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Non-Profit Long-Term Care in Ontario: How Financially Robust Is the System?

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Les conséquences catastrophiques de la maladie à coronavirus de 2019 ont mis en lumière la nécessité de réformer complètement les politiques, la règlementation et le système de financement des soins de longue durée au Canada, y compris par le renforcement du volet philanthropique du système de soins. Cet article évalue les conséquences, pour les fournisseurs sans but lucratif, de l'évolution des politiques ontariennes relatives aux soins de longue durée. On y analyse les tendances des revenus et de la santé financière des établissements caritatifs de soins de longue durée entre 2004 et 2017. Bien que les revenus de ces établissements tendent à la stabilité, leur solidité financière s'est rigidifiée au fil du temps, soumise à leur dépendance croissante au financement gouvernemental et à l'amenuisement de la contribution philanthropique.

Mots clés : financement de charité, soins de longue durée**,** aide financière de soins de longue durée, organismes à but non lucratif, soins de longue durée à but non lucratif, philanthropie

The disastrous effects of the 2019 pandemic have demonstrated the need for comprehensive reform of the policy, regulatory, and financing regimes of long-term care in Canada, including strengthening the non-profit component of the care system. In this article, we assess the implications of the evolution of Ontario's long-term-care policy on non-profit providers. We analyze the revenue trends and financial health of charitable long-term-care homes (LTCHs) from 2004 to 2017. Although the general pattern is one of revenue stability for non-profit LTCHs, their financial robustness has become more constrained over time as a result of greater reliance on government funding and declining philanthropy.

Keywords: charity financing, long-term care, long-term care financial help, non-profit organizations, non-profit long-term care, philanthropy

Across many countries, long-term-care homes (LTCHs) had a disproportionately high number of infections and deaths due to coronavirus disease 2019 (COVID-19). Among high-income countries, Canada has the worst record of COVID-19 deaths in LTCHs (Canadian Institute for Health Information [CIHI] 2021b). In the first and second waves of the pandemic, outbreaks occurred in 63 percent of homes; more than 101,170 residents and 56,770 staff were infected, resulting in approximately 17,000 deaths (National Institute on Ageing 2022), of which 31 percent (4,425) occurred in Ontario's LTCHs (Public Health Ontario 2022, 3). This tragedy has led to widespread calls to reform the long-term-care (LTC) system, including eliminating four-bed rooms, improved inspection and enforcement of standards, better integration of LTC into provincial health care systems, the introduction of national standards, and funding for new construction, among others (Office of the Auditor General of Ontario 2021; Tuohy 2021). The more dramatic policy shift that has long been advocated (Armstrong et al. 2020, 2021) is to transfer ownership of and management responsibilities for the large component of LTCHs operated by for-profit firms to the non-profit sector. Although the Government of Ontario has initiated greater support for select LTCH providers with its announcement in December 2021 of loan guarantees to encourage investment in expanded

bed capacity (Government of Ontario Newsroom 2021), whether non-profits will be in a financial position to significantly extend their presence in LTC remains unclear.

The case, both conceptually and empirically, is that without a profit motive, non-profits will invest in more staff, better pay, and updated facilities; deliver a higher standard of care for residents; and foster greater public trust in the system (Armstrong et al. 2020; Comondore et al., 2009; McGregor et al. 2006; Weisbrod 1975). As charities that can issue tax receipts for donations, this sub-sector should be able to supplement the mainstay of government funding with philanthropy, thereby improving its financial footing. The purposeful expansion of the non-profit component of Canada's mixed delivery system of LTC presumes that this sub-sector is financially robust or could readily become so with some additional investment—an assumption that has not been adequately tested. We address this research gap by analyzing the financial health of LTCHs operated by charities in Ontario over the past 20 years to better understand the potential for expansion and innovation of the charitable component of LTC. *Financial health* refers to an organization's financial capacity, involving the resources available to attain the mission, adapt and innovate, and withstand unexpected crises and its financial sustainability as reflected in the fluctuation of this capacity over time (Bowman 2011; Hung and Hager 2018).

We first provide an overview of the LTC system in Ontario and describe policy changes since 1940, with a particular focus on those that have had significant implications for the configuration and financing of the system. We then analyze trends in the composite revenues of charitable LTCHs, including government funding, philanthropy, and revenues from earned income through the sale of goods and services. The non-profit LTC sector is not uniform, however, so we take a deeper dive into its sub-components, assessing differences by facility size and age, urban versus rural, accreditation status, and faith and ethnocultural affiliation.

Overview of the Long-Term-Care System in Ontario

Like other provinces, Ontario has a mixed LTC delivery system, although it has the most heavily for-profit system in Canada (Marrocco, Coke, and Kitts 2021; Pue, Westlake, and Jansen 2021). Approximately 58 percent (n = 377) of the 653 LTCHs in Ontario are owned by for-profits, 26 percent (n = 172) by non-profits (including charities and community-based non-profits), and 16 percent (n = 104) by municipal governments (Marrocco et al. 2021; Ministry of Health and Long-Term Care [MOHLTC] 2022; Office of the Auditor General of Ontario 2021). The non-profit LTCHs tend to be relatively smaller facilities (46 percent have fewer than 100 beds); 39 percent are medium-sized (100–200 beds), and only 15 percent have more than 200 beds (MOHLTC 2020, 2022). More than 90 percent of the non-profit LTCHs are registered charities that, in addition to being exempt from income and municipal property taxes, can issue tax receipts for donations, and 51 percent of these have faith or ethnocultural affiliations (Office of the Auditor General of Ontario 2021). Although non-profit in concept and ownership, increasingly complicated management structures make it difficult to neatly differentiate the fully non-profit LTCH from its for-profit counterparts (Stevenson, Bramson, and Grabowski 2013, 30). As shown in Table 1, 13 percent of the non-profit or charitable LTCHs contract out their day-to-day operations to for-profit firms. Our analysis focuses on the population of 112 LTCHs that are owned by registered charities, regardless of whether they contract out their operational management.

Table 1: Ontario Non-Profit LTCH Operators That Contract Out Day-to-Day Operations (N = 172)

Homes and Beds	Contract with for-Profit Firm	Contract With Charity	Do not Contract Out
Homes, *n* (%)	22 (12.8)	2 (1.2)	148 (86)
Beds, *n*	3,132	171	17,397

Notes: LTC = long-term-care home.

Source: Ontario Ministry of Health and Long-Term Care (2020, 2022).

Despite significant policy changes over the years, the configuration of the LTC system is designed to be very stable without consumer competition based on price. Licenses for new LTCHs may be granted for up to 30 years, and when existing licenses expire the preference appears to be for renewal (Pue et al. 2021). There are high barriers to entry for LTCH provision, in part because of the heavily regulated environment and capital costs (Daly 2015). The current system falls far short of meeting demand, however, because an estimated 37,000 people are on waitlists for LTC, requiring up to five years in some parts of the province to secure a place (Office of the Auditor General of Ontario 2021). The waitlists suggest a preference for non-profit and municipal homes because more than two-thirds of people are waiting for spaces in these homes (Marrocco et al. 2021, 39).

The provincial government provides the vast bulk of funding for LTCHs on the basis of a per bed, per day, and care-specific formula, no matter whether the home is for-profit, non-profit, or municipal. Of the total $6 billion in revenue of Ontario's LTCHs in 2019–2020, $4.4 billion (73 percent) was provided by the MOHLTC (CIHI 2021a; Office of the Auditor General of Ontario 2021). The government funding envelope is differentiated into health care, non–health care, and capital. Health care funding is a flow-through cost and cannot be transferred to non–health care budgets to ensure that no profit is made from health provision and that residents obtain a consistent level of health care support across homes (Morrison Park

Advisors 2021, 7). The non–health care portion of funding is further divided into three subparts: a global per diem, other accommodations, and development. LTCHs may offer three types of accommodations at differing rates: basic ($62.18/resident day, which is remitted to government), semi-private ($62.18 + a $13.02 premium that is retained by the home), and private ($62.18 + a $27.15 premium that is retained; Morrison Park Advisors 2021, 17). Each LTCH is required to offer 40 percent of its rooms at a basic accommodation price, regardless of the actual overall room configuration (Morrison Park Advisors 2021, 17). Although all homes must be licensed by the province, the MOHLTC provides an incentive of an additional $0.36 per bed per day for homes accredited through a sector self-regulatory system. About 84 percent of all Ontario LTCHs are accredited through this system (Marrocco et al. 2021, 73).

The second component of financing comes from non-governmental sources, notably through earned income involving the sale of top-up services paid by residents and ancillary retirement home rentals and through philanthropy. The resident-paid services include accommodation premiums, short-term-care respite beds, hotel-like accommodation for visitors, and other optional services such as Internet, cable, telephone, parking, and beauty services and products, among others (Morrison Park Advisors 2021, 17). In addition to premiums on semi-private and private LTC rooms, charitable homes may provide other types of seniors' rental accommodation (without nursing care) that are outside the provincial LTC formulas and regulations.

The charitable LTCHs should be able to attract additional discretionary funding through donations. Given that non-profits operate under a constraint of the non-distribution of profits, they are assumed to be trustworthy and come with a presumption of effective performance; donors receive "warm glow" benefits from this trust relationship that enhance the propensity to donate (Hansmann 1980; Weisbrod 1975). Because people tend to give, either through donations or bequests, to causes and organizations that touch them personally (Bekkers and Wiepking 2011; Breeze 2010)—such as having a loved one in care or being the recipient of care—LTCHs should be a prime candidate for philanthropy. An indicator of the importance of fundraising for charitable LTCHs is that 20 percent of them have established affiliated charitable foundations for this purpose (our calculation). Whether philanthropy and earned income are, in fact, significant sources of revenue for LTC charities, however, has not been examined in the Canadian context.

The configuration and financial viability of segments of Ontario's LTC system, as Baum (1999) notes, have been shaped by provincial policies. Although the LTC system is publicly funded with private (non-profit and for-profit) delivery and policy officially gives preference to non-profit provision, the system has evolved over time to favour the growth of the private sector. As Armstrong et al. (2021, 5) argue, it has also been characterized by "decades of underfunding and neglect" that contributed to catastrophic consequences during the pandemic. In the next section, we briefly address the implications of the major changes in the policy and financing regimes since the development of the modern welfare state.

Evolution of Ontario's Long-Term-Care Policy and Financing Regime

The modern era of LTC in Ontario is marked by the passage of the *Homes for the Aged Act* in 1947, with new legislation of the same name in 1949 that introduced regulation and increased provincial funding (Ontario Nursing Home Association 1999; Struthers 1997). For many years, however, the historical and legislative distinction between homes for the aged that served poor elderly individuals and nursing homes that were governed by health authorities produced a fragmented approach to financing and regulation (Berta, Laporte, and Valdmanis 2005; Daly 2015). Initially, for-profit homes of both types were mainly small, family-run facilities; most non-profits had a religious affiliation, and hospitals dominated care for those with more complex medical needs (Armstrong et al. 2020). Beginning in the mid-1960s, the regulatory regime was consolidated and strengthened. Amid wide variations in care and reports of abuse, in 1966 nursing homes were required to be licensed by the Department of Health, and some basic standards of care were mandated (Baum 1999; Daly 2015). Municipalities received provincial funding for re-allocation to facilities and were responsible for regulation and inspection, although oversight remained minimal. Smaller nursing homes that could not afford compliance with the new regulations closed, and during the late 1960s large new private nursing homes were built and the number of private-sector beds more than doubled, from 8,500 to 18,200 (Struthers 1997, 173).

A medicalized model was solidified in 1972 (Daly 2015) with the passage of the Extended Care Units program that provided public funding (through provincial health insurance) to residents with medical care needs (*The Nursing Homes Act* 1972, c 11.13.[1]), and transferred responsibility for regulatory enforcement from municipalities to the provincial Ministry of Health. Public funding, combined with low per diems, propelled the expansion of the for-profit industry and its consolidation into chains to capitalize on economies of scale, and it hurt the financial viability of smaller independent homes (Baum 1999). Over the next decade, the for-profit industry nevertheless lobbied for increased funding for its nursing homes on the basis that they were disadvantaged compared with municipal and charitable homes that were not subject to comparable taxation, could offer tax receipts for donations,

and were governed under separate legislation that provided more flexible funding arrangements (Daly 2015).

A decade-long period of "ad hoc-ism" followed as eldercare fell off policy agendas (Picard 2021). The lack of attention to eldercare is evident in the creation of the *Canada Health Act* in 1984 (Canada 1985), which aims to ensure consistency of access to medical services across the country but, among other services, excludes long-term residential and home care (Armstrong et al. 2020, 87). A New Democratic Party government initiated a new round of reform with *The Long-Term Care Statute Law Amendment Act* (Ontario 1993), which brought homes for older adults under the umbrella of the Ministry of Health and, with its 1994 companion legislation, mandated some basic standards of care, introduced a new envelope system of financing, and tied funding to a classification system based on the complexity of residents' needs (Daly 2015; Ontario Health Coalition 2002). By replacing the global funding model for non-profit and public LTCHs with a more constrained envelope model, the operational flexibility of non-profit LTCHs became more limited. At the same time, competition from the private sector increased when LTC was included in the 1994 North American Free Trade Agreement provisions (Canada 1993), which opened the Canadian LTC sector to ownership by international corporations and weakened the position of non-profit providers (Daly 2015).

When the Harris Conservative government swept to power in 1995 on the promise of tax cuts and privatization, it set about restructuring hospitals while committing to no reduction in the global budget of the Ministry of Health (Sinclair, Rochon, and Leatt 2006). During its term, the Conservative government closed 39 hospitals—one of every three acute care beds in the province—while promising a more integrated system of acute, long-term, and home care (Williams et al. 2016). In 1998, the Harris government announced capital funding of $1.2 billion for home care and LTC facilities, which was to be used to create 20,000 new LTC beds by 2006 and upgrade an additional 16,000 LTC beds in 102 structurally non-compliant facilities, although the demand for this level of expansion at that time was questionable (Williams et al. 2016). A new competitive bidding process was initiated that required bidders to have access to sufficient capital to build or retrofit existing buildings to meet new structural building classifications (Armstrong et al. 2020, 90). Consequently, two-thirds of the bids for new beds were awarded to for-profit chains, mainly for much larger facilities that then needed to be filled, thus further weakening the position of independent, non-profit operators (Armstrong et al. 2020, 90; Daly 2015, 46). The Harris government claimed that its introduction of a single point of access for home care and LTC through the creation of 43 regionally based Community Care Access Centres (CCACs) would produce greater coordination of services and cost efficiencies. Instead, the contracting model for care services, which was based on managed (winner-take-all) competition, resulted in the displacement of smaller non-profit home care service providers by large, primarily for-profit contractors and deepened inequities in access to services across locales (Cloutier-Fischer and Joseph 2000; Jenson and Phillips 2000; Skinner and Rosenberg 2006; Yakerson 2019).[1]

From 2003 to 2018, the successor Liberal government maintained parity of financial support requirements for all licensed LTC beds regardless of ownership, injected additional capital funding, and increased support for personal support workers. With the growth in the number of beds, however, staffing (and staff salaries) remained inadequate, and homes struggled to fill staff vacancies (Ontario Association of Non-Profit Homes and Services for Seniors [OANHSS] 2004, 2007; Sharkey 2008). As OANHSS (2000) observed, non-profit service providers faced ongoing pressure "to fundraise in order to bridge the funding gap and meet ever-increasing demands" (9).

Regulatory parity among for-profit, non-profit, and public providers eventually occurred in 2010 with passage of Ontario's (2007) *Long-Term Care Homes Act*. It amalgamated the three separate legislative authorities, in effect setting the same rules for all types of LTCHs, and aimed to strengthen enforcement of standards (Meadus 2010). Its preamble reinforced a commitment by the people of Ontario and their government to "the promotion of the delivery of LTCH services by not-for-profit organizations" (Ontario 2007).

At the same time, the province introduced an elaborate, standardized tool imported from the United States for the assessment of resident care needs, the Resident Assessment Instrument–Minimum Data Set (RAI–MDS), that was intended to produce more "evidence-based decision making" (Hirdes et al. 2003, 48) and that tied funding to measurement. The medically focused system required investment in sophisticated data systems and technical staff, was time consuming for care staff to administer, and linked funding to residents with more complex needs (Armstrong, Daly, and Choiniere 2016; Morrison Park Advisors 2021). As Daly notes (as quoted in Wells 2020), "It becomes a numbers game. The bigger the organization, the better they are at maximizing their numbers—to capture the highest level of complexity and acuity, and to ensure the highest level of funding." As a result, many smaller homes that had difficulty in effectively implementing the RAI–MDS system or could not play the numbers game well experienced a decrease in funding.

The decade leading up to the emergence of the pandemic was mainly one of policy drift or, in a more critical view, one of policy neglect (Armstrong et al. 2021) involving no serious policy, regulatory, or financing reform. Incremental upward adjustments were made to the government per diems, although they remain low. Workforce standards and data for making policy and managing the

sector were lacking, and integration across residential, community, and acute care was not improved (Estabrooks et al. 2020). Rather, the Conservative Ford government rolled back comprehensive quality inspections and ignored systemic concerns, leaving LTCHs unprepared to deal with the pandemic (Office of the Auditor General of Ontario 2021; Pedersen, Mancini, and Common 2020).

The policy and financial frameworks for non-profit LTCHs are still evolving. The provincial government has made new funding commitments and loan guarantees for the expansion of beds, and in April 2022 the *Fixing Long Term Care Act, 2021* (Ontario 1993) was proclaimed, replacing the *Long-Term Care Homes Act* with key goals of increasing hours of care and the accountability of LTC licensees and enhancing emergency planning. It also introduces greater transparency for retirement homes, which are regulated (to a lesser degree) separately under the *Retirement Homes Act, 2010*.[2]

In a system that has experienced a rapid expansion of large chain-owned for-profits, how have charitable LTCHs remained financially viable, and how robust is their current financial health? As resource dependency theory indicates, organizations will secure resources from their environments as needed and do so in a manner that enhances their position relative to others—which depends on the environment in which they operate (Froelich 1999; Malatesta and Smith 2014). The for-profit component of LTC has maintained financial profitability mainly through consolidation into large chains to capture economies of scale. Given that non-profit homes are more rooted in community, whether that is a place or a faith or ethnocultural community, consolidation to create economies of scale is not a favoured option as it has been for the private sector (Cooper and Maktoufi 2018; Singer and Yankey 1991). Rather, a distinct advantage of charitable LTCHs is their ability to supplement the relatively static provincial revenues with donations, in addition to income earned through the sale of user-pay services. Thus, philanthropy could be a sizable and consistent portion of the total revenues of LTCH charities. Given that earned income has been the fastest-growing source of revenue for the charitable sector over the past decade (Lasby and Barr 2021), we would expect LTCH charities to follow this pattern. In the rest of this article, we examine the patterns and factors in the financial health of Ontario's charitable LTCHs.

Methodology

Our contribution is to analyze how the financial position of Ontario's charitable LTC sector has changed over the past two decades, which we do in three ways. First, we examine the revenues of Ontario's charitable LTCHs since 2004, considering each of the components of government, philanthropy, and earned income. Second, we focus on measures of financial robustness and analyze financial indicators of LTCHs' financial positions. The third component recognizes that the charitable sector is not homogeneous simply because it is not-for-profit. Rather, differences in financial health, particularly the ability to earn discretionary income and raise philanthropic funds, may be influenced by several factors, including facility size and age, urban versus rural location, accreditation status, and faith or ethnocultural affiliation. Consideration of these factors is woven throughout the analysis.

The analysis relies on a panel of the charitable tax return (T3010) data that represents the population of 112 of Ontario's charitable LTCHs from 2004 to 2017.[3] The T3010 includes information on total revenues, as well as revenue from the sale of goods and services, tax-receipted donations, and transfers from other charities (e.g., the fundraising foundations of LTCHs), as well as expenditure and number of employees, which are not part of this analysis. The tax data have been supplemented by information on LTCHs' faith or ethnocultural affiliations, accreditation status, and number of beds gathered from LTCH websites and organizational annual reports, as presented in Table 2.

Revenue Trends

Here we examine the trends of each of the three main sources of revenue: provincial revenues, philanthropy, and earned income, considering differences by type of home where relevant.

Provincial Revenues

As expected, given the dominance of public funding, provincial revenue as a percentage of total revenue is largely stable between 2003 and 2017 for the majority of charitable LTCHs. For most, there has been a slight decline since 2013 that may reflect how they are applying the standardized RAI–MDS assessment that ties funding to the complexity of resident medical needs. However, in the 10th percentile of homes, we observe major variation. From 2004 to 2011, approximately 30 percent of these homes' funding came

Table 2: Ontario Charitable LTCHs by Faith or Ethnocultural Affiliation, Accreditation, and Bed Count, 2017 (N = 112)

LTCH Characteristic	*n* (%)
Religious or ethnocultural affiliation	60 (53.6)
Accredited	71 (63.4)
Bed count	
Small (0–99 beds/home)	44 (39.3)
Medium (100–200 beds/home)	45 (40.2)
Large (> 200 beds/home)	14 (12.5)
Mixed (multiple homes with different bed count)	9 (8.0)

Notes: LTCH = long-term care home.

Source: Ontario Ministry of Health and Long-Term Care (2020, 2022), LTCH websites.

from provincial revenue, whereas from 2014 to 2017 the percentage was nearly zero (Figure 1). The reason for the low proportion of provincial funding for this set of homes pertains to the large amount of income earned from rental units that operate outside the LTC funding regime, as discussed in the Earned Income section. The combination of user-pay rental accommodation and LTC beds increases total revenues for the charity but limits the proportion that is provincial funding.

Philanthropy

The ability to offer tax receipts for donations and to receive gifts from foundations is a distinctive advantage for charitable LTCHs, and as the OANHSS (2000) has indicated, they have been actively pursuing donations through fundraising campaigns for many years. However, the data indicate that philanthropy as a revenue source for non-profit LTC is insignificant, both in amounts and as a percentage of total revenues, and has been in steady decline, as shown in Figure 2. Nearly a quarter of the homes (23.3 percent) issued no tax receipts for charitable gifts from 2009 to 2017. For those that had receipted donations, the vast majority have experienced a consistent decline in the share of revenue they receive from these donations—indeed, in many cases a quite dramatic drop—from the 2003 level. Since 2014, donations have constituted less than 2 percent of total revenues. Support from philanthropy could also come from transfers from other charities, mainly the affiliated fundraising foundations, rather than through donations directly to the homes. However, these transfers are also a small percentage of the revenue portfolio of LTCHs, less than 1 percent of the total revenue for three-quarters of charities, with the 90th percentile receiving between 1 percent and 2.5 percent of revenues from transfers over the study period.

Although a small percentage of the overall revenues, the philanthropy literature suggests that some types of LTCH charities would be more effective at fundraising. In Canada, as elsewhere, charitable giving is highest among those with a faith affiliation and practice and those with a strong community identity (Turcotte 2015). Given that religion remains the dominant destination of charitable giving in Canada, accounting for 31 percent of donations (CanadaHelps 2021), faith- and ethnoculturally affiliated homes may have a pool of committed donors and larger identity-based constituencies from which to fundraise. It is thus anticipated that homes with a religious or specific ethnocultural affiliation will raise higher amounts through donations.[4] Accreditation status is a second factor because accreditation can serve as a signal of or proxy for quality (Prakash and Gugerty 2010), and as Lu (2016) suggests, donations to LTC are sensitive to service quality.

LTC charities with faith or ethnocultural affiliations are more likely to receive donations than their secular counterparts (of those reporting no donations, only 37 percent are faith based), but donations do not constitute

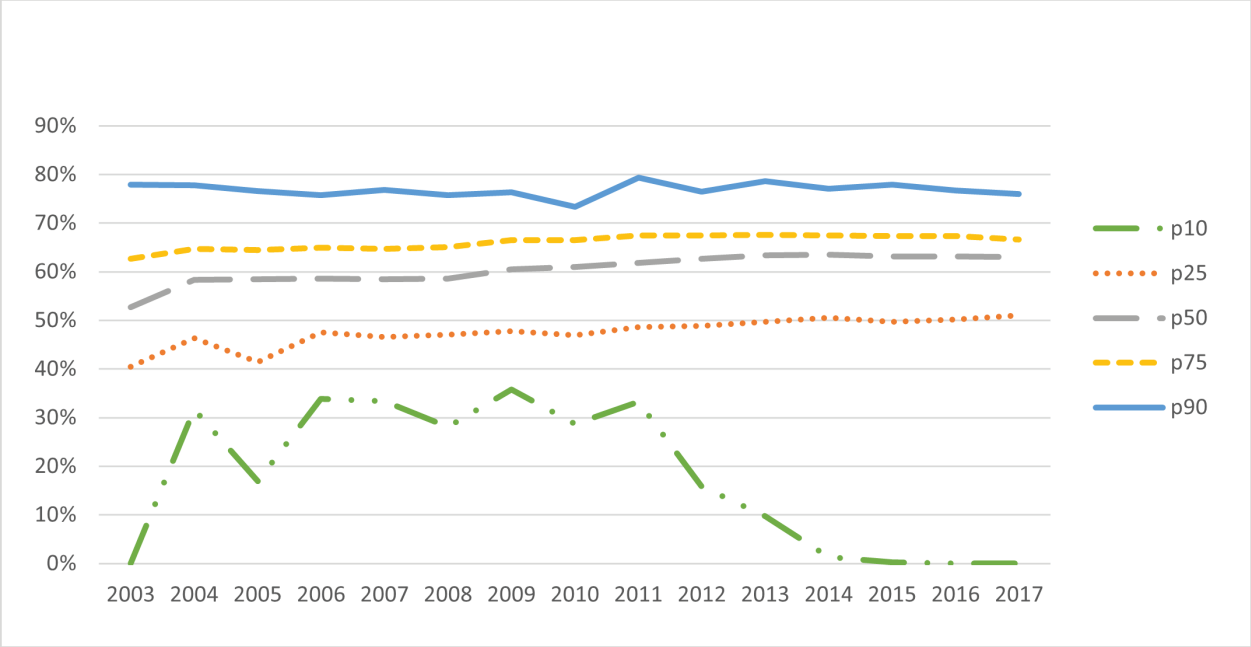

Figure 1: Percentage of Total Revenue of Ontario Charitable LTCHs Provided by Provincial Revenue (2003–2017)

Note: LTCHs = long-term-care homes; p = percentile.

Source: Public data from annual charitable tax returns (T3010) from 2000 to 2017.

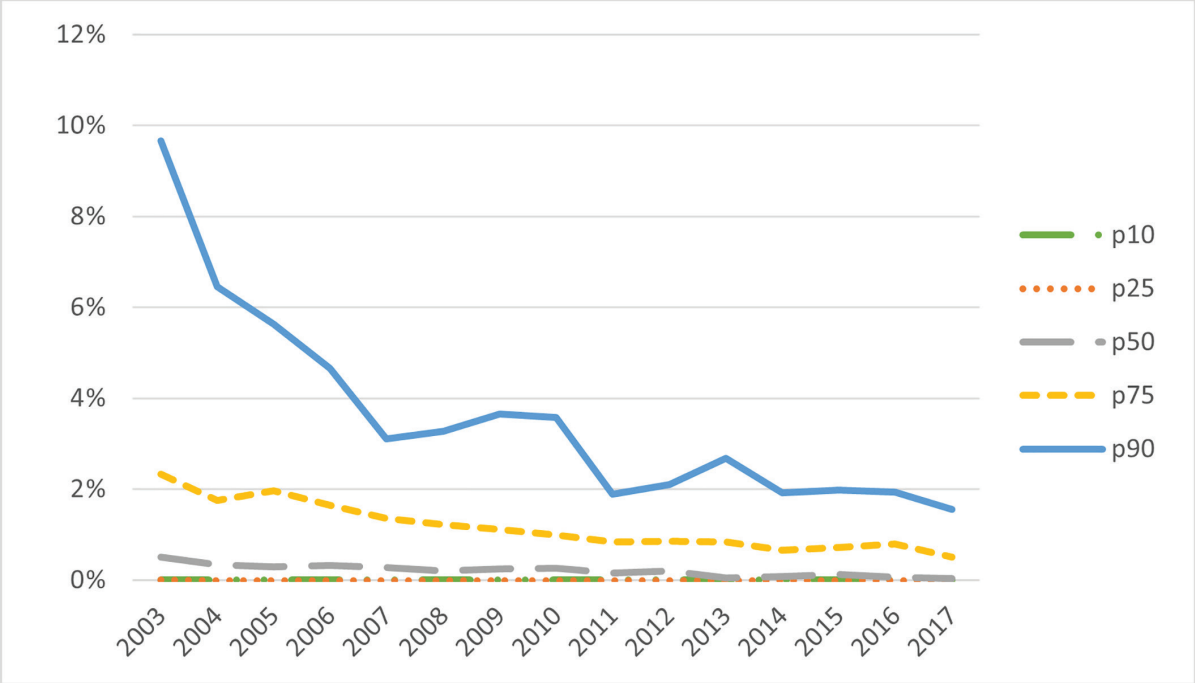

Figure 2: Percentage of Total Revenue of Ontario Charitable LTCHs Provided by Receipted Donations (2003–2017)

Note: The 10th and 25th percentiles are zero, reflecting no revenue from receipted donations for these organizations. LTCHs = long-term-care homes; p = percentile.

Source: Public data from annual charitable tax returns, T3010, from 2000 to 2017.

a larger percentage of their revenues. Accreditation does not appear to be a proxy for quality or trustworthiness in a way that enhances donations: of those homes without donations, 83 percent are accredited.

Earned Income

In contrast to philanthropy, the sale of goods and services, at least for a substantial portion of LTCH charities, has been a growing source of revenue but is highly uneven across homes. As shown in Figure 3, for the 50th percentile, revenues from earned income are less than 5 percent but rising steadily. For this group, the main sources of sales are likely room premiums and optional services paid by residents. Non-profit LTCHs have a higher proportion of single- (50 percent) and double-occupancy (41 percent) rooms than do for-profits (Morrison Park Advisors 2021, 12; Stall et al. 2021), up to 60 percent of which could be offered at premium rates. For example, for a 150-bed home with 75 private rooms, the total annual premium could be more than $740,000.

The opportunity for earned income through the sale of premium rooms should benefit newer homes (because they could be built with a larger portion of such rooms) and larger facilities that can offer a greater number of single rooms.[5] The analysis does not support these propositions, however. A greater percentage of older LTCHs have experienced a rise in earned income over this period (52 percent, vs. 36 percent for new homes), and there is no difference in increase by facility size (the average increase is 35 percent for small, medium, and large homes). A slightly greater proportion of secular and accredited homes have had an increase in earned income since 2009, although the difference between them and their faith-based and unaccredited counterparts is less than 10 percent.

The surprising finding is that in the 90th and 75th percentiles, homes receive about a third of their revenues from earned income, which cannot be accounted for solely by room premiums, hair salons, and related services. We thus dug deeper into this subset of charities with a review of their operations as presented on their websites. Of charitable LTCHs, 46 percent also operate retirement homes, seniors' rental apartments, or both under the same business number and same board of directors as their LTC facility (Table 3); this high earned income subgroup reflects this form of hybrid operation. These ancillary accommodations are often advertised as a continuum of care that enables residents to move from independent living through progressively higher levels of care in the same place. As discussed later, the distinct revenue portfolio of these hybrid LTC–retirement–rental home charities may have different implications for their responsiveness

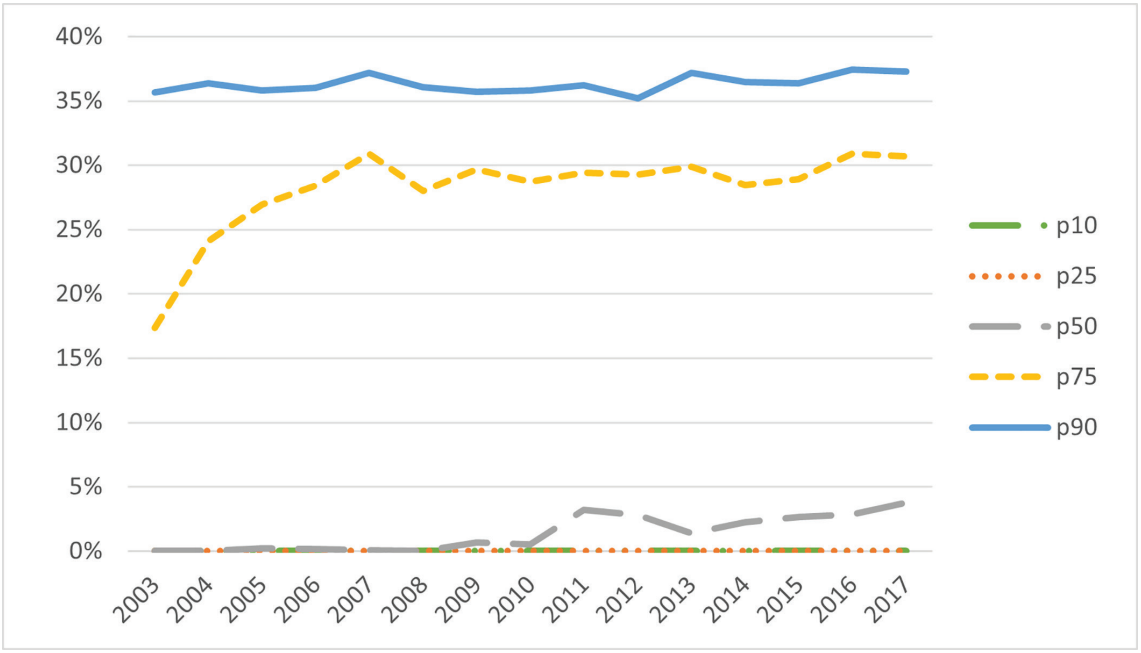

Figure 3: Percentage of Total Revenue of Ontario Charitable LTCHs Provided by Sales of Goods and Services (2003–2017)

Note: The 10th and 25th percentiles are zero, reflecting no revenue from earned income for these organizations. LTCHs = long-term-care homes; p = percentile.

Source: Public data from annual charitable tax returns (T3010) from 2000 to 2017.

Table 3: Ontario Charitable LTCHs that Operate Retirement Homes, Senior Rental Apartments, or Both (*N* = 112)

Homes and Beds	Operate LTCHs and Retirement Homes or Senior Rental Apartments	Stand-Alone LTCH
No. (%)	51 (45.5)	61 (54.5)
No. of LTC beds	7,832	8,794

Note: LTCH = long-term-care home.

Source: Ontario Ministry of Health and Long-Term Care (2020, 2022) and LTCHs' websites.

to expansion of LTC beds than the charities that operate only LTCHs.

Measures of Financial Health

The measurement of financial health represents several dimensions of an organization's operation. This includes its ability to generate support sufficient to maintain operations, sustain shocks, manage debt, maintain a revenue structure, and structure its expenses with a reasonable degree of predictability. For example, in two influential articles, Chang and Tuckman (1991) and Tuckman and Chang (1991) selected four ratios to determine whether a non-profit is financially vulnerable, defined as an organization that is "likely to cut back its service offerings immediately when it experiences a financial shock" (Tuckman and Chang 1991, 445): equity, total surplus divided by total revenue, administrative expenses divided by total expenses, and a Herfindahl index of revenue concentration. Organizations were considered at risk when they were in the bottom quintile for one ratio and severely at risk when they were in the bottom quintile for all four ratios.

We rely on five similar measures to examine the financial condition of Ontario's charitable LTCHs from 2004 to 2017: the savings indicator, which compares revenue and expenses; the defensive interval, which measures liquidity relative to expenses; the equity ratio, which assesses solvency; the administrative expense ratio, which measures percentages of expenses dedicated to management and administration; and the Herfindahl–Hirschman Index (HHI), which measures the diversification of organizations' revenue portfolios.[6] Collectively, these indicators, as presented in Table 4, give a sense of the net income generated by operations, the organization's capacity to sustain these operations in the event of disruptions, the debt reliance of LTCHs, their administrative spending, and their revenue structures.

Although charities would not be expected to attempt to maximize their savings, they are likely to try to break even. A positive value of the savings indicator reflects revenues

Table 4: Ontario Charitable LTCHs' Descriptive Statistics for 2017 Tax Year

Variable	No.	Mean (SD)	Percentile				
			10th	25th	50th	75th	90th
No. of beds	111	142.93 (127.55)	41.00	67.00	120.00	167.00	243.00
Provincial revenue, proportion	105	0.56 (0.22)	0.28	0.53	0.63	0.67	0.76
Receipted donations revenue, proportion	105	0.01 (0.04)	0.00	0.00	0.00	0.00	0.02
Sales of goods and services revenue, proportion	105	0.14 (0.17)	0.00	0.00	0.04	0.31	0.35
Savings indicator	108	0.06 (0.24)	−0.02	0.00	0.02	0.05	0.08
Defensive interval	106	2.82 (3.00)	0.55	1.10	1.96	3.77	5.47
Equity ratio	111	0.23 (0.00)	0.23	0.23	0.23	0.23	0.23
Administrative expense, proportion	109	0.07 (0.08)	0.00	0.03	0.06	0.09	0.15
Herfindahl–Hirschman Index	105	0.52 (0.13)	0.36	0.49	0.52	0.58	0.66

Note: LTCHs = long-term-care homes.

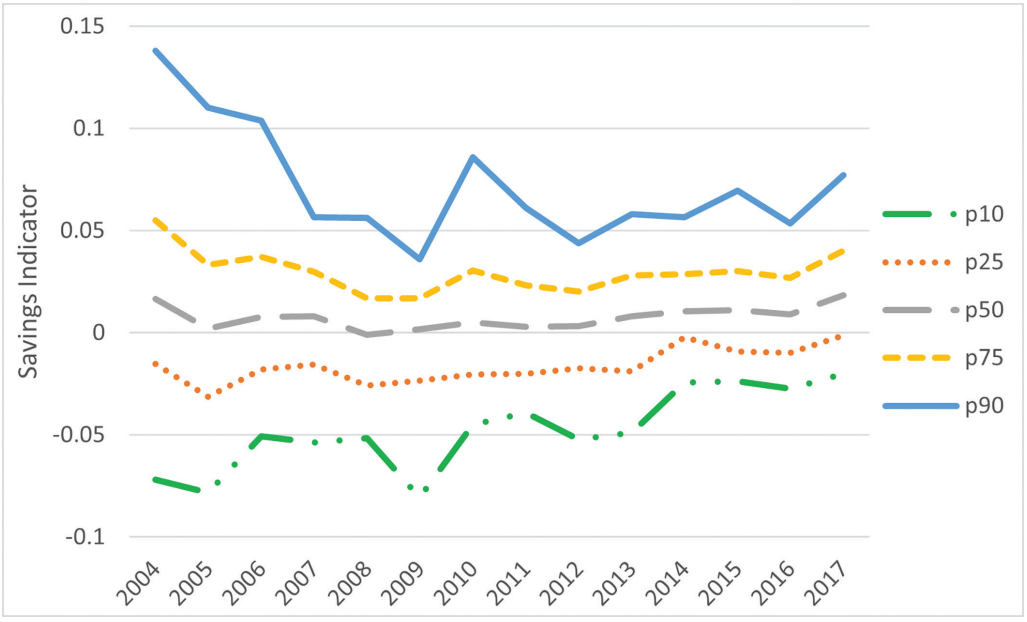

Figure 4: Savings Indicator of Ontario Charitable LTCHs (2004–2017)

Note: LTCHs = long-term-care homes; p = percentile.

Source: Public data from annual charitable tax returns (T3010) from 2000 to 2017.

that exceed expenses; negative values indicate that an organization is spending down its fund balance. Examining Ontario's charitable LTCHs, we see relative stability in the levels of organizations' savings, with median values just above zero, but less variance over time. This includes an improvement in the position of LTCHs with the least savings, as evidenced by the trend in the 10th percentile, although more than one-quarter of LTCHs drew down on their fund balances each year.

The defensive interval compares liquid reserves with organizational expenses, measuring these in the number of months the organization could meet its average expenses if resource flows were interrupted. Although charitable LTCHs would also not be expected to manage to maximize these reserves (Mitchell and Calabrese 2022), they would be expected to attempt to maintain reserves sufficient to sustain the organization for multiple months. Examining the defensive interval from 2004 to 2017, we observe that the median organization held 0.7 months fewer liquid reserves in 2017.

The solvency of LTCHs in this period is relatively stable, except for the most debt-burdened LTCHs. Figure

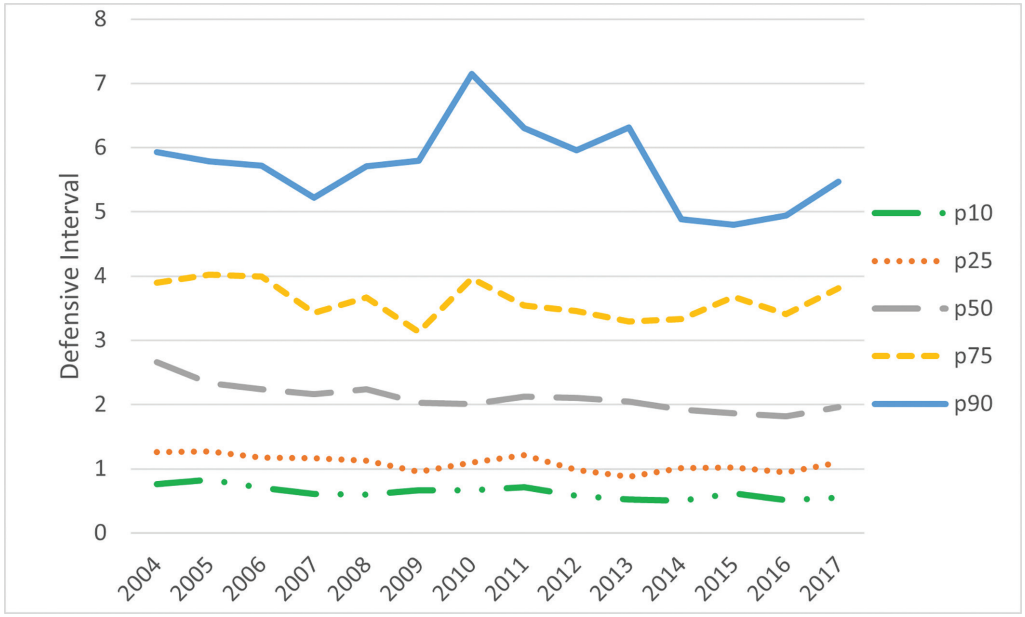

Figure 5: Defensive Interval of Ontario Charitable LTCHs (2004–2017)

Note: LTCHs = long-term-care homes; p = percentile.

Source: Public data from annual charitable tax returns (T3010) from 2000 to 2017.

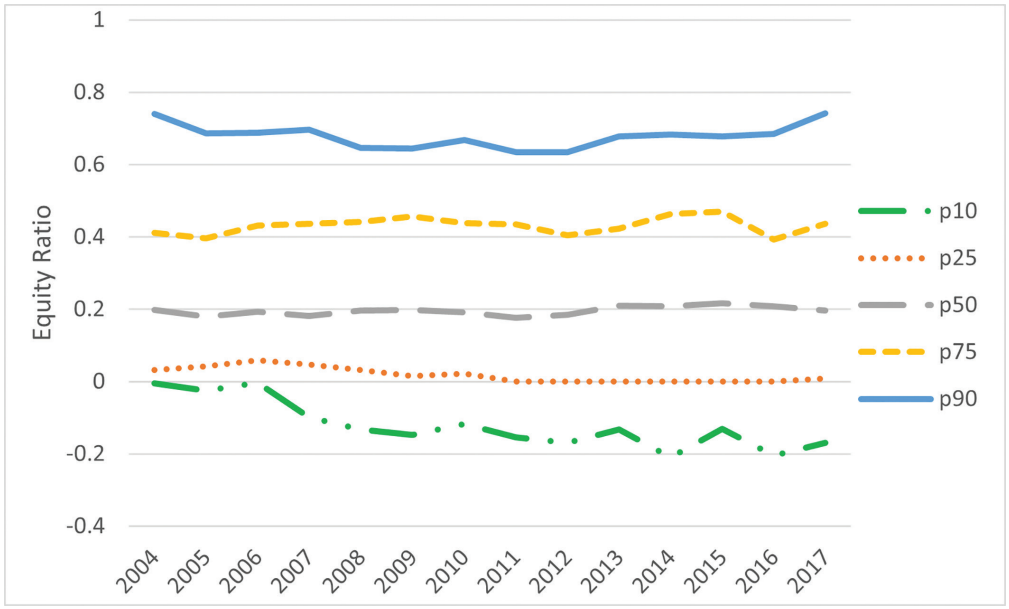

Figure 6: Equity Ratio of Ontario Charitable LTCHs (2004–2017)

Note: LTCHs = long-term-care homes; p = percentile.

Source: Public data from annual charitable tax returns (T3010) from 2000 to 2017.

6 demonstrates the changing position of the LTCHs with the most liabilities, seen in the decreasing 10th percentile. The position of these organizations shifted dramatically after 2006, with the value of their liabilities increasing more than their assets in this period.

The administrative expense ratio for Ontario LTCHs indicates that they report spending little on the management and administration of their organizations, with median values well below 10 percent (see Figure 7). These medians are also well below those reported for the health

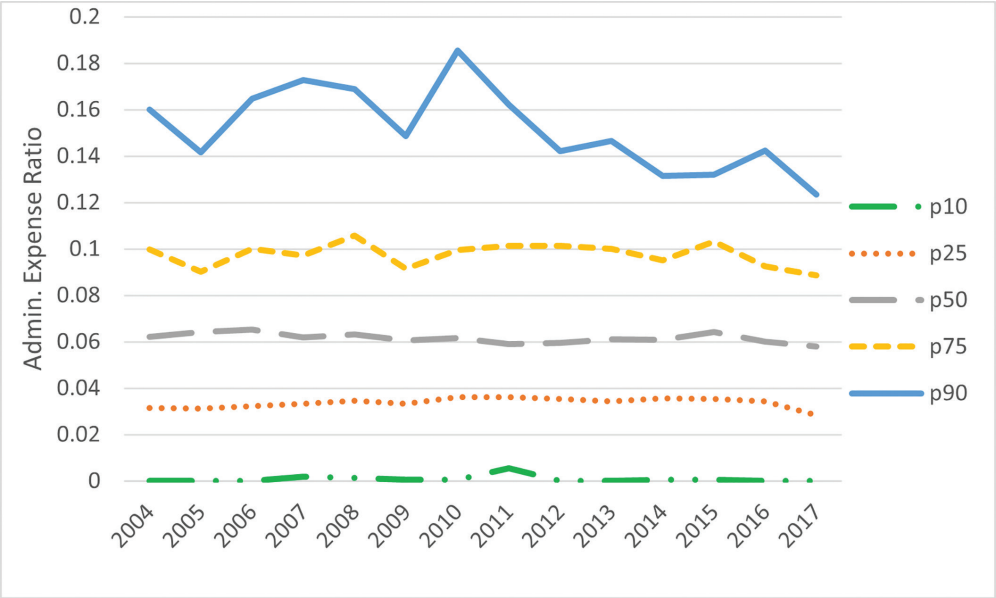

Figure 7: Administrative Expense Ratio of Ontario Charitable LTCHs (2004–2017)

Note: LTCHs = long-term-care homes; p = percentile.

Source: Public data from annual charitable tax returns (T3010) from 2000 to 2017.

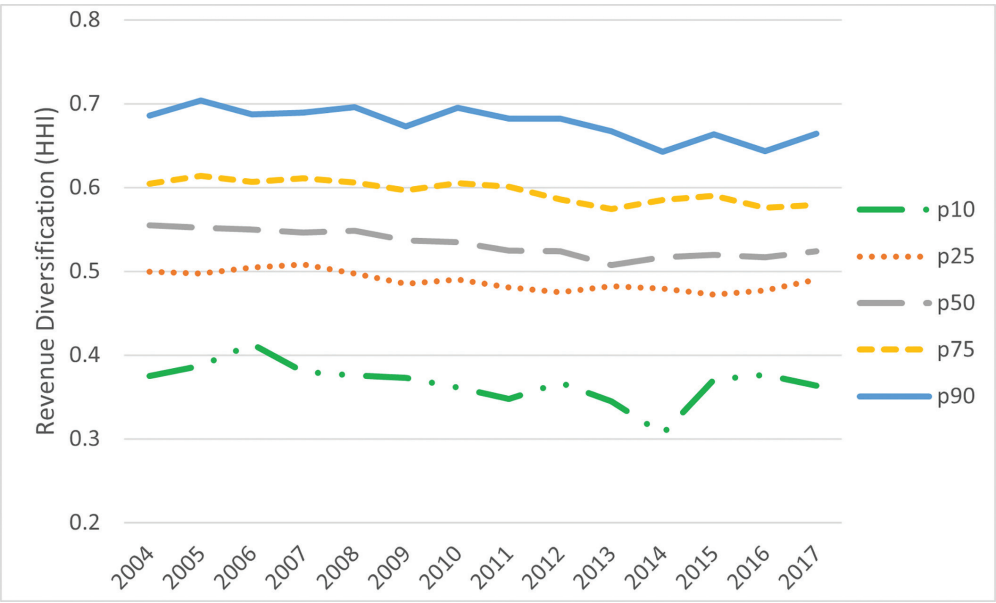

Figure 8: Revenue Diversification of Ontario Charitable LTCHs (2004–2017)

Note: LTCHs = long-term-care homes; p = percentile.

Source: Public data from annual charitable tax returns (T3010) from 2000 to 2017.

sub-sector in other contexts (Greenlee and Bukovinsky 1998; Lecy and Searing 2015).

As shown in Figure 8, the revenue structures of Ontario LTCHs have become more concentrated over time, as demonstrated by the slight decline in HHI values (measuring diversification of revenues) from 2004 to 2017. This effect is concentrated in subgroups of rural LTCHS and among unaccredited organizations.

Discussion

Ontario's regulatory and financing regime for LTC has reinforced path dependency—in which options and outcomes become increasingly channeled and locked in by the system and by an organization's history, making innovation or growth difficult. The growing reliance on provincial funding has concentrated revenue structures, which may increase fragility (Lu, Lin, and Wang 2019). Although relatively stable over the past 15 years, the financial health of charitable LTCHs could not be described as robust. A quarter have drawn down their fund balances year after year, and the differences in savings across homes have diminished over time, suggesting that all are under increased pressure for operational spending. The median charitable LTCH holds less than two months of liquid reserves, which help stabilize finances (Calabrese 2018), whereas a minimum of three months is considered a standard for non-profits (Kim and Mason 2020). Since 2006, the liabilities of a significant portion (the 10th percentile) of LTCHs have increased dramatically relative to their assets. This indicates that it may be very difficult for these homes to borrow further to facilitate expansion or renovations because of limited debt capacity.

We do not observe differences across size categories, as measured in the number of beds. Rural LTCHs may be in a more precarious financial position than their urban counterparts. For a subset of rural homes, the increased revenue concentration has become particularly pronounced, which may be attributed to a variety of factors. Rural LTCHs tend to be small (OLTCA 2018; they have lower annual government per diems per bed (Morrison Park Advisors 2021); there are fewer options for home care and other infrastructure to support aging in place, thus making LTC the only viable option for people with diverse needs; staffing difficulties are significant; and the volunteer base, an essential component of care, is older and shrinking (Skinner and McCrillis 2019).

Limited Philanthropy

An important finding is that, despite ongoing efforts at fundraising, philanthropy is a very small and diminishing component of LTCH revenues. For three-quarters of charitable LTCHs, direct donations now account for less than 2 percent of revenues, and transfers from their fundraising foundations or other charitable organizations account for less than 1 percent. This compares starkly with health care (e.g., hospitals, cancer and heart disease research), which is the destination for 26 percent of charitable giving in Canada, surpassed only by religion and, since the pandemic, by social services (CanadaHelps 2021).

Although it would be difficult to identify and determine non-givers' reasons for not giving, the low and declining rates of philanthropy probably reflect several factors. First, the general donation rate has been declining in Canada for the past 30 years (Lasby and Barr 2018): whereas in 2007, 24 percent of tax filers claimed a charitable credit, in 2017 only 19 percent did so (CanadaHelps 2021). Second, donations are more likely to be made by families or community members than by residents. Only 5 percent of giving in Canada is made through bequests (Canadian Association of Gift Planners 2022), and people entering LTC are now quite frail, with high incidence rates of cognitive impairment, and the length of stay is about two years (Marrocco et al. 2021). An important determinant of giving by family members has been shown to be perceptions of quality and the associated "warm glow" created by trust in a home, whether by direct observation or by a proxy measure, such as accreditation (Lu 2016; Mitchell and Calabrese 2022). However, these positive associations seem to be compromised in the case of LTC. As reported by Ben-Ner, Hamann, and Ren (2018), people are generally unaware of ownership status, or the relationship of non-profit management to quality, and thus may not connect a home with their charitable giving. In addition, the outcomes for residents are not positive—as they often are for hospital treatment—with the result being a sense of loss by families rather than a warm glow that prompts donating.

Finally, the current sector self-regulatory accreditation system is a weak signal of quality. Accreditation, not to be confused with mandatory government licensing, is a voluntary process by which LTCHs apply through Accreditation Canada or the Commission on Accreditation of Rehabilitation Facilities. By any standard of self-regulation, this system is weak, as is the government's financial incentive for attaining certification. Accreditation Canada covers 35 countries with more than 15,000 organizations using its programs, and it offers accreditation to hospitals, prisons, lab and diagnostic facilities, community and social service agencies, and other sub-sectors. Transparency is very limited; any issues identified through the accreditation process are not disclosed other than to the home operator. Couple this with reduced government comprehensive inspection for compliance with quality standards, and the public has little ability to assess quality care, which inhibits philanthropy and which allowed many of the long-standing issues in LTCHs to go undetected until COVID-19 revealed their effects in a dramatic way (Marrocco et al. 2021).

The limited contribution of philanthropy to the financial health of Ontario's LTCHs suggests that it may be difficult for homes to achieve successful capital fundraising campaigns for future development—ancillary support the provincial government appears to be counting on for system expansion.

Implications for Expanding Long-Term Care

In 2025, more than 40 percent of the licenses of Ontario's LTCHs will expire (Office of the Auditor General of Ontario 2021), and the Ontario government has committed

to assisting the development of an additional 10,000 net new beds and more than 12,000 upgraded beds with loan guarantees and subsidies for eligible homes, which after completion of construction can cover up to 60 percent of construction costs (Government of Ontario Newsroom 2022; Howlett 2022). However, Ontario's funding model is premised on attracting equity investors (Armstrong et al. 2021): typically, an organization must raise 30 percent of construction costs and borrow the rest (Howlett 2022). If seeking support from the Canada Mortgage and Housing Corporation, an applicant still needs cash reserves of 15 percent of the mortgage (Armstrong et al. 2021). In contrast to large for-profits, non-profits face major hurdles in securing the upfront capital. As our analysis shows, they have limited reserves to finance such costs, they cannot attract equity investors expecting a return on profits, and they are regularly turned away for mortgages by commercial banks (Advantage Ontario 2022; Armstrong et al. 2021; Morrison Park Advisors 2021). Non-profits also often lack the expertise required to assess community needs, lead new development, or facilitate the use of social investment finance instruments (Advantage Ontario 2022; Jog 2020). The rising cost of land and construction and the effects of higher inflation on the operating side have exacerbated these underlying challenges, and the government subsidy has not kept pace with rising costs (Howlett 2022).

Our analysis indicates that there are two quite different revenue and operational profiles of LTC charities: those that provide only LTC and the hybrids that operate a mix of LTC, retirement homes, and other rental housing for seniors. For most LTC charities, earned income (from room premiums and other resident-pay services) is only about 5 percent of their revenue portfolios and, although rising, does not appear to inject significant financial slack (Cyert and March 1963). The situation is quite different for almost half of Ontario charities that have mixed LTC and other rental accommodation because their financial health is highly dependent on these other rental sources of income. Thus, the incentives to expand the LTC component of their facilities may be different and even more constrained than their specialized LTC counterparts. The regulatory environment in which these hybrids operate is complicated because of the split oversight of the Ministry of Health, Ministry of Municipal Affairs and Housing, and the Retirement Homes Regulatory Authority. Financing needs to be coordinated across different sets of funders, and expanding the ancillary rental accommodation—which represents such a large portion of their income—does not qualify for loan guarantees. As the non-profit long-term-care industry association, Advantage Ontario (2022), argues, there is a "missing middle" of funding to support accommodation that enables people to age in place because lenders assume increased levels of care are available in an LTCH. Yet, these charities value and widely advertise the benefits of an integrated continuum of care: without financial support for the missing (and financially important) middle, the case for extending the LTC end of this continuum may not be strong. In addition, the cost of complying with the new regulations under the *Fixing Long-Term Care Act* is estimated to be between $590,000 to $650,000 per home annually (Advantage Ontario 2022), which acts as a further disincentive to expanding the LTC side of their operations.

The conclusion reached by the Office of the Auditor General of Ontario (2021, 37) is that it is uncertain whether LTCH operators will be able to raise the necessary funds to expand or renovate their facilities. The contribution of our analysis has been to assess the financial health of charitable LTCHs, demonstrating that Ontario's policy regime has made this component of LTC highly dependent on provincial revenues. As a result of the increased concentration of revenues, any change in government funding formulas will have a significant impact on charitable LTCHs. The long-standing implicit assumption that donations provide a financial cushion for charitable LTCHs that facilitate enhanced operations or expansion is no longer valid. With the commitment to fix the LTC system post-pandemic, policy change needs to proceed with caution, recognizing the substantial differences between the non-profit, municipal, and for-profit parts of the system as well as the differences within the charitable component. The challenges of financing expansion for non-profits points to the need to break out of the traditional categories of non-profit and for-profit homes, for instance by following the recommendation of the Long-Term Care Commission (Marrocco et al. 2021) to separate the building and maintenance of homes—which could be undertaken by profit-focused entities—from care delivery, as already occurs with hospitals.

Limitations

Although our analysis is the first to provide a close examination of the financial health of non-profit LTCHs, it has several limitations. First, we focus on revenues without a nuanced assessment of expenditures. Given the reliance on the charitable tax return data, the study is limited to LTCHs operating as registered charities and does not take into account non-profits that are not charities or differentiate among multiple homes operating under a single business number. The analysis is confined to Canada's largest province and, given differences in provincial care systems, the financial health of non-profit LTCHs in other provinces may differ from that of those in Ontario. Moreover, the data (which are the latest set of tax data available at the time) are pre-pandemic and do not capture the enormous disruptions in operations caused by COVID-19. Finally, the analysis does not attempt to address the differences in finances or quality of care between non-profit

and for-profit LTC providers or the broader question of whether for-profit provision should be curtailed—a question that is taken up by a substantial literature (Armstrong et al. 2021; Pue et al. 2021).

Conclusion

The evolution of the policy, regulatory, and financing regime for LTC has created a path-dependent system. Over time, financial and regulatory parity between non-profit and for-profit LTC providers and fixed-formula provincial funding has produced a pattern of general stability in the financing of non-profit LTCHs. Our analysis indicates, however, that the financial robustness of charitable homes has become more constrained over time with greater revenue dependency on government and declining philanthropy. Rural homes may be in a particularly precarious financial situation, although their situation needs more investigation.

The COVID-19 pandemic created a critical juncture in LTC that revealed the flaws in existing policies (Béland and Marier 2020) and has opened a "window of opportunity to make once-in-a-generation changes" (Tuohy 2021) to the policy and financing frameworks. The path forward on which the Ontario government is launched includes an extensive expansion of the number of beds and the renovation of older homes to meet modern care standards. If such development is to be taken up by non-profit LTCHs, rather than merely further extending the dominance of chain-owned for-profits, the ability and willingness of non-profits to take up loan guarantees and access capital financing needs to be better understood. Just increasing the number of beds will not address the inadequacy of LTC, however. The once-in-a-generation fix also involves addressing the workforce crisis, stronger and more integrated infrastructure for aging in place, improved financing, and stronger accreditation and regulation (Ontario 2022). Our case is that to truly reform the system, the financial health of the non-profit component of LTC requires better data, more sophisticated analyses, and evidence-based policy action.

Acknowledgements

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Notes

1 The market-based managed competition model for home care was abandoned, and the CCACs were absorbed into the 14 existing Local Health Integration Networks (LHINs) in 2017, although the delivery system had already been recast as a more concentrated, largely for-profit–dominant configuration. In 2021, health system planning and funding responsibilities were transferred from the LHINs to Ontario Health.

2 Retirement homes provide rental accommodation, with some services but without regular nursing care, for seniors who can live independently with minimal support and who self-fund the accommodation.

3 The T3010 data set provided by the Charities Directorate, Canada Revenue Agency, was first cleaned to correct its numerous errors and arranged as panel data that can be assessed by individual charity under Social Sciences and Humanities Research Council Grant No. 435-2018-1214. The data include only registered charities and omit the LTC homes run by non-profits that are not charities. The entities are represented by the business number (BN) of the registered charity; some operate more than one home under the same BN, but these are counted as one organization because they operate under the same governance structure. Note that the T3010 data do not separate revenues for construction from overall revenues.

4 We determine the faith or ethnocultural affiliation of non-profit LTCHs on the basis of a review of the individual homes' websites. We include specified populations, for example, Deaf Canadians or veterans, in the category of faith- or ethnoculturally affiliated homes.

5 Facility size is categorized as large (more than 200 beds), medium (100–200 beds), or small (fewer than 100 beds); age is divided into old building design when built to the 1972 structural classifications standard, containing "C" beds, which include homes that may have four-person shared wards, or "D" beds, which do not meet the 1972 standard (fewer than 1,300 LTCHs for all ownership types have D beds), and newer building design when meeting or exceeding the 1972 structural classifications and having only new, "A" or "B" beds.

6 Savings indicator = (total revenue – total expenses)/total expenses (Greenlee and Bukovinsky 1998); defensive interval = (cash + marketable securities + receivables)/average monthly expenses (Greenlee and Bukovinsky 1998); equity ratio = assets – liabilities/assets (Bowman 2011); administrative expense ratio = management and administrative expenses/total expenses; and HHI = $(1 - \left(\sum_{i=1}^{n} Ri^2\right))/((n - 1)/n)$. HHI includes receipted gifts, amounts from other registered charities, unreceipted gifts, federal revenue, provincial revenue, municipal or regional government revenue, revenue from interest or investments, gross income from the rental of land or buildings, unreceipted revenues from dues or association fees, unreceipted revenue from fundraising, revenue from the sales of goods or services, and other revenues.

References

Advantage Ontario. 2022. "Advantage Ontario Feedback on Access to Provincial Financing for Not-for-Profit Housing Providers." At https://advantageontario.informz.ca/advantageontario/data/images/AdvantAge%20Ontario%20Feedback%20on%20Access%20to%20Provincial%20Financing%20for%20NFP%20Providers.pdf.

Armstrong, H., T. Daly, and J.A. Choiniere. 2016. "Policies and Practices: The Case of RAI-MDS in Canadian Long-Term Care Homes." *Journal of Canadian Studies* 50(2):348–67. https://doi.org/10.3138/jcs.50.2.348.

Armstrong, P., H. Armstrong, D. Buchanan, T. Dean, G. Donner, A. Donner, S. Scholzberg-Gray, A. Himelfarb, and S. Shiryb-

man. 2021. *Investing in Care, Not Profit: Recommendations to Transform Long-Term Care in Ontario*. Ottawa: Canadian Centre for Policy Alternatives. At https://policyalternatives.ca/sites/default/files/uploads/publications/Ontario%20Office/2021/05/Investing%20in%20care%20not%20profit%20report.pdf.

Armstrong, P., H. Armstrong, M. MacDonald, and M. Doupe. 2020. "Privatization of Long-Term Residential Care in Canada: The Case of Three Provinces." In *The Privatization of Care: The Case of Nursing Homes*, ed. P. Armstrong and H. Armstrong, 87–101. London: Routledge.

Association of Municipalities of Ontario (AMO). 2011. "Coming of Age: The Municipal Role in Caring for Ontario's Seniors—An AMO Paper on Long-Term Care and Senior Services." Toronto: AMO. At https://www.amo.on.ca/sites/default/files/assets/DOCUMENTS/Reports/2011/ComingofAgetheMunicipalRoleinCaringforOntariosSeniors2011.pdf.

Baum, J.A.C. 1999. "The Rise of Chain Nursing Homes in Ontario, 1971–1996." *Social Forces* 78(2):543–83. https://doi.org/10.2307/3005567.

Bekkers, R., and P. Wiepking. 2011. "A Literature Review of Empirical Studies of Philanthropy: Eight Mechanisms That Drive Charitable Giving." *Nonprofit and Voluntary Sector Quarterly* 40(5):924–73. https://doi.org/10.1177/0899764010380927.

Béland, D. and P. Marier. 2020. "COVID-19 and Long-Term Care Policy for Older People in Canada." *Journal of Aging & Social Policy* 32(4–5):358–64. https://doi.org/10.1080/08959420.2020.1764319.

Ben-Ner, A., D.J. Hamann, and T. Ren. 2018. "Does Ownership Matter in the Selection of Service Providers? Evidence from Nursing Home Consumer Surveys." *Nonprofit and Voluntary Sector Quarterly* 47(6):1271–95. https://doi.org/10.1177/0899764018790698.

Berta, W., A. Laporte, and V. Valdmanis. 2005. "Observations on Institutional Long-Term Care in Ontario: 1996–2002." *Canadian Journal of Aging/La revue canadienne du vieillissement* 24(1) :71–84. https ://doi.org/10.1353/cja.2005.0002.

Bowman, W. 2011. *Finance Fundamentals for Nonprofits: Building Capacity and Sustainability*. Hoboken, NJ: Wiley.

Breeze, B. 2010. *How Donors Choose Charities: Finding of a Study of Donor Perceptions of the Nature and Distribution of Charitable Benefit*. London: Centre for Charitable Giving and Philanthropy.

Calabrese, T.D. 2018. "Do Operating Reserves Stabilize Spending by Nonprofit Organizations?" *Nonprofit Management and Leadership* 28(3):295–311. https://doi.org/10.1002/nml.21282.

Canada. 1985. *Canada Health Act*. RSC, 1985, c C-6.

Canada. 1993. *North American Free Trade Agreement Implementation Act*. SC 1993, c 44.

CanadaHelps. 2021. *The Giving Report 2021*. Toronto: CanadaHelps. At https://www.canadahelps.org/en/the-giving-report/.

Canadian Association of Gift Planners (CAGP). 2022. "Will Power." Ottawa: CAGP. At https://www.cagp-acpdp.org/en/will-power.

Canadian Institute for Health Information (CIHI). 2021a. "COVID-19's Impact on Long-Term Care." Ottawa: CIHI At https://www.cihi.ca/en/covid-19-resources/impact-of-covid-19-on-canadas-health-care-systems/long-term-care.

Canadian Institute for Health Information (CIHI). 2021b. *The Impact of COVID-19 on Long-Term Care in Canada: Focus on the First 6 Months*. Ottawa: CIHI. At https://www.cihi.ca/sites/default/files/document/impact-covid-19-long-term-care-canada-first-6-months-report-en.pdf.

Chang, C.F., and H.P. Tuckman. 1991. "Financial Vulnerability and Attrition as Measures of Nonprofit Performance." *Annals of Public and Cooperative Economics* 62(4):655–72. https://doi.org/10.1111/j.1467-8292.1991.tb01372.x.

Cloutier-Fischer, D., and A.E. Joseph. 2000. "Long-Term Care Restructuring in Rural Ontario: Retrieving Community Service User and Provider Narratives." *Social Science & Medicine* 50(7–8):1037–45. https://doi.org/10.1016/s0277-9536(99)00353-6.

Comondore, V.R., P.J. Devereaux, Q. Zhou, S.B. Stone, J.W. Busse, N.C. Ravindran, K.E. Burns, T. Haine, B. Stringer, D.J. Cook, et al. 2009. "Quality of Care in for-Profit and Not-for-Profit Nursing Homes: Systematic Review and Meta-Analysis." *BMJ* 2009:339. https://doi.org/10.1136/bmj.b2732.

Cooper, K.R., and R. Maktoufi. 2018. "Identity and Integration: The Roles of Relationship and Retention in Nonprofit Mergers." *Nonprofit Management and Leadership* 30(2):299–319. https://doi.org/10.1002/nml.21382.

Cyert, R.M., and J.G. March. 1963. *A Behavioral Theory of the Firm*. Englewood Cliffs, NJ: Prentice-Hall.

Daly, T. 2015. "Dancing the Two-Step in Ontario's Long-Term Care Sector: More Deterrence-Oriented Regulation = Ownership and Management Consolidation." *Study Political Economy* 95(1):29–58. https://doi.org/10.1080/19187033.2015.11674945.

Estabrooks, C.A, P. Armstrong, V. Boscart, G. Donner, F. Ducharme, C. Flood, J. Keefe, J. Silvius, S. Straus, and M. Wolfson. 2020. *Restoring Trust: COVID-19 and the Future of Long-Term Care*. Ottawa: Royal Society of Canada. At https://rsc-src.ca/en/covid-19-policy-briefing/long-term-care/restoring-trust-covid-19-and-future-long-term-care.

Froelich, K. 1999. "Diversification of Revenue Strategies: Evolving Dependence in Nonprofit Organizations." *Nonprofit and Voluntary Sector Quarterly* 28(3):246–68. https://doi.org/10.1177/0899764099283002.

Government of Ontario Newsroom. 2021. "Ontario Supporting Not-for-Profit Long-Term Care Homes." Ottawa: Government of Ontario Newsroom. At https://news.ontario.ca/en/release/1001267/ontario-supporting-not-for-profit-long-term-care-homes.

Government of Ontario Newsroom. 2022. "Ontario Building New Not-For-Profit Long-Term Care Beds in Toronto." Ottawa: Government of Ontario Newsroom. At https://news.ontario.ca/en/release/1001728/ontario-building-new-not-for-profit-long-term-care-beds-in-toronto.

Greenlee, J.S., and D. Bukovinsky. 1998. "Financial Ratios for Use in the Analytical Review of Charitable Organizations." *Ohio CPA Journal* 95(1):29–58. https://doi.org/10.1080/1918/19187033.2015.11674945.

Hansmann, H. 1980. "The Role of Nonprofit Enterprise." *Yale Law Journal* 89(5):835–902. https://doi.org/10.2307/796089

Hirdes, J.P., G. Duncan, J.K. Sinclair, J. King, P. Tuttle, and J. McKinley. 2003. "From Anecdotes to Evidence: Complex Continuing Care at the Dawn of the Information Age in Ontario." In *Implementing the Resident Assessment Instrument: Case Studies of Policymaking for Long-Term Care in Eight Countries*, ed. B.E. Fries and C.J. Fahey, 46–66. New York: Milbank Memorial Fund.

Howlett, K. 2022. "How Ontario's Elder-Care Policies Favour For-Profit Homes." *Globe and Mail*, 21 May. At https://www.theglobeandmail.com/canada/article-how-ontarios-elder-care-policies-favour-for-profit-homes/.

Hung, C., and M.A. Hager. 2018. "The Impact of Revenue Diversification on Nonprofit Financial Health: A Meta-Analysis." *Nonprofit and Voluntary Sector Quarterly* 48(1): 5–27. https://doi.org/10.1177/0899764018807080.

Jenson, J., and S.D. Phillips. 2000. "Distinctive Trajectories: Homecare and the Voluntary Sector in Quebec and Ontario." In *The Nonprofit Sector in Canada*, ed. K.G. Banting, 29–67. Montreal and Kingston: McGill-Queen's University Press.

Jog, A. 2020. *Are Charities Ready for Social Finance? Investment Readiness in Canada's Charitable Sector*. Toronto: Imagine Canada.

Kim, M., and D.P. Mason. 2020. "Are You Ready: Financial Management, Operating Reserves, and the Immediate Impact of COVID-19 on Nonprofits." *Nonprofit and Voluntary Sector Quarterly* 49(6):1191–209. https://doi.org/10.1177/0899764020964584.

Lasby, D., and C. Barr. 2018. *Thirty Years of Giving in Canada: The Giving Behaviour of Canadians: Who Gives, Why and How?* Toronto and Ottawa: Imagine Canada and Rideau Hall Foundation.

Lasby, D., and C. Barr. 2021. "State of the Sector and Public Opinion about the Sector." In *Intersections and Innovations: Change for Canada's Voluntary and Nonprofit Sector*, ed. S.D. Phillips and B. Wyatt, 1–46. Edmonton, AB: Muttart Foundation.

Lecy, J., and Searing, E. 2015. "Anatomy of the Nonprofit Starvation Cycle: An Analysis of Falling Overhead Ratios in the Nonprofit Sector." *Nonprofit and Voluntary Sector Quarterly* 44(3):539–63. https://doi.org/10.1177/0899764014527175.

Lu, J., W. Lin, and Q. Wang. 2019. "Does a More Diversified Revenue Structure Lead to Greater Financial Capacity and Less Vulnerability in Nonprofit Organizations? A Bibliometric and Meta-Analysis." *Voluntas* 30(3):593–609. https://doi.org/10.1007/s11266-019-00093-9.

Lu, S.F. 2016. "The Role of Donations in Quality Disclosure: Evidence from Nonprofit Nursing Homes." *American Journal of Health Economics* 2(4):431–62. https://doi.org/10.1162/ajhe_a_00057.

Malatesta, D., and C.R. Smith. 2014. "Lessons from Resource Dependency Theory for Contemporary Public and Nonprofit Management." *Public Administration Review* 74(1):14–25. https://doi.org/10.1111/puar.12181.

Marrocco, F.N., A. Coke, and J. Kitts. 2021. *Ontario's Long-Term Care COVID-19 Commission: Final Report*. Toronto: Ontario's Long-Term Care COVID-19 Commission. At http://www.ltccommission-commissionsld.ca/report/pdf/20210623_LTCC_AODA_EN.pdf.

McGregor, M.J., R.B. Tate, K.M. McGrail, L.A. Ronald, L.A. Broemeling, and M. Cohen. 2006. "Care Outcomes in Long-Term Care Facilities in British Columbia, Canada: Does Ownership Matter?" *Medical Care* 44(10):929–35. https://doi.org/10.1097/01.mlr.0000223477.98594.97.

Meadus, J.E. 2010. "A Brand New World: Ontario's New Long-Term Care Homes Act." *ACE Newsletter*, October. At http://www.acelaw.ca/appimages/file/ACE_Newsletter_LTCHA_Insert_October_2010(1).pdf.

Mitchell, G.E., and T. Calabrese. 2022. "The Hidden Cost of Trustworthiness." *Nonprofit and Voluntary Sector Quarterly*. Published Online First, 9 May. https://doi.org/10.1177/08997640221092794.

Morrison Park Advisors. 2021. *Long-Term Care in Ontario: Funding, Incentives and Attracting Capital*. Toronto: Morrison-Park Advisors. At http://www.ltccommission-commissionsld.ca/presentations/pdf/Morrison_Park_March_5_2021.pdf.

National Institute on Ageing. 2022. "NIA Long Term Care COVID-19 Tracker." At https://ltc-covid19-tracker.ca/.

Office of the Auditor General of Ontario. 2021. *COVID-19 Preparedness and Management: Special Report on Pandemic Readiness and Response in Long-Term Care*. Toronto: Office of the Auditor General of Ontario. At https://www.auditor.on.ca/en/content/specialreports/specialreports/COVID-19_ch5readinessresponseLTC_en202104.pdf.

Ontario. 1949. *The Homes for the Aged Act*, SO 1949, c 41, s 11.

Ontario. 1972. The Nursing Homes Act, SO 1972. c 11.

Ontario. 1993. Long-Term Care Statute Law Amendment Act. SO 1993, c 2.

Ontario. 2007. *Long-Term Care Homes Act*. SO 2007, c 8. At https://www.ontario.ca/laws/statute/07l08.

Ontario. 2010. *Retirement Homes Act, 2010*. SO 2010, c 11.

Ontario. 2022. *Fixing Long Term Care Act, 2021*. SO 2021, c 39, Sched 1.

Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS). 2000. *2000 Annual Report*. Woodbridge, ON: OANHSS.

Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS). 2004. *2004 Annual Report*. Woodbridge, ON: OANHSS.

Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS). 2007. *2007 Annual Report*. Woodbridge, ON: OANHSS.

Ontario Health Coalition. 2002. "Ownership Matters: Lessons from Ontario's Long-Term Care Facilities." Toronto: Ontario Health Coalition. At http://www.ontariohealthcoalition.ca/wp-content/uploads/Full-Report-May-2002-Ownership-Matters.pdf.

Ontario Long Term Care Association (OLTCA). 2018. "This Is Long-Term Care." Toronto: OLTCA. At https://www.oltca.com/OLTCA/Documents/OLTCA_LTC101_May2018.pdf.

Ontario Nursing Home Association (ONHA). 1999. *Compassionate Journey: 40 Years of ONHA*." Markham, ON: HLR Publishing Group.

Ontario Ministry of Health and Long-Term Care (MOHLTC). 2020. *LTCHRB Homes Report 2020-05-19-LTC Homes*. Toronto: The Ministry.

Ontario Ministry of Health and Long-Term Care (MOHLTC). 2022. "Reports on Long-Term Care Homes." Toronto: The Ministry. At http://publicreporting.ltchomes.net/en-ca/default.aspx.

Pedersen, K., M. Mancini, and D. Common. 2020. "Ontario Scaled Back Comprehensive, Annual Inspections of Nursing Homes to Only a Handful Last Year." *CBC News*, 15 April. At https://www.cbc.ca/news/canada/seniors-homes-inspections-1.5532585.

Picard, A. 2021. *Neglected No More: The Urgent Need to Improve the Lives of Canada's Elders in the Wake of a Pandemic*. Toronto: Penguin Random House.

Prakash, A., and M.K. Gugerty. 2010. "Trust But Verify? Voluntary Regulation Programs in the Nonprofit Sector." *Regulation and Governance* 4(1):22–47. https://doi.org/10.1111/j.1748-5991.2009.01067.x.

Public Health Ontario. 2022. "Daily Epidemiological Summary COVID-19 in Ontario January 15, 2020–February 14, 2022." Toronto: Public Health Ontario. At https://files.ontario.ca/moh-covid-19-report-en-2022-02-15.pdf.

Pue, K., D. Westlake, and A. Jansen. 2021. "Does the Profit Motive Matter? COVID-19 Prevention and Management in Ontario Long-Term-Care Homes." *Canadian Public Policy/Analyse de politiques* 47(3):421–38. https://doi.org/10.3138/cpp.2020-151.

Sharkey, S. 2008. *People Caring for People: Impacting the Quality of Life and Care of Residents in Long-Term Care Homes: A Report of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario*. Toronto: Ministry of Health and Long-Term Care.

Sinclair, D.G., M. Rochon, and P. Leatt. 2006. "Riding the Third Rail: The Story of Ontario's Health Services Restructuring Commission, 1996–2000." Montreal: Institute for Research on Public Policy. At https://irpp.org/research-studies/riding-the-third-rail/.

Singer, M.I., and J.A. Yankey. 1991. "Organizational Metamorphosis: A Study of Eighteen Nonprofit Mergers, Acquisitions, and Consolidations." *Nonprofit Management & Leadership* 1(4):357–69. https://doi.org/10.1002/nml.4130010406.

Skinner, M.W., and E. McCrillis. 2019. *Services for an Aging Rural Population & Northern Perspective*. Guelph: Rural Ontario Institute.

Skinner, M.W., and M.W. Rosenberg. 2006. "Managing Competition in the Countryside: Non-Profit and For-Profit Perceptions of Long-Term Care in Rural Ontario." *Social Science & Medicine* 63(11):2864–76. https://doi.org/10.1016/j.socscimed.2006.07.028.

Stall, N.M., K.A. Brown, A. Maltsev, A. Jones, A.P. Costa, V. Allen, A.D. Brown, G.A. Evans, D.N. Fisman, J. Johnstone, et al. 2021. "COVID-19 and Ontario's Long-Term Care Homes." Ontario COVID-19 Science Advisory Table. https://doi.org/10.47326/ocsat.2021.02.07.1.0.

Stevenson, D.G., J.S. Bramson, and D.C. Grabowski. 2013. "Nursing Home Ownership Trends and Their Impacts on Quality of Care: A Study Using Detailed Ownership Data from Texas." *Journal of Aging & Social Policy* 25(1):30–47. https://doi.org/10.1080/08959420.2012.705702.

Struthers, J. 1997. "Reluctant Partners: State Regulation of Private Nursing Homes in Ontario, 1941–1972." In *The Welfare State in Canada: Past, Present, and Future*, ed. R.B. Blake, P.E. Bryden, and J.F. Stain, 171–92. Concord, ON: Irwin Publishing.

Tuckman, H.P., and C.F. Chang. 1991. "A Methodology for Measuring the Financial Vulnerability of Charitable Nonprofit Organizations." *Nonprofit and Voluntary Sector Quarterly* 20(4):445–60. https://doi.org/10.1177/089976409102000407.

Tuohy, C.H. 2021. "Federalism as a Strength: A Path toward Ending the Crisis in Long-Term Care." IRPP Insight No. 36. Montreal: Centre of Excellence on the Canadian Federation. At https://centre.irpp.org/research-studies/federalism-as-a-strength-a-path-toward-ending-the-crisis-in-long-term-care/.

Turcotte, M. 2015. *Volunteering and Charitable Giving in Canada*. Cat. No. 89-652-X201500. Ottawa: Statistics Canada. At https://www150.statcan.gc.ca/n1/en/pub/89-652-x/89-652-x2015001-eng.pdf?st=DNhDWUkH.

Weisbrod, B.A. 1975. "Toward a Theory of the Voluntary Nonprofit Sector in a Three-Sector Economy." In *Altruism, Morality and Economic Theory*, ed. E.S. Phelps. New York: Russell Sage, 171–195.

Wells, P. 2020. "The Endless Crisis in Ontario's Long-Term Care." *Maclean's*, 27 May. At https://www.macleans.ca/politics/the-endless-crisis-in-ontarios-long-term-care/.

Williams, A.P., J. Lum, F. Morton-Chang, K. Kuluski, A. Peckham, N. Warrick, and A. Ying. 2016. *Integrating Long-Term Care into a Community-Based Continuum: Shifting from "Beds" to "Places."* IRPP Study No. 59. Montreal: Institute for Research on Public Policy.

Yakerson, A. 2019. "Home Care in Ontario: Perspectives on Equity." *International Journal of Health Services* 49(2):260–72. https://doi.org/10.1177/0020731418804403.

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