FROM BAD TO WORSE

Residential Elder Care in Alberta

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Abbreviations

AHS: Alberta Heath Services
AL: assisted living
ALC: alternate level of care
C3: Comprehensive Community Care for the Elderly
CHOICE: Comprehensive Home Option of Integrated Care for the Elderly
HCA: health care aide
HFRC: Health Facilities Review Committee
LPN: licensed practical nurse
LTC: long term care
PACE: Programs of All-Inclusive Care for the Elderly
RCF survey: Residential Care Facilities survey
RN: registered nurse
ROI: return on investment

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About Parkland Institute

Parkland Institute is an Alberta research network that examines public policy issues. Based in the Faculty of Arts at the University of Alberta, it includes members from most of Alberta's academic institutions, as well as other organizations involved in public policy research. Parkland Institute was founded in 1996 and its mandate is to:

- conduct research on economic, social, cultural, and political issues facing Albertans and Canadians.
- publish research and provide informed comment on current policy issues to the media and the public.
- sponsor conferences and public forums on issues facing Albertans.
- bring together academic and non-academic communities.

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Executive Summary

Albertans, like other Canadians, are worried about whether they will receive the care they need as they age. News in Alberta is littered with revelations about problems with accessing appropriate elder care and questions about the quality of available care. Staff employed in the elder care field endure difficult conditions that make it challenging to ensure all elders receive the care they deserve.

In this context, it is important to ask if the Alberta government is ensuring elders in this province receive the supports they require to live with dignity and in comfort. In response to this question, the Parkland Institute undertook a study of Alberta's system of residential elder care. The study draws on quantitative data from Statistics Canada's Residential Care Facilities Survey and qualitative data from the reports of Alberta's Health Facilities Review Committee, as well as conversations with government and industry representatives, labour unions, seniors advocates, and front-line workers.

Focusing on assisted living [AL] and long term care [LTC], this report explores the consequences of two major, interrelated shifts in Alberta residential elder care in recent years:

1. **The replacement of LTC with AL**
   Elders who would once have been placed in LTC have increasingly been diverted into AL.

2. **The expansion of for-profit delivery of residential elder care**
   Elder care services in Alberta are delivered either by a public body, a not-for-profit agency, or a for-profit business. Recent years have seen a fall in publicly-delivered elder care and a spike in for-profit facilities.

Between 1999 and 2009, relative to the growth in number of Albertans over age 75, the number of residential elder care (either AL or LTC) spaces fell by 4%, while the number of LTC spaces fell by 20%. By 2008, Alberta had the second lowest availability of LTC spaces in the country.

Problems in Alberta's residential elder care are many and varied, and cannot be exhaustively addressed in the context of this relatively brief report. However, this report does identify three especially troubling areas.

1. **Across residential elder care in Alberta, a significant gap exists between the care provided and the care required to ensure residents' dignity and comfort.** Examples of the consequences of the care gap include waits of up to 2 hours for

response to call bells, meals rushed to a point that choking risk is increased, and inadequate staffing that puts both elders and caregivers at risk.

2. **Based on evidence from beyond and within Alberta, for-profit elder care is inferior to care provided publicly or by a not-for-profit agency.** Measured against benchmarks established by elder care experts, LTC in Alberta has often failed to achieve staffing levels that point to minimally acceptable care. Between 1999 and 2009, for-profit facilities fell short of the staffing levels that indicate reasonable quality elder care by over 90 minutes of care per resident, per day. While public facilities also fell short, they did significantly better than for-profit facilities.

3. **Significant offloading has left many elderly Albertans and their support networks struggling to cope with burdens, both financial and otherwise, that at one point would have been alleviated by the provincial government.** Offloading also has consequences for the wider community and the provincial economy.

This report includes an analysis of Alberta's for-profit residential elder care sector. While providing inferior care, these operations generate substantial profits. Between 1999 and 2009, private long-term care facilities in the province had an average return on investment [ROI] of 2.1%. Private AL facilities had much higher returns over that time, with an average ROI of 9.14%. This means that in recent years the returns received by the private residential elder care industry in Alberta have been higher than those of the US stock market, which over the same time-frame had an average return of 1.23%.

The report also points toward difficulties in accessing information about residential elder care. In light of the termination of the Statistics Canada Residential Care Facilities Survey, the elimination of the Health Facilities Review Committee, repeated changes in programmes and terminology within Alberta, and the inconsistencies that characterize elder care across Canada, there is a need to ensure elders do not become lost in a knowledge gap.

In sum, this report documents significant problems with residential elder care in Alberta. It makes clear how the provincial government's policies of privatizing and offloading have negatively affected the well-being of Albertans. The evidence is clear: as more services have been provided by for-profit enterprises and as the available supports have decreased, elder care in Alberta has gone from bad to worse.

Recommendations

1. **Expand the Canadian public health care system to encompass continuing care services, including all residential and home-based forms of elder care**
   - The Government of Alberta should join with other provinces in lobbying the Federal Government to expand public health care to include continuing care services, including all residential and home-based forms of elder care.

2. **Improve staffing**
   - In recognition of the care gap across Alberta elder care, the Government of Alberta should immediately make available funds to facilitate improved staffing, with the provision that all operators (public, not-for-profit, and for-profit alike) be obliged to expend these funds on direct care staffing. The Government should ensure that all elder care facilities are legally bound to minimum staffing levels established in relation to experts' assessments of the levels required to ensure quality care.

3. **Phase-out private, for-profit elder care**
   - Immediately suspend subsidies and programmes that benefit for-profit elder care corporations and work to phase-out for-profit elder care due to the abundant evidence that for-profit corporations provide inferior quality care.

4. **Increase public access to information about elder care**
   - Improve monitoring and reporting practices to ensure that meaningful data about elder care is available to all Albertans.

5. **Create a watchdog**
   - Establish an elders' advocate to report to the legislature. An elders' advocate would be positioned to monitor elder care, to track change over time, and to ensure the effective integration of the elder care system with other policies and practices that bear on the well-being of Alberta elders. The advocate should work closely with a committee of elder Albertans.

1. Introduction

Canadians are worried about whether they will be able to access the care they need as they age. A recent Canadian Medical Association poll indicates broad concern among seniors about whether they will be able to access suitable health care.[1] In Alberta, the news is littered with revelations about problems with finding appropriate elder care, and questions about the quality of available care. Frequent labour disruptions point to the difficult work environment of staff employed in the elder care field.

In this context, it is essential to ask if the Alberta government is ensuring elders in this province can access the care they may require to live with dignity and in comfort.[2] In response to this question, the Parkland Institute undertook a study of Alberta's system of residential elder care.

This report focuses on the experiences of Albertans in what the government of Alberta terms assisted living [AL] and long term care [LTC], referred to collectively in this report as residential elder care.[3] It deals only peripherally with home care and other forms of elder care, which are beset with their own distinct challenges. Our study explores the consequences of two major, interrelated shifts in Alberta residential elder care in recent years:

1. **The replacement of LTC with AL**

   Elders who would once have been placed in LTC have been increasingly diverted into AL.

2. **The expansion of for-profit delivery of residential elder care**

   Elder care services in Alberta are delivered either by a public body, a not-for-profit agency, or a for-profit business. Recent years have seen a fall in publicly-delivered elder care and a spike in for-profit facilities.

Since AL is predominantly delivered by for-profit businesses and LTC is primarily provided by government-operated facilities, these two developments are related: moving the resident population from LTC to AL amounts to a shift from public to private delivery. As will be explored further in what follows, the shift also involves a significant change in the nature of the care available to residents.

Problems in Alberta elder care are many and varied, and cannot be exhaustively addressed in the context of this relatively brief report. However, this report does identify three especially troubling areas.

1. **A significant gap exists between the care provided and the care required to ensure residents' dignity and comfort.**

   The resident population in LTC has become more medically complex and acute in recent years, and the level of care has not been adjusted sufficiently to compensate. The resulting care gap has many negative consequences for Alberta elders and their friends and families, as well as for workers employed in LTC.

   A shift toward greater acuity is also evident among residents in AL. However, inconsistencies in monitoring mean that there is far less information available on what this care gap has meant for residents, friends and family, and staff in AL. Unfortunately, recent changes affecting both AL and LTC threaten to expand this knowledge gap, making it harder to gain an understanding of Albertans' experiences with residential elder care.

2. **Based on evidence from beyond and within Alberta, for-profit elder care is inferior to care provided publicly or by a not-for-profit agency.**

   In a manner consistent with patterns researchers have identified elsewhere, evidence from Alberta shows that for-profit facilities provide an inferior level of care, with staffing levels far below recommended levels. The evidence also indicates that for-profit corporations provide a difficult work environment for staff.

3. **Significant offloading has left many elderly Albertans and their support networks struggling to cope with burdens, both financial and otherwise, that at one point would have been alleviated by the provincial government.**

   The Alberta government has worked to narrow its range of functions in relation to elder care, with the result that responsibility for procuring and paying for many services has been offloaded onto individuals. The problem of offloading is especially severe for elder Albertans in AL. The consequences of offloading include higher out-of-pocket costs and increased burdens on social networks.

the provincial government's policies of privatizing and offloading have negatively affected the well-being of Albertans.

Our analysis reveals significant problems with residential elder care in Alberta. It makes clear how the provincial government's policies of privatizing and offloading have negatively affected the well-being of Albertans. The evidence is clear: as more services have been provided by for-profit enterprises, and as the available supports have decreased, elder care in Alberta has gone from bad to worse.

This report begins with a survey of the relevant policy background, and then describes recent changes in Alberta's system of residential elder care. It examines in detail the care gaps and knowledge gaps threatening Alberta's elderly, before addressing pronounced variations in care quality between for-profit, not-for-profit, and public facilities. The offloading of elder care is considered in a manner that includes attention to its effects on the elderly, their friends and family, and the wider Alberta public. The report then turns to an examination of the private elder care sector, by looking closely at some of the companies profiting off elder care in the province. It concludes by offering concrete recommendations of ways to begin to address the problems evident throughout Alberta's residential elder care sector.

1. A. Data

The data underlying this report derives from the following sources:

- **Residential Care Facilities [RCF] survey.**

  Until its recent termination, Statistics Canada's RCF survey tracked key aspects of residential care facilities across the country. The Parkland Institute requested Alberta-specific data pertaining to residential care facilities primarily housing elders with age-related afflictions. The data related to the period between 1999 and 2009.

  AL was disaggregated from the overall data by a representative of Statistics Canada, based on a comprehensive list of facilities derived from a Government of Alberta website. The remaining data was assumed to pertain to LTC, as this is the only other type of facility where significant elder care is provided in the province.

- **Health Facilities Review Committee [HFRC] reports.**

  Until it was eliminated in 2013, Alberta's HFRC monitored the quality of care and accommodation provided in health-care facilities. The HFRC, consisting of up to 12 private citizens with varied backgrounds, expertise, and work experience, conducted surprise reviews intended to observe health facilities' routine operations. The HFRC visited facilities operating under the *Hospitals Act*, the *Nursing Homes Act*, or the *Regional Health Authorities Act*. Each year, the Committee inspected between a third and a half of LTC facilities and other health facilities that offer some LTC. AL facilities were considered outside the mandate of the HFRC.

For this study, Parkland Institute reviewed every HFRC report going back three years, based on the logic that such an approach should encompass at least one report for each facility. HFRC reports from earlier periods were reviewed in a less systematic manner.

- **Conversations and workshops with industry representatives, representatives from government, labour unions, Alberta Health Services, elder care activists, and front-line workers.**

- **Review of relevant government, academic, and other expert examinations regarding the costs and quality of elder care.**

2. Background

To understand the state of residential elder care in Alberta, it is critical to recognize how it relates to the Canadian health care system. Canadians enjoy health care services delivered on a tax-funded, single-payer system as laid out in the 1984 *Canada Health Act*. This legislation lays out five key principles that are to define the Canadian healthcare system, which is colloquially known as Medicare. These are:

- Public administration (administered on a not-for-profit basis);
- Universality (covering all insured persons on uniform terms and conditions);
- Comprehensiveness (covering all medically necessary services);
- Accessibility (reasonable access on uniform terms and conditions, unimpeded by discrimination or extra charges such as user fees); and
- Portability (coverage while absent from home province).[4]

The exclusion of residential elder care from Medicare has meant the principles of the *Canada Health Act* are not applied to the sector.

The *Canada Health Act* pertains only to medically necessary physician and hospital services. Falling outside of the *Act's* domain are other, increasingly important, areas of Canada's modern health care system, including pharmaceuticals, home care, and LTC. Although the Act does refer to "extended health services," the Federal government has failed to define these services, or to mandate that the provinces provide them.

The exclusion of residential elder care from Medicare has meant the principles of the *Canada Health Act* are not applied to the sector. As a result, the door has been left open for the involvement of for-profit businesses, the levying of costs on patients, and the use of eligibility criteria designed to limit access. Further, without the application of over-arching federal legislation, residential elder care has evolved differently from province to province.

In Alberta, the history of elder care is intertwined with the broader story of health care. Both have been subject to ideologically-driven efforts to shift costs and responsibility from the government to individual health care users, and to promote increased private-sector participation. The most aggressive efforts in this direction came under the Premiership of Ralph Klein. Significant cuts to the acute care system resulted in patients being shuttled into continuing care beds, thereby limiting availability for seniors in need. Combined with a pattern of underfunding services for elders that predated Klein, the situation in the mid-1990s rapidly became intolerable for Alberta elders and their friends and family.[5]

In the midst of problems in elder care created or exacerbated by Premier Klein's cuts to public services, the Government of Alberta undertook an investigation of the impact of an aging population on Alberta's health care system, with a focus on questions of financial sustainability. David Broda's 1999 report titled *Healthy Aging: New Directions for Care* put forward key principles to guide change in elder care.[6] These included the unbundling of services; creation of three care streams (the home care stream, the supportive living stream, and the facility living stream) under the umbrella of continuing care; and embrace of the 'aging in place' concept, which meant that elders should be supported in their desire to remain in the location of their choosing. In the years since the publication of the Broda report, these principles have become the basic pillars of the Government of Alberta's attempts to limit spending on services for elders.

In late 2001, the Premier's Advisory Council on Health released a report advocating reductions in the range of health services paid by the public purse. Termed the Mazankowski report after Council chair David Mazankowski, this document's recommendations included increased competition among providers of health services.[7] In 2002, the MLA Task Force on Health Care Funding and Revenue Generation produced a report (known as the Graydon report after Task Force chair Gordon Graydon) that continued the emphasis on shrinking public health care expenditures.[8] These reports served to lay further groundwork for continued attempts to shift elder care costs away from the public at large and toward individuals requiring services.

Evidence indicates that the quality of residential elder care in Alberta has gone from bad to worse, with significant negative consequences for elders, their friends and family, employees, and society at large.

The imposition of arbitrary restraint on public spending has had consequences for the quality of elder care in Alberta. In May 2005, the Auditor-General released the results of an audit of elder care in the province.[9] This report made clear that the government had failed to establish a system to ensure elders received adequate care, and laid out specific recommendations for improvements. The provincial government accepted all of the Auditor-General's recommendations.[10] Further, the government followed up with its own investigation, the MLA Task Force on Continuing Care Health Service and Accommodation Standards. The Task Force was struck to solicit input

from members of the public and stakeholders regarding needed improvements to Alberta elder care. Released in November 2005, the resulting report recorded the concerns of Albertans, and suggested further ways of fixing elder care in the province.[11]

Unfortunately, the situation did not improve in the wake of the 2005 reports. In fact, evidence indicates that the quality of residential elder care in the province has gone from bad to worse, with significant, negative consequences for Albertans in need of care, their friends and family, and professional caregivers employed in residential elder care. Further, the effects of inadequate elder care ripple out to touch all Albertans, through inflated health costs and other effects, both economic and social.

2. A. Terminology

In the absence of federal legislation defining the shape of residential elder care across Canada, residential elder care has developed in vastly different ways from province to province. Alberta exhibits its own eligibility requirements, funding level, ownership pattern, care standards, and even its own terminology.

Alberta includes residential elder care under the umbrella term 'continuing care.' Continuing care encompasses a broad range of health care services delivered outside of hospitals and physician offices, from minor assistance with daily living to intensive 24-hour nursing care. While continuing care primarily offers services for the elderly, it also includes residents who may require ongoing, substantial care for reasons besides age-related frailty, such as head injuries or degenerative diseases. As seen in Table 1, continuing care includes an extremely broad range of services organized into three sub-categories: 'Home Living', 'Supportive Living', and 'Facility Living'.

Facility living refers to care provided in either auxiliary hospitals or

Continuing care in Alberta

Home Living	Supportive Living				Facility Living
Independent living in private residence	Level 1 Residential Living	Level 2 Lodge Living	Level 3 Assisted Living	Level 4 Enhanced/Designated Assisted Living	Long term care facility or an auxiliary hospital

Table 1: Adapted from Alberta Health and Wellness, Continuing Care Strategy: Aging in the Right Place (Government of Alberta: December 2008), accessed March 14, 2013, http://www.health.alberta.ca/documents/Continuing-Care-Strategy-2008.pdf

LTC facilities. Spots in these facilities are now reserved for "persons with complex and chronic health needs who require support and 24-hour registered nursing care."[12] Facility living is governed under either the *Nursing Homes Act* or the *Hospitals Act*. These *Acts* serve to ensure a minimum quality of care is maintained at all LTC facilities by setting minimum staffing levels, although these minimums have not been updated and are now drastically out of date.

Supportive living is conceptualized as a form of elder care less intensive than that offered in facility living. The care needs of residents can "be as simple as those offered in home settings, right up to full-service care with the exception of highly complex and serious health care needs."[13] In this way, supportive living is presented as "a bridge between home living and facility living."[14]

Supportive living is subdivided into four distinct levels of care according to the care needs of residents, with the two most intensive levels of care termed AL. Some AL spaces, principally those for the severely incapacitated, are known as designated assisted living. These spaces are governed by a contract between Alberta Health Services (the health authority responsible for delivering medical care on behalf of the Government of Alberta) and the building operator. Under this contract, Alberta Health Services [AHS] "makes decisions regarding admission and discharge" and the building operator "provides health and support services based on assessed need."[15]

AHS undertakes assessments of individuals intended to guide decision-making about their access to both designated assisted living spaces and LTC beds, as well as to other forms of care such as home-care. According to AHS, the assessments are intended to "ensure that LTC beds are used by those who most need them…"[16] The effect of all of this is to position AHS as a gatekeeper with the capacity to ration care, an approach that is sharply at odds with the principle of universality that underlies the Canadian health care system.

This report focuses on LTC (which is a form of facility living) and AL (which consists of supportive living levels three and four). Table 2 indicates the staffing arrangements in LTC facilities and the two most intensive levels of supportive living, as well as AHS's definitions of the medical condition and functional status of the residents who should be residing in them.

Supportive living facilities, including AL and designated assisted living, are governed by the *Supportive Living Accommodation Licensing Act*.[17] This legislation invests the Government of Alberta with the power to regulate supportive living facilities. As it currently exists, however, the *Supportive Living Accommodation Licensing Regulation* specifies very little by way of concrete guidelines. The document is clearly written to offer flexibility to operators, rather than safeguards

Staffing and admission guidelines for AL and LTC

HCA: health care aide; RN: registered nurse; LPN: licensed practical nurse

	Supportive Living Level 3 (assisted living)	Supportive Living Level 4 (assisted living)	Supportive Living Level 4 Dementia (assisted living)	Long term Care
Staffing	HCA: 24 hr on-site RN: 24 hr on-call	LPN and HCA: 24 hr on-site RN: 24 hr on-call		RN, LPN, HCA: 24 hr on-site
Medical Conditions	Stable	Complex but stable Unscheduled assessments may be required		Complex unpredictable needs but medically stable Unscheduled assessments are often required
Functional Status	Mobilizes independently or with a one-person transfer; Requires unscheduled personal care such as assistance with meals or management of incontinence	Will have complex physical care needs that may include: complete meal assistance, including tube feeding, mechanical lift transfers and two person transfers, total assistance to mobilize	May have complex care needs that may include: complete meal assistance, including tube feeding, mechanical lift transfers and two person transfers, total assistance to mobilize	Will have complex physical needs that may include: complex nutritional intake requirements, complex elimination requirements

Table 2: Adapted from Alberta Health Services, *Admission Guidelines for Publicly Funded Continuing Care Living Options.*

to residents. Further, the document pertains purely to accommodation standards, which the provincial government deems separate from health care considerations. While the *Continuing Care Health Service Standards* formalize certain aspects of the available care, this document is often vague and, critically, does not include minimum staffing requirements.[18]

In supportive living, home care services are intended to play a key role in meeting the health and personal needs of residents. Home care services can include home support (personal care, housekeeping, meal preparation, and health tasks), occupational and physical therapies, and even full nursing and medical care. Home care, defined as an extended health service, is not an insured health service under the *Canada Health Act*. Decisions are made at the provincial

level regarding which services are publicly funded, and which are privately paid.

Residents in Alberta residential elder care are levied costs related to room and board, based on the argument by the Government of Alberta that such costs are not a medical expense, and should thus be borne privately. In LTC and designated assisted living, per diems are applied. As of 1 January 2013, the fees in LTC ranged from $48.15 per day for a standard room to $58.70 per day for a private room.[19] Fees currently charged to residents in designated assisted living range from $50.80 per day for a semi-private room to $58.70 per day for a private room.[20] Further, for designated assisted living residents in another sort of accommodation, a one bedroom or two bedroom apartment for instance, Alberta Health Services, in consultation with facility operators, determines what may be charged.[21]

In considering Alberta elder care, it is important to consider alternate level of care [ALC], which refers to sub-acute care provided in an acute care setting, such as a hospital. This makeshift arrangement is often employed to accommodate a resident in hospital awaiting placement in a continuing care facility. According to Alberta Health Services, as of 31 March 2012, there were 1,469 people waiting to be placed in a continuing care facility, with 467 of these individuals waiting in a hospital.[22] Residents in ALC may not have access to the full suite of services, including rehabilitation, which would be available to them in continuing care. Also, it can be more expensive to accommodate a resident in ALC as opposed to continuing care. Data from the Canadian Institute for Health Information indicate that between 2007 and 2009, 3% of hospitalizations in Alberta involved ALC. Conditions associated with aging, such as dementia and stroke, are strongly correlated with the ALC resident population. Between 2007 and 2009, 56% of Alberta residents discharged from ALC went to LTC.[23] This data suggests that a substantial proportion of ALC residents are there because of insufficient access to elder care. Residents accommodated in ALC are responsible for paying the same fee levied on residents in LTC.[24]

Some Alberta elders reside in seniors' lodges, which are facilities operated under the *Supportive Living Accommodation Licensing Act* by local management bodies. Many lodges receive funding from the Government of Alberta under the Lodge Assistance Program. Seniors' lodges are designed to provide room and board for seniors who are functionally independent with or without the assistance of community-based services such as homecare. Lodges are governed under provincial legislation that mandates operators to charge accommodation rates that leave residents with a minimum amount per month for personal expenses. As of early 2013, this minimum amount was set at $265 based on semi-private room rates.[25]

Even this brief survey of relevant terms makes clear the varied arrangements through which elder Albertans receive care. Confusion around terminology is rendered more likely by the government's frequent changes in definitions. Terms are also deployed in confusing or misleading ways. For instance, government officials and documents often refer to continuing care spaces, which means very little given the wide range of services encompassed by that term.

2. B. The sustainability scare

It is important to address, if only briefly, the issue of the financial sustainability of residential elder care. For years, debate about elder care has been framed by influential actors in terms of a broad fear about the public cost of an aging population. A growing share of the population becoming non-working elders who require expensive supports will dramatically inflate costs, so the argument goes, rendering impossible the maintenance of public elder care. The same argument is levied at the health care system more broadly.

As a result of improvements in life expectancy, declining birth rates, and the long term effects of the post-WWII baby boom experienced in Western countries, many countries are experiencing significant aging of their populations. Projecting out to 2061, Statistics Canada predicts that the percentage of the population over the age of 65 will reach between 24% and 28%, compared to 14% in 2009. The aging of the population is predicted to be particularly rapid over the coming two decades, as the baby boom generation reaches this landmark. Further, the number of working-age Canadians for every senior is expected to fall roughly in half, from 5:1 in 2009 to 2.6:1 by 2036.[26]

Health experts and economists have exposed claims about the unsustainability of public health care as little more than fear-mongering.

Much has been made of this trend. Maclean's Magazine featured a 2010 article entitled "The health care time bomb,"[27] the corporate-funded Fraser Institute perpetually uses this premise to call for increased health care privatization,[28] and the federal government employed this rationale to justify increasing the age of eligibility for Old Age Security and the Guaranteed Income Supplement.[29] Similar statements about the unaffordability of public health care have been made by various Alberta government officials. Such arguments are often used to justify reducing government responsibilities for providing health care, in favour of more private payment for privately-delivered services.

Health experts and economists have exposed such statements as little more than fear-mongering. While the logic may sound superficially plausible, the evidence shows that an aging population poses no threat to the future of public programmes such as Medicare. The key variable absent from the above analyses is economic growth, which creates increasing economic output that can be put toward social goods such as health care. Taking that critical aspect into

consideration, the share of national income spent on health care increased just 3.1% between 1971 and 2006.[30] The cost of maintaining existing service levels decreases as a share of GDP over the next three decades under historically average economic activity (3% real GDP growth per year), and if the economy underperforms relative to historical trends (2% real GDP growth per year) costs increase just 1% by 2038.[31] The report of the 2009 Senate Committee on Aging even referred to the demographic scare as a "pervasive myth."[32]

One of the main cost drivers in Canadian health care is the rising cost of prescription drugs. Pharmaceuticals alone have been responsible for 25% of the increase in Medicare costs as a share of GDP since 1975.[33] This is due to both an increase in the prescribing of drugs, as well as an increasing cost of the drugs themselves. As many experts have pointed out, a coordinated national Pharmacare program would do much to contain these rising costs.

The evidence clearly shows that publicly-funded and delivered services such as elder care and Medicare are not under threat from an aging population. Robert Evans, a Harvard-trained economist and Officer of the Order of Canada, explains that the perpetuation of such claims is nothing more than a "propaganda campaign" designed to advance the interests of those who stand to benefit from privatization by attempting to convince "a generally sceptical and unsympathetic public to accept that the current form of public health insurance (which most Canadians still strongly prefer) is simply impossible to maintain."[34]

While the demographic shift is real, the purported financial crisis within public services such as Medicare and elder care is not. Accordingly, provincial policy pertaining to elder care should not be judged against the backdrop of impending financial straits. Rather, elder care policy should be scrutinized according to its ability to provide high quality care to all Albertans in need.

3. Alberta's Elder Care System

In the early 1990s, residential elder care in Alberta consisted of three options: auxiliary hospitals, designed to be less-expensive and provide more permanent care than acute care hospital beds; nursing homes, as stand-alone facilities that provided a slightly lower level of care; and public lodges, which housed elders who required some oversight by non-medical staff and benefited from a social surrounding.[35]

The elder care system was rocked by the massive spending cuts that took place in the decade that followed. Effects included sharp

reductions to front-line staff in LTC facilities, the increase of LTC accommodation fees, and the cutting of seniors' programs that offered housing and health benefits.[36] At the same time, the government eyed introducing a new, less-expensive means to deliver care to elders, ideally with significant involvement of the private sector. Such a vision was in line with its ideological beliefs about the superiority of the private market and its focus on cutting social welfare expenditures. The government's solution was the corporate AL model that was rapidly emerging in the United States.

The essential idea behind AL was to provide health care to seniors based on need rather than setting. The concept was originally developed in Denmark as a means to provide elders with the health care services they required outside of a nursing home. As the Danish government understood it, even fairly independent seniors were being shoehorned into institutions, because it was the only setting in which they could receive public-funded services, equipment, and medication. The Danish model of AL combined universal coverage for 24-hour home care with specialized housing designed to support independent living.

Alberta elders have been left to navigate a complex residential elder care system and to attempt to cobble together sufficient care through a patchwork of public, private, and personal arrangements.

AL in Alberta, however, looked distinctly different from the Danish ideal. In partnership with real estate developers and other corporate interests, the Alberta government embraced AL as a way to privatize and diminish the services provided to elders. There was in Alberta no massive expansion of home care to complement the shift away from nursing homes. Instead, elders have been left to navigate largely on their own through a more complex residential elder care system, and to attempt to cobble together sufficient care through a patchwork of public, private, and personal arrangements.

3. A. The decline of long term care and the rise of assisted living

AL facilities have grown tremendously since the underlying concept initially gained favour in Alberta. But this expansion has not necessarily meant more residential elder care. Instead, the growth of AL has simply compensated for the decline of LTC, at least in terms of available spaces.

Alberta's population has been aging. Over the decade ending in 2009, the number of Albertans over the age of 75 increased by more than 50,000. Despite the increased need for residential elder care spaces in general and LTC spaces in particular that such aging would suggest, the availability of these spaces actually declined over these years. Specifically, between 1999 and 2009, the number of LTC beds per Albertan aged 75 and over decreased by 20% (see Table 3). This reduction in LTC availability is even more dramatic given that it occurred after a decade of deeper cuts. In the 1990s, the Alberta government reduced the number of LTC beds per capita by over 40%.[37]

By 2008, Alberta had the second lowest availability of long term care beds in the country, and sat far below provinces such as Saskatchewan and Manitoba in terms of availability.[38]

Table 3 clearly shows the provincial government's move away from LTC and embrace of AL. AL beds increased both absolutely and relative to the growth of the elderly population. Indeed, over the decade ending in 2009, the availability of AL beds per Albertan aged 75 and older nearly doubled. The implications of this dramatic shift are explored in detail below. As two Canadian health experts recently concluded about this broader national trend:

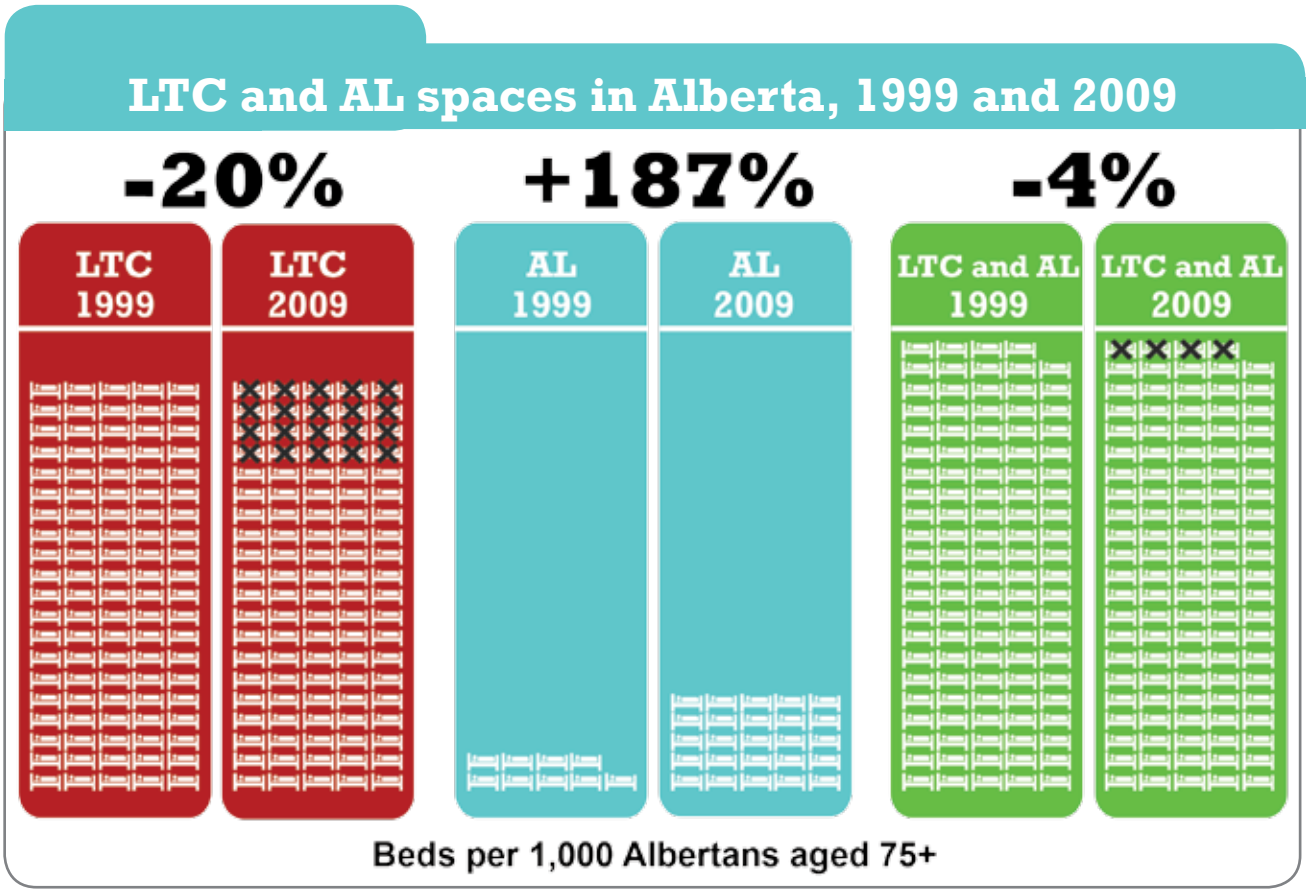

Table 3

> In terms of health care services provided in the home and by community agencies, there have been new investments in all provinces, but progress is uneven, and nowhere is the investment sufficient. Despite government rhetoric about restructuring health care to provide services 'closer to home' and despite decades of studies and commissions calling for investment in home and community care, these services remain severely underfunded across Canada. [39]

Despite the need for more residential elder care in general, and more LTC in particular, the provincial government actually decreased access to these services for elderly Albertans over the decade between 1999 and 2009.

3. B. The decline of public delivery and the rise of for-profit care

In Alberta, LTC and AL facilities are operated by the public sector, the not-for-profit sector, or the for-profit sector. The decade between 1999 and 2009 saw a dramatic shift in the resident population served by each of these sectors.

Over the period in question, the for-profit sector exhibited the most profound change, increasing available beds by 83%. The not-for-profit sector saw a bed increase of 72%, while public participation decreased by 10% in terms of available beds. In terms of delivery model, elder care in Alberta was transformed dramatically in the decade between 1999 and 2009. In 1999, roughly half of the available residential elder care spaces were publicly-operated, with the remaining half almost equally split between the for-profit and not-for-profit sectors. By 2009, each sector (public, for-profit, and not-for-profit) provided roughly one third of Alberta's residential elder care spaces.

Distinguishing between LTC and AL provides a further view on this transformation. The expansion of AL between 1999 and 2009 was driven by the rise of for-profit operations. In 1999, 73% of AL beds were provided by not-for-profit operators and 26% by for-profit operators. By 2009, while the majority of AL beds remained in not-for-profit operations, the gap had closed substantially, with for-profit operations now providing 41% of beds. For-profit operators had achieved an increase in beds of 510% over this period, while not-for-profits grew 230%. The public sector has but negligible participation in the field of AL.

Ownership patterns have also shifted in LTC. In 1999, public operations provided just over half of the available beds; by 2009, the number had dropped to just over 40% of the beds. Not-for-profit operations expanded over the decade, increasing to 22% the resident population they served. For-profit operations grew even more substantially, from 27% to 35% of available LTC beds. The decade in question has seen a 45% increase in for-profit LTC beds, and an 8% decrease in available public LTC beds.

3. C. Conclusion

Alberta's population has been aging significantly. Despite the resulting need for more residential elder care in general, and LTC in particular, the provincial government actually decreased access to these services for elderly Albertans over the years between 1999 and 2009.

In addition to this decline in access, there were two key changes in Alberta's residential elder care in this period:

1. the decline of long term care and the rise of assisted living

2. the decline of public delivery and the rise of for-profit care

These two related shifts amounted to a substantial transformation of Alberta's elder care sector, one in keeping with the recommendations contained within reports written by advocates of increased privatization and offloading like Broda and Mazankowski. The result is an elder care system with a diminished capacity to cope with highly acute or medically complex residents, and one that diverges further from the principles underlying the *Canada Health Act*.

4. Unmet Need

Between 1999 and 2009, as Alberta's system of residential elder care was transformed through the expansion of AL and the decline of LTC, changes were also evident within the resident population itself. Across the Alberta residential elder care system, care needs increased, and the elders with the most severe needs became concentrated in LTC. The experiences of Alberta elders in LTC indicate that available care has not been increased sufficiently to compensate. The result has been that Alberta's elder care system has fallen further away from the goal of ensuring dignity and comfort for the province's elders.

Data from Statistics Canada's RCF survey make clear the changes that have taken place. The survey groups residents into four categories, running from least to most incapacitated: Type I, Type II, Type III, and higher type. According to Statistics Canada's definitions, the needs of Type II residents can predominantly be met by health care and activity aides, while the needs of Type III residents are more complex and require attention from aides as well as intensive medical care from skilled nurses. Tracking shifts among these resident groups over the decade in question indicates that, across LTC and AL, the medical acuity and complexity of residents increased substantially.

Between 1999 and 2009, across AL and LTC, the proportion of residents classified as Type III has increased from 35% to 52%. Residents classified as Type II declined from 56% to 33%. Over that decade, the situation changed from one in which the majority of residents were Type II, to one in which the majority of residents were Type III. Over the same period, the percentage of residents over the age of 85 increased from 43% to 49%.

The expansion of AL and the comparative stagnation of LTC, combined with the increased acuity and medical complexity of the population served by residential elder care, has created a significant gap

between residents' needs and the available care.

4. A. The care gap

Between 1999 and 2009, a dramatic shift in patient population is evident within LTC. In 1999, the resident population was made up of 36% Type III residents and 58% Type II. By 2009, the counts had nearly reversed, with 58% of LTC residents belonging to Type III and 33% to Type II. Throughout this period, the remaining small portion

Patient Population by Acuity, LTC

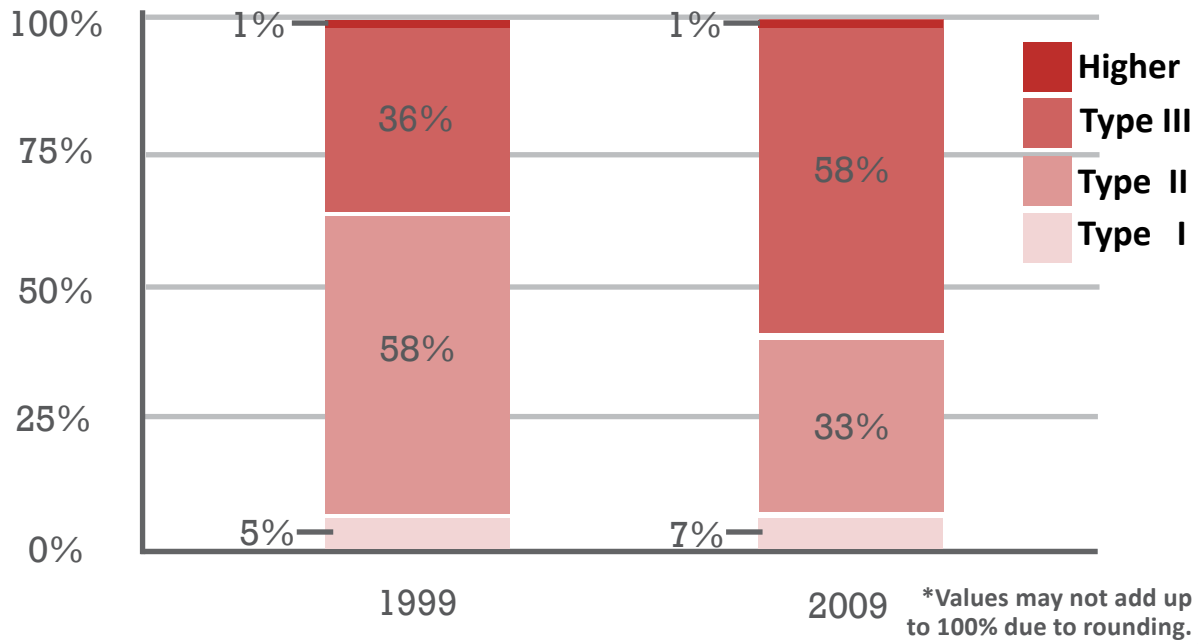

Figure 1: Statistics Canada, Residential Care Facilities.

of residents fell into either Type I or Higher Type.

Increased acuity is not necessarily a problem, if sufficient resources are put in place to ensure adequate care. However, given the diminished capacity of Alberta's elder care sector to cope with severely incapacitated elders in light of the shift toward AL, it is not surprising that increased acuity has meant that elders, their friends and families, and employees in the LTC sector have been suffering the consequences of a care gap. It is no exaggeration to say that the gap between increased needs and available care is devastating the lives of Albertans.

HFRC reports document the consequences of this care gap. The

HFRC was a panel of non-experts charged with conducting an informal, qualitative assessment of the health facilities that fall under its mandate. Members of the Committee were appointed from diverse backgrounds, with the idea of representing a cross-section of Alberta's population. Members served on a part-time basis, and were not provincial government employees. They conducted unannounced reviews of health facilities that were intended to offer snapshot views of a typical day in an Alberta health facility. They also investigated complaints. [40]

As the reports of the HFRC make clear, employees working in LTC, from upper administration through care staff, understand the care gap to have been created through increased resident acuity in the absence of increased staffing levels.

When members of the HFRC visited the Northcott Care Centre in February 2012, the Director of Care commented that "in the five years she has been at the facility acuity levels have doubled, but the funding for care staff has remained the same."[41] Through conversation with the CEO, co-owner, and director of resident care of the Venta Care Centre, members of the HFRC recorded concerns that increased acuity has not been matched with increased funding for staff.[42] As the Director of Care put it: "The low staffing ratio does not allow for quality care and often results in overtime costs, frustrated staff, and upset residents and families." [43] The Director of Care went on to explain that LTC has "become the new 'end of life' or palliative care without the appropriate funding to provide the service." [44]

"…the acuity of many of the residents is almost at the level of acute care, and staffing is not adequate to address the complexity of their care."

At Mount Royal Care Centre, staff "emphasized that the acuity of many of the residents is almost at the level of acute care, and staffing is not adequate to address the complexity of their care."[45] In these centres and many others, directors and staff were loudly sounding the alarm about the care gap in LTC.

The reports of HFRC contain many examples of compromised care clearly related to inadequate staffing. The care gap was evident in a variety of ways, including:

- **Response to call bells**

  Members of the HFRC recorded that elders in LTC had to wait between 30 minutes and 2 hours for a response to their call bell. [46] This led to situations in which residents would be wet or soiled before care staff could respond. In one instance, when members of the HFRC brought the matter to the attention of an executive director, it was explained that the heavy care needs of residents limited the ability of staff to respond more quickly. [47]

  The members of the HFRC heard from family members that

residents were regularly humiliated by having accidents when obliged to wait excessively for care.[48] While elders may suffer from incontinence due to conditions associated with aging, the situation can be exacerbated in situations that do not allow for adequate care. [48]

- **Incontinence care**

  Managing age-related incontinence in a manner that preserves resident dignity is a basic element of quality elder care. The reports of the HFRC provide evidence that the care gap has contributed to situations in which this has not been achieved. At the Venta Care Centre, for instance, a daughter found that "her mother was put in a diaper and only toileted three times a day."[49] At Carewest's Garrison Green care facility, the members of the HFRC heard of feces soiled clothing often left on the floor in residents' rooms for several hours, sometimes overnight. [50]

- **Bathing**

  Members of the HFRC heard concerns that the care gap put residents' scheduled baths at risk. For instance, in January 2012, HFRC members heard from a resident at Valleyview Continuing Care Centre that she was concerned "she might not get her weekly bath because of staff shortages."[51] In a 6 December 2012 letter to the Edmonton Journal, L.G. Anderson of Spruce Grove reported on a similar situation. At her care facility in Stony Plain, Anderson's mother-in-law required two staff-members in order to bathe safely. As Anderson put it, an inadequate resident-to-staff ratio led to a "backlog on scheduled baths."

  At the Carewest Garrison Green facility, numerous residents indicated that, should they miss their baths, they would have to wait until the following week's schedule is started.[52] At the Wing Kei Care Centre, baths are hardly pleasant experiences. Family members advised that care staff are rushed to give residents their baths, which results "in the residents not being properly washed, dried or re-clothed."[53]

- **Dining**

  The records of the HFRC document the effects of the care gap on elders' dining experiences. At the Carewest Garrison Green facility, residents reported being taken early to the dining room, and then having to wait for an hour or longer until the meal was served, as a small number of staff worked to transport a large number of residents.[54] At the Stettler Hospital and

Care Centre, the dietician raised a concern that some residents could use more assistance during meal times. Staff members obliged to care for a large number of residents have little choice but to rush people through their meals, resulting in situations in which elders may not have the opportunity to eat to satiety. In the dietician's expert opinion, this situation can increase the risk of choking, and result in harmful weight loss on the part of residents.[55]

- **Therapies**

The effects of the care gap are also apparent with reference to the available therapies. At the Brooks Health Centre, HFRC members heard that current staffing levels "are not leaving time to provide residents with the physiotherapy necessary to help them maintain their strength and mobility."[56] At Edmonton General Continuing Care in October 2010, one resident and several family members expressed concern for a resident who had been transferred from acute care after suffering a stroke. The woman was admitted with a physician's order for physiotherapy, but in the four months since her arrival, she had only seen a therapist twice.[57] The care gap also bears on residents' abilities to access what therapies may be available. At Capital Care Dickinsfield, members of the HFRC found that lack of staff to help in transportation limits residents' participation in recreational activities.[58] Similarly, at Extendicare Michener hill, staff shortages mean "that residents don't get transported to activities or therapies in time."[59]

Inadequate staffing has resulted in "nursing staff being rushed through medication administration, which could result in errors."

- **Risk of injury**

At the Valleyview Continuing Care Centre, HFRC members commented that short staffing was resulting in "nursing staff being rushed through medication administration, which could result in errors."[60] Staff at the Stettler Hospital and Care Centre worried about whether their training was adequate to cope with residents with "very complex health conditions," feeling that "staff with higher qualifications" would be better equipped to meet residents' needs.[61] Inadequate staffing can lead to situations in which residents are more likely to be placed in risky situations. For instance, a resident advised visiting members that there is not always two staff members present when they are transferring her in a lift.[62] This potentially dangerous situation could result in injury to the resident and the staff member.

Clearly, the care gap is affecting the lives of Alberta's elders in important ways. It impedes their ability to live with dignity and in comfort, and carries real consequences for their physical and mental

health. It is also a cause of distress for friends and relatives of elders in care facilities, and of hardship for employees working in residential elder care.

The direct connection between the expansion of AL and the creation of the care gap in LTC is apparent to those working in residential elder care. The medical director at the Bow View Manor, for instance, reported that "the complexity of the resident population's condition is skyrocketing" because with AHS "moving residents to AL facilities, it is becoming tougher and more difficult to qualify for admission to a LTC facility." [63]

Notably, the Alberta government was warned as early as 1999 about the need to adequately accommodate a more acute resident population in LTC. As it was argued in the 1999 Broda report, "Additional funding should be directed to increasing the number of qualified front line staff available to address the increasing acuity of people in LTC centres."[64] Unfortunately, it seems that Broda's recommendation about staffing increases fell on deaf ears. So, too, have the very clear indications provided by professional caregivers about the problems in the elder care sector. As a result, it has become a sad joke among Alberta elder care staff that it is much better to be a prisoner than a senior in Alberta.[65]

Compared with long term care, there is additional uncertainty regarding the care available to residents in assisted living.

4. B. The knowledge gap

Between 1999 and 2009, AL experienced an increase in resident acuity comparable to that seen in LTC. Within AL, residents requiring Type I care declined from 47% to 30%, while those requiring Type II care held steady. The big change was in the percentage of residents requiring Type III care, which increased from 17% to 34% between 1999 and 2009. In 1999, close to half of AL residents were of Type I and only 17% were of Type III. But by 2009, AL was split relatively evenly among residents requiring Type I, Type II, and Type III care. This change amounts to a major influx of high-acuity residents into facilities designed for less-acute needs.

The records of the HFRC made it possible to put a human face on the care gap in LTC. It is difficult to do something similar for AL because the HFRC did not visit those facilities. AL did not exist when the mandate of the HFRC was defined decades ago, and no effort was later made to bring AL under its purview. This dearth of information amounts to a knowledge gap regarding the experiences of elder Albertans in AL.

The knowledge gap also relates to the regulatory differences between AL and LTC. Under the *Nursing Homes Act* or the *Hospitals Act*, LTC facilities are obliged to meet some key standards. For example, LTC operators are required to provide elders with access to a

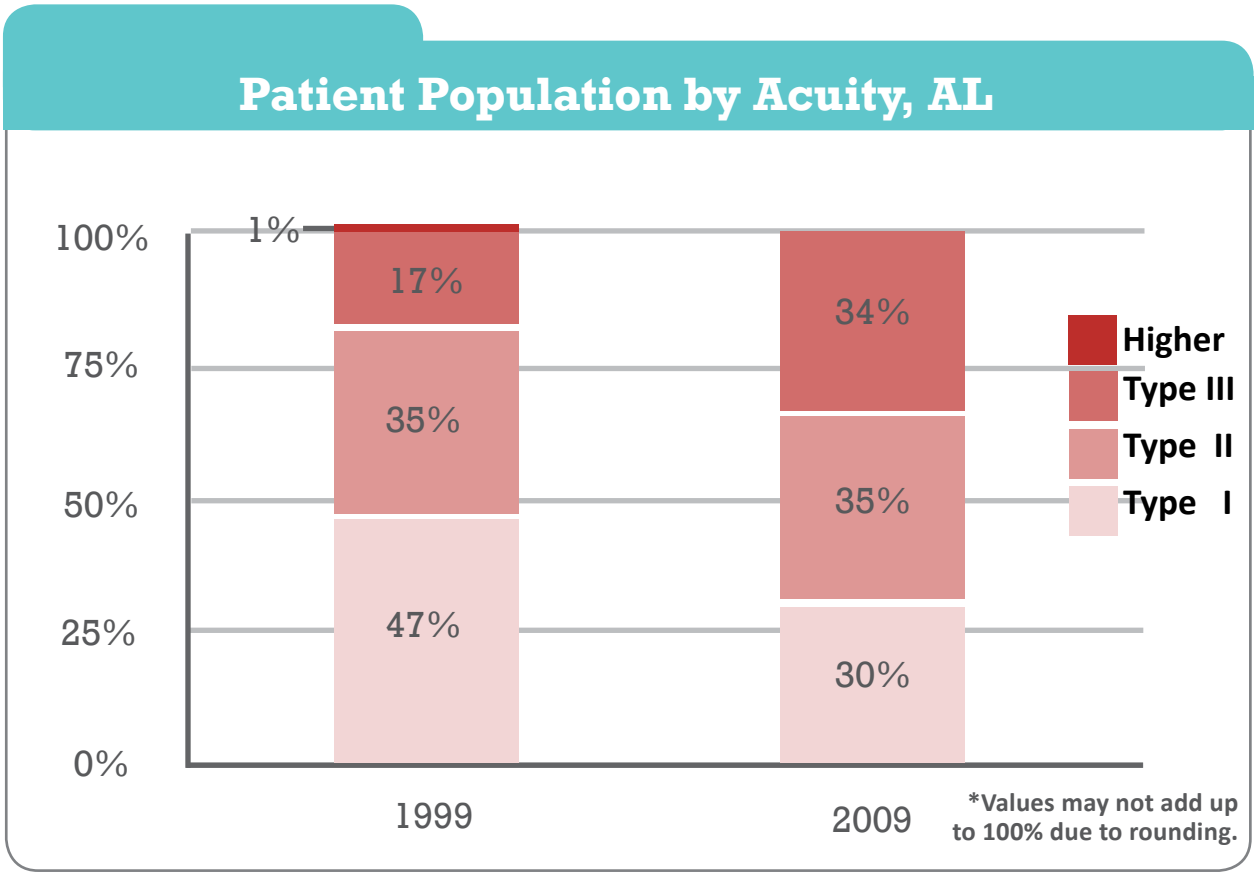

Figure 2: Statistics Canada, Residential Care Facilities.

representative of their religion. They must supply three dietician-approved meals per day, accommodate special dietary requirements, and provide continual access to snacks. Operators of LTC facilities must offer an annual staff education program on topics including gerontology and infection control. LTC facilities are also obliged to meet certain standards related to staffing, both in terms of minimum care to residents and minimum training levels for staff. While these standards fall far short of expert recommendations regarding the staffing levels necessary to ensure adequate care, they do amount to a measure of protection that is unavailable within AL.[66]

Regulated by the *Supportive Living Accommodation Licensing Act*, AL facilities are subject to very little by way of legal requirements, beyond basic provisions for safety and cleanliness. Neither the *Supportive Living Accommodation Licensing Regulation* nor the *Continuing Care Health Service Standards* fills the gap by providing meaningful assurances that residents in AL can rely on care that will safeguard dignity and comfort. Considering also the role of home care in supporting residents in AL, the lines of accountability are substantially less direct within AL as compared with LTC. As a result, there is additional scope for uncertainty regarding the care available

to residents in AL.

As of 2013, the knowledge gap in Alberta elder care has expanded dramatically. The Government of Alberta has eliminated the HFRC, claiming that various other government programmes make its work redundant. It should be noted that the HFRC was by no means an ideal mechanism through which to monitor elder care. As noted above, the committee lacked a mandate to verify compliance with basic standards, or to assess quality of care in a rigorous manner. Committee-members were not trained health professionals. Most importantly, there is little evidence that the reports of the HFRC have prompted meaningful changes in government policy. Both limitations in the scope of the committee's investigations and limitations in the influence of the resulting reports kept the HFRC from having substantial effect on the delivery of health services in Alberta. However, the reports of the HFRC did provide some record of resident, friend and family, and staff experiences that may not otherwise have been preserved. Certainly, it is unclear that other existing government programmes will make public information comparable to that available through the reports of the HFRC.

The severity of the knowledge gap is redoubled by circumstances not under the control of the provincial government. Within the context of this report, it was possible to assess the increased resident acuity in Alberta elder care through examination of Statistics Canada's RCF survey. This data series was terminated in 2010 and has not been replaced by any other statistical documentation of residential elder care across Canada. From this perspective, Alberta residential elder care falls within a nation-wide knowledge gap.

4. C. Workers' experiences

As increased resident acuity has affected resident and family experiences in negative ways, so has it affected the people working in the elder care sector. In the absence of resources sufficient to compensate for changed resident populations, a more incapacitated resident population has created an extremely difficult situation for Albertans employed as caregivers.

In the absence of appropriate workplace supports, residents' increased medical acuity and complexity has created an extremely difficult situation for Albertans employed as caregivers.

The records of the HFRC make clear that employees have sought to make up for inadequate staffing, even at the expense of their own physical and mental wellbeing. Staff at the Vegreville Care Centre indicated that "they did not have time to take their breaks because of the workload."[67] Family members of residents in the Good Samaritan South Ridge Village expressed concerns that staff members are working too hard, indicating that "they never have a break!"[68] At the Edith Cavell Care Centre in Lethbridge, staff explained to members of the HFRC the direct connection between "the increased complexity of care" and "increased injury and illness" among staff.[69] These

Alberta-specific examples confirm the significant risks to elder care staff that national and international researchers working on LTC have documented.[70]

Staff-members forced to overextend themselves may then be obliged to miss work in order to recover. Given apparent employer difficulties in securing replacement workers, the result is that the acuity gap is rendered even more severe by staff absences. The situation was apparent to family members at the Good Samaritan South Ridge Village, who observed that employees are often obliged to work short-staffed, as the facility "can't get someone to come in to cover if staff are off sick."[71] Employees working in residential elder care who were consulted through the research process for this report have indicated that working short-staffed is standard practice.

Labour conditions have a direct bearing on resident experience. Staff turnover can seriously erode resident quality of life due to the value of interpersonal relationships, particularly in light of the intimate nature of many tasks undertaken by elder care staff.[72] At Carewest Garrison Green, one resident said that residents never have the same health care aide (HCA) attending to them for more than a few days, so they never get to know the aide, and the aide never gets to know them.[73] In a letter to the Red Deer Advocate published 15 January 2013, R. Dean Cowan of Red Deer worried that a strike at his wife's facility (Symphony Senior Living, Aspen Ridge) would seriously affect her well-being. His dementia stricken wife depended on her familiar caregivers, with whom she had built relationships. Cowan wrote that, "whenever a new employee starts" his wife "becomes quite aggressive towards them." This example vividly illustrates how upsetting staff instability can be for elders.

Researchers have documented the risk of physical violence faced by elder care staff in their day-to-day work.[74] In conversations with front-line staff undertaken for this report, workers reported being punched, hit, spit on, bitten, and having their hair pulled. Elder care workers also suffer intellectually and emotionally. At Elk Point Healthcare Centre, the HFRC spoke with the head nurse, health care aides, and other staff, all of whom expressed distress at what they saw as the inadequate care provided to residents. Members of the HFRC noted that many staff-members were very emotional about this situation, exhibiting sadness and frustration. The report of the HFRC concluded that feelings of stress amongst staff derived from their perceived inability to provide timely and adequate care are affecting resident care and staff morale.[75] Researchers examining workers' experiences in residential elder care have applied the concept of structural violence as a means of describing the poor working conditions and lack of support experienced by elder care workers. Structural violence impedes careworkers from providing the quality of care that they recognize should be available to elders.[76]

In conversations with residential elder care staff undertaken for this report, a recent trend became apparent. Numerous employees documented increasing concern with 'customer service' among the owners and operators of elder care facilities. Further, Extendicare, a large corporate provider of elder care with 246 facilities across Canada and the United States, notes in its annual report that it has implemented a customer service training program (Courtesy Attitude Responsibility Excellence, or CARE) to train all front line workers on how they can improve their contribution to managing and delivering upon customer service expectations in a competitive market.[77]

Disturbingly, this concern with 'customer service' is manifest not as renewed attention to the well-being of elders, but as preoccupation with cultivating a positive impression of the facility among the friends and family of residents. Some facilities have begun employing greeters to intercept visitors at the door, and to ensure insofar as possible that they are pleased with what they see. Staff responsible for resident care have been ordered to avoid mentioning if they are short-staffed, as this may leave friends and family with a negative impression. Some workers in the elder care sector tell of operators instructing families to call before they visit, which suggests a potential variation in level of care based on whether a visit is pending.

In a situation where the primary focus remained on ensuring quality care for residents, there would certainly be no harm in also working in a sincere manner to improve the experience of visiting friends and family. However, in a situation in which emphasis is placed on cultivating a positive impression despite clear evidence of inadequate care, there is reason for concern. Workers in the elder care sector are being asked to participate in furthering a knowledge gap that may mislead friends and family about the quality of care their loved ones are receiving.

4. D. Conclusion

The shift toward AL, motivated by government desire to trim public expenditures and expand opportunities available to for-profit health care providers, has had serious negative consequences for Albertans served by the elder care system. The concentration of severely-incapacitated elders within LTC has contributed to a discrepancy between residents' needs and available care. This care gap has caused inconvenience, discomfort, and a higher risk of injury to elders in LTC.

The facilities mentioned by name in this report are illustrative of a broader pattern. Roughly half of the HFRC reports examined for this report included at least one example of inadequate care attributable to the care gap, and many facilities included multiple examples. It is clear that difficult conditions in Alberta residential elder care have

serious negative consequences, not only for elders and their support networks, but also for employees working in residential elder care.

This section also considers the knowledge gap in Alberta residential elder care, which inhibits attempts to closely examine resident experiences within AL. In the absence of reports from the HFRC, and in light of the lesser regulation to which AL is subject in comparison with LTC, there is ample reason for concern. The situation is rendered even more worrisome by the elimination of the HFRC and the cancellation of the RCF survey, the key Statistics Canada data set addressing residential elder care. Ultimately, with respect to the availability of information about the experiences of elders in residential care, the situation is becoming increasingly dire in both LTC and AL.

5. Privatization

Along with significant evidence of unmet need across Alberta's entire residential elder care system, there is also reason for concern that the quality of care may be drastically uneven among the province's residential elder care facilities. This section compares care quality among public, not-for-profit, and for-profit LTC facilities.

It seems intuitively obvious that more skilled caregivers, with more time to spend on each resident, provide better quality care. This relationship between staffing and care quality has been substantiated by academic experts.[78] A key factor bearing on the quality of care is the ratio of caregivers to residents, with more caregivers associated with better care. Another important factor is the level of training and expertise among professional caregivers.

Long term care in Alberta only very rarely meets or exceeds experts' benchmarks for minimally acceptable care. In the vast majority of years considered here, the benchmarks for quality care remain far out of reach.

Statistics Canada's RCF survey provides data on staff hours and number of residents in LTC facilities. By incorporating expert benchmarks on care time needed to achieve minimally acceptable and reasonable quality care, it is possible to gauge whether Alberta elders have access to appropriate levels of care.[79] The findings are disturbing. LTC in Alberta only very rarely meets or exceeds the benchmark for minimally acceptable care. In the vast majority of years, across delivery models, the benchmark for quality care is far out of reach. These findings further substantiate the existence of a care gap in Alberta residential elder care.

Importantly, the care gap varies in severity according to delivery model. This section explores the significant differences in staffing patterns among Alberta LTC facilities that are operated publicly, by a non-profit group, or by a for-profit enterprise. In AL, care is often provided primarily through home care, which is not assessed in the Statistics Canada data set employed here.

5. A. Care time by delivery model

Schematic literature reviews are scholarly attempts to analyze the findings of a large number of studies on a given topic. Two such recent reviews have been conducted on the topic of variations in care quality between elder care facilities operated publicly or by for-profit or not-for-profit enterprises. In a review of relevant studies published between 1990 and 2002, Hilmer et al. established that nursing staff levels were lower in for-profit facilities.[80] In an even larger examination of studies published between 1965 and 2003, Comondore et al. found that not-for-profit facilities exhibited more or higher quality staffing.[81]

Recent years have seen the expansion of research along these lines in a Canadian context. Numerous studies of the Ontario situation have connected delivery model to staffing levels. A 2005 analysis of Ontario LTC facilities between 1996 and 2002 found that public facilities had higher nursing intensity levels and higher direct care staffing levels than other delivery models, while for-profit facilities have significantly lower levels than other facility types.[82] A 2005 study of the British Columbia situation found the mean number of hours per resident-day was higher in the not-for-profit facilities than in the for-profit facilities for both direct-care and support staff, and for all facility levels of care.[83] Studies have linked staffing differences to resident outcomes, with residents faring better in better-staffed facilities.[84]

Alberta long term care exhibits significant variations in quality among for-profit, not-for-profit, and public delivery models, with for-profit facilities offering inferior care.

Alberta long term care conforms to these broader patterns, exhibiting significant variation among staffing levels between delivery models. Total direct care hours per resident-day encompasses the various services (including nursing and personal care) that elders in long term care receive from registered nurses [RNs], licensed practical nurses [LPNs] and HCAs, measured in hours per resident per day. As displayed in Figure 3, on average across the decade between 1999 and 2009, public facilities hover around the benchmark for minimal care. Non-profit facilities are, on average over the period considered, just over 40 minutes short of the minimal care benchmark. For-profit facilities fare the worst of all, averaging roughly an hour and ten minutes short of the minimal care benchmark.

It is critical to note that the figures analyzed above overstate the direct care received by LTC residents. The Statistics Canada data employed here addressed time paid, not time worked. Paid hours include holidays, sick time, and other compensation over and above time spent engaged in labour. A study of care facilities in British Columbia found that paid hours were 15 to 30 percent higher than actual hours worked.[85] Had it been possible to subtract paid hours not spent in direct resident care, the situation would be revealed as even more dire.

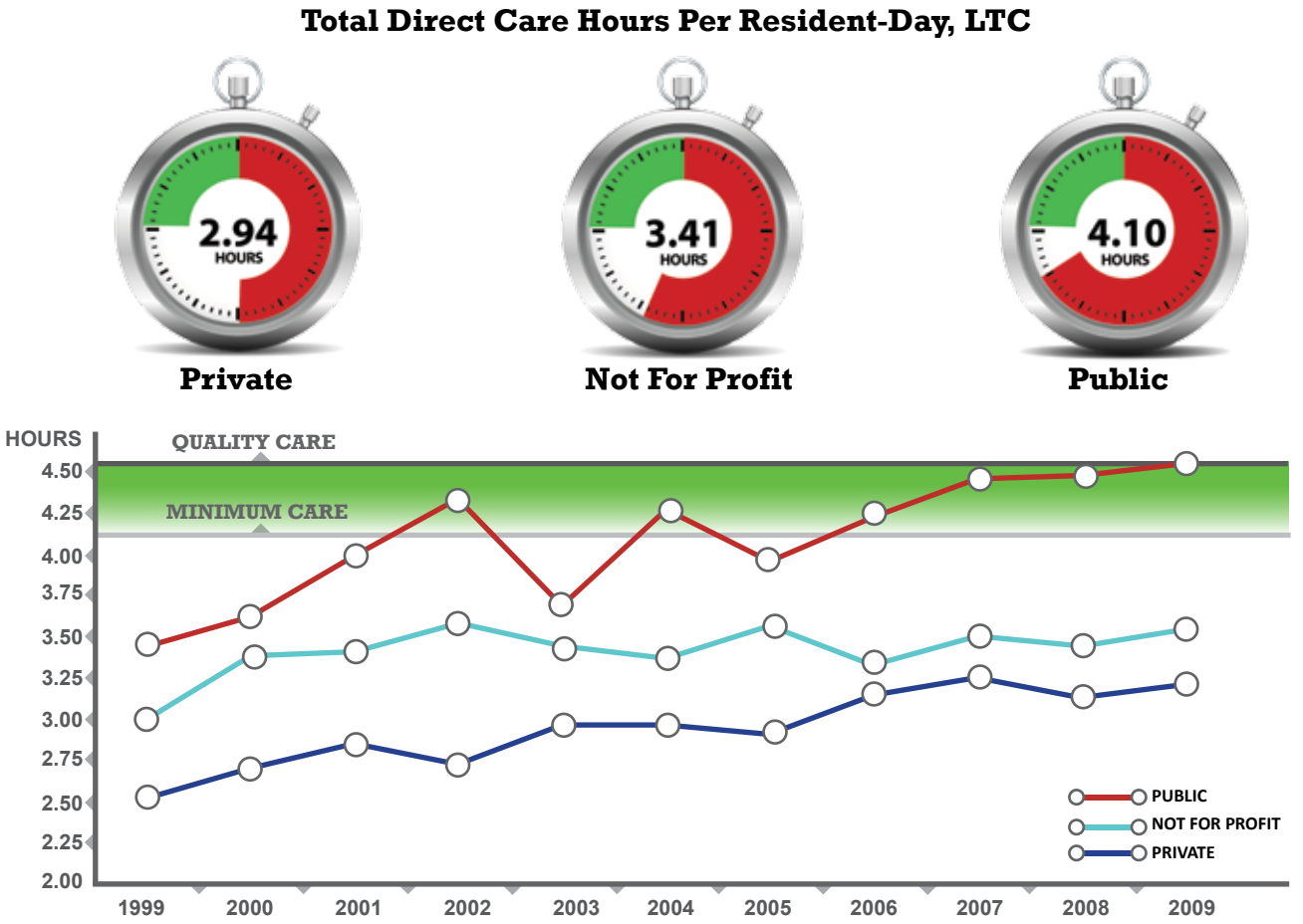

Figure 3: Statistics Canada, Residential Care Facilities.

The situation in Alberta LTC facilities conforms to the prevailing national and international pattern with respect to differences in care quality across delivery models, as indicated by staffing levels. Based on their studies in other jurisdictions, experts Harrington et al. have come to the conclusion that, in elder care, "profit seeking diverts funds and focus from clinical care."[86] Another Canadian study concluded that "public money used to provide care to frail elderly people purchases significantly fewer direct-care and support staff hours per resident day in for-profit LTC facilities than in not-for-profit."[87] These assertions would seem to hold true in Alberta. In expanding opportunities for for-profit participation in Alberta elder care, the provincial government has promoted a move toward a delivery model that is associated with lower quality care.

5. B. Caregiver expertise by delivery model

Care quality is affected not only by the amount of care available, but also by the expertise of those delivering the care. While in a supportive work environment, all caregivers have the capacity to perform their duties conscientiously and compassionately, the advanced

training possessed by staff such as LPNs and RNs allows them to offer specialized care or to perform tasks that are beyond HCAs.

Over the decade between 1999 and 2009, a dramatic transformation took place in the staff mix within Alberta LTC facilities. This is documented in Figure 4. The proportion of care provided by HCAs has increased across all delivery models. The proportion provided by LPNs has decreased drastically, while the proportion provided by RNs has decreased more modestly, though still significantly. Overall, these shifts amount to a de-skilling of the LTC labour force, creating a situation in which there are fewer staff-members positioned to provide specialized nursing care. This is occurring even as the acuity and complexity of the resident population is increasing.

Staff Mix in Alberta LTC Facilities

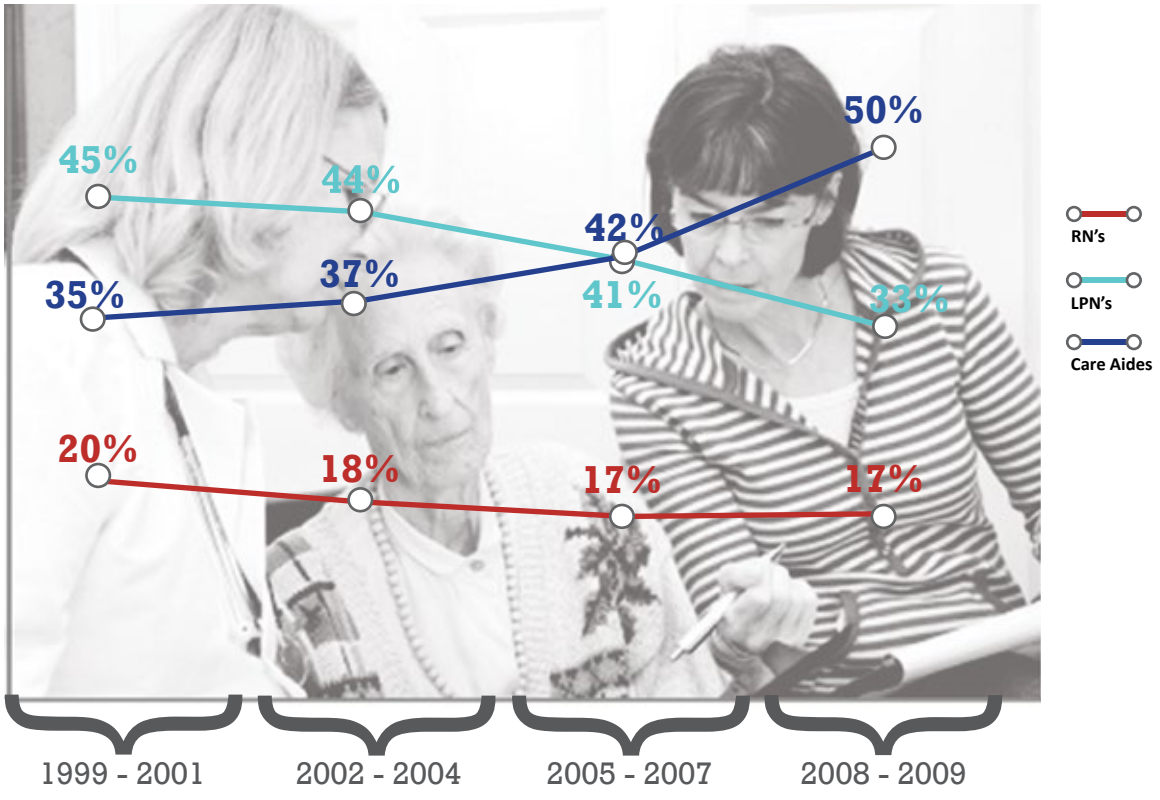

Figure 4: Statistics Canada, Residential Care Facilities.

In relation to the care available from highly-trained staff, there are important differences to note between delivery models. Figure 5 makes clear that all delivery models fall far short of the 69 minutes of care per resident per day by RNs that is considered the benchmark

for quality care.[88] Over the years in question, public facilities hovered around the minimal care benchmark of 45 minutes per resident per day.[89] Both non-profit and for-profit facilities fell short of the minimal care benchmark, with for-profits averaging the worst of all over the period in question. Of all delivery models between 1999 and 2009, public facilities came the closest to hitting the quality care benchmark in 2002, when they offered 52 minutes of care. In contrast, over the decade considered here, private facilities offered, at most, just under 35 minutes of care.

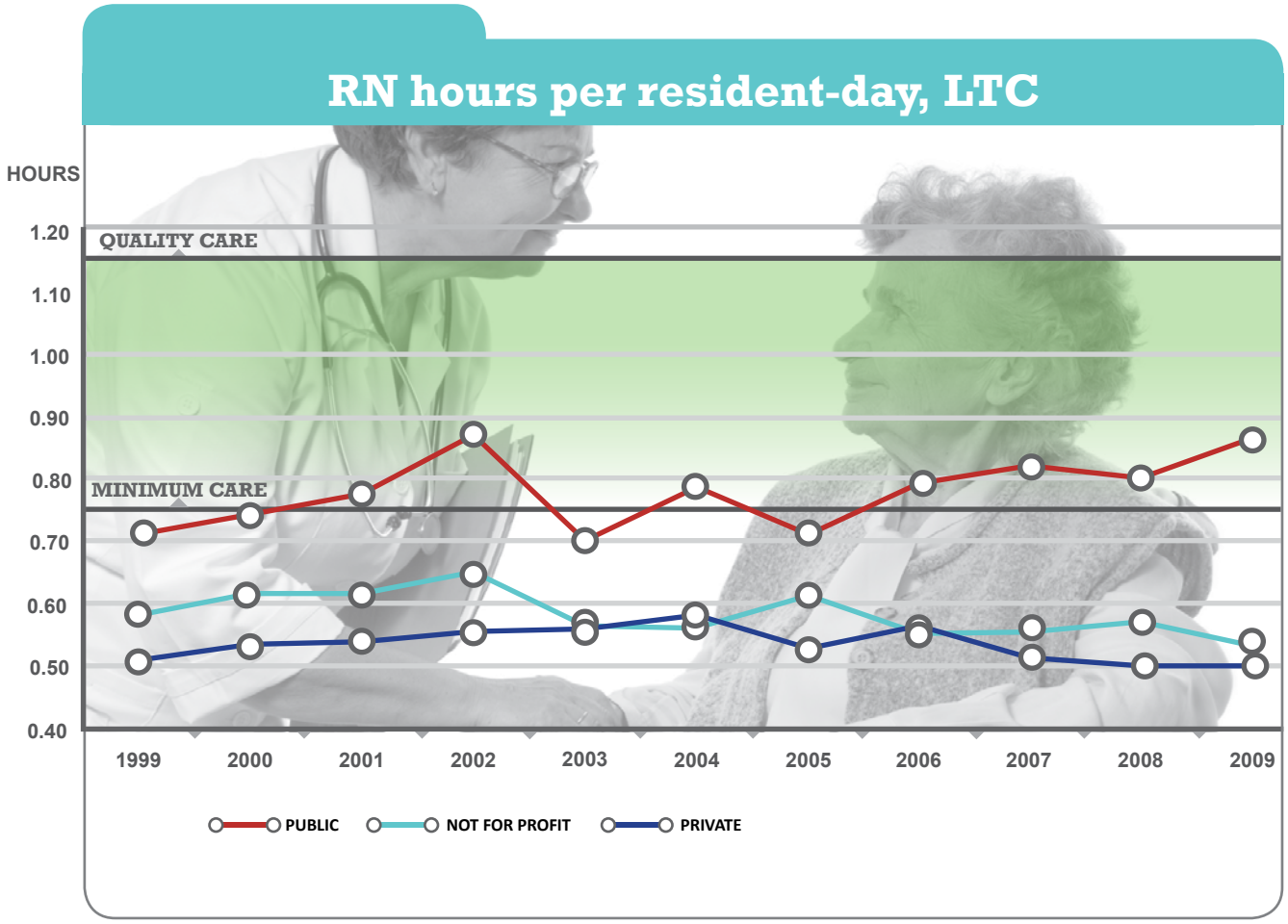

Figure 5: Statistics Canada, Residential Care Facilities.

Notably, in research workshops with staff working in the elder care sector, participants commented numerous times that RNs are increasingly placed in administrative and supervisory positions. Their time might be spent overseeing those engaged in hands-on resident care, or in preparing resident reports. It is possible that residents fail to receive significant benefit from even the minimal period of expert RN care that this data would suggest is available to them.

Further, once again, these measurements of care time pertain to the hours for which employees are paid, not the hours they actually spent working with residents. Subtracting paid time not spent in direct resident care, if the data made it possible to do so accurately, would provide a more realistic picture of the care available to elder Albertans.

5. C. Workers' experiences

Private delivery of elder care has consequences for employees working in the elder care sector. An Ontario study linked for-profit ownership with higher rates of workplace injury, more severe injuries, and greater fear of repercussions for reporting injuries.[90] Further, private operators typically offer lesser compensation packages to their staff. The variation is evident in recent Alberta collective bargaining experiences.

- In 2012, the Alberta Union of Provincial Employees achieved first contracts for the workforces at Hardisty Care Centre[91] and Devonshire Care Centre,[92] both owned by BC-based Park Place Seniors Living Inc. The major achievement in both contracts was to bring staff wages in line with rates of pay at public facilities. Workers at Hardisty were on strike for two months before a settlement was achieved.

- In November 2012, the Canadian Union of Public Employees reached a settlement for workers at a for-profit elder care centre that offered auxiliary nursing staff salary increases of 10.9% over three years, and improvements in shift and weekend premiums in order to bring them in line with rates paid at public facilities.[93] This settlement was achieved with the assistance of a mediator.

- In April 2013, a labour dispute at Monterey Place elder care facility in Calgary was finally resolved after a 280-day lock-out. While the settlement brought a 44% increase in health care aides' wages and a 40% increase in licensed practical nurses' wages, at the end of the four year deal, Triple A Living Communities Inc., the facility's operator, will still be paying its staff at levels below the rates offered to employees in public facilities.[94]

It is obvious that collective bargaining achievements benefit workers by improving wages for the work of caring for the elderly. What may be less obvious is how they benefit Albertans at large. Alberta Health Services funds all facilities in a manner that assumes wage rates equivalent to those paid under Alberta Health Services collective agreements.[95] So private operators are funded to pay their nursing staff at the same level as Alberta Health Services employees

doing the same job, but some operators nevertheless continue to pay lower wages. The result is that public funds intended to ensure sufficient numbers of qualified elder care staff are diverted toward facility owners.

As workers at Hardisty Care Centre found, strike action may even be necessary in order to secure wages paid at the rate Alberta Health Services assumes private operators are paying their staff. Considering this, it is worrying that the Alberta Continuing Care Association, the lobby-group for the elder care industry, has been pressuring the Government of Alberta to take away the right to strike from workers at unionized private and non-profit LTC and supportive living facilities.[96]

5. D. Conclusion

This section considers the quality of care received by Alberta elders in LTC. It makes clear that, measured according to the benchmarks established by experts, LTC staffing has largely failed to meet the levels deemed necessary to ensure even a minimal quality of care. It also makes clear that while even public facilities fail to achieve adequate staffing, not-for-profit facilities do worse, and for-profit facilities worst of all. This is consistent with research conducted elsewhere, which has established a link between for-profit ownership and lower staffing levels. Given the established connection between staffing levels and care quality, this amounts to a lower quality of care for Alberta elders in for-profit LTC facilities. This section also makes clear how inadequate wages paid at for-profit facilities amount to a diversion of public funds toward the coffers of private operators.

Over the past 15 years, residential elder care in Alberta has been administered in a manner that has led to the increased participation of for-profit enterprises. This questionable approach to residential elder care has resulted in negative effects on Albertans in elder care, their friends and families, and employees working in the elder care sector.

6. Offloading

Offloading, the process of transferring costs and responsibilities from the public system to private citizens, is basic to elder care in Alberta. Such transfers have been presented as means of limiting public expenditures on elder care. But changing who pays for or provides care does not make it free. To gain a true understanding of the costs of elder care, including its consequences for Alberta's society and economy, it is essential to track the effects of offloading. This broader conceptualization emphasizes both the economic and noneconomic consequences of offloading and makes clear that

offloading is not in the best interest of elders, their friends and family, or the broader Alberta public.

Elder Albertans are evaluated for placement in LTC or AL through an assessment of unmet health needs. As defined by Alberta Health Services, unmet health needs are "care requirements that remain after the abilities and existing supports of the client, family and of the community have been considered…."[97] The system is structured to ensure the capacities of friend and family caregivers are exploited to the maximum before public supports are put in place. In this way, the goal of minimizing the role of the public system is built into the process through which elders' needs are assessed.

As has already been noted, residents in LTC and AL are levied a cost for their accommodation. The Alberta government contends that the specialized accommodation provided in these facilities is not a health service, with the result that the government is not obliged to ensure free access to all. This unbundling of accommodation and health services rests on the questionable notion that, for elders, health services and accommodation arrangements can be separated. In reality, often elders are faced with little choice but to access the specialized accommodation that makes possible the health care services they require. Notably, Alberta's Auditor General has said that the costs levied on residents with respect to accommodation are not based on any actual summing of relevant expenses. In fact, the Auditor General went on to explain that the Government of Alberta has not "defined what services accommodation rates cover."[98] There is reason to question both the idea that health and accommodation services can reasonably be divided and the specific amount the Government of Alberta has seen fit to levy as accommodation-related charges.

Friends and family of elders in Alberta long term care have been obliged to compensate for inadequate care by paying for more care or performing care themselves.

Beyond the charges they are assessed with respect to accommodation, residents in LTC are also generally obliged to pay out-of-pocket for costs such as laundry, hair-dressing, and television. Personal care items such as toiletries and oral care supplies are also a cost to the resident.

6. A. Inadequate care

Even once elders are accepted into the residential elder care system, substantial responsibilities remain for friends and family-members. In the Alberta case, friends and family of elders within LTC have been obliged to contribute substantially in order to compensate for an inadequate standard of care. These contributions have come either in the form of financial outlays or outlays of time.

The records of the HFRC document efforts by families to hire supplementary caregivers. At Capital Care Dickinsfield, the HFRC noted that

some families felt obliged to hire private caregivers "to provide one-on-one care and attention to their loved ones."[99] These caregivers, committee members go on to explain, also facilitate basic recreational opportunities, such as going for walks or doing some shopping.

In response to a concern of the HFRC with respect to staffing, an administrator with the Edith Cavell Care Centre noted that the facility is "fully staffed according to the Alberta funding requirements."[100] The administrator then went on to note that dissatisfied families "have access to paid companions that provide extra hours for feeding residents and support."[101] At Barrhead Continuing Care, in response to concerns over bathing frequency, staff advised members of the HFRC that those desiring more frequent bathing could pay for the service through a private provider, at their own cost. [102] Such suggestions from elder care providers indicate that the practice of paying out of pocket to ensure adequate care has become well-entrenched across the residential elder care system.

These examples illustrate the financial outlay required of residents and their families in order to achieve a minimum standard of life and quality of care. Such examples also raise concerns about variations in care quality among those able to pay and those of more modest resources.

The reports of the HFRC also document instances of family members' attempts to compensate for inadequate care through their own unpaid labour. At Carewest Garrison Green, the HFRC found a troubling situation in relation to morning dining. Members observed that, on both days they visited, there were no staff-members assisting residents with their meals. What assistance residents did receive was offered by a family member who was delivering food from the kitchen to the residents. The family member informed the HFRC that she had begun coming to help her father with his breakfast, but had been so disturbed by the lack of assistance provided to others that she decided to take the training course that would enable her to participate in serving meals. She noted that her sister had also taken the course, so her sister would be able to assist with the evening meal.[103]

In Alberta LTC, friends and family of elders have been obliged to either pay for additional services, or to provide these services themselves, in order to ensure that their loved ones receive a very basic standard of care. Inadequate care throughout the LTC system has resulted in rampant offloading onto the friends and family of elders. This situation also raises concerns about elders who may lack such personal support networks.

6. B. Assisted living

While offloading exists throughout Alberta's residential elder care

sector, it is more extreme in AL than in LTC. Residents in AL are obliged to pay costs related to accommodation, as in LTC. They are also subject to a wider array of additional costs. These include costs related to:

- **Medications**

  Medication costs are absorbed by the public system when the resident is in an acute care hospital or an LTC facility. Seniors in AL have access to the drug coverage the Government of Alberta extends to all seniors. While this coverage is in flux at the moment due to changes announced with the 2013 provincial budget, to this point all Alberta elders have had access to Blue Cross coverage, including up to $25,000 in health-related benefits per year. Roughly 30% of available drugs were not covered by Blue Cross, and therefore residents were obliged to purchase them privately. Further, elders were also expected to pay up to $25 per prescription or refill.

  Additionally, certain AL facilities establish conditions that increase drug costs, such as requiring residents to have their medications bubble packed (which is available from pharmacies for a fee), or to store only a month's worth of medication at a time (which obliges elders to pay pharmacy dispensing fees more often).

- **Specialized supplies and equipment**

  In LTC, specialized supplies and equipment (such as incontinence products, lifts, grab bars, walkers, and supplies related to diabetes management) are provided to elders in need. In AL, with the exception of selected purpose-built facilities that may include modifications such as grab bars, it is the resident's responsibility to purchase needed supplies and equipment privately, or to take their need directly to Alberta Health Services.

  The financial burden of purchasing such supplies can be substantial. Further, even in situations where financial assistance is available, residents' abilities to access the specialized supplies and equipment they need depend on their success in navigating an unfamiliar, bureaucratic process. Additionally, the Government of Alberta and private insurance companies must then process each and every claim, an arrangement that carries substantial costs in time and human resources.

- **Therapies**

  AL does not include therapies (occupational, physical, or recreational) that would be included in LTC. Whatever therapy may

While many residents in assisted living may pay the same daily rate levied on long term care residents, their additional costs may be substantially higher.

be available is administered separately through Alberta Health Services, which serves to increase the administrative burden on residents and their friends and families. Further, AL facilities often do not include the specialized spaces required for effective therapy. Getting therapy may mean traveling off-site, a process that can be difficult for elders, and which creates additional costs related to transportation and accompaniment.

Notably, it is not only residents in AL who may be obliged to pay privately for therapies in order to ensure adequate care. According to the records of the HFRC, a family member at a LTC facility indicated that "in order for her husband to maintain his mobility she takes him to a private clinic for therapy several times a week because there is not enough therapy available on site."[104] This suggests how offloading through inadequate care may be serving to erode the differences between LTC and AL.

These examples make clear that while many residents in AL may pay the same daily fee related to accommodation that is levied on LTC residents, additional costs may be substantially higher. Further, there is a significant burden of labour that accompanies the financial burden. Elders, or more often their friends and family, are obliged to seek out and arrange all of the various goods and services necessary to supplement the very basic offerings in AL facilities. Whatever financial supports may be available must be identified and arranged, which further increases the labour burden. As offloading occurs, fragmentation of service delivery also becomes a problem, as residents and families in crisis are obliged to negotiate with various providers in order to fulfill care needs.

Another issue is the greater unpredictability of costs in AL as compared to LTC. Many elders living on fixed incomes experience significant difficulty in coping with price volatility. Because private operators work at least in part on a fee-for-service basis, these operators have an incentive to try to upsell their clients. Vulnerable elders may end up paying for services that are not strictly necessary or desirable. There is evidence out of the United States that unnecessary services are provided at a far higher rate by for-profit rather than not-for profit operators.[105]

Offloading costs and responsibilities from the public system to individuals in need carries consequences that extend to society at large.

6. C. The costs of offloading

Offloading does not make the needs of elders disappear. Rather, it shifts the responsibility for meeting these needs, further burdening elders and their friends and families. Notably, the costs of offloading are not limited to those with immediate contact with the residential elder care system. Rather, the effects of offloading have consequences that extend to society at large.

Scholars Janet E. Fast, Deanna L. Williamson, and Norah C. Keating have undertaken a review of academic research on what is called friend/family caregiving. From that basis, they developed a list of stakeholders affected by offloading, including care recipients, caregivers, families of caregivers, and employers of caregivers. They found that friend/family caregiving "is associated with a number of hidden costs that seldom enter into discussions about health care and social policy."[106] This section employs the list of stakeholders developed by Fast, Williamson, and Keating to structure a discussion of the consequences of offloading.

Costs associated with friend and family caregiving include:

- **Costs to informal elder care recipients**

  Primarily non-economic, these costs are largely emotional and relate to concerns over loss of independence and fears of becoming a burden. Evidence suggests that these costs are greater for seniors receiving care from friend/family caregivers than from professional caregivers. Costs can also be related to risks to care recipients' physical health, in cases where over-whelmed caregivers may increase the risk of elder abuse. Costs may also be economic, relating in large measure to subsidies to the living expenses of their caregivers, or other forms of financial assistance that may or may not be explicitly tied to caregiving. Care receivers may also try to reciprocate with labour insofar as they are able. Providing childcare to grand-children is one example.

- **Costs to friend/family caregivers**

  The well-documented costs associated with providing infor-mal elder care include impaired emotional well-being (as in instances of resentment or stress over caregiving), as well as risks to physical health (as in disruptions to sleep or other forms of strain). There are also costs in terms of social well-be-ing, as the time dedicated to care-giving can cut in to time that would otherwise have been dedicated to cultivating other relationships. The economic costs associated with providing informal elder care are also established through research. Caregivers typically contribute a substantial amount of unpaid labour, which may impede their ability to succeed or advance in the paid workforce. Informal caregivers also often absorb substantial out-of-pocket costs associated with care-giving, including those associated with the purchase of specialty supplies, as well as those related to feeding and housing an additional adult. Further, some caregivers make time for caring by purchasing services such as childcare or yard work. Respite

care, purchased to give caregivers a break, is another out-of-pocket cost.

- **Costs to families of friend/family caregivers**

  Caregivers' families share in some of the burdens borne by the caregivers. The quality of social relationships within a family may be affected in a negative manner. The additional burden on caregivers' time is a key factor here. Disruptions to schedules and loss of privacy are other considerations. Resentments may develop among family-members who may be involved to varying extents in caregiving.

- **Costs to employers of friend/family caregivers**

  Employers can experience costs related to employees' caregiving obligations. These include absenteeism, turnover, lost productivity, and lower quality work. Attempts to accommodate the needs of employees engaged in caregiving through family-friendly working arrangements (such as extended leave and employee assistance programmes) can carry economic expenditures to employers, even as these programmes stand to reduce conflicts between caregiving and paid work.

Fast, Williamson, and Keating also highlight the costs to society as a further, if less well-researched, area of concern. As examples of concrete, society-wide impacts of friend and family caregiving, the authors point to decreased tax revenues from unemployed or underemployed caregivers, and increased expenditures on health care for exhausted informal care providers. A further consideration is the substantial regulatory cost required to ensure compliance with care standards in a heavily privatized sector.[107]

Fast, Williamson, and Keating have determined that "informal elder care is not, in fact, the costless solution it often has been assumed to be."[108] Ultimately, they find the argument that there are fewer economic and non-economic costs associated with friend and family caregiving "is untenable when costs beyond public sector costs are considered."[109]

Of course, the consequences of relying on friend and family caregivers are not just negative. For instance, caregivers can experience benefits such as satisfaction in their task, and increased understanding of others. Care receivers might experience diminished loneliness or boredom as compared to other seniors.[110] However, recognizing these considerations should not detract from an understanding that reliance on friend and family caregivers is an approach that carries costs of its own. These expenditures are experienced not only by the individuals directly involved, but also by the wider community.

Unpaid caregiving often falls to women. Regardless of employment status, women are typically more heavily engaged than men in meeting the health care needs of friends and family members.[111] Because they bear the heaviest burden of care, women also experience the most dramatic consequences from their caregiving, including consequences for paid work, physical health, and emotional wellbeing.[112]

6. D. Conclusion

The significant offloading of costs and responsibilities in Alberta AL is a major factor that makes this care model appeal to a government focused on cutting public expenditures. But offloading serves to significantly increase the burden, financial and otherwise, on elders and their families.

Notably, the costs of offloading are not borne solely by those with intimate involvement in the elder care system. Rather, caregivers' families, their employers, and even society at large bear the related costs.

7. Elder care for profit

The expansion of AL in Alberta was motivated by the government's goal of cutting public expenditures, but also by its desire to open opportunities for for-profit enterprise. This section considers the current state of for-profit residential elder care in Alberta. It begins with a survey of the participation by private, for-profit enterprises before moving to a close examination of the track-record of Extendicare, a multi-national elder care operator currently active in the province. Extendicare is publicly-traded, which obliges it to make public significant information about its financial situation and governance structure. Because of this, it offers a window on broader operations within the private elder care sector. Finally, this section addresses the financial rewards achieved by for-profit residential elder care providers operating in Alberta.

7. A. Private elder care in Alberta

The residential elder care market is quite concentrated, with the top six companies by number of beds controlling 45% of all elder care spaces and owning 40% of the facilities.

A wide variety of for-profit entities that specialize in elder care have been attracted to Alberta. The sector ranges from small, privately-held companies who own one or two facilities (e.g. Triple A Living Communities or AdaptaCare Personal Care Homes Inc.), to major multi-provincial and multi-national corporations (e.g. Revera, Diversicare, and Chartwell). There are also medium-sized companies and corporations with a chain of facilities located predominantly within Alberta (e.g. AgeCare, Integrated Life Care Inc., and Qualicare Health Services Corporation), as well as medium-sized chains that are predominantly based outside of Alberta and currently have only a toe-

hold in the province (e.g. Golden Life, Caleb Group, or Touchmark). In total, there were 35 private businesses licensed to operate continuing care facilities in Alberta as of March 2013. Investment is directed more toward AL and less toward LTC, with 93 private AL facilities housing 11,615 beds, and 43 LTC facilities housing 5,304 beds. While the private AL facilities are owned by 30 separate companies, most of which own two or more, the private LTC sector is limited to just 13 companies, with nearly half owned by two major, multi-national corporations: Revera and Extendicare.[113] Most private businesses operating in Alberta's elder care sector specialize in AL facilities, and usually own more than one. Considering companies have more freedom to decide the services provided, the qualifications and numbers of staff, and the prices charged to residents, it is not surprising that companies would see greater opportunity to profit from investing in AL, as opposed to LTC.

Overall, the residential elder care market is quite concentrated among a few large players. The top six companies by number of beds control 45% of all elder care spaces, and own 40% of the facilities. Revera and Extendicare each own 15 facilities. Revera's holdings are split between AL and LTC facilities, while Extendicare's holdings are weighted toward LTC facilities. The other four of the top six Alberta elder care companies are medium-sized chain companies, none of which are publicly traded, and are therefore not obliged to publicly report on their operations: AgeCare Ltd., Rosedale Developments, Integrated Life Care Inc., and Statesman Corporation.

AgeCare, the third largest elder care corporation in the province, was co-founded in 1998 by Kabir Jivraj, a year before he became the Chief Medical Officer at Calgary Regional Health. Jivraj, a financial supporter of the Progressive Conservative party[114] has seen his company secure $24.6 million in government grants from 2006 to 2011, and grow to include 7 AL facilities and 3 LTC facilities.[115] Statesman Corporation is a real estate and resort development corporation founded by Garth Mann that has grown to include luxury retirement and AL facilities in Alberta, Ontario, and the United States. Accommodation fees at one such facility, Staywell Manor, begin at $48,000 per year. The per diem rate at Alberta LTC facilities, in comparison, adds up to an annual rate of $17,575 per year.

7. B. Extendicare

Taking a closer look at a large elder care corporation provides an additional perspective on the world of for-profit elder care. Extendicare is the largest private operator of LTC centres in Canada, including 78 centers in four Canadian provinces. As of 31 December 2011, Extendicare operated another 183 facilities in the United States. It currently operates 14 Alberta LTC facilities with 1406 residents. Extendicare also operates AL services, and in early 2011, it opened

its first Alberta-based AL facilities in Lethbridge and Red Deer. While Extendicare has recently converted to a corporate structure, it operated for years as an income trust, or flow through entity, a structure adopted in order to limit the firm's obligation to pay taxes. The implications of this at the provincial level are significant, as non-Albertan investors are not obliged to pay tax on their returns to the Government of Alberta. In 2006, the Government of Alberta estimated a net revenue loss of approximately $400 million because of the rapid growth of flow through entities.[116]

The Government of Alberta has offered significant subsidies to support Extendicare in expanding its operations in the province. For instance, between 2008 and 2011, forgivable loans were granted to Extendicare by several regional Health Authorities to build four continuing care facilities: LTC and AL centers in Red Deer; an AL center in Lethbridge; and a LTC center in Edmonton.[117] A forgivable loan is essentially a financial payment, as money is loaned and then, after certain requirements are met, the loan is forgiven. These very favourable terms mean that public dollars helped provide the corporation with valuable infrastructure. Considering Extendicare then receives its contracts from the provincial government, the corporation benefits from substantial incentives to undertake relatively low-risk construction projects.

Extendicare includes politically prominent individuals on its board. For instance, Michael J. L. Kirby, a member of the Extendicare board since 1987, was a member of the Senate of Canada from 1984 to 2006. While on the Extendicare board, he chaired a Senate Standing Committee that released The Health of Canadians – The Federal Role.[118] Known as the "Kirby Report," it advocated for the privatization of health services, a change that Extendicare would certainly have been well-positioned to capitalize on. Extendicare management includes individuals with experience in government. For instance, Paul Tuttle, the head of Canadian operations for Extendicare, was previously employed by the Ontario Ministry of Health and Long Term Care, most recently as Director of the Long Term Care Branch.[119]

Large corporate players in elder care do not limit themselves to a single sector. Extendicare, for instance, also operates Paramed, a homecare agency active in Alberta and Ontario. Given that in AL health and personal services are largely provided by homecare, Extendicare clearly perceives another avenue through which to access profit. Mike Harris, former Premier of Ontario and board member of Chartwell, another major for-profit elder care corporation, has recently opened a home care franchise in Toronto.

Extendicare provides an example of an elder care corporation profiting from Alberta elder care. This means assuming corporate

structures that minimize its tax payments. It also involves cultivating relationships with political power brokers, and includes providing opportunities for individuals to move back and forth between government and the private sector. It is difficult to perceive how such processes serve to improve the lives of Albertans in residential elder care.

7. C. Extracting profit

Using Alberta-specific data from Statistics Canada's RCF survey, this section considers the profits achieved in the LTC and AL sectors.

The returns received by Alberta's private residential elder care industry are higher than those of the US stock market.

Privately owned residential elder care facilities are quite profitable in Alberta. In both LTC and AL, facility owners have seen substantial returns. Between 1999 and 2009, private LTC facilities in the province had an average return on investment [ROI] of 2.1%.[120] Private AL facilities had much higher returns over that time, with an average ROI of 9.14%. In comparison, over the same time period Standard & Poor's 500 (an index widely-used to represent the performance of the US stock market) had an average return of 1.23%.[121] This means that in recent years, the returns received by the private residential elder care industry in Alberta have been higher than those of the US stock market (see Figure 6). Even discounting for the effects of the 2008 Great Recession by looking at the years 1999 to 2007, the 9.14% ROI of private AL facilities is nearly three times the 3.17% ROI Standard and Poor's 500 averaged over that time.

These relatively high rates of return translated into significant profits. Private LTC facilities accumulated over $58 million in profit over the decade. The much smaller private AL sector enjoyed profits of $35.5 million. And these profits have been increasing over time. Over the five years beginning in 1999, the private AL industry took in $3.7 million in profits. In the five years ending in 2009, the industry made $27.9 million in profits. In contrast, the not-for-profit and public sectors have had exceptionally tight budgets, and more often than not over the decade considered here, their expenses outstripped their revenues.

How do for-profit elder care providers achieve such returns, particularly in comparison with the experiences of the public and not-for-profit sector? Factors include spending less on direct care costs, and cultivating a population of less severely incapacitated elders. Both are examined below.

Direct care costs include costs related to staff, pharmaceuticals, and medical supplies. In AL, despite some variation in expenditures over the decade, for-profit operators expended only a slightly higher amount on direct care in 2009 than they did in 1999. In contrast, not-for-profit facilities have seen almost continually increasing expendi-

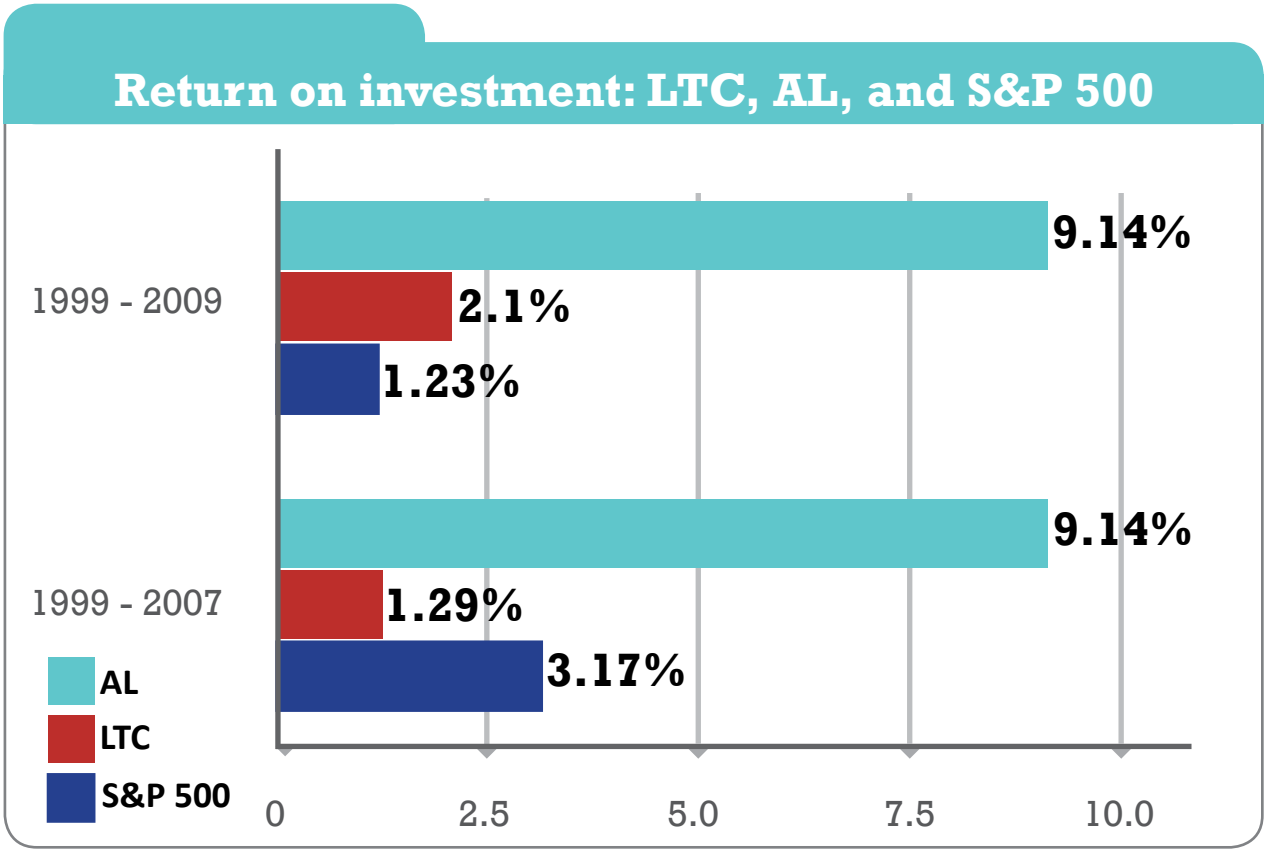

Figure 6: Statistics Canada, Residential Care Facilities.

tures over the decade. In 2009, not-for-profit operations expended

$46.94 more on direct care for each resident every day than did for-profit facilities. In the LTC sector, over the entire decade under study, public and not-for-profit operators spent significantly more on direct care than did for-profit operators. In 2009, for instance, public facilities spent $71 more on direct care per resident per day than did for-profit facilities.

Data on resident acuity by delivery model between 1999 and 2009 indicates that, in both AL and LTC, for-profit operators managed to increase their intake of the least-severely incapacitated elders, and limit their intake of severely incapacitated elders. In the AL sector, for-profit facilities experienced an over-all decline in the acuity of their resident population. In contrast, not-for-profit facilities experienced a dramatic increase in acuity. Given the overall increase in acuity across the residential elder care sector, it is telling that for-profit AL operators managed to achieve a reduction in resident acuity over the period between 1999 and 2009. In LTC, for-profit operators were not spared the increased acuity evident across residential elder care. However, they were far less severely impacted than the not-for-profit or public operators. Between 1999 and 2009,

the LTC sector saw the public system provide care for the most needy elderly, while for-profit operators accommodated the least incapacitated.

Lower resident acuity facilitates private operators' scrimping on direct care expenses in an effort to generate profit from caring for Alberta's elderly. Research indicates that the concentration of higher acuity residents in public facilities is hardly unique to Alberta. A 2005 article based on statistical data on LTC facilities operating in Ontario between 1996 and 2002 found that non-profit facilities provided care to more residents 85 years of age and older than did for-profit and government-owned facilities, while government-owned facilities provided care to a greater proportion of higher needs residents.[122]

The Government of Alberta has argued, following the Mazankowski report, that introducing competition into elder care would lead to improvements in quality and efficiency because of competition. However, Alberta's elder care sector has, over the past 15 years, seen the growth of something quite different. What has emerged is a situation in which private facilities earned substantial profits by scrimping on care for less acute residents, leaving more acute residents for non-profit and public facilities. The result is a situation in which the non-profit and public system bears the burden of the most expensive residents, and for-profit operators maximize their profits by confining themselves to the less expensive task of providing care for the less needy.

7. D. Conclusion

This section has surveyed for-profit elder care in Alberta, providing some basic information about private operators active in the province, and a detailed picture of Extendicare, a major, publicly-traded company operating in the province. It makes clear how for-profit elder care enterprises have sought to expand their reach by diversifying their services and cozying up to those in political power. Finally, this section also explains how for-profit enterprises manage to extract profit: through pursuing a less acute resident population and scrimping on resident care.

Previous sections of this report have made clear how the privatization of residential elder care in Alberta has been associated with lower quality care for residents and more difficult working conditions for employees. This section has highlighted what private elder care providers prioritize above the well-being of residents and employees: the accumulation of profit, as well as the expansion of their political influence and market share.

Clearly, the privatization of residential elder care does not serve the public interest.

8. Achieving high quality elder care

The changes in Alberta residential elder care over the past 15 years have only served to worsen conditions in what was already a highly flawed system.

Over the past 15 years, residential elder care in Alberta has undergone a dramatic transformation. This transformation was two-pronged, driven by the growth of AL and the stagnation of LTC on the one hand, and the expansion of for-profit and the retrenchment of public elder care on the other. The evidence suggests that this transformation has only served to worsen conditions in what was already a highly flawed system of residential elder care.

This report has documented the existence of a care gap in residential elder care, a discrepancy between the needs of elders and the care provided in either LTC or AL. Particularly in LTC, it is clear that staffing levels in Alberta facilities have not increased sufficiently to compensate for increased resident acuity and medical complexity. The result has been a very difficult situation for Alberta elders, their friends and family, and staff working in the elder care sector.

While a care gap also exists in AL, there is less information available about the experiences of elders accommodated in that care model. The resulting knowledge gap is worrying, particularly in the context of the termination of Statistics Canada's Residential Care Facilities survey, which was an important source of information on residential elder care in Alberta and across Canada.

While a care gap exists throughout Alberta elder care, there are important differences in its severity among for-profit, not-for-profit, and public elder care facilities. Across LTC and AL in the period examined here, for-profit facilities offered inferior staffing, which translated into lower quality care. For-profit facilities also provide a more difficult working environment for staff. The evidence is clear: privatization is associated with lower quality residential elder care.

The shifts in Alberta's residential elder care system have been driven in part by the provincial government's goal of minimizing public expenditures. The result has been increased unbundling and offloading in Alberta, as health services are divided up, and responsibility for arranging and paying for them is passed to those in need. The inadequate standard of care throughout the Alberta residential elder care system amounts to an offloading of costs and responsibilities on to residents' friends and families. Further, in AL, responsibilities and costs related to medications, specialized equipment, and therapies often end up being borne by residents and their friends and families. Offloading has significant consequences that affect care recipients, their friends and families who provide care, the loved ones and

employers of caregivers, and society at large. Many of these consequences are negative.

Changes in residential elder care have also been driven by the provincial government's goal of creating opportunities for a well-positioned few to profit. Private operators in both the LTC and the AL sectors have enjoyed substantial profits during the decade between 1999 and 2009. By seeking out less severely incapacitated residents, and spending less money on direct care, for-profit operators have redirected public funds away from needy elders and toward corporate coffers.

Alberta government policies of expanding assisted living and privatizing elder care have been associated with a degraded quality of care.

Alberta elder care is in crisis. There is strong evidence that the Alberta government policies of expanding AL and privatizing elder care have been associated with a degraded quality of care. Changes in Alberta residential elder care over the past 15 years are a story of going from bad to worse.

8. A. Opportunities

In Alberta, the goal of achieving high quality care for elders remains elusive. Still, it is possible to find examples of promising opportunities within the province. Along with the changes to LTC that are necessary to ensure that high quality residential elder care is available to all who require it, the Government of Alberta might look to the programmes outlined below as examples of additional ways to pursue the goal of high quality elder care.

- **The CHOICE programme**

  The Comprehensive Home Option of Integrated Care for the Elderly [CHOICE] programme was launched by the Edmonton Capital Regional Health Authority in 1996. CHOICE was based on successful programmes in the United States, most notably Programs of All-inclusive Care for the Elderly [PACE]. PACE sought to provide the robust supports necessary to enable seniors to remain in their own homes for longer.[123] As of early 2013, there are five CHOICE sites in Edmonton.[124] In 2001, the Calgary Health Authority launched its version of CHOICE, which is called the Comprehensive Community Care for the Elderly program [C3], with 90 spaces.[125]

  CHOICE's mandate is to extend a 'one stop shop' approach to elders who require a variety of services, including medical, rehabilitative, social, and supportive.[126] CHOICE operates through a day programme model, based out of a community facility integrated with adequate home supports available in off-hours, including the possibility of as-needed, short-term, overnight stays. The goal is to reduce or eliminate reliance on acute care,

and delay or eliminate the need for admission to residential elder care.[127] There is evidence that the programme has an effect. In the six months before joining CHOICE, clients visited emergency 299 times; in the six months after, they made 210 emergency visits, a 30 percent decrease.[128]

- **The lodge programme**

  Since the 1950s, the province of Alberta has benefited from a system of seniors' lodges. Unique to Alberta, these lodges emerged from collaboration between the province and local municipalities. For decades, lodges have provided accommodation to elders who are functionally independent (at least with some assistance from homecare) but no longer willing or able to undertake the labour associated with living in a private home. Through the supports available in the lodge system, many seniors are able to live longer in their communities, in a manner consistent with the aging in place concept.[129] In June 2012, there were approximately 150 lodges operating across the province.

  From its inception, the lodge system has catered to low-income seniors. Current arrangements are designed to ensure residents retain $265 after paying for rent, based on semi-private room rates. However, the ability of lodges to serve the needs of low income seniors, and indeed even the viability of the lodge system itself, has been put at risk in recent years through changes to available provincial funding. In its early decades, the provincial government split any operating deficit on a 50/50 basis with the relevant municipality. From 1994, however, the government has moved to a capped grant called the Lodge Assistance Grant, with municipalities responsible for all remaining costs. This has resulted in increased costs and risks downloaded onto municipalities. Further, many lodge structures have deteriorated substantially in the past few decades, and the province has made only minimal contributions to infrastructure maintenance or modernization.

  Alberta's lodges provide an example of a public system positioned to contribute to ensuring quality elder care for all Albertans, including those who lack sufficient financial resources to access other options, such as private AL. Expanding support to the lodge system would increase options for elderly Albertans.

Achieving the promise of these innovative programmes would require that substantial public resources be put into the personal, home, and medical supports required by elders living at home, or in home-like settings. It would involve looking beyond further privatization to focus on evidence-based options for providing high-quality,

cost-effective elder care for Alberta elders. Ultimately, it is through means such as these, in combination with an expanded and improved LTC system, that high quality elder care can be made available to all Albertans who need it.

8. B. Recommendations

Based on research conducted on the Alberta situation and on experts' views of how to best provide high quality elder care, Parkland Institute offers the following recommendations:

Expand the Canadian public health care system to encompass continuing care services, including all residential and home-based forms of elder care

- The Government of Alberta should join with other provinces in lobbying the Federal Government to expand public health care to include continuing care services, including all residential and home-based forms of elder care. This would compel governments to develop the resources necessary to provide free, universal access to elder care for all Canadians, as well as to ensure consistent standards across provinces. It would also help position the health system to work more effectively and efficiently, by eliminating problematic distinctions between acute care and continuing care. Expanding the public health care system would have important, far-reaching implications for how elder care is provided in Alberta and across Canada. This change would lay the groundwork for improved care in years to come.

Improve staffing

- In recognition of the care gap across Alberta elder care, the Government of Alberta should immediately make available funds to facilitate improved staffing, with the provision that all operators (public, not-for-profit, and for-profit alike) be obliged to expend these funds on direct care staffing.
- Ensure that all residential elder care facilities are legally bound to minimum staffing levels established in relation to experts' assessments of the levels required to ensure quality care. These levels should also allow for substantial improvements in the working conditions experienced by professional caregivers working in elder care facilities. The provincial government should provide whatever enforcement is necessary to ensure specified staffing levels are met.

Phase-out private, for-profit elder care

- Immediately suspend subsidies and programmes that benefit for-profit elder care corporations and work to phase-out for-profit elder care, due to the abundant evidence that for-profit corporations provide inferior quality care.

- Build on successful programmes such as CHOICE and seniors' lodges in developing a robust public elder care system.

Increase public access to information about elder care

- Improve monitoring and reporting practices to ensure that meaningful data about elder care is available to all Albertans. This data should be:
    - Oriented to the reporting of meaningful indicators, such as staffing levels;
    - Developed in a manner that facilitates the collection and public reporting of individuals' experiences with elder care facilities, in order to ensure that the elimination of the HFRC does not result in a reduction of available information about Albertans' experiences;
    - Structured in a manner that reveals trends through time and by other key considerations, such as geographical region;
    - Easily accessible to the public over the internet, as well as through other means.
- Lobby the federal government to develop, in consultation with qualified experts, an effective nation-wide data set that would make it possible to compare elder care across Canada, and to track changes over time.

Create a watchdog

- Establish an elders' advocate to report to the legislature. The complexity of the elder care sector and the need for ongoing scrutiny of its operations makes it necessary to create a watchdog to monitor elder care and all related issues. An elders' advocate would be positioned to offer critical assessments, to track change over time, and to ensure the effective integration of the elder care system with other policies and practices that bear on the well-being of Alberta elders.
- Ensure that the elders' advocate operates in consultation with a committee of elder Albertans positioned to provide first-hand insight into the operation of the province's services to the elderly.

Appendix

This appendix provides some additional information about the data from Statistics Canada that underlies much of the report.

Until recent years, Statistics Canada annually administered a mandatory survey of the operations of residential care facilities in Canada. A custom tabulation of RCF survey data was requested from Statistics Canada for use in this study. The custom tabulation isolated for data pertaining only to those Alberta-based facilities that identified the principal characteristic of its residents to be "aged," for the years 1999 to 2009. In the Alberta context, these facilities would include those providing LTC and AL. The Statistics Canada data was disaggregated in attempt to isolate for two broad streams of care: LTC and AL. To do so, a list of every licensed AL facility in operation as of October 2012 was obtained from the Government of Alberta's Accommodation Standards and Licensing website. The list was submitted to a Statistics Canada employee, who isolated those facilities that were also included in the RCF survey. Those facilities included in the RCF survey that did not appear on the government's list of supportive living facilities were, for the purposes of this study, assumed to be LTC centers.

The RCF survey data was used to make calculations regarding staffing levels at the three delivery models of LTC facilities in Alberta. To calculate staff hours per resident-day, the "total accumulated paid hours" for a specific staff category was divided by 365.25 and the number of "total residents." The RCF survey did not isolate health care and nursing aides as a specific staff category, instead grouping them under "other direct care staff" along with dieticians, counsellors, child-dare workers, orderlies, social workers, graduate nurses, chaplains, etc. Because health and nursing aides are the only one of these staff types that would be of any prominence in elder care, for the purpose of this study "other direct care staff" was assumed to equal health care and nursing aides. The RCF survey staffing data did not include voluntary workers.

Endnotes

[1] Patrick Sullivan, "Seniors' Care Now a Dominant Canadian Concern: CMA Survey," http://www.cma.ca/index.php?ci_id=206148&la_id=1, (accessed August 28, 2013).

[2] It should be noted that not all elders are in need of care. In fact, many elders provide care to friends or relatives in need.

[3] The Government of Alberta has repeatedly changed the terms used to describe the provincial elder care system. To promote ease of understanding, terminology current as of spring 2013 has been adopted throughout this report.

[4] Irene Jansen and Janice Murphy, *Residential Long-Term Care in Canada: Our Vision for Better Senior's Care*, Canadian Union of Public Employees, October 2009, 9.

[5] Kevin Taft, *Shredding the Public Interest: Ralph Klein and 25 Years of One-Party Government* (Edmonton: University of Alberta Press and Parkland Institute, 1997), 15-39.

[6] Government of Alberta Long Term Care Policy Advisory Committee, *Healthy Aging: New Directions for Care, Part One: Overview* (Alberta Health and Wellness: November 1999), accessed March 4, 2013, http://www.health.alberta.ca/documents/Healthy-Aging-Overview-1999.pdf.

[7] Premier's Advisory Council on Health, *A Framework for Reform* (December 2001), accessed March 4, 2013, http://www.assembly.ab.ca/lao/library/egovdocs/alpm/2001/132279.pdf.

[8] MLA Task Force on Health Care Funding and Revenue Generation, *A Sustainable Health System for Alberta* (Alberta Health and Wellness: October 2002), accessed March 4, 2013, http://www.health.alberta.ca/documents/Sustainable-system-2002.pdf.

[9] Auditor General Alberta, *Report of the Auditor General on Seniors Care and Programs*, (Office of Auditor General: May 2005), accessed March 4, 2013, http://www.oag.ab.ca/files/oag/OAG_Seniors_2005.pdf.

[10] Honourable Iris Evans and Honourable Yvonne Fritz, *Ministers' Statement: Auditor General's Report on the Government of Alberta's Seniors Core Services and Programs* (Government of Alberta: May 9, 2005), accessed March 5, 2013, http://www.continuingcarewatch.com/ABMinistersStatementonAGReport.pdf.

[11] MLA Task Force on Continuing Care Health Service and Accommodation Standards, *Achieving Excellence in Continuing Care* (Government of Alberta: November 2005), accessed March 6, 2013, http://www.health.alberta.ca/documents/Continuing-Care-Report-2005.pdf.

[12] Alberta Seniors and Community Supports, *Supportive Living Framework* (Government of Alberta: March 2007), 10, accessed March 17, 2013, http://web.archive.org/web/20110103000024/http://www.seniors.alberta.ca/continuingcare/system/standardsframework.pdf.

[13] Alberta Health and Wellness, *Continuing Care Strategy,* 19.

[14] Alberta Health and Wellness, *Continuing Care Strategy*, 19.

[15] Alberta Seniors and Community Supports, *Supportive Living Framework*, 10.

[16] Alberta Health Services, *Admission Guidelines for Publicly Funded Continuing Care Living Options* (Government of Alberta: April 15, 2010), accessed March 13, 2013, http://www.albertahealthservices.ca/Seniors/if-sen-living-option-guidelines.pdf.

[17] Supportive Living Accommodation Licensing Act, S.A., ch. S-23.5, (2009).

[18] Alberta Health Communications, *Continuing Care Health Service Standards* (Government of Alberta: July 2008, amended March 5, 2013), accessed March 13, 2013, http://www.health.alberta.ca/documents/Continuing-Care-Standards-2008.pdf.

[19] Alberta Health, "Accommodation Standards, Forms and Publications," http://www.health.alberta.ca/services/continuing-care-forms.html (accessed April 2, 2013).

[20] Ibid.

[21] There are also some irregularities in fees deriving from differences in practices among Alberta's former regional health authorities, which were eliminated in 2008. For instance, in the Chinook health region, residents in studio DSL suites are charged between $125 to $250 less per month than the regulated rate (Personal phone call, Executive Director of the Alberta Continuing Care Association, November 27, 2012). It should be noted that Albertans of sufficient financial means may access any level of supportive living by absorbing all associated costs. In supportive living, rates for accommodation and care are set by the operator, and can vary widely among facilities.

[22] Alberta Health Services, *Annual Report: 2011-2012*, (Government of Alberta: March 2012), 64.

[23] Canadian Institute for Health Information, *Alternate Level of Care in Canada* (CIHI: January 14, 2009), 18, accessed April 3, 2013, https://secure.cihi.ca/free_products/ALC_AIB_FINAL.pdf.

[24] Alberta Health Services reports on the number of individuals in either acute or sub-acute care awaiting placement in continuing care. Between late 2010 and early 2013, that number has varied between 471 and 600. Over the same period, between 907 and 1150 individuals were waiting in the community. However, we were unable to determine how many of these individuals were in need of elder care services. Alberta Health Services, *Q2 Performance Report 2012/2013*, (AHS: December 13, 2012), 62-63.

[25] Alberta Health, *Supportive Living Guide* (Government of Alberta: August 2013), 7, accessed September 3, 2013, http://www.health.alberta.ca/documents/CC-Supportive-Living-Guide-2013.pdf

[26] Statistics Canada, *Population Projections for Canada, Provinces and Territories* (Minister of Industry: June 2010), catalogue no. 91-520, accessed February 5, 2013, http://www.statcan.gc.ca/pub/91-520-x/91-520-x2010001-eng.pdf.

[27] John Geddes, "The Health Care Time Bomb," *Maclean's*, April 12, 2010.

[28] Brent J. Skinner and Mark Rovere, *Canada's Medicare Bubble: Is Government Health Spending Sustainable without User-based Funding?* (Fraser Institute: April 2011).

[29] Canada Department of Finance, "Economic and Fiscal Implications of Canada's Aging Population," https://www.fin.gc.ca/afc/faq/eficap-rebvpc-eng.asp (accessed February 5, 2013).

[30] Robert G. Evans, "Economic Myths and Political Realities," in *Medicare: Facts, Myths, Problems, Promise*, ed. Bruce Campbell and Greg Marchildon (Toronto: James Lorimer & Company Ltd, 2007), 113-155.

[31] Marc Lee, *How Sustainable is Medicare?* (Canadian Centre for Policy Alternatives: 2007), 15-16; Evans, "Economic Myths," 140; Canadian Institute for Health Information, *Health Care Cost Drivers: The Facts* (CIHI: November 3, 2011), 12, accessed February 6, 2013, https://secure.cihi.ca/free_products/health_care_cost_drivers_the_facts_en.pdf.

[32] Sharon Carstairs and Wilbert Joseph Keon, *Canada's Aging Population: Seizing the Opportunity*, (The Senate of Canada: April 2009), 63; M.L. Barer, R.G. Evans, and C. Hertzman, "Avalanche or Glacier? Health Care and the Demographic Rhetoric," *Canadian Journal on Aging* 14, no. 2 (1995): 193-224; Neena L. Chappell and Marcus J. Hollander, "An Evidence-Based Policy Prescription for an Aging Population," *Healthcare Papers* 11, no. 1 (2011): 8-18; F.T. Denton and

B.G. Spencer, "Population Aging and its Economic Costs: A Survey of the Issues and Evidence," *Canadian Journal on Aging* 19 no.S1 (2000): 1-31; Hugh Mackenzie and Michael Rachlis, *The Sustainability of Medicare* (Canadian Federation of Nurses Union: 2010).

[33] Mackenzie and Rachlis, *Sustainability of Medicare*, 34.

[34] Evans, "Economic Myths," 139.

[35] Wendy Armstrong, *Eldercare – On the Auction Block: Alberta Families Pay the Price* (Consumers' Association of Canada - Alberta Chapter: September 2002), 5.

[36] Ibid., 7.

[37] Aleck Ostry, *Change and Continuity in Canada's Health Care System* (Cha Press: 2006), as cited in Irene Jansen and Janice Murphy, *Residential Long-Term Care in Canada: Our Vision for Better Senior's Care* (Canadian Union of Public Employees: October 2009) 24.

[38] Marcy Cohen, Jeremy Tate, and Jennifer Baumbusch, *An Uncertain Future for Seniors: BC's Restructuring of Home and Community Health Care, 2001-2008* (Canadian Centre for Policy Alternatives: April 2009), 22.

[39] Jansen and Murphy, *Our Vision for Better Senior's Care*, 25.

[40] It should be noted that the HFRC did not verify compliance with all basic standards, such as minimum care hours in long term care facilities. Nor did it review resident records in a manner that would make it possible to connect care quality to health outcomes. Rather, the Committee operated primarily in terms of their own impressions of the facility, combined with the feedback from residents, friends and family, and staff-members who are able and willing to communicate with them. Despite these significant limitations, the reports of the HFRC offered a window on the experiences of Albertans that is not otherwise available.

[41] Health Facilities Review Committee, *Routine Review – Summary of Findings, Northcott Care Centre* (Government of Alberta: February 2, 2012).

[42] Health Facilities Review Committee, *Routine Review – Summary of Findings, Venta Care Centre* (Government of Alberta: February 6-7, 2012).

[43] Ibid.

[44] Ibid.

[45] Health Facilities Review Committee, *Routine Review – Summary of Findings, Mount Royal Care Centre*, (Government of Alberta: January 19, 2012).

[46] Health Facilities Review Committee, *Routine Review – Summary of Findings, Carewest Garrison Green*, (Government of Alberta: August 24-25, 2011).

[47] Health Facilities Review Committee, *Routine Review – Summary of Findings, Our Lady of the Rosary Hospital* (Government of Alberta: August 16, 2011).

[48] Health Facilities Review Committee, *Routine Review – Summary of Findings, The Good Samaritan Stony Plain Care Centre* (Government of Alberta: July 20-21, 2011).

[49] Health Facilities Review Committee, *Summary of Findings, Venta Care Centre*.

[50] Health Facilities Review Committee, *Summary of Findings, Carewest Garrison Green*.

[51] Health Facilities Review Committee, *Routine Review – Summary of Findings, Valleyview Con-*

tinuing Care Centre (Government of Alberta: January 25, 2012).

[52] Health Facilities Review Committee, *Summary of Findings, Carewest Garrison Green*.

[53] Health Facilities Review Committee, *Routine Review – Summary of Findings, Wing Kei Care Centre* (Government of Alberta: February 13, 2012).

[54] Health Facilities Review Committee, *Summary of Findings, Carewest Garrison Green*.

[55] Health Facilities Review Committee, *Routine Review – Summary of Findings, Stettler Hospital*, (Government of Alberta: September 27-28, 2011).

[56] Health Facilities Review Committee, *Routine Review – Summary of Findings, Brooks Health Centre* (Government of Alberta: May 19-20, 2011).

[57] Health Facilities Review Committee, *Routine Review – Summary of Findings, Edmonton General Continuing Care* (Government of Alberta: October 20-21, 2010).

[58] Health Facilities Review Committee, *Routine Review – Summary of Findings, Capital Care Dickinsfield* (Government of Alberta: October 31 - November 1, 2011).

[59] Health Facilities Review Committee, *Routine Review – Summary of Findings, Extendicare Michener Hill* (Government of Alberta: October 26-27, 2011).

[60] Health Facilities Review Committee, *Summary of Findings, Valleyview Continuing Care.*

[61] Health Facilities Review Committee, *Routine Review – Summary of Findings, Stettler Hospital and Care Centre* (Government of Alberta: September 27-28, 2011).

[62] Ibid.

[63] Health Facilities Review Committee, *Routine Review – Summary of Findings, Bow View Manor* (Government of Alberta: May 18-19, 2011).

[64] Government of Alberta Long Term Care Policy Advisory Committee, *Healthy Aging: New Directions for Care, Part One: Overview*, 22.

[65] Ruth Duncan, "Front Line View," *Calgary Herald*, December 9, 2012.

[66] For a discussion of staffing levels needed to support minimal or quality care, see: C. Harrington et al., "Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States," *Gerontologist* 40 (2000): 5-16; A. Kramer and R. Fish, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Report to Congress: Phase II Final: Volume I* (Centers for Medicare and Medicaid Services: December 24, 2001), 1-26.

[67] Health Facilities Review Committee, *Routine Review – Summary of Findings, Vegreville Care Centre* (Government of Alberta: August 24, 2010).

[68] Health Facilities Review Committee, *Routine Review – Summary of Findings, Good Samaritan South Ridge Village* (Government of Alberta: November 29, 2010).

[69] Health Facilities Review Committee, *Routine Review – Summary of Findings, Edith Cavell Care Centre* (Government of Alberta: July 13-14, 2011).

[70] P. Armstrong and T. Daly, *'There are not enough hands.' Conditions in Ontario's Long-Term Care Facilities* (Canadian Union of Public Employees: 2004); M. Ross, A. Carswell, and W. Dalziel, "Staff Burnout in Long-Term Care Facilities," *Geriatrics Today* 5,3 (2002): 132–135; N. Chappell and M. Novak, "Caring for Institutionalized Elders: Stress Among Nursing Assistants," *Journal of Applied*

Gerontology 13 (1992): 299–315.

[71] Health Facilities Review Committee, *Summary of Findings, Good Samaritan South Ridge Village.*

[72] J.E. Bostick et al., "Systematic Review of Studies of Staffing and Quality in Nursing Homes," *Journal of the American Medical Directors Association* 7, no. 6 (2006): 366-376; Marcy Cohen, *Caring for BC's Aging Population: Improving Health Care for All* (Canadian Centre for Policy Alternatives: July 2012, 24).

[73] Health Facilities Review Committee, *Summary of Findings, Carewest Garrison Green.*

[74] Albert Banerjee et al., *"Out of Control": Violence against Personal Support Workers in Long-Term Care* (York University and Carleton University: 2008); Albert Bannerjee et al., "Structural Violence in Long-Term, Residential Care for Older People: Comparing Canada and Scandinavia," *Social Science and Medicine* 74, 3 (2012): 390-98.

[75] Health Facilities Review Committee, *Routine Review – Summary of Findings, Elk Point Health Care Centre* (Government of Alberta: May 5, 2011).

[76] Such situations have been described as instances of 'structural violence.' See Banerjee et al., "Structural Violence in Long-Term, Residential Care."

[77] Extendicare Real Estate Investment Trust, *2011 Annual Information Form* (Extendicare REIT: March 30, 2011), 51, accessed June 24, 2013 http://www.extendicare.com/uploads/public/51/docs/AIF_2011_Final.pdf

[78] J. M. Murphy, *Residential Care Quality: A Review of the Literature on Nurse and Personal Care Staffing and Quality of Care*, (Nursing Directorate, BC Ministry of Health: November 2006), accessed May 5, 2013, http://www.health.gov.bc.ca/library/publications/year/2006/residential-care-quality-a-review-of-the-literature-on-nurse-and-personal-care-staffing-and-quality-of-care.pdf.

[79] The benchmark for quality care is based on C. Harrington et al., "Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States," and John Schnelle et al., "Relationship of Nursing Home Staffing to Quality of Care," *Health Services* Research 39, no.2 (2004): 225-250. The benchmark for minimal quality care is based on A. Kramer and R. Fish, "Relationship between Nurse Staffing Levels and the Quality of Nursing Home Care."

[80] M.P. Hillmer et al., "Nursing Home Profit Status and Quality of Care: Is There Any Evidence of an Association?" *Medical Care Research and Review* 62, no. 2 (2005): 139-166.

[81] Vikram R. Comondore et al., "Quality of Care in For-Profit and Not-For-Profit Nursing Homes: Systematic Review and Meta-Analysis," *British Medical Journal* 339 (2009): b2732.

[82] W. Berta, A. Laporte, and V. Valdamanis, "Observations on Institutional Long Term Care in Ontario: 1996-2002," *Canadian Journal on Aging* 24 (2005): 71-84.

[83] Margaret J. McGregor et al., "Staffing Levels in Not-For-Profit and For-Profit Long-Term Care Facilities: Does Type of Ownership Matter?" *Canadian Medical Association Journal* 172, 5 (2005): 645-649.

[84] Margaret J. McGregor et al, "Care Outcomes in Long-Term Care Facilities in British Columbia, Canada: Does ownership matter?" *Medical Care* 44 (2006): 929-35; E. Shapiro and R.B. Tate, "Monitoring the Outcomes of Quality of Care in Nursing Homes Using Administrative Data," *Canadian Journal of Aging* 14 (1995):755-68; Kimberly N. McGrail et al., "For-Profit Versus Not-For-Profit Delivery of Long-Term Care," *Canadian Medical Association Journal* Supplement 176 (2007): 57-58. See also: Margaret J. McGregor and Lisa A. Ronald, "Residential Long-Term Care for Canadian Seniors: Non-Profit, For-Profit, or Does it Matter?" IRPP Study No. 14, January 2011.

[85] Hospital Employees Union, *Quality of Care in BC's Residential Care Facilities: A Submission to the Office of the Ombudsman on Senior's Care* (HEU: January 12, 2009), accessed April 15, 2013, http://www.heu.org/sites/default/files/uploads/2010%20seniors/HEU%20submission%20to%20Ombudsperson.pdf.

[86] C. Harrington et al., "Does Investor Ownership of Nursing Homes Compromise the Quality of Care?" *American Journal of Public Health* 91 (2001): 1452-5.

[87] Margaret J. McGregor et al, "Does Type of Ownership Matter?"

[88] Academic researchers have found that quality elder care requires 1.15 hours of directed care by RNs per resident, per day. See C. Harrington et al., "Minimum Nurse Staffing Standards."

[89] C. Harrington et al., "Minimum Nurse Staffing Standards."

[90] Pat Armstrong and Hugh Armstrong, "Women, Privatization and Health Care Reform: The Ontario Case," in *Exposing Privatization: Women and Health Care in Canada* (Aurora: Garamond Press, 2001).

[91] Alberta Union of Provincial Employees, "Hardisty Staff Ratifies First Agreement, Strike Ends," http://www.aupe.org/news/hardisty-staff-ratifies-first-agreement-strike-ends/ (accessed August 1, 2013).

[92] Alberta Union of Provincial Employees, "Collective Agreement Ratified at Devonshire," http://www.aupe.org/news/collective-agreement-ratified-at-devonshire/ (accessed August 15, 2013).

[93] Canadian Union of Public Employees, "CUPE Wins Public Sector Rates at Private Nursing Facility," http://alberta.cupe.ca/Alberta-Health-Emplo/wins-public-sector-rates-private (accessed March 5, 2013).

[94] Alberta Union of Provincial Employees, "Longest Labour Dispute in AUPE History Finally Comes to an End," http://www.aupe.org/news/longest-labour-dispute-in-aupe-history-finally-comes-to-end/ (accessed April 15, 2013).

[95] Alberta Health Services, *Activity Based Funding of Long-Term Care User Summary* (AHS: August 2, 2011), 13, accessed March 23, 2013, http://web.archive.org/web/20130320002651/http://www.albertahealthservices.ca/hp/if-hp-in-ltc-user-summary.pdf.

[96] Alberta Continuing Care Association, *Labour and Funding Issues Jeopardize Seniors Care*, July 4, 2012, accessed February 15, 2013, http://www.ab-cca.ca/acca-news-releases.

[97] Government of Alberta, *Supportive Living Guide*, 10.

[98] Auditor General of Alberta, *Report of the Auditor General on Seniors Care and Programs – Frequently Asked Questions (FAQs),* (Office of the Auditor General: May 2005), 2, accessed April 17, 2013, http://www.oag.ab.ca/files/oag/OAG_Seniors_2005_FAQ.pdf

[99] Health Facilities Review Committee, *Summary of Findings, Capital Care Dickinsfield.*

[100] Health Facilities Review Committee, *Summary of Findings, Edith Cavell Care Centre.*

[101] Ibid.

[102] Health Facilities Review Committee, *Routine Review – Summary of Findings, Barrhead Continuing Care*, (Government of Alberta: April 28, 2010).

[103] Health Facilities Review Committee, *Summary of Findings, Carewest Garrison Green.*

[104] Ibid.

[105] Office of the Inspector General, *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009* (United States Department of Health and Human Services: November 2012).

[106] Janet E. Fast, Deanna L. Williamson, and Norah C. Keating, "The Hidden Costs of Informal Elder Care," *Journal of Family and Economic Issues* 20, 3 (1999): 304.

[107] Donna Vogel, Michael Rachlis, and Nancy Pollak, *Without Foundation: How Medicare is Undermined by Gaps and Privatization in Community and Continuing Care*, (Canadian Centre for Policy Alternatives: November 2000), 44.

[108] Fast et al., "Hidden Costs", 322.

[109] Ibid., 303.

[110] Ibid., 306.

[111] Pat Armstrong, "Unpaid Health Care: An indicator of Equity," *Pan American Health Organization*, n.d., 18-19.

[112] Ibid., 21-22.

[113] Authors' calculations. Data retrieved from Accommodation Standards and Licensing, www.asalreporting.gov.ab.ca (accessed February 2013).

[114] "Anonymous Donors Revealed: Numbered Companies Gave $191,000 to Tory Leadership," *Edmonton Journal*, March 16, 2012.

[115] Author's calculations based on Treasury Board and Enterprise, *Blue Book: General Revue Fund, Details of Grants, Supplies, Services, Tangible Capital Assets and Other Payments, by Payee*, (Government of Alberta: 2006 to 2011).

[116] Canada Department of Finance, "Backgrounder: The Rapid Growth of 'Income Trusts,'" http://www.fin.gc.ca/n10/data/10-125_1-eng.asp (accessed March 13, 2013), 3.

[117] Extendicare Real Estate Investment Trust, *2011 Annual Report* (Extendicare REIT: n.d.), 99, accessed April 14, 2013, http://www.extendicare.com/uploads/public/51/docs/EXE_AR11_full%20for%20SEDAR.pdf

[118] The Senate Standing Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role* (The Senate of Canada: October 2002).

[119] Extendicare Redevelopment Services, "About Us," http://www.extendicareredevelopment.com/paul_tuttle.htm# (accessed April 4, 2012).

[120] Return on investment was calculated as (Total revenues – Total expenses)/Total Expenses.

[121] Author's Calculations. Data retrieved from ForeCastChart.com, "S&P 500 Stock Market Index Historical Graph," http://www.forecast-chart.com/historical-sp-500.html (accessed May 6, 2013).

[122] W. Berta, A. Laporte, and V. Valdamanis., "Institutional Long Term Care in Ontario."

[123] K. Shannon and C. Van Reenen, "PACE (Program of All-Inclusive Care for the Elderly): Innovative Care for the Frail Elderly," *Health Progress* 79 (1998): 41-5.

[124] Alberta Health Services, "CHOICE," http://www.albertahealthservices.ca/services.asp?pid=-service&rid=1001469 (accessed March 15, 2013).

[125] Wendy Armstrong, "Briefing Memo Re: CHOICE Programs in Alberta," November 27, 2006.

[126] Alberta Health Services, *Becoming the Best: Alberta's 5-Year Health Action Plan* (Government of Alberta: November 2010), 15, accessed May 13, 2013, http://www.health.alberta.ca/documents/Becoming-the-Best-2010.pdf.

[127] Alberta Health Services, *CHOICE – Comprehensive Home Option of Integrated Care for the Elderly, Program Information*, (Government of Alberta: 2011-12), 2.

[128] Pinnell Beaulne Associates Ltd, *CHOICE Evaluation Project: Evaluation Summary Final Report* (Pinnel Beaulne Associates: November 26, 1998); Alberta Health Services, "Seniors Have Choice," http://www.albertahealthservices.ca/1362.asp (accessed February 2, 2013).

[129] Alberta Urban Municipalities Association, *Mayors' Caucus Request for Decision*: *Lodge Programme Funding and Modernization*, (AUMA: June 14, 2012), 2, accessed April 9, 2013, http://www.auma.ca/working/digitalAssets/65/65335_RFD_Attachment_4.pdf.

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