

# DANCING THE TWO-STEP IN ONTARIO'S LONG-TERM CARE SECTOR: DETERRENCE REGULATION = CONSOLIDATION

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## **Abstract**

This paper explores shifts in public and private care delivery over time through an analysis of Ontario's approach to long-term care funding and regulation in relation to other jurisdictions in Canada and abroad. The case of the evolution of Ontario's long-term care policy—from the 1940s until early 2013—shows how moving from compliance- to deterrence-oriented regulation can support the consolidation of commercial providers' ownership and increase the likelihood of nonprofit and public providers outsourcing their management.

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## **I**ntroduction

The core of the problem is that the present [long-term care] system was never planned; it has simply evolved.<sup>1</sup>

This statement was made by Richard O'Donnell in June 1983, when he was the president of the for-profit nursing homes' lobby group known as the Ontario Nursing Home Association (ONHA). If we consider delivery, regulation, and funding together, then in one sense he was correct: Ontario's long-term care sector had been lacking a clear public delivery role. In another sense, however, he was absolutely wrong because definitive regulatory and funding shifts had guided the sector's evolution in terms of its size and ownership configuration.

This article explores shifts in public and private care delivery over time by comparing Statistics Canada data regarding the size and composition of Ontario's long-term care sector with those of British Columbia, Alberta,

and Manitoba. It also analyzes changes in Ontario's approach to long-term care funding and regulation, and discusses the implications of its policy trajectory for other jurisdictions in Canada and abroad. The case of Ontario's long-term care policy evolution—from the 1940s until early 2013—shows how moving from compliance- to deterrence-oriented regulation can support the consolidation of commercial providers. A deterrence regulation paradigm involves formal rules, measurement-oriented regulations, legal remedies, punitive damages, and sanctions. It assumes that organizations will break rules and try to get away with it. In contrast, a compliance regulation paradigm involves more informal rules, with regulators acting in a more supportive role—trying to develop organizations and choosing to sanction only as a last resort. This latter model assumes a partnership between organizations and policymakers (see endnote 22). In step with the advent of new public management and the adoption of a deterrence-oriented regulatory regime, the large for-profit commercial sector has gained and maintained ascendancy in comparison with small for-profit, charitable, and municipally run homes. The formula—more deterrence-oriented regulation equals ownership and management consolidation—is like dancing the “two-step.” One partner leads the other in taking two quick steps and then two slow steps around the dance floor. Ontario's long-term care policy history shows how, within Ontario's liberal welfare state and its new public management structure, policymakers took leading “steps” towards deterrence regulation that were followed in lockstep by the long-term care sector's increased commercial ownership and management consolidation.

Following the methodology and methods section, this article highlights studies that query links between care delivery ownership models and quality, and those that explore the nature of long-term care regulation and care delivery organization. The third section presents findings that compare ownership trends within selected provinces and trends for Canada overall. Section four outlines Ontario's long-term care system's regulatory and funding trajectory. This section is further subdivided into four main time periods: minimal regulation with private provider proliferation (1940 to 1966); the expansion of the province's funding and regulatory role (1966–1993); ministerial consolidation, funding parity, and the shift to

medicalized long-term care (1993–2007); and regulatory rigidity, austerity, and commercial consolidation (2007–present). A seminal policy was passed during each of these time periods: the *Nursing Homes Act* (1966); the Extended Care Funding Plan (1972); the passage of Bill 101 (1993) and its funding envelope system; and the *Long-Term Care Homes Act* (2007). Each marked a critical regulatory juncture that first supported, then solidified, and finally concentrated chain providers' hegemony over the long-term care sector. The article's final section highlights how private organizations—notably large chain providers—benefitted most from steady public funding, provincial disengagement from public care delivery, and the public funding of private delivery. Furthermore, Ontario's early hesitancy to regulate was replaced by the erection of increasingly high regulatory barriers to entry, as well as very medical and complex care documentation systems. The article discusses how regulations can shape ownership patterns, and explores in what ways ownership and management of long-term care delivery matter, particularly when increasing numbers of nonprofit organizations are being managed by for-profit chains.

**Methodology and Method** The analysis uses political economy assumptions that politics and economics are “enmeshed” and “integrally linked,” and that the form of capitalism underpins relations among the state, for-profit and nonprofit actors, and individuals and families.<sup>2</sup> Using an historical neoinstitutionalist method,<sup>3, 4, 5</sup> this paper analyzes critical policy junctures to explain the current ownership and management configurations between public, for-profit, and nonprofit organizations. The following secondary data sources were triangulated: comparative provincial data of ownership of facilities and beds from the Statistics Canada Residential Care Facilities Survey (1984–2010); the Ministry of Health and Long-Term Care online database “Reports on Long-Term Care Homes”<sup>6</sup> to establish the initial Ontario facilities list; annual reports of public, for-profit, long-term care companies (SEDAR and EDGAR databases); journal articles; the Ontario Long-Term Care Association Directory (2012); newspaper articles; business databases; and the websites of the owners and management firms providing long-term care services.

**Commercial Delivery of Care** A well-developed literature addresses the compatibility of for-profit ownership with quality care. Staffing intensity, which is a measure of the staff-to-resident ratio, is considered by some to be the single most important factor affecting work organization, working conditions, and quality of care in long-term residential care.<sup>7, 8</sup> Canadian research has documented that municipal and nonprofit homes typically operate with a higher staff-to-resident ratio, while for-profits more often staff minimally.<sup>9, 10, 11</sup>

Studies show that, at an aggregate level, commercial provision of care has had negative quality implications. McGregor and colleagues have demonstrated that for-profits tend to average worse performance on clinical quality measures than nonprofit and publicly operated facilities.<sup>12</sup> Three systematic reviews have also explored the long-term care ownership relationship to clinical quality measures. Davis found an inconclusive link<sup>13</sup>; Hilmer and colleagues found that nonprofit facilities outperform and provide better care than for-profit ones on important process and outcome measures<sup>14</sup>; and Commodore and colleagues reviewed studies from 1965 to 2003 and found that nearly half favoured nonprofit care, three favoured for-profit care, and the remainder lacked consistent findings. This led the authors to conclude that, when averaged, nonprofit homes provide care of higher quality than that of for-profit chains.<sup>15</sup>

While some of the quality-of-care debate has centred around ownership patterns and staffing levels, the emergence of new hybrid organizational forms—with nonprofits being managed by for-profit companies—raises important questions about what it means to be a nonprofit if management decisions use a for-profit market model. Although there are no studies exploring this in Canada, Kaffenberger has shown that, in the United States, for-profit ownership composition has changed dramatically since the Medicare and Medicaid programs were put in place in 1965.<sup>16</sup> By 2008, the American long-term care sector had shifted away from small homes and nonprofit providers to large for-profit chains. The adoption of new ownership, management, and financing strategies that include nonprofit companies among the for-profit chains in the United States and the United Kingdom has reduced chain providers' liability and their payment of taxes, and has

increased the rates of bankruptcies.<sup>17, 18, 19</sup> Some deleterious impacts of the complete divestment of public facilities to nonprofit or for-profit ownership—such as an increase in regulatory violations and negative consequences for residents’ quality of life—have been documented.<sup>20</sup> As Stevenson and colleagues have argued, “knowing the proprietary status of a nursing home provider is insufficient to discern how organizational assets are structured and the operational approach of the company managing the delivery of nursing home services.”<sup>21</sup> While the literature points to a tendency at the aggregate level for there to be higher levels of staffing and higher quality of care in nonprofits on some outcome measures, how we interpret poor performance on clinical and performance quality measures when a large and growing proportion of nonprofit beds are managed by for-profit companies has yet to be addressed. Indeed, the phenomenon is so new that the literature is silent on it.

Finally, to what extent does regulatory complexity drive commercialization and consolidation? According to Walshe, states can choose three main regulatory routes: deterrence, compliance, and responsive regulation. The long-term care sector in the United States has been at the forefront of opting for deterrence regulation.<sup>22</sup> The regulatory burden that organizations face as a result of the deterrence model may lead to greater commercialization; since the adoption of the United States’s *Omnibus Budget Reconciliation Act* (OBRA) 1987, major chains have increasingly dominated the sector.<sup>23</sup> Because of the large, fixed costs of regulation, larger organizations may be able to spread the costs over a much greater business volume, as well as develop capacity in regulatory compliance skills. Single-site, owner-operated businesses and nonprofit organizations may find it hard to compete in a heavily regulated environment.<sup>24</sup> With heavily regulated, deterrence-oriented environments, one might expect concentration of long-term care delivery and management within larger chain organizations; this paper explores this relationship.

**The Context: Comparing Commercial Consolidation of Long-Term Care** This section delineates the sector’s concentration of power, focusing on the number and size of players involved in long-term care delivery. It

compares Ontario to three other provinces: British Columbia, Manitoba, and Alberta. The data are divided by ownership. There are three types of privately owned homes. Proprietary homes are run by for-profit companies that are either single homes or part of for-profit chains. Nonprofit religious homes are run by religious organizations and may be stand-alone or linked to another home, but typically they are not linked to more than one other. Nonprofit lay homes are secular, and like nonprofit religious homes they are usually stand-alone, but may include more than one home. Public homes are either municipally run with employees that are municipal government staff, or else they are provincially owned and staffed. This section shows that although commercial consolidation has been most evident in Ontario while the public sector is most expansive outside of Ontario, nonetheless each of the other provinces resembles Ontario in specific ways.

Table 1 shows that there were more proprietary providers operating in 2010 when compared with 1984 data, both across Canada and within Ontario and Alberta. In contrast, there were fewer proprietary providers in British Columbia and Manitoba. Commercialization was most widespread in Ontario with respect to the percentage share of the sector owned by proprietary operators at points in time. In 1984 in British Columbia, more than five in ten long-term care homes were owned by proprietary operators, compared with little more than four in ten homes by 2010. In 2010, Manitoba, Alberta, and British Columbia had the highest percentages of public facilities, which represented between one third and one quarter of the homes. The percent of publicly owned homes in these three provinces was about double that of Ontario, where about one sixth were owned by the municipalities. The other provinces did not have any municipal homes, and Ontario remained the only one of the group without a provincial ownership role. In Alberta, provincial investment followed a substantial divestment by the municipalities, which previously had owned 40 percent of homes. Despite the increased provincial role, this shift meant that commercial and nonprofit providers played a more expansive role than before. In contrast to Ontario, nonprofits in British Columbia, Manitoba, and Alberta played a larger, though declining, role over time. And despite Manitoba's strong public sector role, there was a larger share of commercial owners and a decline in the number of nonprofit lay ones by 2010.

**Table 1. Number of Residential Homes for the Aged Facilities by Ownership Type 1984–2010.<sup>25</sup>**

		Proprietary	Nonprofit Religious	Nonprofit Lay	Municipal	Provincial
Canada	1984/1985	1085	155	306	271	34
	%	58.6%	8.4%	16.5%	14.6%	1.8%
	2009/2010	1145	157	314	132	291
	%	56.2%	7.7%	15.4%	6.5%	14.3%
Ontario	1984/1985	416	42	61	90	4
	%	67.9%	6.9%	10.0%	14.7%	0.7%
	2009/2010	482	39	108	104	5
	%	65.3%	5.3%	14.6%	14.1%	0.7%
Alberta	1984/1985	36	15	9	43	0
	%	35.0%	14.6%	8.7%	41.7%	0.0%
	2009/2010	78	39	24	0	58
	%	39.2%	19.6%	12.1%	0.0%	29.1%
BC	1984/1985	178	14	117	1	4
	%	56.7%	4.5%	37.3%	0.3%	1.3%
	2009/2010	123	22	68	0	68
	%	43.8%	7.8%	24.2%	0.0%	24.2%
Manitoba	1984/1985	32	23	40	28	1
	%	25.8%	18.5%	32.3%	22.6%	0.8%
	2009/2010	27	17	17	0	29
	%	30.0%	18.9%	18.9%	0.0%	32.2%

Statistics Canada. Table 107-5501 (accessed 24 September 2013).

\*\* The highest percentages for each category are highlighted in grey.

With the average size of long-term care homes increasing over time, we must focus not only on the number of homes, but also on the “bed concentration by ownership” category. Table 2 shows that, across Canada, bed numbers grew at a stellar rate in the provincial category (570.5%), and declined (32.1%) in the municipal one. There was significant growth in the number of proprietary owned beds (54.6%). These growth trends reflect a shift to greater provincial ownership in all of the studied provinces except for Ontario, a divestment of municipal beds in all of the provinces except for Ontario, and a tremendous increase in the number of beds owned by the proprietary sector in Ontario (63.2%), Alberta (89.2%), and British Columbia (47.4%). Manitoba is the sole standout, registering a decline (-3.2%). Ontario and Alberta experienced growth in nonprofits’ share of

**Table 2. Number of Residential Care Beds by Ownership Type and by Jurisdiction 1984–2010.<sup>65</sup>**

		Proprietary	Nonprofit Religious	Nonprofit Lay	Municipal	Provincial
Canada	1984/1985	61100	13863	25104	28029	3764
	2009/2010	94482	15616	30292	19030	25236
	% Growth	54.6%	12.9%	20.7%	-32.1%	570.5%
Ontario	1984/1985	32810	4250	6013	17785	868
	2009/2010	53587	4953	13220	17014	311
	% Growth	63.2%	16.5%	119.9%	-4.3%	-64.2%
Alberta	1984/1985	3606	1414	778	2875	0
	2009/2010	6831	3042	2777	0	6147
	% Growth	89.4%	115.1%	256.9%	-100%	-
BC	1984/1985	6995	1217	10159	76	421
	2009/2010	10313	2429	6593	0	7518
	% Growth	47.4%	99.6%	-35.1%	-100%	1685.7%
Manitoba	1984/1985	2716	2058	2680	969	185
	2009/2010	2629	1795	1589	0	3669
	% Growth	-3.2%	-12.8%	-40.7%	-100.0%	1883.2%

Statistics Canada. Table 107-5501 (accessed 24 September 2013).

\*\* The percentage growth is highlighted in grey.

bed ownership; the growth was sometimes stellar, while the actual number of beds remained comparatively quite small.

While the absolute number and the growth of the number of beds reveal important shifts, the distribution of beds across ownership categories is also very important to consider (Table 3) because it shows the relative balance between the for-profit, nonprofit, and public sectors. Two main models appear: most beds owned by the proprietary sector, and most beds owned by the public sector. In Ontario, Alberta, and British Columbia, the proprietary sector owns the most beds. Manitoba is the sole stand-out, with most beds publicly held. An evenly balanced sector would have approximately 33 percent of beds allocated to each of the sectors. Manitoba is weighted on one side with a higher public-sector investment in bed ownership, and Ontario, British Columbia, Alberta are on the other side, with a higher proprietary bed ownership investment. Although tipped in favour of the proprietary sector, Alberta comes closest to a balance. When it comes to a public-private balance, Ontario is the most commercialized, but not a



**Table 3. Comparative Distribution of Residential Beds by Ownership Type 1984–2010.\*<sup>65</sup>**

		% Proprietary	% Nonprofit Religious	% Nonprofit Lay	% Municipal	% Provincial
Canada	1984/1985	46.3%	10.5%	19.0%	21.3%	2.9%
	2009/2010	51.2%	8.5%	16.4%	10.3%	13.7%
Ontario	1984/1985	53.2%	6.9%	9.7%	28.8%	1.4%
	2009/2010	60.2%	5.6%	14.8%	19.1%	0.3%
Alberta	1984/1985	41.6%	16.3%	9.0%	33.1%	0.0%
	2009/2010	36.3%	16.2%	14.8%	0.0%	32.7%
BC	1984/1985	37.1%	6.5%	53.8%	0.4%	2.2%
	2009/2010	38.4%	9.0%	24.6%	0.0%	28.0%
Manitoba	1984/1985	31.6%	23.9%	31.1%	11.3%	2.1%
	2009/2010	27.2%	18.5%	16.4%	0.0%	37.9%

Statistics Canada. Table 107-5501 (accessed 24 September 2013).

\* Numbers may not add to 100 due to rounding.

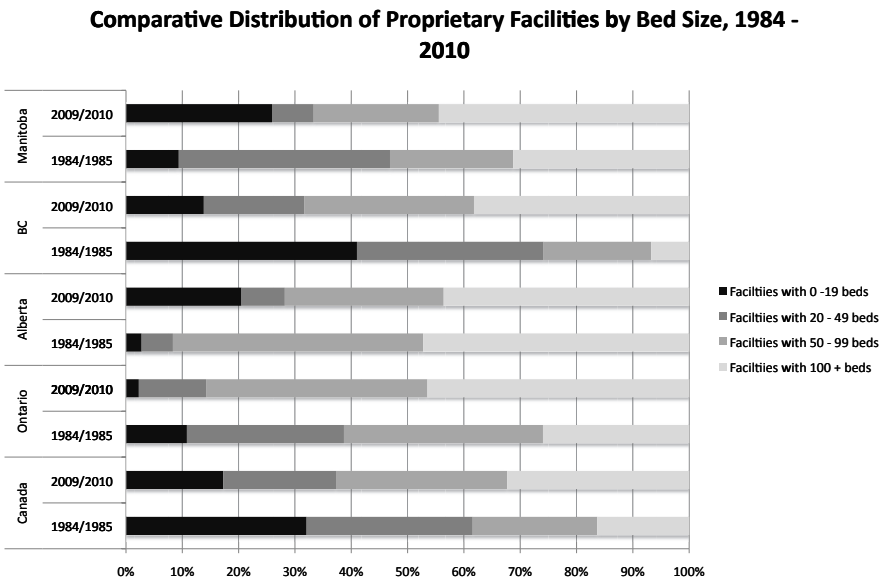
\*\* The highest percentages for each category are highlighted in grey.

complete outlier as in the previous tables. Although there is strong commercial ownership across Canada, other provinces have also increased their provincial public-sector role substantially; this has not been done in Ontario, where homes are still municipally owned. In addition, Ontario has fewer nonprofit beds compared with the distribution common across Canada.

Home size measured by the number of beds is another important metric. Having larger long-term care homes, each with more beds, can consolidate power to fewer players and translate into economies of scale, thus furthering consolidation trends. A home having fewer than 19 beds is considered to be very small; between 20 and 49 beds is small; 50 to 99 beds is seen as medium in size; and 100 and more beds is large. The data show that, by 2010, the majority of proprietary-sector homes in all of the provinces studied (Ontario, Manitoba, and British Columbia) were large in size. In 1984, Canada's and British Columbia's proprietary sectors were made up mostly of very small homes; Manitoba's homes were mainly small; for the most part Ontario's homes were medium-sized; and Alberta had an even spread between homes that were either medium-sized or large. The "size of home" metric reflects a significant change in the composition of the proprietary sector between 1984 and 2010, from very small, small, and medium-sized

homes to large homes. It shows that small proprietary homes comprised a shrinking proportion of for-profit homes overall. Despite the similarities, Ontario still stands out. By 2010, the number of Ontario's proprietary 100+ bed homes almost doubled. When compared with the size of homes in other jurisdictions, the largest proportion of large homes are located in Ontario. In addition, the province has far fewer small homes than do the other provinces.

Figure 2.



Statistics Canada. Table 107-5501 (accessed 24 September 2013).

Ontario is the most commercialized in terms of the number of providers and the number of beds. The province is also more consolidated in that it has a higher number of large, commercially owned homes. In order to better understand the origins of the commercialization and consolidation trends, the next section analyzes Ontario's long-term care regulation and the roles of the public- and private-sector over time.

**Regulation of Long-Term Care in Ontario (1940s–2013)** This section delineates four regulatory phases, starting in the 1940s. The first phase involved an expansion in the number of private providers (1940 to 1966). The second phase—from 1966 to 1993—was defined by the expansion of the public funding and regulatory role, but also by a lack of policy coordination within government. The third phase lasted until 2007 and involved Ministerial consolidation and the introduction of funding parity between for-profit, nonprofit, and public homes. It also involved the expansion of public capital funding, which further solidified the hegemony of for-profit chain providers. Finally, following a series of sensational media exposés, in a climate of public-sector austerity the state erected complex regulatory and reporting requirements that have served as high barriers to entry, and have resulted in the further commercialization and consolidation of the ownership and management of the sector, favouring for-profit chains (2007–present).

***Private Provider Proliferation (1940–1966)*** The public was slow to address the need for residential care for the elderly. The first public municipal home for the aged opened officially in 1949 and housed seven hundred residents. The clientele was younger, less affluent, and more ambulatory than the population in long-term care homes today. This was in keeping with the original mandate of homes for the aged, which focused on “the poor, not the sick elderly.”<sup>26</sup> By the early 1950s, long waiting lists to live at the facilities had developed.

As James Struthers has shown, the commercial provision of nursing home care proliferated in the early 1940s.<sup>27</sup> Calling it an “unintended partnership of convenience,” he argues that it started as an interim emergency measure by the City of Toronto when hospitals began discharging older welfare recipients.<sup>28</sup> The City paid selected, privately owned nursing homes 40 dollars per month per resident. Over the next two decades, the need for residential care outside hospitals was increasingly filled by for-profit providers.

Starting in 1959, an influx of federal unemployment assistance funding meant that the province absorbed 80 percent of the direct costs of housing elderly welfare recipients in private nursing homes, thus relieving municipal-

ities of the ballooning costs of doing so and exponentially expanding the private nursing home sector.<sup>29</sup> But poor conditions in some private nursing homes led the provincial government to respond with a few public alternatives. In the 1950s and 1960s, 70 modern homes for the aged were built or renovated by municipalities with provincial cost-sharing. These replaced the public “houses of refuge” or “county poorhouses” that had previously housed poor and indigent elderly people.

Regulation developed slowly and haphazardly, despite the great need for it. For instance, by the mid 1940s the number of elderly people that the City of Toronto supported to live in private nursing homes had swelled from 30 to more than 600 people. These boarding and payment arrangements were largely without licensure or inspection until a symbolic City of Toronto bylaw, enacted in 1947, specified how many people could reside in a home, how facilities were to be shared and used by visitors, and it defined the buildings’ sanitation and safety codes.<sup>30</sup> In the 1950s, the province drafted a “model bylaw” for municipalities to use to license and inspect private nursing homes, but the bylaw did little more than ensure that the inspection process remained local and that higher provincial costs for oversight and compliance were avoided.<sup>31</sup> These regulatory methods proved largely ineffectual. By 1957, only 12 municipalities engaged in any sort of private nursing homes’ licensure, which often involved little more than bureaucratic oversight. The move did little to address the complaints of poor conditions, anomalous death rates, and poor care that plagued some nursing homes. Even many in the private sector agreed that conditions in some homes were appalling. Following the “First Ontario Conference on Aging” in 1957, the Ontario Welfare Council (OWC) aided the 150-plus operators of private nursing homes to form the Associated Nursing Homes Incorporated of Ontario (ANHIO).<sup>32</sup> With different motivations, these two groups lobbied the provincial government to fund, regulate, and license private nursing homes.

***Expansion of Public Regulation and Funding (1966–1992)*** Amid reports of private nursing home abuses, the *Ontario Nursing Homes Act, 1966* was passed to legislate for-profit care providers. The Act set standards for medical

and nursing care and for the physical plant, including housekeeping and maintenance. It did not provide provincial funding directly to facilities, but maintained a regional system through which municipalities received the funding and retained responsibility for regulation and inspection. Struthers notes that the Act “cemented an uneasy partnership between private enterprise and the Department of Health to ensure that profitability could be reconciled with Ontario’s burgeoning fiscal priorities as well as with the long-term care needs of the elderly.”<sup>33</sup> Privately owned nursing homes remained small during the postwar period; even by the mid-1960s, two thirds of Ontario nursing homes had no more than 20 beds. However, the number of private-sector beds increased significantly after the introduction of licensure and regulation in 1966: from 8,500 to 18,200 beds by 1969.<sup>34</sup> By the late 1960s, the system remained predominantly private and for-profit in terms of delivery, but it was public in terms of funding. Nearly two thirds of residents received a public subsidy from the welfare departments or from the Ontario Hospital Insurance Commission.<sup>35</sup>

Health officials found that the private nursing homes lobbied for continual rate increases while returning as little as they could back to the patients.<sup>36</sup> In response, by the mid 1960s welfare officials warned that the public system needed to build more places for elderly people in order to improve conditions and thwart an over-reliance on commercial facilities. The *Rest Homes Act* (1966) allowed for 50 percent capital and 70 percent operating funding to municipalities to fund and administer public rest homes, which were distinct from “homes for the aged.” But by the late 1960s, the province had built only two of these. In addition, by 1965 because of hospital bed shortages and a lack of capacity in for-profit nursing homes, about half of the beds in the homes for the aged (45 percent) were allotted for more complex “bed care”—what would become known as “extended care” in 1972—even though all beds in homes for the aged were intended to provide custodial care, that is, basic assistance such as washing, dressing, and cooking.<sup>37</sup>

Regulatory standards increased over time. For instance, the *Nursing Homes Act* was amended in 1972 to include standards for the physical plant, medical care, staffing intensity, activation, the dispensation of medications, and

record keeping. To ensure compliance, inspectors were hired to work in field regional offices. An inspection program was housed within the Institutional Division of the Ministry of Health. The inspection process was quite local; a manual to guide the inspection process was not produced until 1992, so regional differences of interpretation persisted throughout this period.<sup>38</sup>

Ontario's private delivery/public funding/medicalized model was entrenched with the 1972 passage of the *Extended Care Plan*. It publicly funded residents with medical care needs, and it required nursing homes to provide at least one and a half hours of skilled nursing and personal care per resident per day, which was funded through the Ministry of Health. This form of funding was criticized for not rewarding a home for providing more than a minimum level of care. The for-profit industry grew quickly after the 1972 increase in provincial public funding. The sector changed from "small, single operator dwellings" of 20 beds that were owned primarily by women, to "highly profitable, modern one-hundred to two-hundred-bed facilities, owned by corporate chains earning up to 15 percent rates of return for investors and dedicated to...make money for shareholders."<sup>39</sup>

During this period, many arguments were made regarding funding fairness. Despite growth in the number of for-profit providers, funding levels tended to favour public and nonprofit homes governed by the *Homes for the Aged Act* and the *Charitable Institutions Act*. Unlike the nursing homes, which operated under the Ministry of Health, for other institutions the funding model followed a "deficit funding," budget-based system—70 percent of the funding came from the provincial Ministry of Community and Social Services, and 30 percent came from the municipalities. Any deficits were covered by governments according to their allotted 70/30 budget share.<sup>40</sup> The Ontario Association of Homes for the Aged argued that deficit funding allowed for "flexibility" in providing care in a way that met the needs of the individual and of the community.<sup>41</sup> This funding model would remain in place until 1993, the year when homes for the aged were brought under the umbrella of the newly formed Ministry of Health and Long-Term Care. The *Extended Care Plan* meant that private, for-profit nursing homes were funded differently than municipal homes for the aged.

**Table 4. Ownership Distribution in the Long-Term Care Sector 1989.<sup>42</sup>**

Regulatory Classification	Homes for the Aged		Nursing Homes							Total
Home Ownership	Municipal	Charitable	Corporate	Independent	Municipal	Charitable	Lay	Hospital	Indian Bands	
Facilities	89	93	264	29	3	12	11	16	2	519
% Facilities	17.1%	17.9%	50.9%	5.6%	0.6%	2.3%	2.1%	3.1%	0.4%	100%
Beds	27,968		24,542	3,191	154	702	729	723	110	58,119
% Beds	48.1%		42.2%	5.5%	0.3%	1.2%	1.3%	1.2%	0.2%	100%
% Extended Care Beds	47%	Approximately 94%								n/a

While homes for the aged (both municipal and charitable) were originally charged with providing custodial care, approximately half of the beds in homes for the aged were classified as extended care beds.<sup>42</sup> The ONHA argued that funding differences favoured municipal and charitable homes that were able to draw on both deficit funding and extended care per diems.<sup>43</sup> In addition, charitable homes could use donations to provide more care or renovate. But for-profit homes benefitted in other ways. Because of a tendency to have more semiprivate and private rooms, private homes could generate extra funds. Forbes argues that bed allocations in municipal homes were based largely on need, meaning that a private room did not amount to a true revenue stream for municipal homes as it did in private homes.<sup>44</sup>

By 1986, the Ontario Select Committee on Health showed that there was a preference for nonprofit applicants in the public tender of nursing homes. This trend eroded slowly and then was reversed a decade later. Despite contemporaneous arguments that long-term care should be provided in nonprofit facilities, Tarman's analysis—based on key informant interviews with Ministry representatives—shows that corporate, for-profit chains increased their ownership stake of the sector to 50.9% of the facilities and 42.2% of the beds (Table 4).<sup>45</sup> By 1989, 35 percent were regulated as homes for the aged. The remaining 65 percent were legislated by the *Ontario Nursing Homes Act* (1972, 1987). Tarman's findings are confirmed by a 1992 study that also uses Ministerial data<sup>46</sup>; however, the numbers differ from the sectors' self-report data gathered for the "Statistics Canada Residential Care Facilities Survey" (Tables 2-5).

In 1982, ONHA hired an accounting firm to argue for more funding for “heavy care” residents. It also worked with a 1986 Ministry of Health committee to develop a Resident Assessment Classification System.<sup>47</sup> Both initiatives foreshadowed funding model changes that were implemented a decade later. In 1986, the province introduced a special “enhancement funding” strategy that tied specific per-resident per diem funding increases to accreditation; the delivery of particular services; the conduct of in-service training; and/or the hiring of particular staff. This special program funding model prompted ONHA president Mel Rhinelander to remark that “[o]n their own, these initiatives may not seem significant. However, the radically new method of special program funding provides us with unlimited possibilities for seeking support for new services.”<sup>48</sup> Indeed, these initiatives signalled the province’s future intentions to initiate targeted funding schemes tied to initiatives or homes’ compliance.

In summary, during this period the Ministry of Health began regulating commercial providers of long-term care. Although some nonprofit and municipal homes began to provide “nursing home” levels of care, the period was defined for the most part by the continued separation of nursing homes that provided more complex and medically oriented care from homes for the aged that provided custodial care. It was also marked by the adoption of increasingly sophisticated regulatory tools to control the behaviour of the homes. Nonetheless, municipal and nonprofit homes that provided custodial and nursing home care were entitled to access more public funds. This funding parity issue would partly define the next period.

***Ministerial Consolidation, Funding Parity, and Containment (1993–2007)*** The ONHA’s main goal of funding parity was realized seven years later with the 1993 passage of *Bill 101*. Homes for the aged were brought under the Ministry of Health funding formula; the formula was tied to a classification system based on the complexity of residents’ needs in a given home compared to an averaged Case Mix Index; and funding parity was established between all nursing homes and homes for the aged. In addition, *Bill 101* eliminated the extended care funding, initially dispensed with minimum staffing requirements, and introduced a new envelope system



that standardized provincial funding of for-profit nursing homes with that for nonprofit and municipal homes for the aged. The envelopes for nursing and personal care included care staff and supplies. The envelopes for program and support services included therapy, pastoral care, recreation, and volunteer coordination; and the envelope for accommodation included raw food, housekeeping, laundry, dietary, administration, and building upkeep and maintenance. The model was roundly criticized by homes for the aged because it replaced public and nonprofit homes' global funding with a constrained envelope model that favoured managing well only by following rules.

During this same period of time, the original Canada-US Free Trade Agreement was renegotiated to include Mexico as a signatory in a new North American Free Trade Agreement (1994). Long-term care was included explicitly in the agreement's terms. This cemented the commercial model in long-term care because it was contained as a substantive clause. This means that it was not subject to the provincial Annex 1 reservations signed in 1996 that exempted social services from the terms of the agreement.

After the introduction of the envelope model, the ONHA lobbied government to adopt interim measures to add more funding. The first, and perhaps most important, interim measure was level-of-care funding. Starting in 1994, the Ministry of Health and Long-Term Care seconded specially trained nurses to conduct chart reviews of all 57,000 residents in long-term care in order to establish a home's Case Mix Measure (CMM) based on the Alberta Resident Classification System. The CMM of all homes were grouped to create a Case Mix Index. The government used this to establish a baseline average value of "100." If a home scored higher or lower than 100, it was funded at a higher or lower level as a reflection of the needs of its resident population. Historically, nursing homes had cared for "heavier care" residents, so this tool increased nursing homes' funding immediately. Eventually, its use would help the Ministry to shift the orientation of the whole sector towards higher medical acuity. Although the Case Mix Index was supposed to determine the amount of nursing and personal care funding destined for a given facility, advocacy by health care unions ensured that the government maintained a 2.25 hour minimum staffing standard and delayed the implementation of level-of-care funding until a 1996 election shifted power to

the Progressive Conservative party. After the election, minimum staffing requirements were eliminated in facilities across Ontario, freeing homes to alter staffing ratios. A second interim measure was a system of red circling that ensured that municipal homes' funding would not drop immediately in 1993, but would be maintained until the whole sector came on par with municipal homes' funding levels. This system was also eliminated in 1996 under the Conservative government, but a "high wage transition fund" was established between 1996 and 1999 to aid all facilities that paid higher than average wages. A third interim measure was related to the government's funding of 90 percent of the previous year's business and realty taxes. Because nursing home operators that had purchased, rebuilt, or refinanced homes faced insolvency, the government established an \$11 million debt servicing fund in 1993. It remained operational until 2002. To fund these measures, the government started to claw back half of the income generated by facilities' preferred accommodation funding beginning in 1993.<sup>49</sup> The ONHA argued that the for-profit sector's credibility was enhanced with an "equitable funding system in place" and the elimination of profit-taking in the nursing and personal care envelope. In theory, the new special program funding focus meant that facilities could start new programs to enhance quality of life.

Like previous governments, the Harris Conservatives sought to put their own stamp on long-term care. In May 1998, they announced an investment of \$1.2 billion for home care and long-term care facilities. This was to be used, in part, to create 20,000 new long-term care beds across the province by 2006, and to upgrade an additional 16,000 existing beds in about 102 of the structurally noncompliant facilities. To start, guaranteed increases were promised for the nursing and program envelopes. What was not clear at the time was that this capital investment amount would balloon to \$1.5 billion by 2003 and that the capital costs would come out of annual Ministerial operating funds for the coming two decades. In the process of expanding the sector, historical capital funding privileges for municipal homes were eliminated. Prior to 1998, municipal homes could access 50 percent capital grants from the provincial government. For-profit homes had been excluded from this program. Once the tenders were announced, two thirds of the new beds were allotted to the for-profits, with Extendicare,

Leisureworld, and CPL REIT building 39.5% of them. Capital costs of the building spree were funded publicly. New or refurbished beds were subject to an extra \$10.35 per bed per day subsidy from the provincial government to cover capital costs for 20 years, after which time homes remain the capital assets of the organizations. This increased funding to \$75,555 per bed over 20 years in order to offset capital construction costs for newly built or retrofit facilities.<sup>50</sup> The newly built homes were much larger and had more beds. In addition, the balance of shared and private accommodation shifted; operators were allowed to designate as much as 60 percent of these new beds as private accommodation for which residents had to pay an extra daily accommodation fee to the organization. The Harris government agreed to increase the copayments paid for preferred accommodations by 15 percent by 2005, and to waive the clawback on preferred accommodation funding, thus returning potential profits/surplus back to operators. This amounted to a complete reversal of earlier approaches.

In summary, the shifts during this period represent a fundamental departure from the past. The role of long-term residential care was cemented firmly in the medical care system, along with the shift to a case mix formula for funding that rewarded the care of more medically complex individuals. The hegemony of the commercial sector was solidified when funding parity with homes for the aged was implemented and a measure of complexity already supported by the large for-profits was adopted. Debt servicing of for-profit operators was established. Finally, the capital infrastructure privilege to municipal homes was not only eliminated, but shifted in favour of chain providers.

### ***Regulatory Parity, Austerity, and Commercialization (2007–Present)***

With the rapid building expansion concluding, the government shifted its focus. To match its previous efforts related to funding parity, the province enacted regulatory and compliance parity between commercial, nonprofit, and public providers by merging three legislative Acts. It also implemented a form of austerity because costly, newly built, and renovated publicly funded beds were not staffed sufficiently. Finally, it adopted an unbalanced growth strategy that served to further the sector's commercial consolidation.

Regulatory parity was achieved with three policy initiatives. The passage of the *Long-Term Care Homes Act* (2007) in 2010 initiated regulatory parity and followed the provincial path pursued in 1993 when funding parity was established. Three separate pieces of legislation were amalgamated: the *Nursing Homes Act*, *Homes for the Aged and Rest Homes Act*, and *Charitable Institutions Act*. The new Act created the same legislative framework of more than 300 regulations. The province also mandated the use of the Minimum Data Set (MDS) 2.0. Canadian version tied to the Resource Utilization Group (RUG-III) for reporting and funding. Use of the former Alberta Resident Classification System had not sufficiently prepared homes for the new system. Homes complained that the new system was more time-consuming, more medically focused, and less usable for day-to-day operations.<sup>51</sup> Many homes had difficulty once funding was tied to MDS after 2012 and experienced a decline in their funding. In addition, a new Compliance Transformation Project—begun in 2008 and completed in 2012—reframed the inspection process, such that a home “may have had very few or no unmet standards, now has some Written Notifications along with actions/sanctions based on the severity, scope and licensee’s past history of compliance.”<sup>52</sup> The province also erected publicly available reporting in conjunction with its stricter compliance inspection process. Taken together, these changes altered the regulatory complexity of the long-term care landscape significantly.

The climate of public sector austerity in Ontario was different in long-term care than in other sectors because capital funding increased by 80 percent to \$3.83 billion in 2013/2014, from a total amount of \$2.12 billion in the year 2003/04,<sup>53</sup> but much of it was used to renovate old facilities and build new ones. Because this capital funding will continue to show up yearly for the next 20 years, the increases have masked sector cutbacks, such as insufficient growth in funding for staffing. Furthermore, critics argue that insufficient operating funding does not address staffing shortages, which increase the likelihood of violence from aggressive residents.<sup>54</sup> Since 2003, the Ministry of Health and Long-term Care has expanded by 2,500 the number of full-time personal support worker (PSW) positions and by 900 the number of full-time nursing positions in long-term care homes.<sup>55</sup>

However, with 20,000 new beds added and new reporting and compliance procedures in place, new staffing amounts to little more than one PSW per eight residents on one shift per 24 hours. In addition, it is not clear whether those hired were front-line care workers or administrative staff members with clinical training to aid organizations to meet new regulatory and compliance criteria. Critics have cited the lack of a mandated minimum care standard in the legislation as the main outstanding issue. The 2007 legislation failed to re-establish a minimum standard that had been eliminated by the Harris Conservatives. A 2008 independent review<sup>56</sup> documented Ontario's staffing standards at levels much lower than what experts recommend.<sup>57, 58</sup>

Many have argued that the sector was highly fragmented. For instance, one chain provider noted in its annual report that "Leisureworld has significant opportunities for acquisitions in the fragmented LTC [long-term care] industry. With the regulatory burden becoming more onerous for smaller industry participants, larger companies with scale are positioned for continued growth."<sup>59</sup> In other words, small, independent providers were most at risk of closing or contracting out management functions. Their inability to reap economy-of-scale gains from bulk purchasing or from sharing back-office functions to aid adherence to reporting and data management requirements could explain closures and consolidation.

Data were triangulated among the Ontario Ministry of Health and Long-Term Care provider list, association directories, newspaper reports, and web searches to analyze the concentration of long-term care players current to 2013. When ownership (the licensee) and a home's management were grouped, there were 16 major delivery and seven major management chains; 16 smaller chains that operate two or three homes; and three single-home management firms that split a home's ownership from its management. These firms totalled almost half of the homes operating in the province. As Table 4 shows, in 1989 when there were 519 homes and 58,119 beds, the for-profit chain controlled 264 homes (50.1%) and 24,542 beds, or four in ten (42.2%) beds.<sup>60</sup> As Table 5 shows, by 2013, 123 more homes and just over 20,000 more publicly funded beds (total = 78,210) were added to the sector. For-profit companies directly owned 285 homes—fewer than half of

**Table 5. Distribution and Proportion of Ontario Long-Term Care Home and Beds by Ownership and Management.**

	Owned Homes						Managed Homes		
Ownership Type	# Homes	% Total Homes	# Beds	% Total Beds	# Beds For-Profit Chain Managed by Location	Distribution of For-Profit Chain-Managed Beds by Location of Ownership	% For-Profit Chain-Managed Beds by Location of Ownership		
For-Profit Chain	285	44.3%	34,480	44.1%					
For-Profit Independent	360	56.0%	41,353	52.9%	5,660	58.0%	13.7%		
	75	11.7%	6873	8.8%					
Nonprofit	101	15.7%	12,022	15.4%	2,636	27.0%	21.9%		
Charitable	51	7.9%	7,207	9.2%	699	7.2%	9.2%		
Nonprofit Hospital	13	2.0%	758	1.0%	265	2.7%	35.0%		
Municipal	103	16.0%	16,535	21.1%	498	5.1%	3.0%		
ELDCAP	15	2.3%	335	0.4%	0	0%	0		
Total	643	100.0%	78,210	100%	9,758	100%	100%		

Analysis of Ministry of Health and Long-Term Care provider list, association directories, and newspaper and web searches.

Ontario homes (44.3%)—and 34,480 beds (44.1%) equal to the same four in ten beds. Nonprofit and charitable homes together owned fewer than one quarter of the homes (15.9% and 7.9% respectively); 16 percent were publicly owned by municipal homes, which tended to be larger and operated just over one fifth of beds (21%). What alters the balance, and was perhaps most surprising, was the number of nonprofit and public beds managed by for-profit companies. More than three in ten (31.1%) residents lived in a nonprofit or charitable home that was managed by a for-profit chain. Almost four in ten residents in hospital long-term care beds were managed by a for-profit chain. Furthermore, more than one in ten lived in a for-profit independent facility with contracted-out management. Almost 10,000 more beds (12.5% of total beds) were managed by a for-profit chain, and almost half of these beds were in nonprofit or publicly owned facilities, and more than half of the beds (56.6%) in the sector were owned and/or operated by

for-profit companies. For-profit ownership or management of beds has grown by 80.3% between 1989 and 2013.

As in other countries, for-profit companies have adopted merger, acquisition, management, and takeover plans.<sup>61, 62</sup> Also similar to other countries is the way that for-profit companies are organized: according to geographic specialization; functional line specialization; parent/subsidiary relationships; the separation of home's ownership and management into two or more companies; and contracted-out management and partnerships. There are four discernible types of for-profit companies operating in Ontario. There are private, "family-run" chains that often began as a for-profit independent. A second type, the investor-focused firm, claims access to solid, stable, guaranteed income and guaranteed demand in long-term care. Often, these investor-focused firms have outsourced day-to-day management to a third type of chain that operates as a management firm, either part of the large delivery chains or as separate management chains; both types tout administrative and managerial expertise to confront the growing regulatory complexity. Finally, the bulk of the homes are large public, for-profit companies promoting their experience, access to best practices, and the ability to be efficient and effective.

In sum, nearly six in ten (45,338) older adults in the province resided in beds owned or managed by a for-profit chain. Thus for-profit companies owned about four of every eight beds (44.3%) and managed an additional one in eight beds (12.5%) owned by a for-profit independent, non-profit, or public facility. With expansion of the number of beds and facilities, and the increased regulatory pressures, there has been considerable consolidation and concentration favouring for-profit companies in the sector. Analysis of the ownership and management patterns in the sector provided little support for a highly fragmented sector; instead, it pointed to the continued predominance of the for-profit chain in the ownership of delivery and a significant shoring up of control within a top tier of chain firms. The patterns in Ontario seem to follow those of other countries with highly developed commercial provision of long-term care. The contracting out of nonprofit and municipal homes in Ontario to management by for-profit companies has been underexplored.

**Discussion and Conclusions** In a comparison of Canada's provincial health care systems, the delivery and management of long-term residential care in Ontario is perhaps the most commercialized area, with the possible exception of pharmaceutical manufacturing. Why is this the case? When viewed in historical context, it is clear that a commercial logic governed the development of the sector almost from the beginning of the postwar period. Past and current actions by provincial and municipal governments have resulted in few commitments to promote nonprofit or public organizations compared with for-profit organizations, in spite of stated aims. For instance, this commercial logic persists today despite what is written in the preamble to the current *Long-Term Care Homes Act* 2007: "[t]he people of Ontario and their Government...[a]re committed to the promotion of the delivery of long-term care home services by not-for-profit organizations."

Table 6 summarizes the key macro and meso trends and regulations. In the period prior to 1966—before the province enacted the *Ontario Nursing Homes Act*—the logic followed a pattern of commercial proliferation, with many for-profit operators opening small homes. This growing commercial logic was fuelled by for-profits' progressively more coordinated efforts lobbying the state for funding increases, for regulatory and funding parity between for-profit and non-profit homes, and for quantitative measurement in line with new public management goals. The shift to a medical orientation and the elimination of historical funding privilege to non-profit and public institutions in 1993 further solidified this trend. Macro level policy such as the NAFTA further supported the commercial orientation of Ontario's long-term care sector. Finally, complex regulatory, reporting, and management tools that have been enacted to ensure minimum quality standards have consolidated homes and opened up a new commercial arena in the form of management. With services located in private for-profit and nonprofit organizations, state-based demands for greater efficiency, quantitative accountability, and lean production techniques have increased demands on provider organizations that are funded with public money.<sup>63</sup> The health sector has adopted numerous new public management tools and approaches. Starting in the 1980s, governments flirted with and implemented competitive quasimarkets in health care, often referred to as "internal markets."<sup>64</sup>



**Table 6. Summary of Key Historical Junctures in the Development of Long-Term Care in Ontario.**

Time Periods and Political/Economic Trends	Provincial Trend	Key Regulations	Ontario Political Party in Power
1940s–1965 Shift to Keynesianism	<ul style="list-style-type: none"> <li>• Proliferation of for-profit independents</li> </ul>	None	Progressive Conservative (1943–1985)
1966–1990 From Keynesianism to neoliberalism	<ul style="list-style-type: none"> <li>• Introduction of provincial regulation</li> <li>• Expansion of public funding</li> </ul>	<i>Ontario Nursing Homes Act</i> (1966) <i>Federal Medical Care Act</i> (1966) Ontario Extended Care Funding (1972) <i>Canada Health Act</i> (1984) Canada-US Free Trade Agreement (1989)	Progressive Conservative (until 1985) Liberal (1985–1990)
1990–2006 Neoliberalism	<ul style="list-style-type: none"> <li>• Centralization in Ministry of Health and Long-Term Care</li> <li>• Funding parity between non-profits / public / for-profits</li> <li>• Introduction of case mix index system to fund on basis of medical complexity</li> </ul>	<i>The Long-Term Care Act</i> (1973) Long-Term Care Statute Law Amendment Act– (Bill 101) (1993) North American Free Trade Agreement (1994)	New Democratic Party (1990–1995) Progressive Conservatives (1995–2003) Liberals (2003–present)
2007–present Neoliberalism	<ul style="list-style-type: none"> <li>• Austerity</li> <li>• Regulatory Rigidity</li> <li>• Consolidation</li> </ul>	Ontario <i>Long-Term Care Homes Act, 2007</i> (passed in 2010)	Liberals (2003–present)

Quantitative tools for measuring accountability have proliferated, including the adoption of the MDS assessment tool in long-term care.

The central argument of this article is that with more onerous reporting requirements and a commercialization logic, smaller independent homes (both for-profit, public, and nonprofit ownership) face closure or outsourcing of their management. The logic has favoured consolidation of ownership and management within large, corporate, for-profit companies. Why is this important? In a review of Canadian and American research evidence, Margaret McGregor and Lisa Ronald found that for-profit facilities are “likely to produce inferior outcomes” when compared with public and nonprofit alternatives.<sup>65</sup> This finding is similar to that of other studies that have found quality differences by ownership. However, the underlying assumption in research that accounts for ownership and quality in long-term care is that public and nonprofits differ from commercial firms in their orientation and approach. The interesting point of tension revealed by this research is that the majority of homes in Ontario are for-profit

companies, with an increasing number of beds managed by for-profit companies, even when the facility is owned by a non-profit, charitable, or public home. What does it mean to be a non-profit or public home if a for-profit is managing the operations? This question raises important tensions to be addressed by researchers, especially as it affects study design, and by policy-makers in terms of discerning how to measure and implement quality programs that are publicly funded but privately delivered. Indeed, increased public reporting of quality data is an option taken in other jurisdictions, such as the United States, but with self-reported data there are limits to data reliability, as shown in the differences between the self-reported survey data (Tables 1 to 3) and the Ministry-reported data (Tables 4 and 5).

Early on in Ontario, most long-term care providers were small, independent for-profits. Over time, for-profit nursing homes began to deliver more medical services that were considered a substitute for hospital convalescence; contemporaneous public and non-profit organizations delivered custodial long-term care oriented largely around social care, food, and shelter for poor older adults. Accompanying the growth of the commercial sector were cautionary tales about for-profit delivery,<sup>66</sup> a growing body of research that questioned the compatibility of profit and care,<sup>67, 68, 69,70</sup> and government attitudes preferring either public or nonprofit delivery. But because the province was slow to regulate and even slower to participate in service delivery, it supported third-party delivery by private, for-profit, and nonprofit organizations, and created only limited public municipal options. Over time, nonprofits and municipalities began to deliver the same levels of hospital convalescence care as nursing homes. But only nonprofits and municipalities were regulated to provide custodial care, thus maintaining some boundaries between for-profits and nonprofits. The hegemony of commercial providers began in the postwar period and continues to the present. Regulation of the long-term care sector intensified following criticisms about care standards, coinciding with governments that wanted to “steer and not row”<sup>71</sup> with the advent of new public management. By the 1990s, the province had legislated long-term care out of the custodial/social care realm. It shifted responsibility away from the Ministry of Community and Social Services and consolidated it within the medical continuum of care

in the newly created Ministry of Health and Long-Term Care. The new regulatory regime resemble what Walshe refers to as deterrence regulation that is “formal, legalistic, punitive and sanction-oriented.”<sup>72</sup> The weight of deterrence-oriented legislation has contributed to the number of nonprofit and municipal homes either outsourcing management or closing. The cautionary tale is that if the sector is to remain balanced, states must understand the consequences of their role as either compliance- or deterrence-oriented regulators, as well as how maintaining public ownership of homes is important; why nonprofit and public delivery produces better quality indicators; and whether there are consequences to the outsourcing of management functions.

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