Jumping on the Alberta bandwagon:

Does B.C. need this kind of Assisted Living?

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Many British Columbians are concerned about the provincial government's plan to drastically alter residential care for seniors. In the spring of 2002, Victoria announced the closure of 3,000 beds in traditional long-term care facilities and a concurrent scheme to invest federal housing dollars in Assisted Living complexes for seniors. To appease the public's worries (and confusion) about these moves, some officials have talked soothingly about B.C. emulating "the Alberta model."

Just what is the Alberta model?

In the last decade the province of Alberta was pulled in two different directions. On the one hand, innovators were able to pilot three new public models that yielded many valuable ideas about alternatives to old-style facility care. Unfortunately, these pilot projects were overwhelmed by another, much stronger trend in Alberta: the unravelling of public coverage and the growth of private-pay markets. Today public coverage of many long-term care services residential and in-home has all but disappeared in Alberta. Public access is not far behind. As their loved one's health deteriorates, elderly spouses and adult children now must deal with buying or providing care on their own. Indeed, so much of the burden and cost of care has been offloaded to families, the Long Term Care Association of Alberta is quietly advising people to purchase private LTC insurance to protect their income and assets.

Public coverage of many long-term care services has all but disappeared in Alberta

If this sounds like American-style health care, it is. And just as the U.S. system is administratively more expensive than Canada's, health authorities in Alberta are now spending more money administering an increasingly fragmented and privatized system, and less money actually funding and delivering health services.

Stepping away from public coverage

The dire situation in Alberta did not arise by accident. In 1990 the province simply stopped constructing new nursing homes and auxiliary hospitals, even though Alberta's population was to increase by almost 500,000 over the next decade. Bed shortages led to restricted access for the neediest patients only. Direct care staffing was cut almost in half. Terminally ill cancer patients were moved out of acute care hospitals into LTC facilities, where they were charged per diem fees. Much-promised home supports for seniors with less serious physical and cognitive impairments failed to materialize and even decreased.

In 1994 the province began to surreptitiously withdraw funding from the support side of long term residential care. This was part of a mounting trend by the Klein government to separate the costs of "health" from the costs of "housing." Direct care costs (health care provided by professionals and others) would continue to be publicly funded, but other support and living expenses (housing, cleaning, meals, laundry, monitoring, etc.) would gradually become the personal responsibility of seniors in LTC settings, whether in an auxiliary hospital, Assisted Living, or at home.

The ever-growing shortfall created by downsizing beds and reducing quality in public LTC created tremendous opportunities for real estate developers. A lucrative private-pay market arose in Alberta, mainly lodges and retirement homes based on the commercialized, U.S.-style "Assisted Living" model.[1]

Assisted Living: What does it mean?

When Assisted Living originated in the U.S. in the late 1980s, it represented a new and progressive approach to the needs of special populations with limited abilities. The original Assisted Living model calls for a home-like setting that gives residents control over their private space. Residents are helped to maintain their existing capacity for self-care, self-direction, and social interactions. In contrast to old-style nursing homes, residents are encouraged to do as much as possible for themselves in an environment of managed risk under the watchful eye of a care organization that coordinates all necessary health and support services.

This approach to Assisted Living may include a basic package of meals, housekeeping, and help with personal care such as bathing, grooming, or transferring. It may also offer the option to purchase individualized services over and above the basics. Naturally, the original philosophy envisions homes and services that are affordable and accessible to seniors in need.

Since its inception in Oregon, Assisted Living has branched out in many less-than-authentic directions in the U.S. and Alberta. The term is now applied to housing situations and care models that do

[1] These support costs are sometimes called “hotel costs”.

not embody the original philosophy. Today, Assisted Living is more likely to refer to multi-unit apartments with varying amounts of on-site personal supports (meals, housekeeping, and social activities) and personal care available 24-hour-a-day, all of which must be purchased by the resident. Regrettably, the original vision has been largely co-opted by commercial operators looking for a high return on investments.

In Alberta, the reality of Assisted Living is a crisis in access, costs, and funding. Let's look at the private and public faces of this kind of care housing today.

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Assisted Living for profit

As in the U.S., developers and realtors in Alberta promote Assisted Living as a residential option that falls somewhere between independent living and nursing home care. Private lodges and retirement complexes offer a combination of safe and secure housing, hotel-type services such as regular meals and housekeeping, and nursing care (provided by personal care aides) all for a hefty price.

Seniors either buy their own unit as a life lease or they pay rent. The facilities sell a range of services. Some have dining rooms only (no "room service"); others have 20- bed locked dementia units. Hotel-type services and personal care are purchased in separate units or in tiered packages, over and above basic housing costs. For example, one private facility charges:

Lunch (daily):	$196 per month
Dinner (daily):	$279 per month
Incontinence care:	$150 per month
Night checks:	$100 per month
Medication assistance:	$150 per month.

Assistance getting out of bed, dressed, bathed, or taken to meals is usually charged in 15- minute increments at $20 28 per hour.

The business of itemizing and tracking these fragmented clusters of service is itself pricey an administrative cost that is passed on to the "consumer."

These for-profit facilities operate in a regulator void, even though many residents are captive and vulnerable consumers due to their emotional, physical, and cognitive impairments. If the price of a bath or incontinence care rises too high, they often have nowhere to turn. If a service or building feature goes

wrong, they often dare not risk complaining. Opportunities for exploitation abound. One Alberta facility charges residents $7 for a single wheelchair ride from the front door to their room.

Alberta pilots a public model

While these private-pay complexes were sprouting on Alberta soil, several innovative models of care were being piloted. The Good Samaritan Society's Assisted Living project was based on the original, non-profit model in Oregon. Caring partnerships among operators, families, and residents were central to the philosophy. The Good Sam model offered basic services (e.g., one meal a day) with opportunities to purchase up. As with traditional nursing homes, residents were placed by the regional health authority (RHA) and paid a per diem fee.

An evaluation of the project by researchers at the University of Alberta identified a number of benefits and limitations.[2] On the plus side, participants were pleased that the care was indeed enhancing the well being of residents. On the minus side, major concerns arose about added costs and burdens for family members. Expressed in dollars, researchers found that families were contributing $5,800 per resident per year or 41% of direct service costs (above per diem expenses). Expressed in time, families were contributing 50 hours per month in direct services out of a total of 95 hours per resident. The researchers strongly recommended that policy makers "incorporate informal costs, like unpaid caregiving time, out-of-pocket costs and personal costs, into their decision-making" about Assisted Living. They were also alarmed about the social and economic well being of the largely part-time staff.

By the time the evaluation was completed in 1998, however, the privatization die had been cast. Recommendations were ignored. Instead, the province and regional health authorities began to see Assisted Living as an opportunity to shift even more costs to residents, including building costs, drugs, and many other services normally covered in facility settings (such as transportation to medical appointments).

Here's how it works today.

"Designated" Assisted Living

Existing commercial Assisted Living operators and new non-profit operators use their own capital and/or public housing money to build suitable rental units. Owner/operators then set a rental price to recover their

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[2] EPICC – Evaluating Programs of Innovative Continuing Care – was an interdisciplinary research project conducted between 1995-1998. Dr. Norah Keating, of the Department of Human Ecology, University of Alberta was principal investigator

investment capital, operating expenses, support service costs, and any profit margin. The RHA contracts with the operator for control over entry to a number of units and for a specific basket of care services (up to $1,500 per month in Calgary, 2002). Candidates for nursing home care are then placed in these units through the region's single point of entry process that is, if the person is able and willing to pay the rent.

Rental agreements are between the individual and the owner/operator. Drugs and many other supplies must be privately purchased from retail pharmacists. Families take on a greater role to make up for less monitoring by health professionals. Definite limits exist regarding aging in place. In fact, seniors and their families may need to purchase extra care even for temporary episodes of illness, or else face dislocation.

Shrinking the healthcare basket

Alberta is now talking about shifting even more costs away from the public healthcare plan. In 1999 the province's LTC advisory committee suggested that individuals should start paying for personal care provided in any LTC setting: nursing homes, Assisted Living, at home, etc. (Personal care is usually delivered by a care aide who assists with dressing, bathing, eating, bedtime, housekeeping, and monitoring.) In short, the province seems to be moving towards making seniors pay for anything that is not, narrowly speaking, a direct healthcare service. Regions would be obligated to pay only for approved services provided by licensed health professionals such as RNs, yet these professionals provide little daily care to at-risk seniors. Only people with very low income would have their personal care covered by the public plan.

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If this direction is embraced, Alberta's LTC sector will be more or less reduced to three functions: 1) care by RNs and other professionals, whose work is very limited in LTC settings; 2) claims adjudication by regional care coordinators (i.e., administering the shrunken system); and 3) care of the destitute.

The myths behind the "Alberta model"

These changes in Alberta's health care are predicated on a few widely promoted assumptions, all of which are ideologically biased and factually suspect. They include the following myths.

Myth #1: People who need LTC services are sophisticated consumers with lots of money

Few Canadians can be called sophisticated consumers of these kinds of care services and care housing. The need for LTC services usually arises due to a major personal crisis such as a stroke or the death of a care giving spouse. Families are often desperate for help. Even with experience, evaluating complex service options is both difficult and time-consuming.

Further, most people over age 65 are not swimming in dollars. The median income of seniors in Alberta was just over $1,400 per month in 1997. The failure of private markets to provide affordable and appropriate rental housing for even independent seniors means that money from the sale of the family home can quickly disappear. Cuts to benefit programs and rising expenses have left many middle-class parents and grandparents struggling to hang on to their lifestyle. The situation of low-income families can be even worse. Loss of projected investment income is another problem for some middle-class households. Grown children are expected to fill the gap by either giving or buying care, yet are themselves often struggling to raise families. Many are only one paycheque away from serious financial problems. In the so-called land of plenty, Alberta families have the highest median debt-load in Canada.

Myth # 2: Shifting the costs and burden of care to family members is costless to society

In fact, shifting sizeable costs and burdens to the family is expensive on personal and societal levels. The stress of constant caregiving can lead to emotional, financial, and health breakdowns. Employers of family caregivers also pay the price in sick time claims, lower productivity, and indirect administrative costs, according to a recent employer benefit plan survey (Aventis, 2002). Caregivers who are forced to drop out of the workforce may become the poor seniors of the next generation. Research also shows that when family members are stretched too thin by my
riad physical tasks and responsibilities, they cannot provide the emotional support that is the key predicator of health in the elderly.

Forcing seniors, who have paid into the public system for years, to give up almost all their income or spend all their savings and assets to obtain care is a grim betrayal of their generation. It could also be viewed as a new kind of inheritance tax. Forcing middle-aged children to buy into the high-priced private health insurance market is nothing more than an ill-conceived economic development scheme to prop up North American insurance industry.

Myth #3: Private healthcare markets will provide better service and better value for the money

Real competition, affordable prices, and quality controls are difficult to achieve in private healthcare markets due to the nature of the demand and the many opportunities for exploitation (i.e., vulnerable and ofttimes desperate people).

Further, a fragmented and privatized system is more costly to run than a public system. As the number of suppliers and payers increase, so too do the costs of documenting, monitoring, and regulating. Alberta is seemingly sprinting towards a U.S.-style private-pay model of LTC, despite the fact that the American healthcare system has administrative costs four times higher than the rest of Canada's. For example, the administrative costs (tracked by function) of Alberta's health authorities rose from 5.6 percent to 15.2 percent of overall budget between 1997-98 and 1999-2000 more than for any other identified function. Alberta's managers are spending ever-increasing amounts of time, energy, and money determining eligibility, evaluating, assessing, documenting, approving, coordinating, billing and collecting, and arranging for ever tinier units of care from multiple agencies instead of delivering services themselves. Billing clerks are displacing RNs.

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Beware the "Alberta model"

Assisted Living's promise is in offering seniors the chance to maintain their independence in a personal domestic setting while receiving the care, social contacts, and attention they need. Assisted Living was conceived as a dignified and responsive model of care for individuals with chronic or declining conditions. But with Alberta's pattern of privatization and its neglect of the progressive public model, Assisted Living could easily regress to the state of yesterday's unregulated and abysmally staffed nursing homes just as today's traditional long term care facilities have deteriorated. There is a very big difference between autonomy and abandonment.

Organizations and individuals are rightfully concerned about the recent proposals for long-term care in British Columbia. Careful monitoring and much lobbying are needed to avoid jumping on the Alberta bandwagon. The "Alberta model" is nothing more than a quick trip down a rocky road to U.S.-brand long term care, fraught with crippling costs, lawsuits for fraud, stories of abuse, underpaid staff, and a high toll in family bankruptcies.

About the author

Wendy Armstrong is a health policy analyst and advocate for consumer organizations, including the Alberta Chapter of the Consumers' Association of Canada. She recently completed an investigation into long term care for the Alberta Chapter. Ms. Armstrong is the author of two CAC reports on the impact of healthcare restructuring: Taking Stock (1996) and The Consumer Experience with Cataract Surgery and Private Clinics in Alberta: Canada's Canary in the Mine Shaft (2000) She can be reached at wlarmstr@telusplanet.net.