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What does it cost to care?

Improving wages and staffing levels in Ontario's long-term care facilities

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Introduction

The COVID-19 pandemic has made the holes in our social safety net and the failures in our social infrastructure painfully obvious. A horrific example of these failures is the impact of the pandemic in long-term care (LTC) homes. Residents in LTC facilities account for 16% of all cases, and 64% of all deaths in Ontario.[1]

The policy failures in Ontario's LTC system did not start with this pandemic. Two pivotal policy decisions of successive Ontario governments set the stage for this tragedy. The first is underfunding that has resulted in insufficient and inadequate care for residents. The second is increased for-profit LTC home ownership and service delivery.

This paper considers only the former. It provides a cost estimate for adequately funded caregiving in Ontario long-term care homes. As Pat Armstrong eloquently states, the conditions of work are the conditions of care.[2] A fairly remunerated workforce with adequate staffing levels is a crucial first step toward a quality LTC system in Ontario.

Context

In 2018-19, at $4.3 billion, the LTC program accounted for 7% of Ontario health spending.[3]

Ontario is the province with the largest share of LTC homes that are owned and operated by for-profit corporations. These corporations account for 62% of LTC homes, while 17% of facilities are publicly owned (municipal) homes, and the remaining 21% are not-for-profit homes run by charitable organizations.[4]

In the current pandemic, within long-term care, for-profit homes account for 16 of the 20 worst COVID-19 outbreaks in the province. Residents in Ontario's for-profit LTC homes are four times more likely to contract COVID-19 and die than those in publicly owned municipal homes.[5]

The most potent factor shaping the quality of care in LTC facilities is staffing levels. Public (municipal) and not-for-profit homes typically have more hours of care per resident per day than for-profit homes. In a study of Ontario's LTC sector from 1996 to 2011, for-profit homes had the lowest staffing levels (about 2.63 hours of direct care per resident per day). By contrast, municipal homes had the highest levels of staffing (3.5 hours), followed by independent not-for-profit homes (3.2 hours).[6]

Low staffing levels endanger both residents and workers. A 2019 report on personal support workers (PSWs) by the Ontario Health Coalition described the impact on care of understaffing. These impacts included rushed care, skipped baths, and other adverse outcomes. PSWs reported too-long shifts, juggling two or more part-time jobs, low wages and inadequate benefits, a punitive work culture, and high rates of injury and violence.[7]

Precarious working conditions and staffing shortages not only result in inferior care, they also take a physical toll on LTC workers. Research suggest that nearly 90% of LTC workers in Ontario have experienced physical violence in their workplace.[8] They experience higher absences due to illness and injury than workers in other occupations.[9]

The workforce in this inadequately remunerated and dangerous work environment is overwhelmingly female, disproportionately racialized, and immigrant. In 2016, the average earnings of workers in that industry were $38,000 or 75% of the $51,100 average wage across all industries.[10] Eighty-six per cent of the workforce in these facilities was female. Racialized women made up 25% of the workers in long-term care, almost double their share of the workforce in Ontario. And while immigrant women made up 15% of the total workforce, they accounted for 29% of the workforce in LTC.[11]

There has been no shortage of reports and inquiries into LTC in Ontario. And, while they differ in their conclusions, they have been consistent in confirming that the LTC system in Ontario is failing its residents by failing its workers. In 2003, the SARS Commission stated that protecting LTC residents was contingent on keeping workers from getting sick.[12] A report from the National Advisory Committee on SARS and Public Health stated that hourly pay and lack of sick leave and benefits meant that workers were more likely to work while sick and reliance on part-time workers meant reduced awareness of infection control protocols.[13]

The 2008 Sharkey Report, a government-commissioned review of staffing and care levels in LTC, confirmed that Ontario's staffing levels were much lower than standards recommended by experts.[14] The 2019 public inquiry into the safety of LTC residents that resulted from the murders committed by Elizabeth Wettlaufer recommended adequate staffing levels, increased numbers of RNs and RPNs, and a reduction of temporary agency nurses.[15]

Funding care in Ontario LTC facilities

The vast majority (87%) of provincial LTC homes' funding flows through a daily subsidy called the level of care (LOC) per diem payment. The table below shows the distribution of these different components of funding for Ontario LTC homes. Fully 50% of the funding is for nursing and personal care. This funding is directed toward hands-on personal care for residents.

Ontario's funding for LTC homes is not contingent on meeting specific staffing standards. The only legislated LTC requirement is "to meet the assessed needs of residents" and a minimum requirement of one registered nurse (RN) on duty at all times. There is no legislated minimum staff-to-patient ratio, and no legislated minimum amount of care that residents are required to be provided on a daily basis.[16]

The Ontario government makes very limited information public on how much care LTC residents receive. The most recent estimate of the average hours of care per resident per day in Ontario's LTC facilities is 2.71 hours.[17] The quality of care — as a function of staffing levels — has, in fact, been declining since 2006.[18]

There has been widespread advocacy to increase care to 4.1 per hours of nursing and personal care per resident per day, based on a mix of care between registered and non-registered staff. Some expert opinion recommends a larger increase to 4.6 hours per day. [19]

TABLE 1 LTC Funding 2018-19

Category	$ Millions	%
Nursing and Personal Care	2,919	50
Program and Support Services	279	5
Raw Food	268	5
Basic Accommodation	1,595	27
Total LOC Per Diem	**5,062**	**87**
Supplementary Funding Programs	764	13
Total Cost of Long-Term Care Homes Program	**5,826**	**100**
Less: Resident Co-payments	-1,537	
Net Cost to Province of Long-Term Care Homes Program	4,289	

Source Financial Accountability Office, Provinical spending on long term care.

Estimates

The most detailed Statistics Canada Labour Force Survey data for long-term care is found under North American Industry Classification System code 623, Nursing and Residential Care Facilities. This code covers: nursing care facilities; residential developmental handicap, mental health and substance abuse facilities; community care facilities for the elderly; and other residential care facilities. This industry group is used as a proxy for LTC in this paper.

Table 2 describes the labour force providing direct care in Ontario's LTC homes. They include RNs, RPNs, and a category that is nurse aides, orderlies and patient service associates, more commonly referred to as personal support workers (PSWs) in Ontario.

In 2019, PSWs accounted for 73% of those employed. RNs accounted for just over 16% of those employed. RPNs accounted for 11% of employment and of hours worked. Other staff including housekeeping, laundry and dietary workers make important contributions to the quality of life and quality of care for LTC residents, but are not included in this funding envelope or in this analysis.[20]

These workers in LTC have very high union density ranging from 61% for RNs to 87% for RPNs. The gaps between average hourly earnings for unionized and non-unionized workers are: 3.9% for RNs, 10.9% for RPNs, and 7.9% for PSWs.

Using the forecasts from the Ontario Financial Accountability Office (FAO) as a baseline for spending, we estimated what it would cost to increase care

TABLE 2 Direct care labour force in LTC homes, 2019

	Employment (000s)	Share of direct care workers %	Union density (%)*	Distribution of total hours worked (%)
RNs	14.4	16.2	61.1	16
RPNs	9.6	10.8	86.5	10
Nurse aides, orderlies & patient service associates	64.8	73.0	71.3	74

Average hourly wages 2019 ($s)	Union	Non-union	Difference	
			$s	%
RNs	30.62	29.46	1.16	3.9
RPNs**	26.31	23.72	2.59	10.9
Nurse aides, orderlies and patient service associates	22.01	20.39	1.62	7.9

Source Statistics Canada, Labour Force Survey, custom tabulation.
* Share of workers covered by a collective agreement. ** Wage rate for non-union RPNs are authors' calculations.

TABLE 3 Costs of increased care work in LTC ($millions)

	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
FAO forecast Nursing and Personal Care	2,900	2,900	3,000	3,200	3,400	3,600
Increase in spending to increase hours of care to 4.1	1,504	1,504	1,556	1,659	1,763	1,867
Equalize wages to union average	275	275	285	304	323	342
Total increase in spending	1,779	1,779	1,840	1,963	2,086	2,208
Increase as a share of net cost of LTC	41%	40%	41%	40%	41%	39%
Increase as a share of total health budget*	3.1%	2.9%	2.9%			
Increase as share of total program spending*	1.2%	1.2%	1.1%			

Source FAO Long term care estimates, Ontario March Economic Update, Statistics Canada Labour Force Survey Special Tabulations, and authors' calculations.

provided in LTC facilities from its current estimated level of 2.71 to 4.1 hours of care per resident over the period 2020-21 to 2023-24. We then estimated what it would cost to increase wage rates in this sector to the unionized average. Using Statistic Canada data on the gap between unionized and non-unionized wage rates, and the shares of hours worked by non-unionized workers, we estimated the additional wage costs for this larger complement of workers.

Table 3 shows that it would cost about $1.8 billion to increase care levels and equalize wage rates across the sector in this fiscal year. The vast majority, $1.6 billion of that increased spending, would go toward hiring more staff or increasing hours of work in order to increase the hours of care available to residents; the remaining $285 million would go to wage equalization.

These increases would account for a sizable share of LTC funding, about 40%. However, they would account for about 3% of total health spending by the provincial government, and just over 1% of overall program spending. Estimates for 2018-19 and 2019-20 are included as a measure of the scale of spending as the Ontario government has not provided forecasts beyond 2020-21.

Limitations

The paucity of data made available by the Ontario government on LTC home staffing and care provision limits these estimates. The estimates are further limited because the available Statistics Canada data includes a broader range of facilities than LTC homes. While the literature also argues for changing the mix of care by different care providers, given data limitations, we did not estimate the costs of those changes. Further, these estimates do not include the costs of benefits that unionized workers have including: sick leave, pensions and health benefits.

Conclusion

The impact of the COVID-19 pandemic in LTC homes in Ontario has been horrific: illnesses, death, neglect, and lonely deaths without loved ones. Many of these tragic results can be directly related to the failures of successive governments to appropriately regulate and fund long-term care in this province.

The size of the costs of improving this situation are an indicator of how big the problem is, and how long governments have neglected to address it.

While increasing funding for caring work is a necessary step, it will not be sufficient. The proliferation of for-profit providers will also need to be addressed. We will consider that in a future paper.

Notes

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