5 Auspice and the care economy

This section examines relevant lessons for early learning and child care to be learned from auspice issues associated with Canadian long-term care. Concerns about the effects of for-profit ownership on the operation of long-term care facilities, especially by large corporations, is not new. But the weaknesses of Canada's market model long-term care, which were exposed in a new way during the COVID pandemic, provide valuable comparisons to, and lessons for child care. While issues of concern about the quality of care in for-profit long-term care facilities had long been documented, demands for change reached the public and political agenda as a result of the pandemic (Canadian Health Coalition, 2018).

Two care sectors: Similarities and differences

Long-term care shares many important characteristics with child care. Sociologists Susan Prentice and Pat Armstrong, experts on child care policy and long-term care policy respectively, have observed that:

> Child care and elder care have a great deal in common. They both are considered primarily family responsibilities, justifying low public investment in caring on such grounds. At an earlier historical moment, both child care and elder care were seen as needs to be solved by charitable and benevolent societies. Today, they both are increasingly a means for profit-making, with the involvement of the corporate sector justified on the

grounds that it will expand access while improving quality and saving money for the public sector (2021).

Long-term care homes are residential settings intended for individuals requiring 24-hour nursing and personal care, frequent assistance with activities of daily living, and on-site supervision or monitoring to ensure safety and well-being. Long-term care residents generally have more care needs than those in assisted or independent living settings, although sometimes all three living options are provided in one location. According to the 2016 census, there were almost 160,000 people living in long-term care facilities in Canada in 2015 (Library of Parliament, 2020).

Under the Canadian Constitution, health care is a shared responsibility of the federal and provincial governments. However, long-term care is considered an "extended health care service" and is not included under the *Canada Health Act*, which defines which services must be provided under the province's public health insurance program for the province to receive federal funding. Long-term care homes are governed by provincial/territorial legislation and funded through both provincial funding and user fees. Since the pandemic, there has been enhanced interest in an increased role by the federal government. This is similar to child care, which is governed by provincial/territorial governments, and not under any federal legislation.

Canadian child care and long term care both operate within market systems based on supply and demand, with funding that is partly public, partly user fees, and regulatory oversight by provinces/territories. Both sectors provide care for vulnerable populations, and the work of both kinds of care is done by low-paid predominantly female workforces. Characteristics of the workforce, such as staff ratios and education, play key roles in the quality and safety of the vulnerable people – whether they are elderly residents or children— in their care. Staffing costs are by far the largest part of long-term care facilities and child care centre budgets. Thus, in

both long-term care and child care, for-profit companies are incentivized to keep wages and benefits low and staffing limited in order to generate a profit.

There are also some key differences between child care and long-term care. Although relatives or friends visit loved ones living in long-term care facilities, it is unlikely to be on a daily basis. However, parents make appearances twice daily at their child care centre in the morning and evening. That children are brought to and collected from child care every day provides a level of built-in risk mitigation, as health and safety cannot deteriorate over multiple days, as it can in a nursing home. As well, in the field of early learning and child care, there is an understanding of the inseparable nature of education and care for young children; education, in the broad sense, is seen as one of the objectives of child care. Although intellectually engaging activities may be integrated into a long-term resident's care, education is not accorded the same importance as it is in child care. Thus, the associated organizational structures and elements related to child care's pedagogical role, such as pedagogical documentation and curriculum frameworks, are not part of long-term care. Connected to this difference, child care quality can be assessed in terms of children's development, while health outcomes are generally the sole measure of quality in long-term care.

Although long-term care and child care both have mixed ownership provision in Canada, large corporations have made more headway in the elder care sector than they have in child care. For-profit long-term care in some provinces is dominated by corporate chains, while in the Canadian for-profit child care sector centres, smaller and medium-size chains are more common. As well, while child care spaces have steadily increased in Canada over the last twenty years, long-term care spaces have decreased. The Canadian Health Coalition describes that although long-term care spaces have decreased, the number of beds per facility and number of corporate chains have increased. Thus, they point out, "the long-term

beds that are available are increasingly in larger corporate-style for-profit facilities" (2018: 9)

Provinces/territories pay for health care costs in long-term care but residents are responsible for rent, and associated living expenses, such as laundry and housekeeping (Library of Parliament, 2020). In 2018, $27 billion was spent on long-term care homes (or nursing homes), 74% of which was public funding and $7 billion from private funds, comprised of both out-of-pocket costs and co-payments from insurance plans (National Institute on Aging, 2019). Subsidies for low income individuals are also available by application to the province. As with child care, the equilibrium between supply and demand for long-term care has not been adequately solved in a market system; long waiting lists, high fees and inaccessibility are common as they are in child care (Noorsumar, 2021).

Like child care, long term care is provided by public, non-profit and for-profit operators, with the share of services delivered by each auspice varying significantly across provinces/territories. Long-term care, however, has a much larger share of public ownership than does child care: 46% of Canada's 2,039 long-term care homes are publicly owned, 28% are private for-profit and 23% are private non-profit (Canada Institute for Health information, 2020). There is significant variation in this by province/territory, however, as there is in child care. For-profit ownership ranges from 57% of all provision in Ontario to 0% in Northwest Territories, Yukon and Nunavut, where all long-term care is publicly operated (Canada Institute for Health information, 2020).

TABLE 3 **Percent of long-term care facilities by auspice. Provinces/territories and Canada (2020).**

Provinces/territories	Public (%)	Non-profit (%)	For-profit (%)
Newfoundland and Labrador	97%	None	3%
Prince Edward Island	47%	47%	6%
Nova Scotia	14%	41%	45%
New Brunswick	None	88%	12%
Quebec	86%	14%[17]	
Ontario	16%	27%	57%
Manitoba	57%	30%	13%
Saskatchewan	75%	21%	4%
Alberta	47%	28%	25%
British Columbia	38%	28%	34%
Yukon	100%	None	None
Northwest Territories	100%	None	None
Nunavut	100%	None	None
Canada	46%	23%	28%

Source: Canada Institute for Health information, 2020.

Although long-term care's 28% for-profit share (of facilities) of the Canada-wide total is identical to that of licensed child care's (28% of spaces in 2019), a much larger share of for-profit long-term care facilities are owned by large, often international, corporations than are child care centres.

Canadian for-profit child care is less corporately owned than long-term care, although there are many medium sized child care chains. Among the biggest corporate child care firms is privately-held Kids & Company, which owns 90+ locations across Canada (predominantly in Alberta, Ontario and British Columbia but in three other provinces as well.) There are now no child care companies trading on Canadian stock exchanges. BrightPath, formerly Canada's sole publicly traded child care chain, was acquired

17 Breakdown between non-profit and for-profit auspice not available for Quebec.

by London-based Busy Bees in 2017. Busy Bees now operates 92 Canadian centres under the name BrightPath and several other names in Alberta, Ontario, and BC. The Ontario Teacher's Pension Fund is the majority owner of Busy Bees, which includes close to 1,000 centres in the UK, Australia, Canada and Asia.

In long-term care, Revera which operates more than 500 long-term care facilities across Canada, the United States and the United Kingdom is owned in part by Canada's Public Sector Pension Investment Board, the pension fund for the Public Service Alliance of Canada. In 2020, the public service union – in response to resident deaths from COVID-19 at Revera facilities – called for the federal government to shift Revera to public ownership and operation (Public Service Alliance of Canada, 2020). Several other publicly traded corporations each operate hundreds of homes in the long-term care sector in Canada, including Extendicare, Chartwell, and Sienna Senior Living. Chartwell, which claims to be the "largest operator in the Canadian seniors living sector" has more than 200 locations in Ontario, Quebec, Alberta, and British Columbia (Chartwell, 2021). In many instances, facilities and operations are owned by different long-term care companies.

The financialization of long-term care is not exclusive to Canada. An analysis of Canada, United States, United Kingdom, Norway, and Sweden demonstrates that the large for-profit nursing home chains in each country are increasingly owned by private equity investors, with shifting ownership over time, and complex and opaque organizational structures (Harrington et al., 2017), These are similar to those involved in the child care sector, as described by Simon, et al (2021, forthcoming) in the U.K., Gallagher (2020) in New Zealand and Brennan (2008b) in Australia.

The workforce in child care and long-term care

In Canada, more than 90% of the workforce in both the child care and long-term care sectors are women. The long-term care workforce is disproportionately racialized and migrant women; comparable workforce data are not available for child care. In Ontario, 58% of long-term care employees are personal support workers (PSWs), which generally requires a six-month course, and usually pays between minimum wage and $20/hr (Ontario Ministry of Long Term Care, 2020). The employment of PSWs suffers from the same recruitment and retention issues as those of early childhood educators, with low remuneration and high staff turnover. In Ontario, 50% of PSWs are retained in the health care sector for fewer than five years, and 43% are reported to have left the sector due to burnout resulting from inadequate staffing (Lakusta, 2018). Comparable data are not available in the child care field but a 2013 cross-Canada study found that 65.5% of the child care employers (usually centre directors) reported at least one permanent staff leaving the centre in the past year; for-profit centres reported somewhat higher mean numbers of qualified staff leaving the centre than non-profit centres (Flanagan et al., 2013).

Many long-term care employees are contracted through temporary staffing agencies or work part-time hours. Neither of these is common in child care, however, nor do child care staff ordinarily move between multiple centres as long-term care staff often do between multiple facilities. Staff often do not have paid sick leave, benefits or employment security in either long-term care or child care. An analysis of the long-term care workforce in British Columbia and Alberta (Duan et al., 2020) showed that 24% of care aides (PSWs) worked in multiple facilities, with more workers working in multiple locations in public and for-profit homes than non-profit homes. This survey of 3,765 care aides also reported that 15% work a second or third job outside the sector. When asked why they

chose to have an additional job out of the sector, 73% attributed it to financial reasons, and 17% stated that they could not get full time hours (Duan et al., 2020). Comparable data on Canada's child care workforce are not available.

Differences in quality of care between for-profit, non-profit and public operators associated with workforce issues have been documented in the long-term care sector as they have been in child care. A study of 167 long-term care homes in British Columbia found that the mean number of hours per resident-day was higher in non-profit facilities than in for-profit facilities for both direct care and support staff and for all facility levels of care (McGregor et al., 2005). A 2016 Ontario study also showed for-profit long-term care facilities – especially those owned by a chain organization – provided significantly fewer hours of care, after adjusting for variation in residents' care needs (Hsu et al., 2016). An international meta-analysis of 82 studies on nursing home quality indicated higher quality care in non-profit facilities. Non-profits had higher quality staffing and lower risk of pressure ulcers compared to for-profit facilities. Results also favoured non-profit homes on the measures of lower rates of physical restraint use and fewer deficiencies in government regulatory assessments, although these results were not statistically significant (Comondore et al., 2009).

Long-term care and the effects of COVID-19

While poor quality in long-term care, the effects of auspice on resident health and safety, and anxiety about workforce and working conditions had been concerns for some time, it was the coming of the pandemic that raised an alarm about all these issues. During the pandemic, there were many deaths in Canada in long-term care and the issues with it were brought to new, high levels of public attention. By March 2021, 74% of COVID-19 deaths in Canada had been in long-term care (Canadian Institute for Health Information, 2021). In an analysis of 623 Ontario long-term care homes between

March and May 2020, Stall et al. (2020) found that for-profit status was associated with the extent of an outbreak of COVID-19 in long-term care homes and with the number of resident deaths, although not with the likelihood of outbreaks. Researchers attributed these differences to the high prevalence of chain ownership of for-profit LTC, and older, not upgraded physical design standards. Staff movement between their jobs at multiple long-term care homes was also identified as a source of COVID-19 transmission into long-term care homes (Stall et al. 2020). Staff movement between jobs has been linked to cost savings on staffing costs by offering less-than-fulltime hours. An American analysis (Chen et al., 2020) estimated that 49% of U.S. nursing home COVID-19 cases were attributable to cross-facility staff movement. In an analysis of Ontario long-term care homes using mobility data, Jones et al. (2021) found that 42.7% of nursing homes shared a connection with at least one other home prior to the provincial government enacting restrictions to reduce worker mobility between multiple homes. In both the non-restricted and restricted periods, inter-long term care movement was higher in homes in larger communities, those with higher bed counts, and those that were part of a large chain.

It is noteworthy that weaknesses in provision of Canada's long-term care provision in all sectors were exposed during the pandemic but that for-profit operations had worse outcomes when comparisons between ownership types are made. As the research and analysis shows, comparison between these two care sectors – child care and care of the elderly – show similar profit-driven factors, especially those associated with staffing, to be linked to the care provided to their respective vulnerable populations.