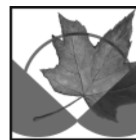
CONTINUING CARE

RENEWAL OR RETREAT?

BC Residential and Home Health Care Restructuring 2001–2004

By Marcy Cohen
Janice Murphy
Kelsey Nutland
and Aleck Ostry



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by Marcy Cohen, Janice Murphy, Kelsey Nutland, Aleck Ostry

April 2005

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Summary and Key Findings

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

This report looks behind the debate to find out what is really going on. It reviews the actual changes in the number of beds and services available to seniors and people with disabilities using sources from the Ministry of Health, the Canadian Institute for Health Information, other provinces, and the regional health authorities themselves. It assesses the government's use of assisted living as a substitute for residential care. And it examines the costs and implications of these changes for the health system, not only for frail seniors and people with disabilities, but also for their families and the communities in which they live.

Key Findings

Changes in Residential Care and Assisted Living, 2001–2004

- There has been a net closure of 26 publicly-funded residential care facilities for a net reduction of 2,529 residential care beds across the province.
- At the same time, 1,065 publicly-subsidized assisted living units were added to the system. Taken together, the reduction in residential care beds and the addition of assisted living spaces translate into a net reduction of 1,464 over three years.
- The government's addition of assisted-living housing represents a valuable contribution to continuing care services. However, there is considerable evidence to suggest that using assisted living as a substitute for residential care is not working.

- In 2001, British Columbia was close to the national average with 100.4 residential care beds per 1,000 seniors aged 75 and over. By 2004, BC's bed rate of 83.4 was 13 per cent below the national average. Along with New Brunswick, BC now has the lowest level of access to residential care beds in the country for people aged 75 and over.
- Cuts to residential care have been uneven across the health authorities, creating greater inequities in access depending on where a person lives in BC. The Interior Health Authority reduced the number of beds per 1,000 seniors aged 75 and over by 29 per cent between 2001 and 2004. This was the most dramatic reduction of any health authority, even when the increase in assisted living units is taken into account. Because of the varying degree of cuts across the health authorities, frail seniors living in the Vancouver Coastal or Northern health authority have far better (though still inadequate) access to residential care than people living in the Fraser, Vancouver Island or Interior health authorities.
- Detailed data on the cuts to residential care beds, as well as acute care beds, are provided by health service delivery area and by municipality in Appendix 15.

Reductions in Home Health Services, 2000/01 to 2002/03

- For seniors 75 and over, home support (i.e. non-professional services such as bathing and housekeeping) hours declined by 13 per cent while the number of clients receiving care declined by 21 per cent.
- For home care (i.e. professional nursing care), there was an 8 per cent reduction both in the number of clients and in the number of visits.
- These reductions continue a trend that began in the mid 1990s.
- By 2003, the number of clients served (as a share of the population aged 75 and over) by BC's home health programs was second to last among Canadian provinces and 30 per cent below the national average.
- Seniors living in the more remote health authorities (i.e. Northern Health and Interior Health) have less access to home support than seniors living in the more urban health authorities (i.e. Vancouver Coastal, Fraser Health, and Vancouver Island). For example, by 2003 the number of home support hours per client in rural health authorities was 18 to 19 per cent below the provincial average.

Reductions in Acute Care

- Cuts to continuing care have taken place at the same time as acute care beds have been reduced.
- By 2001, BC already had the leanest in-patient hospital care system in the country.
- From March 2002 to March 2004, an additional 1,279 hospital beds were closed—a 19 per cent reduction in capacity when population increases in BC over the same time period are taken into account.

A glossary of terms is provided on page 10.

Impacts of the Cuts

The decision of the provincial government and health authorities to reduce access to residential care and home health services at the same time as they were cutting hospital services has disastrous implications. Frail seniors and people with disabilities, some of BC's most vulnerable citizens, and their families are paying a heavy price for the cuts. This has a direct impact on all British Columbians, who depend on and pay for our public health system.

"Some people have been unable to afford private options and do not have family and are not coping well. By the time the system gets to them, they have deteriorated to the point that they need to be fixed by the medical system."

— Capital Regional District Staff Report to the Health Facilities Planning Committee Meeting of Wednesday, February 16, 2005

Increased Costs to Individuals and Families

As a response to the reductions in access to publicly-funded residential care, there has been a dramatic, six-fold increase in corporate investment in residential care and assisted living facilities in BC. Most of these new facilities are private pay—that is, 100 per cent of the costs are paid by the residents and their families. The cost of private residential care ranges from an average of approximately $44,000 to a high of $67,000 per year.

In BC the majority of people requiring this care are unattached women aged 70 years and over. The vast majority—75 per cent—of these women had annual incomes of $25,000 or less in 2000, and only 5 per cent had annual income of $50,000 or more. As a result, these women, as well as many other frail seniors and people with disabilities, must increasingly turn to their families for support. For those who do not have families that can support them, the situation is even worse. They often simply go without until they are admitted to a hospital emergency ward in crisis.

Residential Care (RC) and Assisted Living (AL) Beds by Health Authority

Health authority	Net cut in RC beds, 2001–2004	New AL beds added 2001–2004	Combined RC and AL beds		Combined RC and AL bed rates (beds per 1,000 seniors 75 & older)	
			2004 RC and AL beds	**Net change in RC and AL beds, 2001–2004**	2004 combined bed rate	% change in bed rate, 2001–2004
Fraser	-502	191	7,160	-311	84.4	-14%
Interior	-935	219	4,053	-716	71.7	-25%
Northern	-94	117	1,029	23	107.5	-11%
Vancouver Coastal	-503	135	6,723	-368	101.9	-13%
Vancouver Island	-495	403	4,991	-92	80.8	-8%
BC total	-2,529	1,065	23,956	-1,464	86	-14%

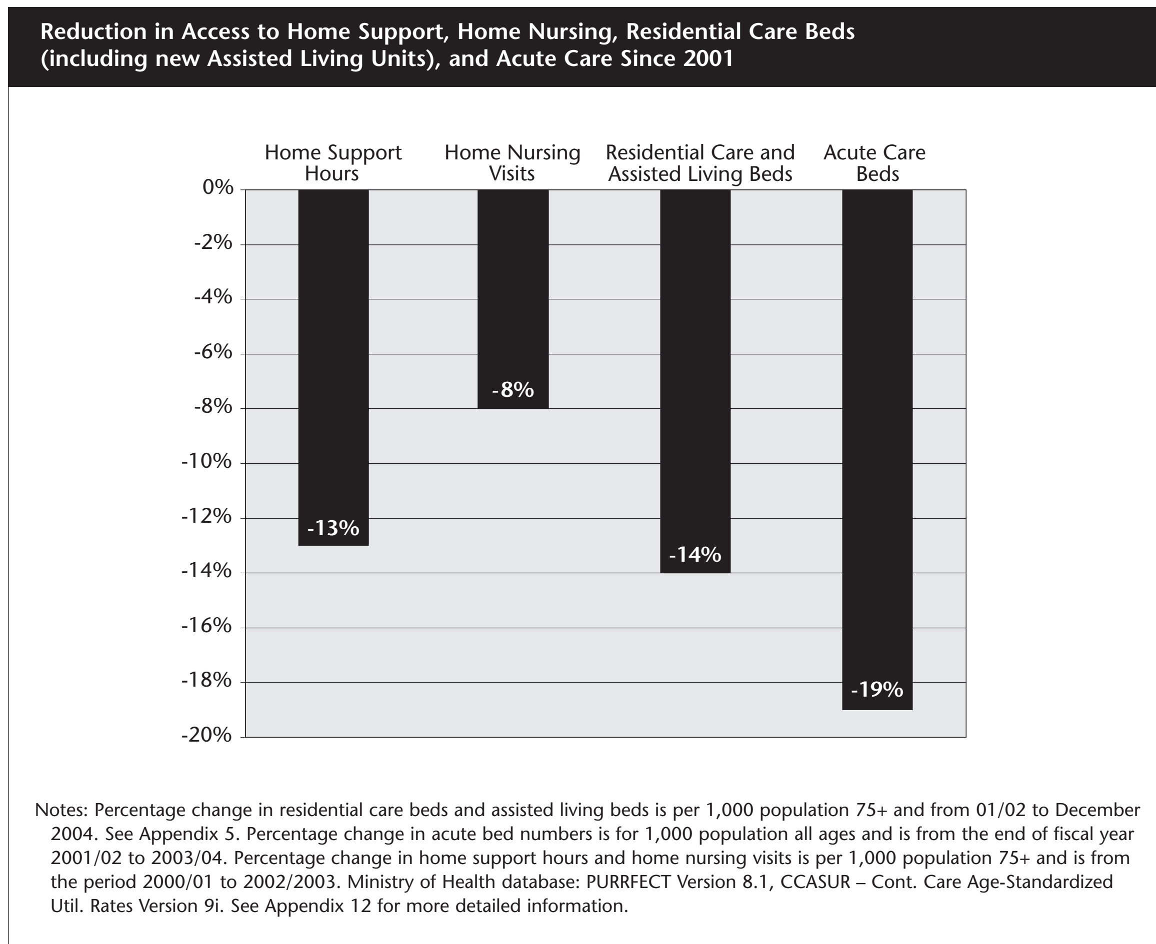
Sources: RC bed numbers obtained from Canadian Health Care Facilities Guides, Health Authority Representatives and Reports. 2004–05 beds effective as of December 2004 (Appendix 5). Population numbers are provided by BC STATS, Ministry of Finance and Corporate Relations, PEOPLE 28.

Increased Wait Times for Hospital Services

- A number of health authorities now acknowledge that cuts to residential care have contributed to increased back-ups in acute care and emergency wards.
- For example, the Interior Health Authority—the authority that has been most aggressive in cutting residential care and substituting assisted living—now admits that the cuts to residential care have caused serious emergency room overflows and increased the number of seniors in acute care beds awaiting placement in residential care.

Increased Overall System Costs

- The lack of residential care beds not only reduces access to acute care for patients who genuinely need these services, it also costs our health care system far more, as acute care beds are so much more costly than residential care beds.
- For example, in the Capital Regional District (CRD), there was a detailed review of the number of people in hospital awaiting placement in residential care in 2004 (after the cuts to residential care and increases in assisted-living housing). In the CRD (Victoria and area) alone, net additional costs to the health system were between $2 and $4 million per year. A similar analysis on a provincial scale would reveal much greater additional costs.



Reduction in Access to Home Support, Home Nursing, Residential Care Beds (including new Assisted Living Units), and Acute Care Since 2001

Notes: Percentage change in residential care beds and assisted living beds is per 1,000 population 75+ and from 01/02 to December 2004. See Appendix 5. Percentage change in acute bed numbers is for 1,000 population all ages and is from the end of fiscal year 2001/02 to 2003/04. Percentage change in home support hours and home nursing visits is per 1,000 population 75+ and is from the period 2000/01 to 2002/2003. Ministry of Health database: PURRFECT Version 8.1, CCASUR – Cont. Care Age-Standardized Util. Rates Version 9i. See Appendix 12 for more detailed information.

Recommendations

The authors of this study recommend that the provincial government immediately set up an external review of continuing care services (residential, community, and home health services). This review *must* include a process of public consultation and participation involving experienced and independent experts in the field to:

- Recreate BC's continuing care plan for residential care, assisted living, supportive housing, and home health services based on the needs of frail seniors and people with disabilities;
- Conduct an evaluation of the assisted living program, its performance and structure;
- Develop a five-year strategic plan for building new community-based, non-profit residential, assisted living, supportive housing, and home health services;
- Develop a process for ensuring the ongoing involvement of seniors and people with disabilities in decision-making on these services at the local, health authority and provincial levels; and
- Develop a public reporting and accountability process for health authorities on continuing care, including the requirement for regular detailed reporting on expenditures and service utilization by population and for all programs and services.

> "A very large portion of patients is waiting in acute care beds for alternative care—significantly more than any other area of the province. Access to available long-term care beds is lower than the provincial average when measured relative to population, and access to available home support and home care is the lowest in the province."
>
> — Fraser Health Authority, 2004/05 Operating Plan

Glossary

ALTERNATIVE LEVEL OF CARE (ALC): Hospital beds occupied by people waiting for placement in residential care, or to return home with the appropriate home health or rehabilitation supports. These individuals do not require acute hospital services, but are unable to leave the hospital until the residential and home health services they require are available.

CONTINUING CARE: Also referred to as Home and Community Care. Continuing Care refers to the range of programs, from home health services to residential care, whose objective is to maintain, restore, or improve the health and functioning of frail seniors and people with disabilities. The current programs include home-based services (home support, rehabilitation and home nursing), community-based services (adult day care and respite care), assisted living and residential care. Each health authority has a Continuing Care (or Home and Community Care) division. Eligibility for these services is based on an assessment by a Continuing Care assessor. The assessor determines the type and level of services required, monitors on-going care, and makes the necessary adjustments.

CARE LEVELS: The classification system used for designating continuing care services to individuals with similar care needs. It consists of three groupings—personal care, intermediate care and extended care. Within these groupings, intermediate care is divided into three levels 1, 2, and 3. The care levels move in progression from lighter care requirements of personal care, through the intermediate levels, to the heavier care requirement of extended care.

HOME HEALTH SERVICES: This includes all professional and non-professional health services provided to individuals in their own homes. It includes home support, home care and rehabilitation services

- **HOME CARE:** Professional nursing services are provided to individuals in their own home and include post-acute, chronic and palliative care. Access to publicly funded home care is based on an assessment by Continuing Care. These services may also be purchased privately.

- **HOME SUPPORT:** Non-profession personal care services, provided by trained Community Health Workers, that assist people to remain in their own homes. The services include personal assistance (bathing, grooming, meal preparation, etc.) and can include housekeeping. Access to publicly subsidized home support services is based on an assessment by Continuing Care. These services may also be purchased privately.

SUPPORTIVE HOUSING: A form of housing for seniors who do not require unscheduled personal care but who could benefit from some assistance with the activities of daily living. Supportive housing includes at a minimum one meal per day, weekly laundry and cleaning and a security system in case of an emergency. It does not include personal care services.

ASSISTED LIVING (AL): A form of housing for seniors who require daily personal support but are still able to direct their own lives. People live in their own apartments and receive personal care from staff employed by the facility (except in the Vancouver Island Health Authority, where assistance is contracted from outside home support agencies). Assisted living was created by the *Community Care and Assisted Living Act* in 2003 and is defined as premises, or part of a premises, in which at least one, *but no more than two*, prescribed personal care services (i.e. assistance with mobility, medication management, bathing) are provided. Assisted living does not include Registered Nurses, and is not designed for people with significant physical or mental needs. The Health Authorities and BC Housing provide subsidies to support a certain number of seniors with low and moderate incomes who have been assessed by Continuing Care as eligible for assisted living. In subsidized AL residents pay no more than 70 percent of their income for the accommodation fee, which covers most meals, weekly laundry and cleaning and only one or two prescribed personal care services. Additional services or assistance are paid for out-of-pocket by the residents or their families. Assisted living is also provided in the private market where the individual or their family pays the full cost. Publicly subsidized assisted living can be provided by the non-profit or for-profit sector.

RESIDENTIAL CARE: Previously referred to as long-term care, residential care includes intermediate care, extended care, complex care, multi-level care and nursing homes. Residential care is for individuals who require 24-hour nursing supervision and who have limited ability to direct their own care. In the past there were different levels of care (personal, intermediate levels 1, 2, and 3 and extended), but now only people with complex care needs are being admitted to residential care. (Complex care includes only those residents who were previously classified at intermediate care level three and extended care.) In publicly funded residential care, residents pay a user fee based on income. There are, in addition, residential facilities in the private market where the residents or their families pay for the full cost. Publicly subsidized residential care can be provided by both for-profit and not-for-profit providers.

NEEDS BASED ACCESS: Waitlists in 2002 were restricted to those individuals who were assessed as requiring complex care within 90 days. These individuals require continuous 24-hour nursing coverage because of their severe physical and/or cognitive disabilities.

Source: Drawn from Jeremy Tate, (February 23, 2005), *2004 Assisted Living Review, "The Capital Health Experience,"* Capital Regional District, Health Facilities Planning

Introduction

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

This report looks behind the debate to find out what is really going on. It reviews the actual changes in the number of beds and services available to seniors and people with disabilities using sources from the Ministry of Health, the Canadian Institute for Health Information, other provinces, and the regional health authorities themselves. It also examines the costs and implications of these changes for the health system, not only for frail seniors and people with disabilities, but also for their families and the communities in which they live.

While the focus of this report is on the changes since 2001, it is important to remember that the story of residential and home health restructuring begins much earlier. In 1991, BC's Royal Commission on Health Care and Costs (the Seaton Commission) published a report emphasizing the benefits of "de-institutionalizing services" and bringing them "closer to home."[1] The idea behind this strategy was that, when possible, it was more beneficial for people to receive care in the community than in a hospital or other institution. The commission argued that by shifting resources from institutional and acute care to the community, and by focusing on health promotion and early intervention strategies, individual health status could be improved and health care costs controlled.[2] The reality of the closer to home strategy has not, however, always kept pace with the government's rhetoric and the funding has rarely "followed the patient."

In 2000, nine years after the publication of the Seaton Commission report, the BC office of the Canadian Centre for Policy Alternatives published a research study, *Without Foundation,* which examined

the shift from acute to community care. The study showed that in the later half of the 1990s, access to community health services—residential care and home support in particular—actually declined. While no residential beds were closed, the government did not build enough new beds to keep pace with the increasing proportion of the population aged 75 years and older, nor did it increase home care and home support services to compensate for reductions in acute care. Rather, home support and home care resources were diverted to higher need post-acute clients and to support frail seniors or people with disabilities who could no longer gain access to residential care. As a result, there was a significant reduction in services for those who required preventive home support and basic assistance with food preparation and/or housekeeping. Increasingly frail seniors and people with disabilities were expected to pay for these services themselves or do without. As Vogel noted, these changes occurred with little fanfare because there is no protection under the *Canada Health Act* to limit increases in user costs, guarantee access, and/or ensure affordability of non-acute residential and home health services.[3]

Media attention did, however, focus on the shortage of residential long-term care beds during the winter flu season of 1999–2000. The issue came under the spotlight because of the notable increase in the number of frail seniors in Alternate Level of Care (ALC) hospital beds waiting for placement in long-term residential care. They became known in the media as "bed blockers" because they were occupying expensive acute care beds that were needed by other patients.[4]

In spring 2001, BC was heading into an election. The provincial Liberal Party, in its *New Era* document, promised that a Liberal government would build 5,000 new not-for-profit long-term residential care beds by 2006, in large measure to reduce the utilization of ALC beds in hospitals.[5] However, shortly after its election the provincial government shifted gears. It began talking about the benefits of "de-institutionalizing" seniors' care and substituting a new assisted living housing model along with increasing access to home care and home support.[6] The government subsequently introduced its "Continuing Care Renewal" plan in April, 2002. The plan included new access criteria for residential care, "Needs Based Access," that limited admission to residential care to people who required the most complex care.[7]

The Liberals promised 5,000 new not-for-profit long-term care beds by 2006, but shortly after the election shifted gears, talking about the benefits of "de-institutionalizing" seniors' care and substituting a new assisted living housing model along with increasing access to home care and home support.

Seniors groups, health policy experts, academics and others have raised questions about this redesign of seniors' services through the "Continuing Care Renewal" strategy. First, this strategy did not require that the money saved from closing residential care beds "follow the patient" into the community. Second, there was no planning process in place to determine whether the shift to a housing model was feasible. There has been considerable concern that "Continuing Care Renewal" was, in reality, more about shifting the responsibility for costs from government onto individuals and communities than it was about "deinstitutionalizing" care. The validity of these concerns is addressed in this research study.

The findings from the study are divided into three sections. The first section examines the overall context in which the restructuring of residential and home health care services is occurring: that is, the reduction in the availability of acute care beds and changes in population demographics. The second section focuses on the reduction in residential care services in BC over time, and in comparison with other provinces. It also examines the shift to assisted living, and the growth of a new private-pay market for both residential care and assisted living. The third section analyzes the reduction in both home care and home support services over time, and in comparison with other provinces. The final section of the paper discusses the implications of these changes for the vulnerable seniors and people with disabilities who use these services, as well as for the health care system as a whole.

Context

Reductions in Acute Care

In the 1990s in BC, as elsewhere in Canada, the provincial government came under pressure to reduce in-hospital acute care utilization. However, not all of the resulting reductions in acute care were due to budget cuts. They also reflect new surgical techniques that shorten hospital stays and increase opportunities for day surgeries. These shifts in acute care medicine have increased the health system's dependence on residential care and home health care, as people leaving the hospital require more follow-up care and assistance.

By 2001/2002, BC already had the lowest acute care inpatient hospital rates (per 100,000 population) of any province in Canada (see Table 1). And yet, from March 2002 to March 2004, 1,279 additional hospital beds were closed—a 15 per cent reduction in capacity (see Table 2). When population increases over the same time period are taken into account, this translates into a 19 per cent reduction.

The largest percentage reduction in acute care beds was in the Interior Health Authority (IHA), which closed five small hospitals with 79 beds, downgraded other community hospitals to health centres, and reduced beds in its remaining acute care facilities (an absolute loss of 387 beds; see Appendix 1 for a complete list of hospital closures).

Given that in 2001 BC already had the leanest in-hospital acute care system in the country, it is not clear that further cuts were justified. One outcome seems certain, however: these reductions to hospital services put additional pressure on residential care and home health services.

Table 1: Inpatient Hospitalization Rates in Canada (age-standardized; per 100,000 population), 1995/96, 2001/02 and 2002/03

Province	1995/96	2001/02	2002/03	% change 2001 to 2002	% change 1995 to 2003
British Columbia	**10,627**	**8,202**	**7,780**	**-5.2%**	**-26.8%**
Nova Scotia	11,964	9,275	8,876	-4.3%	-25.8%
Ontario	10,343	8,224	7,979	-3.0%	-22.9%
Quebec	10,314	8,412	8,049	-4.3%	-22.0%
Newfoundland and Labrador	12,726	10,073	9,970	-1.0%	-21.7%
Saskatchewan	14,803	11,735	11,630	-0.9%	-21.4%
New Brunswick	14,970	12,575	11,833	-5.9%	-21.0%
Prince Edward Island	13,386	11,017	10,825	-1.7%	-19.1%
Northwest Territories	17,491	15,282	14,266	-6.6%	-18.4%
Manitoba	11,963	10,178	9,962	-2.1%	-16.7%
Alberta	11,501	9,826	9,771	-0.6%	-15.0%
Yukon Territory	10,935	9,898	10,528	6.4%	-3.7%
CANADA (Excluding Nunavut)	**10,942**	**8,798**	**8,504**	**-3.3%**	**-22.3%**

Source: CIHI. Accessed February 3, 2005: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_29oct2004_e#tab.

Table 2: Changes in Hospital Acute Beds Staffed and in Operation March 2002 to March 2004

Health authority	Acute beds March 2002	2002 acute beds per 1,000 pop'n	Acute beds March 2004	2003/2004 acute beds per 1,000 pop'n	Change in no. beds	% reduction in no. beds	% reduction in beds per 1,000
Interior	1,596	2.3	1,209	1.8	-387	-24%	-22%
Fraser	2,138	1.5	1,681	1.2	-457	-21%	-20%
Vancouver Coastal	2,262	2.2	2,104	2.0	-158	-7%	-9%
Vancouver Island	1,621	2.3	1,480	2.1	-141	-9%	-9%
Northern	697	2.3	558	1.8	-139	-20%	-22%
Provincial[a]	276		279	n/a	3	1%	n/a
BC total	8,590	2.1	7,311	1.7	-1,279	-15%	-19%

Source: Evaluation & Strategic Directions Branch Performance Management & Improvement Division BC Ministry of Health, Oct 2004.

Notes: [a] Provincial Health Authority includes areas such as BC Women's and Children's Hospitals and the BC Cancer Agency.

The bed numbers provided are a snapshot of the beds set up at the end of fiscal year 2001/02and 2003/04 respectively. Beds per 1,000 population are based on all ages population, from BC STATS, Ministry of Finance and Corporate Relations, PEOPLE 28. Forensic Psychiatric Services (#928) and Riverview Hospital (#929) have been removed from the total bed numbers because Forensic Psychiatric Services was not reporting prior to FY 2003/2004 and Riverview Hospital (#929) was not reporting prior to FY 2002/2003.

Profile of Continuing Care Clients

Despite improvements in the overall health of Canadians over time, as people age they are more likely to have a disability and/or require assistance with activities of daily living. According to Statistics Canada, in 2000, 53 per cent of seniors aged 75 and over who were not already in long-term residential care had a moderate (40 per cent) or severe (60 per cent) disability.[8] In BC population aged 75 and over increased by 45 per cent between 1994 and 2004 (see Appendix 2). This has placed additional pressure on our health care resources.

While most seniors live with a spouse, the majority of seniors who use residential care and home support services are on their own (“unattached”), and women outnumber men two to one. Most unattached seniors have incomes of less than $25,000.

It is also important to note that while most seniors live with a spouse, the majority of seniors who use residential care and home support services are on their own (“unattached”), and women outnumber men two to one.[9] Most unattached seniors have incomes of less than $25,000 (see Table 3).[10]

In addition, the incomes of unattached seniors who use residential and home support services tend to be even lower than for the general population. In 1998–99, 76 per cent of residential care residents and 82 per cent of home support users had incomes of $20,000 or less.[11] Among non-senior disabled applicants utilizing home support services, 94 per cent had incomes of $10,000 or less.

The combination of reductions to acute care, a growing share of the population aged 75 and over, and relatively low incomes among the users of residential and home health services suggests that additional public resources were required to adequately support these services during the 2001–2004 period, and that a significant reinvestment will be required to meet future needs.

Table 3: Low- and High-Income Unattached Seniors in 2000 aged 70 and over in BC

Annual income	Number of unattached women 70+	% of unattached women 70+	Number of unattached men 70+	% of unattached men 70+
Less than $25,000	88,955	75%	24,520	63%
More than $50,000	6,290	5%	4,255	11%

Source: Statistics Canada, Census, 2000, reference number 97F0020XCB01040.
Note: See Appendix 3 and 4 for more detailed information.

Assisted Living Substitution and Private Pay

As was noted in the introduction, the provincial government's pre-election promise to build 5,000 new non-profit residential (i.e. long-term) care beds quickly changed after the election. The reference to non-profit societies was dropped and the 5,000 residential care beds changed to 1,500 residential care beds and 3,500 independent living beds (primarily assisted living, but also some supportive housing).[12]

Then, on April 23, 2002 the province and health authorities announced their three-year plan for "Continuing Care Renewal," including the decision to close 3,111 existing residential care beds while still maintaining the promise of 5,000 net new beds by 2006.[13]

The assumption underlying the province's approach is that assisted living can be used as a substitution for residential care.

This section examines exactly what has happened with cuts to residential care and the addition of assisted living units over the past three years, at both the health authority and provincial levels, and compares BC's experience to recent changes in other provinces. This section also assesses whether BC's assisted living substitution model works, and examines the growth of for-profit care.

Downsizing Residential Care

To determine what has happened to residential care over the last three years, we have tracked the total number of residential care bed closures and openings, as well as the new assisted living units. The health authorities were contacted to verify the information (see Table 4 and Appendix 5).

From 2001 to December 2004, there was a net closure of 26 residential care facilities (see Appendix 8). This amounts to a net reduction of 2,529 residential care beds (Table 5). At the same time there was an increase of 1,065 assisted living units (Tables 6). If we assume for the time being that the substitution model works (i.e. that an assisted living bed is an effective substitute for a residential care bed), this is a net reduction of 1,464 beds in three years.

In terms of access to residential care, it is important to look not only at net bed closures but also at population increases. Even when the new assisted living beds are included, the number of beds per 1,000 people aged 75 and over has dropped over the past decade by 32.8 per cent (Table 4) from 127.9 to 86.0 beds (this includes the 1,065 new assisted living units). During the 1990s there were no bed closures.

GLOSSARY

ASSISTED LIVING (AL): A form of housing for seniors who require daily personal support but are still able to direct their own lives. People live in their own apartments and receive personal care from staff employed by the facility (except in the Vancouver Island Health Authority, where assistance is contracted from outside home support agencies). Assisted living was created by the Community Care and Assisted Living Act in 2003 and is defined as premises, or part of a premises, in which at least one, *but no more than two,* prescribed personal care services (i.e. assistance with mobility, medication management, bathing) are provided. Assisted living does not include Registered Nurses, and is not designed for people with significant physical or mental needs. The Health Authorities and BC Housing provide subsidies to support a certain number of seniors with low and moderate incomes who have been assessed by Continuing Care as eligible for assisted living. In subsidized AL residents pays no more than 70 percent of their income for the accommodation fee, which covers most meals, weekly laundry and cleaning and only one or two prescribed personal care services. Additional services and assistance are paid for out-of-pocket by the residents or their families. Assisted living is also provided in the private market where the individual or their family pays the full cost. Publicly subsidized assisted living can be provided by the non-profit or for-profit sector.

RESIDENTIAL CARE: Previously referred to as long-term care, residential care includes intermediate care, extended care, complex care, multi-level care and nursing homes. Residential care is for individuals who require 24-hour nursing supervision and who have limited ability to direct their own care. In the past there were different levels of care (personal, intermediate levels 1, 2, and 3 and extended), but now only people with complex care needs are being admitted to residential care. (Complex care includes only those residents who were previously classified at intermediate care level three and extended care.) In publicly funded residential care, residents pay a user fee based on income. There are, in addition, residential facilities in the private market where the residents or their families pay for the full cost. Publicly subsidized residential care can be provided by both for-profit and not-for-profit providers.

BED RATES: This report looks at the total number of assisted living and residential care beds in different years within the provincial health authorities and the province as a whole. It also uses "bed rates," which refer to the number of beds per 1,000 seniors aged 75 and over. This is a more accurate way to evaluate the level of access to beds.

A complete Glossary of terms used in this report is provided on page 10.

However, new bed construction did not keep pace with increases in the population aged 75 and older. Since 2001, beds were closed *at the same time as* the population 75 and over grew by more than 3 per cent per year (see Appendix 1).

In addition, the reduction in residential care bed availability has not been consistent across the health authorities, creating greater inequities in access depending on where a person lives in BC. For example, the Interior Health Authority saw the most dramatic reductions in beds per 1,000 seniors aged 75 and over. This is true even when the increase in assisted living units is taken into account (see Tables 5 and 6). Because of the differences in how bed reductions were implemented across the health authorities, frail seniors living in the Vancouver Coastal or Northern Health authorities have far better (though still inadequate) access to residential care than people living in the Fraser, Vancouver Island or Interior health authorities.

The health authorities and other health planners are now beginning to acknowledge the challenges that residential bed closures have created for the health care system. For example, the Fraser Health

Table 4: Reduction in Residential Care Beds and Bed Rate, 1994/95 to 2004[a]

Year	Publicly-funded beds	Bed rate	% cumulative decline in beds rate
1994/1995[b] residential care	24,520	127.9	
2001[c] residential care	25,420	100.5	-21.4%
2004[d] residential care	22,891	82.2	-35.7%
2004 residential care and assisted living[e]	23,956	86.0	-32.8%

[a] Population numbers used are 1994 for 1994/95; 2001 for 2001/02; and 2004 for 2004/05.
[b] From January 12, 2003, Ministry of Health Discussion Paper.
[c] BC numbers from June 2001, January 12, 2003 Ministry of Health discussion paper.
[d] See Appendix 8 for Dec. 2004 residential care numbers (22,891). Methodology explained in Appendix 5.
[e] See Appendix 9, for Dec. 2004 assisted living numbers (1065). Methodology explained in Appendix 5.

Table 5: Residential Care (RC) Beds by Health Authority, 2001–2004

Health authority	2001 RC beds	2004 RC beds	Cuts in beds 2001 to 2004	2001 bed rate	2004 bed rate	% change in bed rate
Fraser	7,471	6,969	-502	98.4	82.2	-16%
Interior	4,769	3,834	-935	95.0	67.8	-29%
Northern	1,006	912	-94	120.8	95.3	-21%
Vancouver Coastal	7,091	6,588	-503	116.8	99.9	-14%
Vancouver Island	5,083	4,588	-495	87.8	74.3	-15%
BC total	25,420	22,891	-2,529	100.5	82.2	-18%

Note: Bed rate refers to the beds per 1,000 population 75 and over.

Authority reported in its 2004–05 Operating Plan that "the closure of residential care facilities has placed enormous pressure on home health care [and that] BC will need to address how to support larger numbers of persons in the community."[14]

The Fraser Health Authority plan goes on to note that "a very large portion of patients is waiting in acute care beds for alternative care—significantly more than any other area of the province. Access to available long-term care beds is lower than the provincial average when measured relative to population and access to available home support, and home care is the lowest in the province."[15]

From 2001 to December 2004, there was a net closure of 26 residential care facilities, amounting to a net reduction of 2,529 residential care beds. With 1,065 additional assisted living units, there was a net reduction of 1,464 beds in three years.

Similarly, the undersupply of residential care and assisted living units in the Capital Regional District (i.e. Victoria and vicinity) has caused back-ups in hospitals with people waiting for placement in residential care. [16] As the staff of the Capital Regional District note, the shortfall in beds is a result of the health authority closing too many residential care beds too quickly, and of not having the alternatives, including assisted living, in place.

In terms of plans for future residential care construction, as of December 2004 there were only 568 new residential care beds approved for development by the health authorities.

Table 6: Residential Care (RC) and Assisted Living (AL) Beds by Health Authority

	RC beds only			New AL beds	Combined RC and AL beds		Combined RC and AL bed rates	
Health authority	2001 RC beds	2004 RC beds	Cuts in RC beds, 2001–2004	2004 AL beds	2004 RC and AL beds	**Net change in RC and AL beds, 2001–2004**	2004 combined bed rate	% change in bed rate, 2001–2004
Fraser	7,471	6,969	-502	191	7,160	-311	84.4	-14%
Interior	4,769	3,834	-935	219	4,053	-716	71.7	-25%
Northern	1,006	912	-94	117	1,029	23	107.5	-11%
Vancouver Coastal	7,091	6,588	-503	135	6,723	-368	101.9	-13%
Vancouver Island	5,083	4,588	-495	403	4,991	-92	80.8	-8%
BC total	**25,420**	**22,891**	**-2,529**	**1,065**	**23,956**	**-1,464**	**86**	**-14%**

Note: RC bed numbers obtained from Canadian Health Care Facilities Guides, Health Authority Representatives and Reports. 2004–05 beds effective as of December 2004 (Appendix 5). Population numbers are provided by BC STATS, Ministry of Finance and Corporate Relations, PEOPLE 28.
Bed rate refers to the beds per 1,000 population 75 and over.

Inter-provincial Comparison

To assess how BC compares to other provinces, we have compared changes in residential care beds across Canadian provinces since 2001.

In 2001, British Columbia was close to the national average with a bed rate of 100.4 beds per 1,000 seniors aged 75 and over (see Table 7). By 2004, BC's rate was 83.4, 13 per cent below the national average, a disparity of 2,924 actual beds.[17] Along with New Brunswick, BC now has the lowest number of residential care beds in the country for people aged 75 and over. Even if the new assisted living units are included in BC's total bed rate number, the province is still 9 per cent or 2,033 beds below the national average (assisted living beds are not included in the totals from the other provinces).[18]

Although other provinces also experienced declines in bed rates, BC's was the most dramatic, and it coincided with a reduction in acute care hospital beds that was also steeper than in most other provinces (see Table 7 and Table 1 earlier in the report).

Table 7: Inter-provincial Comparison of Residential Care (RC) Beds and Bed Rates, 2001–2004

Province	2001 RC beds[a]	2001 bed rate	2004 RC beds[b]	2004 bed rate	% change in bed rate	% change in population 75+, 2001–2004
Manitoba	9,733	125.0	9,791	121.2	-3.0%	3.7%
Saskatchewan[c]	9,240	117.8	8,982	116.8	-0.9%	2.6%
Prince Edward Island	950	107.1	947	106.0	-1.0%	0.7%
Ontario	58,403	89.3	70,100	95.9	7.3%	11.8%
Quebec	43,491	105.4	44,171	95.6	-9.3%	12.0%
Alberta[d]	14,486	107.9	14,263	94.5	-12.5%	11.7%
Nova Scotia	5,806	96.9	5,777	92.6	-4.5%	4.2%
NFLD & Labrador[e]	2,818	102.0	2,636	89.7	-12.1%	6.4%
British Columbia[f]	25,404	100.4	22,891	83.4	-16.7%	11.3%
New Brunswick	4,227	90.1	4,108	83.0	-7.9%	5.5%
National average	173,839	99.8	184,304	95.7	-4.1%	10.4%

See Appendix 6 for notes to Table 7. See also endnote 17, note 2.

Assisted Living: Does the Substitution Model Work?

In addition to examining the changes in bed numbers, it is important to analyze the government's assisted living substitution model. There is no question that the current government's addition of assisted living housing represents a valuable contribution to the continuum of care for people who require daily support, but who are still able to direct their own lives and therefore do not require residential care. The question remains, however: can assisted living be used as a substitution for residential care?

In Canada, Alberta was the early innovator in assisted living substitution. Although BC only recently adopted this model, the provincial government has chosen a much more aggressive substitution strategy. Alberta did not cut its overall stock of residential care beds. And although Alberta *does* plan to meet the increased demand for seniors' accommodation and care through an expansion of assisted living units, it will be 2016 before it achieves substitution levels equivalent to what BC plans to achieve by 2006/07.[19]

The BC government argues that citizens prefer a "housing" model with attractive private suites and homelike atmospheres rather than the communal "institutional" setting of a residential care facility. However, the provincial government's decision to promote the substitution of assisted living beds for residential care beds was based on another assumption: that the costs of assisted living to the health authorities would be about half as much as residential care.[20] In *The Picture of Health* (2002) the provincial government states that its goal in "continuing care renewal" is to see fewer seniors spending time in residential care, where the cost to government averages $125 per day per resident, and more time supported at home or in assisted living, where costs range from $50 to $75 per day per person.[21]

It is important to note that in an institutional (residential) model of care, the health authority is required, through legislation, to take overall responsibility for services and care provided to individuals. In the assisted living model, individuals live in their own homes, and thus retain responsibility for their own care, other than for what the health authority agrees to provide. In assisted living, *most* meals, weekly cleaning and laundry, and one or two care services are included in the fee. Other needs must be paid for by the individual. In other words, although the discussion is framed in terms of the benefits of "de-institutionalizing" care for seniors, the reality is somewhat different. The shift to an assisted living model may be more about limiting government's responsibility than about providing "a homelike atmosphere."

Although the discussion is framed in terms of the benefits of "de-institutionalizing" care for seniors, the reality is somewhat different. The shift to an assisted living model may be more about limiting government's responsibility than about providing "a homelike atmosphere."

A number of research investigators have identified a mismatch between the assisted living funding model and the needs of residents. In the 2004 study *Clients and Services in Assisted Living Settings in British Columbia*,[22] Araki and Gutman set out to "examine the extent to which characteristics of current AL settings, clients, and services are consistent with the policy and goals of the new legislation [and] to identify intended and unintended consequences of the new legislation (the *Community Care and Assisted Living Act*)."[23] The administrators interviewed for the study identified that many residents entering assisted living had care needs that were too high or too diverse to be accommodated in assisted living. These significant care needs included dementia, depression, medication management, and assistance with activities of daily living. In addition, residents entering assisted living tended to move to a higher level of care quickly. The lean staffing levels in assisted living (no RN provision, low staff-to-resident ratios, outsourcing of care services) and the physical environment (not designed for the needs of people with significant mobility limitations or dementia) were the major contributing barriers to accommodating the care needs of these residents.

Similarly, the Capital Health Region's survey of assisted living complexes found that most experienced "increasing disability amongst incoming residents, overstaying of residents requiring residential care, pressure from hospitals to accept patients above and beyond their capacity, and higher costs."[24]

In this regard BC has much to learn from the United States, where the assisted living model has been in place for 15 years. The *New York Times* reported in January, 2005 that a study by the National Center for Assisted Living, an industry group, shows that today "half the residents have some degree of cognitive impairment, three-quarters need help bathing, (and) 8 in 10 cannot administer their own medication…"[25] The ideal of aging in place (i.e. remaining in assisted living) is also unachievable for many Americans, as the residents who leave assisted living do not leave because they die, but because they run out of money to pay for assisted living and end up in subsidized institutional care.

In BC there were 1,065 subsidized assisted living spaces in place by December 2004, with 2,005 more units planned over the next two to three years (see Appendix 9). In these subsidized units, provincial policy requires that people pay no more then 70 per cent of their monthly income for basic accommodation and support services. However, there is also a funding ceiling of $50 to $75 a day that limits the basic services that can be provided in the accommodation fee. This means that if additional care is needed, the individual may be required to pay out-of-pocket for these services. This raises many of the same issues around the affordability of assisted living that have been identified in the U.S.

In addition, there are seniors who cannot access publicly-subsidized assisted living or residential care, either because it is not available in their communities or because they do not meet the eligibility requirements for assisted living or residential care. These seniors may be forced to seek care in the entirely private market where they and/or their families must pay 100 per cent of the cost of care. In the private market, issues of affordability are even more acute.

Growth of Corporate Control and Private Pay Residential Care and Assisted Living

Publicly-funded residential care has always been delivered through a mix of non-profit (75 per cent) and for-profit (25 per cent) providers. Historically the vast majority of for-profit providers were individual proprietorships. However, in BC as elsewhere in recent years, there has been a marked increase in corporate involvement in both residential care and in the newly developing assisted living sector. Since 1990 in BC there has been a six-fold increase in corporate owned and/or managed residential care and assisted living (Table 8). Most of this growth occurred after 1996 when there was a marked decrease in the construction of new publicly-funded residential care beds (Table 4 above).

There are now 41 facilities in BC that are owned or managed by the corporate sector. While 14 of these corporate facilities receive public funding, the remaining 27 are entirely private pay: that is, the resident or their family pays 100 per cent of the cost.[26] The development of this entirely private market reflects the reduced availability of publicly-funded residential care and the slow growth of publicly-subsidized assisted living.

Table 8: Growth in Corporate Control of Residential Care and Assisted Living, 1990–2004

Year	Corporate residential care and assisted living beds
1990	552
1996	1,081
2001	3,424
2004	3,856
% change 1990–2004	599%

Source: This information was collected from annual reports and a telephone survey with the 10 major corporations operating in BC's seniors' residential care and assisted living sectors (see Appendices 10 and 14).

Table 9: Monthly and Yearly Fees for Corporate-Owned Assisted Living and Residential Care, 2004				
Fees	Average		Highest	
	Per month	Per year	Per month	Per year
Assisted living	$3,221	$38,652	$4,375	$52,500
RESIDENTIAL CARE				
Intermediate care 1	$3,660	$43,920	$4,650	$55,800
Intermediate care 2	$4,059	$48,708	$5,050	$60,600
Intermediate care 3	$4,542	$54,504	$6,350	$76,200
Extended care	$4,657	$55,884	$5,555	$66,660
Note: See Appendix 14 and glossary for an explanation of the care levels for intermediate and extended care.				

Between September 2004 and January 2005, a telephone survey was conducted with the 27 private-pay facilities to determine the cost of care to residents or their families (see Appendix 14 for survey methodology). Table 9 details the average and highest monthly and annual fees for the different levels of care provided by these corporate facilities.

Private assisted living accommodation that is already out of reach for many low- and moderate-income seniors, with the additional "hidden costs" of extra services, becomes untenable for even higher-income seniors and their families.

As was noted near the beginning of this report (in Table 3), only 5 per cent of unattached senior women and 11 per cent of unattached senior men have an annual income of $50,000, while 75 per cent and 63 per cent respectively have an average annual income of less than $25,000. Even if these seniors have families willing and able to help, very few families can afford the $40,000 to $65,000-plus per year required for private care.

Additionally, assisted living only provides *most* meals and only *one* and at the most *two* prescribed services in the basic accommodation fee. Extra services individuals require, as their health deteriorates, may result in additional charges. Some facilities offer a range of extra services for additional fees. These services can include assistance with walking to and from the dining room, medication reminders, incontinence care and bathing more than once a week. Table 10 provides examples of the kinds of services available and the fees charged for these services.

Table 10: Examples of Extra Fees for Service in Assisted Living	
Assisted bath	$16 per bath
Visiting guest room	$40 per day
Additional meals	$5 per meal
Medication services	$10 per day
Package services	$150 to $880 per month depending on care needs
Source: See Appendix 14.	

Unfortunately, while providers may consider these costs as extras, to most seniors they are essential. Consequently, private assisted living accommodation that is already out of reach for many low- and moderate-income seniors, with the additional "hidden costs" of extra services, becomes untenable for even higher-income seniors and their families.

With the reduction in publicly-funded residential care beds and the high cost of private care, many frail seniors are turning to family members to either pay for their care, or to provide the care themselves. For

those without family the situation is even worse. As the staff of Capital Regional District noted in their report:

> *Some people have been unable to afford private options and do not have family and are not coping well. By the time the system gets to them, they have deteriorated to the point that they need to be fixed by the medical system.*[27]

The Shift from Not-For-Profit to For-Profit Care

There is an additional change related to the cuts to residential care beds and substitution of assisted living: the shift within the publicly-funded sector from not-for profit to for-profit delivery (for-profit delivery includes both individual proprietorships and corporations). Over 90 per cent of the net residential bed closures since 2001 have been in the not-for-profit sector, while proportionately more of the new residential care and assisted living bed openings have been in the for-profit sector (see Appendices 7 and 8). An examination of residential care closures by health authority shows that the cuts to non-profits have been most dramatic in the Interior Health Authority, where 83 per cent of the beds closed were non-profit and 92 per cent of the new beds opened were for-profit (see Table 11). While these closures may reflect the fact that many of the not-for-profit facilities were older and required replacement, it does not explain why so many of the new facilities are for-profit.

These developments are problematic because of the considerable evidence of poor quality care in the for-profit sector. One very large research study in the U.S., analyzing all inspection surveys conducted during 1998 across all states in close to 14,000 facilities, found that profit-making facilities had 30 per cent more violations of standards than non-profit facilities.[28] Severe deficiencies (which make up one quarter of all deficiencies) occurred at a rate 40.5 per cent higher at for-profit nursing homes. Within the for-profit sector, corporate facilities had the highest violation rates.

Similarly, in Canada, a Manitoba study of residential care facilities' performances found that "for-profit nursing homes had significantly higher hospital admissions for four conditions: dehydration, pneumonia, falls, and fractures."[29] And a very recent BC study of staffing levels in residential care facilities between 1996 and 2000 shows that, for the same government funding, staffing levels for front-line care and support staff is considerably lower in for-profit facilities.[30] However, despite this evidence, support from the health authorities for increased corporate and private sector involvement in residential care appears to be strong and growing.

Table 11: Change in Interior Health Authority's Non-Profit and For-Profit Residential Care Beds, 2001-2004

Interior HA (RC) beds	Beds closed	% closed	Beds opened	% opened	Net change in beds	2004 total RC beds
Non-profit	994	83%	20	8%	-974	2,782
For-profit	204	17%	243	92%	39	1,052
Total	1,198	100%	243	100%	-935	3,834

Source: See Appendix 5.

Home Health Services

Home support and home care include a range of acute, chronic, palliative, and preventative services designed to maintain people in their homes and communities. In the 1970s and 1980s British Columbia was a leader in the provision of home health services. In 1977/78, for example, BC was second only to Manitoba in the proportion of the health care budget allocated to home health services (see Figure 1). By 1987/88 BC had slipped to fourth position, but was still above the Canadian average. By 1997/98 BC had fallen further, to seventh position trailing behind every region except Alberta, Quebec, PEI and the North West Territories and spending less than the Canadian average on home health services

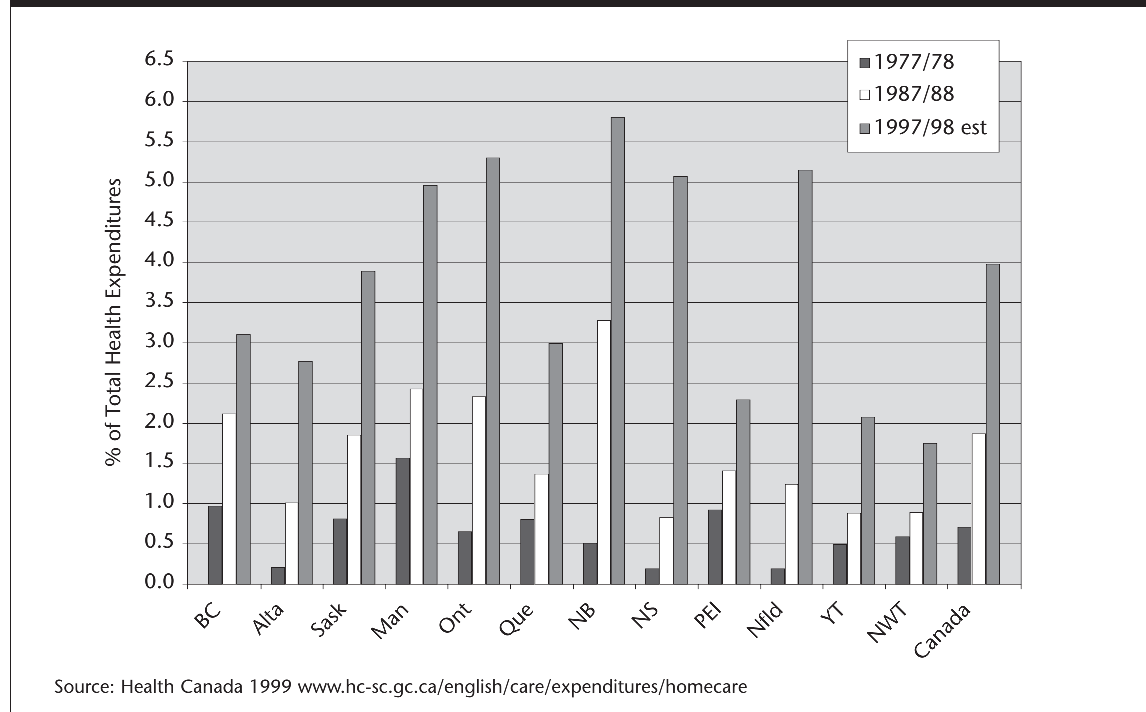
Although there was an absolute increase in BC's spending over time, the inter-provincial comparison suggests that, relative to other provinces, home health services are a relatively low priority in BC. To make matters worse, since 1997/98 there has been a significant reduction in access to both home support and home care for seniors aged 75 and over (see Tables 11 and 12).

Home support hours for all ages (i.e. seniors and people with disabilities) declined by 18 per cent and the number of clients declined by 33 per cent between 1997/98 and 2002/03 (see Table 12). Because the senior population is growing more rapidly than the overall population, an examination of home support service relative to the population aged 75 and over shows a sharper decline—a 29 per cent reduction in hours, and a 40 per cent reduction in clients during the same time period (see Table 11). These reductions occurred under both the NDP and Liberal governments.

Likewise, home care for seniors aged 75 and over declined sharply (Table 13). There was a 17 per cent reduction both in the number of clients and in the number of visits over the five year period from 1997/98 to 2002/03. Again, these reductions occurred both under the NDP and Liberals.

By 2003 there was considerable disparity in the provision of home support hours per client between the more rural health authorities and the urban health authorities (Table 14). For example, Vancouver Island HA's 218 hours per client was 38 per cent more than Interior HA's 158 hours and 36 per cent more than Northern HA's 160 hours per client. Even when compared to the number of hours per client in BC, the rural health authorities are 18 to 19 per cent below the provincial average.

Figure 1: Share of Provincial Expenditures Spent on Home Health Services by Province, 1977/78, 1987/88 and 1997/98



Source: Health Canada 1999 www.hc-sc.gc.ca/english/care/expenditures/homecare

GLOSSARY

HOME HEALTH SERVICES: This includes all professional and non-professional health services provided to individuals in their own homes. It includes home support, home care and rehabilitation services.

HOME CARE: Professional nursing services are provided to individuals in their own home and include post-acute, chronic and palliative care. Access to publicly funded home care is based on an assessment by Continuing Care. These services may also be purchased privately.

HOME SUPPORT: Non-profession personal care services, provided by trained Community Health Workers, that assist people to remain in their own homes. The services include personal assistance (bathing, grooming, meal preparation, etc.) and can include housekeeping. Access to publicly subsidized home support services is based on an assessment by Continuing Care. These services may also be purchased privately.

A complete Glossary of terms used in this report is provided on page 10.

Table 12: Number of Home Support Hours and Clients, 1997/98, 2000/01 and 2002/03						
British Columbia	**1997/98**	**2000/01**	**2002/03**	**% change 1997/98 –2000/01**	**% change 2000/01 –2002/03**	**% change 1997/98 –2002/03**
Home support hours per 1,000 seniors 75+	35,628	29,251	25,423	-18%	-13%	-29%
Home support hours per 1,000 pop'n all ages	1,963	1,759	1,605	-10%	-9%	-18%
Home support clients per 1,000 seniors 75+	215	164	130	-24%	-21%	-40%
Home support clients per 1,000 pop'n all ages	12	10	8	-17%	-20%	-33%

Source: Ministry of Health, PURRFECT Version 7.1, CCASUR – Cont. Care Age-Standardized Util. Rates Version 1.30, Report date: October 26, 2004 used for period 1997/98. Data for the period 1998/1999 to period 2002/2003 from PURRFECT Version 8.1, CCASUR – Cont. Care Age-Standardized Util. Rates Version 9i, Report date: October 21, 2004.

Table 13: Number of Home Care Clients and Visits per 1,000 Population 75+, 1997/98, 2000/01 and 2002/03						
British Columbia	**1997/98**	**2000/01**	**2002/03**	**% change 1997/98 –2000/01**	**% change 2000/01 –2002/03**	**% change 1997/98 –2002/03**
Home care clients per 1,000 seniors 75+	168	151	139	-10%	-8%	-17%
Home care clients per 1,000 pop'n all ages	9.3	9.1	8.8	-2%	-3%	-5%
Home care visits per 1,000 seniors 75+	3,483	3,145	2,894	-10%	-8%	-17%
Home care visits per 1,000 pop'n all ages	192	189	183	-2%	-3%	-5%

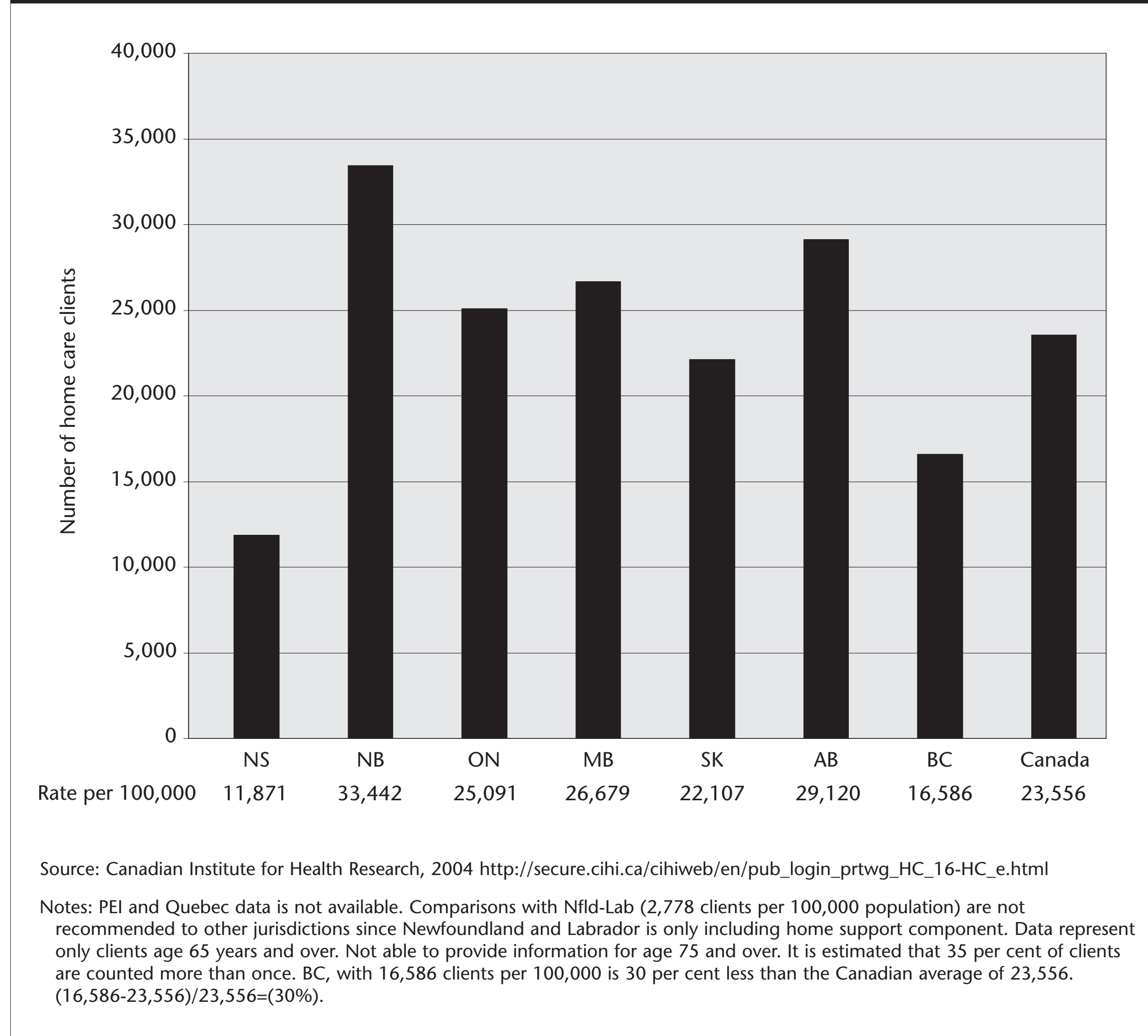
Source: Ministry of Health, PURRFECT Version 7.1, CCASUR – Cont. Care Age-Standardized Util. Rates Version 1.30, Report date: October 26, 2004 used for period 1997/98. Data for the period 1998/1999 to period 2002/2003 from PURRFECT Version 8.1, CCASUR – Cont. Care Age-Standardized Util. Rates Version 9i, Report date: October 21, 2004. Current year data is not available.

Table 14: Total Home Support Hours Per Client by Health Authority, 2002/03			
Health authority	**2002/03 total home support hours per client**	**HA % difference from BC average**	**HA % difference from highest**
Fraser	210	8%	-4%
Interior	158	-19%	-38%
Northern	160	-18%	-36%
Vancouver Island	218	12%	0%
Vancouver Coast	191	-2%	-14%
Total BC	195	0%	-12%

Source: Ministry of Health, PURRFECT Version 8.1, CCASUR – Cont. Care Age-Standardized Util. Rates Version 9i, Report date: October 21, 2004.

This reduced access is reflected in BC's poor showing relative to other provinces by 2002/03. Figure 2 compares the number of home health care clients per 100,000 population aged 75 and over. The number of clients served by British Columbia's home care programs was second to last and 30 per cent below the national average.

Figure 2: Home Health Services Clients per 100,000 Population Aged 75+ by Province, 2002/2003



Source: Canadian Institute for Health Research, 2004 http://secure.cihi.ca/cihiweb/en/pub_login_prtwg_HC_16-HC_e.html

Notes: PEI and Quebec data is not available. Comparisons with Nfld-Lab (2,778 clients per 100,000 population) are not recommended to other jurisdictions since Newfoundland and Labrador is only including home support component. Data represent only clients age 65 years and over. Not able to provide information for age 75 and over. It is estimated that 35 per cent of clients are counted more than once. BC, with 16,586 clients per 100,000 is 30 per cent less than the Canadian average of 23,556. (16,586-23,556)/23,556=(30%).

Costs of Paying Privately for Home Health Services

As a result of the decline in access to home health services, many frail seniors and people with disabilities have seen a reduction in their service hours or have been denied access to publicly-subsidized care altogether.[31] To continue to receive services, these British Columbians and/or their families must pay out-of-pocket. Table 15 provides details on the lowest and highest hourly rates being charged for private home nursing and support services as of February 2003.

Those who most need home care and support, single elderly women and people with disabilities, are least likely to be able to afford alternative care when the government withdraws its support.

Few are able to afford the cost of private home health services. For example, the vast majority of home support clients are low-income women. In 1998/99, among the single seniors who needed subsidies, 82 per cent had incomes of $20,000 or less.[32] Among disabled applicants for home support services, 94 per cent had incomes of $10,000 or less. Thus, those who most need home care and support, single elderly women and people with disabilities, are least likely to be able to afford alternative care when the government withdraws its support.

Table 15: Private Home Health Agencies Rates (effective February 2003)

Service	Lowest hourly rate	Highest hourly rate
Registered Nurse	$37.50	$45.00
Licensed Practical Nurse	$18.50	n/a
Home Support/ Care Aide	$16.00	$24.50

Source: North Shore Health Unit.

Implications for Seniors, the Health Care System, and Communities

> *"Evidence of a shortage of residential care is clear. Too many high level residential care beds have been withdrawn, their substitutes have so far been insufficient to replace them, and future potential efforts are uncertain."* — Capital Regional District Staff Report, February 16, 2005[33]

In 2002, the provincial government promised to renew continuing care to ensure that British Columbians had equitable access to quality residential, home and community care services.[34] And yet, despite our aging and growing population, and reductions in acute care beds, the past three years have seen a steady decrease in services (Figure 3) and growing inequities in the availability of services between health regions. The impact of these cuts is far-reaching, hurting individuals, families, communities, and our health care system.

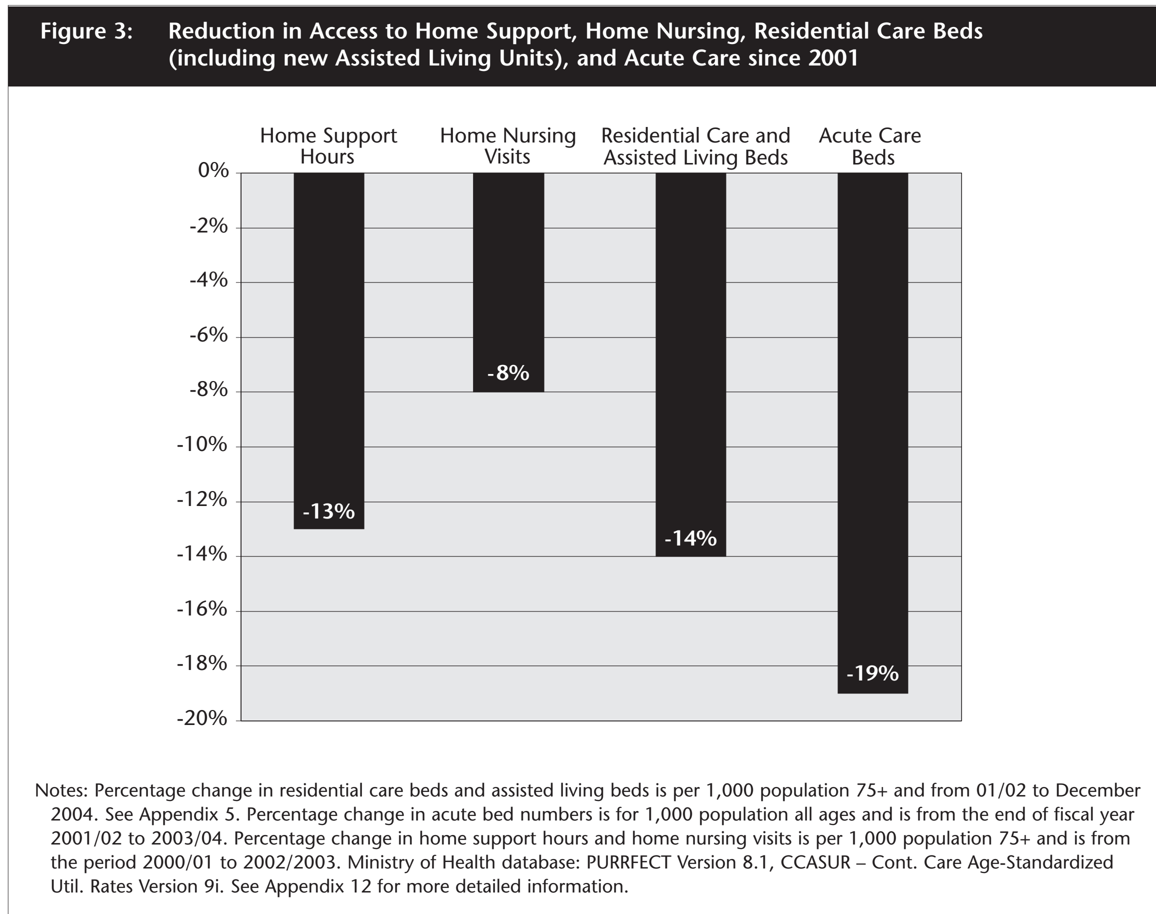
Impact on the Health System

> *"The shortage of residential care is one of the reasons preventing effective use of hospitals by acute patients…It also contributed to congestion in emergency departments with patients waiting to be admitted."* — Capital Regional District Staff Report, February 16, 2005.[35]

While shortages of residential care beds may not explain all of the hospital back-ups, the Capital Regional District, the Fraser Health Authority and the Interior Health Authority report clogged emergency wards and increased rates of people in acute care awaiting placement in residential care. These people occupy Alternate Level of Care (ALC) hospital beds, reducing access for patients who genuinely require acute hospital services. For example, the Interior Health Authority (the health authority that has been most aggressive in cutting residential care and home health services and in substituting assisted living) recorded a dramatic 65 per cent jump in ALC days (i.e. use of an ALC bed by someone waiting for residential care or home health services) in the Okanagan[36] in just one year. They admit that this has caused serious emergency room overflows.[37]

The lack of residential care beds not only reduces access to acute care for patients who genuinely need these services, it also costs more. The Ministry of Health Planning estimates in its 2002 document, *A Picture of Health,* that the cost of acute care is four to seven times higher than residential care (Table 16). A more conservative, and accurate, estimate of the cost of an ALC bed suggests that it is closer to $434.71 per day, or $13,041 for a 30-day period—still more than three times greater than the cost of residential care.[38]

Figure 3: Reduction in Access to Home Support, Home Nursing, Residential Care Beds (including new Assisted Living Units), and Acute Care since 2001



Notes: Percentage change in residential care beds and assisted living beds is per 1,000 population 75+ and from 01/02 to December 2004. See Appendix 5. Percentage change in acute bed numbers is for 1,000 population all ages and is from the end of fiscal year 2001/02 to 2003/04. Percentage change in home support hours and home nursing visits is per 1,000 population 75+ and is from the period 2000/01 to 2002/2003. Ministry of Health database: PURRFECT Version 8.1, CCASUR – Cont. Care Age-Standardized Util. Rates Version 9i. See Appendix 12 for more detailed information.

A recent example of cost increases resulting from the cuts to residential care beds is provided by the analysis of increased use of ALC beds in Capital Regional District hospitals. The district reported that there are now on average 162 elderly people who should be in residential care waiting in hospital each month. Of these 162 people, 32 found a facility placement each month and 130 stayed over.[39] Table 17 illustrates the actual *additional costs* of the cuts to residential care. It uses the Capital Regional District's numbers for the reduction in residential care beds and the increase in assisted living beds, the provincial government's estimates for the daily cost of residential care ($125) and assisted living ($50 to $75), and a conservative estimate of the cost of an Alternate Level of Care bed ($434.71). The table shows that, in the Capital Regional District, the Vancouver Island Health Authority is now housing seniors in acute care at an extra cost of $178,000 to $343,000 a month—or more than $2 to $4 million per year.

Costs would escalate dramatically if increases in ALC utilization across *all* the health authorities were factored into the equation; unfortunately this information is not available. What is clear, however, is that the government's strategy is not only reducing needed access to both residential and acute care, it is actually costing the system considerably more.

Table 17: Additional Cost to Vancouver Island Health Authority from Closure of Residential Care Beds, Opening Assisted Living Units and Increasing Use of Acute Care

VIHA	Beds[a]	Min. cost per month[b]	Max. cost per month[b]
RC bed closures (net)	492	$1,845,000	$1,845,000
AL bed openings	219	($328,500)	($492,750)
ALC utilization	130	($1,695,369)	($1,695,369)
Net "savings" (RC-AL-ALC)	($178,869)	($343,119)	

Notes:

[a] VIHA bed/utilization numbers from: VIHA, *Capital Regional District Staff Report to the Health Facilities Planning Committee Meeting of Wednesday, February 16, 2005, Attachment 1: Assisted Living Review, Summary of Basic Findings and Conclusions*, pg. 1–2.

[b] Cost per unit: BC Ministry of Health Planning (November 2002). *A Picture of Health: How we are modernizing British Columbia's health care system*, p. 34. Accessed on February 2, 2005: http://www.healthservices.gov.bc.ca/cpa/publications/picture_of_health.pdf.

Table 16: Ministry of Health Planning's Estimated 30-Day Cost per Client for Acute Care, Residential Care and Assisted Living, 2002

Acute hospital	Residential care	Assisted living
$21,000 to $30,000	$3,750	$1,500 to $2,250
% less than acute	460 to 700 %	833 to 1,900 %

Source: BC Ministry of Health Planning (November 2002). *A Picture of Health: How we are modernizing British Columbia's health care system*, p. 34. Accessed on February 2, 2005: http://www.healthservices.gov.bc.ca/cpa/publications/picture_of_health.pdf

Impact on Clients—More than a Seniors' Issue

With the reduction in residential care and the introduction of a very restrictive waitlist policy, only those people assessed as requiring complex care within 90 days are accepted on a waitlist for residential care. If a bed becomes available outside the individual's home community, they must take it or lose their place on the waitlist. Other frail seniors who require residential care but do not qualify for complex care and/or who cannot access subsidized assisted living (either because it does not exist in their communities or because they do not meet the eligibility requirements) are left with few options.

The vast majority of these people are unattached frail seniors who cannot afford to pay for private care. As a result, they must either go without, make do with less, or rely on their families to provide. What often happens, particularly for those seniors who do not have families who can support them, is that they go without care and are then admitted to a hospital emergency ward in crisis.[40] While the health authorities have reduced their costs by cutting residential care, the funding has not been passed onto the individuals, their families or communities—the dollars have not "followed" the patient home to help them regain or maintain their health.

> The vast majority of these people are unattached frail seniors who cannot afford to pay for private care. As a result, they must either go without, make do with less, or rely on their families to provide. What often happens is that they go without care and are then admitted to a hospital emergency ward in crisis.

The downloading of government's responsibilities onto churches and community groups has also put unbearable pressures on these service agencies.[41] Volunteer-dependent community agencies and church groups are overworked, under-funded, under-resourced, and have reached or exceeded their maximum service capacity. These groups are seeing the effect of government cuts on seniors and their families'—in the deterioration of seniors' health and an increasing number of crises.[42]

Provincial Role: The Continuing Care Renewal Plan

In January 2003, nine months *after* the government decided to cut 3,111 residential care beds and substitute assisted living units, the Ministry of Health developed a Residential Care Utilization Model that included three substitution scenarios of assisted living for residential care. This report was never officially released to the public (but was leaked).[43]

The projected number of assisted living units needed to substitute for closed residential care beds by 2006/07 was between 6,833 and 6,942. This is six times more than the 1,065 assisted living units the provincial government provided by December 2004, and twice the number (3,070) the provincial government is optimistically planning to build by 2007. This shortfall provides new opportunities for the entirely private sector to make inroads, where individuals and their families pay the full cost of care.

The report itself acknowledges that the model is limited because it does not consider the income level of frail seniors and people with disabilities, changes in their health status, or potential differences between urban and rural areas. Nonetheless, the health authorities, under the direction of the provincial government, have forged ahead with drastic cuts in residential care beds, without the assisted living units or home health services in place to offset the impact. As the staff in the Capital Regional District noted, "The previous plan did not give good direction and appears to have been influenced by financial objectives which favour an unrealistically high substitution of residential care."[44]

Lack of Reporting

Since 2001, the BC government has put $2.4 billion in additional funding into health care.[45] Regional health authority budgets increased by 21 per cent between 2000/01 and 2003/04 (see Appendix 13). The cuts to residential care beds, even when the cost of new assisted living units is taken account, have resulted in a reduction in provincial expenditures of between $86 and $96 million a year. Yet there is no accounting for how and if this money has been used to support seniors' care. Nor is there an accounting for the higher costs of the increased use of ALC beds in hospitals.

Prior to 2000, the health authorities reported their budget allocations for all continuing care services (home health services and residential care).[46] However, since 2001, the health authorities have been given a global budget and more latitude to make decisions about how they allocate funds. The province has stopped tracking health authorities' expenditures on community and residential care programs. As a result it is impossible to determine how and where the health authorities have allocated the increased funding from the province or the reduced expenditures on residential care.

The data presented in this report shows that the reduction in funding for home and community services not only varies greatly between regions, but may in fact be increasing overall health expenditures. Quite clearly, there is a need for accountability in reporting to ensure that government planning and funding decisions are available for public scrutiny.

The cuts have resulted in a reduction in provincial expenditures of between $86 and $96 million a year. Yet there is no accounting for how and if this money has been used to support seniors' care. Nor is there an accounting for the higher costs of the increased use of ALC beds in hospitals.

Table 18: Provincial Government's Minimum and Maximum Net Savings from Closed Residential Care Beds

	Beds[a]	Min cost per year[b]	Max cost per year
RC bed cuts	-2,529	-$115,385,625	-$115,385,625
AL bed openings	+1,065	+$19,436,250	+$29,154,375
Net change in costs	-1,464	-$95,949,375	-$86,231,250

Notes:

[a] Residential Care Beds (effective Dec. 2004) are from Health Authority Representatives, Canadian Health Care Facilities Guide, and from individual facilities.

[b] Cost per unit from BC Ministry of Health Planning (November 2002), *A Picture of Health: How we are modernizing British Columbia's health care system,* p. 34, accessed on February 2, 2005: http://www.healthservices.gov.bc.ca/cpa/publications/picture_of_health.pdf.

Conclusion and Recommendations

> *"The current situation is much larger than the number of assisted living resident care beds. It's about better planning, designing a system that works better, estimating how much it would cost to fund such a system, figuring out who is going to pay for it, deciding and organizing to make the changes. It is also about explaining what is going on and why and evaluating the effect of change. It's about improved information and sharing it and collaboration and working together to improve it."* —Capital Regional District Staff Report [47]

The provincial government's plan for "Continuing Care Renewal" has caused undue suffering for some of the most frail and vulnerable members of our society, their families and communities. It has also reduced access for any British Columbians requiring hospital services.

The Continuing Care Renewal Plan, which was developed without public consultation, needs to be re-written with the participation of British Columbians, who have a right to be directly involved in setting priorities for the health services they require. Service provision must be based on the actual needs of the population—not on the ability of individuals to pay, or on arbitrary health authority policies. Seniors requiring residential care have a right to remain in their own communities.

To address these issues, the authors of this study recommend that the provincial government immediately establish an independent external review of continuing care services. This review would include a process of public consultation and participation involving experienced and independent experts in the field to:

- Recreate a plan for residential care, assisted living, supportive housing, and home health services based on the needs of frail seniors and people with disabilities;
- Conduct an evaluation of the assisted living program, its performance and structure;
- Develop a five-year strategic plan for building new community-based, non-profit residential care, assisted living, supportive housing, and home health services;
- Develop a process for ensuring the ongoing involvement of seniors and people with disabilities in decision-making on these services at the local, health authority, and provincial levels; and
- Develop a public reporting and accountability process for health authorities on home and community care (i.e. continuing care), including the requirement for regular and detailed reporting on expenditures and service utilization by population and for all programs and services.

Appendices

Appendix 1: Hospital Closures (and Beds) March 2002 to March 2004	
Health authority	**No. beds**
Interior HA	
Pleasant Valley Health Centre	13
Summerland Health Centre	21
Ashcroft and District General Hospital	16
Victorian Community Health Centre of Kaslo	5
Kimberley and District Hospital	24
Total Interior HA bed reductions due to hospital closures	79
Fraser HA	
Saint Mary's Hospital	83
Vancouver Island HA	
Port Alice Hospital	6
BC total bed reductions due to hospital closures	168

See Table 2 for additional information.

Appendix 2: Increases in BC's Population Aged 75+, 1994–2004

Year	Total BC population	Population 75+	75+ as share of total population	% Increase population 75+	10 yr % increase in population 75+
1994	3,681,750	191,695	5.2%		
1995	3,784,008	200,428	5.3%	4.6%	
1996	3,882,043	208,715	5.4%	4.1%	
1997	3,959,698	218,203	5.5%	4.5%	
1998	3,997,113	226,811	5.7%	3.9%	
1999	4,028,280	235,550	5.8%	3.9%	
2000	4,060,133	244,147	6.0%	3.6%	
2001	4,101,579	253,038	6.2%	3.6%	
2002	4,141,272	261,436	6.3%	3.3%	
2003	4,179,825	270,057	6.5%	3.3%	
2004	4,225,057	278,595	6.6%	3.2%	45%

Source: PEOPLE28 (provided by BC STATS).

Appendix 3: BC Income Statistics for Women Aged 70+, 2000								
	Total	Married	Unattached					Cumulative % of total
			Never married	Separated	Divorced	Widowed	All unattached	
All Income Levels	200,505	82,250	7,215	3,045	13,225	94,775	118,260	
No Income	590	335	10	0	15	230	255	0%
Under $5,000	1,300	315	25	15	65	870	975	1%
$5,000–9,999	26,155	25,855	10	0	30	250	290	1%
$10,000–14,999	66,905	23,175	2,010	1,490	5,305	34,915	43,720	38%
$15,000–19,999	42,480	11,220	1,370	775	3,680	25,435	31,260	65%
$20,000–24,999	19,185	6,735	755	300	1,405	9,995	12,455	75%
$25,000–29,999	12,985	4,790	630	175	790	6,605	8,200	82%
$30,000–34,999	8,815	2,930	665	100	610	4,520	5,895	87%
$35,000–39,999	6,215	1,895	420	95	465	3,335	4,315	91%
$40,000–44,999	3,735	1,170	300	30	200	2,035	2,565	93%
$45,000–49,999	3,010	970	245	20	175	1,595	2,035	95%
$50,000–59,999	3,720	1,100	310	20	200	2,085	2,615	97%
$60,000–74,999	2,445	755	240	0	90	1,360	1,690	98%
$75,000–plus	2,970	990	225	15	195	1,550	1,985	100%
Average Income	$20,404	$17,633	$27,782	$18,146	$20,861	$22,252	$22,328	
Median Income	$15,498	$12,749	$21,094	$15,018	$16,224	$16,748	n/a	
Pct. Distribution		41%	4%	2%	7%	47%	59%	

Source: Statistic Canada, Census, 2000, reference number: 97F0020XCB01040.

Appendix 4: BC Income Statistics for Men Aged 70+, 2000								
	Total	Married	Unattached					Cumulative % of total
			Never married	Separated	Divorced	Widowed	All unattached	
All Income Levels	154,270	115,090	6,645	3,280	7,445	21,805	39,175	
No Income	140	90	15	0	10	30	55	0%
Under $5,000	1,020	885	15	0	10	110	135	0%
$5,000–9,999	3,855	3,770	10	10	0	80	100	1%
$10,000–14,999	33,735	23,760	2,060	1,015	2,070	4,835	9,980	26%
$15,000–19,999	29,790	20,035	1,635	850	2,025	5,260	9,770	51%
$20,000–24,999	19,035	14,555	760	375	815	2,530	4,480	63%
$25,000–29,999	15,610	12,650	395	245	555	1,770	2,965	70%
$30,000–34,999	12,110	9,440	345	145	545	1,635	2,670	77%
$35,000–39,999	9,285	7,105	315	175	415	1,275	2,180	83%
$40,000–44,999	6,515	5,135	180	105	190	900	1,375	86%
$45,000–49,999	4,860	3,690	220	100	205	660	1,185	89%
$50,000–59,999	7,095	5,435	300	100	215	1,045	1,660	93%
$60,000–74,999	5,020	3,860	200	75	150	730	1,155	96%
$75,000–plus	6,190	4,685	210	90	240	960	1,500	100%
Average Income	$29,651	$30,087	$26,117	$28,887	$26,762	$29,828	$28,537	
Median Income	$22,107	$22,981	$18,078	$17,746	$18,336	$20,978	n/a	
Pct. Distribution		75%	4%	2%	5%	14%	25%	

Source: Statistic Canada, Census, 2000, reference number:97F0020XCB01040

Appendix 5: Research Methodology—Residential Care and Assisted Living Bed Numbers

Document analysis, internet searches, surveys and phone interviews with health authority representatives were all used to develop our database of residential care and assisted living bed numbers as of December 2004.

Starting with information from an existing Hospital Employees' Union database, which included information from BC Housing, the health authorities' web pages, and the Canadian Health Care Facilities Guide (published by the Canadian Health Care Association), surveys were sent to health authority representatives to confirm the bed numbers in the database. Telephone interviews were conducted with individual facilities and with health authority representatives when necessary to verify information.

The bed numbers provided reflect the number of beds that health authorities were officially funding. There was some fluctuation in beds as facilities were in transition due to renovations or closures, and these temporary numbers were not included—only the officially-recognized, funded beds.

Appendix 6: Notes for Table 7: Inter-provincial Comparison of Residential Care (RC) Beds and Bed Rates, 2001-2004

[a] Residential Care Beds per 1,000 population 75 and over were obtained from the Saskatchewan Survey, 2001. The rates for BC were effective June 2001. The number of 2001 residential care beds in BC was obtained from the Ministry of Health Planning, 2003, *Home and Community Care, Residential Care & Assisted Living Planning Model*.

[b] Residential Care Bed numbers for 2004 were obtained from Health Authority representatives and documents and are effective December 2004.

[c] The number of long-term care beds (includes licensed special-care home beds and long-term care beds in hospitals) at March 31 of the respective years are: 2001 – 9,240 beds; 2002 – 9,060 beds; 2003 – 8,982 beds. The numbers for 2004 are not yet finalized.

[d] Correspondence with MOH, Alberta, on Oct. 1, 2004 states: "The number of long-term care (LTC) beds has increased from 14,486 (2001) to 14,875 (2003). However, in 2003 the number of LTC beds was composed of: 14,063 (conventional LTC) and 812 (designated assisted living)." The number of LTC beds in 2003/04 is 14,263, an increase of 200 beds since 2002/03. AL beds increased from 812 in 02/03 to 1033 in 03/04. With the inclusion of the AL bed numbers in AB RC beds, the RC & AL Bed Rate per 1,000 Pop'n 75 and over becomes 101.3.

[e] Correspondence with MOH, NFLD, indicated no substantial change in LTC Bed numbers. However, the NFLD 03/04 Annual Report states that there were 2,757 Nursing Home Beds during that time period in the Health & Community Care system; using this number, the 2004 RC Beds per 1,000 Pop'n 75 and over would be 93.8. In addition, while there are no assisted living bed numbers available for NFLD, the St. John's Nursing Home Board advocates the development and implementation of assisted living alternatives (http://www.gov.nf.ca/health/guide/sjnhb.html).

[f] BC has adopted an assisted living substitution model and has introduced 1,065 AL beds since 2002. With the inclusion of these bed numbers in BC's RC beds, the RC & AL Bed Rate per 1,000 Pop'n 75 and over becomes 86.0.

[g] Estimates of Total Population, Canada, Provinces and Territories, July 1, 2004 (Preliminary post-Censal estimates).

Appendix 7: Residential Care Facilities Closed[a] Between 2001/02 and December 2004 (does not include new beds or facilities)				
Health authority	Facility name	Location	Profit/Non-Profit	Beds
Vancouver Coastal	Balfour House		Non-Profit	18
	Cooper Place	Vancouver	Non-Profit	71
	St. Vincent's Hospital – Arbutus	Vancouver	Non-Profit	75
	St. Vincent's Hospital – Heather	Vancouver	Non-Profit	75
		Non-Profit Count	4	239
	Britannia Lodge	Vancouver	Profit	45
	South Granville Park Lodge	Vancouver	Profit	110
	Southpines Private Hospital	Vancouver	Profit	32
		Profit Count	3	187
	Vancouver Coastal HA total		7	426
Vancouver Island	Alberni Lodge	Port Alberni	Non-Profit	40
	Gorge Road Hospital	Victoria	Non-Profit	288
		Non-Profit Count	2	328
	Central Island (Halliday) Independent	Parksville	Profit	20
	Shelmarie Rest Home	Victoria	Profit	21
		Profit Count	2	41
	Vancouver Island HA total		4	369
Fraser	Cascades ECU (Burnaby Hospital)	Burnaby	Non-Profit	121
	Central Park Manor	Burnaby	Non-Profit	97
	Haney Intermediate Care Centre	Maple Ridge	Non-Profit	90
	Parkholm Lodge site	Chilliwack	Non-Profit	84
	St. Mary's Hospital ECU	New Westminster	Non-Profit	25
		Non-Profit Count	5	417
	Bel Air Resthome	White Rock	Profit	31
	Bonnymuir Lodge Ltd.	Surrey	Profit	36
	Centennial Park Lodge	Surrey	Profit	23
	Grand Vu Lodge	White Rock	Profit	36
	Ladner Private Hospital	Delta	Profit	64
	Twin Cedars Lodge	Surrey	Profit	25
	Vel Rey Lodge	Langley	Profit	35
		Profit Count	7	250
	Fraser HA total		12	667
Northern	Bulkley Valley Hospital ECU	Bulkley Valley	Non-Profit	5
		Non-Profit Count	1	5
	Northern HA total		1	5

Health authority	Facility name	Location	Profit/Non-Profit	Beds
Interior	A Q'uam Care Centre	Cranbrook	Non-Profit	5
	Alexander Wing ECU (Vernon Jubilee Hospital)	Vernon	Non-Profit	75
	Boundary Lodge	Grand Forks	Non-Profit	29
	Cariboo Lodge	Williams Lake	Non-Profit	59
	Deni House (Cariboo Memorial ECU)	Williams Lake	Non-Profit	38
	Fernie District Hospital LTC Beds	Fernie	Non-Profit	8
	Fountain View ECU (Shuswap Lake Hospital)	Salmon Arm	Non-Profit	26
	Golden and District General Hospital ECU	Golden	Non-Profit	8
	Halcyon Community Home	Nakusp	Non-Profit	27
	Juniper Court ECU (Enderby Memorial)	Enderby	Non-Profit	16
	Kelowna General Hospital LTC	Kelowna	Non-Profit	2
	Kimberley and District Hospital	Kimberly	Non-Profit	18
	Kiro Manor	Trail	Non-Profit	86
	Mater Misericordiae Health Care Facility	Rossland	Non-Profit	41
	May Bennet Home	Kelowna	Non-Profit	24
	Moberly Park Manor	Revelstoke	Non-Profit	20
	Penticton Retirement Centre	Penticton	Non-Profit	101
	Pioneer Lodge	Salmon Arm	Non-Profit	75
	Pioneer Villa	Creston	Non-Profit	50
	Ponderosa Lodge	Kamloops	Non-Profit	191
	Royal Inland Hospital LTC beds	Kamloops	Non-Profit	25
	Shuswap Lake General Hospital LTC beds	Salmon Arm	Non-Profit	5
	Slocan Community Hospital	New Denver	Non-Profit	5
	St. Bartholomew's Hospital ECU	Lytton	Non-Profit	10
	Tom Uphill Memorial Home	Fernie	Non-Profit	50
		Non-Profit Count	25	994
	Country Squire Villa	Osoyoos	Profit	31
	Joseph Benjamin	Kelowna	Profit	38
	Summerland Lodge	Summerland	Profit	35
	Willowdale	Armstrong	Profit	30
	Willowhaven Private Hospital	Nelson	Profit	70
		Profit Count	5	204
	Interior HA total		30	1198
BC TOTAL			54	2665

Notes

Total Non-Profit Facilities closed is 37 or 67 per cent of total closures. Total Profit Facilities closed is 17 or 31 per cent of all closures. In terms of bed numbers, 74 per cent of beds closed were Non-Profit, while 26 per cent were Profit.

[a] As of December 2004, VIHA reported that Gorge Road no longer has funded LTC beds. However, some residents from Sandringham and James Bay Lodge have been temporarily relocated to Gorge Road while those two facilities undergo major renovations. In addition, Veronica Doyle, VIHA's director of housing and community resource development, announced on January 26, 2005 that an additional three dozen patients have taken up residence indefinitely at Gorge Road due to VIHA's chronic shortage of residential care beds. Source: Clarke, Brennan (January 26, 2005), "Gorge Road re-opened to ease care-bed shortage," Victoria News. Accessed January 31, 2005: http://www.vicnews.com/.

Similarly, the facility and bed numbers reported reflect those facilities that the health authorities are no longer funding. However, some facilities, such as Pioneer Villa in Creston, are temporarily being used to house residents during renovations or construction of another facility. Nonetheless, the health authorities consider the above facilities as closed and are not counting their bed numbers in their reports.

Appendix 8: Changes in BC Residential Care (RC) Non-Profit and For-Profit Facilities and Bed Numbers, 2001/02 to 2004/05

Health authority	Facilities 2001/02	Facilities Dec. 2004	Net change in facilities	2001/02 beds[a]	2004/05 beds[b]	Net change in beds 2001/02 to 2004/05	% reduction in beds 2001/02 to 2004/05
Non-profit facilities							
Fraser	46	47	1	5,679	5,125	-554	-10%
Interior	72	52	-20	3,756	2,782	-974	-26%
Northern	22	24	2	876	796	-80	-9%
Vancouver Coastal	48	45	-3	5,164	4,964	-200	-4%
Vancouver Island	44	42	-2	4,262	3,735	-527	-12%
Total non-profit	232	210	-22	19,737	17,402	-2,335	-12%
Non-profit as % of BC	75%	74%	85%	78%	76%	92%	
Profit facilities							
Fraser	29	30	1	1,792	1,844	52	3%
Interior	16	16	0	1,013	1,052	39	4%
Northern	1	1	0	130	116	-14	-11%
Vancouver Coastal	17	13	-4	1,927	1,624	-303	-16%
Vancouver Island	14	13	-1	821	853	32	4%
Total for-profit	77	73	-4	5,683	5,489	-194	-3%
Non-profit as % of BC	25%	26%	15%	22%	24%	8%	
BC total	309	283	-26	25,420	22,891	-2,529	-10%

Notes: [a] 2001–02 Residential Care (RC) bed numbers from Canadian Healthcare Facilities Guide, health authorities and facilities.
[b] 2004–05 Residential Care (RC) bed numbers obtained from health authority representatives and documents, and facilities, effective December 2004.

Appendix 9: Assisted Living (AL) Non-Profit and For-Profit Beds as of December 2004 and Planned to 2006-07

Health authority	Non-profit	For-profit	Total	Planned for 2005-2006/07 AL beds (non-profit and for-profit)	Total current and planned AL beds
Fraser	100	91	191	604	795
Interior	0	219	219	596	815
Northern	111	6	117	17	134
Vancouver Coastal	84	51	135	443	578
Vancouver Island	185	218	403	345	748
Total beds	480	585	1,065	2,005	3,070
% of total	45%	55%	100%		

Source: 2004–05 assisted living bed numbers obtained from health authority representatives and documents, and facilities, effective December 2004.

Appendix 10: Ten Major Corporations Involved in the Seniors' Housing and Residential Care Sector in BC

Amica Mature Lifestyles

Berwick Retirement Communities

Chartwell Senior Housing Real Estate Investment Trust*

CPAC (Care) Holdings

Diversicare

H&H Total Care Services

Holiday Retirement Corp.

Retirement Concepts

Retirement Residences Real Estate Investment Trust (REIT)*

Sunrise Senior Living

Notes: These corporations all operate in more than one jurisdiction and own or manage three or more residential care/seniors housing complexes in BC. They were identified through Internet searches and further information was obtained from their annual reports.

Appendix 11: Revenue Growth of the Five Major Publicly-Traded Companies, 1998 and 2003/04

Company	Revenues		
	1998	2003/04	% Change
CPAC (Care) Holdings	$12,617,000	$31,468,426	149%
Amica Mature Lifestyles	$18,376,560	$32,865,000	79%
Chartwell Seniors Housing REIT	N/A	$9,220,000	N/A
CPL/Retirement Residences REIT	$252,681,000	$931,793,000	269%
Total (CND)	$283,674,560	$1,005,346,426	254%
Sunrise Senior Living	US$170,700,000	US$1,188,301,000	596%

Notes:

Appendix 11 shows that in 1998, the four Canadian companies had combined revenues of $284 million; in 2003/04 these revenues increased to over $1 billion. This is an increase of over 254 per cent, or, a more than 36 per cent annual rate of growth over seven years. This considerable jump can be partially explained by the introduction of both Retirement Residences and Chartwell into the seniors' housing and long-term care sector, but even when we remove these companies from the analysis we find that revenues still grew by over 100 per cent, or 14 per cent annually.

The growth by U.S.-based Sunrise—nearly 600 per cent—is due in part to its takeover in 2003 of Marriot Senior Living and EdenCare, acquisitions that added 148 new facilities to its portfolio and alone accounted for 135 per cent growth over 2002. Also in 2003, Sunrise divested 43 properties while retaining long-term management contracts for these properties. See: http://phx.corporate-ir.net/phoenix.zhtml?c=115860&p=irol-newsArticle&ID=644219&highlight= (accessed January 3rd 2004).

Appendix 12: Summary of Changes in Acute, Residential and Home Health Care Since 2001			
British Columbia	**2000/01**	**2002/03**	**% change**
Home support hours per 1,000 seniors 75+	29,251	25,423	-13%
Home care visits per 1,000 seniors 75+	3,145	2,894	-8%
British Columbia	**2001/02**	**2003/4**	**% change**
Residential care beds per 1,000 seniors 75+	100.5	82.2	-18%
Residential care plus assisted living beds per 1,000 Seniors 75+	100.5	86	-14%
Acute care beds per 1,000 pop'n (all ages)	2.1	1.7	-19%
BC population aged 75+	253,038	278,595	+10%

Notes: Residential Care Beds for 2001/02 and 2004/05 (effective Dec. 2004) are from Health Authority Representatives, Canadian Health Care Facilities Guide, and from individual facilities. Population Data Source: PEOPLE28 (provided by BC STATS, Ministry of Finance and Corporate Relations). Acute bed numbers can vary from period to period. The numbers provided are a snapshot of the beds set up at the end of fiscal years 2001/02 and 2003/04 respectively. Home Support and Home Nursing utilization for all ages from 1998/1999 to 2002/2003 from PURRFECT Version 8.1, CCASUR – Cont. Care Age-Standardized Util. Rates Version 9i, Report date: October 21, 2004. Data for 2003/04 not available.

Appendix 13: Funding to Health Authorities, 2000/01 to 2003/04						
Health authority or board	**1999/2000**	**2000/2001**	**2001/2002[a,b]**	**2002/2003[c,d]**	**2003/2004**	**% change 2000/01 to 2003/04**
Fraser	$1,045,888,061	$1,195,575,705	$1,288,159,354	$1,360,209,985	$1,406,945,601	18%
Interior	$689,516,003	$786,117,956	$835,482,803	$913,862,207	$939,185,170	19%
Northern	$238,645,972	$270,663,809	$290,110,577	$317,113,248	$326,036,378	20%
Vancouver Coastal	$1,702,627,740	$1,934,255,937	$2,031,489,618	$1,661,208,434	$1,706,762,810	-12%
Vancouver Island	$771,943,799	$868,999,274	$945,344,255	$988,038,915	$1,018,170,715	17%
Provincial Health Services	$141,783,366	$146,598,005	$231,268,022	$818,648,172	$871,040,540	494%
Nisga'a Valley Health Board	$674,865	$780,107	$709,377	$ 643,690	$643,690	-17%
To be distributed					$13,000,000	
Total funding allocations	$4,591,079,806	$5,202,990,793	$5,622,564,006	$6,059,724,651	$6,281,784,904	21%

Notes attached by the Ministry of Health Services:

The above figures include base and one time budget allocations.

The 2003/04 figures agree to the most recent funding letter dated February 4, 2004 plus $13 M yet to be distributed.

[a] In 2001/02, the 52 former HAs amalgamated into five HAs; in 2001/02, BC Centre for Disease Control was released from Vancouver/Richmond Health Board and amalgamated with PHSA.

[b] In 2002/03, the HAs transferred $470.2m in Tertiary Programs and $18.2m in Acute Programs to the PHSA. Most of this funding ($422.5m) transferred from VCHA to PHSA.

[c] In 2002/03, the MOHS transferred approx $339m in centrally administered programs to the HAs/PHSA. These Programs included BCCDC, BCMHS, Forensic, Addictions, BC Transplant, HIV/AIDS and Aboriginal.

[d] It is anticipated that an additional $13m will be distributed in 2003/04.

Appendix 14: Survey of Corporate Private Residential Care and Assisted Living Facilities in BC

Telephone survey conducted between September 2004 and January 2005.

Response rate: 24 of 27 facilities

The research protocol was reviewed and approved by the Simon Fraser University Ethics Review Board in 2004.

Survey instrument:

What levels of care do you provide?

Do you have any assisted living units?

How many beds do you have in total?

How many beds are allocated to assisted living (if relevant)?

What are your charges/fees for each level of care?

Are there additional services available for additional costs? If so, what are these services and what do they cost? Can I get a price-list?

Appendix 15: Changes in Residential Care (RC), Assisted Living (AL) and Acute Care (AC) Beds 2001–2004, by Municipality										
Location	Residential care beds		Assisted living beds	Residential care and assisted living beds combined			Acute care beds			
	2001/02	Dec 2004	Dec 2004	Dec 2004	Net change 2001–04	% change	2001/02	2003/04	Net change 2001–04	% change
BC total	25,420	22,891	1,065	23,956	-1,464	-5.8%	8,590	7,311	-1,279	-14.9%
Interior HA	4,769	3,834	219	4,053	-716	-15.0%	1,596	1,209	-387	-24.2%
East Kootenay HSDA	554	377	33	410	-144	-26.0%	233	129	-104	-44.6%
Elkford	0	0	0	0	-	-	0	0	-	-
Fernie	58	50	0	50	-8	-13.8%	68	20	-48	-70.6%
Sparwood	0	0	0	0	-	-	12	12	0	0.0%
Cranbrook	167	120	25	145	-22	-13.2%	78	65	-13	-16.7%
Kimberley	78	51	0	51	-27	-34.6%	24	0	-24	-100.0%
Invermere	40	20	8	28	-12	-30.0%	15	8	-7	-46.7%
Radium Hot Springs	0	0	0	0	-	-	0	0	-	-
Creston	173	110	0	110	-63	-36.4%	21	16	-5	-23.8%
Golden	38	26	0	26	-12	-31.6%	15	8	-7	-46.7%
Kootenay Boundary HSDA	751	503	41	544	-207	-27.6%	207	146	-61	-29.5%
Kaslo	20	20	0	20	0	0.0%	5	0	-5	-100.0%
Nelson	188	117	0	117	-71	-37.8%	45	30	-15	-33.3%
Salmo	0	0	0	0	-	-	0	0	-	-
Slocan	0	0	0	0	-	-	5	5	0	0.0%
Castlegar	105	105	15	120	15	14.3%	30	30	0	0.0%
Nakusp	31	8	0	8	-23	-74.2%	13	6	-7	-53.8%
New Denver	35	30	0	30	-5	-14.3%	0	0	-	-
Silverton	0	0	0	0	-	-	0	0	-	-
Fruitvale	0	0	0	0	-	-	0	0	-	-
Montrose	0	0	0	0	-	-	0	0	-	-
Rossland	41	0	0	0	-41	-100.0%	0	0	-	-
Trail	235	156	26	182	-53	-22.6%	85	63	-22	-25.9%
Warfield	0	0	0	0	-	-	0	0	-	-
Grand Forks	96	67	0	67	-29	-30.2%	24	12	-12	-50.0%
Greenwood	0	0	0	0	-	-	0	0	-	-
Midway	0	0	0	0	-	-	0	0	-	-

Location	Residential care beds		Assisted living beds	Residential care and assisted living beds combined			Acute care			
	2001/02	Dec 2004	Dec 2004	Dec 2004	Net change 2001–04	% change	2001/02	2003/04	Net change	% change
Okanagan HSDA	2,458	2,134	113	2,247	-211	-8.6%	657	596	-61	-9.3%
Oliver	126	126	33	159	33	26.2%	28	18	-10	-35.7%
Osoyoos	83	52	0	52	-31	-37.3%	0	0	-	-
Penticton	389	369	0	369	-20	-5.1%	122	119	-3	-2.5%
Keremeos	25	25	0	25	0	0.0%	0	0	-	-
Princeton	36	37	0	37	1	2.8%	10	6	-4	-40.0%
Armstrong	70	40	0	40	-30	-42.9%	13	0	-13	-100.0%
Spallumcheen	0	0	0	0	-	-	0	0	-	-
Coldstream	0	0	0	0	-	-	0	0	-	-
Lumby	0	0	0	0	-	-	0	0	-	-
Vernon	422	331	23	354	-68	-16.1%	140	123	-17	-12.1%
Kelowna	1,064	962	57	1,019	-45	-4.2%	323	330	7	2.2%
Lake Country	32	32	0	32	0	0.0%	0	0	-	-
Peachland	0	0	0	0	-	-	0	0	-	-
Summerland	164	129	0	129	-35	-21.3%	21	0	-21	-100.0%
Enderby	47	31	0	31	-16	-34.0%	0	0	-	-
Thompson Cariboo Shuswap HSDA	1,006	820	32	852	-154	-15.3%	499	338	-161	-32.3%
Revelstoke	48	28	0	28	-20	-41.7%	23	10	-13	-56.5%
Salmon Arm	207	176	0	176	-31	-15.0%	54	40	-14	-25.9%
Sicamous	0	0	0	0	-	-	0	0	-	-
Chase	0	0	20	20	20	n/a	0	0	-	-
Kamloops	491	371	0	371	-120	-24.4%	266	218	-48	-18.0%
Logan Lake	0	0	0	0	-	-	0	0	-	-
100 Mile House	90	90	12	102	12	13.3%	27	16	-11	-40.7%
Clearwater	0	21	0	21	21	n/a	10	6	-4	-40.0%
Williams Lake	97	66	0	66	-31	-32.0%	46	24	-22	-47.8%
Lillooet	22	22	0	22	0	0.0%	22	6	-16	-72.7%
Ashcroft	16	21	0	21	5	31.3%	16	0	-16	-100.0%
Cache Creek	0	0	0	0	-	-	0	0	-	-
Clinton	0	0	0	0	-	-	0	0	-	-
Lytton	10	0	0	0	-10	-100.0%	10	10	0	0.0%
Merritt	25	25	0	25	0	0.0%	25	8	-17	-68.0%

Location	Residential care beds		Assisted living beds	Residential care and assisted living beds combined			Acute care			
	2001/02	Dec 2004	Dec 2004	Dec 2004	Net change	% change	2001/02	2003/04	Net change 2001–04	% change
Fraser HA	7,471	6,969	191	7,160	-311	-4.2%	2,138	1,681	-457	-21.4%
Fraser East HSDA	1,392	1,362	25	1,387	-5	-0.4%	325	326	1	0.3%
Hope	46	46	10	56	10	21.7%	6	10	4	66.7%
Chilliwack	439	372	0	372	-67	-15.3%	115	104	-11	-9.6%
Abbotsford	753	770	5	775	22	2.9%	162	192	30	18.5%
Mission	154	174	0	174	20	13.0%	42	20	-22	-52.4%
Harrison Hot Springs	0	0	0	0	-	-	0	0	-	-
Kent	0	0	10	10	10	n/a	0	0	-	-
Fraser North HSDA	3,351	2,878	146	3,024	-327	-9.8%	948	638	-310	-32.7%
New Westminster	511	487	0	487	-24	-4.7%	487	327	-160	-32.9%
Burnaby	1,676	1,408	100	1,508	-168	-10.0%	243	185	-58	-23.9%
Maple Ridge	398	325	46	371	-27	-6.8%	113	67	-46	-40.7%
Pitt Meadows	0	0	0	0	-	-	0	0	-	-
Anmore	0	0	0	0	-	-	0	0	-	-
Belcarra	0	0	0	0	-	-	0	0	-	-
Coquitlam	452	452	0	452	0	0.0%	105	59	-46	-43.8%
Port Coquitlam	239	131	0	131	-108	-45.2%	0	0	-	-
Port Moody	75	75	0	75	0	0.0%	0	0	-	-
Fraser South HSDA	2,728	2,729	20	2,749	21	0.8%	865	717	-148	-17.1%
Langley	619	650	0	650	31	5.0%	200	166	-34	-17.0%
Surrey	940	1,026	0	1,026	86	9.1%	416	370	-46	-11.1%
White Rock	694	544	0	544	-150	-21.6%	183	146	-37	-20.2%
Delta	475	509	20	529	54	11.4%	66	35	-31	-47.0%
Vancouver Coastal HA	7,091	6,588	135	6,723	-368	-5.2%	2,262	2,104	-158	-7.0%
Richmond HSDA	681	647	0	647	-34	-5.0%	208	163	-45	-21.6%
Richmond	681	647	0	647	-34	-5.0%	208	163	-45	-21.6%
Vancouver HSDA	4,738	4,335	117	4,452	-286	-6.0%	1,622	1,482	-140	-8.6%
Vancouver	4,738	4,335	117	4,452	-286	-6.0%	1,622	1,482	-140	-8.6%
North Shore/Coast Garibaldi HSDA	1,672	1,606	18	1,624	-48	-2.9%	432	459	27	6.3%
North Vancouver	776	712	0	712	-64	-8.2%	309	309	0	0.0%
Lions Bay	0	0	0	0	-	-	0	0	-	-
West Vancouver	523	521	0	521	-2	-0.4%	0	0	-	-
Bowen Island	0	0	0	0	-	-	0	0	-	-
Gibsons	38	38	18	56	18	47.4%	0	0	-	-
Sechelt	111	111	0	111	0	0.0%	33	66	33	100.0%
Sechelt Ind. Gov Dist	0	0	0	0	-	-	0	0	-	-
Powell River	156	156	0	156	0	0.0%	39	33	-6	-15.4%
Pemberton	0	0	0	0	-	-	0	0	-	-
Squamish	61	61	0	61	0	0.0%	25	25	0	0.0%
Whistler	0	0	0	0	-	-	0	0	-	-
Bella Coola	0	0	0	0	-	-	10	10	0	0.0%
Waglisla	7	7	0	7	0	0.0%	16	16	0	0.0%

Location	Residential care beds		Assisted living beds	Residential care and assisted living beds combined			Acute care			
	2001/02	Dec 2004	Dec 2004	Dec 2004	Net change 2001–04	% change	2001/02	2003/04	Net change 2001–04	% change
Vancouver Island HA	5,083	4,588	403	4,991	-92	-1.8%	1,621	1,480	-141	-8.7%
South Vancouver Island HSDA	3,148	2,658	224	2,882	-266	-8.4%	975	914	-61	-6.3%
Esquimalt	0	0	12	12	12	n/a	0	0	-	-
Oak Bay	0	0	12	12	12	n/a	0	0	-	-
Victoria	2,789	2,304	101	2,405	-384	-13.8%	905	848	-57	-6.3%
View Royal	0	0	0	0	-	-	0	0	-	-
Colwood	0	0	10	10	10	n/a	0	0	-	-
Sooke	0	0	0	0	-	-	0	0	-	-
Highlands	0	0	0	0	-	-	0	0	-	-
Langford	0	0	0	0	-	-	0	0	-	-
Metchosin	0	0	0	0	-	-	0	0	-	-
Saanich	150	146	50	196	46	30.7%	51	48	-3	-5.9%
Sidney	127	127	29	156	29	22.8%	0	0	-	-
Salt Spring Island	82	81	10	91	9	11.0%	19	18	-1	-5.3%
Central Vancouver Island HSDA	1,451	1,438	91	1,529	78	5.4%	430	385	-45	-10.5%
Duncan	253	213	0	213	-40	-15.8%	105	82	-23	-21.9%
North Cowichan	74	75	0	75	1	1.4%	0	0	-	-
Lake Cowichan	0	0	0	0	-	-	0	0	-	-
Ladysmith	31	49	16	65	34	109.7%	22	14	-8	-36.4%
Nanaimo	479	558	75	633	154	32.2%	241	236	-5	-2.1%
Parksville	185	158	0	158	-27	-14.6%	0	0	-	-
Qualicum Beach	161	161	0	161	0	0.0%	0	0	-	-
Port Alberni	233	189	0	189	-44	-18.9%	52	43	-9	-17.3%
Shawnigan Lake	35	35	0	35	0	0.0%	0	0	0	
Tofino	0	0	0	0	-	-	10	10	0	0.0%
Ucluelet	0	0	0	0	-	-	0	0	-	-
North Vancouver Island HSDA	484	492	88	580	96	19.8%	216	181	-35	-16.2%
Comox	125	125	0	125	0	0.0%	0	0	-	-
Courtenay	126	127	88	215	89	70.6%	109	96	-13	-11.9%
Cumberland	76	72	0	72	-4	-5.3%	0	0	-	-
Campbell River	138	148	0	148	10	7.2%	70	59	-11	-15.7%
Sayward	0	0	0	0	-	-	0	0	-	-
Gold River	0	0	0	0	-	-	0	0	-	-
Tahsis	0	0	0	0	-	-	0	0	-	-
Alert Bay	9	10	0	10	1	11.1%	6	4	-2	-33.3%
Port Alice	0	0	0	0	-	-	6	0	-6	-100.0%
Port Hardy	10	10	0	10	0	0.0%	15	12	-3	-20.0%
Port McNeill	0	0	0	0	-	-	10	10	0	0.0%
Zeballos	0	0	0	0	-	-	0	0	-	-

Location	Residential care beds		Assisted living beds	Residential care and assisted living beds combined			Acute care			
	2001/02	Dec 2004	Dec 2004	Dec 2004	Net change 2001–04	% changes	2001/02	2003/04	Net change 2001–04	% change
Northern HA	1,006	912	117	1,029	23	2.3%	697	558	-139	-19.9%
Northwest HSDA	258	247	26	273	15	5.8%	195	143	-52	-26.7%
Masset	16	16	0	16	0	0.0%	4	4	0	0.0%
Queen Charlotte	0	0	0	0	-	-	13	8	-5	-38.5%
Stewart	0	0	0	0	-	-	3	3	0	0.0%
Port Edward	0	0	0	0	-	-	0	0	-	-
Prince Rupert	73	53	5	58	-15	-20.5%	41	31	-10	-24.4%
Hazelton	4	4	0	4	0	0.0%	28	15	-13	-46.4%
New Hazelton	0	0	0	0	-	-	0	0	-	-
Houston	0	0	0	0	-	-	0	0	-	-
Smithers[a]	55	69	0	69	14	25.5%	32	25	-7	-21.9%
Telkwa	0	0	0	0	-	-	0	0	0	
Kitimat	35	35	0	35	0	0.0%	22	18	-4	-18.2%
Dease Lake	0	0	0	0	-	-	0	0	-	-
Terrace	75	70	21	91	16	21.3%	52	39	-13	-25.0%
New Aiyansh	0	0	0	0	-	-	0	0	-	-
Telegraph Creek	0	0	0	0	-	-	0	0	-	-
Northern Interior HSDA	497	443	46	489	-8	-1.6%	340	283	-57	-16.8%
Quesnel	115	107	6	113	-2	-1.7%	38	31	-7	-18.4%
Wells	0	0	0	0	-	-	0	0	-	-
Burns Lake	30	34	0	34	4	13.3%	26	13	-13	-50.0%
Granisle	0	0	0	0	-	-	0	0	-	-
Fort St. James	0	3	0	3	3	n/a	15	6	-9	-60.0%
Fraser Lake	0	0	0	0	-	-	0	0	-	-
Vanderhoof	41	38	0	38	-3	-7.3%	27	24	-3	-11.1%
Mackenzie	0	0	0	0	-	-	12	5	-7	-58.3%
McBride	8	8	0	8	0	0.0%	8	3	-5	-62.5%
Prince George	303	253	40	293	-10	-3.3%	214	201	-13	-6.1%
Valemount	0	0	0	0	-	-	0	0	-	-
Northeast HSDA	251	222	45	267	16	6.4%	162	132	-30	-18.5%
Chetwynd	0	5	0	5	5	n/a	11	5	-6	-54.5%
Dawson Creek	43	44	10	54	11	25.6%	62	58	-4	-6.5%
Pouce Coupe	114	81	0	81	-33	-28.9%	0	0	-	-
Tumbler Ridge	0	0	0	0	-	-	0	0	-	-
Fort St. John	94	85	35	120	26	27.7%	64	44	-20	-31.3%
Hudson's Hope	0	0	0	0	-	-	0	0	-	-
Taylor	0	0	0	0	-	-	0	0	-	-
Fort Nelson	0	7	0	7	7	n/a	25	25	0	0.0%
Provincial Health Services Authority	n/a	n/a	n/a	n/a	n/a	n/a	276	279	3	1.1%

Notes: [a] Smithers: Bulkley Lodge total of 69 beds includes 14 Riverview beds.
2001-02 residential care (RC) bed numbers from Canadian Healthcare Facilities Guide, health authorities and facilities. 2004-05 residential care (RC) bed numbers obtained from health authority representatives and documents, and facilities, effective December 2004. BC Ministry of Health Services, Data source: OASIS/HAMIS as of September 2004, Prepared by Knowledge Management and Technology Division. Information Resource Management. HSDA is the acronym for "Health Service Delivery Area."

Notes

[1] Justice Peter D. Seaton et al., 1991, *Closer to Home: The Report of the British Columbia Royal Commission on Health Care and Costs,* Volume 2, Victoria: Crown Publications.

[2] Ibid., B 49–55.

[3] D. Vogel, 2000, "Unfulfilled Promise: How Health Care Reforms of the 1990s are Failing Community and Continuing Care in BC," in M. Cohen and N. Pollack (Eds.) *Without Foundation: How Medicare is Undermined by Gaps and Privatization in Community and Continuing Care,* Vancouver, BC: Canadian Centre for Policy Alternatives, pp. 37-38.

[4] HEU News Release, December 14, 1999, "Emergency Room Crisis Highlights Critical Need to Improve Seniors Health Care Services."

[5] In 1999, the Ministry of Health staff prepared a 10-year projection for residential care beds from 2000 to 2010. The MoH planners concluded that to meet the projected demand and utilization, 4,495 long-term residential care beds were needed in 2001/02 with an additional 1,000 to 1,400 each subsequent year. This plan was reported in Ministry of Health, Continuing Care Model Working Group, *Continuing Care Residential Services Planning Model,* September 24, 1999.

[6] BC Ministry of Health Planning, December 2002, *The picture of health: How we are modernizing British Columbia's health care system.*

[7] Ministry of Health, April 15, 2002, *Home and Community Care Policy Manual: Residential Care Services,* http://www.interiorhealth.ca/NR/rdonlyres/E1740D23-3F22-4322-8F2D-41B3572C0D6E/1639/chapter061.pdf.

[8] Statistics Canada, December 2002, "A Profile of Disability in Canada, 2001," Ottawa: Ministry of Industry, Catalogue number: 89-577-XIE, pp. 7-8.

[9] D. Vogel, 2000, "Unfulfilled Promise: How Health Care Reforms of the 1990s are Failing Community and Continuing Care in BC," in M. Cohen and N. Pollack (Eds.) *Without Foundation: How Medicare is Undermined by Gaps and Privatization in Community and Continuing Care,* Vancouver, BC: Canadian Centre for Policy Alternatives, pp. 37-38.

[10] The 2000 Census provides the most recent reliable income data. Since 2000, the CPP pension rate increased by 9 per cent. The OAS rate is up 12 per cent. However, most private investment incomes have either remained flat or decreased.

[11] D. Vogel, 2000, "Unfulfilled Promise: How Health Care Reforms of the 1990s are Failing Community and Continuing Care in BC," in M. Cohen and N. Pollack (Eds.) *Without Foundation: How Medicare is Undermined by Gaps and Privatization in Community and Continuing Care,* Vancouver, BC: Canadian Centre for Policy Alternatives, p. 38.

[12] M. Cohen, January 24, 2003, A Dramatic Reversal of Policy on Long-Term Care, *In Health Care Restructuring in BC,* Vancouver: Canadian Centre for Policy Alternatives, pp. 13-18.

[13] Ibid.

[14] April 19, 2004, page 10.

[15] April 19, 2004, page 12.

[16] Capital Regional District, *Minutes of Meeting of the Health Facilities Planning Committee,* October 20, 2004, Victoria, BC, accessed February 3, 2005 at: http://www.crd.bc.ca/minutes/healthfacilitie_/2004_/hfoct20finalmin/HFOct20FinalMinutes.pdf.

[17] Note 1: (95.7- 83.4)/95.7 = 13%. 13% x 22,891 (Table 4, 2004/5 residential beds) = 2,924.
Note 2: The bed rates and percentages in Table 7 vary slightly from the same information in Table 5 and 6 because in Table 7, estimates of total population for Canada, provinces and territories, were obtained from Statistics Canada, effective July 1, 2004 and were based on preliminary post-Census estimates. The population numbers used in Table 5 were obtained from PEOPLE28 (provided by BC STATS, Ministry of Finance and Corporate Relations) and are more accurate for BC, but could not be used in Table 7 because they did not include population numbers for Canada or other provinces.

[18] (95.7- 83.4 +3.8)/95.7 = 9%. 9% x 22,891 (Table 4, 2004/5 residential care beds) =2,033.

[19] Ministries of Health Planning and Health Services, January 2003, *Meeting the Ongoing Care Needs of Seniors and People with Disabilities, A Planning Model: Home Support, Assisted Living and Residential Care Services*, p. 9.

[20] BC Ministry of Health Planning, December 2002, *The Picture of Health: How we are modernizing British Columbia's health care system,* p. 34.
http://www.healthservices.gov.bc.ca/cpa/publications/picture_of_health.pdf.

[21] Ibid.

[22] Y. Araki and G. Gutman, October 23, 2004, "Clients and Services in Assisted Living Settings in British Columbia," presentation at the 33rd Annual Scientific and Educational Meeting, Canadian Association on Gerontology. Araki and Gutman surveyed 47 per cent (41 of 88) of assisted living settings that they identified through reference to two current professional directories.

[23] Ibid, p. 4.

[24] VIHA, *Capital Regional District Staff Report to the Health Facilities Planning Committee Meeting of Wednesday, February 16, 2005, Attachment 1: Assisted Living Review, Summary of Basic Findings and Conclusions*, p. 2.

[25] Jane Gross, January 30, 2005, "One Roof, Aging Together Yet Alone," *New York Times*.

[26] In publicly-funded residential care, individuals pay from approximately $27 a day or $810 a month to $65 a day or $1,950 a month, depending on their income. The minimum rate of $27 is set at approximately 85 per cent of Old Aged Supplement (OAS) and the Guaranteed Income Supplement (GIS). For publicly-subsidized assisted living, individuals pay no more than 70 per cent of their income.

[27] VIHA, Capital Regional District Staff Report to the Health Facilities Planning Committee Meeting of Wednesday, February 16, 2005, p. 4.

[28] Charlene Harrington, "Does Investor Ownership of Nursing Homes Compromise the Quality of Care," *American Journal of Public Health*, 2001, Vol. 91, No. 9, p. 1453. "Quality of care" deficiencies were outcome and process measures directly related to resident care (assessments, infection control, and nursing, physician, dietary, rehabilitative, dental and pharmacy services). "Quality of life" deficiencies included those concerned with patient dignity and choice (use of restraints, transfer and discharge policies), the physical environment (facility cleanliness), and the provision of social and recreation services.

[29] Evelyn Shapiro and Robert B. Tate, "Monitoring the Outcomes of Quality of Care in Nursing Homes Using Administrative Data," *Canadian Journal on Aging,* 1995, Vol. 14, No. 4, pp. 755-768.

[30] M.J. McGregor et al., March 1, 2005, "Staffing levels in long-term care facilities in British Columbia: Does ownership matter?" *Canadian Medical Association Journal,* 172, pp. 645-649.

[31] N. Pollak, 2000, "Cutting Home Support: From 'Closer to Home' to 'All Alone,'" in M. Cohen and N. Pollack (Eds.) *Without Foundation: How Medicare is undermined by gaps and privatization in Community and Continuing Care,* Vancouver, BC: Canadian Centre for Policy Alternatives, pp. 87-147.

[32] D. Vogel, 2000, "Unfulfilled Promise: How Health Care Reforms of the 1990s are Failing Community and Continuing Care in BC," in M. Cohen and N. Pollack (Eds.) *Without Foundation: How Medicare is Undermined by Gaps and Privatization in Community and Continuing Care,* Vancouver, BC: Canadian Centre for Policy Alternatives, pp. 37-38.

[33] VIHA, Capital Regional District Staff Report to the Health Facilities Planning Committee Meeting of Wednesday, February 16, 2005.

[34] BC Ministry of Health Planning, December 2002, *The Picture of Health: How we are modernizing British Columbia's health care system,* cover page.

[35] VIHA, *Capital Regional District Staff Report to the Health Facilities Planning Committee Meeting of Wednesday, February 16, 2005, Attachment 3: Assisted Living Review Executive Summary,* p. 1,

[36] IHA, *Interior Health Financial Report – Executive Summary YTD to September 9, 2004 (Period 6),* p. 9. Accessed February 17, 2005 at: http://www.interiorhealth.ca/NR/rdonlyres/AE1DED05-4CF5-43A3-9B54-17D15A83F7E1/1801/Period60405IHFinancialStatements1.pdf.

[37] IHA, August 30, 2004, *Okanagan Health Service Area COO Report,* p. 9, accessed February 17, 2005: http://www.interiorhealth.ca/NR/rdonlyres/7A3ED5F8-FF13-4956-84CA-0DE1429FEF23/1424/OKANAGANCOOReportAug30_05.pdf.

[38] Cost estimates were based on institutional estimates from a fully-allocated cost model at Vancouver Hospital. Estimates produced by Dean Regier, Health Economist, Centre for Clinical Epidemiology and Evaluation, Vancouver Coastal Research Institute, 2005.

[39] Capital Regional District Staff Report to the Health Facilities Planning Committee Meeting of Wednesday, February 16, 2005, Attachment 1: Assisted Living Review, Summary of Basic Findings and Conclusions, p. 2.

[40] Capital Regional District Staff Report to the Health Facilities Planning Committee Meeting of Wednesday, February 16, 2005, p. 4.

[41] Ibid., Attachment 1: Assisted Living Review, Summary of Basic Findings and Conclusions.

[42] Ibid.

[43] The report was unofficially provided to the research project; repeated requests to obtain the report directly from the Ministry of Health were unsuccessful.

[44] Ibid. p. 1.

[45] BC Ministry of Health Services, November, 2004, *Toward a Better Health Care for British Columbians*, p. I, accessed February 2, 2005 at: http://www.healthservices.gov.bc.ca/cpa/publications/better-healthcare_2004.pdf.

[46] D. Vogel, 2000, "Unfulfilled Promise: How Health Care Reforms of the 1990s are Failing Community and Continuing Care in BC," in M. Cohen and N. Pollack (Eds.) *Without Foundation: How Medicare is Undermined by Gaps and Privatization in Community and Continuing Care,* Vancouver, BC: Canadian Centre for Policy Alternatives, pp. 28.

[47] VIHA, Capital Regional District Staff Report to the Health Facilities Planning Committee Meeting of Wednesday, February 16, 2005, p. 6.

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