Continuing care strategy falls short for seniors

Edmonton Journal, January 5, 2009 by Carol Wodak

'Enhanced service options' benefit private agencies

The December press release from the Alberta government promises that a "new continuing care strategy" would give Albertans "more support and more choice."

Are these reassuring words for many seniors and their families? Perhaps for some -- if we can believe this promise to "enhance" home care and community support programs. But we've heard these promises for more than 20 years. This new strategy is the "third stage" of Alberta's continuing care policy, and it has a lot in common with the "third way" health proposals.

In 1988, the "New Vision for Long Term Care" promised "increased home care, more supportive-living options and upgrades to long-term care." So did the Broda policies in 1999. And we've learned that the devil is in the fine print and it all depends on government fiscal priorities.

The "New Vision" succumbed to the deficit fears of the mid-90s. And Broda's been hijacked -- it turns out that the words "seniors want to be independent" meant to the government that they prefer to shop in the private marketplace for their health-care needs (if they, or their adult children, have the time, skills and money).

Home-care services for seniors have been cut to the bone and then diverted to "sub-acute" care -- as have many nursing home beds -- so that acute care hospital patients can be discharged earlier. The "improved assessments" have steadily raised the bar for care needs to be recognized. Support for family caregivers is a referral to a private care provider agency -- or maybe a tax credit next year.

In many ways, Health Minister Ron Liepert's strategy is an economic bailout package for private-market developers and service providers. The "incentives" for the increased shift to supportive living, the "enhanced service options," and the "equitable pharmaceutical coverage" are good news for property developers, private service providers, and the insurance industry.

For seniors and their families concerned about the long waits for any level of care, the adequacy or quality of the care they receive, the cost of care no longer included in public health care, and the increasing level of cost and responsibility left to families and charity, this new version of the same-old strategy is not good news.

Worse yet, prices of health-care products and services are inevitably higher in private markets.

"Aging in Place" -- or the new version, "Aging in the Right Place" -- is a very catchy slogan. So is the refrain of "choice." The shift to community care is not only a good idea, but one that has worked incredibly well in other countries. They understood that what keeps frail and ill seniors as well as possible is providing a full range of publicly funded comprehensive, co-ordinated health and social care before the situation requires emergency intervention.

And they found that these preventive measures reduced overall health-care costs, as well as the need for nursing home care for many seniors.

We do it differently here. We restrict access to care, replace the nurse in "nursing care" with personal care aides, and reduce the number of nursing home beds as the population increases. We allow the wait lists for urgent placement in every level of continuing care to increase to crisis proportions. We tell seniors they won't have to pay health-care premiums, "saving" each senior $500 a year --but we raise the income eligibility levels for benefits and increase nursing-home fees.

When the scarcity of care is well-established, we tell seniors that they need to be independent and responsible for their own health, that public funding for long-term care is "unsustainable," and that more subsidies to private providers will give them more "choice."

We deregulate the nursing home fees so developers will be encouraged to provide new spaces at whatever price they want to charge. We shift hundreds of high and complex care needs seniors from nursing-home care to Designated Assisted Living, where they have to pay for many nursing home services, and then, just to keep things "equitable," we make seniors in nursing homes and auxiliary hospitals pay for their prescriptions, so they don't have an advantage over the folks in assisted living. We initiate an "enhanced service option" choice, which means that you can buy a second bath every week, hire a private care aide to care for someone in a nursing home, or pay for therapy to help a recovery from a stroke.

For many seniors, choice is limited. A senior ravaged by Parkinson's, or crippled by arthritis, or lost in the mists of dementia, or with other progressive and unstable chronic illnesses, can't really take advantage of the choices promoted by the government.

The 27 per cent of seniors who live alone and struggle on an income less than $21,000 don't have the same choices as the 50 per cent of Alberta's senior families whose income is more than $46,000 -- and none of these folks have the same "choice" or access to "enhanced services" as the seniors among the eight per cent of individual Albertans with a total income over $100,000.

The "continued government support for those in need" gives new meaning to "welfare state." In this land of incredible riches and promise, where the gap between the rich and the poor is ever-increasing, are we content to hear the most ill and vulnerable seniors continue to ask "Please, sir, may I have some more?" Or to leave families desperately trying to compensate for the gaps and shortcomings of underfunded health care?

Despite Premier Ed Stelmach's promise not to abandon programs for families and seniors, this continuing care strategy does just that. Liepert did speak the truth when he said, "There is no strategy that will have greater impact on system access than what we are announcing today."

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