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Long-Term Care as a Social Responsibility without Financialization

Lanyan Chen[a], *

[a] *Faculty of Arts and Science, Nipissing University, North Bay, ON, Canada*

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ABSTRACT

Indigenous peoples in Canada, who have experienced generational trauma, value care as a collective effort that is accessible equitably for all. This paper adopts feminist political economy that observes this Indigenous perspective as an alternative to neoliberal valuation of care as personal services. This valuation has contributed to government policies, including Ontario's Bill 7, the "More Beds, Better Care Act, 2022," favoring the privatization and financialization of long-term care delivery and urban bias. An outcome is the devaluation of care through exploitation of racialized and gendered care workers for profit-maximization and the deprivation of care for Indigenous peoples and disadvantaged. Indigenous peoples who see care social in nature because it is relational and is oriented towards wholistic healing among members of the community helps envision a wide range of policy changes to achieve long-term trauma-informed care as a social responsibility and a political practice. Drawing on a feminist political economy analysis of policy, financing and evidence on long-term care (LTC) outcomes in Ontario, the paper recommends a two-pronged strategy. Its goal is to enhance city development and planning in strengthening the essential social infrastructure such as the definancialized LTC as a precondition for just, inclusive and age-friendly living. The case study of the Cassellholme is a concrete illustration of the definancialized, municipal led LTC model that promotes cross-municipal governance and public accountability, including investing in quality care, contributing to broader community services, and servicing Indigenous communities.

Introduction

Since the 1980s, neoliberal influences have propelled the privatization of social services, including long-term care (LTC), that has made financialization particularly possible in an expansion of the financial capital in everyday life. Research has shown that the interactive process of privatization and financialization has emerged in health financing through public-private partnerships (Ronald et al., 2016). This partnership has undeniably created a penetration of investment into LTC sector under the facade of expanding supportive housing and care for seniors and residents. This penetration means that financialized care providers as corporations are regularly making compromises at the expense of the provision of care, turning the latter into means for profit-making. It intensifies devaluation of care through exploitation of the caregiving workforce dominated by racialized and female workers, who are frequently casualized and underpaid. It has also made care more than ever as commodified personal services to shore up health systems that deprive Indigenous peoples and the disadvantaged of quality, trauma-informed care.

LTC as part of the urban care infrastructure in countries like Canada dominated by Eurocentric values, is premised on neoliberal gendered valuation of market-based services. Neoliberalism regards that care as personal services, or "nurturance" of a feminine virtue, is valued when it involves transactions. This neoliberal perspective serves the interests of political and economic elites in profitability in Canada, where there are widespread experiences with trauma that is intergenerational due to colonialism giving rise to social oppressions, systemic racism, violence, discrimination and marginalization. Indigenous peoples, who have experienced historical, intergenerational trauma, value care as a collective effort that is accessible equitably for all. For Indigenous peoples, care is social by nature because it is relational and is oriented towards healing

* Corresponding author.
E-mail address: lanyanc@nipissingu.ca (L. Chen).

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among members of the community that exercise self-determination to achieve well-being in all dimensions from physical, emotional, to mental, psychological, social and spiritual (Call for Justice, Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). Building on this perspective, trauma-informed care, emphasizing healing as individuals and as the (First Nation) community, is the Indigenous meaning of quality care, also known as wrap-around care, that entails community-oriented, team-based services, involving multi-sectors, in response to comprehensive and wholistic needs (Kirmayer et al., 2009; Chen et al., 2024).

This study adopts feminist political economy in a historical analysis of financialized LTC and is distinct from, but in dialogue with, existing research on LTC and financialization as it explicitly brings in an Indigenous perspective and municipal governance as part of city development and planning. It regards LTC as a pillar of inclusive city development and insists that LTC facilities and their financing are essential social infrastructure in city-region planning (alongside housing, transit and so on). It contests that especially from the Indigenous perspective of care, the promise of LTC as public good cannot be fulfilled without eliminating its reliance on the devaluation and deprivation of care and financing through private debt. LTC is a social responsibility that can be cost-shared among different levels of the government and managed locally by municipalities and communities collectively.

As a critique of financialization that is centred on the exploitation of gendered and racialized labour and residents, the study proposes a two-pronged strategy that supports a policy vision for a definancialized, municipally and community-led LTC model, as illustrated by the concrete example of Cassellholme. While promoting investments in definancialized LTC, in one hand, the strategy, on the other, mobilizes support for it as a precondition for just, inclusive and age-friendly living. This mobilization is a political practice whereby Indigenous and racialized communities are centred and participate in the negotiation of delivery of quality care together with caregivers' associations and unions at the community level. It is the exercise of self-determination by citizens' groups at the community level that can democratically and truly decide on the health needs and the delivery of quality care to meet the needs. This practice overcomes urban bias in access to care in metropolitan versus rural areas at the core of urban-rural and intra-urban spatial justice debate. It upholds the right to age in place and in one's own community in a response to the concerns of Ontario's controversial Bill 7 - freeing up hospital beds for patients with needs for acute care from those deemed with needs for Alternative Level of Care (ALC) (Government of Ontario, 2022). This legislation allows hospitals to charge ALC patients $400 a day for refusing to move to a LTC home not of their choosing albeit it is up to 70km away from their preferred location in southern Ontario, mostly urban, and 150km in the north, mostly rural. Also, it permits more beds to corporate care home operators regardless of legal challenges and criticism for their poor care and COVID-19 related deaths (Goden, 2025). The case study of Cassellholme, which functions as regional care infrastructure for Nipissing District and helps reduce pressure on hospitals and urban systems, points to the need to strengthen regional planning, municipal finance and city-region resilience.

The following analysis begins with an examination of higher COVID-19 death rates in financialized LTC homes than those of municipal, non-profit, and other for-profit homes in Canada. This is supplemented with an historical account of a neoliberal policy approach that encouraged financialization of LTC to become dominant. A feminist political economy critique of the neoliberal practice of devaluation and deprivation of care then lends support to the adoption of the Indigenous perspective as a basis for policy changes to achieve long-term trauma-informed care for healing and the universal delivery of quality care. An LTC example for seniors in northeastern Ontario operated collectively by adjacent municipalities, lastly, helps outline the necessary changes.

Methods: A Critical Analysis of Systematic Evidence

The methodological approach to systematic evidence is built on a critical literature review and a documentary analysis from a feminist political economy perspective, focusing on Ontario and Canada. Evidence of COVID-19 outcomes, ownership patterns, financing mechanisms, and policy changes is derived from published studies, reports, and grey literature. Sources including peer-reviewed articles, government reports, advocacy reports, corporate reports, media investigations, policy and legislative texts are selected and assembled chronologically on a focus of policy reforms since the 1980s that have influenced financialization. The final case study of Cassellholme serves as a critical illustrative example of the recommendations advanced by the analysis of evidence.

During the recent pandemic, Ontario had one of the highest rates of infections and deaths in Canada. Many of the infections and COVID-19 related deaths were in for-profit LTC facilities. From 29 March to 10 May 2020 for-profit LTC facilities, in comparison to non-profit homes, had a greater extent of outbreaks (1.96-fold) and a higher number of deaths (1.78-fold) (Stall et al., 2020). A similar comparison was found in a pre-COVID-19 Ontario-based study where long-term for-profit care homes had higher mortality rates and hospitalizations than non-profit homes (Tanuseputro et al., 2015). Researchers have attributed such outcomes at for-profit facilities to outdated design standards such as ward-style accommodations, shared washrooms, and centralized rather than self-contained common areas. Moreover, low staff to resident ratio and poorly paid workforce, who have to work in several facilities to make a livable wage, are also among the identified factors to have led to poor care, negligence, and, too often, deaths (Liu et al., 2020). These poor outcomes are also related to the absence of a national legislative framework to regulate the operation of the long-term care in Canada, which instead fell primarily to provincial governments, each of which, under neoliberal influence, has a diverse mix of policy approaches (Armstrong and Marcy, 2020).

Using Ontario as an example, the rise of financialized care providers began when private equity firms such as a real estate investment trust (REIT), purchased care homes, including the properties on which they are situated, and leased them back to the original operators (Brown, 2022). Such buyout, or the "sale-leaseback," allowed the growth from 30 to 144 LTC homes under for-profit chain operations between 1971 and 1996 (Baun, 1999). While this buyout initially appeared to help cash-strapped LTC operators, they were then locked into paying rent in order to continue running the facilities (Whoriskey and Keating, 2018). As of 2025, 57 percent of the province's 627 homes were owned privately, while 27 percent were operated by non-profit entities, and 16 percent publicly owned by municipalities (Canadian Institute for Health Information, 2025).

The expansion of financialized chains was possible, especially in the 1990s, when policies favoured combining financial investment vehicles with social services. For instance, the expanded financialized chains that became dominant, such as CPL REIT (now Revera), Extendicare, and Leisureworld (now Sienna Senior Living), in fact gained political favour not just by making large contributions to the Conservative government but also through influencing policies (Ontario Health Coalition, 2002). One such policy is the government's decision to fund health services and personal and nursing care at all care homes, regardless of ownership types. This policy is implemented through the licensing system administered by the Ministry of Long-Term Care. This administration was governed by the Long-Term Care Homes Act, 2007, legislation that outlined care, design, and safety standards through licensing and inspection and that was repealed in the adoption of Fixing Long-Term Care Act in 2021 (Government of Ontario, 2021). Although the 2021 legislation made no intention to overhaul the policy that has benefited for-profit financialized chains, it (Part 1, 8) did set as a target to achieve no later than 31 March 2025 a higher care standard of an average of four hours of direct care per resident per day. While the attainment of the target is not in sight, Bill 7 amending the Fixing Long-term Care Act is being challenged for further infringing on patients' rights to privacy, autonomy, and choice of care and causing their potential financial hardship.

While the Ontario Health Insurance Plan (OHIP) covers residents' health services, the Ontario government funds LTC through paying the owner of the home on a per bed per day basis. Although this subsidy is allocated to cover the costs of residents' daily care, financialized homes, often concentrated in urban centres, more than municipal or non-profit homes have benefitted from the province's bed allocation system. This system was introduced by the conservative government in the 1990s and allowed large for-profit chains to have a greater access to the capital required to build or retrofit homes (Armstrong et al., 2020). During the period of 1998 and 2003, the three financialized for-profit chains were found to be awarded the greatest number of beds: 1,895 new beds for Leisureworld (then Sienna Senior Living), 1,493 for Central Care Corporation (then Revera), and 1,164 for Extendicare. Also, the top five municipal and non-profit homes together received only 2,049 new beds while 6,573 beds went to the top five private chains (McKay, 2003). One explanation is that government's funding for construction is issued through reimbursements once a facility is built, meaning that the applicant must be able to finance the building upfront. While the government repaid some of these building costs, it did so over a 20-year time horizon, which put municipal, non-profit, and independent for-profit operators with limited finances or loan collateral at a disadvantage (Brown, 2022). The financialized chains' significant competitive advantage lies with their large real estate portfolio as they can collateralize properties to secure bank loans and mortgage insurance. In other words, LTC chains are dependent on government funding to offset the cost of not only day-to-day operations but also the development of new homes, a business expansion that is often backed by their access to mortgage insurance from Canada Mortgage and Housing Corporation (CMHC).

CMHC established by the federal government in 1946 provides, among other services, mortgage insurance to homebuyers as well as to individuals and companies engaged in the construction and purchase of rental properties, including multi-tenant buildings, housing for senior homes, and student residences. In contrast to loans guaranteed by private insurance providers, mortgage insurance guaranteed by CMHC ensure bank loans repaid in case the borrower fails are government-backed, meaning that risk of default is assumed by the public. Financialized chains secure access to mortgage insurance by entering "Large Borrower Agreements" with CMHC, which requires them to meet a set of criteria including maximum indebtedness and minimum investments in capital and maintenance in the properties. Standards of care are, unfortunately, not high in the CMHC criteria to measure LTC chains that seek its mortgage insurance (Brown, 2022). With CMHC-backed mortgage insurance, banks are likely to favour the financialized chains that carry debt in the hundreds of millions of dollars, producing high annual interest charges, over LTC homes of other ownership types that are without significant assets.

Moreover, government inspection has been lax about the funding being used properly for the delivery of care. For example, approximately 67 percent of the revenue generated by Sienna Senior Living's Ontario LTC homes comes from the provincial government, while the rest comes from resident co-payments for room and board (Hsu et al., 2016). Residents are expected to pay for room and board at a government-set rate of approximately $1890 per month (with public subsidies made available to low-income individuals). However, operators are permitted to charge a premium for private and semi-private accommodation (Government of Ontario, 2022; Government of Ontario, 2021). Although fee structures are capped by the provincial government, given lax inspection, for-profit homes have found ways to increase occupancy and lower labour costs including cutting back on care workers to increase profit. Studies have demonstrated that for-profit home chains had low staffing levels in comparison to municipal or non-profit home facilities and thus provided fewer hours of direct care (Liu et al., 2020; Hsu et al., 2016).

Furthermore, the financialization continued expanding when large chains such as Chartwell, Extendicare, and

Sienna Senior Living were listed on the TSX as they transitioned from private businesses to the publicly traded companies that dominate the market today. TSX-listed LTC chains are expected by investors to demonstrate consistent growth and often prioritize short-term performance over long-term investments under quarterly reporting requirements. Revera, for instance, one of the top five for-profit LTC chains in Canada, formerly structured as a REIT and traded on the TSX until 2006, was then purchased by the Public Sector Pension Investment Board (PSPIB) and became its wholly owned subsidiary at an asset value of $2.8 billion. Representing the pension plans of federal public servants and members of the Canadian Armed Forces, the Royal Canadian Mounted Police, and the Reserve Force, the PSPIB had $169.8 billion of assets under management as of March 31, 2020 (Public Sector Pension Investment Board, 2020). Given that some Canadian pension funds are among the largest institutional investors in the world, there is still an absence of regulation of such pension fund's investment performances. The expansion of pension funds into the ownership and management of public goods like LTC facilities, as seen with Revera, is highly controversial. Revera facilities had a high rate of COVID infections and deaths, resulting in class action lawsuits for inadequate care and negligence (O'keefe, 2018).

The government's unchecked support for LTC home construction and the ongoing care, in effect allows financialized corporations to accrue profits for shareholders while it socializes risks that are borne by the public. Through CMHC, moreover, the federal government guarantees mortgage loans for long-term care facilities, potentially putting public money at risk in case of default. If inadequate care results in hospitalization, furthermore, it is taxpayers that cover this cost through the public health insurance plan. Clearly, financialization contradicts the popular understanding of health care as a public good ensued after the enactment of the Canada Health Act that stipulates the standards of public administration, comprehensiveness, universality, affordability, and accessibility. Also, care defined as a personal service, even if delivered as a public good, namely, paid by taxpayers, may still be unavailable to many who are disadvantaged due to its delivery tied to corporate financing and interest in profitmaking through devaluation of care. It is for the reasons of deprivation and devaluation of care that form the basis for calls to diminish the power of, and even, eliminate, financialized for-profit chain operations.

Discussions: A Feminist Political Economy Analysis

Standardized services, also known as 'assembly line' care, adopted by financialized LTC chains through a managerial approach to allow centralized controls and streamlined operations, make efficiency and speed a top priority. This managerial approach of care work is supported by neoliberal economics that considers the form of paid personal services in house cleaning, daycares, and nursing homes as a resource to be distributed among autonomous individuals. This dominant economic theory is based in part on the idea that the scarcer a resource, the higher its compensation in the market (Woodly et al., 2021). Nurturance seen as a feminine virtue, is not economically highly valued because it is in abundant supply, a factor that is used to justify care workers' relatively low wages in comparison to, for example, financial analysts (Folbre, 2006). Thus, this managerial approach completely undermines quality care that requires time for building relationships, involves emotions, and preserves dignity. It is at odds with quality care because even as LTC chains grow their portfolio of homes, the cost of labour per resident is likely to be similar regardless of special individual needs that reflect health conditions, and local cultural and social milieu. Quality care offered by many municipal and non-profit homes, is gender-aware, racial and ethnic sensitive, cultural and language appropriate and trauma-informed.

Specifically, the devaluation of care takes place when care serves the purpose of profit against the principle of quality trauma-informed care for improving well-being. This devaluation has placed in jeopardy dignity and quality of life for residents, as well as autonomy and decent working conditions for workers. The emotional component of this labour often goes unacknowledged and down-valued due to its perceived "feminine quality" undervalued in a male-dominated society. This can take a significant toll on residents' wellbeing as well as that of care workers themselves.

Most residents in LTC facilities are women while caregivers are overwhelmingly dominated by women, especially racialized women. Both groups of women (residents and caregivers) are negatively affected by the financialization process. The Personal Support Workers (PSWs) are the majority care workforce assisting LTC residents with activities of daily living whereas in Ontario, 90 percent are women, and 41 percent are visible minorities. A report on staffing in Ontario's LTC sector during the COVID found that the average wage for PSWs ranged from $21.41 to $22.69 per hour (Zagrodney and Mike, 2017; Statistics Canada, 2011; Long-Term Care Staffing Study Advisory Group, 2020). They were frequently underpaid and often did not have full-time positions and the attendant benefits. Many have to take several jobs in different facilities to make ends meet, increasing the risk of transmission of viruses among facilities as was evident during COVID (Liu et al., 2020). The combination of emotional overloads, overwork, and poor compensation regularly leads to care worker burnout (Ontario Health Coalition, 2019).

One of the most pressing workplace challenges facing PSWs is lack of time to care. According to a 2009 report, 39.2 percent of direct care workers in Canada, as opposed to only 25.7 percent of their Scandinavian counterparts, experienced feelings of inadequacy all or most of the time, as they were too overburdened to provide the care and attention that they felt residents deserved (Armstrong et al., 2022). Rushed care, estimated 2.71 daily hours of direct care in Ontario versus 4 daily hours of direct care, the target to be achieved in 2025 and internationally known standard, leads to increased health and safety risks (Liu et al, 2020). PSWs lament the fact that 'assembly line' care is dehumanizing to residents (Armstrong et al., 2022). This feeling of inadequacy and stress takes a heavy toll on PSWs

contributing to their frequent burnout as well as increased sick leave.

Approximately 68 percent of 78,000 LTC residents across Ontario were women and there is a long waitlist (Long-Term Care Staffing Study Advisory Group, 2020). Nearly two thirds of the residents are diagnosed with some form of dementia, and many suffer from other health conditions including arthritis, osteoporosis, and heart disease (Ontario Long Term Care Association, 2019). While residents' physical as well as social and emotional needs go unattended due to staff shortages and time constraints, their family members are frequently their caregivers and advocate for them by calling attention to abuse, neglect, and other issues occurring at care homes. The family members are often pressed by the chronic understaffing that they have to consider hiring a personal caregiver at an expense that many of them cannot afford, or providing care directly, which is unpaid.

Eurocentric male earner model embedded in neoliberal economics is at the root of the devaluation of care work in the delivery of care that is controlled largely by white men. Neoliberal economics belittles care work done by women at home and excludes it from national accounting of economic activity. This care work is unpaid and made invisible under the designation of 'care' when it continues to serve capital accumulation. This unpaid work is central to the functioning of capitalist system based on segregating care work and restraining women's access to employment. Women are recruited into the economy when it thrives. Conversely, unpaid care work cushions the fall of the economy when social services shrink due to government's cutbacks on social spending and when corporate chain operations reduce cost of labour to maximize profit. Women's subordination as a result of gender-based power imbalance continues to affect women, including in the LTC sector where they face low wages, job insecurity, and limited opportunities for advancement. Women also have to provide unpaid care for the young, old and sick in order to make up for the cuts in social services in childcare, senior care as well as health care under the profit-making drive of corporations.

It has been revealed that unpaid care work imposed on women by the male earner model was never recognized as an issue among women of colour. Historically, as Canadian women, especially of European descent, entered the labour force in growing numbers, there was a corresponding surge in demand for paid care. This need was largely filled by migrant workers from the Global South. Often women of colour were employed as domestic servants in middle-class households and as such subordinated to white families, who benefited from their work. This, separating the hard labour of the housework from the nurturant aspect of care and transferring it to women of colour, reinforces the home/market split and the menial/spiritual split, facilitating the devaluation of care. This separation of manual labour and social nurturing supports profitmaking on the ongoing neoliberal market logic of gendered and racialized division of care.

Recommendations: Towards a Political Practice of Definancialized Care

To overcome financialization supported by policies influenced by neoliberal economics that has devalued care and deprived LTC residents, workers, municipalities, and Indigenous communities of adequate funding for quality care, a new conceptual framework is needed. This framework supports a two-pronged strategy in city-region development and planning. One approach is to strengthen LTC as essential social infrastructure alongside housing, transit and so on through investing in a definancialized LTC model as an alternative to financialization. The goal of this model, as the other aspect of the strategy, is to promote definancialized LTC as a precondition for just, inclusive and age-friendly living whereby Indigenous and racialized communities are centred and participate in the design and delivery of community-oriented quality care.

To begin, we must recognize care for what it is: a social responsibility and a political practice essential to policy changes for a continued improvement of social wellbeing in a more equitable and inclusive society (Woodly et al., 2021). Care as a social responsibility is an Indigenous as well as feminist model of society that is to be supported by policies for regulating time to work, earnings to share, and tax, tax credits, and benefit regimes to allow people, both men and women, room to care (Pascall, 2012). This model is premised upon care not as personal service but collective responsibility. This responsibility is a site of mutual aid to fulfil the reproductive tasks required for collective survival against state cutbacks and corporate exploitation. In other words, collective care is an inherent survival strategy rooted in interdependence, where non-hierarchal relationships, mutual respect, and reciprocal actions allow communities to collaboratively create the conditions for living well. To extend collective care requires changes in policies implemented by institutions including the state and those premised upon the protection of private property and profit.

Hence, care requires a practice of consciousness raising and political organizing to deliver more just relations of power and structural conditions for equitable access. Seen through contemporary and historical Indigenous struggles, care as a social responsibility opens not only a gateway to, but also preparation for, a different kind of politics, one presenting us with new possibilities for raising children with a whole community of equals for a common purpose of social well-being (First Nations Health Authority, 2025). As a foundation for political organizing, and a prefigurative politics for building a world in which all people can live and thrive, care is a collective responsibility for making a place, including racialized and gendered spaces, to prescribe what gets counted as care in national accounts. This counting finally puts to an end the exploitation of underpaid and unpaid care through definancialization by way of utilizing public regulation and funding. It also allows for policies to regulate work hours, earnings to share, and tax, tax credits, and benefit regimes to take time to care and improve social well-being. It is through this vision of care that we examine LTC based on the community that exercises self-determination to ascertain the needs as well as the means of quality care to meet the needs among community members.

There is the two-pronged strategy to mitigate the negative effects of financialization on the LTC sector.

Concretely, one aspect is to empower community-based non-profit care facilities that are owned by local governments or collectives of individuals, communities, and not-for-profit organizations. The second is to restrict financialized LTC chains' ability to exploit care workers and encourage structural changes through policy measures focusing on funding models, ownership regulations, and labour standards. To promote various forms of non-financialized LTC ownership, such as municipal and non-profit homes, is to move forward with alternative models of care that are not driven by a profit motive and reinvest any revenue they generate into the organization.

Municipal owned LTC facilities, for instance, exist in most towns and districts in Ontario. Historically, local governments in Ontario have been involved in LTC provision since at least 1860 (Passmore, 1977). However, it was the Homes for the Aged and Rest Homes Act, 1949 that formally obligated each municipality to provide these facilities. Today, the province requires every southern municipality characterized as an upper or single-tier municipality to build and operate a LTC home (AdvantAge Ontario/Advancing Senior Care, 2022). The continued existence of this requirement is perhaps indicative of a propensity to classify LTC as a public good that the government should play a role not only in financing, but also in delivering. One argument in favour of municipal homes is that they are accountable to the public; for example, they are governed by boards of directors composed of elected officials (Association of Municipalities of Ontario, 2011) and periodically host public consultations (Long-Term Care Homes & Services, 2015a). Moreover, municipal LTC homes are attuned to specific needs in their communities because they work together with local governments to maintain quality care and meet the community's needs. This collaboration fosters a solid commitment to the residents and their families, promoting trust and confidence in the quality of care. The City of Toronto's ten care homes deliver language and cultural services tailored to the resident population of each facility — for example, Castleview Wychwood Towers provides Japanese, Korean, and Portuguese support, while Seven Oaks offers Armenian and Tamil (Long-Term Care Homes & Services, 2015b). Some municipal homes have programs for LGBTQ residents, while culturally relevant resources are available in those located in Indigenous communities.

Case Illustration: Cassellholme as a Municipally Led LTC Model

An example of municipal owned care facility from online research is Cassellholme in northeastern Ontario. It is selected because it represents a long-standing, municipal led, non-financialized model that is alternative to corporate chain ownership and stands out in public accountability and municipal governance. This facility is owned and managed by a coalition of municipalities and has a history of offering LTC and support services for seniors and vulnerable populations of the Nipissing District (Cassellholme: Compassionate care for life's journey, 2025). Established in 1924, this home was built with funding from 23 participating municipalities of the district with 50 LTC beds, providing essential care at $0.07 per resident per day. It, according to its Handbook, continued to receive 17 percent operating budget from nine of those municipalities until 1962 when the district was split. The current building was built in 1961 to have 196 beds and Cassellholme was then designated as the District Home for East Nipissing. In 1986 Cassellholme underwent significant transformations when the Cassellholme Board of Management set up the non-profit Castle Arms Senior Apartment Corporation to create 60 units in 1988 as independent and assisted living to meet the community's growing ageing needs for LTC services. This transformation has seen Cassellholme upgrade its facilities, converting all beds to private or semi-private accommodations. This upgrade not only improved the living conditions for the residents but also resulted in the need for additional staff to maintain the enhanced facilities and provide quality care to the increased number of residents.

Today, Cassellholme has 240 beds, accommodating residents aged 40 to 102, and 241 units in Castle Arms for independent and assisted living. "More than 250 seniors in North Bay and Mattawa live in the five buildings Castle Arms owns" (Briggs, 2024). With this substantial increase in bed count, the associated fees have risen to $229 per resident per day in connection to the overall growth in the cost of living, advancements in medical care, and the rising demand for specialized care for residents with conditions like dementia. The employee levels have also seen a significant change over time. The home now employs approximately 340 people, making it a significant contributor to the local economy, injecting between $18 million and $22 million annually. The growing workforce is not only a result of the increased bed count but also due to the specialized care required for a large portion of the residents. Approximately 75 percent of the residents suffer from some form of dementia, requiring additional support and expertise from the staff. This specialized care demands more training and a more extensive employee base to meet the residents' needs.

Maintaining public funding and operation for Cassellholme is essential to ensure the continuity of high-quality, affordable care for the residents of the Nipissing District. By continuing to operate under public funding, Cassellholme can uphold its commitment to providing the best possible care to the community's residents, particularly those with limited financial resources. As the Cassellholme Handbook explicates, "The Ministries of Health and Long-Term Care set the accommodation rates annually, taking effect on July 1 of each year." Every resident's rate is determined based on one's most recent income tax notice of assessment from Revenue Canada. If needed, one can also apply for a rate reduction, which is, however, not applicable to residents who are paying for preferred accommodations such as a private room.

Moreover, public funding allows the facility to invest in staff training and retention, enhancing the overall quality of care and ensuring that all residents receive the attention and support they need. As the Cassellholme Handbook indicates, residents receive free coordinated services that include prescription drugs listed in the Drug Benefit Formulary, non-prescription drugs and treatment products, supplies and medications obtained through the Ontario Government Pharmaceutical and Medical Supply Service

and Ontario Drug Benefit Program, 24/7 nursing and personal care provided by Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs), equipment to assist daily living, hygiene and grooming, housekeeping, laundry, maintenance, and so on so forth.

Upon a resident moving in, a Care Conference is called to establish a plan of professional personal care. This Conference is attended by a collaborative team of nurses, personal support staff, resident and family navigator, manager of support services (nutrition and food, housekeeping and laundry), manager of activities, spiritual and cultural care lead, physiotherapy assistant, restorative therapy / rehab nurse, and the resident's designated power of attorney. This plan is reviewed yearly, although it can be revisited any time at the resident's request or decisions by nursing staff who keeps on a quarterly basis data on residents, known as Resident Assessment Instrument or the Minimum Data Set RAI-MDS 2.0, and determines if there is a significant change in care. Fundamentally, residents have the right to have a say as laid out in Every Resident Bill of Rights. Through the Council of Residents and the Council of Family, both which meet monthly, issues and concerns are addressed. They both also make policy suggestions and proposals for change to the facility and in turn the governing bodies. The Cassellholme's Quality Council is also a space for all stakeholders to be involved in quality care improvement, while its Ethic Committee helps residents, caregivers as well as staff, volunteer and healthcare service providers deal with difficult ethical issues including conflicts and abuse. The Behaviour Supports Ontario (BSO) team at Cassellholme, consisting of two RPNs and four PSWs with special skills, training and experience, furthermore, helps sustain the quality level of care.

A recent issue has been that the participating municipalities no longer have representation in the Cassellholme Board of Management which is the same as the Castle Arms Board of Management (Briggs, David, 2024). To maintain transparency with the changes in the by-laws and governance of both Cassellholme and Castle Arms has been raised as a concern among the participating municipalities. This concern is increasing, especially as Cassellholme is undergoing another round of expansion that began in 2022, with a redevelopment project of $121 million to upgrade to a state-of-the-art facility including all 240 beds while adding an additional 24 beds and a separate unit for people with dementia. There will also be a special unit for Indigenous peoples as Cassellholme CEO, Jamie Lowery states, "The Indigenous community is a part of North Bay and the Nipissing region. … So it makes sense to have a unit" (McKee, 2021). The provincial government is investing $65 million, while the City of North Bay takes up about 80 percent of the remaining balance and eight other municipalities (East Ferris, Bonfield, Papineau-Cameron, Chisholm, Calvin, Mattawa, Mattawan, and South Algonquin) cover the rest of the cost. This expansion follows Cassellholme's vision of extending residents' ability to move around and to better manage infections control as well as services to all citizens, not just the residents through enhancements to retirement living, supportive housing, but also home care and community involvement. Creating a large area for clinics and outreach programs may help reduce the volume of emergency room visits to the local hospital.

Overall, Cassellholme aims to providing quality care and support services for the vulnerable populations in the Nipissing District by offering models of care that permit greater autonomy, including day programs, home care, co-housing, and supportive housing. Expanded government assistance for such interventions would likely decrease pressure on the LTC system although there is a concern that the operations and upkeep of LTC homes is becoming increasingly unaffordable for many municipalities. A report by the Association of Municipalities of Ontario, asserts that provincial subsidies are insufficient to cover basic expenses, let alone additional services that add to quality of care, including higher staffing levels. Accordingly, municipalities typically contribute extra funding from property tax revenues. These costs, as well as capital expenditures, put a strain on municipal budgets. While the same report makes clear that many cities lack the resources to operate additional LTC homes, there may be opportunities to utilize surplus municipal land for facilities managed by non-profit groups (Association of Municipalities of Ontario, 2022).

Therefore, overall lessons from Cassellholme as an example of definancialized LTC model include its strengths in cross-municipal governance and public accountability that is demonstrated through reinvestment in quality care, contribution to broader community services, and servicing Indigenous communities. To move forward with this non-profit, definancialized model of care calls for a range of government initiatives to distinguish between various forms of non-financialized LTC ownership, such as municipal and non-profit homes. With the same per diem subsidy received from the provincial government, municipal and non-profit LTC homes use the entire amount toward administration and care provision and achieve the target of 4 hours of daily direct care. Moreover, changing the structure of construction subsidies to provide more funding upfront will benefit municipal and non-profit organizations that have a comparative lack of assets required to secure loans. This reduction of financial barriers will encourage these organizations to successfully complete projects that benefit their communities.

Furthermore, government funding and capacity building programs can help organizations, such as cooperatives, overcome the challenges regarding lack of capital and managerial expertise. Co-operative housing can be implemented on a smaller scale by residents and organizations motivated to meet the local needs and encourage more seniors to remain in their community. Lessons can be drawn from housing and worker co-operatives, which are collectively owned and often democratically governed by key stakeholders, such as residents, workers, and service users. A report on behalf of the British Columbia Co-op Association explores existing cooperatively owned seniors' care organizations, finding several examples in the domains of seniors' housing, assisted living, and home care (Restakis, 2008). Thus, the government funding and capacity building programs in favour of non-profit homes, including co-ops, will reduce or eliminate the trajectory of financialized LTC facilities,

and benefit communities including those in rural areas. Curbing the tax benefits available to REITs, governments can remove financialized LTC homes from the list of eligible property types altogether. To adhere to the target of 4 hours of daily direct care and a safe nurse to patient ratio, provincial governments can diminish some of financialization's harmful consequences through legislation that imposes minimum staffing levels and distribute licenses for new beds more often to non-profit homes. Unions can (as the union representing federal civil servants has done) call for the PSPIB to divest itself from Revera and demand the transfer of the chain to public ownership (Smith, 2023). Sustained pressure from fundholders will facilitate changes to pension funds' investment strategies.

Conclusions

The financialization of social services is an issue that requires an interdisciplinary analysis of the drawbacks of providing care as a public good in a manner that is also expected to generate financial returns. The intermingling of private interests and public goods has long been a cause for concern in city development, municipal governance, and health financing. As financial vehicles expand into real estate intended for a social purpose towards social well-being, including LTC homes, social housing, childcare, and more, they are further obscuring the boundaries between public goods, such as care, and private business. This results in not only the absence of quality care, including unequal access to care due to understaffing and burnout, but also a growing commodification and corporatization of social life. Subsequently, the prioritization of maximized profits in financialization perpetuates inequalities and even oppressions. Dignity and quality of life for residents as well as autonomy and fair working conditions for care workers are downplayed and even ignored.

A feminist political economy that respects Indigenous perspective of care as a social responsibility and a political practice highlights the role of financialization in the devaluation of care. By situating an analysis of financialization in the ideals of politics of care, this study aimed to draw attention to the importance of care work as a social responsibility accessible to everyone in society under a single payer system, as opposed to neoliberal regime where it is typically devalued by the market. A single-payer system is more inclusive and possible through a two-pronged strategy, where LTC is definancialized in a political practice that aims to strengthen essential social infrastructure primarily in city-region development and planning. The inclusion and representation of the disadvantaged in a definancialized LTC model, equally importantly, necessitates policy commitment and diligence in challenging exploitations and deprivations. The inclusion of Indigenous perspective of collective care better aligns government policies with the objectives of universal access to quality LTC care as a precondition for just, inclusive, and age-friendly living. Upholding these tenets of equality in the policy conceptualization and practice of definancialized LTC will ensure residents to have dignity and freedom from discrimination and violence, while dismantling the oppressive paradigms of exploitation based on devaluation of care.

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The author declares no conflict of interest.

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