RESOURCE ALLOCATION IN ONTARIO LONG-TERM CARE FACILITIES

POLITICAL ECONOMY OF RESOURCE ALLOCATION IN ONTARIO LONG-TERM CARE FACILITIES:

HOW DOES FUNDING AFFECT THE RISK OF MISTREATMENT?

By SAMANTHA POLLEX, B.A.

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Lay Abstract

This paper examines the funding procedure in Ontario long-term care facilities and seeks to identify whether current resources for protecting the elderly from mistreatment is allocated fairly and effectively. The topic is viewed through the lens of the COVID-19 pandemic. The analysis of the five expert interviews identified four themes including whether the issue is under-resourced, poor allocation of resources; funding according to need; the struggle to define and assess the quality of care; and general work conditions in long-term care. The result of this research will help us to better understand the resource allocation of Ontario long-term care facilities which could in turn highlight improvements that could be made to create better quality of life for residents as well as frontline workers.

ABSTRACT

This paper examines the funding procedure in Ontario long-term care facilities and seeks to identify whether current resources for protecting the elderly from mistreatment is allocated fairly and effectively. The research also observes how the political economy may influence the needs-based allocation built to protect seniors from mistreatment in institutional care settings and the consequences of these resources on residents' autonomy. The topic is also viewed through the lens of the current COVID-19 pandemic.

Five experts in the area of long-term care participated in this research work including academics, scholars and institutional or agency advocates. Interviews lasting up to 60 minutes interviews were conducted, transcribed and analyzed using a political economy lens. Participants described their knowledge and experience with the funding procedure for long term-care facilities, particularly in Ontario and provided their view on areas that they felt could be improved.

The analysis identified four themes including whether the issue is under-resourced, poor allocation of resources; funding according to need; the struggle to define and assess the quality of care; and general work conditions in long-term care.

The result of this research will help us to better understand the resource allocation of Ontario long-term care facilities which could in turn highlight improvements that could be made to create better quality of life for residents as well as frontline workers.

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INTRODUCTION

Canada's senior population is growing, with an estimated 23 to 25% of its population being over the age of 65 by the year 2036 (Statistics Canada, 2010). More times than not, institutional care is the only option for these individuals, however, this care is rationed, and governments are not wanting to spend more with the rising need. This may result in a resource crunch that will lead to more caregiver burn-out and, as a result, a higher risk of abuse and neglect, including a lack of autonomy and respect for the residents (Lawrence & Banerjee, 2010). For seniors, autonomy involves the ability to make decisions for themselves and come to terms with their capabilities, both in a personal and legal capacity manner (Dabove, 2018). This is completely unacceptable for government and society to allow seeing as these residents are in public institutions and deserve to be treated with dignity. Even though many of these facilities may not be publicly owned, they are always publicly funded, which emphasizes society's responsibility for addressing these issues. Hence, this thesis will study how resources, such as healthcare workers and funding for materials, and their allocation can affect neglect or abuse in residential care facilities.

The issue of elder abuse has been explored along a number of dimensions, including examining abuse by formal and informal caregivers inside and outside institutions, financial abuse by family members, as well as exploitation by fraudulent companies (Acierno et al., 2010; Buzgova & Ivanova, 2009; Buzgova & Ivanova, 2011). Possible remedies to elder abuse currently being examined are controversial. For example, video surveillance is being advanced as a possible solution as caregivers or nurses may be less likely to engage in abusive behaviours if they are aware that they are being watched (Meier, 2014). Yet, surveillance of caregivers also

compromises the privacy of elders (Meier, 2014). In a study by Buzgova and Ivanova (2011), it was found that the elderly individuals who reside in institutional care facilities felt a loss of their rights to make decisions as the caregivers would make them on their behalf. This includes a loss of privacy and dignity, according to the participants in Buzgova and Ivanova's (2011) study, where residents are informed that doors are left open, people do not always knock, and they are often treated as though they are children.

Dong and Simon (2011) state that there is a lack of funding for policies, such as those which include education and training in the area of elder abuse. This would help encourage healthcare providers to detect and report abuse, or even just how to prevent themselves from getting into a situation where abuse could occur. Thus, the funding of long-term care needs to be addressed and re-thought, particularly with the knowledge that the senior demographic of the population continues to rise. As Pagels (2016) has revealed, long-term care facilities are essential to society and many people could not live without them, therefore, they should be appropriately funded to allow these individuals to have a proper quality of life.

This thesis uses the terms "long-term care institutions/facilities" to refer to long-term care facilities which host solely seniors whom are unable to reside on their own. These facilities can be for-profit, not-for-profit, or municipally run as they all fall under the Ontario Ministry of Long-Term Care funding. An important distinction needs to be made, however, when it comes to retirement residences and long-term care facilities. It is often thought that they fall under the same category and can be used interchangeably, however, they are indeed different and do not have the same funding processes. Therefore, retirement residences do not fall under the term "long-term care facility" in this particular research paper.

As the literature review chapter of this thesis will demonstrate, it is extremely difficult to address or measure elder abuse. Therefore, in order to research the topic, I use another way to assess the potential for abuse, neglect or poor quality of care directed at the residents in long-term care: I enquire whether resource allocation to each residential care facility in Ontario is determined by political economy considerations and if, in turn these choices of resource allocations can have any relationship with the case-mortality observed in facilities during the COVID-19 epidemic's first wave (March to August 2020) in that province. The connection between resource allocation and to elder abuse, can be made as follows: if there are not sufficient resources available to care for a resident, the quality of care of that resident may suffer, and this may lead to them being neglected and deprived of their basic human needs; for example, no caregiver may notice they have fallen out of bed and they would be left there, unable to get up. Or facilities not receiving enough resources may pressure PSWs (personal support worker) to spend less time with each client, which in turn might lead to some PSW having to dismiss the requests of some residents and be "rude" and morally abusive in the process. Elder abuse, with no actual criminal intent to harm the resident would essentially be the absolute worst-case scenario of poor resource allocation. Though the issue also exists, this study is not looking at elder abuse in a criminal or malicious way but rather as injuries, illnesses, and so on that result from neglect and/or improper care due to poor resourcing. The thesis looks to understand elder abuse from a society and funding perspective, rather than the individual criminal intent of performing the act of abuse or neglect.

Henceforth, the lens I chose to analyze this research through is the political economy perspective. I chose this theoretical perspective as it demonstrates how power relations exist in society, and the fact that social policies related to the institutional facilities are a result of the

commodification of seniors within them (Estes, Linkins, & Binney, 2001). The next chapter will demonstrate these connections further.

Theoretical Lens: Political Economy

The theoretical underpinnings of this research, henceforth, are centered around that of the social science perspective of political economy. Gouveia (1997) demonstrates that decisions around health care are not typically market-based, rather, they are political, in the sense that a regulator makes decisions on behalf of a community instead of letting each individual makes their own choices (and pay for them). This, of course, has implications on how much funding the different sectors of health care are allocated and/or how much resources go to specific providers (e.g., if geographical considerations are taken into account in the policy-making process). Seeing as these decisions are political, it reflects the theoretical perspective of political economy. Political economy is a perspective that examines the economy and how it is structured throughout society to understand how different aspects of society function, as well as relationships between members of society and the institutions which govern them (Otani, 2018). Political economy, which is originated from the work of Karl Marx, is commonly used to critique economic institutions, such as the healthcare system, and the way in which they function, from a normative point of view (McDonnell, Lohan, Hyde, & Porter, 2009).

One critique that this theoretical lens places on the healthcare system is that it has built healthcare as a commodity, which makes healthcare unattainable to many individuals within society by creating a competitive market for it (McDonnell et al, 2009). What political economy shows us is that every health care system rations access to health care and is, as a result, a complex mechanism to ration sub-populations differently (either through the ability to pay, direct rationing of individuals, or via the type and extent of rationing of various services) (Bevan & Brown, 2014). This is how the various governments decide how they want to allocate their resources throughout the health care system and there exist two frames of thought around this.

One is to have interested parties play an important role in some countries' health care systems, and the other is to ignore the desires of the interested parties, making the assumption that elected bodies reflect the will of the population (Bevan & Brown, 2014). For example, Bevan and Brown (2014) found that in England, the government maintains the power to not only dictate the budget for the health care system, but also how it is allocated through the various health care sectors. However, in the United States, the government is solely a third party in this decision-making. This impacts how much health care costs, and who receives what.

The rationing of health care can also be known as "priority setting." It appears when the term "rationing" is used, it has to do with decisions being made around the denial of care, whereas, "priority setting" seems to be portrayed in a more positive light as difficult decisions of care (Kimmel, 2019). Regardless, these are ethical concepts in society and one can see how a political economy lens can be applied through the power relations which may exist between many different levels, such as which patients receive care or who chooses this (Kimmel, 2019). Here, the idea of vested stakeholders could come into play to sway these types of decisions towards their related interests.

Looking more closely at the concept of political economy in long-term care brings us to the impact on the residents in these facilities. Here, there are multiple levels of power and control. The first level one could consider is the power which health care workers hold over seniors. These workers control the care the residents receive: even though they are bound by the requirements of their jobs, the overall quality of care the seniors receive is at the hands of the care workers.

There also exists the power imbalance which is created by the political entities who dictate the standards of care and funding which residents receive in these facilities. This

relationship is not as close as that which exists between health care workers and residents, and thus often these individuals do not receive the direct impact of resident's concerns. The distance here creates policy makers or political entities to feel detached from the issue as they do not see first-hand the results of their decisions. These parties can only rely on the academic, and other political advice they receive to make their decisions. Once again, the aging population becomes more invisible and their voices are not heard so their needs are pushed aside at the expense of their care.

Another relationship which maintains a power imbalance in long-term care facilities is that between family member and loved ones of the resident and the resident themselves. When these so-called "informal caregivers" of the resident are required to put the senior into long-term care facilities, tensions can often be created, and the senior can develop resentment towards the family. However, frequently, when the senior has a cognitive impairment, which is a common reasoning for the loved ones being unable to provide adequate care for the senior, it is truly up to these individuals to ensure the resident is receiving adequate care. Therefore, these informal caregivers hold power over the senior to ensure their proper care and to make decisions for them.

Residents of long-term care are truly at the hands of their informal and formal caretakers to advocate for them. A clear example of this is the recent COVID-19 pandemic outbreak at long-term care facilities as will be discussed in further detail in the analysis chapter.

LITERATURE REVIEW

Much of academic literature which exists surrounding the topic of elder abuse, specifically that within institutional care facilities, typically examines the issue as a social problem and tries to find a definition to clarify what exactly it is (Harbison & Morrow, 1998). One reason as to why elder abuse is viewed as a social issue is that seniors' voices are not heard as a result of society's lack of consideration of this population's needs. As well, society maintains a concern that the demographic is taking away valuable resources from children, who are viewed as holding a higher societal value (Harbison & Morrow, 1998). Finally, it is a social issue as most of the residents in these facilities suffer from dementia, and thus, as society has deemed populations with dementia as posing complex societal problems, these facility residents have become an isolated population. The theoretical lens for this project, political economy, will further demonstrate the social issue through its impact on the resource allocation in the long-term care facilities.

Though the topic of elder abuse explicitly is not overly present in recent literature, it has indeed become much more prevalent in current years. In fact, the whole social gerontology field has been increasingly present in academia as a result of the aging population, especially in Canada. One of the obvious reasons for this would of course be the growing senior population, and thus the necessity for a high influx of seniors to move into retirement and long-term care home settings. Common forms of academic literature discuss risk factors, intervention strategies or remedies for elder abuse, yet these articles seem to lack the depth or research to prove they function and rather simply pose suggestions (Lachs & Pillemer, 2015; McDonald, 2011). Ayalon, Lev, Green, and Nevo (2016) estimated that, though there are thousands of studies which discuss the issue of elder abuse, only 24 of them actually contributed to evidence of its

occurrence. Thus, this highlights the importance for more research to be done in order to increase this number of studies. This review of literature attempts to unpack themes within the bodies of literature which are currently present and highlight gaps which need to be closed on key topics that may help mitigate the issue of elder abuse in long-term care facilities. To do so, key phrases such as, "resource allocation in long-term care" and "elder abuse reporting" are used to search the McMaster online library database and articles are chosen that are accessible, in English and clearly related to the topic. The method used for this can be found outlined in appendix 7.

While research on elder abuse has become increasingly popular, with longitudinal studies and some data sets developing out of long-term care institutions, there is a need for larger, mandatory studies to draw conclusions about where there may be space for improvement in policies and programmes within these institutions. As discussed, previous literature contains many suggestions as to what future research could accomplish to improve the situation, yet there seems to be a lack of a "landmark" study which truly opens society's and policymakers' eyes to the realities of elder abuse (Lachs & Pillemer, 2015; McDonald, 2011). One of the reasons behind this is a lack of funding or desire for research opportunities in this field (Dong & Simon, 2011). Once again, this research seems to be pushed aside time and time again because of competing priorities and the lack of recognition for this research tends to paint an unglamorous picture for potential academics (Teaster, Wangmo & Anetzberger, 2010). Political entities are cautious to approach the subject as well, seeing as there is a lack of research, and therefore to expend too many resources in an area that may not benefit their platform. There is also an access to information barrier which causes academics, including myself, to be forced to deter or change paths and project plans which would draw attention to the importance of this type of research.

In this literature review, I consider two key themes: the issue of underreporting and the significance of needs-based allocation in quality of care. The second theme identifies a sub-theme of the interRAI tool as it determines how the so-called "need" is assessed within long-term care facilities, for the purposes of funding. It is a current tool for collecting information on long term care facilities, and thus is a way to evaluate the resource allocation in long-term care facilities (Carpenter & Hirdes, 2013). The InterRAI was initially developed to make clinical decisions, however governments saw the opportunity to use it as a decision-making tool for allocating resources (Carpenter & Hirdes, 2013). Due to the way it is structured, the tool incentivises institutions to report as much need as they can, otherwise they could risk losing funding to other institutions.

There exists a third theme in relation to the specific literature I review for this project which is the debate on how to create policies to prevent elder abuse in institutional care facilities as well as how to enforce these policies. For the purpose of this study, I have left this section out of the research paper, but the resources reviewed can be found in appendix 8. To summarize that literature (and explain why I left it out), it considers the problem of elder abuse at a legal and correctional level only, and never from a political sphere.

UNDERREPORTING

The underreporting of elder abuse is a persistent theme in the literature. In Canada, Webb (2014) considers the fact that the criminal law does not have required reporting of elder abuse; however, recognizes that some provinces have implemented some forms of legislation which aim to promote reporting. Ontario is a province which has created and changed laws to prevent abuse and improve reporting specifically in long-term care homes (Webb, 2014).

Presently, it is mandatory to report elder abuse in Ontario if it takes place in a retirement home or a long-term care facility (Elder Abuse Prevention Ontario, 2020).

There is an obvious population shift ongoing: baby-boomers are aging and thus the number of seniors is growing. There also exits a shift within the population which relates to the fact that there is a general betterment of the knowledge surrounding cognitive illnesses such as Dementia, causing institutions to develop and create specific facilities for individuals who suffer from these diseases (Howze & White, 2010). Consequently, individuals who have cognitive disorders typically are those who reside in institutions, while those who suffer physically remain in the community until they can no longer function (Nieboer. Koolman & Stolk, 2010). Mixson (2010) discusses three key aspects of elder abuse policy to be reviewed in order to ensure policies are going to be functional to stop the abuse from worsening. These aspects involve the focus on vulnerability of elderly individuals who cannot care for themselves, managing cases on an individual basis due to their personalized needs and services, and finally, the fact that mandatory reporting laws are currently set too high (Mixson, 2010). Mixson (2010) reports the laws are set too high in the sense that there are many steps required to proceed with when reporting abuse, and while it is important to verify there are no false reports made, it should perhaps not be such a formal process as it can prove to be daunting to witnesses. A critical way to ensure the reporting of abuse is through public awareness, understanding of the signs of abuse, and knowledge of the reporting process. Though it is important to implement these policies to ensure the protection of seniors, there still remains a lack of funding in terms of policies around training and education, which has been discussed as a crucial factor in elder abuse (Dong & Simon, 2011). Another issue with the creation of policies around the subject of elder abuse is that the information which is provided to the policy makers is not seen as valid due to

inconsistency or small sample sizes (Teaster et al., 2010). This can be due to a lack of funding for research in the area, and as Teaster et al. (2010) discuss, the funding for research and programmes is still less than that of child and domestic abuse.

Having a publicly available database with supporting statistics which discuss reporting of abuse allows a baseline to be created to allow one to monitor trends and indicators. According to the World Health Organization (WHO) (2020), it is estimated that while one case may be reported, 24 others go unreported, which proves to be an incredibly poor ratio. There exist many estimates of the ratio of reporting elder abuse as it is difficult to measure instances of abuse that are not reported. As well, politics can often drive research either in ways to create new policy or support existing policy. Seeing as the WHO is research based, rather than a politically based organization, it can be inferred that this is not a policy driven estimate.

There currently exist mandatory reporting laws which can be considered either beneficial or not beneficial for promoting the security of the seniors as outlined through a study by Mixson (2010) who looked at the potential issued with mandated reporting. This is important because it allows for an explanation of why the issue of elder abuse is so delicate and difficult to study. It demonstrates why there is so little data on the subject and emphasizes the need to find better ways to analyze the problem and address it. Mixson (2010) states the need for a review of the pre-existing laws in order to minimize the mandated requirement to report, while still ensuring reports are reviewed and evaluated for any false claims.

Liao, Jayawardena, Bufalini, and Wiglesworth (2009) find that emergency medical workers generally state that their reasons for not reporting elder abuse is due to the uncertainty surrounding the process of reporting and mandatory reporting laws. Therefore, there is a general need for education among health care workers on the topic of elder abuse, more specifically, the

reporting of it (Liao et al., 2009). The issue is, due to underreporting, it is difficult to complete research on the topic of elder abuse to further the understanding of what training could help these individuals comprehend the procedures, as well as the information to inform the procedures (Natan & Tabak, 2013). To add to this, there is a realization that, often, residences will attempt to strategically suppress the reporting of abuse so that the companies will not have to deal with the issue or have a negative outlook placed upon their particular facilities (Moore, 2016).

The underreporting can also be a result of the senior's fear of the repercussions after coming forward and exposing the abuse. Charpentier and Soulieres (2012) discuss the fact that elderly individuals who live in long-term care become vulnerable and very dependent as a result of their institutionalization, increasing the likelihood that they may be subject to abuse and not report it. Legally, seniors who live in long-term care need to be assured that they are protected against backlash from reporting the abuse and that they will be guided through the entire process, so they do not feel like they are alone in the procedure (Natan & Tabak, 2013).

There exists a so-called "grey zone" when it comes to defining and measuring a case of elder abuse. In addition to potential cognitive impairments in many seniors, the institutionalization will cause victims of abuse to feel powerless, and question whether or not actions, or lack of actions, taken towards them could be reported as abuse. It was discovered that seniors foresee many barriers in the reporting process such as whether it is necessary to report if there is no serious injuries or sufficient proof, the potential that reporting may worsen the situation, and the embarrassment involved with reporting to people they trust (Aday, Wallace & Scott, 2017). Cohen et al. (2007) acknowledged that when it came to identifying abusive behaviours through their study's questionnaire asking how often certain abusive behaviours took place, only 6% of seniors reported any incidents from their sample of two hospitals in Israel.

However, over 20% of the seniors in this study had been identified as having evident signs of abuse by a professional team (Cohen et al., 2007). One can see how this number differs slightly from the WHO research which took place more recently in the United States, but is still comparable, showing that this issue of underreporting is not just one of North America. However, this study still exemplifies the grey zone for seniors when it comes to reporting abuse.

As hypothesized in the introduction, I recognize for this thesis, that the obligation to report should not be an obligation to punish or penalize. Literature insists that reporting could be anonymous in many cases as it is truly more about monitoring systematic issues rather than punishing individual crimes. There can be a discussion of a systemic approach to underreporting and bringing light to the positive aspects of reporting. If a caretaker makes a mistake while performing his or her duties, something which may be seen as neglect or abuse, and they or another individual reports it, it can be considered an issue that needs to be addressed throughout the system. For example, if a caretaker is overburdened and has too many residents whom they have to care for, and a situation occurs involving one of their patients, this can be brought to the attention of policymakers who can decide that there must be a better ratio of caretakers to residents. Or, perhaps a caretaker is unsure of how to deal with a particular patient due to their mental state (such as a patient who suffers from dementia) which then results in improper care. A situation like this can reveal a lack of training in certain areas and have the positive impact of creating more opportunities for caretakers to receive proper training.

As elder abuse is difficult to report on, and thus measure, I will address it from a different perspective and use the recent Coronavirus (COVID-19) outbreak as an extreme case study revealing the factors that can lead to abuse and neglect: if elderly residents are neglected and deprived of their basic needs on a daily basis, their risks of dying as a result of an outbreak of

COVID-19 will be much greater than if they live in a facility that provide them with their basic needs and treats them with respect. I therefore use the mortality rates by facilities in Ontario as a result of COVID-19 outbreaks as the basis for the discussion in this project.

NEEDS-BASED ALLOCATION

Amongst academic literature on elder abuse, the concept of "needs-based allocation" is a common point of discussion, and how it can be a problematic way in which to allocate resources to long-term care facilities for seniors. The definition of "need" can be blurred, as found when analyzing the literature present. For example, Ross and Wright (1998) defined need broadly as someone's ability to function independently, whereas authors, Hill, Savundranayagam, Zecevic and Kloseck (2018) found that need should be assessed differently based on the senior's state (i.e., palliative/end-of-life). Luppa et al. (2010) also found that need could be measured based on the reasoning of use of health services, the ability to follow medical necessities independently, or the kind of or amount of treatments required. This also highlights the question of *who* exactly gets to choose what this definition is, what individuals receive in terms of resources, and why this person has the authority to make these decisions. Here, one can see the connection to power relations, and thus a political economy lens enters.

When comparing homes based on need, one must delve one layer deeper and understand an emotional need in addition to regular care needs. Hill et al. (2018) found that caregivers in palliative care facilities tend to create more emotional connections between themselves and patients, therefore, they find they require more time for each patient, especially if the patient is in their last few moments. Having decisions made at a higher level, without proper consultation with direct interested parties can cause a divide between the political level and frontline care worker level on what the realistic needs are. As discussed in the theoretical lens section, priority

setting is a major component of how these decisions are made. Kong (2019) explains how socioeconomic status and physical health are large contributors to how much need is required to a given individual or class of individuals. Resource allocation is evaluated based on two different means, according to Zhang, Fry & Krishnan (2015), efficiency and equity. Efficiency is measured by allocating appropriate resources to long-term care facilities, while minimizing wait time (Zhang et al., 2015). Equity, on the other hand, is the objective of ensuring fairness throughout the distribution of care for different patients (Zhang et al., 2015).

The theme of needs-based allocation is an important contribution to my research as it looks directly to the research question which examines how resources are currently being allocated to prevent elder abuse. It is found that, for patients with dementia, the willingness to pay is a key factor in the suitableness of a long-term care facility for their care (Nieboer et al., 2010). Therefore, resources are clearly being allocated based on one's financial status, however, often it is better for patients with dementia to remain in their own home if they have family to take care of them as well as the financial resources required for at-home care (Nieboer et al., 2010). Zhang et al. (2015) found that a Canadian healthcare authority for long-term home care is currently using a needs-based policy that looks at informal care requirements, including the care required from families and friends, in addition to the regular needs of a patient in home care. This is much more individualized than other needs-based policies but is not necessarily more efficient or equitable than others, yet it could address a different measurement, one which minimizes needs for residents, and reduces the burden for their families (Zhang et al., 2015). This would be suitable for private services where resources are improved based on the patient or their family's ability to pay for improved care (Zhang et al., 2015). In sum, a "needs-minimizing" policy which looks through a more individual case lens could benefit home care

patients, however for the purpose of this study, needs-based allocation will focus on need at a long-term care and institutional level.

When considering needs-based allocation, literature examined the staffing levels and staffing mix for need. Ward (1998) found that in the state of New York, there was almost no change in the number of personnel working in long-term care facilities over a seven-year period. This study also noted that there was a heavy reliance on nursing aides (or personal service workers), rather than actual registered or licensed nurses (Ward, 1998). This raises the question of why these numbers have not changed, seeing as many seniors are entering long-term care at an older age, with more complex health issues, and whether using nursing aides is the best option for caring for the seniors who reside in the facilities. It places a great amount of stress on individuals who may not be trained or prepared to deal with issues which arise in long-term care centres, and as demonstrated in literature, caregiver stress and lack of training is one of the contributing risk factors to the abuse of seniors (Pagels, 2016). Cardona, Tappen, Terrill, Acosta, & Eusebe (1997) find that both nurses and nursing aides often take less personal time than what they are allotted at work, which demonstrates a possible mismatch in the appropriate number of staff to residents. Having an increased number of staff-to-resident ratio allows for improved services and more opportunities for physical and social activities for the residents, which has been proven to improve their well-being (Nieboer et al., 2010). There are two issues raised here: the first is that of the too low overall staffing ratio and the second is that there is a maldistribution of resources that causes the ratio to be so substandard in some places that it actually generates elder abuse cases.

A political economy perspective has also been applied to a handful of studies which examine the care of seniors in residential facilities as well as care in their own homes. Funk and

Outcalt (2019) found, for example, that frontline health care workers often create negative feelings towards the individuals who own the facilities or control their labour requirements as they tend to be over worked and under paid. This is a perfect demonstration of how individual who hold power end up be resented due to their lack of interaction and consideration for those who they hold power over. Therefore, one method political economy can be looked at in terms of the tension created between individuals is through the care workers and those who manage their labour requirements and the pay they receive. This could simply be the management of a long-term care facility, or the entities which fund long-term care.

Needs-based allocation can also reflect the resources which are present to deal with the people who are responsible for assisting with cases of elder abuse, such as social workers and law enforcement. Ernst and Smith (2012) examine the benefits of having a multidisciplinary team available to deal with cases of elder abuse, in as much as there are often variances in need for the victim of abuse. For example, one might involve a health care professional to assess the health of a victim and a social worker to ensure their social well-being (Ernst & Smith, 2012). However, Ernst and Smith (2012) do point out that the cost for developing this "team" would be too high in comparison to current research on its benefits, particularly in contrast to the lack of funding available for the caregivers in long-term care facilities. This concept can also be expanded to include the research funding currently available for elder abuse and long-term care, as it is indeed on the rise, however, there still prove to be many gaps.

Tools for assessing needs: the interRAI.

This leads into a discussion of a current tool used for collecting information on the needs or health status of residents of long-term care facilities, the interRAI (Carpenter & Hirdes, 2013). This section analyzes the InterRAI's methods and why it is chosen as a tool in various studies

through an analysis of existing research and literature on. This allows for a better understanding of the system as it is used to assess long-term care facilities. A review of this literature also allows for a deeper understanding of what precisely this text can aim to achieve through this assessment for informing resource allocation decisions.

The interRAI, founded in 1992, maintains a vision that is to collect critical information throughout healthcare systems internationally to promote the appropriate care of "frail persons," as well as ensure resources are allocated both efficiently and equitably within a facility (Carpenter & Hirdes, 2013). From this, the interRAI suite was developed, which allows for more reliable information to be recorded throughout various care settings and for this information to be easily compared to promote change (Carpenter & Hirdes, 2013). This tool also encourages the training of healthcare workers, such as nurses, to use the instrument, allowing for information to come directly from the assessors. Algorithms titled "Clinical Assessment Protocols" (CAPs) are developed which help to interpret findings and what risk may be associated with these findings in order to ensure appropriate care of patients based on factors which look at their clinical issues, functional performance, cognition or mental health, and social life (Carpenter & Hirdes, 2013).

Sinn et al. (2018) discuss their use of the interRAI in its ability to link together assessment and action in the health care system to improve the care of patients, specifically in long-term care. This study involved the use of interRAI tools, in collaboration with the authors' own decision tool to demonstrate potential areas in patients that could signify that they are in need of a change in their care plan (Sinn et al., 2018). The interRAI screening tool can also help improve the caregivers' well-being through identifying scenarios where caregivers may need support with mental and social health struggles such as depression and loneliness as a result of

their role (Betini et al., 2018). Using the interRAI systems that have previously been assembled, for example the interRAI Home Care (interRAI HC) and the interRAI Long Term Care Facilities (interRAI LTFC), researchers are able to identify problems that may relate to the various aspects and risk factors of both caregivers and vulnerable patients requiring both at home and long-term care (Betini et al., 2018). A study by Kim et al. (2015) finds that both the interRAI LTCF and the interRAI HC are reliable tools to use for measuring the need for care in Korea, as they both have virtually perfect scores for reliability which were measured through internal consistency of various scales. The interRAI is therefore proven to be a reliable tool to measure and assess multiple aspects of long-term care facilities in terms that are thought, by its promoters, to reflect the level of need of a given patient. However, the question that is raised here is whether the current level of care is adequate, which is something this tool is unable to ascertain.

RESEARCH QUESTIONS

After the completion of the literature review, the following question was developed:

> Are current resources for protecting the elderly from mistreatment, including all forms of abuse and neglect, within long-term care facilities in Ontario allocated fairly and effectively throughout society?

I will decompose that research question into two sub-questions:

a) How does the political economy influence the needs-based allocation in place to protect seniors from mistreatment from poor quality to neglect to all forms of abuse in institutional care settings?

b) What are the consequences of these resources on residents' autonomy?

The next section will discuss how exactly this project aims to respond to these questions.

METHODS

Now that the gaps in academic literature are identified and it is clear why we are asking the research questions at hand, there needs to be explanation on how the research will be conducted to answer these questions. To tackle the research questions, I conducted semi-structured expert interviews for an exploratory analysis. Unfortunately, due to limitations further explained in the discussion chapter, I was unable to access data I had wanted to use for a quantitative analysis. Once realizing this, I looked to interview frontline healthcare workers from long-term care, however, as a result of COVID-19, this would have been a potentially harmful experience for this population, as explained in more detail in the limitations section. Therefore, given these constraints, expert interviews were the best option to answer the research questions at hand as I was able to explore more information than what is readily available in literature. The title presented to the experts for the interview was, "Elder abuse in Ontario long-term care facilities: How does funding affect the risk of mistreatment?". I use a different title for the paper to better reflect the study's focus, findings and conclusions. As explained, there are very few studies which demonstrate political economy in terms of care in long-term care facilities, and, as one can see thus far, it is a perspective which highlights problems in the sector.

The interviews, which lasted anywhere from 30 minutes to an hour in duration, were audio-recorded and transcribed using the dictate function on Microsoft Word. Due to the COVID-19 pandemic, in-person interviews were not an option in order to adhere to strict social-distancing regulations in place at the time of the research. Therefore, the interviews were held over the Zoom platform, where participants could either phone in, or participate using the video-conferencing option. Using qualitative methods allows for an analysis of the insights of experts who have an in-depth knowledge of various aspects of long-term care in Ontario, from the

residents and workers to the funding processes. This project was cleared by the McMaster Research Ethics Board.

PARTICIPANTS

The experts approached to participate in this research work in the area of long-term care, either as academics/scholars or as institutional/agency advocates. It was important to hear both from researchers (with an outsider view) and representatives of the various organizations/agencies working in the sector (e.g., the Ontario Long-Term Care Association (OLTCA), who can provide an insider perspective). Views and perspectives differ on how funding is and should be allocated across beds and residents (according to need) as well as on how residents payments affect care. The academics I wanted to interview had backgrounds in health care policy, geriatric assessment, and labour market policy. It was purposefully decided to not interview the seniors who reside in these homes or frontline workers due to their vulnerability and the sensitivity of the subject, as it involved a risk to do more harm than good to include these individuals, especially in the COVID-19 context.

Participant contact information was all available publicly online and the names of the academics and agencies were determined through prior knowledge from research, or snowball sampling. Emails were sent to eleven academics and six individuals or groups involved directly with long-term care, such as advocacy groups, the Ministry and not-for-profit organizations, with the information letter attached to request their participation in the research. Given time constraint, I started the interviews after receiving five positive answers out of these 18 solicitations, even though my initially planned number was eight. Of the five participants, four were academics and the other was from an advocacy agency for long-term care, but also had an academic background. The informant from the OLTCA, being the only non-academic, covers all

Ontario long-term care licensees. Had I had more time; I would have waited for representatives of other agencies in the sector to also respond.

While there were no incentives, reimbursements or compensation involved in the participation in this research, the benefits to this study could have contributed to the willingness of individuals to participate. It will benefit society to have participants involved in the study because they are key to understanding how exactly the long-term care facilities function, especially in terms of the level of funding received. Being aware of the areas of concern and hardship within these facilities will highlight whether or not resources are allocated fairly and reasonably.

This study looks to expand upon research to gain knowledge about a potential gateway to mistreatment of seniors in long-term care facilities or if current resource allocation has a negative impact on the quality of long-term care provided in some parts of the long-term care sector in Ontario. This could lead to future research which dives deeper into the areas of concern or which appear to have a lack of funding and how society or policy makers can mitigate these issues.

DATA COLLECTION: INTERVIEW PROCESS

I held the interviews which were always one-on-one with the participant. Prior to the interviews, participants were encouraged in the letter of information and oral consent form to read the article "The case for public long-term care insurance" to understand their perspectives on the concept of long-term care insurance and its impact on existing resource allocation and funding issues. This article discussed the concept of introducing a public long-term care insurance to ensure everyone has access to suitable care when required. The insurance would not just be available for use in the institutional setting, but also for home care, which would provide individuals the opportunity to remain in their homes longer.

Interview questions were intended to gain a deeper understanding of the experts' knowledge on the topics of funding in Ontario long-term care facilities. As informants pointed out, quality of life in the facilities that currently exist could be improved greatly if more funding was put into even just the infrastructure of these institutions (Participant 4). The interview guide can be found in appendix 3. While resident neglect is not the focus of the questions set out in the interview guide, it was possible that the discussion could touch on the correlation between funding and neglect, especially in the discussion of quality of care. The questions which were outlined in the interview guide allowed me to understand the expert's perspective on whether resources are allocated fairly throughout long-term care and then lead the discussion into whether the funding allocation affects the level of care the residents receive. The COVID-19 pandemic was not the basis of the study; however, it is a factor that could not go without discussion due to the devastating impact it had on the Ontario long-term care facilities. Interviewees were asked to provide some details around what they believed could have been done better to improve the circumstances from the beginning, as well as how we can move forward.

The thesis' research sub-question which asks how the political economy influences the needs-based allocation in place to protect seniors from abuse in institutional care settings was sought to be answered through discussions in the interviews around the fairness of resource allocation both within long-term care facilities and comparing them to other healthcare institutions. This same approach was applied for the second sub-question which asks what the consequences of these resources on residents' autonomy are, but through interview discussions on quality of care for the residents in these facilities and how the resource allocation impacts their ability to voice concerns. As explained in the introduction, autonomy is relating to the

personal and legally determined capacity of a senior to make decisions for themselves and come to terms with their capabilities.

To answer the high-level research question, "Are current resources for protecting the elderly from physical abuse and neglect within long-term care facilities in Ontario allocated fairly and effectively throughout society?", I considered the discussions around quality of care, particularly in terms of the COVID-19 pandemic's impact on long-term care in Ontario, and how the experts suggested the situation could have been better handled. Additionally, to contribute towards answering this research question, I leveraged the questions around fairness of resource allocation and the impact it has on the quality of care residents received. This will be discussed in detail in the data analysis chapter.

ANALYSIS

In my analysis of the expert interviews, a variety of themes emerged as indicators of the issues in the resource allocation process of long-term care facilities in Ontario. Through a thematic analysis informed by a political economy perspective of my notes and transcripts from the interviews, four major themes emerged which provide insight into the process the Ontario Ministry of Long-Term Care utilizes for funding long-term care and how it may be creating a potentially dangerous environment for seniors. The first major theme is that the Ontario government has a poor resource allocation technique for long-term care. A second theme that emerged is that the Ontario Ministry of Long-Term Care does not appropriately fund facilities in relation to the level of care or need required. Additionally, the third theme presented in the analysis is the complicated issue of defining and measuring quality of care in long-term care. Finally, the fourth theme this analysis revealed is that staffing levels is an issue in long-term care in Ontario in both a qualitative and quantitative sense due to the working conditions that exist surrounding the facilities.

UNDER-RESOURCED, POOR ALLOCATION OF RESOURCES OR BOTH?

A theme which quickly became apparent through my discussions with many of the experts in my sample is the question of whether long-term care facilities are actually lacking funding or whether resources are simply being improperly allocated throughout the healthcare system as well as with types of resources (i.e., nurses, funding for materials such as surgical masks, PSWs). These experts did not necessarily argue that Ontario long-term care facilities were purposefully underfunded, but more so were concerned around the chosen method of resource allocation between long-term care and the rest of the health care system. Participant 1

pointed out that there are efforts being made to make resource allocation decisions based on the needs of the residents in the long-term care facilities including health care, social services, and housing needs rather than using bed numbers. Participant 1 noted that to adequately fund long-term care in general, an integrated approach must be taken to assess all these components of need and care whether the senior is in a large or small long-term care facility, their own home, or a retirement residence.

When it comes to funding of staffing, while the option of giving PSWs more training to ensure they are more prepared to tackle the complex care in long-term care was discussed, Participant 4 pointed out that,

> PSW's have a limited amount of training. College programs are getting more intensive but, you know, it can be as little as six weeks of training, could be six month's worth of training. Versus a registered nurse that has a University degree, four years of clinical training, and is a regulated health professional. Giving a couple of days a year of additional training to a PSW is not going to make up on the clinical gap that's there.

This all being said, most of the experts did agree that the Ontario Ministry of Long-Term Care worked closely with academics and advocacy groups when determining the resource allocation procedures. In order to submit any proposals or requests in governments, it is required that there is evidence to back it up, which is often where these experts come into play. InterRAI is often used to support these submissions through the use of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) 2.0. The findings of this tool will be discussed further in the "Efficiency and facility size" section of this chapter.

Resource allocation was the most common point brought up when the COVID-19 pandemic topic was analyzed in the interviews. The lack of access to personal protective equipment (PPE) was a clear illustration of how under-resourcing, or poor resource allocation, can physically jeopardize the lives of both residents and frontline workers. Participant 4 also noted,

> Even though a nurse or PSW in a nursing home has much more physical contact with a nursing home resident than an ICU nurse does in an intensive care unit, but those staff in long-term care were not given access to PPE. It was one of the huge mistakes that was made in the system.

Therefore, this was a clear demonstration of poor allocation or resources between long-term care and hospitals. Participant 4 also noted on this matter that, "complex continuing care hospitals get much more money for the same resource intensity resident than long term care homes do," and therefore there are more nurses to care for the individuals and provide adequate care. A solution was also offered by Participant 4,

> We don't need more PSW care, we need more clinical care in there. That would be about 5 billion dollars a year for the country, which is not easy to find, but that, I think, would make a meaningful difference to quality and outcomes.

The application process for the admission to long-term care is also something that needs to be addressed, and it has been suggested by experts in the interviews that it could be analyzed at a higher level to determine what the greater issue is. Funding needs to be put into looking at ways to minimize need for long-term care in society, perhaps keeping seniors in their homes longer through better distribution of resources to home care services. Using the concept, brought up in the article participants were asked to read, of public long-term care insurance could allow

for this possibility of keeping seniors in their homes longer. Participant 3 noted, "I think public insurance makes more sense. That includes things like home care, that includes the supportive living options that are maybe a bit different than long-term care."

In conclusion, this theme demonstrates ultimately that informants agree there is a resourcing issue in the long-term care sector vis-à-vis the rest of the health care sector. It raises questions, however, of whether it is a shortage of funding or just poor resource allocation, as the next sections will justify the complications involved with funding long-term care.

FUNDING ACCORDING TO NEED

An issue which was raised in terms of difference in level of care is the fact that often the care requirements for each resident vary immensely. Facilities can have variances in need due to the comorbidities and complex care requirements of each individual patient within their institution. Healthcare workers cannot always build relationships with residents, if they constantly move around in the facilities, and need to learn how to care for each patient every shift. This begs the question of whether the current structure of long-term care is indeed the most efficient, or whether moving to a different system, where caretaker-resident relationships are part of the equation of defining efficiency, could perhaps work better.

Participant 1 informed me that the RAI-MDS 2.0 tool (see page 28) has enabled them to see that there are different sub-populations in long-term care. One cohort is younger and is subject to enter long-term care as they do not have anyone to care for them and do not have the financial independence to reside on their own. However, Participant 1 stated.

> The vast majority of individuals who are admitted to long term care are individuals who are suffering from dementia and multiple comorbidities that

> probably contributed to their dementia. Also, that those individuals, for the most part, are very near the end of life.

Often, this second cohort is frail and at the end of their life, so their length of stay is shorter than that of the younger cohort. To put this in perspective, in the years 1995-2005, the life expectancy in long-term care facilities in Canada was 2 years (M. Grignon, personal communication, September 18, 2020; calculations based on NPHS longitudinal data). It must be noted, as well, that some individuals enter long-term care facilities at the end of their life, as a place where they can die. Typically, these individuals would receive end-of-life care in a hospice, hospital, or in their own home, however, due to the large wait times in hospices, the lack of beds in hospitals and the expenses involved with having this care at home, however, as Participant 1 explained, "we are providers of primarily end-of-life care for individuals with advanced dementia and multiple comorbidities."

To this point, the RAI-MDS 2.0 tool has also demonstrated that the Case Mix Index (CMI) is regressing, meaning that the cases in long-term care are becoming more and more similar. The concept of the younger cohort is becoming less common, with only 11% being in this position (Participant 1). This is due mostly to waitlists for facilities having become extremely long, 36,000 individuals long, according to Participant 1, and the vast majority of residents are now entering long-term care with dementia and multiple comorbidities and potentially are at the point that they are only entering for end-of-life care. Considering the average life expectancy for residents of long-term care facilities in Canada is approximately 2 years (M. Grignon, personal communication, September 18, 2020), this is an extremely pressing issue. This further highlights the concern from Ward's (1998) study which stated that there has

not been an increase in staffing numbers, even though the level of care required in facilities is clearly on the rise.

Typically, the way residents are cared for in the current model of long-term care facilities can be seen as efficient, having people who are in need of care into the same space, as it works in hospitals, but informants pointed out some notable differences between a hospital and a residential care facility. Because seniors often have many comorbidities, their care requirements are complex and very heterogeneous, since residents are at many different levels of dependency. Therefore, it takes an integrated team and multiple different care requirements to ensure their well-being. When one goes to a hospital, they typically do not plan on living in the institution, but rather go to fix their health issues and there are normally specialists who can help individuals with their particular issue. These notions in hospitals are not the case with long-term care for many reasons. One reason is that seniors are admitted into these facilities to live, it is not viewed as a temporary placement until they are "cured". Henceforth, the model of the hospital does not work for long-term care facilities, which are required by residents to feel like a home rather than a temporary place of healing, while still being able to accommodate the vast care necessities of the residents. There have been many improvements made to facilities to make them more welcoming to the residents, but it begs the question of how it can really happen with large facilities that have multiple beds in one room. In sum, experts in my interviews find that efficiency cannot be measured in long-term care facilities as it is in hospitals due to the various circumstances and differences between the two. Participant 1 outlines one of these key differences,

> It's unlike a hospital where you can sort of say, we can predict what's going to happen and we know we're going to have so many empty beds and so we can fill

> those beds. You literally are charged with maintaining a high quality of life the best quality of life for individuals to keep them alive, and living, and enjoying life to the end. But to the end is dependent on them, not on you.

On this point, the COVID-19 outbreak in long-term care facilities raised question among the interviewees on the ability to control the spread of potentially deadly diseases in institutions housing residents with extremely vulnerable and weak immune systems. A first observation which was made by experts was that the rooms with multiple beds were an obvious breeding ground for the virus, as it would be for many influenzas to be spread. Participant 1 explained, "Long-term care homes have now been given a directive that they can have no more than two people in… a three or four-person ward, which means that we just decreased capacity at the sector by some 3 to 5000 beds." Thus, eliminating the rooms with three or four beds was one step the Ontario Ministry has begun taking in the improvement of facilities. Unfortunately, this is now adding to the issue of the waitlist to enter facilities as they are now taking away beds which people have been waiting for. A second problematic area which exists in the facilities is that by making them "welcoming", operators often add carpeting, drapes, and many other surfaces that are not as easy to disinfect, décor that is absent in hospitals for this exact reason. Participant 4 stated that part of the pandemic recovery could be to,

> Take a look at getting rid of all those crappy old nursing homes, tearing them down, building new ones as an infrastructure initiative that you know, if they were to spend a couple of billion dollars of doing that they would actually improve quality of life [in a] fairly substantial way and reduced pandemic related risk in the nursing home population based on the scientific evidence.

This option would be costly, but in the long run could vitally change the future for long-term care in Ontario. Finally, Participant 5 questioned,

> Whoever is in charge of long term care homes, nursing homes, and however they are organized, and the body that represents them is organized, they seem to not have a seat at the table when it comes to major health care decisions that are being made and I don't know how that is possible but it clearly is.

This comment stemmed from the conversation on COVID-19 and highlighted what many other informants were alluding to when they expressed their dismay around how poorly the outbreaks were handled.

Another reason is to the point of the specialists in hospitals, as long-term care facilities do not have a variety of specialists readily available to assess and treat residents. They rather have doctors who specialize in geriatrics and are able to generically assess the residents. It is not efficient to have multiple specialists on hand to help when they are needed, yet, seniors do have complex care needs, and this further iterates the question of whether the current structure of institutions and what resources are available makes sense. Could the principle of long-term care be tackled in a different way to be more effective and efficient, while bettering quality of life and care for the residents? Could it be evolved in a way that promotes autonomy for seniors as a demographic, shattering the impact of political economy?

Thus, this theme demonstrates that funding processes in long-term care needs a hard look. It exemplifies that need is difficult to determine and varies significantly from resident to resident for different reasons. Therefore, funding should not be simple either.

THE STRUGGLE TO DEFINE AND ASSESS QUALITY OF CARE

The theme of difference in level of care, and the progression towards higher level of care also raises the concern of the quality of care residents are given. If staffing ratios and resource allocations do not reflect the need of populations in various facilities, there will undoubtedly be an impact on the quality of care healthcare workers are able to give to residents.

Yet, this discussion also raised an interesting and vital consideration within the interviews for the regulation of care. That is, how can caretakers provide good quality of care and quality of life to someone who is not entirely able of recognizing what this means for them? It will require much more one-on-one time with residents, which is something that is currently almost impossible to do with the resources available. While there are standards of quality that do not require resident recognition and are apparent to family members and caretakers, the quality of a resident's mental well-being is very difficult to assess when they are cognitively impaired. Proper care for dementia patients is much more difficult to assess or define than for other illnesses, as Participant 1 stated, "with breast cancer, your breast cancer, my breast cancer, probably follows a very similar pattern. And care for that could be very easily prescribed, and you can get an order, and you can figure out what you're going to do." This observation is also consistent with the literature in the area of palliative care in Canada especially. Delivering quality palliative care requires even more time and resources than a typical long-term care facility, especially as there becomes an emotional attachment between staff and patients, therefore when a patient is coming to the end of their life, staff do not want to leave their side (Hill et al., 2018).

This creates an issue when it comes to ensuring quality of life, as experts agreed that in order to have a good well-being, risks may need to be taken with quality of care in terms of safety. For example, allowing a resident to take a walk outside, while caretakers may ensure the

residents have assisted devices such as walkers and are being supervised, there is always a risk the individual may fall. However, forcing residents to stay locked up inside all the time does not prove to be good quality of life. Another example is one that experts shared around the idea of only having private rooms in facilities. As mentioned, Ontario long-term care facilities are required to eliminate any rooms which include more than two beds to minimize the risk of disease, however, experts pointed out that while this may mitigate this risk, moving to private rooms can also cause loneliness and negative quality of life. Participant 2 gave the example, "I've interviewed lots of residents who say, 'oh I love having my roommate, I have somebody to talk to, they can watch out for me, they can go get a nurse when I need one, I can share their visitors'." Thus, individuals may benefit immensely from having a roommate to keep them company and be able to share visitors with their roommate to prevent loneliness. Therefore, this demonstrates that quality is not simple or straightforward and requires balance.

One of the points that remained a debate amongst experts was the question of what facility maintains better quality of care. While some experts argue that for-profit facilities tend to provide the worst quality of care, a key point was made by Participant 1,

> For-profit operators cannot profit from care. So, there's no incentive for them to not provide care because if they don't provide the care, those dollars go back to the ministry and if they don't send that back to the ministry… then they are charged with fraud.

Since care is funded by ministry, the for-profit facilities make cuts in other aspects of operation to make profit. The way that these facilities are run and how cuts are made differs from ownership to ownership. Therefore, this is an important point to note as it highlights the importance of needing to define quality of care. Though the same time may be given to all

residents, the question that is raised is what is the quality of that care, and does it truly need to be defined by the number of hours a staff gives to a patient, or is there more to it than that?

To sum up, this finding demonstrates the problem involved with measuring quality of care. Many factors go in to assessing quality, and it can be defined in many ways. The complication is that there needs to be a clear definition which is informed from multiple experts that come from a range of backgrounds. This will help ensure the proper definition informs decisions made at the political level.

WORK CONDITIONS IN LONG-TERM CARE

When discussing the benefits of opting for at home care rather than long-term care facilities, experts raised concerns around the ability of staffing home care. As Participant 1 highlighted, "Wages have to go up. There is a huge gap between wages in home care and wages in long-term care. In long term the average wage for a PSW is $22.00 an hour in home care its $15.00," therefore, the workers will obviously choose the higher paying option. The experts explained that there has been an ongoing argument between academics and the province that current working conditions in long-term care are not adequate. Participant 2 discussed that workloads for the care providers in these facilities are immense with minimal recognition due to the nature of the work. Participant 5 explained how, "The very general snapshot is that, you know, they tend to have very little job security unlike almost every other health care profession, and they tend to have reasonably low pay." Many PSWs are part-time workers, and therefore, this contributes to their lack of job security, and, as Participant 5 explained, often involves them having multiple different contracts at different facilities. Here, Participant 5 made the connection to COVID-19, "You had multiple contract holders working in these institutions and

moving from one to the other on a regular basis, and thereby being a very active transmitter for the virus, bringing them from one long-term care home to another."

Participants noted that our society's unappreciation for this occupation and lack of recognition of its importance paints a drab picture for individuals to desire to work in this field. Working in any position in long-term care facilities is considered to be unglamourous, dull and not require skill, therefore staff in these facilities are not credited as they should be. Participant 4 explained how "we think about emergency Department we glamorize you know the staff that are doing stuff in high tech emergency departments to save somebody from a horrible accidental or gunshot wound," which only happens every once in a while. As mentioned, patients in long-term care facilities have multiple comorbidities, including physical and cognitive disabilities which need to be managed and cared for on a daily basis, using skills from PSWs to social workers to registered nurses. With wide varieties of medical histories and issues, there is a lot of work which needs to be done and caring for each individual is different and complex. On top of the healthcare aspect, caretakers need to develop relationships with the residents as the facility is their home and this relationship will help the caretaker understand the individuals and what their specific needs are.

Another important distinction that was raised was, "In the long-term care side you get very little regulated professional care compared to the hospital side" (Participant 4). This goes back to the earlier points raised on the complex care requirements needed in long-term care facilities. PSWs, who do not hold the same level of training and certification as nurses, are responsible for caring for individuals who hold complex health issues and likely need specific care. However, Participant 4 also noted that the way geriatric care is positioned needs to be shifted to be more attractive to upcoming nurses through appreciating how complex and

interesting the care is as "Their health needs are very complicated. It's all interconnected between psychosocial, medical, environmental, and other factors and drug interactions."

This was once again exemplified by the COVID-19 pandemic as Participant 4 highlighted, "the way that that we acted in March was to put all effort into protecting hospitals then we left nursing homes on their own." In fact, the pandemic resulted in bringing in the military as participants discussed, due to staff refusing to work, being too sick to work or having dependants who had autoimmune issues and could not risk being exposed to the virus.

This demonstrates that staffing is a complicated area of long-term care and there must be many adjustments made to address the problems. Having quality, experienced, and knowledgeable staff is imperative to a functioning long-term care system and thus, we must encourage the experts and upcoming experts to want to pursue careers in this area. As the myth of long-term care being dull has been debunked, it is time to start expressing this in all types of schools and the clinicals which young, upcoming nurses are required to partake in. Unfortunately, however, it is also noteworthy that long-term care will never be as glamorous as the intensive care unit (ICU), as it will remain a matter of accompanying dying residents, versus saving vibrant lives.

SUMMARY OF FINDINGS

The first conclusion that can be drawn from this research is that, while there are continued improvements to the funding and resource allocation processes for long-term care, there is still much work to do. Another important argument which has been made is that, in the consideration of funding and resource allocation requirements, decision makers need to be aware of the differences in level of care, and how over time, the care needs have changed. Resources need to be rethought and re-evaluated in terms of the number of nurses and other healthcare workers required to have a functioning long-term care facility. Nurses have higher wages than PSWs, therefore, more funding needs to be allocated to these facilities to ensure the right staff are present. Finally, in order to provide proper care, the caretakers need to be inclined to work in these settings and value their work.

In summary, one can see how these expert interviews and their analysis provided arguments which delivered insight of the research question in place: Are current resources for protecting the elderly from mistreatment, including all forms of abuse and neglect, within long-term care facilities in Ontario allocated fairly and effectively throughout society? The analysis demonstrated that this was not the case through experts pointing out funding comparisons between hospitals and long-term care facilities, while also demonstrating that long-term care needs just as much resources as hospitals when it comes to staffing, specifically in terms of nurses, social workers, and qualified PSWs. Many arguments were made about the resourcing between facilities, but from a Ministry standpoint, the ratios are the same in the funding formula between for-profit, not-for-profit and municipally run homes, as well as between the different sizes of facilities. However, that being said, if need is not well adjusted and systematically hurts

one sector of long-term care more than others, due to being able to choose the patients through the care they offer (i.e., memory care, etc.), there can be issues of allocation across facilities.

The analysis also offered responses to the two sub-questions in place. The first question, how does the political economy influence the needs-based allocation in place to protect seniors from mistreatment from poor quality to neglect to all forms of abuse in institutional care settings, was answered through the expert interviews as it was stated that funding did indeed affect the quality of care residents received. As discussed in the theoretical lens chapter, political economy demonstrates how heath care institutions have formed from the economy and gain power based on society's perception of their value (McDonnell et al., 2009). This perspective can be used to demonstrate how hospitals are held at higher value in society and therefore, receive the lion's share of the resourcing. More nurses need to be brought into long-term care homes as they are more equipped to deal with the healthcare needs than the PSWs. Nurses are able to treat residents and provide them with medication, where a PSW would have to wait for a nurse to become available if they needed to have medication administered to the patient. As well, quality of care requires time from caretakers, and it has been demonstrated through the analysis of the interviews, that this is not something residents are receiving due to inadequate staffing ratios.

The second sub-question, what are the consequences of these resources on residents' autonomy, was answered somewhat indirectly when discussing the difficulty involved with measuring quality of care. Seniors lose autonomy as a result of institutionalization and political economy. Throughout these discussions, there was no emphasis on asking the residents for their opinion or preference on the issues which were raised. They became defined by need, rather than what their wishes were. As was stated by experts, long-term care is often determined by beds, rather than residents. This means all residents are deemed to be the same on a political front, a

result of institutionalization as they are all viewed as just another bed, rather than individuals with unique needs. Further, the protection of seniors is a lost priority as validated in the resource allocation processes between hospitals and long-term care facilities.

SIGNIFICANCE AND SUGGESTIONS

This research is significant as it draws suggestions for improving quality of care in long-term care facilities. The first suggestion that arises relates to the point of reactivity (or lack thereof) from the Ministry in the COVID-19 pandemic. This is evidently not acceptable, and it should not have taken so many deaths, the media drawing attention to the issue, and military stepping in to have controlled the outbreaks. As discussed in the interviews, long-term care facilities fell victim to political economy as resources were mostly allocated towards hospitals to protect patients and staff because they were deemed more important. However, this political decision was made without a full consideration of all the different aspects involved, for example, as discussed in the analysis, long-term care facilities tend to be more susceptible to influenza spread due to staffing, structural differences, and the vulnerable population. Residents of long-term care deserve equal quality of care per level of need as patients in hospitals. We do seem to be making some progress in ensuring this imbalance does not happen to such an extent in the future, however, these decisions and changes need to be evaluated by academics and experts to ensure all pieces of the puzzle are considered.

As well, the work of caretakers in these facilities needs to be appreciated and workers deserve compensation relatable to their workload and contribution. The analysis demonstrated that there is a variance in compensations between long-term care facilities and hospitals. Once again, political economy plays a role as demonstrated through hospitals receiving funding for more nurses and better salaries. The standards of work and healthcare provider respect need to be

raised to be equal throughout long-term care, and also in relation to hospitals. It has been demonstrated in this research that long-term caretakers need to be just as qualified and certified as hospital caretakers, this means more nurses and adequate training for the PSWs. The quality of care will be improved upon having the qualified staff to care for the residents and have the ability to deal with the multiple co-morbidities that the residents typically have.

Finally, in agreement with the fact of a lack of proper funding for the long-term care institutions, there does indeed need to be a reallocation of budgets and resources to ensure these facilities get sufficient funding and employees to run properly. There is and will continue to be a high demand for nurses and caretakers in this sector, which will continue to create a stress on the resources allocated. This begs the question of whether the overall structure long-term care currently possesses will work for the massive influx that will likely results from the baby-boomer generation aging. Political entities involved in the long-term care system and the decisions made around it need to ask, is the current structure of long-term care economically efficient, and further, does it make sense for the most dignified and effective care for the population? This analysis points towards the answer of no due to the resourcing issues and waitlists, however its scope does not cover these questions and more research is required. In long-term care institutions, policymakers should see efficiency and equity as one and the same to ensure resources are allocated on the basis of need, and need is the efficient way to allocate resources. Additionally, this concept relates to the point that for-profit facilities cannot profit off of care, therefore, they need to find other ways to cut and make profit. Resources for quality of life are typically, then, the areas which take the hits. This begs the question of whether having for-profit, not-for-profit and municipally run facilities really makes sense or if there could be more

guidelines in place to ensure no one tries to cut corners. These questions will be discussed further in the future research section.

Using a political economy perspective in this research allowed for many power relations to be highlighted and expanded upon my initial scope of where to look for power relations. Adding the layer of comparing healthcare institutions between one another (long-term care and hospitals) was a key addition to this piece. As well, looking at seniors as a commodity from the perspective of political economy really enhanced this research (McDonnell et al, 2009). It demonstrated how the market takes advantage of vulnerable populations like seniors and makes something that is essential to them, cost money. On top of this, the market increases costs when individuals in long-term care require more or extra care. This is a perfect example of a power relation which political economy highlighted in my research.

It was interesting using expert interviews for this research, as it demonstrates another power relation, that between long-term care residents and academics/advocates. While many of the experts I interviewed had experience working directly with long-term care residents, it reinforces the fact that they are unable to use their own voices to advocate. This is quite the dilemma, as academics do not want to put the vulnerable population in harm's way through incorporating them in research, however, it is also important to understand their concerns. They must rely on advocates and experts to speak for them, which is why expert interviews were the next best option for this research with the multiple constraints that existed.

COVID-19 Impact

While this initial research project began well before the COVID-19 pandemic, it happened that the data collection phase took place during it. This resulted in many limitations for data collection which will be reflected in the limitations section of this chapter. Nevertheless, it

also added an additional consideration and layer to the research which needed to be analyzed. The pandemic highlighted much of what this research was looking to uncover in terms of quality of care, resource allocation in the healthcare system, and political economy's impact on residents. It was an eye-opening experience for much of society through the media attention it received, especially with the findings of the military when they were brought in.

As discussed throughout the analysis, COVID-19 had devastating impacts on the long-term care facilities, from the residents to the caretakers. Through deaths, isolation and, for some, horrible living conditions, it was made abundantly clear that there was a massive problem in long-term care, especially in Ontario. These are issues that were raised throughout the interviews in this research and have created more studies to be done on this sector, which will hopefully create continuous improvements.

LIMITATIONS

In research, there are often limitations which occur for the researcher that are out of their scope or which they are unable to control. Throughout this research project I found myself realizing a variety of limitations for myself which are important to note, and which could potentially be addressed in future studies on the topic.

A limitation but also a valuable piece of information which I encountered in this research experience came as a result of data accessibility issues. My original plan for this project involved an analysis of the data in the Statistics Canada "nursing and residential care facilities survey" (NRCFS) to understand the level and quality of care in these facilities (especially by ownership status). This data was not available to me or any other researchers, either as a public use file or through the Research Data Centre. The survey is mandatory, which makes it even more concerning that results are not made available to researchers and reinforces the view that

some actors involved in resource allocation may be hiding something in their cost structure or case mixes. Work needs to be done to ensure a more open and transparent government or long-term care sector.

The COVID-19 pandemic also caused some delays and complications in the research which added some limitations. Due to the stressful environment that long-term care facilities had throughout the pandemic, my original plan to interview frontline workers and managers of these facilities was no longer ethical. This would have beneficial to understand from an insider's first-hand experience of the result of funding. Therefore, I had to find a new way of gathering information, which required me to re-submit the ethics application for this project. Ethics was already quite backed-up due to the incoming projects looking at COVID-19, and therefore, my timelines were quite constrained when I finally received ethics clearance and was able to begin the interview phase. As the interviews took place during the July/August timeframe, many people were on vacation and I was unable to schedule time with them for an interview.

Ethically, it would not have been feasible to interview seniors even without COVID. Due to the vulnerability of the demographic and the difficult topics of mistreatment, quality of care, etc. It would have been an extremely sensitive topic for a multitude of people, and I would have had difficulty finding participants from any sphere related to these institutions and many ethical considerations would have been required. I do recognize, however, that this would have allowed an opinion from many individuals who do not normally have a voice, including the vulnerable population of seniors. It would have also allowed the potential to speak to the caretakers who work in these facilities and are currently the ones being addressed as one of the roots of the problem, these individuals' inputs are advantageous as they understand the reality of the workplace and would offer genuine solutions.

Future Research Directions

This brings me to my final point, which is potential research which should be conducted around the topic of resource allocation in long-term care to enhance the knowledge and give new direction to how to prevent the issue in the future. To begin, future research that would be beneficial would be, as previously mentioned, evaluating the current structure of long-term care. Research which looks into the efficiencies involved with facility size and resource allocation processes could demonstrate possible ways to adjust the long-term care structure as it currently exists. One would need to consider this from both a financial and resident perspective to make sure it is not just benefiting for-profit or governmental entities. This research could be conducted by comparing other models of long-term care, in other parts of the world, that prove to have success in care and well-being, while still being efficient financially. Research in this area could also look to the different ownerships of facilities, those being for-profit, not-for-profit and municipal, to dive deeper into the differences of care, in terms of both quality of care and of life, to see if cuts are being made inappropriately. If this is the case, perhaps some research needs to look into whether having these different levels of ownership makes sense for the long-term care sector.

Another potential for research is, as discussed as a limitation in this study, interviews or even surveys involving the participation of frontline workers and staff in long-term care facilities. The input of these individuals is key to understanding realistic and practical changes that can be made in these facilities to alleviate certain pressures which can result in poor quality of care, or neglect. It is also worth noting whether or not these individuals are aware of the funding procedures that long-term care uses. Engaging with new or upcoming nurses would also

help with understanding how unions and the sector in general can make working in a long-term care facility more appealing.

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APPENDIX 1

Email Recruitment Script
Samantha Pollex BA,
Masters Candidate in Health and Aging
Elder abuse in Ontario long-term care facilities: How does funding affect the risk of mistreatment?

E-mail Subject line: McMaster Study – Elder abuse in Ontario long-term care facilities: How does funding affect the risk of mistreatment

I am inviting you to participate in an interview via telephone or video calling (Zoom) that will take about 45-60 minutes. As part of graduate program in Health and Aging at McMaster University, I am carrying out a study to gather information on the experts' knowledge and reaction to the current state of long-term care facilities, and the impact funding has had on this state. I'm interested in learning if this population believes that the resources are sufficient to give an adequate quality of care to the residents within these facilities.

I located/found your name by visiting the _____website, based on your position/academic interests, I believe you may be interested in helping with this study.

You can stop being in this study any time during the interview and afterwards up to 2 weeks after the interview. I have attached a copy of a letter of information about the study that gives you full details. This study has been reviewed and cleared by the McMaster Research Ethics Board. If you any have concerns or questions about your rights as a participant or about the way the study is being conducted, you can contact:

The McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Research Office for Administration, Development and Support (ROADS)
E-mail: ethicsoffice@mcmaster.ca

I would like to thank you in advance for your time and consideration.

Samantha Pollex, BA,
Masters Candidate in Health and Aging
Department of Health, Aging and Society
McMaster University, Hamilton Ontario
Tel: 613-795-6975 pollexs@mcmaster.ca

APPENDIX 2

Telephone Recruitment Script

Samantha Pollex BA,
Masters Candidate in Health and Aging

Elder abuse in Ontario long-term care facilities: How does funding affect the risk of mistreatment?

Hello, my name is Samantha Pollex, I am a Master's candidate in Health and Aging. I am inviting you to participate in an interview via telephone or video calling, via Zoom, that will take about 45-60 minutes. As part of graduate program in Health and Aging at McMaster University, I am carrying out a study to gather information on the experts' knowledge and reaction to the current state of long-term care facilities, and the impact funding has had on this state. I'm interested in learning if this population believes that the resources are sufficient to give an adequate quality of care to the residents within these facilities.

I located/found your name by visiting the ___ website, based on your position/academic interests, I believe you may be interested in helping with this study.

You can stop being in this study any time during the interview and afterwards up to 2 weeks after the interview. I have attached a copy of a letter of information about the study that gives you full details. This study has been reviewed and cleared by the McMaster Research Ethics Board. If you any have concerns or questions about your rights as a participant or about the way the study is being conducted, you can contact "The McMaster Research Ethics Board Secretariat". I can provide their contact information if you so wish.

Do you have an interest in participating? You can have a week to think about and then please let me know by contacting me at 613-795-6975 or via email at pollexs@mcmaster.ca.

APPENDIX 3

Semi-Structured Interview Guide

Participant #:

Interview introduction:

Length: 45-60 minutes
Primary goal: To understand your experience and knowledge with the funding allocation for long-term care facilities. There will be no questions asked regarding cases of elder abuse.

Consent:

Verbal consent is given and recorded at this time and kept in a log on the Student Principal Investigator's password protected laptop.

Background information:

Overview: Invite interviewee to briefly introduce themselves and their experience with long-term care facilities.

Knowledge of funding procedures:

- What is your knowledge of the funding procedure for long-term care facilities?

Funding experiences:

- What are some aspects in which funding allocation is done fairly?
    a. Discussion on for profit, not for profit and municipal differences
- Research/experience in relation to LTC funding generally.
- Research/experience senior programs in relation to funding
- Research/experience with staffing in relation to funding
    a. Training
    b. Staffing levels

Quality of care:

- In our experience, does the funding allocation affect the level of care provided to residents?
- Could something be improved?

Impacts of COVID

- Views of what could be done better
- Link to article to discuss findings.

Thank you, if you have a contact you believe I would be interested in speaking with, please reach out.

APPENDIX 4

Snowball Recruitment Script (via e-mail)

Samantha Pollex BA,
Masters Candidate in Health and Aging

Elder abuse in Ontario long-term care facilities: How does funding affect the risk of mistreatment?

E-mail Subject line: McMaster Study – Elder abuse in Ontario long-term care facilities: How does funding affect the risk of mistreatment

(As discussed during previous exchanges/interview/etc.,) Would you be willing to pass along my name and contact information, and the following short description of my study, to your friends or co-workers who may be interested in participating? There is no obligation for you to pass along this information, and there will be no penalty if you do not provide this information.

The study is taking place to gather information on the experts' knowledge and reaction to the current state of long-term care facilities, and the impact funding has had on this state. It is interested in learning if this population believes that the resources are sufficient to give an adequate quality of care to the residents within these facilities.

You can find out more information by reaching out to:

Samantha Pollex, BA,
Masters Candidate in Health and Aging
Department of Health, Aging and Society
McMaster University, Hamilton Ontario
Tel: 613-795-6975 pollexs@mcmaster.ca

APPENDIX 5

McMaster University
Inspiring Innovation and Discovery

Study about Elder abuse in Ontario long-term care facilities: How does funding affect the risk of mistreatment
Researcher: Samantha Pollex

Oral Consent Script

Introduction:
Hello. I'm Samantha Pollex. I am conducting interviews about the resident neglect in Ontario long-term care homes. I'm conducting this as part of research for my master's thesis at McMaster University's Department of Health, Aging and Society in Hamilton, Ontario. I'm working under the direction Dr. Michel Grignon of McMaster's department of Health, Aging and Society.

I located/found your name by visiting the websites of *[insert website name]; b*y having your name suggested to me by *[possibly insert name of contact here, if appropriate].*

Study procedures:
I'm inviting you to do a semi-structured, one-on-one interview over Zoom that will take about 45-60 minutes. This study will use the Zoom platform to collect data, which is an externally hosted cloud-based service. A link to their privacy policy is available on the website https://zoom.us/privacy. Please note that whilst this service is approved for collecting data in this study by the McMaster Research Ethics Board, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the research team. Please talk to the researcher if you have any concerns. You can also phone into the Zoom platform if that method is preferred. With your permission, the interview will be audio-recorded using the researchers personal cellphone and then transcribed immediately following the interview. We can set up a time that works for us both.

I will be asking you questions about your reaction to the article listed in the Letter of Information titled "The case for public long-term care insurance", knowledge of the funding procedure for long-term care facilities, especially in Ontario, areas you think could be improved in long-term care, and your experience with this topic throughout the COVID-19 pandemic.

Risks:
The risks involved in participating in this study are minimal. You may feel distressed discussing some of the sensitive topics such as the COVID-19 related issues. As the video-conferencing platform, Zoom, will be used, I have taken many precautions to ensure I am using it in the safest way. I will automatically generate Meeting IDs and require a meeting password, the video will be set to "off" initially, you will be able to join in by telephone if you prefer, you will be muted upon entry and a waiting room will be enabled to ensure no uninvited guests can participate.

You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. I will remind you of this prior to the start of the interview. And you can withdraw at any time. I describe below the steps I am taking to protect your privacy.

Benefits:
I hope to learn more about why the COVID-19 pandemic devastated the long-term care facilities, and how exactly the finding from the article about the death rate in for profit facilities was higher. I hope that what is learned as a result of this study will help us to better understand the resource allocation of Ontario long-term care facilities. This could help highlight improvements that could be made and create better circumstances for residents as well as frontline workers. Participants may not benefit from participating in the study.

You are participating in this study confidentially. I will not use your name or any information that would allow you to be identified. No one but me or other members of the research team will know whether you were in the study unless you choose to tell them.

The information/data you provide will be kept in a password-protected computer where only I will have access to it. Prior to one year after the study has been completed, the data (transcribed interviews) will be destroyed.

Voluntary participation:

- Your participation in this study is voluntary.
- You can decide to stop at any time, even part-way through the interview for whatever reason, or up until approximately **2 weeks after the interview date.**
- If you decide to stop participating, there will be no consequences to you.
- If you decide to stop, we will ask you how you would like us to handle the data collected up to that point.
- This could include returning it to you, destroying it or using the data collected up to that point.
- If you do not want to answer some of the questions you do not have to, but you can still be in the study.
- If you have any questions about this study or would like more information you can call or email Samantha Pollex at **(613) 795-6975** or pollexs@mcmaster.ca.

This study has been reviewed and cleared by the McMaster Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Research Office for Administration, Development & Support (ROADS)
E-mail: ethicsoffice@mcmaster.ca

I would be pleased to send you a short summary of the study results when I finish going over our results. Please let me know if you would like a summary and what would be the best way to get this to you.

Consent questions:

- Do you have any questions or would like any additional details?
- Do you agree that the interview can be audio recorded?
- Would you like to receive a summary of the study results? If yes, How mail/email?
- Do you agree to participate in this study knowing that you can withdraw at any point with no consequences to you?
  [If yes, begin the interview.]
  [If no, thank the participant for his/her time.]

APPENDIX 6

DATE: _____

LETTER OF INFORMATION
A Study about Elder abuse in Ontario long-term care facilities: How does funding affect the risk of mistreatment

Faculty Supervisor:
Dr. Michel Grignon
Department of Health, Aging, and Society
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 23493
E-mail: grignon@mcmaster.ca

Student Investigator:
Samantha Pollex
Department of Health, Aging and Society
McMaster University
Hamilton, Ontario, Canada
(613) 795-6975
E-mail: pollexs@mcmaster.ca

Purpose of the Study:
You are invited to take part in this study on the funding in Ontario long-term care facilities. We want to determine experts' views on the funding procedure in long-term care facilities. We are hoping to learn if there are particular pain points where funding is scarce and should be reviewed.

I am doing this research for a Master's thesis in Health and Aging.

Procedures involved in the Research:
To gather an understanding prior to participating in this study, it is encouraged that you read the article "The case for public long-term care insurance" (https://policyoptions.irpp.org/magazines/may-2020/the-case-for-public-long-term-care-insurance/).

You will be asked to participate in a semi-structured one-on-one interview which will last approximately 45 to 60 minutes. This study will use the Zoom platform to collect data, which is an externally hosted cloud-based service. A link to their privacy policy is available here (https://zoom.us/privacy). Please note that whilst this service is approved for collecting data in this study by the McMaster Research Ethics Board, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the research team. Please talk to the researcher if you have any concerns. You can also phone into the Zoom platform if that method is preferred. With your permission, the interview will be audio-recorded using the researchers personal cellphone and then transcribed immediately following the interview.

I will be asking you questions about your reaction to the article, knowledge of the funding procedure for long-term care facilities, especially in Ontario, areas you think could be improved in long-term care, and your experience with this topic throughout the COVID-19 pandemic.

Potential Harms, Risks or Discomforts:
The risks involved in participating in this study are minimal. You may feel distressed discussing some of the sensitive topics such as the COVID-19 related issues. As the video-conferencing platform, Zoom, will be used, I have taken many precautions to ensure I am using it in the safest way. I will automatically generate Meeting IDs and require a meeting password, the video will be set to "off" initially, you will be able to join in by telephone if you prefer, you will be muted upon entry and a waiting room will be enabled to ensure no uninvited guests can participate.

You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. I will remind you of this prior to the start of the interview. I describe below the steps I am taking to protect your privacy.

Potential Benefits:
I hope to learn more about why the COVID-19 pandemic devastated the long-term care facilities, and how exactly the finding from the article about the death rate in for profit facilities was higher. I hope that what is learned as a result of this study will help us to better understand the resource allocation of Ontario long-term care facilities. This could help highlight improvements that could be made and create better circumstances for residents as well as frontline workers.

Participants may not benefit from participating in the study.

Confidentiality:
You are participating in this study confidentially. I will not use your name or any information that would allow you to be identified. No one but me or other members of the research team will know whether you were in the study unless you choose to tell them.

The information/data you provide will be kept in a password-protected computer where only I will have access to it. Once the study has been completed, the data will be destroyed.

Participation and Withdrawal:

Your participation in this study is voluntary. If you decide to be part of the study, you can withdraw from the interview for whatever reason, even after providing verbal consent or part-way through the study or up until **2 weeks after the interview date.**

If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

Information about the Study Results:

I expect to have this study completed by approximately **October 2020**. If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the Study: If you have questions or need more information about the study itself, please contact me at:

pollexs@mcmaster.ca
(613) 795-6975

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat
Telephone: (905) 525-9140 ext. 23142
C/o Research Office for Administrative Development and Support
E-mail: ethicsoffice@mcmaster.ca

APPENDIX 7

Literature Review Procedure:

1. See below for all searched keywords and exclusion criteria in the McMaster Online Library database
2. Narrowed down through looking, first at the title and dismissing any that did not seem relevant or that were already covered under a different keyword
3. Further narrowed down by reading abstracts and dismissing ones that would not add any benefit to the thesis
4. Some articles were also found using reference lists from previous studies or literature that I had previously read for other papers

*Note: sometimes articles repeated themselves in the search.

Searched Keywords	**Article Title**	**Authors**	**Country of Data**	**Year of Publication**
"Elder abuse" • English • Canada/US • Academic Journals • Available online = 562	A systematic review and meta-analysis of interventions designed to prevent or stop elder maltreatment	Ayalon, Lev, Green & Nevo	Netherlands, USA, Germany, Norway, Canada, Hong Kong, Iran, Japan, Sweden, Taiwan, UK, England	2016
	Re-examining the social construction of 'elder abuse and neglect': A Canadian perspective	Harbison, J. & Morrow, M.	Canada	1998
	Elder abuse and neglect in Canada: The glass is still half full	McDonald	Canada	2011
	Elder Abuse	Lachs & Pillemer	USA	2015
	Elder abuse: Disparities between older people's disclosure of abuse, evident signs of abuse, and high risk of abuse.	Cohen, Levin, Gagin, & Friedman.		2007
"InterRAI long-term care" • English	Development and validation of a screener based on interRAI assessments to measure informal caregiver	Betini, Hirdes, Curtin-Telegdi, Gammage, Vansickle, Poss, & Heckman	Canada	2018

• Available online • 2000-2019 = 67	wellbeing in the community			
	Chapter 3: Using interRAI assessment systems to measure and maintain quality of long-term care	Carpenter & Hirdes	Canada, USA, Iceland, Finland, China, UK, New Zealand, Belgium, Italy	2013
	Reliability of the interRAI long term care facilities (LTCF) and interRAI home care (HC)	Kim, Jung, Sung, Lee, Yoon & Yoon	South Korea	2015
"Elder abuse in long-term care" • English • Available online • 2000-2019 = 406	The prevention of abuse and neglect in Ontario long-term care homes.	Webb	Canada	2014
	Elder abuse and neglect in institutional settings: The resident's perspective.	Charpentier & Soulieres		2012
	You cannot protect elders unless you protect the institutions that care for them: How streamlining the definition of elder abuse will positively impact the long-term care industry	Pagels	United States	2016
	Public Policy, Elder Abuse, and Adult Protective Services: The Struggle for Coherence	Mixson	United States	2010
"Elder abuse policy" (more were used as part of the piece that was removed) • English • Available online • 2000-2019 = 736	Enhancing national policy and programs to address elder abuse	Dong & Simon	United States	2011
	A glass half full: The dubious history of elder abuse policy	Teaster, Wangmo, T & Anetzberger	United States	2010
	Preferences for long-term care services: Willingness to pay estimates derived from a discrete choice experiment	Nieboer, Koolman,& Stolk	Netherlands	2010
	Resource allocation in New York state long-	Ward	United States	2018

"Resource allocation in long-term care" • English • Available online = 164	term care facilities: Changes over time and ownership differences			
	Efficiency and Equity in Healthcare: An Analysis of Resource Allocation Decisions in a Long-Term Home Care Setting	Zhang, Fry & Krishnan.	??	2015
	Nursing staff time allocation in long-term care: A work sampling stud	Cardona, Tappen, Terrill, Acosta, & Eusebe	??	1997
	Assessment in adult protective services: Do multidisciplinary teams make a difference?	Ernst and Smith	United States	2011
"Elder abuse reporting" • English • Available online • 2000-2019 = 832	See no evil, hear no evil, speak no evil? Underreporting of abuse in care homes	Moore	United Kingdom	2010
	Generational differences in knowledge, recognition, and perceptions of elder abuse reporting.	Aday, Wallace & Scott		2017
	Combating the maltreatment of older persons by staff in long-term care nursing homes: Legal aspects	Natan & Tabak	Israel	2013
	Elder Mistreatment Reporting: Differences in the Threshold of Reporting between Hospice and Palliative Care Professionals and Adult Protective Service	Liao, Jayawardena, Bufalini, & Wiglesworth	??	2009
Other (retrieved in list of references of previous sources, through snowballing)	Judicial Response to Elder Abuse.	Howze, & White		2010
	Elder abuse: Key facts	World Health Organization		2020
	Staff Perspectives of Barriers to Access and Delivery of Palliative Care for Persons with Dementia in Long-Term Care.	Hill, Savundranayagam, Zecevic, & Kloseck.		2018

	Prediction of institutionalization in the elderly. A systematic review	Luppa, Luck, Weyerer, König, Brähler, & Riedel-Heller.		2010
	Maintaining the 'caring self' and work relationships: a critically informed analysis of meaning-construction among paid companions in long-term residential care	Funk & Outcalt		2019
	Legislation & Reporting	Elder Abuse Prevention Ontario		2020
	Adverse Events in Home Care: Identifying and Responding with interRAI Scales and Clinical Assessment Protocols	Sinn, Betini, Wright, Eckler, Chang, Hogeveen, . . . Hirdes	Canada	2018

APPENDIX 8

References: Creating and enforcing policies to monitor and prevent elder abuse

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Goodridge, D.M., Johnston, P., & Thomson, M. (1996). Conflict and aggression as stressors in the work environment of nursing assistants: Implications for institutional elder abuse. *Journal of Elder Abuse and Neglect, 8*(1), 49-67. doi:10.1300/J084v08n01_03

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Justice Canada (2015). *Legal Definitions of Elder Abuse and Neglect.* Retrieved from https://www.justice.gc.ca/eng/rp-pr/cj-jp/fv-vf/elder-aines/def/p212.html