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COST ESTIMATE FOR MOTION 77: IMPROVEMENTS TO LONG-TERM CARE



OFFICE OF THE PARLIAMENTARY BUDGET OFFICER
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The Parliamentary Budget Officer (PBO) supports Parliament by providing economic and financial analysis for the purposes of raising the quality of parliamentary debate and promoting greater budget transparency and accountability.

This report estimates the cost of implementing House of Commons Motion 77, which proposes several financially significant changes to long-term care for seniors. This report was prepared at the request of Mr. Paul Manly, MP for Nanaimo—Ladysmith.

Parts of this material are based on data and information provided by the Canadian Institute for Health Information, Statistics Canada, and various provincial administrative bodies. However, the analyses, conclusions, opinions and statements expressed herein are those of the author and not necessarily those of the Canadian Institute for Health Information, Statistics Canada, or those provincial administrative bodies.

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Executive Summary

House of Commons Motion 77 proposes several financially significant changes to long-term care for seniors, including:

- providing long-term care to all persons who need such care,
- increasing average employee pay and benefits for all non-public long-term care providers to match those paid by public sector long-term care providers,
- requiring an average of four hours of care per resident per day, and
- increasing spending on home care to 35% of public spending on long-term care.

Implementing these changes would require increasing public spending by \$13.7 billion each year. This consists of an \$8.5 billion (63%) increase in spending on facilities-based care for seniors and a \$5.2 billion (52%) increase in spending on home care. This cost is expected to grow at 4.1% a year due to rising demand and costs.

These changes would:

- increase the number of long-term care beds for seniors by 52,000 (26%) at a cost of \$3.1 billion each year;
- increase average wages and benefits for persons providing long-term care in the private and non-for-profit sectors by \$3.24/hour (15%) to \$25/hour, at a cost of \$1.1 billion each year;
- increase the number of hours of care provided to residents in long-term care facilities each year by 0.95 hours per resident per day (31%) at a cost of \$4.3 billion each year;
- increase the number of hours of publicly funded home care provided in Canada by 82 million hours (52%), at a cost of \$5.2 billion each year.

Stepwise Cost Estimate

House of Commons Motion 77 includes several financially significant changes to long-term care for seniors.¹ To illustrate the relative financial significance of those changes, this section presents those costs as a series of changes relative to the cost of Canada's current long-term care system.

1. Meeting Current Demand

Facilities Based Care

Step A1:

Meeting Current Demand

Baseline public cost: \$13.6 bn/y
Incremental public cost: \$3.1 bn/y
Running total public cost: \$16.7 bn/y

In 2019-20, Canada's provincial and territorial governments spent \$13.6 billion to provide facilities-based long-term care to about 205,000 seniors.²

Motion 77 is intended to increase the number of long-term care beds to provide long-term care to all who need it. Some provinces, notably Ontario, have a significant wait list of seniors who have been deemed eligible for long-term care, but for whom no acceptable long-term care bed is available.

The PBO estimates that approximately 52,000 unique persons are on wait lists for long-term care, including those in hospitals.³ Based on provincial average net expenditures per resident in the provinces where additional capacity would be required, the net public operating cost for 52,000 additional beds would be \$3.1 billion.⁴ This represents a 26% increase in the number of long-term care beds in Canada.⁵ This cost is incremental to 2019-20 spending levels rather than current spending plans; some provinces have already announced plans to increase their number of long-term care beds.

2. Increasing Pay and Benefits

Step A2: Increasing Pay

Incremental public cost: \$1.1 bn/y
Running total public cost: \$17.9 bn/y

Motion 77 requires all long-term care workers to receive adequate pay and benefits. We understand this to require that all workers receive the same pay and benefits, on average, as workers in public sector long-term care homes.

This change would increase average private sector hourly wages by 15%, from \$21.78/hour to \$25.02/hour. After accounting for the share of hours worked by private sector workers, this is expected to result in a 10% increase in personnel costs, representing a \$1.1 bn (6.7%) increase in the overall cost of the long-term care system.⁶

3. Providing Four Hours of Care

Step A3: Increasing Direct Care

Incremental public cost: \$4.3 bn/y
Running total public cost: \$22.1 bn/y

Motion 77 is intended to ensure that seniors in long-term care receive an average of at least four hours of regulated direct care per day. We assume that this average will be achieved through minimum requirements at the facility level over some period, adjusted based on the case mix at each facility.⁷

Each hour of direct care requires additional time that also has to be remunerated. The total hours paid to deliver an additional hour of care is estimated to be about 23% greater than time spent directly providing care. Employers have to cover the cost of breaks and lunch, as well as vacation, sick leave, employee benefits, and employer contributions to the Canada Pension Plan and Employment Insurance.⁸

Currently, residents in long-term care receive an average of 3.0 hours of direct care per resident per day.⁹ For residents to receive 4 hours of care per day, a 31% increase in both worked and paid hours would be required. This represents about 96 million additional hours of direct care per year. For long-term care providers to be willing and able to deliver these additional hours, additional care funding would be required.¹⁰

The proposed standard refers to 'regulated' direct care. However, personal support workers provide most personal care in long-term care facilities and they are not regulated in most provinces.¹¹ We assume that provinces would regulate personal support workers rather than replacing them with regulated carers like nurses.

Assuming a typical split across types of direct care provider and typical cost per hour of direct care worked, increasing the number of direct care hours to an average of four hours per resident per day would cost \$4.3 billion

annually. Again, this cost is only partially incremental, as some provinces have already announced their intention to increase the amount of care hours per day.¹²

4. Increasing Home Care Spending

Home Based Care Step B: Increasing Home Care Spending

Baseline: \$10.1 bn/y for home care
Incremental public cost: \$5.2 bn/y
Resulting total home-care spending:
\$15.4 bn/y

Motion 77 would increase spending on home care to 35% of public spending on long-term care.¹³ Both facilities-based care and home care are provided to persons other than seniors, notably persons with disabilities, and we assume funding for these other beneficiaries is included in this target. In 2019/20, provinces and territories spent about \$10.1 billion on home-based long-term care and \$20.0 billion on facilities-based long-term care (including care for non-seniors).¹⁴ With the above noted \$8.5 billion increase in spending on facilities-based care, total spending on long-term care would be \$28.5 billion.

To reach the motion's target of having home-care spending represent 35% of public spending on long-term care, and additional \$5.2 billion would have to be spent each year on home care. This represents a 52% increase in spending on home care and approximately 82 million additional hours of home care.

5. Meeting Future Demand

Home and Facilities Base Care Step C: Meeting Future Demand

Incremental public cost +4.1%/y

Motion 77 is intended to expand the number of long-term care beds to meet future demand.

The number of residents in long-term care is expected to rise due to population growth, population aging and changing socioeconomic circumstances of the elderly. We estimate that there were about 205,000 residents in long-term care in 2019-20, with a further 52,000 on waiting lists. We project that demand for long-term care among seniors will rise by about 1.6% a year, reaching 260,000 seniors in 2020-21 and 277,000 seniors in 2025-26.¹⁵

In addition, over the last 20 years, average hourly wages in the health care and social assistance sector have been rising by about 2.5% a year.¹⁶

In combination, rising numbers of residents and rising wages are expected to increase the cost of long-term care by 4.1% a year over the next five years.

The above incremental cost of \$13.7 billion was calculated for 2019-20 populations and spending. The incremental cost of the motion is expected to be \$14.9 billion in 2021-22 and rise to \$17.5 billion in 2025-26.

The cost trend may be sensitive to some changes proposed in M-77. In particular, promoting the regulation and unionization of personal support workers may generate greater future wage increases.¹⁷

6. Cost-Sharing

The cost of Canada’s long-term care system for seniors is shared between federal, provincial and territorial governments, but almost all direct funding is provided by provincial and territorial governments. The federal government finances long-term care indirectly through the Canada Health Transfer, which supports the capacity of provinces to offer health care services, including long-term care. However, no specific amount is allocated for long-term care within the Canada Health Transfer.

Table 1 Current Spending on Long-Term Care for Seniors

	Spending (\$ billions)
Total Public Spending	13.6
Provincial Direct Spending	13.2
Federal Direct Spending	0.4
Federal Transfers	43 for health care generally

Source: PBO

Note: Based on Canadian Institute for Health Information National Health Expenditure Database; GC InfoBase; Finance Canada [Major federal transfers](#).

The federal share of the direct cost of the changes proposed in the motion would have to be determined through negotiations.

7. Behavioural Responses

We assume that Motion 77 will not affect the number of seniors seeking facilities-based long-term care as eligibility is generally based on need as assessed by physicians.

There is, however, some potential for residents to choose between home care, community care, and nursing-home care. About 11% of residents admitted to nursing homes have mild or moderate health conditions and physical limitations such that their needs could have been met at home with proper supports.¹⁸

However, Motion 77 makes both home-based care and nursing-home care more attractive. Increasing spending on home-based long-term care may make it more feasible for some individuals to choose to remain in their homes or communal settings rather than entering nursing homes. However, with more hours of direct care per day per resident and higher salaries to attract and retain higher quality staff, some persons who would have otherwise opted to stay homes or in communal settings may opt for nursing home care.¹⁹

Regardless, such substitution would likely not result in significant cost savings; empirical evidence suggests that for persons around the threshold of need for admission to facilities-based care, the net cost of home-based care and facilities-based care is similar, despite the lower average cost of home care.²⁰ Furthermore, home care services benefit a far wider population than the subset of persons in the nursing home who could have their needs met at home and prefer to stay at home. Home care is already available and often subject to a limit reflecting the threshold beyond which high needs make facilities-based care more cost-effective.²¹

We assume that this rise in spending on long-term care will increase the labour force participation of caregivers to some extent. About 40,000 family caregivers interested in paid work report that affordable care would allow them to work at a paid job.²² However, most studies have shown that increased publicly-funded home care does not actually substitute for informal home care provided by family.²³ As a result, there isn't sufficient evidence to provide an exact estimate of the tax revenue recoveries that would result from increased caregiver labour participation arising from this motion.

We interpret the motion as permitting provinces and territories to continue to charge accommodation fees, provided that long-term care remains affordable for all who need it.²⁴ Changes to accommodation fees for residents, if implemented, could affect demand for institutional long-term care.

8. Summary

Implementing the changes proposed in Motion 77 would increase the public cost of long-term care by \$13.7 billion if implemented in 2019-20. This consists of an \$8.5 billion (63%) increase in spending on facilities-based care for seniors and a \$5.2 billion (52%) increase in spending on home care. Costs would continue to rise by 4.1% per year thereafter. We assume the direct cost would be primarily borne by provincial and territorial governments, although federal transfers could be increased to cover a portion of the incremental costs. We also assume the cost would not be particularly aggravated or offset by behavioural responses.

Table 2 Incremental and Running Total Cost of Changes (\$ millions per year)

Change	Incremental public cost	Running total cost of measures
Meeting Current Demand	3,122	3,122
Increasing Pay and Benefits to Public Sector levels	1,126	4,248
Providing Four Hours of Care	4,268	8,517
Increasing Home Care Spending to 35% of LTC Spending	5,226	13,743
Meeting Future Demand	+4.1%/y	13,743+4.1%/y

Notes

- ¹ In this report, “long-term care” refers to publicly subsidized medical and personal care for persons who require such care for an extended period. Long-term care may be provided to residents in their own home, or in dedicated long-term care facilities.
- ² ‘Facilities-based long-term care’ refers to publicly funded institutions where long-term care is provided to residents. These homes have different names and scopes across provinces and include some systems not labelled as long-term care, such as designated supportive living facilities in Alberta.

This estimate was compiled from provincial administrative sources. Figures are compiled from main estimates for the subsequent year, the financial statements of regional health authorities, and GC Infobase. It is lower than the Canadian Institute for Health Information’s estimates of spending on facilities-based long-term care because it does not include long-term care for children and persons with disabilities. This figure also reflects net spending, after accounting for revenues from accommodation charges.
- ³ Wait lists were only available from provincial reporting for Ontario, Quebec, British Columbia and Nova Scotia. Other provinces were assumed to have the same average number of persons on wait lists per person over 80 years of age.
- ⁴ Net average costs per resident were calculated from provincial administrative data regarding appropriations and residents.
- ⁵ The number of residents in long-term care by province was compiled from reporting by provincial ministries and regional health authorities.
- ⁶ The wage differential was estimated from the Labour Force Survey. Average hourly wages are weighted based on the number of hours worked by different groups of employees. The differential in non-wage benefits was assumed to be equal to the differential in hourly wages.
- ⁷ This is to say, individuals will receive more or less care in proportion to their need, but a high level of care at one provider does not offset deficiencies at another. However, because residents’ needs levels vary between providers, it is assumed that the required hours per resident per day will be adjusted between providers to achieve the required overall average.
- ⁸ This ratio is based on correspondence from Ontario’s Ministry of Long-Term Care, which indicated that the 3.33 paid hours of direct care per resident per day in their staffing study corresponded to 2.75 worked hours of direct care per resident per day (both figures excluding allied health professionals). It is corroborated by the analysis of the B.C. Housing Advocate whose recent report indicates that “Paid hours should exceed worked hours by a margin of 15-20%,” Office of the Seniors Advocate, [A BILLION REASONS TO CARE: A Funding Review of Contracted Long-Term Care in B.C. 2020](#); Ontario, [Long-term care staffing study](#).

- ⁹ Hours of care per resident per day, both worked and paid, were compiled from various province-specific data sources and correspondence with provinces. There is some uncertainty around this figure as reliable recent data was only available for Ontario, Alberta, British Columbia, and Prince Edward Island.
- ¹⁰ In B.C., private long-term care providers delivered about 2% less care hours than they were funded to deliver. This indicates there is limited scope for long-term care providers to increase staffing with the funding already available to them. Office of the Seniors Advocate, [A BILLION REASONS TO CARE: A Funding Review of Contracted Long-Term Care in B.C. 2020](#).
- ¹¹ Personal Support Workers are also known as Care Attendants, Health Care Aides, and by many other names. For example, unregistered Health Care Aides provide 67% of direct care in British Columbia and 59% of direct care in Ontario. Office of the Seniors Advocate, [A BILLION REASONS TO CARE: A Funding Review of Contracted Long-Term Care in B.C. 2020](#); Ontario, [Long-term care staffing study](#).
- Quebec regulates “Care Attendants”. LegisQuebec, [S-4.2, r. 5.01 - Regulation respecting the conditions for obtaining a certificate of compliance and the operating standards for a private seniors’ residence](#).
- Regulation has been proposed in Ontario and British Columbia. Ontario, [Proposed Legislation to Strengthen the Health and Supportive Care Workforce During COVID-19 and Beyond](#); British Columbia, [Health Care Assistant Oversight Policy Intentions Paper for Consultation](#).
- ¹² Notably, Ontario has already set a target to increase the average hours of daily direct care provided to long-term care residents by nurses and personal support workers from 2.75 hours per day in 2018 to four hours per day by 2024-25 at an expected cost of \$1.5 billion. FAO, [Ministry of Long-Term Care: Spending Plan Review \(26 May 2021\)](#).
- Because provinces do not publish long-term spending plans, it is not possible to isolate the incremental cost.
- ¹³ Private spending on long-term care is excluded because there are no credible estimates of private spending on home care. Private spending on home care is not included in WHO/OECD Global Expenditures Database and both public and private spending on personal and medical care in communal settings like seniors’ residences is included as spending on long-term “institutional” care in that database.
- ¹⁴ These estimates were obtained from the Canadian Institute for Health Information’s National Health Expenditures Database and validated against provincial estimates documents. Home care costs were projected forward one year using a similar linear projection.
- ¹⁵ Growth in the number of persons requiring long-term care was indexed to projected mortality among persons over age 65 under Statistics Canada’s medium growth scenario. This indexation is intended to capture the impact of population growth and aging, offset in part by improving health among seniors. For a more nuanced projection yielding a similar short-term result, see Bonnie-Jeanne MacDonald, Michael Wolfson and John P. Hirdes, [The Future Co\\$t of Long-Term Care in Canada](#).
- ¹⁶ Statistics Canada. Table 14-10-0063-01 Employee wages by industry, monthly, unadjusted for seasonality.

- ¹⁷ Occupational regulation tends to increase wages. See Maria Koumenta, Mario Pagliero, [Occupational Regulation in the European Union: Coverage and Wage Effects](#).
- ¹⁸ Canadian Institute for Health Information, [1 in 9 new long-term care residents potentially could have been cared for at home](#).
- ¹⁹ Demand for institutional care is responsive to the quality of institutional care. See Peter Alders, Dorly J.H. Deeg, Frederik T. Schut, [Who will become my co-residents? The role of attractiveness of institutional care in the changing demand for long-term care institutions](#).
- While Canadians generally prefer home care over institutional care, those residents whose needs could have been met at home are more likely to live alone and in rural areas, so they may have different preferences from the general population. See Canadian Institute for Health Information, [1 in 9 new long-term care residents potentially could have been cared for at home](#).
- ²⁰ Pieter Bakx, Bram Wouterse, Eddy van Doorslaer, Albert Wong, [Better off at home? Effects of nursing home eligibility on costs, hospitalizations and survival](#). The [2002 FINAL REPORT OF THE NATIONAL EVALUATION OF THE COST-EFFECTIVENESS OF HOMECARE](#) did suggest that home care was more cost-effective for clients with stable lower need. However, since that time provinces have expanded home care and raised the need thresholds to enter nursing home care, leaving nursing homes with residents with greater need.
- ²¹ OECD, [Can We Get Better Value for Money in Long-term Care?](#)
- ²² Statistics Canada, 2012 General Social Survey Cycle 26 Caregiving and Care Receiving, Q INE_Q41_C03.
- ²³ Lydia W. Li, [Longitudinal Changes in the Amount of Informal Care Among Publicly Paid Home Care Recipients](#); Margaret J. Penning, [Hydra Revisited: Substituting Formal for Self- and Informal In-Home Care Among Older Adults With Disabilities](#).
- ²⁴ For an overview, see Sonya Norris “[Long-Term Care Homes in Canada – How are They Funded and Regulated?](#)” Library of Parliament Hillnote (22 October 2020)