PUBLIC INTEREST ALBERTA
SENIORS TASK FORCE
POSITION PAPER ON LONG-TERM CARE

At present, the provision of long term care services (LTC) in Alberta and throughout Canada has failed to keep pace with increased need, resulting in unnecessary suffering for people and greater costs for patients, their families and the public purse. Albertans now have a situation where an inordinate number of acute care hospital beds are occupied by 'alternate level of care' patients. These are people who no longer require treatment in an acute care hospital, but are awaiting placement in LTC beds that simply do not yet exist.

This chronic shortage of LTC beds doesn't only affect seniors. It has adverse effects on all of us – except the corporate interests that have taken over much of seniors care. Our whole health care system is suffering because of the failure to deal effectively with LTC.

What is Long-Term Care (LTC)?
Long-term care is a small part of what the government defines as its Continuing Care system. Continuing care covers everything from Home Care, the four levels of Supportive Living and what the government calls Facility Living, which is LTC. The government frequently announces the opening of Continuing Care beds or spaces, but that does not necessarily mean LTC beds.

The Government of Alberta defines long-term care as care received in either a Nursing Home or Auxiliary Hospital. Adults assessed by Alberta Health Services as having complex and unpredictable medical needs requiring a Registered Nurse to be on site 24/7, meet the criteria for placement in these facilities. Once in such a facility, residents are, by Alberta's current definition, receiving long-term care.

LTC costs are not fully covered under the Canada Health Act - i.e. not covered by "Medicare." Depending on the number of residents per room, individuals in Alberta currently pay $50 to $60 per day to cover the cost of accommodation, meals and housekeeping. However, the cost of basic personal and medical care, pharmaceuticals or supplies is covered by AHS for residents in Alberta LTC facilities.

While it is true that many individuals would much prefer to remain in their own homes or in other less medicalized settings, a small percentage inevitably reach a point where even the best supportive living or home care system cannot provide the 24-hour care and monitoring they require and they do need long-term care.

What is the need for LTC?
By 2016, the government's own population projections[1] predict that Alberta's seniors population will number half a million people. Studies[2] done by the OECD indicate that, in its 34 member countries, an average of 4% of the population over the age of 65 require LTC. By that count, Alberta needs about 20,000 LTC spaces. AHS reports 14,370 LTC beds in 2014, with further reductions projected in AHS's 2013 Capital Plan. That leaves us with a sizable shortage of about 6,000 LTC beds.

What are the causes of the LTC shortage?
A recent study[3] by the Canadian Institute for Health Information (CIHI) sheds light on these causes. It notes that Alberta's $4,699 per capita spending on health care is way above the Canadian average of $3,960 (i.e. 18.7% more). However, the percentage of that spending that goes to seniors care (nursing homes and other care facilities) is only 7.5% in Alberta compared to the Canadian average of 10.3%. The $506 per capita spending on seniors care in Alberta compares to the Canadian average of $625 (i.e. 19% less).

To curtail the costs of seniors care compared to its spending on health care, Alberta has used a variety of measures.

Since at least 2008[4] the government of Alberta has implemented a policy of arbitrarily limiting the number of LTC beds in the province to approximately 14,500. Instead of building the number of LTC beds required, the policy has been to cap the number of LTC spaces and "shift" individuals into Supportive Living settings that are cheaper for the government to operate, but much more expensive for those who require the care and for their families.

Supportive Living covers a wide-range of accommodation levels ranging from group homes and lodges to seniors' complexes with varying levels of care. However even at the highest level of care, Supportive Living accommodations are staffed by fewer and less-qualified staff than required in a LTC facility. In fact, only at the highest level of Supportive Living 4 (SL4) are any regulated health professionals (Licensed Practical Nurses) required to be on site on a 24-hour basis. The next highest level of Supportive Living 3 (SL3) requires only that "qualified or trained staff," (i.e. not necessarily a regulated health professional) be on site 24/7.

A second way that the Alberta government has curtailed its costs of seniors care is by contracting the delivery of such care to private operators – both non-profit or voluntary and for-profit providers. In these private Supportive or Assisted Living facilities the operator can charge for 'enhanced' or 'supplemental' services not covered by home care. These can include unregulated charges for care services such as assistance with bathing, escorting to and from dining room, night checks, incontinence management, support stockings and the cost of administering medications, all of which would be covered in a LTC facility.

Despite a 2012 election promise of an additional 1,000 Long-Term Care spaces per year for the next five years, the current government has failed to increase the number of LTC beds and has continued to increase the number of Supportive Living spaces, which do not provide the care required by those with complex and unpredictable medical needs.

What are the unnecessary costs of the current situation?

The government's effort to curtail expenditures of public money on seniors care has had many largely hidden costs.

- The huge and unnecessary cost to taxpayers of $1,200 to $1,500 a day to accommodate those waiting in acute care beds for LTC placement.
- The undermining of the health care system when as many as 20% to 30%[5] of acute care beds in some hospitals are occupied by patients awaiting LTC placement.
- The lack of staff in supportive living facilities who are trained to anticipate and identify potential health issues means that many are transferred to emergency rooms and, from there, to acute care hospital beds for treatment of conditions that could have been taken care of, in-house, in properly staffed LTC facilities. Some care settings have even used public hospitals as a way of evicting patients whom they decline to accept back after being sent to the ER because their care needs have become too high.
- The government's active encouragement of partnerships in the construction and operation of nursing homes and supportive living accommodations has resulted in a significant increase in private, for-profit delivery of care. Such facilities need to generate a return for shareholders which can result in under-staffing, inadequate pay and training for staff, and a deterioration in quality of care.

- The increase in off-loading of physical, financial and emotional costs of care to individuals and their families, at times resulting in patients' having to forego necessary care, thereby exacerbating their illness.

What needs to be done to fix the shortage of LTC beds?
To address the chronic shortage of LTC beds, the government needs to stop imposing arbitrary limits on the number of LTC spaces in Alberta and focus on adequately addressing the often complex and changing medical needs of our frail and elderly.

This may require the government to build and staff, on its own or in partnership with community groups, a sufficient number of publicly operated LTC beds to eliminate the current backlog.

LTC beds can be publicly built, staffed, and operated at a fraction of the cost of acute care hospital beds that we now rely on to accommodate patients awaiting LTC placement.

There is a better way?
For many years now, ill-considered policies have taken us down the wrong road. Rather than trying to avoid the reality that the percentage of seniors in the population will double over the next 20 years, the government needs to confront the problem proactively and stop trying to pass it off to the private sector to solve.

The government defines LTC as care offered in Nursing Homes and Auxiliary Hospitals. But surely, the essential element of LTC is not the venue in which it is offered but rather the high level of medical and care services provided. Consequently, there is no reason why these LTC services cannot be offered in smaller, patient-centered facilities, with much greater community engagement and local autonomy. As documented in OECD studies[6], some Nordic countries have developed a different method of delivery. Long-term care is funded, regulated and overseen nationally, but delivery is the responsibility of regional and local governments.

Yes, we can do it and we must!
Canadians are justly proud of their health care system. It is intended to provide care on the basis of need, not ability to pay. It treats not only our major health crises but also our sports injuries and the consequences of obesity or addiction, all at public expense. Are we not, therefore, also capable of providing the people who helped build that system with the care they require when they have suffered the adverse effects of aging?

There have been many calls lately for a national strategy on seniors care, including a recent call from the Canadian Medical Association. A major step in that direction would be to include LTC as a covered expense under the Canada Health Act.

What needs to be done!
1. Implement an effective home care and drug coverage system focused on preventing the deterioration of seniors' health to minimize the need for LTC.[7]
2. Build and operate sufficient LTC beds to eliminate the current backlog.
3. Provide access to medications, goods and services in all Supportive Living facilities on the same basis as in LTC facilities.
4. Increase funding to implement LTC professional nursing and therapeutic staffing standards either in the form of minimum patient/staff ratios, or in providing 4.5 direct care hours (not paid hours) of care per resident per day[8], with at least 25% of that care provided by RNs.

5. Use the Patient/Care-Based Funding Model[9] as a way of determining what allocation is required to meet actual LTC needs, rather than a way of dividing up an allocation arbitrarily determined on the basis of 'Weighted Resident Days'.
6. Implement regular, unannounced inspection to ensure compliance with high standards of care and safety.
7. Make public all contracts entered into with private operators (either non-profit or for-profit).
8. Continue to regulate the cost of accommodation to ensure affordability and uphold the principle of universality of care.

Furthermore, all care settings receiving any form of public funding (either capital grants or operating funding) should be required to:

- Establish meaningful Patient/Family Councils that have authority to address complaints and to refer unresolved difficulties to a Seniors or Health Advocate who is an officer of the legislature.
- Have effective fire and evacuation provisions (both structural and staffing) as a condition of licensing in all care facilities.

Footnotes:

1. Alberta Treasury Board and Finance "Population Projection Alberta 2014-2041"- Highlights, P 5 of 7.
2. Country Notes. A Good Life in Old Age. Monitoring and Improving Quality in LTC. OECD Publishing 2013.
3. CIHI, National Health Expenditure Trends, 1975 to 2014 Tables 5 and 6.
4. Alberta Health and Wellness Continuing Care Strategy, 2008.
5. "Dr. Parks: Our health-care system is on verge of collapse", Calgary Herald 10/5/2014.
6. OECD Ibid.
7. See PIA Home Care and Pharmacare Position Papers <http://pialberta.org/action-areas/seniors>
8. Zhang, Unruh et al, "Minimum Nurse Staffing Ratios in Nursing Homes". Nurs Econ, 2006.
9. J M Sutherland et al, "The AHS Patient/Care-Based Model for LTC; A review and Analysis." p 8.

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