OFFICE OF THE
SENIORS ADVOCATE
BRITISH COLUMBIA

Billions More Reasons to Care

Contracted Long-Term Care-Funding Review Update

September 25, 2023

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MESSAGE FROM THE SENIORS ADVOCATE

How money is spent in long-term care directly impacts the quality of life for people who live there. Residents and their families have told us what they value. Staff to provide care, comfort and engagement, having food and mealtimes that are enjoyable, ensuring a life of dignity where autonomy is respected and family relationships valued, these are the things that bring joy to the lives of people who call long-term care home. In all cases, the ability to provide these is linked to the resources directed to support them.

In early 2020, my office released *A Billion Reasons to Care*, a report that analyzed the spending of both for-profit and not-for-profit long-term care facilities contracted by the regional health authorities to provide publicly subsidized long-term care to over 20,000 seniors in 2017/18. The report identified several issues that were of concern to my office given their potential to impact quality of care. We found significant differences between care facilities in the funding allocated to direct care, the number of funded care hours provided, the wages and benefits paid to care staff and the amount spent on capital building costs. There were different financial reporting systems in each of the health authorities and an overall lack of clarity, transparency, and public reporting. Within these overall concerns, the report found differing patterns of spending depending on whether a care facility was operated by a for-profit company or a not-for-profit society.

Shortly after the report was released, British Columbia, like the rest of the world, was consumed with the COVID-19 pandemic. Among the many challenges presented by the pandemic, issues in long-term care, at least initially, were at the forefront. There were many lessons learned during the pandemic – some the result of personal tragedies. These lessons have helped create changes in long-term care that we hope will create lasting benefits. In addition to pandemic related changes, there has been work undertaken by the provincial government to address some of the issues raised in our previous report. Together, these factors led my office to determine it is timely to review new data and measure our progress to date.

This report, *Billions More Reasons to Care,* analyzes revenues and expenditures in long-term care today and compares them to five years ago. It is important to recognize much has happened over this time span including: significant funding increases to boost staffing levels; wage levelling within each job classification to ensure staff are paid the same wage; development of a standard provincial financial reporting template; and the new Health Care Career Access Program which has successfully recruited and trained thousands of new care aides.

While there have clearly been efforts over the past five years to improve long-term care in B.C., our review found the initiatives undertaken have not yet produced the measurable progress we would hope to see, as most of the underlying issues identified in our previous report remain. Unfortunately, these unresolved issues are making it difficult for long-term care to fully benefit from the significant investments the Province has made. There is work underway to try and align funding with an outcome of quality care, but it is unclear when this work will conclude and if it will be sufficient to deliver the results needed.

The importance of reforming the publicly subsidized long-term care funding model cannot be overstated. This review shows that while we may be achieving excellence in some care homes, we are not achieving it in all. We still have much work ahead of us to ensure that all residents in long-term care in B.C. enjoy the same high level of support to help them enjoy the best quality of life possible.

As always, these reports reflect the work of many people both within the Office of the Seniors Advocate and beyond. In addition to the staff here at the OSA, I would like to thank the staff at the Ministry of Health and the regional health authorities for providing us with needed information and data confirmation. I would also like to thank contracted care home facilities for providing the detailed financial records that form the basis for this report.

Sincerely,

Isobel Mackenzie
Seniors Advocate
Province of British Columbia

EXECUTIVE SUMMARY

A Billion Reasons to Care was released by the Office of the Seniors Advocate in 2020. It reviewed contracts, audited financial statements and expense reports for long-term care facilities contracted by regional health authorities to provide publicly subsidized long-term care in 2017/18. The review highlighted deficiencies with the long-term care funding and financial reporting systems and outlined opportunities for improvement. This updated report, *Billions More Reasons to Care,* analyzes revenues and expenditures in contracted long-term care facilities for 2021/22, compares them to previous results and highlights changes over the past five years.

British Columbians have seen many changes over the past five years within long-term care and in the aging population. In addition to the many tragedies from the COVID-19 pandemic, significant new investments have been made in publicly subsidized long-term care in the past five years for measures related to staffing, training, and infection control. This review seeks to measure the impact of these events by determining to what degree care facilities are directing revenues to enhancing the quality of life for residents and how that has changed.

This review examined 181 contracted facilities representing 93% of all contracted sites and found revenues and expenditures have universally increased with distinct patterns of spending, depending on whether a facility was operated by a for-profit company or a not-for-profit society.

Highlights of the review include:

- $1.89 billion in revenue and expenses were generated in 2021/22, a 35% increase over 5 years.
- Increases were not uniform across all expenditures, over the past 5 years there was:
    - 33% increase in direct care costs;
    - 33% increase in non-direct care staff compensation;
    - 18% increase in capital building costs;
    - 61% increase in the cost of supplies/administration/other; and a
    - 113% increase in profit.
- Not-for-profit facilities spent 25% more per resident on direct care than for-profit.
- For-profit facilities spent 42% more per bed on capital building costs.
- 74% of all facilities generated a profit in 2021/22, an increase from 68% five years ago.
- 80% of total profit is concentrated in 20% of the facilities, 82% of which are for-profit
- Not-for-profit facilities delivered 93,000 hours more care than they were funded to deliver, while for-profit facilities delivered 500,000 less hours than they were funded to deliver.

Variation in accounting and reporting processes identified in the 2020 report were also found in this review and funding decisions are still based on the different health authority financial reporting forms. However, in response to the previous review, the Province has developed a standard financial reporting form that all care facilities will be required to complete and submit provincially. It is expected that all care facilities will be fully compliant, and data will be available within the next two years.

This report provides the following recommendations to improve quality of care and transparency in financial reporting in the contracted long-term care sector in B.C.

1. **Funding for direct care must be spent on direct care.**

Financial incentives are needed to ensure the money facilities receive for direct care is spent on providing direct care. If additional revenue is needed to fund other operational costs, it should not be shifted from direct care.

2. **Improve accuracy and transparency of monitoring and reporting for compliance with publicly funded care hours.**

The current self-reporting of care hours is vulnerable to inaccuracies. Multi-skilled workers, who provide both direct care and indirect care (i.e., a care aide who also provides food services or housekeeping) could be counted as direct care hours. The current reporting system tells us how many people the facility has classified as direct care staff, how much they were paid and how many hours they worked. There is not a similar level of detail for non-direct care staffing and the system cannot accurately capture if there is a shifting of direct care staff to non-direct care jobs.

3. **Define profit.**

There is currently no standardized approach to determining what is counted as profit. The degree to which mortgages, head office allocations, management fees, subcontracting to a related company, executive compensation and financing of other businesses is providing facilities with additional net revenue is not known. A greater understanding of the details of these expenses is required to begin to address the issue of what expenditures will be allowed, what are reasonable and equitable building costs and what is a reasonable profit.

4. **Make revenues and expenditures for publicly subsidized care homes available to the public.**

The public is entitled to know how their money is spent. Residents and their families are entitled to access information about revenues, expenditures and delivered care hours for their facility.

INTRODUCTION

Long-term care, sometimes referred to as facility care or nursing home care, is a model of housing that provides people with cognitive and/or physical challenges a place to live with 24-hour on-site care. Long-term care is subject to provincial regulatory oversight through either the *Community Care and Assisted Living Act* or the *Hospital Act*. In B.C., 95% of people living in long-term care are seniors aged 65 or older.

A long-term care facility, sometimes referred to as a 'care home', can be owned and operated by the regional health authority, a not-for-profit society or a for-profit company. An individual can choose to pay privately for the total cost of their long-term care, or they can be assessed by the health authority and if long-term care is required, they will be eligible for placement in a facility that offers publicly subsidized long-term care. Private-pay long-term care can be provided in a facility that also offers publicly subsidized care or in a facility where all residents pay privately for the total cost of their long-term care.

Currently, residents of publicly subsidized long-term care are charged 80% of their net income to a maximum of $3,847 per month. For this fee, residents are provided all meals, prescription medications, necessary medical equipment, nursing care, physiotherapy, occupational therapy, recreational therapy and varying degrees of social programs and transportation. Residents who pay privately for the total cost of their long-term care are charged monthly rates that can range from approximately $6,000 to over $20,000 depending on the facility and the level of care provided.

A snapshot of long-term care in B.C. in 2021/22:

- There are 294 publicly subsidized long-term care facilities with 27,702 publicly subsidized beds and 1,492 co-located private-pay beds;
- 8,925 of the publicly subsidized beds are in facilities owned by a health authority, 9,162 in not-for-profit facilities and 9,615 in for-profit facilities;
- The average age of a long-term care resident is 83, with 53% of residents 85 years of age or older;
- The average length of stay is 851 days, and the median is 496 days;
- The average waiting time for a publicly subsidized long-term care bed is 178 days;
- Over 90% of all long-term care beds in British Columbia are located in facilities that offer publicly subsidized beds and over 80% of publicly subsidized beds are in single rooms;
- There are an estimated 2,000 private-pay beds located in facilities with no publicly subsidized beds.

The total annual average cost for a subsidized long-term care bed is $100,855, consisting of an estimated average resident co-pay of $24,132 and an estimated average health authority subsidy of $76,723[1].

A Billion Reasons to Care was released by the Office of the Seniors Advocate in February 2020. The purpose of the report was to analyze the extent to which the contracted long-term care sector was providing quality care for residents and effective use of public money. To achieve this, our office analyzed the 2017/18 financial reporting records for 174 contracted long-term care facilities in British Columbia. Overall, the report found that contracted long-term care facilities collected $1.4 billion in revenue predominately from health authorities and resident co-payments.

Expenditures were placed in five categories and the review found that:

- 53% was spent on direct care;
- 19% on non-direct care;
- 10% on supplies/administration/other;
- 15% on buildings/properties; and
- 3% for profit/surplus.

The review found significant variation between care homes on:

- total revenue and expenditure per resident;
- the proportion of revenue directed to expenditures such as staffing, building costs and profit;
- wages and benefits paid to staff; and
- the number of care hours delivered relative to the number of care hours that were funded.

The review highlighted differences in expenditures based on whether a facility was operated by a for-profit company or a not-for-profit society. The review found that, on average:

- Not-for-profit care facilities spent 24% more per resident on direct care;
- For-profit care homes spent 155% more of total revenues on building/property costs;
- Not-for-profit facilities delivered more care hours than they were funded to deliver, and for-profit care facilities delivered fewer care hours than they were funded to deliver; and
- For-profit facilities generated 12 times more in surplus/profit than not-for-profit facilities.

The review highlighted the different reporting templates used by each health authority, the different approaches to what was an allowable expenditure, and a lack of clarity and detail of expenditures for items such as management fees and head office allocations.

The report issued five recommendations:

1. Ensure funding for direct care is spent on direct care;
2. Increase accuracy of monitoring for compliance with funded care hours;
3. Standardize the definition of what is considered profit;
4. Standardize financial reporting for all publicly funded care homes in B.C.; and
5. Make public the revenues and expenditures of each funded care home.

The complete 2020 report can be found on the Office of the Seniors Advocate website or through this link.

THE CURRENT LANDSCAPE

Over the past five years, 674 net new beds have been added to publicly subsidized long-term care in B.C., a 2% increase. Overall, the number of sites and beds operated by health authorities have decreased, while the number operated by for-profit companies and not-for-profit societies have increased. The number of private-pay beds has increased in the not-for-profit sector and decreased in the for-profit sector. In the case of the latter, this is a result of converting private-pay beds to publicly subsidized beds.

Publicly Subsidized Long-Term Care (LTC) Homes and Beds by Ownership, 2017/18 to 2021/22

Fiscal Year	2017/18	2018/19	2019/20	2020/21	2021/22	% Change in 5 Years
Total Publicly Subsidized LTC Sites	296	297	296	297	294	-1%
Health Authority Operated	112	112	109	109	109	-3%
Not-For-Profit	83	83	82	84	82	-1%
For-Profit	101	102	105	104	103	2%
Total Publicly Subsidized LTC Beds	27,028	27,214	27,506	27,931	27,702	2%
Health Authority Operated	8,969	8,962	8,919	8,945	8,925	0%
Not-For-Profit	8,766	8,776	8,952	9,192	9,162	5%
For-Profit	9,293	9,476	9,635	9,794	9,615	3%
Total Private Pay LTC Beds	1,527	1,421	1,552	1,499	1,492	-2%
Health Authority Operated	-	-	1	-	-	0%
Not-For-Profit	189	183	165	234	215	14%
For-Profit	1,338	1,238	1,386	1,265	1,277	-5%
Total LTC Beds	28,555	28,635	29,058	29,430	29,194	2%

Overall, 69% of publicly subsidized long-term care beds are contracted with the private sector (both for-profit companies and not-for-profit societies). For-profit companies operate 55% of sites and 54% of the beds in contracted long-term care. This is similar to five years ago, and ownership trends across health authorities have remain unchanged:

- In Interior Health, 49% of funded facilities are health authority operated and 51% contracted (of these 78% are for-profit and 22% are not-for-profit);
- In Fraser health, 19% are health authority operated and 81% are contracted (of these 51% for-profit and 49% not-for-profit);
- In Vancouver Coastal, 29% are health authority operated and 71% are contracted (of these 35% for-profit and 65% not-for-profit); and
- In Island Health, 29% are health authority operated, and 71% are contracted (of these 50% for-profit and 50% not-for-profit).

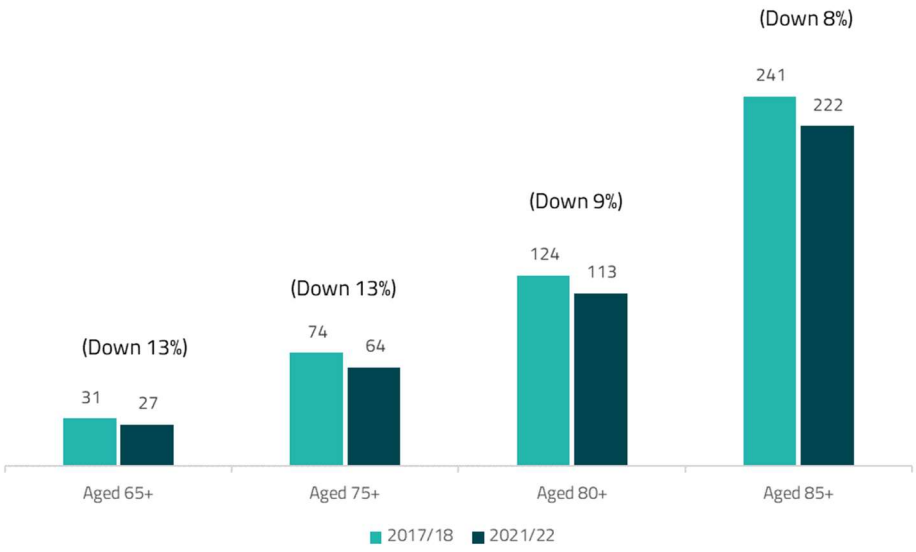
Trends in Long-Term Care

To measure the capacity of the long-term care system to meet demand, the BC Ministry of Health has traditionally measured the number of beds per 1,000 of the population aged 75 and older. Using this metric, B.C. has seen a 13% decrease in the rate of long-term care beds in the last five years. If we look at the target population as people aged 85 and older, which may be a better metric for the current seniors

population, there has been an 8% decrease in the number of long-term care beds over the last five years.

This lack of growth in long-term care beds is reflected in both the number of seniors on the waiting list and the amount of time they are waiting before a publicly subsidized long-term care bed becomes available. While there is great variation by health authority, overall, there were 3,430 people on the waiting list for a long-term care bed on March 31, 2022 – a 149% increase over the number of seniors waiting on this date five years ago. A senior is spending an average of 196 days on the waiting list before placement – a 48% increase from five years ago.

Rate of Long-Term Care Beds per 1,000 Population (65+, 75+, 80+, 85+), 2017/18 and 2021/22



Long-Term Care Funding in B.C.

Each year, the Ministry of Health funds the five regional health authorities to deliver long-term care services. To determine the level of funding, the ministry reviews prior year base funding and adjusts for population, demographics and inflation using a Population Needs-Based Funding Model[2] and adds any additional funding required to support specific operational needs. For long-term care, specific operational needs include funding for increased direct care hours, COVID-19 related expenses and collective agreement wage increases. In 2021/22, the total amount spent by health authorities on long-term care was $2.87 billion, a 45% increase in the last five years[3]. Of this amount, $1.9 billion, or 65% of all spending for long-term care, was contracted to the private sector (for-profit and not-for-profit); this is one of the largest annual transfers of public funds to the private sector across government.

It is the health authority, not the Ministry of Health, that decides who provides long-term care services and how much they will be paid. Each contracted care facility negotiates with the health authority on the funding that is required for that facility to deliver basic long-term care services in the coming year which is funded from a combination of health authority base funding and the resident co-payment. For ease of comparison and reporting, the funding is expressed as a 'per diem'. This takes the total amount of funding required and divides it by the number of beds over 365 days. Facilities generate additional revenue through private-pay beds, room rentals, fee paying programs and additional funding from the health authority for non-recurring expenses.

The actual per diem (all revenue sources and all beds) ranges from $205.29 to $276.32 with an average of $237.71, a 35% increase over the last five years while the base per diem (base funding and resident co-payment over publicly subsidized beds only) currently averages $231.57, a 23% increase over the past five years. Both rates exceed the 15% rate of inflation over the same time.

The range of per diems reflects several operational factors unique to any one facility, however it also reflects the lack of a provincial standardized model for long-term care facility funding. This issue was identified in a 2017 review by the ministry that found health authorities use different methods for assigning funds to care facilities, differences in how these funds are monitored and implemented, and a lack of clarity with site operating costs. The ministry's review recommended options be explored to move towards a provincewide standard funding model. These recommendations were echoed in 2020's *A Billion Reasons to Care* where the same lack of consistency and clarity on long-term care funding was identified by our office.

The ministry has committed to developing a new standardized provincial funding model for long-term care that will align funding with a provincial quality framework and address many challenges including:

- Lack of financial transparency and inconsistent funding approaches;
- Lack of a standard provincial funding methodology or contract model;
- Per diems paid to operators not consistently related to actual costs;
- Significant differences in the accounting of capital building and other costs;
- Significant variation in the per-resident spending by operator type;
- Lack of standardized monitoring, data definitions and collection; and
- Challenges with existing human resource capacity for oversight.

The ministry states the primary objective of a new model is to optimize the allocation of available funds to operators and improve oversight and accountability. Historically, there are significant variations in funding requirements between health authority operated, for-profit, and not-for-profit organizations, even though all are funded to deliver the same services. The new funding model aims to:

- improve equity;
- support consistency of care for residents; and
- increase transparency and predictability for residents, operators, decision makers and stakeholders.

It is currently unclear when the new funding model will be implemented and if the model will sufficiently address the issues raised by both the Office of the Seniors Advocate and the 2017 ministry review.

Accountability: How is Funding Monitored

Health authorities require financial reporting from each contracted facility operator on a quarterly or semi-annual basis. These reports detail the operating revenue and expenditures, including staffing levels, and they can provide meaningful information on how a facility is spending the government funds they receive. These reports are prepared and submitted by the facility operator and are not audited by a third party. In addition to quarterly or semi-annual financial reporting, most care facilities provide the health authority with annual financial statements that are independently audited. The audited financial statements are of limited value as they are often for a company with several facilities or lines of business and they lack details on staffing, care hours and funding sources, which are important elements of transparency and accountability.

Each health authority has a unique financial reporting template with differences in the detail of financial information required. In our 2020 review, the Office of the Seniors Advocate highlighted these differences including the treatment of capital building costs and details for large expenditures such as management fees, head office allocations and administrative costs. These issues remain unresolved in the current health authority accounting. There is a new provincial reporting template that has been developed to address some, but not all, of these issues. It is expected that over the next two years, the transition from health authority-based financial reporting to provincial-based financial reporting will be complete.

2021/22 Funding Review

This review analyzes current financial reporting templates used in four regional health authorities that contract long-term care services: Fraser Health, Vancouver Coastal Health, Interior Health and Vancouver Island Health. Consistent with our previous report, Northern Health, with only two contracted sites, has been excluded from this review. In addition, changes to reporting in Interior Health limit our ability to compare the details (although not the total) of their expenditures to both the 2017/18 review and the other health authorities in 2021/22. The report notes where adjustments have been made to reflect this limitation.

This report, as with the previous report, has created four main categories in which all revenue is reported and five categories in which expenditures are reported. What is included in each category has remained constant, however the revenue category of *Other* is where most of the health authority-funded COVID-19 pandemic-specific revenue is recorded.

Facility revenue is reported in four main sources:

- Health authority grant funding
- Resident co-payment
- Private bed fees
- Other

Facility expenditures are reported across five broad categories (or cost centers):

- Direct care staff compensation
- Non-direct care staff compensation
- Building
- Administration/supplies/other
- Profit/surplus

CONTRACTED SECTOR LONG-TERM CARE REVENUE

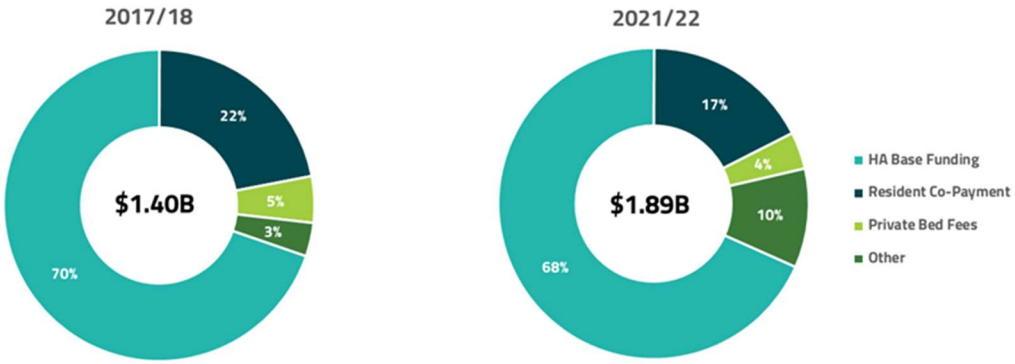
We examined financial reports for 181 contracted facilities from 2017/18 to 2021/22 encompassing 93% of contracted publicly subsidized sites in B.C.

Revenues

Contracted facilities, both for-profit and not-for-profit, reported $1.89 billion in revenue in 2021/22 – a 35% increase over the last five years – with the following breakdown:

- $1.29 billion in health authority base funding, 32% increase over five years;
- $330 million in resident co-payment fees, 7% increase over five years;
- $82 million from private-pay beds, 21% increase over five years; and
- $186 million from other sources, 281% increase over five years.

Overall Contracted Long-Term Care Sector Revenue by Source, 2017/18 and 2021/22



Health Authority Base Funding

Base funding is generally considered to be the basic amount needed to run the facility on a day-to-day basis and does not reflect funding that might be received for one-time expenditures. Not all health authority funding is reflected in base funding; some will also be reflected in '*other revenue'.* Base funding is generally increased to reflect inflationary cost increases including wages, decreases in resident co-payments and increased care hours. Total health authority base funding increased 32% in the last five years. This reflects significant increases to care hours, some pandemic funding (most pandemic related funding is in *other revenue*) and a reduction in resident co-payments.

Of the total health authority base funding in 2021/22, Fraser Health had the largest share (38%), followed by Vancouver Island (23%) and Vancouver Coastal (23%). These proportions have remained relatively unchanged year-over-year and are reflective of the relative number of contracted beds in each health authority.

Resident Co-payment and Private Bed Fees

The Ministry of Health sets a fee for publicly subsidized long-term care. Residents pay 80% of their after-tax income towards the cost of housing and care services subject to a monthly minimum and maximum with rates adjusted each year to reflect inflation. As of January 1, 2023, the minimum/ maximum rate is $1,337 and $3,847 per month respectively.

Some facilities have additional beds that are not funded by the health authority. These are referred to as co-located private beds. For private pay beds, the facility will charge the full cost of the bed. The private pay resident receives the same care services, meals, and recreational supports as publicly subsidized residents.

In 2021/22, facilities reported a 7% increase over five years in resident copayments and a 21%[4] increase in private bed fees. The relatively smaller increase in resident co-payments shifts more of the cost for long-term care to the health authorities who need to compensate through increased base funding.

Other Revenue

The revenue category *other revenue* showed a significant increase in the past five years with a 400% surge reported in 2020/21, the first year of the pandemic. Most health authorities have recorded most pandemic funds in *other revenue* although some has been recorded in base funding.

The pandemic placed significant fiscal pressures on operators because they were required to implement heightened infection control practices, increase staffing, and absorb increased overtime and sick leave. In response, the provincial and federal governments provided additional funding including:

- $25.6 million to address initial costs for screening, infection prevention and control, sick time and self-isolation[5]
- $160 million to hire up to three additional full-time equivalent staff in care homes and assisted living residences for infection prevention and control and support safe visitation[6]
- $32 million over three years for EquipCare BC for health, safety and quality improvement[7]
- $134 million for the Safe Long-term Care initiatives program[8]

One of the major measures taken to address COVID-19 in long-term care was the Single Site Order and Wage Levelling. The public health order limited each employee to work at only one long-term care or assisted living facility to help control the spread of COVID-19. Before the pandemic, direct care staff often worked at multiple sites. To ensure there were sufficient staff at all sites, not just those that paid the best wages, the provincial government mandated temporary wage increases up to the industry standard[9] for staff in long-term care and assisted living and provided facilities with additional money to pay the higher wages. When government announced the wage levelling initiative, it estimated the cost at approximately $10-$15 million per month[10]. The initiative was applied to all public and private long-term care and assisted living operators.

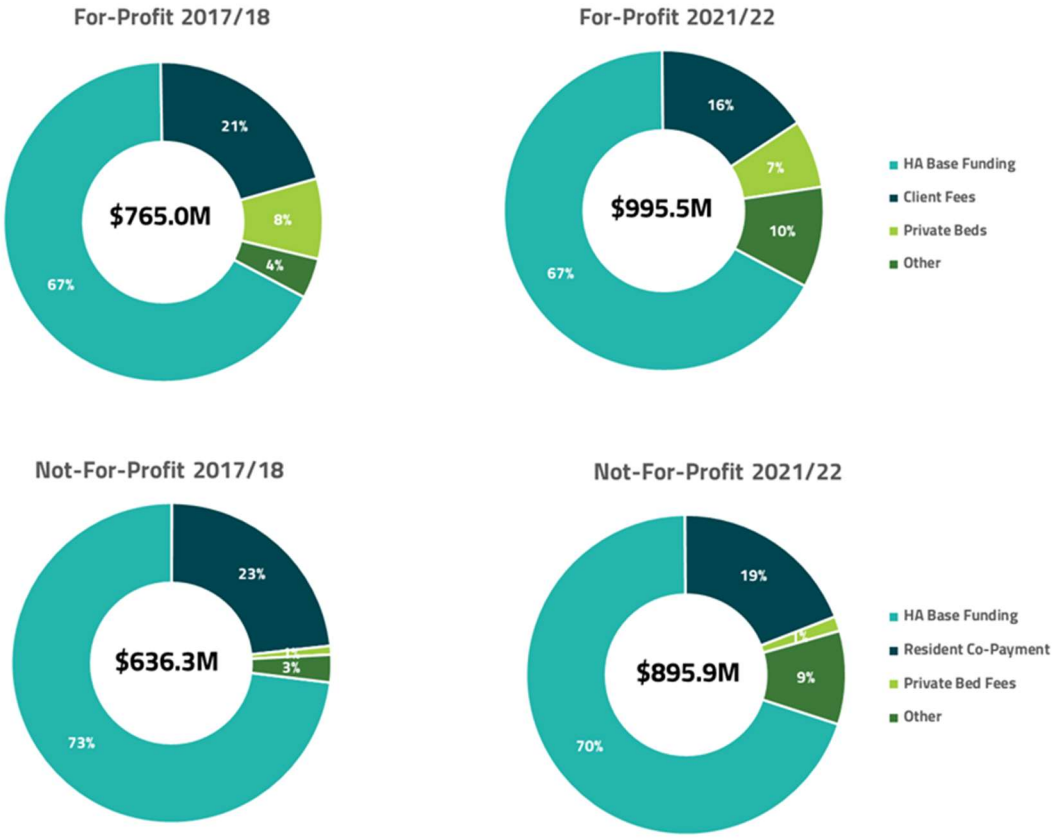
While the single site order has been rescinded, the Province has continued to fund wage increases on a temporary basis through standardized contracts between health authorities and employers in the long-term care and assisted living sector. The Ministry of Health committed to providing these workers with 'levelled up' wages after the pandemic to ensure they receive competitive wages as part of the Province's Health Human Resource Strategy[11].

Total Revenue by Facility Ownership

There is variation in revenue sources between for-profit and not-for-profit facilities which was also observed in 2017/18. Although the for-profit facilities generated four times more in private-pay revenue (as expected given that 85% of the co-located private beds are in the for-profit sector), not-for-profit operators experienced a much higher percentage increase as it doubled private bed revenue with 49 additional co-located private beds over the past five years. The not-for-profit facilities also received proportionately more of *Other* revenue than the for-profit sector.

Overall, the per bed revenue grew by 35% over the past five years with almost no difference between the for-profit and not-for-profit sectors.

Proportion of Revenue by Source and Facility Ownership, 2017/18 and 2021/22

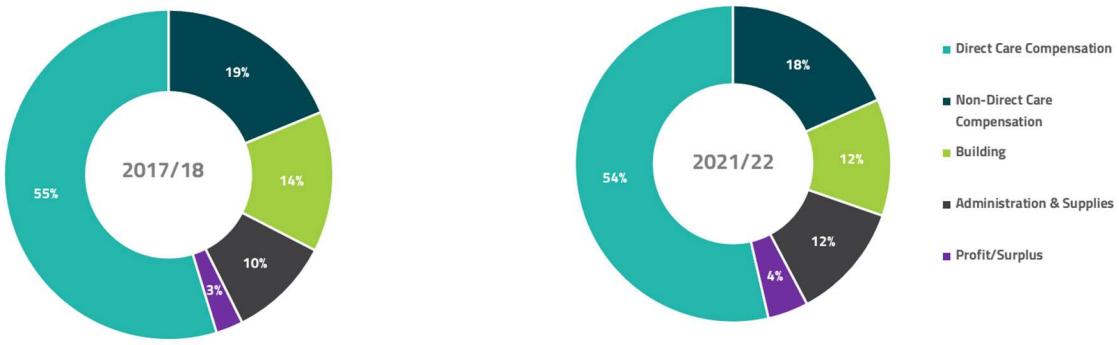


CONTRACTED SECTOR LONG-TERM CARE EXPENDITURES[12]

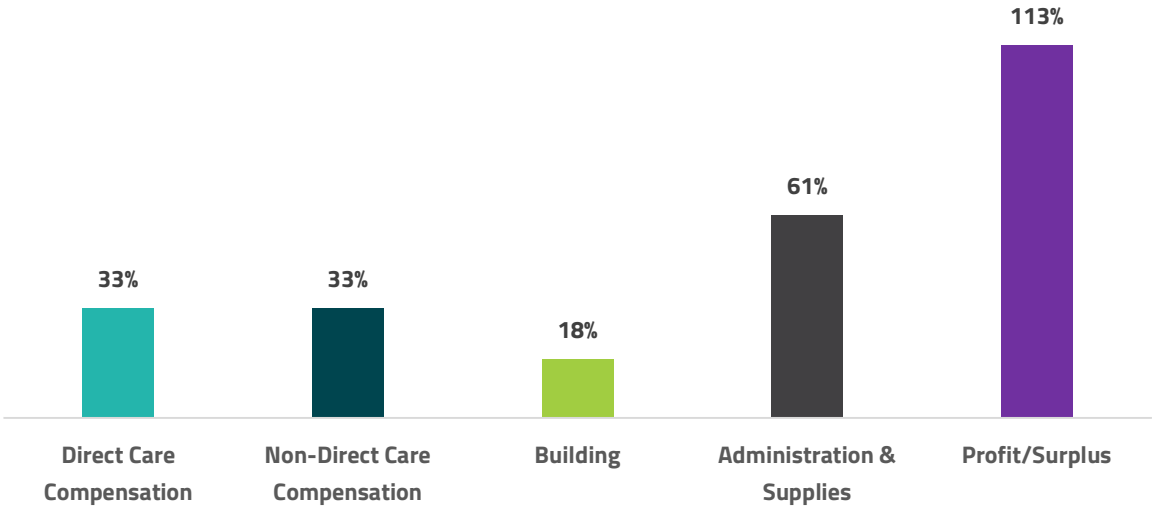
Expenditures have been placed in five categories: direct care, non-direct care compensation, building, supplies/administration/other, and profit/surplus.

Spending grew, on average, 7% per year for an increase of 34% over the last five years. In long-term care, the largest expenditure is labour, at 70% of total spending, followed by building costs (12%) supplies/administration/other (12%) and profit/surplus (4%). While the largest dollar increase in the past five years is in direct care, the largest percentage increase is profit/surplus which grew 113%.

Overall Contracted Long-Term Care Sector Expenditures, 2017/18 and 2021/22



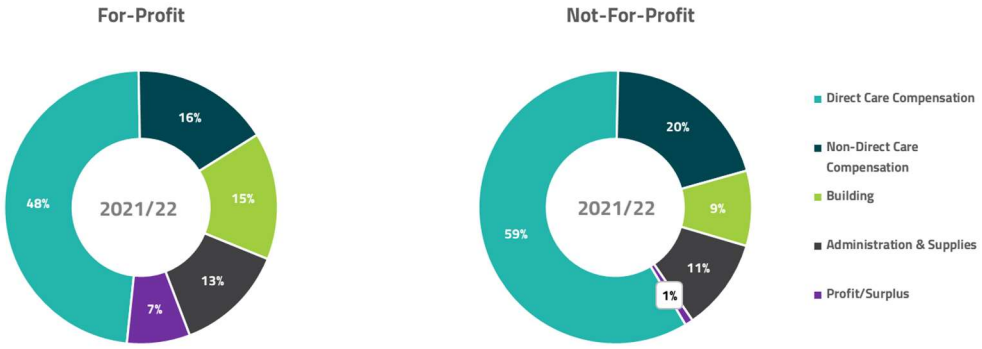
Percentage Increase in Expenditures - Past 5 Years, 2017/18 to 2021/22



Expenditures by Facility Ownership

As we observed five years ago, there are distinct differences in the distribution of expenditures when analyzing for-profit facilities versus not-for-profit facilities. Overall, there is proportionately more spent on direct care and support staff in the not-for-profit sites and more spent on building and profit/surplus in the for-profit sites.

Expenditures by Facility Ownership, 2021/22

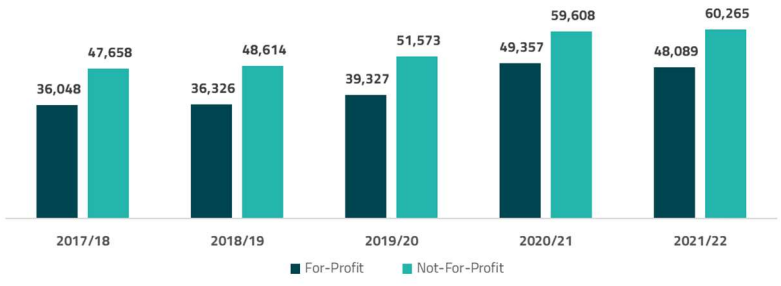


Direct Care Staffing Costs

Direct care staffing costs include nurses, care aides and allied health care workers, such as physical, occupational or recreational therapists, speech language pathologists, social workers and dietitians. It does not include cleaning, food services or administrative staff. The Ministry of Health set a guideline that residents in long-term care facilities should receive, on average, at least 3.36 hours of direct care daily.

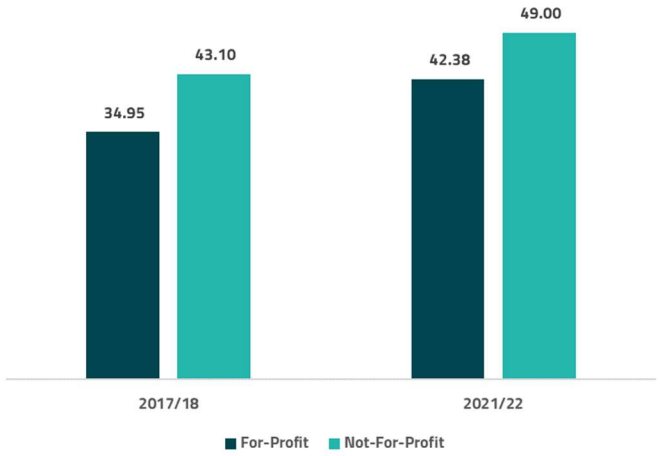
As we observed five years ago, not-for-profit facilities report proportionately higher spending on direct care staffing compared to for-profit facilities. Five years ago, the difference reflected both higher wages and benefits in the not-for-profit sector as well as more care hours delivered relative to the hours funded. In 2021/22, wages were levelled across all sites, and while this closed the gap for wages between for-profit and not-for-profit, a sizable difference in the proportion of revenue allocated to direct care remains. In 2021/22, not-for-profit operators spent 25% more per resident on direct care compared to for-profit facilities. This is relatively unchanged from five years ago.

Total Direct Care Staffing Expenditures per Bed, 2017/18 to 2021/22

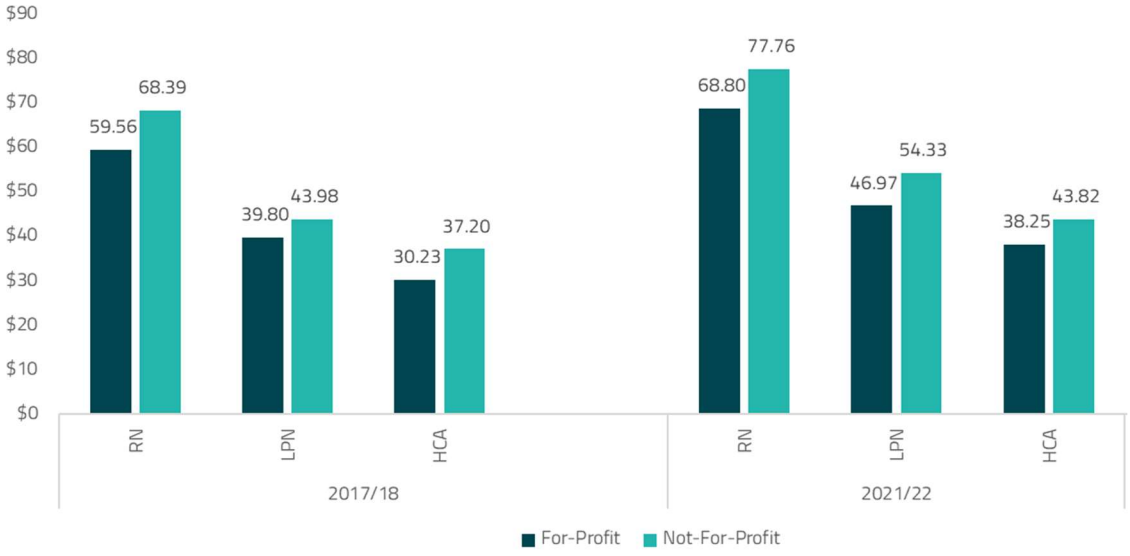


The total cost for staff and the total number of care hours delivered provide a “cost per hour worked”. Wage levelling reduced the difference in cost per hour worked, due to wage differences, but did not eliminate the overall differential. In addition to wages, cost items such as benefits, training and overtime will influence the cost per hour worked. Total cost per hour worked (all direct care staff) rose by 22% in the for-profit sector and 15% in the not-for-profit sector over the last five years. The cost per hour worked in the not-for-profit sector is currently 17% higher than in the for-profit sector, similar to five years ago.

Consolidated Cost Per Hour Worked, 2017/18 and 2021/22



Cost Per Hour Worked by Classification, 2017/18 and 2021/22

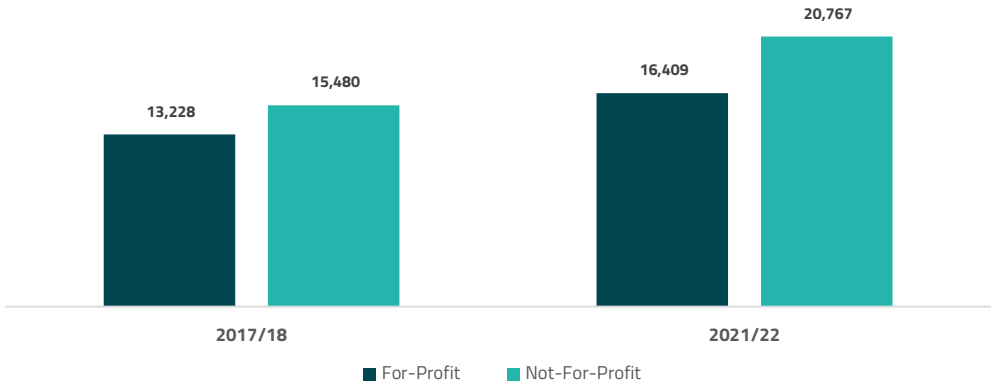


Non-Direct Care Staffing Compensation

This expense category reports the wages and benefits for staff who provide non-direct care services such as food services, housekeeping/laundry, maintenance (i.e., maintaining the building and grounds) and resident care administration. The resident care administration staffing costs include general management, resident care management, support management (i.e., human resources, finance, department managers) and administrative support.

Details for these labour costs are not as precise as direct care, however many of the staff in this category would have received wage levelling and some of the non-clinical staffing increases required to support visitations and enhanced infection control during the pandemic would be captured in this category. Overall, this category experienced a 33% increase over the past five years with higher increases in not-for profit facilities who experienced a 42% increase in non-direct staffing compensation over the past five years.

Non-Direct Care Compensation per Bed, 2017/18 and 2021/22



Building Expenses

Building expenses reported by contractors can include mortgage costs (principal and interest) depreciation, amortization, replacement reserves, leasing costs and capital expenses for building operations and maintenance[13]. Overall, contractors reported an 18% increase in building costs over the last five years. As we saw five years ago, there remains a measurable difference between the for-profit and not-for-profit sectors in the amount allocated for building expenses. For-profit operators spent 15% of their revenue while not-for-profit operators spent 9% of the total expenditures on building expenses. Overall, for-profit facilities spent 66% more per bed on building costs than not-for-profit facilities in 2021/22.

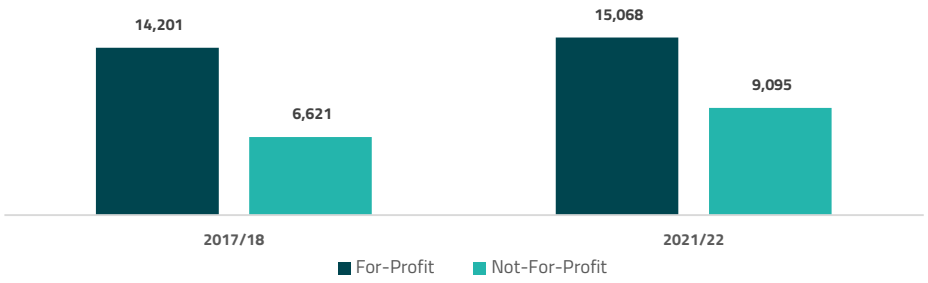
Building expense is the area with the most variation between health authorities. The range of allowable expenses related to capital costs include:

- Some health authorities allow amortization, depreciation and replacement reserves as an operating expense, while some health authorities do not require contractors to report depreciation/amortization;
- One health authority allows only for-profit operators to expense depreciation, but it is not allowed as an expense in not-for-profit facilities; and
- One health authority allows mortgage principal and interest to be reported together as an operating expense.

Overall, there continues to be no standardized approach to determining the market value of the building and/or allowing a standardized rate of capitalization. The funding and reporting system continues to allow facilities to effectively determine the value of their building by flowing through mortgage costs (principal and interest) and/or depreciation.

Ultimately, differences in the accounting of building and capital expenses (including non-operating expenses) impact how each health authority calculates and monitors the projected surplus/loss for each operator. Similar to five years ago, this review found that not-for-profit facilities were not equitably treated in terms of allowable building expenses and funding to address building capital.

Building Expenses Per Bed, 2017/18 and 2021/22



Administration/Supplies/Other

This expense category reports the expenses related to administration, medical supplies, drugs, food, housekeeping, laundry supplies and other sundry items. This expenditure increased 43% over the last five years with the not-for-profit facilities experiencing a higher rate of increase than for-profit facilities. The increase is assumed to be largely attributed to increased spending on supplies during the pandemic.

Supplies/Other Expenditures	2017/18	2021/22	% Change in 5 Years
For-Profit	$81.60M	$112.89M	38%
Not-For-Profit	$62.34M	$92.41M	48%

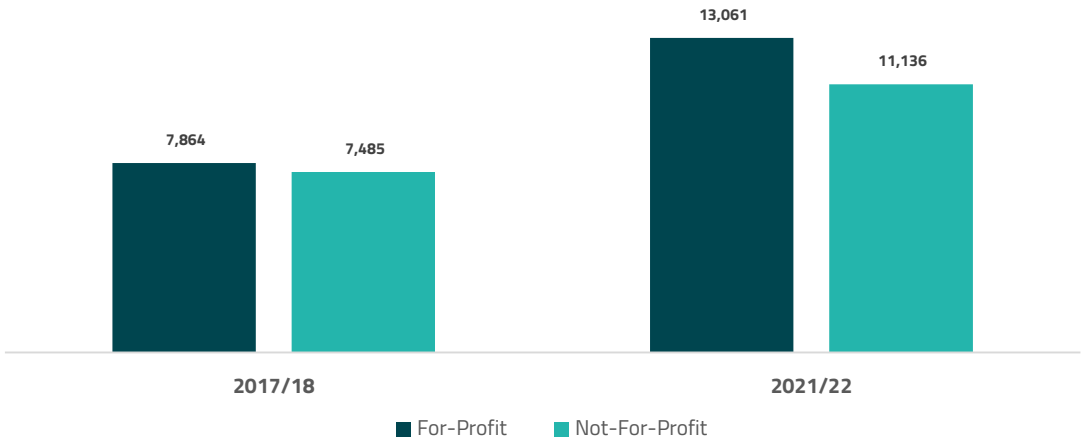
This is also the category where some administrative costs are captured, although how this is captured is not universal across health authorities or between facilities within the same health authority. For example, while most health authorities account for nursing administration under non-direct care staffing costs, others report it under general administration. In some cases, management staff of non-direct care services, such as food services, housekeeping/laundry, or human resources, are reported under general administration while others allocate them to their respective departments.

Costs related to management and/or head office fees are largely found in for-profit sites. Many for-profit facilities are part of larger corporate chains and pay a monthly fee to the parent company. Most health authorities allow operators to report a lump-sum amount for these fees, but with no details as to what these expenses are intended to cover. Some reporting templates itemize these fees separately, while others are reported together with administrative fees.

Two health authorities, Vancouver Coastal and Fraser Health, specifically reported contractor management fees and/or head office allocation totalling just over $16 million. In Fraser Health, head office allocation fees ranged from $40,000 to $1.68 million. In Vancouver Coastal reported management fees, ranged from $222,000 to $1.21 million. A majority (69%) of contractors reporting these fees are for-profit operators.

Executive compensation and contracts were identified as areas of concern in the last report. Executive compensation is not always clearly represented as owners may pay themselves an administrative salary, which would be reported as an expense, but may also be remunerated via profit sharing. In addition, many services are contracted by operators and there is no requirement for the owners to declare if they have financial interests in the subcontracted services. These services may include, but are not limited to, care services, food, laundry, housekeeping or building maintenance.

Administration/Supplies/Other Expenses Per Bed, 2017/18 and 2021/22

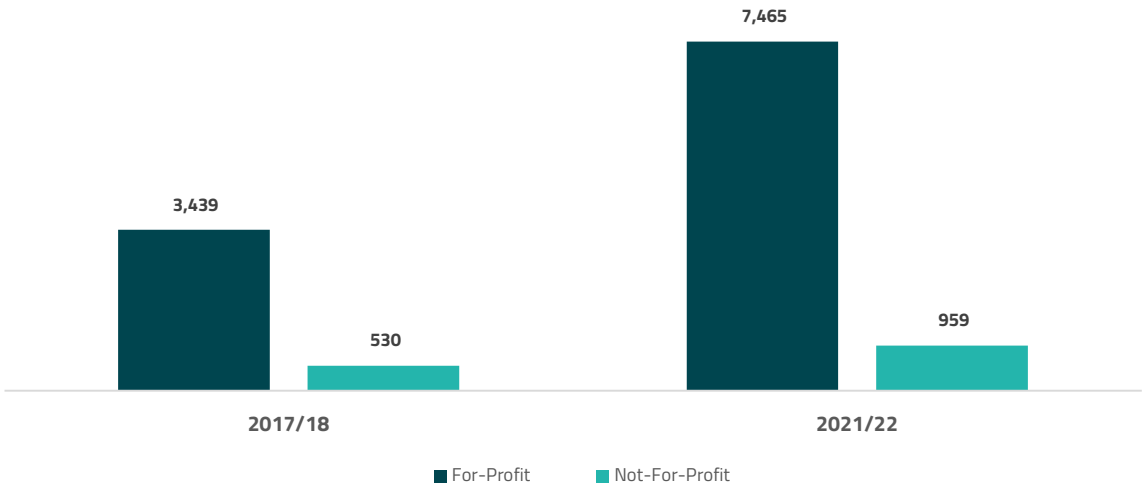


Profit/Loss

Most facilities receive more in revenue than they spend. In not-for-profit facilities, this is referred to as a surplus and in for-profit facilities, it is known as a profit. The profit/surplus is net of all expenses including mortgage costs/depreciation, management fees and head office allocations.

Overall, 74% of facilities earned a profit/surplus in 2021/22, up from five years ago. Of the facilities that made a profit/surplus, 59% were for-profit. As we found five years ago, the amount of profit/surplus was not evenly distributed across facilities or between the not-for-profit and for-profit sectors. Currently, 80% of profit is concentrated in 20% of facilities, most of which are for-profit. Overall, the for-profit sector is generating 7 times more profit/surplus than the non-profit sector.

Profit/Surplus Per Bed, 2017/18 and 2021/22



In our previous report, there were several examples of the relative differences between the not-for-profit and for-profit facilities in terms of the profit/surplus generated and its link between spending on direct care, costs per hour worked for direct staff, funded hours that were delivered, and per diems. Those themes are still relevant. Facilities with higher profits are generally spending less on direct care, not delivering all funded care hours, incurring lower costs per hour worked, expensing high building costs and receiving above average per diems. On the following page is an example of two 40-year-old facilities that were part of this review and illustrates the challenges of our current funding formula.

Comparison of Not-For-Profit and For-Profit Mid-Size Facilities (Average 151 Beds)

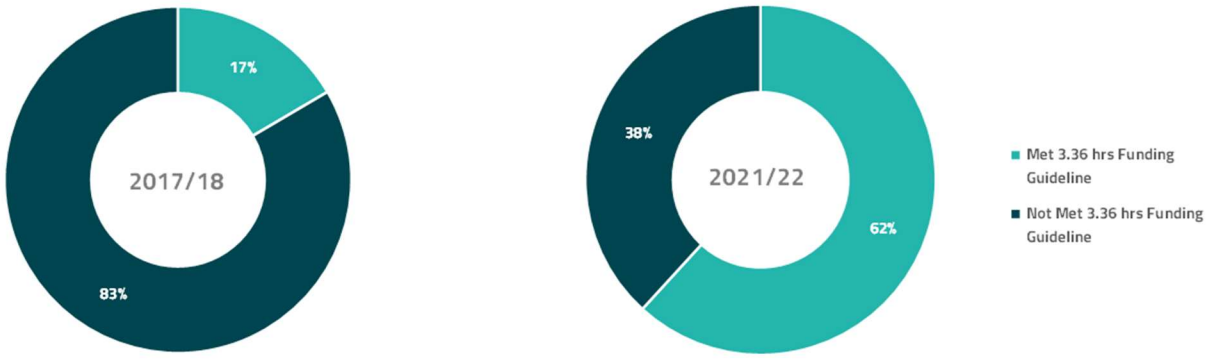
	Care Home A - Not-For-Profit	Care Home B – For-Profit
Total Revenue	$14,979,548	$15,961,192
Staffing Costs		
Direct Care	$7,780,301	$6,412,311
Indirect Care	$2,330,893	$1,559,041
Benefits	$2,738,406	$207,216
Total Staffing Costs	$12,849,600	$8,178,568
Total Staffing Costs per Resident Day	**$228.60**	**$151.40**
Building Expenses		
Mortgage	$295,634	$2,329,309
Property Taxes/Utilities/Waste Management	$294,336	$305,398
Maintenance and Repairs	$492,672	$183,751
Replacement Reserves (Equip. and Furn.)	$296,715	$19,148
CMHC Replacement Reserve	$18,000	-
Total Building Expenses	$1,397,357	$2,837,606
Administrative Expenses		
Administration/office expenses	$253,574	$217,259
Audit/insurance/association dues	$75,724	$102,329
Management fee	-	$342,404
Total Administrative Expenses	$329,298	$661,992
Supplies		
Total Supplies	$975,392	$932,916
Total Expenses	$15,551,647	$12,611,082
Surplus/Loss	**-$572,099**	**$3,350,110**

FUNDED AND DELIVERED DIRECT CARE HOURS

In 2018, the Province announced investments of over $240 million over three years to increase the amount of direct care to 3.36 hours per day that residents receive in publicly subsidized long-term care. Direct care hours include all care provided by registered nurses (RNs), licensed practical nurses (LPNs), health care assistants (HCAs) and professional and non-professional allied health providers (such as physiotherapists).

The OSA monitors and reports on the funded direct care hours in our *Long-Term Care and Assisted Living Directory* for all publicly subsidized care homes in the province. In 2017/18, the average number of funded direct care hours was 3.13 per resident per day. In 2021/22, the average funded direct care hours were 3.39 across the province, with 74% of contracted facilities and 100% of health authority operated facilities meeting the 3.36 funding guideline.[14]

Total Facilities (HA Operated and Contracted) Meeting 3.36 Hours Funding Guideline, 2017/18 and 2021/22

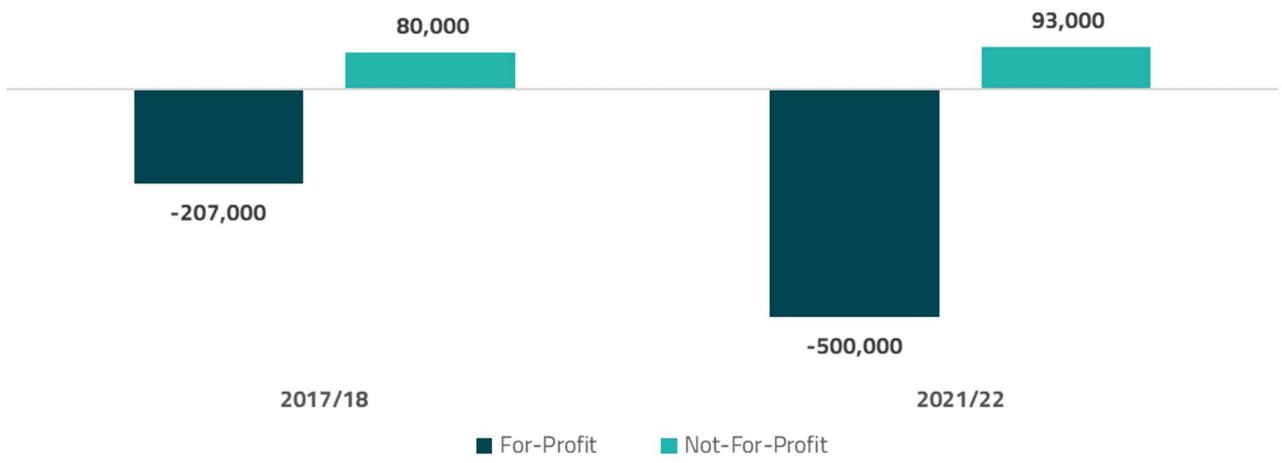


It is important to note that funded hours per day are an average and may not reflect what each resident receives. Funded hours are also a blend of care received from several different health care disciplines (RNs, LPNs, HCAs and Allied Health) and there are no provincial minimum standards for how much care must be delivered by each discipline. There is no legislation that governs detailed staffing requirements in long-term care facilities in B.C., including no requirement to have a registered nurse on site and/or on duty 24/7. For facilities that receive public subsidy, the health authority and the facility develop their own staffing mix and how the hours of direct care are distributed across all direct care disciplines including care aides, licensed practical nurses, registered nurses and allied health.

Operators are funded to deliver direct care hours and each operator reports total worked hours by direct care staff to health authorities. Worked direct care hours are the number of hours delivered to residents by care staff as opposed to the number for which the facility is funded. For example, hours paid for vacation, training, sick or other paid leave are not included in worked hours. One worked hour is considered one hour of direct care.

Currently, 55% of not-for-profit facilities meet or exceed delivery of their funded care hours, while only 38% of for-profit facilities meet or exceed delivery of their funded care hours. In terms of total funded care hours delivered, the review found not-for-profit facilities delivered 93,000 more care hours than they were funded to deliver, and for-profit facilities failed to deliver 500,000 hours of care they were funded to deliver. This compares to 2017/18 when not-for-profit operators delivered 80,000 more hours of care and for-profit operators delivered 207,000 less hours of care than they were funded to deliver.

Comparison: Funded vs Delivered Care Hours in For-Profit vs Not-For-Profit, 2017/18 and 2021/22



CONCLUSIONS AND RECOMMENDATIONS

Over the past five years, British Columbians have seen many changes that have impacted the long-term care sector from both the COVID 19 pandemic and changes in our aging population. Cost pressures are outstripping inflation, our supply of long-term care beds is not keeping pace with current or future demand, and the public is demanding better care for seniors. These are all the reasons why it is crucial to ensure that our $2 billion annual investment in contracted long-term care results in the best possible quality of life for B.C. seniors and good value for the public.

This review demonstrates that our current funding model for the contracted sector is not providing facilities with a financial incentive to provide excellent care or value for the taxpayer. We must accept that for-profit facilities perform differently than not-for-profit facilities, create a funding formula that recognizes this, and ensure that financial incentives align with the objectives of publicly subsidized long-term care – quality care for residents and overall good use of public resources.

The purpose of this review is not to debate the merits of various types of care providers and whether facilities should be operated by health authorities, for-profit companies or not-for-profit societies. The care provided to residents across long-term care homes should be equitable, no matter who is running them. This review highlights that this is not currently the case. The degree to which we observe differences in resources allocated to care, support staff, capital assets and profits speaks directly to the issue of an inequitable system for both residents and facility operators.

The government has taken an important first step in addressing this issue with the introduction of a standardized financial reporting tool. The next step is to ensure it is fully operationalized and then applied to create a standardized funding formula that addresses the inequities and misaligned incentives of the current model. British Columbians both deserve and expect this, and it should be a priority for government given the current cost pressures and demographics.

There were five recommendations in the previous Office of the Seniors Advocate report on long-term care funding. Of these, one has been implemented. The remaining four continue to be necessary if we are to achieve the objectives of high-quality equitable care across all publicly funded care homes. These recommendations are:

1. **Funding for care must be spent on care.**

Financial incentives are needed to ensure the money facilities receive for direct care is spent on providing direct care. If additional revenue is needed to fund other operational costs, it should not be shifted from direct care.

2. **Improve accuracy and transparency of monitoring and reporting for compliance with publicly funded care hours.**

The current self-reporting of care hours is vulnerable to inaccuracies. Multi-skilled workers, who provide both direct care and indirect care (i.e., a care aide who also does provides food services or housekeeping) could be counted as direct care hours. The current reporting system tells us how many people the facility has classified as direct care staff, how much they were paid and how many hours they

worked. There is not a similar level of detail for non-direct care staffing and the system cannot accurately capture if there is a shifting of direct care staff to non-direct care jobs.

3. **Define profit.**

There is currently no standardized approach to determining what is counted as profit. The degree to which mortgages, head office allocations, management fees, subcontracting to a related company, executive compensation and financing of other businesses is providing facilities with additional net revenue is not known. A greater understanding of the details of these expenses is required to begin to address the issue of what expenditures will be allowed, what are reasonable and equitable building costs and what is a reasonable profit.

4. **Make revenues and expenditures for publicly funded care homes available to the public.**

The public is entitled to know how their money is spent. Residents and their families are entitled to access information about funding, expenditures and care hours provided by their facility.

By acting now, we can help ensure British Columbians receive the same high quality long-term care no matter which publicly subsidized long-term care facility they call home.

Appendix 1: Revenue and Expenditures Description

Care Home Revenue	
Health Authority Base Funding	The base funding received by a facility from the health authority is dependent on both the contract negotiated between the two parties and the amount of resident co-payment collected. As the amount of resident co-payment varies depending on the incomes of the current residents, the exact amount will fluctuate over time to ensure the total revenue available to the facility remains the same.
Resident co-payment	Residents contribute up to 80% of their income as monthly fees up to a maximum of $3847.20 per month (2023). Regardless of this rule, every resident must be left with at least $325 per month for incidental expenses meaning that those with very low incomes may pay less than 80% of their income in fees.
Private Beds	Both for-profit and not-for-profit facilities may have private-pay beds co-located with publicly subsidized beds. The residents in these beds share the same care staff and common amenities with residents of publicly subsidized beds, but they pay the full cost of their care directly to the facility.
Other	Facilities have a variety of additional sources of revenue such as fundraising, fees for services such as bathing provided to non-residents and additional charges to residents for services not covered by the basic per diem. This category has increased substantially in the last three years as it now also includes additional funding allocated to the facility for COVID-19 measures, including screening staff and wage levelling.
Care Home Expenditures	
Direct Care Staff Compensation	This category reflects the wages and benefits of all staff who provide direct care to residents including Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Health Care Aides (HCAs) and allied health disciplines such as occupational, physical and speech therapists.
Non-direct Care Staff Compensation	Wages and benefits for non-direct care staff include all staff not listed above such as cleaners, maintenance workers, administrators and those who prepare and serve food.
Administration/ Supplies/Other	This category includes all non-wage administrative expenses including insurance, professional services, in-service education and office expenses. Supplies/Other includes raw food costs, medical supplies, incontinence supplies, drugs/pharmaceutical supplies and all other miscellaneous supplies.
Building	Non-wage building expenses include mortgage payments, rent depreciation/amortization, property taxes, utility fees, maintenance costs and waste management.
Profit/Surplus	The profit/surplus is the amount remaining once all the above expenditures have been deducted from the total revenue.

Note: These are general categories with examples of what type of revenues and expenses are included, but the detailed items in each category may vary by health authority.

Appendix 2: Data Sources

1. Contracted Long-Term Care Quarterly Financial Reporting, Fiscal Years 2018/19 to 2022/23. OSA Data Request to Health Authorities, May/July, 2023.

2. Office of the Seniors Advocate British Columbia Long-Term Care Facilities Directory. Extracted August, 2023.

3. BC Stats Population Extrapolation for Organizational Planning with Less Error (PEOPLE) for British Columbia. BC Ministry of Health. Extracted February, 2023.

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Appendix 4: Endnotes

[1] Calculated using total revenue/total beds.

[2] BC Auditor General. Health Funding Explained 2. [Online] FINAL_HFE2_2.pdf (bcauditor.com). March, 2017.

[3] BC Ministry of Health, Regional Grants and Decision Support

[4] For Vancouver Coastal health authority, calculated using % of private beds/total beds.

[5] BC Ministry of Health. Investments mean safer visits at long-term care, seniors' facilities. News Release [Online] Investments mean safer visits at long-term care, seniors' facilities | BC Gov News. June 30, 2020.

[6] Ibid.

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[8] Health Canada. Government of Canada Invests close to $134 million to Support Canadians Living and Working in Long-Term Care in British Columbia. News Release [Online] Government of Canada Invests close to $134 million to Support Canadians Living and Working in Long-Term Care in British Columbia - Canada.ca. August 13, 2021.

[9] Wage increases gave workers the same hourly wages as their counterparts in the applicable Health Employers Association of British Columbia collective agreement.

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[11] ---. BC's Health Human Resources Strategy: Putting People First. [Online]. BCHealthHumanResourcesStrategy-Sept2022.pdf (gov.bc.ca). September, 2022

[12] Analysis related to Expenditures exclude Interior Health due to changes in their reporting processes. For comparison purposes they are removed from both the 2017/18 and 2021/22 data.

[13] Reserves used to replace or repair what are known as capital items.

[14] Office of the Seniors Advocate. Long-Term Care and Assisted Living Directory 2022. [Online] OSA-LTCAL-Directory-Summary-Report-2022.pdf (seniorsadvocatebc.ca)