

Lessons from Alberta: Two Case Studies

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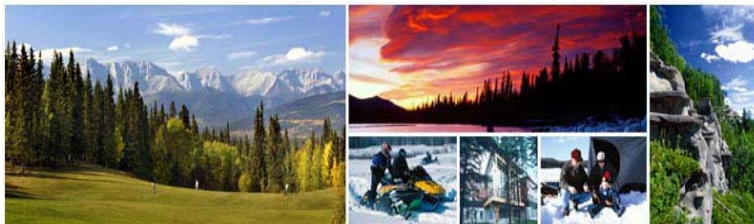
Case study

- Missing Pieces of the shift to home and community care: a case study of the conversion of an Alberta Nursing Home to a Designated Assisted Living Program
- March 2006

The policy issue: Shift from

- Old model - traditional long term care facilities
- to
- New model: Designated Assisted Living (DAL) settings
- Goal: allow seniors to remain more independent

Hinton, Alberta



Thanks to Lynda and Ron Jonson, Hinton Alberta, founding members of Seniors I Care, and the community and families of residents in the Mountain View care centre

The Hinton example

- Population: 10,000 permanent residents
- Location: Rocky Mountains, 3 hours west of Edmonton
 - In Aspen Health Region
- New building (built 2002), attached to local hospital.
 - 20 nursing home beds, 5 secure “dementia cottage beds”, 27 independent housing units (low occupancy rates)
- 2004: shifted from being nursing home to DAL status.

Snapshot (October 2005)

- Eligibility for entry controlled by Health Authority
 - must have unmet health needs in current living situation;
 - All parties must agree to placement
 - Families must be able to afford (and willing to pay) all related costs.

Differences: DAL and nursing homes

- DAL settings are considered homes, not institutions.
- Entry and eligibility still controlled by RHA
- Province does not regulate accommodation fees charged residents, or scope and quality of services provided (For nursing homes, it does)
- Far less included in package of prepaid goods and services than for nursing homes.
- Residents and their families pay costs of services not included.

Unbundling: Pay for what you use

- But - most of the residents were very high needs.
- Cost of those services which are used/needed shifted from province to residents and their families
 - But, province did have *multiple individually assessed* programs to help those with low incomes – *however, low income families lost “accommodation subsidy” for institutional care (since changed).*
- Expenses less predictable and controllable for those with higher care needs
 - And, residents had less buying power (*retail prices*)

Unbundling: Pay for what you use

- Cheaper if residents do not require particular services
 - But - most of the residents were very high needs.
- Cost of those services which are used/needed shifted from province to residents and their families
 - But, province did have multiple individually assessed programs to help those with low incomes – however, low income families lost “accommodation subsidy” for institutional care (since changed).
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Impact on staffing

- Fewer on-site professional services
 - Services shifted to off-site professionals working for Region’s Community Care Office (*reduced frequency physio, less continuity of assessment*).
 - I.e., same as individuals living in any ‘home’ setting

Impact on costs

- Paper gives “before” and “after” cost comparisons.
- Before: \$1470/month for a private room
- After: \$950/month for studio - \$1250/month for dementia care, plus
 - Telephone (*call bell system*), laundry, bed, furniture, medical supplies, personal care supplies, medications, transportation (*ambulance*), *tray service*....
- Impact depended heavily on care needs
- *Required medication packaging tripled costs compared to home*

Impact on services

- More fragmentation
- Price and quality controls de-regulated
- Entitlement based on financial need, not just health need
- *Increased “transaction costs” related to reliance on multiple programs, billing, etc.*
- More stress/responsibility on spouses and families

Why the problem?

- Model assumes that services are being provided for:
 - Relatively healthy people
- And that they are largely discretionary
- But
- That is not who is admitted.
- Who is the model designed to serve?

Conclusion

- Choice is good
- But

*Real choice limited
because entry still
controlled by RHA and
available services
dependent on ability to
pay and family support.*

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DEVIL

Second case

- Reading the Fine Print:
- Focus on Long Term Care Insurance
- Wendy Armstrong did a systematic review of long-term care insurance and comparison of 3 company policies

They are complex!

- The hope:
 - Cover the costs not included under Medicare
 - Note: in Canada ca 30% of health expenditures private:
 - As of 2000, private health insurance policies paid for:
 - 11.4% of total expenditures in Canada
 - 1.6% in Denmark
 - 0.9% in Japan
 - 3.3% in UK\
 - Etc.

Options

- Influence monthly premiums and value at time of claim
 - Pre-purchased limits
 - Limitation and exclusion clauses
- Marketing often misleading
 - Do not cover circumstances implied
- Premiums often rise over time
 - Many can't afford it
- The sick are often uninsurable
 - 15-30% of those applying for policies are rejected

Current policies often not helpful

- Daily cash benefits may buy very little care
 - Policies provided between \$20 and \$200/day
 - Current costs of care from private home health agencies:
 - RN care is \$43-\$48/hour
 - LPN care is \$25-\$30/hour
 - Personal care aids \$18-\$22/hour
- Having coverage may restrict eligibility for publicly paid programs

What she concluded

- Remarkably, it appears as though long-term care insurance policies often provide less choice and less coverage than existing public programs in most (but not all) Canadian provinces.
- Beyond the reach of most Canadians, particularly seniors, over life of policy.

Comparison

- Nature and scope of long term care insurance
 - Underwriting requirements and information sharing
 - Promise and realities (e.g. *limits on home care*)
 - *Nowhere for consumers to turn for information other than industry*

Conclusion

- Choice is good
- But

Choice limited by pre-existing conditions, fine print in policies and ability to pay rising premiums over time.

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