reported as 3.41 hours per resident-day,[1] but the funding model would provide only 2.83 hours of direct care. Furthermore, facilities are usually unable to staff to 100% of the funding formula. Although it is probably true that these long-term care facilities would like to be able to staff at the "essential staffing levels" on file with the Labour Relations Board, these values do not reflect actual staffing levels. One possible explanation for the discrepancy is that McGregor and associates used data for paid hours per resident-day rather than worked hours. Paid hours include vacation time, statutory holidays and sick leave and are therefore significantly higher than worked hours, which reflect hands-on care.

Given that the validity and accuracy of the hours of care being delivered are questionable, the resulting interpretation and conclusions of the article are similarly debatable. If valid conclusions are to be drawn regarding the overall impact of staffing, staffing levels must be tied directly to outcomes and to client and family satisfaction levels. The level of staffing is obviously a critical factor in quality of care, but other factors such as experience, training, productivity and innovation can be equally important.

We believe that the major determinant of differences in staffing levels in private and nonprofit facilities relates to inconsistencies in funding. Nonetheless, excellent services are provided in both sectors, and the provincial ministry of health and the regional health authorities have not identified any differences in quality of care between not-for-profit and for-profit facilities.

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Competing interests: None declared.

DOI:10.1503/cmaj.1050089

[Three of the authors respond:]

Ed Helfrich writes that the staffing levels in our study[1] appear too high. However, the "funding model" to which he refers relates to funding (not staffing) guidelines developed over a decade ago by the BC Ministry of Health.[2] At the time of our study each facility was receiving a global budget and could decide how to allocate the money among staffing, administration and property costs. Our findings suggest that, with the same funding from government, not-for-profit facilities decided to allocate more of their resources to staffing than did for-profit facilities.

In addition, the funding guideline of 2.83 staff hours per resident-day applies only to "intermediate care III" residents. The same guidelines suggest 3.1 hours per resident-day for more debilitated "extended care" residents. These latter residents would partly account for the higher average staffing hours for this facility designation, as would the decision of not-for-profit facilities to put relatively more money into staffing.

Helfrich speculates that we might have used data for paid rather than worked hours. The staffing levels obtained from the BC Labour Relations Board represent counts of full-time and part-time staff positions, and the expectation is that people are replaced by casual staff for vacation and sick time. In addition, all facilities operated under a master contract with the same wages and benefits. We have no reason to believe that for-profit facilities were less likely than not-for-profit ones to replace people on sick leave or vacation.

Finally, Helfrich makes the point that if valid conclusions are to be drawn about the overall impact of staffing, this measure must be tied directly to outcomes and user satisfaction. Although there is a substantial body of published research supporting the measurement of staffing as a recognized "structural" indicator of nursing home quality,[3,4] we were careful in our article to also make this point. We hope that our study will encourage further Canadian research on this question.

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Competing interests: Marcy Cohen is a researcher for the Health Employees Union (formerly the Hospital Employees Union). None declared for Drs. McGregor and McGrail.

DOI:10.1503/cmaj.1050127

Correction

In Table 2 of the article on the WOW health survey on older women's health priorities and perceptions of care delivery,[1] the heading of the second data column should have read "Priority is of some concern or importance," with the corresponding footnote worded as "Includes health priorities rated by respondents as being somewhat important. Does not include health priorities rated as being a little bit or not at all important."

Reference

1. Tannenbaum C, Mayo N, Ducharme F. Older women's health priorities and perceptions of care delivery: results of the WOW health survey. *CMAJ* 2005;173(2):153-9.

DOI:10.1503/cmaj.050975