial information regarding Canadian retirement homes. The CORE database was developed cooperatively between (i) Ontario Retirement Communities Association (ORCA), a not-for-profit association whose membership is stated to represent over 93% of the retirement home industry in Ontario¹⁰⁶, and (ii) ProMatura Group, LLC, a global market research firm focused on the age-qualified housing industry. The first CORE reports and subscriptions were made live in June 2015, using the data of approximately 335 properties across Ontario, compared with a total of 728 RHs per the RHRA public register.

- (v) ***Financial data regarding costs of accommodation and care for LTCHs*** were provided by MOHLTC bulletins and level-of-care per diem funding summaries.¹⁰⁷ For RHs, the relevant data were available from the CMHC Ontario Report and from the CORE database.
- (vi) ***For data regarding occupancy rates, vacancy rates and waiting lists***, LTCH data were obtained primarily from the MOHLTC’s Long-Term Care Home System Reports for October 31, 2015³, with comparisons to October 31, 2010¹⁰⁸ and from the MOHLTC’s LTCH Occupancy Targets Policy¹⁰⁹. For RHs, these data were available principally from the CORE database and from the CMHC Ontario Report.

In the Results of Phase 1 (Chapter 5), much of the analysis is presented in the form of tables, which list, summarize and compare the statistical, quantitative and descriptive data from the sources listed above. Also, all LTCHs and RHs are presented in map form by location, LHIN region, numbers of beds and (in the case of RHs) according to certain service offerings. This is done using the Excel 2016 3D Map program. In the case of RHs, homes were mapped according to LHIN jurisdiction by inserting the postal code for each RH into the “Find Your LHIN” function available on the Ontario LHINs website.¹¹⁰ In addition to the presentation of the data, interpretive comments are included to outline trends, differences or prevalent features in the data.

It should be noted that references to numbers of beds or homes or other characteristics of LTCHs and RHs throughout this document may differ slightly according to the sources of the data as well as the dates at which data were collected or reported by external sources or analyses. In general, statistics regarding LTCHs are from reports of the MOHLTC, though reports showing,

for example, wait lists, may refer to bed counts that are of less recent date than the reports themselves. Every effort was made to reflect the most up-to-date and reliable numbers at the time they were collected. With respect to RHs, the RHRA data best define the population of homes that are of interest in this study. This is because the RHRA governs all licensed RHs that provide two or more care services, which is the relevant legal definition used in this study. As noted below, data describing RHs which are from the CMHC Ontario Report, the CORE database or other sources, may be based on either a slightly different definition of RHs or a less complete sample. As such, these data are considered to be descriptive of the RH sector and relevant to this inquiry, though less definitive of the relevant population of RHs.

The CMHC Ontario Report is a product of the CMHC Seniors Housing Survey, which is done for the purpose of informing industry stakeholders and the general public regarding trends in the market across Canada. The housing survey is conducted nationally, with details provided on a provincial basis. At the time of compiling Phase 1 data, the latest survey had been completed in February and March of 2016. CMHC uses a standard definition for a retirement home residence in its survey, which requires homes to have more than 50 per cent of their residents aged 65 and over, offer an on-site meal plan and not administer heavy care to *all* of its residents. This corresponds closely with the RHRA inclusion criteria, since a retirement home under the license provisions of the RHA includes a residence where the majority of residents are over 65 and the home offers two or more care services, of which one may be a meal (in fact, virtually all RHs include meals). In addition, the RHA specifically states that the Act does not apply to LTCHs, which is similar to CMHC's exclusion of homes that administer heavy care to all of its residents (defined as more than 1.5 hours of care per day per resident). An area where CMHC's statistics

differ is in excluding homes under 10 residents, while the RHA excludes those under six residents. More significant is the CMHC's categorization of two-bedroom units as only one "space", whereas the RHRA looks at total "capacity" of each home, which corresponds with the number of beds.

The CORE database is less closely aligned with the definitions under the RHA and the RHRA, as it includes RHs that may not have care services. Though its coverage is increasing in terms of number of homes, it also encompasses a smaller sample of RHs, including approximately half those in the RHRA population. In this study, CORE data are used with regard to occupancy, care levels and cost measures where data already exist from the RHRA or CMHC. In general, the CORE data were found to be consistent with, and in certain cases, corroborate that of the other sources. For each indicator, all applicable sources were used. For example, data regarding accommodation charges in RHs were drawn from both CMHC and CORE sources and compared.

4.2.2. Phase 2

While Phase 1 provided considerable detail of a descriptive nature, it raised numerous issues requiring the input of knowledgeable informants able to explain how the service offerings in the sector came about, and what the implications are from a policy perspective. These issues and the corresponding knowledge gaps are detailed in Chapter 5.7 (Summary of Findings from Phase 1 and Issues to Explore in Phase 2) and were the basis of the interview questions formulated for Phase 2. The interview questions (see Table 4.3) primarily query the reasons for patterns of service offerings, the bases for government funding and governance policies regarding seniors'

residential care, the rationale for policy differences between RHs and LTCHs and the implications of maintaining existing policies. Questions were guided by the conceptual framework, where policy, market and organizational characteristics were identified as possible factors determining Owner strategies and service offerings.

Twenty participants were recruited for Phase 2, including both Owners and other key informants in a position to evaluate the strategies of Owners and to assess the role of existing policy instruments and the implications of their use. Prospective participants were selected on the basis of purposeful sampling, using three criteria. First, individuals were identified as being knowledgeable about the sector, based on their positions, experience, job titles or brief resumes, which were found through publicly available information, including internet searches. Second, with respect to the Owners recruited, the effort was made to have relative proportions of characteristics in the sample of participants correspond with the proportions of the same characteristics in the population of homes examined in Phase 1. For example, the numbers of participants in the sample who had current or past experience with LTCHs and RHs were approximately equal, as are the relative number of beds in LTCHs and RHs in the province. Also, the proportions of FP, NFP and municipal home Owners in the sample were similar to the proportions of FP, NFP and municipal homes in Ontario. Table 4.1 summarizes the characteristics of participants in the sample with regard to both their current and past roles in the sector. Most participants filled more than one characteristic in the sector (either current or past) with an average of four current and past characteristics. In addition, at least 15 of the 20 participants had significant work experience in both the LTCH and RH sectors, in a capacity related to operations, regulatory, governance or a residence association executive.

Table 4.1. Characteristics of Key Informants

<u>Characteristic (Including Current or Past Role):</u>	<u>Number of Participants:</u>
RH Owner	13
LTCH Owner	13
National chain	7
Rural area	8
Government, LHIN or regulator	5
Seniors' residence association (board or executive)	8
For-Profit	10
Not-For-Profit	4
Municipality	2
Health professional	3
Seniors' advocate	1
Other position on care continuum, e.g., hospice, community care, seniors' apartments, relevant research	6

Third, given that this study has a policy focus, participants were considered on the basis of their possible roles within the relevant *policy subsystem*. While definitions of groups within the policy universe vary somewhat, Figure 4.2 presents a useful way of seeing the constituent parts and borrows heavily from the policy text of Howlett, Ramesh and Perl.¹¹¹ They define the policy subsystem to include only those with sufficient knowledge or stake in the problem to warrant their involvement in policy formulation, while a smaller *policy community* participates in idea-based discourse and a smaller subset of that community, the *policy network*, drives the actual formulation and consideration of concrete policy options. The important theme in this analysis is that policymaking is seen to occur mainly within existing institutional structures, a concept shared by other policy scholars. Jochim and May¹¹² state that “the predominant foci of the policy process literature are the dynamics of policymaking within subsystems that comprise established bases for addressing particular policy issues.” (p.304). Baumgartner and Jones¹¹³ view the participants of the subsystem as advancing the ideas or problem definitions and Sabatier and Jenkins-Smith¹¹⁴ employ the term “coalitions of interest” to describe these structures.

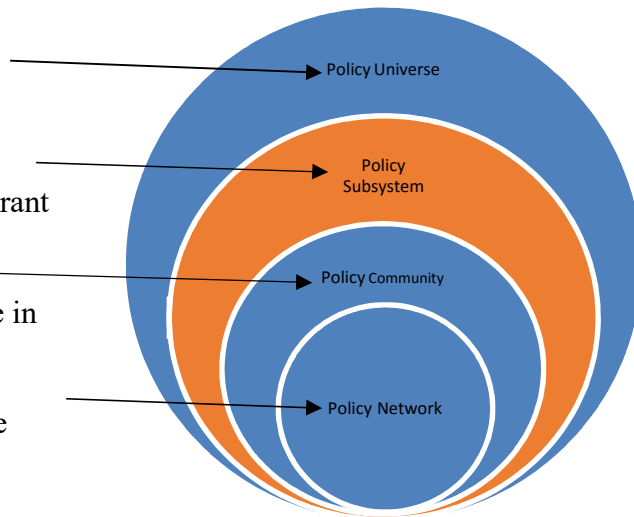
Figure 4.2. Concentric Systems in Policy Formulation

Policy Universe: all actors involved in identifying problems and demanding government action

Policy Subsystem: actors with sufficient knowledge or stake in the problem to warrant their involvement in policy formulation

Policy Community: actors who participate in idea-based discourse

Policy Network: actors who determine the actual formulation and consideration of concrete policy options.



Howlett, et al. point out that the relevant group of key actors can depend on the stage of the policy process. For example, the early stages of the process, involving problem recognition or agenda setting, can engage the broad policy universe, whereas proposal formulation and implementation tend to draw on the input of the narrower policy subsystem. At the apex of decision-making, it is only the government actors that exercise authority. Table 4.2 illustrates the effect of the policy stages by combining exhibits from Howlett, et al. that depict (i) applied problem-solving, (ii) stages in the policy cycle and (iii) key actors involved.

Table 4.2. Problem-Solving, Policy Stages and Key Actors

<u>Applied Problem-Solving</u>	<u>Stages in Policy Cycle</u>	<u>Key Actors Involved</u>
1. Problem recognition	Agenda Setting	Policy Universe
2. Proposal of Solution	Policy Formulation	Policy subsystem
3. Choice of Solution	Decision-making	Government decision-makers
4. Putting solution into effect	Policy implementation	Policy subsystem
5. Monitoring results	Policy evaluation	Policy universe

Source: Adapted from Howlett, et al.

The benefit of recognizing the policy subsystem in this study is that it gives attention to the relevant group of actors who are typically consulted on possible policy solutions and policy formulation. Therefore, to the extent interview subjects in Phase 2 can include the policy subsystem, responses may represent not only knowledge about the sector and its dynamics, but views that are likely to *matter* in the formulation of policy ideas. Further, since the policy subsystem is influential in policy implementation – also shown in Table 4.2 – this group of actors may inform an understanding of where current implementation is wanting, and whether and how new policy formulations may be feasible and practical.

As the policy subsystem includes those with sufficient knowledge or stake in the issue to warrant their involvement in policy formulation, participant recruitment included stakeholders with current or previous government, regulatory, advocacy, executive or operating roles. It was considered noteworthy that stakeholders from these groups have been represented in previous policy inquiries or expert panels, such as the Long-Term Care Innovation Expert Panel report⁶², or the Bringing Care Home (Gail Donner) report.²⁶

In terms of recruitment protocol, all participants signed a consent form to participate. Ethics approval was obtained from the Research Ethics Board of the University of Toronto. A list of interview questions was provided to all participants in advance of the interview. Table 4.3 contains the interview questions. The questions were developed on the basis of issues that arose from Phase 1, particularly where qualitative responses were expected to be valuable in explaining strategic and decision processes of Owners. Questions pertained to observed changes in the sector, rationale and effects of differential funding and governance between LTCHs and

RHs, exploration of policy options around equity of access, and appropriate services to cover with public funding. Several questions pertained to strategies and competitive factors that led Owners' to their various service offering, consistent with the conceptual framework. Slight modifications were made to the questions depending on the participant. For example, those who did not represent Owners were not asked what types of seniors they were trying to attract (question 10). However, all participants were asked about risks and benefits of operating as an Owner, issues of economies of scale, geographic location, etc. regardless of whether they represented an Owner.

A total of 39 prospective participants were recruited by email with a description of the study and its purposes. Where a positive response was received regarding willingness to participate, a consent form and the list of questions were sent and arrangements were made to schedule the interview. In addition to the 20 who participated, 18 of those contacted failed to confirm participation after at least two email attempts and one responded that there was insufficient time available to participate.

Where participants were within a reasonable driving distance of the researcher, they were given a choice between an in-person interview and a telephone interview. Flexibility was offered as to scheduling. Five of the twenty interviews were conducted in person with the balance by telephone. Interviews were conducted on a semi-structured basis, where additional questions permitted the discussion to follow logically from initial answers provided. All interviews were conducted by the researcher. They averaged 61 minutes in length, and were audio-recorded and transcribed by the researcher.

Table 4.3. Interview Questions

1. The stock of Long-Term Care Home beds in Ontario has not grown significantly in the past several years, despite growth in the seniors' population. What do you consider to be the reasons for this?
2. Do you see retirement homes playing a role in meeting unmet demand for beds in Long-Term Care homes? If so, how?
3. Seniors who reside in Long-Term Care Homes are able to receive nursing and personal care as well as therapies funded by government. Where the same services are provided to seniors in Retirement Homes, they are not eligible for the same coverage. What do you see as the basis for the distinction and what are the implications of maintaining it?
4. Government funding for Long-Term Care Homes is paid to the home, rather than to the resident and is based on the number of residents in the home. Some seniors face long waiting lists for a bed in a Long-Term Care Home and, for them, such funding is not available. Rather than funding the home, does it make sense for the government to fund the person and allow the person to purchase care services where they wish?
5. Government funds the cost of nursing services in Long-Term Care Homes, but also funds services related to activities of daily living, such as bathing, dressing and mobility. Government also funds the cost of food. Do you think that the right types of services are being covered by government? What should the appropriate set of funded services include (e.g., meals, drug administration bathing, hygiene, dressing, ambulatory assistance, continence, feeding, wound care, dementia care)? Should the same types of services that are funded by government in Long-Term Care Homes also be funded in Retirement Homes?
6. Eligibility for funding of care services in Long-Term Care Homes is based on need, but is not subject to a means test (e.g., income or assets of the resident). Should residents cover the costs of care services from their own resources if they are able? Should it matter whether the services are related to professional care (e.g. nursing) as opposed to personal care (e.g., bathing or dressing)?
7. Long-Term Care Homes are governed by the Ministry of Health and Long-Term Care (MOHLTC), while Retirement Homes are governed by the Ontario Seniors' Secretariat. Given that Retirement Homes provide care services, does it make sense that they, too, should be governed by the MOHLTC in respect of those services?
8. How long have you worked in the Long-Term Care sector? Describe the evolution of the sector since you started. Have things changed over time? If so, how? How would you compare this with the evolution of the Retirement Homes sector?
9. As an owner or operator of a Long-Term Care Home(s) [or Retirement Home(s)] what do you find attractive about the sector? Can you comment on some of the risks and benefits as an owner? How might ownership of a Long-Term Care Home differ from a Retirement Home in terms of risks and benefits?
10. Are there particular types of seniors you are trying to attract? How do you distinguish your service offering from that of other Long-Term Care homes or Retirement Homes? How do you decide what level of care (or how many care services) to provide? Is it based on resident demand, geography, cost, availability of professional staff?
11. Are economies of scale important in the seniors' residential care business (e.g., sharing of resources, fixed overheads, administration costs)? If so, does this encourage owners to seek a minimum number of homes, or beds per home?
12. How do you decide where to locate? Certain geographic areas of the province seem under-represented in terms of residential care. Why do you think this is? What could be done to attract more homes there?

4.3. Content Analysis

This study employs content analysis to analyze the Phase 2 interview data. Applications of content analysis in qualitative research tend to examine both *manifest content*, which are the visible components of what the text actually says as well the *latent content*, which is the interpretive meanings of the text.^{115,116} In this study, latent content is important, since the concepts explored (e.g., equity, acuity, risk, choice) can be expressed with many different words, are value-based, tend more toward the ideological than the literal, and require interpretation of data items in the context of the interviews themselves.

Content analysis generally begins with a decision about the *unit of analysis* to be studied, which in this study is the whole interview, as recorded and transcribed. Within this, the researcher identifies a *meaning unit*, which consists of words, phrases and sentences containing aspects that relate to one another.^{117,118} These meaning units can be abstracted to create *codes* and *categories*. Here, *codes* are essentially labels of meaning. In this study, the codes used incorporated concepts identified in the conceptual framework, relating to characteristics of the firm, ownership structures, public policy and market influences, organizational strategies, and service offerings. As Saldaña describes it in *The Coding Manual for Qualitative Researchers*,¹¹⁹ a code in qualitative inquiry is a short phrase that symbolically assigns a summative, salient or essence-capturing portion of language-based data. *Categories* are groups of content that share some commonality, can be identified by a thread throughout the codes and express the content of the text.¹¹⁷

Saldaña describes numerous coding methods, which he notes are not mutually exclusive. For studies employing conceptual frameworks, he recommends the use of a method that enables direct analysis of the research questions posed. This study uses *structural coding*, which is able to apply a content-based phrase that represents a subject of inquiry. Structural coding can be used for multiple participants and standardized or semi-structured interviews of the type employed in Phase 2.

Saldaña refers to *coding filters* to recognize that the interpretation of the data depends on the lens employed by the researcher. As such, a particular data item can fit more than one code and even more than one category, depending on how it is viewed. The use of more than one filter can be accommodated with *simultaneous coding*, which Saldaña defines as the application of two or more different codes to a single qualitative datum. In the analysis of Phase 2 interviews, there were numerous incidents of text data that were assigned multiple codes. As an example, a comment that “the shortage of LTCH beds cannot be met by RHs because they are too expensive for those who cannot afford the private care option”, could be coded (see Chapter 7, Table 7.1) for affordability of seniors’ residential care (category 2, code 2) and private pay as a form of means testing (category 6, code 2).

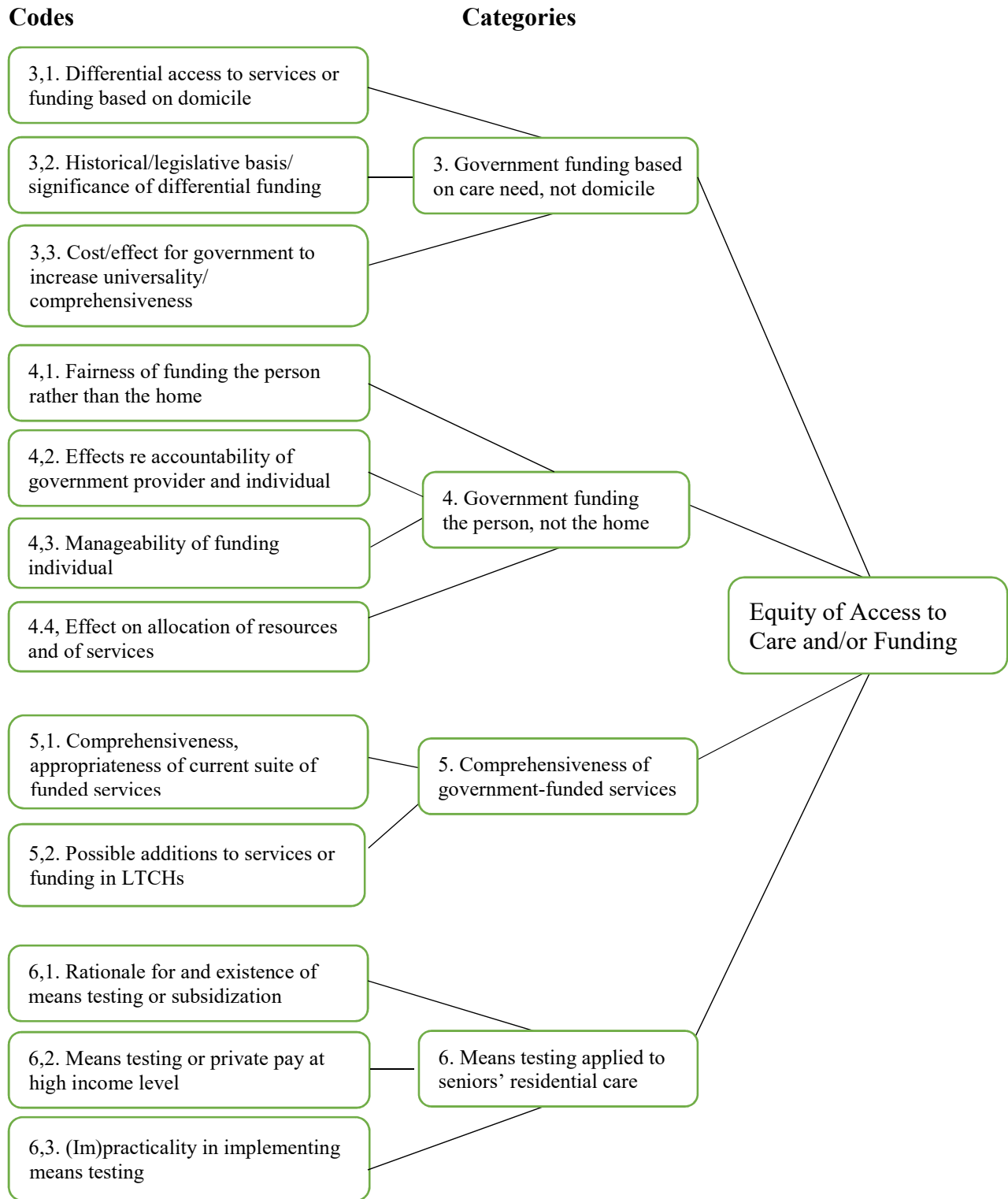
The assignment of codes was, as expected, a recursive process. Data were divided into several meaning units (codes) in the initial coding, with the list numbering over 100. These codes were grouped on further reading into 45 codes. There were 12 categories, which corresponded with the subject areas of the interview questions. All interviews in the data set were coded by the researcher and six interviews were the subject of independent coding, auditing or other

verification by a second coder to ensure consistency. Any differences were recorded and discussed to reach consensus.

A list of codes and categories for the study is provided in the Appendix. The categories correspond with the interview questions listed in Table 4.3. In order to perform the coding exercise, the text of all 20 interviews was combined in one Microsoft word©-formatted document to constitute the data set, which was searchable with the “find” function in the software. All data items were identified as excerpts within the data set by means of comment boxes containing codes that related to meaning units and were numbered. For example, 4,1 refers to category 4, code 1, where category 4 relates to *government funding the person rather than the home* and code 1 refers more specifically to data items that discuss fairness or equity in funding the person rather than the home (see Box 4,1 in Figure 4.3). The “find” function enabled all references to be counted with a record, beside each code, of the number of references found for that code in the data set. Numerous data items pertained to more than one code and were simultaneously coded accordingly.

Figure 4.3 provides an example of how categories 3,4,5 and 6 are the culmination of underlying codes. In addition, these four categories (of 12 categories in total) relate to equity of access to care and/or funding, which is a subject of discussion in Chapter 7. Chapter 6 of this study provides the finding for all 12 categories in the Phase 2 qualitative analysis. Chapter 7 analyzes the codes and categories from the Phase 2 data to define broader subjects of interest and integrates the results of the Phase 1 with Phase 2 along these subject areas. These subjects are: (i) the growing need for seniors’ care and services and the system capacity to meet the need;

Figure 4.3. Example of Codes and Categories



(ii) equity of access to funding and care, including principles of universality, comprehensiveness and choice; (iii) the role, extent and consistency of regulation and governance; and (iv) Owners perspectives on risk/return trade-offs in the sector and the evolving operating model for seniors’ residential care.

In interpreting the findings by code, analysis was done to parse the responses within each code to provide further detail about the responses. For example, Box 3,1 in Figure 4.3 contains the code “Similar care needs currently receive (dis)similar government funding”, within the category “Government funding based on care need, not domicile”. To understand the specific views expressed by participants who made comments that were coded as 3,1, the data items were analyzed to profile the views/observations by number of respondents. As Table 4.4 shows, 16 respondents made the observation that funding is differentiated depending on domicile.

Table 4.4. Example of Analysis of Code 3,1.

<u>Code 3,1: Similar care needs currently receive (dis)similar government funding</u>	<u>Number of Respondents</u>
Funding is differentiated, varies or is tiered depending on domicile	16
Funding could/should go the person in the appropriate setting, e.g., RH	13
People could stay in RHs longer if the care were funded	8
CCAC service is limited or variable across the province	7
There is difficulty obtaining CCAC or other public dollars or service in RHs	6

Where content analysis is summative of the responses given, it requires some assessment of the prevalence of responses provided. In tabulating and assessing prevalence, all 45 codes were analyzed in Microsoft excel© by the method shown in Table 4.4. Prevalence can be determined by various means, where conventions may include measures such as “majority of participants”,

“many participants” or “a number of participants”. In analyzing the Phase 2 data set, prevalence was considered in different ways, depending on the pattern of responses by interviewees. For some codes, the analysis highlights the prevalence of responses in terms of proportion of respondents relative to the sample of 20 interviewed, using terminology such as “all”, “almost all”, “a majority”, “most”, “many”, or “some”. These categorizations were considered more relevant for responses to narrow questions (i.e., those that elicited a simpler positive or negative response), such as whether economies of scale are important in the seniors’ residential care business (interview question 11).

For more open-ended questions, where interviewees had greater discretion as to the subject matter of the response, prevalence was assessed by ranking the popularity of responses, using terminology such as “most common”, “second most common”, etc. For example, when asked about changes observed within the seniors’ residential sector (interview question 8), the increased age of residents was a common response, but was not given by a majority of respondents, perhaps because interviewees had greater latitude to speak about a variety of changes important to them, including various indicators of acuity.

Also of interest were responses that occurred repeatedly, despite not being solicited by the direct question posed. For example, question 7 asks whether homes that provide care services should be governed by one regulatory regime rather than two (one for LTCHs and one for RHs), but a common occurrence was for respondents to direct the discussion to aspects of the existing MOHLTC governance regime, which they considered to be punitive, overbearing and counter-productive.

In measuring prevalence, the practice observed was to measure frequency based on the number of respondents answering in a particular way, rather than the frequency of responses.¹²⁰ This was done in order to remove the effect of individual respondents repeating a particular view several times in the course of an interview, increasing the number of data items.

4.4. Rationale for and Use of Mixed Methods

The Phase 1 data and their subsequent analysis provide a general description of the research problem, while the Phase 2 qualitative data and their analysis refine and help explain the Phase 1 results by soliciting the views of people most likely to be familiar with the data. Creswell & Plano Clark explain that, depending on the nature of the inquiry, the use of quantitative and qualitative approaches together may provide a better understanding of research problems than either approach alone. Furthermore, as Onwuegbuzie and Johnson¹²¹ explain, the use of an explanatory sequential design allows Phase 1 data to inform the Phase 2 inquiry by framing the interview questions to address issues raised in the quantitative data. Integration of quantitative and qualitative data in this study occurred at two junctures. First, the quantitative data from Phase 1 were used to inform the questions asked of interviewees in Phase 2. Second, analysis of Phase 2 qualitative information was integrated with Phase 1 results in order to achieve the most complete answers to the research questions posed.

5. Phase 1 Findings

Phase 1 is intended to answer research question 1 by informing an understanding of the service offerings and regulatory environment in the sector, using descriptive data for LTCHs and RHs.

Data included:

- (i) regulatory framework (purposes, funding, governance, residents' rights and remedies, safety and security, care services, staffing);
- (ii) numbers and locations of homes and residents (geographic dispersion of homes, migration of residents, wealth effects on choice, health indicators by geography);
- (iii) sectoral characteristics (market concentration, ownership type, barriers to entry, economies of scale, profitability and return on capital, business risks);
- (iv) prevalence of care services and amenities;
- (v) cost of accommodation and care; and
- (vi) occupancy rates, vacancy rates and waiting lists.

5.1. Regulatory Framework

The LTCHA and the RHA address the licensing of LTCHs and RHs, respectively, as well as residents' rights, care standards, safety and security, protections against abuse and neglect, powers of inspectors, and the establishment of offences, penalties, appeals and enforcement.

The LTCHA came into force in 2007, replacing three statutes that had governed long-term care homes in Ontario: The *Charitable Homes Act*, the *Homes for the Aged and Rest Homes Act*, and the *Nursing Homes Act*. By contrast, retirement homes in Ontario were not regulated as an entity prior to 2010, though the rights and obligations of their residents and operators were

certainly the subject of legislative oversight in numerous areas. Homes were governed by the *Residential Tenancies Act* (RTA) and at least a dozen other Ontario statutes applied – and still apply – to the residents, employers, patients and buildings involved. Table 5.1 provides a list of statutes that apply to RHs, most of which also apply to LTCHs.

Table 5.1. Ontario Statutes Applicable to RHs and LTCHs

<p><u>Residential/Building</u> <i>Residential Tenancies Act, 2006</i>, S.O. 2006, c.17 (applies to RHs but not LTCHs) <i>Building Code Act, 1992</i>, S.O. 1992, c.23</p> <p><u>Worker-Related</u> <i>Occupational Health and Safety Act</i>, R.S.O. 1990, c.0.1 <i>Workplace Safety and Insurance Act, 1997</i>, S.O. 1997, c.16 <i>Labour Relations Act, 1995</i>, S.O. 1995, c.1 <i>Employment Standards Act, 2000</i>, S.O. 2000, c.41 <i>Regulated Health Professionals Act, 1991</i>, S.O. 1991, c.18</p> <p><u>Health</u> <i>Smoke-Free Ontario Act, S.O. 1994</i>, c.10 <i>Health Protection and Promotion Act, R.S.O. 1990</i>, c.H.7</p> <p><u>Residents' Rights</u> <i>Accessibility for Ontarians with Disabilities Act, 2005</i>, S.O. 2005, c.11 <i>Human Rights Code, R.S.O. 1990</i>, c.H.19</p> <p><u>Resident Safety/Security</u> <i>Personal Health Information Protection Act, 2004</i>, S.O. 2004, c.3 <i>Fire Protection and Prevention Act, 1997</i>, S.O. 1997, c.4</p> <p><u>Decision/Authority</u> <i>Health Care Consent Act, 1996</i>, S.O. 1996, c.2 <i>Substitute Decision Act, 1992</i>, S.O. 1992, c.30</p>
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In Ontario, the regulatory regimes that govern LTCHs and RHs evolved differently, with the result that policies with regard to funding are distinctly different between the two regimes and governance is the responsibility of different authorities under the two Acts. However, rules

regarding care and safety standards have many similarities as between LTCH and RH regimes, as is the case with regulatory processes concerning the establishment and enforcement of residents' rights.

5.1.1. Fundamental Principles

The LTCHA describes the statute's "fundamental principle" in section 1 as follows:

A long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met.

In addition, the preamble to the Act highlights the importance to "the people of Ontario and their Government" of (paraphrased):

- resident-centred care that preserves and promotes a comfortable, home-like environment;
- collaboration and mutual respect amongst residents, their families, providers, caregivers, volunteers, the community and governments;
- access to LTCHs based on assessed need;
- public accountability and transparency;
- clear and consistent standards of care, services and security;
- a strong compliance, inspection and enforcement system;
- a respect for diversity in communities;
- continuous quality improvement; and
- the promotion of the delivery of LTCH services by NFP organizations.

Residents of a LTCH must meet certain eligibility criteria, based primarily on care needs as assessed by the local CCAC. Section 155(1) of Ontario Regulation 79/10 under the LTCHA requires applicants to (i) be over 18 *and* (ii) be insured under the *Health Insurance Act* and (iii) require (a) nursing care on site 24 hours a day or (b) throughout the day, assistance, supervision or monitoring to ensure safety or well-being, where other available publicly-funded community-based services and other caregiving arrangements are not sufficient. The LTCHA defines a long-term care home in section 2(1) as "a place that is licensed as a long-term care home under this

Act”. Licensure determines the eligibility of the home to receive government funding on the condition that it meets the obligations in the Act and the regulations.

Similar to the LTCHA, the RHA contains a fundamental principle, which states that:

A retirement home is to be operated so that it is a place where residents live with dignity, respect, privacy and autonomy, in security, safety and comfort and can make informed choices about their care options. (RHA, s.1.)

The RHA stipulates no eligibility criteria for its residents, and defines “retirement home” in s.2(1) as a residential complex that is occupied primarily by persons who are 65 or older, where there are at least six occupants unrelated to the operator of the home and where the operator makes at least two care services available to the residents. As the Act defines the provision of meals as a care service, the addition of one other care service brings most retirement homes within the purview of the RHA, requiring a license to operate. The Act specifically excludes its application to LTCHs and hospitals, which have their own regulatory regimes.

It is the provision of care services by both RHs and LTCHs that establishes the nexus between the two settings and is critical to this research inquiry. From a policy perspective, the regulation of both modes of residential accommodation according to care, security and comfort of seniors has become critical to the purpose and operation of LTCHs and RHs.

5.1.2. Government Funding

Operational funding– and to a lesser extent capital funding – constitute a significant differentiator between the regulatory regimes of LTCHs and RHs. Essentially, LTCHs receive full government funding to cover the cost of nursing care, therapies and food. Government does

not fund the equivalent services in RHs, though RH residents are eligible for those programs that are available to all Ontarians, such as OHIP and local services of the CCAC, described in Chapter 1. LTCHs are also eligible for certain government-sponsored funding programs for capital and other purposes (see Chapter 5.1.2.2 below) which are not available to RHs.

5.1.2.1. Operational Funding Envelopes for LTCHs

For LTCHs, the MOHLTC provides base level care funding under four categories that include (i) nursing and personal care (NPC), (ii) programming and support services (PSS), (iii) raw food (RF) and (iv) other accommodation (OA). Funding is provided to the LTCH on a per-person-per-diem basis as follows (as of July 1, 2016):¹⁰⁷

Nursing and personal care (NPC)	\$94.37
Programming and support services (PSS)	9.42
Raw food (RF)	8.33
Other accommodation (OA)	<u>54.33</u>
Total	<u>\$166.44</u>

Source: MOHLTC Homes Financial Policy: LTCH Level-of-Care Per Diem Funding Summary, July 2016.

Because of its medical nature, the NPC envelope is funded according to individual homes' case-mix index, which is calculated on a weighted average, acuity-adjusted basis. The PSS, RF, and OA envelopes are funded based on a flat-rate, per-person-per-diem basis.

Definitions of the envelopes are provided in MOHLTC's policy for Eligible Expenditures for Long-Term Care Homes.¹²² Essentially, eligible NPC expenditures must be for (i) compensation

to direct nursing and personal care staff or personal care administrators in connection with a plan of care, including ADLs, such as personal hygiene services, administration of medication, and nursing care; (ii) expenditures for NPC training, including attendance costs, if the training is related to the NPC staff's ability to fulfill their primary job function, or (iii) expenditures on NPC equipment, supplies, and devices (excluding furnishings) used by NPC staff in the provision of direct NPC as outlined in residents' plans of care.

Eligible PSS expenditures fall into the same three categories of compensation, training and equipment, where the active staff include physiotherapists, speech-language therapists, occupational therapists, OT/PT aides, recreational staff, volunteer co-ordinators, social workers and registered dietitians, where support services are provided directly to residents in accordance with programs required under the LTCHA or are part of the resident's plan of care.

The RF envelope includes expenditures for the purchase of food materials and condiments (as distinct from the cost of preparation) as well as prepared therapeutic food supplements ordered by a physician, registered nurse, or registered dietitian for a resident.

The OA envelope applies to housekeeping services, buildings and property operations and maintenance, dietary services, laundry and linen, general and administrative services, and facility costs to maintain the care environment of the LTCH. As is the case with the other funding envelopes, categories of expenditure are related to compensation, training and equipment related to such costs.

The NPC, PSS and RF envelopes are provided to LTCHs on a pass-through basis, whereby amounts that are not spent by the home are to be refunded to the MOHLTC/LHIN. By s. 245 of Ontario Regulation 79/10 made under the LTCHA, residents may not be charged for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from a LHIN. An accompanying service accountability agreement which must be entered with the LHIN requires that all funding obtained by the LTCH must be expended for the goods and services to which the agreement applies. The effect of these pass-through provisions is that Owners of LTCHs cannot earn a profit from any of these services and they are prohibited from charging the resident in respect of any item or service that would fall into one of these envelopes. Further, to ensure against abuses by Owners that may contract out any of the services to non-arms length service providers, O.Reg.79/10 (s.265) stipulates that licensees may not enter into a non-arm's length transaction unless "the supplier has been selected from an open, fair and transparent competitive procurement process involving at least three unrelated bids and has demonstrated economy, efficiency and effectiveness for the money spent superior to that of the other bidders."

Accommodation revenues from the OA envelope may earn a profit but accommodation charges are regulated as to amount and are the same for all Owners, whether NFPs, FPs or municipalities. Section 247 of O.Reg.79/10 prescribes the maximum charges for accommodation according to three levels: basic, semi-private and private. As of July 1, 2016, the basic fee paid by residents in LTCHs (i.e., the minimum) was \$58.99 per day or \$1,794.28 per month, but varies according to the level of accommodation and design classification. The MOHLTC recognizes three design classifications for beds (A, B and C) which depend on design standards and age of the home. The

maximum payable per day was \$84.27 per day for a private room in a so-called “A” bed (a bed in a newer home meeting the latest standards). For private and semi-private beds, lower daily rates applied to beds in older homes (B and C beds).⁵

In addition to operational funding through the four envelopes described above, the Ontario government offers limited assistance with the capital costs related to LTCHs. For example, in 2015, the MOHLTC published the Construction Funding Subsidy Policy for Long-Term Care Homes,¹²³ which provides assistance with certain renovation and new construction costs of LTCHs, though the policy does not apply to either the cost of land on which the home is situated or to the cost of purchasing an existing LTCH.

As noted, the funding of care services by non-physicians, whether in LTCHs or RHs, is not a matter to which the CHA applies, as they fall into the category of “extended services” and are governed by legislation that differs by province or territory. Ontario health policy, as it relates to insuring the costs of LTCHs, as distinct from RHs, involves numerous factors, including fiscal capacity and public opinion. With respect to the latter, Deber and Gamble¹²⁴ surveyed key stakeholder groups in Canada in 2002 as to their views on the funding of long-term care services and the consensus was that governments should not be fully responsible for these costs. Rather, the view was that costs of LTCHs and other residential and home-based services should be shared between the public and the recipients of care. The opinion that governments should have a lesser role in funding seems to become stronger as the continuum of care moves from direct care (such as nursing), to other supports, (such as adult day programs, feeding and homemaking). In this regard, it is worth noting that many of the services in the four LTCH funding envelopes

described above (food, other accommodation, and therapies) fall outside of direct nursing, including many of the ADLs described in the nursing and personal care envelope.

5.1.2.2. Capital and Other Funding Assistance for LTCHs

The MOHLTC provides funding for LTCH homes for structural compliance and capital according to the three A, B, and C design classifications described above. Class A beds meet the MOHLTC's most recent design standards, issued in 1998. Capital renewal initiatives are available through the following programs:

Structural Compliance Premiums provide funding on a per-person-per-day basis for home operators who have fully or partially financed their own construction costs. Amounts depend on the design standard met and on any other government grants already received. Amounts range from \$1 per day for Class C homes to \$5 for Class A homes.

Capital Cost Funding for New Beds applies to homes that have new beds as a result of construction after April 1, 1998. Under the development agreements, new beds (whether converted or newly constructed) receive a 20-year commitment from the MOHLTC to provide per diem funding of up to \$10.35 per bed.

Class B and C Bed Redevelopment funding is available as part of a MOHLTC renewal strategy to support the upgrade of older LTCH homes. At present, there are approximately 35,000 Class B and C beds in Ontario. In October 2014, the MOHLTC announced a number of initiatives, including a commitment to continue to increase premiums for preferred accommodation, and an

extension to 30 years for the licence terms of Class A homes. More recently, the 2015 Construction Funding Subsidy Policy for Long-Term Care Homes increased the per diem funding amount to a minimum of \$16.65 per resident per day.

In addition to capital renewal initiatives, LTCHs can receive additional funding from the MOHLTC if criteria are met with respect to the following:

Accreditation: LTCHs can earn an additional per diem of \$0.33 per bed from the MOHLTC if they are accredited by the Commission on Accreditation of Rehabilitation Facilities, a not-for-profit organization that provides healthcare organizations with a self-regulatory review process to assess and improve care quality.

Municipal Taxes, High Intensity Funding, Pay Equity & Preferred Accommodation: The MOHLTC also provides funding or reimbursement for various other items including municipal property tax obligations (currently up to 85%) and additional funding for high intensity needs and specialty programs (e.g., convalescent care, and peritoneal dialysis). Funds are also provided to LTCHs to cover pay equity obligations for LTCHs, such as costs related to the administration of employee and union agreements including union negotiations, arbitration meetings, and pay equity negotiations.

5.1.3. Governance

With respect to LTCHs, the Minister of the MOHLTC is specified as the authority for all matters under the LTCHA. In addition, the Act provides that the Lieutenant Governor in Council (i.e., provincial cabinet) may make regulations for carrying out the Act's purposes and provisions.

Funding for LTCHs generally flows from the MOHLTC through the LHINs, which administer

the four envelopes described above. In terms of contractual obligations, each LTCH is also responsible for entering a Long-Term Care Home Service Accountability Agreement (“L-SAA”) with the LHIN, which incorporates over 40 other documents detailing the responsibilities and conditions of funding.

Governance matters related to RHs are more complex and became the subject of considerable debate at the time that RHA came into effect. Central to governance under the RHA is the RHRA, whose objects are to administer the Act and regulations, grant licenses, oversee compliance and enforcement, conduct inspections, maintain a public register and educate licensees, consumers and the public on matters regarding prescribed care and safety standards, the rights of residents and best operating practices for RHs. The Act provides that the RHRA’s board is to be populated with representatives from the retirement home industry, business, government and consumers, with the stipulation in s.10(5) that appointments by government must *not* represent a majority of the board. Legally, the RHRA is an independent corporation responsible by contract to the Minister for Seniors through a Memorandum of Understanding (“MOU”). The Act states explicitly that the RHRA and its directors are not agents of the Crown.

During the consultation process prior to enactment of the RHA, over 250 written submissions were received by the Ontario Seniors’ Secretariat.¹²⁵ There was much disagreement among respondents as to how the RHRA would be constituted. Previously, many retirement homes either opted for voluntary accreditation with ORCA or had their own internal policies. Though self-regulation by ORCA was put forward as an option, this was opposed by advocacy groups, seniors and the nursing profession. The Advocacy Centre for the Elderly (ACE), which regularly

engages in law reform activities on behalf of seniors, argued that ORCA had not demonstrated adequate compliance in the past with existing tenancy laws, eviction protocols, or obligations to keep tenants informed.¹²⁶ ACE also argued that municipalities were not suitable to assume the regulatory role, since not all municipalities would have the means to create and enforce the necessary by-laws, leading to unequal application across the province.

When Bill 21 was presented, the Ontario Nurse's Association (ONA)¹²⁷, the Registered Nursing Association of Ontario (RNAO)¹²⁸ and ACE all objected on the basis that the RHRA would be dominated by industry representatives who would not protect the interests of residents. As recorded in Hansard, this was echoed by the legislative opposition during debates, when Mme. France G elinas, a New Democratic Party member of the legislature, surmised "you would have the owners and representatives of retirement homes policing themselves".¹²⁹ The ONA's proposed solution was that RHs should have clear limits placed on the level of care they were permitted to offer. The RNAO supported this position, arguing that anyone with moderate-to-complex health care needs should not be allowed to receive care from a RH. Opposition member (and Progressive Conservative Party member) Gerry Martiniuk advanced this argument in the Legislature, stating "we're building up a mini long-term care facility. The long-term care facilities are full so the rest must go to private retirement homes where they will have to pay."¹²⁹

The ONA, RNAO and ACE all took the position that any aspects of the Act relating to care should be under the authority of the MOHLTC, as was the case with LTCHs, which served elderly individuals who require 24-hour nursing care. They argued that the MOHLTC was recognized as having greater familiarity with care standards, as well as the infrastructure to

conduct inspections, regulate compliance and ensure enforcement. Despite opposition, the government decided to constitute the RHRA as an independent corporation with a majority of non-government appointees, responsible by contract to the Ontario Seniors Secretariat. The resulting governance regime for RHs is compared with that of LTCHs in Table 5.3.

Table 5.3. Comparison of Governance Responsibility for RHs and LTCHs

Governance	RHs	LTCHs
Governing legislation	-Retirement Homes Act, 2010 (the “Act”) and Ont. Reg. 166/11, as amended by Ont. Reg. 53/12; -Residential Tenancies Act, 2006 and other statutes related to health, property and civil rights	-Long-Term Care Homes Act, 2007 (the “Act”) and Ont. Reg. 79/10 -other statutes related to health, property and civil rights
Administrative authority and Governance	-Retirement Homes Regulatory Authority (an independent corporation responsible to the Crown through a MOU between the Minister and the RHRA). -the RHRA board is to be a mix of consumers and representatives from the retirement home industry, business, government and government organizations	Local Health Integration Network
Minister responsible	“Minister” means the Minister Responsible for Seniors or any other member of the Executive Council to whom responsibility for the administration of the Act is assigned or transferred under the <i>Executive Council Act</i> .	Minister of Health and Long-Term Care

In making the policy decision to govern RHs in this way, the government walked a fine line by introducing enforceable care standards for seniors in RHs while confining its funding activities only to LTCHs. Indeed, if the MOHLTC were to regulate the provision of care in both RHs and

LTCHs, the difference in funding would be brought into closer focus and might be difficult for the government to defend. ACE captured the logic as follows at page 13:

It is at least arguable that certain high-level care services being provided within retirement homes fit within the definition of “home care services” as found in the Regulation to the *Health Insurance Act*. ACE sees no principled reason why such services should not be funded as insured extended care services...The failure to fund such services leads to the clear creation of two-tiered health care in Ontario.¹²⁶

5.1.4. Resident Rights and Remedies

Both LTCHs and RHs are governed by extensive rules regarding the licensing of homes, residents’ rights, care standards, safety and security, protections against abuse and neglect, and powers of inspectors. Both also establish offences, penalties, appeals and enforcement. The RH regulatory regime drew heavily from the LTCH regime in providing (i) requirements for a bill of rights; (ii) assurances that residents may participate in their own plan of care; (iii) a residents’ council for each home, which is to be composed solely of residents, and the rights of residents to be informed of their rights, to attempt to resolve disputes between the licensee and residents, and to report their concerns or recommendations about the operation of the home to the licensee.

Table 5.4 compare the rights and remedies under the RHA and the LTCHA. To ensure compliance, both Acts provide for (iv) inspections of homes, including unannounced inspections; and (v) enforcement, which is bolstered under both Acts by complaint processes, compliance orders, and license revocation. The RHA also establishes penalties in the form of fines or imprisonment of individuals.

Table 5.4. Residents’ Rights and Remedies for RHs and LTCHs

Rights and Remedies	RHs (source: RHA)	LTCHs (source: LTCHA)
Residents’ Bill of Rights	Per the Act, s.5(1), includes right to information (re. services and charges), to external care, to choice of services, to participate in decisions and plan of care, to privacy and dignity, to clean environment, to respect for lifestyle choices, etc.	Per the Act, s.3(1), includes right to be treated with courtesy and dignity, not to be abused or neglected, to privacy, to participate in decisions and plan of care, to be fed, sheltered, clothed, groomed, to have safe and clean environment, to pursue social and cultural interests, etc.
Plan of Care	Required to be written, to state goals and directions to staff, to cover all aspects of care, including externally-provided services.	Required to be written, to state goals and directions to staff, to cover all aspects of care (medical, personal, dietary, social, religious).
Residents’ Council	Advises residents of rights, settles disputes, informs of activities, facilitates collaboration, provides feedback to licensee and to Registrar, acts as tenants’ association under Residential Tenancies Act, etc.	Advises residents of rights, settles disputes, informs of activities, facilitates collaboration, provides feedback to licensee and to Director, etc.
Inspections	At reasonable times without notice to assess compliance with the Act and to occur at least once per year.	At reasonable times without notice to assess compliance with the Act and to occur at least once per year.
Enforcement	Complaint process, compliance orders, licence revocation, fines, imprisonment	Complaint process, compliance orders, licence revocation.

5.1.5. Safety and Security

For LTCHs, The LTCHA requires (s.5) that the home provide a safe and secure environment.

O.Reg.79/10 under the Act provides detailed standards regarding all aspects of the physical environment, including doors, elevators, floor space, furnishings, privacy curtains, shower grab bars, bed rails, windows, lighting, temperature, plumbing and communication devices. For RHs, the RHA and O.Reg.166/11 are less detailed, but provide standards for temperature, cleanliness, hazardous substances and pest control. In terms of security of the person, specifically, both Acts contain provisions that specify zero tolerance for abuse or neglect.

5.1.6. Care Services

Central to both LTCH and RH statutory regimes are standards regarding care services. For both statutes, the plan of care is the starting point for provision of care. Regulations under the LTCHA and the RHA require initial assessments of residents, including physical, psychological and cognitive needs upon which the plan of care is developed and approved, with input from the resident and/or a representative. The plan of care ultimately determines which care services are utilized by the resident. In RHs, where registered nurses are not required to be on staff by the RHA or regulations, section 48 of the RHA stipulates that the plan of care must be approved by a person acting under the supervision of a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario. In addition, if the assessment indicates that care needs may include dementia care, skin and wound care or the use of a personal assistance device, the plan of care must be approved directly by a member of one of the above colleges.

Perhaps the most significant difference between LTCH and RH requirements for care is that all LTCHs are required to make available the care and services to which O.Reg.79/10 applies, whereas care services in RHs need to meet specified standards only in homes where those services are provided. This relates to the fact that RHs are defined as homes that provide *two or more care services* from a list in the RHA but are not required to provide all of these services.

For LTCHs, O.Reg.79/10 lists the requirements for all nursing and personal support services, such as bathing, personal hygiene, oral care, foot and nail care, dressing and bed-time routines. The regulation is quite detailed and includes, for example, the frequency of bathing and mouth

care. The regulation also contains specific provisions for four “Required Programs”, including (i) falls prevention and management, (ii) skin and wound care, (iii) continence care and bowel management and (iv) pain management. Each program must provide for screening protocols and assessment and reassessment instruments.

For RHs, O.Reg.166/11 outlines the care standards under ten care categories, including the administration of drugs or other substances (s.29); assistance with feeding (s.34); assistance with bathing (s.35); continence care (s.36); assistance with dressing (s.37); assistance with personal hygiene (s.38); assistance with ambulation (s.39); provision of a meal (s.40); dementia care programs (s.41) and provision of skin and wound care (s.42). In respect of care standards, the RHA (s.60) requires the home to ensure that the care services *provided* meet the prescribed standards. As such, the stated standard in the regulations for each care service begins with the words “if one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is [e.g., dressing]” and the standard then provides some flexibility depending on the circumstances of the resident. Because the care services in RHs are provided by the home on an opt-in basis, section 6 of O.Reg.166/10 also stipulates that a home must give at least 90 days’ notice to residents before any reduction in care services is to take effect.

Where the RH provides only a limited number of care services, this restricts admission to seniors whose needs it is able to accommodate. As an example, s.41 of O.Reg.166/11 under the RHA requires that a home providing a dementia care program be able to monitor the resident’s safety and well-being, offer appropriate therapies, develop adequate strategies for communicating with the resident and for identifying and addressing triggers for responsive behaviours. Similarly, if

the home provides skin and wound care, s. 42 requires the home to have programs and strategies for skin and wound care assessment and intervention, prevention of infection, appropriate transferring and positioning, with all programs incorporated into the plan of care.

Recognizing that the care services in a RH may not be comprehensive of the needs of all residents, the Act also stipulates that a home shall not “prevent a resident of the home from applying for care services from an external care provider of the resident’s choosing”, nor “interfere with the provision of care services to a resident of the home by an external care provider” (s.60). This would permit the resident to obtain services privately or from the CCAC, as described in Chapter 2.1. While this section ensures that the resident has access to outside services, it would not appear to overcome the limitations of the home in admitting residents for whom it cannot meet the appropriate standards required by the regulations (e.g., for dementia, wound care, feeding).

In addition to the 10 care services above, every RH is required to develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home (s.22) and manage resident behaviours that pose a risk to the resident or others in the home (s.23).

5.1.7. Staffing

O.Reg.79/10 under the LTCHA (s.214) requires that every LTCH have a medical director who is responsible for the development, implementation, monitoring and evaluation of medical services, as well as advising on clinical policies and procedures, where appropriate. There are, however, no requirements in terms of his/her presence in the home. The LTCHA has no requirements as

to minimum numbers of staff in LTCHs, except that it requires (s.8) every home to have *at least one registered nurse* (RN) who is both an employee and a member of the regular nursing staff of the home to be present in the home at all times, with certain exceptions. Also, section 74 requires every home to have a registered dietitian on site for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. In addition, O.Reg.79/10 (s. 31) stipulates that every home is to have a written *staffing plan* for the nursing and personal support services that is consistent with residents' assessed care and safety needs and promotes continuity of care by minimizing the number of different staff. O.Reg.79/10 deals with *qualifications of the staff* in the home, including nurses (s.46), PSWs (s.47), therapy services staff (s.61), social workers (s.63) and dietitians (s.74).

The issue of minimum staffing standards in LTCHs has gained attention in Ontario in the scholarly discourse as discussed previously (Chapter 3), in the media¹³⁰ and by governments⁹⁹, care providers¹²⁸ and owners/operators of homes.³⁶ Factors that have brought the subject of staffing levels to prominence include evidence of the connection between staffing and quality of care, recent increases in care needs as a result of greater acuity among LTCH residents, and budgetary constraints that affect staffing.

Perhaps the strongest voice for implementing staffing level standards comes from workers providing the care. The Ontario Council of Hospital Unions has submitted¹³¹ that care for seniors in LTCHs is suffering due to routine understaffing of both PSWs and registered practical nurses (RPNs). They argue that staffing levels have not kept pace with the increasing complexity of care needs and that a mandatory minimum staffing ratio of one PSW per eight

residents should be implemented. Similarly, the Canadian Union of Public Employees (CUPE)¹³² has called for an amendment to the LTCHA to invoke a care standard of a minimum 4 hours per resident each day, adjusted for acuity level and case mix.

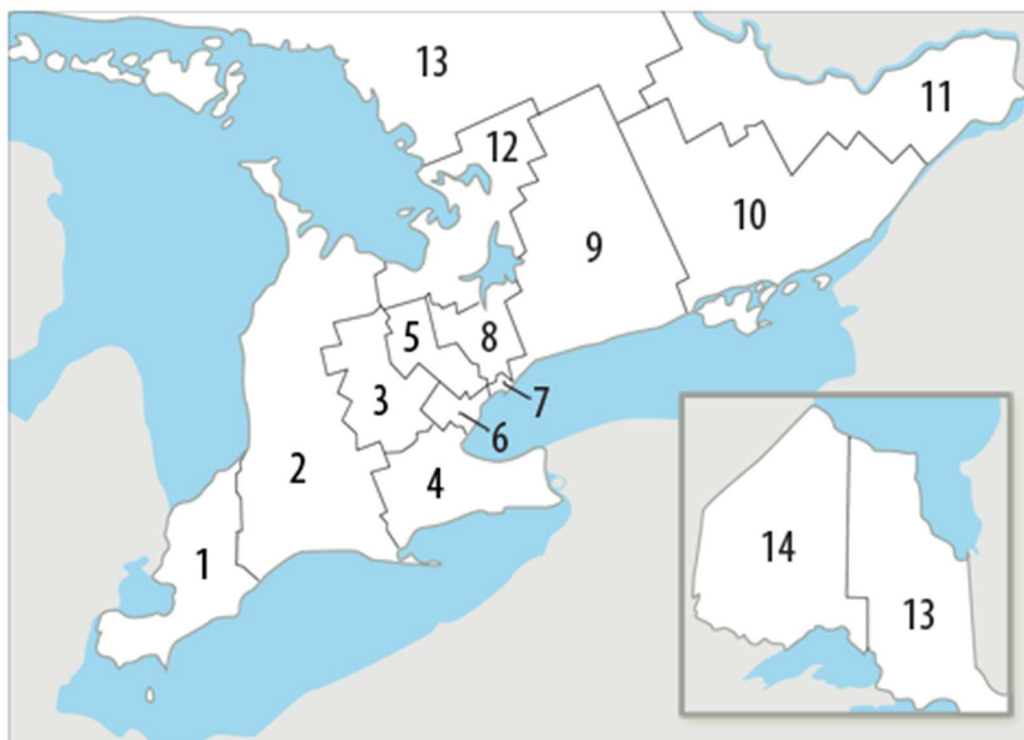
Among the organizations representing the owners and operators of the homes, OANHSS advocated in their 2015 Provincial budget submission¹³³ for the implementation of a system to increase staffing levels in order to improve the level of safety and care quality in LTCHs. Rather than an amendment to the regulations, however, they called on the MOHLTC to set and fund over the next three fiscal years a system target of 4.0 paid hours of direct care per resident day (PHPRD). That compares with the current level of 2.99 PHPRD, comprised of RNs (0.28), RPNs (0.55) and PSWs (2.16), according to the OLTCA.

For RHs, the RHA stipulates hiring and screening practices as well as qualifications and training. However, there are no legislative requirements regarding type or number of staff required, as the staff complement in RHs varies according to the care service offering within the particular home. For example, a home that provides only meals and bathing would not require nursing staff. Section 65 of the Act states the requirement that all staff who work in the home have the proper skills and qualifications to perform their relevant duties, and that they receive certain minimum training in such matters as the use of personal assistance devices, no tolerance for abuse, protection for whistle-blowers, injury prevention, fire and safety, evacuation and infection prevention and control. In addition, staff who have direct contact with residents are required to receive ongoing training on matters of abuse recognition and prevention; mental health issues, including caring for persons with dementia; and behaviour management.

5.2. Numbers and Locations of Homes and Residents

Data in this Chapter make reference to LHIN Zones which are numbered according to the map in Figure 5.1. Corresponding LHIN names are shown in the tables throughout this Chapter.

Figure 5.1. Ontario Map of LHIN Zones



Source: <http://www.lhins.on.ca/>

There are approximately 640 LTCHs in Ontario with a total of over 78,000 beds, and approximately 730 RHs with over 72,000 beds. Table 5.5 shows the distribution of LTCH and RH beds by LHIN region throughout the province.

Table 5.5. Numbers and Locations of Homes and Beds (LTCHs and RHs)

<i>Local Health Integration Network</i>	<i>Zone #</i>	Long-Term Care		Retirement	
		Homes	Beds	Homes	Beds
<i>Erie St. Clair</i>	1	37	4,588	50	4,435
<i>South West</i>	2	80	7,619	80	6,145
<i>Waterloo Wellington</i>	3	38	4,131	50	4,581
<i>Hamilton Niagara Haldimand</i>	4	87	10,592	100	8,401
<i>Central West</i>	5	23	3,490	17	1,408
<i>Mississauga Halton</i>	6	28	4,096	42	5,663
<i>Toronto Central</i>	7	36	5,879	34	4,771
<i>Central</i>	8	46	7,270	58	7,436
<i>Central East</i>	9	69	9,400	69	6,709
<i>South East</i>	10	36	4,028	48	3,100
<i>Champlain</i>	11	60	7,622	110	12,462
<i>North Simcoe Muskoka</i>	12	27	3,004	40	3,572
<i>North East</i>	13	53	5,322	25	2,896
<i>North West</i>	14	21	1,717	5	546
Ontario		641	78,758	728	72,125

Sources: LTCH data from MOHLTC’s Reports on Long-Term Care (2016)
 RH data from RHRA public register (2016)

5.2.1. Geographic Dispersion of LTCHs and RHs

When the numbers of LTCHs and RHs in Table 5.5 are compared with the population of Ontarians over the age of 75, it is clear that LTCHs are more evenly distributed in accordance with the seniors’ population than is the case with RHs. As Table 5.6 shows, there are approximately 12.3 Ontarians over age 75 per LTCH bed in Ontario, with a range from 9.2 in the North East LHIN to 17.0 in Mississauga Halton. The corresponding ratio for RHs is similar on a province-wide basis at 13.4, but there is considerable variability among LHINs, ranging from 7.1 seniors over 75 per RH in the Champlain LHIN to over 30 in the Central West and North West LHINs.

Table 5.6. LTCH and RH Numbers per Population > 75

<i>Local Health</i>			Population > 75		Pop > 75 / # of Beds	
<i>Integration Network</i>	<i>Zone #</i>	Population	#	%	Long-Term Care	Retirement
<i>Erie St. Clair</i>	1	655,073	50,690	7.7%	11.0	11.4
<i>South West</i>	2	991,016	77,516	7.8%	10.2	12.6
<i>Waterloo Wellington</i>	3	810,457	50,263	6.2%	12.2	11.0
<i>Hamilton Niagara</i>	4	1,458,947	120,385	8.3%	11.4	14.3
<i>Central West</i>	5	928,160	43,047	4.6%	12.3	30.6
<i>Mississauga Halton</i>	6	1,277,172	69,463	5.4%	17.0	12.3
<i>Toronto Central</i>	7	1,159,030	80,586	7.0%	13.7	16.9
<i>Central</i>	8	1,918,865	119,095	6.2%	16.4	16.0
<i>Central East</i>	9	1,698,470	119,709	7.0%	12.7	17.8
<i>South East</i>	10	502,412	44,722	8.9%	11.1	14.4
<i>Champlain</i>	11	1,316,066	89,040	6.8%	11.7	7.1
<i>North Simcoe Muskoka</i>	12	497,671	38,869	7.8%	12.9	10.9
<i>North East</i>	13	574,729	48,868	8.5%	9.2	16.9
<i>North West</i>	14	237,157	17,584	7.4%	10.2	32.2
Ontario		14,025,225	969,837	6.9%	12.3	13.4

Sources: LTCH data from MOHLTC's Reports on Long-Term Care (2016)

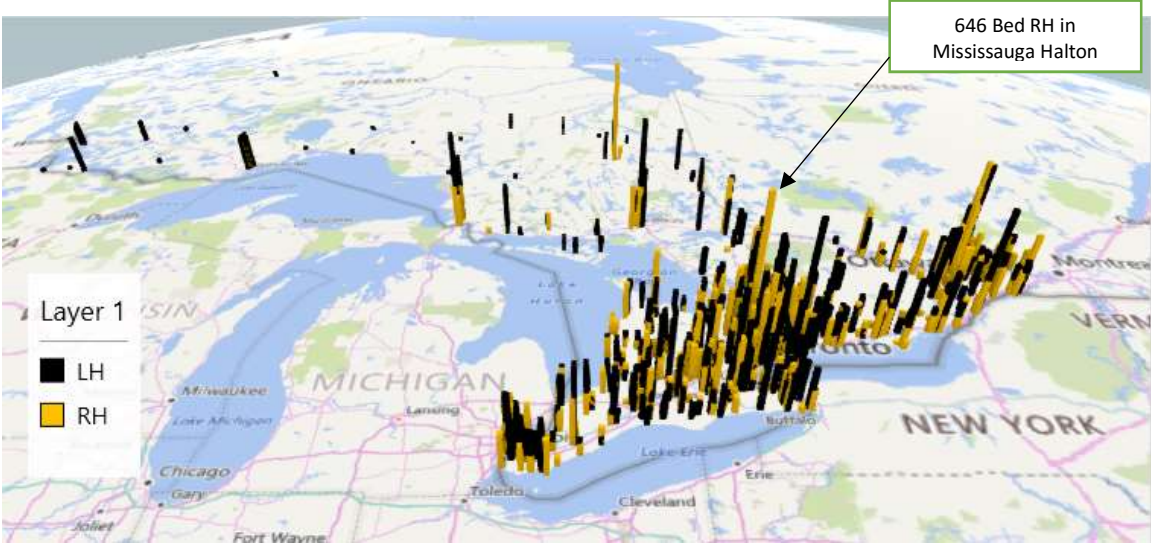
RH data from RHRA public register (2016)

Population statistics from Statscan census data as provided by the Ministry of Finance to the MOHLTC and referenced in HDB's Long-term Care Homes Report (2015).

It is conceivable that the more even dispersion of LTCHs is a function of government policy to have equal access across the province. In this regard, the location of LTCHs is influenced in large part by the MOHLTC, as stipulated by s.96 of the LTCHA. The Minister, in determining *whether* there should be a LTCH in an area, and *how many* beds there should be, is to consider the public interest, including (i) the existing LTCH bed capacity in the area or other areas, (ii) the other facilities or services available, (iii) the current and predictable continuing demand for LTCH home beds in the area, and (iv) the funds available for LTCH homes in Ontario.

Supply of RHs, on the other hand, is determined according to the interests of would-be Owners of homes, which may not coincide with consumer need in the particular geography. As noted in Chapter 1, the vast majority of RH homes are owned by FP entities, which need to justify the capital investment necessary to build and operate a RH in terms of prospective returns, whereas a significant proportion of LTCHs are owned by non-profit entities and municipalities that may be more focused on the needs within a geographic, ethnic or religious community. The map in Figure 5.2 shows the locations of all LTCHs (in black) and RHs (in gold) throughout Ontario. The height of the bars corresponds with the number of beds in each home, where the largest home (a RH in Mississauga Halton) has a bed capacity of 646.

Figure 5.2. Geographic Dispersion of LTCHs and RHs in Ontario



Sources: Data compiled from RHRA Public Register and MOHLTC’s Reports on Long-Term Care

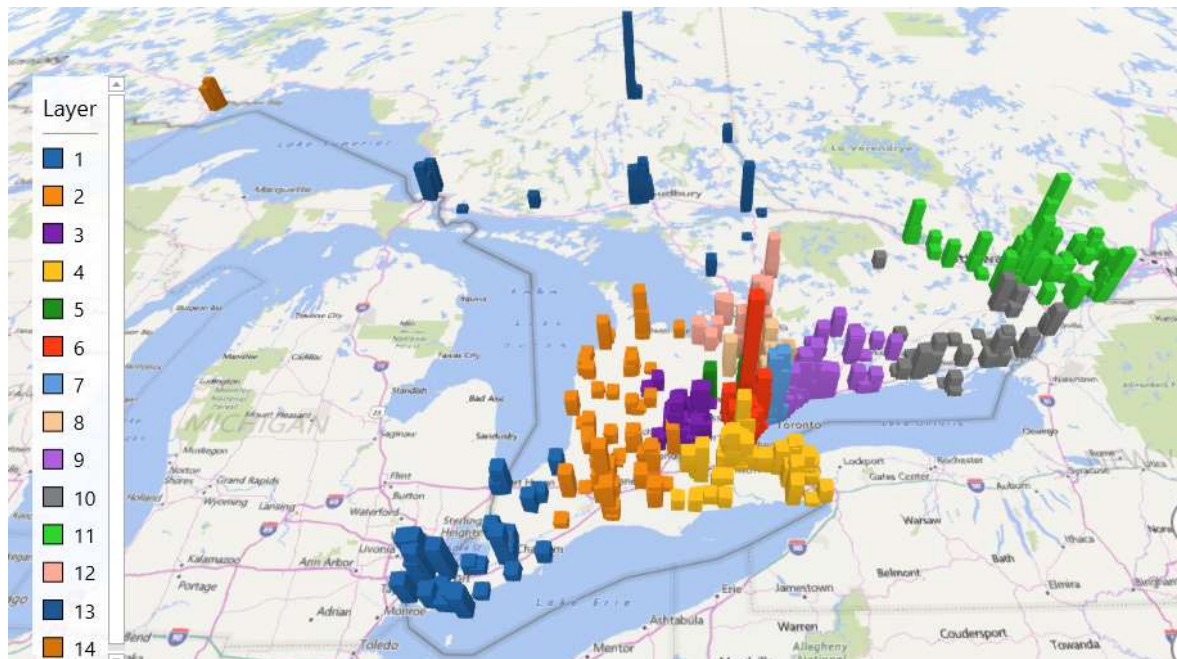
As can be expected, the density of homes (both LTCHs and RHs) increases with proximity to the higher population centers within the province. It is also apparent that RHs are few in number in

Northern Ontario. Consistent with Figure 5.2, above, Figure 5.3 below shows that RHs are most prevalent in the Champlain LHIN, (Ottawa), even relative to the number of seniors living there.

Figure 5.4 shows the corresponding location and bed capacity of LTCHs by LHIN.

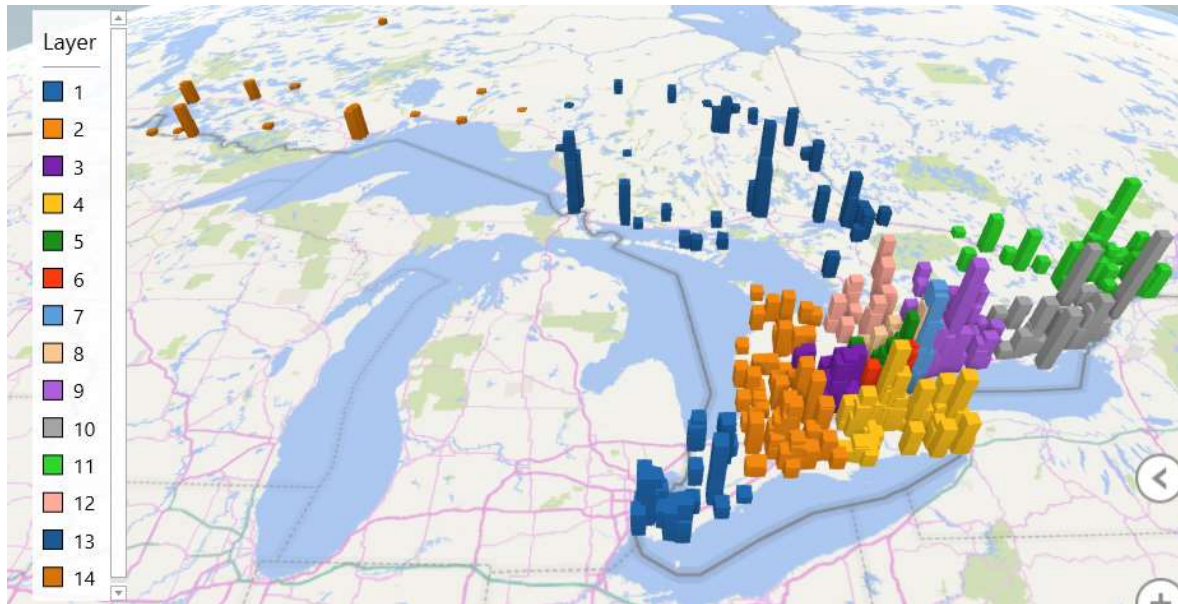
Based on LTCH statistics for the period 2010 to 2015 (comparing HDB's Long-Term Care Home System Reports as of October 31, 2015 and October 31, 2010), the number of licensed LTCH beds in Ontario grew by only 1.5% over the five-year period, compared to an increase of 12% in the population of people over 75. By contrast, the RHRA 2015 annual report shows that the number of RH licenses increased from 565 in 2012-13 to 716 in 2014-15. These numbers have increased further to 728 as of July 2016.

Figure 5.3. Location of RHs by LHIN, Depicting Number of Beds per Home



Source: Data compiled from RHRA Public Register

Figure 5.4. Location of LTCHs by LHIN, Depicting Number of Beds per Home



Source: Data compiled from MOHLTC Reports on Long-Term Care

5.2.2. Migration between LHINs

Table 5.6 illustrated the ratio of homes to the seniors (75+) population within the particular LHIN. While this is helpful in assessing capacity throughout Ontario, it does not factor in the effect of movement by seniors across LHIN boundaries. Table 5.7 below shows the extent to which seniors utilize LTCHs within their own LHIN versus those in neighbouring LHINs. Not shown are the North West and North East LHINs, where significant distances make movement across LHIN boundaries the exception, though there are likely to be long distances travelled within such boundaries to access LTCHs. As can be seen in Table 5.7, while most seniors stay in their home LHIN, there are substantial differences geographically. For people in the Erie St. Clair LHIN, 95% tend to select a LTCH within their home LHIN. However, those in the

Central, Central West, Mississauga Halton and Toronto Central LHINs have a higher likelihood of moving elsewhere, possibly because these LHINs are closely clustered and movements across boundaries may represent minimal dislocation to the resident. Referring back to Table 5.6, these four LHIN regions rank among the highest in terms of the number of people over 75 relative to the number of available LTCH beds in their geography. Of course, while residential resources should be planned for areas where people seek residential care, it is difficult to confirm where migration is a result of consumer preference (e.g., ethno-cultural preference or proximity to family) and where it is due to a lack of availability in the home LHIN. Also cross-LHIN mobility may be more expected within more dense urban geographies such as Toronto, which occupies five different LHINs.

Table 5.7. Tendency to Stay within LHIN (LTCHs)

Resident LHIN	LHIN Zone	Percent Remaining in Home LHIN
<i>Erie St. Clair</i>	1	95
<i>South West</i>	2	92
<i>Waterloo Wellington</i>	3	90
<i>Hamilton Niagara</i>	4	94
<i>Central West</i>	5	77
<i>Mississauga Halton</i>	6	73
<i>Toronto Central</i>	7	64
<i>Central</i>	8	73
<i>Central East</i>	9	88
<i>South East</i>	10	93
<i>Champlain</i>	11	96
<i>North Simcoe Muskoka</i>	12	84

Source: Adapted from Preyra Report, Ministry of Finance, Statistics Canada

5.2.3. Wealth Effects on Residential Care Choices

There are significant differences across income groups in terms of the use of LTCHs. As Table 5.8 below shows, there is an inverse relationship between income and likelihood of residing in a LTCH in Ontario, with seniors in the lowest income group being 42% more likely to reside in a LTCH than those in the highest income group. This may be due in part to the affordability of LTCHs as opposed to RHs, since care requirements are funded by government in LTCHs. In addition, s.253 of the LTCHA permits low income residents to apply for a reduced amount payable for basic accommodation in LTCHs. Section 144 of O.Reg.79/10 further prohibits the discharge of a LTCH resident unless specifically “permitted or required” by the regulation, effectively ensuring that residents not be discharged for failure to pay the accommodation charge. The lower utilization of LTCHs by the high and very high income groups in Table 5.8 point to the role of privately-funded care and accommodation among wealthier seniors. This may include RHs or privately-paid home care. Table 5.8 does not provide statistics with regard to income levels and the likelihood of choosing a RH. Chapter 5.5, however, compares the cost of accommodation and care services between LTCHs and RHs.

Table 5.8. Income Stratification and Probability of Residing in a LTCH		
<u>Income Stratification</u>	<u>Age Standardized LTCH Days per 100,000</u>	<u>Divided by Lowest Standardized Rate</u>
Very low income	224,711	1.42
Low income	189,391	1.20
Median income	193,171	1.22
High income	183,067	1.16
Very high income	158,406	1.00

Source: Adapted from Preyra Report, Statistics Canada, LTC 2010/11-2012/13

5.2.4. Availability of Other Care Options

As discussed in Chapter 2, the propensity of seniors to seek residential care is influenced, in part, by the other care alternatives available locally. The MOHLTC set up the Health Based Allocation Model (HBAM),¹³⁴ a decision-making tool for the LHINs in allocating funds among service providers with the use of an evidenced-based assessment of each regions' health needs. HBAM is intended to recognize the geographic variation in access to home care, sub-acute and acute care and to identify and address disparities in access to health care services by region. This has shown that, in certain LHINs, such as Toronto Central, residents have greater access to care services than in others, such as Central West and North Simcoe Muskoka. Differences in access are important from both an efficiency and an equity perspective and a lack of other care services in the community may be a factor leading to increased demand for LTCH accommodation.

5.2.5. Geographic Health and Healthcare Characteristics

Table 5.9 compares the LHINs according to the prevalence of certain medical conditions among the population over 65, and Table 5.10 shows the differences among LHINs of healthcare-related population characteristics that may affect the demand (or unmet demand) for residential care.

LHIN ID	LHIN Name	Diabetes	Asthma	High Blood Pressure	Mental Health Visits	COPD
1	<i>Erie St. Clair</i>	29.9	11.5	72.7	10.2	26.7
2	<i>South West</i>	26.9	9.9	68.0	7.4	21.8
3	<i>Waterloo Wellington</i>	28.0	9.7	63.8	7.0	17.6
4	<i>Hamilton Niagara</i>	27.9	11.3	69.7	8.2	21.1
5	<i>Central West</i>	35.9	14.9	71.2	8.8	15.1
6	<i>Mississauga Halton</i>	30.2	13.1	68.0	8.6	15.3
7	<i>Toronto Central</i>	27.1	13.9	63.2	9.2	18.8
8	<i>Central</i>	31.3	13.4	68.0	8.6	15.8
9	<i>Central East</i>	32.0	13.9	70.6	7.6	20.7
10	<i>South East</i>	26.6	10.9	65.8	6.8	23.4
11	<i>Champlain</i>	26.3	13.7	63.4	8.4	20.2
12	<i>North Simcoe Muskoka</i>	26.5	11.7	68.0	7.3	23.7
13	<i>North East</i>	30.5	11.0	70.5	7.9	26.9
14	<i>North West</i>	28.5	9.6	66.3	5.3	23.5
	<i>Province of Ontario</i>	29.2	12.4	68.0	8.1	20.1

Source: MOHLTC's Ontario Health Profiles database

The northern LHINs (including North Simcoe Muskoka) also rank among the highest in terms of rates of hospitalizations for people over 85, the percent of hospital days that are ALC among people over 85, and the percent of population over 65 in private households who live alone.

These characteristics could drive greater need for residential care within those LHIN regions.

Table 5.10. Select Health Care-Related Characteristics by LHIN

LHIN ID	LHIN Name	% Pop>19 Not enrolled in Primary Health	Average annual rate of hospitalization per 1000 >85	% of Pop > 65 In Private household who live alone	% of hospital days that are ALC in Pop >85
1	<i>Erie St. Clair</i>	19.7	375.8	27.7	26.2
2	<i>South West</i>	16.7	389.0	27.1	23.0
3	<i>Waterloo Wellington</i>	18.7	337.2	24.3	27.2
4	<i>Hamilton Niagara Haldimand Brant</i>	16.2	359.7	26.6	24.3
5	<i>Central West</i>	23.1	349.5	14.8	21.9
6	<i>Mississauga Halton</i>	22.7	344.5	19.0	22.3
7	<i>Toronto Central</i>	27.5	382.5	34.0	25.2
8	<i>Central</i>	20.4	359.8	18.7	27.1
9	<i>Central East</i>	19.7	350.0	21.2	24.3
10	<i>South East</i>	13.6	343.0	25.9	24.3
11	<i>Champlain</i>	22.8	332.7	26.1	27.3
12	<i>North Simcoe Muskoka</i>	17.5	408.7	23.1	34.6
13	<i>North East</i>	24.3	491.5	28.3	37.7
14	<i>North West</i>	27.8	535.7	30.1	31.8
	<i>Province of Ontario</i>	20.7	369.3	24.4	26.5

Source: MOHLTC’s Ontario Health Profiles database

As the foregoing analysis demonstrates, the relative demand/supply balance of LTCHs across the province is a much more complex dynamic than a simple ratio of seniors-to-beds conveys. It must be considered in the context of (i) the migration of seniors who take up residence in LTCHs of other LHINs, which in turn could be driven by either desire to move or scarcity in the home LHIN; (ii) wealth effects that lead lower income Ontarians to opt for LTCH accommodation in greater numbers than the wealthy, the latter favouring other residential offerings; (iii) the availability of other care options in the region, including home care, which drive the relative need for LTCH beds; and (iv) the health profiles of seniors, which vary by region and can

account for differences in acuity and therefore residential care needs. In addition, and not considered in the tables above, are factors related to (i) ethno-cultural aspects of the various residential alternatives and (ii) the desires and locations of family and friends, some of whom are also potential caregivers and could therefore obviate the need to seek residential care.

5.3. Seniors' Residential Care Industry

The residential care industry is composed of large and small entities, ranging from national chains to sole proprietorships. From an ownership perspective, most homes (both RHs and LTCHs) are owned by FP corporations, though many LTCHs are NFPs, charities and municipalities, the purpose or mission of which can vary broadly. All homes and their Owners experience some level of competition with other providers of residential care in their communities and all are subject to environmental factors that include consumer demand and preferences, demographic trends, government regulation, capital markets, technological innovations and general economic climate.

For many seniors requiring higher acuity care, residential care may become the only practical option. As such, the supply side of the industry is of critical importance in understanding the capacity of home Owners to meet care needs as the population of seniors increases in coming decades. In the context of the present inquiry, it is also important to understand the extent to which LTCHs and RHs share similar challenges, serve common consumer groups and compete with one another.

5.3.1. Sector Concentration

The seniors' residential care industry remains quite fragmented, though there has been considerable consolidation in recent years among some of the larger operators. The 15 largest LTCH operators in Canada, by number of units (defined as separate living areas), are shown in Table 5.11. These large operators comprise approximately 25% of all units in the market. All of the largest five LTCH entities operate in Ontario and are FPs. Table 5.12 shows a similar list for RHs in the Canadian market, where the top 15 operators constitute 38% of the market. Most of these predominantly FP operators have a presence in Ontario, including the largest three.

<u>LTCH Operator</u>	<u>No. of Properties Operated (a)</u>	<u>No. of Units Operated (b)</u>
Extencicare	95	12,598
Revera	76	9,465
Sienna Senior Living	42	6,738
Chartwell Retirement Residences	28	3,747
Schlegel Villages	13	2,107
Retirement Concepts	17	1,837
Group Champlain	14	1,746
Shannex	14	1,588
Rykka Care Centres	9	1,520
Park Place Seniors Living	13	1,497
Omni Health Care	18	1,475
Jarlette Health Care	13	1,437
Caressant Care	15	1,247
Good Samaritan Society	13	1,228
Steeves & Rozema	7	928
15 Largest LTCH Operators' Share of Total Units		24.60%

Sources and footnotes: See Table 5.12

For both LTCHs and RHs, the largest operator (Extendicare in the case of LTCHs, and Chartwell Retirement Residences in the case of RHs) operate over ten times the number of units as those ranking 15th on the respective list. Note that the statistics for both LTCH and RH operators include properties managed for third parties as well as those that are owned by the operator. According to the CORE database, over 10% of RHs are operated by third parties and it is likely that the percentage is greater in the case of LTCHs.

<u>RH Operator</u>	<u>No. of Properties Operated (a)</u>	<u>No. of Units Operated (b)</u>
Chartwell Retirement Residences	150	21,254
Revera (c)	105	11,401
BayBridge Senior Living (d)	64	8,077
Cogir	36	7,954
Reaseau Selection (d)	26	6,334
Groupe Savoie	14	5,331
La Groupe Maurice	18	4,660
All Seniors Care	29	4,383
Verve Senior Living	34	4,078
Atria Senior Living	29	3,354
Shannex	11	1,972
Symphony Senior Living	11	1,902
Good Samaritan Society	25	1,713
Schlegel Villages	7	1,602
Extendicare	16	1,593
15 Largest RH Operators' Share of Total Units		38.20%

Sources: Adapted from Chartwell Retirement Residences Annual Information Form, February 2016, compiled by Chartwell based on publicly available information as well as information from CBRE Limited.

- a. Includes properties managed for third parties and properties under development.
- b. For LTCHs, includes only those operated within above-noted properties.
For RHs, includes IL, ISL, AL and MC within above-noted properties.
- c. Excludes US holdings.
- d. Reflects recent transfer of property management and/or announced transactions.

The mission statements of some of the largest providers also show that they foster a broad, holistic view of the industry and their own service offering. For Chartwell, Extencicare, Revera and Schlegel Villages, each of which owns and operates both LTCH and RHs, mission statements in Table 5.13 contemplate coverage of the full continuum of seniors’ residential care along with physical and mental health and general well-being. Consistent with goals of providing a breadth of service coverage in the sector, large publicly-traded firms such as Chartwell and Sienna Senior Living place consolidation and acquisition among their key competitive strategies, as publicly reported in their respective Annual Information Forms.

<i>Chartwell</i>	To provide a happier, healthier and more fulfilling life experience for seniors.
<i>Extencicare</i>	To be the best provider of senior care and services in Canada.
<i>Revera</i>	To help older adults live life to the fullest.
<i>Schlegel</i>	To provide holistic health care in a home environment, located within an internal neighbourhood design that promotes a caring community, with emphasis on optimal health and life purpose for each Resident.

Sources:
 Chartwell website: <http://chartwell.com/about-us/our-vision-mission-and-values>
 Extencicare website: <https://www.extencicare.com/about-extencicare/>
 Revera website: <http://www.reveraliving.com/about-revera/about-revera>
 Schlegel Villages website: <http://schlegelvillages.com/about-us/mission-life-purpose-within-caring-community>

5.3.2. Ownership Type

The vast majority of RHs in Ontario are owned by FPs, though LTCHs are owned by a mix of FPs, NFPs and municipalities. As Table 5.14 shows, approximately 54% of LTCH beds in Ontario are owned by FPs, while 25% are owned by NFPs and 21% by municipalities.

Participation by Ontario’s municipalities in the LTCH sector is mandated by statute. Part VIII of the LTCHA sets out requirements of municipalities (based on location and tier) to establish and maintain a municipal LTCH. Homes owned by municipalities tend to be larger, at an average of 161 beds per home, whereas homes owned by FPs and NFPs tend to be smaller by approximately 25 beds on average.

Table 5.14. Supply of LTCH Beds by Ownership Type

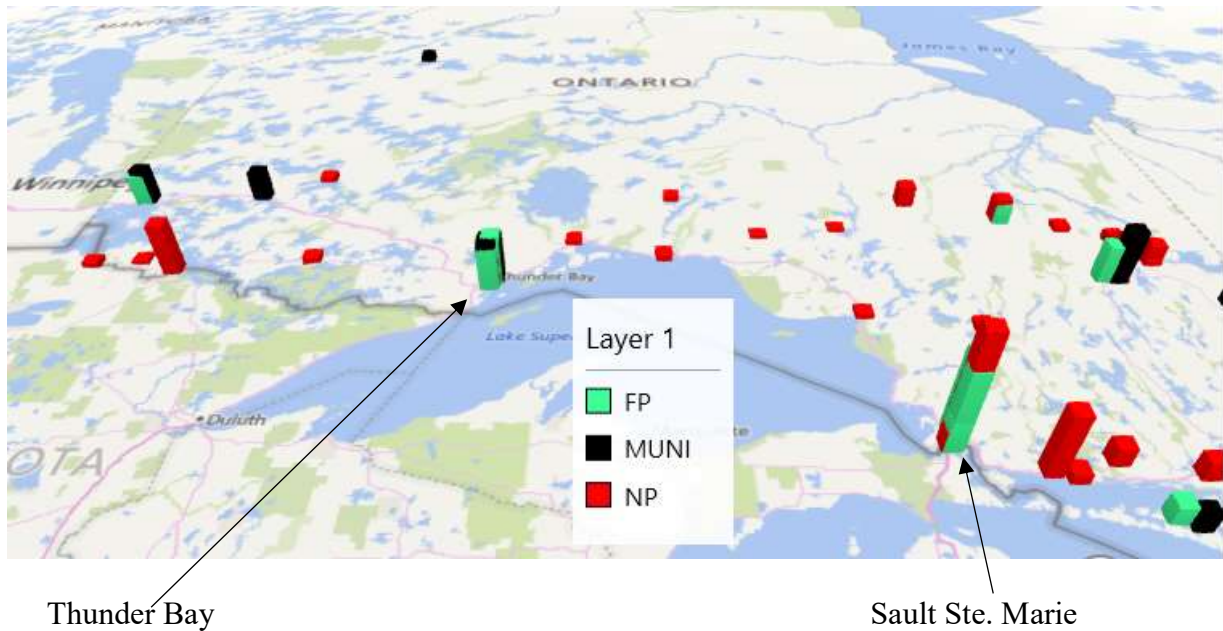
LHIN ID	LHIN Name	Total	FP	NFP	Municipal
1	<i>Erie St. Clair</i>	100%	71%	5%	23%
2	<i>South West</i>	100%	60%	14%	25%
3	<i>Waterloo Wellington</i>	100%	67%	23%	11%
4	<i>Hamilton Niagara Haldimand Brant</i>	100%	51%	30%	19%
5	<i>Central West</i>	100%	65%	9%	26%
6	<i>Mississauga Halton</i>	100%	65%	17%	18%
7	<i>Toronto Central</i>	100%	32%	50%	18%
8	<i>Central</i>	100%	47%	41%	12%
9	<i>Central East</i>	100%	62%	16%	21%
10	<i>South East</i>	100%	56%	11%	33%
11	<i>Champlain</i>	100%	47%	35%	18%
12	<i>North Simcoe Muskoka</i>	100%	57%	25%	19%
13	<i>North East</i>	100%	44%	26%	30%
14	<i>North West</i>	100%	32%	25%	43%
	<i>Province of Ontario</i>	100%	54%	25%	21%
Memo:	<i>Province of Ontario</i>	Total/Ave	For Profit	Non-Profit	Municipal
	<i>Homes by Ownership Type</i>	100%	57%	27%	16%
	<i>Average Beds per Home</i>	123	116	115	161

Source: MOHLTC Health Data Branch, HSI MI Division Bed Supply Report - October 2015 and <http://publicreporting.ltchomes.net/en-ca/homeprofile.aspx?>

The representation of beds owned by NFPs and municipalities, as opposed to FPs, is greater in northern Ontario than in the south, as shown in Figure 5.5. The FPs in the north tend to be larger

in terms of the numbers of beds and clustered in the higher population centres, including Thunder Bay and Sault Ste. Marie.

Figure 5.5. LTCH Ownership in Northern Ontario



Source: MOHLTC's Reports on Long-Term Care

As discussed in Chapter 3.4, there has been considerable research conducted with respect to differences or perceptions of care quality depending on whether NFPs or FPs are the providers of care. In the Ontario context, where all LTCHs receive government funding on the same flow-through basis, there may be less opportunity, as compared with other jurisdictions, to achieve efficiencies by limiting care-related expenses. However, it may also be the case that NFPs and municipalities are able to access alternative sources to fund operations from donations or local tax revenues that are not available to FPs and thereby supplement expenditures for staffing and other care services. According to an internal study conducted by OANHSS¹³⁵, its member municipalities contributed over \$225 million in 2008 to the operation of their LTCHs, over and

above the funding provided by the province. OANHSS calculated that this represented an additional \$37.28 per resident per day in municipal homes, which was used for direct care, as well as restorative care and other support services.

5.3.3. Barriers to Entry and Economies of Scale

Barriers to entry are both regulatory and operational. The regulatory regime provides a significant barrier for LTCHs and, to a lesser extent, RHs. Both LTCHs and RHs that provide care services must be licensed in order to operate (LTCHA s.95; RHA s.33), and care and safety standards (see Chapters 5.1.5 and 5.1.6) are onerous and detailed. In the case of LTCHs, the MOHLTC must approve both the issuance of new licenses, which has been very limited in recent years, and the transfer of existing licences (LTCHA s.105).

The operation of a seniors housing residence, whether LTCH or RH, requires a broad range of skills, including property management, food and lodging, social activation and management of health care programs. Many of these competitive factors depend on economies of scale, such as successful sales and marketing; community and labour relations; liaising with government, regulators and other professionals; and supply chain management. In addition, larger operators may be better able than smaller operators to attract and retain skilled managers, professionals and front-line staff by offering better career paths, working conditions and management support. Operationally, larger operators may also benefit from bulk purchasing. Access to financial markets for equity and debt capital can also be easier for larger or more established entities.¹³⁶

5.3.4. New Features and Technologies

The CMHC Ontario Report highlights the extent to which new seniors' residences (particularly RHs) are expanding the lifestyle features such as flexible care service options, larger spaces, activity programs, more amenities and services, and greater socialization opportunities. CMHC also points to a greater ability of seniors to afford upscale residences, given recent increases in household wealth and in the prices of homes, from which they may be downsizing. Many of the new features offered in RHs can be seen as catering to the demands of seniors to age in place. This is evident both in the types amenities being offered, which may make RHs a more desirable home environment, and in the spectrum of care services, which allow for graduated care as seniors' needs and care acuity levels increase with age.

Improvements in technology offer a means to enhance the experience of residents in RHS and LTCHs, and are becoming a differentiating factor in the competition to attract residents. Many of these new technologies are highlighted in the public reports of sector participants, such as Chartwell's 2016 Annual Information Form¹³⁶ and include emergency response and resident tracking systems, enhanced ventilation systems, anti-microbial/anti-bacterial carpets, new food preparation systems, computer based monitoring and communications systems, and portable telephones that permit staff to monitor a building's safety and security and respond promptly to resident requests. Internet stations and wireless Internet have been introduced as a standard component in the design of many new RHs. The ability of market participants to provide these technological differentiators often depends on the scale of operations, as the costs are typically fixed in nature.

5.3.5. Stability and Nature of Income

Consumer demand in the seniors' residential care sector depends on age demographics, which are largely predictable. For RHs, the principal factors affecting a residence's occupancy levels and revenues are the size of the seniors' population in the surrounding area, the income of the seniors in that area and the existing comparable supply of seniors housing in that market. In Ontario, LTCHs are less affected than RHs by competitive supply factors, as occupancy levels are characteristically near 100%, and affordability is less an issue, since accommodation charges in LTCHs are regulated within a fairly narrow band and the care expenses are funded by the provincial government.

For FPs, profit margins for RHs are generally higher than for LTCHs.¹³⁷ The ownership and operation of LTCHs tend to involve lower revenue fluctuations, but also generate lower profit margins than for RHs. Furthermore, as noted earlier where government funding of LTCHs is involved, much of it is of a "pass through" nature, such that monies received must be spent entirely on the designated service or returned to the government, without the opportunity to earn a profit margin.

The LTCH sector has historically been fairly well insulated from economic cycles. This can be attributed to several factors, including (i) the demand for LTCH housing not being discretionary but driven by need, which does not fluctuate during economic cycles; (ii) the stability of tenure, as seniors are generally unable to relocate to alternative accommodation once having moved into a facility; and (iii) the continual increase in the demand for LTCHs relative to supply.

The RH sector is less insulated from economic cycles when compared to the LTCH sector, as seniors tend to move into retirement residences based more on choice and affordability than is the case with LTCHs. However, some of the factors that support the stability of the RH sector¹³⁶ are that (i) seniors may be retired and receiving stable, fixed and predictable income from private and public pensions, RRSPs and other fixed income investment securities; and (ii) stability of tenure, as seniors, once having moved into a retirement home are less likely to seek alternative accommodation, at least until they require the level of care that makes them eligible to move to a LTCH.

5.3.6. Profitability and Return on Capital

The residential care industry is highly capital intensive due to required investments in land, buildings and fixtures. RHs are able to set rents and prices for care service according to market, which allows them to earn returns on capital committed, subject to competitive forces within the capital markets. For LTCHs, financial returns are affected by the flow-through structures of funding envelopes which do not allow for a profit margin on care services, and by controls on accommodation charges. Some of the larger chains that own and operate LTCHs and RHs are publicly traded and their annual and quarterly financial statements are subject to disclosure requirements. However, returns on capital are difficult to decipher, even from publicly available information, given the limited level of disclosure provided. Reports often combine the results of LTCHs and RHs as well as the revenues from third party management contracts and related business ventures, which make it difficult to separate margin and return metrics for specific lines of business, e.g., owned LTCHs versus owned RHs.

For LTCHs, the majority of which are FPs, profits are earned primarily from the OA funding envelope, with some supplementary in-flows from charges for non-care-related amenities (e.g. grooming and other non-care services). As explained profits cannot be earned from any care services to which the care funding envelopes apply and residents may not be charged for goods and services that a licensee is required to provide from those envelopes.

As noted earlier in Table 5.2, the OA funding rate for LTCHs was set at \$54.33 per diem in 2016, equal to approximately \$19,830 per annum. The OLTCAs, in its Pre-Budget Submission, purports to summarize the annual audited financial statements of 50% of the LTCHs filed with the province in 2012, including the expenses to which the OA funding envelope are applied.

Table 5.15 shows the percentage breakdown of OA funding according to those expenses.

Table 5.15. OA Expenses as a Percentage of OA Funding

Salaries, benefits and purchased services	53%
Utilities	9%
Management and allocated fees	6%
Maintenance and building services	4%
Supplies and equipment	7%
Property taxes	2%
Insurance and communication	1%
Other items	2%
Debt service, mortgage interest, capital expenditures and return on investment	<u>16%</u>
Total	100%

Source: Adapted from OLTCAs Pre-Budget Submission, 2015

The financial data referenced by the OLTCA suggests that only 16% of OA funding remains to cover (i) returns on capital, (ii) capital expenditures, such as roof and heating system repairs, furniture, hospital bed and technology infrastructure, and (iii) excess costs (beyond what is funded) for NPC, PSS and RF and (iv) corporate income tax (where applicable).

Estimates vary for the capital costs per bed in LTCHs. In a 2010 letter from KPMG to the OLTCA¹³⁸, a representative costing for the construction of a 100-bed LTCH was provided, which allocates \$10.5 million to construction, \$1.4 million to land and \$3 million for other capitalized costs, for a total of \$15 million, or \$150,000 per bed. This costing is consistent with the MOHLTC's Construction Funding Subsidy Policy, which bases the maximum financial assistance for construction costs of a LTCH bed (without land) on a *minimum* expenditure by the applicant of \$120,000 per bed. This figure includes the costs of construction, furniture, equipment, building permit, municipal development charges, architect and other professional fees, and related net taxes. Table 5.16 derives a return on capital per LTCH bed based on capital costs ranging from \$150,000 to \$200,000 per bed, which assumes some allocation to land costs. The implied returns on capital, assuming a 16% profit margin on OA funding, is in the range of only 2% per annum. This may, in fact, overstate the return on capital, as the calculation is before any outlays by the Owner for capital expenditures or the payment of corporate taxes. On the other hand, returns may be enhanced with addition of government capital assistance programs, and the "management and allocated fees" listed in Table 5.15, above, may represent a form of compensation to the Owner.

Table 5.16. Analysis of Return of Capital for LTCH Investment

Capital cost per bed	\$ 150,000	\$ 175,000	\$ 200,000
OA Annual Funding	19,830	19,830	19,830
OA Expense	84%	84%	84%
	16,657	16,657	16,657
Profit margin	16%	16%	16%
	3,173	3,173	3,173
Annual Return on Capital	2.12%	1.81%	1.59%

5.3.7. Other Business Risks

Owners of LTCHs and RHs are subject to numerous business risks related to the ownership of real property or inherent in the seniors' housing industry. As an equity investment, real property is illiquid, which can limit the ability of Owners to respond to changing economic or investment conditions. The greatest risks for all types of seniors' housing residences tend to be in the development phase, which includes land assembly, zoning approvals, construction and lease-up. Other risks related to the seniors housing sector include general economic conditions, capital expenditure requirements, occupancy levels, rents (rent control regulations for RHs and regulated accommodation charges for LTCHs), labour costs and labour relations, increases in taxes and fluctuations in other operating costs. Risks also include health-related risks, such as disease outbreak and control risks. As a capital-intensive sector, financial risks include the availability and cost of money for long-term financing. In addition, there are reputational and legal risks involved in providing housing and health care services to seniors. The limited mobility and vulnerability of some seniors, particularly in LTCHs, increase those risks.

5.4. Availability of Care Services and Amenities

LTCHs and RHs both provide care services related to nursing, personal care and ADLs. Homes may also compete on the basis of other amenities related to life enrichment or recreational activities. This is particularly the case among RHs, where there may be a greater proportion of residents who are able to take advantage of lifestyle features.

5.4.1. Care Services

Each resident in a LTCH is assessed with respect to his or her individual plan of care, which covers all aspects of the resident's care. Section 26 of O.Reg.79/10 requires that the plan be based on an interdisciplinary assessment of specified care domains, which include not only health conditions, but activity and sleep patterns, drug treatments, cognitive abilities, behaviours, and physical functioning. In principle, every LTCH must provide a care service offering that is comprehensive for residents of all needs, recognizing the generally high acuity needs of residents in LTCHs. In practice, as the OLTCA points out in its 2014 report entitled *This is Long-Term Care*,¹³⁹ there is variability in the provision of certain care services across the province with some homes better able than others to offer medical treatment previously done in hospitals such as dialysis and IV therapy.

In contrast, the availability of care services in RHs is determined by each home, depending on the array of services that the Owners decide to provide. Thus, while residents are assessed by the RH in order to provide the necessary plan of care, the home will be unable to admit a resident whose needs are beyond the array of care services provided by the home.

O.Reg.166/11 under the RHA lists care standards under ten care categories (see Chapter 5.1.6 Care Services). The RHRA website indicates, as disclosed by each licensed RH, the availability of each of these care services available in every home. Table 5.17 is a compilation showing the percentage of homes in each LHIN that provide each of the care services listed. It should be noted that it is not possible to determine from the table how many living units within each home can avail the indicated service – only that it is offered in the home and is being utilized by some residents. As the table indicates, all 728 licensed RHs provide meals and virtually all (99%) offer assistance with the administration of drugs. On the right side of the table are the services that are less prevalent, including feeding, wound care and dementia care, which are available in only 34%, 27% and 15% of homes, respectively. The mean offering across all homes is 7.02 of the ten care services categories.

There is considerable variability throughout the province in the availability of feeding and dementia care services for RH residents, with greater prevalence in the larger population centres and in Ottawa. Assistance with feeding ranges from 53% availability in the Toronto Central LHIN to 20% in the North East LHIN and no availability in the North West LHIN. Similarly, dementia care ranges from 27% availability in Champlain and 24% in Toronto Central, to no offering at all in the North East and North West LHINs.

Table 5.17. Retirement Homes - Provision of Care Services by LHIN

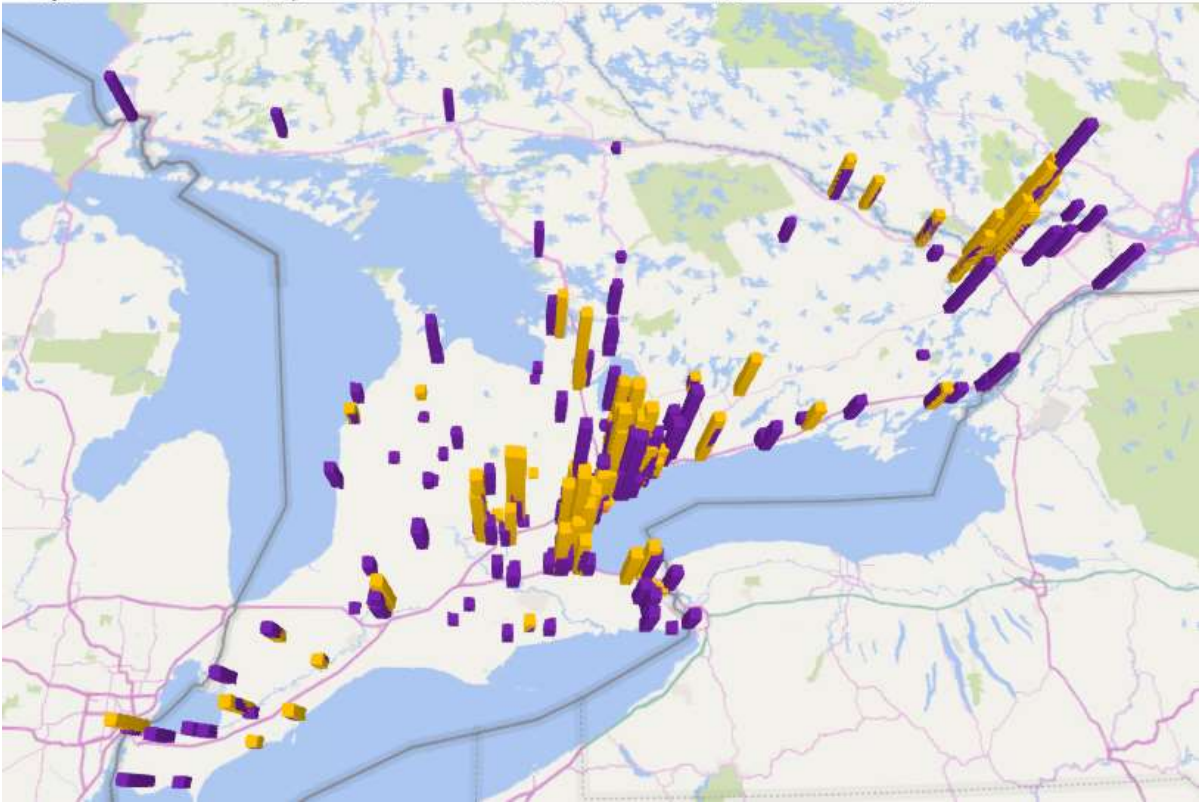
Percentages of Homes Providing Ten Care Services

LHIN	Homes	Meals	Drugs	Bathing	Hygiene	Dressing	Ambulation	Continenence	Feeding	Wound Care	Dementia
<i>Erie St. Clair</i>	50	100%	100%	96%	92%	86%	92%	86%	26%	32%	8%
<i>South West</i>	80	100%	99%	96%	85%	84%	75%	66%	30%	36%	10%
<i>Waterloo Wellington</i>	50	100%	100%	98%	84%	86%	76%	68%	34%	16%	14%
<i>Hamilton Niagara</i>	100	100%	100%	93%	85%	83%	78%	77%	42%	25%	16%
<i>Central West</i>	17	100%	94%	88%	94%	88%	76%	59%	24%	12%	12%
<i>Mississauga Halton</i>	42	100%	100%	93%	83%	86%	79%	71%	38%	43%	17%
<i>Toronto Central</i>	34	100%	100%	91%	94%	88%	85%	76%	53%	41%	24%
<i>Central</i>	58	100%	98%	98%	93%	95%	91%	83%	38%	31%	24%
<i>Central East</i>	69	100%	99%	99%	94%	93%	87%	88%	32%	26%	12%
<i>South East</i>	48	100%	96%	83%	77%	75%	81%	71%	25%	19%	4%
<i>Champlain</i>	110	100%	99%	93%	92%	89%	89%	82%	36%	23%	27%
<i>North Simcoe Muskoka</i>	40	100%	100%	98%	93%	88%	83%	73%	35%	25%	10%
<i>North East</i>	25	100%	100%	92%	64%	76%	76%	56%	20%	16%	0%
<i>North West</i>	5	100%	100%	100%	80%	80%	100%	60%	0%	20%	0%
<i>Ontario</i>	728	100%	99%	94%	88%	86%	83%	76%	34%	27%	15%

Source: data compiled from RHRA website: <http://www.rhra.ca/en/>

Figure 5.6 illustrates the geographic availability of feeding and dementia care in map format, with the purple bars indicating the location of RHs offering assistance with feeding and the yellow bars for dementia care. The heights of the bars correspond with the number of beds in each facility, though, as stated, this does not indicate the number of beds for which feeding or dementia care are provided in the home. Here again, the density around Toronto and Ottawa is observable in contrast with other areas of the province. As the yellow bars indicate, there are no RHs with dementia care in Northern Ontario (i.e., North East and North West LHINs).

Figure 5.6. RHs Offering Feeding Assistance (Purple) and Dementia Care (Yellow)



Source: data compiled from RHRA website

CMHC data categorize care services differently than RHRA data, sorting homes according to the number of meals per day provided in rent, and the availability of medical, nursing, and

pharmacy services (Table 5.18). Across the sample of Ontario homes surveyed by CMHC, 74% provide medical services, 68% provide nursing, 94% provide 24-hour call bell services and 9% have a pharmacy. The vast majority offer three meals per day though some offer one or two meals. The availability of these services is fairly consistent across all geographic centres throughout the province.

Table 5.18. Proportion (%) of Structures Where Select Services Are Available

Centre	Meals				On-Site Medical Services	On-Site Nursing Services	24-Hour Call Bell	Pharmacy
	Number Included in Rent							
	Optional	1	2	3				
<i>Greater Toronto Area</i>	0.7	0.6	10.3	88.4	76.8	73.6	96.7	9.1
<i>Central Ontario</i>	-	0.5	3.8	95.7	71.3	63.7	92.2	9.3
<i>Ottawa</i>	-	*	5.4	92.9	75.2	71.9	98.4	5.2
<i>Eastern Ontario</i>	-	2.4	2.2	95.4	69.7	55.5	87.7	7.5
<i>Southwestern Ontario</i>	1.6	0.8	3.2	94.3	77.5	75.3	96.8	10.7
<i>Northern Ontario</i>	*	-	2.9	90.8	*	*	81.2	*
<i>Ontario</i>	0.8	0.9	5.1	93.2	73.9	67.7	93.5	8.6

* suppressed for confidentiality or statistical reliability

Note: On-site nursing services include RN, RPN or LPN.

Medical services are not defined in the Report.

Source: CMHC Ontario Report.

CORE classifies levels of care in retirement residences according to independent living (IL), independent supported living (ISL), assisted living (AL) and memory care (MC). Table 5.19 shows the percentage of homes in the CORE database that provide each of these levels of care. IL units are defined as those that offer meals, housekeeping and laundry services without the availability of personal care services or other personal assistance. Only 23% of homes in the CORE database offer units without any personal care or assistance, i.e., the balance of 77% of homes provide some level of personal care or assistance for *all* units in the home. Approximately 79% of homes have units that provide ISL, which offer some level of personal care or assistance in addition to meals, housekeeping

and laundry. Homes that offer AL make up 33% of homes, where AL involves an addition to the base fee for an additional level of personal assistance services in a separate wing, floor or building. Homes with MC represent about 13% of all homes and include services in the base fee for persons with Alzheimer’s disease or other form of dementia, in a separate, secured wing, floor, or building. In addition to these services associated with RHs, 7.5% of homes have beds that are licensed as LTCH beds within the same residential complex.

Table 5.19. Proportion of RHs Offering the Following Levels of Care

Independent Living	23.0%
Independent Supported Living	79.2%
Assisted Living	33.0%
Memory Care	13.2%
Long-Term Care	7.5%

Source: CORE database

The CMHC Ontario Report also noted that average residence sizes are increasing in recent years and that older homes have been expanding their capacity, partly as a means to accommodate people with higher needs. This includes a growing trend in the market for older homes to increase their service level by adding a new wing or floor for residents who need high levels of care such as assisted living and memory care.

5.4.2. Other Amenities and Activities

The LTCHA requires that each resident’s plan of care address recreational, social, restorative, religious and spiritual needs, in addition to care needs. Section 10 of the Act states that there must be an organized program of recreational and social activities to meet the interests of the residents, including services for residents with cognitive impairments and those who are unable

to leave their rooms. The regulations under the LTCHA (Section 65) require the home to provide supplies and appropriate equipment and develop, implement and communicate a schedule of recreational and social activities. Included in the schedule must be a range of indoor and outdoor activities, leisure and outings that are of a type and frequency to benefit all residents and reflect their interests. In addition, the activities must be offered during days, evenings and weekends.

For RHs, there is no regulatory requirement for amenities or activities, though they are more prevalent than in LTCHs, both because residents themselves tend to be better able to access and enjoy these features, and because they form part of the consumer offering designed to attract residents with greater choice of living alternatives. Table 5.20 lists some of the more common amenities offered in retirements residences, according to the proportion of homes that provide them.

Table 5.20. Proportion (%) of Structures with Access to Select Amenities

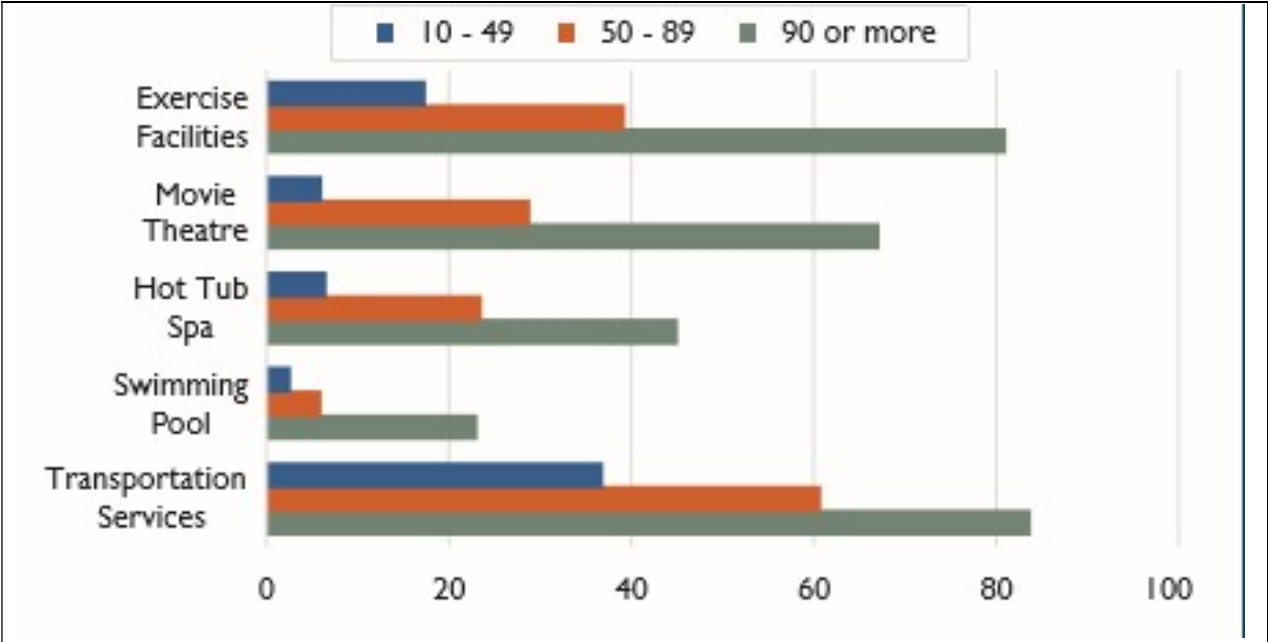
<i>Internet</i>	84.2
<i>Exercise Facilities</i>	49.6
<i>Movie Theatre</i>	37.6
<i>Hot Tub/Spa</i>	27.3
<i>Swimming Pool</i>	11.8
<i>Transportation Services</i>	63.2

Source: CMHC Ontario Report, 2016

As Figure 5.7 shows, the larger residences tend to be the ones that provide the greater offering of amenities. This may be because they have a critical mass of residents necessary to make

sufficient use of facilities such as theatres, swimming pools and movie theatres, or perhaps because of the high fixed cost nature of these features, which necessitates adequate scale to allocate such costs.

Figure 5.7. Percentage of RH Structures (by Size) with Access to Selected Amenities



Source: CMHC Ontario Report, 2015

5.5. Cost of Accommodation and Care

For LTCHs, the resident is responsible for the cost of accommodation, while costs for care are paid via the MOHLTC per diem funding envelopes (see Chapter 5). For RHs, accommodation and care services are at market rates and paid by the resident, as shown in Table 5.21.

Table 5.21. Basis of Accommodation and Care Charges

	RHs	LTCHs
Basis of rental charges	Market	Accommodation charges set by regulation, subject to resident’s eligibility for government subsidy
Basis of care charges	Market, paid privately, subject to standard services provided through CCAC or OHIP	Nursing, therapies and raw food costs paid on pass-through basis by LHIN to home. Homes are not permitted to charge in excess of prescribed rates.

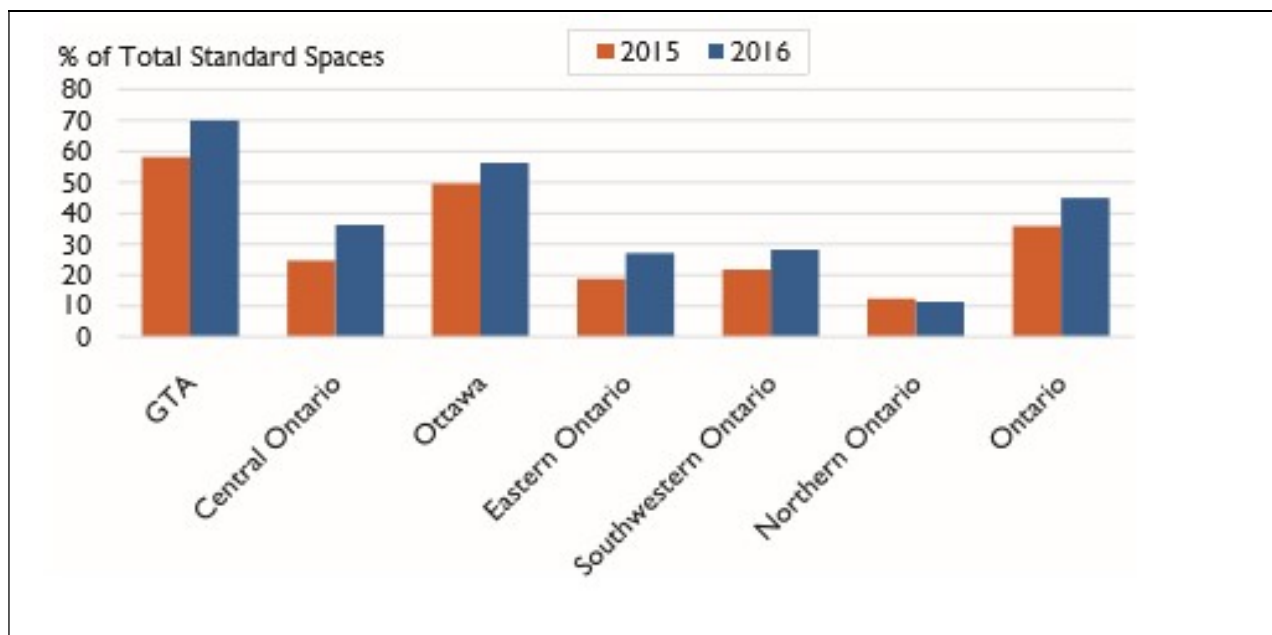
As noted earlier (Chapter 5.1.2.1), accommodation charges in LTCHs vary according to the level of accommodation, the design standard and the age of the home and residents are responsible for these charges, subject to eligibility for subsidies based on income level. As of July 1, 2016, rates for beds in the “A” category across the three accommodation levels are as follows:⁵

<u>Accommodation Level</u>	<u>Per Diem</u>	<u>Monthly</u>
Basic	\$58.99	\$1,794.28
Semi-Private	71.12	2,163.24
Private	84.27	2,563.22

For RHs, rates vary according to the size of the room or unit, the level of care provided and the geographic location, as shown in Table 5.22. Accommodation charges are the responsibility of the resident. As noted, CMHC data record the cost of retirement residence spaces according to unit type (semi-private through to two-bedroom) and distinguishes between standard spaces and heavy care spaces. Monthly rents for standard care spaces range from \$1,973 for semi-private

and ward accommodation to \$5,253 per unit for a two-bedroom space. There is a substantial range in rents by geographic location, with the Greater Toronto Area being the most expensive by about \$650 per month for the average standard space, compared with the provincial average. As Figure 5.8 shows, approximately 70% of standard accommodation offered in the Greater Toronto Area exceeds \$3,500 on a monthly basis, compared with only 10% of standard spaces in Northern Ontario. All geographies, with the exception of Northern Ontario, experienced increases in 2016.

Figure 5.8. Share of RH Standard Spaces Rented for Over \$3,500



Source: CMHC Ontario Report

Note: Regions depicted by CMHC data do not correspond with LHIN regions

For heavy care spaces, the average cost per unit is \$4,847 per month, as shown in Table 5.23.

Since heavy care spaces tend to be the smaller units (e.g., private studio or one-bedroom), this represents a premium of approximately \$700 to \$1,900 per month over the cost of a standard space of the same size.

Table 5.23. Average RH Rent by Unit Type by Centre

Centre	Standard Care Spaces					Heavy Care Spaces
	Semi- Private and Ward	Private Studio	One Bedroom	Two Bedroom	Average Standard	
<i>Greater Toronto Area</i>	2,468	3,484	4,558	5,856	4,154	5,130
<i>Central Ontario</i>	1,928	2,895	3,967	4,771	3,246	4,425
<i>Ottawa</i>	1,477	3,270	4,801	5,586	3,904	5,248
<i>Eastern Ontario</i>	1,629	2,552	3,829	4,535	2,909	*
<i>Southwestern Ontario</i>	2,014	2,714	3,654	4,369	3,109	3,893
<i>Northern Ontario</i>	1,981	2,399	2,872	3,634	2,570	*
Ontario	1,973	2,978	4,177	5,253	3,499	4,847

* suppressed for confidentiality or statistical reliability

Source: CMHC Ontario Report

The all-in cost of care and accommodation in a heavy care space can be compared with the cost in a LTCH, though the two are not identical in terms of size. CORE data indicate that the average studio unit in AL accommodation measures 351 square feet. For LH units, the MOHLTC regulates minimum space requirements for Resident Home Areas (as defined in MOHLTC’s Long-term Care Home Design Manual, 2015¹⁴⁰), employing the concept of useable net floor space, which excludes the area associated with closets, washrooms and vestibules. However, using private studio accommodation in a retirement residence as a comparator to private accommodation in a LTCH, the all-in costs are shown in Table 5.24, using CMHC data for levels of care. It should be noted that the first line in Table 5.24 (Cost of Accommodation) represents the cost paid by the individual resident in both LTCH and RH settings, while the second line (Cost of Care) represents the portion paid by the provincial government for care. Since the care portion for RHs is included in the first line, and is not subsidized by government, the result is that RH residents pay almost double the amount personally that LTCH residents pay for a similar basket including accommodation and care (\$4,847.00 versus \$2,563.22), while the total cost (to the individual and government) is actually lower in the RH setting.

Table 5.24. Monthly Care and Accommodation Costs: LTCH Compared to CMHC Data

	<u>LTCH (Private)</u>	<u>RH (Studio, Heavy Care)</u>
Cost of Accommodation (a)	\$2,563.22	\$4,847.00
Cost of Care(b)	\$3,408.45	<u>Included</u>
Total Cost Per Month (c)	<u>\$5,971.67</u>	<u>\$4,847.00</u>

- (a) Monthly cost of private accommodation per Table 5.22 re LTCH and Table 5.23 re RH
- (b) Per diem funding for NPC (\$94.37), PSS (\$9.42) and RF (\$8.33) times 30.4 days per month.
- (c) Combines the resident’s accommodation cost with the payments by the Ministry for NPC, PSS and RF and excludes the Ministry payment for OA, in order to portray the cost of private accommodation and care comparable to the RH scenario.

The CORE data separates accommodation and care costs where applicable, recognizing that some homes include all cost components together, where care services are included in the base amount for the specific level of care. Table 5.25 shows the combined cost of accommodation, general services and care services. Care services in the CORE database are defined in terms of the same 10 categories used in the RHA and tabulated in the RHRA data.

Table 5.25. Total Monthly Costs (\$) by Accommodation and Care Service Level in RHs

	IL	ISL	AL	MC
Studio	2,897	3,041	4,275	4,923
One Bedroom	3,403	4,172	5,398	5,754
One Bedroom + Den	3,860	4,788	4,800	4,324
Two Bedroom	4,103	5,288	5,182	4,395
Two Bedroom + Den	3,329	5,563		
Three Bedroom	3,285	7,500		
Town Home	3,214			

IL=Independent Living; ISL=Independent Supported Living; AL=Assisted Living; MC=Memory Care
 Source: CORE Database, 2016.

The all-in costs of assisted living care and memory care in a studio unit are \$4,275 and \$4,923, respectively, as shown Table 5.25. These are considered the most direct comparators in the LTCH context, as these levels of care are the highest and the studio unit accommodation is the most similar to LTCH private room. What these comparisons indicate is that the total costs of care and accommodation are similar in LTCHs to RHs at comparable care levels. Similar to the comparison using CMHC data in Table 5.24, the principal distinction relates to how the costs are funded, with the full cost in the RH setting being borne by the RH resident and only the accommodation cost (first line in Table 5.26) being borne by the LTCH resident. As was the case in the CMHC example, the CORE example shows the individual in the RH setting paying almost double the amount paid by the individual in the LTCH setting, even though the all-in cost of accommodation and care (individual plus government) is lower in the RH setting.

Table 5.26. Monthly Care and Accommodation Costs: LTCH Compared to CORE Data

	<u>LTCH (Private)</u>	<u>AL (Studio)</u>	<u>MC (Studio)</u>
Cost of Accommodation	\$2,563.22	\$4,275.00	\$4,923.00
Cost of Care	\$3,408.56	<u>Included</u>	<u>Include</u>
Total Cost Per Month	<u>\$5,971.67</u>	<u>\$4,275.00</u>	<u>\$4,923.00</u>

While Tables 5.24 and 5.26 give an indication of relative costs of accommodation and care between LTCHs and RHs, they are inclined to underestimate total RH costs on a comparable basis. CMHC’s heavy care category, which includes a minimum of 1.5 hours of care per day, may still offer fewer care services or time than LTCH service levels provide. Similarly, the CORE figures for AL and MC do not specify the average levels of care provided, and the CORE definition for AL, for example, states that additional care services may be added on top of the base fee.

5.6. Occupancy Rates, Vacancy Rates and Wait Lists

Occupancy rates tend to be significantly higher among LTCHs than RHs in Ontario.

Correspondingly, there are long wait lists for LTCHs.

5.6.1. LTCH Funding Based on Occupancy Rates

The MOHLTC's Long-Term Care Homes Financial Policy¹⁰⁷ includes certain occupancy targets for all LTCHs, which, in turn, affect their funding. Essentially, the Ministry requires all homes to maintain the occupancy rate of its long-stay beds at a minimum of 97% in order to receive 100% of the LOC per-person-per-diem-funding, according to the funding envelopes (shown in Table 5.2). Per-person-per-diem funding reduces on a sliding scale as occupancy rates decline below 97%. As shown in Table 5.27, the average long stay utilization exceeds 98% in all LHINs. This utilization level is fairly consistent across all levels of accommodation in LTCHs, including basic, semi-private and private accommodation. Of course, the high occupancy rates in LTCHs is ultimately due to the excess demand for beds, given the increase in seniors requiring residential care, the lack of growth in supply of LTCH beds in recent years, and the dearth of suitable options in the community.

5.6.2. Wait Lists for LTCHs

As illustrated in Table 5.27, the long-stay wait list was approximately 35.7% of existing supply in October 2015, represented by about 27,500 people on the wait list and about 77,000 beds in supply. This wait list excludes those who are already residing in a LTCH and waiting to transfer to a preferred location. According to the Ministry's System Overview Report, the

number of clients being placed in LTCHs in the month of October 2015 totalled approximately 1,400, or one-twentieth of the people on the wait list.

There is considerable variation in the length of the wait lists across Ontario, with several LHINs (Mississauga Halton, Central, Central East and North Simcoe Muskoka) experiencing wait lists equal to approximately 50% of the existing supply. This contrasts with LHINs in the southwest of the province, where the wait lists represent less than 20% of existing supply. Actual wait times to placement also vary according to the turnover within each LHIN. The OLTCAs calculated that placement times in 2015 ranged between 36 days in the Erie St. Clair LHIN and 247 days in Central East LHIN,¹⁴¹ though this includes only those who are eventually placed.

Table 5.27. Long-Stay Utilization and Demand for LTCH Beds in Ontario

LHIN	Long Stay Utilization	Long Stay Wait List as % of Supply	Total Long Stay Demand as % Of Supply
<i>Erie St. Clair</i>	99.2%	13.0%	112.2%
<i>South West</i>	98.5%	17.2%	115.7%
<i>Waterloo Wellington</i>	98.4%	28.4%	126.8%
<i>Hamilton Niagara Haldimand Brant</i>	99.1%	23.6%	122.7%
<i>Central West</i>	99.2%	20.1%	119.3%
<i>Mississauga Halton</i>	99.8%	48.3%	148.1%
<i>Toronto Central</i>	98.9%	44.0%	142.9%
<i>Central</i>	99.1%	58.1%	157.2%
<i>Central East</i>	99.1%	54.7%	153.8%
<i>South East</i>	99.5%	26.7%	126.2%
<i>Champlain</i>	99.0%	37.6%	136.6%
<i>North Simcoe Muskoka</i>	99.1%	48.4%	147.5%
<i>North East</i>	99.0%	32.3%	131.3%
<i>North West</i>	98.8%	32.3%	131.1%
Province of Ontario	99.0%	35.7%	134.7%

Source: MOHLTC, HDB, HSIMI Division, System Overview Report - October 2015.

When the long-stay wait list is segregated according to ownership type, it is apparent that applicants view accommodation in NFP-owned LTCHs more favourably. As Table 5.28 shows, NFP homes make up only 25% of the stock of LTCH beds in Ontario but account for 43% of the total wait list. Conversely, FP beds make up 54% of all LTCH beds, but only 31% of the wait list. This may be due to several factors, including a perception of quality differences, as well as the attractiveness of certain NFPs that cater more to specific community, religious and ethnic groups. By comparison, FP homes tend to be more secular in nature.

Table 5.28. LTCH Wait List by Ownership Type

	For- Profit	Non-Profit	Municipal
Long-Stay Wait List	31%	43%	26%
Total Beds	54%	25%	21%

Source: MOHLTC, HDB, HSIMI Division, System Overview Report - October 2015

Wait lists for LTCHs are maintained by the local CCACs, whose geographic boundaries correspond with those of the LHINs. According to the CCAC Client Service Policy Manual¹⁴² which deals with management of LTCH wait lists, the CCACs are to categorize all applicants on the wait list by priority levels which rank as follows: (i) crisis applicants, (ii) spousal reunification applicants, (iii) people whose linguistic, religious or ethno-cultural origin is served by the particular LTCH, (iv) people whose various other circumstances require priority and (v) those who otherwise qualify for admission but do not fit within a higher priority category. As the OLTCA notes, the regulatory framework governing admissions requires “up to five home choices by each applicant, 10 wait list categories, 14 accommodation classes, two gender categories and 10 ranking rules”¹⁴¹, all of which add complexity to the placement process.

Actual wait times for placement in a home can therefore vary significantly depending on a particular resident’s circumstances.

5.6.3. LTCH Supply by Type of Accommodation

LTCHs offer accommodation according to three categories, including basic, semi-private and private. As shown in Table 5.29, basic accommodation beds are the most numerous, representing 45.5% of supply on a provincial basis, with private accommodation constituting 35.3% and semi-private 17.2%. This distribution is fairly consistent across all LHINs in Ontario.

Table 5.29. Percent of Supply by Type of Long-Stay Accommodation for LTCH Beds(a)

LHIN	Basic	Semi-Private	Private
<i>Erie St. Clair</i>	43.4%	14.4%	40.0%
<i>South West</i>	46.3%	19.1%	33.3%
<i>Waterloo Wellington</i>	44.7%	11.3%	43.5%
<i>Hamilton Niagara Haldimand Brant</i>	44.4%	15.3%	38.1%
<i>Central West</i>	46.6%	12.2%	39.7%
<i>Mississauga Halton</i>	44.0%	15.8%	38.3%
<i>Toronto Central</i>	51.6%	17.7%	29.7%
<i>Central</i>	43.5%	17.1%	37.0%
<i>Central East</i>	44.9%	22.2%	30.5%
<i>South East</i>	45.5%	23.3%	29.8%
<i>Champlain</i>	45.0%	14.3%	38.6%
<i>North Simcoe Muskoka</i>	43.3%	12.3%	41.5%
<i>North East</i>	48.9%	20.8%	26.1%
<i>North West</i>	45.9%	20.5%	32.1%
Province of Ontario	45.5%	17.2%	35.3%

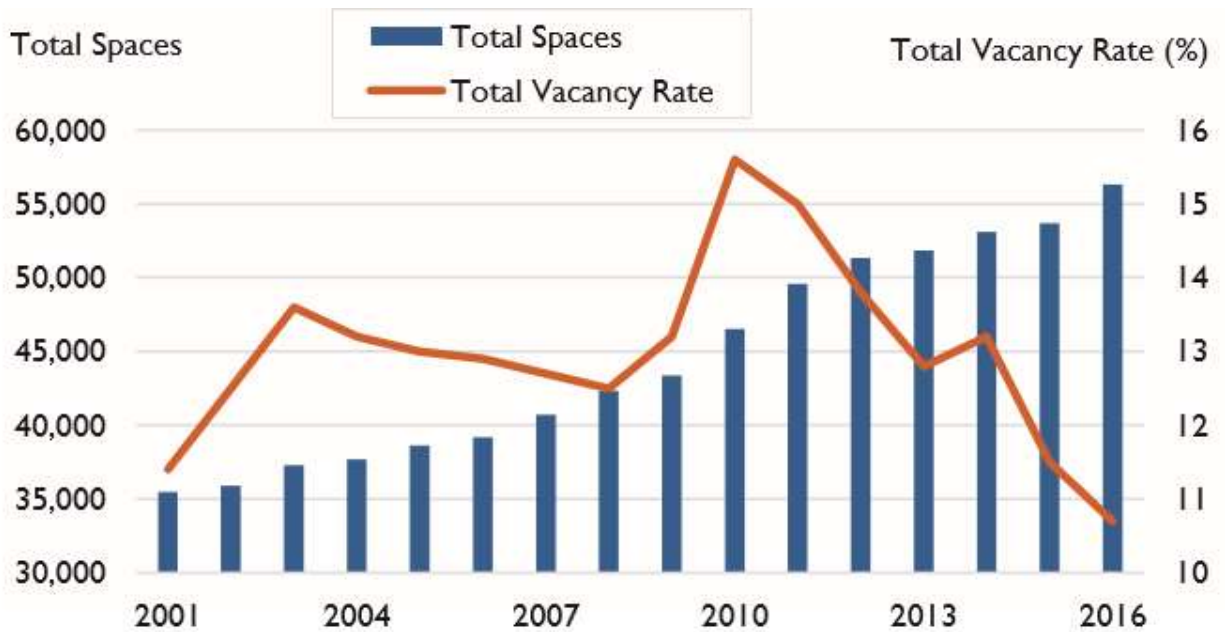
Source: Ministry of Health and Long-Term Care, Health Data Branch, HSIMI Division, System Overview Report - October 2015.

(a) The balance of supply, to total 100%, is attributable to short-stay beds.

5.6.4. Occupancy Rates in RHs

The RHRA does not track occupancy rates in RHs, though data from CMHC and CORE are considered indicative of the supply/demand balance. With some exceptions as noted in Chapter 4, the population of residences covered by the CMHC Ontario Report is similar to that of the RHRA.

Figure 5.9. CMHC Data re Total RH Spaces and Vacancy Rates for Seniors' Housing



Source: CMHC, Seniors' Housing Survey (2009-2016)
ORCA Survey (2001-2008)

In Ontario, the overall seniors' housing vacancy rate as determined by CMHC was 10.7% in 2016, which compares with rates over 15% in 2010 and 2011, and was the lowest level recorded since the standardized survey for Ontario began in 2001 (see Figure 5.9). During the period from 2001 to 2016, the number of spaces in seniors' housing increased from approximately 35,000 to over 56,000. However, with the steady growth in the number of seniors' housing

residents, vacancy rates have gradually decreased in Ontario. The increase in residents was 6.5% in 2016.

The vacancy rate varies by geographic centre within the province as shown in Table 5.30. In 2016, Northern Ontario had the lowest vacancy rate, while Southwestern Ontario and Ottawa were the highest. The low rate in Northern Ontario occurred despite an 11.6% increase in supply during the year, as demand has remained strong for additional capacity.

Table 5.30. CMHC Data re RH Spaces, Residents, Residences and Vacancy Rate

Centre	Total No. Of Spaces	Vacancy Rate (%)	Number of Residences	Number of Residents
<i>Greater Toronto Area</i>	16,802	10.9	162	16,256
<i>Central Ontario</i>	15,425	10.2	214	14,909
<i>Ottawa</i>	6,829	11.8	64	6,478
<i>Eastern Ontario</i>	5,731	9.0	92	5,629
<i>Southwestern Ontario</i>	8,850	12.1	127	8,385
<i>Northern Ontario</i>	2,664	8.2	35	2,624
Ontario	56,301	10.7	694	54,280

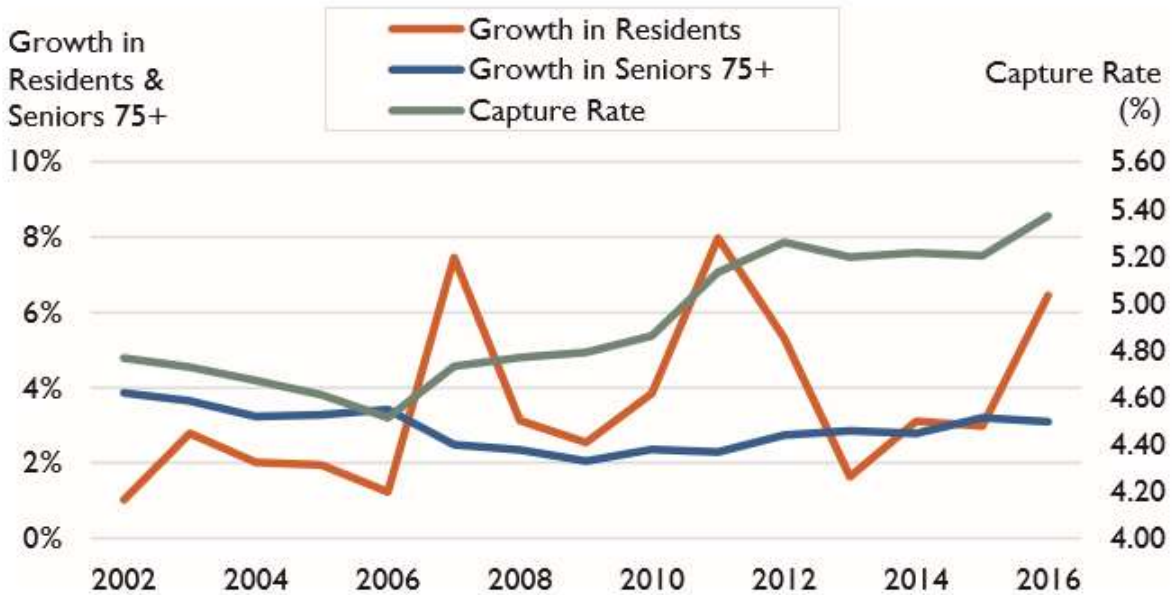
Source: CMHC Seniors' Housing Survey, 2016

Though the vacancy rate for residential homes averaged 10.7% provincially, CMHC notes that rate was 8.8 % when residences added after 2009 are excluded. This is because it normally takes a few years for a new home to complete its lease-up phase and achieve a stabilized occupancy rate.

As Figure 5.10 shows, the population of Ontarians over 75 has grown at a rate between 2% and 4% annually since 2002. This rate has been surpassed by the growth rate in the number of residents in almost all years since 2007. Similarly, the capture rate, which measures the

percentage of those over 75 who choose a RH, has increased steadily from 4.5% in 2006 to 5.4% in 2016.

Figure 5.10. CMHC Data re RH Growth Rates in Residents, Senior 75+ and Capture Rate



Source: CMHC Ontario Report
 Statistics Canada Population Estimates, 2001-2005
 Ontario Ministry of Finance, Population Projections, Fall 2015

Table 5.31 displays the distribution and vacancy rates for retirement residences according to unit type and corresponding vacancy rates. As can be seen, the majority of units are either private studio or one-bedroom units, where vacancy rates are lowest. Semi-private and ward accommodation are the least popular unit type by numbers of residents and also have the highest vacancy rate, at 18% provincially. Regionally, Northern Ontario records the lowest overall vacancy rate at 8.2%, reflecting the lower stock of units relative to the population of older adults (see Table 5.2).

Table 5.31. CMHC Data for RH Spaces by Unit Type and Vacancy Rates

Centre	Semi-Private and Ward	Private Studio	One Bedroom	Two Bedroom	Total/ Average
<i>Greater Toronto Area</i>	404	7,736	7,378	1,284	16,802
<i>Vacancy rate</i>	11.9%	11.3%	10.3%	11.5%	10.9%
<i>Central Ontario</i>	865	9,249	4,700	611	15,425
<i>Vacancy rate</i>	20.5%	9.7%	9.1%	11.5%	10.2%
<i>Ottawa</i>	174	4,039	2,274	342	6,829
<i>Vacancy rate</i>	16.6%	10.7%	12.7%	16.1%	11.8%
<i>Eastern Ontario</i>	411	3,740	1,441	139	5,731
<i>Vacancy rate</i>	15.4%	8.7%	8.0%	8.3%	9.0%
<i>Southwestern Ontario</i>	554	4,846	3,025	425	8,850
<i>Vacancy rate</i>	22.4%	11.0%	12.0%	10.6%	12.1%
<i>Northern Ontario</i>	45	1,523	958	138	2,664
<i>Vacancy rate</i>	*	8.6%	7.5%	*	8.2%
<i>Ontario</i>	2,454	31,134	19,777	2,940	56,302
<i>Vacancy rate</i>	18.2%	10.2%	10.3%	11.8%	10.7%

* suppressed for confidentiality or reliability

Source: CMHC Seniors' Housing Survey, 2016

Table 5.32 summarizes the vacancy rates for standard spaces in Ontario's seniors' residences, which reached 11.3% in 2016, the lowest level since the introduction of the measure in 2009. Increased demand for suites and larger rooms has been the trend. The vacancy rates for heavy care spaces, however, were substantially lower, at 5.8%, provincially, reflecting high demand by people with greater care needs. Of particular note are Central Ontario, where the vacancy rate was 2.9% and Northern Ontario where the rate was 0% (of 571 spaces in the CMHC survey for Northern Ontario, none was identified as a heavy care space). Southwestern Ontario, by contrast, had a vacancy rate of 12.8% for heavy care spaces.

Table 5.32. Vacancy Rates for Standard and Heavy Care Spaces

Centre	Number of Residences	Vacancy Rate by Space (%)		
		Standard	Heavy	Total/Ave
<i>Greater Toronto Area</i>	162	11.6	5.8	10.9
<i>Central Ontario</i>	214	10.8	2.9	10.2
<i>Ottawa</i>	64	12.9	6.8	11.8
<i>Eastern Ontario</i>	92	9.7	*	9.0
<i>Southwestern Ontario</i>	127	12.4	12.8	12.1
<i>Northern Ontario</i>	35	8.8	0.0	8.2
Ontario	694	11.3	5.8	10.7

Source: CMHC Seniors' Housing Survey, 2016

* suppressed for confidentiality or reliability

The CORE database shows occupancy rates across four levels of care in retirement residences, with the highest rates showing in ISL and AL, which are the most common unit types. (Table 5.33). Compared with the CMHC data, the CORE data suggest higher corresponding vacancy rates (i.e., 86% occupancy rate, or a 14% vacancy rate), though CORE data represent a smaller sample of homes and may over-represent the larger chains. Recent growth in available RH units is believed to be largely among the chains and many units may be in the lease-up phase.

Table 5.33. RH Occupancy Rates by Unit Type and Level of Care, Q1 2016

	IL	ISL	AL	MC
<i>Studio</i>	75.88%	87.22%	83.05%	79.50%
<i>One Bedroom</i>	83.21%	84.20%	83.08%	77.27%
<i>One Bedroom + Den</i>	88.44%	72.78%	76.50%(a)	
<i>Two Bedroom</i>	81.99%	78.16%	75.28%	
<i>Average</i>	83.06%	86.61%	86.06%	83.28%

Source: CORE database

(a) Q4 2015

5.7. Summary of Findings from Phase 1 and Issues to Explore in Phase 2

The LTCH sector in Ontario is characterized by high and growing levels of care acuity among residents, a rising age demographic, little growth in the supply of beds, and long wait lists.

Forecasts show increased need for seniors' residential care. HCC is an attractive solution to absorb the growth in demand for seniors' care services, but it has limits in meeting the needs of seniors who require more intensive care and closer monitoring, particularly where the numbers of informal caregivers become increasingly constrained.

The regulatory regime introduced for RHs in recent years is similar to that of LTCHs in terms of stated purpose, care standards, resident's rights and enforcement. The primary difference regarding care standards is that they apply to RHs only in respect of the care services that homes decide to offer. However, governance differs significantly between LTCHs and RHs in terms of the reporting structure. Governance of LTCHs is through the MOHLTC and the LHINs, whereas RHs are the responsibility of the Minister for Seniors and the RHRA, the board of which has only a minority of government appointees.

Government funding is the biggest differentiator between LTCHs and RHs. LTCHs are funded by government in respect of operations (nursing, therapies and food) and also for limited capital expenditures, while RHs receive no direct funding of either type.

Ontario has a significant stock of beds in both LTCHs and RHs with a ratio of 12.3 (LTCH) and 13.4 (RH) people over 75 to each bed. LTCHs are more evenly dispersed on a geographic

basis, while RHs are less represented in low income and rural areas, particularly the North. The supply demand-balance for seniors' residential care is driven not just by numbers of beds in each geography, but by migration patterns with neighbouring locations, wealth effects, availability of other care options in the community and health profiles within regions. In some areas, such as Northern Ontario, these factors tend to exacerbate, rather than mitigate the imbalances.

As an industry, seniors' residential care is fragmented but has experienced some level of concentration among national chains in recent years. There is a noticeable tendency among larger chains to participate in both LTCH and RH sectors. RHs are dominated by FPs, while the majority of LTCHs are owned by FPs, but with significant participation by NFPs and municipalities.

The operation of a seniors housing residence, whether LTCH or RH, requires a broad range of skills, including property management, food and lodging, technology, social activation and management of health care programs. Success in many of these factors depends on Owners achieving economies of scale in terms of numbers of homes and beds per home.

The residential care industry is highly capital intensive due to required investments in land, buildings and fixtures. RHs are able to set rents and prices for care service according market, which allows them to earn returns on capital at market rates. For LTCHs, returns are restricted by the flow-through structures of funding envelopes which do not allow for a profit margin on care services and by controls on accommodation charges. Return on capital in the LTCH sector

appears a challenge, particularly for FPs that may not enjoy economies of scale or derive additional revenues for third party management contracts or supplementary, non-care services.

In RHs, care service offerings vary by home and also by geographic region. Of the ten care services RHs provide, the average offering is 7 per home. A minority of RHs offer service or assistance related to feeding, wound care or dementia and these services are particularly scarce in Northern Ontario.

The costs of accommodation vary significantly by geography in the case of RHs, but can be compared with the costs in LTCHs, subject to differences in room configurations and amenities. The costs of care services can also be compared between RHs and LTCHs, though the precise service offering in RHs is difficult to define. With these caveats, the average all-in cost of high-level care in RHs appears to be similar to that of LTCHs. To the resident, however, there is a substantial cost advantage in the LTCH setting due to the government funding of care, which does not apply to RHs. Conversely, there may be an affordability issue for residents in RHs, as they are not eligible for the same funding for the care services offered in RHs.

In the LTCH sector, demand for long-stay beds exceeds supply by approximately 35% across the province. Without additions in supply of LTCH homes and beds, and given the significant growth in the seniors' population in coming years, the wait lists and acuity levels of residents are destined to increase. RHs, by contrast, show higher vacancy rates and supply has grown substantially in recent years in accordance with demand, with pressure showing in lower vacancy rates for heavy care beds.

These findings point to a number of issues that warrant further exploration in Phase 2, particularly issues where complexities or insights may be within the knowledge of key stakeholders who understand the factors impacting the supply and service offerings in seniors' residential care. These include:

1. The reasons LTCH home supply has not kept pace with the growth in the seniors' population and the role policy has played in this;
2. The part that RHs can play in addressing the unmet demand for seniors' residential care;
3. The basis for the distinction in funding between LTCHs and RHs and the implications of maintaining these differences;
4. As an extension of 3, above, whether funding the person instead of the home and allowing the person to direct the purchase of care, might address issues of wait lists, improve accountability and empowerment of consumers;
5. Whether government is covering the appropriate array of care services in LTCH, including professional nursing and support services;
6. The role that means testing should play in determining eligibility for care funding, including stated policies as well as care purchase patterns driven by recourse to the private-pay sector;
7. Whether one common governance and regulatory regime should apply to all residential care for seniors, especially where higher acuity care is involved;
8. How the seniors' residential care has evolved in recent years, both for LTCHs and RHs, and how these changes have affected those operating in the sector;

9. The risks, challenges, opportunities and attractive features associated with owning and operating residential care facilities, and how these differ between LTCHs and RHs;
10. Given the regulatory, competitive, financial, human resource and demand factors, how industry participants decide what level of care or services to provide;
11. How economies of scale affect capital and operating decisions for Owners;
12. How decisions are made around location and, conversely, why some geographies might be underserved for seniors' residential care.

These issues are the subject of the 12 interview questions posed to participants in Phase 2 of the study. The interviews are intended to address research question 2, which asks how the Phase 1 findings about service offerings can be explained in terms of strategies pursued by the Owners of LTCHs and RHs and how, in turn, those strategies relate to antecedent policy instruments or the interaction of policy instruments with other factors.

6. Phase 2 Findings

In accordance with Chapter 4.2, all Phase 2 interviews were analyzed according to 12 key categories and more detailed codes within each category. In addition, to break down the findings within codes, data items were further examined to identify prevalence. Throughout this Chapter, illustrative quotes are shared for each category.

6.1. Category 1: Limited Growth in LTCH Beds and Capacity Constraints

Category 1 related to the lack of growth of LTCH beds in recent years, despite growth in the seniors' population. Most respondents attributed the stagnation in growth of beds to government policy that purposely limits the issuance new licenses. Many referred to the process by which the government decides when and where new LTCH licenses are to be granted and that, without this process being initiated by the MOHLTC, there was no means by which Owners could unilaterally undertake to build new beds. Several described the policy as an unstated one – that the government's policy to restrict growth in LTCH beds could be assumed by inaction in granting new licenses, but had not been clearly articulated as policy.

In commenting on the reasons for the policy to limit growth in LTCH beds, the most prevalent responses from interviewees centered on the government's greater attention to community care, the high budgetary cost of funding long-term care, the focus within long-term care on upgrading the existing stock to meet regulatory standards rather than financing new stock, and government concerns around overbuilding to meet cyclical demand for seniors' residences.

Most respondents referred to the government's focus on home and community care as being the principal reason for diverting attention from LTCH bed capacity, with the goal of delaying the move of seniors to LTCHs until acuity has reached a higher level.

R7: Even for people with high acuity needs, there are a number of different settings where they can be served, depending on what is driving that acuity. So we now see high acuity seniors, residents, patients being cared for at home with appropriate supports.

R8: The whole sector is shifting. We're getting people staying in the community longer, we're having people admitted to long-term care later in life with more significant issues, you know, 4 to 6 to 8 comorbidities, who are much more challenging, so more complex care. I think the Ministry is putting a lot of faith into home care.

Many respondents found the focus on community and home care to be misconceived or lacking in terms of efficiency and regulatory oversight, or not comparable to LTCHs in terms of the level of care provided. This view was shared by respondents from both LTCHs and RHs and FPs as well as NFPs.

R9: Their model for home care is a really inefficient model where somebody goes for whatever it is – 20 minutes a day. They're paying for the drive time, they're not held accountable for the risk to those residents or for the statistics if there's abuse or illness or death in the homes. There's an out-of-sight-out of mind.

The policy to focus resources on home and community care was also attributed by most interviewees to the high cost of funding LTCHs, relative to home care.

R17: First, the government does not have the funds or the resources to provide more long-term care home beds. We also know that the government is finding that they are in many instances now funding people in long-term care 100%. The numbers are quite astonishing.

In speaking to the funding priorities in long-term care, respondents considered the redevelopment of existing LTCH stock to be of greater urgency to government than adding new beds to the system. The so-called B and C beds, which are currently non-compliant with regulatory standards, are the subject of government programs to renovate, enlarge or rebuild.

R11: So there's a big huge redevelopment effort and homes that have the old-style beds will have to, within a period of time, convert their homes to meet the new standards. So any money in the system appears to be supporting that.

R9: Theoretically all the Ds are gone but some Bs and Cs remain. So there are already – call it 30,000 residents – living in an environment that the government has said is below its standard. They won't upgrade these buildings and at some point they'll be forced out, their licenses will expire and they'll walk away from the business.

Several pointed out the significant capital commitment that residential care required and surmised that government was concerned about building too many homes while the seniors population was peaking, only to be left with stranded assets when the cycle abates.

R16: If you look at the population growth and what's happening with that tsunami now and how fast we're building up that pool of seniors with all those long-term care needs, if you forecast for the future, that's going to decline. And if we invest in all of these long-term care home beds now, what are we going to do with all those beds in the future when that need is declining? I believe that's part of the reason.

With regard to the existence of LTCH bed shortages currently, many expressed concern about the current stock and about the growing demand for beds as the population ages.

R1: We've got 25,000 people waiting today. I was just talking to one of the LHINs and she said they need another 4200 in their LHIN over the next five years. Well every LHIN in the province is in the same situation and so by five years from now, its going to be a horrific situation because these people cannot live at home. They are incontinent, they have dementia and most have mobility issues.

R6: At some point, you can invest in the community all you want. The reality of acuity and complexity of care can't be avoided and we'll have to invest in some form of residential care, whatever that looks like.

However, there were several views expressed by others that a strict reading of wait list statistics does not fully capture. Some felt that the bed shortages varied quite considerably by region or that many residents were in fact misplaced in LTCHs and could live safely in the community.

R10: And there are people who come into long-term care because they are not being managed well in the community for lack of community services. We get them on the right track and within three to four months, technically they would not have qualified if they were in the community at that point, but they're in so they get to stay in.

R12. So you get people into long-term care who are only there because they can't afford to go anywhere else. And they don't need the care. They don't need two hours of care. They just need some TLC, some cuing, reminding, but they can't afford it, so they have to go to long-term care. There's nowhere else for them to go. There's a huge gap in the system there.

6.2. Category 2: The Role of Retirement Homes in Meeting Demand for Residential Care

The essence of category 2 was whether and to what extent RHs can address the unmet demand for residential care for seniors. The codes that informed this category included respondents' comments on the similarity of RHs and LTCHs in terms of the service offerings and resident profiles, affordability issues related to RHs, and the availability of RH beds to meet demand, as compared to LTCH beds.

Most respondents commented on the similarities in the type of care services or acuity level of the resident between LTCHs and RHs and the majority felt that significant overlaps existed between the care services and populations of the two residential sectors. Those who estimated this overlap offered figures of between 20% and 33%, suggesting that this percentage of residents could or were represented in either residential setting. Many respondents pointed out the difficulty in measuring the overlap directly, since RHs cover a wider continuum of resident acuity than LTCHs do, ranging from seniors' apartments, where acuity levels are quite low, through to assisted living and memory care, where care services are more intensive and similar to care in LTCHs. The following are comments from Owners operating both LTCHs and RHs.

R9: What we offer is a spectrum, so we offer independent, standalone units that are basically apartments with one meal a day and no care, right through to care that is almost indistinguishable from our long-term care homes.

R12: With assisted living and memory care, most of the staffing levels are very, very similar. So I've run homes and I had a building with both in it. Basically, my staffing model of assisted living had two hours of care per day. You may get two and a quarter or two and a half for long-term care.

In addition, since RH Owners are able to choose their clientele, some may focus exclusively on lower acuity, more active seniors and may therefore have less in common with LTCHs. Even among those that offered a higher level of care service, many RHs indicated that there were some limits to the type of resident they could accommodate. These limits tended to be mostly around aggressive behaviours or medical complexities such as wound care, respiratory issues, or tube feeding. In addition, some RHs indicated that they were unable to do two-person lifts.

A number of factors were highlighted as increasing the tendency for RHs to serve higher acuity seniors. These included the persistence of wait lists for LTCHs, which force many 'would-be' LTCH residents to opt for accommodation in RHs.

R5: The industry says this repeatedly, that people choose to be in retirement homes. For the most part, they don't. It's the only option, its not really a choice.

R19: We have a lot of people who wait to be in a long-term care home. So, they would go into a retirement home and they would stay here until they are on a wait list to be eligible.

Some RH Owners also felt that RH residents who had been accepted to join the LTCH wait list tended to be assigned lower priority than other seniors on the list, with the effect of staying in the RH longer and extending their wait time beyond that of seniors in the community of similar acuity. The following comment was from an Owner of an LTCH and a RH.

R15: Yes, it's a waiting period. Again, its determined by CCAC. If they're a priority and they're perceived to be in crisis, they'll move sooner. This group, because they're getting care and support from us and CCAC, their priority, I sense, isn't as high because they're not as at risk in the community. A lot of retirement homes have a significant portion of the population that would qualify and do qualify for long-term care now. I'm guessing at least 40 people in this building out of 120, 30% of our people in the retirement home have applied and have been accepted into long-term care.

Others pointed out the role that choice plays among RH residents in deciding to age in place and defer or decline a spot in a LTCH, despite being eligible.

R14: I have a lot of people in our home here, that, if they were to do an assessment, they would meet the criteria, yes. But they also function very well here. Long-term care, for some, is not the best step for them. They are not going to grow there. We are big promoters of independence and obviously everything has to be within the realms of safety. Whereas in a long-term care home setting, some of the people that we have here, I feel would decline.

The availability of beds in RHs, relative to LTCHs, was a factor cited by many respondents as diverting seniors to RHs, where occupancy rates are lower and waiting lists shorter or non-existent. Also, the flexibility of RHs to expand in number to meet demand was seen as a means to continue absorbing the overflow from LTCHs.

R6: The private sector has stepped in and filled the unmet need left by the inadequate supply of long-term care home beds. So there are huge waiting lists. So the retirement home sector has not only expanded significantly. But more and more the retirement home operators – not all – are becoming quite adept at delivering care, both to those who are cognitively well, as well as those who are living with dementia and other forms of mental health issues.

R12: But if you look at the number of retirement homes, it's a supply and demand issue, so if you look at it now with the way we're building, we can't keep up with the demand.

Some felt that government was actively or tacitly supporting reliance on RHs to absorb the excess demand for residential care that cannot be met by the LTCH stock. The following comment was expressed by a RH Owner.

R4: The government has no interest in building any more [LTCHs]. So what we have found from the retirement home perspective is that they are pushing everyone into retirement homes because it is cheap for them, government.

Almost all respondents raised the issue of affordability of RHs, in particular that they are private pay and therefore more expensive than LTCHs, since both accommodation and care are paid by the resident. In many cases, affordability was seen as influencing the resident decision between choosing RH accommodation versus LTCH accommodation.

R4: And the problem is, most of the people who need that kind of care can't afford it and retirement homes are private pay. That's one of the problems we've had with retirement homes is that, especially in rural areas, people don't have a lot of money and can't afford the \$3,000, \$4,000, \$5,000 a month homes. But its very hard to run a retirement home and offer care – especially dementia care to the average person.

R10: I think the implications of maintaining it are that there's going to have to be a whole lot more money going into the system or we are going to end up with the situation where those who can afford it are going to go private and those who can't are going to go long-term care.

Several respondents perceived that residents often make the move from RH accommodation to LTCH accommodation because of depleting financial resources as opposed to the need for greater care.

R11: Well, I do think that they do take care of the medically complex, because you pay for it. That's my experience.... So, I mean, if you want to stay in the retirement home and you need those services, you pay...And, you know, they talk about a continuum so if the person needs more and more, you'll pay more and more. And if you're not willing to pay, I think there'd be a discussion, are you going to transfer into long-term care.

Several respondents indicated that the decision by RH Owners to serve only the wealthier seniors market was driven by concerns that residents would not be able to meet the increasing costs of care as they aged in place. Some RHs suggested that they would be able to cater to more mid-income seniors if there was greater assurance that their rising care costs would be covered.

R3: There's a whole economic strata that we all play in right now and a couple of us play in a mid-priced range. That mid-priced range could increase dramatically... imagine how many people would be able to be in congregate retirement care if you just provided the care outside to those individuals.

R15: As soon as you start adding care, the costs of care are high. I know some homes, some organizations have tended to try to stay away from moving into the heavier assisted living.

6.3. Category 3: Government Funding Based on Care Needs, Not Residence

Category 3 concerned the fact that government funding for seniors' residential care, including nursing and personal care, is provided for residents in LTCHs, but that residents in RHs who receive the same services are not eligible for the same funding. Almost all respondents acknowledged that coverage of seniors with the same acuity differed by the site of care delivery, some noting that the inconsistency in funding extended to home care as well. Most interviewees felt that seniors requiring the same care needs should be funded equally with government dollars, regardless of where they reside.

R5: But if they're getting into what is the same care you get in a long-term care home, the seniors should be covered by health dollars... From a legal sense, it makes no sense. Its just blatant discrimination... this ties into everything, like the funding because, I think, we have a public health system. Why are seniors in a retirement home not covered by the public health system? It doesn't make any sense to me.

Although RHs are not funded directly, residents are eligible to receive home care services funded and administered by their local CCAC, on the same basis as they would if they were living at home. However, many considered that home care services were not adequately geared to people of higher acuity and that the availability or reliability of CCAC services was not consistent across time or geographies.

R4: But the reality is that there isn't much funding in the community to support everyone's needs. You don't get 24-hour care and you're lucky if you get an hour a day.

R17: What we've seen typically over all the years... they [CCACs] run out of money and nobody gets anything. And that could be halfway through the year. With some, and actually the retirement homes in [city in Ontario] this year got put on wait list in September, so it meant that anybody in a retirement home in [another city in Ontario] that needed home care, there's been no new dollars to support those people since the first of September, and the year end is March 31st. So you know, you can say that home care is offered for an hour, maybe two hours in a week with consistency, but it doesn't because when they run out of money, nobody gets anything.

Where CCAC services are available, several RH Owners expressed concern that their residents were low priority for receiving community care, either because RH residents were perceived by the CCAC to be less in need, or they were already adequately looked after by a private sector provider.

R9: Residents in retirement homes – I'm not sure I would use this word, but some would say – are discriminated against compared to their long-term care counterparts and they're also discriminated against versus the home care counterparts. They're denied services, not all that expressly, but in fact they are denied services because they have an operator nearby who they can pay to provide it so the CCAC and the contracted staff will tend to provide less or dissuade them from using them at all.

R19: So people when they come in [to a RH] from living in their home and let's say they received 12 hours in the community per week, let's say they come here and they receive six hours. They do reduce it.

With respect to care funding for RH residents, most respondents felt that it would be appropriate to fund either the home on behalf of the resident, similar to the way LTCHs are funded, or to fund the individual in the RH to defray the cost of care purchased there.

R4: If retirement homes are going to expand and have more service options or care options, I think the government has to pitch in with some kind of funding to make that work, because the whole health care burden being placed on the back of the resident is unfair and I think you're going to end up with a two-tiered system.

6.4. Category 4: Government Directing Funding to the Person

Category 4 addressed the concept of funding the care of the person rather than the home.

Category 4 is, to some extent, an extension of Category 3, with funding directed to the individual who can then choose to purchase care from any care provider, whether in a residence, in the community or at home. When asked about this concept, almost all respondents expressed agreement that funding the person made sense in principle, based on greater equity or fairness to seniors as well as flexibility to choose where to purchase their care and accommodation. Many referred to the concept as the “voucher system”, whereby seniors would be awarded funding credits to utilize towards their care. Many interviewees in the RH sector indicated that the concept had garnered considerable attention within the RH Owner community and had also been the subject of discussions with the MOHLTC.

In addition to the fairness this concept would afford, other prevalent codes related to the level of discretion of the individual to make decisions and corresponding accountability of the government; issues around managing the responsibility of making care decisions, especially where vulnerable seniors are concerned; and the various effects of purchaser-based decisions on resource allocation, purchase patterns and demand/supply balances.

Those who saw personal funding as fostering empowerment and accountability were from all sectors, including RHs, LTCHs and government. Empowerment was seen as derived from the choices seniors would make regarding their own care. Accountability was seen to follow from the direct relationship that providers – whether homes, agencies or government – would have with seniors as the consumers.

R6: But I think it will empower the consumer, it will force all parts of the system to compete in a way that makes them better and more innovative and so on, which is good for those organizations and good for the system and good for the consumer. In fairness to the Ministry, as they are getting pushed by the aging demographic and the funding wall that they're going to be hitting sooner rather than later – and they're well aware of that – they're becoming increasingly interested in looking at alternative funding models that inject more accountability, more competition into the system.

When funding is given to the individual, this affords greater discretion to the senior purchasing care services, but it also invokes personal responsibility to make sure that the money is spent prudently on care that meets the person's needs. In cases where seniors are compromised as to their decision-making abilities, whether cognitively or by frailty, there is a heightened risk around purchase decisions being made in the best interest of the senior. Respondents had different views on the matter, which did not appear to relate to ownership type or sector. Half of respondents felt that these decisions could be managed, where necessary, with the assistance of family, Powers of Attorney (POAs), or publicly designated authorities.

R8: Well, I think there are ways to deal with it because we have that situation right now. We have other people who are quite capable of making those decisions. That's where powers of attorney come in, decision-makers. As soon as someone is not able to make that decision, somebody's appointed, whether it's a family member or a public trustee, or whatever. Somebody's available to take care of steering the ship, so I think the systems are in place for that.

R17: So if you look at how other countries are doing it, if you have a substitute decision maker, they can handle it. If its too complicated, then the agency manages the program. So this exists everywhere.

Approximately one-third of respondents had reservations and were concerned about the interests of vulnerable seniors and whether adequate safeguards could ensure their protection against decisions of their own and of others.

R18: Their care needs should be defined by a robust care plan that's agreed to by them and their power of attorney, the nurse in charge and a physician that's working with them. And as long as that defines and is updated every four months or six months, we should be able to capture the needs. My concern would be the individual making choices on their own care needs. They may miss out on things or push things away that might otherwise be detrimental to their health.

Others expressed the concern that the safety and security that individuals have come to expect in an institutional setting, managed within a tight regulatory regime, might be lost when purchasers are making their own decisions in the marketplace.

R9: As a way to increase the pool of services to seniors, is a more economical way to allow a voucher system for seniors to go out and find a solution of their own from retirement operators, is that going to be more economical than building more long-term care homes? Yes. And at the same time you have to say with that pool, if people that go the voucher path, they will have not as much of a safety net as those in long-term care.

R7: With all due respect to my fellow Ontarians and Canadians, there's also a kind of expectation that comes into this in terms of what the person should have to control versus what they expect to have available and already paid for.

Numerous respondents commented on the beneficial effects that could come in terms of resource allocation, including competition among providers, savings in care delivery, and promotion of all forms of congregate care where care can be provided more efficiently to groups of seniors.

R6: I've always argued that the more competition we can incorporate into the system, the better, because the consumer and the market as a whole will make the choices that are right for them. There is a certain wisdom in the marketplace that is greater than any one bureaucrat designing policy at Queens Park will ever have. So I think it makes a ton of sense when people are armed with a certain amount of funding, based on their care assessment and they can deploy those resources in a variety of settings. It might be for home care. It might be for retirement spending and it might be for long-term care.

6.5. Category 5: Government Funding Appropriate Services in LTCHs

Category 5 covered respondents' views on the types of care services that the government is funding in LTCHs. This category is informed by one of the interview questions, which asks whether a distinction should be drawn between medical types of services such as nursing care,

and care services that were more in the nature of supports, such as assistance with ADLs. The responses were categorized into two codes: first, views on the current suite of service that are funded and whether any should be eliminated from public coverage and, second, what, if any additional services should be covered.

Respondents were almost unanimous that all of the care services currently being provided should continue to be funded, either because they are fundamental to the care of the resident or because they were in some way essential to the person's well-being. No interviewees suggested that any of the currently funded services should be de-funded.

R11: No, I've visited a lot of long-term care homes and I've never seen anything that I wouldn't fund.

R12: I think the services being provided now all have importance for different people in different situations. You need the extra nursing care for some people, whereas you need the spiritual and social work and that sort of thing for other people. I don't know that you could trim too much out of that.

Many felt that it would be also impractical to separate the care provided into categories of nursing versus ADLs, since the two types of service are often interconnected or performed at the same time and become indistinguishable in practice.

R4: I mean, because they're so interconnected. When you're bathing someone, you're doing skin assessment, you're doing a cognitive assessment. So much goes on when you're doing one activity. So to say, don't look at their skin, that's nursing, would be impractical.

R5: Also, if you really look at care, and particularly people in long-term care now, a majority of people have dementia. The kind of care, like bathing is not just bathing. With bathing, you have to understand dementia and the staff need to have higher skill sets, which I think is what they're struggling with, because even though you're doing a very basic task, you have to have a real strong knowledge of the disorders and how to treat people, how to care for people...Its not divisible. And even food, there are a lot of specialized diets. There are some pureed food diets. So it's a lot of care.

Others felt that it was important to maintain items like food in the funding envelopes to ensure that homes observed appropriate quality standards.

R15: They want to make sure that we spend enough, so that we don't cut, cut, cut. So they want to see that our per diem is a reasonable amount and that we keep that per diem amount so the quality of the food is a reasonable quality. This is all long-term care. We don't have to have that in retirement homes because if we don't provide good food, they're going to leave us.

Some pointed out that maintaining regulatory standards around matters such as food and ADLs doesn't necessarily mean that governments should also have to provide the funding, but to de-fund these services or move them to the accommodation envelope would be politically untenable.

R15: Ya that would be revolutionary [to de-fund services] in most seniors' minds. You'd basically be increasing what they'd pay.

R20: There's a political implication here too for what's been put in place and to take that away.

Respondents offered numerous suggestions for additional care services to be covered that are not currently funded by government. Most indicated that the greatest need for additional funding was in areas related to psychosocial supports, including aggressive behaviours and dementia. Several mentioned the requirement of specialized units to address these needs.

R5: And the piece that the homes need better funding for is the aggressive behaviours, it's the psychiatric care. They don't have the skill sets internally. They don't have the money for it. It's the BSO program – the Behavioural Supports – its nowhere near enough what people need.

The second most prevalent subject regarding care services in need of additional funding involved staffing, especially skilled nursing staff. This related to the numbers and skill levels of staff, as well as the increased duties of staff involved in administration and regulatory compliance. Reference was made to the fact that only one registered nurse is required to be on

duty at a time and that the demands of high acuity residents warranted a higher professional complement funded by government.

R1: The challenge today with the funding provided is that, you know, you only have one registered nurse on. It could be a 250-bed home with one RN around the clock. Well, that's inadequate.

R4: So from a nursing perspective, the classification system is looking at what are your bedsores, how continent are you, how much time do you need for ADLs and so that's all tracked out to how many personal support workers per person you need. But that's all task-based. How long does it take to bathe and toilet? The residents want you to sit down and have a talk with them, get to know them, have a meaningful dialogue, but there's not time for that. It's not built into the model.

6.6. Category 6: Means Testing Applied to Seniors' Residential Care

As described in Phase 1 of this study, responsibility for LTCH costs follows the basic principle that the resident pays for the accommodation portion, while the government pays for the care portion. Within these parameters, the LTCHA states that access to LTCHs is to be based on assessed need. Category 6 deals with the concept of means testing in the context of long-term care. Respondents were asked to comment on the propriety and practicality of means testing wealthier seniors, such that those with greater resources should pay for all or a portion of their care.

Responses here clustered into three basic codes, which were comments regarding (i) means testing among lower income seniors, (ii) means testing among wealthier seniors, and (iii) issues of practicality regarding means testing the wealthy.

Although the interview question posed to respondents centered on means testing wealthier seniors with regard to care, a significant portion of the respondents chose to speak about means

testing of lower income people with regard to accommodation charges. References were made to the fact that the government subsidizes the accommodation charge for those who are less able to afford it.

R7: In some ways we do income test... because we do say that if you don't have income to pay for long-term care, we will give you a rate reduction or we will give you a supplement to help you stay in a long-term care home.

While agreeing with the concept that means testing should be applied to assess subsidies for the accommodation charge, two caveats were raised. First, government's role in subsidizing LTCH accommodation should only be in cases of real need. Second, greater diligence should be exercised to avoid abuses by those who access subsidies improperly.

R13: I think that more of the individual's assets should be taken into consideration before a basic rate is granted. Far too often I've seen scenarios where... Here's a really good example is individuals who have hundreds of thousands of dollars in assets but yet the monthly income falls below the basic rate. So therefore, they were entitled to a rate reduction... even though they had thousands and thousands of dollars in the bank. That happens all the time. . . I also think, and this is sort of a pet peeve with me and I just have to make mention of this. It has to do with people not being held responsible for their funds. What's very difficult is sometimes getting assistance and pursuing individuals who are not paying their bills.

Regarding the second code, i.e., means testing the wealthy in respect of the care provided in long-term care, there was no clear consensus among respondents either supporting or opposing. Most of those in support of the concept stated the principle in terms of people paying in accordance with ability.

R1: I think the real opportunity that we should be talking about in the province of Ontario is means testing for access to service. So if you're eligible for a long-term care home and you're extremely wealthy, maybe your co-payment should be higher than someone who's only getting CPP of \$12,000 or \$13,000 a year...If you can afford to pay more, the resident co-payment should be higher. I mean it shouldn't be priced for all.

Many also explained the need for means testing of the wealthy as an economic reality, given the budgetary constraints of government, combined with the growing seniors' population.

R6: The reality is that as we continue to face the aging demographic wall within society, the provincial treasury is going to be overwhelmed by the need and so, as a society, we're going to have to rethink how we utilize and leverage the public dollars within the system. The way we've done it in the past will likely need to change and so even though someone with means has received nursing and personal care from the government in long-term care in the past, that doesn't necessarily mean that should be the case going forward, as we find better ways to leverage our scarce resources in the face of the aging demographic.

Several interviewees pointed out that wealthier seniors are already being means tested, in effect, on the accommodation charge, to the extent they pay more for a private room.

R14: But should some have to pay themselves? I mean, they do pay. People in long-term care have to pay for their private rooms.

Against the proposition that the wealthy should pay more for care, many were of the view that long-term care is, in essence, health care and should be subject to some form of the universality doctrine, where all seniors should be entitled to the same benefits without having to pay extra.

R19: Towards the end of someone's life when you've paid into, like an insurance program, because that really is what your income tax is, you know for certain things, like OHIP is an insurance program, you know, your end-of-life long-term care and hospital, you know like you're paying for it. Who is to say that at the end, you have to pay more? There are certain things that we pay with our taxes and you could say that [the taxpayer] was probably a greater contributor to the Ministry of Health or to those dollars than other people so why wouldn't she have access to those same services?

A significant number of respondents felt that when seniors residential care is considered more broadly to include RHs as well as LTCHs, means testing is a prominent feature of the current system. This was supported by the observation that those with greater means tend to be the ones making more use of the private pay system. Many characterized it as a two-tier system, though respondents' attitudes about the public-private dichotomy diverged quite significantly.

Some considered a two-tier system to be a natural and equitable way of having people pay according to their means.

R11: I like looking at it as a continuum, but I would clearly say there should be discussions for, you know, people that can pay and the sector says that is already happening. You know, make sure you have enough retirement home offerings for those who can pay and then the long-term care homes would be available for those who cannot... I think if you are wealthy, you probably are not in long-term care. If you're very wealthy, you can afford to have 24-hour nursing. And so its kind of where you are on the continuum, and then you'll probably be in a retirement home.

Others felt the distinction between public-pay and private-pay offended principles of fairness, incited the wrong behaviours among seniors, or marginalized the proper role of LTCHs.

R17: Why is that person who's actually made the good decision to sell their house and move into a retirement home being penalized?

Several others saw the two-tier nature of residential care funding as a tacit policy goal of the government.

R9: I think retirement will fill the demand by default, not by plan. Frankly, I think that's the Liberal's strategy is to have a two-tier system. It's a for-pay system and a not-for-pay system, they just won't come out and say it. Its an unspoken strategy.

R12. You have your two-tier health care system now. Its just no one wants to admit it.

Aside from the rationale as to whether means testing makes sense, the third code pertained to the actual implementation of wealth-related tests for seniors. Responses focused on the challenges of devising workable measures of wealth and on dealing with those seniors and their families who might be prone to deception or abuse of the system.

Respondents differed as to whether they thought means testing could be practically implemented. While most thought that income could be tested, particularly through the tax

system, it was recognized that many seniors can be income-poor but asset-rich, and that the tax system is unable to accurately track assets.

R19: There is a T4, which is people's income, but not assets, right? And so people have very big assets, but their income is just showing that they're receiving, you know, \$18,000 a year.

Even if an asset-based wealth test could be devised, numerous respondents perceived a serious risk of deception on the part of some seniors and their families.

R11: There's usually a relative, it may be an immediate family member or a distant family member, but once they kind of trigger the decision to put them into long-term care, they usually get rid of all their assets. So, you know, their house is sold and all of that and, you know, probably distributed in some way.

Finally, some respondents pointed to the political risk that any government would take in introducing means testing of seniors for LTCH eligibility.

R6: The question then becomes that the Ministry may be open to those things, but the grey power as a voting block is influential and whether there's political appetite to do that remains to be seen because politicians are always reluctant to look like they're beating up on seniors or taking things away from them.

6.7. Category 7: Regulatory and Governance Regimes in Seniors' Residential Care

The findings for category 7 were informed by an interview question which asked whether it would make sense to have care services in RHs and LTCHs both regulated by the MOHLTC, rather than having separate regimes for LTCHs and RHs. Most respondents gave their views on the rationale for having one regime, with the most prevalent code being the consistency and clarity that this would bring to governing seniors' residential care. There was fairly strong support among respondents for the principle of one regime, at least as it applies to higher acuity seniors, and particularly as services of LTCHs and RHs become more intermingled.

R5: But yes, I think its just fundamental fairness and safety, I think we have to have the same kind of regulation.... We do think the Ministry should be regulating the care [in RHs]. These are pseudo-health facilities. Like they are not regulated health facilities. But the care should be covered where its care. So why are they splitting this up? I thought it was a joke that they put it into the Ontario Seniors Secretariat. It's a Secretariat. It does not have money.

Almost equal support was shown for a dichotomous regulatory approach, with RHs continuing under the existing RHRA governance structure. Much of this support was, understandably from Owners of RHs or Owners of both RHs and LTCHs. The rationale put forward for separate RH regulation and inspection came down to issues around the preservation of resident choice, the benefits of “risk-based” regulation, and the perceived success of current regulation under the RHRA.

R17: So the Retirement Homes Act is based on risk and managing risk and the process requires that they have to trust the home to a certain degree. If all of the systems are in place and there's evidence that the home is following their own procedures, etc. then in the event that something even does go wrong, the home is going to have the mechanism to address it.

Interestingly, several of the respondents who preferred to keep the RH regulatory regime felt that a merging of regulatory regimes would become more logical if the care funding were directed to the individual (as per category 4) rather than to the home, since this would remove the conceptual barriers between the LTCH and RH sectors.

R6: If you gave the dollars to the individual, wherever they spend it within the range of options, they could be regulated by a common regulator, and that has a certain elegance to it and consistency that would make sense. The regulatory piece is disjointed now because the system is disjointed.

On the topic of consistency of regulation and inspection, a significant number of respondents gave their perspective on seniors care generally, with numerous comments about home care being the area in greatest need of improved regulatory standards.

R16: When you're looking at the clientele in home care, it's their home and they have a right to have their home as they choose. If they choose to live in an unsafe environment, that's their choice to do so. In the long-term care environment, we're the ones accountable for these residents now so we have to ensure that we are compliant.

R13: If there were any energies put into anything, the individuals who are at the greatest risk are those in the home, receiving home care, because it is not regulated. You don't know who you are getting.

Many respondents drew attention to the fact that RHs cover a wide spectrum of acuity and that regulation may need to address these differences with a flexible, graduated, or evolving regulatory regime. While the RHA and its regulations already prescribe different standards depending on the care service provided in the home, suggestions by respondents included placing limits on the complexity of care needs that RHs are permitted to provide, or the introduction of graduated or differentiated licensing, according to the level of care provided in the home.

R5: Why do we have licensing of long-term care if you can do a light version – we always call it long-term care light in retirement homes. So the legislation should have put a cap to what they could offer...we always argue that there should be graded licenses, because we know a lot of the retirement home operators do not want to do all the care...as soon as you get into dementia and the person needs these different supports and need the different care, I think you've got to license it in a different way.

R19: In the Retirement Homes Act, there are stricter regulations for assisted living and memory care... So with the idea that people in assisted living and memory care are at a higher acuity, similar to, maybe similar to what you might see in a long-term care home. So there are more stringent standards about the kind of care that you provide, the kind of training that the staff need to have, but it's not to the level of long-term care.

Most respondents framed the difference in regulatory regimes between LTCHs and RHs in terms of trade-offs, where stringent regulation gave greater protection to more vulnerable seniors, but at a cost to the liberties of the resident, including flexibility and lifestyle.

R4: The model for retirement homes is all about resident choice – this is your own home and its under the Residential Tenancies Act and they receive assisted living support. That makes a huge philosophical difference in how you build and operate a retirement home versus a long-term care facility, which is really more like a chronic hospital. [LTCHs] operate under more of a health model. So I wouldn't want retirement homes to turn into long-term care facilities and lose that resident choice, that resident model. [In LTCHs], the classification system is looking at what are your bedsores, how continent are you, how much time do you need for ADLs and so that's all tracked out to how many personal support workers per person you need. But that's all task-based. How long does it take to bathe and toilet?

Most respondents commented on a connection between funding and regulation, particularly the tendency for government funding of residential care to lead to and legitimize enhanced regulation. Some saw this as a natural sequence if governments began funding care in RHs, though Owners of both RHs and LTCHs voiced concern that funding RHs directly would bring about excessive regulation. Several Owners cited this concern as one of the reasons for having governments fund seniors' care via the individual rather than the home.

R3: Don't fund the homes, fund the individuals. I could give you 20 reasons but most of them surround what governments always like to do and that's if we're funding you then we get to say something about how your business operates, either what you pay people, what degrees they have, how big the lunchroom is, how big the washrooms are, I could go on and on and on.

One of the interview questions was originally meant to ask whether it made sense to have MOHLTC govern RHs in respect of care services, rather than to have two separate regimes. During most interviews, however, respondents were simply asked whether a single regulator would make sense, without reference to the MOHLTC. This change was made during the first set of interviews because responses tended to focus on the current inspection practices followed by the Ministry rather than the broader rationale of merging governance regimes. Nevertheless, views concerning the adverse and unintended consequences of the regulatory burden imposed by the Ministry were universally expressed by the Owners of LTCHs interviewed and were frequent among other constituencies represented in the interview sample.

R1: The current compliance model in long-term care homes is not sustainable. Its so prescriptive and micro-managed. The government cost to administer the program is prohibitive and it doesn't work because there's no differentiation in risk – if there's something not on the care plan, that's equal risk to something that's serious.

R16: The inspection process has become just more of that, right, like its an inspection process looking for wrong things instead of a collaborative, let's work together, make it better approach. So I think that has put a strain on the long-term care home sector, because there's so much emphasis on needing to do things right and having everything written down to show it, taking time away from that practical hands-on that we used to have with residents in long-term care.

6.8. Category 8: Observed Changes in Residential Care in Recent Years

Respondents were asked about their experience in the seniors' residential care sector and what major changes they had witnessed in the sector in recent years. Almost all referred to changes in the resident population, describing increases in the average age and acuity levels. Most referred also to particular care needs, the most common references being to dementia, behaviours, ambulation and medication. These descriptions applied to both LTCHs and RHs.

R7: So what you end up with entering long-term care is a person who ten years ago may have had three comorbidities, now they have ten. And they're on 20 medications. You know, its hard to kind of think of someone on that kind of volume of care, but that is what long-term care will now become.

While both LTCH and RH residents were seen as having moved further along the care continuum, several indicated that LTCHs had moved closer to end-of-life of care, while RHs had assumed a role in seniors' care akin to what LTCHs had filled earlier.

R1: What's significant is over the last 5 years, since the new LTCHA came in in 2010 that the average length of stay has gone from about 5 years to about 18 months and that's because the eligibility changed, so long-term care has really become sort of an end-of-life service provider. Very different from 10 years ago or 6 or 7 years ago and it would not be uncommon to see seniors who did not have dementia and were ambulatory and just needed more support and more medication and more like a retirement home.

Many described how the change in functionality of residents had altered the social environment and the focus of activities within seniors' care homes. This was seen as applying to both RHs and LTCHs.

R12: I think what's happened is, when I started in the business 25 years ago a retirement home was still a retirement home where you could play golf every day and all you wanted was a housing area that had some support services if you needed it. There were no walkers and no wheelchairs.

R16: When I first started in long-term care, we literally, we spent time with our residents doing cooking classes, and knitting, and all of those things that you did with the little grandmothers and grandfathers of the day.

Second to changes in the resident population were responses regarding changes in the operating environment affecting Owners, including primarily the regulatory, financial and staffing aspects of running homes. While comments were directed predominantly at the LTCH regulatory regime, the new regulatory regime in RHs was also mentioned by several interviewees. For LTCH operators, in particular, the increased regulation was seen as having profound effects on the inspection requirements, staffing challenges and the funding model, with its financial implications.

R10: Well I think the biggest change for both sectors was the introduction of new legislation or revised, updated legislation for long-term care homes and the whole introduction of legislation for retirement homes... And also, for both sectors, the inspection process, and the other big change for long-term care was the introduction of the MDS, the standardized assessment process with the related change to our funding structure.

Aside from the more specific changes affecting residents (age, acuity and care needs) and Owners (regulation, funding and operational challenges), several respondents described how the fundamental model for seniors' residential care has begun to change in recent years. The principle concept discussed by interviewees was the continuum of care, whereby individual Owners/operators are increasingly offering a spectrum that may include community care,

seniors' apartments, RHs and LTCHs, and other forms of acute care. This broader offering was discussed in terms of the change in environment for the resident as well as the operating requirements of Owners.

R19: I see a continuum of business because, you know, the community programs feed into independent living and then once we have assisted living and memory care, independent living will feed into assisted living and memory care. So absolutely, for the quality of life reasons but also for business reasons, I really see a lot of opportunity.

Also from a qualitative perspective, several mentioned the move to the more social model, as opposed to the institutional model of care, where attention is given more to active engagement, quality of life and social interaction.

R6: ...shifting away from the traditional medical model of institutional care to a more social model of living where the focus is on putting living first and active engagement no matter what the stage of life is and what the diagnosis is, so not defining the person by their diagnosis, which is more the hospital approach and supporting that person to be able to live life to the fullest and to have meaning and purpose in that person's life no matter what age or diagnosis...that's a movement that's been working its way through the senior living and long-term care system in the US and in Canada now as well.

6.9. Category 9: Risk, Return, Opportunities, Threats to Owners

Category 9 comprised risk and return in the industry, including Owners' perceptions of attractive features in residential care as well as opportunities and threats. Respondents also compared LTCHs with RHs. The most prominent concept raised by interviewees related to creativity versus restrictiveness in the operating environment, which drew in key differences between LTCHs and RHs. Greater flexibility and creativity in RHs included being responsive to community demographics, varying room designs, building additional units, pricing according to demand, finding cost efficiencies in delivering care services, developing niches and brands, choosing clientele and providing unique service offerings.

R9: Retirement is more interesting because there's more opportunities to differentiate yourself and beat the competition. In long-term care, there's a wait list. Everybody is winning because the wait list is so big. Even the bad operators succeed. It's just less interesting from a competitive point of view.

R11: I think there's a lot of focus on the long-term care homes being prescribed by regulations around the rooms having to be so big, they have to have a washroom, they have to have this, they have to have that. I've seen designs maybe more in supportive housing or assisted living where they have clusters, where the rooms are part of a cluster and then there's a common area. I'd like to see a lot more flexibility.

In terms of the risk/return profile of LTCHs and RHs, many saw LTCHs as providing lower financial returns, but with potentially lower risk as well, in comparison with RHs. The critical economic drivers related to differences between LTCHs and RHs in occupancy rates and competition for residents. Also noted were the differences in government funding and regulatory standards and enforcement between LTCHs and RHs, which have been profiled in findings summarized earlier (see categories 3,4,7). With regard to occupancy rates, respondents felt that higher rates in LTCHs, due to the existence of wait lists, made Owners of LTCHs less vulnerable to competitive forces than was the case for RHs.

R18: Now the difference between the two is I am not, as an operator, at risk of an occupancy less than 97% in long-term care, so I don't have to spend dollars to go out and compete, and the residents flow in so there's not fill up, whereas if you do a retirement community, you may take 18 months of 2 years to fill it up and staff it and get to a level of profitability that's reasonable for a return. So there's a very different dynamic there. The other thing is in long-term care, versus retirement, in retirement, people expect a more hospitality-like, leisure-like service level, so we spend an inordinate amount of time training staff to be able to do that in a way that also is balanced with support and care where needed.

Of note, with regard to the risk/return differential between LTCHs and RHs, was the preponderance of comments depicting LTCHs as being financially unattractive to Owners. Comments regarding LTCHs being uneconomic or unviable were made by all current Owners in the sample, including FP, NFP and municipally-owned operators.

R1: Financially, its difficult for operators [of LTCHs] because there's very little margin to make it work and you're taking on a lot of risk... I think its becoming less and less attractive all the time. People are getting out of the business. Its pretty tough, particularly in Ontario.

R15: So some of the bigger corporations are moving away from long-term care. They're not increasing their inventory of long-term care home beds. There's no incentive. Financially, it doesn't make sense as a business. So for the business people, I don't see them doing it...So its kind of two sides in some cases. The government doesn't want to build out more long-term care homes and the owners may not be excited about it either.

Many respondents mentioned operating challenges associated with staffing, particularly labour costs and shortages of qualified staff. These issues were common to LTCHs and RHs, but more prevalent in LTCHs, where labour costs were considered to be higher, due to unionization and requirements to hire more professional staff, such as nurses.

R16: Definitely staffing is a huge one [risk]... I would say, depending on the type of home, whether it's a for-profit, not-for-profit or municipal, the wages vary. So some homes would struggle greater than others. Its not an attractive field as far as the workload, especially the registered staff. They'd prefer to work in an acute care environment where there's less residents per staff or patient per staff. And as far as the unregulated health care workers, it's a hard job, an extremely hard job.

Both LTCHs and RHs are also at risk of adversity in the form of media criticism or lawsuits.

This was observed more noticeably among LTCHs, where regulatory standards are higher and media scrutiny was considered to be harsher.

R1: The funding is inadequate for the level of care that's being provided and so you wind up with a lot of risk and that's why there's a lot of negative press around it, because there's going to be bad things happen – the resident aggression, behaviours and so on.

Related to the operating environment of residential care homes were comments describing the different or evolving value proposition offered by Owners and the image they were trying to portray to consumers. For RHs, respondents spoke of transitioning more towards enhanced

community, resident independence and control, more focus on a wellness model, greater social interaction, and increased emphasis on lifestyle, leisure and programs.

R2: Whereas, with my community, we're looking at the whole community and how that person is going to fit in and one of the things that I find with my community is that we do integrate. There are residents with dementia here but the community looks after and supports. Its like a home, its like a neighbourhood where they're all looking after each other and you know, functioning as a group. They all support each other, whereas I didn't see that as much in long-term care...Its more of a medical model. You're sick. We're going to look after you. Whereas here, it's a wellness model.

For LTCHs, where the operating model is more restrictive, respondents mentioned successes in moving away from the institutional model, raising the profile of LTCHs within the health services community, and recruiting skilled staff.

R13: There was a very long time I think when long-term care was just, well its just where we have all the elderly go and that's it. That's the end of it. The nurses were not top notch. They didn't have the clinical skills that they had in the hospital. That's all changing. So I think long-term care is being viewed as more of the health care system. I don't think its always been that way.

6.10. Category 10: Strategies for Targeting Clients or Levels of Care Services

Category 10 examined how Owners of LTCHs and RHs positioned themselves within their market sector, what types of seniors they tried to attract and how they distinguished their service offering from others in the market. Responses differed considerably between LTCH Owners and RH Owners.

LTCH Owners indicated that they had limited discretion in the choice of resident profile for two principal reasons. First, as opposed to RHs, which can choose what service level to provide, LTCHs are generally required to provide a full array of care services to residents of all acuity

levels, short of those who require hospitalization. Second, as a practical matter, placement in LTCHs is mostly determined by the local CCACs, which oversee resident assessments, determine priority status and manage the wait lists. Some respondents noted that LTCHs were able to resist intake of residents in cases where they had reached the limits of care resources in the home, particularly for residents of very high acuity.

R12: What you also see in long-term care homes, is they're becoming selective. They actually turn people down now and that also pushes people back into the system... they balance their RAI score [assessment score which outlines care need], so if they have a lot of people with high acuity, they do push back and say they can't take them. So if you have 10 people that need feeding, at some point you've got to cap it off because your staffing level just can't match it.

R20: Sometimes the long-term care home is resistant in taking the patient back because behavioural patients often are a problem.

RH Owners, by contrast, have considerable discretion in terms of whether, where and what level of services they provide. As discussed in Chapter 5.4 (Availability of Care Services and Amenities), homes are required to designate which services they choose to provide and then must meet the standards for the array of care services they choose to provide. In describing the services they could not – or chose not – to provide, the most common responses from RH interviewees related to complex medical conditions, behavioural issues, dementias or residents requiring two-person transfers.

R15: We do some screening to make sure we can take care of them. We try to assess. We don't admit people who are heavy, complex care. We try to admit the people where we see we can take care of their needs. We prefer to have retirement folks because they're a little easier to manage. Their needs are less complex.

Aside from the care limitations that RH Owners established, their choice of resident profile and care service offerings varied considerably. The most common inclusion criterion related to the

independence and activity level of seniors or to the ability to afford RH accommodation, but other Owners aimed to serve the full spectrum of care needs through to end of life.

R12: I think we still have the opportunity to attract the baby boomer. Everyone's talking about how to get the more independent younger person in. I think there's lots of opportunity there.

R3: We do everything right through to palliative care so we're very proud of that...We do full assisted living and in some buildings, we're now building memory care and we do care all the way through the end of life. So unless your need has become overwhelmingly medical you can stay with us through the end of life.

Across the full array of respondents, the most prevalent response conveyed the goal and benefits of offering services at more than one position on the continuum of care. The rationale for this was expressed as enabling people to age in place or to diversify operations across the seniors' residential care sector.

R11: I've toured around to a lot of organizations and the ones I like the best are the ones where there's a campus of care and, you know, the kind of continuum of retirement home and long-term care home.

6.11. Category 11: Economies of Scale, Numbers of Beds and Homes

In Ontario, there is a wide range in the size of operations in seniors' residential care, from small, single-home operators to large national chains. In recent years, the industry has experienced consolidation and growth within both LTCH and RH sectors. In addition, numerous Owners currently combine RHs and LTCHs in one organization. The industry is characterized by a cost structure that includes numerous fixed costs associated with land, buildings, overheads and staffing.

Interviewees were asked about the importance of economies of scale in owning and operating homes. In terms of economies at the home level, most respondents indicated that along with a greater number of beds in a home came greater efficiencies, both financial and operational.

This was commonly expressed as a minimum number of beds per home, below which the business became economically unviable to run, whether it be a LTCH or RH and whether FP or NFP. These minimum numbers ranged from 100 to 160, with many suggesting that 100 beds represented the breakeven point.

R18: The other dynamic which is extremely important is size and scale of the long-term care homes. So today, [there are] a number of these old C licenses which are 60-bed, 80-bed communities that are not efficient to run. They're not efficient to staff. They're in locations where you question do you need them. You cannot build and run anything on the program that's less than 128 beds.

Most respondents felt that the economies at the home level were a function of the fixed overhead and administration costs. Here, the most common responses involved the ability to spread the senior management and other staffing costs over a larger number of residents.

R8: You've got these small 40-bed Mom & Pop homes – I don't know how they're going to survive...Its administrative burden. So you've got an executive director or CEO in a small home doing health and safety, reception, nursing, accounting, public relations, communications, maintenance, and all of these reporting mechanisms they have to accomplish.

In LTCHs, it may be that economies of scale advantages are limited somewhat to items associated with the accommodation envelope, since costs in the other three envelopes are reimbursed on a flow-through basis on a dollar-for-dollar basis, where savings for efficiencies are not realizable by the home.

R18: You do get some benefits in some senses from scale over time, which you can have work positively for you for retirement again versus envelopes in long-term care homes that really don't do a lot of that.

The second most prevalent item pertaining to economies at the home level were time and the costs of regulatory compliance. While these challenges apply more to LTCHs, regulatory burden was also cited in respect of RHs.

R6: But the regulatory complexity has increased so much that you need the resources of a large organization to be able just to deal with it. So the regulatory burden has basically forced those people out over time and consolidated in larger organizations.

While the number of beds per home was considered most important to economies of scale, the total number of homes in the organization was considered next most important. The spreading of costs across several homes was noted as applying to back office expenses, purchasing, corporate infrastructure, management oversight, marketing, and the ability to specialize.

R1: Well certainly, we benefit in that we can recruit a strong team, you have an infrastructure, you have an operating platform with efficiencies. I mean if you have one home, you still have to write the same policies and procedures and guides and operate by the same standards. It's a little harder to get that level of expertise given that its such a specialized business.

Against the economic advantages of scale at the home and organization level, several respondents defended the role of the smaller home as being a mainstay of the community, particularly in rural areas, and as having a closer, more intimate connection to residents.

R2: Yes, but the bigger you are, the less you are a home. You know, we don't want to be an institution. We don't want to be an environment that just provides housing and services. We want to be able to do hands on. I know every resident in this building. Everyone of my staff knows every resident in this building, including housekeeping and dietary and nursing. So if there is something different about the resident, everyone notices. Everyone knows when there's something a little bit different. Maybe the behaviour. Maybe they're not dressing quite the same way. Maybe they're dishevelled. We know when there's a problem.

6.12. Category 12: Owners Choosing Home Location

Respondents were asked what factors influence Owners in the choice of location. The perspective here was different between LTCHs and RHs. First, LTCH Owners are currently restricted to those geographies where the MOHLTC decides to issue licenses, and second, occupancy levels are less determined by geography for LTCHs, with almost all having occupancy rates over 98%. For LTCHs, therefore, the more attractive locations tend to be those that can accommodate a sufficiently large home to realize economies of scale, consistent with the findings regarding category 11, though both LTCH and RH Owners expressed concerns about community infrastructure and the cost of land.

For RHs, the most prevalent responses regarding location related to consumer characteristics, including the number of people in the community (size, growth and density), the level of existing competition for that population, and whether there were high enough income levels to support private-pay service offerings.

R10: Population, average age, income level, what is the cultural breakdown in that community, what are the providers, how many beds are there, what's their occupancy.

Aside from the population of seniors to be served, the most prevalent responses regarding location had to do with the existence of sufficient infrastructure within the community to support residents with transportation, activities, shopping, hospitals and opportunities for social interaction. This applied to both RH and LTCH Owners.

R2: So you have to look, when you're locating seniors, you have to look at what their needs are going to be not only in the environment but also in the community. What do they need to access if they're going to live here?

The third most common response regarding choice of location concerned the cost of land, particularly in urban areas of the province. This was a concern for both LTCH and RH Owners.

R18: Urban settings are extremely difficult. Like, for me to redevelop or have the business case to redevelop, a long-term care home in the GTA, the only place you can even remotely make it work is in a suburban setting where you can get cheap land and ... in the GTA, there's no economies that work. So there needs to be a different solution for urban settings... what it incents is a suburban model on a four-acre site that you can buy for less than two million dollars. If you can do that, you can make the economics work.

Respondents were asked specifically why certain regions of Ontario, such as rural areas and the north, might be less well served by seniors' residential services. Most of the responses raised the same matters considered above, as well as the economies of scale issue discussed in category 11.

R2: That's a problem with small country areas – people, especially seniors, want to be close to the amenities because if they're not driving anymore, they want that bus or they want that kind of transportation ...

Among those who offered possible solutions to regional disparities around residential care, most felt that government dollars were likely the best way of addressing the issue. It was pointed out that the LTCHA already has minimum requirements regarding the minimum number of municipally-owned LTCHs in each area. In addition, there were suggestions for incentives to private-pay organizations, direct funding, or tax incentives.

R4: Well, you'd have to make it economically feasible. So I don't know if the government could look at tax breaks, that kind of thing. The problem with funding capital is that that is a slippery slope. I don't know if that can happen too easily, but I'm sure there are incentives from a tax perspective that might make it easier or getting loans easier, something like that.

7. Analysis, Interpretation and Discussion

Following mixed methods methodology, this Chapter draws on the quantitative/descriptive data found in Phase 1 and the qualitative data obtained from interview respondents in Phase 2 to address the research questions posed in Chapter 4. Reference is also made to the conceptual framework introduced in Chapter 3 and the literature noted throughout the study regarding sectoral background, trade-offs and tensions in residential care, and health policy.

This chapter discusses the findings in four sections, according to the issues raised in the study. These are (i) the growing need for seniors' care and services and the system capacity to meet the need; (ii) equity of access to funding and care, including principles of universality, comprehensiveness and choice; (iii) the role, extent and consistency of regulation and governance; and (iv) risk/return trade-offs for Owners in the sector and the evolving operating model for seniors' residential care.

7.1. Growing Need for Residential Care and Services

The issue of capacity constraints within the seniors' care system involves matters examined in the study that relate to government policy to restrict growth in the number of LTCH beds; allocation of resources for other seniors' care priorities, such as HCC and redevelopment of existing LTCH stock; the increasing prominence of the RH alternative as a means to absorb excess demand; financial and capacity implications of funding diverse sites of care or direct funding to individuals, and the costs of comprehensive service offerings; and alleviating cost pressures on the government by transferring them to wealthier individuals through means testing.

This study helps to explain the reason behind the availability of LTCH stock in Ontario as well as the implications of the limited growth in LTCH stock relative to increases in the seniors' population. Phase 1 data (Table 5.27) indicated a long-stay wait list equal to 35.7% of existing supply. In addition, the gap between demand and supply has widened in recent years, with the number of licensed beds growing much more slowly than the seniors' population. As noted in Chapter 6, respondents expressed concern about this widening gap. Almost all respondents observed significant increases in age and care needs among LTCH residents, consistent with Phase 1 data. In addition, most attributed the lack of growth in beds to government policy, since increases in stock can only come from the issuance of new licenses, which have not been forthcoming in recent years.

Hacker describes 'policy drift' as "changes in the operation or effect of policies that occur without significant changes in those policies' structure."¹⁴³ The legal test for admission to a LTCH facility has not changed in recent years. However, the increase in the seniors' population in Ontario, without commensurate increases in the stock of LTCHs, has resulted in discernible policy drift. The cohort of seniors funded by government in LTCH facilities today is a diminishing and higher acuity subset of what it was a decade ago and therefore represents a departure from the situation in existence at the time the legal test for admission was first implemented. The essence of policy drift is that formal policy is intentionally held constant even while significant changes in its application causes a change in outcomes. While this can occur inadvertently, Hacker explains (p. 246) that "much of it is quite clearly mediated by politics, a result not of failures of foresight or perception, but of deliberate efforts by political

actors to prevent the recalibration of social programs.”¹⁴³ As respondents noted, a key reason behind the limited growth in LTCHs is constrained government funding to finance new capacity. Indeed, with the current cost of LTCHs exceeding \$4 billion annually (\$51,000 per resident), the LTCH option is an expensive means for government to provide seniors’ care. Recent attention to home and community care alternatives and the redevelopment of existing long-term care beds may be the less costly alternative, as perceived by government.

There is little doubt that a combination of residential and community alternatives will be required to address the increasing needs of seniors over the coming decades as the seniors’ population and the dependency ratio both increase, with the latter being a proxy for the dearth of informal caregivers. Certainly, the recent government focus on HCC has helped to delay the influx of seniors to LTCHs by absorbing much of the demand for ADL care. Initiatives such as *Roadmap*, discussed in Chapter 2, have set HCC as a priority for the Ontario government. However, the heightened acuity levels being experienced in LTCHs now suggest that the home care alternative may not be sufficiently comprehensive for many seniors. This concern was expressed by respondents and is consistent with the assessments by the OLTCA that acuity levels are rising in LTCHs, and by OAHNSS that divertibility of residents to home care is quite limited (Chapter 2). In addition, many respondents expressed concerns that HCC – even where care levels were appropriate – was not subject to the same regulatory safeguards as those applied to LTCHs by the MOHLTC and was a more costly and less efficient solution for consumers than residential care. On this latter point, respondents’ views were consistent with the conclusions of the Ontario-based home care study described in Chapter 2.³⁴

Several respondents pointed to the risks of overbuilding LTCHs to meet current demand, only to have these assets stranded when the seniors' population later decreases. However, 2016 population statistics indicate that the largest 5-year cohort in Canada is currently between 50 and 55 years of age, which will not reach the age of the average LTCH resident for approximately 35 years. Furthermore, the cohorts that follow are similar in size for decades thereafter.¹⁴⁴

As a matter of policy, the preamble to the LTCHA states the principle of access to LTCHs based on assessed need. Section 96 provides that the Minister, in determining *whether* and *how many* beds there should be in an area, should consider the existing LTCH bed capacity in the area, the other facilities or services available and the current and predictable continuing demand for LTCH beds in the area. Phase 1 shows that the underlying need for more LTCHs can be difficult to discern by region, since local demand tends to be a function of the migration of seniors to LTCHs of other LHINs, wealth effects by which lower income seniors are more represented in LTCHs than are the wealthy, the availability of other care options in the region, and the variation in health and socio-economic profiles of seniors by region. Nevertheless, wait lists for LTCHs remain significant across all LHINs.

As articulated by respondents, the demand for more beds in LTCHs is accompanied by the needs for specific health and supportive services for seniors who occupy those beds. At present, LTCHs offer an array of services for residents delineated in the funding envelopes, which include nursing, personal care, food, programming and support services. When respondents were asked whether the government was covering the right types of services, including support

services for ADLs, virtually all respondents agreed that these services were required as an integral part of overall resident health and well-being. As such, ADLs were viewed as an extension of or ancillary to professional nursing services. In addition, rather than putting limits on the existing government-funded services, most respondents, from different backgrounds and roles, urged the addition of other care services to be covered, including psychosocial supports, programs for aggressive behaviours and dementia, and specialized units to address these needs. Others pointed to the need to fund additional staffing, especially skilled nursing staff. These comments from respondents regarding the need for more staffing, particularly in the area of complex care, accord with the research discussed in Chapter 3 (section 3.4) and Chapter 5 (section 5.17).

As pressures grow on government for additional spaces and services in residential care in Ontario, RHs are assuming a greater role in absorbing the unmet demand. The scarcity of beds in LTCHs, combined with longer lifespans and higher care needs in later life are causing seniors by choice or circumstance to opt for private alternatives.

In assessing the capability of RHs as a substitute for LTCHs, a distinction needs to be drawn between the broader role of RHs in the seniors' sector and the more specific role they can fill in addressing the care needs of those at higher acuity levels. The consumer market for RHs extends from seniors with full independence and active lives to those with needs for dementia or palliative care. Many RH Owners depict the sector as one based on principles of choice, attractive amenities and risk-based oversight. However, the context in which these features are highlighted by RH Owners is sometimes marketing, (i.e., to attract lower-need seniors whose

health care costs are less problematic), and sometimes governance, (i.e., to distance the sector from the prospect of regulatory oversight by the MOHLTC).

While this positioning of RHs may contrast with the end of life role played by LTCHs, both the descriptive and interview phases of this study reveal a significant overlap between RHs and LTCHs for seniors needing high levels of care. Phase 1 data indicated that fewer than a quarter of RHs in the CORE database offer fully independent living and significant proportions of homes now offer services that include assistance with ambulation, continence and feeding as well as on-site medical and nursing services. Many respondents also describe their assisted living services as similar or indistinguishable from those in LTCH accommodation. Others referred to a large percentage of their residents who would fit in either the LTCH or RH setting based their personal care needs.

A shift in demand from LTCHs to RHs appears due to RH residents choosing to age in place and defer or decline a spot in a LTCH, despite being eligible to go on the LTCH wait list. Some RH Owners also felt that RH residents who had been accepted to join the LTCH wait list tended to be assigned lower priority than other seniors of similar acuity, and were therefore forced to remain in the RH for longer periods. The availability of beds in RHs, relative to LTCHs, was a factor cited by many respondents as diverting seniors to RHs, where occupancy rates are lower and waiting lists are shorter or non-existent. Indeed, the capability of RHs to meet the growth in the older-adult population is a matter of market demand as opposed to LTCH processes that involve government tenders or supply-restricted licensing. Many RH Owners saw attractive

prospects for expansion in the number of homes, services and geographic locations in step with demographic demand.

Almost all respondents raised the issue of affordability of RHs, indicating that the cost to the resident of accommodation and care was higher than in LTCHs, and that affordability was seen as influencing the resident decision between LTCH and RH accommodation. As Chapter 5.5 shows, there is wide variation in the cost of RH accommodation, depending on geographic location, the features and amenities of the home and the particular care services being purchased. However, when the full cost of care and accommodation in LTCHs and RHs is compared, according to CMHC and CORE data – and ignoring *who* pays – the evidence from Phase 1 data is that RHs are not more expensive than LTCHs. Rather, the higher cost to the residents in RHs is largely a function of the fact that the care cost is borne by the residents themselves.

A concern expressed by respondents was that the higher cost of care in the RH to the resident put it out of reach initially or caused the resident to move from RH to LTCH as increasing care needs depleted the person's financial resources. In fact, some RH Owners indicated a strategic decision to cater only to higher income seniors because of the concern that less affluent seniors would be unable to meet their monthly commitments as their care needs rose. These observations highlight the importance public funding could play in the RH settings, since it would appear that both the demand by seniors and the supply by Owners is a function of the out-of-pocket cost to the consumer, even though the all-in cost of care and accommodation for RHs may be comparable to LTCHs.

7.2. Equity of Access to Funding and Care

The equity of access issue includes matters examined in this study related to the contrasting funding models between LTCHs and RHs; inconsistent availability of publicly-financed home care and differential access to it for RH residents; waiting lists for LTCH that assign lower priorities according to current domicile; affordability of RHs for those who cannot access the necessary resources elsewhere; viability and implications of funding sites other than LTCHs; funding the person by means of a voucher or approved-provider system; and means testing as an equitable means of placing care costs on seniors with greater resources.

Almost all respondents recognized that government funding of seniors with the same care needs differed by the site of care delivery and most interviewees agreed in principle that seniors with the same care needs should be funded equally with government dollars, regardless of where they reside.

Although RHs are not funded directly, residents are eligible for home care services through their CCAC, on the same basis as they would be if they were living at home. However, many respondents felt that this did not put RH residents on an equal footing with LTCH residents, since home care services were not seen as suited to seniors of higher acuity, or that availability of CCAC was inconsistent, or that RH residents were viewed by CCACs as being low priority for receiving home care services. Several of these observations by respondents are corroborated by research in the sector, as described in Chapter 2. For example *Roadmap*²⁵, in proposing a Levels of Care Framework, identified a pressing need for greater uniformity in

HCC services across the province as well as better transparency in the way needs of individuals are assessed. Similarly, the Rotman³⁹ study found that the unreliability of HCC services to RHs resulted in residents bearing the replacement cost of home care services and Owners of RHs experiencing disruptions to their staff who then had to provide unscheduled care. In addition, the observation that RH residents are assessed low priority for receiving home care services appears consistent with the 2017 Ontario-based study described in Chapter 2.3⁴⁰ that found RH residents received fewer hours of publicly-funded support service than seniors in private homes, and were paying privately for a significant portion of their services, rather than receiving care through the CCAC.

With respect to care funding for RH residents, most respondents felt that it would be appropriate to fund either the home on behalf of the resident, similar to the way LTCHs are funded, or to fund the individual directly. In the latter case, the funding received by the individual could be used to defray the cost of care purchased privately, in a RH or other site where the person chose to reside. Respondents felt that focussing on the need of the individual afforded greater fairness and choice to the senior in purchasing care and accommodation, while helping allay concerns of a two-tier system. Many confirmed that the concept of a voucher system had already been the subject of discussion with the MOHLTC. Respondents across RHs, LTCHs and government saw benefits from empowering seniors with control over their own care and from placing more accountability on providers, which would then be directly responsible to consumers. Research referenced in Chapter by Rotman³⁹ and the C.D. Howe Institute⁴⁷ would confirm these benefits as observed in other jurisdictions that have adopted self-directed funding.

For some respondents, a voucher system raised concerns with ensuring the protection of vulnerable seniors in cases where their decision-making abilities might be compromised, since responsibility for prudent decisions necessarily accompanies greater consumer discretion. Respondents were divided on whether sufficient safeguards existed to protect seniors, though reference was made to families, POAs or other designated authorities as possible solutions. Others suggested an approval process for confirming the eligibility of providers to offer certain care services and that seniors might be required to direct their funding towards those approved providers, including licensed RHs. Here, an appeal to the experience of other jurisdictions using voucher systems (as discussed in Chapter 2.3.2) may offer useful precedents.

The financial and resource allocation aspects of funding based on need rather than domicile drew positive comments from respondents. Many anticipated increased competition among providers, savings in care delivery, and promotion of all forms of congregate care which can be provided more efficiently to groups of seniors. The net cost or savings to the provincial government of funding the individual rather than the home is a matter for much needed analysis. There is a risk of viewing a voucher system as an incremental cost to government, since payments of this nature are not currently being made in the manner envisioned by respondents. However, the net cost differential depends on one's baseline assumptions for future funding requirements of seniors. Following OANHSS's position paper on capacity planning (p. 4), the population of Ontarians over 85 years is expected to quadruple between 2011 and 2031. If current LTCH statistics were to hold *ceteris paribus*, this would imply over 300,000 LTCH residents, a 100,000-person wait list and an annual provincial expenditure of \$16 billion on LTCHs in today's dollars. Such an outcome is clearly untenable and sensitivity analyses of the

type prepared by Preyra Report can be valuable in evaluating different scenarios (see Table 2.2). Alternatively, Ontario could continue to hold the stock of LTCHs closer to the present level (with policy drift ensuing further), save LTCH capacity for seniors of high acuity or low income, and fund the incremental care needs of seniors through a more flexible voucher system, with the extent of care services and costs to be more customized according to government policy.

Financial issues such as these draw focus to a broader question of how Ontario should share equitably the cost of seniors' residential care when government finances are already constrained. Respondents were asked their views on means testing and, in particular, whether wealthy seniors should be responsible for contributing to the cost of care in LTCHs. This question seems all the more cogent, since the financial responsibility for similar care already rests on the resident in the private, RH system.

The propriety of means testing is an issue that stands apart from all other questions asked of respondents in Phase 2. Other issues were assessed on the basis of the support they might provide for underlying truths about the seniors' residential care sector or its policies. However, as can be demonstrated from the findings for interview question 6, support for means testing really turns on one's personal views, rather than on any shared sense among key informants of what is fair. Essentially, there was diversity of opinion on whether long-term care funding represents a social need, a health care need or neither. Perhaps more importantly, this reveals a lack of consensus as to what the policy is – or should be – regarding financial responsibility for senior's care.

Many respondents felt that long-term care is, in essence, health care and should be subject to the universality doctrine, with all seniors being entitled to the same benefits without having to pay extra, regardless of their personal wealth or income. Rationale for this came partly from the view that wealthier seniors had likely contributed more tax dollars to the health care system through their taxes and should not be denied coverage when their time has come to derive the benefits. A somewhat equal number of respondents felt that the wealthier should contribute directly to the cost of their care, based, again on principles of fairness and ability to pay. Some pointed simply to the limits of government financing as sufficient rationale to draw on the resources of the wealthy to pay more.

If the services of LTCHs are considered more applicable to those in financial need, there is a stronger argument that the wealthy should not be ‘subsidized’, whereas if these services are truly health-related, the perception may be that benefits should be available to all. The latter position gains support from the fact that LTCHs are in fact a health expenditure incurred by the MOHLTC. Where the preamble to LTCHA states that access to LTCHs is to be based on assessed need, one might assume that residential care is a health need and not a financial one. Unfortunately, appeal to the *Canada Health Act’s* principle of universality is problematic, since LTCHs fall within that Act’s definition of “extended services” and therefore do not fall under the CHA requirements. Clearly there is disagreement among key informants in the sector as to where policy lies on this issue and the reason is an absence of a stated policy on the matter.

In the context of LTCHs, the debate is complicated by the fact that accommodation charges, as opposed to the care envelopes, are the subject of government subsidies for lower income seniors. Thus, where the accommodation charge is the primary responsibility of the resident, individuals can apply for assistance, which is funded by the MOHLTC. This might be seen as a form of social expenditure, since it is essentially housing and sits outside of the care funding envelopes. In fact, different respondents referred to this instance of means testing as support for, or alternatively against, means testing of the wealthy with regard to the care component.

The debate around means testing gained another dimension when RHs were introduced into interview discussions, since care services similar to those covered by the LTCH care envelopes are paid for privately by many RH residents. If wealthier seniors are not to be subjected to means testing in LTCHs, does it make sense that they be responsible for paying for the same services in RHs? Those who favoured the idea of universality, saw the two-tier system as a form of discrimination. Others saw the private pay alternative as a legitimate form of voluntary means testing. Some drew the generalization that wealthier Ontarians do not use LTCHs, though Phase 1 data from Preyra Report suggests that the relationship between wealth and LTCH usage is linear, not binary (Table 5.8). Several were able to rationalize the universality concept among residents within LTCHs, without having to extend it to RHs. Another view was that RH residents who are on the LTCH wait list should be covered by public dollars while those who have not applied should not be. This view seemed to be based on the idea that seniors who choose the private pay system are also *choosing* not to receive public dollars.

There is a logical connection between the financial cost of comprehensiveness and that of universality, where the former considers what care services should be covered by government and the latter considers who should be covered. As noted, respondents strongly supported the continued funding of a comprehensive list of services in LTCHs, which included ADLs (e.g., dressing, bathing, ambulation) and the cost of food, despite the fact that annual funding totals over \$50,000 per resident. However, when asked to consider *who* should be covered, many respondents were willing to exclude the wealthy from coverage (compromising on universality) rather than reduce the array of services offered in LTCHs (compromising on comprehensiveness), even where some services seemed to be more in the nature of support than health care. This discussion raises the same issues highlighted in the Colombo Report referenced in Chapter 2,³³ where OECD countries were found to be gravitating more towards systems that provide a basic level of coverage to all. Unfortunately, in Ontario, the basic level of government funding for seniors' care appears to vary considerably by the site of care.

Aside from the fairness issues around means testing the wealthy, the practicality of means testing was seen as problematic, particularly among those who thought that a true test of means includes both assets and income. Respondents were divided on whether reliable information on assets could be obtained, whether assets were at risk of being hidden or gifted away, or whether the political will existed for government to introduce such measures.

7.3. Regulation and Governance

With regard to regulation, issues examined in this study include the role, extent and consistency of regulation and governance in the seniors' residential care setting. This includes matters

related to the separate regimes for LTCHs and RHs, the trade-offs created by strict regulatory standards as experienced by Owners (service offering, branding, marketing, segmentation) and residents (choice, risk, lifestyle, flexibility); the intersection of regulation/inspection and government funding; and unintended consequences of regulatory burden.

RHs provide a wide range of care offerings that vary by home and also within homes. As such, the RH industry makes the argument that issues of independence, choice and personal freedom bode for a more flexible and less intrusive regulatory regime than is the case for LTCHs. Many RH Owners described the regulatory function recently developed through the RHRA as sufficiently robust to protect residents, and felt that its jurisdiction with respect to RHs should continue. The RHA regulations currently recognize the ‘opt-in’ nature of care service offerings in RHs and stipulate safety and service capabilities depending on what the home provides, e.g., bathing, feeding, wound care, continence, memory care.

However, as RHs have come to offer an expanding array of care services for high acuity seniors, the separation of regulatory and governance regimes has become harder to rationalize, at least for residents in assisted living or memory care, where safety and vulnerability are more critical and both the residents and care services provided to them resemble those in LTCHs. Most respondents recognized the consistency and clarity that a single regime could ensure for high acuity residents in RHs and LTCHs, employing the same rules, regulators and inspectors. As suggested by some, this might involve graduated licensing, where the portion of the RH that houses seniors of high acuity would require a LTCH-type licence.

The catalyst that bring RHs within the purview of a common regulator may be the recognition that RHs are administering more intensive care services, but it may also be the introduction of government funding as considered above. Thus, if the MOHLTC were to begin funding residents in RHs, either directly to the home or by way of voucher, most respondents recognized that regulation by the MOHLTC would likely follow. As discussed in Chapter 3, there is ample precedent in the policy literature for regulation to follow funding.⁵⁹ While the RH regulations currently require a resident assessment on admission and a plan of care for each resident, a move to oversight by the MOHLTC would likely make it necessary for these procedures to be adapted to correspond with those in LTCHs, as would be the case with inspection protocols.

If the government were to decide to fund the person for care, rather than the home and permit seniors to take their portable funding to a RH, this might give the regulator jurisdiction to regulate and inspect on matters related to the person's assessment as well the content and adherence to the care plan, but not matters related to housing, such as floor plans, hallways, lighting, generators, etc. Indeed, one of the stated reasons RH Owners favoured funding of the individual was to confine regulation to the person rather than the home. Here, the boundary between the care plan and the home would require clear definition and the ability of the home to avoid scrutiny may present a greater challenge than RH Owners assumed.

There was considerable resistance expressed by respondents of all backgrounds over the inspection practices followed by the MOHLTC. In fact, virtually all LTCH Owners described these processes negatively, with many giving accounts of punitive attitudes of inspectors. It would be wrong to take these comments as evidence of systemic intolerance on the part of

inspectors, though the relationship between the Ministry and the LTCH Owners and operators is obviously wanting. LTCH Owners felt that this relationship had grown less collegial over time, a departure from the advisory role that several respondents expressed the Ministry had played earlier.

The relationship between the Ministry and LTCHs was not examined specifically in this research study, but the matter clearly needs investigation. It may be that excessive vigilance on the part of inspectors is a by-product of the responsibility the Ministry assumes whenever it acts as steward of the home environment. As noted in Chapter 2, Armstrong's research⁴³ indicates a growing concern, evidenced in Ontario, that strict regulation can be exercised at the expense of fostering trust in the Owners being regulated. In addition, as noted by both Armstrong and Kane,⁴⁴ there are risks that personal freedoms, choice and quality of life can be compromised by overly protective safety protocols. Considered in this light, a policy that emphasizes home care may be favoured by government for the side benefit of minimizing the heavy responsibility and public criticism that come with regulating and inspecting the environment within so many LTCHs. In the same way, funding of the person, who can then take the funding to a residential setting other than a LTCH (e.g., a RH), may allow the government to minimize the stewardship responsibility that it shoulders in its governance role over LTCHs.

7.4. Risk/Return Trade-offs for Owners and the Future of the Sector

Concerning the Owners' perspective, issues examined in this study include the opportunities and threats, risks and return considerations; importance of economies of scale; criteria for selection of service offerings, such as location, consumer affluence, population density,

community infrastructure, cost of land; financial issues, including profitability and return on capital considerations; and determination of the value proposition offered to seniors, which may include independence, control, community, wellness, social interaction, leisure and programs. Also considered are the significant impacts on care service offerings that arise from separate policies and rules between LTCHs and RHs for funding, flexibility of service offerings, regulated pricing, choice of where to locate and occupancy rates.

Phase 1 described the seniors residential care sector in terms of care service offerings, amenities, costs and occupancy, as well as the characteristics of the industry and its Owners. The Owners are essentially the suppliers of residential care and Ontario's ability to meet the increasing demand over coming decades requires us to understand the perspective and decision criteria of those who will provide that supply.

As noted in Phase 1, residential care is a highly capital-intensive sector. Chapter 5 (section 5.3.6) described the return on capital metrics using indicative capital costs of \$150,000 to \$200,000 per bed, and this range was supported by Owners' comments from Phase 2 interviews. If additional supply of residential care is to be made available to the province's seniors, there is a key question as to how the necessary capital will be sourced and how the cost of capital or capitalization rate is to be recognized in the building of more homes. As one Owner described it, capitalization rates for seniors' residential care are likely to range between 6% and 10% per annum, depending on whether it is an existing home or new construction with commensurate completion risks.

Currently, FPs account for the ownership of 57% of LTCHs (Table 5.14) and for the vast majority of RHs. However, cost of capital considerations apply regardless of whether the Owner-investor is a FP, NFP or municipality. For FPs, the cost of capital is normally returned to the Owner in the form of profits, but for projects run on a non-profit basis, the cost of capital employed is represented by opportunity cost, i.e., the return which is foregone by the government, taxpayer or donor that provides the capital.

RHs can charge residents for care and accommodation in accordance with market conditions, based on demand and competitive forces and therefore select amenities, care packages, locations and price points that will meet required return criteria. As a result, their choice of resident profile and care service offerings varies, with some homes targeting the affluent, others preferring the active, independent seniors and some serving the full spectrum of care needs through to end of life. Subject to this freedom, there was a stated preference among many RHs for seniors with sufficient financial resources to pay for rising care costs as they aged in place.

For LTCHs there is little flexibility in the operating environment or in market positioning, since LTCHs are required by regulation to provide a full array of nursing and support services and are largely at the discretion of the CCAC (now the LHIN) as to whom they admit as new residents. In addition, their accommodation charges are set by regulation and they are not permitted to earn a profit on the flow-through funding for the care envelopes. On this last point, some LTCH Owners criticized the flow-through structure as discouraging LTCHs from finding efficiencies in nursing and personal care since there were no financial incentives to do so. These factors, combined with the fact that competition among LTCHs is muted by occupancy

rates of almost 100% across all homes, may have the effect of limiting innovation in the sector. Here, the observations of respondents are consistent with the findings of the Long-Term Care Innovation Expert Panel, referenced in Chapter 3, which noted that LTCHs are restricted by the extent of regulation of the sector, making it difficult to experiment with new models of service delivery.⁶²

As LTCH Owners reported in interviews, earning sufficient returns to justify the capital employed is problematic. Virtually all LTCH Owners described the business as financially unattractive, at least as a standalone business. The feedback appears consistent with the analysis in Chapter 5.3.6, which showed minimal returns on capital using financial assumption from the OLTCA. For LTCH Owners, the benefits of high occupancy rates seem to be overshadowed by the challenges of attracting and paying for qualified staff, contending with negative media and potential lawsuits, and focusing only on the accommodation envelope as a means to earn a return.

Negative sentiment expressed by LTCH Owners regarding expansion in the sector may be moot at present, since any new supply of LTCHs is already restricted by the government's reluctance to issue new licenses. In addition, closure of LTCHs is a protracted process because O.Reg.79/10 (s.308(4)(b)) requires any licensee of a LTCH wishing to close a home to provide notice at least five years before the date of the intended closure. However, any efforts by government to restart construction of new LTCHs at significant scale would probably require a rework of the funding scheme to make it attractive to LTCH Owners.

Economies of scale are reportedly of importance for Owners and operators of homes, since many of the costs associated with operating homes are largely fixed in nature, such as land, buildings, administrative overheads, purchasing, marketing, management oversight, staffing, functional specialization, finance, and regulatory compliance. These views of respondents, are consistent with the research discussed in Chapter 3,⁶⁷ regarding economies of scale in seniors' residential care. Economies at the home level led respondents to cite certain minimums in terms of numbers of beds per home, which were said to dictate the viability of both RHs and LTCHs. Economies at the enterprise level were also said to confer advantages from operating more than one home. Many respondents alluded to the demise of the small "Mom and Pop" home, unable to muster the financial and operational resources to survive. Some noted that the repercussions of losing the smaller homes went beyond the competitive dynamics of sector and had cultural impacts, particularly in rural neighbourhoods, where smaller homes have been part of the fabric of the community.

These same issues of scale impact the locations where Owners – both LTCHs and RHs – can operate efficiently. The cost of land also affects the financial viability of homes, particularly for LTCHs, which are not able to adjust their accommodation charges to the local real estate market. For RHs, the choice of location is also a function of the affluence of the local population, since residents must have sufficient savings to cover both accommodation and the burden of care, which tends to increase as they age. Also, Owners were concerned with the existence of sufficient infrastructure within the community to support residents with transportation, activities, shopping, hospitals and opportunities for social interaction.

All of these factors account for the pattern of existing seniors' residences, their dispersion across the province and the paucity of homes, particularly RHs, in rural or less affluent parts of Ontario. In addition, the pattern of FP homes is consistent with the research profiled in Chapter 3, which suggests that FP Owners will gravitate to markets where there is adequate demand to justify investment in the sector.

Regarding the future of residential care, many respondents extolled the benefits of offering a continuum of care, all in one setting, ranging from independent seniors through to the frail elderly with chronic health or memory issues. Furthermore, this continuum model is compatible with goals of specialized care at stages along the spectrum. This was seen as having both business diversification and resident diversity effects with benefits to Owners and consumers. It was also viewed as encouraging greater socialization and permitting seniors to age in place.

The Owners' perspectives, as examined in this study, can be illustrated in terms of the conceptual model introduced in Chapter 3. Ultimately, all features of the service offering in seniors' residential care can be explained by the strategies and actions of Owners, which in turn are driven by antecedents in government regulation and market forces in combination with characteristics and competencies of the Owners themselves (internal and external factors):

Internal and external factors →→ Owner strategies →→ service offerings

This sequence is portrayed in greater detail in Figures 7.1 and 7.2, which illustrate, respectively, the conceptual model as applied to RHs and LTCHs. For both sectors, size – in terms of both the number of beds in the home and number of homes – is a factor in terms of the internal characteristics of Owners and in the growth strategies pursued by Owners. The predominant FP nature of RH firms distinguishes the mix of Owners from LTCHs, where about 43% are NFPs and municipalities. Both sectors also face similar market factors, which feature a growing seniors' demographic, a high fixed cost component in operating costs and substantial capital costs. Perhaps the most notable difference is that RHs must contend with a more competitive market to fill bed capacity, whereas LTCHs generally have occupancy rates over 98%, due to capacity constraints and waiting lists.

A clear divergence in external factors between RHs and LTCHs occurs in relation to policy instruments, which is evident by comparing Figures 7.1 and 7.2. What becomes more obvious when the two models are compared, is that the heightened regulation in LTCHs, which affects funding and compliance, has a substantial effect on strategies and service offerings by muting responses to the demand for services in the market. Owners of RHs perceived much more latitude with regard to strategic decision-making than did Owners of LTCHs. This includes choices around which consumers to attract, leading to diversity of service offerings. However, the predominance of FP Owners, combined with relatively less regulation, leads RH Owners towards regions of higher population density, near existing community infrastructure, and urban or suburban areas of greater affluence. Exacerbating this dynamic is the cost of care, which (i) for many would-be RH residents, is a substantial and increasing (acuity-related) cost that can put private-pay RHs out of reach, and (ii) for some RH Owners, is a reason to avoid

Figure 7.1 Conceptual Framework Applied to Retirement Homes

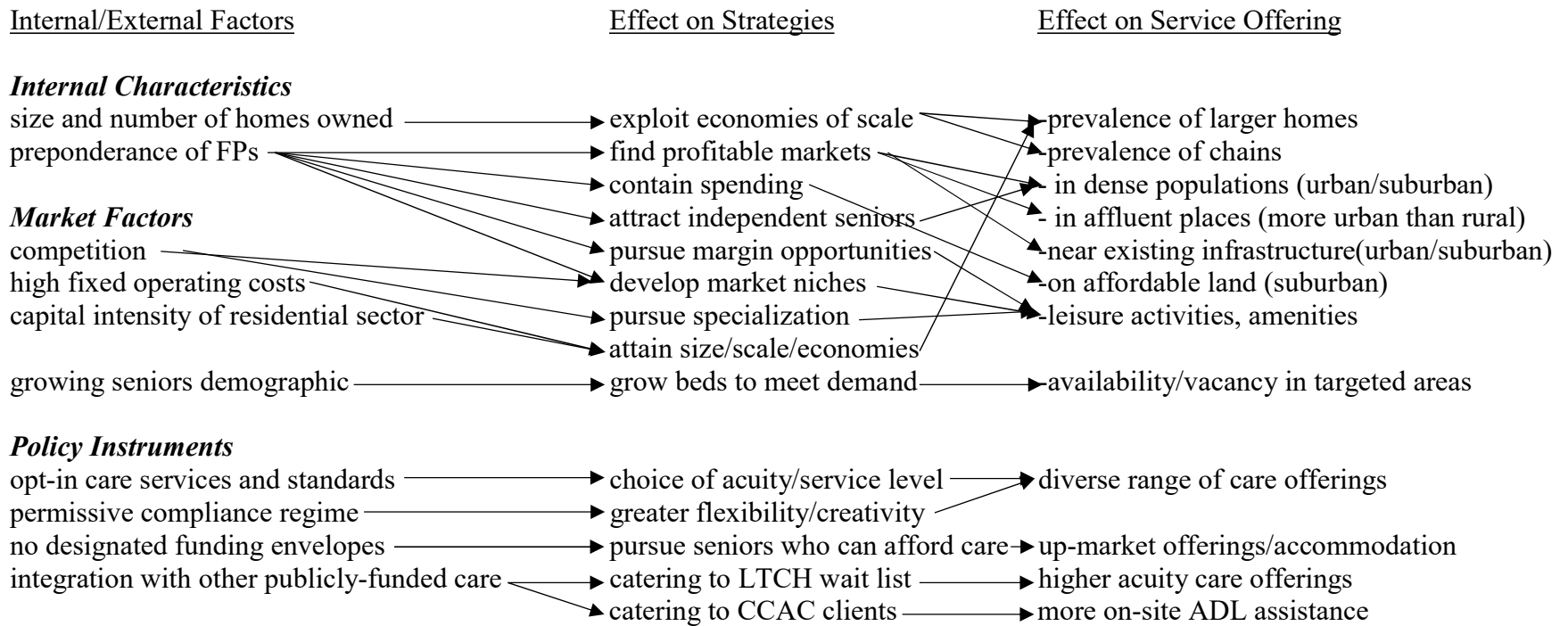
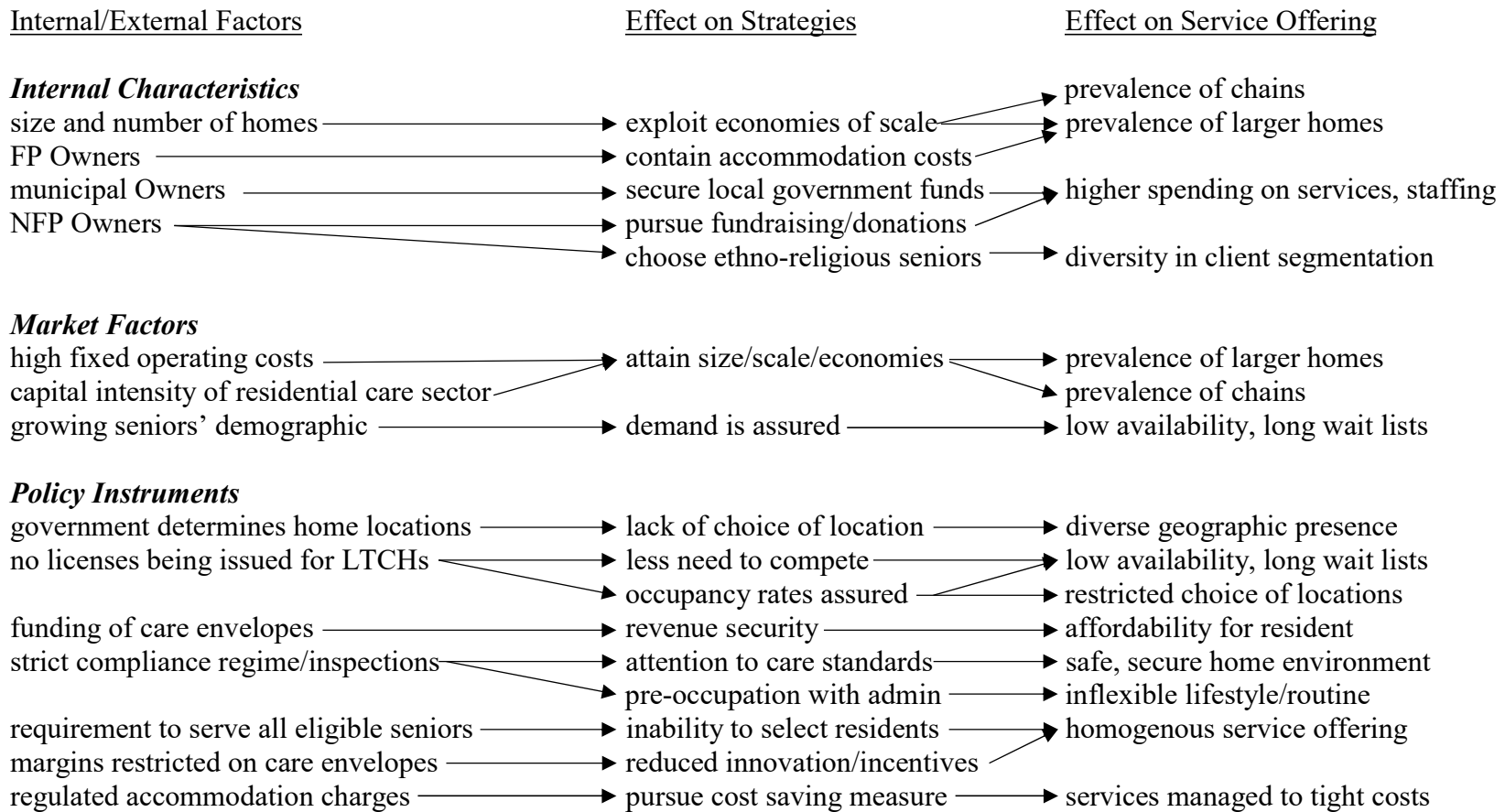


Figure 7.2 Conceptual Framework Applied to Long-Term Care Homes



catering to the lower-wealth segment of the population for whom accelerating care costs can become problematic. Respondents also identified indirect consequences of policy instruments in other segments of seniors' care, such as LTCH wait lists that assign low priority to RH residents, and access to CCAC-funded services that may be less available than for people in private homes. The effects of these on RHs may be to increase the service offerings in the home for more and higher acuity residents.

For Owners of LTCHs, important policy instruments relate to the restraint on the issuance of new licenses, the requirement to admit virtually all eligible seniors referred by the CCAC, restrictions of profit margins on care services and the stipulation of accommodation charges. These have the effects of reducing competition (since occupancy for most homes is close to 100%), creating homogeneity of (i.e., providing all) care services, and reducing incentives for innovation or efficiency (since cost savings in care services are not rewarded).

A stricter compliance regime in LTCHs may have the effect of ensuring a safer, more secure environment for residents, though many respondents pointed to a consequent pre-occupation with staff administrative duties and overly-structured routines and rules for residents. Regulation around funding is obviously beneficial to residents as the out-of-pocket cost for the combined suite of care and accommodation is considerably lower than for the private-pay solution. In addition, provisions in the LTCHA and O.Reg.79/10 are designed to place LTCHs in geographies of need, rather than on the basis of strictly market forces (e.g., minimum numbers of municipal homes and criteria for new licenses based on regions of greater need).

8. Conclusions and Implications

This chapter identifies certain limitations to the study, summarizes key findings and contributions to the research literature and underscores areas of further research.

8.1. Limitations

The CORE database, which was used for certain RH information in Phase 1, was less representative of the population of RHs of interest in this study (i.e., licensed RHs) than were RHRA data or CMHC data sources (see Chapter 5.1). However, where these data were applied – mainly with respect to occupancy levels, care levels and costs of care and accommodation – they corroborated or were not inconsistent with other data sources.

Precise estimates of the overlap in LTCH and RH populations were difficult. Whereas the average resident acuity levels are publicly available for residents of LTCHs, this is not the case for RH residents, even though RHs do assess residents and administer care plans. Rather, resident acuity levels for RHs were inferred from the publicly available data on the *services provided* by RHs and the prevalence of those services across the RHs in Ontario, as well as by accounts or estimates of the overlap from key informants interviewed in Phase 2.

While Phase 1 profiled the total population of licensed LTCHs and RHs, Phase 2 was limited to the responses of 20 interviewees identified as key informants. Responses could therefore not be comprehensive of all possible perspectives, but there did appear to be saturation in the sense that few new views were introduced in later interviews.

Phase 2 questions were of a qualitative, open-ended nature, allowing respondents to discuss what was important to them. This facilitated a greater depth and richness of answers and also led to issues of relevance to respondents that would not have been uncovered in a survey. The limitation of open-ended questions, however, was in establishing the prevalence of responses, because of the vast number of possible topics that could be raised by respondents.

Since the focus of the study was on views of Owners operating in the seniors' residential care sector, the perspective of those operating in the home and community care sector was not well represented, possibly resulting in a biased view of home care services available and their utility for seniors. Similarly, the study design did not allow for negative comments regarding the inspection regime of the MOHLTC to be addressed or explained by Ministry inspectors. In addition, because the study focused on the decisions and actions of Owners in supplying residential care services, the perspective of consumers and their families is not represented.

8.2. Key Findings and Implications for Policy and Research

This study is concerned with understanding how the differential use of policy instruments (such as government funding, licensing, regulatory standards, and compliance) interacts with other factors (such as market forces, ownership models and organizations' characteristics) to shape the service offerings in seniors' residential care (such as service array, care levels, location, pricing and occupancy/availability). The Ontario context, with its distinct policy regimes for LTCHs and RHs, served as a case study to assess the effect of differential policy instruments, aided by three operational questions. The first question asked to what extent there is convergence between LTCHs and RHs in Ontario in terms of the care services provided and the people served, with

particular attention to the effect of differences and similarities in the government funding and regulation/inspection regimes as between the two sectors. Answers to this question were addressed in Chapter 3, which provided detail regarding the service offerings of LTCHs and RHs. The two sectors were found to provide considerable overlap in terms of the services offered and the consumers served, though notable differences were found in the funding for care services, which is directed principally to LTCHs; governance regimes, which incorporate stricter inspection and compliance practices for LTCHs; breadth of the acuity spectrum served, which is narrower for LTCHs; occupancy rates, which are higher for LTCHs; accessibility, based on geography and socio-economic status, which is higher for LTCHs; and opportunities for Owners to earn returns on capital deployed, which are fewer for LTCHs.

The second question asked how the Phase 1 findings about service offerings could be explained in terms of strategies pursued by the Owners of LTCHs and RHs and how, in turn, those strategies related to antecedent policy instruments or the interaction of policy instruments with other factors. Chapter 7 (section 7.4) examined the risk/return trade-offs for Owners, and Figures 7.1 and 7.2 illustrated the conceptual model as it applies to RHs and LTCHs, respectively. Both sectors were found to face similar market factors, though RHs must contend with a more competitive market to fill bed capacity. With respect to policy instruments, the heightened regulation in LTCHs, which affects both funding and compliance, has a substantial effect on strategies and service offerings. Owners of RHs perceived much more latitude with regard to strategic decision-making than did Owners of LTCHs. However, the predominance of FP Owners, combined with relatively unfettered regulation, leads RH Owners towards regions of higher population density, near existing community infrastructure, and urban or suburban areas

of greater affluence. For Owners of LTCHs, the restraint on the issuance of new licenses, the requirement to admit virtually all eligible seniors referred, restrictions of profit margins on care services and the regulation of accommodation charges, have the effects of reducing competition, creating homogeneity of care services, and reducing incentives for innovation or efficiency.

The third question built on the answers to question 2, the input from key informants, and the information from Phase 1, to understand the implications of current government funding and governance policies regarding seniors' residential care in Ontario, and the merits of considering modifications to existing policy instruments or the introduction of new ones. This included consideration of the impacts of differential funding and governance frameworks for LTCHs and RHs; care funding that could be directed to the eligible senior or to a care service or residence that meets the senior's needs; and funding based on a resident's needs, even where they have the means. On the regulatory front, Ontario draws a clear distinction in the use of policy instruments between LTCHs and RHs. For LTCHs, regulations restrict licensing of new homes; determine the amounts, uses and profitability for care services; cap accommodation charges; and prescribe strict care standards, compliance and inspection protocols. For RHs, regulation is confined principally to care and safety standards in the home, which vary according to the level and array of services provided, and for which compliance is risk-based and less stringent. Licenses for RHs are more easily obtained than for LTCHs and the numbers of RHs in the province have been growing steadily while the number of LTCHs stagnate and waiting lists grow.

With regard to self-directed funding, comments from respondents and available research would support a closer look at more flexible funding models for seniors' care, in the interests of both fairness and efficiency.

With regard to needs and means, discussions with respondents pointed to differing views around equity of access to residential care services for seniors, which may exist among Ontarians more generally. This went beyond problems of having to wait for a bed in a LTCH and included broader issues of whether RHs should be eligible for funding of care services on a basis similar to LTCHs, or whether seniors should be able to receive direct funding based on their care needs. Disagreement among respondents was also evident on the matter of whether care costs should be borne more by individuals with greater means. This debate is seen as turning on whether such care is properly regarded as *universal care* or whether citizens should have differential access to government subsidization on the basis of their own ability to pay. In turn, the need to draw on the resources of individuals to fund their own care depends on what level and breadth of care (i.e., comprehensiveness) we expect our government to cover.

In the course of exploring the research questions above, findings indicated that policy decisions in the seniors' care sector can result in numerous indirect or unintended effects manifest in the care service offerings. These include:

- (i) a preponderance of waitlists across all regions and home ownership models of LTCHs as a result of the restriction on new licenses;
- (ii) noticeable policy drift, evidenced by the higher acuity profile of seniors now being admitted to LTCHs (and therefore funded), as compared with seniors admitted historically;

- (iii) increasing incidence of seniors opting for or defaulting to private pay residential care alternatives such as RHs, partly as a result of capacity constraints in the system;
- (iv) differential access to funding for care between LTCHs and RHs, with the result that the cost of the RH alternative is considerably higher on an out-of-pocket basis to RH residents than LTCH residents, even though the all-in cost (public and private combined) is similar;
- (v) a lesser need for Owners of LTCHs to compete and innovate, given the low vacancy rates and long wait lists in this sector;
- (vi) a revenue model for LTCHs that renders many Owners unable to earn returns on capital that are commensurate with the business risk undertaken in the sector; and
- (vii) inspection and compliance protocols that sometimes sacrifice trust of Owners, increase costs and administration unnecessarily, and compromise on the quality of life for residents.

While RH Owners face fewer policy interventions, the tendency in the FP-dominated sector of RHs is for Owners is to seek out locations and service offerings that meet business objectives. This may put RH accommodation out of the reach of many seniors, with the bulk of homes being in urban or suburban settings with higher population densities, consumer affluence and community infrastructure.

Despite the lighter regulatory impact in the RH sector, respondents noted certain indirect effects of funding and eligibility policies within seniors' care that they saw as distorting service offerings for RHs. These included:

- (i) observations that RH residents tended to wait longer for LTCH beds because they were considered to be of lower priority than people in private homes;

- (ii) observations that RH residents were afforded fewer care and support hours from CCACs because they were considered to be well served relative to seniors in private homes; and
- (iii) stated intentions of some RH Owners to cater to the more affluent seniors in the market for the reason that wealthier seniors are better able to finance the burden of growing (and unfunded) care costs as they age in place.

If current trends continue, a substantial portion of care for seniors will be administered outside of the LTCH setting, including in RHs. This demands consideration of greater consistency and clarity of policy instruments, including regulation and inspection across these settings. Though key informants to this study support this in principle, current experience with the inspection regime under the MOHLTC suggests that work needs to be done to restore trust on the part of LTCHs operating under the current regime.

It has been less than five years that the RHA has been in full effect, including licensing of homes, collecting of information about their services, implementing care and safety standards, conducting inspections, and exercising compliance and enforcement measures. This research provides valuable insights as to how RHs have assumed a role within the seniors' care sector, how that role complements and contrasts with the role of LTCHs, and how governments' use of policy instruments positions RHs within the care sector more generally.

With respect to further research in this area, responses from key informants support the concept of care funding by government that would extend beyond LTCHs, either directly to individuals of similar acuity to those in LTCHs or to other residences such as RHs that serve such seniors.

The concept offers benefits in terms of fairness to seniors in need of care, but there is much left to be learned about (i) how seniors would be assessed and qualified for such funding, (ii) what safeguards would ensure protection of vulnerable seniors in the deployment of the funding, and (iii) what incremental cost or savings would result from such a policy versus the pursuit of other options. Numerous jurisdictions that have adopted self-directed care can serve as examples of how self-directed funding might apply in Ontario.

All countries with public-pay health care systems are forced to make decisions that balance demands for comprehensive care with the ideal of making it available to all, at government expense. Demographic and financial considerations may force Ontario to compromise on both goals, to seek greater consensus on what its citizens can expect of government and to find new and creative ways of attaining balance and fairness in seniors' residential care.

As stated at the outset, this study examines the perspective of Owners making decisions around their care service offerings, as influenced by factors that include the policy landscape. Though the focus is not on seniors as the consumers of these services, their interests are served by understanding the supply factors that may be outside their control, yet within the purview of policy makers able to influence the strategies and service offerings of Owners. Thus, where vulnerable seniors are constrained in their choice of care services – whether pressed by immediate need, delayed by wait lists, or confronted by affordability concerns – policy instruments can fill a critical role in addressing seniors' needs for residential care.

8.3. Policy Directions

Ontario's fiscal challenges, combined with the growing seniors' population, have placed constraints on health spending and led to expansion in the private-pay side of seniors' care, including RHs. As long as the private-pay side remains outside of the MOHLTC funding and governance responsibility, there is unlikely to be equitable treatment of seniors in terms of who is covered (universality) or what is covered (comprehensiveness).

Coherent policy requires that Ontario seniors are able to understand what services government will be responsible for funding, regardless of the setting. This can follow a set of minimum service offerings, such as a levels-of-care entitlement, beyond which the individual is responsible. It implies that seniors should not be denied coverage for basic care services based on the site of care.

The introduction of self-directed funding can level the playing field in terms of eligibility for publicly-funded care and the range of options extends from direct payments to seniors to the funding of approved suppliers, including residential care. Though safeguards need further study to ensure the protection of vulnerable seniors, there is some promise here of an increase in autonomy for the consumer with a corresponding reallocation of resources in seniors' care. In addition, where the dollars follow the person, there is greater likelihood of realizing a continuum of care model that sees the individual transition to gradually higher acuity care in a campus-type setting. In concert with an expansion of government-funded care options, there will need to be sufficient education of LHIN staff to ensure that seniors are given access and information

regarding the full array of opportunities, including those that have heretofore been considered part of the private-pay system.

There are financial consequences of broadening the population of seniors who have access to funded care services to those in other settings. In order to provide some level of coverage to those currently in the private-pay system, whether using home care or residential services, government funds may need to be redirected from other applications or supplemented from private sources. This may necessitate reducing the array of services that government will cover in the LTCH setting. It does not necessarily mean eliminating the regulatory requirements of LTCHs to provide food, therapies and care, though it could entail increasing the resident co-payment to cover a portion of the care component.

The concept of some seniors paying more toward their own care than others is likely a matter of disagreement among Ontarians, but an examination of the private-pay seniors' care system – which includes RHs – shows clearly that concept is in full practice already. What is missing is any objective measure of ability or responsibility of individuals to pay in the private system. If seniors of greater wealth are those who should be paying more towards their care, government should ensure that the seniors paying a higher share of their care are not simply those waiting in line for access to the public system. Understandably, measuring ability to pay is more complicated for seniors than a simple examination of income or tax returns. Such seniors are generally post-career and may be income poor, while asset rich, or may have diverted the substantial assets they had to others.

The need for a common regulator – at least at the high acuity level – would bring consistency of application and enforcement. This would become more necessary if MOHLTC dollars begin to flow through additional channels such as self-directed care or to RH residents, as the Ministry would have a legitimate interest in the care plans of all those they are funding. At the same time, there is evidence that some greater balance must be found between the relatively light regulatory safeguards that apply in home care settings as compared with those in long-term care, where complaints of excessive vigilance in inspections are common.

The prevalence of Owners who are arms-length from government is likely to continue, if only because of the need for capital in the residential care sector. A preponderance of FP firms, particularly among RHs, steers the location of homes towards locations of greater population density and affluence with the common goal being maximization of revenue. However, these strategic decisions of FP firms can be influenced by government funding that is directed to the consumer, increasing the affordability of the RH alternative to seniors regardless of their geography. In addition, the assurance of government funding may entice more RH Owners to build for the lower income population, knowing that residents can age in place with less risk of exhausting their financial resources.

Finally, it must be noted that the most common sites for seniors' care in Ontario remain the home, where often one person lives alone, and the institutional setting, which averages over 100 residents. Policy has done little to enable much in between. Owners of LTCHs cite to the need for economies of scale, where the regulatory burden is a significant fixed cost and includes the expense of a 24/7 nurse, a backup generator, rooms and hallways of minimum dimensions, and detailed reporting. Under the LTCHA (s.95), these requirements apply to any residence being

operated for two or more unrelated people, wherever nursing care is involved. For groups of seniors looking to create their own solutions to the care-accommodation problem, a home care exemption that could be increased from one to perhaps six, or ten individuals would go some way to foster the efficiencies and socialization benefits that are critical to seniors' care.

Appendix: Codes and Categories

Category 1: Limited growth in stock of long-term care home beds

Codes:

- 1,1 (36 refs) Lack of growth in stock of LTCHs is government policy, or decision of government not to act/approve increases in stock, or inattention/ignoring/misunderstanding the issue
- 1,2 (49 refs) Government focus is on other priorities, e.g., home care, community care/supports, upgrading stock of older homes
- 1,3 (27 refs) Government budgets constrained, LTCHs are expensive, other options are less costly to government
- 1,4 (25 refs) Growth limited by unattractiveness to owners of LTCH expansion/rebuild due to insufficient financial returns or challenges of regulatory compliance
- 1,5 (10 refs) Risks of overbuilding, demand/demographic cycles re seniors' residential care
- 1,6 (35 refs) Risks/shortages re long-term care home beds

Category 2: The Role of RHs

Codes:

- 2,1 (87 refs) Similarity/dissimilarity of service provided or resident served in LTCH compared to RH
- 2,2 (56 refs) Affordability of accommodation and care for seniors in retirement homes
- 2,3 (22 refs) Availability/supply of rooms in RHs
- 2,4 (21 refs) Connections between policy and greater use of RHs, e.g., government encouraging use of RHs, default to use of RHs from government policy, government-sponsored transitional care in RHs

Category 3: Government funding to be based on care need, not domicile

Codes:

- 3,1 (78 refs) Similar care needs receiving (dis)similar government funding, e.g., provision of government-funded care in RHs, access to CCAC services in RHs, existence of two-tier system around funding LTCHs and RHs, uneven funding for the senior across the continuum
- 3,2 (8 refs) Differential funding by domicile is historically, legislatively based
- 3,3 (13 refs) Cost to government of removing the link between domicile and funding, effects on comprehensiveness of care

Category 4: Government funding the person, not the home

Codes:

- 4,1 (48 refs) Fairness of funding person rather than home
- 4,2 (17 refs) Effects on accountability of government, of provider and of individual, empowerment of individual

- 4,3 (31 refs) Manageability of funding individual, e.g., eligibility of expenditures; safety; issues of competence, abuse, substitute decision makers
- 4,4 (34 refs) Effect on demand/supply of services/providers and purchase patterns/resource allocations

Category 5: Whether government is funding the right services in LTCHs

Codes:

- 5,1 (23 refs) Comprehensiveness, appropriateness of current suite of funded services, (im)practicality of separating ADLs from other funded care services
- 5,2 (34 refs) Additional service needs or funding needs in LTCHs

Category 6: Whether means testing should apply to seniors' residential care

Codes:

- 6,1 (22 refs) Rationale for and existence of means testing or subsidization of residential care and accommodation at low income levels
- 6,2 (59 refs) Rationale for or existence of means testing or private pay in residential care at high income level
- 6,3 (18 refs) Issues of (im)practicality in implementing means testing

Category 7: Regulatory and governance regime in seniors' residential care

Codes:

- 7,1 (55 refs) Consistency, clarity of one regulatory and inspection regime for care in seniors residences
- 7,2 (18 refs) Graduated/differentiated licensing, regulation, inspection regimes based on resident acuity or level of care provided
- 7,3 (47 refs) Trade-offs between strict adherence to care standards versus issues of resident choice, risk, lifestyle, flexibility, quality of care, service branding, self-regulation
- 7,4 (21 refs) Intersection of regulation/inspection and government funding
- 7,5 (57 refs) Unintended consequences of regulatory burden in residential setting, e.g., overbearing, punitive, complex, restrictive, dysfunctional

Category 8: Significant changes in residential care sector in recent years

Codes:

- 8,1 (35 refs) Changes in resident acuity, age, care needs of seniors in LTCHs and RHs
- 8,2 (21 refs) Changes in operational, financial, regulatory, funding environment for owners/operators
- 8,3 (12 refs) Changes in the home environment, e.g, continuum of care, social model, physical design/surroundings, catering to choice

Category 9: Opportunities, threats, risks, returns to owners/operators of LTCHs and RHs

Codes:

- 9,1 (25 refs) Creativity versus restrictiveness in operating environment
- 9,2 (64 refs) Financial risk/return/growth issues
- 9,3 (27 refs) Value proposition offered by owner/operator, e.g., community, independence, control, wellness model, social interaction, higher quality care, leisure, programs

Category 10: Strategy re targeted clients or levels of care service

Codes:

- 10,1(20 refs) Ability/mandate/objective to serve/attract residents based on their level of acuity or care needs
- 10,2 (14 refs) Issues of continuum of care, resident homogeneity, complementarity
- 10,3 (3 refs) Affordability, affluence, income strata

Category 11: Economies of scale, numbers of beds/homes

Codes:

- 11,1 (32 refs) Economies at home level
- 11,2 (20 refs) Economies at infrastructure/chain level
- 11,3 (3 refs) Ability to specialize re skills and services at scale
- 11,4 (11 refs) Trade-offs re community, service, management

Category 12: Location

Codes:

- 12,1 (18 refs) Demographics, e.g., population density, income levels
- 12,2 (13 refs) Community/provider infrastructure and amenities, scale
- 12,3 (3 refs) Cost of land
- 12,4 (20 refs) Issues re underserved geographies
- 12,5 (10 refs) Comparison with other provinces, countries

Totals: 12 Categories; 45 Codes

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