Assisted Living in British Columbia

Trends in access, affordability and ownership

By Andrew Longhurst

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By Andrew Longhurst
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Summary

TODAY, SENIORS IN BRITISH COLUMBIA HAVE LESS ACCESS to publicly subsidized assisted living than in 2008.

This is because the provincial government's reliance on a market-based approach to capital financing has failed to increase access to publicly subsidized assisted living. For-profit providers have focused new construction on more profitable private-pay units. However, private-pay assisted living is unaffordable for most low- and moderate-income seniors.

The provincial government's reliance on a market-based approach to capital financing has failed to increase access to publicly subsidized assisted living.

This report looks at trends in access, affordability and ownership of assisted living services, focusing on BC's challenge of maintaining and increasing access to publicly subsidized assisted living. More specifically, the report examines the effects of the provincial policy approach that relies on private-sector financing for new assisted living facilities. It determines that this policy approach has not been effective.

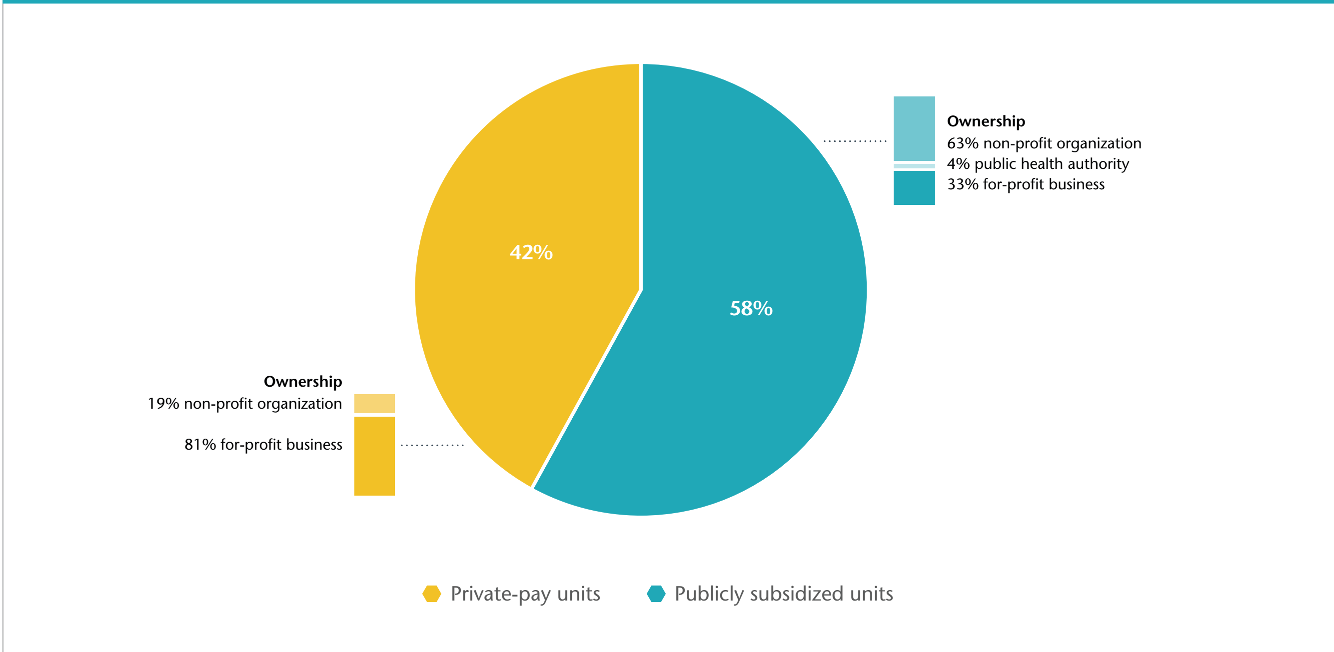
Part I explains the policy and fiscal context under which the assisted living model originated in BC. Part II uses Ministry of Health data to demonstrate that the result of the government's capital financing decisions means seniors have less access to publicly subsidized assisted living today than in 2008. Part III turns to the broader public policy implications of relying on private-sector financing. It analyzes what share of seniors' care is controlled by corporate chains and why the financialized business practices of these chains are a risk to seniors and the public health care system.

Policy and fiscal context of assisted living in British Columbia

In 2002, the BC government introduced a new assisted living model with the promise that it was an appropriate substitute for long-term care and would allow more seniors to live in home-like settings. At the time, this direction was attractive because it was assumed that the cost of assisted living to government would be about half the cost of long-term care. Available evidence did not support this rationale then, nor can it be justified now.

Also in 2002, the BC government embarked on a far-reaching agenda of fiscal austerity that included program cuts, public-sector layoffs and health care privatization. In particular, the provincial government aimed to reduce public capital spending by attracting private-sector investors to finance new capital infrastructure through public-private partnerships (P3s).

Figure A: Assisted living units by funding type in British Columbia, 2016



This report shows that access to publicly subsidized units has fallen and the private, for-profit sector—especially corporate chains—are more likely to build private-pay assisted living units.

Aside from an initial injection of federal and provincial capital funding in the early 2000s, virtually all new assisted living and long-term care infrastructure in BC has been financed through a public-private partnership approach. A health authority and an operator sign a contract for an indefinite term. The operator receives a per diem (daily resident rate) from both the health authority (for care services) and BC Housing, a crown corporation (for housing costs).

Assisted living thus evolved as a new model of seniors' care that favoured investment from the private, for-profit sector—an approach aligned with the provincial government's fiscal austerity objectives in the early 2000s.

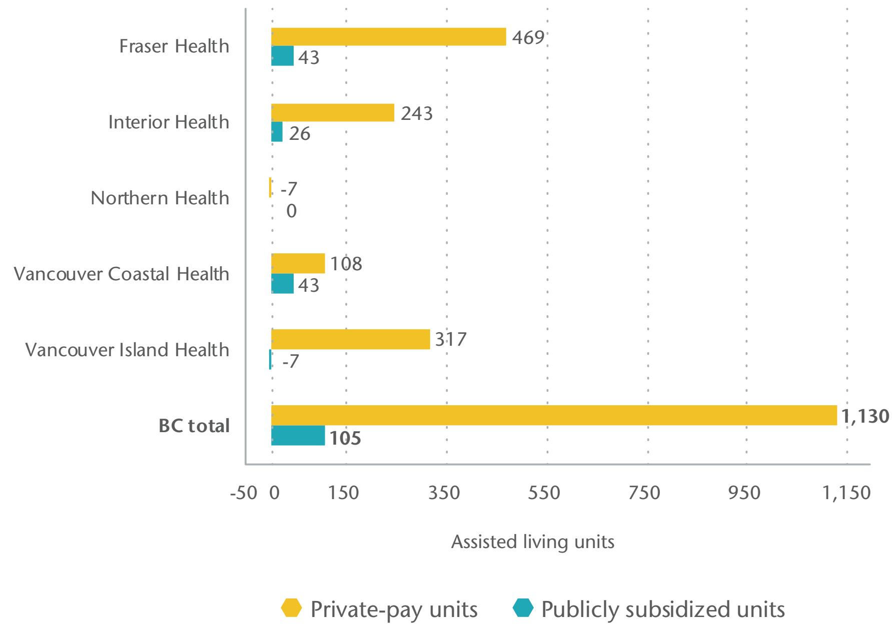
Unlike other P3 arrangements where government assumes ownership over the capital asset at the end of the contract term, BC's P3 model of financing assisted living and long-term care infrastructure means that British Columbians pay for the assisted living infrastructure but the private sector owns it. Thus, only the private-sector partners realize the benefits of asset ownership (including increased property value).

But this policy approach is not working. This report shows that access to publicly subsidized units has fallen and the private, for-profit sector—especially corporate chains—are more likely to build private-pay assisted living units where the rate of return on capital invested is higher.

Declining access to publicly subsidized assisted living

In 2016, 63 per cent of all publicly subsidized assisted living units in BC were owned and operated by non-profit organizations, and 33 per cent were for-profit owned and operated (see Figure A). Health authorities owned only 4 per cent of publicly subsidized units in 2016. Of the total number of private-pay units in BC, 81 per cent were in the for-profit sector while 19 per cent were owned and operated by non-profit organizations.

Figure B: Net new private-pay and publicly subsidized assisted living units added by health authority in British Columbia, 2010 to 2017



Sources: The 2010/11 data are from BC Ombudsperson (2012). The 2017 data are from the Assisted Living Registry as of March 31, 2017, and published in the Office of the Seniors Advocate, 2017, 16.

Between 2010 and 2017, BC added only 105 new publicly subsidized assisted living units (Figure B). And while the number of publicly subsidized assisted living units marginally increased in absolute terms between 2008 and 2017, access to publicly subsidized units fell by 17 per cent in BC. This access is measured by the number of units relative to the population of seniors aged 75 and over who are likely to require assisted living.

In BC in 2008, there were 14.7 publicly subsidized assisted living units per 1,000 seniors 75 and over, but by 2017 that number had fallen to only 12.2 units.

In four of the five regional health authorities in BC, access to publicly subsidized units fell between 2008 and 2017: Vancouver Coastal Health (-25 per cent), Fraser Health (-19 per cent), Vancouver Island Health (-17 per cent), and Interior Health (-11 per cent). The assisted living access rate increased by 5 per cent in Northern Health over this period. In 2017, Vancouver Coastal Health had the lowest number of units relative to the population aged 75 and over (10 units per 1,000 seniors).

As access to publicly subsidized assisted living has fallen, the private-pay assisted living market has benefited.

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Private-pay assisted living unaffordable for many BC seniors

Drawing on data from Statistics Canada and the Canada Mortgage and Housing Corporation (CMHC), the cost of private-pay assisted living exceeds the financial resources of seniors at or below the median income.

The CMHC definition of affordable housing assumes that households should spend no more than 30 per cent of their income on housing. BC seniors couples at the median income ($61,900) can scarcely afford an average rent, private-pay *bachelor unit* (39 per cent of their income). Only with considerable financial difficulty and risk can they afford a private-pay *one-bedroom unit* (58 per cent of their income). For seniors living alone, even a bachelor suite would require over 80 per cent of their income, which is clearly unaffordable.

The effect of declining access to publicly subsidized assisted living means that private-pay assisted living often becomes the last resort for seniors and their families, and trends suggest that the private-pay market is likely to become even more unaffordable over time.

Investors are interested in the real estate assets in seniors' care.

For-profit ownership, corporate chains and the financialization of seniors' care

The absence of significant ongoing public capital funding to support health authorities and non-profit organizations in developing new spaces has meant that very few new publicly subsidized assisted living facilities are being built. This lack of public capacity has benefited the private-pay market as some seniors and families will—in the absence of alternatives—pay for private-pay care even if it puts significant pressure on their financial resources.

For-profit companies are more likely to build and own private-pay units when the government fails to provide publicly subsidized ones. We know this from the fact that 81 per cent of private-pay units in BC are owned by for-profit businesses (Figure A).

A stagnant supply of publicly subsidized units has significant financial consequences for seniors and their families, given the reality that most lower- and middle-income seniors cannot afford private-pay assisted living.

Corporate chain consolidation in seniors' care is a reflection of *financialization* in the health care and housing sectors. Financialization occurs when traditionally non-financial firms become dominated by, or increasingly engage in, practices that have been common to the financial sector.

Globally, there is growing interest among investors in seniors' care because assisted living and long-term care are capital-intensive and require real estate. Therefore, seniors' care facilities and housing are treated as financial commodities that are attractive to global capital markets.

Financial services giant UBS identifies Canada as the second most-attractive market for investing in independent living, assisted living and long-term care facilities behind Japan and slightly ahead of the US. For-profit assisted living operators can expect a 30 to 40 per cent operating margin compared to 15 to 25 per cent in long-term care. Ultimately, investors are interested in the real estate assets in seniors' care.

In 2016, corporate chains controlled 29 per cent of publicly subsidized spaces and 66 per cent of private-pay assisted living and long-term care spaces in BC. Although chains did not control the

majority of total assisted living and long-term care units in 2016, they had a strong presence in BC, particularly in the private-pay segment of the seniors' care sector.

The BC government's longstanding reliance on attracting private capital into the seniors' care sector has benefited corporate chains with the ability to finance new developments.

There are three main concerns with financialized corporate chains increasing their dominance in BC:

- First, government can finance new seniors' care infrastructure at a lower rate than the private sector. BC is thus paying more by relying on private-sector financing, but getting less capital infrastructure than it would through government financing and working with the non-profit sector and public health authorities.
- Second, as a handful of financialized corporate chains increase their market share of publicly subsidized capacity, government becomes increasingly reliant on these chains for the delivery of publicly subsidized services.
- Third, we do not know what effect business practices of financialized corporate chains has on the quality of care, but based on the evidence from the long-term care sector, more research is required.

In sum, the financialization of seniors' care—in which real estate assets are treated as financial commodities to be bought and sold on international markets—is at odds with the basic social purpose of providing care to vulnerable seniors, many of whom have low and moderate incomes and cannot afford private-pay services.

The financialization of seniors' care is at odds with the basic social purpose of providing care to vulnerable seniors, many of whom have low and moderate incomes and cannot afford private-pay services.

A lack of provincial government capital funding has constrained the expansion of publicly subsidized assisted living services provided by public health authorities and non-profit organizations. The private-pay assisted living market grew more quickly than the supply of publicly subsidized assisted living units between 2008 and 2017. And, financialized corporate chains benefit from a policy approach that relies on the private sector to finance construction and deliver assisted living services. Chains are more likely than non-profits and small companies to have access to capital on the scale required to build seniors' care infrastructure.

Also, government has no long-term guarantee that these publicly funded, privately owned assets will remain part of the publicly subsidized seniors' care system. Ultimately, however, it is the failure of provincial governments to invest in new public and non-profit-owned assisted living units that has contributed to the shortfall in publicly subsidized spaces.

This report makes two major recommendations:

1. Create new capital and operating funding opportunities for non-profit organizations and health authorities to increase the supply of publicly subsidized assisted living units as part of a home and community care capital and operating funding plan. The most effective way to address the shortfall in access to publicly subsidized care is to create new capital and operating funding opportunities for non-profit organizations and regional health authorities to develop publicly subsidized assisted living facilities. These should begin in communities where new units are most urgently needed.
2. Require detailed disclosure and public reporting to improve transparency and accountability in assisted living and long-term care. A large body of evidence demonstrates the importance of public disclosure and reporting of ownership, costs and quality of services to enhance accountability and transparency in the seniors' care sector.

Introduction

Retirement Concepts' decision was motivated by a desire to increase the profitability of the assisted living residence.

IN APRIL 2017, RETIREMENT CONCEPTS—BRITISH COLUMBIA'S LARGEST SENIORS' CARE CHAIN—threatened to prematurely end its contract with Vancouver Coastal Health (VCH) for the provision of publicly subsidized assisted living units, if the health authority did not agree to increase payments to the company. VCH officials expressed significant concern about the company's actions and how these would affect seniors living in publicly subsidized units at the Terraces on 7th facility in Vancouver. A document obtained by *The Globe and Mail* through the Freedom of Information and Protection of Privacy Act showed that officials with the health authority were concerned by the company's "outrageous funding proposal to extend the contract."[1] Under Retirement Concepts' proposal, the health authority would need to increase payment to the company for the subsidized units. If VCH did not agree, seniors in publicly subsidized units would be required to pay $4,500 a month for a private-pay unit compared with the $2,500 that many were paying at the subsidized rate.[2]

Retirement Concepts' decision was motivated by a desire to increase the profitability of the assisted living residence, either by pressuring the health authority to increase the monthly rate it paid the company for assisted living units under contract or by converting the entire facility to private-pay units and directly charging residents a market rate without any restrictions. Concerns about the potential loss of publicly subsidized units and the financial pressure and anxiety it would place on lower-income seniors currently occupying those units were not lost on VCH officials: "We are trying to negotiate an attrition agreement to go beyond six months." But the administrator of the health authority lamented, "[Terraces on 7th] is one of the only publicly funded [assisted living] sites on the west side of Vancouver."[3]

It was not until Retirement Concepts' plan to evict the seniors in publicly subsidized units attracted media attention in the weeks before the May 2017 provincial election that the corporate chain decided not to follow through with that particular approach and, instead, planned to convert the units to private-pay as residents vacated them over time.[4]

This story illustrates the challenges that the provincial government and health authorities face by relying on the private, for-profit sector to build and finance assisted living facilities rather

1 Stueck, 2017.
2 Ibid.
3 Ibid.
4 Ibid.

than by publicly financing this infrastructure to be operated by non-profit organizations and health authorities.

Assisted living is a type of supportive housing for seniors with moderate levels of disability who can direct their own care but who require daily personal assistance to live independently (Table 1). It is part of the publicly funded home and community care system, but a growing share of assisted living facilities require BC seniors and their families to pay privately for these services.

Over the last decade and a half, the BC Office of the Canadian Centre for Policy Alternatives (CCPA–BC) has documented changes to the seniors' home and community care system in this province.[5] Between 2001 and 2016, access to publicly funded seniors' care, including home support, assisted living and long-term care, fell precipitously. Today, these services are less available than in the early 2000s.[6] As a result, seniors and their families may find it increasingly difficult to access publicly funded care in a timely manner. When public options are not available or the wait is too long, seniors who have the financial resources may be encouraged to seek out private-pay care. But for low- and moderate-income seniors, the out-of-pocket costs required for private-pay care exceed what many can afford. In this case, seniors may go without care entirely—or wait until their health deteriorates to the point that they can access publicly funded community care—usually only after a fall or visit to the hospital. Yet we know this approach does not serve seniors or our public health care system well at all. An appropriately resourced home and community care system can provide the preventive care and supports that allow seniors to age with dignity, and delay—or avoid—ending up in hospital and long-term care.

An appropriately resourced home and community care system can provide the preventive care and supports that allow seniors to age with dignity, and delay—or avoid—ending up in hospital and long-term care.

This report looks at trends in access, affordability and ownership of assisted living services, with a focus on the policy challenge that BC faces in maintaining and increasing access to publicly subsidized assisted living. More specifically, this report is concerned with the effects of the provincial policy approach to assisted living that relies on private-sector financing and provision of assisted living. This policy approach has not been effective: assisted living is less available today than it was in 2008. By relying on the private sector to build and finance assisted living facilities, the BC government has pursued a more expensive and riskier approach to the provision of these services. A secondary effect of the provincial government's policy approach over the last decade and a half has been that corporate chains—primarily those with real estate interests—control a sizable portion of assisted living services in BC. These corporate chains are more likely to focus on the private-pay segment of the market because it is more profitable, which does not serve provincial policy objectives of providing equitable access to seniors' care.

This report builds on previous CCPA–BC research by recommending a provincial seniors' care policy framework and capital plan that will ensure consistent and adequate increases in operational and capital funding to support the expansion of more cost-effective care provided by health authorities and non-profit organizations. Without a capital plan to expand non-profit and health authority provision of publicly subsidized assisted living, corporate chains are likely to continue consolidating their control over the assisted living sector and demanding that government increase funding levels—or else they will threaten closure of publicly subsidized units.

5 Vogel, 2000; Cohen et al., 2005, 2009; Cohen, 2012; Longhurst, 2017.

6 Cohen et al., 2005, 19, 28; Longhurst, 2017, 16, 18.

Table 1: Characteristics of assisted living and long-term care in British Columbia

	Definition	Services included	Staffing level and mix
Publicly subsidized registered assisted living	Type of supportive housing for people with moderate levels of disability who require daily personal assistance to live independently.	Included in the monthly rate, operators must provide: • A private housing unit with a lockable door; • Personal care services; • Two nutritious meals per day, one of which is the main meal; • Access to basic activity programming such as games, music and crafts; • Weekly housekeeping; • Laundering of towels and linens; • Access to laundry equipment for personal laundry; • Heating or cooling as necessary to maintain the safety and basic comfort level of the residence; and, • A 24-hour emergency response system.	No minimum staffing requirements other than there must be licensed nursing oversight of unregulated care staff.
Private-pay registered assisted living	Same as above	Same as above	Same as above
Publicly subsidized long-term care	Residential long-term care (nursing home care) is facility-based care that provides 24-hour nursing supervision and care for individuals with complex medical needs.	Operators must provide: • Housing; • Hospitality services (meals; housekeeping, routine laundry services; physical, social and recreational opportunities; • 24/7 emergency response system); • Maintain personalized care plan; 24/7 nursing care; allied health professional care as identified in the care plan; general hygiene and medical supplies; incontinence management; basic wheelchair and maintenance; other specialized service as needed.[i]	• 24/7 nursing care (provided by a regulated nurse). • Provincial guideline (not law) of 3.36 hours per resident per day of direct care, includes regulated and unregulated nursing care providers and allied health professionals.

Sources: Community Care and Assisted Living Act, Assisted Living Regulation and *Home and Community Care Policy Manual* (effective January 1, 2019).

i BC Ministry of Health, "Long-Term Care."

Table 1: Characteristics of assisted living and long-term care in British Columbia (continued)

	Service funding model	Additional personal costs (beyond monthly charge)	Regulatory oversight	Regular inspections
Publicly subsidized registered assisted living	• Residents pay 70% of their after-tax income to the health authority, subject to a maximum and minimum monthly rate. • The maximum rate is based on the market rate for housing and hospitality services for the geographic area where the resident lives, as well as the cost of personal care services. For 2019, the minimum monthly single client rate was $1,018.90 and $1,552.00 for a couple living together. • Low-income seniors can request a fee reduction.	Allowable chargeable items include: • A surcharge for hydro services and a one-time charge for a damage deposit, based on half the monthly rent for the unit. • Cable connection and monthly fee; • Personal telephone connection and basic services; • Guest meals and suite rental; • Client outings or special events; • Hair styling, foot care or other personal grooming services; • Housekeeping beyond weekly service; • Personal laundry services; • Parking and deposit on garage door opener; • Fee for pet damage and cleaning; • Transportation; • Equipment rental, at or below market rates; and, • An administration or handling fee associated with the service, where reasonable, to perform a task or service that would normally be the client's responsibility.	As per the Community Care and Assisted Living Act, assisted living residences must be registered with the provincial Assisted Living Registry (an office of the Ministry of Health).[ii]	No
Private-pay registered assisted living	Residents pay 100% of costs directly to the operator. There are no minimum or maximum rates.	• Not regulated, therefore additional personal costs are determined by the operator and set out in the contract signed between the resident and the operator. • There is no legislated maximum housing charge and there are no limits on increases in monthly charges in private-pay units (i.e., rent control).	Same as above	No
Publicly subsidized long-term care	• Residents pay 80% of their after-tax income to the health authority, subject to maximum and minimum rates. • The maximum single client rate is $3,377.10 per month in 2019; the minimum monthly client rate is $1,162.80. • The minimum monthly rate for a couple sharing a room and both in receipt of the Guaranteed Income Supplement is $1,616.30 ($808.15 per person).[iii] The minimum client rate is adjusted annually based on changes to Old Age Security/Guaranteed Income Supplement. • Low-income seniors can request a fee reduction.[iv]	Additional charges are much more limited than in assisted living, but may include personal phone and cable, hearing aids, personal transportation, additional or preferred medical equipment, and supplies are that are for the resident's exclusive use.	As per the Community Care and Assisted Living Act, long-term care facilities must be licenced by the health authority through a community care licencing office.	Yes

Sources: Community Care and Assisted Living Act, Assisted Living Regulation and *Home and Community Care Policy Manual* (effective January 1, 2019).

ii The Residential Tenancy Act does not govern any aspect of publicly subsidized or private-pay assisted living.

iii BC Ministry of Health, "Long-Term Care."

iv In private-pay residential care (which represents a relatively small market), there are no maximum or minimum rates.

With declining access to publicly subsidized assisted living, and a reliance on private-sector financing and delivery of care, for-profit companies are focused on the expansion of more profitable private-pay assisted living services.

Report overview

Part I of this report explains the policy and fiscal context under which the assisted living model originated in BC, and the important role of capital financing. Part II uses Ministry of Health data to demonstrate that the result of the British Columbia government's capital financing decisions is that seniors have less access to publicly subsidized assisted living today than in 2008. With declining access to publicly subsidized assisted living, and a reliance on private-sector financing and delivery of care, for-profit companies are focused on the expansion of more profitable private-pay assisted living services. This section documents how private-pay assisted living is not affordable for low- and moderate-income seniors. Part III returns to the broader public policy implications of relying on private-sector capital financing by analyzing the share of seniors' care controlled by corporate chains, and why the financialized business practices of these chains are a risk to seniors and the public health care system. The report concludes with a discussion of the significance of the study findings and provides policy recommendations.

Methods

This research report is based on data from the BC Ministry of Health, BC Seniors Advocate, Canada Mortgage and Housing Corporation, and Statistics Canada. Academic research, policy literature and industry publications were also reviewed in order to document restructuring of the assisted living sector and its relationship to the corporate control and financialization of seniors' care more broadly. This report also draws on qualitative data from a University of British Columbia ethics-approved seniors' care study that involved interviews with frontline care staff and health system key informants working in BC. The UBC study, entitled *Contracted Out,* was led by Dr. Margaret McGregor (principal investigator, UBC Department of Family Practice).

Public capital expenditures and assisted living ownership data were drawn from two Ministry of Health Freedom of Information requests.

PART I

The policy and fiscal context of assisted living in British Columbia

IN EARLY 2001, THE BC LIBERAL PARTY MADE AN ELECTION CAMPAIGN commitment to build 5,000 new non-profit long-term care beds by 2006. Shortly after forming government, the newly elected government shifted its focus to "de-institutionalizing" seniors' care and introduced a new assisted living housing model with the promise that it would allow more seniors to live in a more home-like environment.[7] This direction was attractive to the newly elected government because of the assumption that the cost of assisted living to the province's health authorities would be about half the cost of long-term care.[8] With this policy shift came the announcement that 3,500 of the 5,000 new long-term care beds promised would instead be assisted living units.[9] The "Continuing Care Renewal" plan, introduced in 2002, set new eligibility criteria that restricted long-term care to individuals with the most complex care needs.[10] The intent of this new eligibility criteria was to restrict access as a method of decreasing residential care demand at a time when the government was reducing the supply of long-term care beds. Between 2001 and 2004, the government closed 26 long-term care facilities, resulting in the loss of 2,529 long-term care beds.[11]

Between 2001 and 2004, the government closed 26 long-term care facilities, resulting in the loss of 2,529 long-term care beds.

7 Cohen et al., 2005, 13.
8 BC Ministry of Health, 2002, 34.
9 Mick, 2002; Cohen et al., 2005, 17.
10 Araki, 2004, 24; Araki and Gutman, 2004.
11 Cohen et al., 2005, 19.

And yet, this political direction was not consistent with the BC Ministry of Health's own analysis, which indicated that the proposed 3,500 assisted living units would fall significantly short of meeting the need. In January 2003, nine months *after* the government announced plans to close long-term care beds and pursue the assisted living model as a substitute for long-term care, the Ministry of Health modelled several substitution scenarios. As CCPA–BC noted at the time, the Ministry's own modelling suggested that nearly 7,000 assisted living units would be required by 2006/07.[12] This timeline reveals that the government announced its plans to pursue assisted living substitution and long-term care closures before the Ministry had even conducted its analysis of community needs.

The shortfall in the number of assisted living units was not the only troubling issue. In 2002, the government argued that assisted living was an appropriate substitute for long-term care and would fill the gap created by closures.[13] However, this argument was not supported by available evidence then—nor can it be justified now.[14]

Fiscal austerity and the financing of new assisted living capital infrastructure

The BC assisted living model, as it evolved in BC, was based on minimal staffing and private-sector financing and reflected a trend of fiscal austerity that began in the 1990s and intensified in the early 2000s.

The BC assisted living model, as it evolved in BC, was based on minimal staffing and private-sector financing and reflected a trend of fiscal austerity that began in the 1990s and intensified in the early 2000s. Provincial government retrenchment from capital financing in the latter half of the 1990s meant that new non-profit and health authority long-term care construction could not keep up with the needs of a growing population.[15] Between 1996 and 2000, only two non-profit long-term care facilities were built, and no new health authority–owned care homes were constructed.[16]

Beginning in 2002, the BC Liberal government (elected in 2001) embarked on a far-reaching program of fiscal austerity that included spending cuts, public-sector layoffs and health care privatization.[17] In particular, the provincial government aimed to reduce public capital spending by attracting private-sector investors to finance new capital infrastructure (i.e., a new public-private partnership (P3) model for hospital construction and a bidding process for long-term care construction that favoured for-profit corporations).[18] This fiscal policy direction was operationalized through the Procurement Services Act (2003) and the Capital Asset Management Framework released by the BC Ministry of Finance in 2003—a framework that remains in place today.[19]

Assisted living thus originated as a new model of seniors' care that favoured investment from the private, for-profit sector—an approach aligned with the provincial government's fiscal austerity

12 Cohen et al., 2005, 34.
13 Cohen et al., 2005, 34.
14 Prior to 2003, BC had intermediate care and complex care facilities that provided services to residents based on three progressively higher levels of care: Intermediate Care 1, 2, 3, and Complex/Extended Care. Intermediate and complex care facilities were staffed 24/7 by a nurse.]
15 Vogel, 2000, 23; Longhurst et al., 2019.
16 Authors' calculations from Office of the Seniors Advocate, 2016.
17 Klein, 2002; Cohen et al., 2005; Lee and Cohen, 2005; Cohen, 2006, 233; McBride and McNutt, 2007. Cuts and privatization were justified by a self-inflicted budget deficit created in part by significant tax cuts for corporations and individuals.
18 Whiteside, 2015.
19 See the Capital Asset Management Framework at https://www2.gov.bc.ca/gov/content/governments/policies-for-government/capital-asset-management-framework-guidelines.

Table 2: Assisted living and long-term care capital expenditures as a share of total health sector capital expenditures in British Columbia, 2009/10 to 2017/18

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	Total, 2009/10 to 2017/18	Average, 2009/10 to 2017/18
Assisted living ($)	401,869	395,448	-	40,908	627,030	739,924	23,776	-	1,038,671	**3,267,626**	-
% of total health sector capital expenditures	0.04%	0.04%	0.00%	0.01%	0.09%	0.08%	0.00%	0.00%	0.12%	-	0.04%
Long-term care ($)	8,437,049	4,595,282	3,715,939	967,177	9,087,743	2,871,243	1,928,024	2,316,290	3,480,793	**37,399,540**	-
% of total health sector capital expenditures	0.92%	0.51%	0.50%	0.13%	1.33%	0.33%	0.21%	0.23%	0.40%	-	0.51%

Source: BC Ministry of Health, 2018. Percentages calculated by the author.

objectives.[20] The provincial government could avoid investing directly in assisted living capital infrastructure that would appear on the public accounts as direct capital debt. Facility ownership would remain in the private sector, and health authorities (funded by the provincial government) would be required to contract with these companies on a long-term basis. However, the BC government (through health authorities) was still financing the costs of assisted living capital infrastructure for the private sector, but doing so indirectly through "per diem" (i.e., daily) rates with the contracted private operators.[21] The negotiated per diem rate includes a capital portion (financing and maintaining the capital asset) and an operational portion. Despite the provincial government indirectly funding these assets, the benefits of facility ownership (including increased property value) are realized exclusively by the private sector.

Despite the provincial government indirectly funding these assets, the benefits of facility ownership (including increased property value) are realized exclusively by the private sector.

Nonetheless, the most significant capital funding for assisted living capital infrastructure in BC originated from federal dollars intended for affordable housing. Beginning in 2002 (and lasting until 2006), the federal government, through the Canada Mortgage and Housing Corporation (CMHC), provided BC with $88.7 million in capital funding for affordable housing construction to be matched by the provincial government—and $62.5 million of those funds were redirected to seniors' supportive housing and assisted living.[22] Limitations were placed on the level of

20 Mick, 2002.

21 The per diem rate is the daily rate that the contracted operator can bill the health authority for the publicly subsidized assisted living unit. It can be considered a form of operating funding whereby the contracted operator bills the health authority for services provided.

22 Canada Mortgage and Housing Corporation and British Columbia Housing Management Commission, 2001, B-1; BC Housing, n.d.; BC Housing, 2003, 13. The majority of assisted living units in the province were created through Independent Living BC, a program established by the province in 2001.

care that could be provided, since the federal funding was earmarked for affordable housing. Because the federal capital funding was intended for affordable housing, and since the Province preferred a private-sector approach to delivery, the provincial regulatory and policy approach evolved from this context. As much as assisted living has evolved in many parts of the United States—as a private-market housing model with very limited services and staffing—the burden and costs of "extra" services in BC are offloaded to seniors and family members. This is a form of privatization.

The effect of declining long-term care access places greater pressure on publicly subsidized assisted living providers to house seniors who require higher levels of care but must remain in assisted living because long-term care spaces are not available.

Public expenditures reveal that the evolution of BC's assisted living model served the provincial government's fiscal austerity objectives. After the initial injection of public funds that it took from the federal housing dollars, the provincial government provided very little ongoing direct public capital investment. This is why the number of publicly subsidized assisted living units has not grown much beyond its peak in 2008, following the injection of federal and provincial capital dollars. Based on available data, assisted living made up, on average, 0.04 per cent of total health sector capital expenditures between 2009/10 and 2017/18 (Table 2). The $3.3 million in public capital funding for assisted living invested during this period is negligible. As a result, most of the sector's growth has been in the private-pay market where private investors and operators can expect to make a higher return on investment. Table 2 also provides public capital expenditures for long-term care. It is worth noting that the long-term care sector has received limited capital investment as well—averaging 0.51 per cent of total health sector capital expenditures between 2009/10 and 2017/18. This lack of public capital investment is one of the reasons why access to publicly subsidized long-term care has also declined significantly since 2001.[23] The effect of declining long-term care access places greater pressure on publicly subsidized assisted living providers to house seniors who require higher levels of care but must remain in assisted living because long-term care spaces are not available.

In sum, the lack of provincial public capital funding made available to health authorities and non-profit organizations for developing new publicly subsidized assisted living infrastructure since the early 2000s has left the Province reliant on the private sector to build new assisted living facilities. And yet, the data and trends analyzed in the following sections demonstrate that this policy approach is not working. Access to publicly subsidized units has fallen, and the private, for-profit sector—especially corporate chains—is more likely to build private-pay assisted living facilities where the rate of return on capital invested is higher.

Private-sector financing: a more expensive approach

Over the last 20 years across high-income countries, governments of all political stripes have become reluctant to invest in publicly owned capital infrastructure, including seniors' care facilities and housing. In BC, there is a fear that public-sector borrowing will add too much debt to the provincial budget and put the Province's credit rating at risk.[24] While this fear is misplaced, governments tend to use privatization, including contracting out and public-private partnerships (P3s), to avoid upfront capital debt. P3s come in many varieties, but they are essentially long-term contracts whereby government makes payments to the private-sector partner (often over a period of 30 years or more) for a bundled package of some or all of the following: private financing, design, construction and maintenance of the capital asset as well as service delivery.

23 Longhurst, 2017, 12, 24.

24 Longhurst et al., 2019.

As leading academic researchers note, this approach has political appeal for politicians who want to defer capital costs into the future and avoid adding upfront public debt to the budget:

> In a typical [P3], government pays little or nothing "upfront" and relatively large amounts "over time". Thus, incumbent governments can provide current users and voters with current benefits, thereby garnering political credit, while deferring costs to future politicians, future voters or users. Importantly, however, the government's cash costs are shifted, they are not eliminated and might increase over the life of the project.[25]

Aside from the initial injection of federal and provincial capital funding in the early 2000s, virtually all new assisted living and long-term care infrastructure has been financed through a P3 approach. The P3 approach used for assisted living construction is based on a contract between a health authority and operator for an indefinite term (called a "continuing service agreement") with a per diem rate that may be adjusted annually by the health authority and BC Housing, a provincial crown corporation. The operator receives a per diem (daily resident rate) from both the health authority (for care services) and BC Housing (for housing costs). As previously mentioned, the P3 approach in seniors' care is unique in that the private sector's capital costs are built into the per diem rate. A senior health system administrator explained how the per diem is structured to cover the private sector's capital cost compared with what government can borrow:

The concern about the higher costs of financing seniors' care infrastructure through the private sector is consistent with a growing body of evidence from provincial auditor generals and researchers.

> Embedded within the price of the contract [continuing service agreement] is the private sector's cost of debt servicing, or mortgage, or capital, however you want to describe it, but basically paying for the building. In fact, I am not sure that if you look at the totality of the money that it is cheaper for government to go this way because… generally there was a view [held by the private sector] that "I get my money back in 10 years. So, it cost me a million dollars to build it, over 10 years I am going to get a million dollars from the health authority in capital funding spread out, but at the end of 10 years I have my million dollars and I still have my building." So we have allowed private sector interests, to be fair, a bunch of them are non-profits too… we have allowed them to build up wealth or equity on the taxpayers' dime, whereas if we had done it as government our costs of borrowing will always be cheaper [than the rate obtained by the private sector] and we will still own the building… (Senior administrator interview, 2018)[26]

The senior administrator's concern about the higher costs of financing seniors' care infrastructure through the private sector is consistent with a growing body of evidence from provincial auditor generals and researchers.

In a review of 16 P3 projects, the Auditor General of British Columbia expressed concerns about the higher cost of debt financing:

> The interest rates on this $2.3 billion of P3 debt range considerably, from 4.42% to 14.79%, and have a weighted average interest rate of 7.5%. Over the last two years, government had a weighted average interest rate on its taxpayer-supported debt of about 4%.[27]

In a recent academic study, accountants Opara and Rouse added that BC's "P3 projects are not only saddling the province with higher debt levels than if the project had used traditional

25 Boardman et al., 2016, 12.

26 Ponder et al., under review.

27 Office of the Auditor General of British Columbia, 2014, 18.

BC's P3 model of financing assisted living (and long-term care) infrastructure development means that British Columbians have paid for the assisted living infrastructure but the private sector owns it.

infrastructure procurement, as interest rates are almost double with P3s, but also higher overall project cost."[28] Another recent (2018) evaluation of 17 P3 projects in BC found that if these projects had been procured through traditional public financing, they would have cost $3.7 billion less—saving the provincial government roughly 20 per cent.[29] In Ontario, the auditor general has raised similar concerns about the more expensive cost of private financing based on 75 infrastructure projects. The extensive use of short-term P3 construction financing has been $6.5 billion (or 14 times) more costly than government borrowing.[30]

In summing up the Canadian and international evidence on the cost efficiency of P3s, professors Anthony Boardman (University of British Columbia), Matti Siemiatycki (University of Toronto) and Aidan Vining (Simon Fraser University) identify the following disadvantages of P3s in terms of value for money for taxpayers: P3s have higher financing costs and higher private-sector transaction costs and risks; private-sector profit margins are built into contracts and are a cost to government; and significant (and often unaccounted for) "transaction costs" are borne by government to initiate, negotiate and manage the P3 relationship over the life of the contract.[31]

But unlike other P3 arrangements where government assumes ownership over the capital asset at the end of the contract term, BC's P3 model of financing assisted living (and long-term care) infrastructure development means that British Columbians have paid for the assisted living infrastructure but the private sector owns it. Thus, the benefits of asset ownership (including increased property value) are exclusively realized by the private sector. Furthermore, this P3 model means the provincial government has no guarantee that these assets—paid for through long-term funding from the public sector—will remain part of the publicly subsidized seniors' care system. The problems inherent with this policy approach are illustrated through the Retirement Concepts example in the introduction to this report; in the process of converting publicly subsidized units to private-pay ones, the corporation threatened to evict the seniors currently in those units. Retirement Concepts is still pursuing the conversion of publicly subsidized units to private-pay ones despite receiving years of funding from the health authority to help Retirement Concepts finance the asset.

28 Opara and Rouse, 2019, 85.
29 Reynolds, 2018, 10–11.
30 Boardman et al., 2016, 13; Office of the Auditor General of Ontario, 2014, 203.
31 Boardman et al., 2016, section 5.

PART II

The decline of publicly subsidized assisted living spaces and the growth of the private-pay market

IN 2016, 63 PER CENT OF ALL PUBLICLY SUBSIDIZED ASSISTED LIVING UNITS in BC were owned and operated by non-profit organizations, and 33 per cent were for-profit owned and operated (Figure 2). Only 4 per cent of publicly subsidized units were health authority–owned in 2016 (Figure 2). Of the total number of private-pay units in BC, 81 per cent were in the for-profit sector while 19 per cent were owned and operated by non-profit organizations (Figure 2). Although most publicly subsidized units are operated on a non-profit basis, the assisted living sector is dominated by for-profit companies who own the majority—53 per cent—of all assisted living units in the province (Figure 1). The following sections are intended to illustrate how the lack of public capital funding to expand publicly subsidized non-profit and publicly owned assisted living spaces is benefiting the private-pay assisted living market, which is dominated by for-profit corporations.

Today, seniors in British Columbia have less access to publicly subsidized assisted living than in 2008.

The decline in access to publicly subsidized assisted living spaces

Today, seniors in British Columbia have less access to publicly subsidized assisted living than in 2008. Although the number of publicly subsidized assisted living units marginally increased in

Table 3: Publicly subsidized and private-pay assisted living units by ownership in British Columbia, 2016

	Publicly subsidized units		Private-pay units		Total units	
	Publicly subsidized units	Share of publicly subsidized units in BC	Private-pay units	Share of private-pay units in BC	Total units	Share of total units in BC
Public health authority	183	4.1%	-	0.0%	183	2.4%
For-profit business	1,438	32.6%	2,600	81.4%	4,038	53.1%
Non-profit organization	2,792	63.3%	596	18.6%	3,388	44.5%
Total	**4,413**		**3,196**		**7,609**	

Source: Compiled from BC Ministry of Health Assisted Living Registry website, April 2016.

Table 4: Access to publicly subsidized assisted living (AL) by health authority region in British Columbia, 2008 to 2017

	2008			2017			Rate of change, 2008-2017
	AL units	Seniors 75+	Access rate (units per 1,000 seniors 75+)	AL units	Seniors 75+	Access rate (units per 1,000 seniors 75+)	AL access rate
Fraser Health	1,317	89,492	14.7	1,393	117,364	11.9	-19%
Interior Health	897	60,831	14.7	952	72,269	13.2	-11%
Northern Health	228	11,247	20.3	288	13,551	21.3	5%
Vancouver Coastal Health	944	70,803	13.3	859	85,761	10.0	-25%
Vancouver Island Health	1,007	66,020	15.3	993	78,121	12.7	-17%
BC total	**4,393**	**298,393**	**14.7**	**4,485**	**367,066**	**12.2**	**-17%**

Source: AL counts are from Cohen et al. (2009, p. 23) and the Assisted Living Registrar as of March 31, 2017 and published in Office of the Seniors' Advocate (2017, p. 16). Population estimates are from BC Stats P.E.O.P.L.E (report generated December 17, 2019).

Figure 1: Assisted living units by ownership in British Columbia, 2016

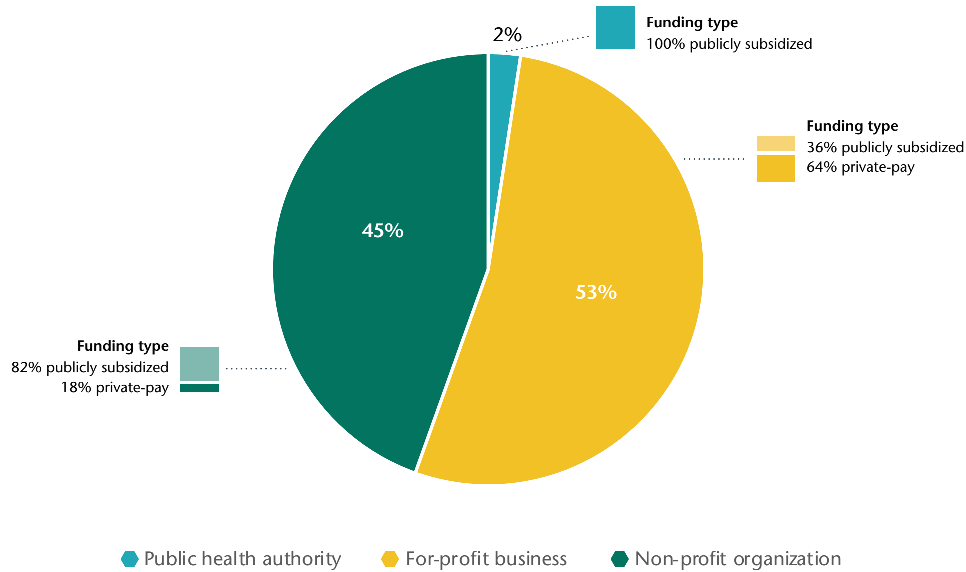
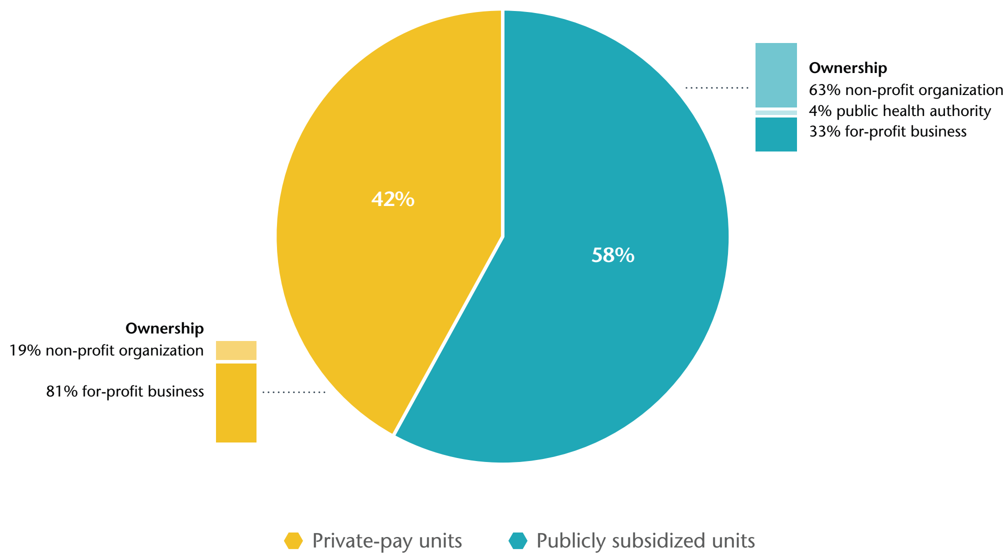


Figure 2: Assisted living units by funding type in British Columbia, 2016



absolute terms between 2008 and 2017, access to publicly subsidized units *fell* by 17 per cent, measured by the number of units relative to the population of seniors aged 75 and over who are likely to require assisted living (Table 4). In 2008, there were 14.7 publicly subsidized assisted living units per 1,000 seniors 75 and over, but by 2017 there were 12.2 units per 1,000 seniors.

In four of the five regional health authorities in BC, access to publicly subsidized units fell considerably: Vancouver Coastal Health (-25 per cent), Fraser Health (-19 per cent), Vancouver

Between 2010 and 2017, the share of private-pay units in the province increased eight percentage points while the share of publicly subsidized units fell by the same amount.

Island Health (-17 per cent), and Interior Health (-11 per cent). Vancouver Coastal Health had the lowest number of units relative to the population aged 75 and over (10 units per 1,000 seniors).

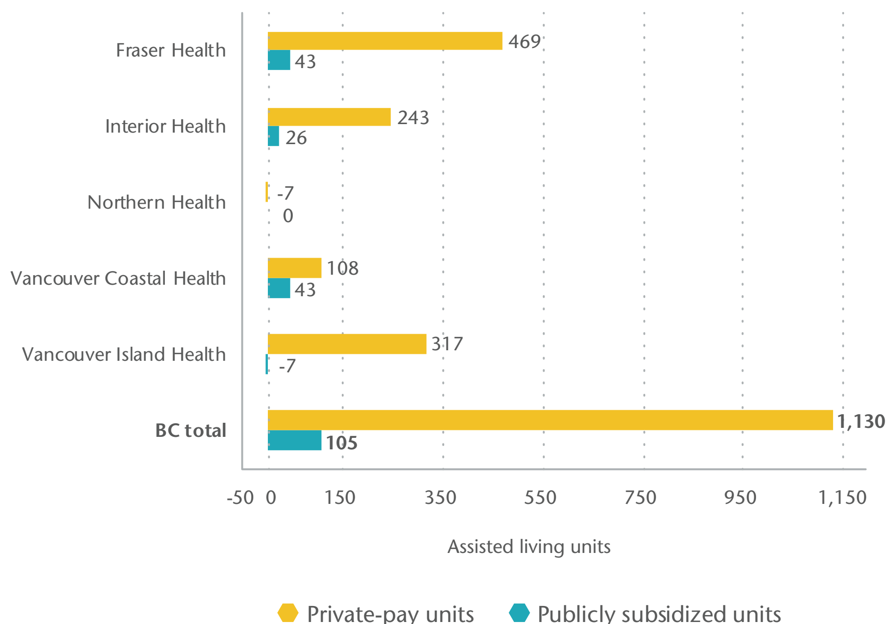
Waitlists for subsidized assisted living units is one of the consequences of declining access for seniors. Health authority data reported by the Office of the Seniors Advocate indicate that a total of 943 individuals were on waitlists in 2015, 918 in 2016, and 750 in 2017.[32] Notably, 189 individuals were on the waitlist in Northern Health in 2017, only slightly below Interior Health (201), despite the smaller number of seniors 75 and over in the Northern Health region relative to other regions.[33] Caution should be exercised when interpreting these figures as waitlists for publicly subsidized seniors' care in BC underestimate actual need. In many cases, people cannot wait for care and/or decide not to put their name on a waitlist when they realize how long the list is. The private-pay assisted living market benefits from seniors and their families facing long waits and challenges accessing publicly subsidized assisted living—a trend examined next.

The growth of private-pay assisted living

As access to publicly subsidized assisted living units has fallen, the private-pay assisted living market has benefited. Between 2010 and 2017, the share of private-pay units in the province increased eight percentage points (36 to 44 per cent) while the share of publicly subsidized units

32 Office of the Seniors Advocate, 2016a, 18; Office of the Seniors Advocate, 2017, 18.
33 Office of the Seniors Advocate, 2017, 18.

Figure 3: Net new private-pay and publicly subsidized assisted living units added by health authority in British Columbia, 2010 to 2017



Sources: The 2010/11 data are from BC Ombudsperson (2012). The 2017 data are from the Assisted Living Registry as of March 31, 2017, and published in the Office of the Seniors Advocate, 2017, 16.

Table 5: Publicly subsidized and private-pay assisted living units by health authority region in British Columbia, 2010 to 2017

	2010				
	Publicly subsidized units		Private-pay units		Total units
	No.	% of total units	No.	% of total units	
Fraser Health	1,350	63%	781	37%	2,131
Interior Health	926	51%	904	49%	1,830
Northern Health	288	90%	31	10%	319
Vancouver Coastal Health	816	67%	393	33%	1,209
Vancouver Island Health	1,000	74%	343	26%	1,343
BC total	**4,380**	**64%**	**2,452**	**36%**	**6,832**

	2017				
	Publicly subsidized units		Private-pay units		Total units
	No.	% of total units	No.	% of total units	
Fraser Health	1,393	53%	1,250	47%	2,643
Interior Health	952	45%	1,147	55%	2,099
Northern Health	288	92%	24	8%	312
Vancouver Coastal Health	859	63%	501	37%	1,360
Vancouver Island Health	993	60%	660	40%	1,653
BC total	**4,485**	**56%**	**3,582**	**44%**	**8,067**

	Change, 2010 to 2017					
	Publicly subsidized units		Private-pay units		Total units	
	No.	%	No.	%	No.	%
Fraser Health	43	3%	469	60%	512	24%
Interior Health	26	3%	243	27%	269	15%
Northern Health	0	0%	-7	-23%	-7	-2%
Vancouver Coastal Health	43	5%	108	27%	151	12%
Vancouver Island Health	-7	-1%	317	92%	310	23%
BC total	**105**	**2%**	**1,130**	**46%**	**1,235**	**18%**

Source: The 2010/11 data are from BC Ombudsperson, 2012. The 2017 data are from the Assisted Living Registry as of March 31, 2017, and are published in Office of the Seniors Advocate, 2017, 16.

fell (64 to 56 per cent). Furthermore, private-pay units are increasing in BC at a much faster rate (46 per cent between 2010 and 2017) than publicly subsidized units (2 per cent between 2010 and 2017) (Table 5).

Taking a closer look at the numbers between 2010 and 2017, only 105 new publicly subsidized assisted living units were added in BC. Over this same period, 1,130 private-pay units were added in the province—more than 10 times the number of publicly subsidized units (Figure 3). On a regional basis, no health authority added more than 50 publicly subsidized units. Fraser Health added 43 units; Vancouver Coastal Health, 43 units; and Interior Health, 26 units, which represents a marginal increase. Northern Health did not add any new publicly subsidized units, and Vancouver Island Health lost seven publicly subsidized units. In each health authority (with the exception of Northern Health), the growth of private-pay units significantly outpaced publicly subsidized units.

The absence of significant ongoing public capital funding to support health authorities and non-profit organizations in developing new spaces has meant that very few new publicly subsidized assisted living facilities are being built.

What explains this trend towards private-pay assisted living? The absence of significant ongoing public capital funding to support health authorities and non-profit organizations in developing new spaces has meant that very few new publicly subsidized assisted living facilities are being built (and publicly subsidized units may be converted to private-pay). This lack of public capacity has benefited the private-pay market, as some seniors and families will—in the absence of alternatives—pay for private care even if it puts significant pressure on their financial resources. For-profit companies are more likely to build and own private-pay units when the government fails to provide publicly subsidized ones. We know this from the fact that 81 per cent of private-pay units in BC are owned by for-profit businesses (Table 3). A stagnant supply of publicly subsidized units has significant financial consequences for seniors and their families, given the reality that most lower- and middle-income seniors cannot afford private-pay assisted living.

The unaffordability of private-pay assisted living

Private-pay assisted living is unaffordable for most seniors in BC. It is unaffordable due not only to the monthly resident charge (i.e., rent), but also to the many additional user fees associated with it. Desperate families may use all their resources just to cover the monthly charge, and then do not have the means to pay for additional support and care services, prescription drugs, medical supplies and other living expenses not included in the basic monthly charge. (This basic monthly charge is referred to as "monthly rent" by the Canada Mortgage and Housing Corporation (CMHC) as outlined in Tables 6 and 7.)[34] There is no maximum monthly resident charge for private-pay assisted living, and operators have the unrestricted ability to raise it.

34 Living expenses not included in the basic monthly rate may include: a third meal per day; cable connection and monthly fee; personal telephone connection and basic services; meals and suite rental for guests; outings or special events; hair styling, food care or other personal grooming services; housekeeping beyond weekly service; personal laundry services; parking and deposit on garage door opener; fee for pet damage and cleaning; transportation; equipment rental, at or below market rates; and an administration or handling fee to perform a task or service that would normally be a resident's responsibility (see https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/assisted-living).

Table 6: Income required for private-pay assisted living in British Columbia, bachelor unit, 2016

	Number of persons	After-tax median annual income ($)	Bachelor average rent		% of income required for bachelor unit
			Monthly ($)	Annual ($)	
Senior families	550,000	61,900	2,014	24,168	39%
Single seniors (not in an economic family)	213,000	27,600	2,014	24,168	88%
Single senior men	71,000	29,500	2,014	24,168	82%
Single senior women	142,000	27,600	2,014	24,168	88%

Source: Income data are from Statistics Canada's Canadian Income Survey, Table 11-10-0190-01. Average rents are from CMHC, 2017.

Table 7: Income required for private-pay assisted living unit in British Columbia, one bedroom unit, 2016

	Number of persons	After-tax median annual income ($)	One-bedroom average rent		% of income required for one-bedroom unit
			Monthly ($)	Annual ($)	
Senior families	550,000	61,900	3,015	36,180	58%
Single seniors (not in an economic family)	213,000	27,600	3,015	36,180	131%
Single senior men	71,000	29,500	3,015	36,180	123%
Single senior women	142,000	27,600	3,015	36,180	131%

Source: Income data are from Statistics Canada's Canadian Income Survey, Table 11-10-0190-01. Average rents are from CMHC, 2017.

The majority of seniors (individuals aged 65 and older) are in economic families[35] (72 per cent) whereas 28 per cent are single. This distinction is important because seniors living alone tend to have lower incomes. Based on 2016 data, 550,000 seniors in BC were living in economic families and their after-tax median income was $61,900.[36] In comparison, that year single senior men in the province had an after-tax median income of $29,500 while senior women living alone—two-thirds of single seniors in BC—had an after-tax median income of $27,600. In 2016, the annual

35 Statistics Canada, Canadian Income Survey, Table 11-10-0190-01, "Market income, government transfers, total income, income tax, and after-tax income by economic family type," accessed June 2018, https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1110019001. A "senior economic family" refers to "two or more persons who live in the same dwelling and are related to each other by blood, marriage, common-law union, adoption or a foster relationship. A couple may be of the opposite or same sex" (for definitions see Statistics Canada). An economic family is a broad definition that assumes the income is shared among those living together, which is not always the case. Seniors not in an economic family are seniors who are living alone. In this report, "seniors not in an economic family," "seniors living alone," and "single seniors" are used interchangeably.

36 Statistics Canada, Canadian Income Survey, Table 11-10-0190-01, "Market income, government transfers, total income, income tax, and after-tax income by economic family type," accessed June 2018, https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1110019001.

As the data demonstrate, private-pay assisted living is simply unaffordable for low- and middle-income seniors.

cost of a private-pay assisted living bachelor unit was $24,168; and a one-bedroom unit, $36,180 (Tables 6 and 7).[37]

Based on these figures, the cost of private-pay assisted living exceeds the financial resources of senior families and single seniors living at or below the after-tax median annual income. Senior families at the median income ($61,900) can afford an average rent bachelor unit (39 per cent of their income), but only with considerable financial difficulty and risk can they afford a one-bedroom unit (58 per cent of their income). Based on the CMHC definition of affordable housing, this assumes that households should spend no more than 30 per cent of their income on housing. For single seniors, even a bachelor suite would require over 80 per cent of their income, which is clearly unaffordable.

The effect of declining access to publicly subsidized home and community care means that private-pay assisted living often becomes the last resort for seniors and their families. Yet, as the data demonstrate, private-pay assisted living is simply unaffordable for low- and middle-income seniors. Trends suggest that the private-pay market is likely to become even more unaffordable over time. Based on CMHC data, BC's Seniors Advocate notes that the number of private-pay units costing less than $2,000 per month has steadily decreased since 2012.[38] The dramatic increase in land values in the Lower Mainland and southern Vancouver Island, in particular, means that for-profit operators and their investors will charge higher and higher private-pay assisted living rates to reflect the increased asset values of their properties, and the cost of buying land and developing new facilities.

37 "Average rent" is derived from what the Canada Mortgage and Housing Corporation (CMHC) defines as a "standard space," which refers to private-pay assisted living in BC, where a resident does not receive high-level care (less than 1.5 hours of care per day) or is not required to pay an extra amount to receive high-level care. In this paper, "monthly resident rate" is used to refer to what CMHC calls "rent."

38 Office of the Seniors Advocate, 2017, 18.

PART III

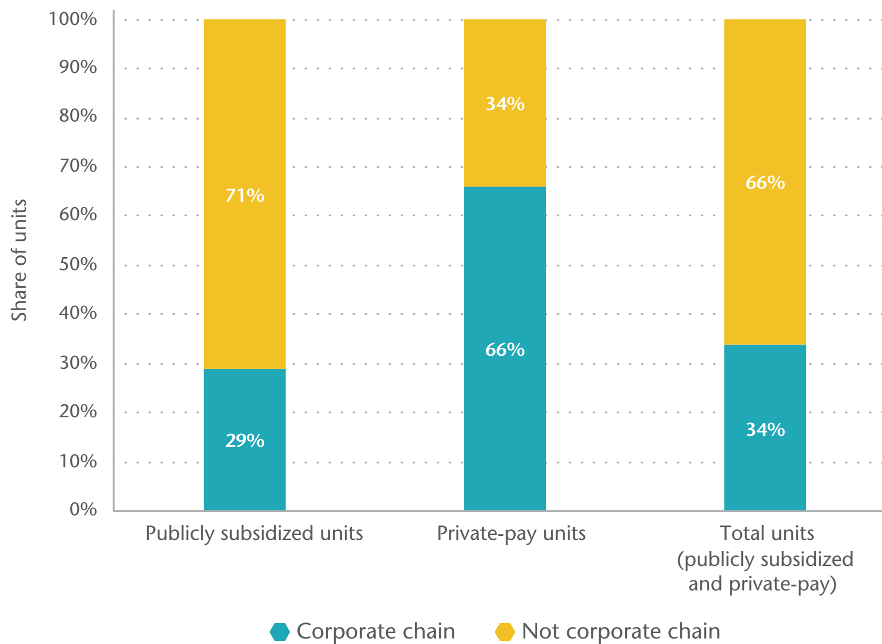
Corporate chains and the financialization of seniors' care

AS DISCUSSED IN PART I, THERE HAS BEEN VERY LITTLE PUBLIC CAPITAL FUNDING for assisted living in BC since the initial injection of federal and provincial capital dollars in the early 2000s. In more recent years, from 2009/10 to 2017/18, provincial capital investment in assisted living averaged 0.04 per cent of total health sector capital spending annually (Table 2). This lack of public capital investment explains why access to publicly subsidized assisted living has fallen precipitously. Health authorities and non-profit organizations have not been able to construct new assisted living residences, let alone maintain their existing capital infrastructure.

By 2017, four out of five private-pay units were owned and operated by for-profit providers.

The provincial government's policy preference of restricting capital spending for assisted living infrastructure has encouraged for-profit operators to secure their own financing and investors. To finance construction of these facilities, investors require a certain return on their investment that is more quickly achieved by focusing on private-pay assisted living units. As shown in Table 5, private-pay units increased at a much faster rate than publicly subsidized units between 2010 and 2017. By 2017, four out of five private-pay units were owned and operated by for-profit providers. The province's longstanding reliance on attracting private capital into the seniors' care sector has benefited corporate chains with the ability to finance new developments. Chains are defined as for-profit operators that operate two or more facilities.

Figure 4: Share of assisted living and long-term care units controlled by corporate chains in British Columbia, 2016



Sources: Author's calculations from data obtained from the Office of the Seniors Advocate, 2016b, and Assisted Living Registry as of March 31, 2016.

In 2016, corporate chains controlled 29 per cent of publicly subsidized spaces and 66 per cent of private-pay assisted living and long-term care spaces in the province.

Corporate chain ownership of assisted living and long-term care units

Many corporate chains are diversified and operate both assisted living and long-term care units. It is, therefore, useful to examine both types of units together in order to understand the business models. In BC in 2016, corporate chains controlled one-third (34 per cent) of all publicly subsidized and private-pay assisted living and long-term care spaces while 66 per cent of units were owned by either non-profit agencies or health authorities (Figure 4). Corporate chains controlled 29 per cent of publicly subsidized spaces and 66 per cent of private-pay assisted living and long-term care spaces in the province. Although chains did not control the majority of total assisted living and long-term care units in 2016, they had a strong presence in BC, particularly in the private-pay segment of the seniors' care sector.

Top 10 corporate chains by market share

Another way to look at the significance of corporate chains is by looking at the top 10 largest corporate chains by market share (i.e., each chain's share of the total number of provincial units they own). Over one-quarter (26.5 per cent) of total assisted living and long-term care units (publicly subsidized and private-pay) are controlled by 10 corporate chains (Table 8). Retirement Concepts, now owned by the Chinese company Dajia Insurance (the successor company of Anbang Insurance Group, which is majority Chinese state-owned), controls the greatest share of assisted living and long-term care in BC. It has 2,158 units or 7 per cent of the market share of publicly subsidized assisted living and long-term care units in BC—nearly double the number of publicly subsidized units held by the second-largest chain (Park Place

Table 8: Top 10 assisted living and long-term care corporate chains in British Columbia, 2016

		Assisted living units				Long-term care				Assisted living and long-term care units by funding					
Rank	Provider	Publicly subsidized units	Private-pay units	Sum of publicly subsidized and private-pay units	% of assisted living units in BC	Publicly funded beds	Private-pay beds	Sum of publicly funded and private-pay beds	% of residential care beds in BC	Publicly funded units	% of publicly funded units in BC	Private-pay units	% of private-pay units in BC	Sum of publicly subsidized and private-pay	% of publicly subsizied and private-pay units in BC
1	Retirement Concepts	433	348	781	10.3%	1,725	273	1,998	7.1%	2,158	7.0%	621	13.3%	2,779	7.8%
2	Park Place Seniors Living Inc.	139	28	167	2.2%	1,062	56	1,118	4.0%	1,201	3.9%	84	1.8%	1,285	3.6%
3	Revera	60	110	170	2.2%	911	148	1,059	3.8%	971	3.1%	258	5.5%	1,229	3.4%
4	Chartwell	89	343	432	5.7%	380	86	466	1.7%	469	1.5%	429	9.2%	898	2.5%
5	Sienna Senior Living Inc.	55	113	168	2.2%	539	84	623	2.2%	594	1.9%	197	4.2%	791	2.2%
6	Golden Life Management Corp.	125	167	292	3.8%	310	8	318	1.1%	435	1.4%	175	3.8%	610	1.7%
7	The Care Group	0	0	0	0.0%	473	105	578	2.1%	473	1.5%	105	2.3%	578	1.6%
8	Ahmon Group	0	0	0	0.0%	417	59	476	1.7%	417	1.3%	59	1.3%	476	1.3%
9	Trellis Group	0	0	0	0.0%	403	9	412	1.5%	403	1.3%	9	0.2%	412	1.2%
10	Kaigo Senior Living Group	67	16	83	1.1%	307	13	320	1.1%	374	1.2%	29	0.6%	403	1.1%
	Top 10 total	**968**	**1,125**	**2,093**	**27.5%**	**6,527**	**841**	**7,368**	**26.3%**	**7,495**	**24.2%**	**1,966**	**42.2%**	**9,461**	**26.5%**
	BC total	**4,413**	**3,196**	**7,609**	-	**26,585**	**1,463**	**28,048**	-	**30,998**	-	**4,659**	-	**35,657**	-

Sources: Dataset constructed by author using data from the Assisted Living Registry as of March 31, 2016, and Office of the Seniors Advocate, 2016.

Seniors Living, Inc.). Although the 10 top chains do not control the majority of the market, these figures reveal that corporate chains do control a notable share of units in both the assisted living and long-term care sectors. Six of the top 10 corporate chains in BC have a presence in at least one other Canadian province, and Revera and Chartwell previously were invested in properties with a US-based multinational chain with properties in the US, UK and Canada.[39]

The financialization of seniors' care

Corporate chain consolidation in seniors' care is a reflection of *financialization* in the health care and housing sectors. Financialization occurs when traditionally non-financial firms become dominated by, or increasingly engage in, practices that have been common to the financial sector.[40] Globally, there is growing interest among investors in seniors' care because assisted living and long-term care sectors are capital intensive and rooted in real estate. In this way, seniors' care facilities and housing are treated as financial commodities that are attractive to global capital markets. The UN Special Rapporteur on Adequate Housing provides a useful explanation of this global trend: "Housing and commercial real estate have become the "commodity of choice" for corporate finance. … Financialized housing markets respond to preferences of global investors rather than to the needs of communities."[41] As such, housing is reduced to financial commodities that are bought and sold on international markets, and removed entirely from housing as a basic social good necessary for human survival.

Globally, there is growing interest among investors in seniors' care because assisted living and long-term care sectors are capital intensive and rooted in real estate.

The business activities of real estate, property rental and leasing averaged 18 per cent of BC's gross domestic product (GDP) from 2012 to 2018, the highest among the provinces, and well above the provincial GDP of Ontario (13 per cent), and Quebec and Alberta (11 per cent) over those years.[42] Although no data indicate how much of that 18 per cent of GDP seniors' care constitutes, financial services giant UBS identifies Canada as the second most attractive market for investing in independent living, assisted living and long-term care facilities, behind Japan and slightly ahead of the US.[43] For-profit assisted living operators can expect a 30 to 40 per cent operating margin compared to 15 to 25 per cent in long-term care.[44]

Ultimately, investors are interested in the real estate assets. As an industry publication notes, "Buying into a seniors' home, you're really investing in a business backed by real estate. Seniors' housing is a lot like a hotel where there's real estate but, at the same time, there's housekeeping and care…"[45] The acquisition of Retirement Concepts by Anbang Insurance Group in February 2017 is illustrative of increasing interest in seniors' care by financialized firms and investors who often introduce high-risk business practices into a sector that should be low risk.

In seniors' care, corporate chains often separate the business of daily operations from the real estate assets to attract capital investment from private equity firms and institutional investors. These corporate chains and their investors expect high profit margins that would be more common with high-risk, high-return business activities (e.g., tech start-ups) but are not appropriate

39 Harrington et al., 2017, 5–7.
40 Aalbers, 2019, 3.
41 United Nations Human Rights, Office of the High Commissioner, 2017, 3.
42 Statistics Canada. Table 379-0028. Retrieved December 17, 2019.
43 Holzhey, 2017.
44 BayBridge Seniors Housing, 2012, 4.
45 Korstrom, 2016.

for seniors' care.[46] For example, three of the top five largest publicly traded seniors' care chains in Canada reported rates of return (earnings before interest, tax, depreciation and amortization [EBITDA]) of 8.8 per cent (Extendicare), 13.2 per cent (Sienna Senior Living) and 27.9 per cent (Chartwell) in 2015/16.[47] Sienna and Chartwell are in the top four and top five of the largest assisted living and long-term care corporate chains in BC by market share (Table 8).

There are three main concerns with financialized corporate chains increasing their dominance in seniors' care in BC. First, as discussed earlier, government can finance new seniors' care infrastructure at a lower rate than the private sector. This is reflected in the high rates of return expected in the seniors' care sector, as the private sector must service debt at higher rates. Thus, BC is paying more by relying on private-sector financing, but getting less capital infrastructure at the end of the day than it would through government financing and working with the non-profit sector and regional health authorities.

Second, as a handful of financialized corporate chains increase their market share of publicly subsidized units, government becomes increasingly reliant on the sector for delivery of publicly subsidized services. It also becomes more difficult to negotiate reasonable contracted rates when these corporations expend significant resources lobbying government and mounting media campaigns that threaten bed closures if funding is not increased. This issue was illustrated when Retirement Concepts was trying to renegotiate the per diem rate with Vancouver Coastal Health and threatened the closure of publicly subsidized units (and eviction of seniors from their units). In BC, it is not just one corporate chain threatening closure of publicly subsidized units, but the industry association lobbying government to increase funding levels and threatening that more closures may be on the way across the industry.[48] As corporate chains increase their market share, they become a powerful lobby that can influence policy decisions in their favour, a trend that has been observed in the United States,[49] Ireland,[50] England,[51] Nordic countries[52] and Canada.[53]

As corporate chains increase their market share, they become a powerful lobby that can influence policy decisions in their favour.

Third, we do not know what effect business practices of financialized corporate chains has on the quality of care and resident outcomes, but based on the evidence from the long-term care sector, more research is required. Although there is a large body of research evidence on chain ownership—including by private equity firms—and care quality in long-term care, no recent Canadian research has focused on the assisted living sector. Nonetheless, lessons from the long-term care research evidence should be carefully considered (see inset box). Greater transparency and public reporting would enable researchers to examine the relationship between ownership and care quality in the assisted living sector and to ensure the BC Ministry of Health can fulfill its responsibilities to steward the health system.

46 Burns et al., 2016, 3.
47 Harrington et al., 2017, 5.
48 See BC Care Providers Association, 2017, 4. BC Care Providers is the industry association representing non-government operators and chains. A similar industry narrative exists in England (see Burns et al., 2016).
49 Harrington et al., 2016, 16.
50 Mercille, 2017.
51 Burns et al., 2016; Horton, 2017; Scourfield, 2007; 2011.
52 Meagher and Szebehely, 2013.
53 Daly, 2015, 52.

ANBANG INSURANCE, GLOBAL CAPITAL AND THE FINANCIALIZATION OF SENIORS' CARE IN BRITISH COLUMBIA

In February 2017, Retirement Concepts, the largest for-profit long-term care and assisted living chain in British Columbia, was acquired by Cedar Tree Investment Canada Inc., a subsidiary of the Anbang Insurance Group. Retirement Concepts has the largest market share of all for-profit providers (based on number of units) and it is also the highest-billing publicly subsidized provider, in receipt of $86.5 million in 2015/16.[54] In 2016, Anbang made a big entrance into the BC real estate market by purchasing prime office towers at the Bentall Centre in downtown Vancouver for over $1 billion.[55] The company's later acquisition of Retirement Concepts involved 21 properties with a purchase price also reportedly exceeding $1 billion.[56] Because the purchase price exceeded $600 million, it triggered an automatic review under the Investment Canada Act to determine whether the foreign takeover was a "net benefit" to Canada. In February 2017, the federal government approved the deal, and as *The Globe and Mail* reported, it provided "a Beijing-based insurance titan with a murky ownership structure… a foothold in Canada's health-care sector."[57]

Even before Anbang's acquisition of the Retirement Concepts chain, US national security officials, scholars and the financial press raised concerns about Anbang's business model, ownership and financial health in light of the firm's acquisition of billions of dollars of international real estate in a short time.[58] By April 2018, Anbang had gone from being one of the most acquisitive private equity firms to a company on the brink of collapse. Following growing concerns over Anbang's liquidity and the risk it posed to the wider financial sector, the company's assets were seized by the Chinese government regulator and its CEO was sentenced to 18 years for fraud.[59] By mid-2018, Anbang, bailed out and controlled by the Chinese government, was reported to be "looking to sell about US$10 billion of overseas property to shore up its finances,"[60] including a luxury hotel collection that it had acquired for $5.5 billion and a Dutch insurance company.[61] In March 2019, Anbang sold the Vancouver Bentall office towers to private equity giant Blackstone Group for an undisclosed amount.[62] In mid-2019, Dajia Insurance Group became the successor company to Anbang and started taking over Anbang's assets. Dajia remains controlled by the Chinese government.[63] At this time, Anbang's BC seniors' care properties do not appear to be for sale.

As of December 2019, three Retirement Concepts long-term care facilities owned by Anbang were put under health authority administration following complaints and health authority investigations over the failure to protect the health and safety of residents related

54 Chase, 2017.
55 Lee-Young, 2018.
56 Lee-Young, 2019b.
57 Chase, 2017.
58 Forsythe and Ansfield, 2016; Solomon, 2016.
59 Deng and Areddy, 2018. See also: BC Health Coalition, 2016; 2018.
60 Yu et al., 2018.
61 Karmin et al., 2018; Chatterjee, 2018.
62 Younglai, 2019; Lee-Young, 2019a.
63 Hunter, 2019.

to low staffing. Vancouver Island Health Authority is overseeing daily operations and has brought in additional staff to address serious deficiencies in care.[64]

The Anbang case is an unfolding story and remains a public policy concern. International experience tells us that financialized care chains typically employ risky business practices in a vulnerable sector where care is provided to frail seniors. Chains are typically bought and sold frequently using debt-leveraged buyouts, inflating asset sales prices and leaving the chains loaded with ever more debt until the cash flow—dependent on public contracts—cannot meet the private-sector financing costs. This situation can result in financial crisis, bankruptcy and chain failure.[65] The United Kingdom's largest care chain—Southern Cross Healthcare Group—collapsed in 2011 as a result of these risky financial practices and successive flips of the real estate assets to different investors.[66] Southern Cross's collapse created months of uncertainty for 31,000 residents and their families—as well as for 44,000 employees[67]—until other buyers could be lined up. Generally speaking, the financialized business model is often structured around short-term real estate asset flipping (three to five years) where government and taxpayers assume the financial risk of failure.[68] The disruption that can result from these business practices undermines the conditions necessary for stable, long-term "relational care" in which "continuity in staff… allows those who provide care not only to know residents and their families but also the rest of the staff."[69] The opposite of relational care is high staff turnover and workforce instability, which can have a negative effect on quality of care.[70]

Do financialization and corporate chain ownership affect quality of care?

The weight of the peer-reviewed Canadian and international research literature has focused on long-term care. This body of research demonstrates that staffing levels and mix are key predictors of resident outcomes and care quality, and that care provided in for-profit long-term care facilities is generally inferior to care provided by government and non-profit-owned facilities.[71] A prominent US study found that "the top 10 for-profit chains received 36 per cent higher deficiencies and 41 per cent higher serious deficiencies than government facilities, [with] [o]ther for-profit facilities also [having] lower staffing and higher deficiencies than government facilities."[72] Studies show that staffing levels—a key predictor of care quality[73]—were already falling before private equity takeover.[74] There were no significant changes in staffing levels following private equity purchase "in part because staffing levels in large chains were already lower than staffing in other ownership groups."[75]

64 Ibid.
65 Burns et al., 2016, 3.
66 Ruddick, 2015; Burns et al., 2016.
67 Lloyd et al., 2014, 7; Ruddick, 2015.
68 U.S. Government Accountability Office, 2010, 7.
69 Armstrong, 2018, 30.
70 McGregor and Ronald, 2011, 16.
71 Ronald et al., 2016; McGregor and Ronald, 2011.
72 Harrington et al., 2012, 106.
73 Ronald et al., 2016; McGregor and Ronald, 2011.
74 Stevenson and Grabowski, 2008, 1403.
75 Bos and Harrington, 2017, 2.

Furthermore, two other studies show "significantly higher levels of deficiencies after private equity purchases, being an indicator of worsened care quality."[76] Bos and Harrington's longitudinal, in-depth case study of a large US chain concluded that private equity ownership continued—and reinforced—corporate chain business strategies, including low staffing levels.[77] In 2007, a high-profile *New York Times* investigation of more than 1,200 long-term care facilities purchased by private investment groups found that, "on average, resident outcomes worsened after private equity groups bought the nursing homes and that their outcomes were worse relative to other nursing homes."[78] US congressional hearings subsequently followed the *New York Times* investigation.

Lessons from the research on long-term care should be carefully considered in relation to assisted living. Reducing labour costs is one of the key business strategies among corporate long-term care chains. Since labour is the primary expense in seniors' care facilities, finding ways to reduce labour costs (e.g., subcontracting, not backfilling, maintaining low staffing levels) is likely to be a business strategy common to both for-profit long-term care and assisted living. In the absence of published research on care quality and corporate chain ownership in assisted living, it is incumbent upon the provincial government to improve data collection and reporting so that researchers can examine the relationship between ownership type and quality in the assisted living sector (see Conclusion and Recommendations section).

76 Bos and Harrington (2017), 2, citing the Pradhan et al. (2014) and Harrington et al. (2012) studies.
77 Bos and Harrington, 2017, 8.
78 Wells and Harrington, 2013, 4–5 citing Duhigg, 2007.

Conclusion and recommendations

THIS STUDY HAS LOOKED AT TRENDS IN THE AVAILABILITY AND AFFORDABILITY of assisted living in BC. A lack of provincial government capital funding has constrained the expansion of publicly subsidized assisted living services provided by the public health authorities and non-profit organizations. As a result, seniors have less access to publicly subsidized assisted living today than in 2008. The private-pay assisted living market grew more quickly than the supply of publicly subsidized assisted living units between 2008 and 2017.

This report has also documented the consequences of the provincial government's reliance on private-sector financing of assisted living—and seniors' care infrastructure, more generally—which has benefited well-capitalized corporate chains and investors. These chains have a tendency to focus their business model on more profitable private-pay units and to lobby governments to increase subsidies in order to make it more profitable for the chains to provide contracted publicly subsidized assisted living. The Retirement Concepts example from the introduction to this report demonstrates how doing so makes the provincial government's ability to contain costs and ensure value for money much more difficult. Corporate chains benefit from a policy approach that relies on the private sector to finance, design and deliver assisted living services, since chains are more likely than non-profits and small companies to have access to capital on the scale required to build seniors' care infrastructure. This *financialization* of seniors' care—in which the real estate assets associated with this care are treated as financial commodities to be bought and sold on international markets—is at odds with the basic social purpose of providing care to vulnerable seniors, many of whom have low or moderate incomes and cannot afford private-pay services.

The trends documented in this study raise concern about the growth of private-pay assisted living at the expense of publicly subsidized care—and a provincial policy direction that leaves the development of assisted living to the private, for-profit sector. If the BC government becomes more reliant on contracting with corporate chains to provide publicly subsidized assisted living, these corporations will exert greater influence over public policy decisions, making it difficult for the provincial government to ensure assisted living services are cost effective, high quality and free of the vagaries of a speculative real estate market. As an alternative, public investment in assisted living capital assets owned by regional health authorities and non-profit organizations would ensure that costs can be effectively controlled over time and that the windfall gains

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associated with increases in property values do not flow entirely to for-profit corporations and investors. It also ensures that the assisted living capital assets that are publicly or non-profit-owned will remain part of the seniors' community care system in perpetuity rather than being at risk of conversion to another use should private investors choose to pursue another more profitable land use (e.g., stratified condominiums). Even though the public sector has indirectly financed these privately held capital assets through ongoing per diem payments, the existing contracts between health authorities and private assisted living operators allow these operators to change the use of the assisted living facility at will. In effect, the provincial government has no long-term guarantee that these privately owned assets will remain part of the publicly subsidized community care system. Ultimately, however, it is the failure of the BC government to invest in new public and non-profit-owned assisted living that has contributed to the shortfall in publicly subsidized spaces in this province.

In conclusion, this report makes the following recommendations intended to improve access to publicly subsidized assisted living provided by health authorities and non-profit organizations.

1. Create new capital and operating funding opportunities for non-profit organizations and regional health authorities to increase the supply of publicly subsidized assisted living units as part of a home and community care capital and operating funding plan.

It is the failure of the BC government to invest in new public and non-profit-owned assisted living that has contributed to the shortfall in publicly subsidized spaces in this province.

In 2018, the newly elected BC NDP government committed to building 114,000 units of "affordable market rental, non-profit, co-op, supported social housing and owner-purchase housing" over ten years.[79] In the first three years, the government promised 2,000 new modular supportive housing units for people who are homeless or at risk of homelessness, and 1,700 affordable rental units for a variety of populations including seniors and adults with mental health issues.[80] In 2018/19, the provincial government provided $228 million in capital funding for housing, and in 2019/20 the government is expected to invest another $247 million in housing infrastructure.[81] This capital investment is welcome and should be used for affordable housing, as it has been earmarked. However, a capital plan with specific commitments about how the government will expand the stock of publicly subsidized assisted living units operated by non-profit organizations and health authorities has not been developed.

This report has revealed that access to publicly funded assisted living fell 17 per cent between 2008 and 2017. The most effective way to address this shortfall in access is to create new capital and operating funding opportunities for non-profit organizations and regional health authorities to develop publicly subsidized assisted living units, beginning in communities where new units are most urgently needed. These new funding opportunities should be developed as part of a broader home and community care strategy and funding plan as CCPA–BC has recommended.[82] A public capital plan should focus on both assisted living and long-term care. And it should be integrated with a comprehensive planning approach to projecting demand and identifying appropriate transitions for seniors across the continuum of supportive housing, assisted living and long-term care. Although the BC Ministry of Health has overall responsibility for seniors' care, BC Housing has technical expertise that could be deployed immediately to support the community-based non-profit sector as well as health authorities expanding on existing sites and developing new assisted living residences.

79 BC Ministry of Finance, 2018, 83.
80 BC Ministry of Finance, 2018, 20.
81 BC Ministry of Municipal Affairs and Housing, 2019, 12.
82 Longhurst, 2017.

This policy direction is consistent with the recommendations of leading academic experts on infrastructure financing. "In our opinion," note Anthony Boardman (UBC School of Business) and Aidan Vining (SFU School of Business), "it is quite likely that there will be relatively more public-sector financing of infrastructure in Canada. There are two main reasons for this. First, private-sector capital has in some cases become unavailable or excessively expensive. Second, it does not make sense for governments to rent or borrow expensive capital from the private sector when they can borrow the equivalent amounts at considerably lower cost."[83] This conclusion is consistent with the findings of this report. The provincial government's reliance on a market-based approach to capital financing has failed to increase access to publicly subsidized assisted living since for-profit providers have focused new construction on private-pay units.

2. Require detailed disclosure and public reporting to improve transparency and accountability in assisted living and long-term care.

A large body of research evidence demonstrates the importance of public disclosure and reporting of ownership, costs and quality of services to enhance accountability and transparency in the seniors' care sector.[84] Although public reporting requirements in the United States have not improved care quality or reduced corporate chain ownership, facilities in receipt of federal funding are required to disclose ownership information and chain affiliation.[85] This public reporting is necessary to analyze care quality and resident outcomes at an aggregate level across ownership types (and not only at the facility level).[86] On its own, this recommendation may not improve quality but at least it will allow researchers, health authorities and the BC Ministry of Health to examine how ownership and chain affiliation influence the quality of care based on a number of indicators (e.g., falls, transfers to emergency, adverse events).

A large body of research evidence demonstrates the importance of public disclosure and reporting of ownership, costs and quality of services to enhance accountability and transparency in the seniors' care sector.

Specifically, regulated assisted living and long-term care facilities (both publicly subsidized and private-pay) should disclose the following publicly available data:

- Detailed information about individuals and entities that have direct or indirect ownership interest in or managing control of their operations (including chain affiliation) and beneficial ownership interest of the real estate assets, in addition to any other parties that provide governance, management, administration, operations, finances and clinical services.
- Annual payroll data on direct care staffing levels, including nursing and allied health hours, turnover and retention rates.
- Facility expenditure reporting by functional category including direct care, indirect care, capital assets/costs and administrative services.

These disclosure and public reporting requirements should be enshrined in legislation. Health authorities should publicly disclose funded per diem rates to contracted assisted living and long-term care facilities.

In BC, the lack of public reporting of all corporate and legal entities, including real estate owners/investors and direct and subcontracted operators, means that the most basic data about who

83 Boardman and Vining, 2011, 381.
84 Wells and Harrington, 2013; Harrington et al., 2017.
85 For example, see disclosure requirements on the Department of Health and Human Services Centers for Medicare & Medicaid Services, "Long-Term Care Facility Application for Medicare & Medicaid": https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms671.pdf.
86 Wells and Harrington, 2013. This includes the beneficial owners of real estate assets and operating companies and all related parties (i.e., subcontractors).

owns, operates and who is accountable for care are not available in any consistent format for policymakers, health authority administrators, researchers or the public.[87] The data compiled and analyzed for this report come from a variety of sources and required significant effort to compile and analyze. The BC Ministry of Health should maintain a database of detailed information about asset and operating ownership interest and entities in all assisted living and long-term care facilities. The lack of readily accessible information on the financial, ownership and service delivery characteristics of seniors' care facilities is a major barrier to effective policy development and reduces the Ministry's ability to negotiate effectively with the industry and improve the overall quality of care.

As interest rates remain low, now is the time to expand publicly subsidized and not-for-profit assisted living services, which are most likely to provide quality, affordable care.

British Columbia is a wealthy province with a strong fiscal outlook.[88] As interest rates remain low, now is the time to expand publicly subsidized and not-for-profit assisted living services, which are most likely to provide quality, affordable care. Seniors and their families across the province would benefit from new publicly funded assisted living services that bring together affordable housing, health care services and social supports that may allow more seniors to age in their communities with dignity, joy and social connection. It is possible and necessary.

87 The BC Legislature passed the Land Owner Transparency Act in May 2019 to establish a public registry of beneficial landowners, which will enhance public transparency around the actual owners of seniors' care properties in BC. However, this proposed registry is focused on land ownership and therefore would not include the entities involved in the operations and provision of care.

88 Canadian Centre for Policy Alternatives–BC Office, 2019, 2–5.

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