DIGNITY
DENIED
LONG-TERM CARE AND CANADA'S ELDERLY

National Union of Public and General Employees
NUPGE  February 2007
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National Union of Public and General Employees (NUPGE) is a family of 11 component unions that represent provincial public sector workers and a growing number of workers in the private sector.

NUPGE Components

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

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CANADIANS CHERISH our universal, public health care system. In repeated surveys and opinion polls, support for medicare is reaffirmed as a fundamental value. Our system, for the most part, provides universal access to quality care for all, regardless of wealth, social status or other barriers. Sadly, this universality and quality of care ends for seniors at the doors of long-term care (LTC) facilities. Too often LTC is not available for the seniors who need it. When available, it is frequently unaffordable.

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

There are profound demographic changes just around the corner. We need a cogent, national long-term strategy to meet the health care needs of seniors, which are becoming ever more pressing. Here are some salient facts:

- People aged 80 and over are the fastest growing age group in the country. Many seniors will enjoy healthy and active lives long into retirement, but most will experience disability near the end of their lives.
- In 2002, there were 157,500 beds in LTC facilities across Canada. Estimates are that between 560,000 and 740,000 seniors will need a LTC facility by the year 2031. This is an incredible gap and it requires governments to get serious about long-term planning.
- More than 28% of Canada's seniors in 2001 were people who arrived as immigrants. Providing appropriate care for these seniors is a challenge. Many worked in low wage industries and are now doubly disadvantaged by a LTC system that favours the wealthy.
- Income from OAS and the GIS totals $1,079 per month.
- Charges for basic accommodation in publicly supported LTC institutions range from $540 to $3,960 a month. Private accommodation costs are much higher.
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- In 2003, 17.7% of unattached seniors and 18.9% of unattached female seniors fell below the Low Income Cut-Off. Another 19% of seniors had incomes barely above the Cut-Off. For these seniors, existing LTC facilities present a costly and often inaccessible option.

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

There are also issues with the quality of care that residents receive. Workers caring for the frail elderly are run off their feet. The media reported on a hunger strike in 2005 by an 86-year-old Alberta woman to protest against the lack of staff to provide adequate care. Other stories report inadequate care, poor food, substandard facilities and rip-offs by for-profit owners.

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

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

Older Canadians are not and must never be seen as a burden. They worked hard to build Canada into the modern and compassionate country that it is today. They survived the Great Depression and many wore our country’s uniform during a world war. They paid their fair share of taxes and they continue to do so. They are a continuing source of wisdom, experience and talent.

In this paper we discuss the issues confronting LTC in Canada, including the lack of access to adequate and affordable care. We speak to the stress endured by families that have to make difficult choices regarding their parents and grandparents. We also consider the circumstances of the women and men who work in LTC facilities, providing care to our nation’s seniors. Too often those workers are undervalued, underpaid and burned out.
It is time for bold and fundamental change. LTC is excluded from the Canada Health Act and, as a result, our parents and grandparents are largely left to fend for themselves at a time of life when they most need support.

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

Our plan would reform the fragmented, unequal and inefficient delivery of LTC that currently exists. Our proposals would greatly augment the quality of that care and the enforcement of optimal care standards. We propose enhancing the role of public, not-for-profit LTC which has been proven to provide better services at less overall cost. We want to see improved working conditions and wages for people working in the LTC system. The dignity and respect we wish for our parents and grandparents should be extended to those who provide care to them.

Our proposals would also open new windows of democratic disclosure in the LTC system and provide more public accountability and scrutiny.

Finally, the availability of information on the sector that is timely and complete is lacking. Building and maintaining an effective long-term care system requires reliable national information on the sector. We're calling on all levels of government to do a much better job of gathering and providing systematic information about the sector. Another challenge we faced at the time of writing this report was that several provinces were in the process of reviewing and amending the existing legislative framework for the sector. We are committed to updating this report as new information is made available.

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

Precious time is slipping away. We must act now.

James Clancy
National President
"How old would you be if you didn’t know how old you are?"

_Satchel Paige_

Satchel Paige was an active pro baseball pitcher until he was 60 years old. Joe DiMaggio called him “the best and fastest pitcher I’ve ever faced.”
Definitions Involving LTC Facilities

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

**Home Care**

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

**Retirement Homes**

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

**Assisted Living Centres**

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

**LTC Facilities**

Are known by various names in different Canadian provinces and territories. They may be called nursing homes, residential care facilities, special care homes, continuing care centres or personal care homes. They provide accommodation, but they also offer on-site personal support and health care services. Most of-
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ten a person enters a LTC facility on the recommendation of a
doctor or social service agency. The facilities are provincially regu-
lated, receive some government funding and, in many instances, act as chronic-care hospitals.

This paper identifies them as long-term care (LTC) facilities. They are the focus of our attention here because of the great need for research, policy and action to enhance the lives and maintain the dignity of frail elderly senior citizens.

The Demographic Challenge

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

- Baby boomers (people born between 1946 and 1964) are the most populous generation in Canadian history. Those born in 1946 will officially become seniors in 2011 and many of them are already moving into retirement.

- Seniors comprised 7% of the population when hospitalization was introduced in Canada in the 1950s. In 2004, they were 13% of the population, and in 2031 that number will rise to approximately 25%.

- Canadians are living longer. Life expectancy, at age 65 years, is now 83 years overall: 79.5 years for men and 85.3 years for women. People aged 80 and over are the fastest growing age group in the country.

- In 2004, there were 324,800 Canadians aged 85 years or over, more than double the number in 1981 and almost 20 times the number in 1921.

- The percentage of older Canadians who live in LTC institutions has been declining, yet the absolute number is growing. In 2002, there were 157,500 beds in LTC facilities throughout Canada.

- Estimates are that between 560,000 and 740,000 seniors will live in LTC facilities by the year 2031.

- The health care needs of the frail elderly are becoming more complex. Alzheimer’s disease and related
dementias affect 364,000 Canadians over the age of 65, and these numbers are projected to increase to 750,000 by 2031.⁶

- More than 28% of Canada’s seniors in 2001 were people who arrived here as immigrants.⁷ In Toronto, 43% of those on waiting lists for LTC spaces do not have English as their first language.⁸

- An estimated 700,000 working Canadians today exist in what is called the “sandwich generation”. These informal caregivers, most of them women, are raising their own children while caring for elderly parents or relatives.⁹ This places a great burden upon them and their families.
I grow old . . .
I grow old . . .
I shall wear
the bottoms
of my
trousers
rolled.

T. S. Eliot
CANADA’S HEALTH care system is much admired throughout the world. The original legislation surrounding hospital and medical care insurance attempted to ensure that every Canadian had access to medically necessary services regardless of ability to pay. But we are abandoning this vaunted commitment when it comes to LTC for our frail and elderly citizens.

LTC & Public Health Care

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

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

Over the years the definition of health has been broadened to include health promotion and disease prevention as well as treatment, but few people realize how narrowly the principles outlined in the Canada Health Act are applied. The Act’s most serious limitation is that it covers only physician and hospital services. Home care, long-term care and pharmacare are not covered under the Act. Provinces and territories are free to develop their own systems and insurance for these services, but LTC is not a fully insured service in any Canadian province or territory.

The system that has developed is a bewildering patchwork of plans and policies, with wide variations in the number of spaces available, the length of time people have to wait and the range of fees attached. This means that the availability, cost and quality of LTC depends to a great extent upon where people live in Canada.
Beyond that regional question exists another one of individual means. There are significant differences between services within LTC facilities that are covered by the public purse, and those for which individuals are forced to pay out-of-pocket. Those costs are a barrier to citizens of low or even modest incomes.

Throughout the 1990s, governments across Canada decided to slash funding on a wide range of social programs. In the 1995 budget, the federal finance minister reduced cash transfers to the provinces by 40% over the following two years. The minister announced that by 1996-97 program spending would be lower (relative to the size of the economy) than at any time since 1951 – an era in which public, universal health care did not even exist.12

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

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

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

However, since its inception, Assisted Living has branched out in many less-than-authentic directions in the US and Canada. The term is now applied to housing situations and care models that do not embody the original philosophy. Regrettably, some provinces, like Alberta, while talking about investments in Assisted Living centres surreptitiously withdrew funding and cut direct care staffing levels from long-term residential care. Today, Assisted Living is more likely to refer to multi-unit apartments...
with varying amounts of on-site personal supports and care available 24-hours-a-day, all of which must be purchased by the resident at a hefty price. The original vision has been largely co-opted by commercial operators looking for a high return on investments. According to the Alberta Chapter of the Consumers’ Association Canada, the reality of Assisted Living in Alberta is a crisis in access, costs, funding and accountability.

The 1995 federal budget also changed the manner in which Ottawa transferred health care money to provinces and territories. The Canada Health and Social Transfer (CHST) replaced the separate, targeted transfers that had existed for health, post-secondary education and social programs. After making deep cuts to health transfers in the 1990s, Ottawa was convinced to use some of its burgeoning surpluses to restore funding. In his 2002 report, health care commissioner Roy Romanow called on the federal government to increase its funding to the equivalent of 25% of total provincial-territorial spending, a minimum amount long demanded by health care advocates. Federal-provincial agreements have resulted in federal funding increases that should meet those targets. But the discussion of public health care by various government commissions has been dominated by the needs of the acute care system. Reform of the LTC sector has largely been neglected. Regrettably, the Romanow report, and the Kirby report before it, said little and recommended less regarding LTC.

The 2003 funding accord also returned to the practice of a dedicated transfer payment for health care. But it made no announcements regarding LTC. Ottawa’s health care dollars will flow to the provinces without any targeting to LTC, or any commitment that provinces will use new money to improve the accessibility and quality of LTC. Nor was there anything in the agreement to prevent for-profit companies from making further incursions into LTC, and the health care sector in general.

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

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

Despite attempts made to prevent and forestall illness, and efforts to maintain elderly people in their own homes for as long as possible, a percentage of seniors will always need more support than their families or home care services can provide. Many of the elderly, inevitably, will need LTC facilities. It is crucial that the service be available to them and that all Canadians share the financial burden with the frail elderly and their families.

Personal Costs of LTC

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

Per diem-based model (Alberta, Yukon Territory, Nunavut Territory)  
A per diem rate is set based on public pension incomes available to individuals. Residents are not subject to a means test.

Income-based model (BC, Saskatchewan, Manitoba, Ontario)  
Individuals pay a per diem rate which is adjusted to actual income. There is a means test but it does not apply to family assets.

Income/asset-based model (Quebec & Atlantic provinces)  
In these provinces, charges to individuals are based not only on income but also on assets. Before being admitted, an individual must liquidate a percentage of the family’s assets, including savings and investments. In some cases that includes some or all of the value of the family home. This policy can impoverish families with modest incomes, often leaving a spouse who may not be in a LTC facility with very few resources.  

The charges to residents for standard accommodation in publicly-supported LTC institutions as of May 2006 ranged from the Yukon Territory’s $540 a month ($6,480 per year) to $3,960 a month in PEI ($47,520 per year). These charges applied to the minimum level of accommodation as defined in each province, which may
mean two or more residents sharing a room. The charges for a
semi-private or private accommodation were considerably higher.

The rates in public, not-for-profit LTC facilities are almost al-
ways lower than those charged in for-profit facilities. In British
Columbia, for example, the cost of care in a for-profit facility ranged
from an average of $44,000 per year to a high of $67,000. In On-
tario, the average rate for a space in a for-profit facility ranged
from $43,650 to $55,884 per year, with some exceeding $80,000 per
year. In Alberta, private care can cost well over $60,000 a year.

All provinces and territories claim to have mechanisms in place
to ensure anyone who requires long-term care will receive it, re-
gardless of ability to pay. This may be true, but the wait for
standard accommodation can be a long one. And once installed
in a long-term care facility, seniors may discover a costly list of
services they are expected to pay for out-of-pocket. They are usu-
ally forced to turn over all their income for accommodation and
care, with the exception of a paltry personal care allowance, which
varies from $88 to just over $200 per month.

### Monthly Charges to Residents in LTC Facilities in May 2006

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Minimum Monthly Accommodation Rates</th>
<th>Maximum Monthly Accommodation Rates</th>
<th>One Charge for all Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>$864</td>
<td>$2076</td>
<td></td>
</tr>
<tr>
<td>Alberta</td>
<td></td>
<td></td>
<td>$1188</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>$911</td>
<td>$1727</td>
<td></td>
</tr>
<tr>
<td>Manitoba</td>
<td>$825</td>
<td>$1938</td>
<td></td>
</tr>
<tr>
<td>Ontario</td>
<td>$862</td>
<td>$1480</td>
<td></td>
</tr>
<tr>
<td>Quebec</td>
<td>$949 (3 in room)</td>
<td>$1277 (2 in room)</td>
<td></td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>NA</td>
<td></td>
<td>$2235</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>NA</td>
<td></td>
<td>$2370</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>$3555</td>
<td></td>
<td>$3960</td>
</tr>
<tr>
<td>Newfoundland</td>
<td>$540</td>
<td>$630</td>
<td>$2800</td>
</tr>
<tr>
<td>Yukon Territory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NWT</td>
<td></td>
<td></td>
<td>$712</td>
</tr>
<tr>
<td>Nunavut Territory</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Combined monthly OASGIS payments</td>
<td>$1079</td>
<td>$1079</td>
<td>$1079</td>
</tr>
</tbody>
</table>

Adapted from Canadian Healthcare Association,
Charges to Residents in Facility-Based Long-Term Care by Province/Territory, May 2006
Accessibility & Low Income

Almost all Canadians over the age of 65 receive an Old Age Security (OAS) benefit of $485 per month. In addition, seniors with low incomes are eligible for a Guaranteed Income Supplement (GIS). It is means-tested and the maximum payable is $594 per month for a single senior. Combined income from OAS and GIS is about $1,079 per month, or $12,948 per year. Some provinces and territories use this amount as a basis for their per diem or monthly charges to LTC residents. As of May 2006, charges to residents for standard accommodation in LTC facilities varied from $540 to $3,960 per month. For seniors who rely on public pensions of $1,079 per month, these are costly and often inaccessible options.

About 35% of seniors received the GIS in 2003. This indicates they were either living below or just above a measure that is called the Low Income Cut-Off (LICO), a measurement used by researchers and policy analysts as an indicator of economic vulnerability.

In 2003, close to 7% of all Canadian seniors lived below that Low Income Cut-Off. Seniors with low incomes were concentrated in certain groups, including elderly visible minorities and immigrants, and seniors without partners. In 2003, 17.7% of unattached seniors and 18.9% of unattached female seniors fell below the LICO. In numerical terms, 258,000 seniors were living below the after-tax LICO in 2003, and 154,000 of them were unattached women.

Another 19% of seniors in 2001-04 had pre-tax incomes just slightly above the LICO. They live in near poverty, but most often they cannot gain access to the benefits of various income-tested programs and they must get by on extremely tight budgets.

| Percentage of Seniors with Low After-Tax Income, Canada 2003 |
|------------------|---------|--------|
|                  | Both sexes | Men   | Women |
| All seniors      | 6.8%      | 4.4%  | 8.7%  |
| Unattached seniors| 17.7%     | 14.7% | 18.9% |

Source: Statistics Canada, 2005

All of these individuals are forced, to the limit of their meagre resources, to pay for the crushing expenses that can be associated with LTC. Saskatchewan, for example, is one of the less expensive provinces for LTC. But a resident there in 2005...
paid $875 for standard accommodation plus 50% of that portion of their income between $1,057 and $2,621. For a senior with a monthly income of $2,621 that meant paying the basic charge, plus an extra $600 per month (for a maximum charge of $1,657). This amount did not cover an array of out-of-pocket expenses, including prescription drugs, incontinence supplies and personal items.27

The charges to individuals vary greatly depending upon where they live. Some provinces and territories pay for the cost of prescription drugs. Others have an income tested drug plan, which can have the effect of dramatically increasing the resident’s out-of-pocket costs. Some jurisdictions also charge for a variety of medical supplies, wheelchairs, prosthetic devices, even incontinence supplies, not to mention laundry, housekeeping, personal care and transportation.

In some cases the out-of-pocket contribution goes far beyond that. The Toronto Star reported that an increasing number of families are hiring private attendants to supplement the care their family member is receiving in a LTC facility. The Star reported examples of families spending $25,000 to $30,000 a year for a bed, and another $40,000 a year for a private care attendant who performs tasks the facility won’t do or doesn’t perform adequately, including walking, feeding, bathing and helping frail seniors go to the toilet.28

What financial burden should we expect the frail elderly to bear? They do not choose to enter a LTC facility on a whim. All applicants are assessed and LTC is allocated based on a need for that level of service.

It is generally accepted that, income permitting, seniors should pay for a part of their LTC because the facility is also their residence. But these individuals are usually chronically ill and they also need health care. Yet the charges in place across Canada go far beyond the reasonable costs of accommodation.

The irony and the injustice is that services under the Canada Health Act are not subject to means or asset tests. If a frail and elderly person receives medically necessary services in a hospital, those are provided from the public purse. Yet the same person receiving essentially the same services in a LTC facility is often expected to pay for it out-of-pocket.

This can involve a means test and, in some provinces, an asset test as well.

This discriminates against the frail elderly.
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Funding Formula Inadequate

Licensed LTC facilities, both not-for-profit and for-profit, receive a per diem subsidy from provincial governments or territories for each resident. For example, the per diem in Ontario as at March 31, 2002 was $102.32. That amount was comprised of the following components:

• $52.38 for nursing and personal care;
• $5.24 for programming and support services; and
• $44.70 for accommodation (including a “raw food” amount of $4.49 per day). 29

Per Diem Rates for Ontario Residents, October 1, 2001

<table>
<thead>
<tr>
<th>Nursing and Personal Care</th>
<th>$52.38</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programming and Support Services</td>
<td>$5.24</td>
</tr>
<tr>
<td>Accommodation (Including the &quot;raw food&quot; amount of $4.49 per day)</td>
<td>$44.70</td>
</tr>
<tr>
<td>Total</td>
<td>$102.32</td>
</tr>
</tbody>
</table>

Source: Ownership Matters: Lessons from Ontario’s Long-Term Care Facilities, Ontario Health Coalition, 2002

This per diem is far too low. An obvious example is the impossibility of providing nutritious meals on a food allowance of $4.49 per day, an amount that has increased by only 23 cents per day in the previous decade. 30

Nor do provincial-territorial funding formulas adequately take into account unique and changing care needs. The
number of residents with dementia and Alzheimer’s, for example, is not adequately considered when determining funding levels. Residents with dementia related illnesses make up an increasing part of the LTC population and require higher staffing levels, more intensive care and specially trained staff.

LTC facilities often attempt to make up the difference between the provincial subsidy and their costs by increasing accommodation rates. Governments, through underfunding, have in effect shifted costs to residents and their families.

This is especially a problem in provinces where for-profit facilities dominate the sector. LTCs are operated by a mix of providers that include religious institutions, provincial or municipal governments, regional health boards and, increasingly, by large corporations.

For example, in Ontario 52% of publicly funded LTC facilities are for-profit, as compared with 15% in Manitoba. If for-profit and not-for-profit facilities receive the same provincial government subsidy, corporate profits must be squeezed out of the monies intended for accommodation, food and care.

### For-Profit and Not-For-Profit Ownership: LTC Comparison Across Jurisdictions

<table>
<thead>
<tr>
<th>Province</th>
<th>Public/Not-for-profit*</th>
<th>Private for-profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>68.3%</td>
<td>31.7%</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>96.2%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Manitoba</td>
<td>84%</td>
<td>15%</td>
</tr>
<tr>
<td>Ontario</td>
<td>48.4%</td>
<td>51.6%</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>72%</td>
<td>28%</td>
</tr>
</tbody>
</table>

*Public/not-for-profit includes provincial and municipal government LTC facilities and facilities provided by not-for-profit societies. Source: Ownership Matters: Lessons from Ontario’s Long-Term Care Facilities, Ontario Health Coalition, 2002
Some for-profit facilities have also been permitted to set aside a number of private spaces for wealthier residents who can afford to pay higher fees for private accommodation. This practice reinforces a system in which accessibility is based on ability to pay rather than need. When spaces are reserved for wealthier clients, the waiting lists grow for those seniors who can’t afford the private accommodation rates.

Some governments, such as Ontario, have also reduced or eliminated important regulations, such as the minimum number of nursing hours to be provided each day, or the minimum number of resident baths per week. In effect, costs are being shifted from the public purse to individuals in the form of a reduced quality of care.

Long Wait Times

Government cutbacks and the reduction of LTC spaces, especially in the mid-to-late 1990s, occurred at a time when waiting lists were already a problem and a large number of baby boomers were moving toward retirement.

It is difficult to gather precise and current information on waiting lists in provinces and territories. Maclean’s magazine arrived at the following waiting list numbers in the year 2000: Ontario, 10,000; British Columbia, 7,000; Quebec, 3,000; Manitoba, 1,100. Waiting lists in New Brunswick, Prince Edward Island and Newfoundland were smaller, both in real and per capita terms. The information was not available from Alberta, Saskatchewan and Nova Scotia.32

In 2003, The Ottawa Citizen reported that wait times for LTC spaces in Ontario were approaching two years.33 A significant number of Canadians are searching for space in long-term care facilities. Those numbers will inevitably grow as the absolute number of frail elderly Canadians grows in the coming years.

In 2002, there were 157,500 beds in LTC facilities throughout Canada.34 Estimates are that between 560,000 and 740,000 seniors will need LTC by the year 2031.35

This is a daunting gap and it demands long-term planning and investment on the part of governments. The Canadian Healthcare Association has concluded that “there is an urgent need for increased funding for facility-based long-term care in almost every province.”36

NUPGE agrees wholeheartedly.
Difficult Decisions

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

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

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

Canada, despite its reputation for compassionate social policy, is offering LTC that parallels what the United States offers for health care in general: a mix of public and private payment and delivery instead of a publicly administered, single-payer, universal system.

NUPGE believes that comprehensiveness, compassion and community, the values upon which our public health care system is built, must be extended to the way we provide care for the elderly.

Accessibility & Affordability

Political & Corporate Cronyism

The LTC sector has a long history of compassionate involvement by community and religious groups and the public sector. But recently, in several provinces such as BC and Ontario, it has become increasingly profit-oriented, and the corporate sector is consolidating quickly.

In British Columbia the government of Gordon Campbell embarked on a much-touted “renewal” of LTC in that province. But most of the LTC beds opened between 2001 and 2004 were in the expensive for-profit sector.
The Consumers’ Association of Canada (CAC) studied LTC in Alberta’s 17 regional health authorities in 2002. Alberta drastically reduced the number of acute care hospital beds in the 1990s. Private real estate developers picked up the gap in service providing “assisted living” facilities with varying amounts of on-site personal supports and care, all for a hefty price. The CAC report described LTC care for Alberta’s seniors as being “costly and inaccessible.”

The growth of the private LTC sector has been driven by political and corporate cronyism, and nowhere has the relationship been cozier than in Ontario. The Mike Harris government decided in 1998 to respond to growing waiting lists for LTC. The government announced that more than $1 billion would be spent to create 20,000 new spaces by 2004. When the contracts were awarded for construction of beds, 67.7% of them were handed over to the for-profit sector. Three giant corporations, Extendicare, Leisureworld and Central Park Lodges, received 39.5% of the contracted spaces. The public was to pay for the construction of LTC facilities that will be owned and operated by corporations to enrich their shareholders and executives.

Extendicare has its Canadian headquarters in Markham, Ontario, and counts among its directors former Liberal Senator Michael Kirby. He led a Senate inquiry into the state of Canada’s health care system which, not surprisingly, recommended a larger role for the private sector.

The wealthy Reichmann family owns Central Park Lodges. They have sold millions of shares in their Retirement Residences Real Estate Investment Trust (REITs) to eager investors. The company has an aggressive expansion plan, which includes the takeover and construction of new properties in Canada and the US. A subsidiary known as Central Care Corp. is the vehicle for new LTC facilities. Former Ontario premiers Bill Davis and Ernie Eves have both been trustees for the corporation.

Ontario election finance records indicate that between 1995 and 1999 for-profit LTC companies donated over $336,000 to the Ontario Conservative Party. This does not include the thousands of dollars donated to the leadership campaigns of Ernie Eves, Tony Clement (now the federal health minister) and Jim Flaherty (now the federal finance minister).

Political and corporate cronyism is having severe implications for elderly Canadians. When all costs are considered, care in these facilities is simply more expensive than in the public, not-for-profit sector. And as we shall see, the quality of care in for-profit facili-
ties is simply not as good as that in the not-for-profit facilities. These are the consequences of placing corporate greed ahead of citizen need.

For-profit care, by its very nature, means draining of profits out of resident care and into the pockets of owners and shareholders. Canadians have repeatedly indicated they don’t want their health care system governed by the same market forces that govern software developers, cable companies and fast food chains.

A Better Way

Canadians view our universal, public health care system with pride. We should apply it beyond hospitals and doctors’ offices to include the services provided to vulnerable seniors in LTC facilities as well. Governments must begin taking steps, through existing funding and licensing levers, to privilege public, not-for-profit facilities, and in so doing to phase out corporately owned LTC facilities.

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

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

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

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

Provincial and territorial governments must also establish clear guidelines to protect against off-loading of patients from acute-care hospitals to LTC facilities that may not have space available or may be inadequately staffed to provide appropriate care.

We can ensure that accessible and affordable LTC is equally available to everyone who needs it.

Our parents, our grandparents, our aging friends and neighbours deserve no less.
Dignity Denied
IN APRIL 2005, 86-year-old Marie Geddes launched a hunger strike to protest the staffing shortages in her LTC facility in Camrose, Alberta. She said that seniors there had to wait too long for help with everything from going to the bathroom to getting bathed to going to bed.\(^{41}\)

Ms. Geddes, who was a diabetic, refused food for four days. She became ill after breaking her fast and was placed in hospital, where she died.\(^{42}\)

Canaries in the Mine

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

Lynda Johnson is someone who has. She visited 100 of Alberta’s LTC facilities. Her conclusion was that staff didn’t have enough time to give patients the care they need.\(^{43}\) She presented a petition with 5,000 names to the provincial legislature calling for higher staffing standards. Marie Geddes died just a few days later.

Numerous other news investigations have chronicled a LTC system in which many elderly residents live in desperate straits while their families won’t complain for fear of retribution.\(^{44}\)

The revelations included: seniors who were ill or had broken bones and inadequate food and fluid intake for residents at risk of nutritional deficiencies. Substandard dietary practices included: synthetic crystals instead of real fruit juices, powdered potatoes and processed vegetables instead of fresh ones, smaller portions and, in some cases, microwaved leftover airplane food.\(^{45}\)

Government & Academic Reports

The various media investigations have been validated by a number of government and academic reports.
PriceWaterhouseCoopers

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

The study found, for example, that Ontario’s LTC facilities provided 2.04 nursing hours per resident per day, the lowest among the jurisdictions studied. Saskatchewan, by contrast, provided 3.06 hours per day and the state of Maine, 4.40 hours.\(^{46}\)

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

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

Provincial Auditor of Ontario

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

The Auditor’s report concluded that 68 nursing homes with more than 7,000 beds needed to be entirely retrofitted because they were decrepit. Facilities with a further 9,000 beds were found to need substantial renovations.\(^{47}\)

Clinical Nutrition Studies

A 2003 study in Saskatoon showed that over half of LTC residents assessed were at least moderately malnourished.\(^{48}\) This result is similar to other international studies that show that dehydration and malnutrition are becoming endemic in the LTC sector, especially in for-profit facilities.\(^{49}\)
CUPE Survey of LTC Workers

A survey of more than 900 LTC workers completed in 2004 for the Ontario division of the Canadian Union of Public Employees (CUPE) concluded that, “Heavy workloads mean that there is not enough time to complete tasks in a way that complies with standards ... There is too much work and too little time to care.”

Ownership Matters

Dr. Michael Rachlis, a respected Canadian health care researcher, is one of a growing number of academics to find that not-for-profit facilities provide better LTC than for-profit businesses. Rachlis observed in 2001 that there was “much recent rhetoric” claiming that introducing more private markets in health care finance and delivery would lead to more efficient health care. “The reality,” Rachlis concluded, “is exactly the opposite.” Rachlis performed an extensive examination of the international research literature comparing the performance of for-profit and not-for-profit continuing care organizations. Within his study, Rachlis reviewed the literature for 39 LTC facilities. The following are some of his conclusions:

For-Profit LTC providers

**Impact of for-profit services on continuing care**

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Source: Dr. Michael Rachlis, *The Hidden Costs of Privatization: An International Comparison of Community Care*
Not-for-profit LTC providers

- Not-for-profit LTC institutions provided higher or equal quality of care.
- Studies of infrastructure and environmental characteristics all found in favour of not-for-profits.
- Not-for-profits had more staff and provided higher salaries and benefits.
- Not-for-profits had lower staff turnover rates.
- Not-for-profits were less likely to be cited for deficiencies than for profits.
- Not-for-profits were much less likely to use physical restraints on residents.
- Ontario not-for-profits had higher expenditures per resident-day than for-profit homes, spending more on nursing care but less on overall administration.
- Not-for-profits attracted more volunteers, played the major role in planning community networks of services and provided more support for research and education.

Canadian Medical Association Journal

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

- Empirical research in the past 12 years has found that systematic differences exist between for-profit and not-for-profit nursing homes.
- For-profit nursing homes appear to provide lower quality of care in many important areas of process and outcome. 52

Michael Hillmer, the lead author on the Toronto study, said that the reason not-for-profit homes perform better may be because they put any profits back into care.53

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

The study found that:

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

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

American Journal of Public Health

A study published in the American Journal of Public Health in 2001 analyzed data from state inspections of almost 14,000 nursing facilities, both investor-owned and not-for-profit. The researchers, drawn from the University of California, Harvard and other educational institutions, concluded that:

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

The Aspen Institute

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

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

There is always room for more research, but it can safely be concluded that not-for-profit LTC facilities provide better care to the frail elderly, and do so more efficiently than for-profit homes.
The privatization of LTC leads to the neglect of our most frail elderly citizens. The profit-seeking behaviour of private facilities diverts funds and focus from providing care and leads to cutting corners in staffing. For-profit facilities pursue profit by cutting staff or spending on services and care. Every dollar in shareholders’ dividends represents money that is not being spent on care for elderly residents. It is our most vulnerable citizens who pay the price.

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

Monitoring, Inspection & Quality Care

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

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

In Alberta, a new direction was announced only after the death of the 86-year-old hunger striker Mary Geddes. In that province, the Consumers’ Association of Canada described LTC as existing in a “regulatory void”.

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

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

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

The minister of health promised to put an end to advance notice of inspections, and to change the licensing system so that homes with violations receive only a temporary licence.  

In Ontario, the media exposed a for-profit chain, called Royal Crest, which had a record of bankruptcies, financial negligence and fraud against vulnerable residents in Canada and the US. The Royal Crest facilities were shut down after their owners declared bankruptcy and vanished. The company owed the provincial workers’ insurance program $3.2 million and money was also reported missing from residents’ bank accounts.  

The governments of Ontario, New Brunswick and Alberta have committed recently to increasing the number of surprise inspections of facilities, but these commitments came only after increased public pressure and media scrutiny.  

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

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

Governments have a responsibility to enforce optimal staff ratios and LTC standards to ensure the frail elderly receive good care and that they do not become the victims of neglect. There must be thorough background checks on owners and operators before awarding them a licence. Residents must rest assured that they will not lose their personal savings if a facility goes bankrupt.  

Governments must monitor facilities and enforce tough measures against those that do not comply with optimal standards. Governments must provide the tools necessary to prevent financial abuse and mismanagement and ensure fiscal integrity at facilities.  

All of these measures are important, but they are not enough. Ultimately the answer to Canada’s crisis in LTC must be the recognition that it is an essential part of our health care system. LTC must become an ensured service under the umbrella of the Canada Health Act. It is time for Canada to provide its most vulnerable citizens with the quality of life and care they need and deserve.
THOUSANDS OF women and men work in Canada’s long-term care system and are trying to provide high quality care in an environment of respect and dignity. Today, these people are working harder than ever before under incredibly stressful conditions. There can be no doubt about it: staff are the backbone of quality long-term care. And let’s be clear that every occupational category, not just doctors and nurses, is critical to care, including: therapists, pharmacists, social workers, dieticians, health care aides, personal support workers, cleaners, cooks and administrative staff. Building a first-class long-term care system depends on an adequate supply of all types of skilled workers.

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

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

Privatization & Low Pay

One might expect the workers who care for the elderly would be valued and compensated accordingly, but this is not the case. Wages and benefits in LTC facilities lag behind those in other health institutions. For example, governments have decided that more health services should be delivered in LTC establishments, but nurses and other health care professionals in those facilities earn less than they would in hospitals.62

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

recreation therapy are often viewed as frills and, as a consequence, services are reduced and eliminated, hurting residents’ quality of life and increasing the risk of injury and illness, including depression. There is also a growing trend to contract out ancillary services such as cleaning, maintenance, food preparation, security and laundry to large multinational companies such as Aramark, Sodexho and Compass Group.

Once jobs are contracted out to companies such as these, previous collective agreements are scrapped, wages and benefits reduced, staffing levels lowered, training programs gutted and service levels minimized. Contracting out also lowers the continuity and quality of care. Residents receive meals delivered by trucks. Cleaning, security and other staff may work for a myriad of different companies, rather than from a cohesive workforce united in the common goal of providing quality care and services. The cutbacks and fragmentation are distressing for residents, but are also difficult for LTC workers.63

Stress, Burnout & Turnover

The average number of days of work that Canadians in health occupations lost due to illness or disability since 1987 has been at least 1.5 times greater than that for all workers. In 2004, full-time workers in health occupations across Canada missed an average of 12.8 days of work due to illness or disability.64

Dr. Margaret Ross, a professor at the University of Ottawa School of Nursing, led a research team studying stress and burnout among staff in nine LTC facilities in the Ottawa-Carleton Region. The results were reported in Geriatrics Today in September 2002.65

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

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

High rates of turnover can have negative effects on working conditions, staff morale and the quality of care. There is an impact on residents because they develop a comfort level with the individuals who assist them with health care and personal tasks and this requires a certain comfort level.
Hearing from the Workers

Several unions representing workers in the LTC facilities have surveyed their members, asking about workload, quality of care, working conditions and safety in the workplace.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION (OPSEU/NUPGE)

December 2002, Long-Term Care Sector Survey

OPSEU/NUPGE represented approximately 1,000 members working in LTC facilities in Ontario in 2002. Surveys were sent to union members, most of them front-line workers, asking about pressures they faced on the job, especially in the areas of health and safety. 66

Here are some of the results:

• 84% of workers said they work alone always or often.
• 65% work always or often with clients who may become aggressive.
• 78% reported coming into contact with body fluids, many on a daily basis.
• 62% reported working in facilities with poor air quality.
• 19% lost time at work due to a work related injury within the past year.
• 84% said their workload had increased levels of stress at work.

Quotes from OPSEU Survey Respondents

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

CANADIAN UNION OF PUBLIC EMPLOYEES (CUPE)

In March 2004, the Canadian Union of Public Employees, Ontario Division commissioned an independent study of Ontario’s LTC workplaces represented by CUPE. 67 Here are some of the results:

Workload

• 10% of the respondents reported working with between 40 and 60 residents on their usual morning shift.
Dignity Denied

• 44.1% cared for between one and five residents who were completely confined to bed.
• 40.3% worked alone while tending residents.
• 18.1% were able to complete their task less than half of the time. Another 14.3% said they are never able to complete tasks in the time available.

Work-life Balance
• 44.5% worked part-time.
• 18% infrequently or never had control over what they do during the day.
• 38.8% said their employer or manager decided their work schedule and they lack choice about how schedules were organized.

Physical Conditions
• 35.8% reported cleaning services in their facilities are adequate, but another 15.1% found them either poor or very poor.
• 27.7% rated dining rooms as poor or very poor in meeting residents’ needs.
• 57.4% rated ventilation as poor or very poor and 41.4% rated bathrooms as poor or very poor.

A Dangerous Workplace
• 96.7% had been ill or injured as a result of work in the previous five years.
• 96.3% had some type of violent incident occur in their nursing home in the previous three-month period.
• 73.3% had violence directed at them in the previous three-month period.

Rating Programs
• 28.9% considered their facility’s exercise program to be poor or very poor.
• 75.6% said medical services were moderate or good, with 12.7% considering them very good.
• 28.3% rated the recreation program as poor or very poor.

Reporting Problems
• Two-thirds would not feel comfortable reporting unsafe practices to their employer.
Workers Who Care for the Elderly

- 14.2% would feel comfortable reporting such occurrences to the Ministry of Health.

Quote from CUPE Survey Respondent
"There are not enough hands to effectively, and with dignity, feed these residents as they deserve to be fed. There are not enough hands to provide the care these elderly residents require and deserve."

The Union Advantage

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

If working in the sector is to be a rewarding experience, staff must feel respected, valued and protected. A collective agreement helps to create a better environment for everyone in the workplace.

The union advantage for individual workers includes: improved wages and benefits, better work schedules, access to more sick leave, health and safety protection, opportunities for training, a voice in the operation of the facility and help defending his or her interests in any dispute with an employer.

The wages of unionized non-managerial employees across all occupations are $5.00 per hour more than for the unorganized. The difference is even greater for unionized female employees who generally earn almost $6.00 more than their non-unionized counterparts.

Unionization is also a benefit for part-time employees. According to Statistics Canada, in 2003 unionized part-time workers averaged $18.28 an hour and worked 19.3 hours a week. Non-union workers averaged $11.03 an hour and worked 16.8 hours a week. When total weekly pay is calculated the average unionized part-time worker earned nearly twice as much per week as a non-union worker.

No comprehensive studies have been done to compare the quality of the workplace in union and non-union LTC facilities, but information can be drawn from looking at studies undertaken in home care settings.

These studies point to higher wages and improved benefits for most workers who belong to a union. On average, unionized workers earned $3.26 an hour (or 15%) more than their non-unionized counterparts.
counterparts. Unionized registered nurses earned an average of $3.32 an hour more than their non-unionized counterparts and the differential for home support workers was $1.54. Hourly wages are only part of a worker’s take home pay package. Unionized workers in the home care sector also worked significantly fewer unpaid hours than their non-union counterparts.

Belonging to a union also makes a difference in non-wage benefits such as drug and dental coverage. A 2001 report from Statistics Canada found that 89% of unionized workers were likely to have non-wage benefits. Only 64% of non-unionized workers had such coverage in 2003.

Union membership also offers workers an opportunity to improve conditions for the people to whom they provide care. Through the collective bargaining process, unions can negotiate minimum staffing levels, health and safety committees and the promotion of safe workplace practices.

Often it is the union that suggests and implements skills upgrading and advanced training for people in specialized fields, such as caring for residents with unique and complex needs.

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

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

Finally, staff members are an important source of information about standards of care and safe facilities. Governments and the public would learn much more about what is occurring in LTC facilities if staff were confident that they could report problems confidentially and without reprisals. NUPGE and other unions have called upon governments to provide whistleblower protection for workers. LTC workers, in particular, need such protection to ensure they can report candidly on any conditions or actions that threaten the well-being of residents or staff.

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

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

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

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

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

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

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

CANADA HEALTH ACT

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

ACCESSIBILITY AND AFFORDABILITY

Federal Funding

• The federal government should introduce targeted transfers to provincial and territorial governments for LTC linked to the principles of the Canada Health Act.

Provincial and Territorial Funding

• Provincial and territorial governments should provide new funding to:
  - Recruit and retain staff for facilities to improve staff-resident ratios, provide for an optimal mix of staff, and guarantee optimal standards and hours of care per resident.
  - Build more facilities and spaces needed to reduce wait lists.
  - Renovate LTC physical infrastructure and upgrade equipment.

Accountability for Public Funds

• Funding provided by governments for LTC should privilege public and not-for-profit facilities. Funding to for-profit facilities should be phased out.

Per Diem Rates

• Provincial governments should increase the public per diem to a level that ensures all health services (personal and medical) are covered for residents. Further, the per diem should have a built-in escalator to ensure increased funding as costs rise.
Recommendations

Resident Fees

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

Off-Loading from Hospitals

• Provincial and territorial governments should establish guidelines to prevent off-loading of patients from acute and chronic-care hospitals to LTC facilities that may be inadequately staffed to provide appropriate care.

Assisted Living Facilities

• Provincial governments should declare a moratorium on the reclassification of long-term care facilities into assisted living facilities.

QUALITY OF LIFE AND STANDARDS OF CARE

A National Long-Term Care Commission

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

Long-Term Care Facilities Act

• Provincial and territorial governments should consolidate the legislation governing LTC facilities into a single, comprehensive Act to ensure consistent, high quality standards of care, as well as clear accountability and enforcement measures.
• Governments should include in this legislation the ratios and standards recommended by a Long-Term Care Commission, and make it mandatory that facilities meet them.
• The legislation should provide for swift and progressive penalties for facilities that fail to meet optimal staff ratios, hours of care and other standards.

A Public and Not-for-profit System
• Governments should award new facility licences only to public and not-for-profit facilities.
• Where public investment has been made in a for-profit facility that is placed on the market for sale, the government in question should acquire the facility at market value and convert it to a public, not-for-profit facility.

Inspection and Compliance System
• Provincial and territorial governments should create dedicated inspection teams consisting of a range of specialists, including health care, food, hygiene and safety experts.
• Provincial governments should establish a system of multiple, random, surprise inspections of LTC facilities.
• Inspection teams should have clear investigative and enforcement powers in order to ensure swift, effective and substantive interventions.
• Inspectors should be permitted to issue mandatory compliance orders and impose progressive sanctions for non-compliance.
• Inspection teams should file an annual report to their legislature describing inspection results.
• Provincial governments should post all inspection reports, including disclosure of any violations, on their website to allow families to make comparisons and fully informed decisions before choosing a facility.
Recommendations

Public Accountability
• Facilities should be compelled by the government to provide public access to information that includes: number of beds in the facility; inspection results; enforcement orders; staffing levels, staff mix and turnover rates; culturally sensitive care; reports on revenue and expenditures; and out-of-pocket fees charged to residents. The information should be made available on the appropriate government ministry website.

Resident and Family Councils
• Governments should require, in legislation, the establishment of Residents’ Councils. Attendance of a management and staff representative should be mandatory at regular meetings of these councils.
• Family Councils should have a legislated mandate to perform advocacy on behalf of residents, and facilities should be required to inform the families of residents about the existence and role of such a council.

Dietary Practices
• It should be a legislative requirement that every facility have a qualified dietician on staff to evaluate the nutritional status and needs of each resident and approve all meal plans.

Infectious Diseases
• It should be a legislative requirement that every facility have a qualified infectious disease control specialist on staff.
• Provincial governments should track outbreaks of contagious diseases to identify and resolve systemic problems.

Protecting Residents from Financial Abuse
• Provincial and territorial governments must perform thorough background checks on owners and operators of LTC facilities before awarding them a licence.
• Facility operators must be required to disclose all previous cases of bankruptcy and convictions for fraud.
Dignity Denied

• Provincial and territorial governments should establish a fund to protect the financial accounts of residents against unscrupulous operators, financial mismanagement and bankruptcies.
• Governments should perform rotating financial audits, with the results kept strictly confidential, to help prevent abuse and ensure fiscal integrity at facilities.

THE LONG-TERM CARE WORKFORCE

Recruitment, Retention and Training
• Governments must make a financial commitment to improve the wages, benefits and working conditions of currently employed LTC workers, and to provide additional training for staff to deal with the increasingly complex needs of LTC residents.
• Governments should ensure that compensation, benefits and working conditions are equalized across the health care system.
• All levels of government should collaborate to improve Canada-wide health human resources planning, ensuring an adequate supply of LTC workers now and in the future.

Health & Safety
• Governments and employers must take measures to reduce violent and abusive behaviour toward LTC workers.

Whistleblower Protection
• Provincial and territorial governments must introduce whistleblower legislation to protect LTC workers who report on incidents or conditions that negatively affect a patient’s care and/or any unlawful activities in LTC facilities.

Unionization
• Provincial and territorial governments should undertake progressive labour law reform to assist LTC workers who wish to exercise their right to join a union and bargain collectively.
Endnotes

2. Ibid.
4. Stitching the Patchwork Quilt Together, p. 52. This number is based on a survey completed by the Canadian Healthcare Association (CHA).
5. Ibid., p. 88.
10. This historical material is drawn partly from Robin Stadnyk, The Status of Canadian Nursing Home Care: Universality, Accessibility, and Comprehensiveness. Atlantic Centre of Excellence for Women’s Health, June 2002.
14. Ibid.
16. Adapted from Robin Stadnyk, The Status of Canadian Nursing Home Care.
18. Charges to Residents in Facility-Based LTC By Province/Territory. Canadian Healthcare Association website: www.cha.ca. Note: New Brunswick has since announced that LTC residents will pay a maximum of $79 per day and will no longer have to use proceeds from the sale of their primary residences to pay for care.
21. Ibid.
22. Charges to Residents in Facility-Based LTC By Province/Territory, Canadian Healthcare Association website: www.cha.ca.
23. Stitching the Patchwork Quilt Together, CHA.
Dignity Denied

26 Ibid., p. 11.
29 Ontario Ministry of Health and LTC, Public Inquiries Branch, LTC Division.
34 Stitching the Patchwork Quilt Together, p. 52. This number is based on a survey completed by the CHA.
35 Stitching the Patchwork Quilt Together, CHA, p. 88.
36 Ibid., p. 63.
37 Ibid., p. 2.
38 Ownership Matters, Ontario Health Coalition.
39 Ibid.
46 Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long-Term Care Facilities and Selected Comparators, PricewaterhouseCoopers, prepared for the Ontario Association of Not-for-profit Homes and Services for Seniors and the Ontario Long-Term Care Association, January 2001, p. 65.

50 P Armstrong and T Daly, There are not enough hands: Conditions in Ontario’s long-term care facilities, Canadian Union of Public Employees, July 2004.


54 MJ McGregor, M Cohen et al., “Staffing levels in not-for-profit and for-profit long-term care facilities: Does type of ownership matter?” Canadian Medical Association Journal, March 1, 2005; 172 (5); pp: 645-650.


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63 T Walker, “Who is Sodexho?”, Privateer Watch, Hospital Employees Union, May 2002.

64 Canada’s Health Care Providers 2005 Chartbook, Canadian Institute for Health Information. Available at www.cihi.ca.


66 OPSEU Long-Term Care (Sector 8) Survey, December 2002.

67 There are not enough hands, CUPE Ontario, July 2004.


69 Ibid., p. 28.

70 Ibid., p. 16.