ALBERTA UNION OF PROVINCIAL EMPLOYEES

New Continuing Care Legislation

FEBRUARY 19, 2021

Written Submission - New Continuing Care Legislation

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Date of Submission
Friday, February 19, 2021

About AUPE

The Alberta Union of Provincial Employees (AUPE) is pleased to be invited to provide feedback on the Government of Alberta's review of continuing care legislation. AUPE is the largest public sector union in Alberta and represents approximately 95,000 workers across the province in four sectors including: Health care, Education, Government Services, and Agencies, Boards and Commissions.

AUPE represents roughly:

1. 23,000 workers who are direct employees of the Alberta provincial government;
2. 58,000 health care workers at public, private, and not-for-profit health care providers, this includes nursing care employees and the general support services employees of Alberta;
3. 10,000 members in the Education sector who work in support roles at fifteen post-secondary institutions and three school boards across Alberta; and
4. 4,000 members at Boards, Agencies, and Commissions who work for a variety of mostly public sector employers like municipal governments.

Of the 58,000 health care workers, AUPE represents workers in a variety of classifications including those who work directly with and in support of the full continuing care sector: home care, supportive living, designated supportive living and long-term care. These classifications include but not limited to Administrative Support, Therapy Aide, Health Care Aid, Service Worker, Food Services Worker, Cook, Activities Convener, Therapy Assistant, Housekeeping, and Maintenance Worker. They work in a variety of settings across Alberta in both the private sector and the public sector. They provide vital health care and support to many Albertans.

AUPE believes that the Government of Alberta should be focused on providing a strong universal, accessible, public health care system. This must include a publicly funded continuing care system that focuses on the needs of workers and patients. Our short-term and long-term recommendations are grounded in the Government of Canada health care principles of universality, comprehensiveness, accessibility, portability, and public administration and focuses on workers and patient's needs.

Executive Summary

Unfortunately, COVID-19 has placed a glaring spotlight on the challenges in the continuing care system in Canada. The COVID-19 pandemic revealed a confusing labyrinth of the level, quality, and cost of services to both governments and individuals that vary from province to province. There should be a seamless transition for seniors from home care through palliative care in Alberta. Individuals relying on assisted living services or persons with developmental disabilities should be receiving levels of services that are consistent across the province. There are major gaps in care across Canada that have resulted in people not receiving the services they need and deserve. Furthermore, through successive funding cuts to Alberta's health care, a mix of private care and public care services has resulted in financial barriers to services, this means that wealthier individuals receive better care regardless of need.

Provincial governments across Canada have tended to treat continuing care as the responsibility of the individual and an unwanted drain on finances rather than a vital public service. This has created a system that is both chronically underfunded and a target for further budget reductions that invariably reduces the quality of care. This has left the long-term care system unable and unprepared to address pandemics like COVID-19 and larger health care crisis. This has meant that citizens, governments, and patients have had to deal with a global pandemic while also dealing with the crisis in long term care. The overcrowding of patients and residents in single rooms, the lack of adequate numbers of staff, workers forced into precarious and part-time jobs at multiple sites, and the revolving door employment at contracted-out laundry, housekeeping and food preparation providers led directly to the wildfire spread of COVID-19 and the unforgivably high mortality rates among seniors.

Understaffing and the Ideology of Care

High quality care is not simply a matter of receiving sufficient physical and medical care to prevent harm. Seniors, especially those with dementia, confront loneliness, depression, and anxiety from social isolation, dependency, and loss of contact with friends and family. Caregivers, if they are to meet the psychological and social needs of seniors, must have the time and skills to address those needs. Unfortunately, current funding models focus on measurable task completion, allocating funds (and paid time) for feeding, dressing, bathing and other similar tasks. These tasks are necessary for seniors' care, but they are insufficient for real quality care. Quality care requires that staff be given the time and training to interact with seniors and to provide them with understanding, empathy and companionship. Furthermore, it is not just direct care staff who provide this level of support as on-site laundry, food, and housekeeping staff not only develop skills particular to seniors' care, they can also provide important relational care to residents.

In the constant landscape of penny-pinching 'accountabilities' of continuing care in Alberta achieving a high level of service provision will not be possible. Instead, the current system rewards operating with the lowest number of staff and the lowest paid staff. There are studies that estimates the number of hours of care a senior in a nursing home needs on average per day to ensure care needs are being met, which is different than the number needed to provide the emotional and relational care that helps seniors thrive. A standard of 4.1 hours per resident day (HPRD) should be immediately implemented in Long Term Care. Currently Alberta does not meet these standards.

The Disaster of For-Profit Seniors' and Long-term Care

In their search for budgetary 'savings', provincial governments have been turning increasingly to for-profit corporations to provide seniors' and long-term care over recent years. This has happened despite overwhelming evidence that for-profit operators provide inferior care and services. They typically have fewer skilled staff, less staff overall, and have more verified complaints for insufficient care. Despite this, successive Alberta governments, including the current United Conservative Party (UCP) government, have made increased involvement of for-profit operators their 'solution' to the crisis in seniors' and long-term care.

Low-wages, Dangerous Conditions, and Precarious Women's Work

Continuing care workers are extremely underpaid, particularly in comparison with predominantly male jobs that have similar skill and effort requirements. This is partly because continuing care is a highly gendered and racialized workforce and the skills involved relate to women's traditionally unpaid work in the home and are therefore undervalued. The jobs are also increasingly precarious, and employers often exploit their workers by not paying fair wages and benefits. In Alberta, nearly two-thirds work as casuals or part-time. Recruitment to these jobs is focused on immigrant women. Understaffing has increased the risks for injury on the job through rushed and unassisted lifting and from dealing with anxious, responsive patients without adequate support.

What should be done?

A. Short-term

1. Increase wages and benefits of all continuing care workers and ensure they are fairly compensated.
2. Ensure paid sick leave so care workers don't feel pressure to come to work while ill.
3. Ensure all workers have access to proper Personal Protective Equipment.
4. Make full-time work the standard. Maximize full-time positions.
5. Increase hours of care per resident day adjusted for acuity to a minimum of 4.1 HPRD at the highest level. (Administrative hours must not be included in the calculations)
6. Re-examine the current hours of care per resident funding models to ensure that optimal hours of care – not minimal care hours – are funded in all facilities and in-home care. Fund research on optimal, as opposed to minimal care.
7. Ban the practice of charging extra fees for 'hospitality' services.
8. There must be an absolute requirement that all direct care money and any new funds due to the COVID-19 pandemic, be actually spent on direct care – not redirected into other operations such as management salaries or into profit-taking.
9. Call a public inquiry to investigate the outbreak of COVID-19 in Alberta continuing care facilities, with the ability to audit use of special pandemic funds by operators.

B. Long-term

1. Alberta should work with the federal government to create legislation that requires continuing care facilities to operate under the same principles as public health care: public administration, accessibility, comprehensiveness, universality and portability, with public ownership and an equal cost-sharing between the federal government and provinces as added features.
2. Alberta Health Services (AHS) should be building and operating all new continuing care facilities.
3. All existing private facilities should be transitioned into public ownership.
4. An Alberta pharmacare drug plan should be implemented that covers the full cost of all prescription drugs.
5. Provincial standards governing hours of work, wages, benefits, and working conditions should be negotiated into a province-wide collective agreement
6. The government must commit to providing optimal care at all levels of care.
7. The primary assessment of continuing care should be done independently of AHS based upon the advice of each individual's physician or qualified professionals.
8. Staffing ratios and appropriate levels of care and services need to be standardized and enforceable through legislation.

Introduction

AUPE welcomes this review of continuing care in Alberta as we represent 58,000 health care workers and our members work in all aspects of the continuing care continuum from home care, assisted living to long-term care. The horror stories coming out of seniors' and long-term care facilities across Canada during the COVID-19 crisis laid bare the failings of our current continuing care system. The death toll in seniors' care centres is grim. Of the 21,311 Canadians who have died of COVID-19 to February 15, 2021, 71.2 per cent (15,146) were in continuing care facilities.[1] Alberta has reported 1,780 total COVID-19 deaths to February 15, 2021 of which 65.8 per cent (1,171) were in continuing care facilities.

As the pandemic progressed, Canadians received an inside look at continuing care facilities that was heartbreaking. Care homes with 2 and 4 people per room separated only by curtains, and shared bathrooms made infection control impossible. The facilities were designed for conjugal eating, and normal mealtimes depended upon crowded gatherings. The ongoing staffing issues during the outbreak shone a light on the miserable wages and precarious employment suffered by continuing care workers. Overworked, stressed, forced to work part-time or casual jobs at multiple sites to make ends meet, care workers became vectors of disease spread.

Continuing care, especially seniors' care, in every province across the country proved incapable of coping with the crisis. The system was overwhelmed despite provincial governments desperately adding funds for wages to attract workers and the federal government committing soldiers to work in care centres.

It is imperative that the sufferings of patients (and their families) and care workers in the pandemic force governments to seriously rethink continuing care in this country. How, when and why the system went so far off the rails must be analyzed and publicly discussed. Then, a new, better public system that's based on optimal care and with strong enforcement mechanisms needs to be created so that this national tragedy is never repeated.

While the focus of this submission is on seniors' care which includes long term care, home care, and continuing care, we do recognize that some of the residents in these facilities or who are receiving care are not all seniors. There are individuals and residents in some of these facilities that require supportive and assisted living who are not seniors. However, the issues that arise in seniors care impacts all residents and the recommendations will improve care for everyone who is impacted.

The structure of this written submission will cover research overview of continue care in Alberta and Canada, AUPE's experiences in continuing care, our responses to the written submission questions, and AUPE's recommendations for improving continuing care in Alberta.

The Degeneration of Continuing Care in Alberta

Societies can be judged by how they treat their most vulnerable citizens. Do we have a moral obligation to reward peoples' past contributions by ensuring that their final years are as comfortable and stress-free as possible? Should we ensure those individuals that require assisted living or specialized care be of the highest quality services? Or, should we decide that, since they are no longer economically productive, we should spend the bare minimum on their needs?

In Alberta, the answer has, unsurprisingly, leaned toward the latter. Until the late 1950s, continuing care was limited to nursing homes owned and operated by private owners or charitable organizations. The dominant government consensus was that the elderly were the responsibility of their family, and the state had little duty to them. However, this very quickly became an issue of class. Although the wealthy could afford to place their family members elderly in private nursing homes or private care facilities, working class families could not.

By 1958, eighteen per cent of acute care hospital beds in Alberta were occupied by seniors who didn't need that level or kind of care. In response to the growing hospital costs, the province created its first seniors' care programs designed to move seniors to less expensive facilities. In 1958, the government, with the substantial financial aid from the federal government, created a seniors' lodge program. Fifty lodges providing low-cost room and board were built around the province and administered by local authorities as foundations. In 1959, the government began building auxiliary hospitals to provide care for seniors with complex but chronic medical needs.[2]

The decision to build continuing care facilities was driven by economics and not any sense of ethical or moral obligation to the patients, or any sense of compassion or empathy with the particular needs of individuals and their families. This is, ultimately, still the way governments across Canada view continuing care. It is a cost to be

minimized, not a social obligation to its citizens. All of the various programs and policies developed since, despite high blown rhetoric to the contrary, have had cost containment, rather than the well-being of the patient, as the driving motivation.

The drive to minimize spending on continuing care, even at the expense of the quality of that care, became more urgent with the ascendancy of neoliberal governments beginning in the 1980s. Neoliberal governments hold that individual citizens are responsible for their own wellbeing, not the state. Therefore, care is supposedly the responsibility of the patient themselves and their near families. Assistance is grudgingly doled out at the absolute minimum.

Another core belief of neoliberals is that the private sector will always produce superior results and be more efficient than the public sector. This typically results in downsizing government through privatization, contracting out, eliminating services, and subjecting the remaining public services and programs to the logic of the marketplace.

These two tenets of neoliberal thinking spelled disaster for continuing care programs in Alberta, especially seniors care. By the early 1990s, the official position of the Alberta government was that "In terms of the well-being of individuals, as well as cost considerations, the most appropriate philosophy was one that sought to maintain individuals in the community as long as possible."[3]

Since then, the government has continued to limit funding to continuing care facilities by reducing funding through various means, shifting much of the cost of care to patients and their families, and by turning over more and more of the provision of care, in both facilities and in-home care, to the private sector, with an emphasis on encouraging for-profit companies.

The Rapid Rise of For-Profit Continuing Care in Alberta

The government's intention to turn seniors' care over to the corporate sector is evident in the transformation of ownership in the past three decades. In 1991 Alberta had 13,496 continuing care beds, with just over 40 per cent (5,432) publicly owned, and just less than a third owned by a combination of non-profit and for-profit operators.[4] By March 31, 2019 there were 26,914 continuing care beds in Alberta. The number of publicly owned beds had actually shrunk by 37 to 5,395 – and now represented only 20 per cent of total beds. Meanwhile, the number of for-profit beds had ballooned to 12,076 – 45 per cent of all the beds. The non-profit share of beds had increased modestly to slightly to 35 per cent (9,443) of all beds.

In other words, the number of beds had increased by 13,418, but for-profit operators had constructed about 8,000 (60%) of them. The government was so keen to hand continuing care over to the private sector that they paid up to half the construction costs of new facilities through the Rural Affordable Supportive Living grant program and the Affordable Supportive Living Initiative grant program. Hundreds of millions of dollars were given to the private sector to fund construction of beds that would be funded out of the public purse.

The switch to for-profit ownership was facilitated by the creation of a lower level of care than traditional nursing homes and auxiliary hospitals. The new designated supportive living (DSL) beds were situated in largely for-profit facilities and had lower staffing skill requirements and few of the regulations present in nursing homes. By March 31, 2019, 42 per cent of all continuing care beds in Alberta were these lower care DSL units. The majority of those beds were for-profit.[5]

What's Wrong with For-Profit Care? Experience from Privatizing Seniors Care

Central to the idea that the private sector is better suited to provide high quality efficient care for less money is the idea that competition in the marketplace will produce that outcome through seniors' choice of facility. However, there is really no effective way for people to exercise choice since the assessment of eligibility is not in seniors' hands, there are a limited number of beds funded by government available at any one time, and real pressure on seniors to take an immediately available bed.[6]

Secondly, critics of providing public services like health care and education through for-profit companies point out that non-contractible qualities essential to those services (e.g. empathetic interactions) will be sacrificed to maximize profits. Furthermore, when the purchaser's preference is low cost – as in the government's purchase of seniors' care – competition will push down not only prices, but also quality.[7]

A Swedish study from residential care homes concluded that competition among for-profit operators did not produce better quality of care, nor did the presence of for-profit competition spur improvements in the quality of care in public nursing homes.[8] An English nursing home study also found a negative effect of competition on quality in those cases where it pushes prices to a level where providers can only produce minimum quality. Again, this will occur when the buyers (the government funders) make cost containment the priority.[9]

Evidence of Inferior Performance by For-Profits

There is a wealth of scientific studies providing evidence of poor performance by for-profit operators. For-profit owners in the United States cut nurse staffing, particularly at the highest skill level, Registered Nurses. They also reduce wages and benefits to improve profits. It is not just the skill level of staff that is reduced. American for-profit nursing homes have 16 per cent less staff overall than non-profits after accounting for differences in resident needs.[10] Homes with the highest profit margins have the lowest quality of care, and the biggest chains have lower nurse staffing and more deficiencies.[11] A recent Canadian nursing home study concluded that the evidence was incontrovertible – provision of seniors' care in any form by for-profit seniors' care means higher cost and lower quality.[12] [13]

Scandals involving serious problems in nursing homes have been linked to the growing number of large for-profit chains and private equity firms involved in seniors' care.[14] For-profit facilities also had the most verified complaints against them when compared to public or not-for-profit facilities.[15] Related to verified complaints is the fact that for-profit homes have more transfers to hospitals, and higher rates for both ulcers and morbidity.[16]

Because the primary obligation of for-profit entities is to maximize returns to their shareholders, there is little chance that the quality of care is a real consideration beyond the absolute minimum needed to meet their contractual obligations. Or, as law professor Harry Glasbeek so succinctly put it:

> "A symbiotic, perniciously anti-social arrangement emerges. The corporation becomes a vehicle in which the major actors – directors, executives and shareholders – encourage each other to focus as little as possible on the impacts the pursuit of their mutual goal [maximizing profits] is likely to have on outsiders."[17]

This corporate redirection of priorities from quality of care to maximization of profits in continuing care erodes democratic oversite and control over an essential public service. The pursuit of maximum profits has led for-profit seniors' facility operators into ethically questionable tactics such as selling their property to REITS (real estate investment trusts) or setting up REITs and then redirecting operating profits back to the REITs through inflated rental rates to take advantage of lower tax rates. Large U.S. chains have made uses of tax havens to shelter their operating profits, and it has become a standard practice to set up non-arm's length companies to provide laundry, housekeeping, food services, and management services to the parent company thereby underreporting profits and over representing spending on care.[18]

For-Profit Operators Pursue a Precarious Low-waged Workforce

Operating funds redirected into profits must come from somewhere and since continuing care is a labour-intensive endeavour, the most obvious cuts that take place is from labour. For-profit operators have consciously kept staffing levels, wages and benefits low to increase profits. A Canadian study concluded that for-profit nursing homes in Ontario provide 20 minutes less direct care per resident per day than publicly owned homes (adjusted for acuity).[19]

For-profit operators not only have less staff[20], they also have less care workers at the highest skill level, providing measurably less registered nursing staff hours based upon acuity than non-profits or public homes.[21] [22] Skill mix, the ratio of registered nursing staff to licensed practical nursing and health care aide staff is important in seniors' care. Another strategy of for-profit operators is to hire part-time, casual and 'self-employed' workers to avoid paying benefits, pensions, sick-time and other protections normally enjoyed by full-time workers.[23] The precarious nature of these forms of employment also makes the workers less capable of securing wage increases or improving their working conditions. Failure to replace workers absent for various reasons is another method of maximizing profits.[24]

An unfortunate side effect of the increased presence of for-profit operators is that they exert pressure on voluntary, not-for-profit operators to adopt the same low-wage and benefit, precarious employment practices

– including work intensification and contracting out parts of their care staff (e.g. laundry, housekeeping, food services).[25] Extracting wage, benefit and pension cuts is often done as a method of increasing profit. This can be done by fiat in non-unionized settings, or through contracting-out work to non-union firms (or using the threat of contracting-out to extract concessions) in unionized firms.[26] [27]

Reducing Public Funding for Seniors' Care

Although the number of continuing beds has gone up overall, it has not matched the growth in seniors' population in Alberta. One of the obvious, but ethically questionable, ways of limiting spending on continuing care is simply not to have beds for people who need them.

Exactly how may beds Alberta might need now and in the future depends upon many factors, among them the availability of adequate home care, medical research, research on the long-term impacts of COVID-19 and the wishes of seniors, themselves. There has been a concerted effort to keep seniors in their homes as long as possible. For the government, again, the driving motivation is cost cutting. Home care is the least expensive of the three levels of the care in the province.

Designated Supportive Living would be the medium expense and long-term care (auxiliary hospitals and nursing homes) the most expensive. There is also no doubt that most seniors would prefer to stay in their own homes as long as possible, if they have a home free from loneliness and isolation. However, there is a limit to how long seniors can remain safely at home.

There are some benchmarks that can help determine how many continuing care beds (DSL plus LTC) are needed today and in the future. Historically, Alberta measured the number of beds per thousand people over the age of sixty-five as a benchmark in seniors' care – although that number has been steadily dropping.

Table 1

Year	Beds Per '000 Albertans 65+[28] [29]
1971	68.6
1981	71.4
1991	61.1
2019	46.4

In 1993, the government set a lower target of *55 beds per 1000* aged 65+. An expansion of home care was proposed to deal with any further bed demands beyond the target.[30] A slightly different method is to use the Canadian average for placement in seniors' facilities. According to the 2016 Canadian census, 6.8 per cent of Canadians over the age of 65 were in nursing homes or senior's residences.[31]

Alberta population over-65 in 2019 was 580,397.[32] By the government's old target of 55 beds per thousand, there should have been 31,922 DSL and LTC beds in operation in 2019. By the Census average calculation, 6.8 per cent, or 39,467 of those seniors should have been in funded beds. Using the American and German statistics, there should have been 29,600 beds and 31,922 respectively. However, in 2019 Alberta was funding 15,597 LTC beds and 11,317 DSL beds for a total of 26,914.[33] That is about 5,000 beds short of their own target – and represents 46.4 beds per thousand seniors.

Many of the seniors who would be filling those missing beds are in acute care hospitals waiting for continuing care beds to come open – at great expense to the government. In the 2nd quarter of 2019-20, patients who no longer needed that level of clinical care took up 15 per cent of all hospital inpatient days. The average waiting time for continuing care placement from the hospitals was 36 days.[34] In 2017, Alberta Health Services estimated the cost of keeping seniors in these beds was about $550 per day – as opposed to $72 - $129 per day in DSL and $182 in LTC.[35] However, the majority of Albertans waiting for placement at any one time are living in their own homes and getting by on whatever level of homecare they have been assessed, and with whatever care relatives and friends (mostly women) can provide.

As the number of beds per capita has steadily declined, there has been a shift upward in the acuity of those who actually were placed in the various levels of care. This is of course the objective of the 'Aging in Place' programs – to keep people out of institutional care as long as possible by limiting bed numbers. But a consequence of that is that those who do get admitted have greater average needs than previous residents. Greater acuity requires more staffing and correspondingly more funding or else there will be a decline in the quality of care.[36] [37]

This increase in acuity has a domino effect. Seniors who used to be in long-term care are now being placed in DSL facilities and taking spaces there that would have gone to seniors with lower needs. By 2013, Bruce West, then the Executive Director of the Alberta Continuing Care Association, warned that this was short-sighted and would lead to more hospitalizations: "We have an aging population with very complex care needs that are now being placed in supportive living settings that don't even have a registered nurse on site."[38]

So, while it is true that DSL residents have lower nursing needs than nursing homes, it also true that the average acuity of residents in both LTC and DSL has been going up over the past decade, with many residents of Designated Supportive Living Level 4 and Level 4D (Dementia) matching the profiles of people previously cared for in nursing homes.[39] [40] [41]

Those more complex residents placed in DSL beds meant that seniors with lesser needs would no longer have a place in DSL but be forced to remain at home. This has both increased the average acuity of homecare recipients, and, because budget increases have not been adequate to meet demand, reduced the home care available to others who may have received homecare in the past. According to one national study, 40 per cent of those now receiving homecare have unmet needs.[42]

One of the key problems in the system in Alberta, according to Bruce West, is that Alberta Health Services has too many roles. It is the funder, deliverer, regulator and enforcer of continuing care. For example, AHS does the first assessment that determines which level of care each person needs. Since it is in their budgetary interest to keep patients in the lowest level of care for the longest possible time, there is an incentive for them to underestimate health needs.[43] Stripped of its lofty rhetoric of consumer choice, the implementation of lesser care supportive living facilities, the limitation of available beds, and the encouragement of for-profit operators through capital grants, have all had cost containment as the primary objective. The quality of care and the lives of vulnerable seniors are secondary considerations.

Lack of Government Funding Part of the Problem

Although missing beds are a crucial shortfall in Alberta's seniors' care system, there is an equally important shortfall in the funding of care. According to Bruce West, when he was Executive Director of the Alberta Continuing Care Association:

> "It is not the distribution of funds available that is the issue, but the total dollar amount of funding available."[44]

The issue of overall funding shortfalls was masked by the introduction of a new funding system in Alberta's continuing care sector. In essence, AHS stopped measuring inputs and processes, and began focusing on measurable, quantifiable outcomes.[45] Alberta began introducing the new Patient Care Based Funding (PCBF) model as the basis of funding long-term care in 2010/11 and completed that transition in 2013.[46] [47]

On the surface, the system appears to provide both transparency and fairness to the funding of seniors' care. Residents are assessed when they are admitted using a tool developed in the U.S., the Resident Assessment Instrument – Minimum Data Set (RAI MDS 2.0). The RAI is a standardized system designed to provide reliable measurements of patient acuity.[48] This assessment is used to assign residents to discrete resource utilization groups (RUGs), and then into clinical categories of similar RUGs. Each resident within the same group is assigned a value (case mix index) representing their relative expected care costs for one day. The CMI is applied to each day a resident is in a facility.

Note that this benchmark funding is based upon average labour costs and average task times. It provides a powerful incentive for owners to keep their costs (labour, supplies, equipment) per resident below their revenue for that resident. [49] Critically, Alberta's case-mix funding system is based upon average costs/task times that may not represent best practices in terms of quality of care, staffing mix, staffing levels or labour relations.[50]

The effect on labour relations is particularly pernicious, putting a severe downward pressure on caregivers' wages and benefits. Those operators who pay their workers less wages and benefits have an advantage since there is standard payment to facilities based upon perceived work to be done at an abstract average wage. Higher wages and benefits, usually a direct result of staff unionization and collective bargaining, are therefore a disadvantage under the AHS funding system – something pointed out to them in a study they commissioned:

> "Providers with higher fixed wage rates, often unionized with a collective agreement or remote location adjustments, will find the current policy inequitable since they cannot reduce compensation over the short-term. In the absence of a policy intervention, these providers will either become more cost-efficient by cutting front-line staff or find their business models unsustainable."[51]

However accurate or efficient the system is in dividing available funding between facilities based upon resident acuities, there is one thing the PCBF model does not do: it in no way establishes what amount of funding is required for either minimal care or for good quality care. As the AHS itself has pointed out, the funding model is about dividing up the pie, not whether the pie is big enough to do a proper job.[52] Dividing up inadequate resources fairly does not make them any less inadequate. This conclusion is corroborated by a study of a similar use of RAI-MDS in Ontario that concluded that matching resources to needs may make funding consistent, but it does not make funding sufficient.[53]

One of the major criticisms of the RAI – MDS assessment tool and activity-based funding systems like PCBF is that they fail to properly weight/measure many essentials of quality of care.[54] Specifically, the tool does not allocate enough importance to the social and psychological aspects of care, such as spending time talking to and comforting residents.[55]

The Impact of Contracting Out Ancillary Services

An often-overlooked consequence of the chronic underfunding of continuing care is the contracting out of important support services within both long-term care and designated supportive living facilities, ignoring the central role they play in health, especially in nursing homes. Cleaning, laundry and food preparation are increasingly being contracted out to reduce (mainly wage) costs.[56] [57]

In general, contracting out lowers the wages and benefits paid to workers, creates poorer working conditions, forces workers into precarious causal and part-time work, and reduces job satisfaction.[58] However, it does not save much, if any money for government. A systematic review of forty-nine academic studies on contracting-out conducted between 2000 and 2014 suggest that savings for government from contracting out average just 6.4 per cent in Anglo-Saxon countries, and that those savings did not generally account for transaction costs (negotiating and policing the contract).[59] The profits for private sector contractors appear to come solely at workers' expense.

This is a natural consequence of contracting continuing care to for-profit organizations whose primary objective is to maximize profits. This low-wage strategy also sets a precedent that not-for-profit providers are pressured to adopt to remain competitive in the quest for public funding.[60] However, evidence suggests that, despite being described as ancillary or even 'hotel' services, such services are actually an integral part of care provided to residents.[61] There are several pathways through which in-house laundry; dietary and cleaning staff are vital to better quality care for residents. First is the importance of familiarity. Having the same people cleaning, preparing meals and doing laundry every day allows the residents and workers to know each other and particularly for workers to recognize the many different needs and preferences of particular residents. Knowing and socially interacting daily with support staff also provides continuity, trust and comfort for residents.

There is also a definite gap in quality of care between in-house and contracted out services. For example, in house food preparation can provide personalized food and flexible mealtimes that encourage unrushed, social mealtimes, often with locally sourced produce. In contrast, contracted out food services generally provide meals prepared offsite, with narrow windows for every meal so that residents are fed with as little workers' time as possible.[62]

Cleaning is another area where contracting out creates lower quality care that actually increases risks to residents. A recent study concluded that cleaning standards declined under contracting-out of custodial services in British hospitals.[63] As the current COVID-19 crisis has made clear, competent workers trained in infection control are essential to seniors' facilities. Yet operators continue to contract out cleaning despite evidence that this results in a reduction of cleaning staff and increase in workload linked to increased infections.[64]

A facility that looks and smells clean increases the well-being of staff, residents and visiting family.[65] Keeping the facilities clean is a complex task. Residents can spill food, drink and bodily fluids in many places at unpredictable intervals. Cleaning them up quickly should be an immediate priority for cleaners, but prompt cleaning is often delayed while requests are redirected through offsite managers.[66] Laundry services can also play an important role in the quality of life for residents. In house laundry workers can get to know residents, and take care that clothing is carefully washed, and folded and put away where the resident wants when returned.[67] In contracted out laundry services, clothes were frequently lost or destroyed, and laundry workers had little or no interaction with residents.[68]

Meal preparation and social eating, clean, nice-smelling facilities and being able to dress in favourite, properly cleaned clothing are some of the things that give seniors a sense of dignity and place – things that make life richer and more worth living.[69] Contracting them out to low wage, high turnover for-profit companies at the expense of the quality of life of residents and staff directly opposes quality care with government austerity and restraint.

Government Funding Cuts and Privatization of Continuing Care Services

Systemic underfunding by provincial governments as a direct result of prioritizing cost containment over care has produced a system that is understaffed and stripped of the highest skilled workers. Understaffing has led to high work stress from overwork, missed care, high levels of workplace injuries, and high staff turnover. Low wages and benefits and precarious part-time, term, and casual contracts have made recruiting and retaining staff difficult even as the need for staff is increasing. Lack of paid sick-time has led to presenteeism (coming to work sick) that is particularly dangerous in the continuing care continuum. Improper skill mix through the substitution of nursing staff with unregulated workers has negatively affected the quality of care for seniors. Lack of adequate funding has also encouraged facilities to contract out food services, laundry, and housekeeping to for-profit operators, despite the fact that this is known to be bad for the quality of care.

AUPE Recommendations and Suggestions for Legislative Improvements to Continuing Care in Alberta

It is AUPE's position that the new continuing care legislation include all aspects of continuing care: home care and support services, adult day services, meals programs, laundry and housekeeping services, respite services, care management, long-term care services, palliative and end-of-life care services, home oxygen program, assisted living services, community nursing services, community rehabilitation services, persons with developmental disability services.

This new framework should focus only on publicly funded and publicly operated continuing care facilities where optimal care is the focus of these facilities. It should also guide the regulation of continuing care facilities and enforcement of these regulations must be strong and done by a public agency with rigorous reporting requirements.

Having reviewed MNPs survey on continuing care, there were some obvious flaws with survey design that we had to highlight. Its structure and questions are misleading and does not address any key aspects of optimal care. Its focus was on funding levels and creating opportunities to cut funding while offloading costs to the patient and their families. AUPE is strongly against the approach privatizing different services of care and charging patients for these services. Given the evidence across Canada highlighted in this submission, this method of care delivery will result in poor outcomes such as higher infection rates, less relational care, higher death rates given that COVID-19 still poses a great risk. It will further create inequities in the continuing care system where the ability to pay determines the quality of care a person receives.

AUPE strongly believes that legislation can support and improve the quality of life of patients and family experiences in the continuing care system. With a focus on standardizing optimal care and removing the profit sector from continuing care, this government can get back on track to providing high quality health care services that Albertans rely on. This means legislating staff to patient ratios, providing adequate paid sick leave, adequate PPE supports, adequate level of resources to perform job duties, adequate training opportunities for staff, and taking strong actions to enforce minimum staff ratios. Ensuring that staffing ratios are well maintained with a focus on full-time jobs. While in the long term we firmly believe all continuing care centres should be publicly funded and provided, in the short-term minimum standards for optimal care should be established through legislation and enforced in all public and private care facilities.

AUPE Recommendations for Short Term Action

1. Increase the pay for all workers in continuing care in Alberta.

   a. This must be done to correct the gender-based inequality of wages. One study suggests that because residential care workers are predominantly racialized, immigrant women, they face a 42 per cent wage penalty when compared to male, non-immigrant, non-care workers.[70] That provides some indication of the scale of the wage deficit in seniors' care that needs to be addressed.
   b. A second reason to increase wages is to prevent the constant churn of turnover that afflicts the sector with huge retention and recruitment problems.
   c. Increasing the pay demonstrates how valuable this work is and values the workers who are keeping seniors healthy.

2. Ensure adequate Paid Sick Leave for all workers.

   a. This should be legislated immediately. During the pandemic this is absolutely critical, but it is also vital for the safe care of vulnerable seniors at all times.
   b. Ensuring paid sick days also helps to protect the families and the health of workers

3. Ensure all workers and residents have access to proper Personal Protective Equipment (PPE).

   a. Again, it must be mandatory in the future for all residential and home care employers to maintain a comprehensive supply of personal safety equipment for care workers.
   b. Provincial governments should be required to publicly report how much PPE has been provided to workers, the period of time that was required to distribute PPE, which types of PPE and the manufacturer, as well as the classifications of workers that received the PPE

4. Full-time employment should be made the standard in continuing care, and part-time workers should be entitled to maximize their hours before any casual workers are brought in.

   a. This will provide continuity of caregivers for residents and help build positive relationships and better-quality care. It will also alleviate the necessity for many caregivers to work at multiple sites, thereby providing a safer environment.
   b. Part time workers should receive benefits as well as access to public defined benefit pension plans.

5. Re-examine the current hours of care per resident funding models to ensure that optimal hours of care – not minimal care hours – are funded in facilities and in-home care.

   a. A standard of 4.1 HPRD should be immediately implemented in Long Term Care, (pro-rated downward for DSL 3, DSL 4 and 4Dementia based upon average acuity). This should be made up of .75 hours by a Registered Nurse (RN), .55 hours by a Licensed Practical Nurse (LPN) and 2.8 hours by a Health Care Aide (HCA).
   b. The HPRD should include only direct care, not administrative duties. This standard should remain in place while all levels of care are reassessed for HPRD needs.

6. A panel should be struck to investigate and recommend optimal hours of care at all levels to provide best quality care.

   a. The panel must have representatives from all health care workers organizations and independent academics and gerontologists.
   b. All levels of seniors care need to be fully regulated and those regulations need to be properly enforced.
   c. This panel should not include private care providers as they have a vested interest in the outcomes of the panel (or something like that)

7. Reverse policies of charging seniors for "hospitality" services.

   a. 'Extra' Bathing, portering to and from meals, trips to doctor's appointments and other so-called hospitality services should be provided to seniors free of charge.

8. There must be an absolute requirement that all direct care money and any new funds due to the COVID-19 pandemic, be actually spent on direct care – not redirected into other operations that do not directly affect frontline workers or patients or into profit-taking.

9. A public inquiry should be called to investigate the outbreak of COVID-19 in continuing care facilities in Alberta.

AUPE Recommendations for Long Term Action

1. Alberta should work with the federal government to create legislation to require continuing care to operate under the same principles as public health care: public administration, accessibility, comprehensiveness, universality and portability, with public ownership and an equal cost-sharing between the federal government and provinces as added features.
    a. There is inequality of access to continuing care in Canada based upon both income and geographic location that is contrary to the interests of patients and their families and to Canadian health care principles. Bringing continuing care under a federal Act would regulate access and affordability to all aspects of continuing care.
    b. It would also recognize that social care is as essential to individual's health as medical care and should be provided similarly.
2. AHS should be building and operating all new continuing facilities.
    a. The government needs to schedule the construction of publicly owned and operated facilities that will meet the present and future needs of Alberta's seniors based upon demographic predictions. All the information and statistics used to predict future needs should be publicly available. Past LTC closures of public beds need to be re-examined.
    b. Contracting-out direct care or support services in continuing care should be eliminated in AHS funded operations. These support services play an important role in quality care and are not suitable for-profit takers.
3. A plan to nationalise (bring into public ownership) existing for-profit facilities should be developed.
    a. The negative consequences of for-profit operators at all levels of continuing care are well documented. A number of class-action lawsuits against the sites have been initiated in Alberta, alleging negligence in protecting clients from the COVID-19 pandemic.[71] We strongly condemn any legislation that will protect private operators from negligence and that legislation should not be created on behalf of private care providers to avoid accountability throughout this pandemic or future pandemics. Private care operators, including charitable and non-profit operators, have been unable to resist underfunding and have adopted for-profit management strategies. Public ownership and operation is the only option for high quality and accessible continuing care services.
4. Develop a pharmacare program that is accessible and will cover the cost of all prescription drugs, medical supplies, and pharmacy services.
5. Developing provincial standards for continuing care workers.
    a. The resolution of both nursing care and general support services staff issues surrounding hours of work, wages, and benefits, and work intensification needs to be resolved within the collective bargaining process as a first step in improving the care relationship between caregivers and patients.
6. The government needs to ensure that enough beds are being built at the highest level of care.
    a. These new nursing home/auxiliary hospital facilities should be able to accommodate the transfer of seniors and patients who are inappropriately housed in DSL facilities, and there must be a thorough review of exactly what level of acuity merits placement in LTC, DSL or home care.
    b. New facilities should be much smaller in size, perhaps with a 50-bed maximum and then physically broken into smaller units within that.
7. The primary assessment of seniors and their subsequent care should be done independently of AHS based on the advice of the patients own physicians or qualified professionals.
    a. The funder and employer cannot be the gatekeeper to access care needs. There is an inherent conflict of interest between the funding body's cost containment policies and patients' needs for best quality care.
8. Staffing ratios and appropriate levels of care and services need to be standardized and enforceable through legislation.

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