MAPPING ALTERNATIVE SYSTEMS OF ACCOUNTABILITY IN RESIDENTIAL LONG-TERM CARE IN BRITISH COLUMBIA AND ONTARIO

by

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Abstract

Cases of abuse and neglect frequently arise in residential long-term care facilities. This thesis studies the systems of accountability within the residential long-term care sectors of British Columbia and Ontario. Using structured comparative case studies and documentary analysis it categorizes existing mechanisms of accountability into the five conceptions of accountability established by Bruce Stone. These are: parliamentary control, managerialism, judicial quasi-judicial, constituency relations and market. It then applies Richard Mulgan’s theory of accountability deficits to identify areas where the current mechanisms fail. Overall, it finds that contemporary reliance on alternative service delivery for the delivery of residential long-term care has significantly increased the need for new and different systems of accountability.

The thesis then assesses how mechanisms of accountability can be adapted while maintaining a system that includes alternative service delivery. Changes will require clear definitions of the role of accountability mechanisms and emphasis on preventative mechanisms. Improving systems of accountability in long-term care is important, as there will be increased pressure on such systems from an ageing Canadian population. This thesis contributes to the Canadian public administration literature by examining the relationship between alternative service delivery and a complex hybrid accountability system.
Lay Summary

This thesis examines systems of accountability in the residential long-term care sector for seniors in British Columbia and Ontario. Seniors living in such facilities are often abused or neglected. In addition, over the past two decades governments have increasingly used private or non-profit service providers in this sector. This creates new challenges in terms of accountability and oversight in the residential long-term care sector. Recent injuries and death of seniors in such provincial long-term care facilities have shown current systems of accountability have fallen short. This research finds that the alternative accountability mechanisms introduced in response to the increasing use of private and non-profit providers also face accountability deficits. Therefore, it is vital that these mechanisms are adapted and supported with adequate financial and human capital resources.
Preface

I in conjunction with the advice of my graduate supervisor, Dr. Allan Tupper completed the research design and topic identification for this project. Additionally, I conducted all of the documentary research and textual analysis for this project.
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Glossary

**Residential Long-term Care:** Twenty-four-hour-a-day supervised nursing care provided in a facility setting. Services provided generally included meals, medications monitoring, as well as assistance with dressing, bathing, and toileting. Residents of these facilities are generally elderly or persons with disabilities who cannot otherwise live independently.

**Alternative Service Delivery:** Services provided by non-governmental organizations on a contractual basis with the government. These organizations can be for-profit businesses or non-profit organizations.

**Public Accountability:** the principle of the government taking responsibility for the services it provides. In a new public management context this generally involves overseeing that services are provided efficiently and effectively. It also encompasses accepting blame for policy failures or crises that result from policy failures.

**Ministerial Accountability:** The historically dominant principal of accountability in Westminster style democracies where the Minister is expected to accept responsibility for issues or crises within his/her ministry as they are expected to manage and oversee the workings.

**Accountability deficit:** The “absence of political control by democratically elected officials.” Politicians no longer feel as though they have the responsibility to answer for issues in given policy areas as a result of the decoupling of government and service provision. This indicates that ministerial accountability has ceased to function.

**Systems of accountability:** The way in which mechanisms of accountability work together to prevent incidents from happening and ensure that they responsibility is taken when they do arise.

**Mechanisms of accountability:** the methods by which responsibility may be taken for incidents. Or encourage accountability.

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I would like to express my utmost gratitude to my supervisor Dr. Allan Tupper for his continuous feedback and assistance in completing this project.

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Additionally, I offer my heartfelt appreciation to my partner Harry who has provided me with support throughout this process and is always willing to talk about ideas. Finally, I would like to extend a special thanks to my parents who have always invested in my education and from an early age encouraged me to learn, try my best and to serve others.
Dedication

I would like to dedicate this work to the many seniors I have met and learned from throughout my time volunteering in residential long-term care facilities and to great residential care staff like Jay Bowen and Donna Stevens who work tirelessly to ensure quality of life for each and every resident.
Chapter 1: Introduction

All too frequently media reveal stories of cases of abuse and neglect in residential long-term care facilities in Canada. Examples range from seniors sitting in soiled clothing to physical abuse and outright neglect. Residential long-term care refers to facilities that provide 24-hour nursing care to seniors and persons with disabilities. In 2013 there were over 1,500 cases of abuse and neglect by care facility staff reported across the country.\(^2\) This begs the question: are the mechanisms of accountability in place sufficient to protect Canadian seniors? Provincial governments have increasingly utilized alternative service delivery, in order to respond to the growing demand for residential long-term care services, with private companies and non-profit organizations operating the majority of facilities. According to the Canadian Institute for Health Information, 44 percent of facilities in Canada are operated by private for-profit organizations and 29 percent are operated by non-profit organizations.\(^3\) This shift has created public management challenges, particularly in terms of accountability, oversight, and evaluation. Accountability is particularly important in residential long-term care, given the vulnerability of the population being served.

This thesis maps the accountability systems that have evolved in British Columbia and Ontario in response to accountability problems that have arisen from extensive reliance on alternative service delivery. Current accountability systems have, fallen short of their goal to protect seniors from abuse and neglect, as evidenced by the high number of complaints filed each year. This is because alternative accountability mechanisms, particularly managerialism,


quasi-judicial review and constituency relations, are not solidly defined and sufficient resources to enforce accountability are not provided. Furthermore, existing mechanisms come into play only after incidents have occurred. Therefore, systems of accountability in this area must be re-conceptualized. This is possible while still retaining a model based around alternative service delivery, however, it will require greater resources, stronger regulation, and streamlined complaints processes to prevent reoccurring accountability issues.

This thesis has five chapters. The first chapter will outline the methodology used, provide an overview of residential long-term care in Canada and review the literature on accountability, particularly as it relates to accountability deficits and alternative service delivery. The second chapter examines long-term care provision in British Columbia and the third chapter examines the long-term care system Ontario. The fourth chapter compares the British Columbia and Ontario systems and considers reform options. Chapter five draws conclusions about best practices for ensuring accountability in residential long-term care systems that heavily rely upon alternative service delivery.

1.1 Methodology

This project draws on documentary and discourse analysis through the review of legislation, regulations, Hansard, academic literature and reports published by non-profits and independent officers of legislatures. This analysis will form the basis of a structured comparison of cases that will draw descriptive inferences about current systems of accountability function in British Columbia and Ontario. My focus is on the impacts of alternative service delivery on accountability.

A review of the literature on accountability is conducted with a focus on accountability and alternative service delivery. It will examine how traditional systems of
vertical accountability are challenged when alternative service delivery agents are used. I will also consider the multiple mechanisms of accountability that have been adopted by governments in this transition such as, regulation and inspection, values promotion and the creation of independent officers. These mechanisms will be categorized into Stone’s five conceptions of administrative accountability: parliamentary control, managerialism, judicial quasi-judicial review, constituency relations, and market accountability. Bruce Stone’s taxonomy and Richard Mulgan’s theory of accountability deficits will inform the analysis of accountability systems in British Columbia and Ontario.

The second and third chapters will provide an overview of the systems of accountability in residential long-term care in British Columbia and Ontario. British Columbia and Ontario were chosen for a number of reasons including their broadly similar characteristics. The two provinces have large populations with Ontario having a population of approximately 13 million and British Columbia having 4.7 million citizens. Both exist within the same federal context, with the provinces having responsibility to provide healthcare under the Canada Health Act. More importantly both provinces face similar challenges when it comes to ageing populations. They have both embraced alternative service delivery as a means of increasing the number of residential long-term care beds to respond to increasing demand and as vehicles for cost containment. Both provinces have changed their legislation governing long-term care in the past two decades. Despite this, every year each province faces increasing numbers of complaints about the long-term care system.

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A major difference between British Columbia and Ontario is the creation of an independent Seniors Advocate in British Columbia. Significant organizational differences also exist between the two provinces with inspections and complaints processes in Ontario being run by the Ministry of Health and Long-Term Care, whereas, in British Columbia these programs are run by the regional health authority. Ontario also funds non-profits that support the work of resident and family councils and clearly defines the role of these councils in the *Long-Term Care Homes Act*. Finally, the funding structures for long-term care in each province differ slightly. In Ontario funding is given to service providers based on the complexity of care needed for each resident whereas, in British Columbia it is based purely on the number of beds.

By studying two broadly similar cases it is possible to follow Mill’s Method of Difference, where holding many independent variables constant allows for analysis of the independent variable that differs and the effect this has on the dependent variable. Of course, problems of generalizability also arise. However, this issue leaves room for testing on a wider array of cases in future research. In addition, provincial governments across Canada frequently borrow policy ideas from one another in this area, which may indicate that there is some degree of generalizability.

Klijn and Koppenjan argue that when examining accountability in areas using alternative service delivery, the structure of the system must first be defined explicitly before accountability changes can be made.\(^5\) Making the structure of the system explicit clarifies the relationship between complex accountability mechanisms for policy makers in the system.

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Therefore, this chapter also maps accountability flows in the long-term care sectors in British Columbia and Ontario and locates the accountability mechanisms in each. The similarities and differences will then be considered and some potential solutions will be proposed. The final chapter will draw conclusions on what insights can be gained from mapping these two systems of accountability.

1.2 Residential Long-Term Care in Canada

Residential long-term care policy is becoming increasingly important given Canada’s demographics. In 1998, 3.7 million Canadians were over the age of 65, making up 12.3 percent of the population; by 2041, this number is projected rise to 10 million, making up 22.6 percent of the population.\(^6\) As people age, they require greater medical care and assistance in daily living. The majority of Canadians will experience at least some limitations with completing the activities of daily living by age 85.\(^7\) Additionally, 76 percent of seniors over age 65 are living with at least one chronic condition.\(^8\) Residential long-term care serves those who can no longer eat, bath, dress, and handle their personal hygiene without assistance. The majority of those living in residential care facilities are over the age of 65 although these facilities may also serve younger people with physical or intellectual disabilities. It is projected that between 2011 and 2026 the number of Canadians, both seniors and persons with disabilities, requiring long-term care will rise by 71 percent.\(^9\) While the benefits of ageing in place and community-based care are numerous, many seniors do not

\(^6\) David Cheal, Ageing and Demographic Change in Canadian Context (Toronto: University of Toronto Press, 2002), 3.
\(^8\) Ibid.
have the family support, or the financial resources for these to be viable care options. Thus, residential long-term care will continue to fill a need for elder care in Canada.

In Canada, residential long-term care is under provincial jurisdiction. While the provision of residential long-term care is not required by the Canada Health Act, “[s]uch programs were introduced mainly to reduce the cost of more expensive medical and hospital services thus the overall cost of health care.”\textsuperscript{10} The Canadian Medical Association argues that there is a “significant difference in the cost of hospital care (approximately $846 per day) versus long-term care ($126 per day).”\textsuperscript{11} However, provincial policy control leads to interprovincial diversity. Chan and Kenny note that a “source of diversity in long-term care systems is the differing sizes and compositions of the provincial populations and their social and economic circumstances.”\textsuperscript{12} The result is that “the different approaches in funding have had a direct impact on the types of services seniors receive.”\textsuperscript{13} Significant differences exist between provinces in terms of how they assess user fees for long-term care, with some calculating them based on individual income (British Columbia and Ontario) and others basing these fees on combined spousal income (Manitoba). Despite this, the provinces have resisted federally established national standards. They prefer autonomy that allows them to organize the long-term care sector according to provincial circumstances populations needs.\textsuperscript{14}

\begin{thebibliography}{9}
\bibitem{chan12}Ibid.
\bibitem{chan14}Ibid., 71.
\end{thebibliography}
The provinces use money from the federal health transfers to fund residential long-term care services. Until the most recent bilateral health funding deals between the provinces and the federal government, which included targeted money for home-care, there was “no targeted federal funding for long-term care.”15 British Columbia and Ontario signed bilateral agreements with the federal government in early 2017, which included a 3 percent annual increase in health care funding.16 This figure is considerably lower than in the 2004 Health Accord, which included a 6 percent annual increase in health spending. Early on in the negotiation process several provinces (especially British Columbia) pushed for an age-based calculation of federal funding, as this would give provinces with large elderly populations an increase in the transfer payments.17

Public expenditure for residential long-term care is large, approximately 1.7 billion dollars in British Columbia and 5.3 billion dollars in Ontario.18 Provinces contribute to the cost of service delivery and in some cases the construction of new facilities. However, those in residential long-term care also contribute to the cost of their care. Fernandes and Spencer state that “[t]otal expenditure on nursing homes and residential care facilities in 2006 in Canada is estimated at $15.5 billion, of which about $3.8 billion was from private sources.”19 Charging user fees for residential long-term care has been traditionally defended “based on

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the ability of the public pension system to cover the costs.” Therefore, minimum user fees are often based on federal social benefits, such as Old Age Security and the Guaranteed Income Supplement, which is the case in British Columbia and Ontario.

Currently in Canada residential long-term care is provided by a combination of public providers, non-profit providers, and for-profit providers. Over the past twenty years provincial governments have increasingly looked towards the alternative service delivery as a way of increasing the number of long-term care beds available. Hirdes argues, “[t]his diversity in care providers may have the advantage that the system has more flexibility in responding to the needs of different kinds of individuals. On the other hand, it has also led to fragmentation of care delivery and inequality in access to services, because these different providers do not necessarily receive consistent levels of funding.” A small number of private companies dominate the sector. These include Revera, Retirement Concepts, Amica, Chartwell Seniors Housing and Signature Retirement Living. Quality control issues arise in this sector. As McGregor and Ronald argue that “[t]here is a growing body of evidence confirming the association between for-profit ownership and inferior quality care.” They suggest that this is largely because of the incentive to reduce staffing levels to cut costs, which may comprise the quality of care. Additionally, most long-term care facilities in Canada operate at capacity and staff are very busy. For example, Canadian care workers are

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21 John P. Hirdes, “Long-Term Care Funding in Canada,” 77.
23 Ibid., 16
responsible for twice as many residents as Swedish care workers. In Sweden long-term care is a jurisdiction of municipalities and is generally delivered as home care or small-scale residential care, these services are largely funded by municipal taxes.

Provincial governments have a limited role in direct service delivery, yet they are responsible for ensuring the regulation, licensing, and oversight of these facilities. As a result, regulation and licensing become major accountability devices. However, there are many examples of abuse and neglect in residential long-term care facilities. For example, McDonald notes in a telephone survey of 804 nurses in Ontario, “20 percent reported witnessing abuse of patients in nursing homes, 31 percent witnessed rough handling of patients, and 28 percent witnessed yelling and swearing at patients.”

1.3 Literature Review

Public service delivery must be both efficient and effective. Perrin notes “a major purpose of accountability (some would say its prime function) is the legitimization of the exercise of authority, including the most appropriate use of public resources.” Systems of accountability are, therefore, put in place to prevent issues of misconduct or misuse of funds from arising and to hold someone responsible if they do arise. These systems comprise a collection of mechanisms which each have independent functions. Bovens defines public

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accountability as “a social relationship in which an actor feels an obligation to explain and justify his or her conduct to some significant other.” Providers of public services are accountable to many different actors, including the government (as a result of contracts), courts, independent oversight bodies, professional peers, and the clientele themselves.

Accountability has also become a buzzword in modern government. It is often used without a full explanation of what “being accountable” entails. Interestingly, the Canadian House of Commons notes that government accountability is one of the most discussed topics in the House being mentioned 3513 times thus far in the first session of the 42nd Parliament. While this focus on accountability has its merits, the wide and diverse use of the concept also weakens its conceptual clarity. Accountability takes on a wide variety of meanings including, political accountability, financial accountability, and administrative accountability. Perrin also argues that learning and innovation should be the primary focus of systems of accountability, so it is not simply used as a sanctioning device.

In Westminster systems, government accountability was primarily exercised through individual ministerial accountability. This is a notion of accountability where cabinet ministers are held accountable for the actions of those working for them. It is based on the notion that the minister provides oversight and should be aware of the actions of those working below them. When an incident occurs ministerial accountability can take form in a number of ways through responding to questions from the opposition or media, and issuing a public apology.

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29 Ibid.
31 Burt Perrin, “Bringing accountability up to date with the realities of public sector management in the 21st century,” 199.
Over time governments have grown in complexity. With new public management principles becoming dominant in the 1980s, privatization and alternative service delivery became a new norm for the provision of public services. This change led to considerable public debate about the consequences for public accountability. Contracts are intended to shape alternative service delivery relationships but other new forms of accountability have been discussed.

Hodge and Coghill argue that “accountability in the privatized state is characterized by lower political accountability (as expected) but with higher managerial and market accountability.” The decline in political accountability is because democratically elected politicians have less power to make changes to the legislation and regulation of the service in response to their constituents and there is less concern with public consultation once a service has been privatized. The increase in managerial and market accountability is largely because the service is being managed in a direct fashion more like a business that sees citizens as customers. Along with this, alternative service delivery providers may also face less legal and administrative accountability, as “there are fewer, or less accessible, mechanisms for external complaints and redress.” However, Bovens notes that proponents of privatization argue that market competition may create accountability by providing incentives to publish information about their performance, which can be assessed in relation to other private providers. This assumes that this information is provided to the public in a format where they can objectively assess it and compare it to alternatives. Mulgan finds that

33 Ibid., 693.
34 Mark Bovens, “Public Accountability,” 201.
accountability deficits are often present in decoupled and network governance given that
direct political control is minimal and alternative mechanisms introduced to address this
problem may also face deficits. Such deficits are often denied and politicians stress that
alternative mechanisms of accountability can compensate for the loss of direct political
control and ongoing administrative oversight.

At the very least, alternative service delivery complicates accountability. Traditional
ministerial accountability functioned as a principal-agent arrangement when the public
service proper was the primary service provider. With alternative service delivery, the public
service now manages complex service provision systems. In this regard, Conteh argues:
“Lines of causality between actions and consequences become impossible to trace.”

Similarly, Dennis Thompson’s famous notion of “many hands,” describes how modern
government engages many different actors, institutions and political forces. within institutions
many actors are involved to varying extents for any given policy decision or program. Thus,
when a problem occurs it may be challenging to determine who should be held accountable.
For example, in a case of neglect in a residential long-term care facility an individual staff
member or many staff members may be responsible, the management of the facility may be
responsible, or the provincial government may hold some responsibility for not inspecting the
facility on a regular basis or all the above are engaged somehow.

37 Ibid., 551.
38 Charles Conteh, “Rethinking accountability in complex and horizontal network delivery systems,”
39 Dennis F. Thompson, Restoring Responsibility: Ethics in Government, Business and Healthcare
A tragic example of accountability and alternative service delivery can be found in the events leading to the death of Alex Gervais, a teenager in care in British Columbia whose requests for emotional support were ignored by social workers and contracted out care givers. Laegreid argues that alternative service delivery “tends to supplement the vertical mandatory accountability relationship with more voluntary horizontal accountability arrangements such as social accountability to customers and users of public services as well as market based forms of accountability.”

Some authors argue that the values of ministerial accountability and horizontal accountability are at odds. Haque suggests that alternative service delivery and network governance have led to accountability being measured in terms of efficiency and competition, which conflict with public sector values of equity, representativeness, and fairness. For example, in residential long-term care nurses may be efficient and care for a large number of patients in one day, however, given time constraints they may fail to observe subtle changes that may be an early indication of a larger health concern. Laegreid argues “what we see instead is the co-existence of different and partly contradictory interpretations of administrative accountability, which create potential dilemmas and contradictions for the individual civil servant.”

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Bruce Stone looks at how systems of administrative accountability have developed in Westminster democracies alongside greater use of alternative service delivery. He emphasizes that ministerial accountability is still an important principle but it is increasingly combined with other mechanisms. He favours a pluralistic system of accountability that combines elements of parliamentary control, managerialism, judicial and quasi-judicial instruments.\(^{44}\) Stone also recognizes that complex, pluralistic accountability systems often involve difficult tradeoffs. For example, inefficiency may result from overlap between multiple mechanisms and reporting requirements to multiple mechanisms of accountability may be burdensome for service providers and the public service.\(^{45}\)

Some authors note serious problems with contemporary accountability systems. Mulgan argues that, “an accountability deficit has been most commonly linked with the absence of political control by democratically elected political representatives.”\(^{46}\) This situation typically occurs in decoupled or network governance where responsibility and accountability for programs has been transferred away from the ministers to independent agencies or private service providers. These transfers have been justified in the name of efficiency and effectiveness. In long-term residential care decoupling has occurred at two levels with responsibility being transferred to regional health authorities and then understanding must be broadened and modernized.\(^{47}\) He notes that for an area to be considered to have an accountability deficit “judgments of accountability deficits need to be made against an explicit normative view of why the deficit is regrettable and why is should, if


\(^{45}\) Ibid, 522.


\(^{47}\) Ibid., 552.
possible be mitigated or removed altogether.”

In the new world of accountability, Laegreid finds that politicians now take on the role of chief executive and public servants are now seen as managers. Within this paradigm, politicians often “redefine policy weaknesses as managerial failures.”

Discussion abounds about governments heavy reliance on private service providers whose capacity may be lacking. Conteh argues that under alternative service delivery the terms of the contracts may not be enough to ensure that the service provider is accountable to the government. He suggests that there is a need for “emphasis on principles of trust, openness and reciprocity rather than mechanical instruments of control.” This may be achieved with greater public reporting, peer review, and deliberative forums.

Romzek and Johnston also find that while accountability is achievable with alternative service delivery it is greatly dependent on the quality of the contracts with service providers, the capacity of government to manage these contracts and the contracting environment in which it is occurring. A major challenge of alternative service delivery is that government services are typically established for public goods, areas where the market fails. For private service providers, the incentive is generally to make profits and if not properly regulated and managed they may do so by understaffing or cutting corners.

Mechanisms of accountability are used to prevent issues from arising, as well as to deal with problems that have occurred. Prevention is frequently done through a combination

48 Ibid., 554.
51 Ibid.
of rules and values. Wake-Carroll notes that “[w]hen responsibility for program delivery is devolved to external agencies, the bureaucratic accountability system – which is the most powerful pre-audit system – ceases to function.” It therefore, becomes very difficult for the government to supervise the actions of service providers and instill a culture of accountability. As a result, the government may only be able to rely on regulatory mechanisms of accountability. Hodge and Coghill conceptualize a pyramid with “hard mechanisms” at the top, such as legal mechanisms used by the government and sanctions from independent regulators, and “soft mechanisms” such as professional values and individual ethical procedures at the bottom. This argument stresses that the presence of both are necessary to ensure accountability.

Thompson argues, “an approach that preserves a traditional notion of personal responsibility – with its advantages for democratic accountability – can accommodate many of the complexities of a political process in which many different officials contribute to policies and decisions.” Promoting values personal responsibility may be important in the residential long-term care sector, as it may prevent issues of accountability before they happen. This could be done by educating seniors, family members and staff on their rights and ensuring that all are aware of the duty to report infringement of these rights. It may also be done through sharing the personal life stories of residents with staff so they see them for who they are as people and not just as patients of a residential care facility.

55 Ibid., 17.
Given major concerns for public sector accountability, independent oversight bodies, including auditors, ombudspersons, independent inspectors and citizen advocates have proliferated. Shepherd argues that these bodies are successful if they work “discreetly and with a great deal of care.”

This may explain why there have been an increasing number of independent oversight bodies introduced with specific mandates, such as the Seniors Advocate in British Columbia. Such arms-length bodies may provide necessary oversight within the public sector but their proliferation has also faced criticism. Stoney notes that some have suggested that in carrying out their mandates these bodies may undermine traditional systems of vertical accountability and supplant the role of parliamentary committees.

Politicians may feel less pressure to ensure accountability for their constituents if an independent officer is tasked with providing that. Further, “[t]he fundamental issue is how best to hold these independent, accountability agencies themselves accountable for their performance.”

Long-term care is a policy area where accountability is of great importance as the population receiving the service is vulnerable and sometimes physically unable to voice their complaints.


Chapter 2: British Columbia

2.1 Residential Long-term Care in British Columbia

The population of British Columbia is ageing, and will continue to do so over the next few decades. This increase will put more pressure on the residential long-term care system. Banerjee notes that “between 1991 and 2001 the number of seniors age 80 and older increased dramatically from 87,065 to 134,175.” Furthermore, by 2038 it is projected that those over the age of 65 in British Columbia will comprise 27 percent of the population (roughly 1.4 million), which is slightly higher than the projected national average of 25.4 percent.

Public expenditure on long-term care in British Columbia comprises approximately 5.1 percent of health spending. Spending on residential long-term care amounts to approximately 1.7 billion dollars. According the Canadian Institute for Health Information, in 2016 public expenditure on health in British Columbia was approximately 20 billion dollars. Overall, it is estimated that long-term care serves over 100,000 individuals. However, the Canadian Centre for Policy Alternatives found that since 2001 British Columbia has had the lowest annual increases in health spending, approximately 3.3 percent.

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59 Albert Banerjee, “An Overview of Long-Term Care in Canada and Selected Provinces and Territories,” 27.
61 Martha MacDonald, “Regulating Individual Charges for Long-Term Residential Care in Canada,” 84.
per year, of any province. Its expenditures are significantly below the national average of 4.2 percent.

In British Columbia, the Ministry of Health establishes policy for residential long-term care in the province. The provincial government plays a role in funding, licensing and regulating long-term care under the 1978 *Continuing Care Act*. This Act is important as it represents the first time the provincial government in British Columbia became involved in the area of long-term care. Regional health authorities were created in 1996. They receive a budget from the provincial government and plan, coordinate, and implement the service delivery of health care in a geographic region. Regional health authorities are responsible for planning and overseeing the delivery of residential long-term care services. There are six health authorities: Fraser Health, Interior Health, Vancouver Island Health Authority, Northern Health, Vancouver Costal Health and Provincial Health Services Authority. The 2002 *Community Care and Assisted Living Act* is now the primary piece legislation that guides the provision of residential long-term care in the province. According to the Act every facility that provides care to more than three people, not related through blood or marriage, is required to be licensed. Additionally, some private hospitals and extended care hospitals also provide these services and these are regulated under the *Hospital Act*.

In British Columbia residential long-term care facilities are run by a combination of public (regional health authorities), private, and non-profit providers. However, the composition of providers for residential long-term care in the province has changed greatly

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65 Andrew Longhurst, “Privatization and Declining Access to BC Seniors’ Care: An Urgent Call for Policy Change.” *Canadian Centre for Policy Alternatives*, (March 2017): 22.
over the past two decades (See Figure 2.1). Since 2000 all new facilities in the province were approved through a competitive tendering process, which favors for-profit providers given the technical knowledge required to create a competitive bid and the upfront capital required for such projects.\textsuperscript{71} In addition, the provincial government “has phased out infrastructure support to non-profit agencies.”\textsuperscript{72} Without support in developing plans for capital spending on infrastructure, non-profits often do not have the technical expertise to put together a competitive bid. As a result, “Since 2001, there has been a more than 20 percent increase in the number of for-profit residential care facilities and a decline of more than 11 percent in non-profit facilities.”\textsuperscript{73} In 2016 there were 107 for-profit facilities in British Columbia of which twenty facilities were run by Retirement Concepts, eight were operated by Amica and another ten were operated by Revera. Last year Retirement Concepts was sold to Anbang Insurance, a Chinese multinational, which sparked a review by the federal government given that the size of the

\begin{table}
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\begin{tabular}{|l|c|c|c|}
\hline
Ownership Type\textsuperscript{67} & 2001\textsuperscript{68} & 2008-2009\textsuperscript{69} & 2016\textsuperscript{70} \\
\hline
Private & 38\% & 44\% & 37\% \\
Public & 10\% & 24\% & \\
Non-profit & 44\% & 24\% & 63\% \\
Religious & 8\% & 7\% & \\
\hline
\end{tabular}
\caption{Facility Ownership Type (B.C.)}
\end{table}

\textsuperscript{70} Andrew Longhurst, “Privatization and Declining Access to BC Seniors’ Care,” 14.
\textsuperscript{71} Margaret J. McGregor, and Lisa A. Ronald, “Residential Long-Term Care for Canadian Seniors,” 27.
\textsuperscript{72} Ibid., 27-28.
\textsuperscript{73} Marcy, Cohen, Jeremy Tate and Jennifer Baumbusch, “An Uncertain Future for Seniors,” 12.
transaction was above 600 million dollars. This purchase was approved by the federal government and the provincial government subsequently approved the licenses for the twenty facilities they will acquire across the province. There is little discussion of why regional health authorities have maintained a small role in service provision, however, this may be because of an expectation of some public provision from citizens, a level of path dependency, or a need to provide the service in areas where it would not be profitable for a non-governmental provider.

In British Columbia there are public facilities and private facilities where the resident pays a market rate for the service. In public facilities, each regional health authority receives funds from the provincial government, and then allocates budgets for long-term care based on the basis of number of beds per facility. These facilities can be run either by the health authority, a private provider on a contract basis, or a non-profit provider. The Ministry of Health sets guidelines for how many public residential care beds should be available. The capacity-planning ratio used in British Columbia is 75 beds per 1,000 persons over 75. Therefore, the health authority decides when it must increase the number of beds and puts out a tender for contracts.

The cost of residential long-term care is divided between funding from the government and assessed user fees. The 1997 Continuing Care Fees Regulation established

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rules for how user fees for residential long-term care services are assessed in public facilities. MacDonald notes that in British Columbia fees are based on an individual’s income after tax and minimum fees are pegged to the amount provided by Old Age Security and the Guaranteed Income Supplement. The regulation states that if an individual’s income is above $1625 per month the fee is 80 percent of the after tax income with a maximum charge of $2932 per month. If an individual’s income is less than $1625 per month then the fee for residential care is the individual’s after tax income minus $325 retained as disposable income. Private residential long-term care beds are costly at around $50,000 per year and it is estimated that only around eight percent of men and five percent of women in British Columbia can afford these services. Therefore, providing publically funded long-term care is important for the majority of elderly British Columbians.

Each of the regional health authorities has a long-term care office, which acts as a single-entry point for assessment of eligibility for long-term care. Over time the province has tried to encourage those with moderate care needs to receive home care or move into assisted living facilities. Since 2002 “Changes to BC’s Long Term Care Act restricted access to residential care to those with complex care needs (severe cognitive impairment, dementia, multiple disabilities and complex medical problems).” Publically funded long-term care facilities are often operating at capacity and as a result those requiring care often wait three

77 Martha MacDonald, “Regulating Individual Charges for Long-Term Residential Care in Canada,” 98.
78 British Columbia, Continuing Care Fees Regulation (Victoria, BC: Legislature of British Columbia, 1997).
79 Ibid.
months or longer to be placed in a facility.\textsuperscript{83} This may be costly to the province as these individuals are often spending this transitionary time, waiting to be placed in residential care, in acute care wards of hospitals, which costs the health care system more money and results in longer wait times for procedures as hospital beds are occupied.

A Seniors Advocate was created in 2014 with the passage of the \textit{Seniors Advocate Act}. The Seniors Advocate has a mandate to analyze and monitor seniors services and provide recommendations on systemic issues in health care, housing, income supports, personal supports, and transport. The advocate is independent of the Ministry but reports to the Minister of Health on a yearly basis. As such, the Advocate is not an officer of the legislature. The 2017 annual report from the Seniors Advocate found that 91 percent of residential care facilities were not meeting the 3.36 “care hours” per resident per day recommended by the province.\textsuperscript{84} Since 2009 when this target was set the average care hours per resident have increased from 2.88 to 3.06 in 2012.\textsuperscript{85} However, the findings of the Seniors Advocate sparked a staffing review and a new action plan on home and community care. Over the next three years the Ministry will work to implement the aims of the staffing review through developing a monitoring an evaluation plan, a new health human resources recruitment strategy and promoting quality of care initiatives.\textsuperscript{86} This will be supported by $500 million of new funding over the next four years.\textsuperscript{87}

\begin{itemize}
  \item \textsuperscript{85} British Columbia, “Ministry of Health: Residential Care Staffing Review,” (Victoria, BC, 2017).
  \item \textsuperscript{86} British Columbia, An Action Plan to Strengthen Home and Community Care for Seniors, (Victoria, BC 2017).
\end{itemize}
2.2 Mechanisms of Accountability

Beyond the Seniors Advocate, other mechanisms are in place in order to ensure public accountability for the treatment of vulnerable seniors in long-term care in British Columbia. These mechanisms can be categorized into Stone’s five conceptions of accountability.

In British Columbia, parliamentary control exists on the topic of residential long-term care to some extent although it is largely indirect and episodic. The opposition actively raises questions in the legislature on critical incidents, staffing levels, and spending. However, given the devolution of responsibility to the regional health authorities and the increasing use of alternative service delivery providers, a decoupling exists and ministers are often able to avoid taking public accountability. However, the annual report of the Seniors Advocate provides an opportunity for debate in the legislature on the more systemic issues in residential long-term care.

Managerialism has become the dominant accountability approach in residential long-term care. It can be defined as government setting the strategic vision for a program area while devolving responsibility for implementation to other actors. The establishment of the regional health authorities in British Columbia is a strong example of managerialism. The Ministry of Health sets the strategic policy direction for residential long-term care, but disperses funding to the health authorities on a per capita basis and leaves implementation up to the regional health authorities. Regional health authorities negotiate contracts with service providers and have the responsibility for licencing. Within the long-term care sector, the regional health authorities exercise managerialism primarily through inspection of residential long-term care facilities. Inspection of non-governmental providers by the health authority can be seen as a form of external evaluation. Under the Community Care and Assisted Living
A long-term care facility operator is expected to permit an inspector to investigate their facility at any time, however, the legislation does not establish how frequently, or under what circumstance inspections will take place. Since 2008 reports of these inspections are posted on the websites of the health authorities providing the public with this data.88

Several mechanisms provide judicial and quasi-judicial accountability. In 2009 the Community Care and Assisted Living Act was amended to include a Residents’ Bill of Rights. This was modeled on the Residents’ Bill of Rights in Ontario. The rights outlined are organized into four categories, which include: commitment to care; rights to health, safety, and dignity; rights to participation and freedom of expression; and rights to transparency and accountability.89 Violation of these rights provides a basis for filing a complaint with the facility or the province.

The complaints process in British Columbia is complex with multiple pathways to initiate a complaint. As a first course of action, a complaint may be filed with the operator of the long-term care facility. In British Columbia residential long-term care “operators are allowed to determine what their own complaints processes will be.”90 In addition, residents or their legal representatives can file a complaint with a Patient Care Quality Office located within their regional health authority, which will be responded to within 30 days.91 A complaint can also be directed to the regional health authority through the Community Care Licensing Officer and any complaints filed in this way will be subsequently investigated by a

89 British Columbia, Community Care and Assisted Living Act (Victoria, BC: Legislature of British Columbia, 2002).
90 British Columbia Ombudsperson, “The Best of Care: (Part 2),” 309.
91 Ibid., 315.
provincial medical officer. Importantly, there is no established timeline for responding to complaints submitted in this manner.\textsuperscript{92} To support this process the government “has established a province-wide Seniors Health Care Support line where seniors can raise concerns.”\textsuperscript{93} Overall, the complaints process is primarily centred at the level of the regional health authority.

A problem with such a diffuse complaints system is that residents and family members may not know the best channel to submit their complaint. Lack of information sharing between these channels may pose challenges for ensuring that all complaints are dealt with in a systematic manner. The Ombudsperson in British Columbia has also been active in investigating concerns arising in the provision of residential long-term care, launching a systemic investigation after 50 individual complaints were filed between June and August 2008.\textsuperscript{94} “In 2010/11, the Fraser, Interior, Northern and Vancouver Island Health Authorities received a combined 186 complaints.”\textsuperscript{95} The \textit{Community Care and Assisted Living Act} also incorporates protection for persons who report abuse. It states “[n]o action or other proceeding may be brought against a person for reporting abuse under this part if the report is made in good faith.”\textsuperscript{96} The subsections further specify that this protection specifically apply to both employees and residents of long-term care facilities.

\begin{flushright}
\footnotesize
\textsuperscript{92} Ibid., 314. \\
\textsuperscript{95} Ibid., 313. \\
\textsuperscript{96} British Columbia. \textit{Community Care and Assisted Living Act.}
\end{flushright}
As noted, the BC government established a Seniors Advocate in 2014, the first position of this kind in Canada. Isobel Mackenzie, the first advocate did studies systemic of issues of concern to seniors, monitored the provision of social services to seniors in British Columbia, and presented policy recommendations to the government. The Seniors Advocate also acts as an independent quasi-judicial review, as the Advocate acts as an independent review on systemic issues affecting seniors. However, unlike the Ombudsperson the Seniors Advocate does not investigate individual complaints. The Office of the Seniors Advocate acts as a point of contact and directs people to the other resources. In doing so, the office tracks the general trends in concerns or questions and investigate systemic issues. The Act provides that the Advocate must report at least annually to the Minister of Health and has the power to promote awareness of systemic challenges and resources available, make recommendations to the government and refer individual complaints to the appropriate resources. The Advocate also has the authority to form an advisory council, conduct interviews surveys and public consultation, and can request information from service provider. To provide British Columbians with adequate information about residential long-term care, the seniors advocate maintains an online directory of all facilities in British Columbia with details of inspections and complaints.

For matters involving the conduct of residential care home staff, review and disciplinary processes are largely left up to professional associations. In British Columbia, registered nurses and licenced practical nurses fall under the Health Professionals Act. Their colleges, the College of Registered Nurses of British Columbia and Licenced Practical Nurse

Association of BC, have complaint processes and disciplinary committees in place. However, care aides who do the majority of day-to-day care of residents are part of the BC Care Aide and Community Health Worker Registry, but not of a regulatory college. Anyone working in a publically funded facility is required to be on the registry and prove that they have attended an accredited training program.

The *Residential Care Regulation* specifies that a licensee must provide an opportunity for residents and their families to form councils with the goal of “promoting the collective and individual interests of the persons in care, and involving the persons in care in decision making on matters that affect their day-to-day living.” The licensee must also provide an opportunity once a year to speak with these councils. This would fit with Stone’s criterion as the councils and the duty of the licensee to meet with the councils is specified within the *Residential Care Regulations*. Additionally, the Ministry of Health does have a website which has resources for establishing these councils.

When it comes to market accountability it is important to note that consumer sovereignty does not really exist in the long-term care sector as the majority of seniors go through the government run placement process and must accept the first bed that becomes available.

### 2.3 Critical Incidents

Every year the Seniors Advocate and the British Columbia Ombudsperson receive complaints about improper care, abuse, and neglect in residential long-term care facilities. Many of these stories gain media attention.

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In late 2007 issues of neglect at Beacon Hill Villa in Victoria became known to the government through a tip from an anonymous caller who reported details of a suspicious death to the health authority inspector. The details of this were uncovered during the coroner’s investigation of the death of a 91-year-old woman who fell out of her wheelchair, was strangled by its seatbelt and not found for hours after the incident. The woman died three days after this incident, but the fall was never recorded in her medical charts. Reports of other forms of neglect in the home, such as infrequent bathing of residents, violence and emotional abuse also emerged. The status of this facility quickly became a political issue and the opposition called for an independent investigation of all homes run by Retirement Concepts. The then Minister of Health, George Abbott, argued that the Vancouver Island Health Authority did look into the issue after it occurred. Eventually a review of the Beacon Hill Villa was initiated, however, it did not examine all of the facilities run by this company. The quality of care review undertaken produced 13 recommendations that were to be implemented immediately, new admissions to the home were halted and an independent administrator was brought in to oversee the home for six months.

Even in facilities that do not suffer from systemic accountability issues isolated incidents often occur. For example, in 2015 James Edward Christie a licensed practical nurse physically assaulted three residents with advanced stage Alzheimer’s and dementia at Selkirk...


Village Nursing Home in Victoria. The care aides who initially witnessed these incidents did not immediately come forward. One testified that he had brought complaints to management before that were never acted upon, so he was reluctant to step forward. However, eventually he was overwhelmed by guilt and reported what he had seen. The families of the individual subsequently pressed charges. In 2016 the nurse was charged with three counts of assault. His nursing license was suspended and he was sentenced to six months in prison with a two-year probationary period with a no-go order for two blocks around Selkirk Village and no contact with vulnerable populations unless under direct supervision. The fact that it took time for witnesses to report this indicates even with isolated indicates that there are still issues that must be worked out with complaints process and whistleblower protection policies.

A common theme in critical incidents is under-staffing leading to neglect. Hilda Casey’s daughter Monica Burrell started advocating on her mother’s behalf after finding out that she would have to wait for extended periods of time to use the bathroom and would even end up sitting in soiled clothing. Such problems are echoed by the results of the Residential Care Survey conducted by the Seniors Advocate. In this survey 25 percent of residents reported not being able to receive timely assistance to the washroom and 62 percent reported

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that they do not receive a bath or shower as often as they would like.\textsuperscript{106} The Seniors Advocate also finds that as nursing home staff are over extended to attend to the physical needs of residents, As a result, they often do not have time to attend to the emotional needs of residents.

Chapter 3: Ontario

3.1 Residential Long-Term Care in Ontario

Ontario also has an ageing population. In 2013 there were approximately 2 million Ontarians over 65, a number comprising 15.2 percent of the population. This number is projected to increase to 4.8 million, or 26.2 percent of the population by 2036. In 2015 Ontario had 630 long-term care homes which house 77,600 residents. Government spending on residential long-term care is approximately 5.3 billion per year, which amounts to 7.5 percent of the health budget.

In Ontario the Ministry of Health and Long-Term Care is responsible for residential long-term care services. Every facility caring for two or more unrelated persons is required to be licensed by the province. While other provinces chose to regionalize the responsibility for health services in the 1990s, “Ontario chose not to implement regionalization and its Ministry of Health and Long-Term Care set the operating budgets for hospitals, nursing homes, and homes for the aged on a facility-by-facility basis.” This changed in 2006 with the implementation of fourteen Local Health Integration Networks. Local Health Integration networks were established under the Local Health System Integration Act to make system improvements and “plan, coordinate, integrate and fund health services at the local level.”

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110 Ontario, Long-Term Care Homes Act, (Toronto, ON: Legislature of Ontario, 2007).
111 John P. Hirdes, “Long-Term Care Funding in Canada,” 73.
They differ from regional health authorities in British Columbia, in that they have less discretion on how their budget is spent and the boards of hospitals and other services were retained. These networks are now responsible for running Community Care Access Centres, local point of contact offices that determine an individuals’ eligibility for long-term care services, and provide information on care options. The eligibility criteria for residential long-term care are outlined in the *Long-term Care Regulation*. It specifies that individuals must require assistance with activities of daily living, at frequent intervals, and onsite supervision to ensure safety and well-being.

In Ontario residential long-term care facilities are operated by municipal, private, non-profit and religious providers (See Figure 3.1). When these facilities were first established in the early 1950s they were often either run by the municipal governments or by non-profits flanked by a small unregulated private sector. Municipal and non-profit facilities received funding from the government as they were providing health services to parts of the population that would otherwise require long-term hospitalization. In 1972 the *Extended Care Plan* allocated public funds to be provided to non-governmental providers for resident’s care needs. However, each kind of facility in Ontario was subject to different regulations under the *Nursing Homes Act, Homes for the Aged and Rest Homes Act and Charitable Institutions Act*. The regulations applying to the *Homes for the Aged and Rest Homes Act and Charitable Institutions Act*. The regulations applying to the *Homes for the Aged and Rest Homes Act and Charitable Institutions Act*.

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Institutions Act were more demanding about record keeping as they applied to municipally run facilities and non-profit-run facilities. In 1993, the Long-Term Care Statute Law Amendment Act standardized the funding structure of all these facilities but it was not until 2007 and the passage of the Long-Term Care Homes Act that these different types of residential long-term care service facilities were brought under one piece of legislation.

In the past few decades the composition of residential long-term care facility ownership has changed greatly in Ontario. Data collected by Statistics Canada shows the growth in private sector provision of long-term care (See Figure 3.1). Between 2001 and 2008 the proportion of privately owned for-profit residential long-term care facilities increased from 17 percent to 66 percent. In the same period the amount of publically provided long-term care services declined. This shift occurred because the health care system was recovering from large cutbacks made in the 1990s. Alternative service delivery was seen as a way to improve efficiency and lessen

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administrative overhead. In addition, non-profit provision has also declined somewhat but not as significantly as public provision.

Many private facilities are operated by a small number of private companies, including 76 facilities operated by Revera, and 23 operated by Amica. Both of these providers are also have many facilities in British Columbia. There is some publically provided provision of long-term care services at the municipal level, given that this was initially mandated in the 1949 *Homes for the Aged and Rest Homes Act* and today is included in the *Long-Term Care Homes Act*.^121^ Thus, “[m]any municipalities are required to build a home for the aged in their area either on their own or in partnership with a neighboring municipality.”^122^ This has led to a continued public role in service provision, as “[e]xperience has shown that if municipalities try to withdraw from their long-term care role citizens will object.”^123^ Overall the need to expand capacity has driven governments towards greater reliance on private-providers for residential long-term care.

Given the high capital cost of building residential long-term care facilities, Queen’s Park has also offered funding for the construction of new residential long-term care homes. For example, in the 1980s the Conservative government announced it would tender the construction of 20,000 new long-term care beds in response to increasing demand.^124^ In order to provide incentives to service providers the provincial government promised $75,555 per

^121^ Ontario Association of Non-Profit Homes and Services for Seniors, “Municipal Delivery of Long Term Care Services,” July 2012.

^122^ Pat Armstrong, et al. *A Place to Call Home: Long-Term Care in Canada*, 93.

^123^ Ontario Association of Non-Profit Homes and Services for Seniors, “Municipal Delivery of Long-Term Care Services,” 2.

bed and lowered staffing requirements.\textsuperscript{125} Due to the capital required upfront for construction of such a facility the bidding process greatly favored large, for-profit providers.

All licensed residential care facilities in Ontario receive funding from the provincial government to assist in their ongoing operation costs. Since 1993 these payments have been divided into four envelopes: nursing and personal care, program and support services, food, and accommodation costs. Funding for nursing and personal care is allocated to the facility based on the annual assessed care needs of the residents of the facilities.\textsuperscript{126} Program and support service funding, which includes pastoral care, recreation and volunteer coordination, and food receives a set amount based on the number of residents in the facility.\textsuperscript{127} Accommodation costs are charged to the individual residents with rates being set by the provincial government. MacDonald notes “accommodation is the only envelope from which for-profit facilities may extract capital.”\textsuperscript{128} In Ontario a variety of room types are offered, however, only the basic room, which is often shared, is publically funded. The calculation for accommodation costs is based on individual’s income after tax. For those whose income is only the OAS and GIS, the individual is only allowed to retain $136 per month as a “comfort allowance.”\textsuperscript{129} Other sources of funding may also exist for some facilities. For example, in 2008 it was estimated that “municipalities contributed well over $225 million to home operations over and above provincial long-term care funding.”\textsuperscript{130}

\begin{flushright}
\textsuperscript{125} Ibid.
\textsuperscript{126} Albert Banerjee, “An Overview of Long-Term Care in Canada in Select Provinces and Territories,” 19.
\textsuperscript{127} Tamara Daly, “Dancing the Two-step in Ontario’s Long-Term Care Sector: Deterrence Regulation = Consolidation,” 45.
\textsuperscript{128} Albert Banerjee, “An Overview of Long-Term Care in Canada in Select Provinces and Territories,” 19.
\textsuperscript{129} Martha MacDonald, “Regulating Individual Charges for Long-Term Residential Care in Canada,” 98.
\textsuperscript{130} Ontario Association of Non-Profit Homes and Services for Seniors, “Municipal Delivery of Long-Term Care Services,” 3.
\end{flushright}
3.2 Mechanisms of Accountability

As in BC, parliamentary control occurs with the opposition raising questions about long-term care in the legislature. This process is episodic and often results from critical incidents that receive media attention. In 2017, for example, the Minister of Health and Long-Term Care, Eric Hoskins, was heavily questioned following murders of eight residents by a care giver.\textsuperscript{131} Teresa Armstrong, the NDP Long-Term Care and Seniors’ Affairs critic argued that a major investigation was required into accountability and policy in the long-term care system.\textsuperscript{132}

Ontario has embraced managerialism in long-term care, however, not as significantly in comparison to British Columbia as less responsibility is devolved to local health integration networks. Ontario was the last province in Canada to regionalize its health care system with the introduction of local health integration networks in 2006. These networks primarily coordinate bodies that deliver services, such as hospitals, community care access centres, and long-term care facilities. In comparison to regional health authorities, local health integration networks have less control over their budgets with funding that flows through them already earmarked for specific service providers.\textsuperscript{133} Additionally, the Ministry of Health and Long-Term Care has retained control of the long-term care inspection program.

Inspections are an important part of accountability in Ontario. The Ministry of Health and Long-Term Care is responsible for the Long-Term Care Homes Quality Inspection Program in Ontario. Four types of inspections can occur: comprehensive inspections, critical

\textsuperscript{132} Ibid.
incident inspections, complaint inspections, and follow up inspections. Inspector’s reports are made available to the facility operator as well as the resident and family councils. Inspection reports are also made publically available through the Ministry’s website. McGregor and Ronald argue that “Ontario has so far developed the most extensive system of public reporting.” Despite having this system, the Auditor General found that “the ministry did not take timely action to ensure that residents were safe and their rights were protected.” The inspection program is struggling given a very heavy work load and competing demands of comprehensive inspections and critical incident follow up inspections. A considerable variation in frequency of inspections and wait times for follow up and response are noteworthy.

Multiple mechanisms of quasi-judicial accountability are in place. The 2007 Long-Term Care Homes Act included a Residents’ Bill of Rights. Violation of these rights is the basis for filing a complaint to the Ministry of Health and Long-Term Care. Non-urgent complaints are to be dealt with by the care facility. As in British Columbia a facility can determine its own process for responding to these complaints. Urgent complaints can be submitted to the Ministry in writing or over the phone on the ACTION phone line. The Ministry defines urgent complaints as “cases of harm, neglect or danger to residents” and non-urgent complaints as “less serious complaints related to diet, activities, or care.”

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136 Ibid.
137 Ibid.
complaint is not adequately resolved by the Ministry it can be taken to the Patient Ombudsperson.

Every facility is required to have a complaints procedure. Additionally, it is mandatory for anyone with reasonable grounds to suspect improper care resulting in harm; abuse or neglect; misuse or misappropriation of residents’ money; and misuse of public funds by the licensee to report it immediately to the provincial Director of Licensing. Staff, physicians, and social workers are all required to report incidents. The Director of Licensing has a duty to contact a Ministry of Health and Long-Term Care inspector or conduct an inquiry. The 2007 Long-Term Care Homes Act also established protection for whistle-blowers and establishes that no one shall retaliate or threaten to retaliate against an individual who discloses information to an inspector or the home director.\footnote{139} In 2014 the Ministry of Health and Long-Term Care received approximately 3,300 complaints and 2,030 critical incident complaints.\footnote{140} Critical incidents complaints are defined by the potential harm that they may pose to residents and include things such as fire, neglect or abuse, and unlawful conduct.\footnote{141} Other complaints may relate to level or quality of care.

Conduct of registered nurses and licenced practical nurses is regulated by professional associations and colleges (College of Nurses of Ontario, Registered Practical Nurses Association of Ontario) as outlined in the Regulated Health Professions Act. However, personal support workers who make up the majority of staff in long-term care facilities are unregulated. The Ontario Health Professions Regulatory Advisory Council advised the government in 2006 that a regulatory association for personal support workers was not

\footnote{139} Ontario. Long-Term Care Homes Act (Toronto, ON: Legislature of Ontario, 2007).
\footnote{141} Ibid.
needed because they receive oversight from regulated professions.\textsuperscript{142} This argument is largely unconvincing given that many staff conduct issues have been reported involving personal support workers.

This \textit{Long-Term Care Homes Act} also creates a requirement for resident councils to be established at each facility. Section 63 establishes the duty of the licensee to meet with the council if invited.\textsuperscript{143} With the yearly opportunity to meet with management. At present, 624 councils are in place in Ontario. They vary in size depending on the size of the facility.\textsuperscript{144} In addition, the legislation also encourages family councils. Such councils, although not required, are often active advocates for improvements in care and quality of life for residents. The powers of these councils include advising residents on their rights, bringing forward complaints and reviewing inspections and other reports.\textsuperscript{145} In Ontario, the government funds two non-profit organizations – the Family Councils Ontario and the Ontario Association of Residents’ Councils - to support the work of residents and family councils.

Market based accountability largely does not exist in the long-term care sector given the high demand and limited supply which removes consumer sovereignty. In Ontario, eligible applicants can choose to be on waitlists for up to five facilities. They are given 24 hours to accept a bed offer and must move in within five days.\textsuperscript{146} If they refuse, their names are taken off all of the lists and they may reapply after twelve weeks. These policies mean


\textsuperscript{143} Ibid.


\textsuperscript{145} Ontario. \textit{Long-Term Care Homes Act} (Toronto, ON: Legislature of Ontario, 2007).

that there is little real “consumer” choice. Demand for residential long-term care is so high that even those who are looking for pay-for-service care will encounter waitlists.

### 3.3 Critical Incidents

As in BC, a number of incidents of abuse and neglect have occurred in Ontario long-term care facilities over the last decade. Frequently these incidents gain media attention. In all of these cases mechanisms of accountability have failed in some way resulting in serious injury or death.

An alarming case is the murders conducted by Elizabeth Wettlaufer. Wettlaufer was a registered nurse working in London and Woodstock, Ontario. Between 2007 and 2016 she murdered eight seniors in her care and attempted to murder four others by injecting them with insulin. Wettlaufer confided her crimes to multiple sources who did not report her to authorities including: her girlfriend, psychiatrist, pastor, a student nurse, a criminal lawyer, narcotics anonymous sponsor, and boyfriend. In fall of 2016 she checked herself in to the Centre for Mental Health and Addiction and confessed. As a result, she was charged with eight counts of first-degree murder, four counts attempted murder, two counts aggravated assault for which she pleaded guilty and was sentenced to serve eight concurrent life terms in prison.

In August 2017 the Ontario government announced a two year inquiry, led by Justice Eileen Gillese, into the circumstances leading to the crime and the safety of seniors in long-

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term care facilities thought the province.\(^{149}\) A major concern was the range of persons with knowledge of, or suspicions about Wettlaufer, who did not expose her activities.

Neglect due to inadequate staffing is a systemic issue in private care facilities in Ontario, as the case of Arthur Ross Jones suggests. Arthur Ross Jones died in 2014 as a result of an untreated sepsis infected bedsore.\(^ {150}\) He had been a resident at a long-term care facility operated by the nursing home chain Revera. After his death, Arthur’s daughter launched a class action lawsuit against Revera. Since then 82 people have come forward with incidents of neglect and the lawsuit claims $200 million in damages.\(^ {151}\) Revera operates 76 facilities in Ontario which serve over 6000 residents.

Another case shows that in some facilities multiple staff members may be abusive towards residents. In 2013 Hellen MacDonald, a resident at St. Joseph’s in Peterborough, Ontario was abused by four staff members. Video footage from a hidden camera installed by her son shows one nurse putting a soiled cloth with feces on it in Hellen’s face and another nurse using her bedding to blow his nose.\(^ {152}\) This footage went on the internet and sparked an internal investigation and an inspection from the Ontario Ministry of Health. The four employees were fired as a result. A few months later the Minister of Health visited the facility.


to announce that they planned to double the number of inspectors in the province.\footnote{David Andreatta, “Store owner advocates against elderly abuse,” \textit{The Globe and Mail}, July 5, 2013, https://beta.theglobeandmail.com/news/national/store-owner-advocates-for-the-elderly/article13049890/?ref=http://www.theglobeandmail.com&.} The fact that these behaviors were occurring among several care staff in the facility is particularly troubling, as these people are in positions of trust and power when caring for such a vulnerable population.

The above incidents show that current mechanisms of accountability are not working well enough and more preventative mechanisms are needed. It is important that these changes are made because each of these incidents erodes the public’s trust in the residential long-term care system.
Chapter 4: Analysis

4.1 Introduction

Residential long-term care needs accountability systems that address the problems resulting from alternative service delivery. Stone argues that active choices about accountability mechanisms are necessary “where systems cannot overlap without generating major costs and inconsistencies.” Residential long-term care is a powerful example with reliance on alternative service delivery creating horizontal accountability structures.

In both British Columbia and Ontario, accountability mechanisms are numerous but under-resourced and ineffective. This situation is likely due to the evolutionary nature of the accountability where new mechanisms have been added for increased accountability without full analysis of how they work together in a system of non-governmental service provision. Hence Klijn and Koppenjan’s argument about understanding the overall system and assessing its overall effectiveness. Only then is it possible to analyze how the system can be strengthened.

4.2 Mapping Accountability Systems

When Stone’s five conceptions of accountability are applied to residential long-term care, traces of each type of accountability are evident. A summary of this is provided in Figure 4.1.

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156 Ibid.
<table>
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<tr>
<th>Conception of Accountability</th>
<th>Logic of conception of Accountability</th>
<th>Corresponding Mechanisms in BC</th>
<th>Corresponding Mechanisms in Ontario</th>
</tr>
</thead>
</table>
| Parliamentary Control        | Vertical hierarchy with Ministers ultimately responsible for oversight of those below  
Deterrent power of parliamentary question leads to bureaucratic caution | Yes, although only really involved with significant incidents  
Tendency to pass blame to regional health authority or provider | Yes, although only really involved with significant incidents  
Tendency to pass blame to regional health authority or provider |
| Managerialism                | Devolution of power guided by strategic leadership  
Agency self-evaluation  
Periodic formal evaluation | Devolved responsibility at two levels regional health authority and service provider  
Health authority responsible for inspection | Devolved responsibility local health integration networks and service provider  
Ministry responsible for inspection |
| Judicial Quasi-judicial review | Independent review of practices | Complaints process diffuse: regional health authority, care provider, Ombudsperson, Seniors advocate (systemic issues) | Ministry Responsible for the urgent complaints process  
Patient ombudsperson |
| Constituency Relations       | Accountability above and accountability below | Resident and family councils – establishment noted in regulation | Resident and family councils – powers defined in legislation  
Councils supported by government funded non-profits |
| Market                       | Market incentives drive efficiency and delivery that is more responsive to the consumer | Little choice in service provider | Little choice in service provider |
4.2.1 Parliamentary Control

According to Stone, parliamentary control is a vertical accountability system in Westminster democracies where “administrators should be continuously responsive to the concerns of members of parliament”\textsuperscript{157} A hierarchy of power provides that those more senior are responsible for the conduct and oversight of those below them. Public servants are diligent given the hierarchy. However, public servants are now directly engaged. They appear before legislative committees and even answer questions before the media.\textsuperscript{158}

Parliamentary control is indirect and limited in British Columbia and Ontario given the devolution of responsibility to regional health authorities and networks and alternative service delivery. In both British Columbia and Ontario we see that the parliamentary question serves as an episodic accountability mechanism to reinforce ministerial accountability. However, this often only results after a critical incident that has gained significant and sustained media attention. Given the vulnerability of the population in residential long-term care facilities family advocacy is often needed to bring these issues to the forefront. Legislative questions focus on individual episodes not systemic problems. In British Columbia and Ontario, ministers are often able to sidestep questions on residential long-term care. Accountability is transferred to regional health authorities, networks and non-governmental service providers.

Weak Parliamentary control creates an accountability deficit as defined by Mulgan.\textsuperscript{159} The transition towards network governance and alternative service delivery provision has led to the decoupling of accountability within parliamentary control in favour of managerialism.

\textsuperscript{157} Bruce Stone, “Administrative Accountability in the ‘Westminster’ Democracies,” 511.
\textsuperscript{158} Ibid., 512.
\textsuperscript{159} Richard Mulgan, “Accountability Deficits,” 545.
However, systemic problems reoccur and are not adequately dealt with by alternative mechanisms of accountability.

### 4.2.2 Managerialism

As Stone notes managerialism emphasizes “strategic, rather than detailed control; an emphasis on agency self-evaluation and reporting plus periodic, formal external evaluation; and a “rationalization” of agency responsiveness.”\(^{160}\)

British Columbia has devolved greater administrative responsibility than Ontario to regional health authorities. Regional health authorities in British Columbia are responsible for inspecting long-term care service providers, whereas, that role is done by the ministry of Health and Long-Term Care in Ontario. Particularly in British Columbia important questions arise about whether regional health authorities have the autonomy and capacity to provide oversight and to run effective inspection programs. While the Ministry of Health and Long-Term Care has retained this, we can also see that their inspection system may lack resources and capacity, as shown by the decision in 2016 to forgo yearly comprehensive inspections and to concentrate on inspecting higher-risk facilities.\(^{161}\)

Managerialism is now the guiding conception of accountability in the residential long-term care sector. As a result, governments have become decoupled by devolving responsibility to regional health authorities and local health integration networks. Such arms-length bodies then decouple themselves by relying on alternative service delivery providers.

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External evaluation is provided by inspections in both provinces. Inspections are badly under-resourced. Such mechanisms are complaint driven not preventative.

4.2.3 Judicial Quasi-Judicial Review

Stone’s third conception notes how judicial and quasi-judicial review are major parts of modern administrative accountability. This approach includes “providing aggrieved citizens with an ability to initiate a review to enforce these values on discretionary decision makers”162 Within residential long-term care, the Residents Bill of Rights is the basis on which a complaint can be made. Elements of quasi-judicial review are present in the residential long-term care sector with complaints processes and the development of independent oversight bodies such as the Seniors Advocate and Ombudsperson. Regulated health professionals have review processes for discipline and misconduct.

In BC and Ontario, complaints processes are centred in different parts of the system. In British Columbia, the regional health authority coordinates the complaints process, whereas in Ontario this task is done by the Ministry. In Ontario, a Patient Ombudsperson addresses individual complaints about in the health care services. The provincial Ombudsperson in British Columbia serves this function.

British Columbia also has a Seniors Advocate who serves as a quasi-judicial review within the long-term care system for systemic issues. Both provinces have comparable self-regulating health professionals’ associations or colleges and in both provinces, care aides and personal support workers are less strictly regulated than registered nurses.

Judicial and quasi-judicial mechanisms are important, although, they are not always effective nor are they panaceas. In British Columbia, government is not directly engaged with the complaints process and follow up may well be weak as a result.

4.2.4 Constituency Relations

Constituency relations suggest that an accountability system that looks “downward” to clienteles and “horizontally” to peers and other involved groups.”¹⁶³ In decision making and implementation there should be involvement of those effected by policy. Constituency relations includes: citizen representation on boards, participation in consultations, ability to appeal decisions, ability to pose questions to decision makers and formal reporting of program results. Stone notes that the concerns raised by interest groups should inform decision makers, however, they do not have to be entirely responsive to them to be accountable.¹⁶⁴

Mechanisms such as these are “soft mechanisms” of accountability that work to instill personal responsibility in staff and facility administration. A major challenge though is that individuals receiving residential long-term care might not have the mental or physical capacity to actively participate in residents’ councils and other participatory devices. Residents’ and family councils in Ontario are receiving more public resources and their role has also been defined in the legislation in Ontario In British Columbia, however, councils are covered in regulation, and council obligations are minimal thereby weakening their potential as accountability mechanisms.

¹⁶⁴ Ibid.
Mechanisms like resident and family councils are intended to make the service provider responsive to the clients and their families. Councils on the other hand are not directly linked with government. Linkages are needed because currently councils can only address problems at the facility level, when many of them are trying to address common concerns that should likely be addressed by the government through policy or program funding. Councils meet infrequently and accountability is therefore episodic and largely depended on individual facility’s management that is open minded and will to work with the councils.

4.2.5 Market Accountability

Finally, Stone suggests that the introduction of markets into public service provision does establish a sense of accountability. Competition via markets creates incentives for improved service quality and consumer responsiveness. Additionally, competing firms have incentives to share information with consumers about their service quality. However, Stone recognizes that for market accountability to occur consumer sovereignty is needed, which “requires a choice in suppliers, a choice as to quality and quantity of service, and the ability of the consumer to opt out of the purchase.” With marketization governments are somewhat constrained in their monitoring and enforcement of service quality, although this is primarily done through regulation.

Ontario and British Columbia have increasingly used non-governmental service providers to keep up with growing demand for long-term care. But consumer sovereignty does not exist in the long-term care sector. Most seniors are reliant on publically funded care

166 Ibid.
167 Ibid.
and are required to go through the government run placement processes that force them to accept the first bed that becomes available. Waitlists are long. Information on facility performance is made available to the public, but such information is far from comprehensive.

4.3 Potential Solutions

Ontario and British Columbia have responded to critical incidents by adopting additional accountability mechanisms. This evolutionary development has led to patchwork accountability systems. My main point is that further accountability mechanisms are not needed. Instead, existing mechanisms need reform and better coordination. Inaction on these accountability flaws may become more politically costly for governments as demand on the system continues to grow.

In my view, accountability systems that stress prevention are necessary. Resident and family councils can likely play a larger role through their capacity to advocate improvements in care quality. Common initiatives councils pursue include: organizing entertainment and educational sessions, developing a vision and mission statement for the home, and improving protocol for addressing missed baths.\(^{168}\) Funding of non-profit organizations that support these councils, like in Ontario, could well be expanded upon to allow councils do better research and to cover a broader range of issues. In addition, educational campaigns for both residents and staff on the Residents Bill of Rights would be beneficial. Particular attention should be paid to how vulnerable elderly individuals who may not have full cognitive capacity could be made more aware of their rights possibly through a system of lay advocates. Regular, comprehensive inspections of facilities needs to be expanded

considerably in order to deter critical incidents and to highlight issues where problems are occurring ideally before a crisis has happened. Effective inspections require more financial and human resources.

Improvements must also be made in post facto accountability mechanisms. Equally, work is badly needed to increase the report of incidents and ensuring, prompt effective responses. More straightforward processes are needed. In British Columbia, better coordination and information sharing are needed between multiple complaint pathways. Resident and family councils need resources to become navigators of the complaints process and to allow them direct aggrieved residents and their families to the best channels. In its study of resident and family councils, the Change Foundation found that resident and family councils were well situated to advocate for quality of life, whereas they could only direct individuals with quality of care complaints to other mechanisms.¹⁶⁹ British Columbia and Ontario need a tougher, better enforced timetable and follow up to complaints. As staff conduct is at the root of many critical incidents higher standards for the education and conduct of non-professional support workers is needed.

Finally, the Seniors Advocate in British Columbia is a valuable addition especially for investigating and reporting on systemic issues within the sector. Ontario may benefit from the creation of a similar position. The Patients Ombudsperson in Ontario was introduced to relieve pressure on the provincial Ombudsperson as a lot of the complaints received were health related. However, unlike the Seniors Advocate in British Columbia the Patient Ombudsperson only addresses individual complaints and does not investigate and report on

systemic issues. The Seniors Advocate could be given more resources over time and could be made a full independent officer of the legislature with additional powers to access information. This would elevate the profile of the advocate, and ensure that the budget for the advocate is set and reviewed by a parliamentary committee rather than the Ministry. The advocate would then report yearly to the Standing Committee on Health rather than to the Minister, which might strengthen political accountability by ensuring that the report of the advocate is debated in committee. This would help strengthen parliamentary control.
Chapter 5: Conclusion

Public administration scholarship has paid little attention to hybrid accountability systems in Canada. Alternative service delivery in residential long-term care has created numerous accountability challenges. A complex combination of accountability mechanisms has been created to address these challenges.

This thesis examines whether existing mechanisms of accountability are sufficient to protect seniors in British Columbia and Ontario from abuse and neglect. It does so by mapping existing mechanisms and applying Stone’s five conceptions of accountability. When Mulgan’s theory of accountability deficits is applied to these five conceptions, it is found that managerialism has largely supplanted parliamentary control as the dominant accountability mechanism in the residential long-term care sector. But it has fallen short of its goal to protect seniors from abuse and neglect. Additionally, alternative mechanisms such as judicial quasi-judicial and constituency relations, also face accountability deficits. Another important factor is that market accountability does not function in this sector given the high demand and limited supply of residential care, however, the private sector is heavily used for service delivery. They do not provide the continuous oversight which this sector needs and it lacks necessary public support and resources.

The situation is not bleak. Adjustments can be made to existing accountability systems to improve outcomes for those in residential long-term care. More resources can be given for accountability mechanisms that are proactive and preventative. Easily implementable changes should include strengthening resident and family councils and ensuring that comprehensive inspections are conducted on a regular basis. Additionally, more regulation is needed to ensure that complaints are dealt with in a timely manner and to ensure
better training and accountability measures for care aides and personal support workers. The Seniors Advocate in British Columbia has been a valuable addition to the accountability system. Ontario may benefit from creation of a similar officer to investigate systemic issues. It is recommended that the Seniors Advocate be given more independence from the Ministry of Health and stronger investigatory powers.

This research is exploratory in nature and aims to map the complex hybrid systems of accountability existing in British Columbia and Ontario. Ideally, my descriptive inferences further the understanding of hybrid accountability systems in service delivery areas beyond long-term care. These findings may be potentially generalizable to other residential long-term care systems across Canada and to other policy areas with hybrid accountability systems. Overall it is hoped that this thesis contributes to knowledge of the effectiveness of alternative accountability mechanisms in the residential long-term care sector.
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Appendix B: Accountability in Residential Long-term Care in Ontario

Legislation and Regulation

Inspection Program

Complaints Through LTC ACTION Line

Provincial Government

Ministry of Health and Long-Term Care

Patient Ombudsperson

Local Health Integration Networks

Facility Administration

Resident Council (Ontario Association of Residents’ Councils)

Staff (RNs, LPNs, PSW)

Family Council (Family Councils Ontario)

Regulatory Colleges (PSW unregulated)

Resident

Family