Private Pay Long Term Care: A Sensible Option to Consider

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Key Messages

This project is an attempt to discuss private pay long term care against the realities and challenges of the present long term care system. Many Canadians may not understand or appreciate the gaps in current services, and will likely be shocked with that reality as they or their family members age and enter into its system. Whether the argument is financial related to funding, or philosophical related to consumer choice, an increased private pay model is worthy of consideration to address these challenges. It is critical for private pay operators to communicate the realities of the present publically governed system, address issues and myths within the private pay option, and then promote their services against the backdrop of our present long term care system reality. While governments may place an emphasis on home care services throughout Canada, it is clear that facility-based options for those unable to support themselves within their own homes will continue to exist. Canadians should consider private pay services as one of those options. Costs related to healthcare will increasingly shift to individuals as government fiscal realities restrict funding and further limit the public healthcare system. Given the increased level of financial responsibility and burden for their own health care, governments should encourage Canadians to save for their health care through tax and savings incentives. As well, Canadians should consider acquisition of long term care private insurance. Regardless of one's philosophical opinions related to private pay long term care or private healthcare in general, it is essential for Canadians to understand the present realities of our current system and begin planning for a realistic future.

Executive Summary

In Canada, long-term care services are primarily provided within a publically funded and governed system. However, this system is beset by challenges and issues that threaten its present sustainability. Within such an environment, there is another option that exists within the care delivery system for Canadians to consider – that of private pay long term care. This project presents issues facing long term care today, and presents the option of private pay long term care within the context of our present long term care system. In doing so, the project outlines and refutes arguments that may exist towards this delivery system, presenting a case for its promotion to Canadians as a reasonable and increasingly sensible option for consideration.

Long term care delivery and systems are regulated and governed provincially, with variation in services, delivery and terminology across the country. Challenges however, exist across jurisdictions within our existing long term care system include those related to demographics, client expectations, waiting lists for services, funding, aging infrastructure, and government directions and oversight. These issues provide barriers for regulatory and funding bodies to meet current and future demands for long term care services.

Given these challenges, it is reasonable to conclude that the system as it presently operates must change and that government should look for long term care operators and its present system of care and service delivery for solutions. One such option to examine is the area of private pay long term care.

However, discussions of private pay long term care are often clouded by myths and misconceptions. These myths involve such factors as the creation of a “two-tiered” health care

system, the responsibility of governments to provide long term care, excessive financial costs, and a lack of standards.

This project refutes these myths and presents private pay long term care as a valuable service within a continuum of service delivery, offering a choice for Canadians and for operators to consider.

While Canadians may differ philosophically on their approaches to health care funding and delivery, the reality is that a private pay long term care system can support the existing publically governed one. Increasing the visibility of this option through marketing and communication of its benefits, and the publically governed system's shortfalls affords an opportunity for Canadians to have more choice for such services.

This project is an attempt to discuss the private pay long term care option against the realities and challenges of the current long term care system. Many Canadians may not understand or appreciate that the current state is one of unsustainability, and will likely be shocked with that reality as they or their family members age and enter into its system. Whether the argument is financial related to funding or philosophical related to consumer choice, an increased private pay model delivery is a worthy option for Canadians to consider. It is critical for private pay operators to communicate the realities of the present publically governed system, address issues and myths within their operations, and then promote their services against the backdrop of our present long term care system reality.

The findings presented in this paper are relevant throughout the country. In order to disseminate the knowledge gained, I will be submitting abstracts to journals and conferences related to this topic and communicating its value further with external stakeholders.

Private Pay Long Term Care: A Sensible Option to Consider

Context

In Canada, long-term care services are primarily provided within a publically funded and governed system. However, this system is beset by challenges and issues that threaten its present sustainability. Within such an environment, the reality is that another option exists within the care delivery system for Canadians to consider – that of private pay long term care. This project will outline the issues facing long term care today, and then present the option of private pay long term care within the context of our present long term care system. In doing so, the project will outline and refute the arguments that many have towards this approach and present a case for its promotion to Canadians as a reasonable and increasingly sensible option for consideration.

Report

Summary.

Following a discussion of the methodology used for this project, the paper will be divided into three sections that mirrored progress within it: an outline detailing present long term care delivery in Canada along with gaps and pressures within this system; a section dealing with private pay long term care, which will include a discussion of the myths and challenges of this service; and a final section outlining conclusions and recommendations derived within the project, and how this project can contribute to both the theory and practice of health leadership in Canada.

Approach and Methodology.

In order to fully understand the approach taken and facilitate replication, this section is divided into the methods used for the project's literature review and survey.

During an initial phase of data gathering, information was collected from literature searches described in the next section and subsequently analyzed and integrated into two primary sections which could:

(a) provide an understanding and picture of long term care in Canada today; and
(b) support the identification and discussion of challenges with private pay long term care delivery.

Categorizing information in this manner during this initial phase facilitated further delineations of each of these two sections. For example, the review of literature regarding long term care in Canada enabled further categorizations of challenges within this system that were then presented. As well, the information researched that indicated challenges within a private pay long term care model enabled further categorizations of myths within this service option. This method also assisted in ensuring that the project's scope remained centered around the issue of private pay long term care as opposed to other delivery streams such as home care and acute care.

The review of literature was initiated as a first step, a validation of Grady's (1998) identification of the importance of document analysis to not only understanding a situation but also setting its context. Once the two primary sections outlined above were established and delineated as described, further integration of additional literature and survey information occurred.

The approach used for this project incorporated qualitative methods referenced by the Pell Institute (2013), with a six stage methodology incorporating the processing of received data, its analysis, data reduction, the identification of themes, the display of data, and the drawing of conclusions.

Literature.

Several sources of evidence were used for this project including a review of literature which incorporated a review of provincial and federal regulatory bodies responsible for the care and services of seniors, and a review of some present private pay options within organizations. Databases within web-based resources such as those of Statistics Canada, provincial continuing care associations, www.LongTermCareCanada.com, www.senioroplis.com, and provincial regulatory bodies were accessed to obtain information. This process was facilitated by searching such resources using terms and words such as “private pay long term care”, “Canada Health Act”, “long term care fees”, and “long term care access”, among others with “nursing home” used alongside “long term care”. As well, an Environics Communications daily media release service that pulled national long term care articles from newspapers across the country was accessed to add current and topical information of relevance.

In total, over 50 reference materials were involved in the literature to support this project, including that from books, periodicals, newspaper reports, provincial association documentation, industry studies and regulatory body information. As mentioned, on-line searches were conducted and included those of provincial continuing care associations, and provincial regulatory bodies. In addition, articles and books were obtained from known subject matter or

organizational leaders in the field and other materials were located from general internet searches.

Selection criteria that led to inclusion and exclusion of information related to the material's age, author or source, and country of origin. The majority of the material selected for review was from January of 2008, in an attempt to capture more recent information, given the changing nature of healthcare delivery in Canada. Included by design as recent material were several newspaper articles, providing a current source of a timely issue in the public domain, thereby adding further relevance to the project. Materials chosen were typically Canadian in nature, representing a cross-section of our healthcare delivery system and approaches, a recognition of healthcare as a provincial jurisdiction.

Information regarding regulatory environmental conditions was provided to outline the context of a jurisdiction's approach to long term care, but did not necessarily provide detail on their specific frameworks or historical approaches. Literature was also selected to ensure competing viewpoints of healthcare delivery and funding models were represented and analyzed. Such a diversity of source authors ensured that information was not weighted to one viewpoint, thereby facilitating a robust examination of the issue of private pay long term care. Given that qualitative data is a subjective process, such diversity of selected sources was deliberate to also lessen the potential for author bias.

Following a review of applicable literature, information was categorized as described earlier into the relevant themes and sections within the project. Such sections then provided a general context for the state of this health care sector as well as its challenges, thereby framing a subsequent discussion of private pay long term care.

Surveys.

Feedback was also obtained from 24 representatives of the continuing care system, primarily through surveys (21) and interviews (3), which used the identical survey tool that is located in the Appendix. While this sample size might be considered small and some respondents did not answer all questions, information yielded provided important context to the issue of private pay services.

Some criteria were used to include and exclude information. Individuals whose feedback was sought represented long term care operators across the country serving in public, voluntary and private operations, overseeing both single site and multi-site organizations. The majority of respondents were at levels of Executive Director or above within their organizations or regulatory bodies as these individuals were regarded as being able to speak to the questions, and services, requested. As well, many respondents based their comments not only on their present environments but their observations of private pay long term care through previous employment in, or other exposure to, such settings. To ensure more relevance, feedback was solicited only from Canadian participants.

Some information was not requested of respondents by design. For example, exclusion criteria included demographic information related to the medical conditions of clients served as that was beyond the scope of this project. As well, comments provided remained anonymous within the report. Although feedback was requested from individuals with positions of Executive Director or above within their organization, no information was collected related to their individual professional or organizational backgrounds, or their service length in the industry. Such a decision was made to respect anonymity and also to manage the scope of this project

which focused information requests on services provided rather than on the individuals providing feedback on such services. It is also important to note that no information related to rates charged to clients was requested as that was viewed as proprietary as well as unethical by the author given his employment in the industry.

As noted in the Appendix, survey questions asked were open-ended, allowing opportunities for participants to provide information of their experiences related to private pay long term care including their organization's rationale for deciding whether to provide this service. Such questions were used to promote a broader understanding of the subject matter, a view shared by Maher and Kur (1983), who argue that these types of questions also allow for more original responses and should be encouraged. While this largely qualitative methodology had an absence of numerical data, the inclusion of survey information did add a small sample data set that indicated those who did provide private pay services.

As referenced earlier, the methodology used with survey data began with the immediate processing and recording of returned data, a process facilitated by the fact that survey information was received electronically and transcribed similarly into a composite survey template, with responses to each individual question placed into the composite document. As this survey template mirrored the survey itself, it also facilitated data gathering. A record of survey participants was maintained from the list of those who received a survey, which was also sent electronically.

The next step provided for the initiation of analysis as soon as data was received, and involved sorting data according to the survey questions, again facilitated by having the survey information transcribed electronically into the composite survey template, as identified in the

previous step. Data was also easily sorted through the structure of the composite template between those respondents who provided a private pay option and those who did not.

The third step involved data reduction, which was facilitated by focusing on the scope of the project. Extraneous information including respondent identifiers was removed during this stage. For example, site or organizational names as well as regulatory body locations received within a response, was removed to ensure project focus as well as to maintain confidentiality.

Identifying meaningful patterns and themes emerged during the fourth step. At this stage, some themes evolved naturally from the design of the survey questions given the set-up of the composite survey template, while others emerged from a further analysis of returned survey information. This step entailed recurrent reading of survey results in order to ensure appropriate labelling of information received. In this project's surveys, for example, themes that became evident at this stage related to cost, marketing and communication, and services provided.

The fifth step involved data display. The design and use of the composite survey template provided a textual display of such data, and supported the identification of themes among, and between, those survey respondents who currently provided private pay long term care services and those who did not.

The final step of conclusion drawing was facilitated by information referenced in previous stages. As noted by Wanjohi (2010), once data is generalized into themes, it can be interpreted and incorporated within literature available. These themes were further presented into the project's subsequent sections, from which they were able to inform the project's conclusions and recommendations.

While themes and conclusions were woven through subsequent sections, a summary of themes that emerged from respondents is briefly presented below.

Among the themes noted from those twelve respondents who identified that they provided private pay long term care services:

- all dispersed their private pay beds within their funded beds allotment;
- the majority identified challenges which needed to be addressed related to:
    - cost;
    - marketing; and
    - services provided;
- in order to be successful, attention is required to:
    - marketing and communication;
    - current reputation; and
    - staff awareness of private pay clientele.

Among the themes noted from the nine respondents who indicated that they do not currently provide private pay long term care services:

- the primary reason related to the ownership category of their organization, notably being municipal or voluntary based;
- many respondents identified issues of cost and revenue opportunities as potential influences on future decisions related to private pay service delivery; and
- issues of costs and regulatory environments were noted.

Further information and analysis from all respondents is integrated into subsequent sections. As indicated earlier, the survey tool is located in the Appendix, as are specific responses to each question grouped into themes.

Summary of Approach and Methodology.

In summary, this project began by developing an understanding of long term care delivery across Canada and the differences among jurisdiction. An appreciation of the present challenges facing our long term care system was obtained from an analysis of the multiple sources of information identified earlier, which was then organized into common patterns and trends. An examination of private pay long term care and the myths associated with such delivery was also reviewed. The use of multiple sources of data in this manner supported a more inclusive understanding of private pay long term care. This methodology then allowed conclusions and recommendations to be drawn that were evidence-based. By following a systematic approach to reviewing such a topic, an issue of relevance to our delivery system was examined. Such an approach also provides a path to follow for those wishing to replicate, or build upon, the methods used.

Structure.

The paper's structure will mirror the approach described in the previous section, beginning with an outline of present realities across Canada related to long term care, specifically how they are delivered, and some of the gaps and pressures within the current system. The first section on delivery explores the definitions of long term care within the country including terminology used across jurisdictions. The section on gaps and pressures within the system demonstrates how provincial governments currently fund and regulate long term care

services within their jurisdictions. It is followed by a discussion of the numerous challenges faced by regulatory and funding bodies in meeting current, let alone future, demands for long term care services. The next section of the paper focuses on private pay long term care, with subsections of: (a) overview of existing reality with private pay long term care; (b) myths and challenges of private pay long term care; and (c) benefits of a private pay service option.

The overview sub-section is a brief discussion of private pay long term care, specifically an outline of the rationale for their use, and their current inclusion within a regulatory body framework. The next subsection explores some myths and challenges of private pay long term care. A concluding commentary within this section discusses the need for private pay operators to address issues and myths within their operations and promotion of their services.

A final section outlines how this project can contribute to both the theory and practice of health leadership in Canada. This discussion highlights how the project advances a practical solution to existing challenges, providing an opportunity to translate conclusions to other settings in health leadership beyond long term care, namely the ability for Canadians to access increased private health care services.

Results

Present Realities of Long Term Care Delivery in Canada.

This section will outline some of the present realities across Canada related to long term care specifically: (a) how long term care is delivered; and (b) the challenges, gaps and pressures within the current system. Within this section, results of literature reviewed and survey information received will be referenced.

Delivery of Long Term Care in Canada.

Any discussion of long term care delivery across Canada must also explore the definitions of long term care within the country including the varying terminology used across jurisdictions. Pitters (2002) outlines the numerous terms used within provinces including nursing homes, care centres, continuing care facilities, homes for the aged and personal care homes. While terms may vary, they all describe facility-based care.

Statistics Canada (2008) uses the term "residential care facilities" to refer to facilities with four beds or more that are funded, licensed or approved by provincial and territorial departments of health and/or social services, and which include facilities that provide health or social care. According to Statistics Canada, there were 4,845 residential care facilities in Canada serving some 250,387 residents at the end of the 2008-2009 financial year, with most of the activity in these residential care facilities concentrated in the 2,216 residences for the aged (2008). For the purpose of this project, long term care refers to those individuals requiring facility-based care and services.

Long term care is primarily provided across Canada through a publically-funded and governed system, with public, private and voluntary or not-for-profit operators delivering care and services. These long term care beds are accessed through a system governed by the regulatory body of a jurisdiction which assesses clients for appropriateness to long term care and manages the placement and coordination of their care and services within the public model. In fact, as mentioned by Pitters (2002), a “bias towards community-based care is built into all these models to ensure that all community options for care have been explored before a long-term care facility admission is considered” (p. 171). Outside of this public system exists some beds that are

privately paid for by clients and which may exist within or outside of existing long term care homes. In either event, the private pay beds are beyond the funded beds managed and governed by the public system.

As a provincially regulated service, long term care varies depending on the jurisdiction within Canada it is found with a resulting patchwork of care delivery and services across the country. The Canadian Union of Public Employees (CUPE) note that these differences across provinces extend beyond the terminology used to describe facility-based care for seniors, to include the actual services provided to those within such a system, and the rates Canadians are charged for such services (CUPE, 2009).

In all provinces, publically-governed and funded long term care typically has two primary revenue streams: care funding and resident accommodation fees. Within these two revenue categories, provincial governments play a role in their governance, administration, and monitoring.

Care funding is typically determined through provincial health care bodies and based on a measure of resident acuity. Such public funding also comes with specific requirements, often referred to as accountabilities, which may include staffing levels, types of staffing, and care expenditures. Regardless of jurisdiction, the regulations and structure of this public funding and its requirements are similar to all operators receiving such funding – public, private or voluntary. In other words, within a regulatory area, all long term care operators are funded for the care services they provide using the same funding determination and requirements for care services within their homes. Variability across provinces occurs due to the method of determining

resident acuity funding, the financial ability of funding bodies within a province, and the requirements set forth by regulatory and funding bodies related to care services.

Resident accommodation fees typically support the non-care portion of the long-term care operation, such as support services, and physical plant expenses. As identified through the Alberta Government (2012), the actual accommodation fee a resident pays varies greatly from each province, as shown below.

Province	**Accommodation rate (per month, maximum, private room)**
Alberta	$1,785
British Columbia	$3,023
Manitoba	$2,312
New Brunswick	$3,072
Newfoundland and Labrador	$2,800
Nova Scotia	$3,011
Ontario	$2,275
Prince Edward Island	$2,360
Quebec	$1,712
Saskatchewan	$1,931

Specific rules governing these rates paid by residents may also vary by province as outlined by Stadnyk (2000). Accommodation fees can be asset-based, income-tested, a combination of these, or based on neither assets nor income. Manulife (2010) note this variability in which, for example, fees in Manitoba are income-based; those in Nova Scotia are determined through a review of one's income and assets; and in Alberta, no means testing exists for assets or income.

As well, provincial bodies determine the timing of any accommodation rate increases. For example, as referenced by Senioropolis (n.d.), the Quebec Ministry of Health and Social Services sets fees every January 1 for residents of nursing homes in that province. According to

the Government of New Brunswick (n.d.), the government has announced rate increases for the next two years, with the maximum amount to be paid by nursing home residents increasing from $101 per day or an average monthly payment of approximately $3072 to $107 per day in April 2013 and then to $113 per day in April 2014.

In summary, the rates and criteria of resident accommodation fees varies within each jurisdiction, as does the services provided within those fees. The funding inequities caused by the differing rules and requirements across provinces are one challenge faced within long-term care. Regardless of the province, other challenges exist to the present system of long term care across the country.

Challenges within Long Term Care Today.

As noted earlier, provincial governments currently fund and regulate long term care services within their jurisdictions. Within the regulatory environment and long term care industry, there exists numerous challenges in meeting current, let alone future, demands for long term care services. These challenges include those related to demographics, client expectations, waiting lists for services, funding, aging infrastructure, and government directions and oversight. Such issues point to a system where gaps and pressures are only widening and the present system is failing current and future clients. An examination of these issues will now follow.

Demographic Pressures on the Existing System, and the Changing Face of Long Term Care.

Golant (2001) notes in his study the change in Canadians over the age of 65, from 12.3% of Canada's population in 1998, to projected levels of 17.8% in 2021 and 21.7% in 2031. Such a trend places pressure on the existing long term care sector and public policy, impacting the

delivery and financing of a continuing care system. The financial burden faced by governments associated with this demographic trend will be enormous. McGregor and Donald (2011) highlight the demographic challenge in their conclusion that by 2041, "Canada will need 320,000 long term care beds, up from 200,000 now" (p. 1). Indeed, Frank (2012) notes that the combination of Canada's rapidly aging demographic with a longer life expectancy are two trends with dramatic increases in the demands for long term care over the next 35 years. Despite such evidence, other stakeholders including CUPE (2009) note that many provinces are decreasing long term care beds.

With a shift to community care in recent years, Canadians entering long term care are being admitted older, and more medically complex than years ago. Given the demographic pressures, and the health status of seniors entering and needing long term care placements, long term care homes will be faced with increased demands and clients with higher levels of care and services. In fact, it can be argued that long term care homes are increasingly becoming locations primarily to provide end of life care.

Expectations of Consumers.

Canadians may enter into a long term care environment sharing a belief noted by Maclean and Klein (2002) that "their health care needs would be met in their senior years" (p. 71). However, expectations for care and services may not match the reality of the present system. With the growth of the internet and public dialogue surrounding health care, it is safe to say that today's seniors and their families are typically more informed about services available to them, the aging process, and healthcare in general than previous generations were, and that this increased awareness and knowledge can lead to even higher expectations of services to be

provided.. To many Canadians, the thought of long term care may conjure up ideas where choices are always respected. While such choices are attempted to be met, the harsh reality is that they are met within an existing system that can inadvertently restrict choice. For example, the first available bed policies within jurisdictions drives the placement of an individual within long term care. As such, regardless of one's choice to have a private room in a new home at a specific location of a city operated by a voluntary organization, the reality is that an individual may be in a semi-private room in a completely opposite end of the city operated by a private organization, and may also be separated from a spouse who may live in another location. While an individual can refuse such a match, they do so with the knowledge they would then go to the bottom of a placement priority process. As well, although most jurisdictions allow placement onto a transfer list once admitted into a home, the reality is that capacity challenges are such that the priority for admissions to long term care homes is for acute care and community clients, meaning that individuals already living in a long term care home wanting to transfer to another home are a lower priority for placement.

Consumers expecting service variation due to types of homes and fees charged will also face a system that is geared towards standardization, including the system's requirements of a similar price for any bed. A semi-private or private rate can be identical despite differences in the age of homes, organization type or reputation, site structure, or location. A more informed consumer and the expectations of a consumer society will only increase pressures on the current system.

Waiting Lists for Long Term Care.

Waiting lists for long term care are common across Canada. The Ontario Long Term Care Association (2012) note that close to 20,000 individuals are on waiting lists for long term care in that province. Many Canadians are assessed for long term care services but waiting in acute care and community placements. Reasons for these placement delays include a lack of existing long term care homes, the demographic pressures within a community, government directions to restrict or change policies related to admission criteria, and the regulatory system itself. Feedback from survey respondents alluding to few challenges with the occupancy of their private pay beds provides some validation of the need for placements.

In acute care, for instance, Simpson (2012) notes that health care "has to be de-hospitalized so that hospitals can do what they are just equipped to do: provide acute care" (p. 6). As well, the higher cost to the health care system of having individuals receive care in hospitals as they await placement for long term care cannot be ignored.

Pressures related to waiting lists for long term care also exist among those living in their own homes. Individuals receiving care and services in the community from home care organizations or informal caregivers such as family members will at some point in time likely require more involved care. However, home care is also facing pressures of increased demands, higher acuity of clients, and an inability to place clients into long term care due to regulatory preferences to fill long term care beds with individuals from acute care (Keefe, 2002). As well, government directives to prioritize home care are often curtailed by financial constraints from those same governments, as highlighted by McClure (2012d).

Golant (2001) notes that long waiting lists for nursing homes exist in Ontario, Alberta and British Columbia. Indeed, the Long Term Care Innovation Expert Panel (2012) notes that "14% of Ontario's 27,000 hospital beds are occupied by patients who could be more appropriately cared for elsewhere" (p. 7). As well, in the run-up to the 2012 provincial election in Alberta, numerous stories were published highlighting the reality of too many patients in hospitals who should be in long term care homes. As referenced by McClure (2012a), the Health Quality Council of Alberta concluded that up to 8% of acute care beds in that province fit that category.

Provincial Government Finances.

The funding inequities discussed earlier and the varying requirements for care and services lead to gaps within long term care delivery across Canada. These gaps are compounded by the financial pressures faced by provincial governments and funding bodies. Provincial governments are struggling with healthcare costs as a growing and major portion of their total budgets. As identified by Simpson (2012), "health care eats up 42 to 46 per cent of provincial budgets" (p.1). In addition, he notes that Canada is in a period of slow economic growth making large investments to provinces highly unlikely. Such financial reality points to the need to look closely at how health care services are funded as well as alternative models of health care including those involving long term care. Alexander (2002) notes the impact of economic factors on provincial funding and healthcare services, specifically the effect a previous Canadian recession's impact had on government debt, and the strengthening of community-based health services it fostered.

Clearly, the declining ability of governments to fund long term care as a result of their fiscal situations showcases the need to explore alternatives, and such options should be encouraged, promoted, and welcomed.

Aging Infrastructure.

Compounding the issues related to government finances is a need to build new long term care homes and rejuvenate existing aged stock. As noted by Simpson (2012):

> observers of health care have long championed for years the need for more nursing and long-term care facilities. If we wait for our cash-strapped governments to build them, we will be waiting too long, and for the many frail elderly at great cost. (p. 6)

Private pay long term care can transfer financial risk to the operator from government, for not only the operating costs of services but also for their associated capital investment. The pressures to rejuvenate existing homes are extensive. As noted by the ACCA (2012), 50% of Alberta Continuing Care Association members' long term care homes are over 40 years old and many do not meet existing regulatory standards. As well, in some provinces, suggestions have been made to stop building new long term care centers and focus efforts on rejuvenating existing ones. For example, the Long Term Care Innovation Expert Panel in Ontario (2012) recommends not building new homes for five years in that province, focusing instead on the need to "redevelop existing 35,000 long term care beds to meet emerging consumer preferences and system needs" (p. 8).

However, given the financial pressures faced by provincial governments and long term care funding bodies, compounded by the inability of operators to raise accommodation fees beyond a government-mandated rate referenced earlier, it is difficult for operators to fund some

of this new construction or renovation. As a result, infrastructure will not keep up with the growing capacity challenges within provinces and their increasing number of clients awaiting placement.

Government Oversight and Changing Directions.

Provinces have specific guidelines, licensing requirements, and regulations related to long term care, and have processes in place to ensure compliance with such standards that all operators must meet. Such monitoring is increasingly being tied to public reporting, allowing Canadians to view results of a home's compliance to standards and better inform them of such a home. Routine audits and anonymous inspections based on reported complaints are commonplace in long term care homes across Canada.

No long term care operator would disagree that providing quality care and services is the primary purpose of their home and would welcome the ability to showcase such quality. However, the prevalence of such audits does not necessarily measure such quality. As mentioned by the Canadian Healthcare Association (2009), "some long term care professionals have been especially concerned that the compliance process is adversarial…with little or no effect on resident care" (p. 86). While a process should exist to measure quality outcomes, present systems appear to focus on simply quality assurance versus quality improvement of a given service. Furthermore, there is no measure of the financial and administrative burden caused by these often unnecessary requirements. Many jurisdictions are calling for a revamping of their regulatory systems, including Ontario's Long Term Care Innovation Expert Panel (2012).

As described earlier, provinces and regulatory bodies drive funding sources for long term care operators. Accommodation fees are set by government, as are the rate increases and timing

of such increases. Care funding is set by government; however, even with standard acuity-based assessments, this care funding is still dependent on government finances.

Revenue uncertainty is not the only unknown faced by operators that creates an environment which prohibits investment by operators into existing or new infrastructure. Changing rules and regulations also occur within such care funding and accommodation funding envelopes. For example, in Alberta the government has developed a continuing care delivery continuum involving supportive living and long term care (Government of Alberta, 2012). Such a model has highlighted the issue of a "downloading" of care to supportive living level environments, where care funding is lowered, staffing requirements are less rigid, and resident out-of-pocket payments for care are increased when compared to facility-based long term care.

Government directions compound existing pressures in long term care. Golant (2001) notes that governing bodies "worried about the increasing costs of publicly subsidized nursing care, are beginning to restrict admittance to only the frailest elders" (p. 3). And Armstrong's (2003) discussion of private assisted living describes this option, that provides meals, housekeeping, hotel-type services and some care at a price, as having lower standards for staffing and funding. McClure (2012a) references long term care funding rates in Alberta of approximately $156 per resident per day (prd), compared to funding of $105 prd or $80 prd in some supportive living environments. Indeed, McClure (2012b) notes that assisted living environments provide insufficient care and staffing for complex needs, with residents of such homes more likely to end up in acute care when compared to residents of long term care homes.

It is clear that there are numerous challenges faced by regulatory and funding bodies in meeting current, let alone future, demands for long term care services. Given these challenges, it

is reasonable to conclude that the system as it presently operates must change and that government should look to long term care operators and its present system of care and service delivery for solutions. One such option to review is the area of private pay long term care.

Private Pay Long Term Care

In order to make improvements to the issues identified earlier within the long term care system, a combination of new ideas, practical solutions and innovation are required. One such option that might not be viewed as such is that of private pay long term care. Using information obtained from reviewed literature and returned surveys, a focused discussion of this delivery model will be offered. Included in this section will be a brief overview of private pay long term care, and a presentation of some of the myths, challenges and benefits of this option.

An Overview of Private Pay Long Term Care.

Private pay long term care does exist within provincial jurisdictions. Private pay beds provide options for individuals not wishing to wait for long term care services within a jurisdiction, as well as providing respite services to individuals and their families, and offering a service to those individuals who may not meet residency requirements of a particular area and therefore are unable to access the publically funded system described earlier. As such, they provide a needed service to not only those requiring long term care but also to the public system which is unwilling or unable to meet the needs of some individuals. It should also be recognized that there may exist structural barriers preventing this option, evident from among the ten survey respondents who indicated an inability to provide such services because of the mandate or philosophy of their organization.

The promotion of this care and service model as an integral component of a continuum of options to Canadians may help address the challenges that were identified earlier. However, to many individuals private pay long term care is often faced with myths and challenges that leave it as an unknown or misinterpreted service to many Canadians.

Myths, Challenges and Opportunities of Private Pay Long Term Care.

To detractors, private pay long term care may represent a system of care delivery beyond their comprehension, and this attitude may reflect a barrier in and of itself to this type of service. Canadians, some may argue, are entitled to a publically funded and governed system, and improvements and investments should be made within that framework. However, given the myriad of challenges faced by government and operators in long term care presented earlier, a rational discussion of these myths against the realities of the current system and its challenges would be of use.

Private pay long term care beds can be found in existing long term care homes, with a portion of such beds in the home designated as such. Indeed, this scenario is what exists in the twelve organizations who indicated in this project's survey that they provide such services. However, there are other potential private pay options including the model operated by Exquisicare in Edmonton where services are provided in a 10-bedroom estate home arrangement in an upscale residential neighbourhood (Exquisicare, n.d.). Such an approach provides a potential model for private pay long term care beyond that which exists in existing long term care homes.

For the purpose of this project's discussion, eight issues are presented, at times in pairs given their similarities, within which some of the myths and challenges related to private pay

long term care may occur. As outlined in the project's methodology, these issues were identified through the literature reviewed, and allowed for a further understanding of private pay long term care. Openly presenting, and responding to, these issues affords private pay long term care operators with an opportunity to refute negative accusations and position themselves to offer a sensible option for Canadians.

Issue 1: Takes resources from the publically funded system and creates a two-tier health care system.

Issue 2: Better care able to be afforded and accessed by wealthier individuals.

Private pay long term care is often a target of those who may view the option as a threat to the existing system. CUPE (2009), for example, argues that residential long term care is two-tiered with variation across Canada in the fees charged and services provided. Whether the argument is taking resources from the publically funded system, or creating what is often referred to as a two-tiered or "Americanized" health care system, where better care can be accessed by wealthier individuals, the arguments do not hold up to scrutiny.

Armstrong (2002) argues against an American-style private pay model of long term care, noting that health care administrative costs in America are four times higher than in Canada with "crippling costs, lawsuits for fraud, stories of abuse, and a high toll in family bankruptcies" (p. 7). However, as mentioned in an Ontario study by continuing care associations that examined staffing and service levels, the care ratios in some American states are higher than those existing in Canadian provinces (OANHSS & OLTCA, 2001).

Despite some negative opinions of the healthcare systems of other countries, it is clear, as described earlier, that the present long term care system across Canada can be improved. With

government resources not likely available to sustain or enhance the sector, Canadians will have to share an increasing cost for their future health care including long term care.

Those who argue against private pay long term care should realize that a promotion of such services can enhance the existing public delivery system and therefore support the issues identified earlier. For example, if private pay options expand and lead to an increase in beds available within a system, then waitlists for care are decreased, freeing up spaces in acute care and helping demands in the community. Respondent survey feedback included comments of referrals to private pay services from the acute care system, reinforcing the positive impact that those beds can provide to the system. In fact, the connection to the public system was noted as critical by survey respondents. For example, one used their relationships with hospital social workers to inform them of their services; another organization commented how they work collaboratively with acute care discharge planning staff and home support nurses; and another respondent indicated that the familiarity of health authority social workers and hospital discharge planners was crucial as a referral source for their services. Golant (2001) notes that fiscal savings in long term care can be achieved by governments with private pay long term care as part of that solution, given that seniors with higher incomes would likely be more attracted to such an option, thereby allowing spaces to be freed in the public system. In other words, increased private pay beds can lead to less demand on the public system.

As well, one should not ignore the impact of further competition into the system and the positive impact on cost and services it can provide. Private pay operators noted the effect of peer competition when describing their marketing strategies. For example, one individual identified that their organization lowered its rates to attract clients to compete with competitors who charged an initial lower price. Another respondent validated this approach, mentioning that they

set their initial price point below what they determined as the market rate in order to market their home.

Issue 3: It is the government's responsibility to provide long term care.

Issue 4: The Canada Health Act prohibits Private Pay.

Canadians may believe that our present healthcare programs will pay for their long term care requirements, a view supported by Frank (2012). As well, they may incorrectly assume and argue that public health care is a right, embedded in the Canada Health Act. Madore (2005b) summarizes the Canada Health Act's five components of public administration, comprehensiveness, universality, portability, and accessibility, and notes that the Act does not prohibits either the private delivery of health services or private health care insurance. While CUPE (2009) recommends extending medicare to include residential long term care, implicit in that demand is the understanding that it is not presently included in the Act. The argument seized by private pay detractors that all health care is a right, embedded in the Canada Health Act is also refuted by Simpson (2012) who notes that the Act, "contrary to the public view, does not prohibit private delivery of health-care services" (p. 6), and Frank (2012) who specifies that long term care is not included under the Canada Health Act.

Alexander (2002) notes that the federal government did at one time provide direct monies to provinces for long term care under its Extended Health Care Services (EHCS) program, which began in 1977-78. This program ended with the introduction of the Canada Health and Social Transfer (CHST) in 1996, which provided block funding to provinces for health, welfare and post-secondary education with no direct allocation of these funds. As a result, the targeted long term care funding in the EHCS was removed.

While some Canadians may believe that a federal long term care program should be part of our universal medicare system, and funded through general tax revenues, a broader question raised is which, if any, healthcare services should be the government's responsibility. This question also relates to the potential impact of historical, geographical, and generational differences regarding the role of government in healthcare within Canada. This larger philosophical view centers on the issue of responsibility, and the role of government and individuals, specifically the responsibility of government to citizens, but also the responsibility of individuals for their own care and services. Armstrong (2003) notes a concern of "forcing seniors who have paid into the public system for years, to give up almost all their income or spend….all their savings and assets to obtain care is a grim betrayal of their generation" (p. 6). What many critics appear to ignore is this philosophical proposition - that of choice and the ability of a person to make an informed decision in their best interests.

Issue # 5: Financial drain on consumers.

Critics of private pay long term care may point to the costs of private pay services as a deterrent for consumers. For example, CUPE (2009) note that private-pay residential care facilities are beyond the means of seniors, using ranges of $30,000 to $60,000 per year for such services. Indeed, cost was identified as a consideration by survey respondents regardless of whether or not they provided private pay long term care. For the twelve survey respondents who provided such services, ensuring an appropriate rate and long term affordability was noted as key elements of focus. As one respondent notes, appropriate pricing was based on a comparative analysis with local competition and included such services as on-site nursing and therapy positions, and involvement with accreditation. Other respondents identified how rates were

lowered to attract clients and manage competitors who charged lower initial amounts. As well, respondent marketing and price strategies references conservative occupancy projections when initiating private pay services. One respondent mentioned that they set a 75% target occupancy rate for their first year, and are currently after two years at a 95% utilization of their private pay beds.

Indeed, Grignon and Bernier (2012) report that the cost of long term care could be approximately $60,000 per year, and a reference from one respondent to more successful private pay operators being located in above average income communities appears to reinforce this affordability issue. Through appropriate price setting, survey respondents providing private pay services appear to have identified an applicable cost structure for their clientele and themselves.

However, if Canadians wish to use their own financial resources to support their own care and services, what business is it of others to disagree? It may surprise some Canadians of the costs within the publically governed system that exist now. Currently, residents of long term care homes pay additional costs for such expenses as companion services, and some medical products. Maclean and Klein (2002) note that with a current system which includes co-payments from residents, the "reality is that seniors have been paying to access long term care for quite some time" (p. 76).

It has also been argued that more financially secure seniors will want to pay the living and care costs associated with their future needs (Long Term Care Canada, n.d.). Respondent feedback from those operators providing private pay long term care demonstrate that they did not consider occupancy a challenge within an appropriate fee structure, reinforcing the viability of this option and the need to ensure appropriate market studies and cost placement. The importance of understanding their local community and the price points that the market can

support was crucial for respondents. Some of the strategies mentioned by these individuals that helped them understand their local market included those to set initial price offerings and occupancy targets.

Canadians can also purchase long-term care insurance for use within a public or private system. Madore (2005b) notes that such insurance does not violate the Canada Health Act. However, CUPE (2009) argues that private long-term care insurance is beyond the reach of most Canadians, and is actually an expensive product characterized by high premiums, insufficient coverage, misleading advertising, and difficulties with claims, and held by only 54,000 Canadians or approximately one per cent of the seniors population. Grignon and Bernier (2012) also question the utility of such private insurance in their argument for a publically insured approach to long-term care.

Philosophically, one can argue that individuals should be able to purchase and finance their own long term care, as they do other medical services. With equity in their own homes, options such as reverse mortgages, and their savings and investments, some Canadians are likely able to support private pay services. As well, those individuals should also be able to include such costs as medical expenses through our income tax system. The role of choice and personal responsibility is crucial for detractors of private pay long term care to understand. Simply stated, why should those able to afford a private pay option be excluded from such a service? As well, do we actually all expect the same level of publically governed long term care in the future given its present challenges? The increasing reality related to future health care is that the financial burden is shifting –and will continue to shift – to consumers.

Issue #6: Consumer choice.

It may surprise many Canadians that the present system of long term care placement is characterized by little choice. While a person assessed and waiting for a long term care home may choose to list for example, their preferences of location within an area, the ultimate decision typically centres on first available bed policies. As such, forced matches of individual and home are often made, regardless of spouse separation, location within a desired area, type of accommodation (i.e. semi-private or private), or operator (public, private or voluntary). Golant (2001) highlights the effect of long waiting lists in Ontario, Alberta and British Columbia for nursing homes, notably that seniors are not able to be admitted into their first choices. As noted by Pitters (2002), "respect for consumer choice related to care options – need to be recognized and supported" (p. 172). For those twelve survey respondents providing private pay services, they are successfully providing their clients with the choice of living accommodation that they desire. This element of meeting one's choice ties in to respondent feedback that noted the importance of marketing, and the communication of the choices in services and options that they are providing.

Increasing demands for consumer choice will also drive service delivery and ensure that all operators focus on addressing the needs of their clients. If a private pay option provides a better level of care and service than that provided within a public system, then individuals should have the right to select what is best for their own needs. Respondent feedback indicates that operators of private pay care are addressing this issue by providing additional services to their clients than those who are occupying their funded care beds, although caution was noted by some against such a move perhaps concerned with creating a "two-tiered" service system within a home. However, as noted by one respondent, clients and families have expectations of not only

superior levels of services but also of services to be provided beyond the levels as those required by the regulatory body, such as those related to nursing and meals. Regardless of services provided within such an option, it appears from these operators that occupancy challenges were not evident in these environments, validating the need for such a service. If operators in the public system cannot adequately provide such services, then it appears that an argument is being made to let market forces decide accommodation choices.

Operators following a private pay model may also increase the specialization within homes for such services geared to cultural groups, community outreach and day programs, along with respite care. This option exists among some survey respondents who offer private pay beds to specific cultural groups. Such options therefore increase choices within the system for consumers.

Private pay long term care offers a market that should be encouraged. Indeed, as identified earlier, the promotion of a private pay option can create more opportunities for long term care placements in the public system. Survey feedback supports this view, with acute care settings and placement bodies contacting organizations with private pay beds for placement support. Any ability to increase the net number of beds available within a system should be encouraged, as waitlists for beds in the public system are decreased, spaces are freed up in acute care, and the demands within the wider community and system as a whole are lessened.

Issue # 7: Private Pay Operators would not be required to maintain standards.

Some opponents of private pay long term care may suggest that operators would not be required to maintain standards, and that a lack of regulatory oversight would place elders in care at risk. Indeed this concern is well noted in the review completed for this project. Armstrong

(2003) notes that private pay options operate in a regulatory void. Indeed, the CHA (2009) note an emerging trend with the growth of unlicensed retirement residences and assisted living homes that while not intended to provide health services, are now doing so, regardless of their ability to adequately provide such services, and in which individuals may feel compelled to access in a time of crisis. Tam (2012) also reports on care concerns related to seniors discharged from hospitals to retirement residences in Ottawa.

A chief concern related to standards involves the staffing levels within a home. In support of a public system, Deber (2002) notes that care expenses are higher in non-profit long term care homes than private ones. As well, McGregor and Donald (2011) conclude that private homes provide lower quality care and services than not-for profit homes, one reason being that "one of the principal mechanisms for generating profit is decreasing staffing levels, which results in inferior quality of care" (p.1). In addition, the CHA (2009) references the British Columbia Care Providers Association which note that the "level of staffing in a care facility has a direct correlation with positive outcome measures and quality care" (p. 95). However, agreement on a standard for staffing is difficult to determine. CUPE (2009) references United States Congress research indicating minimum staffing levels of 4.1 paid hours of care to be required to avoid jeopardizing long term care residents, which is then compared to ratios in British Columbia at 2.6-2.7 and Ontario at 2.6. The CHA (2009) notes the variability in care staffing levels across Canada, including 3.06 in Saskatchewan, 2.44 in Manitoba and 3.1 in New Brunswick. Given such variability, it is safe to assume that there is no one singular standard related to staffing levels. That said, it is difficult to believe that operators would staff a home at such levels that could place residents at risk, and jeopardize their reputation.

It is critical for private pay long term care operators to be aware of these concerns while being attentive to the care and services they provide. Any belief that operators would not want to maintain staffing or other operational standards appears suspect. In a review of market conditions and labour, Vogel, Rachlis and Pollak (2000) note the unionization of staff in British Columbia's for profit and not for profit homes which limited the ability of private employers to pay low wages. This is one example of a market economy ensuring that all operators maintain an appropriate standard, and a perspective seemingly validated by those twelve survey respondents offering private pay services who indicated that they had no challenges with staffing.

Operators who would deliberately operate at a less than minimal standard within their regulatory environment would do so at their peril, not only placing clients in jeopardy but also risking their reputation and market share. It is worth noting that all twelve survey respondents providing private pay services dispersed such beds within their publically funded beds. In such environments, if standards in private pay services were lower than existed among their publically funded ones, then a regulatory body would find evidence of such during routine or random audits of those funded public services. As well, residents and families would be able to note any infractions of standards. Consequently, if one was operating a home with a mix of private and publically funded beds, and less than minimal standards were applied to a portion of those beds, it could potentially place an organization's funded beds in peril, an outcome that would be appropriate. Interestingly, the involvement of regulatory body officials in this manner can have a positive impact. As several respondents identified, having connections with such individuals not only allow them to become familiar with your services but also provide a referral source for such services.

There is also value in private pay operators ensuring their beds are incorporated into an accreditation process such as that offered by Accreditation Canada (2012). Participation in such an external validation of care and services would provide evidence of an ability to meet a recognized set of accepted standards of care, which could further be used as a marketing tool. In doing so, an accreditation process would be an important component of promoting public confidence and in validating and improving existing services.

Private pay long term care operators would also be required to meet industry standards including those related to regulatory building and fire codes. Respondent information included references to ensuring that standards related to cleanliness and environmental quality must be met and should not be different in areas of a home offering both private and public beds. However, standards may actually be enhanced by operators who, recognizing and respecting that individuals have chosen their homes to live, cater to a philosophy of client satisfaction, and target care and services to better meet the needs of their clients. This focus on client satisfaction and meeting client needs could then be used by operators to market their services and enhance their reputation. Information from survey respondents indicates that this attention to clients is a key driver in promoting their private pay option. Furthermore, the importance of ensuring a positive reputation within their local community was viewed by them as crucial to their success.

As well, it should be noted that our existing system sadly contains examples where standards are not met. Golant (2001) notes that a significant percentage of nursing home professionals interviewed for her study agreed that their homes were of poor quality. Also, Ferguson (2012) highlights quality of care concerns in the present Alberta long term care system.

Issue #8: Private pay is not currently part of long term care.

As indicated earlier, the reality is that private pay does exist in long term care now, be it in the models of assisted living, the charges paid by individuals not meeting provincial residency requirements, and the services paid by clients within the public system such as companion services. Survey respondents and the literature referenced earlier reinforce this reality. As mentioned previously, Canadians can expect to pay for portions of their care within the publically governed system, and in all likelihood an increasing share in the future given limited government resources. For example, Frank (2012) notes that Canadians will need to pay more for their own health care, suggesting that governments could provide incentives for Canadians to save for their own long term care needs. As costs rise within the public system with its gaps and pressures outlined earlier, the differential between private pay long term care and the public system will decrease, creating further options for private pay services. Interestingly, it is worth noting that among eight of the ten survey respondents who did not provide such services, there was an acknowledgement that cost and revenue opportunities could influence future decisions related to offering private pay long term care. In other words, such a service could be viewed as an alternative if financial circumstances warranted, creating the potential for private pay long term care to become an even more available option in the future.

The challenges represented in this section are ones that relate to myths within which private pay operators may operate. While operators should focus on these potential obstacles, survey feedback does provide evidence of the successful implementation and delivery of private pay long term care. While the primary challenges identified by those survey respondents offering private pay services are of cost, marketing and communication, and services provided, it is

noteworthy that such operators have clearly addressed these challenges successfully, reinforcing the view that this option can become a more accepted form of care delivery.

Conclusions and Recommendations

Private pay long term care is a sensible option for Canadians to consider. As noted in the literature reviewed for this project, our current state of long term care is not sustainable in its present form and must change. Governments should look to long term care operators for solutions and explore all options including those related to aspects beyond this project's focus such as home care and acute care. While the private pay long term care option faces challenges, it is evident from the successes that all twelve survey respondents providing this option have found that these can be addressed. Information presented in this paper has outlined the benefits that such a delivery model can provide for Canadians and the public system, and in doing so support a brighter future for the industry.

Assuming that operators have validated a business model to support either a stand-alone private pay site or a select number of private pay beds within an existing publically governed site, there are some additional factors that they may wish to consider from this study. While there is no singular method of system delivery among private pay operators, survey respondents who provide private pay services identify two critical areas of their success: (a) a dispersal of these beds within their funded allotment of beds, and (b) a focus on marketing and communication. Based on information reviewed for this project the following framework is offered to provide guidance for operators considering a private pay option:

- if operating a combination of private pay and funded beds within one building:

  - the incorporation of private pay long term care beds with funded care beds (i.e. not a separate unit), with funded beds providing a stable base of funding, and efficiencies of scale provided within such operations. As identified by all survey respondents providing private pay long term care, the dispersal of such beds within a home's existing population was viewed as critical, to allow for more economical service delivery and to avoid the overt tiering of clientele within a home; and
  - no disclosure to direct care and service staff of those residents who are paying for private long term care.

As identified earlier, the adoption of private pay long term care would not be without its challenges. As evident from the literature reviewed and the information provided by survey respondents providing such an option, challenges are particularly noted in the areas of cost, marketing and communication, and services provided. As such, the following framework is offered:

- for all options including stand-alone private pay or a mixed delivery service:
  - a thorough understanding of local cost structures and market conditions to support a private pay option is required. While operators should have such revenue and expense data available within a business model, meeting the challenges associated with cost, including pricing strategies, were highlighted by survey respondents and literature reviewed;
  - a marketing plan must ensure that services and care provided are clearly communicated to ensure myths and challenges discussed earlier are addressed, including barriers of the existing system;

- provision of additional care and service components are provided to those within a private pay option (i.e. not simply “a bed”). While this issue could be described as a tiering of services, it is reasonable to assume that those paying more for a service would expect more in return. While such a suggestion may appear counter to a perspective to not disclose such clients to direct care staff, the key factor is that there is no overt identification of such clients within the home;
- services are provided that are beyond those required by the regulatory body, including those related to dining experiences, culturally-specific programs, and enhanced nursing and therapy services. The issues identified earlier of choice and attention to services provided in a home also lend credibility to this suggestion and is one that could also assist occupancy and enhance reputation;
- clear communication is provided to the public including media and regulatory bodies that care and services provided meet present regulatory standards. While recognizing that differences in approach and philosophies towards healthcare exist, engaging the political and regulatory body environment is essential to counter myths and challenges discussed earlier, and to present the appropriateness of such services;
- staffing levels are monitored to ensure comparable regulatory staffing standards are met were they to be applied. Although private pay operators would not have to report such hours to their regulatory body, the monitoring of such hours would ensure evidence to refute any charges of staffing inappropriately;

- close interaction with regulatory bodies occurs. As noted by survey respondents, the importance of this relationship is validated by the regulatory body being a referral source for its private beds. The relationship is particularly critical for operators having private and publically funded beds in a home, where regulators can be not only a source of referral, but also are routinely auditing and ensuring applicable standards are maintained;
- private pay operators participate in an accreditation program. Among its benefits, an accreditation process can validate an organization's services, identify strengths and opportunities for improvement, and in so doing provide reassurances to present and future users of this service. An accreditation program that is also recognized by a regulatory body would be inherently advantageous for an operator, further lending legitimacy to its operations and existence in the long term care system;
- evidence of service delivery successes is submitted to journal publications, conferences and service sector awards. For example, communication of successes similar to those enjoyed by the twelve survey respondents would further validate and position this option as one to consider; and
- involvement with continuing care associations is sought to ensure networking and sharing of leading practices, and also to position services within the current health care delivery system.

Given the information and considerations presented above, private pay long term care leaders should consider utilizing the LEADS framework of the Canadian College of Health Leaders (CCHL) to advance their service delivery model (2010). Leaders must be able to

communicate and respond professionally and ethically to competing viewpoints on delivery including emotionally charged topics such as private healthcare delivery. As well, the ongoing pressures and needs caused by our present system referenced in this report provide an opportunity for leaders to advance improvements for the future. Through the engagement of others, the development of coalitions, and the achievement of results, the likelihood of system transformation is advanced. The fact that twelve survey respondents successfully provide private pay long term care services bolsters the argument of the service as a viable one, from which others could look to emulate and build from. The use of the LEADS framework can enhance this model. Within the context of promoting a private pay long term care delivery option, the following suggestions are presented related to the LEADS framework:

- it will be imperative for operators to engage others, and to build networks, coalitions and partnerships with each other as well as such external stakeholders as insurance industry representatives, political bodies, long term care associations, health sector groups and regulatory bodies in order to promote the benefits of their services and further their delivery model; and
- it is essential to showcase work and achieve quality outcomes. Operators should participate in accreditation programs, as well as measure and report their clinical outcomes. Showcasing results in abstract submissions, poster presentations and industry conferences affords opportunities to professionally engage in dialogue of their services. Publishing findings in long term care journals and at healthcare conferences also allows organizations to advance and validate this service option. Operators can seek further recognition for the results they achieve through national and vendor-sponsored awards related to healthcare delivery. By providing and

sharing evidence of successful implementation and delivery of this option, operators can further enhance their services as well as communicate its potential to others.

Such an approach, coupled with an understanding and critical examination of our current system, facilitates the advancement and transformation of our healthcare delivery system. Whether operators innovate within existing locations by adding a small number of private pay beds or develop models with a larger or complete private pay bed allotment, it is crucial that they evaluate and communicate such an implementation to leverage the success of this option presented earlier.

While operators can use the framework presented earlier to assist their decision-making of this option, there are also improvements of our larger healthcare system that should be considered from this project. As such the following macro recommendations are presented in order to engage Canadians of the present system, its limitations and costs, and the options available to them:

- Canadians must understand that our existing system does include costs to users;
- governments should review pre-funding mechanisms for long term care, promoting long term care insurance, tax-prepaid savings approaches similar to Registered Retirement Savings Plans or Tax Free Savings Accounts but for long term care (or health care in general). Such approaches will support Canadians to pay for future long term care and home care needs, whether for use in a publically governed or a private pay system; and
- private long-term care insurance should be more actively promoted and encouraged.

Whether the argument in support of private pay long term care is financial related to sustained funding or philosophical related to consumer choice, an increased private pay model can address many of the challenges within our existing system, and is a worthy option for Canadians to consider. Many Canadians may not understand or appreciate the realities of the current long term care system that have been highlighted within this project, and will likely be somewhat shocked with that reality as they or their family members enter into it. It is critical for private pay operators to communicate these realities, address issues and myths within their operations and delivery model that this project has articulated, and then promote their services as suggested in this paper against the backdrop of our present long term care system. In doing so, operators will be building upon not only the focus on marketing and communication identified as so critical by survey respondents but also on the successes with a private pay model these respondents enjoy. Such an approach will contribute to advancing our healthcare delivery system and health leadership.

Contribution to Health Leadership

This discussion of private pay long term care contributes to the theory and practice of health leadership in Canada. While governments may place an emphasis on home care services throughout the country, it is clear that a facility-based option for those unable to support themselves within their own homes will continue to exist. However, Canadians must be informed of the reality of our present long term care system, its limitations and costs, as well as the options available to them should such care be required. As such, they should consider private pay services as one of those options along with savings vehicles and the acquisition of long term care private insurance to support their future health care needs.

Healthcare leaders should also understand that the topic of this project represents an important and timely issue as evident from current newspaper articles used to contribute information for this project, and other media reports related to our healthcare system and the challenges within it that continue to be reported. As the financial pressures faced by provincial governments continue, and Canadians begin to demand the care and services to meet their expectations and needs, the growing weaknesses of the present system will be further highlighted. Healthcare leaders should position themselves strategically for the future and take action to advance change and renew our healthcare system, as the twelve respondents to this project's survey have done. Similar to their approach, operators considering a private pay option should ensure they heavily market the benefits of their system, showcasing how their services can meet client needs and respect client choices. As well, regulatory bodies should promote private pay long term care as an alternative option, as it also reduces demands on a struggling system which the project has identified.

This project is not a proposal to remove public funding of long term care. Indeed the private pay option can help sustain and enhance the public system through the innovation it offers, as well as the removal of pressures on the public system referenced earlier. Private pay long term care requires engagement between proponents and detractors, as dialogue can strengthen our existing system. A critical thrust of this project is that Canadians should be able to make informed choices of services and select an option to meet their needs and preferences, as those who currently living in the homes of the twelve respondent organizations are doing now.

Regardless of one's philosophical opinions related to private pay long term care or private healthcare in general, healthcare costs will increasingly shift to individuals as government fiscal realities restrict funding and further limit the public healthcare system. Given

this increased level of personal financial responsibility for their own health care, knowledge from this project can also be used by healthcare leaders to advocate for public policy changes, including those related to pre-planned tax-deferred savings for future health care needs, and the promotion of tax and savings incentives targeted to health care. Healthcare leaders should also ensure that social supports are maintained in order for those with limited means to be able to continue to receive care and services within a public system.

Whether a private pay long term care option increases in use, the reality borne from the literature reviewed for this project is that Canadians will need to shoulder a greater burden of their health care costs. Acknowledging this fact is critical for operators, regulatory bodies, long term care insurance providers, and Canadians to not only understand this future but more importantly to begin preparing for it now. Advancing system transformation requires critical thinking of our present reality and a desire to improve it in order to meet future needs and challenges.

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Appendix

A. Survey

Introductory Greeting

I am currently researching Private Pay Long Term Care as part of my Fellowship Program for the Canadian College of Health Leaders.

As such, I wondered if you would take a couple of minutes and consider responding to the few questions below

I would be happy to share the results of my study with you if interested once the project is completed, and to answer any questions that you may have.

A. If you provide – or have ever been in an organization that provided – Private Pay LTC in your homes:

1. Are these beds separated (ie a separate unit within the home) or are they dispersed among funded beds within the home?
2. What are/were some of the challenges your home faced with Private Pay LTC beds, and strategies to overcome?
3. How are/were you able to make Private Pay LTC a success?
4. Any other comments related to Private Pay LTC you would like to share?

B. If you do not provide Private Pay LTC in your homes:

1. What reasons are/were behind this decision?
2. What – if anything – would cause you/your organization to reconsider this decision?
3. Any other comments related to Private Pay LTC you would like to share?

Closing remarks

B. Survey Results

A. If you provide – or have ever been in an organization that provided – Private Pay LTC in your homes:

1. Are these beds separated (ie a separate unit within the home) or are they dispersed among funded beds within the home?

   12/12 respondents who answered this question indicated that their Private Pay LTC beds were dispersed among funded beds within the home

2. What are/were some of the challenges your home faced with Private Pay LTC beds, and strategies to overcome?

   Although some respondents indicated that their organization had no challenges with Private Pay LTC beds, the majority indicated challenges in the areas of marketing, cost, and services provided. These responses are provided below:

   Marketing:

- Difficulty marketing a "substandard" location with a reputation in the community as having high crime (negotiated some temporarily funded programs from the acute hospital and the residential care sector)
- Marketing with resources available: need dedicated resource to do
- Initially we did not know if there is a market for private pay in our community. The primary challenge for our organization was marketing and ensuring maximum utilization. We were not known for private pay services. Developed a comprehensive marketing strategy. The strategy included a comparison of our services to our local competitors. Pricing was based on the comparison of a variety of factors including compliance with new facility standards, accreditation, enriched program offerings, Registered Physiotherapist and Nurse Practitioner on-site for all residents, bus/bus outings, in-house laundry etc). Have achieved and maintained full occupancy.
- Key challenge is marketing and keeping them filled.

   Cost:

- Biggest challenge was affordability. Residents could only afford on a short term basis until a funded bed became available. That led to challenges on the staffing side since bed turnover was high. As well, since the census varied it was difficult to staff efficiently.
- Competition with other organizations who opened at the same time and charged a much lower rate strategy…rate was lowered at times to attract people touring

- Inability of client to continue to pay private rate (they thought they would be funded sooner than occurred)
- Determining appropriate cost
- We did have a couple of initial strategies: we made sure our initial price point was a little below "market" rate; we connected with Hospital social workers to let them know about the option
- Some problems with accounts receivable
- Estimating utilization for budgeting purposes, since we did not have a history with private pay services. We conservatively estimated 75% occupancy in year 1 which we achieved. We currently budget for 95% utilization

Services Provided:

- Family expectations regarding "superior" service
- Different services: meals, nursing services that are provided by regulatory body and private residents have to pay on their own, different levels of care and care needs

No Challenges:

- Very short wait list but usually fill them quickly
- No significant challenges
- I believe the fact of no differentiation between the private pay and funded beds resulted in limited challenges. If there were visible differences (quality of the environment, cleanliness, staffing, to name a few), I believe there may have been public concerns especially if private pay clients were seen as receiving care and services of a higher quality than funded beds.
- The occupancy of these beds was consistently at 100% including short term respite arrangements which were booked months in advance
- No challenges

3. How are/were you able to make Private Pay LTC a success?

Respondents to this question indicated the importance of marketing and communication, and the organization's current reputation. As well, the issue of staff not differentiating between clients in private pay and those in funded LTC beds was identified as a critical feature to success. These responses are provided below:

Marketing and Communication:

- Marketing in local area and on website of home/organization
- By being able to attract temp funding into a number of them and by attracting clients from our Convalescent Care program
- The beds were well advertised.

- Communication strategy focused on the pp beds as meeting a community need for beds and respite for family members
- Maintaining a very strong focus on client service. Building up a marketing team that understands and is able to properly assess the care needs of the elderly
- Advertising to the community. Working with acute care discharge planning staff and home support nurses

Current Reputation:

- We are a desirable facility already so it was quite easy
- Our reputation in the community has been key. We have many referrals from word-of-mouth from families who have had a positive experience with our organization. We have maintained a constant advertising presence and have an annual budget for advertising. We have a strong social media presence including web, facebook and twitter accounts; we have utilized search engine optimization in all of our internet applications, to ensure that we are easily found in a search. We are active in our business community. It is important to be "top of mind" in LTC in the community so that when LTC services are needed, our name comes up. And it does. We do marketing surveys annually to find out how folks find us; we also ask prospects how they found us and we document their responses and use this information in our annual advertising plan.

Staff Awareness of Private Pay Clients:

- Staff are not advised as to status of client in the room
- Direct care and service staff not aware of who was occupying private pay vs funded beds
- Cannot over-emphasize how important non-differentiation between funded and pp beds was. It was critical.

Other Responses:

- Added value that clients received
- Ensure private pay beds are a component of services provided – most beds are funded ones and provide a stable base of funding
- A lot of factors at play. Here are some possible reasons: a new building in an area with some older inventory – the contrast may have led some families to explore private pay; a community which allows spouses with different care needs to remain on the same property; a faith based community which is important to a lot of people; strong reputation for excellent care (Accredited, low hazard licensing report etc); demand for funded residential care is higher than the supply; central location

4. Any other comments related to Private Pay LTC you would like to share?

Other comments received from respondents indicated a general positive experience or attitude towards Private Pay LTC. However, concerns were raised related to a preference

for funded beds instead of private pay ones, as well as cost and organizational philosophy. Responses received are provided below:

Positive Comments:

- Facilities in our health authority who successfully fill Private Pay beds are located in (location removed by author) among people in a community with above average income.
- Acute care sometimes calls and asks us if we have one available
- This is a great topic of discussion. We are currently wondering what the future will hold as well. In Canada there is an expectation that the government will fund this type of care and a growing demographic that will require LTC services. The question at that point is a fairly simple one: will the governments be able to meet this demand or will they increasingly rely on the private/not for profit sector to provide?
- A very positive for profit experience, Very cost effective. My experience was that it filled a well needed gap in the communities.
- There is significant advantage to having a mix of private pay and funded beds. If you have funded beds, the health authority social workers and discharge planners at the hospital become familiar with your facility and are able to recommend it to those seeking private pay.
- The organization provided the full continuum of services all under one roof. In fact, their model is to build in the added # of private pay beds in each of their facilities. Their services ranged from Independent Living to Assisted Living and Residential Care. The latter were the beds funded by the province.
- They provide a valuable "bridge" to the community but affordability is a major issue

Negative Comments:

- We were forced to get into the private pay market; was not a preferred strategy. We do not earn the same revenue from private pay beds; funded beds are a revenue combination of government subsidy and resident co-pay; we do have folks turn us down because the rate is unaffordable. The annual differential for private pay revenues is significant, therefore if the regulatory body purchased our private pay capacity we would graciously accept.
- We have had inquiries about tiered levels of care; eg. Should the private pay client receive a higher service level? Such an approach is not aligned with our philosophy of care. We believe that all residents, regardless of their ability to pay, government funded or self-funded, are entitled to the highest standard of care and service levels that we can achieve and provide. Our RNs know the method of funding for MDS; but other staff do not have access to this information.

B. If you do not provide Private Pay LTC in your homes:

1. What reasons are/were behind this decision?

   Of the 9 respondents to this question, the primary reason given for not providing Private Pay LTC in their homes was related to the ownership category of their organization. Other factors related to the cost of long term care and funding requirements. These responses are listed below:

   Ownership Category:

- The not for profit provincially operated sites do not have consideration for private funded beds.
- We are a non-profit organization and it is not part of our mandate
- As a municipal organization, only provide public services
- Currently working in a municipal sector that has licensed LTC beds with the province of Ontario and no expressed interest in considering alternate service provision option.

   Other Responses:

- Concern about the high cost of LTC and the size of the market willing to pay
- Our Board is risk averse and sees government funding (as inadequate as it is) as a more "stable" source of funding
- Our culture is such that our staff are reluctant to provide two levels of service – one level to publically funded beds and another to private pay. This has been one impediment to our success in this area
- We do not provide private pay LTC. We have private assisted living but not private LTC
- The major reason for not having private pay LTC is that organization has positioned itself as a key contractor partner to regulatory body, and has been able to get a commitment from them for all of its beds. A good number of the facilities we operate were not purpose built, and would not be an attractive option for private pay.

2. What – if anything – would cause you/your organization to reconsider this decision?

   10 responses were provided to this question. With the exception of 2 respondents who indicated that such services could not be provided because of their organizational philosophy, all others indicated that cost and revenue opportunities could influence future decisions related to Private Pay LTC. These responses are provided below:

- Declining government revenues and a need to reduce our reliance on public funding as our primary income source
- More success in others' private pay initiatives
- Revenue opportunity

- Declining margins from operations
- Reduced margins or funding from funding body
- If the current arrangement with regulatory body changes, and for new builds. We are building new facilities, and have a plan to include private pay. This would reduce dependence on one funder, and help the organization enhance its customer relations capabilities. It would also allow success, as the facility would be new and purpose built
- Maybe something that the private operators in Ontario would venture into, in fact a number of the Retirement Home beds in Ontario which is all fee for service (private pay) have services and acuity levels that have residents that are very similar in acuity levels to those in LTC homes. Families and residents that are able to pay for this service often continue to add services as they age in place in retirement residences as there is less stigma attached to living in retirement that long-term care.
- Potential partnership opportunities that would reduce risk

Unable to Reconsider:

- Not the current municipal operator.
- I think the City would view it not within their purview to compete with other providers who may wish to provide private pay LTC; i.e. not the role of municipalities.

3. Any other comments related to Private Pay LTC you would like to share?

Other comments received from respondents indicated that Private Pay LTC might have some relevance in the future, although issues of costs and current regulatory environments were also identified. Responses received are provided below:

Future Relevance:

- Ontario's retirement homes will permit private pay LTC which provides another option for seniors to age in place and to purchase the required healthcare services from the basket of services available, if and when they require them (should they so choose). This is clearly not an alternative for all, as the costs are prohibitive for some. Nonetheless, it is viable alternative for many - time will tell re the effectiveness but it should work - given the licensing regime and care standards have been developed to guide the sector.
- I think it will be a bigger portion of services into the future, and needs to be seen as an option by current providers.
- Private projects offering higher level health and personal care services will need to provide something special to residents. The level of fit and finish and quality and range of services may need to be higher.
- Smaller, boutique facilities may be attractive to some people, with their higher staffing ratios and more personalized services. One Edmonton example is Exquisicare, with 10

private pay LTC level beds set in a purpose-built home in a higher end residential neighbourhood.

- Another place I see private LTC having a chance to succeed is in retirement communities that allow people to age in place in private, accessible homes, then move to a LTC-level suite for a short time to receive end of life care. Even this approach could be affected by new "continuing care centre concept" facilities.
- One advantage to private pay facilities could be ease and timeliness of access from the community and choice of preferred setting. Increasingly public facilities are accessible only from hospital settings and even then there is little choice as to where you are placed.

Costs and Regulatory Environments:

- People will simply feel that they are paying too much for the services they receive when they compare publicly-funded and private pay facilities/rooms.
- I am only aware of Nova Scotia and BC offering private pay LTC. Ontario and other provinces do not allow it. When the province pays for the majority of the cost of LTC, they carry the right to set standards and monitor for compliance. Is a private pay LTC program exempt from this oversight?
- Although Nova Scotia allows this option to their LTC providers, there are less than 10 private pay beds listed in their inventory. This probably is a reflection of the demand for this service. I believe a major reason why operators are not interested in private pay LTC, especially operators that provide different levels of care, is that the demand can also be met in assisted living programs in retirement residences. Residents and their families seem to prefer paying for supportive care in a retirement residence setting in order to avoid the negative connotations associated with putting mom in “a home”.