Economic Security Project

An Uncertain Future for Seniors

BC'S RESTRUCTURING OF HOME AND COMMUNITY HEALTH CARE, 2001–2008

FULL RESEARCH REPORT

A 12-page popular summary of this report can be downloaded from www.policyalternatives.ca/reports/2009/04/uncertain_future

by Marcy Cohen
Jeremy Tate and
Jennifer Baumbusch

April 2009

CCPA
CANADIAN CENTRE for POLICY ALTERNATIVES
BC Office

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Summary

ACCESSIBLE, HIGH-QUALITY CARE FOR SENIORS: this issue touches everyone at some point in their lives—seniors receiving health services, people caring for aging relatives, anyone who worries about what their own life will be like when they grow old.

Access to home and community health care services in BC has declined significantly since 2001. Years of inadequate funding, restructuring, and lack of leadership have led to a system in serious decline.

It's a safe bet that most of us have similar ideas about what we want for ourselves and others as we age, including:

- The ability to stay in our own homes and communities as long as possible;
- Free or affordable health care;
- Respectful treatment that allows us to maintain dignity, independence and choice; and
- Services that are responsive and well coordinated, so that as we age and our needs change, we get the appropriate level of care.

Home and community care (formerly called continuing care) was developed in BC to meet people's needs for respectful and effective care in their own communities, and at the same time save costs by reducing the need for more expensive hospital services.

In the mid-1990s, funding cuts and restructuring began to weaken the home and community care system. In 2001, during the provincial election, the BC Liberals promised to improve services for seniors, specifically by adding 5,000 new not-for-profit residential care beds. Despite this promise, today's community care system is in serious decline, after years of inadequate funding, restructuring and lack of leadership.

This study is a follow-up to our 2005 report *Continuing Care Renewal or Retreat*? *Residential and Home Health Care Restructuring 2001–2004*. Here we examine the ongoing changes, looking behind the numbers to consider the serious consequences for seniors, their families and the health care system as a whole. A companion report, *Innovations in Community Care: From Pilot Project to System Change*, highlights promising innovations in home and community care that, if implemented system-wide, could not only improve services, but also save costs. British Columbians need to know about the serious gaps in our home and community care system—and also about the innovative, cost-effective solutions that are already being piloted in our province.

The CCPA is not alone in raising concerns about home and community care. Key BC organizations have reported that the system is seriously compromised: the BC Medical Association, the BC Auditor General, the Ombudsman's Office, BC Care Providers Association and the Centre for Health Services and Policy Research at UBC. And it's not just these high-profile agencies that have identified problems—it's seniors themselves, seniors' family members and friends, and staff and administrators in the home and community care sector—those who are working with the system every day.

REVA—GERIATRIC PHYSICIAN

"There has also been a change in how sick you need to be to have your nursing home care covered in BC. Now you have to be actually very frail and very unable to manage at home, whereas before you had to be a little less frail to live in a facility and get the help that you needed."

Watch the interview with Reva at www.policyalternatives.ca/reports/2009/04/uncertain_future

WHAT IS HOME AND COMMUNITY CARE?

The Canadian health care system has three main areas: primary care (physicians, clinics and community health centres), acute care (hospitals) and home and community care.

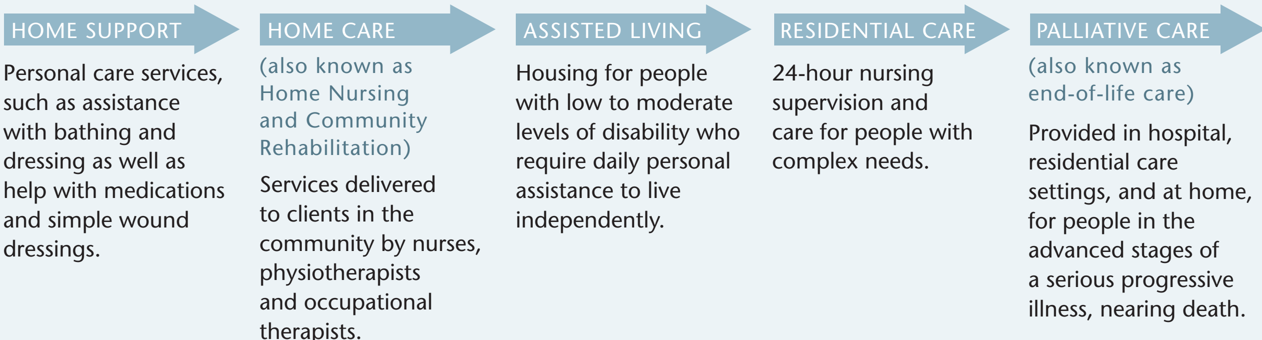
Today, most health care resources are focused on caring for people with chronic conditions. It's estimated that chronic conditions (e.g. diabetes, heart disease, arthritis) account for two thirds of hospital admissions through emergency departments and 80 per cent of physician visits.

When home and community care services are adequately funded, well coordinated and accessible, they can be a key part of caring for people with chronic conditions, reducing pressure on the more expensive primary and acute care systems.

However, home and community care is not covered by the Canada Health Act: there are no national standards or minimum service levels required of provincial governments. In other words, there is no "right" to community health care, and fees can be charged for publicly-funded services.

Home and community care includes both in-home and residential services, from personal care and home nursing, to assisted living and residential care. It also includes palliative end-of-life care (see glossary).

Glossary



HOME SUPPORT
Personal care services, such as assistance with bathing and dressing as well as help with medications and simple wound dressings.

HOME CARE
(also known as Home Nursing and Community Rehabilitation)
Services delivered to clients in the community by nurses, physiotherapists and occupational therapists.

ASSISTED LIVING
Housing for people with low to moderate levels of disability who require daily personal assistance to live independently.

RESIDENTIAL CARE
24-hour nursing supervision and care for people with complex needs.

PALLIATIVE CARE
(also known as end-of-life care)
Provided in hospital, residential care settings, and at home, for people in the advanced stages of a serious progressive illness, nearing death.

These services should form a well-coordinated continuum of care, but the reality is that they are fragmented and inadequate.

Other home and community care services include adult day care, supportive housing, community mental health services and others. A complete list can be found at www.health.gov.bc.ca/hcc/.

Clients of home and community care services include frail seniors and people with multiple chronic conditions involving physical and/or mental disability. The vast majority of service users are seniors over 75. Services for this group are more important than ever given BC's rapidly aging population: since 2001, the population aged 75 to 84 has increased by 15 per cent; the population 85 and over has increased by 43 per cent. This study focuses primarily on what has been happening to services for the frail elderly.

Changes and Cuts, 2001–2008

During the 2001 provincial election, the BC Liberals promised to build 5,000 new non-profit residential care beds by 2006. However, today there are actually 804 fewer *residential care* beds. In their place, 4,393 new *assisted living* units have been added since 2001, albeit with lower support and staffing levels. Instead of 5,000 new residential care beds only 3,589 net new assisted living units have been added to the public system.

Even assuming that assisted living is an adequate substitute for residential care, the province has fallen short of its 5,000 bed promise by 1,411 beds. In the meantime, the number of seniors over 85 has grown by 45 per cent.

In 2006, the government acknowledged that it had not met its 5,000 bed target, and moved the target date to 2008. The target remained 5,000 beds. However, the number of beds should have been adjusted to reflect the growth in the elderly population and other factors that influence the demand for residential care. Just looking at population growth alone for seniors 75 and older, the 5,000 bed target should have changed to 6,815 beds by 2008 and 8,988 by 2010, and should be increased as long as the population continues to age.

In 2002, changes to BC's Long Term Care Act restricted access to residential care to those with complex care needs (severe cognitive impairment, dementia, multiple disabilities and complex medical problems). This policy change was based on the view that people with

THE BEDS EQUATION

+ 4,393 new assisted living beds	− 804 fewer residential care beds	= 3,589 net new "long-term care" beds

- Because the aging population has grown while residential care has been cut, the bed rate (number of residential care beds per 1,000 people over 75) has declined by 20.5 per cent. In other words, there is significantly less access to residential care than there used to be.
- Even assuming that assisted living is an adequate substitute for residential care, the province has fallen short of its 5,000 bed promise by 1,411 beds.
- Given increases in the population over 75, the province should actually have built 6,815 beds by 2008 to meet the growing demand.
- The provincial government claims to have met and even exceeded its 5,000 bed target. However, government calculations include many different types of housing that are not at all equivalent to residential care (see *Reality Check* on page 11).

less complex needs could be more appropriately supported with more "homelike" services such as assisted living and home support. However, access to home health services has also decreased (see page 9).

Not only has access to residential care decreased, but it has decreased unevenly across the province, meaning that seniors have unequal access depending on where they live (see map).

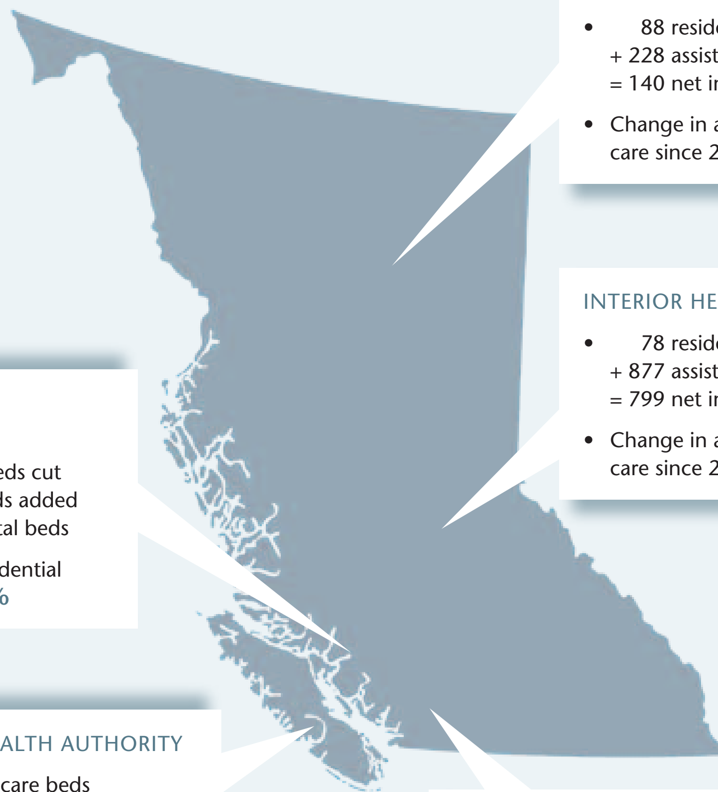
Not only has access to residential care decreased, but it has decreased unevenly across the province, meaning that seniors have unequal access depending on where they live.

Regional Differences in Residential Care

Since 2001, most of BC's five health authorities have made significant cuts to residential care. Cuts were deeper in some regions than others. In the meantime, the population of seniors has grown, putting even more strain on access.

While every health authority has created new assisted living units, assisted living is not an effective substitute for residential care, which provides a much higher level of service.

CHANGE IN ACCESS reflects the change in the number of residential care beds per 1,000 seniors aged 75 and older between 2001 and 2008.



NORTHERN HEALTH AUTHORITY

- 88 residential care beds cut
  + 228 assisted living beds added
  = 140 net increase in total beds
- Change in access to residential care since 2001 **–35.1%**

INTERIOR HEALTH AUTHORITY

- 78 residential care beds cut
  + 877 assisted living beds added
  = 799 net increase in total beds
- Change in access to residential care since 2001 **–20.6%**

VANCOUVER COASTAL HEALTH AUTHORITY

- 641 residential care beds cut
  + 944 assisted living beds added
  = 303 net increase in total beds
- Change in access to residential care since 2001 **–27.2%**

VANCOUVER ISLAND HEALTH AUTHORITY

- 143 new residential care beds
  + 1,007 assisted living beds added
  = 1,150 net increase in total beds
- Change in access to residential care since 2001 **–11.8%**

FRASER HEALTH AUTHORITY

- 140 residential care beds cut
  + 1,317 assisted living beds added
  = 1,177 net increase in total beds
- Change in access to residential care since 2001 **–18.2%**

SUBSTITUTING ASSISTED LIVING FOR RESIDENTIAL CARE

The BC Ministry of Health Services has counted new assisted living beds towards its goal of adding 5,000 new residential care beds. But while assisted living can be a positive choice for many seniors with limited needs, it is not an effective substitute for residential care. Assisted living is for people who can live relatively independently and who are able to direct their own care. Residential care provides a much higher level of service (see glossary).

To date, there has been no formal evaluation of the effectiveness of assisted living as a substitute for residential care. The health authorities now appear to be changing direction; there are no plans to build additional assisted living units. Instead, there is a recognition of the high demand for residential care services and a shift in focus for new construction back to residential care. However, the provincial government still has no overall plan for determining the number and level of residential care and other home and community care services needed to support BC's aging population over the next 5 to 10 years.

BC IN CONTEXT

How Does BC Compare to Other Provinces?

OVERALL HEALTH CARE FUNDING

- In 2001, BC ranked second in Canada in per capita health funding. By 2007, we had fallen to sixth place, with the lowest annual increase in Canada.
- BC's funding increases in residential services have been much lower than increases to other home and community care services and to the overall health care budget.

RESIDENTIAL CARE

- In 2001, BC was just above average compared to other provinces in terms of access to residential care for people 75 and over. By 2008, BC had the second lowest rate of access, after New Brunswick.
- Along with Alberta, BC had the greatest rate of decline in access to residential care between 2001 and 2008.

HOME HEALTH SERVICES

- In the mid-1990s, BC was a leader in the provision of home health services, which include home nursing and rehabilitation. However, by 2003, BC had fallen well below the national average in terms of per capita spending on these services.

By 2008, BC had the second lowest rate of access to residential care of any Canadian province, after New Brunswick.

REDUCED ACCESS TO HOME SUPPORT AND HOME NURSING

The downward spiral in services explains why there was a 60 per cent increase in the death rate in residential care—not because of negligence or poor service, but because of delays in getting in.

Home support can provide important support for seniors whose needs are not high enough to qualify for residential care. In fact, a document prepared by the BC Ministry of Health Services in 2003 described home support as an appropriate substitute for residential care. As access to residential care was restricted, beginning in 2002, access to home support was supposed to increase.

However, the promised increase in home support has not materialized. On the contrary, between 2001 and 2007, there was a 30 per cent decrease in access to home support services for seniors over 75. There was also an 11 per cent decrease in access to home nursing, a key service for those with significant health concerns who want to remain in their own homes.

Downward Spiral

Health authorities make cuts to residential care.

Seniors who can't access residential care turn to assisted living, home support and home nursing, where they are given priority over seniors with lower needs.

Seniors with lower needs do not have access to less intensive services.

The prevention and early intervention functions that home support and home nursing can provide are undermined.

Seniors' health deteriorates.

By the time seniors are able to access home support and home nursing, they have higher needs.

By the time seniors enter residential care they are in poorer health and more likely to need palliative care.

Death rates in residential care have increased by 60 per cent since 2001.

SHIFTING THE FOCUS TO HIGH-NEEDS CLIENTS

There are more and more elderly people in our province who need home and community care services, but those services have been cut and restructured to reduce access for those with lower level needs. Because there are not enough services to go around, priority is given to those with the highest needs. The impact of this shift in focus affects all areas of home and community care and has created a "downward spiral."

This downward spiral explains why there was a 60 per cent increase in the death rate in residential care between 2001 and 2006—not because of negligence or poor service, but because of delays in getting in, meaning that seniors were in worse health by the time they arrived.

Quite clearly, end-of-life care is becoming an increasingly important part of residential care. But most residential care facilities do not receive funding to provide palliative care, and thus cannot offer the necessary staff, equipment or medications. End-of-life patients in residential care facilities often pay for equipment or medication out of their own pockets, or, if they can't afford it, simply receive inadequate care.

The BC Care Providers Association, comprised of both non-profit and for-profit care providers, has stated that staffing levels and training in residential care facilities have not kept pace with the higher needs of residents. In addition, many facilities are running deficits, as government funding does not even cover the existing negotiated wage and benefit costs.

REALITY CHECK

Numbers Game Highlights Lack of Transparency and Accountability

It's extremely difficult to accurately assess the current and future state of home and community care in BC, due to a number of transparency and accountability problems.

NUMBERS GAMES: In 2008, when the Ministry of Health Services reported on its progress towards the 5,000 new residential care bed commitment, its bed numbers conflicted with those reported by the health authorities. It included:

- 672 supportive housing units — these units cannot be included because supportive housing has no care component; and
- 976 beds that were inaccurately counted, or were ineligible because they include convalescent care (short-term reactivation following hospitalization and hospice care for those who are terminally ill), group homes, independent living units and mental health facilities.

LACK OF TRANSPARENCY: The province does not make accurate information freely available; Freedom of Information requests were required to get information on residential care bed numbers and staffing levels in residential care for this research.

LACK OF ACCOUNTABILITY: There is no provincial tracking or monitoring system to ensure that home and community care services are meeting the needs of the aging population. For example:

- There is no standardized method for designating or tracking the number of seniors waiting in hospital for residential and home health services — or for tracking how much time they spend waiting.
- There is no province-wide policy for palliative care. Funding for palliative care is provided to hospitals and hospices, but not to most residential care facilities, where more and more people are dying.
- Some policies have not been updated since before the major restructuring of residential care in 2002.

LACK OF LEADERSHIP: There is a lack of strategy and planning at the Ministry of Health Services.

- A 2008 report by the BC Auditor General criticized the government for not adequately fulfilling its stewardship role in helping to ensure that the home and community care system was meeting the needs of an aging population.
- The Auditor General called on the government to develop a new strategic direction for home and community care. The ministry commissioned a private consultant, Deloitte & Touche, to develop this report. The report was to be completed by October 31, 2008 but has not been released to the public as of March 2009.

All of these factors contribute to and indicate an inadequate level of services, lack of planning for the future, and a disappointing lack of accountability on the part of the provincial government.

A 2008 report by the BC Auditor General criticized the government for not adequately fulfilling its stewardship role in helping to ensure that the home and community care system was meeting the needs of an aging population.

CRISIS RESPONSE INSTEAD OF PREVENTION AND EARLY INTERVENTION

The focus on high-needs patients means reduced capacity for home and community care to provide preventive care and early intervention, once a key strength. Instead of intervening early and thereby reducing the likelihood of more intensive and expensive care down the road, services are increasingly delivered in response to a crisis such as an emergency room visit or hospital admission.

More seniors end up in hospital. These seniors often must wait in hospital until they are able to get into residential care, becoming "bed blockers" in the acute care system.

Indeed, the lack of prevention and early intervention, combined with reduced access to residential care, means that more seniors end up in hospital. These seniors often must wait in hospital until they are able to get into residential care, becoming "bed blockers" in the acute care system. This reduces the capacity of hospitals to serve acutely ill people, and contributes to elective surgery cancellations and emergency room overcrowding.

Not only do these patients increase pressure on the acute care system, but health authorities also have the discretion to place these patients in residential care ahead of seniors who are waiting in the community, yet again leading to a delay in services for seniors with lower needs and an increase in the number of residential care residents with high needs.

It is difficult to assess the extent of this problem, in part because the five health authorities have different ways of reporting the numbers of such patients. It appears that there has been a decrease in days taken up by these patients province-wide, but there has been an increase in three out of five authorities and overall BC levels are well above the Canadian average.

COMPROMISED QUALITY

The Shift to For-Profit Care

Since 2001, the BC government has required that all new publicly-funded residential care facilities be tendered through a request for proposals (RFP) process. This favours private corporations and a few large non-profits with the infrastructure to participate in a bidding process. Not surprisingly, since 2001, there has been a more than 20 per cent increase in the number of for-profit residential care facilities and a decline of more than 11 per cent in non-profit facilities. Most new residential care facilities are now private and for-profit.

International and BC studies have shown that private for-profit facilities provide a lower quality of care than non-profit facilities. There are higher rates of hospitalization for conditions like anemia, pneumonia and dehydration, and more substantiated complaints from residents and families.

In 2002, Bill 94 gave employers unlimited rights to contract out direct care and support services in residential care facilities. Employers also gained the right to terminate and re-tender contracts for these services with just 60 days' notice. Employers have taken advantage of this provision, and terminated contracts in cases where staff advocated for higher wages and better working conditions.

High turnover in residential care staff has a significant impact on residents, who consider the facility to be their home. Research has shown that residents have better health when they are able to form strong, stable connections with staff.

INCREASED STRESS AND SUFFERING FOR PATIENTS AND FAMILIES

The gaps in home and community care, and the shift towards privatization, have left individuals and their families shouldering more of the burden and cost of care.

In 2007, the average cost for a private residential care bed was $50,000 a year. At the same time, average annual income for unattached seniors (those most likely to be in residential care) was $38,000 for men over 65 and $24,000 for women. Only eight per cent of unattached men over 65 and five per cent of women earn more than $60,000 a year and could therefore afford private residential care. The vast majority of seniors rely on publicly-funded care, which, as noted above, is in short supply.

More and more seniors are turning to family and friends to make up for the shortfall in services. Seniors living at home or in assisted living who need more services than those provided by the health authorities have to pay for additional services privately. If they can't afford it, they must rely on family and friends. And in residential care the story is much the same: because of inadequate staffing, residents increasingly rely on family members and friends to pay for or assist with their care. Seniors without family and friends to look after them simply go without.

This is effectively leading to a two-tiered system based on income and availability of friends and family.

Currently, 80 per cent of care of the elderly is provided informally by families and friends. As the population ages and family size shrinks, informal support may become less available and baby boomers might find it more difficult to stay at home through declining health. But they may also find it difficult to get the care they need from our home and community health system.

CARLA — HOME SUPPORT WORKER

"It's very clinical now, as opposed to how the service was meant to be. I can still remember our original motto which was 'to foster independence in the home.' And we're not doing that anymore. I feel like when I'm working it's more of a stopgap... So that's how it's changed."

Watch the interview with Carla at www.policyalternatives.ca/reports/2009/04/uncertain_future

COMPANION PAPER

Pilot Projects To Improve Home and Community Care

Innovative projects have already improved the lives of seniors in a number of communities and regions. But they have not been incorporated into the mainstream of the health system or instituted province-wide. To do this, strong leadership is required from the provincial government.

The companion paper to this report, *Innovations in Community Care: From Pilot Project to System Change*, looks at case studies of such projects. Download the report at www.policyalternatives.ca/reports/2009/04/innovations.

RECOMMENDATIONS

There are serious weaknesses in BC's home and community care system that will only be repaired with a committed, concentrated effort by the provincial government. We have developed ten recommendations for creating a strong system of cost-effective services that would allow all British Columbians to age with dignity and comfort. The top five are:

- The provincial government should increase the number of residential care beds, prioritizing funding for under-served regions. If the government returned to the 2001 proportion of total health authority funding that was spent on residential care, in 2009 BC would be spending about $94.5 million more on residential care—the equivalent of adding 1,500 new beds.
- The government should provide public financing so that new residential care facility services can be delivered by not-for-profit organizations and/or the health authorities.
- The government should fully fund current operating costs of residential care facilities sufficient to bring all residential care facilities up to a minimum of 3.2 hours of care per resident per day, the level proposed by the BC Care Providers Association and the Hospital Employees' Union. (Research indicates that 4.1 hours is the minimum required to prevent adverse outcomes, and 4.5 hours would actually improve quality of life.)
- The government should develop a provincial standard of core services for palliative care whether they are provided in residential care or assisted living or to individuals living in the community.
- The government should provide $100 million in additional funding for home support to cover provincial implementation of a team-based delivery model, ease recruitment and retention pressures and enable a 15 per cent increase in services.

Now is the time for a focused and thorough process to determine the best way to ensure effective, respectful care for all BC seniors.

Other recommendations include: annual public reporting on home and community care using a standardized system for all health authorities and a full public consultation process on future directions for home and community care.

Now is the time for a focused and thorough process to determine the best way to ensure effective, respectful care for all BC seniors.

PART 1

Introduction

There is an intense debate underway in BC about changes in residential care and home health services: the provincial government claims it is successfully implementing a plan for "continuing care renewal" while seniors' groups are adamant that cuts to residential care and home health services are leaving frail elders without access to affordable care.

This quote is from the March 2005 Canadian Centre for Policy Alternative publication, *Continuing Care Renewal or Retreat?* The report reviewed the changes in the number and types of residential care beds and home health services between 2001 and 2004 using data provided by BC's Ministry of Health, the health authorities, and the Canadian Institute for Health Information. The report concluded that there had been a significant reduction in the availability of provincial home and community care services (previously known as continuing care. Furthermore, these reductions involved negative implications not only for the people who depend on these services—the frail elderly and other adults with chronic disabilities—but also their families, communities and the larger health care system.

The debate about the adequacy of home and community care services has not gone away; if anything, it has intensified. In 2008, the BC Medical Association (BCMA), the Centre for Health Services Policy Research (CHSPR) at UBC, the BC Auditor General and the BC Ombudsman Office all weighed in on this question.[1] Families, community advocates and provider associations are also speaking out more and more about their concerns over funding, access and affordability issues in BC's home and community care sector.

Our contribution to this debate is two-fold. First, this report serves to update the 2005 *Continuing Care Renewal or Retreat?* report. The update includes a comparison of current home and community care program service levels to those in 2001. In addition, it provides an analysis of the implications of the restructuring of residential care services on the quality and cost of these services to users, their families and communities. Due in part to the lack of specific information on the needs of younger adults with disabilities, the focus of this report is on seniors and their families. The younger disabled population is different in many ways from the elderly and more attention is needed specific to their situation.

The 2005 CCPA report *Continuing Care Renewal or Retreat?* found a significant reduction in the availability of provincial home and community care services in BC. This report provides an update, and finds that the debate about the adequacy of home and community care services has not gone away; if anything, it has intensified.

Our second contribution is the companion report, *Innovations in Community Care: From Pilot Projects to System Change*. This report focuses on the changes required to ensure a more integrated approach to the delivery of home and community care services. This second publication uses local examples of effective and innovative approaches to the delivery of residential and home health services. The purpose of the report is to show how these approaches, if implemented province wide, could improve care and at the same time contribute to the sustainability of our public health system.

Interestingly, a May 2008 publication from BCMA physicians has very similar policy prescriptions. Their report points to the decline of BC's home and community care services over the last five years and suggests that rebuilding the system requires both a return to an adequate level of residential and home health services as well as a more integrated and innovative approach to service delivery.[2]

About Home and Community Care

Home and Community Care was established in BC as a provincial program in 1978 (as the Long-term care program) for the purpose of supporting adults, mainly the elderly, with chronic disabilities of various types and levels. The objective of the set of programs that make up home and community services is to maintain, restore or improve the health and functioning of persons with chronic physical and/or mental disabilities. Home and community care programs also covers personal needs for post-acute, rehabilitation and palliative care. Support can be provided on either a short or long term basis.

Home and community care services are managed by the five regional heath authorities. Some services are provided by health authorities themselves, but the majority are delivered by independent agencies (non-profit and for-profit) contracted by the health authorities.

Eligibility for home and community care services is determined by case managers in the employ of health authorities. Depending on the service and individual income, the cost may be subsidized or provided at no cost.

The programs include in-home services such as home support, home care nursing, rehabilitation and palliative care, community-based services such as adult day programs, as well as assisted living, residential care and convalescent care.

The Ministry of Health Services has a Home and Community Care Division responsible for overall co-ordination, monitoring and strategic direction. The annual public cost of home and community care is approximately $2 billion, involving support of more than 100,000 clients each year.

No Right to Home and Community Care

Unlike the health services provided by family physicians or in a hospital, home and community care services are not covered under Medicare (i.e. Canada Health Act). This means there is no legal requirement to ensure universal access and no prohibition against user fees. In many home and community care services—most notably in residential services and home support—clients/ residents are income-tested and pay a co-payment based on the level of their income.[3] As a result, if there are shortages of publicly-funded home and community care services and/or if an individual requires assistance with equipment or medications not covered by home and community care programs, the individual and/or their family are responsible for these costs—or they do without.

Residential care (see definition in Appendix A) provides a clear example of problems that arise when there is a shortage of publicly-funded beds and the only alternative is a private-pay facility (there are approximately 1,700 private-pay residential care beds in BC).[4] In 2007, the average cost of a bed in private-pay residential care facility (including the Okanagan, Vancouver Island, and the Lower Mainland) was $4,237.50 per month or $50,850 per year.[5] As of 2005, less than 5 per cent of unattached women over 65 and just over 11 per cent of unattached men over age 65 had incomes over $60,000 and therefore could afford a private-pay facility. (Table 1). Those people who cannot afford a private-pay facility must wait until a publicly-subsidized facility vacancy comes up.

The average cost of a bed in private-pay residential care facility in 2007 was $50,850 per year. Less than 5 per cent of unattached women over 65 and just over 11 per cent of unattached men over age 65 can afford a private-pay facility.

Table 1: Income Level of Unattached Seniors in BC 2005

Income Category	BC males 65+	BC females 65+	BC total 65+
Median income	$27,341	$17,908	$21,113
Average income	$37,774	$24,401	$30,593
# 65+ with income below $25,000	117,195	210,930	328,145
% 65+ with income below $25,000	44.4%	68.4%	57.3%
# 65+ with income $60,000 and over	30,080	13,730	43,810
% 65+ with income $60,000 and over	11.4%	4.5%	7.7%

Source: Statistics Canada—2006 Census. Catalogue Number 97-563-XCB2006005; income data from 2006. Census relate to the calendar year prior to the census year, i.e. 2005.

It is also important to note that the median income for unattached women aged 65 and over is only $17,908 and close to 70 per cent of these women had incomes of 25,000 or less. And while most seniors live with a spouse, the majority of seniors who use residential care and home support are on their own (i.e. unattached), and women outnumber men by approximately two to one.[6]

THE CHALLENGE OF GETTING THE NUMBERS RIGHT

Assessing whether there is adequate capacity and quality in the home and community care system requires an accurate assessment of the current level of services, a determination as to whether these services are appropriate to meet population needs, and projections of future service requirements. As the BC Auditor General has pointed out, the Ministry of Health Services has a lead role in this regard. In 2008, the Auditor General conducted an audit of the home and community care system to determine whether the ministry was "adequately fulfilling its stewardship role in helping to ensure that the home and community care system has the capacity to meet the needs of the population."[7] He concluded the ministry was not and noted three areas where it fell short: (1) setting a new strategic direction for the home and community care system; (2) developing a planning model that incorporates information on population health trends, system costs and accessibility of services; and (3) providing accurate information to the public on the system's performance.[8]

In *Continuing Care Renewal or Retreat?* a number of similar concerns were raised, including the fact that the planning model for the province's continuing rare renewal strategy was never made public and was completed nine months after the government decided to cut more than 3,000 residential care beds and substitute residential care with assisted living.[9]

The BC government's response to concerns about reduced capacity in the residential care system was to challenge the numbers by providing different numbers, which shifted attention away from substantive questions.

Much of the debate about the continuing care renewal strategy has focused on the provincial government's 2001 pre-election commitment to build 5,000 new not-for-profit residential beds and the changes in this commitment over time. This debate was often less than constructive. For example, the government's response to concerns raised in *Continuing Renewal or Retreat?* about reduced capacity in the residential care system was to challenge the numbers by providing different numbers. The government's numbers combined replacement beds (i.e. residential care beds that were converted to assisted living housing units) with new beds.[10] This made it difficult to identify the net increase in beds and the impact of substituting one type of service for another. What it did do, however, was shift attention away from the substantive questions of access into a contest about who had the right numbers.

This report takes a close look at the 5,000 bed commitment. The purpose of this analysis is not to simply re-open the debate about the numbers, but to address the concerns raised by the Auditor General and others regarding the need for a new strategic direction for the home and community care sector. To this end, the report:

- Examines the changes in long-term residential care service levels and access from 2001 to 2008;
- Outlines the policies that guided the restructuring of residential care services;
- Discusses the impact of these policies on the quality and cost of these services to users, their families and communities;
- Examines the changes in home health service levels and access from 2001 to 2008; and
- Reviews the changes in funding for home and community care from 2001 to 2008.

The report concludes with a set of recommendations outlining the information and service requirements central to rebuilding the capacity within the home and community care sector to meet the needs of an aging population now and into the future.

PART 2

Restructuring of Residential Services, 2001–2008

PRIOR TO THE 2001 ELECTION, the BC Liberal Party promised, if elected, that it would build 5,000 new not-for-profit, long-term residential care beds by 2006.[11] This commitment changed over time to the building of 1,500 residential care beds and 3,500 independent living beds (primarily assisted living, but also supportive housing units).[12] The reference to non-profit beds was dropped and the completion date extended two years from 2006 to 2008.[13] These shifts were based on the assumption that:

- Assisted living and supportive housing are viable substitutes for residential care, based on the idea that many residential care residents would do as well or better in assisted living and supportive housing, despite lower levels of care and lower levels of government funding;[14]
- Care in for-profit facilities is of equal quality and affordability as care provided in not-for-profit facilities; and
- A two-year delay in the delivery of the 5,000 bed commitment is immaterial.

This report raises a number of important questions related to each of these assumptions. As stated above, the intent of this exercise is not only to assess the government's progress on its 5,000 new-bed promise, but more importantly to identify the key components of a new strategic plan for rebuilding BC's home and community care system, moving forward to 2010 and beyond.

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Licensed residential care facilities, assisted living, supportive housing and convalescent (transitional) care services are all residential services that fall under the Home and Community Care Program in the BC Ministry of Health Services. Definitions of each of these services, the level and type of care provided, and health authority per diem costs are outlined in Appendix A. Licensed residential care and assisted living provide long-term care services, with licensed residential care providing services to people with high level, complex disabilities, and assisted living to those with low to moderate disabilities. Supportive housing is intended for the relatively independent elderly person and no personal care is provided by the supportive housing provider. Convalescent or transitional care is a short-term residential service for people who have been hospitalized and require a period of reactivation before returning to their previous or new residence.

It is our position that an assessment of the BC government's progress in meeting its 5,000 long-term bed commitment can only include those services that actually provide long-term residential services, namely licensed residential care facilities and registered assisted living sites.

In BC today, there is no publicly available data on publicly-funded licensed residential care facilities. Information on the number of beds, their location, and changes over time can be obtained only through Freedom of Information requests.

In BC today, there is no publicly available data on publicly-funded licensed residential care facilities. Information on the number of beds, their location, and changes over time can be obtained only through Freedom of Information (FOI) requests. The bed numbers in this report are based on FOI requests to each of the health authorities in August 2008. In the case of the Vancouver Island Health Authority, information has been updated to December 2008.

The health authority bed numbers are then compared to the numbers provided by the Ministry of Health Services from an FOI request related to the September 22, 2008 announcement that the 5,000 bed target had been achieved. In addition to the FOI process, the ministry has provided information on the number of residential and home care clients and the population's rate of use of these services from 2000/01 to 2006/07. The latter information enables us to look at changes in access to home health services as well as residential care.

CHANGES IN ACCESS TO RESIDENTIAL CARE BEDS

In determining whether there is sufficient capacity in the residential care sector, it is important to look at growth in the populations who use typically use these services—mainly elderly British Columbians. And while the demand for residential care services depends on other factors (e.g. disability rates specific to age and gender, the existence of affordable and appropriate alternative services, the socio-economic status of the population), increases in the population who typically use these services are key.

In looking at the population who uses these services in the Fraser Health Authority (in the absence of provincial age-specific rates), 86 per cent are aged 75 and over and about 56 per cent are over age 85 (see Appendix B1). Between 2001 and 2008, the provincial population of those over 85 years of age increased by 43 per cent while the population between age 75 and 84 increased by 15 per cent (Appendix B2). Given these high rates of growth, additional residential care beds would certainly be expected. Instead, there were 804 fewer beds in 2008

than there were in 2001 (see Table 2). Table 2 also shows a significant 20.5 per cent decline in access to licensed residential care for people 75 and older between 2001 and 2008—from 102 beds per 1,000 population aged 75-plus, to just over 81 beds in 2008.

In comparing access across the province, it is also interesting to note the variation in bed rates across the health authorities. Vancouver Coastal Health Authority has the highest rate, 9.2 per cent higher than the provincial average, and the Interior and Vancouver Island Health Authorities have the lowest rates at 4.7 and 3.2 per cent below the provincial average. Interestingly, rates can also vary within health authorities between Health Service Delivery Areas (each health authority is divided into three or four HSDAs). This more detailed information on changes in beds and bed rates by Health Service Delivery Area and community is provided in Appendix C.

There were 804 fewer residential care beds in 2008 than there were in 2001—a 20.5 per cent decline in access to licensed residential care for people aged 75 and older.

The reduction in access to residential beds is not unexpected. In 2002, as part of the restructuring of the residential care sector, the eligibility criteria for admission to a residential care facility increased so that only people with high-level complex care needs would be admitted (see Appendix A). This change was premised on the view that people not eligible for admission to residential care could be more appropriately supported in "homelike" settings through the provision of additional assisted living and home support services.[15] However, as we note later in this report, the promise of additional home support has not come to pass and while there has been considerable growth in assisted living, there are ongoing concerns about the low levels of care provided in assisted living facilities.

Table 2: Residential Care Bed Rate (Beds per 1,000 Population Aged 75+) by Health Authority, 2001 and 2008

	2001 beds	2008 beds	Change in beds 2001 to 2008	2001 beds per 1,000 aged 75+	2008 beds per 1,000 aged 75+	% change in bed rate 2001 to 2008
Fraser	7,471	7,331	-140	99.9	81.7	-18.2%
Interior	4,769	4,691	-78	96.6	76.7	-20.6%
Northern	1,006	918	-88	123.9	80.4	-35.1%
Vancouver Coastal	7,091	6,450	-641	119.4	87.0	-27.2%
Vancouver Island	5,083	5,226	143	89.6	79.1	-11.8%
BC Total	25,420	24,616	-804	102.3	81.3	-20.5%

Sources: Residential Care Beds for 2001/02 are from health authority representatives, Canadian Health Care Facilities Guide, and individual facilities. 2001 beds are as of June 2001. Population estimates (1986–2008) by BC STATS. All figures are as of July 1 of the year stated; i.e. data periods (e.g. 1999/2000) are Census year (July 1 to June 30). All figures correspond to current geographic boundaries of all regions, with the exception of the 2008 boundary change affecting Stikine Region and Kitimat-Stikine Regional District). Report Run February 23, 2009. Information on 2008 bed numbers comes from freedom of information requests to the regional health authorities, August 2008 and is cross-referenced with a long-term care site tracking spreadsheet with information from the Canadian Healthcare Association Guide and health authority websites. The numbers for Vancouver Island region have been updated to December 2008 based on information provided by VIHA on recent openings and closures. Bed rates refer to the beds per 1,000 population aged 75 and over.

INTERPROVINCIAL COMPARISONS

BC has the lowest level of access to residential care of any province in Canada with the exception of New Brunswick.

Another measure of how well BC is doing in providing licensed residential care services is to compare it with other provinces. In 2001, BC was just above the national average in terms of access to licensed residential care for people aged 75 and over. By 2008, BC had the lowest level of access of any province in Canada with the exception of New Brunswick (Table 3). Today BC is 9.7 per cent below the national average in terms of access for people 75 and over, and has experienced, along with Alberta, the greatest rate of decline since 2000/01. The higher rates of decline in residential care access in BC and Alberta may be a function of the introduction of assisted living as a substitute for residential care in both provinces.

ADDITION OF NEW ASSISTED LIVING BEDS

As indicated in Table 2, there were 804 fewer licensed long-term residential care beds in 2008 than in 2001. This means that *all* the additional capacity needed to meet the target of 5,000 long-term care beds must come from additional assisted living units.

To reach the 5,000 promised new beds, a total of 5,804 new assisted living beds are needed (this would bring the total beds from 25,420 in 2001 to 30,420 in 2008). However, based on information provided by the health authorities through Freedom of Information requests, only 4,393 publicly-funded assisted living units have opened (Table 4), resulting in a total of 3,589 new combined assisted living and residential care beds—still 1,411 or 28 per cent less than the 5,000 promised beds.

The combination of additional assisted living units and remaining residential care beds creates an access level equivalent to 95.9 beds/units per 1,000 seniors aged 75 and over, approximately 6.4 per cent lower than the 2001 access level of 102.3 beds per capita.

Table 3: Residential Care Bed Rate (Beds per 1,000 Population Aged 75+), by Province, 2001 and 2008

	2001 beds	2001 beds per 1,000 aged 75+	2008 beds	2008 beds per 1,000 aged 75+	% change in pop'n 75+ 2001 to 2008	% change in bed number 2001 to 2008	% change in bed rate 2001 to 2008
BC	25,420	102.3	24,616	81.3	21.8%	-3.2%	-20.5%
Alberta	14,486	106.0	14,654	83.9	27.7%	1.2%	-20.8%
Saskatchewan	9,240	123.4	8,944	112.8	5.9%	-3.2%	-8.6%
Manitoba	9,733	124.5	9,833	116.1	8.4%	1.0%	-6.8%
Ontario	58,403	88.2	75,958	91.5	25.3%	30.1%	3.8%
Quebec	43,491	104.8	46,091	88.3	25.8%	6.0%	-15.7%
New Brunswick	4,227	89.6	4,175	78.5	12.7%	-1.2%	-12.4%
Newfoundland	2,818	101.3	2,643	84.2	12.8%	-6.2%	-16.8%
Nova Scotia	5,806	96.3	5,986	89.4	11.0%	3.1%	-7.1%
PEI	950	106.5	978	100.1	9.5%	-2.9%	-9.3%
Canada	174,574	99.2	193,858	90.0	22.4%	11.0%	-9.3%

Notes and sources for this table are provided in Appendix D.

There are, however, ongoing concerns about the level of care provided in BC's assisted living facilities. Assisted living is widely recognized as a very positive option for people with low to moderate disabilities.[16] It is, however, much less clear whether and to what extent it is an appropriate substitute for licensed residential care.[17]

Assisted living is intended for people with low to moderate disabilities and those with sufficient mental capacity to direct their own care (see Appendix A for definitions). It includes hospitality services and personal assistance to adults who can live independently, but require help with at least one, but no more than two, prescribed services (e.g. assistance with activities of daily living, medication management). Eligibility for residential care, on the other hand, is limited to people with high-level, complex conditions (i.e. severe cognitive impairment and/or complex medical needs) requiring "total" care. There may be a gap in services, particularly for those with dementia who have higher care needs than can be accommodated in assisted living, but who may not require residential (complex) care. These people would have previously been accommodated in intermediate care. (See *Are the new assisted living facilities providing the same level of care as the facilities they replaced?* on page 24.)

Even assuming that assisted living is an adequate substitute for residential care, the province has fallen short of its 5,000 bed promise by 1,411 beds. In the meantime, the number of seniors over 85 has grown by 45 per cent.

Concerns about the adequacy of the assisted living model, to meet population needs, were explored in a 2004 study by Yuriko Araki.[23] The study found that many residents entering assisted living had care needs too high or too diverse to be accommodated within the assisted living model. The study also pointed to a combination of low staffing and physical environments not designed for people with dementia and/or significant mobility limitations as major barriers to accommodating these people. The study also commented on the feedback from assisted living administrators who reported that tenants entering assisted living tended to move to a higher level of care quite quickly.

Unfortunately, this research has not been updated. And although the assisted living program has now been in place for six years, there has been no formal review or evaluation of its effectiveness as a substitute for residential care.[24] What we do know, based on communications with BC Housing and others, is that there are no plans to build additional assisted living units—instead the focus has shifted back to increasing capacity in the residential care sector.[25] For example, in 2008 the Fraser Health Authority advised it had reached its target of 13.75 units per 1,000 population over 75 years and will be focusing on the high demand for residential care.[26]

Table 4: Residential Care and Assisted Living Beds, 2008

	2008 residential care beds	2008 assisted living beds[a]	2008 residential care and assisted living beds	2008 combined RC + AL bed rate per 1,000 aged 75+[b]
Fraser	7,331	1,317	8,648	96.4
Interior	4,691	897	5,588	91.3
Northern	918	228	1,146	100.4
Vancouver Coastal	6, 450	944	7394	99.7
Vancouver Island	5,226	1007	6,233	94.3
BC Total	24,616	4,393	29,009	95.9

Note and sources: [a] Assisted living bed numbers obtained through Freedom of Information requests to the regional health authorities, August 2008. [b] Bed rates refer to the beds per 1,000 population aged 75 and over. Population estimates (1986–2008) are from BC STATS, report run February 23, 2009.

The Vancouver Island and Fraser Health Authorities have made some small changes that reflect the limits of assisted living to substitute for residential care. In VIHA, because the assisted living's staffing model is inappropriate for people with dementia, one assisted living residence has been converted to a licensed facility.[27] VIHA has another small-scale licensed dementia cottages project nearing completion, and the Fraser Health Authority is looking at a similar model, which it refers to as "Assisted Living Plus."[28]

Somewhat belatedly, there is a promising new research initiative underway that will look at the effectiveness of assisted living in "delaying or reducing the need for residential care or higher care (e.g. acute care)" and at optimizing the health and physical and social wellbeing of residents.[29] In the meantime, however, it appears the focus for growth has shifted away from assisted living back to residential care, and to a lesser extent on new models of assisted living that can accommodate people with high levels of dementia.

REALITY CHECK

Are the new assisted living facilities providing the same level of care as the facilities they replaced?

Media reports quote BC Minister of Health Services George Abbot as saying that assisted living is similar to intermediate care facilities that had existed for decades.[18] Prior to 2002, intermediate care facilities housed people assessed at three levels of progressively higher disability: IC 1, IC 2 and IC3. We did a reality check on this statement and found that:

- Funding provided by health authorities to assisted living facilities is about half that previously provided to intermediate care.[19] This means that care staffing levels are also much lower. Staffing levels for intermediate care Level 2 (IC 2) residents, the main type of resident to be accommodated in assisted living, was between 2.3 to 2.5 hours of direct care for each resident per day in 2000.[20] In assisted living there is approximately 1.5 hours of care, per resident, per day.[21]
- In assisted living, individuals are considered to be living in their "own home" with a certain amount of care provided by the health authority. If care needs increase beyond what the assisted living facility provides, individuals or their families are expected to supplement the care or, if eligible, move to residential care.[22] Intermediate care facilities were responsible for the total care of residents; if care needs increased, it was the facility's responsibility to provide the additional care.
- In assisted living, where people are required to direct their own care, only people with low to moderate dementia are eligible. Intermediate care, and more recently multi-level care (facilities accommodating intermediate and extended care clients), routinely accommodate all types of dementia clients.
- Intermediate care facilities had licensed nursing services (i.e. registered nurses or licensed practical nurses) available 24 hours a day, seven days a week. Assisted living facilities do not have registered nurses on site and generally do not have any staff available overnight.

DIFFERENCES IN HEALTH AUTHORITY AND MINISTRY NUMBERS

On September 22, 2008, a Ministry of Health Services press release announced that the 5,000 bed target had been achieved with an inventory of 30,762 beds and units. As noted above, the five health authorities report only 29,009 combined residential care beds and assisted living units—1,753 fewer than the Ministry of Health Services' number. Health authority figures were obtained through Freedom of Information requests.

The difference between the provincial and combined health authority numbers is explained below and documented in Appendices E and F. The ministry's numbers are artificially high because they include:

- 672 supportive housing units—these units cannot be included because supportive housing has no care component (See Appendix A); and
- 976 beds that were inaccurately counted, or were ineligible because they include convalescent care (short-term reactivation following hospitalization and hospice care for those who are terminally ill), group homes, independent living units and mental health facilities (Appendix E).

The under or over-counting of beds by the Ministry of Health Services in relation to health authority numbers was verified by searching facility and other websites, or by phoning facilities. This double-checking confirmed the accuracy of health authority numbers over the ministry's numbers (Appendix F). While there are a few grey areas, including respite beds and facilities for young persons with physical disabilities, there is 99.6 per cent correlation between the health authority bed/unit numbers and the adjusted Ministry of Health Services' numbers.

This painstaking exercise of reconciling the numbers illustrates the problems that arise when basic information is not clearly and transparently reported to the public. Public reporting would necessitate the reconciliation of inconsistencies in the numbers and categories of services reported by the health authorities and Ministry of Health Services.

The under or over-counting of beds by the ministry in relation to health authority numbers was verified by direct contact with individual facilities. This painstaking exercise of reconciling the numbers illustrates the problems that arise when basic information is not clearly and transparently reported to the public.

IMPLICATIONS OF DELAYING THE 5,000 BED COMMITMENT

When the BC government failed to reach the 5,000 bed target by 2006, it simply extended the deadline by two years, without an adjustment to the number of beds needed. The nature of the demand for residential care and assisted living denies the government's simple solution of extending the target date. The target, at a minimum, should have been adjusted to reflect the 2006 to 2008 increase in the populations using these services.

The common way of projecting future residential care need, and also the method used to establish the original 5,000 new bed target,[30] is to project current age-specific rates of use onto future (larger) populations. We know, for example, that people aged 85 and older represent 56 per cent of residential care residents, and that 14.5 per cent of this age group live in residential care. From government population projections (Appendix B), the BC population aged 85 and older grew by 12 per cent between 2006 and 2008.

To estimate the increase in demand for residential care between 2006 and 2008, we followed this common practice of using age-specific rates of utilization to estimate future needs. Based on this method, the need for residential care and assisted living in BC increased by 1,815 beds between 2006 and 2008. It will increase by another 1,673 beds by 2010 (see Appendix G). The adjusted provincial target to 2008 should therefore be 6,815 beds — not 5,000. A projection to 2010 using the same method brings the total to 8,988 beds.

The limitations of a projection methodology that assumes continuation of current levels of residential care utilization for future populations are acknowledged. There are many other factors at play in the need and demand for residential care. These include disability rates specific to age and gender, household type (closely related to the availability of informal care), social economic status, and changing patterns of care delivery (e.g. access to home support and prevention services, and/or the introduction of new, more integrated models of care delivery). Delayed access to residential care is also a key factor leading to the increasing acuity of incoming residents and their generally shorter lengths of stay before death (see also pages 32). This trend has enabled existing residential care facilities to accommodate a greater number of people each year, thereby reducing the need for new beds. How much longer the trend of delaying access to residential care can continue is questionable.

Because there appears to be no existing methodology in use in the province that takes these factors into account, we are reluctant to make firm projections of bed requirements. However, it is clear that a substantial increase in capacity is needed and by all accounts most of the new capacity should be residential care rather than assisted living. In the final section of this report, we project the number of additional residential care beds that would be available if health authority spending on residential care and assisted living was the same in 2008 as it was in 2001 (see page 44).

What clearly emerges from this discussion is the need for the provincial government to play a greater leadership role in developing and publishing projections of future residential care requirements, taking into account the factors listed above. In the meantime, we point to sections in our companion report, *Innovations in Community Care: From Pilot Projects to System Change,* relevant to this discussion. These include sections on preventive services appropriate to the frail elderly, a discussion of the benefits of having multi-disciplinary primary care teams in residential care, and the importance of community-based, integrated care delivery models for the frail elderly.

SHIFT TO FOR-PROFIT DELIVERY

Thus far, this report has focused largely on the reduction in the number of residential care beds. But this is only part of the story. Another important concern has been the shift in ownership from not-for-profit to for-profit facilities. Most closures have occurred at not-for-profit sites and most openings have occurred at for-profit sites. Between 2000 and 2008, capacity in for-profit facilities increased by over 20 per cent, while capacity in not-for-profit facilities declined by over 11 per cent (Table 5).

This change in ownership is a result of a decision by the provincial government, beginning in the late 1990s, to withdraw direct capital funding grants for residential care facilities in favour of private capital financing. After 2001, the government introduced the requirement that all new publicly-funded residential care facilities be obtained through Request for Proposal processes. These processes favour large organizations with the infrastructure to participate, primarily private corporations and a few large non-profits. Prior to regionalization of the health system, the ministry and regional hospital districts provided the majority capital funding and technical support to non-profit societies in the design and building of new residential care facilities.

Between 2000 and 2008, capacity in for-profit facilities increased by over 20 per cent, while capacity in not-for-profit facilities declined by over 11 per cent.

In addition, in 2002 government legislation (Bill 94) provided employers with unlimited rights to contract out work in residential care. This is occurring primarily, although not exclusively, in for-profit facilities. Today the hands-on care of residents is contracted out in 39 facilities (see Appendix H1) or 14 per cent of all residential care facilities. In addition 107 facilities or 37 per cent (Appendix H2) of all facilities have contracted out support services (i.e. dietary, laundry, and/or cleaning services). This legislation not only provides employers with the ability to enter into commercial contracts with third-party providers, who pay wages and benefits far below industry standards, it also allows them to re-tender contracts with 60 days' notice and hire replacement contractors, often with an entirely new workforce. This re-tendering provision undermines both the continuity of care for residents and the ability of workers to organize and seek improvements in their wages and working conditions.

The shift to for-profit ownership of residential care and contracting out of the workforce can impact residents, their families and the health system in terms of both quality of care and costs. These issues are discussed in the next section.

Table 5: Changes in For-Profit and Not-for-Profit Ownership of Residential Care Facilities, 2000 to 2008

	Facilities						Beds					
	2000 facilities	% of total	2008 facilities	% of total	Change in # of facilities	Change in share of total	2000 beds	% of total	2008 beds	% of total	Change in # of beds	Change in share of total
For-profit sites and beds	83	27.0%	100	33.8%	17	20.5%	6,211	24.4%	7,588	30.9%	1,377	22.2%
Non-profit and health authority sites and beds	225	73.1%	196	66.2%	-29	-12.9%	19,209	75.6%	17,028	69.2%	-2,181	-11.5%
Total	308		296		-12	-3.9%	25,420		24,616		-804	-3.2%

Source: Canadian Health Care Facilities Guide, and health authority and facility websites.

PART 3

Impacts of Changes in Residential Care

Changes and shortfalls in the residential and community care system have implications for residents, families, communities, and BC's health care system.

CHANGES AND SHORTFALLS outlined above have implications for residents, families, communities and the health care system. Four of these impacts are outlined in this section:

- INAPPROPRIATE USE OF HOSPITAL BEDS, as a result of too many people waiting too long in hospitals for an alternate level of care, often residential care, home support or home health services;
- INADEQUATE PALLIATIVE CARE RESOURCES, as a result of inadequate residential care funding to accommodate the increase in palliative care residents;
- COMPROMISED QUALITY OF CARE, as increased complexity of care needs has not been met with adequate staffing; and
- OVERBURDENED FAMILIES, as the shift in the burden of care and costs moves to individuals and the people who support them.

This more in-depth analysis helps to identify a number of key recommendations for improving service delivery, monitoring and accountability, which are outlined in the conclusion of this report.

INAPPROPRIATE USE OF HOSPITAL BEDS

The 2005 predecessor to this report, *Continuing Care Renewal or Retreat?,* included considerable discussion about the increased costs and wait times when hospital patients, who no longer need hospital treatment, continue to occupy a hospital bed due to the unavailability of alternate forms of care, most often residential care. These patients are classified as Alternate Level of Care (ALC) patients. In 2007/08, 45 per cent of ALC patients in BC (who account for 59 per cent of all ALC days), ultimately moved to residential care, and 17 per cent (accounting for 11.5 per cent of ALC days) received home support after leaving the hospital.[31]

The extent of ALC patients in hospitals is an important measure for the performance of the overall health system. ALC patients reduce the capacity of hospitals to serve acutely ill people, and contribute to problems such as elective surgery cancellations and emergency room overcrowding.

At first glance, ALC data for BC (as shown in Table 6) appears to demonstrate some gains between 2001/02 and 2007/08. The data shows a small increase in the percentage of people (cases) identified as ALC (from 3.8 to 4.1 per cent) and a fairly significant reduction in the share of all hospital days (from 14.8 to 11.3 per cent), due to reduced lengths of stay.

However, on closer examination, these gains are far less certain. These uncertainties relate to the following points:

- Virtually all of the reductions in case and day rates occurred in two health authorities: Fraser and Vancouver Coastal (Appendix I). The other three health authorities (with some yearly fluctuations) have seen increasing ALC cases and ALC days, as well as higher proportions of ALC patients occupying hospital beds. The percentage of ALC days, out of total hospital days, in these three health authorities is 13.2 per cent (Interior), 14.7 per cent (Vancouver Island), and 18.6 per cent (North). Rates in Fraser and Vancouver Coastal are 8.7 and 8.3 per cent respectively.
- Among the inconsistencies in reporting across the health authorities, Fraser and Vancouver Coastal use a different measure for reporting ALC.[32] Officials in Fraser Health Authority acknowledge that a dramatic decline in ALC cases and days between 2004/05 and 2005/06 "related to an initiative to standardize how ALC patients are assigned and classified."[33] In Vancouver Coastal, a manager interviewed for this report suggested that while access to residential care was a factor in reducing ALC utilization (VCH has the greatest availability of residential care beds in the province), a new, more rigorous definition of ALC and more effective workflow processes for people at risk also had a positive impact on reducing ALC utilization.[34] A recent Canadian Institute for Health Information report acknowledges concern over data quality with "little concern about ALC being over-reported and … greater concern that ALC may be under-reported."[35]

Virtually all reductions in alternate level of care (ALC) rates occurred in two health authorities: Fraser and Vancouver Coastal. The other three health authorities have seen increasing ALC cases and ALC days, as well as higher proportions of ALC patients occupying hospital beds.

Table 6: Alternate Level of Care Activity in BC 2001/02 to 2007/08

	ALC cases			ALC days			
Year	ALC cases	All hospital cases	ALC as % of all hospital cases	Average length of stay (days)	ALC days	All hospital days	ALC as % of all hospital days
2001/2002	13,458	353,609	3.8	28.8	387,550	2,623,103	14.8%
2002/2003	12,463	341,845	3.6	27.1	338,108	2,556,948	13.2%
2003/2004	13,165	350,023	3.8	22.9	301,577	2,572,618	11.7%
2004/2005	15,419	353,508	4.4	21.0	323,607	2,604,556	12.4%
2005/2006	13,794	358,751	3.8	19.9	274,495	2,658,217	10.3%
2006/2007	14,249	359,766	4.0	19.7	281,103	2,687,485	10.5%
2007/2008	14,759	363,552	4.1	21.0	310,594	2,759,002	11.3%

Note: See Appendix I for breakdown by health authority.
Source: Ministry of Health Services, Management Information, Health System Planning, BC Acute Care Utilization Rates, September 30, 2008; excludes newborns.

- In the past, people waiting in the community for residential care placements received higher priority than ALC hospital patients because those waiting in hospitals were deemed to be "safe."[36] In April 2002, access to residential care was modified by provincial policy. Changes included the "first available bed" policy, where clients are required to accept and occupy the first available bed within 48 hours of notification (see *Have residential care waitlists really been cut from one year to 30 to 90 days?* on page 31). The amendments also provided health authorities with discretionary authority for priority admissions of hospital clients who are "assessed and awaiting placement" when "systems pressures require it."[37] Because of overcrowding in emergency rooms and hospitals, this discretionary authority is likely to be frequently applied. However, because of the lack of available data, there is no reliable information on changes in the proportion of placements or wait times for those waiting in the community compared to those waiting in hospital.

- Some of the reduction in ALC days relates to an increase in convalescent/transitional care beds, a growing number of which are located in residential care facilities. While it makes sense to increase transitional/convalescent capacity to take pressure off hospitals and provide time for patients to recover after leaving hospital, at least some of the increase in transitional/convalescent care beds has been at the expense of residential care. We estimate that approximately 320 residential care beds across the province have been re-designated to convalescent care (see Appendix G).

Until 2005, alternate level of care (ALC) patient days, as a percentage of all hospital patient days, were regularly reported by health authorities as part of their performance agreements with the ministry. There is no longer a requirement for public reporting of ALC and no attempt has been made to develop a common provincial approach for measuring or reviewing ALC utilization.

Until 2005, ALC patient days, as a percentage of all hospital patient days, were regularly reported by health authorities as part of their performance agreements with the Ministry of Health Services. There is no longer a requirement for public reporting of ALC and no attempt has been made to develop a common provincial approach for measuring or reviewing ALC utilization. There are, however, recent reports—two from Ontario and one from the Canadian Institute of Heath Information (CIHI)—that point to the importance of tracking and preventing ALC utilization among the frail elderly.

In Ontario a major, multi-sector collaborative position paper (*Alternate Level of Care—Challenges and Opportunities*) lead to the formation of an expert panel that analyzed ALC in detail. After a year's work, the panel reached the conclusion that ALC was a "serious system wide problem" that represented a significant challenge to the health care system.[40] The report referenced 2005/06 ALC days in Ontario at 9.3 per cent of all hospital days.[41] In the same year, the national average was 8.7 per cent, and in BC it was 10.3 per cent of hospital days.[42] The Ontario panel made a number of recommendations focused on the importance of preventing ALC through the expansion of more traditional residential and home health services as well as the development of more integrated, community-based programs for high risk populations.

The CIHI report describes three groups that account for a significant proportion of ALC patients: the frail elderly, those with cognitive/behavioural problems (dementia), and neurology/stoke patients.[43] The report notes that these patients have a mix of complex health problems that require follow-up or ongoing services from a variety of non-acute service providers.

An additional interesting finding from the CIHI report was that 83 per cent of ALC clients (as compared to 63 per cent for non-ALC patients) began their hospital experience in an emergency department.[44] In other words, ALC patients were much more likely to be admitted because of a health crisis than other patients. This raises many questions as to the potential to reduce high rates of emergency department usage, which might well relate to the availability and quality of various home and community care programs and primary care services.

Another Ontario report, *Improving Access to Emergency Care: Addressing System Issues,* documents the very high rate of emergency room visits by seniors: over 50 per cent of visits were people over the age of 75, an increase of over 50 per cent between 1992 and 2006.[45] According to the report, the overarching reasons for this increase in emergency room use were insufficient beds (in acute, long-term care and mental health) and the lack of integration between community and hospital services.[46] Unfortunately, in BC there is no publicly available information on emergency room visits, admissions rates by age group, and changes over time. This is yet another area where improved public reporting could contribute to better planning and more appropriate service delivery.

REALITY CHECK

Have residential care waitlists really been cut from one year to 30 to 90 days?

The BC government reports that residential care wait times have been cut from one year to 30 to 90 days.[38] However, because the waitlist process is entirely different now than it was prior to the restructuring of residential care in 2002, meaningful comparisons are not possible.

Because the waitlist process has been entirely changed, meaningful comparisons are impossible. Currently only individuals who require care within three months are eligible to be waitlisted at all.

Prior to April 2002, the waitlist was mainly chronological. Although there was provision for an emergency admission to bump the next person in line, generally admissions were based on the length of time on the waitlist—not urgency of need. There was considerable choice in that those waiting were offered a preferred and alternate placement. In instances when a person decided not to accept a placement they would go to the bottom of the waitlist.

The current wait list policy is no longer chronological. Only individuals who require care within three months are eligible to be waitlisted. Health authority officials, who manage the wait system, prioritize placement based on the urgency of need. While the system allows selection of a preferred facility, if there is no vacancy the person must accept the "first available bed" in another facility and occupy it within 48 hours. Once in the first available bed, the person can request a transfer to the preferred facility when a vacancy occurs. If the first available bed is turned down, the person is assumed to not have an urgent need and is removed from the priority access list. If the first available bed is refused by a person waiting in hospital, 30 days after being assessed as no longer requiring hospital services, the full hospital rate (minimum $700 per day) is charged.[39]

Taken together, these three reports bring the discussion full circle back to the importance of not only expanding access to traditional residential and home based services, but also creating more integrated approaches to the delivery of these services. These strategies might help ensure that people with complex conditions do not unnecessarily end up in hospital emergency departments and/or become ALC patients waiting placement in residential care or in the community.

INADEQUATE PALLIATIVE CARE RESOURCES

There has been a significant increase in the proportion of deaths occurring in residential care facilities, from 19.7 per cent in 2001 to 31.4 per cent in 2006 — an increase of almost 60 per cent.

With the shortage of residential care beds, there is growing concern that people are not getting access to residential care until their health is seriously compromised. These concerns are substantiated by the significant increase in the proportion of deaths occurring in residential care facilities, from 19.7 per cent in 2001 to 31.4 per cent in 2006 — an increase of almost 60 per cent (Table 7). The proportion of deaths in hospital correspondingly declined by 19.3 per cent, resulting in 3,532 fewer hospital deaths over the last five years. If this trend continues to 2011, between 43 to just over 50 per cent of all deaths in the province could occur in residential care facilities. Interestingly, although there has been considerable discussion about the importance of giving people the choice to die at home, the proportion of people dying at home did not change from 2001 to 2006.

Residential care's increasing focus on providing support to people who are dying (i.e. palliative care) is illustrated in Table 8. It shows that between 2001 and 2006 the rate of deaths in residential care increased from 14.6 per cent of all clients to 26.4 per cent—an 81 per cent increase in just five years.

Table 7: Deaths from Natural Causes in BC by Location, 2001 and 2006

	2001		2006	
	Number of deaths	% of all deaths	Number of deaths	% of all deaths
Hospital	16,699	63.3%	14,793	51.1%
Residential Care	5,197	19.7%	9,090	31.4%
Home	4,221	16.0%	4,574	15.8%
Total	26,380	99.0%	28,457	98.3%

Source: Romayne Gallagher, *Palliative Care in Long-term Care*, VGH Family Practice Rounds, Fall 2008 (using data from BC Vital Statistics).

Table 8: Residential Care, Resident Death Rate, 2001 and 2006

	2001		2006	
	Number of deaths	Death rate (%)	Number of deaths	Death rate (%)
Deaths[a]	5,197	14.6%	9,090	26.4%
Clients/residents[b]	35,596		34,400	

Source: [a] Romayne Gallagher, *Palliative Care in Long-term Care,* VGH Family Practice Rounds, Fall 2008 (using data from BC Vital Statistics). [b] BC Ministry of Health Services, 2008.

Despite this shift in end-of-life care from hospital to residential care, resources and policies have not been adjusted to reflect the increase need for palliative services in residential care. In late 2007, two academic experts in geriatric and palliative care raised concerns about serious inequities in funding for dying people.[47] They found that the average cost per patient in Vancouver Coastal Health Authority hospices was between $300 and $350 per day compared to an average daily cost in residential care of $165 per day. The only funding in residential facilities for palliative care is a very limited amount of "added care" funding, which is also for residents experiencing marked behavioural changes usually associated with dementia. This funding is very limited, does not cover the actual costs of care, is short term (for a week or less) and in some health authorities, like VIHA, is no longer available. This means there is not sufficient staff with appropriate skills available in residential care facilities to support people at the end of life, despite the fact that more and more people are dying in residential care.

There are other inequities, as well, including access to the BC Palliative Care Benefits Program. All hospices have access to this program, as do the relatively few residential care facilities served by hospital pharmacies. In most residential care facilities, however, residents must pay the cost of special medications and equipment themselves.

There is not sufficient staffing or funding for residential care facilities to support people at the end of life, despite the fact that more and more people are dying in residential care.

The BC Auditor General, in his recent review of home and community care services, raised specific concerns about this issue, pointing to the exclusion of end-of-life services from the Ministry of Health Services' home and community care vision and strategic direction.[48] In response to the Auditor General, the ministry indicated it was developing clinical standards and guidelines for these services, as well as a provincial policy on client co-payment.[49] The ministry also indicated it will not be developing a new provincial standard to define the core palliative care services that will be funded wherever the patient/client resides (i.e. in hospital, residential care, hospice, or their own home). In the ministry's opinion "the current framework is adequate" and there is no need to extend palliative policy further.[50] However, as the auditor general notes, this was not the view of a number of stakeholders, who believe that a provincial standard with a clear definition of funded services is needed to ensure equity of access and costs across the province.

COMPROMISED QUALITY

Along with the decision to reduce the number residential care beds, the eligibility criteria for admission was increased so that only people with high-level, complex care needs could be referred to licensed residential care (see Appendix A). Staffing levels and skill requirements, however, have not been increased to reflect the higher care needs of residents. As noted in a recent briefing note by the BC Care Providers Association (an industry association representing 95 not-for-profit and for-profit residential care facilities), health authorities are admitting more and more people with sub-acute and palliative care needs into residential care, but without "allowing comparable increases in funding to pay for specialized staff and equipment to effectively deliver these services."[51]

There is substantial evidence linking inadequate staffing to poor outcomes and increased hospitalizations for residents.[52] In 2006, the Ministry of Health's Nursing Directorate published a comprehensive review of the research literature on the relationship between staffing

and quality of care. The study concluded that higher staffing levels lead to improved quality, and that all levels of direct care staffing—registered nurses, licensed practical nurses and care aides—contribute to quality of care.[53] These studies examine both the direct care staffing levels needed for residents to avoid preventable adverse outcomes that can result in hospitalizations—such as falls, fractures, infections, malnutrition, dehydration and pressure ulcers—as well as the additional staffing required to improve the quality of life of residents.

Health authorities report staffing levels far below the minimum 4.1 hours per resident per day recommended by experts.

Freedom of Information requests were submitted to each of the health authorities to obtain current direct care staffing levels (RN, LPN and Care Aide). Four health authorities responded, and all reported staffing levels (see Table 9) far below the minimum 4.1 hours per resident per day (hprd) recommended by experts and researchers as necessary to avoid preventable adverse outcomes for residents, and the 4.5 hprd needed to improve quality of life.[54]

Moreover, in both the Fraser and Vancouver Coastal Health Authorities there are also very sizable differences in staffing levels between facilities that contract with the health authorities (i.e. as non-profit societies, family businesses, or for-profit corporations) and those owned and operated by the health authority. These discrepancies reflect, to some degree, the historical differences in funding between former extended care facilities (the highest level of care), most often owned and operated by the health authorities, and former intermediate care (with three lower levels of care), operated independently under contract with health authorities. In the Fraser and Vancouver Coastal Health Authorities, additional funding was not provided to increase staffing levels in the contracted facilities to reflect the shift to higher-need, more complex care clients. In the Vancouver Island Health Authority, on the other hand, funding levels were equalized by reducing staffing in some facilities and increasing it in others. This option did not, however, produce the overall increase in staffing levels recommended by researchers as essential to appropriately care for higher acuity of residents (see Table 9).

To complicate matters even further, contracted facilities are not being provided with sufficient funding to cover even the government's approved negotiated wage and benefit increases. According to the BC Care Providers Association, many facilities are in a deficit position with a shortfall in operating grants across the sector of 6 per cent, or $81 million per annum.[55]

Inadequate staffing related to rising levels of resident acuity has been an issue in other provinces as well. Five provincial governments—Nova Scotia, New Brunswick, Ontario,

Table 9: Average Direct Care Staffing (RN, LPN and Care Aide) by Health Authority, 2007/08

	Average hours per resident day (hprd) for direct health authority sites	Average hprd for contracted not-for-profit and for-profit sites	Overall average hprd
Fraser Health	3.1	2.5	2.7
Vancouver Coastal	3.44	2.74	2.98
Vancouver Island	2.88	2.84	2.86
Northern Health	2.96	not contracted	2.96

Sources: Direct care staffing levels (RN, LPN and Care Aide) FOI requests: Fraser (1-109) October 22, 2008 staffing level 2007/08; Vancouver Coastal (08-0608), December 23, 2008; Northern (2008-43), January 30, 2009; Vancouver Island (2008095), December 19, 2008 and February 13, 2009.

Compromised Quality in For-Profit Facilities and Contracted-Out Services

As noted earlier in this report (see page 27), there has been a significant shift over the last seven years from not-for-profit to for-profit provision of residential care services. Concerns raised by staff, residents and families about lower quality care in for-profit facilities are substantiated in the research literature. Evidence from a review of 33 studies looking at the relationship between ownership and quality in residential care across North America found lower levels of staffing, higher staff turnover, and more quality deficiencies in for-profit than not-for profit facilities.[58]

These findings have been replicated in BC. A study from 2001 comparing staffing in for-profit and not-for-profit residential care found considerably lower levels of direct care and support staff in for-profit compared to not-for-profit facilities.[59] Another BC study, focused on care-related hospitalizations, reported higher hospitalization rates for anaemia, pneumonia, and dehydration in for-profit facilities than not-for-profit facilities.[60] Interestingly, in this study facilities attached to hospitals had the lowest rates of hospitalization, while stand-alone non-profit and for-profit facilities had the highest rates. In addition, a more recent pilot study of licensing complaints from 2003 to 2008 in the Fraser Health Authority found significantly higher substantiated complaints in for-profit than in not-for-profit facilities.[61]

A review of residential care across North America found lower levels of staffing, higher staff turnover, and more quality deficiencies in for-profit than in not-for profit facilities.

There is similar evidence of the erosion of quality of care in facilities where care and/or support services have been contracted out, leading to lower wages and higher staff turnover, particularly if employers take advantage of the legislation allowing them an unrestricted right to terminate contracts and staff with 60 days' notice.[62] A residential care facility is home to the seniors who reside there, and often staff become like family. A major 2006 research report on the health of Canadian seniors by Statistics Canada noted that, according to National Population Health Survey (NPHS) data, "seniors in institutions who were close to at least one staff member and those with at least one close friend in the institution tended to have positive self-perceived health."[63] High rates of turnover among care staff have been shown in many studies to have negative effects on the quality of care and health status of residents. The kinds of outcomes discussed in the literature include: increased incidence of pressure ulcers, increased dehydration, increased rates of hospitalization, and decreased ability of residents to engage in the activities of daily living (e.g. dressing and grooming).[64]

As the evidence suggests, the combination of the shortfall in provincial funding for staff, the shift to private for-profit provision, and the legislation giving employers unlimited rights to contract out the work has resulted in an erosion of quality in the residential care sector. To restore quality in the residential care sector, new provincial policies are needed to provide increased funding for staffing, support the construction of non-profit residential care facilities, and put limits on contracting-out.

Alberta, and Manitoba—have committed additional funding for direct care staffing to address this problem.[56] In 2007, the Vancouver Island Health Authority announced a new funding model with a target of 3.24 hprd, including activities and rehabilitation. It did not, however, provide the funding needed to meet this target. The BC Care Providers Association and the Hospital Employees' Union have since come out in support of 3.2 hprd, but with the additional recommendation that the 3.2 be a minimum and that actual wage and benefit costs be fully funded.[57]

OVERBURDENED FAMILIES

Family members and friends are providing more personal care services and are more likely to manage the care if their loved ones are living in residential care or assisted living than if they are being cared for at home.

According to a recent study by Statistics Canada, family members and friends are providing more personal care services (e.g. assistance with meals, personal hygiene, bathing) and are more likely to manage the care if their loved ones are living in residential care or assisted living than if they are being cared for at home. Thirty-four per cent of people living in residential services receive personal care assistance from family members and friends (compared to 27 per cent living at home), and 45 per cent receive assistance with managing their medical care (compared to 36 per cent).[65] The study notes that while some family members may choose to provide some of these services to maintain a connection with their family member, the increased role of the family reflects the decline in staffing in residential care and the shift to assisted living. As the study notes, "In some new types of facilities such as 'assisted living' each additional service comes with an additional cost. Family and friends may choose to assist with some task to reduce the costs."[66]

In BC, assisted living residents are provided with one, and at most two, prescribed personal care services. If they need additional care, in most although not all circumstances, these services must be either provided or paid for by family members and or friends (see Appendix A). And while in the past residential care residents were provided with "total care," families who can afford it are increasingly hiring private caregivers to compensate for the shortfall in staffing.[67]

And yet, most people living in residential care are low-income, primarily women over 85, many of whom are on their own with no family or friends to help.[68] These women can ill afford to pay privately for any additional care they need. As the Ministry of Health recently noted, 63 per cent of people living in residential care "pay the lowest daily rate for residential care," now $30.90 a day, or $11,280 a year.[69] This means that their only income is Old Age Pension and the Guaranteed Income Supplement, with a yearly total of $14,034.[70] This leaves residents with at most $2,754, or $229.50 a month, to cover everything not provided by the residential care facility, including dentures, wheelchairs, specialty mattresses, over-the-counter drugs, personal hygiene products, cablevision, telephone, and palliative and/or rehabilitation services.

The services and costs that residential care providers are required to cover, as defined in the BC Ministry of Health Services' *Home and Community Care Policy Manual*, are subject to considerable interpretation, and many policies have not been updated to reflect the higher acuity of complex care clients.

Rehabilitation services are one example. The policy manual still states that rehabilitation services must be provided in extended and multi-level (these are pre-2002 categories of residential care that are no longer used) care facilities.[71] The policy has not been revised to reflect the shift to complex care. In a recently-completed Ph.D thesis, Jennifer Baumbusch compared services and care in a for-profit and not-for-profit facility. She found that the non-profit facility had rehabilitation therapists as part of its core staff available to all residents, whereas in the for-profit facility, residents had to pay for this service.[72] Interestingly, the non-profit facility providing rehabilitation services had not been a multi-level care or extended facility prior to 2002. The provider made a choice to provide these services and was able to do so in large measure because as a non-profit agency it is able to raise considerable funds through outreach to the community.[73] It is common for non-profit residential care facilities to have a fundraising arm and to receive donations in-kind for items such as wheelchairs and specialty mattresses that can then be used by their low-income residents.

Most recently, on Vancouver Island, residents who were moved from Cowichan Lodge (a non-profit residential care facility that was closed) to Sunridge Place (a new, private for-profit facility) have complained about extra charges in the new facility.[74] Some extra charges reflect higher charges for cablevision in the new facility (i.e. there is no requirement that the facility provide these services at the lowest cost possible) and over-the-counter medication (previously provided to the non-profit facility through the Cowichan District Hospital).

BC may be moving to a two-tiered health care system: one for those who can afford to purchase additional services and/or who have family who can support them, and another for those who depend entirely on services provided through the public system.

The inconsistencies in charges among facilities can include relatively small items, such as individuals paying for a dessert option not on the menu, specialty incontinent products (i.e. for someone who is overweight) or outings, to much large items such as wheelchairs, non-prescription medications, the additional supports needed for palliative care (see page 32) and rehabilitation therapy. Because long term residential services are not covered under the Canada Health Act, there are no legislative limits on extra charges in residential care. Alberta has just announced a new policy direction in long-term care in which individuals and families are expected to be less reliant on government, and have “more choice to buy additional services and amenities,” with government still providing assistance to “seniors most in need.”[75]

As the examples above suggest, BC may also be moving (at least informally) to a two-tiered arrangement within the publicly-funded residential services sector: one for those who can afford to purchase additional services and/or who have family who can support them, and another for those who depend entirely on services provided through the public system. This will disadvantage not only low-income residents without family supports, but also the majority of families across the province with aging parents who are already overworked and ill-equipped to take on the additional pressures and costs of caring for an aging relative or friend.

In this context, we should be reminded that Canadian research literature on care of the elderly shows that 80 per cent of care is provided informally by family and friends.[76] A recent report from the UBC Centre for Health Services and Policy suggests that the high proportion of informal care to total care has serious implications for future service need: “As the population ages and family size shrinks informal support may become less available and baby boomers might find it more difficult to stay at home through declining health.”[77] As the examples above suggest, they may also find it difficult to get the care they need within the residential sector.

PART 4

Changes in Access to Home Health Services

To address the greater demand for home support with limited resources, home support services have shifted to clients with higher levels of acuity and complexity and away from people with more limited needs.

TO UNDERSTAND THE FULL IMPLICATIONS of restructuring in residential care services, it is necessary to examine the changes in home health services—both home support and home care—over the same time period.

Home support services comprise personal assistance with the activities of daily living, such as bathing, dressing and medication management, as well as housekeeping tasks required to maintain a safe and secure environment, such as cleaning, laundry and meal preparation.

Home care includes home nursing and community rehabilitation services (i.e. physiotherapy and occupational therapy).

These services (particularly home support) are often considered to be alternatives or substitutes for residential care. For example, Fraser Health Authority's eligibility for residential care requires that applicants "have made reasonable attempts to have care provided at home that has either failed or is considered unsafe or unreasonable to continue."[78]

The information in this section covers 2000/01 to 2006/07. This was the most recent information available from the Ministry of Health Services.

HOME SUPPORT SERVICES

Following the decision to restructure residential care in 2002, a planning document was prepared by Ministry of Health Services' staff, and never released publicly, in which both home support services and assisted living were positioned as appropriate substitutes for residential care.[79] As access to residential care became more restrictive, access to home support services, such as assisted living, were supposed to increase. This increase, however, never materialized. In fact, in 2006/07, there were 17 per cent fewer clients accessing home support than in

2000/01 (Table 10). The decline is steeper still when the increase in the population over 75 years of aged and older is taken into account. Access to home support services for every 1,000 people aged 75-plus declined by 30 per cent between 2000/01 and 2006/07.

At the same time, the decrease in home support hours was much less—3.3 per cent over the seven years or 18.5 per cent when taking into account the increase in population 75 and older (Table 11).

Access to home support services for every 1,000 people aged 75-plus declined by 30 per cent between 2000/01 and 2006/07.

To address the greater demand for home support with limited resources, it is well documented that home support services have shifted to clients with higher levels of acuity and complexity and away from people with more limited needs.[80] Home support hours (Table 10) measure the amount or intensity of service. And so it should not be surprising that with the shift to higher-acuity, more complex clients, there has been an increase in hours of care for each client: between 2000/01 and 2006/07, the hours for clients each month increased from an average of 14.7 hours to 17.1 hours. A 16 per cent increase in hours per client (or the equivalent of 2.4 hours per month) seems small, but there is no other evidence that we

Table 10: Home Support Clients (excludes CSIL[a]), All Ages, and per 1,000 Population Aged 75+, 2000/01 and 2006/07[b]

	Client count (all ages)			Rate per 1,000 population 75+		
	2000/01	2006/07	% change	2000/01	2006/07	% change
Interior	8,188	7,042	-14%	172	122	-29%
Fraser	10,452	9,364	-10%	160	108	-32%
Vancouver Coastal	11,645	7,740	-34%	202	114	-43%
Vancouver Island	8,131	8,286	2%	148	129	-13%
Northern	1,935	1,083	-44%	246	105	-57%
BC	40,351	33,515	-17%	166	116	-30%

Notes [a] Choice in Supports for Independent Living (CSIL) is a self-managed care option chosen by a small number of BC's home support clients.
[b] Population estimates (1986–2008) by BC STATS, report run February 23, 2009.

Table 11: Home Support Hours (excludes CSIL[a]), All Ages, and per 1,000 Population Aged 75+, 2000/01 and 2006/07[b]

	Home support hours (all ages)			Hours per 1,000 population 75+		
	2000/01	2006/07	% change	2000/01	2006/07	% change
Interior	1,309,335	1,100,265	-16.0%	27,513	19,017	-30.9%
Fraser	1,935,858	2,021,278	4.4%	26,631	23,361	-12.3%
Vancouver Coastal	1,943,359	1,594,574	-17.9%	33,727	23,566	-30.1%
Vancouver Island	1,634,137	1,942,769	18.9%	29,663	30,176	1.7%
Northern	298,279	225,601	-24.4%	37,910	21,848	-42.4%
BC	7,120,967	6,884,486	-3.3%	29,565	24,009	-18.8%

Notes: [a] CSIL: Choice in Supports for Independent Living (see note Table 10).
[b] Population estimates (1986–2008) by BC STATS, report run February 23, 2009.

can rely upon to discern whether this is a sufficient increase commensurate with the acuity of home support clients.

This shift in home support services to people with higher needs began in the mid-1990s with the introduction of two policies. The first, introduced in 1994, eliminated "stand-alone housekeeping," meaning housekeeping in the absence of other care needs, which was available only on an exceptional basis. This was followed in 1999 with a policy requiring that priority be given to clients assessed at the highest levels of need and risk. As a result, home support is increasingly focused on providing personal and more medically-oriented services (e.g. simple wound dressings and medication management) to people with multiple chronic conditions.[81] The shift has also left behind a group of frail elderly, who are unable to afford private home support, have few family members to assist them, and who are therefore increasingly likely to be living at risk in the community.[82]

The shift in home support services to people with higher needs has left behind a group of frail elderly, who are unable to afford private home support, have few family members to assist them, and who are therefore increasingly likely to be living at risk in the community.

Most home support services have not been reconfigured to reflect the greater training and team work required to serve a population that is both more complex and more acute.[83] There are, however, innovations in some communities that are beginning to move in this direction. These are featured in the companion report, *Innovations in Community Care: From Pilot Project to System Change*. And, in April 2009 the Canadian Centre for Policy Alternatives will release a report that estimates the cost of introducing this model province-wide. The report also estimates the cost of addressing recruitment and retention issues, and increasing access to home support, including for people with more limited needs. The total comes to $100 million.[84]

HOME NURSING AND COMMUNITY REHABILITATION SERVICES

Home health services include professional nursing care and rehabilitation services (occupational therapy and physiotherapy). These services are available to people requiring post-acute, rehabilitation, chronic and palliative care services and are essential for ensuring that people with significant health issues can be cared for in their own homes.

Table 12: Provincial/Territorial Government Home Care Expenditures, 1994/1995 and 2003/2004, Constant 1997 Dollars

	$ per capita 1994/1995	$ per capita 2003/2004	% change
Alberta	40.54	86.64	113.7%
BC	66.19	81.82	23.6%
Manitoba	65.72	140.15	113.3%
New Brunswick	93.18	156.35	67.8%
Nova Scotia	25.12	105.24	318.9%
Ontario	60.79	98.74	62.4%
PEI	25.99	46.21	77.8%
Quebec	41.72	78.93	89.2%
Saskatchewan	60.78	80.36	32.2%
Canada average	53.22	91.14	71.3%

Note: Home care services include professional nursing and health services only (not home support).
Source: Canadian Institute for Health Information, 2007, *Public-Sector Expenditures and Utilization of Home Care in Canada: Exploring the Data*, p. 30, accessed at secure.cihi.ca/cihiweb/products/trends_home_care_mar_2007_e.pdf. Data not available for Newfoundland.

According to a 2007 CIHI report, in the mid-1990s BC was a leader in the provision of these services. However, by 2003/04 BC had fallen well below the national average in terms of per capita spending on home health services (see Table 12). Over the 10 years from 1994/95 to 2003/04, BC had the lowest per capita increases in funding of home nursing and rehabilitation services of any province in the country.

The much lower rate of home care per capital spending in BC is reflected in home nursing care trends. As shown in Table 13, the number of home nursing clients increased by 6 per cent between 2000/01 and 2006/07. However, taking population growth into account, access to home nursing care declined by 10 per cent between 2000/2001 and 2006/07.

Access to home nursing care declined by 10 per cent between 2000/2001 and 2006/07.

Community rehabilitation shows the opposite trend. As shown in Table 14, the total number of annual clients using community rehabilitation increased by 48 per cent between 2000/01 and 2006/07. After adjusting for population growth for the aged 75-plus population, access to community rehabilitation services increased by a smaller, but still significant, 25 per cent.

In October 2008, the Centre for Health Services and Policy Research at UBC released a report analyzing changes over a 10 year period (from 1995/96 to 2004/05) in the use of *all* home health services (i.e. home support, home nursing, community rehabilitation services, and

Table 13: Home Nursing Clients, All Ages, and per 1,000 Population Aged 75+, 2000/01 and 2006/07

	Client count (all ages)			Rate per 1,000 pop 75+		
	2000/01	2006/07	% change	2000/01	2006/07	% change
Fraser	10,313	10,316	0%	142	119	-16%
Interior	8,202	10,455	27%	172	181	5%
Northern	2,474	2,243	-9%	314	217	-31%
Vancouver Coastal	8,440	7,771	-8%	146	115	-21%
Vancouver Island	7,675	8,560	12%	139	133	-5%
BC	36,815	39,098	6%	153	136	-11%

Source: Population estimates for 75+ by BC STATS, report run February 23, 2009.

Table 14: Community Rehabilitation (includes Physio and Occupational Therapy) Clients, All Ages, and per 1,000 Population Aged 75+, 2000/01 and 2006/07

	Client count (all ages)			Rate per 1,000 pop 75+		
	2000/01	2006/07	% change	2000/01	2006/07	% change
Fraser	4,614	7,468	62%	63	86	35%
Interior	4,240	8,079	91%	89	140	57%
Northern	955	1,295	36%	121	125	3%
Vancouver Coastal	7,427	8,991	21%	129	133	3%
Vancouver Island	6,451	9,342	45%	117	145	24%
BC	23,615	35,068	48%	98	122	24%

Source: Population estimates for 75+ by BC STATS, report run February 23, 2009.

adult day care programs) by long-term users (i.e. 90 days or more) by British Columbians aged 65 and older.[85] Interestingly, the report found that a 30 per cent decline in the proportion of the population accessing home health services was a result of the decrease in long-term users — from one in 10 seniors in 1995/96 to one in 17 by 2004/05. The report also found that, compared to a decade earlier, a greater proportion of long term-users had access to home nursing and rehabilitation services and a lower proportion were receiving home support.[86] The authors note that while this shift to more professional care was consistent with the higher acuity of the users, the reduction in home support services for long-term users was inconsistent with the broad policy objective of government "which emphasized providing more community based services in an effort to keep people out of hospitals and long-term care residential facilities."[87] The authors also noted that the decrease in long-term use was disproportionately greater among those in lower income groups.[88]

Frail seniors, particularly those with low incomes and limited informal support, may remain at home without appropriate care and support until they are in crisis and hospitalized. By the time they enter residential care their health is seriously compromised.

These research findings add to the concern around the "first available bed" policy and the likelihood that, given ongoing hospital occupancy pressures, people waiting for residential care in hospital will get higher priority over those waiting in the community (see page 30). It suggests that frail seniors, particularly those with low incomes and limited informal support, may remain at home without appropriate care and support until they are in crisis and hospitalized, following which when they enter residential care their health is seriously compromised. This research reinforces the need for more oversight to ensure there is enough capacity in home health services to meet the needs of an aging population now and into the future.

PART 5

Funding of Home and Community Care

IN REVIEWING CHANGES in funding levels for home and community care services, it is important to look first at the overall trends in spending in BC compared to other provinces. As Table 15 shows, BC ranked second in Canada in per capita health spending in 2001. By 2007, BC had fallen to sixth place, with the lowest annual rate of increase in per capita spending of any province in Canada.

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Table 15: Interprovincial Comparison of per Capita Total Health Expenditures, 2001 and 2007

	2001		2007		
	$ per capita	Ranking	$ per capita	Ranking	Annual % change
Alberta	2,301.09	4	3,695.21	1	12.8
Newfoundland	2,555.02	1	3,636.86	2	8.9
Saskatchewan	2,266.09	5	3,580.07	3	8.4
Manitoba	2,426.92	3	3,499.10	4	7.0
New Brunswick	2,127.56	7	3,273.56	5	6.2
BC	2,480.95	2	3,153.58	6	4.3
Nova Scotia	2,021.76	10	3,144.47	7	6.2
Ontario	2,122.90	8	3,082.32	8	5.0
PEI	2,235.93	6	3,010.09	9	8.6
Quebec	2,100.30	9	2,853.09	10	5.2
Canada average	$2,209.65		$3,155.96		6.1

Source: Canadian Institute for Health Information, National Health Expenditure Trends, 1975–2007, Table B.4.2.

The impact of the lower rate of increases in health funding has been disproportionately shouldered by the by licensed residential care sector. As Table 16 shows, between 2001/02 and 2007/08, the increase in funding for licensed residential care facilities was much lower than the overall increase in health authority spending—23 as opposed to 36 per cent. For residential care and assisted living combined, the increase was 28 per cent and for home support it was 34 per cent. It is also interesting to note that if the health authorities increased funding for residential care and assisted living at the same rate as overall health authority spending, there would be an additional $94.5 million for residential services—enough funding for 1,523 additional residential care beds.[89]

The one area of home and community care where there was a significant increases in funding was home nursing/community rehabilitation services, where funding increased by 113 per cent. In other words, health authorities are spending more money on professional home-based medical services, and less on ongoing support and core services such as residential services and home support. As noted in our companion report, *Innovations in Community Care: From Pilot Projects to System Change*, these basic services are essential if low-income seniors with complex care needs are to be successfully cared for in the community. Failure to fund these services means these individuals are more likely to be hospitalized for conditions that could potentially be prevented, delayed or treated in the community.[90]

Table 16: Funding for Health Authorities and Home and Community Care, 2001/02 and 2007/08

Ministry funding to home and community care	2001/02 (millions)	2007/08 (millions)	% change
Home support	$258	$345	34%
Residential care	$1,158	$1,424	23%
Residential care and assisted living	$1,159	$1,482	28%
Home care nursing/community rehabilitation	$141	$301	113%
Total home and community care spending	$1,559	$2129	37%
Ministry funding to health authorities	$5,932	$8,047	36%

Note: Expenditures as reported by the regional authorities June 1, 2008.
Source: BC Ministry of Health, HCC Health Sector Expenditure Report, October 8, 2008.

PART 6

Conclusion

THIS REPORT PROVIDES an update to CCPA's 2005 report *Continuing Care Renewal or Retreat?* The 2005 report raised concerns that, rather than continuing care renewal, the changes introduced after 2002 represented a retreat by government and shift in responsibility to individuals, families and communities. Nothing uncovered in this report suggests a reversal of this trend. While there have been some increases in a limited number of services, overall access to home and community services continues to decline, and funding increases for home and community care are lower than for other health authority services (such as acute care).

While there have been some increases in a limited number of services, overall access to home and community services continues to decline, and funding increases for home and community care are lower than for other health authority services (such as acute care).

We have three serious concerns about the ongoing decline of the publicly-funded home and community sector. The first concern is its impact on people: care users and their families. The second is the generally negative impact that insufficient home and community care programs have on hospital services. The third is the prospect of further private, for-profit expansion within the publicly-funded home and community sector, as well as the growth of the private-pay sector.

To these three concerns we would add the findings of the BC Auditor General about the lack of strategic direction by the Ministry of Health Services. As the Auditor General's report points out, government expenditures on home and community care were over $2 billion in 2008 and, all told, services under the umbrella of home and community care support approximately 100,000 clients each year. A program of this size and importance deserves much better stewardship and accountability.[91]

This report identifies a number of specific examples where the provincial government fell short in its management of home and community care. This includes the errors in reporting out on the 5,000 bed commitment, the absence of provincial definition for Alternate Level of Care (people in hospital awaiting placement in the community), and the lack of provincial standards for palliative care services. In our view, the province's forthcoming new strategic directions document needs to address the shortfall in both service delivery and accountability.

The Ministry of Health Services contracted with Deloitte and Touche to prepare a strategic directions document for home and community care.[92] This reliance on external consultants creates considerable uncertainty about the capacity within the Ministry of Health Services to provide the leadership required over the long term to set a new strategic direction and address shortcomings in the current system. And while it is our understanding that the report from Deloitte Touche has been submitted to the ministry, it has not, as yet, been released publicly.[93]

Notwithstanding this point, we conclude with some recommendations on key initiatives, based on the findings of this report, that should be part of BC's strategy for home and community care.

- A commitment to increase the number of licensed residential care beds. As a guideline, we suggest the province commit to spending the same proportion of health authority funding on long term residential services that it did in 2001. This would provide approximately $94.5 million, or the equivalent of about 1,500 residential care beds. Funding should be distributed to health authorities, prioritizing under-served regions, to allow them to catch up to regions with higher levels of service.

The province should commit to spending the same proportion of health authority funding on long term residential services that it did in 2001. This would provide approximately $94.5 million, or the equivalent of about 1,500 residential care beds. Funding should be distributed to health authorities, prioritizing under-served regions.

- A commitment to provide public financing so that new residential care facility services can be delivered by not-for-profit organizations and/or the health authorities.

- Development of a planning model for the supply of residential care. The model should take into account population projections, disability rates and trends specific to age and gender, socio-economic status (for informal support), resident turnover, and the availability of alternate forms of care (including assisted living, traditional home and community care services, and more integrated community-based models). The model should also consider convalescent care, sub-acute care and other speciality services.

- A commitment to fully fund current operating costs of residential care facilities sufficient to bring all residential care facilities up to a minimum of 3.2 hours of care per resident, per day.

- Development of a provincial standard of core services for palliative care, whether they are provided in residential care, assisted living, or to individuals living in the community.

- Provision of $100 million in additional funding for home support to cover provincial implementation of a team-based delivery model, relieve recruitment and retention pressures, and increase services by 15 per cent.

- Annual public reporting on every home and community program (i.e. residential care services, home support, home care, community rehabilitation, integrated and geriatric specialty services) in each health authority, using a standardized format that includes the volume and rates of use and expenditures by service type.

- Development of a common provincial standard for measuring Alternate Level of Care patients as part of a detailed, systematic, province-wide review of the causes of high levels of ALC and the various solutions at hand.

- A major retrospective review of frail elderly emergency department visits. The review should focus on what led to the visit and what could have been done to prevent it.

- Organization of a full, public consultation process to seek the views of British Columbians and key stakeholders on strategic options for home and community care, including the document prepared by Deloitte & Touche. There has not been any meaningful or public examination of BC's home and community care system in 10 years. Now is the time to take a serious look at the best ways forward.

Types of Residential Services

RESIDENTIAL CARE

Provincial oversight of residential care began in 1978 with the passage of the Long-term care Act and creation of the provincial Long-term care program. Residential care, currently also known as complex care, was previously called long-term care and included different levels of care from personal care, intermediate care to multi-level care and extended care. Residential care is intended for persons with high levels of physical and/or mental disabilities who require 24 hour nursing supervision, continuous professional care and specialized care. Residential care facilities typically provide all five prescribed personal assistance services defined in the Community Care and Assisted Living Act. There has been a long history, dating back to the late 1980s, of government progressively restricting residential care access in favour of alternatives such as expanded home support and community-based services and, more recently, assisted living. The last major provincial policy change was in 2002 when access to residential care was limited to those with complex care needs (severe cognitive impairment—dementia, multiple disabilities and complex medical problems), those needing care within three months (wait-listing in anticipation of future need precluded), and a requirement to accept the first available bed within 48 hours of notification. Eligibility for publicly-funded facilities is determined by the health authorities. There is both publicly-funded residential care, which is subsidized by the government, and private-pay facilities, in which residents or their families pay the full cost. Residents in publicly-funded facilities pay rates based on their taxable income, ranging from $939 to $11,268 per month (January 2009). Publicly-funded facilities can be owned either by non-profit or for-profit organizations.

ASSISTED LIVING (AL)

Assisted living is a form of housing for persons with low to moderate levels of disability who require daily personal assistance to be able to live independently. It includes hospitality services (i.e. meals, housekeeping, laundry, social and recreational opportunities and a 24-hour emergency response system) and a minimum of one, but not more than two, prescribed personal assistance services. There are six personal assistance services: (1) activities of daily living; (2) central storage, distribution, administering or monitoring of medication; (3) maintenance or management of resident cash, resources or property; (4) monitoring of food intake or therapeutic diets; (5) structured behavioural programs; and (6) psychosocial rehabilitation or intensive physical rehabilitation. Assisted living is not suited for persons with mental/cognitive disabilities unable to make decisions on their own behalf. Assisted

living originated in 2001 as part of the Independent Living BC (ILBC) program to create an option between living at large in the community and residential care. Assisted living has a philosophy of encouraging and enabling residents to make choices, to do as much for themselves as possible and thereby stay as independent as possible. Independence is also facilitated by the physical environment. Resident rooms are like apartment suites: they include bathrooms (with showers), kitchenettes and are lockable. With residents being able to live more according to their wishes and devices they theoretically maintain higher levels of functioning. Commensurate with lower level and less complex disabilities, there is no registered nursing care and the amount of care and its cost is much less than for residential care. The Community Care and Assisted Living Act also stipulates that assisted living cannot house persons unable to make decisions on their own behalf.[94] Eligibility is determined by the health authorities. There are both publicly-funded and private-pay assisted living developments. The publicly-funded facilities entail subsidies from both health authorities and BC Housing, the former for personal assistance and the latter for housing and hospitality (e.g. meals, housekeeping, laundry). Individuals pay 70 per cent of their after-tax income in assisted living under the ILBC program. Publicly-subsidized assisted living developments are owned and operated by both non-profit and for-profit entities.

SUPPORTIVE HOUSING

Supportive housing is a form of housing for low-income seniors who are either independent or have minor disabilities, but need some assistance to continue living independently. The provincial program involves converting and upgrading existing seniors' housing to enhance accessibility and improve safety systems. Supportive housing includes a daily meal, weekly housekeeping and linen laundry, social and recreational opportunities, and a 24-hour emergency response system. No personal care or prescribed service is available on-site, except where individual residents arrange to receive home support from external home support agencies. Tenants in supportive housing pay 50 per cent of gross household income. Close to 800 units around the province will eventually be created.

CONVALESCENT CARE

Convalescent care, also called transitional care, is for patients who have had an acute care hospital episode, but are now stable with a diagnosis and treatment plan. These patients no longer meet acute care criteria, but may require additional assessment, therapy and medical services to restore functioning before returning home. Convalescent care is provided mainly in hospitals or in specially designated residential care facilities. Convalescent care units are licensed under the Community Care and Assisted Living Act.

SUB-ACUTE CARE

Sub-acute care is for patients who have had an acute care hospital episode, but still require frequent medical supervision and intense therapy. Patients are less stable than convalescent care patients. The purpose of sub-acute care is the functional improvement of patients, enabling them to return to a home environment. Sub-acute care is provided only in hospitals and all sub-acute care units are designated under the Hospital Act.

Table A1: Comparison of Residential Care, Assisted Living and Supportive Housing

	Residential care	Assisted living	Supportive housing
Residents	High-level, complex disabilities	Low to moderate disabilities	Independent or minor disabilities
	Unable to make decisions on own behalf	Able to make decisions on own behalf	Able to make decisions on own behalf
	Routine palliative	Occasional palliative	Infrequent palliative
Services	Hospitality[a]	Hospitality[a]	Hospitality[a]
	Continuous 24-hour professional care (nursing)	Scheduled and unscheduled non-professional care[d]	No personal care[c]
	All prescribed services[b]	Minimum one, no more than two, prescribed services[b]	No prescribed services[b]
Staffing levels	2.2 to 3.2 hours per person, per day	1.5 hours per person, per day [e]	0.7 hours per person, per day [e]
Health authority per diem costs	$130.92 to $146.01[f]	$55.46	$0[g]
Accommodation	Special purpose designed	Conventional self -contained apartment units with age-adapted features	Conventional self -contained apartment units with age-adapted features

Notes and sources: [a] Hospitality includes meals, housekeeping, laundry, social and recreational opportunities, and 24-hour emergency response system. [b] The six prescribed (personal assistance) services include: activities of daily living, medications, therapeutic diets, purchases or paying bills, psychosocial rehabilitation or intensive physical rehabilitation, and structured behavioural program. [c] Residents of supportive housing are able to receive personal assistance from home support agencies. [d] Vancouver Island Health Authority assisted living residents receive personal assistance from home support agencies; all other health authority contracted assisted living facilities provide personal care with their own staff. [e] Assisted living and supportive housing staffing levels provided by Fraser Health Authority. [f] Health authority per diem costs (excluding resident co-payment) for residential care from Fraser and Interior Health Authorities. Average for Fraser Health Authority is $130.92, and for the Interior Health Authority, $146.01 (2007/11) [g] Supportive housing owners receive no health authority funding except indirectly through residents' individual purchase of subsidized home support, delivered by external agencies.

Table A2: Comparison of Convalescent, Sub-Acute and Palliative Care

	Convalescent care	Sub-acute care	Palliative care (hospice)
Residents	Post-acute, clinically stable, multiple, complex conditions requiring slower-paced reactivation prior to return home	Post-acute, some instability, requiring frequent medical supervision, for shorter period to restore functional improvement	Advanced stages of a serious progressive illness, nearing death (the most complex of the terminally ill)
Expected length of stay	2 to 16 weeks	4 days to 4 weeks	17 days (in-patients)
Staffing levels	5.0 hours per client, per day (direct care)	N/A	8.8 hours per client, per day (direct care)
Daily cost (per client, per day)	$274	$309 to $313 (sub-acute rehabilitation and sub-acute medical, respectively)	$530 per patient, per day (excludes capital, building operations, food, laundry, and housekeeping)
Location	Hospitals and designated residential care facilities	Hospitals	Hospital sites

Notes and sources: Convalescent and sub-acute care length of stay, staffing levels and daily cost information from Fraser Health Authority (Convalescent Care and Pre-Residential Care Project, Draft, June 2007). Palliative care (hospice) definition is for in-patient hospice unit. Palliative care (hospice) data from Victoria Hospice (2007/08), 17–bed, in-patient unit.

Age Distribution of Residential Care Residents and BC Population Change

Table B1: Age Distribution of Residential Care Residents (Fraser Health, 2008/09)

Age group	Residential care clients	Age group (%)
Adults under 64	438	5.6%
65 to 74	648	8.3%
75 to 84	2,364	30.4%
85+	4,328	55.6%
All Adults	7,778	100.0%

Note: Fraser Health is the only health authority for which this data is available.
Source: Residential care clients are as of April 2008 (one month snapshot), obtained from Fraser Heath Authority FOI response, December 2008.

Table B2: BC Population Change, 2001 to 2008

Year	Total	75+	75+ as % of total	75 to 84	75 to 84 as % of total	85+	85+ as % of total
2001	4,076,264	248,402	6.09%	188,466	4.62%	59,936	1.47%
2002	4,098,178	255,855	6.24%	193,474	4.72%	62,381	1.52%
2003	4,122,396	263,408	6.39%	198,660	4.82%	64,748	1.57%
2004	4,155,170	270,917	6.52%	203,636	4.90%	67,281	1.62%
2005	4,196,788	278,521	6.64%	206,920	4.93%	71,601	1.71%
2006	4,243,580	286,752	6.76%	210,260	4.95%	76,492	1.80%
2007	4,310,305	294,934	6.84%	213,536	4.95%	81,398	1.89%
2008	4,381,603	302,610	6.91%	216,912	4.95%	85,698	1.96%
% increase 2001–2008	7.49%	21.82%		15.09%		42.98%	

Note: Population estimates are final intercensal for 2001 and preliminary postcensal (based on 2006 Census) for 2008.
Source: Statistics Canada, Table 051-0001, Estimates of population, by age group and sex for July 1, Canada, provinces and territories, annual (persons unless otherwise noted), CANSIM (database), accessed January 16, 2009.

Residential Care and Assisted Living Beds by Municipality and Health Services Delivery Area, 2001 and 2008

Health Service Delivery Area	Residential care beds			Assisted living (public-pay) beds			Change from 2001–2008 RC + AL Beds
	2001 beds	2008 beds	Change	2001 beds	2008 beds	Change	
British Columbia	**25,420**	**24,616**	**-804**	**20**	**4,393**	**4,373**	**3,549**
Fraser Health Authority	**7,471**	**7,331**	**-140**	**0**	**1,317**	**1,317**	**1,177**
Fraser East	**1,392**	**1,462**	**70**	**0**	**296**	**296**	**366**
Abbotsford	701	731	30	0	134	134	164
Agassiz	0	19	19	0	10	10	29
Chilliwack	439	432	-7	0	100	100	93
Clearbrook	52	44	-8	0	0	0	-8
Harrison Hot Springs	0	0	0	0	0	0	0
Hope	46	62	16	0	12	12	28
Kent	0	0	0	0	0	0	0
Mission	154	174	20	0	40	40	60
Fraser North	**3,351**	**2,827**	**-524**	**0**	**420**	**420**	**-104**
Anmore	0	0	0	0	0	0	0
Belcarra	0	0	0	0	0	0	0
Burnaby	1,676	1,403	-273	0	187	187	-86
Coquitlam	452	495	43	0	60	60	103
Maple Ridge	398	323	-75	0	46	46	-29
New Westminster	511	400	-111	0	57	57	-54
Pitt Meadows	0	0	0	0	0	0	0
Port Coquitlam	239	131	-108	0	70	70	-38
Port Moody	75	75	0	0	0	0	0
Fraser South	**2,728**	**3,042**	**314**	**0**	**601**	**581**	**895**
Aldergrove	88	87	-1	0	0	0	-1
Delta	475	537	62	0	88	88	150
Langley	531	585	54	0	122	122	176
Surrey	796	1,023	227	0	265	265	492
White Rock	838	810	-28	0	126	126	98

Health Service Delivery Area	Residential care beds			Assisted living (public-pay) beds			Change from 2001–2008 RC + AL Beds
	2001 beds	2008 beds	Change	2001 beds	2008 beds	Change	
Interior Health Authority	**4,769**	**4,691**	**-78**	**20**	**897**	**877**	**799**
East Kootenay	**554**	**447**	**-107**	**0**	**92**	**92**	**-15**
Cranbrook	167	158	-9	0	28	28	19
Creston	173	120	-53	0	23	23	-30
Elkford	0	0	0	0	0	0	0
Fernie	58	51	-7	0	12	12	5
Golden	38	28	-10	0	8	8	-2
Invermere	40	35	-5	0	8	8	3
Kimberley	78	55	-23	0	13	13	-10
Radium Hot Springs	0	0	0	0	0	0	0
Sparwood	0	0	0	0	0	0	0
Kootenay Boundary	**751**	**536**	**-215**	**0**	**102**	**102**	**-113**
Castlegar	105	117	12	0	15	15	27
Fruitvale	0	0	0	0	0	0	0
Grand Forks	96	80	-16	0	17	17	1
Greenwood	0	0	0	0	0	0	0
Kaslo	20	20	0	0	0	0	0
Midway	0	0	0	0	5	5	5
Montrose	0	0	0	0	0	0	0
Nakusp	31	8	-23	0	10	10	-13
Nelson	188	124	-64	0	29	29	-35
New Denver	35	30	-5	0	0	0	-5
Rossland	41	0	-41	0	0	0	-41
Salmo	0	0	0	0	0	0	0
Silverton	0	0	0	0	0	0	0
Slocan	0	0	0	0	0	0	0
Trail	235	157	-78	0	26	26	-52
Warfield	0	0	0	0	0	0	0
Okanagan	**2,458**	**2,553**	**95**	**20**	**485**	**465**	**560**
Armstrong	70	40	-30	0	20	20	-10
Coldstream	0	0	0	0	0	0	0
Enderby	47	39	-8	0	0	0	-8
Kelowna	917	1,014	97	20	162	142	239
Keremeos	25	25	0	0	13	13	13
Lake Country	0	0	0	0	0	0	0
Lumby	0	0	0	0	0	0	0
Oliver	126	126	0	0	33	33	33
Osoyoos	83	62	-21	0	0	0	-21
Oyama	0	4	4	0	0	0	4
Peachland	0	0	0	0	0	0	0
Penticton	389	421	32	0	88	88	120
Princeton	36	37	1	0	0	0	1
Spallumcheen	0	0	0	0	0	0	0
Summerland	164	123	-41	0	18	18	-23
Vernon	422	469	47	0	85	85	132
Westbank/West Kelowna	147	144	-3	0	41	41	38
Winfield	32	49	17	0	25	25	42

Health Service Delivery Area	Residential care beds			Assisted living (public-pay) beds			Change from 2001–2008 RC + AL Beds
	2001 beds	2008 beds	Change	2001 beds	2008 beds	Change	
Thompson Cariboo Shuswap	**1,006**	**1,155**	**149**	**0**	**218**	**218**	**367**
100 Mile House	65	65	0	0	17	17	17
Ashcroft	16	21	5	0	10	10	15
Barriere	0	0	0	0	10	10	10
Cache Creek	0	0	0	0	0	0	0
Chase	0	0	0	0	20	20	20
Clearwater	0	21	21	0	0	0	21
Clinton	0	0	0	0	0	0	0
Kamloops	491	546	55	0	86	86	141
Lillooet	22	22	0	0	0	0	0
Logan Lake	0	0	0	0	0	0	0
Lytton	10	0	-10	0	0	0	-10
Merritt	50	58	8	0	13	13	21
Revelstoke	48	45	-3	0	11	11	8
Salmon Arm	207	262	55	0	30	30	85
Sicamous	0	0	0	0	0	0	0
Williams Lake	97	115	18	0	21	21	39
Northern Health Authority	**1,006**	**918**	**-88**	**0**	**228**	**228**	**140**
Northeast	**251**	**214**	**-37**	**0**	**39**	**39**	**2**
Chetwynd	0	7	7	0	0	0	7
Dawson Creek	43	44	1	0	15	15	16
Fort Nelson	0	7	7	0	0	0	7
Fort St. John	94	78	-16	0	24	24	8
Hudson’s Hope	0	0	0	0	0	0	0
Pouce Coupe	114	78	-36	0	0	0	-36
Taylor	0	0	0	0	0	0	0
Tumbler Ridge	0	0	0	0	0	0	0
Northern Interior	**497**	**473**	**-24**	**0**	**123**	**123**	**99**
Burns Lake	30	35	5	0	17	17	22
Fort St. James	0	6	6	0	2	2	8
Fraser Lake	0	0	0	0	0	0	0
Granisle	0	0	0	0	0	0	0
Mackenzie	0	0	0	0	0	0	0
McBride	8	8	0	0	0	0	0
Prince George	303	267	-36	0	52	52	16
Quesnel	115	107	-8	0	38	38	30
Valemount	0	0	0	0	0	0	0
Vanderhoof	41	50	9	0	14	14	23
Wells	0	0	0	0	0	0	0
Northwest	**258**	**231**	**-27**	**0**	**66**	**66**	**39**
Dease Lake	0	0	0	0	0	0	0
Hazelton	4	9	5	0	6	6	11
Houston	0	0	0	0	5	5	5
Kitimat	35	33	-2	0	15	15	13
Masset	16	12	-4	0	0	0	-4
New Aiyansh	0	0	0	0	0	0	0

Health Service Delivery Area	Residential care beds			Assisted living (public-pay) beds			Change from 2001–2008 RC + AL Beds
	2001 beds	2008 beds	Change	2001 beds	2008 beds	Change	
New Hazelton	0	0	0	0	0	0	0
Port Edward	0	0	0	0	0	0	0
Prince Rupert	73	53	-20	0	0	0	-20
Queen Charlotte	0	0	0	0	4	4	4
Smithers	55	54	-1	0	14	14	13
Stewart	0	0	0	0	0	0	0
Telegraph Creek	0	0	0	0	0	0	0
Telkwa	0	0	0	0	0	0	0
Terrace	75	70	-5	0	22	22	17
Vancouver Coastal Health Authority	**7,091**	**6,450**	**-641**	**0**	**944**	**944**	**303**
Richmond	**681**	**686**	**5**	**0**	**116**	**116**	**121**
Richmond	681	686	5	0	116	116	121
Vancouver	**4,738**	**4,201**	**-537**	**0**	**617**	**617**	**80**
Vancouver	4,738	4,201	-537	0	617	617	80
North Shore/Coast Garibaldi	**1,672**	**1,563**	**-109**	**0**	**211**	**211**	**102**
Bella Bella	0	7	7	0	0	0	7
Bella Coola	0	5	5	0	0	0	5
Bowen Island	0	0	0	0	0	0	0
Gibsons	38	80	42	0	60	60	102
Lions Bay	0	0	0	0	0	0	0
North Vancouver	776	651	-125	0	81	81	-44
Pemberton	0	0	0	0	0	0	0
Powell River	156	154	-2	0	40	40	38
Sechelt	111	99	-12	0	0	0	-12
Sechelt Ind. Gov Dist	0	0	0	0	0	0	0
Squamish	61	59	-2	0	0	0	-2
Waglisla	7	0	-7	0	0	0	-7
West Vancouver	523	508	-15	0	30	30	15
Whistler	0	0	0	0	0	0	0
Vancouver Island Health Authority	**5,083**	**5,226**	**143**	**0**	**1,007**	**1,007**	**1,150**
South Vancouver Island	**3,148**	**2,834**	**-314**	**0**	**600**	**600**	**286**
Colwood	0	0	0	0	10	10	10
Esquimalt	0	0	0	0	12	12	12
Highlands	0	0	0	0	0	0	0
Langford	0	0	0	0	80	80	80
Metchosin	0	0	0	0	0	0	0
Oak Bay	0	0	0	0	0	0	0
Saanich	150	143	-7	0	54	54	47
Salt Spring Island	82	81	-1	0	40	40	39
Sidney	127	129	2	0	0	0	2
Sooke	0	30	30	0	0	0	30
Victoria	2,789	2,451	-338	0	404	404	66
View Royal	0	0	0	0	0	0	0

Health Service Delivery Area	Residential care beds			Assisted living (public-pay) beds			Change from 2001–2008 RC + AL Beds
	2001 beds	2008 beds	Change	2001 beds	2008 beds	Change	
Central Vancouver Island	**1,451**	**1,857**	**406**	**0**	**318**	**318**	**724**
Chemainus	74	75	1	0	0	0	1
Duncan	253	326	73	0	0	0	73
Ladysmith	31	89	58	0	42	42	100
Lake Cowichan	0	0	0	0	50	50	50
Nanaimo	479	676	197	0	100	100	297
Parksville	185	278	93	0	60	60	153
Port Alberni	233	188	-45	0	26	26	-19
Qualicum Beach	161	190	29	0	30	30	59
Shawnigan Lake	35	35	0	0	0	0	0
Tofino	0	0	0	0	0	0	0
Ucluelet	0	0	0	0	10	10	10
North Vancouver Island	**484**	**535**	**51**	**0**	**89**	**89**	**140**
Alert Bay	9	10	1	0	0	0	1
Campbell River	138	194	56	0	54	54	110
Comox	125	125	0	0	0	0	0
Courtenay	126	129	3	0	35	35	38
Cumberland	76	66	-10	0	0	0	-10
Gold River	0	0	0	0	0	0	0
Port Alice	0	0	0	0	0	0	0
Port Hardy	10	11	1	0	0	0	1
Port McNeill	0	0	0	0	0	0	0
Sayward	0	0	0	0	0	0	0
Tahsis	0	0	0	0	0	0	0
Zeballos	0	0	0	0	0	0	0

Source: Same as Table 2 on page 21 and Table 4 on page 23.

Notes and Sources for Interprovincial Comparison of Residential Care Facilities, 2001 and 2008 (Table 3)

BRITISH COLUMBIA residential care beds per 1,000 population 75+ were obtained from the Saskatchewan Survey, 2001. Residential Care Beds for 2001/02 are from health authority representatives, Canadian Health Care Facilities Guide, and from individual facilities. Beds for 2001 are as of June 2001; 2004 beds are for December 2004. Information on the 2008 bed numbers comes from Freedom of Information requests to the regional health authorities, August 2008, and is cross-referenced with a long-term care site tracking spreadsheet with information from the Canadian Healthcare Association Guide and health authority websites. The numbers for VIHA were updated to December 2008, based on information provided by VIHA on recent openings and closures.

ALBERTA 2001 bed numbers are from the Saskatchewan Survey, 2001; 2008 bed numbers are from correspondence with Thuy Nguyen, Alberta Health & Wellness. The number of LTC beds is as of March 31, 2008.

SASKATCHEWAN 2001 bed numbers are from the Saskatchewan Survey, 2001; 2008 bed numbers are from correspondence with Gaye Holliday, Saskatchewan Health, October 1, 2008.

MANITOBA 2001 bed numbers are from the Saskatchewan Survey, 2001; 2008 beds are as of March 31, 2008 and include a limited number of respite beds. At a maximum, a facility may have two respite beds, and not all facilities have respite beds. Non-licensed interim beds (150) that are being phased out are not included in the number 9,833. Information from Lorene Mahoney at Manitoba Health, October 23, 2008.

ONTARIO 2001 bed numbers are from the Saskatchewan Survey, 2001; 2008 LTC beds from Ontario Health System Information and Management Information (HSIMI), July 31, 2008 Health Data Branch, Ministry of Health and LTC.

QUEBEC 2001 bed numbers are from the Saskatchewan Survey, 2001; 2008 bed numbers are from the table "Capacités: Lits ou Places autorisés au permis. Sommaire provincial selon les mission-classe-type" (a provincial summary of licensed beds according to class types) retrieved January 5, 2009 from wpp01.msss.gouv.qc.ca/appl/M02/M02SommLitsPlacesProv.asp, last updated December 12, 2008.

NEW BRUNSWICK 2001 bed numbers are from the Saskatchewan Survey, 2001; 2008 bed numbers are from Mike Leger, Manager of Nursing Home Services.

NEWFOUNDLAND 2001 bed numbers are from the Saskatchewan Survey, 2001; 2008 bed numbers were obtained from Beverly Griffiths, Regional Consultant, Newfoundland Department of Heath and Community Services (January 16, 2009). Respite and palliative care beds may be included in this total number. Ms. Griffiths estimates there are approximately two respite beds in each facility, and as there are a total of 40 facilities, the actual bed numbers might be approximately 2,563. However, it is possible that respite bed numbers were included in the 2001 bed numbers as well.

NOVA SCOTIA bed numbers are from the Saskatchewan Survey, 2001; 2008 bed numbers are from correspondence with Annette Fougere, Nova Scotia Department of Health. The number of “nursing home” beds is as of August 1, 2008.

PRINCE EDWARD ISLAND 2001 bed numbers are from the Saskatchewan Survey, 2001; 2008 bed numbers were retrieved from the Department of Health at www.gov.pe.ca/health/index.php3?number=1020341&lang=E. Identified respite beds (51) have been removed from the total of 997 beds.

Population estimates are final intercensal for 2001 and preliminary postcensal (based on 2006 Census) for 2008. Source: Statistics Canada, Table 051-0001, Estimates of population, by age group and sex for July 1, Canada, provinces and territories, annual (persons unless otherwise noted), CANSIM (database), accessed January 16, 2009.

Errors in BC Ministry of Health Services 5,000 Bed Numbers

After comparing bed numbers from the Ministry of Health Services as of June 2008 with health authority bed numbers as of August 2008 (or December 2008 for VIHA), we discovered that the ministry reported 976 beds that do not match health authority figures. These beds were inaccurately counted, or were ineligible because they include convalescent care (short-term reactivation following hospitalization and hospice care for those who are terminally ill), group homes, independent living units and mental health facilities.

The under or over-counting of beds by the ministry in relation to health authority numbers was verified by searching facility and other websites, or by phoning facilities. This double-checking confirmed the accuracy of health authority numbers over the ministry's numbers (Appendix F). While there are a few grey areas, including respite beds and facilities for young persons with physical disabilities, there is 99.6 per cent correlation between the health authority bed/unit numbers and our adjusted Ministry of Health Services numbers.

We identified only one error in the health authority numbers: McGivney Manor in Kelowna has public funding for six beds that are not included in the Interior Health Authority bed numbers list.

The following table lists those facilities where discrepancies were uncovered.

Site	Location	Ministry bed numbers	Variance to HA numbers	Explanation of ministry error
British Columbia – Beds over-counted by ministry: 976				
Fraser Health Authority – Beds over-counted by ministry: 331				
Maplewood House	Abbotsford	207	131	Over-reported beds
Menno Hospital	Abbotsford	0	-151	Under-reported beds
MSA Manor	Abbotsford	80	46	Over-reported beds
Sherwood Crescent Manor	Abbotsford	57	13	FHA reports 10 convalescent beds
Burnaby Hospital	Burnaby	42	42	FHA reports 42 convalescent beds
Rotary House Centre	Burnaby	5	5	Developmental disabilities site
The Cascades	Chilliwack	93	8	FHA reports 10 hospice beds
Langley Health Service Hospice (Maple Hill)	Langley	10	10	Hospice

Site	Location	Ministry bed numbers	Variance to HA numbers	Explanation of ministry error
Ridge Meadows Hospital	Maple Ridge	10	10	FHA reports 10 convalescent beds
Glenwood	Mission	11	11	FHA reports 10 convalescent beds, 1 respite bed
Mission Memorial	Mission	93	18	FHA reports 10 hospice beds
Queen's Park	New Westminster	178	28	FHA reports 8 hospice, 25 convalescent beds
Crossroads Inlet Hospice	Port Moody	10	10	Hospice
Eagle Ridge Hospital	Port Moody	113	38	FHA reports 25 convalescent beds
Bear Creek Lodge	Surrey	31	20	FHA reports 45 temporary beds
Bethesda Christian Association	Surrey	1	1	Developmental disabilities support
Evergreen Cottages	Surrey	38	5	Greater than 10% variance from HA data; may be temporary beds
Laurel Place	Surrey	162	55	FHA reports 35 convalescent beds and 20 hospice beds
LFVCPA – Bear Creek Villa	Surrey	4	4	Cerebral Palsy Association site
LFVCPA – Guildford Glen	Surrey	3	3	Cerebral Palsy Association site
Morgan Place	Surrey	66	-62	FHA reports 128 funded RC beds; confirmed by site
Surrey Memorial – Shirley Dean Pavilion	Surrey	56	56	FHA reports all beds transferred, but some could still have been there as of the ministry data point
Fraser North Residential Temporary Beds			4	
Fraser South Residential Additional Beds			26	
Interior Health Authority – Beds over-counted by ministry: 142				
Fischer Place/Millsite Lodge	100 Mile House	56	-9	65 beds confirmed since 2001
Ashcroft Extended Care	Ashcroft	25	4	IHA reports 4 convalescent beds
Steepleview (Cranbrook Regional)	Cranbrook	1	1	Set for demolition
Marjorie Willoughby Memorial Hospice House	Kamloops	12	12	Hospice
Ponderosa Lodge	Kamloops	126	22	IHA reports 22 convalescent beds
Avonlea Care Home	Kelowna	1	1	Acquired brain injury bed
Cottonwoods	Kelowna	258	57	IHA reports 60 convalescent beds
Randy Villeneuve Home	Kelowna	1	1	6 bed ABI site
Kimberley LTC Home	Kimberley	61	6	55 beds, confirmed by site
Moog and Friends Hospice	Penticton	12	12	Hospice
Bastion Place	Salmon Arm	98	1	IHA reports 4 convalescent beds
Summerland Extended Care	Summerland	51	3	IHA reports 2 convalescent beds
Carrington Place	Vernon	10	10	IHA reports 10 convalescent beds
Hospice House	Vernon	12	12	Hospice
Norway House Group Home	Vernon	4	4	Group home
Poplar Grove Group Home	Vernon	5	5	Group home

Site	Location	Ministry bed numbers	Variance to HA numbers	Explanation of ministry error
Northern Health Authority – Beds over-counted by ministry: 88				
Wrinch Memorial Hospital	Hazelton	10	1	NHA reports 1 respite bed
Kitimat General Hospital	Kitimat	36	3	NHA reports 3 respite beds
GEMS/TCU – PG Regional Hospital	Prince George	32	32	NHA reports 31 transitional beds
Parkside Care	Prince George	61	2	NHA reports 2 respite beds
Rotary Hospice House	Prince George	5	5	Hospice
Simon Fraser Lodge	Prince George	136	16	NHA reports 1 respite bed, 15 transition beds
Peace River Haven	Pouce Coupe	28	2	NHA reports 2 respite beds
Pouce Coupe Care Home	Pouce Coupe	54	2	NHA reports 2 respite beds
Acropolis Manor	Prince Rupert	31	1	NHA reports 3 respite beds
Prince Rupert Regional Hospital	Prince Rupert	32	9	NHA reports 9 transitional beds
Dunrovin Park Lodge	Quesnel	74	7	NHA reports 2 respite beds and 3 short stay convalescent beds
Terrace View	Terrace	75	5	NHA reports 6 respite beds
Stuart Nechako Manor	Vanderhoof	53	3	NHA reports 3 respite beds
Vancouver Coastal Health Authority – Beds over-counted by ministry: 453				
Bella Coola General Hospital	Bella Coola	7	1	VCHA reports 1 respite bed
Lion's Gate Hospital – Evergreen House	North Vancouver	289	55	VCHA reports 48 transitional, 7 hospice beds
North Shore Disability Resource Centre – Gordon	North Vancouver	21	21	Supported living program
Olive Devaud	Powell River	81	1	VCHA reports 1 respite bed
Evergreen ECU	Powell River	76	2	VCHA reports 1 respite bed
Rotary Hospice House	Richmond	10	10	Hospice
Steveston Residence	Richmond	9	9	Independent living
Shorncliffe	Sechelt	61	5	VCHA reports 2 hospice, 1 respite bed
Hilltop House	Squamish	61	2	VCHA reports 2 respite beds
Balfour House	Vancouver	18	18	Mental health residential care
Banfield Pavilion	Vancouver	192	1	VCHA reports 1 respite bed
Braddan Home	Vancouver	70	19	VCHA reports 20 transitional beds
Canadian Paraplegic Association – Creekview	Vancouver	6	6	Quadriplegic-accessible units in a co-op
Canadian Paraplegic Association – Noble House	Vancouver	7	7	Quadriplegic-accessible units in a co-op
Dr. Peter Centre	Vancouver	25	25	Hospice
Fair Haven	Vancouver	111	12	VCHA reports 12 respite beds
False Creek Residence	Vancouver	24	24	VCHA reports 24 special purpose beds
George Pearson	Vancouver	144	25	VCHA reports 119 special purpose, 1 respite bed
Kensington Private Hospital	Vancouver	30	30	Not funded by VCHA

Site	Location	Ministry bed numbers	Variance to HA numbers	Explanation of ministry error
L&T Services Ltd.-Gladstone/Collingwood	Vancouver	7	7	Brain injury care
Little Mountain Place	Vancouver	117	1	VCHA reports 1 respite bed
Purdy Pavilion	Vancouver	213	64	VCHA reports 56 transitional beds
St. James Social Services – May's Place	Vancouver	15	15	Hospice
Vancouver Resource Society for the Physically Disabled – Blair Court Centre	Vancouver	81	81	39-unit special needs housing for seniors and others
Windermere	Vancouver	204	12	VCHA reports 12 respite beds
Vancouver Island Health Authority – Beds over-counted by ministry: -38				
Cowichan Lodge	Duncan	89	75	Beds closed after ministry data point
Nanaimo Regional General Hospital – Dufferin	Nanaimo	122	16	VIHA reports 36 transitional beds
Wexford Creek	Nanaimo		-110	Site opened after ministry data point
Trillium Lodge	Parksville	102	3	VIHA reports 6 transitional beds
Ty Watson House	Port Alberni	5	5	Hospice
West Haven	Port Alberni	32	4	VIHA reports 4 transitional beds
Brentwood House	Saanich	14	-17	17 new dementia beds opened after ministry data point
Island View Place Care Inc.	Saanich	5	5	Site confirms 4 of 19 beds licensed complex care, but all private pay
Aberdeen Hospital	Victoria	113	33	14 beds closed, 30 converted to transitional
Anderson Manor	Victoria	7	-9	Site confirms 16 beds
Capital Health Region – Intermediate Care	Victoria	23	23	
Gorge Road Hospital	Victoria	174	92	VIHA reports 60 transitional beds
Hart House Rest Home	Victoria	2	2	Site confirms no funded beds
Individual Living Housing Society of Greater Victoria	Victoria	8	8	Independent living
Individual Living Housing Society of Greater Victoria – Heathers	Victoria	7	7	Independent living
Palliative Unit – Royal Jubilee RP3	Victoria	10	10	Palliative care
Selkirk Place	Victoria		-185	Site opened after ministry data point

Comparison of Ministry of Health Services and Health Authority Bed Numbers

Health authority	Ministry bed number[a]	Ministry supportive housing units[b]	Ministry incorrectly counted beds[c]	Ministry number less the supportive housing units and incorrectly counted beds	Health authority bed number[d]	Remaining variance[e]
Fraser	9,285	96	331	8,858	8,648	-210
Interior	5,825	83	142	5,600	5,588	-15
North	1,293	31	88	1,174	1,146	-28
Vancouver Coastal	8,087	336	453	7,298	7,394	96
Vancouver Island	6,272	126	-38	6,184	6,233	49
BC	30,762	672	976	29,114	29,009	-108

Notes and references:

[a] Bed numbers announced by Ministry of Health Services and Fraser Health Authority in a press release September, 22, 2008.
[b] Supportive Housing bed numbers from Freedom on Information request to the ministry.
[c] Appendix E documents incorrectly counted beds.
[d] Table 4, Assisted Living in health authority and ministry FOI, August 2008.
[e] The "remaining variance" is calculated by subtracting from: ministry beds numbers from the 2008 RC and AL + supportive housing + incorrectly counted ministry beds. Remaining variance represents facilities where the variance between ministry and health authority reported beds was less than 10 per cent: these smaller discrepancies were not examined due to normal fluctuations in occupancy.

5,000 Bed Promise Adjusted to Increases in Elderly Population

Needed Increases in Residential Care and Assisted Living Beds, Based on Usage by Age Group

Year	Population aged 85+	Annual increase in population aged 85+	Annual increase in population needing RC/AL (projected increase in needed beds)
Residential care and assisted living usage by population aged 85+: 14.5%			
2006	78,400	0	
2007	83,340	4,940	716
2008	88,200	4,860	705
2009	92,800	4,600	667
2010	96,900	4,100	595
Year	**Population aged 75–84**	**Annual increase in population aged 75–84**	**Annual increase in population needing RC/AL (projected increase in needed beds)**
Residential care and assisted living usage by population aged 75 to 84: 3.96%			
2006	211,800	0	
2007	214,701	2,901	115
2008	218,000	3,299	131
2009	220,400	2,400	95
2010	223,500	3,100	123
Year	**Population aged 65–74**	**Annual increase in population aged 65–74**	**Annual increase in population needing RC/AL (projected increase in needed beds)**
Residential care and assisted living usage by population aged 65 to 74: 0.77%			
2006	311,500	0	
2007	319,776	8,276	64
2008	330,800	11,024	85
2009	343,700	12,900	99
2010	356,000	12,300	95
Projected increase in community care and assisted living residents			
2006 to 2007			895
2007 to 2008			920
2008 to 2009			861
2009 to 2010			812
2006 to 2010 Total			3,488

Note: Age specific rates of use = VIHA South Island 2004 @ 14.5% (85+), 3.96% (75–84) and 0.77% (65–74).
Source: Population data provided by BC STATS, Forecast 08/06 (P.E.O.P.L.E 33).

Care and Services Contracted Out in BC's Unionized Residential Care Facilities

Table H1: Care Services Contracted Out in BC's Unionized Residential Care Facilities

Health authority	Number of care facilities: WITH contracted care	NO contracted care	Total	% with contracted-out care
Fraser	15	51	66	23%
Northern	1	24	25	4%
Interior	7	53	60	12%
Vancouver Coastal	10	55	64	15%
Vancouver Island	5	49	54	9%
All regions	39	232	271	14%

Source: Hospital Employees' Union, database of contracted out services in facilities bargaining unit sites, September 2008.

Table H2: Support Services Contracted Out in BC's Unionized Residential Care Facilities

Health authority	Number of care facilities: WITH contracted care[a]	NO contracted care[a]	Total	% with contracted-out care[a]
Fraser	37	29	66	56%
Northern	1	24	25	4%
Interior	5	55	60	8%
Vancouver Coastal	35	29	64	55%
Vancouver Island	21	33	54	39%
All regions	101	170	271	37%

Note: [a]Support services refers to the three main support services: dietary, housekeeping and laundry.
Source: Hospital Employees' Union, database of contracted out services in facilities bargaining unit sites, September 2008.

Alternate Level of Care Activity in BC

Alternate Level of Care Activity in BC 2001/02 to 2007/08, by Health Authority

	ALC cases		ALC days			
	ALC cases	ALC as % of all hospital cases	Average length of stay (days)	ALC days	All hospital days	ALC as % of all hospital days
BC						
2001/2002	13,458	3.3	28.8	387,550	2,623,103	14.8%
2002/2003	12,463	3.0	27.1	338,108	2,556,948	13.2%
2003/2004	13,165	3.0	22.9	301,577	2,572,618	11.7%
2004/2005	15,419	3.7	21.0	323,607	2,604,556	12.4%
2005/2006	13,794	3.2	19.9	274,495	2,658,217	10.3%
2006/2007	14,249	3.3	19.7	281,103	2,687,485	10.5%
2007/2008	14,759	3.4	21.0	310,594	2,759,002	11.3%
Fraser						
2001/2002	4,904	3.9	28.6	140,148	796,417	17.6%
2002/2003	4,676	3.7	29.2	136,606	803,427	17.0%
2003/2004	4,660	3.7	25.2	117,278	811,797	14.4%
2004/2005	5,104	4.0	20.8	106,393	812,070	13.1%
2005/2006	3,585	2.7	20.1	72,179	853,644	8.5%
2006/2007	3,574	2.7	21.8	78,036	884,894	8.8%
2007/2008	3,923	2.9	20.0	78,446	901,366	8.7%
Interior						
2001/2002	2,324	3.0	24.9	57,972	493,598	11.7%
2002/2003	2,273	2.9	19.7	44,669	449,175	9.9%
2003/2004	2,815	3.5	13.7	38,589	454,894	8.5%
2004/2005	4,131	5.0	14.5	60,003	459,902	13.0%
2005/2006	3,923	4.7	14.9	58,317	466,926	12.5%
2006/2007	4,361	5.2	14.3	62,221	469,750	13.2%
2007/2008	4,389	5.2	14.2	62,480	474,354	13.2%

Alternate Level of Care Activity in BC 2001/02 to 2007/08, by Health Authority *continued*

	ALC cases		ALC days			
	ALC cases	ALC as % of all hospital cases	Average length of stay (days)	ALC days	All hospital days	ALC as % of all hospital days
Northern						
2001/2002	572	3.2	43.2	24,702	187,688	13.2%
2002/2003	608	3.4	32.7	19,904	180,204	11.0%
2003/2004	777	4.4	27.2	21,170	184,865	11.5%
2004/2005	862	4.9	31.5	27,189	193,217	14.1%
2005/2006	1,004	5.5	28.5	28,594	195,642	14.6%
2006/2007	858	4.7	35.7	30,638	198,508	15.4%
2007/2008	713	3.8	54.4	38,804	208,472	18.6%
Vancouver Coastal						
2001/2002	3,491	3.5	26.1	91,114	595,708	15.3%
2002/2003	2,792	2.8	23.4	65,321	573,964	11.4%
2003/2004	2,924	2.9	16.5	48,279	571,204	8.5%
2004/2005	3,176	3.1	14.8	46,915	573,209	8.2%
2005/2006	3,081	3.0	14.6	44,947	588,499	7.6%
2006/2007	3,009	2.9	14.4	43,462	590,666	7.4%
2007/2008	3,191	3.0	15.8	50,480	611,248	8.3%
Vancouver Island						
2001/2002	2,097	2.5	33.9	71,011	531,777	13.4%
2002/2003	2,056	2.4	34.1	70,014	530,685	13.2%
2003/2004	1,932	2.2	38.7	74,778	529,730	14.1%
2004/2005	2,050	2.3	39.3	80,571	541,735	14.9%
2005/2006	2,071	2.3	33.0	68,367	526,284	13.0%
2006/2007	2,277	2.4	28.2	64,205	508,302	12.6%
2007/2008	2,374	2.5	32.7	77,726	528,224	14.7%

Source: Ministry of Health Services, Management Information, Health System Planning, BC Acute Care Utilization Rates, September 30, 2008; excludes newborns.

Data Limitations

1. Some inconsistencies between the Ministry of Health Services supplied data from the Continuing Care Information Management System (CCIMS) and health authority supplied data were found. Since our review was provincial in scope, we relied on the CCIMS because it was the only source of provincial data, year over year.

2. The ministry was unable to provide CCIMS data for 2007/08 (period ending March 31, 2008), thereby preventing analysis and reporting of information on non-residential care programs beyond March 31, 2007.

3. Three of the five health authorities did not respond to Freedom of Information requests seeking 2007/08 and 2008/09 home and community care basic program data for residential care, assisted living and home support. This further compromised this report's ability to provide up-to-date information.

4. This report did not review every type of home and community care program, but focused on the larger programs where more information was available. Consequently, various programs and activities, including adult day care, quick response teams, case management, rehabilitation, nutrition, convalescent care and specialty, hospital-based geriatric units and programs, are not discussed in the report.

1 BC Medical Association, 2008; McGrail, 2008; BC Auditor General, 2008; BC Ombudsman, 2008.

2 BC Medical Association, 2008.

3 In residential care, there is a co-payment for everyone, beginning at $30.90 per day for people who have only their Old Age Pension and the Guaranteed Income Supplement. In home support, people below a specified income level do not have to make a co-payment.

4 Canada Mortgage and Housing, 2008, p. 9.

5 Ibid.

6 Vogel, 2000, pp. 37-38.

7 BC Auditor General, 2008, p. 6.

8 Ibid.

9 Cohen et al., 2005, p. 34.

10 BC Ministry of Health Services, 2005, p. 2.

11 BC Liberal Party, 2001.

12 Cohen et al., 2005, p. 17.

13 BC Ministry of Health Services and Fraser Health Authority, 2008, p. 1.

14 BC Ministry of Health, Health Planning, 2002, p. 34. The cost estimates provided for residential care are $125 per day compared to $50 to $75 per day in assisted living.

15 Cohen et al., 2005, p. 22.

16 The Fraser Health Authority commissioned an Assisted Living Resident Satisfaction Survey in 2008. A final report is not available, but a preliminary summary shows very high rates of resident satisfaction.

17 Cohen et al., 2005, p. 22.

18 Fletcher, 2008.

19 Supra, note 14.

20 McGregor et al., 2005, pp. 645-9.

21 Keith McBain, Fraser Health Authority, interview, November 19, 2008.

22 Assisted living registrar policy allows assisted living operators to provide short-term professional care to residents who encounter episodes of decreased physical or mental functioning (while recovering from an injury, an acute illness or exacerbation of a chronic illness), and also residents receiving palliative care or awaiting transfer to a licensed (residential) care facility.

23 Araki, 2004. This research included a survey of 41 of the 88 assisted living settings identified through reference to two professional directories.

24 The Home and Community Care Research Network has initiated Phase 1 of a major assisted living evaluation.

25 Craig Crawford, BC Housing, email communication, January 26, 2009.

26 Keith McBain, Fraser Health Authority, interview, November 6, 2008.

27 Mark Blanford, Former Manager of Assisted LIving, Vancouver Island Health Authority, interview, October 10, 2008.

28 Keith McBain, Fraser Health Authority, interview, November 6, 2008.

29 Home and Community Care Research Network, 2008.

30 In 1999, the BC Ministry of Health Services prepared a 10-year projection for residential care beds for 2000 to 2010. It concluded that to meet projected demand, 4,495 beds were required in 2001/02 with an additional 1,000 to 1,400 beds each subsequent year. This appears to be where the 5,000 new beds target originated.

31 Canadian Institute for Health Information, 2009, p. 18. In 2007/08, ALC patients in BC discharged to residential care accounted for 59 per cent of all ALC days.

32 Randi West, BC Ministry of Health, interview, March 2006.

33 Catherine Barnardo, Fraser Health Authority, e-mail communication, December 2, 2008.

34 Shannon Berg, Director, Community Care Integration, email communication, December 1, 2008 and January 26, 2009.

35 Canadian Institute for Health Information, 2009, p. 3.

36 Shannon Berg, Director, Community Care Integration, email communication, December 1, 2008.

37 BC Ministry of Health Services, 2002.

38 Government of British Columbia, 2009. The webpage (www.bc.ca/yourbc/seniors_care/sc_seniors.html) states that "Wait times in residential care have decreased from one year in 2001 to 30 to 90 days today."

39 Fraser Health Authority, 2008, p. 4.

40 Ontario Joint Policy and Planning Committee, 2006, p. 3.

41 Ibid, p. 8.

42 Canadian Institute for Health Information, 2006, *Waiting for Health Care in Canada: What We Know and What We Don't Know*, Chapter 4, "Beyond Acute Care."

43 Ibid.

44 Canadian Institute for Health Information, 2009, p. 6.

45 Physician Hospital Care Committee, 2006, p. 1.

46 Ibid, p. 2.

47 Romayne Gallager and Elisabeth Drance, *Vancouver Sun*, October 22, 2007, p. A11.

48 BC Auditor General, 2008, p. 32.

49 Ibid, p. 33.

50 Ibid.

51 BC Care Providers Association, 2007.

52 Murphy, 2006.

53 Ibid.

54 Center for Medicare and Medicaid Services, 2002. This very large national study found that minimum staffing levels of 4.1 hprd (including 2.8 nursing assistant hprd and 1.3 licensed hours, of which 0.75 are RN hours), are required to avoid jeopardizing the health and safety of residents. This 4.1 hour staffing level has been supported by numerous studies published since the CMS report. Schnelle et al., 2004: This study recommended staffing levels that allowed about 4.5 hours of direct care per resident per day in order to improve quality of care.

55 Daikiw, 2008, p. 1.

56 Hospital Employees' Union, 2008, p. 12.

57 BC Care Providers Association, 2006; Hospital Employees' Union, 2008, p. 14.

58 Hillmer et al., 2005.

59 McGregor et al., 2005.

60 McGregor et al., 2006.

61 McGregor, 2008.

62 Hospital Employees' Union, 2008, pp. 19-20.

63 Ramage-Morin, 2005, p. 52.

64 Murphy, 2006.

65 Cranswick and Dosman, 2008, p. 52.

66 Ibid.

67 Baumbusch, 2008, p. 236; Armstrong and Daley, 2004.

68 Cohen eta al., 2005, p. 16.

69 BC Government, 2009.

70 Services Canada, Tables of Rates for Old Age Security, Guaranteed Income Supplement and the Allowance April–June 2009, accessed at www1.servicecanada.gc.ca/eng/isp/oas/tabrates/tabmain.shtml.

71 BC Ministry of Health Services, 2002, 8B, p. 3.

72 Baumbusch, 2008, p. 171.

73 Ibid.

74 Clark, 2008.

75 Alberta Health and Wellness, 2008, p. 14.

76 McGrail, 2008, p. 13.

77 Ibid, p. 18.

78 Fraser Health Authority, 2008.

79 BC Ministry of Health, 2003.

80 Cohen et al., 2006; McGrail, 2006.

81 Cohen et al., 2006.

82 Ibid.

83 Ibid, page 32.

84 Ivanova, 2009.

85 McGrail, 2008, p. 8.

86 Ibid, p. 70.

87 Ibid.

88 Ibid, p. 9.

89 Calculated as follows: 1,158.8 x .36 = 417.7; 1482.4. – 1159.3 = 323.2; 417.7 – 323.2 = 94.5 million. One bed for one year costs $170 x 365 = $62,050; 94.5 million / 62,050 = 1,523 beds. The $170 rate is at the high end of current per diem rates (see Appendix A).

90 Canadian Institute for Health Information, 2008.

91 BC Auditor General, 2008, p. 1.

92 BC Bid (October 2008), *Home and Community Care Consulting Services,* NOIHC146, Notice of Intent to extend the contract to Deloitte Touche for completion of the home and community care strategic document including feedback from stakeholders, HCC logistics, roll out and communication strategy.

93 Ibid. The report from Deloitte & Touche was to be completed by October 31, 2008.

94 The ability to make decisions on one's own behalf is reflected in the ability to: (1) make informed decisions regarding daily activities and personal assistance; (2) express wishes so as to be understood by personal assistance staff; (3) to not exhibit behaviours that jeopardize the wellbeing of others; and (4) to use an emergency response system and take directions in an emergency.

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ECONOMIC SECURITY PROJECT

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