

# For-profit versus not-for-profit delivery of long-term care

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Public funds can be used to pay for health care services that are delivered either by for-profit or not-for-profit agencies. A systematic review of patient outcomes in US hospitals by ownership status showed that not-for-profit hospitals tended to produce better results.<sup>1</sup> Although there are no Canadian acute care hospitals in the for-profit sector, the issue of interest here is whether the same trend in outcomes applies to for-profit and not-for-profit ownership of long-term care facilities.

About 60% and 30% of all publicly funded long-term care beds in Ontario and British Columbia, respectively, are in for-profit institutions.<sup>2,3</sup> The co-existence of for-profit and not-for-profit providers in the same province creates a “natural laboratory” for examining their differences. This is particularly true because the funding paid by the province to these facilities is tied to resident care requirements and thus the same amount is paid per standardized patient whether he or she is in a for-profit or a not-for-profit facility. Despite this, there has been relatively little Canadian research that examines the experiences of residents in these 2 types of facilities. Although there is an abundance of evidence from the United States demonstrating superior performance of the not-for-profit sector in measures of quality of care, there are claims that these findings have limited generalizability in Canada because of differences in the 2 countries’ health care systems. However, a few Canadian studies are now starting to provide a portrait of what public investment “buys” in for-profit and not-for-profit facilities.

## How is the money spent?

Long-term care facilities, like hospitals, are labour-intensive; therefore, staffing costs account for a significant portion of total expenditures. Unlike many parts of the United States, Canada has no legislated minimal requirements for staffing in long-term care facilities. Instead, institutions either face requirements for minimum spending in different categories as dictated by “funding envelopes” (as in Ontario), or are free to choose how to apportion their funding (as in British Columbia).

There is now increasing evidence that the for-profit and not-for-profit sectors in Canada make different spending decisions. In an Ontario study, government-operated facilities were found to provide more hours of direct patient care per resident than for-profit facilities, although the public-sector facilities also care for residents with greater health needs.<sup>2</sup> In British Columbia, not-for-profit facilities were also found to provide more hours of direct patient care per resident than for-profit facilities, with the same funding level from government; this difference remained after adjustment for the size and level of care of the facilities.<sup>3</sup> Adjustment for the mix of

patients cared for by the 2 types of facilities is important. For example, most extended-care beds, reserved for the care of the frailest elderly patients, are in not-for-profit facilities.

## What are the outcomes of care?

Do differences in staffing levels result in differences in care? Two studies in Canada have identified a link between ownership type and care outcomes. Although this was not the primary question under study, Shapiro and Tate<sup>4</sup> found that, in Manitoba, for-profit long-term care facilities had higher rates of acute care hospital admission of residents because of several quality-of-care related diagnoses than did not-for-profit facilities.

In another study, the influence of ownership on patient outcomes was addressed directly with the use of data from the late 1990s in British Columbia.<sup>5</sup> This study compared hospital admission rates for 6 care-sensitive diagnoses among British Columbia residents in for-profit and not-for-profit long-term care facilities. Rates of admission because of anemia, pneumonia and dehydration were found to be higher in for-profit facilities than in their not-for-profit counterparts, after adjustment for resident case mix and other potential confounders. The aggregated superiority of the not-for-profit sector was largely driven by not-for-profit facilities that were attached to acute care hospitals, were amalgamated to a health authority or had more than one site. In the case of not-for-profit single-site facilities, hospital admission rates were the same as, and for 2 diagnoses were higher than, rates in for-profit facilities. The variation of performance among not-for-profit facilities with different organizational characteristics was not replicated in the for-profit sector. Hospital admission rates for all for-profit groups — chain, multi-site and single-site — were uniform and higher.

## Why the difference in performance?

One possible explanation for the improved outcomes observed in the not-for-profit long-term care facilities that were attached to acute care hospitals, were amalgamated to a health authority, or were multi-site facilities is that these institutions are able to benefit from the economies of scale afforded by their connection to larger administrative structures. They may, for example, have greater access to specialized professionals capable of developing and implementing care policies. Larger groupings of public facilities may also promote the sharing of clinical services that would be too expensive to operate at a single site. For example, a single clinical or geriatric nurse specialist might be shared among several sites. In addition, facilities attached to acute care hospitals likely have direct access to general, specialty and diagnostic services that may well im-

prove care outcomes. Whatever the reason, however, any possible advantage of larger administrative groupings does not appear to extend to for-profit facilities.

Differences in staffing between for-profit and not-for-profit long-term care facilities are not surprising. Given the same level of funding, for-profit facilities must, by definition, divert some of their funding to profits. Since staff costs account for a large portion of total budget expenditures, this is a natural place to try to realize cost savings. The fact that differences in spending decisions appear to result in better care outcomes, at least in larger affiliated not-for-profit facilities, is important information for future policy decisions. Further study is necessary, however, because all of these variables have not yet been analyzed together in a Canadian study, and because we need a better understanding of the reasons for the substantial differences in patient outcomes among the different types of not-for-profit facilities.

Nevertheless, we are beginning to acquire evidence from Canadian data that public investment in not-for-profit, rather than for-profit, delivery of long-term care results in more staffing and improved care outcomes for residents. This information is essential to planners as they make funding decisions about long-term care.

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