

Health Care Restructuring in BC

Sylvia Fuller

Colleen Fuller

Marcy Cohen

A CCPA POLICY BRIEF

JANUARY 2003



**CANADIAN CENTRE FOR POLICY
ALTERNATIVES — BC OFFICE**

Health Care Restructuring in BC

About the authors

Sylvia Fuller is a researcher with Canadian Centre for Policy Alternatives — BC Office. Her areas of specialization at the Centre are the public sector and public services in BC. She holds an MA in sociology from Dalhousie University and is a PhD candidate in sociology at Rutgers University.

Colleen Fuller is a health policy consultant, author, and a research associate with the CCPA-BC. She is the author of *Caring for Profit*, published by the CCPA and New Star Books in 1998, and co-author of *Exposing Privatization: Women and Health Care Reform in Canada*, published by Garamond Press in November 2001.

Marcy Cohen has worked as the Senior Research and Policy Planner for the Hospital Employees' Union for seven years. In that capacity, she has been involved in a number of research projects on health policy issues related to long term and continuing care, and was a member of the Steering Committee for the Ministry of Health's Review of Continuing Care Services in 1999. Marcy is also a research associate and board member with the CCPA.

The content, opinions and any errors in this paper are those of the authors.

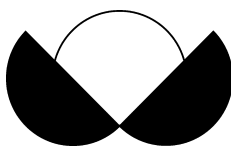
Contents

Introduction by Sylvia Fuller	3
Why private medicine is bad for your health by Colleen Fuller	7
A dramatic reversal of policy on long-term care by Marcy Cohen	13

The CCPA would like to thank the Columbia Foundation for its financial support of this work.

CCPA National Office

410—75 Albert Street
Ottawa, Ontario K1P 5E7
tel: 613-563-1341
fax: 613-233-1458
email: ccpa@policyalternatives.ca



Canadian Centre for Policy Alternatives

BC Office

1400—207 West Hastings Street
Vancouver, BC V6B 1H7
tel: 604-801-5121
fax: 604-801-5122
email: info@bcpolicyalternatives.org

Please make a donation...

Help us continue to offer our publications free on-line.

We make most of our publications available free on our website. Making a donation or taking out a membership will help us continue to provide people with access to our ideas and research free of charge.

You can make a donation or become a member on-line at www.policyalternatives.ca, or you can print and fill out the form at the back of this publication. Or you can contact the BC office at (604) 801-5121 for more information.

Suggested donation for this publication: \$5 or whatever you can afford.

INTRODUCTION

Health care restructuring in BC

by Sylvia Fuller

THE BC HEALTH CARE SYSTEM HAS ENTERED A PERIOD OF UPHEAVAL. ALL AROUND the province, changes are being made to what health care services are available and how they are delivered. Health care “reform” is a hot topic, and it is easy for politicians to claim that radical changes must be made. But are the changes that we are currently seeing in BC the right medicine for the health care system? The recently released Romanow report, based on extensive research and consultation with Canadians, sets out one path for improving our system—more money, faster and more comprehensive services, less for-profit involvement in health care. While not perfect, it is a hopeful first step, and it has the support of most Canadians.

At the most basic level, health care reorganization in BC involves two main trends: reductions in service, and privatization.

But the BC government is taking a very different route, cutting services and increasing the role of profit in our health system, despite the fact that most British Columbians heartily disapprove. As the following pieces demonstrate, British Columbians are right to be suspicious.

What is happening to health care in BC?

On April 23, 2002, BC's Health Ministers and the leaders of the province's six new health authorities jointly announced their plans to re-organize health care delivery in BC. At the most basic level, this reorganization involves two main trends: reductions in service, and privatization.

Health care coverage has been reduced in a number of ways, including:

- The elimination of coverage for supplementary therapies such as physiotherapy, chiropractic, massage therapy and routine eye exams from the Medical Services Plan (MSP) and reduced coverage for those with MSP premium assistance;
- The closure of numerous hospitals and long-term care facilities and the reduction of services and beds in others;
- Restrictions in the subsidy most seniors received to help cover their drug costs;
- The elimination of housekeeping services from the home care services received by the disabled and frail elderly;

The reduction in publicly-available medical care is in turn being accompanied by an expansion of private participation in the health care system.

- Public-private partnerships (P3s) are proposed for a privately financed and operated \$90 million ambulatory care centre near Vancouver General Hospital, and for a new hospital in Abbotsford;
- Non-medical services such as laundry and cleaning are being contracted out in hospital after hospital;
- After the Interior Health Authority closed Kimberley's hospital, the City bought the hospital from the province for less than 14 per cent of its assessed value and invited a for-profit surgical centre to move in and provide services; and
- After cutting operating rooms and surgical time in the public system, the province is proposing to fund a private hospital in Kelowna to provide surgical services.

Faced with higher out-of-pocket costs, many British Columbians of low to moderate means will simply go without treatment and therapies that are no longer covered by MSP.

It is hard to imagine how any of these changes will actually improve health services and outcomes. Indeed, the reverse is likely true. Faced with higher out-of-pocket costs, many British Columbians of low to moderate means will simply go without treatment and therapies that are no longer covered by MSP. Rural residents with urgent medical needs may arrive too late to be helped because they have been forced to make long commutes to receive care. Many of the seniors and disabled people pushed out of long-term care facilities and those losing vital home support services may find their health deteriorates as a consequence. Those forced to seek care from for-profit centres may also suffer unnecessarily—for-profit health care is associated with worse health outcomes, including higher mortality.¹

Cutting costs or cost-shifting? The false economy of BC's reforms

To any but the most biased observer, it is clear that most of the so-called “reforms” are not about improving health services at all, but simply about cutting costs. Many of these reforms do not actually *reduce* costs, they simply *shift* them on to other shoulders. When governments spend less for health care, individual British Columbians, their families and employers end up bearing the burden instead.

Equally problematic is the fact that many of the cost “savings” for one part of the health system appear to be predicated on shifts to other parts of the system that are also experiencing cutbacks. For example, small rural hospitals are closed with the assumption that individuals will seek care at regional centres or provincial facilities such as Women’s and Children’s—but these regional and provincial centres are themselves faced with decreased, not increased, bed capacity. Seniors are forced out of long-term care facilities, but adequate services to support them at home are unavailable. Taken in isolation, some plans of individual health authorities may seem reasonable, but as a whole, they simply do not add up to a good plan for health care in BC.

Moreover, because so many of the cost “savings” are actually cost shifts, they ultimately create false economies (meaning they may in fact cost money down the road), undermining both efficiency and equity. To give but a few examples:

- Cutting Pharmacare may not save the health care system money, and it will likely increase overall drug costs. The government has claimed BC’s public plan was more generous than in any other province. But combined private *and* public per capita drug expenditures were actually the lowest in Canada. Because we paid for a larger share of drugs collectively, British Columbians reaped the benefits of government’s ability to control costs through bulk purchasing and other strategies such as the Reference Drug Program. We lose these efficiencies when we cut Pharmacare coverage. We also risk making people sicker, and increasing costs in other parts of the health care system as a result. When Québec raised the cost of prescriptions for those on social assistance and the elderly, fewer patients took the drugs they were prescribed. More people got sick, resulting in increased visits to expensive emergency rooms.²
- Cutting long-term care beds and cancelling important forms of home support will ultimately send more people to the (already overstressed) hospitals at much greater cost. According to the Ministry of Health, about 13 per cent of acute care patients in BC hospitals are only there because of a lack of long-term, rehabilitation, or community services. This is now bound to get worse. Among other effects, it will increase the surgery waiting lists for other patients.
- Public-private partnerships do not save money. They may make the government’s books look better in the short run by ensuring that the debt associated

To any but the most biased observer, it is clear that most of the so-called “reforms” are not about improving health services at all, but simply about cutting costs.

with new capital costs stays off the government's balance sheets, but these costs are built into the annual charges government pays the private partners. Because governments can borrow money more cheaply than the private sector, and because the private sector requires a profit margin, the sum total of these annual charges is generally much higher than what the government would have paid had it simply undertaken the project itself.

- Profit margins and greater costs for administration and marketing make for-profit health provision in general more costly than the public alternative.
- Contracting-out can also be costly. Estimated cost savings from contracting-out often do not include the cost of administering and supervising contracts, which must still be paid by the public system. The lower wages paid to workers translates into poorer training and higher staff turnover, ultimately jeopardizing patient safety. Moreover, the public system does not necessarily benefit from savings from lower wages for workers, as these often simply go to the shareholders of the private firm offering the service.
- Small communities that lose vital health services may also see population and resources drain from their communities, as families and seniors in particular move to places where they have a better chance of accessing services.

Perhaps the saddest part of what is happening to health care in BC is that the financial “crisis” driving the cuts is mostly self-imposed. It is true that health care spending in BC has been rising gradually over time, as it has in much of the industrial world. This is to be expected given the ongoing development of effective but expensive new technologies to which we desire access. But the BC government has undermined its ability to pay health care costs by drastically reducing its own revenue stream with the tax cuts enacted in 2001. The tax cuts were supposed to stimulate so much economic growth that they would pay for themselves, but instead have created a huge gap in provincial revenues. To give up a major revenue stream and then cry that we have a health funding crisis is clearly disingenuous.

British Columbians value health care, and we expect governments to do their utmost to ensure that we all have access to the best system of care possible. We should not be satisfied with the status quo, but should look to governments to foster genuine reform and improvements. However, the “reforms” currently underway are not improvements at all. Rather, they are creating a poorer, less accessible, and less efficient health care system. British Columbians deserve better.

Notes

¹ P.J. Devereaux et al., “A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals,” *Canadian Medical Association Journal*, 2002, 166(11).

² R. Tamblyn et. al., “Adverse events associated with prescription drug cost-sharing among poor and elderly persons,” *American Medical Association*, 2001, 285(4): 421-429.

Why private medicine is bad for your health

by Colleen Fuller

CANADIANS HAVE AN ADVANTAGE MOST PEOPLE AROUND THE GLOBE LACK: we have a bird's eye view of what Dr. Arnold Relman, Professor Emeritus of Medicine and Social Medicine at Harvard Medical School, and Emeritus Editor-in-Chief of the *New England Journal of Medicine*, called the most “commercialized... expensive, inefficient, inequitable—[and] unpopular” health care system in the industrialized world.¹

Some would argue that the United States isn't the only or even the best example of how the market operates in health care. The Fraser Institute, for example, points to a spate of other countries from which Canadians can shop for market models they like.

But it is with the US that Canada is integrating under the North American Free Trade Agreement, not Sweden or Europe or Asia. This integration is extending the reach of an essentially American health market both north into Canada and south into Mexico. In the southern US border region, for example, health “consumers” with cash move freely back and forth across the international boundary to purchase hospital, physician and other services. Similarly, some BC hospitals are hoping to attract insured Americans northward with cheaper surgical services.

With the BC government looking to increase the role of for-profit health care, and the Romanow report arguing strongly that for-profit care is inconsistent with Canadian values, debate in BC about public and private health care is escalating. While those looking to make a profit on health care are quick to capitalize on public discontent with an increasingly under-funded and struggling system, there are good reasons to be wary of any expansion of the role of for-profit providers and insurers in the health system. Here are just a few of them:

While those looking to make a profit on health care are quick to capitalize on public discontent with an increasingly under-funded and struggling system, there are good reasons to be wary of any expansion of the role of for-profit providers and insurers in the health system.

For-profit companies deliver lower quality care

Numerous academic studies show that the drive for profits lowers the quality of health care and compromises patient safety:

- Kidney dialysis: A 1999 study by researchers at Johns Hopkins Medical Institute and Harvard Medical School discovered that patients with kidney disease who went to for-profit dialysis clinics were 20 per cent more likely to die and 26 per cent less likely to be placed on a transplant waiting list within 18 months of starting dialysis. The study also found that for-profits employed fewer staff than their non-profit counterparts.

The study's authors concluded that the higher number of deaths in for-profit clinics was associated with an emphasis on controlling costs and maintaining high patient volumes. The lead author of the study, Dr. Pushkal Garg, said understaffing at the for-profit centres limited patient care and education about transplants. For-profit centres were also reluctant to arrange kidney transplants because "If the person gets a transplant, the facility loses that stream of revenue."² The finding of higher mortality in for-profit dialysis centres was confirmed by a major study published in the *Journal of the American Medical Association* in 2002 that compared mortality rates in for-profit and not-for-profit kidney dialysis centres from 1973 to 1997. The authors concluded that if American patients received care in not-for-profit dialysis facilities instead of for-profit facilities, approximately 2,500 lives would be saved each year.³ The authors added that if Canada switched to for-profit dialysis centres, approximately 150 additional dialysis patients would die each year.

- Support work in hospitals and other health care agencies, for example in dietary and laundry departments, is highly specialized work involving complex equipment and requiring advanced skills. In-house staff have valuable training and experience that contractors have difficulty matching. Contractors like Sodexo, expected to take over a substantial portion of BC's hospital laundry and housekeeping services, pay lower wages, and experience higher turnover. In general these companies offer their staff less training than in-house staff are able to

Support work in hospitals and other health care agencies is highly specialized, involving complex equipment and requiring advanced skills. In-house staff have valuable training and experience that contractors have difficulty matching.

obtain. Often the contractors specialize in the hotel industry, which requires a vastly different set of skills, training, procedures, material and equipment.

- For-profit companies that provide hospital services spend less on staff and shorten stays.⁴
- Nursing homes: A study by researchers at the University of California and Harvard University, published in the September 2001 issue of the *American Journal of Public Health*, found that for-profit nursing homes were cited for deficient quality 46.5 per cent more frequently than their non-profit counterparts. The study analyzed data from government inspections of 13,693

nursing homes during 1998, a figure that represents virtually every nursing home in the US. Higher rates of severe quality problems in which patients were harmed were also attributed to for-profit nursing homes, where staffing levels by licensed nurses and nurses' aides were found to be significantly lower.⁵

- A 1999 study published in the *Journal of the American Medical Association* ranked for-profit Health Maintenance Organizations (HMOs) lower on 14 quality measures than not-for-profit HMOs.⁶
- For-profit and not-for-profit hospitals were compared in a study published in the April 2000 edition of the *Journal of General Internal Medicine*. The study was conducted at the University of Texas (Houston) and showed that among 15,000 patients, those cared for in for-profit hospitals were two to four times more likely than patients at not-for-profit hospitals to suffer adverse events such as complications following surgery or delays in diagnosing and treating an ailment.⁷
- In May 2002, the *Canadian Medical Association Journal* published the results of a systematic review and analysis of studies comparing mortality rates at private for-profit and private not-for-profit hospitals. The review, led by PJ Devereaux of McMaster University, involved more than 26,000 US hospitals and 38 million patients and compared the risk of death in for-profit and non-profit facilities. The study's authors found that "private for-profit ownership of hospitals, in comparison with private not-for-profit ownership, results in a higher risk of death for patients." Furthermore, they concluded that if Canada adopted the same for-profit model that exists south of the international border, Canadians could expect to see about 2,000 more in-hospital deaths each year.⁸

For-profit hospitals are 3 to 11 per cent more expensive than not-for-profit hospitals. No peer-reviewed study has found that for-profit hospitals are less expensive than not-for-profit hospitals.

For-profit companies provide fewer services at a higher cost

- *The New England Journal of Medicine* recently published a review of all of the literature on health financing. The review found that for-profit hospitals are, on average, 3 to 11 per cent more expensive than not-for-profit hospitals.⁹ No peer-reviewed study has found that for-profit hospitals are less expensive than not-for-profit hospitals.¹⁰
- Total costs at for-profit hospitals are higher because they spend far more on administration and ancillary services than not-for-profit hospitals.¹¹ One US study also found that for-profit rehabilitation facilities are costlier than their not-for-profit counterparts, charging US Medicare \$4,888 more per admission in 1997.¹²
- According to health economist Dick Scotton of Australia's Monash University, the efficiencies of the private sector "are always illusory." Commenting on

Australia's experiment with privatization, Scotton told the *Toronto Star* in March 2000, "Governments think they will save money [from privatization]. But the private operators always bid low—then they threaten to go into bankruptcy and the contracts have to be restructured." ¹³ His argument that private sector advantages are illusory is borne out by studies from both the United States and Britain.¹⁴

- Advocates of for-profit health care suggest that private contracting avoids costly public investment in facilities and equipment. But this too is an illusion, as the Private Finance Initiative (PFI) in Britain has shown. According to the *British Medical Journal* and other reputable British publications, PFIs in Britain—called public-private partnerships in Canada—have been plagued by shoddy construction standards and huge cost overruns that have siphoned funds away from patient care. The BMJ also noted that costs for these private facilities are 18 to 64 per cent higher than conventional public hospitals.¹⁵
- Vancouver General Hospital is hoping to capture a new source of revenue: American patients. Doctors have been complaining for years of difficulties in gaining access to hospital operating rooms. This causes unacceptably high waiting times, many doctors charge. VGH now says those ORs will be opened up to US patients who can pay but that this will not decrease access for BC residents.

Does this mean American patients will pay to go to the back of the line? Of course not. It means BC patients will get bumped. It also means that BC taxpayers may be subsidizing the US insurance industry since most Americans who travel to BC for an operation will be covered by an insurance policy. While it is nice to realize that BC's publicly-funded hospital system can compete successfully with more expensive US hospitals, American patients should not benefit from our publicly subsidized system, particularly when this is likely at the expense of BC residents.

A few facts about BC's private sector

- In 1994, the Kilshaw Report, a government-commissioned study of diagnostic services in British Columbia, showed that provinces with privatized outpatient blood testing had higher per capita costs for these services. The report suggested that patients should be encouraged to use non-profit hospitals instead of for-profit labs, a recommendation that was never implemented.¹⁶ Today, BC has the highest per capita costs for diagnostic services in the country.¹⁷
- Over the last six years private surgical facilities have mushroomed in BC. The first one to open, in 1996, was the Cambie Surgical Centre. At that time, the charge for private surgery stood at \$450 for an hour in the OR.¹⁸ Four years later, according to Dr. Mark Godley of the False Creek Surgical Centre, the

basic cost is “in the ballpark of \$1,000” per hour depending on the support services needed.¹⁹

- During the 1990s, hospitals moved more and more out-patient physiotherapy to the private sector. Patients who were covered on a private insurance plan probably didn't pay much attention to the fees that physio clinics were charging—first it was \$7.50, then it was \$10.00. By the end of 2001, the fee was \$20 per visit. Then, in January 2002 the province de-listed outpatient physiotherapy altogether. Patients are now paying \$45 per visit, a cost that is predicted to increase.
- These fees may or may not be picked up by private plans. If they are, we can expect to see premiums increase.
- Many workers aren't covered by private plans. Statistics Canada data indicate that in 1999, slightly more than half (52.9%) of Canadians were covered by supplementary medical insurance, not including dental. (Only 51.8% are covered by a dental plan.) Broken down by gender, only 47.3 per cent of women are covered compared to 58.9 per cent of men. Broken down by occupation, coverage for managers is 64.5 per cent and for professionals it is 65.6 per cent. For technical trades and clerical workers it is around half (50.5% and 55% respectively), and for production and unskilled workers it is 43.9 per cent. Only two in ten sales workers (22.4%) have coverage. Nearly 60 per cent of full-time workers are covered, compared to just under 20 per cent of those who work part-time. Among those who earn less than \$12 an hour, only 26.9 per cent are covered, compared to 70.8 per cent of those who earn \$20 or more an hour. Unionized workers are more likely to be covered than their non-union counterparts (67.5% versus 47.7%), and the smaller the employer, the less likely the workers are to be covered—coverage is 31.3 per cent for those working in places with under 20 employees, compared to 70.5 per cent of those in a workplace with 500 or more other employees.²⁰

Provinces with privatized out-patient blood testing have higher per capita costs for these services. Today, BC has the highest per capita costs for diagnostic services in the country.

Notes

¹ A. S. Relman, “For-Profit Health Care: Expensive, Inefficient and Inequitable,” A Presentation to the Standing Senate Committee on Social Affairs, Science and Technology. Ottawa, February 21, 2002.

² P.P. Garg, K.D. Frick, M. Diener-West and N.R. Powe, “Effect of the Ownership of Dialysis Facilities on Patients’ Survival and Referral for Transplantation,” *New England Journal of Medicine*, 1999, 341(22):1653-1660.

³ P. J. Devereaux et. al., “Comparison of Mortality Between Private For-Profit and Private Not-For-Profit Hemodialysis Centers: A Systematic Review and Meta-analysis,” *Journal*

- of the American Medical Association, 2002, 288: 2449.
- ⁴ J.M. Watt, R.A. Derzon, S.C. Ren, C.J. Schramm, J.S. Hahn and G.D. Pillari, "The comparative economic performance of investor-owned chain and not-for-profit hospitals." *New England Journal of Medicine*, 1986, 314:89-96.
- ⁵ C. Harrington, S. Woolhandler, J. Mullan, H. Carrillo and D.U. Himmelstein, "Does Investor Ownership of Nursing Homes Compromise the Quality of Care?" *American Journal of Public Health*, 2001, 91(9).
- ⁶ D.U. Himmelstein, S. Woolhandler, I. Hellander and S.M. Wolfe, "Quality of care in investor-owned vs not-for-profit HMOs," *Journal of the American Medical Association*, 1999, 282:159–163.
- ⁷ E. Thomas, J. Orav, T. Brennan, "Hospital Ownership and Preventable Adverse Events," *Journal of General Internal Medicine*, April, 2000.
- ⁸ P.J. Devereaux et al., "A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals," *Canadian Medical Association Journal*, 2002, 166(11).
- ⁹ E.M. Silverman, J.S. Skinner, and E.S. Fisher, "The Association between For-Profit Hospital Ownership and Increased Medicare Spending," *New England Journal of Medicine*, 1999, 341:420-426.
- ¹⁰ S. Woolhandler, D.U. Himmelstein, "When Money is the Mission — The High Costs of Investor-Owned Care," *New England Journal of Medicine*, 1999, 341:444-446.
- ¹¹ B.H. Gray, ed. *For-profit enterprise in health care*. Washington, D.C.: National Academy Press, 1986.
- ¹² L. Chan, T.D. Koepsell, R.A. Deyo et al., "The effect of Medicare's payment system for rehabilitation hospitals on length of stay, charges, and total payments," *New England Journal of Medicine*, 1997, 337:978-85.
- ¹³ T. Walkom, "A very public failure of a private hospital," *Toronto Star*, March 19, 2000.
- ¹⁴ First Report of the Session 2001–2002 on the Role of the Private Sector in the NHS submitted by the House of Commons Health Committee to British Parliament by the Secretary of State for Health in July 2002.
- ¹⁵ D. Gaffney, A.M. Pollock, D. Price, J. Shaoul, "PFI in the NHS: is there an economic case?" *British Medical Journal*, 1999; 319:116-119.
- ¹⁶ M. Kilshaw, "Review of Diagnostic Services: A Report to the Minister of Health of the Province of British Columbia," September 1993.
- ¹⁷ THIINC Group, "Laboratory Reform in British Columbia," report submitted to the Government of British Columbia and Laboratory Stakeholders, June 21, 2002.
- ¹⁸ D. Jones, "His own private hospital," *Canadian Medical Association Journal*, 1997, 157:297-300.
- ¹⁹ P. Fayerman, "Private clinics offer to sell operating time," *Vancouver Sun*, December 9, 2000.
- ²⁰ See Workplace and Employee Survey Compendium, 1999 Data, Statistics Canada.

A dramatic reversal of policy on long-term care

by Marcy Cohen

ON APRIL 23RD 2002, THE PROVINCE AND HEALTH AUTHORITIES ANNOUNCED THEIR three-year plan for “continuing care renewal.” It was a dramatic reversal of the new government’s election promises. In the *New Era* document published prior to the election, the Liberals promised to “work with non-profit societies to build an additional 5,000 long-term care beds by 2006.” Shortly after the election it was simply 5,000 new long-term care beds: the reference to not-for-profit’s had been removed. In the fall of 2001, it was 1,500 new long-term care beds and 3,500 assisted living units.

On April 23RD, the numbers changed once again. NO new long-term care beds would be created (other than one facility in Vanderhoof). Instead, over three years, there will be a reduction of 3,111 long-term care beds (see table one), and a substitution with 3,799 assisted living units.¹

These broken promises will have very serious implications, not only for frail seniors and their families, but for anyone trying to access health care services in the province. A shortfall in long-term care beds will intensify the pressure on every other part of the health care system, from emergency and acute care to home care and physician services.

To understand the full implication of these changes it is important first to outline why 5,000 new long-term care beds were required, and second to explain what assisted living is, and why it is not an effective substitute for long-term care.

The need for new long-term care beds

In 1999, staff from the Ministry of Health prepared a ten-year plan for residential care based on current utilization and taking into account population growth and the aging of the population.² The document states that:

A shortfall in long-term care beds will intensify the pressure on every other part of the health care system, from emergency and acute care to home care and physician services.

An additional 4,495 beds are needed in 2001/2002 in order to provide the service required. From 2002/2003—2009/2010 an additional 1,000–1,400 beds are required in each year in order to meet the service requirements due to population growth and aging.

The shortfall of close to 5,000 beds stems from the fact that there was very little construction of new long-term care units since the mid 1990s, despite the influx of seniors into the province and the aging of British Columbia’s population. As a consequence, seniors’ access to long-term care has declined by about 20 per cent since the mid 1990s.³

Shortfalls in long-term care beds translate into longer waiting lists (the waitlist increased by 76 per cent from 1993 to 1999), and increased pressure on family caregivers, physicians, home support and nursing care, emergency services, and acute care.⁴ According to recent projections by the Ministry of Health, about 13 per cent of acute care patients are in acute care only because of the lack of long-term, rehabilitation and community services. Acute care is the most expensive part of the health care system, and the Liberals’ election promise to build 5,000 not-for-profit long-term care beds was designed in part to reduce this pressure on acute care.⁵

However, on April 23rd, instead of announcing 5,000 new beds, the government announced the closure of 3,111 beds across the province. To manage the declining number of beds, waitlists have been cut off and a new assessment process has been developed to limit access to those who qualify under the new rules and require care within three months. Frail seniors will no longer be able to choose their long-term care facility; instead they will be placed in the first available bed in the region, which could be a considerable distance from their home community.

The new assessment process restricts access to those who have been designated as having “complex” care needs. Those who are not defined as requiring “complex care” will have three options: they can remain in their own homes, be assessed for entrance into assisted living housing/supportive housing, or pay for residential care privately.

Table I: Long-term care (LTC) bed changes by region—April 23, 2002 announcement

Health authority	LTC beds current	LTC beds by 2004/5	Bed reduction	LTC bed reduction (%)	Assisted living by 2005 (# of units)
Vancouver Coastal	6,922	6,349	573	8.3%	884
Fraser	8,000	7,200	800	10.0%	1,100
Vancouver Island	4,960	4,040	920	18.5%	1,100
Interior	4,708	3,890	818	17.4%	715
North	No information available				
Provincial totals	24,590	21,479	3,111	12.7%	3,799

Source: All the information in this table is from the websites of the B.C. Health Authorities

Somewhere between 6,000 to 8,000 frail seniors and people with disabilities who, up to now, were eligible for entrance into publicly-funded long-term care will no longer be eligible under the new rules.⁶

And yet the demand for long-term care will likely grow quite dramatically in the future: by 2019 the seniors' population over 85 will increase by over 90 per cent.⁷

The failure to fund an adequate number of long-term care beds will, in all likelihood, generate a crisis in health care that will push many of those who can afford to pay in the direction of private care. Is this the underlying intent of the policy—to make the individual rather than the government responsible for the cost of long-term care and to support the provision of private for-profit care? And if it is, what will happen to the moderate and low-income seniors who cannot afford to pay for their care privately?

Assisted living: Is it the solution?

Assisted Living/Supportive Housing is being presented by the provincial government as a more positive alternative than “institution” (i.e. facility) based long-term care, and the solution to the shortfall in long-term care beds. While it is true that assisted living, if affordable, can be a very positive alternative for many people with limited care needs, it is not an adequate solution to the shortage in long-term care beds.

Assisted living is a housing model in which the person lives somewhat independently—usually in a small apartment unit—and is provided with meals, basic housekeeping, social opportunities and some personal health care. It is generally viewed as a positive alternative for people who are able to live somewhat independently, but not appropriate for those with dementia and/or people who require regular assistance with all or most of the activities of daily living (i.e. toileting, dressing, eating, etc.).

Alberta and the United States have moved much more aggressively to an assisted living model of care and have promoted this model as an effective substitute for long-term care. In 1999 the US Department of Health and Human Services conducted the first survey with a nationally representative sample of assisted living facilities.⁸ Based on an analysis of the survey results, the authors came to three main conclusions:

1. Assisted living is a very positive model for seniors with limited care needs.
2. Assisted living is not an effective substitute for residential long-term care because the staffing levels and staffing mix are not adequate for the care requirements of most residents currently in long-term care.
3. Assisted living is largely unaffordable for moderate and low-income seniors.

In addition, the authors found that one out of every four people who moved out of assisted living said they were dissatisfied with the care and the cost. A US General Accounting Office 1999 study of assisted living in four states found that more than one quarter of the facilities it examined had at least five quality or consumer-protection problems, ranging from poor care to inadequate staff to faulty admission and discharge practices.⁹

It is true that assisted living, if it is affordable, can be a very positive alternative for many people with limited care needs. It is not, however, an adequate solution to the shortfall in long-term care beds.

In BC the government plans to address the affordability issue by taking advantage of the newly announced joint federal/provincial funding for affordable housing to be administered by BC Housing. All of the new funding designated for affordable housing will be used to create 3,500 additional assisted living/supportive housing units for the frail elderly. These new assisted living/supportive housing units will replace many of the long-term care facilities across the province.

Problems related to appropriateness, affordability and quality were not addressed and yet the government announced the program as a *fait accompli*. A number of community organizations including seniors groups, affordable housing societies and health care unions began to organize in opposition to these changes.

While these groups were supportive of the concept of assisted living/supportive housing as a positive alternative for people with limited care needs, they did not see assisted living and supportive housing as an effective substitute for long-term care or as an appropriate use of affordable housing dollars. A number of very serious flaws in the program were identified:

1. The use of federal affordable housing dollars for health care means, in effect, that the 10,000 people currently on waiting lists for affordable housing—single parents, relatively healthy seniors and people with disabilities, low income single people and the homeless—have no opportunity to access housing in the foreseeable future. All of the available funding for affordable housing is being used to meet the health and housing needs of one population—the frail elderly.
2. The substitution model was put in place without a proper planning process. All of the decisions to date—the reduction in the number of long-term care beds, the determination of the amount of direct care to be provided in assisted living and the allocation of the number of assisted living/supportive housing units—were made without first assessing the care and support needs of the 6,000 to 8,000 frail seniors and people with disabilities who would no longer be eligible for publicly-funded long-term care. At this point it is not clear how many frail seniors are appropriate candidates for assisted living/supportive housing.
3. It is also unclear if the new assisted living/supportive housing units will really be affordable. Three quarters of the current residents in long-term care—the future tenants in subsidized assisted living/supportive—have annual incomes of less than \$20,000 a year. In long-term care their drug costs and most of the costs for medical supplies and equipment and recreational activities are covered; in assisted living these costs fall on the individual.

BC Housing is prepared to subsidize the rental charges and the Health Authority will pay for the direct care costs. It will be up to the individual senior to pay the remaining rental charges, at least some of the support costs (i.e. meals and laundry) and still have enough left over to cover the costs of drugs, medical supplies and equipment, recreation and entertainment, personal needs, and clothing.

4. Another unresolved issue is how care will be provided to an individual in assisted living who falls ill and requires additional assistance for a limited time. There is no guarantee that the Health Authority will live up to their commitment to provide this support through the existing home nursing or home support services

when these services are already overburdened and there is no new money for home nursing or home support. This could put an additional burden on family members who would be expected to provide additional care or pay for it privately.

5. Assisted living is defined as “housing” and not facility care. This means that it is not licensed and regulated in the same way as long-term care. When the government introduced its new Community Care Licensing Act, Bill 16, in the spring of 2002, there was no mention of assisted living/supportive housing. At the same time, the government stated clearly that assisted living/supportive housing would not be covered under the Residential Tenancy Act. In other words there is no regulatory framework in place to protect the residents of assisted living/supportive housing and to ensure that they receive a high quality of care.

Mounting opposition to the program and negative publicity in the media has resulted in several positive modifications to these plans, including:

- A provincial commitment from the Ministry of Health that the rental and support costs (i.e. for meals, laundry and cleaning) will be subsidized by the Health Authorities and will not exceed 70 per cent of an individual’s income.
- The withdrawal of the Community Care Licensing Act, Bill 16, and the inclusion of at least some minimum protection for residents of the BC Housing Assisted Living program under a new Community Care Licensing Act, Bill 73.
- Provincial policies limiting access to assisted living/supportive housing to individuals who are able to direct their own care (i.e. there is an acknowledgment that people with dementia are not appropriate candidates for assisted living/supportive housing).

While these changes are clearly positive, fundamental problems remain. No additional funding has been allocated to build new long-term care beds, seniors waitlisted for complex care still have no choice of where they will be placed, and the number of long-term care facilities slated to close or convert to assisted living has not changed.

The impact of these changes on frail seniors, their families and the community where they live

With the anticipated growth in the senior population and the closure of more than 3,000 publicly-funded long-term care beds, it is highly unlikely that the number of subsidized assisted living units and publicly-funded long-term care beds will be sufficient to meet the residential care needs of frail seniors and people with disabilities either now or five to ten years down the road.

In desperation, more and more seniors and people with disabilities will turn to the private sector. But the costs of private care—\$3,000 to \$5,000 per month for long-term care and \$2,000 to \$3,000 per month for supportive housing—are well beyond the means of most moderate and low-income seniors (according the latest Revenue Canada figures, 75 per cent of seniors in BC had annual incomes of \$30,000 or less, and half of all seniors had incomes below \$20,000).¹⁰

The consequence? Over time more and more low-income seniors and people with disabilities will be left on their own to cope as best they can until a health crisis takes them to emergency and/or acute care. It is widely acknowledged by health care experts that once a person is in crisis the costs of care escalate and the potential of positive health outcomes diminish.

The shift away from this type of “crisis” orientation has been the goal of health care reform in BC since the publication of the Seaton Commission Report, “Closer to Home” in the early 1990s. The argument presented in the report is quite simple: the sustainability of our public health system depends on the development of early intervention and prevention strategies and sufficient resources in the community and residential care to support the implementation of these strategies with specific populations.

The provincial government’s policies move health care quite clearly in a different direction—limited government funding, more responsibility shifting to individuals and families, access increasingly based on ability to pay. Such short-term “solutions” do not simply hurt seniors and the disabled, they ultimately threaten the overall sustainability of the public system.

Notes

¹ B.C. Housing, *News Release: Province will Develop 3500 Supportive Living Units*, April 22, 2002. Of the 3,500 plus assisted living units announced only 1,500 are new assisted living units, the remainder will be conversions and rental supplements, primarily for the private sector.

² Ministry of Health, Continuing Care Model Working Group, “Continuing Care Residential Services Planning Model,” September 24, 1999: v.

³ Canadian Centre for Policy Alternatives et al., *Without Foundations: How Medicare is Undermined by Gaps and Privatization in Community and Continuing Care*, CCPA, November 2000: 27.

⁴ City Spaces Consulting Ltd., “Non-Profit Continuing Care—New Projects and Partnerships,” March 3, 2000: 2.

⁵ Gordon Campbell, *Guardian* interview, Dec. 3, 2000.

⁶ These numbers are based on information from the Regional Authorities. The vast majority of people assessed in the current system at an IC2 level and some people assessed at an IC3 level will not be eligible under the new rules.

⁷ Review of Continuing Care Services, B.C. Ministry of Health, *Continuing Care: Community for Life*, October 1999: 17.

⁸ C. Hawes et al., *A National Study of Assisted Living for the Frail Elderly: Results of a National Survey of Facilities*, Myer Research Institute, December 14, 1999.

⁹ A. Goldstein, “Philosophy of Assisted Living is Social Not Medical,” *Washington Post*, February 19, 2001: A17.

¹⁰ *Without Foundations*, p 39; Hospital Employees’ Union Research Department Report on Private Seniors Care, June 2000; Mulligan, Gloria, personal communication, Revenue Canada, May 2002.

Membership

Annual Individual Membership

\$300 Sponsoring Member (or \$25/month)

Receives *The Monitor*, all new publications (approximately 15 books and research reports each year), and a \$75 tax receipt.

Sponsoring Members can also choose to receive a larger tax receipt *instead* of receiving publications (you still receive *The Monitor*, but no books, monographs, or *Our Schools, Our Selves*). Please check here if you would prefer to receive a \$275 tax receipt *instead of* receiving publications _____.

\$100 Supporting Member (or \$8.50/month)

Receives *The Monitor* and a \$75 tax receipt.

\$25 Student / Low Income Membership

Receives *The Monitor*.

\$175 Education Membership (or \$14.75/month)

Receives *The Monitor*, *Our Schools/Our Selves*, *Missing Pieces*, all books on education, and a \$75 tax receipt.

Please note that all individual membership renewals are due on January 1st. All tax receipts, including for monthly donors, will be issued in December.

Annual Organizational Membership

Sponsoring Organization

\$12,000 plus

Contributing Organization

\$500—\$1,999

Sustaining Organization

\$2,000—\$11,999

Low Income Organization

\$300—\$499

Organizational Membership Benefits

One free copy of every publication the Centre puts out over the year—*The Monitor*, *BC Commentary*, and approximately 15 original research reports and books.

Additional Copies

Limited additional copies of our material are available to Sponsoring or Sustaining organizational members. Please contact our membership department at 613-563-1341, ext. 305, or email <membership@policyalternatives.ca> for more information.

Please return your completed membership form to The Canadian Centre for Policy Alternatives • 410-75 Albert St • Ottawa • ON • K1P 5E7

Please send me your catalogue of publications.

I do not wish to become a member, but here is my donation of \$_____.

Contact Information

Name _____

Organization _____

Address _____

City _____ Prov. _____ Postal Code _____

Tel. _____ Fax _____

Email _____

Do not trade my name with other like-minded organizations.

Payment Options

Become a monthly donor!

Monthly \$_____ (monthly amount)

For automatic monthly payments, please enclose a voided cheque or fill out your credit card information below. You can stop payments at *any* time by contacting the CCPA office.

Annually \$_____ (annual amount)

Please enclose a cheque (made out to "CCPA") for your annual contribution, or fill in your credit card information below.

Visa, or Mastercard Card #: _____

Exp: _____ Signature: _____

www.policyalternatives.ca

The best source of free, progressive, on-line opinion in Canada.

✓ news

✓ publication downloads

✓ fact sheets

✓ opinion pieces

✓ news releases

✓ policy briefs

✓ Monitor articles

✓ on-line publication purchases

Canadian Centre for Policy Alternatives



ABOUT THE

Canadian Centre for Policy Alternatives

The Canadian Centre for Policy Alternatives is an independent, non-profit research institute funded primarily through individual and organizational memberships. It was founded in 1980 to promote research on economic and social issues from a progressive point of view. The Centre produces reports, books and other publications, including a monthly magazine. It also sponsors public events and lectures.

www.policyalternatives.ca

A great resource. The Centre makes most of its reports, studies, commentary and opinion pieces, backgrounders, and policy briefs available free on its website.

National Office

410-75 Albert St.
Ottawa, ON K1P 5E7
Tel: 613-563-1341
Fax: 613-233-1458
ccpa@policyalternatives.ca

Manitoba Office

309-323 Portage Ave.
Winnipeg, MB R3B 2C1
Tel: 204-927-3200
Fax: 204-927-3201
ccpamb@policyalternatives.ca

BC Office

1400-207 W. Hastings St.
Vancouver, BC V6B 1H7
Tel: 604-801-5121
Fax: 604-801-5122
info@bcpolicyalternatives.org

Nova Scotia Office

P.O. Box 8355, 6175 Almon St.
Halifax, NS B3K 5M1
Tel: 902-477-1252
Fax: 902-484-6344
ccpans@policyalternatives.ca

Saskatchewan Office

2717 Wentz Avenue
Saskatoon, SK S7K 4B6
Tel: 306-978-5308
Fax: 306-922-9162
ccpasask@sasktel.net



**CANADIAN CENTRE FOR
POLICY ALTERNATIVES**

CAW TCA
CANADA