An Overview of Long-Term Care in Canada and Selected Provinces and Territories

Albert Banerjee

October 2007

Formerly the National Coordinating Group on Women and Health Care Reform

The **Women and Health Care Reform Group** is part of the Women's Health Contribution Program of Health Canada. The Group coordinates research and policy advice on the effects of health care reforms on women. The views expressed herein do not necessarily represent the official Health Canada Policy

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Fact Sheet: Long-Term Care across Canada

Introduction

This document is intended to provide a snapshot of long-term care in Canada. It begins with a brief discussion of the national context followed by an outline of long-term care within several provinces (Nova Scotia, Ontario, Manitoba, and British Columbia) and one territory (Yukon) in order to ground the previous discussion and illustrate the diversity of long-term care across the country.

Caveat

A word of caution before beginning. The idea of "long-term care in Canada" is somewhat misleading. It lends a sense of concreteness and congruence that does not exist. Long-term care has different developmental histories in each province and territory leading to a varied set of present circumstances. What's more, while Statistics Canada has been gathering data on residential care since 1974, there are few pan-Canadian analyses of long-term care, making any conversation at the national level a challenge.

This information deficit is starting to be addressed. For instance, the Canadian Institute for Health Information (CIHI) has embarked on a project to provide standardized information across Canadian provinces and territories. The first phase of this project resulted in a report released in 2007 on *Facility-Based Continuing Care in Canada, 2004-2005* (CIHI, 2007). However, to date, this report only covers the provinces of Ontario and Nova Scotia. Furthermore, as the Ontario sample is drawn from hospital based continuing care facilities, it is therefore not what some people mean when they ask about "long-term care." And in Nova Scotia, the sample only includes seven of the 71 long-term care facilities. Thus, confident statements about long-term care in Canada – such as the claim that 5% of residents are under the age of 65 – need to be taken with a grain of salt.

Another recent study draws on Statistics Canada data to provide a national portrait (Berta et al., 2006). However, as a result of differences in reporting style Quebec is omitted from the picture, as are the territories. Indeed, it is a challenge to find any analysis comparing Quebec or the territories with other provinces. The report further groups the Prairie Provinces and the Atlantic Provinces in its analysis. This is problematic for a number of reasons. Not only is considerable information lost, but more importantly, in terms of understanding the organization and development of long-term care, provincial policy differences may well trump geography. Nonetheless, this study is a good beginning and this fact sheet owes much to it.

Speaking about long-term care in the Canadian context is further complicated by the lack of a common language. Not only have national comparators not been established but given the differing patterns of historical development, the formation of long-term care facilities, their function, and their role in relation to other care institutions are somewhat location specific. Thus, across jurisdictions, similarly named facilities do not necessarily provide similar services. For instance the CIHI (2007) report examines "residential facility based care" by which they mean "nursing homes." Yet in Nova Scotia "residential care facilities" are not nursing homes at all. They are institutions offering intermediate levels of care more akin to the type of care provided in what Nova Scotians call "community based options" or what people in other provinces, such as Ontario, might term "supportive housing." Such

differences in terminology can lead to confusion. And certainly caution is warranted. In assessing any national portrait, one does well to keep in mind the concern (if not frustration) expressed by the Federal/Provincial/Territorial Working Group on Home Care. In their words: "Review of available information revealed that there is hardly a statistic or description that would not be misleading or inaccurate without lengthy and complicated elaboration of its nuances, special circumstances, or unique meaning in a provincial or territorial context" (1990; qtd in Alexander 2002: 26).

What is long-term care?

Long-term care typically refers to ongoing, indefinite, care for individuals who can no longer fully care for themselves. Long-term care straddles both *health care* in the form of nursing/medical care and *social services* in the form of income supported housing, assistance with "activities of daily living,"[1] and the provision of recreational and social programs (Vladeck, 2003). Long-term care in Canada is commonly defined as representing:

> a range of services that addresses the health, social and personal care needs of individuals who, for one reason or another, have never developed or have lost some capacity for self-care. Services may be continuous or intermittent, but it is generally presumed that they will be delivered for the "long-term" that is, indefinitely to individuals who have demonstrated need, usually by some index of functional incapacity. (F/P/T subcommittee1988, qtd in Havens, 2002).

These fact sheets are oriented by a notion of "long-term care" as referring to facilities that provide indefinite care for the elderly. Not all residents of long-term care facilities are elderly, as noted above. However, in many provinces separate facilities are provided for children and young adults; the idea being that while their health care needs may be similar their social and recreational needs are not. Such facilities and individuals are not the focus of this document.

Long-term care as continuing care

Long-term care is also commonly used to denote *continuing forms care*. As such, it may refer to hospital based continuing care, which generally tends to be more intense, complex and of shorter duration than long-term residential care. It may also be used to refer to home care or assisted living arrangements that provide basic levels of support and assume that the elderly are independently mobile and do not require 24 hour nursing care.

While neither continuing hospital care nor home care are the focus of this report, it is helpful to bear in mind that long-term care facilities for the elderly exist in the context of a *continuum of care* (Hollander, 2002). Indeed, the "continuum of care" concept is gaining momentum in policy making, as all levels of government are striving to better meet community needs, eradicate redundancies, and increase efficiencies through the integration and co-ordination of services. With typical mission statement zeal, one often reads of the aim to provide "the right services, in the right place, at the right time" (Alexander, 2002). More practically, the concept of a continuum of care reminds us that long-term care facilities

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[1] Activities of daily living are basic functional tasks performed on a daily basis, such as general mobility, being able to clothe or feed oneself, to be continent and use the toilet, and to shower or bathe.

relate to other institutions such as home care, assisted living, supportive housing, chronic care, and complex continuing hospital based care.

The continuum of care model thus has many implications for long-term care facilities. Decisions, for instance, around resource allocation and the building of new long-term care facilities are often made in relation to other institutions, in order to materially construct a continuum of care. At present, this appears to result in the allocation of funds away from long-term care facilities, towards home care, assisted living and other modes of keeping residents out of institutions. Similarly, most jurisdictions have moved to single entry point systems in order to implement the continuum of care ideal at the individual level. Once again, as Pitters (2002) notes, a bias toward community care is built into intake assessment models. This means that assessment practice attempts to exhaust community care options before long-term care facilities are even considered. Whether or not this bias is sensitive to the needs of the elderly is an open question, but what appears clear is that when they do enter long-term care they are older and have greater health needs. Long-term care also exists in relation to hospitals. The goal of shortening hospital stays, for instance, has resulted in the downloading of patients into long-term care facilities and the development, in some instances, of long-term sub-acute care beds. This has increased the number of residents with complex health care needs and has affected, not least, staff workloads and training requirements.

The federal policy context

At present, long-term care – as institutionalized elderly care – is practically invisible at the federal level. The recent Romanow Report (2002), for instance, scarcely mentions long-term care. Two reasons are indicated in the report for this absence. On the one hand, the report privileges home care over long-term institutional care, the assumption being that residing in the home is more desirable and more cost effective than institutional care. However, priority home care services are limited in the report to mental health, palliative care, and post acute services. Specific services for the elderly do not appear as a priority area. On the other hand, there is concern that institutionalized long-term care does not offer the flexibility required to respond to shifting population demographics and errors in demand forecasting. As Romanow explains: "Because it may be impossible to accurately forecast the health needs of the population too far in advance…flexible approaches need to be taken to avoid the trap of investing in facilities and programs that may or may not be needed as Canada's population ages" (23).

Long-term care does not fall under the Canada Health Act. It therefore remains outside of the universally insured health services (Alexander, 2002). In the past, the federal government provided targeted funding for long-term care through its Extended Health Care Services program (EHCS). Through this program money was transferred to provinces for long-term care facilities. Funding levels were set at $20 per capita when the program was established in 1977; an amount which had risen to $51.51 per capita by the early 1990s or a total of $1.5 billion annually in 1994/5. Despite such growth, federal transfers for extended health care services were dwarfed by transfers for health services insured by the Canada Health Act. The EHCS program was abolished in 1996 with the introduction of the Canada Health and Social Transfer (CHST). The CHST collapsed federal transfers to the provinces for health, postsecondary education, and welfare, thus eliminating targeted federal funding for long-term institutional care.

The federal government continues to have a hand in long-term care through its funding of First Nations' community care and Veterans' long-term care.

First Nations and Inuit Home and Community Care
Through Health Canada's First Nations and Inuit Home and Community Care (FNIHCC) program, the federal government provides assistance to First Nations and Inuit peoples across Canada (Health Canada, 2004). The program is open to First Nations and Inuit people who live on a reserve (or North of 60 in a First Nations community) or in an Inuit settlement. The program receives approximately $90 million dollars annually and is available in over 600 communities across Canada. FNIHCC provides funding for home care services – including funding for non-medical personal care services such as meal preparation, light housekeeping, respite care, and minor home maintenance. Of course, home care requires adequate homes, so it should be noted that in 2000/01, only 55.8% of homes on First Nations reserves were considered to be adequate (FNIH, 2007). Approximately 15% were in need of major repairs, and 5% were no longer habitable or had been declared unfit for human habitation.

The FNIHCC program also provides funding for institutional care. In 2002/3, approximately $36 million was spent on long-term institutional care. However, FNIHCC funding only covers lower levels of care (Type 1 and Type 2 in the federal classification system, which refer to care requirements of less than 2 hours per day). This care is provided through provincial or territorial institutions (Health Canada, 2004). The failure to provide funding for higher levels of care is an area of ongoing conflict between First Nations communities and the federal government.

Veterans Affairs Canada
Through Veterans Affairs Canada (VAC) the federal government provides long-term institutional care for eligible veterans (VAC, 2002). Care is provided to more than 550 veterans at Ste. Anne's Hospital outside of Montreal, the only remaining veterans' hospital administered by VAC. VAC also contracts with approximately 170 care facilities across Canada in order to ensure that priority access beds (PABs) are available to veterans. There are approximately 3,750 veterans residing in contract facilities offering PABs and another 4,500 veterans receiving long-term care in community care facilities across Canada. One study of institutionalized VAC clients notes that the average age upon admission is between 79 and 80 years (VAC, 1997). And unlike other long-term care jurisdictions, VAC clients are 94% male, half of whom are married.

Who stays in long-term care?
Only a very small percentage of the Canadian population reside in long-term care facilities (Havens, 2002). In 1991, the figure was 1% of the total population. Residency in long-term care facilities is, of course, age related. For those between the ages of 65 and 74 years, the percentage, while still small, nearly doubles to 1.8. A dramatic change is observed for those over 85 years or older. Of this group, 33.9% are institutionalized in long-term care facilities. This undoubtedly reflects the increasing average age of admission, which has shifted over the past three decades from an average of 75 years in 1977 to an average of about 86 years today (Pitters, 2002).

The number of Canadians institutionalized is higher if we consider those individuals with disabilities (Havens, 2002). Approximately six percent of the total Canadian population with disabilities and nearly half of all those 85 years or older with disabilities live in long-term care facilities (See Table 1).

Table 1: Number and percentage of people with disabilities in Canada in 1991 by age and residence.

Age group	Living in homes		Living in Facilities		Total
	#	%	#	%	
0-14	389,350	100			**389,350**
15-34	675,055	98.4	11,205	1.6	**686,255**
35-54	992,830	97.8%	22,215	2.2	**1,015,055**
55-64	629,245	97.5	15,895	2.5	**645,135**
65-74	698,830	95.4	33,885	4.6	**732,715**
75-84	424,800	83.6	83,035	16.4	**507,835**
85+	112,325	53.9	96,000	46.1	**208,325**
TOTAL	**3,922,435**	**93.7**	**262,235**	**6.3**	**4,184,670**

Source: Havens, 2002.

The majority of long-term care residents are women. Between the ages of 65 and 74 the proportion of women to men is relatively equal (Pitters, 2002); however the proportion of women begins to outstrip men at about age 75 – perhaps reflecting women's longer life span or a lack of informal care. By the age of 85 the proportion of women to men is nearly double (see Table 2) prompting many to note that long-term care is not just a health issue but a women's issue.

Table 2:
Percent of population in long-term care facilities by age and gender, 1995

Age	Women (%)	Men (%)
65-74	2	**2**
75-84	10	**7**
85+	**38**	**24**

Source: Pitters, 2002

Uncertainly around the impact of changing demographics is a key concern in long-term care policy and planning. The effects of the baby boom generation is of particular concern. Baby boomers will reach the key ages of 65 by 2011, 75 by 2021, and 85 by 2031 (Doupe et al., 2006). It is feared that the aging of baby boomers will increase the demands on the health care system, without a compensating increase in the work force (who, given the current funding structure, pay for insured health services). According to Berta et al. (2006)the number of Canadians over the age of 65 will increase from 18.5% of the working-age population in 2001 to 33.6% in 2026 and 41.0% in 2040. By the year 2051, almost 30% of the entire Canadian population will be over the age of 65.

Another way of looking at the likely expansion in demand for long-term care services is to consider that while the total Canadian population is expected to expand by 51% between

1991 and 2031, the population of those over 65 is predicted to increase by 182% (Havens, 2002). This demand will not likely be distributed evenly across Canada. Not only will internal migration and immigration play a role in an unequal and changing geographic picture of long-term care, but at present, the elderly are not equally distributed across the country. In 1998, for instance 84% of seniors lived in four provinces (Ontario, Quebec, British Columbia, and Alberta).

Number and type of facilities

In 1993, there were a total of 6,148 long-term care facilities (238, 386) in Canada, of which 2,422 were geared to seniors for a total of 178,023 beds (Pitters, 2002). The more recent study by Berta et al. (2006) puts the number of beds for 2001/2 at 187,896.[2] During their study time frame – between 1996 and 2001 – they found a 6.7% increase in long-term care beds.

The varied history of long-term care and mixed legislation has given rise to different types of facilities. Facility types are generally classified by ownership. Pitters (2002) has identified the following useful classifications:

- Proprietary (or for profit)– owned by an individual or corporation and run for profit
- Religious – owned an operated by a religious organization and are not run for profit
- Lay/charitable – owned and operated by a voluntary, non governmental and non religious body. Also not for profit.
- Municipal – owned and operated by a municipality on a not for profit basis
- Regional – owned and operated by a regional health authority
- Provincial/territorial - owned by a division of a provincial or territorial government.
- Federal – owned and operated by a department of the federal government.

For the most part, researchers tend to distinguish between profit and non profit. Common as well are distinctions among government, religious, and other not for profits and for profit institutions. Using the latter distinctions, Berta et al. (2006) find that 25.2% of long-term care beds are in government owned facilities, 10.2% in religious, 23.9% in not for profit, and 40.7% in for profit facilities. For a detailed regional breakdown see Table 3.

Table 3: Ownership type by region, 2001

Region	Ownership	%
Atlantic	For profit	40
	Government	22
	Not for profit	28
	Religious	10
Ontario	For profit	17
	Government	46
	Not for profit	18
	Religious	19

[2] It should be noted that their study excludes Quebec, Nunavut, the Northwest and the Yukon territories.

Prairies	For profit	17
	Government	46
	Not for profit	18
	Religious	19
Alberta	For profit	21
	Government	41
	Not for profit	22
	Religious	16
British Columbia	For profit	38
	Government	10
	Not for profit	44
	Religious	8

Source: Berta et al., 2006

Clearly considerable regional variation exists. In the Atlantic provinces, for-profits dominate, accounting for 40% of long-term care beds. In contrast, in Alberta, the Prairies, and Ontario, government ownership prevails with at over 40% in each region. Finally, the situation is more or less evenly split between for profits and not for profits in British Columbia, with a minimal percentage of government (10%) and religious (8%) beds.

Recalling the earlier caveats around long-term care statistics, a considerably different picture emerges if ownership patterns for long-term care facilities (rather than beds) is examined and especially if government and religious facilities are included in the not for profit category. Consider the following breakdown provided by the Ontario Health Coalition (OHC, 2002):

Table 4: Ownership type by selected provinces

Province	Public/Not-for-profit	**Private for-profit**
British Columbia	68.3%	31.7%
Saskatchewan	96.2%	5.8%
Manitoba	84%	15%
Ontario	48.4%	51.6%
New Brunswick	100%	0%
Nova Scotia	**72%**	28%

Source: OHC, 2002

When analyzing data by beds versus facilities, differences may be partially explained by the fact that the number of beds varies by institutional type. In other words, some institutional types tend to be bigger than others. As Berta et al. (2006) observe:

> Government owned facilities are significantly larger than For-Profit and Not-For-Profit facilities, which a means facility size of 77 LTC beds. Facilities owned by Religious organizations are significantly larger than For-Profits and Not-for-Profits, with a mean size of 74 beds compared to 50 and 30 beds

respectively. Lay Not-For Profits operate the smallest facilities with an average facility size of 30 LTC beds. (180)

Who pays for long-term care?
To the degree that funding for long-term care comes from the federal government, it arrives through a block transfer to provinces and territories. There is no targeted federal funding for long-term care.

Provinces are responsible for system design, funding allocation, policy development and regulatory compliance. Provinces cost share long-term care with residents through the application of a set – often income dependent – per diem accommodation rate (see Table 5). In some provinces, this rate varies with the type of room (e.g. one pays more for private accommodation). In Quebec, for instance, the 2007 maximum rate for a bed in a room with 3 or more other beds is $968.00. This rate increases to $1,302.80 for a "semi-private" room and $1,559.70 for a private room (RAMQ, 2007).

Table 5: Basic accommodation rates of provinces, as of November 2001

Province	Minimum Daily Accomodation Rates	Minimum Monthly Accomodation Rates
British Columbia	$27.20	$816.00
Alberta	$28.22	$858.21
Saskatchewan	$27.23	$817.00
Manitoba	$25.80	$774.00
Ontario	$44.21	$1326.30
Quebec	$27.76	$832.80

Source: OHC, 2002

Entry to long-term care
Individuals generally access long-term care through a single entry point system in order to ensure their needs are correctly assessed and they are appropriately placed within the continuum of care. These entry points are often established and co-ordinated by Regional Health Authorities or other local bodies.

In Quebec, for instance, someone finding it difficult to support themselves would approach (or have a caregiver approach) their local "health and social service centre" (CSSS). There a "multiclientele tool" – which is used across the province – would help determine the level of care required and whether or not it can be met by home care, "intermediate resources" or residential and long-term care centers (RLTCCs in Quebec). This assessment tool, as with most others, inquires into one's state of health, one's ability to conduct daily activities and one's level of social support. If the individual is able to remain at home with the addition of psychosocial services (often provided by social workers) and/or home support services such as meals and house keeping (often provided by volunteer agencies) some form of home care is organized. If the level of care is greater than this, the individuals will likely be directed to an intermediate form of housing. If 24 hour nursing care is not required then this might be some form of assisted living or supportive housing. This type of housing has not been the focus of this document and would appear to vary widely across the country in terms of

ownership, fee structure, design and integration into local health networks. If, on the other hand, 24 hour nursing care is required, then the individual will enter long-term residential care, or more likely be put on a wait list.

Health needs and care provision

The typical long-term care resident has some form of cognitive impairment, has difficulty moving independently, is incontinent, suffers from chronic (often multiple) diseases, and may have lost a spouse or partner. As noted above the typical long-term care resident is an elderly women with an average age of 85.

A recent study by PricewaterhouseCoopers (2001) provides a useful indication of the types of impairments faced by long-term care residents. This study examines data from a number of Canadian provinces, US states, and Nordic Countries. The most common diagnoses found were dementia and/or Alzheimer's, and with few exceptions over half the residents in the various sites studied were diagnosed with such. Cognitive impairment and a fair to high degree of difficulty with the activities of daily living was found again nearly in half of all residents. Depression was also relatively common found in around 10 to 30 percent of residents. Common physical impairments were arthritis, diabetes, stroke, and congestive heart failure.

While such broad based inter-provincial and international comparisons provide an idea of the 'typical' long-term care resident, there are also important differences can only be assessed by inquiring into the distribution of resident health status among specific long-term care institutions and ownership types. Berta et al. (2006), for instance, find that residents requiring more complex care predominantly reside in government-owned facilities, though there is considerable variability across the country. Table 6 illustrates the way the most intense level of care (Type 3 Care: specifying a minimum requirement of 2.5 hours of direct care and the 24 hour availability of nursing care) distributes among region and ownership type.

As Berta et al. (2006) suggest there are a number of reasons to assume a relationship between both level of care and amount of direct care provided (measured in terms of hours), and there is also reason to assume facility ownership type might influence the levels of care provided. Table 6 also provides a description of the average amount of care provided in various institutions. Their analysis suggests that not for profit lay organizations offer the highest levels of direct care at an average of 5.96 hours a day. This is compared to 5.22 hours for government, 3.96 hours for religious, and 2.71 hours for for-profit institutions. Furthermore it would seem that care is provided by different workers depending on the type of institution. Government run facilities provide the highest level of professional nursing care, whereas in not for profit facilities the highest proportion of direct care is provided by aides or workers other than registered nurses or registered nursing assistants.

Table 6: Care levels and amount by region and ownership type, 2001

Region	Ownership	% of 'beds' with Type 3 care	Total hours of direct care	RN+RNA care hours
Atlantic	For profit	4	1.98	0.91
	Government	31	8.32	2.57
	Not for profit	42	5.91	1.84
	Religious	23	3.27	2.18
Ontario	For profit	46	2.41	0.66
	Government	39	4.26	1.15
	Not for profit	8	5.79	1.13
	Religious	7	3.90	0.8
Prairies	For profit	19	2.69	1.24
	Government	53	4.22	1.68
	Not for profit	10	5.56	1.49
	Religious	18	3.47	1.96
Alberta	For profit	9	4.44	1.59
	Government	65	5.20	3.30
	Not for profit	14	5.68	1.87
	Religious	12	4.84	2.32
B.C.	For profit	32	4.12	1.02
	Government	14	5.13	1.60
	Not for profit	45	6.62	1.20
	Religious	9	4.30	1.25

Source: compiled from Berta et al., 2006.

Fact Sheet: Long-Term Care in Nova Scotia

Nova Scotia LTC in Numbers	
Nursing Homes	71
Beds	5835
Non profit homes	29
For profit homes	21
Residential Care Facilities	35
Community Based Options	28
Gender in Nursing Homes	71% women
Percent 85 years and older	43%
Accommodation Cost	$2265/month

Types of continuing care residences

There are three types of long-term continuing care homes in Nova Scotia operating under the jurisdiction of the Department of Health. These are: Nursing Homes, Residential Care Facilities and Community-Based Options (Department of Health, 2007). While this fact sheet focuses on nursing homes, the basic features of the three types of residences are described below.

Community Based Options (CBOs) provide care for seniors for whom home care is no longer appropriate and nursing home care is not required. CBOs are small home-like supportive environments that typically serve a maximum of three individuals. They provide personal care by workers available on site 24 hours a day. Such care may include help with bathing and dressing, administration of medication, meal service as well as reminders about daily routines. Residents have a private bedroom and share common areas (dining room, bathroom, and outdoor space). There are currently 28 CBOs in Nova Scotia, though most are in the Sydney and Halifax region. They are privately owned and operated.

Residential Care Facilities (RCFs) – provides an intermediate level of care for those people who need supervision and non-nursing personal care. RCFs may operate either under the jurisdiction of the Department of Health or the Department of Community Services. RCFs under the department of Health provide mainly care to the elderly and provide personal care that may include: help with bathing and dressing, meals, administration of medication, and reminders about daily routines. RCFs have a care worker available 24 hours a day. RCFs are mostly owned and operated by private individuals or organizations. Residents either have a private bedroom or share with one other person. There are currently 35 RCFs in Nova Scotia ranging from 6 beds to 85 beds each.

Nursing Homes - also referred to as Homes for the Aged – are facilities provided for people who need high levels of nursing care. Nursing Homes operate under the jurisdiction of the Department of Health and serves primarily seniors, although there are some young adult residents and one children's unit in the province. There are currently 71 nursing homes in Nova Scotia with a total of 5835 beds. Facilities range in size from 5 to 538 beds and are of mixed ownership. Twenty-two are municipally owned, 21 are private for-profit and seven are hospital-based.

Regulation of long-term care in Nova Scotia

Long-term care in Nova Scotia is administered through the Nova Scotia Department of Health's Continuing Care Branch. In addition to long-term care, the Continuing Care Branch administers home care and the Adult Protection Services (i.e. protection for vulnerable adults). All long-term care facilities fall under the jurisdiction of the *Homes for Special Care Act*.

Who pays and how much?

Long-term care is paid for jointly by the provincial government and by long-term care residents (Department of Health, 2007).

In Nova Scotia the provincial government covers the health care costs for each resident. These costs may be related to the salaries, benefits and operational costs of nursing and personal care; social work services; recreation therapy; and physical, occupational and other therapies. These costs will only be covered for residents who enter long-term care homes that participate in the provincial Single Entry Access System.

Residents are expected to pay the accommodation charges which include: salaries, benefits and operational costs of maintenance, dietary services, housekeeping, management and administration departments, capital, and return on investment. This charge is collected by the long-term care facility. Accommodation costs for 2006-7 were $75.50 dollars per day for nursing homes, $49.00 for RCFs and $46.00 for CBOs.

Reduced accommodation charges are available, though a yearly needs assessment is required. As of January 2005, this assessment no longer includes the resident's financial assets in order to prevent residents from drawing down their assets to pay for accommodation costs. This assessment also accounts for spouses who remain at home, allowing them to retain 50% of the joint family income and control over all assets.

Personal expenses must also be paid by the resident (e.g. clothing, eyeglasses, hearing aids, dental services, funerals, pharmacare co-payment, and transportation). However, transportation for dialysis or inter-facility transfers is paid by the province. There is also a specialized equipment loan program available for residents in long-term care. This program is administered by the Red Cross. Depending on income, residents may be required to pay a fee.

Who stays in long-term care?

Admission to the three types of long-term care facilities in Nova Scotia is centralized through the Single Entry Access System of the Continuing Care Branch. They assess the level of care required and determine the most appropriate type of institution.

RCFs and CBOs are intended for residents with similar health capacities (Department of Health, 2007). A typical RCF or CBO resident is someone who has care needs that cannot be safely provided at home. While they generally have decreased physical and/or mental abilities, they are mobile (with or without the assistance of canes, wheelchairs, walkers) and they do not require more than 1.5 hours a day of supervision or personal care. They also do not require the services of an on-site registered nurse. CBO residents also do not typically require nighttime care. RCF and CBO residents commonly suffer from chronic diseases such as arthritis and hypertension. Yet in case of emergency they must be able to vacate the premises unassisted.

Women comprise the majority (71%) of nursing home residents (CIHI, 2007). While 5% of residents are under the age of 65, most (43%) are 85 years old or more. Twenty percent of residents are between the ages of 75 and 84. Between the ages of 75 and 84 the proportion of

women to men is roughly 2:1. This increases to a ratio of nearly 3 to 1 for residents over 85 years of age (see Table 1).

Table 1: Age and Gender Distribution (CIHI, 2007)

Age Group	**Female**	**Male**	**All**
Younger than 65	2%	3%	5%
65 to 74	6%	3%	9%
75 to 84	20%	11%	31%
85 and older	43%	12%	55%
All Ages	**71%**	**29%**	**100%**

As is to be expected, nursing home residents suffer from more aggravated and complex health conditions (CIHI, 2007). The most common diagnoses were Alzheimer's and dementia (64% of residents). Sixty percent showed moderate to severe cognitive impairment, 44% showed limited or no social engagement and 18% showed signs of depression. Just over one third (31%) experienced daily unrelieved pain, with and additional 5% experiencing severe daily pain. The most common physical conditions experienced by residents were hypertension (45%), arthritis (31%) and diabetes 26%.

Fact Sheet: Long-Term Care in Ontario

Ontario LTC in Numbers	
Total beds in 2004	70,100
Total LTC homes	577
For profit homes	343
Non-profit homes	68
Municipal homes	102
Charitable homes	64
Per Diems (per resident)	$102.32 in 2001
Accommodation Cost	$1500 to $2100 per month in 2007
Average age	82.1
Gender	76.6% women
Care (RN, RPN, aide)	2.04 hrs

Types of continuing care residences

Residential continuing care in Ontario is delivered through three mechanisms: retirement homes, supportive housing and long-term care facilities (MoHLTC, 2007). These forms of housing are distinguished principally by level of care, though cost, ownership structure, and governing legislation are also key points of distinction. While this fact sheet focus on long-term care facilities the basic features of the three types of residences are enumerated below:

Retirement homes – also referred to as retirement residences, care homes, assisted living, and rest homes – are intended for individuals or couples requiring a minimum level of support (e.g. light housekeeping, social activities, meals, low levels of personal care, and depending on the institution availability of staff on a 24 hours basis). These homes are largely run by private for profit corporations (though there are a small number of non-profits) and cost can vary from $1500 per month for a private room to $5000. While some municipalities may have "care home" by-laws, these institutions are not governed by special legislation and thus fall under the *Tenant Protection Act*. Unlike long-term care institutions, individuals apply directly to the provider for admittance.

Supportive Housing – also know as non-profit housing, social housing, senior's housing – is intended for those who require a greater amount of care, though not 24 hour nursing or specialized care. Supportive housing provides daily personal care, meal preparation and homemaking support, as well as the 24 hour availability of a personal support worker. While building management varies, the provision of services is managed by non-profit corporations and covered by the Ontario Ministry of Health and Long-term Care (MoHLTC). Costs range from $699 to $1200 per month and rent subsidies are available in some locations. Building residences within supportive housing are governed by the *Tenant Protection Act*, while the *Long-Term Care Homes Act* governs service provision. Individuals apply directly to the provider for admittance.

Long-term care homes – also referred to as nursing homes, homes, and homes for the aged – are intended for those who require specialized daily personal care and the availability of 24 hour nursing care and/or supervision. The majority of long-term care homes in Ontario are owned by private for-profit corporations though there are a number owned and operated by non-profit corporations and municipal governments. While the Ministry of Health and Long-Term Care (MoHLTC) provides funding, resident co-payment is required, with rates set by the MoHLTC according to the type of room. As of July 2007 room rates were: $1543 per month for basic accommodations (e.g. a room shared among 4 people), $1787 for semi-private, and $2091 for private accommodations. Long-term care facilities are governed by *Long-Term Care Homes Act* and

admission is processed through one of the 14 Community Care Access Centres (CCACs) in Ontario.

Number of facilities and ownership type

The most recently available figures show that in 2004 there were currently 70,850 long-term care beds in Ontario, up from 57,000 beds in 2000 (Smith, 2004). More than half these beds (38,057) are in for-profit homes, as compared to 16,654 beds in municipal homes, 6,588 beds in non-profit homes, and 8,841 beds in charitable homes. This represents the highest proportion of private sector involvement in the country (OHC, 2002).

Regulation of long-term care in Ontario

Until the mid 1960s two statutes governed long-term care facilities in Ontario: The *Homes for the Aged and Rest Homes Act* (1949) and the *Charitable Institutions Act* (1951). Homes for the Aged were operated by municipalities and Charitable Homes were operated by charities. Both are non-profit enterprises. There were also number of private for-profit nursing homes that went unregulated until the introduction of the *Nursing Homes Act* in 1966.

In 1994, Bill101 and Bill 173, *The Long-Term Care Act* was passed to bring nursing homes, homes for the aged and charitable homes under the purview of one Ministry. This move towards consolidations was furthered by the passing of Bill 140 "*An Act Respecting Long-term Care Homes*" in June of 2007. The new *Long-Term Care Homes Act* came on the heals of a number of 'scandals' and poor evaluations of long-term care facilities in Ontario (PwC, 2001; McKay, 2003). Not surprisingly, the act was touted as strengthening enforcement and improving care and accountability. Among other things, the new Act includes:

- Yearly unannounced facility inspections with reports made publicly available in LTC facilities and on line.
- Whistle-blowing protections for persons, including staff, residents and volunteers, who report abuse or neglect
- A detailed "least restraint policy" limiting the use of restraints and including appropriate safeguards
- An enhanced and more clearly enforceable Residents' Bill of Rights
- Strengthened requirements related to the development of an integrated, interdisciplinary plan of care for every resident.

Regulation of long-term care facilities is also provided through Resident's and Family Councils. Residents' and Family Councils are autonomous bodies that act as advocates for seniors in homes, advising residents of their rights, monitoring facility operations, reviewing inspection reports and financial statements, and filing complaints. As of 2004, there were 178 Residents' Councils and 154 Family Councils within long-term care facilities (Smith, 2004). The *Long-term Care Act* mandates the establishment of Residents' Councils in each home and strongly encourages the creation of Family Councils.

Finally, there is a toll free ACTION line (1-866-434-0144) available for residents and home care clients to voice complaints, concerns, and questions. The 2007 Act expanded this service to include family members.

Who pays and how much?

As noted, while the MoHLTC provides funding for long-term care institutions, residents are required to make a "co-payment" with the amount depending on the type of room (MoHLTC, 2007). As of July 2007 room rates were: $1543 per month for basic accommodations (e.g. a room shared among 4 people), $1787 for semi-private, and $2091 for private accommodations. Government subsidies are available for basic accommodation only. As 60% of available beds are reserved for those who can pay the additional daily fee for "preferred" accommodation, these may remain empty while there are waitlists for "basic" accommodation (Smith, 2004).

How is long-term care funding determined?

In 1993, the Ministry of Health set out a new needs- based funding system for long-term care facilities (OHC, 2002). Residents are assessed annually by the Ministry and categorized according to the Albert Classification System, which measures eight indicators of care requirements: eating, toileting, transferring, dressing, potential for injury to self or others, ineffective coping, urinary continence, and bowel continence. This information is then aggregated to provide a sense of the total care requirements for each facility or what is called a *Case Mix Measure*. By averaging the Case Mix Measure for all facilities a *Case Mix Index* is produced, which enables the Ministry to determine base line funding levels. The funds allocated to each facility depend on where it falls in relation to this average.

Funding is allocated through four envelopes: 1) nursing care and personal care, 2) program and support services, 3) raw food, and 4) accommodation costs (facility costs, administration, housekeeping, building and operational maintenance and dietary and laundry services). The amount allocated for nursing and personal support is based on the Case Mix Index described above. The amounts for programming and support as well as for accommodation are set by the province and are the same for each institution. With the exception of accommodation – which is paid by the resident – all unused funds must be returned to the province. Thus accommodation is the only envelope from which for-profit facilities may extract capital.

Table 1 illustrates that in 2001 the total per diem rate amounted to $102 for an 'average' long-term care resident. Or $57.62 if we do not include the amount paid by the resident herself. As McKay (2003) observes, public funds for long-term care residents are considerably less than the $140 per diem spent on inmates in jails and detention centers.

Table 1: Per diem rates per resident, as of October 1, 2001 (OHC, 2002)

Nursing and Personal Care (Average CMI)	$52.38
Programming and Support Services	$5.24
Accommodation (Including the "raw food" amount of $4.49 per day)*	$44.70*
Total	**$102.32**

* In 2004, raw food is treated as a separate envelope.

Who stays in long-term care?

Women comprise the majority (76.6%) of long-term care residents in Ontario (PwC, 2001). The average age of long-term care residents is 82.1 years.

Long-term care residents cope with a complex mix of age related physical diseases and cognitive challenges (PwC, 2001). Several measures assessing levels of impairment find that almost half of

long-term care residents in Ontario (44.8%) show high levels of cognitive impairment (levels 4 to 6 on the CP scale) and similarly 47.9% show high impairment when it comes to independence in activities of daily living (levels 4 to 6 of the ADL scale). More specifically, over half of Ontario residents (53%) have been diagnosed with either dementia or Alzheimer's. When assessed with a depression rating scale (DRS), 30.5% of residents indicate the presence of minor or major depression. Physically, 70% of residents suffer from incontinence, 19% from diabetes, 22% from stroke, 30% from arthritis, and 11% have congestive heart failure.

It is well known, though perhaps less well documented, that residents in long-term care facilities are entering older and requiring increasingly more care. According to the Ontario Association of Non-Profit Homes and Services for Seniors (in OHC, 2002), for instance, care requirements of residents increased an average of 13.7% between 1993 and 2001. The greatest increase – of 30.8% - was seen in Charitable Homes for the Aged, twice that of Municipal Homes (15%). Nursing Homes evidenced the smallest increase in acuity levels: 9.9%.

In sum, according to the PriceWaterhouseCooper's (2001) survey, Ontario long-term care residents are among the oldest, have one of the highest rates of mental impairment and are the most depressed.

Fact Sheet: Long-term care in Manitoba

Manitoba LTC in numbers	
Beds (2006)	9822
Occupancy rate	96%
Institutions	122
Not for profit	103
For profit	19
Average Age	83
Per diem (resident charge)	$28.80 to $67.60 per day
Gender ratio	
75 to 84 years	2:1 (women: men)
85 + years	3:1 (women: men)

Types of continuing care homes:

Residential continuing care in Manitoba is delivered in three forms: assisted living, supportive housing, and personal care homes (Manitoba Health, 2007a).While this fact sheet focus on long-term care facilities (or PCHs) the basic features of the three types of residences are discussed below:

Assisted living combines independent apartment living with purchased services such as housekeeping, meals and laundry. Individuals must apply and contract directly with the landlord. Some sites provide supervision and assistance and individuals have access to provincial or local programs – e.g. home care – which are currently being deepened through Manitoba Health's "Aging in Place" strategy.

Supportive housing provides intermediate personal care to individuals requiring 24 hour support and supervision. Supportive housing targets mainly seniors and houses individuals in group, community settings. While the province funds the health care component, the individuals pays for rent and any additional support services (e.g. housekeeping, meals, laundry). Some locations may have rental assistance but the majority do not. Within the Winnipeg Regional Health Authority, for instance, only 20 of the 272 spaces offer rent geared to income (WRHA, 2007).

It is worth noting that supportive housing and assisted living are sometimes found in combination. One such site is the Riverside Lions Seniors Residences in St. Vital, a suburban section of Winnipeg. This complex is currently a fully accessible five-storey, 75 unit apartment building that is to be linked with another existing independent living seniors building nearby. The completed $2 million dollar project will have 27 one-bedroom units offering assisted living and 48 supportive housing studio units for seniors with early-stage dementia/Alzheimer's.

Personal Care Homes (PCHs) are facility based, congregate settings providing 24-hour professional nursing services to those who can no longer manage independently at home with family and/or home care support. Residents pay a daily, income-based rate set by Manitoba Health. The province also funds the health care component. According to Manitoba Health (2007a), PCHs offer the following services:

- meals (including meals for special diets);
- assistance with daily living activities like bathing, getting dressed and using the bathroom;
- necessary nursing care;
- routine medical and surgical supplies;
- prescription drugs eligible under Manitoba's Personal Care Home Program;
- physiotherapy and occupational therapy, if the facility is approved to provide these services;
- routine laundry and linen services

Number of facilities and ownership type

In June 2004 there were 122 Personal care homes (PCHs) in Manitoba with a total of 9,586 beds (Doupe et al., 2006). By 2006 the number of beds had increased to 9822 (Manitoba Health, 2007b).

PCH are not evenly distributed across the province. The largest proportion of PCHs (31.1%) were located in the district covered by the Winnipeg Regional Health Authority (Doupe et al., 2006; WRHA, 2007). Since these institutions tend to be bigger, over half (57.6%) of the total PCH beds in the province are concentrated in the WRHA (see table 1)

Table 1: Number and percent of PCH facilities and beds in Manitoba, by Regional Health Authority (RHA)

RHA	PCHs	Beds
Assiniboine	27 (22.1%)	909 (9.5%)
Brandon	5 (4.1%)	597 (6.2%)
Central	15 (12.3%)	831 (8.7%)
Interlake	11 (9%)	552 (5.8%)
Nor-man	3 (2.5%)	126 (1.3%)
North Eastman	5 (4.1%)	190 (2%)
Parkland	11 (9%)	544 (5.7%)
South Eastman	7 (5.7%)	334 (3.5%)
Non-Winnipeg	84 (68.9%)	4,083 (42.6%)
Winnipeg	38 (31.1%)	5,503 (57.4%)
Manitoba	**122 (100%)**	**9,586 (100%)**

Source: Doupe et al. (2006)

PCHs in Manitoba are classified as proprietary (for profit) and non-proprietary (not for profit). As of 2004, eighty-four percent or 103 PCHs were non-propriety (Doupe et al., 2006). This is compared to 16 percent that were run for profit. PCH facilities in Manitoba are further classified as free-standing or juxtaposed to another health care facility. All proprietary facilities are free-standing. In contrast, 64 nonproprietary facilites are freestanding (or 52.5% of the PCHs in Manitoba) compared to 39 juxtaposed PCHs (or 32% of the provincial total).

Table 2: Number and percent of PCHs in Manitoba by ownership type

RHA	Total # of PCHs	Non-Proprietary PCHs	Proprietary PCHs
Assiniboine	27	27 (60%)	0
Brandon	5	3 (60%)	2 (40%)
Central	15	15 (100%)	0
Interlake	11	9 (81.8%)	2 (18.2%)
Nor-man	3	3 (100%)	0
North Eastman	5	5 (100%)	0
Parkland	11	11 (100%)	0
South Eastman	7	6 (85.5%)	1 (14%)
Non-Winnipeg	84	79 (94%)	5 (6%)
Winnipeg	38	24 (63.2%)	14 (36.8%)
Manitoba	**122 (100%)**	**103 (84.4%)**	**19 (15.6%)**

Source: Doupe et al. (2006)

Given the concentration of beds in Winnipeg, the WRHA (2007) data is worth examining more closely. As of 2007, there were 39 PCHs in Winnipeg, for a total of 5,697 PCH beds (up by almost 200 beds from the 2004 data above). Of these, 3,555 beds were within the 25 non-proprietary PCHs. The 14 proprietary PCHs currently have 2,142 beds. Not all beds are for the elderly. The WRHA reports that of the 5,697 beds, there are:

- 4,977 general personal are beds
- 352 behavioural special needs beds
- 36 beds for the young disabled adults
- 20 beds for deaf or hearing impaired individuals
- 9 behavioural treatment beds
- 249 interim Personal Care Home beds
- 34 respite beds

Recent policy developments around long-term care in Manitoba

Admission to PCHs fall under the Manitoba Home Care Program. This program was established in 1974 as the first province-wide, co-ordinated, continuing care program in Canada. Manitoba Health administered the program until 1997, when regional health authorities assumed control for the majority of functions including assessment and admissions to PCHs

In January 2006 Manitoba Health launched a new long-term care strategy for seniors, called Aging in Place (Manitoba Health, 2006). This program is intended to address the fact that Manitoba has the highest rate of PCH placements in the country (126 beds per 1000 over the age of 75). This is perceived to be a key problem. The aim of the strategy is therefore to maximize community living options. Nevertheless, Aging in Place incorporates plans to improve PCH environments by moving towards single-bed accommodations rather that shared accommodations. For instance, in Winnipeg, approximately 70% of PCH beds are in single rooms. The Aging in Place goal is to raise this to 97% within five years. In keeping with the continuing care model, Aging in Place provides $98 million for, among other things: supportive housing, specialized supports and supports for seniors in group living.

Who pays and how much?

The costs of staying at a PCH are shared by the province and the resident (Manitoba Health, 2007a). Manitoba Health pays the majority of the cost through regional health authorities. The individual pays an income based “residential charge” that is set annually. In 2007, residential charges ranged from $28.80 per day to a maximum of $67.60 per day. The residential charge structure is intended to ensure residents retain a certain amount of disposable income for personal expenses. In 2007 the allowed amount was a minimum $254 per month or $3,048 per year for those paying the minimum residential charge. Spousal ‘allowances’ are also calculated and, for a resident paying the minimum, can range from $13,356 to $27, 925.

Who stays in long-term care?

In 2000, Manitoba currently had the highest rate of PCH placement in the country at 126 beds per 1,000 people over the age of 75. Most residents (93%) entering PCHs come from home care (Roos et al., 2001). The average resident is 83 years old and resides in a PCH for 2.8 years (Manitoba Health, 2007b).

In study of PCH residents over a 5 year period (from 1999 to 2003), Doupe et al. (2006) found that half of all residents admitted during this period were 85 years or older. Approximately, one third (36.2%) were between the years of 75 and 84, while only 9.9% of admissions were for people between 65 and 74. Younger people were admitted, though they comprised only 3.9% of all admissions.

As with other provinces, residents of long-term care tend to be elderly women (Doupe et al., 2006). While the gender distribution is relatively equal up to the ages of 74, beyond this the gap increases. Residents between 75 and 84 years of age are twice as likely to be women, and residents 85 years or older are over three times as likely to be women (Doupe et al., 2006). Similarly, there is a significant gender gap in marital status, an important indicator of potential informal care. While 26% of both men and women younger than 75 are married, nearly half (40.2%) of men 75 years or older are married. This is compared to only 11.5% of women 75 years or older.

The care levels required by admitted residents would seem to be split between low and high needs. During the five-year study period, Doupe et al (2006) found that nearly half (46.0%) of the admitted residents were assigned to low levels of care (requiring less 2 hours of care per day) and were thus assumed to be less frail However, 42.3% of admitted residents were believed to need higher levels of care – from 2 to 3.5 hours a day – and 11.7% of admitted residents were thought to require more than 3.5 hours of care per day.

The health care needs of residents are not particularly surprising. The majority (65.3%) of PCH residents had been diagnosed with dementia (Doupe et al, 2006). And many, if not most, residents (70%) suffered from two or more chronic diseases. The most common of these being arthritis (28%), followed by diabetes (17%), stroke (16%), and 13% with congestive heart failure (PwC, 2001).

As with other areas in Canada, the majority of care is provided by care aids. Only 0.4 hours of the total 2.44 average total hours of care in Manitoba are provided by RNs (PwC, 2001)

Fact Sheet: Long-term care in British Columbia

Types of continuing care residences

Within British Columbia long-term care is administered through the Community Care Facilities Branch (CCFB) of the provincial government, which provides residential elderly care through assisted living and residential care facilities (Ministry of Health, 2007a). While this fact sheet focuses on residential care facilities (RCFs), both types of housing services are described below.

B.C. LTC in Numbers	
% of beds by ownership type:	
For profit:	38%
Not for profit	44%
Government	10%
Religious	8%
Cost	$29.40 to $70.60
% over 85 living in a facility	
Women	29%
Men	17%

Assisted Living Residences - also referred to as supportive housing – provide housing and care to seniors and people with disabilities who can direct their own care and do not require the availability of 24 hour nursing care. Assisted living residences combine hospitality services such as laundry and housekeeping with personal assistance, such as help with eating, the monitoring of medications, and mobility assistance. Assisted living is distinguished from residential facility care by the number of "prescribed services" provided. Only one ore two prescribed services are provided. Residents are therefore required to self-direct most of their care. Residents of publicly-funded assisted living residences pay a monthly charge based on their after-tax income.

Residential facility care (RCFs) form part of what the CCFB refers more generally to as *Licensed Community Care Facilities.* Licensed community care facilities include both child day care facilities (e.g. preschool, day care) and residential care facilities (RCFs) for adults. The term residential care facility does not refer only to senior care, but group homes for disabled individuals and drug and alcohol facilities. RCFs are typically sites where care is provided to three or more individuals. Residents of RCFs pay a per diem amount based on their after-tax income. RCFs are distinguished from assisted living as they provide three or more prescribed services which may include:

- Regular assistance with daily activities (e.g. mobility, eating, dressing, grooming, bathing and personal hygiene)
- Monitoring of food intake or therapeutic diets.
- Administering and monitoring of medication
- Distribution of medications.
- Maintenance or management of residents' cash and valuables.
- Structured behaviour management and intervention.
- Psychosocial and physical rehabilitative therapy.

In addition to RCFs, British Columbia also has Family Care Homes, which are single family residences that provide supportive accommodation for up to two clients. Family care homes may serve as an alternative to staying at an RCF. While they are found across the province, family care homes are more prevalent in rural settings.

As well, BC has Group Homes that are private residences geared primarily towards adults with disabilities. Group homes are similar but larger than Abbeyfield housing, a type of shared

supportive housing based on a model developed in Great Britain. An Abbeyfield house resembles a large house where residents have a private room, perhaps a private bath room, but share other living spaces. Meals, cleaning support and other non-nursing forms of assistance are provided by a housekeeper. Abbeyfield type housing is becoming common in British Columbia.

Number of facilities and ownership type

British Columbia currently has the lowest long-term care bed capacity in the country (Berta et al., 2006). In 2001 there were 3.626 beds for every 100 individuals over the age of 65. This proportion has decreased slightly from 1996 when it was at 3.769. The majority of residential care beds are located in either non profit (44%) or for profit (38%) facilities. In British Columbia, government run facilities comprise only 10% of the long-term care beds. This is similar to religious facilities which have 8% of the provincial beds.

Regulation of long-term care facilities

Long-term care is administered through the Community Care Facilities Branch (CCFB) of the Government of British Columbia's Ministry of Health. The CCFB is responsible for the development and implementation of legislation, policy and guidelines to protect the health and safety of people being cared for in long-term care facilities.

Long-term care facilities are regulated by the *Community Care and Assisted Living Act* (Ministry of Health, 2007b). This act was brought into force on May 14, 2004 replacing the *Community Care Facilities Act*.

The new act enumerates the type of prescribed services that may be provided. The number of prescribed services differentiates a licensed community care facility from an assisted living residence.

The new act also requires operators of assisted living residences to register with the provincial Office of the Assisted Living Registrar. The Registrar maintains a registry of assisted living residences and investigates health and safety concerns.

The new act also brings under its purview public extended care facilities – which also have provided 24/7 professional nursing care for seniors and people with disabilities. These institutions used to operate under the 1996 *Hospital Act*, the same legislation as public acute care hospitals. Transferring these facilities to the new Act is intended to ensure that they are consistent with licensed residential care facilities, which provide similar services.

Who pays for long-term care?

The province shares the cost of long-term care through accommodation charges, which are generally income adjusted. In 2007, the RCF per diem rate ranged from a minimum of $29.40 to a maximum of $70.60. Family care homes are operated under the same fixed cost structure, whereas group home rental rates are set by the landlord. The province also sets rates for residents of assisted living. These rates are based on 70% of residents after-tax income.

Senior demographics and facility residency

British Columbia has one of the most rapidly aging populations in Canada (Ministry of Health, 2004). Between 1991 and 2001, the median age in British Columbia increased 3.7 years, from 34.7 to 38.4 years. This is higher than the national average of 37.6 years. Between 1991 and 2001

the number of seniors age 80 and older increased dramatically from 87,065 to 134,175. This was a 54% increase and the highest level of growth amongst all provinces.

One of the factors predicting the need for long-term care is the death of a spouse and the consequent loss of informal care. Senior women are much more likely to suffer the death of a spouse then men. Just over three-quarters (78%) of women 85 and over are widowed, compared to only 36% of men.

Living arrangements among seniors aged 85 and older also vary considerably with gender. Almost half (43%) of women 85 years old or older live alone. This is compared to 25% of men in the same age group. Similarly, almost one third (29%) of women 85 years old or older live in a health care institution. This is compared to 17% of men 85 or older.

Entry to long-term continuing care

Admittance to RCFs is obtained through a single entry point system. Potential residents or someone on their behalf must apply by contacting the Home and Community Care Office of the local health authority. Depending on the level of urgency, a case manager will be appointed and an at home assessment made. A care plan is designed and appropriate services provided, which may not necessarily involve residency at an RCF but could involve: home support, home care nursing, palliative care, community rehabilitation, adult day centre, assisted living, residential care, or hospice.

Who uses RCFs?

Residential care facilities target seniors with complex health problems, in particular Alzheimer's disease or other types of dementia. RCFs also target seniors who are physically dependent with medical needs caused by advanced age. RCFs are not exclusive to seniors however and may include younger adults with disabilities such as Parkinson's disease.

Fact sheet: Long-term care in the Yukon

Long-term continuing care in the Yukon is delivered by Yukon Health and Social Services' Continuing Care Branch (CCB), which also delivers home care. The CCB describes the philosophy of care guiding residential care programs as follows:

> "We are a community that respects and promotes dignity, individual freedom, choice and lifestyle, and meaningful quality living. We continually strive to create a feeling of home and belonging for all who live here by being responsive to the uniqueness of each resident" (YHSS, 2007).

There are only three residential care facilities in the Yukon. Two (Copper Ridge Place and Macaulay Lodge) are located in Whitehorse and the third (McDonald Lodge) services Dawson City. Below is a brief description of these facilities.

Copper Ridge Place is a 96-bed facility providing complex chronic care and extended care for individuals who require significant assistance with activities of daily living, monitoring and/or professional care on a 24-hour basis. Copper Ridge Place serves people of all ages, though it offers a Special Care Program, providing individualized care for residents with dementia.

Macaulay Lodge is a 44-bed, intermediate care, facility offering residential and respite care for both seniors and adults. The care levels provided at Macaulay Lodge are less intense than at Copper Ridge Place. The lodge targets individuals who require moderate assistance with the activities of daily living, monitoring and/or professional care on an intermittent basis throughout the day.

McDonald Lodge, located in Dawson City, is an 11-bed facility providing residential care to people who require light to moderate personal care, such as help with the activities of daily living, monitoring and/or professional care on an intermittent basis throughout the day. McDonald Lodge also offers Home Care Nursing and Home Support Services to people who live at home.

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