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Comparison of Nursing Home Financial Transparency and Accountability in Four Locations

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Abstract The marketization and privatization of nursing home care has grown in many countries along with expenditures. Using documents and government reports, this study explored three research questions about nursing homes in California, Ontario, England, and Norway. What were: (1) the contextual and privatization differences; (2) payment methods and trends in revenues and expenditures for direct care, administration, and profits; and (3) the financial reporting and accountability systems? The findings showed nursing homes were highly privatized in all locations except Norway.

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Revenues and expenditures increased steadily in all locations. Direct care services were lower in California and England where privatization was highest. Administrative costs were high especially in for-profit companies, except in Norway's municipal nursing homes. Profit margins were generally not reported or under reported, but high margins were found in for-profits and chains where reports were available. Contrary to the hypothesis that financial transparency and accountability would increase with privatization, only California and the U.S. had developed detailed public financial reporting, although these reports could be improved. Ontario required detailed financial reporting except for administration and profits and the information was not publicly available. England and Norway had no public systems for financial reporting. None of the locations had cost controls on administration and profits, except for Medicaid administration controls in California. Policy makers need to focus on improvements in financial transparency and accountability to assure value for expenditures and to potentially improve quality.

Keywords Ownership · Accountability · Financing · Transparency

A major trend in Europe and Canada has been the marketization and privatization of nursing homes, similar to the long-standing pattern in the US. Marketization refers to government efforts to encourage and enforce competitive markets with buyers and sellers within the private or public sectors (Brennan et al. 2012; Meagher and Szebehely 2013). Privatization refers to shifts in ownership from government to private for-profit and non-profit companies. These contentious changes, supported by new public management theory to improve choice, efficiency, and effectiveness, have been found to have negative consequences on access and quality, and have not reduced

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overall costs (Allan and Forder 2012; Meagher and Szebehely 2013; Pollock et al. 2006; Vabo et al. 2013a,b).

Nursing home expenditures, which are a sizable proportion of total LTC expenditures in most countries, have been growing steadily (OECD 2014), in spite of cost containment efforts in some areas such as global budgeting (Di Giorgio et al. 2014). Marketization has encouraged the growth in size and complexity of nursing homes, especially for-profit nursing homes and chains in the U.S, Canada, the U.K, and other OECD countries (Baum 1999; Berta et al. 2006; Laing and Buisson 2013a,b). Some large nursing home chains are publicly traded companies while others are owned by private investors or private equity companies (Herning 2012; Institute of Public Care 2014; Stevenson et al. 2013). Many chains have diversified their holdings by purchasing other long-term care entities and have created multiple layers of corporate ownership and separate property companies or real estate investment trusts (REITs) to reduce taxes, litigation actions and regulatory oversight (Harrington et al. 2011; Herning 2012; Lloyd et al. 2014; Stevenson and Grabowski 2008; Stevenson et al. 2013; US GAO 2010).

The profit goals of publicly-traded and privately-held for-profit companies, which operate on the concept of shareholder value to benefit investors, conflict with government policies that attempt to slow costs (Harrington et al. 2014a,b). In the U.S., Medicare profit margins steadily increased until 2011 and then dropped following a payment reduction (MedPac 2014). Medicare profit margins in for-profit companies were three times greater than those of non-profit homes. In order to maintain high profits, for-profit nursing homes often reduce nurse staffing levels, labor costs, and patient expenses which can result in quality of care problems (Harrington et al. 2012b; Weech-Maldonado et al. 2012). Nursing homes with the highest profit levels have been found to have the most quality problems (O'Neill et al. 2003).

For-profit nursing home companies generally have poorer quality of care than non-profit and government facilities (Comondore et al. 2009; Grabowski et al. 2012; Harrington et al. 2012b; Hillmer et al. 2005; McGregor and Ronald 2011; O'Neill et al. 2003; US GAO 2009). The ten largest U.S. for-profit chains and other for-profit companies had lower nursing staffing levels and more numerous and serious violations of federal quality regulations compared to non-profit and government nursing homes (Harrington et al. 2012b). For-profit facilities also have higher hospitalization rates for pneumonia, anemia, and dehydration and emergency room use (McGregor et al. 2006; McGregor et al. 2014). Total nurse staffing and registered nurses (RN) staffing levels have been shown to improve care processes and resident outcomes and lower the rates of deficiencies (Bostick et al. 2006; Castle 2008; Spilsbury et al. 2011).

To address some of the problems of complex ownership structures, profit-taking, and poor quality of nursing home care, United States legislators passed the Nursing Home Transparency and Improvement Act as part of the Patient Protection and Affordable Care Act in 2010. Transparency can be defined as complete and accurate information to provide a clear understanding of ownership and financing, while financial accountability is answerability and account-giving for public funding. The Act included requirements for detailed ownership and financial reporting and stronger regulation (Wells and Harrington 2013). Financial transparency and accountability for public funding of nursing homes could also be a concern in other countries. This study was undertaken to explore nursing home financial transparency and accountability policies and how they are related to privatization levels in different locations.

Study Research Questions

Nursing homes in four geographical locations were examined: California, Ontario, England, and Norway. These locations were selected for two reasons. First, the authors had access to government documents and financial data from reliable sources and second, the locations have different LTC financing and reporting systems that allowed for useful comparisons. The study had three specific research questions. First, what were the contextual differences and the extent of privatization in nursing homes by location including: beds, ownership types, occupancy rates, total expenditures, and the percent of total nursing home expenditures paid by government? Second, what were the government nursing home payment systems and trends from 2007 to 2013 in revenues and expenditures by specific categories including direct care, administration, and profits? Finally, what were the nursing home financial reporting and accountability systems by location?

The general hypothesis was that greater privatization (i.e. a higher percentage of private for-profit nursing homes and chains) in a location will be associated with greater government financial transparency and accountability requirements. The rationale is that when governments have less direct control of nursing home expenditures in public facilities, they will choose to develop more detailed requirements for the allocation and spending of public funds as well as for reporting of how public funds are spent by private nursing homes. The goal would be to ensure value for public funding.

Although it is beyond the scope of the paper to examine whether greater transparency and accountability is associated with better care in different locations, the study assumes that this may occur. Because for-profit nursing homes and chains have reported lower staffing and poorer quality than non-profit and government facilities (Comondore et al. 2009; Grabowski et al., 2012; Harrington et al., 2012b; Hillmer et al. 2005; McGregor and Ronald 2011; O'Neill et al. 2003; US GAO 2009), facility-specific financial reporting and requirements for spending public funds may reduce nursing home financial decisions that result in poor care. Data for this study was obtained from government sources, market reports and documents, as well as survey data in Norway.

Methods

Study Design and Data Collection Descriptive financial data for 2007–2012/13 were collected on nursing homes in each location. Background documents were obtained describing the number of nursing homes, government reimbursement systems, and the number and type of nursing homes available.

In California, financial data were obtained for each nursing home from a mandatory annual cost report that has a uniform format and is publicly available (California Office of Statewide Health Planning and Development (OHSPD) 2013). All 861 free-standing nursing homes in California were included (excluding homes serving individuals with mental or developmental disabilities and hospital-based homes). In Ontario, government documents were collected describing the government's nursing home payment system, rates, aggregate revenues, and expenditures. The data for England were gathered from private industry market reports since government data on actual

expenditures were not available. In Norway, financial data for 2007 were collected from an on-site survey for a sample of 22 municipal nursing homes (as part of a larger study) located in 11 municipalities and 7 counties (Havig et al. 2011;2013). These data were trended forward at a 4 % inflation rate) because national government data were not available for individual facilities over time. The small sample of nursing homes in Norway may not be representative of other nursing homes, which is a study limitation.

Data Analysis The data were analyzed separately for each location on: (a) overall government expenditures and the number and type of nursing homes, (b) government reimbursement systems, (c) nursing home expenditures (or payment rates) by types of categories, (d) nursing home administration and profits by ownership types, and (e) financial reporting and transparency issues. Government payments or expenditures were presented by the categories each location used. The financial data were standardized by converting expenditures and profits to a percent of total revenues (or expenditures) by category. Study limitations on data were described by location.

Findings

United States and California

The U.S. has private health insurance for the general population and public health insurance for the aged and disabled. Long term care (LTC) is means-tested and about 0.6 % of gross domestic product (GDP) was spent on LTC in 2010 (OECD 2011). Nursing home spending in the U.S. increased steadily from $85 billion in 2000 to $155.2 billion in 2012 (US CMS 2014b). The majority of nursing home revenues came from Medicare (22.7 %) and Medicaid and other government programs (40.8 %) in 2012 (U.S. CMS 2014b).

In 2012, the U.S. had 15,643 nursing homes with about 1.7 million beds, and an excess supply of beds (with an occupancy rate of 82.5 %) (US CMS 2014a) (Table 1). Of the nursing homes, most (69 %) were for-profit and chains (55 %). California with over 1120 nursing homes also had an excess supply of beds. The state had substantially more for-profit nursing homes than the national average (Kaiser Commission 2013).

Nursing Home Payers and Payment Methods The federal Medicare program paid for about 1.7 million aged and disabled individuals who needed short-term nursing home care in 2011 (MedPac 2014). The Medicare program uses a prospective payment system (PPS) to pay for daily rates, adjusting for resident casemix (or acuity) and for regional wages and benefits (US CMS 2012). The payment methodology gives nursing homes a financial incentive to report that residents are in high case-mix groups (upcoding) (Bowblis and Brunt 2014; MedPac 2014). After Medicare payments are received, facilities may use the funds without regard to the payment formula, as long as they submit annual cost reports which are not audited by government.

The state Medicaid program pays for low-income aged and disabled people who meet each state's financial eligibility and need criteria for nursing home care. States are given wide flexibility in establishing state payment methods and rates; most states pay on a prospective per diem basis, taking resident case-mix into account (Miller et al.

Table 1 Nursing home beds, ownership, and expenditures, 2012

	United States[a–d]		Canada[e]		England[f,g]	Norway[h,i]
	US	California	Canada	Ontario		
Number of Facilities	15,643	1120	1357	609	4672	992
Number of Beds	1,700,000	110,833	144,198	75,282	215,463	41,732
Average Number of Beds	109	98	106	124	46	42
Ownership Type (%)						
For-profit	69 %	88.1 %	43 %	61 %	52 %	4.3 %
Non-profit	25 %	11.5 %	30 %	21 %	44 %	5.2 %
Government	6 %	0.4 %	27 %	18 %	4 %	90.5 %
Chains (%)	55 %	51 %	30 %	NA	48 %	4 %
Occupancy Rates (%)	82.5 %	85.5 %	92.9 %	92.8 %	90 %	98 %
Total Expendi-tures (US $ in billions)	$155.2	$9.7	$9.9 ($9.8 Can)	$5.0 ($5.0 Can)	$7.60* (L 4.8)	$6.0 (NOK 42)
% Paid By Government	63.5 %	80 %	73 %	70 %	57 %	86 %

[a] U.S. Centers for Medicare and Medicaid Services (CMS). (2014a)

[b] U.S. Centers for Medicare and Medicaid Services (CMS). (2014b)

[c] California Office of Statewide Health Planning and Development (2014).

[d] Kaiser Commission on Medicaid and the Uninsured (2013)

[e] Canadian Institute for Health Information (2014). Health Spending on Nursing Homes 2012 Ottawa, Ontario: CIHI. ISBN 978-1-77,109-232-6 November 25. (In Canadian Dollars) https://secure.cihi.ca/free_products/infosheet_Residential_LTC_Financial_EN.pdf

[f] England Care Quality Commission. (2013)

[g] Laing and Buisson (2012/13). (*estimated)

[h] Statistics Norway (2014a, b, c). Nursing and Care Services. July 2014. (In Norwegian Kroner) http://www.ssb.no/en/helse/statistikker/pleie/aar-forelopige/2014-07-08#content https://www.ssb.no/statistikkbanken/SelectVarVal/Define.asp?MainTable=KostHelseTjen&KortNavnWeb=helsesat&PLanguage=0&checked=true; http://www.ssb.no/offentlig-sektor/kommune-stat-rapportering/kostra-databasen

[i] Herning, L. (2012). Konkurranseutsatte sykehjem i Norge. *Notat*, *1*, 2012., ISBN 978-82-92,515-11- 2

2009). California has a complex Medicaid prospective rate setting system where each facility receives its own rate, based on its past expenditure pattern for five cost categories with ceilings on the categories except for profits (Mukamel et al. 2012). California nursing facilities are audited for rate-setting purposes only, and facilities do not have to spend Medicaid funds within established cost categories.

California Nursing Home Revenues and Expenditures California's 861 free-standing nursing homes had $7.4 billion in revenues from all sources in 2012 (a 28 % increase between 2007 and 2012) (Table 2). Expenditures for nursing care were 35 % of total revenues in 2012, and the percent of nursing expenditures declined steadily (by 11 %) over the study period (Table 2). Nursing and ancillary therapy expenditures were a total of 48 % of revenues in 2012. Ancillary expenditures increased while support services (16.6 % of the total) declined steadily as a proportion of total revenues, and property costs declined slightly.

Table 2 California Nursing home expenditures and profits as a percent of revenues, 2007 to 2012

	2007 N = 881	2008 N = 879	2009 N = 876	2010 N = 873	2011 N = 850	2012 N = 861	Change in % of Total 07–12
Total Revenues	$5.8 B	$6.3 B	$6.7 B	$7.0 B	$7.2 B	$7.4 B	27.6 %
Expenses							
Nursing & direct care	39.2 %	37.8 %	36.4 %	35.7 %	34.5 %	34.9 %	−11.0 %
Ancillary services	11.3 %	12.1 %	12.4 %	12.6 %	12.8 %	13.4 %	18.6 %
Support services	18.1 %	17.9 %	17.2 %	17.0 %	16.5 %	16.6 %	−8.3 %
Property	7.8 %	7.6 %	7.5 %	7.3 %	7.3 %	7.5 %	−3.8 %
Fees & other	4.7 %	4.7 %	4.9 %	6.4 %	6.7 %	7.5 %	59.6 %
Income tax	0.2 %	0.3 %	0.3 %	0.3 %	0.3 %	0.2 %	0 %
Administration	15.5 %	15.2 %	15.6 %	15.0 %	15.4 %	15.5 %	0 %
Profits	3.1 %	4.4 %	5.7 %	5.6 %	6.5 %	4.4 %	41.9 %

Source: California Office of Statewide Health Planning and Development Financial Data, 2007–2012. Revenues are reported in billions. Includes all free standing nursing; excludes facilities with residential care and those with developmental disability or mental health residents

Note: Direct care services included the labor costs for nursing managers and nursing personnel. Ancillary services included therapy services, supplies, pharmacy, laboratory and other services. Support services included: plant operations and maintenance, laundry and linen, dietary, social services, and in-service education. Capital costs included depreciation, leases and rentals, interest, property taxes, insurance and interest on the property. Other expenses included other interest payments, provision for bad debts, income taxes, quality assurance fees, and licensing fees. The administrative expenses included all administration except Medicaid quality assurance fees and licensing fees. Profits were the net income from health operations

California Administrative Costs and Profits Administrative expenses were stable at 15.5 % but varied widely across facilities. (Table 2). For-profit nursing homes had substantially higher administrative costs (15.6 %) than government homes (7.9 %) and non-profits (13 %). Profits margins increased to 6.5 % in 2011 and declined to 4.4 % in 2012, after the state instituted a Medicaid rate cut (Table 2). Over the period, total profit margins increased by 42 %. Profit margins in California nursing home chains (103 chains) were double the rate for non-chains in 2012 (no table). The combination of administrative costs and profits was 20 % in for-profits, 16.9 % in non-profits, and 13.6 % in government. Some California nursing homes had administrative costs and profits that exceeded 20 % of total revenues, defined as excessive in one study (Harrington, et al. 2013).

California Policy Issues Even though California has a uniform cost report that provides publicly available data, many sources of profits are not required to be reported on the cost reports. Some hidden or unreported profits are included in: parent company fees; management company fees; expenses paid to other companies owned by the parent company (related party transactions); leases and rental agreements with property companies owned by the parent company; interest rates on loans paid to the parent companies; and the owners' use of company assets (Harrington et al. 2014a). These nursing home expenses may result in profits to the owners of parent companies and their related companies that are not disclosed.

California and other states have had long-standing quality problems and weak regulatory oversight of providers (California State Auditor 2014; Harrington et al., 2014b; US GAO 2009; 2010; US OIG 2014). To improve transparency in nursing home quality, the Centers for Medicare and Medicaid Services (2013) developed a federal website rating system which identifies many quality problems based on nursing home deficiencies, enforcement actions, staffing levels, and quality measures. Some of the reported quality problems may be related to market pressures for profit-taking.

Canada and Ontario

Canada has a government-funded health system. Home care and institutional care are funded by the government and operated at the provincial/territorial (OECD 2011). Canada spent about 1.2 % of its GDP on LTC in 2010 (OECD 2011). Canadian nursing home expenditures were $9.9 billion in 2012 (excluding residential care, physician, drug costs and excluding expenditures for Quebec) (CIHI 2014). (See Table 1). The public share of spending was 73 % split between provincial/territorial and/or regional authorities.

Canada had 1357 nursing homes with 144,198 beds in 2012. Of the total beds, 43 % were for-profit, 30 % were non-profit, and 27 % were municipally owned and 30 % were chains (CIHI 2014). (Table 1). Ontario, Canada's largest province, reported 609 nursing homes and 61 % were for-profit, with a growing percent owned by chains. In Ontario, the 10 largest nursing home chains owned and operated 28–30 % of the homes and beds (calculated from website data, OMHLTC 2014). Ontario nursing homes reported over 90 % occupancy rates, with the median waiting time of 73 days in for-profit homes, 166 days in non-profit homes, and 129 days for municipal in 2013 (Ontario Association of Non-Profit Homes and Services for Seniors, personal communication 2014).

Eligibility and service policies for nursing homes, staffing requirements, government reimbursement policies and payment levels, as well as quality regulations vary within and across provinces in Canada (Berta et al. 2006). In Ontario, 14 Local Health Integration Networks are mandated to plan, fund, conduct competitive bidding, and coordinate services delivered by 14 Community Care Access Centers (CCACs) that also determine eligibility and arrange admissions to nursing homes.

Ontario Nursing Home Payment System Ontario reimburses nursing homes using a per diem rate for each licensed bed divided into four funding categories (called envelopes) (OMHLTC, 2012b). Each resident pays a co-payment for a basic room ($1731 per month in 2012), private room ($2438 per month), or semi-private room ($2066 per month), which goes directly to the providers (Long-Term Care Homes Act 2007). Residents who cannot afford to pay and/or need to dependent support can apply for a rate reduction.

Nursing and personal care payments for short stay respite beds are adjusted for the average case mix, but not for long-stay residents (OMHLTC 2012b). In 2013, a high intensity need fund ($0.063 per day) was established for special care (OMHLTC 2012b). An extra per diem was also added for raw food ($0.12 per day) for high

intensity care categories. Construction funding for new or renovation of facilities was available separately (about $14.30 and $14.80 per diem) in 2012/13 (OMHLTC 2014).

Ontario Nursing Home Rates Table 3 shows the annual payment rates by category in Canadian dollars from 2007 through 2012 (OMHLTC 2012b). The percentage of total payments allocated for nursing and personal care services increased slightly over time to 56 % of payments in 2012. Program and support services remained fairly stable (5 % of total payments), while raw food costs (5 % of total payments) increased. Finally, the other accommodation payments declined slightly from 34.7 to 33.6 % of payments. The total payments increased from $132.32/day to $155.19/day (17 %) with a corresponding increase in copayments. New 2013 rules gave providers greater flexibility to shift surplus funds across categories (excluding raw foods and accommodations) (OMHLTC 2012a). Unspent or surplus funds for nursing, programs and support and raw food must be returned to the government at the end of the year, although these may be reallocated for special needs.

Although facility-level data were not publicly available, actual aggregate revenues including co-payments were $4.9 billion while expenditures were $5.0 billion (CIHI, 2014). Aggregate per diem expenditures were $182.43 in 2012, or 17.6 % higher than the government payment rates because facilities received copayments and other revenue sources (Table 3). Of total actual expenditures, 54 % was for nursing and personal care and 36 % was for other accommodations (CIHI, 2014).

Nursing Home Administration and Profits Administration and profits were not identified separately in the per diem payment rates. Unlike the other three payment categories, no ceilings were placed on the accommodation category and no requirements for a return of funds at the end of the year, so that extra funds were profits. Nursing homes were able to shift some accommodation costs into the nursing and personal support category over time in order to increase profits, probably because of a lack of specificity regarding the accommodation category (Canadian Union of Public Employees, 2011). Aggregate administration expenditures were $25.08 per day (13.7 % of total expenditures) and other accommodations including profits were 22.4 % of the total (CIHI, 2014).

Profit margins were not reported by the government but data were available for three large publicly-traded chains. The largest chain, Extendicare (2012) reported $525 million in revenues in 2012 from its Canadian operations and 9–10 % profits between 2007 and 2012. Chartwell (2012) and Leisureworld Senior Care Corportation (2010-2012) reported revenues of $206 million and $319 million respectively and had profit margins of 11–13 % in 2012. Some of their reported profits may be from related businesses. Most revenues were from government payers (65–70 %).

Ontario Policy Issues Ontario had a number of reports of poor quality care that led to passage of the Long Term Care Homes Act in 2007. Continued quality problems have led to complaints that the legislation did not set a minimum staffing standard and failed to protect residents in the inspection and enforcement process (Ontario Health Care Coalition 2012; Canadian Union of Public Employees (CUPE) 2009; 2011). The government established a public reporting system for quality inspection data in 2010 that shows many quality problems (OMHLTC, 2014) and facility quality indicators

Table 3 Ontario ministry of health nursing home resident per diem payment rates and actual expenditures (in Canadian dollars)

Per Diem Payment Rates[a]							Change in % of Total 2007–12	Actual Per Diem Expenditures[b]
	2007	2008	2009	2010	2011	2012		2012
Nursing and Personal Care Services (1)	$73.69 (55.7 %)	$76.07 (55.4 %)	$79.60 (55.5 %)	$82.25 (56.0 %)	$86.05 (56.3 %)	$86.91 (56.0 %)	0.5 %	$98.61 (54.1 %)
Program and Support Services (2)	$7.12 (5.4 %)	$7.25 (5.3 %)	$7.57 (5.3 %)	$8.09 (5.5 %)	$8.35 (5.5 %)	$8.43 (5.4 %)	0	$8.01 (4.4 %)
Raw Food (3)	$5.57 (4.2 %)	$7.15 (5.2 %)	$7.31 (5.1 %)	$7.33 (5.0 %)	$7.46 (4.9 %)	$7.68 (4.9 %)	16.7 %	$9.82 (5.4 %)
Other Accommodations (4)	$45.94 (34.7 %)	$46.74 (34.1 %)	$49.14 (34.2 %)	$49.26 (33.5 %)	$51.08 (33.4 %)	$52.17 (33.6 %)	−3.2 %	$65.99 (36.1 %)
Total Per Diem Payments	$132.32	$137.21	$143.52	$146.97	$152.94	$155.19	17.3 %	$182.43

1. salaries, wages, benefits, training, equipment, supplies, and devices, repair, purchased services for active direct care staff as well as medical director fees, and personal support workers. 2. salaries and benefits and purchased services for active therapy staff, coordinators, social workers, and dieticians as well as training, equipment, supplies and devices, computing, and maintenance and repair. 3. food materials and supplements. 4. salaries, benefits, education, training, and other costs and services for housekeeping and laundry; equipment, buildings, property operations; maintenance, laundry and linen, administrative services; and profits. Actual administrative expenditures were $25.08 per day or 13.7 % of total expenditures and included in the other accommodation category

*Rates shown are based on July 1 of each year

[a] Ontario Ministry of Health and Long-Term Care (2013). Per Diem Payment Rates

[b] Canadian Institute for Health Information (2014). Health Spending on Nursing Homes 2012 Ottawa, Ontario: CIHI. ISBN 978-1-77,109-232-6 November 25. (In Canadian Dollars). https://secure.cihi.ca/free_products/infosheet_Residential_LTC_Financial_EN.pdf

(e.g. restraints, anti-psychotics, falls) are expected to be reported in 2015. Quality problems may be linked to low staffing levels, long waiting lists, low funding levels, and private for-profit ownership.

Each long-term care home in Ontario was required to submit an audited annual reconciliation report, a management information system report (not audited), and a staffing report (not audited). Facilities reported total revenues and expenditures to the national database (CIHI) for aggregate comparisons across provinces and territories but facility-specific data were not made publicly available.

England

Health services are a devolved function in the U.K to the four nations of England, Wales, Scotland and Northern Ireland (Pollock 1999). Each Nation has a national health service funded from taxation and largely free at point of use, but the legislation, delivery system, funding share, and data collection differ markedly. In 2012, the government in England passed the Health and Social Care Act 2012 to abolish the National Health Service (NHS) as a system of care (Pollock and Price 2011). Under the Act 2012, the government finances health care through a system of local authorities, general practice commissions, and private providers rather than through the NHS. The LTC system is funded in part through income tax (which goes to both the NHS and local authorities) with means testing to determine LTC eligibility, under the jurisdiction of local authorities/local government.

The U.K spends less than 1 % of GDP on LTC (OECD 2011). A total of £24 billion was spent on LTC in the UK in 2011, of which £14 billion was spent on residential care (care homes and nursing homes). Of the £14 billion spent on residential care, £10 billion was spent in the independent sector (for-profit and not-for-profit), of which 7.2 % (£720 million) was paid for by the NHS (National Audit Office 2011; Laing and Buisson 2011/12). Total government spending in England for nursing and residential homes was estimated at $7.6 billion in US dollars (£4.8 billion) for 2012 (Table 1). The remaining expenditures were for day and domiciliary care and other services (Health & Social Care Information Centre 2013a).

England reported having 4672 nursing homes with 215,463 beds for all population groups (excluding residential care homes) in 2012, and most beds (85 %) were for the aged (ECQC 2013). (See Table 1). Over half (52 %) of care homes in England were for-profit owners and almost half were chains, and the five largest chains accounted for one-fifth of the beds (Allan and Forder 2012). England had about 46 beds per facility and overall occupancy rates of 90 % with a competitive market (Laing 2008). Local authorities manage the social care programs including nursing homes, determine each person's needs, and set their own eligibility thresholds for state-funded community or nursing home services (ECQC 2013).

England Nursing Home Payment Methods Over 43 % of nursing home residents paid the full costs of their care in 2012/13. Local government councils supported 14 % of residents (who also received additional funds from family and friends) and paid full fees for 23 %, while the National Health Service paid for 20 % of residents (Laing and Buisson 2012/13). Local authorities have discretion in contracting practices and rate

setting with nursing homes, which vary by the type of care provided, dementia diagnoses (which receive higher payments), and the area (the London area receives higher payments) (Laing 2008; Laing and Buisson 2012/13). The payment rates are calculated locally by using a cost model or through some negotiating (tendering) process, but details on how payment rates were calculated by local government was not available, another data limitation.

England Nursing Home Payment Rates Because government data were not available on actual payment rates, rates recommended for the principal cost categories from market reports were used (Laing 2008; Laing and Buisson 2010–2012; 2013a, b). Table 4 shows that recommended nursing staff rates were 35 % of the payments (of which 41 % was for qualified nurses) in 2012/13 (Laing and Buisson, 2010–14). Payment rates include holidays, national insurance, sick pay, but Laing (2008) recommended that no pension contributions be made for nursing, care assistants and domestic staff, but only for management and administrative staff. Support services were recommended to be 19.7 % of total payments in 2012/13. Capital costs of buildings and equipment were estimated to be about 30–32 % of total rates) in 2008–2011 but at 17.5 % in 2012/13. The percent of recommended rates for nursing declined by 8 % during the study period, while other support services increased by 2.6 %, and capital increased by 36.9 %.

England Nursing Home Administration and Profits Administrative payments were recommended to be 6.5 in 2008/09 and this increased substantially to 8.9 % of total payments including home office costs in 2012/13 (Table 4). Large corporate groups were expected to have additional costs of head office and regional office overhead (about 4–5 % of gross income) (Laing, 2008). Profits of 4.3 % were only estimated on capital in 2008–2011 while total profits were recommended to be 18.6 % of total payments in 2012/13 (Laing & Buisson 2013b). Corporate owners were also expected to recoup profits through better financial engineering, higher leverage with banks, lower interest rates, operational efficiencies, and sales and leaseback arrangement in order to achieve a 25 % or higher return on equity capital per year (Laing 2008).

Actual payment rates by councils were reported by the industry to be less than fair market value or £764 per resident per week for homes with frail elderly in 2012/13, which allowed for a profit margin of 7.7 % (Laing & Buisson 2013b). The National Audit Office (2014) also reported that local authorities paid less than providers expected. In spite of the claims of low actual payment rates, chains had higher profitability than average homes. Three of the four largest chains (Four Seasons Health Care, Bupa Care Homes and HC-One) had high profits in Earnings Before Interest, Tax, Depreciation, Amortisation of Goodwill and Rent (EBITDAR), although not as high as Barchester Healthcare's operating profitability, which was above 30 % in 2013/14 (Laing & Buisson 2013b).

England Policy Concerns England has reduced the amount of data that is collected centrally, focusing on quality outcomes developed in 2011–12 to: (1) indicate outcomes and (2) allow benchmarks and comparisons across councils (HSCIC 2013b; England National Audit Office 2014). The indicators included: measures for quality of life, delays or reductions in the need for care and support, reports of resident experiences, and measures of safety.

Table 4 Proposed nursing home per week payments for frail older people in for-profit nursing homes in London, 2008–2012

	2008/09 (1)	2009/10 (2)	2010/11 (2)	2011/12 (2)	2012/13 Payments (2)	Change in % of Total 08–12
Nursing Staff						
All Nursing Care	296 (38.4 %)	285 (37.3 %)	293 (37.1 %)	286 (36.5 %)	324 (35.2 %)	−8.3 %
Other support services						
Catering, cleaning and laundry staff	49	50	49	48	64	
Food	23	23	24	26	26	
Utilities & Insurance	27	27	28	31	29	
Maintenance, capital expenses & repairs & other	49	52	54	57	62	
Subtotal	148 (19.2 %)	152 (19.8 %)	155 (19.6 %)	162 (20.7 %)	181 (19.7 %)	2.6 %
Capital Costs						
Capital Costs	244 (31.6 %)	244 (31.9 %)	251 (31.8 %)	251 (32.1 %)	161 (17.5 %)	
Administrative costs						
Management costs	50 (6.5 %)	50 (6.5 %)	56 (7.1 %)	50 (6.4 %)	54	
Corporate overhead	–	–	–	–	28	
Subtotal	50 (6.5 %)	50 (6.5 %)	56 (7.1 %)	50 (6.4 %)	82 (8.9 %)	36.9 %
Profits						
Profits*	33 (4.3 %)	33 (4.3 %)	34 (4.3 %)	34 (4.3 %)	171 (18.6 %)	332.5 %
Total Proposed Payments Per Week	771	764	789	783	921	19.5 %
Estimated Actual Nursing Home Payments Per Week					764	

in £ per resident per week with percent of total payments in parenthesis

Data reclassified into categories. For the for-profit sector. Excludes nursing homes for dementia care. *Profits for 2008–2011 are only on capital while total profits were estimated for 2012/13. **Source:** (1) Laing,W. (2008). Calculating a fair market price for care: A toolkit for residential and nursing homes. 3rd Edition. York, England: Joseph Rowntree Foundation. (2) Laing and Buisson (2010–2014). Care of Older People: Annual Market Reports. London: LaingBuisson

England has had its own scandals about financial problems and poor quality of care. A recent quality of care scandal occurred when Southern Cross, a large nursing home chain, became bankrupt in part related to separating its operations from its property and a lack of capitalization, and eventually sold its facilities (Allan and Forder 2012; Lloyd et al. 2014; National Audit Office 2014). As a result of this scandal, the Department of Health began monitoring the financial sustainability of the five largest chains (National Audit Office 2014) to ensure sufficient number of providers to ensure market stability (Institute of Public Care 2014).

No reports of policy concerns about financial transparency were found. With the decentralization of LTC services to local authorities, England has no centralized system for collecting and tracking nursing home revenues, expenditures, and staffing data. Thus, financial reporting relies on private market reports, with an industry bias, and lacks public financial transparency and accountability.

Norway

Norway has a universal health care system that includes LTC fully funded by the government, and LTC spending of about 2.7 % of GDP on LTC (OECD 2011; Statistics Norway 2014a). Norway also has a universal old age pension plan. About $6 billion dollars (35 % of total health spending) was spent on nursing and care services in institutions in 2012. The remainder was spent on home care services, preventive services, primary care, rehabilitation, emergency care and other services (Statistics Norway 2014b). National funds are provided to municipalities in the form of a block grant, and adjusted to account for differences in LTC demand. In 2012, reforms were implemented to increase coordination between hospitals (paid by the central government) and the municipalities.

Norway reported 992 nursing homes for short and long stay residents with 41,732 beds in 2012 (Statistics Norway 2014b). The average nursing home was small (42 beds) and nursing homes generally were fully occupied. Most nursing home residents (89 %) were aged 67 or older. Norway adopted a national policy to upgrade its nursing homes, which resulted in 97 % of beds in single rooms with private bathrooms (Statistics Norway 2014b).

Norway's municipalities owned and operated over 90 % of nursing homes while about 4 % were operated by for-profit and 5 % by non-profit companies (Statistics Norway, 2014b). The privatization of nursing home services occurred in late 1990s as a way to increase competition (Vabo et al. 2013a; 2013b). There has been a recent trend in competitive tendering with for-profit nursing homes which are operated by chains and are subsidiaries of large international corporations, primarily located in the largest cities (Herning 2012; Vabo et al. 2013a,b).

Norway's 428 municipalities have local autonomy to plan, spend, and coordinate LTC services, but are also influenced by national legislation, regulations, judicial decisions and block-grant funding (Vabo et al. 2013a). Municipalities differ widely in their income per capita, age composition, geographic conditions, property taxes, and block-grant funding. Eligibility criteria, service benefits and obligations vary across municipalities. Nursing home residents pay a fee to the municipality for nursing home care depending on their total annual income (about 75 % of their income up to $15,000

per year and 85 % of income above $15,000 per year excluding property and savings). Low income residents are guaranteed $320 per month for private consumption.

Nursing Home Payment Methods Although some local authorities use fee-for-service reimbursement and/or take resident case-mix into account when paying nursing homes, the majority do not (Vabo et al., 2013a,b). Local authorities determine the supply of beds, tender out services, and make short or long term contracts (Vabo, et al. 2013a,b). They have to use competitive bidding with contractual agreements for services when these are operated by private for-profit providers, but not for contracts with non-profit providers, according to the European Economic Area (EEA) agreement with the European Union.

Nursing Home Reimbursement Rates Payment data were not available for either government or private nursing homes. Even when municipalities used a competitive bidding process, the contractual agreements with private nursing homes were considered confidential and proprietary. Aggregate Norwegian data showed that the average annual expenditures per bed increased from $116,500 in 2007 to $162,800 in 2013 (4 % annual increase).

Data from 22 government-operated nursing homes showed that direct care services and labor costs were 59.6 % of total expenditures. (Table 5). Support service costs, including supplies, medications, equipment, and consultants were 4.1 % of total expenditures, food and dietary services were 4.9 %, and the remaining electricity, utilities, laundry, and cleaning costs were 3 %. Capital expenditures were estimated at 25 % of the total (and generally are paid out of a separate budget). These costs were high in part because of the major rebuilding or remodeling to support private rooms and high construction costs. Municipalities generally own the nursing home buildings, so that public and private nursing home operators do not have to pay rent. Total annual costs per bed in the sample nursing homes were $158,600 in 2013, similar to the national average.

Nursing Home Administration and Profits Administrative costs in municipal homes were 3.3 % of total expenditures, but costs for private nursing homes were not available. Municipal home revenues were typically equal to total costs with no profits, but administration and profit data for private nursing homes were unavailable.

Lower pensions are a potential source of profits in for-profit nursing homes in Norway. Both public sector and non-profits guarantee a relatively high pension level for their staff (66 % of earnings), while the for-profit sector does not guarantee a fixed pension level (Vabo et al. 2013b). Earlier research (Dahle & Bjerke 2001) documented several instances where private companies in the nursing home sector offered lower pensions than the public sector, started pension payments at a higher age and stopped at a certain age, and required five years employment to receive pensions in contrast to public homes where pension payments start earlier and last for a lifetime.

Norway Policy Issues There are few guidelines for staffing levels and staff competence in Norway, except that nursing homes are required to have a medical doctor and a registered nurse on hand around the clock with ‘sufficient staffing’ and ‘professional staffing’, such as registered nurses and auxiliary nurses (Harrington et al. 2012a).

Table 5 Nursing home costs per resident per year in Norway

Expenditures	2007	2008	2009	2010	2011	2012	2013*	% of Total Expenditures
Norway (1)								
Total expenditures per bed	$116.5	$129.6	$136.2	$139.9	$146.6	$158.3	$162.8	NA
22 Nursing Homes (2)								
Direct Care								
Care workers	$74.7	$77.6	$80.8	$84.0	$87.3	$90.8	$94.5	59.6 %
Support Costs								
Supplies, Rx, Equipment and Consultants	$5.1	$5.3	$5.6	$5.8	$6.0	$6.2	$6.5	4.1 %
Electricity/Utilities	$1.4	$1.4	$1.5	$1.5	$1.6	$1.6	$1.7	1.1 %
Food and Dietary	$6.2	$6.4	$6.7	$6.9	$7.2	$7.5	$7.8	4.9 %
Laundry & Cleaning	$2.6	$2.7	$2.8	$2.9	$3.0	$3.1	$3.3	2.1 %
Capital Costs								
Capital/building costs	$31.3	$32.6	$33.9	$35.2	$36.6	$38.1	$39.6	25.0 %
Administration								
Administration costs)	$4.2	$4.3	$4.4	$4.6	$4.8	$5.0	$5.2	3.3 %
Total expenditures per resident per year	$125.5	$130.3	$135.5	$141.0	$146.6	$152.5	$158.6	100 %

Shown in US Dollars, Numbers in 1000 s) (Norwegian Kroner are divided by 6 for US Dollars

Sources:

(1) Statistics Norway (2014). Detaljerte nøkkeltall, F. Pleie og omsorg - nivå 2

http://www.ssb.no/offentlig-sektor/kommune-stat-rapportering/kostra-databasen

(2) Havig, A. K. (2013). Study of 22 selected nursing homes in Norway in 2007 with data trended forward at a rate of 4.0 % for inflation in 2013

Direct care included salaries, wages, benefits, pension's costs (minimum12-13 % of wages) and payroll tax (0 to 14.1 % - varies between the different 19 counties, most nursing homes have a 14.1 % payroll tax). Compensation from the federal Government from sick leave and maternity leave, training and education for care workers was not included. Support costs included training and education for care workers and also some miscellaneous costs. Food costs included food materials, supplements and labor costs. Capital costs were estimated based on data from the Norwegian Housing Banking (3.3 MNOK per nursing home bed) and an annual rate of 7 % were used to estimate the annual cost. (7) Included all administrative staff at the facility

Norway has no national system for quality indicators at the facility level, but municipal governments report 10 nationally-established quality measures the municipality (Norwegian Directorate of Health 2013). Municipalities are encouraged to use mapping of quality to compare measures among themselves using satisfaction surveys of residents, relatives, and staff and other indicators (such as level of educated staff, absenteeism among staff, etc.) (Vabo et al. 2013a,b). Some nursing homes have had quality deficiencies (Kirkevold and Engedal 2008; Malmedal et al. 2009) and variations in leadership, staffing, and the use of teams in nursing homes (Havig et al. 2011; Havig et al. 2013).

Although Norway's privatization of nursing homes has been small, they have not been immune to problems. Recently, a nursing home owned by a foreign for-profit chain was involved in a scandal concerning the violations of worker's rights in the failure to pay for overtime and pension benefits and in understaffing (Lloyd et al.

2014). In addition, the scandal led to a public debate on profit making both of the chain in focus and other for-profits in eldercare and beyond. Eventually, the private contracts with the chain were cancelled. While this addressed the immediate issue, Norway does not have a policy to require public reports of staffing levels and financial information. Financial transparency and accountability were not found to be on the national policy agenda.

Discussion

Marketization and privatization of nursing home care has been the choice of many countries to address the LTC care needs, with each country spending billions on nursing home services. Nursing homes were highly privatized in California and England (96–99 %), less privatized in Ontario (82 %), with small but increasing privatization (9.5 %) in Norway. The majority of nursing homes were for-profit in California, Ontario, and England and about half were chains in California and England. These countries are at different points along the continuum of privatization, with different approaches to the delivery, financing, and oversight of nursing home care.

California and Ontario have state eligibility and payment policies for nursing homes while England and Norway have decentralized policy decisions to local authorities and municipalities allowing variations in eligibility and payment systems. As a way of controlling costs, the locations generally use prospective rate-setting systems for nursing home services. Once the payments were made, nursing homes had flexibility in spending the payments except in Ontario, which required nursing homes to spend their allocations within the categories or return the funds at the end of the year. Ontario, however, did not set these same requirements for returning excess funds for the accommodation category that included profits and administrative costs.

Revenues and expenditures increased at an annual rate of about 5–5.5 % in California and England, 4 % in Norway, and 3.5 % in Canada over the past 4–5 years. The majority of expenditures in Norway (60 %) and Canada (54 %) were for direct care services compared to 35 % in California and England in 2012. Thus, as might be expected, these two countries with higher levels of for-profit and chain ownership spent less on direct care, and direct care declined as a proportion of revenues in both California and England. Capital costs were estimated to be highest in Norway (25 %), although Norwegian municipalities owned their nursing home properties.

Administrative costs were high in California (15.5 %) and Ontario (13.7 %) and somewhat lower in England (recommended at 8.9 % of expenditures). In contrast, Norway municipal nursing homes reported very low (3.3 %) administrative costs. Although administrative expenditures were stable in the US, they were increasing in the UK and were higher in for-profit nursing homes and chains. Norway's municipal homes did not have transaction costs associated with multiple payers in the U.S and also did not have complex administrative structures and marketing costs. Norway, however, did not require or report data on administrative costs and profits in private nursing homes, which could be high in their growing number of for-profit chains.

Profit margins, which were largely not reported or under reported, varied across locations. California had profit rates of 4.4 % with higher profit margins in for-profit

and chain nursing homes in 2012. Profit margins were not reported in Ontario but three publicly-traded nursing home chains reported 10–13 % profits in 2013. In England, recommendations were 18.6 % for profit margins in 2012/13, and chains expected 25–30 % profits. Within the market environment, high administrative costs and strong pressures to maximize profits were expected (Harrington et al. 2011; Institute of Public Care 2014; Laing and Buisson 2013/13; Stevenson et al. 2013).

Contrary to the study hypothesis, none of the countries had strong financial accountability for public dollars on administration and profits. In spite of high administrative costs and profits reported for some nursing homes, governments did not set ceilings and cost controls for administrative costs (except for Medicaid in California) and profit margins. One approach to controlling costs would be to place ceilings on administration and profits (Harrington, et al. 2013). At the same time, reducing cost controls on staffing and food could perhaps result in improved quality of services.

As expected, Norway with low privatization did not have detailed government cost reporting for individual nursing home payments and expenditures. Contrary to expectations, England, with high privatization of nursing homes, did not have detailed cost reporting and it was unique in relying on industry market reports for financial data and giving guidance to local authorities on payment rates. Ontario, which was also highly privatized, did have cost reporting by nursing homes but data were not publicly available.

Only the U.S. and California, with high privatization levels, had a policy focus on financial transparency. The U.S. Nursing Home Transparency and Improvement Act required detailed ownership and expenditure reporting, similar to the California reports, but the new law has not been fully implemented (Wells and Harrington 2013). Moreover, cost reports are often inaccurate or incomplete because they are not audited and penalties are not issued for reporting problems (Harrington et al. 2014a). Although the California cost reports were detailed for each individual nursing home, greater reporting by nursing home parent companies, management companies, property companies, and other related companies could be required.

Countries with growing marketization and privatization of nursing homes need to develop mechanisms for reporting how public resources are spent and adopting appropriate cost controls on administration and profits to assure value for expenditures. Within each country, poor quality and nursing home scandals have been identified (Lloyd et al. 2014) that may possibly have been avoided or minimized, if governments were providing stronger financial oversight. A new international policy focus should be on greater financial transparency and accountability for nursing homes to protect public resources and to potentially improve quality.

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Compliance with Ethical Standards

Conflict of Interest The authors declare no conflict of interest.

Informed Consent As there is no person or personal data appearing in the paper, there is no one from whom a permission should be obtained in order to publish personal data.

Ethical Treatment of Experimental Subjects (Animal and Human) This article does not contain any studies with human or animal subjects performed by any of the authors.

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