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Modernizing medicare for an aging population

The 1990s were a turbulent decade for health care in Canada, with changes in funding, management structures, and service organization and delivery. Perhaps as a result, public confidence in the health care system fell from 56% to 20% between 1988 and 1998. Problems seemed endemic, and everyone had a ready reason for them: "under-funding", "overuse", "not enough beds", "long waiting lists", "doctor/nurse shortages".

But at the same time, more than half the people surveyed for the *Health Care in Canada Report 2000* said the medical care they and their families had received in the past year was very good or excellent.

So what's wrong?

NACA's view is that the system no longer reflects today's demographics and social realities. Health care must be realigned to accommodate the changes that have occurred in the four decades since medicare was introduced – and realignment must serve everyone, including the aging population.

These are the issues explored in this issue of *Expression*. We'll look at what population aging means for the health care system and what's right and wrong with how the system works now. We'll wrap up with NACA's prescription for a healthier health care system – and healthier Canadians.

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NACA

The National Advisory Council on Aging consists of up to 18 members from all parts of Canada and all walks of life. The members bring to Council a variety of experiences and expertise to advise the federal Minister of Health, his/her colleagues and the public on the situation of seniors and the measures needed to respond to the aging of the Canadian population. Current NACA members are:

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Putting the health in health care

Debates about health care often focus on whether we can afford a high-quality, publicly funded system in an aging society. NACA believes not only that we can afford such a system but that **Canadians will accept nothing less**. NACA also believes it is time to enhance the health care system by shifting some of the focus from the original intent of medicare — providing acute care mainly through hospitals — toward today's more pressing needs, including community- and home-based care. But can we afford such a system?

We can, and we must

The **National Advisory Council on Aging**'s recently published position paper entitled *The NACA Position on Enhancing the Canadian Health Care System* asserts that a comprehensive health care system is both viable and affordable. Most arguments against long-term sustainability are based on projections of program costs. As NACA's paper points out, however, it's unwise to estimate future costs simply by projecting today's patterns of health care use.

Canadians are healthier today than in the past. If the number of days seniors spent in hospital in 1971 had been projected to 1991, for instance, the projection would have exceeded actual 1991 hospital use figures by 50%.[1] And there's good evidence that tomorrow's seniors will be even healthier than today's. A study comparing the health of Canadians who were between the ages of 32 and 85 in 1996-97 with those who were the same ages in 1978-79 found the earlier group was less healthy – with higher mortality rates and more heart disease, high blood pressure, arthritis and activity limitations.[2]

[1] Carrière, Yves, "The impact of population aging on hospital days: will there be a problem?" Paper presented at the 9th John K. Friesen Conference and Lecture. Simon Fraser University, May 1998.

[2] Chen, Jiajian and Wayne J. Millar. "Are recent cohorts healthier than their predecessors?" *Health Reports* 11/4. Spring 2000. Statistics Canada catalogue 82-003.

In addition, cost arguments often ignore the availability of revenues to sustain cost increases. Today, the federal government and many provincial governments are projecting large surpluses in the years to come, suggesting that governments will have the revenues needed to sustain and even extend a publicly funded health care system. What's more, if health care costs rise because of population aging, those same demographics will reduce costs in other program areas used more heavily by the younger members of the population (such as education and correctional services). In short, just as government policy and public revenues accommodated sharp increases in housing, infrastructure and education needs in the post-war period, they should be able to adjust to meet future needs as priorities shift.[3]

A publicly funded system is not just something Canadians have come to expect: it's also the best way to ensure equitable access to health care while containing costs.[4] The single-payer system is simpler and therefore reduces administrative costs; it distributes the costs of health care more evenly throughout the economy; and it gives the payer greater bargaining power in relation to the cost of services. This view was reinforced in the final report of the **National Forum on Health:** "International evidence suggests that public funding and administration are the best ways to achieve fairness and value for money."

Some argue for privatizing services on the grounds that waiting lists are too long. But analyses based on actual medicare records show that waiting list reporting is often unsound, with duplication and other inaccuracies. The British Columbia Cancer Agency, Ontario's Cardiac Care Network, and the Western Canada Waiting List Project demonstrate that it is possible to manage waiting lists better, with positive results for patients, health care providers and the system as a whole. This co-ordination and optimal resource use would not be possible in a multiple-payer system – yet another reason for public funding and administration.[5]

Aging and costs

Health care needs do tend to increase with age. But by itself, this isn't an explanation for higher health care costs. **Dr. Michael Rachlis**, a policy consultant who has studied extensively the workings of our Canadian health system, firmly believes that health costs are directly related to the system's structure and delivery system. The current organization of medicare is not the most cost-effective way to respond to the health needs of Canadians today. Here are some examples:

- In most parts of the country, preventable diseases such as influenza aren't being

[3] Denton, Frank T. and Byron G. Spencer. "Population aging and its economic costs: a survey of the issues and evidence." *Canadian Journal on Aging* 19/supplement 1. Summer 2000.

[4] Deber, R. et al. *The public-private mix in health care: report to the National Forum on Health.* Department of Health Administration, University of Toronto: 1996; National Forum on Health. *Canadian health action: Building on the legacy.* Final Report, Volume 1. Ottawa: 1996.

[5] Rachlis, Michael M. *Modernizing medicare for the twenty-first century.* British Columbia Ministry of Health and Ministry Responsible for Seniors. Victoria: 2000.

tackled systematically, leading to crowded emergency rooms and hospitals each winter. Seniors are more likely than younger members of the population to be hospitalized as a result of flu, so preventing flu through vaccination and other measures would relieve personal suffering and pressure on the health care system.

CIHI Report:
Total Expenditure on Health, 1996

Country	Per Capita expenditure	Share in GDP
Australia	1,775	8.5
Canada	2,065	9.6
Italy	1,584	7.8
Japan	1,677	7.2
New Zealand	1,270	7.3
Sweden	1,675	8.6
United States	3,898	14.0

- People with terminal illnesses are cared for mainly in hospital. They could be cared for more appropriately, more cost-efficiently and often more in line with their wishes – in specialized facilities or at home, provided support for them and their families is available.

- Higher health care costs aren't simply the result of people getting older. As a result of advances in medicine and technology, seniors are being treated much more intensively today than in the past. Cataract surgery, joint replacements and arterial bypasses are now considered essential to improve the quality of life for many seniors. The more such services are provided, the greater the cost. At the same time, they increase the autonomy of seniors and reduce the need for other kinds of services, such as home care or long-term care.[5]

International experience demonstrates that an aging population need not imply unmanageable health costs. Other countries – Japan, Italy, Sweden, New Zealand, Australia – have comparable or higher proportions of seniors and similar or greater life expectancy than Canada. Yet they spend less on health care than we do. It's also possible to spend *more* than Canada does without increasing life expectancy – the United States is the prime example.[6]

Where to from here?

NACA's most recent position paper argues that publicly funded, comprehensive health care is affordable and sustainable, as well as being equitable and cost-effective. The paper also goes further, arguing for the development, *in stages*, of a much broader medicare system. As the paper points out, "home care, pharmacare and other health services and products are becoming as essential to health as physician and hospital services." The paper therefore recommends that "publicly funded services be extended to comprise all services necessary to restore and preserve

[6] Organisation for Economic Co-operation and Development. *Maintaining prosperity in an ageing society.* Paris: OECD, 1998. (www.oecd.org/subject/ageing)

health and functional capacity, including home care, prescription drugs, care provided in long-term care facilities, dental care, and vision, hearing and other assistive technologies."

At the same time, NACA recognizes that health care is more than institutions, services and products. Good health depends on education and income, whether we grew up in a safe and nurturing environment, and the genes we inherited from our parents. Our personal habits – smoking, wearing seatbelts, diet – make a difference, as do the physical and social environments in which we live and work. Government policies and programs play a role, from garbage collection to environmental protection to income redistribution.[7]

Canadians have universal health care, yet there are still sharp differences in health and life expectancy among us, so modernizing health care demands action on the broad determinants of health throughout the life cycle and paying special attention to groups at greater risk for poor health.

This brings us to the prescription for modernizing medicare to meet the evolving needs of Canadians. NACA sees three priorities:

- strengthening selected elements of the health care system: primary care, home care, drug care, and end-of-life care
- strengthening health promotion and disease prevention
- adopting a comprehensive, integrated and flexible approach to care focusing on needs.

Primary care

Primary care is the usual first point of contact with the health system – a doctor's office, a health clinic, a community health centre. Strengthening primary care and making sure everyone has access are vital, because this is where people get information and support to help them care for their own and their family's health. It's also the route to prevention and screening programs – immunization, pap smears, blood pressure testing, mammograms and prostate exams. Finally, primary care offers opportunities to monitor people with chronic conditions such as diabetes and high blood pressure, reducing the risk of more serious health problems.

CHOICE

At the heart of Edmonton's CHOICE (Comprehensive Home Option of Integrated Care for the Elderly) is health promotion through nutrition, exercise and social contact. Three or four mornings a week, CHOICE staff go into the community to help people get ready for transport to a day centre. After spending the day at the centre, participants are accompanied home, with help if they need it to prepare for bed. At the centre, doctors, nurses, social workers, dentists, foot care specialists and rehabilitation professionals provide services and monitor people with chronic conditions, for timely treatment of flare-ups before they become serious. Participants enjoy nutritious meals, the company of friends, and supervised activities. (Source: Rachlis)

CHOICE

[7] Canadian Institute for Health Information (CIHI) and Statistics Canada. *Health care in Canada 2000: a first annual report.* Ottawa: 2000.

The services of family doctors can be organized more efficiently than at present. Especially effective is working in teams with other professionals – nurses, pharmacists, social workers, dietitians. This allows more cost-effective use of the right professional at the right time, depending on what the patient needs. For example, an office visit may not always be necessary. Quebec and New Brunswick have province-wide after-hours telephone advice lines staffed by nurses, which have shown high rates of satisfaction among callers and significant reductions in repeat visits to doctors' offices and visits to hospital emergency rooms. British Columbia is launching a similar program.[5] Organizing primary care this way also makes it possible to place more emphasis on health promotion and illness prevention.

What kind of health care do seniors want?

Services that are...

- effective, sufficient, available, accessible and affordable
- delivered with continuity and predictability
- consistent with values and cultural preferences
- flexible and adaptable as needs change, with options to make decisions and choices
- offered at the right time and delivered at the right speed
- family centred, with family caregivers included in care planning and instruction

Service providers that are...

- clear and honest communicators
- caring, competent and well trained
- willing to go the extra mile, anticipate needs, solicit opinions, and make time for questions and concerns

A health care system that offers...

- adequate staff and well co-ordinated gap-free services
- transportation if and when needed
- expanded roles for volunteer seniors to help others and use their knowledge
- care in the appropriate setting and more flexibility in new care options, such as group homes
- opportunities for self-managed care
- ways to meet concerns about the availability, cost and use of medications

NACA, *How are health reforms affecting seniors?* (from a survey of Canadian seniors)

Home care

Home care involves a range of services – nursing, help with daily activities and domestic chores – enabling people with health problems or disabilities to live at home. Home care can be a cost-effective alternative to hospital admission or institutionalization. It helps people with chronic conditions maintain independence and provides support and relief for informal caregivers, usually family members. Home care availability increased in the 1990s, but the services available and payment arrangements present an uneven patchwork across the country. As a result, depending on income and location, seniors may be forced to do without the services they need, rely more heavily on informal

caregivers, relinquish their home for a long-term care institution, or pay to receive additional care from a private agency – if they can afford it.

NACA believes that home care should become part of the continuum of publicly funded and managed health services, so that current gaps are closed, disparities between jurisdictions are eliminated, and future needs are met.

Drug care

Retail drug sales account for more than 15% of health care spending – that's up from 8.6% in 1979, making it the fastest rising component of health care spending. (It overtook spending on physician services – until then the second-largest component, after hospitals – in 1997.)[7] Much of the increase comes in two ways: first, doctors are prescribing more new drugs, often with no evidence that they are more effective than older, cheaper drugs; second, drugs are being prescribed that are inappropriate for the condition being treated. Another concern is over-prescribing. At least 5% of hospital admissions of seniors are for drug-related illnesses.[5]

Just as serious is the fact that an estimated 20% of seniors don't even fill their prescriptions, while those who do may not follow instructions concerning dose and duration of treatment.[8]

Cost is one reason some seniors fail to take the medication prescribed. Canada is near the bottom among OECD countries in terms of the public share of drug costs. Provincial and territorial drug benefit plans also vary widely in their coverage, eligibility criteria, and kinds and levels of user charges (premiums, deductibles and co-payments) and just half of Canadian seniors are covered by private insurance. This is why NACA believes that pharmacare should become part of the spectrum of services covered by the publicly funded health insurance.

In parallel with this, strategies can be put in place to help control drug costs and improve results.[5] For example, non-drug approaches have been demonstrated effective for some conditions, including cardiac rehabilitation, mild hypertension, and certain psychological problems. Yet the cost of these is often not covered by provincial health insurance plans. If they're

Victoria's Quick Response Team

The QRT was developed in 1987, originally to ease pressures on emergency wards and acute care beds. Before the QRT, a frail senior who lived alone and suffered a fall often ended up in hospital. Even people with no fracture or other reason for acute care would be hospitalized if they were too bruised or shaken to manage on their own. With the QRT, seniors can be assessed promptly and offered more appropriate care, such as short-term 24-hour care at home or home care if services are still needed after three days. QRT services are available 15 hours a day, with referrals coming from emergency rooms, community agencies, family doctors, neighbours and relatives. The concept has spread to Alberta and Saskatchewan, where it's available 24 hours a day in some regions. (Source: Rachlis)

QRT

[8] Tamblyn, Robin and Robert Perrault. "Prescription drug use and seniors". *Canadian Journal on Aging* 19/supplement 1. Summer 2000.

provided by social workers, psychologists and rehabilitation therapists, they may not even be considered part of health care – yet they deliver health benefits.

Better prescription practices are another strategy. Programs in Toronto and East Vancouver show that doctors working in teams with pharmacists, social workers, physiotherapists and others can reduce overall drug use, produce better results when drugs are prescribed, and reduce health costs.

Finally, British Columbia has a system known as reference drug pricing, which mandates use of only the most cost-effective drugs (based on independent assessment of effectiveness and efficiency). The B.C. government estimates annual savings of $44 million.

Palliative care

The most intensive and expensive health care occurs mainly at the end of life. People with terminal illnesses enter hospital, where they may experience multiple medical interventions. The result can be a painful, undignified death. Yet the availability and funding of palliative care – treating not only physical needs but also the social, emotional and spiritual needs of people with terminal illness, their families and caregivers – vary widely from place to place.

Most cancer patients die in hospital, when they would prefer to die at home or in a home-like setting. Edmonton has demonstrated through its regional palliative care program that this is entirely feasible.[5] Again the key is to integrate palliative care – especially home- and community-based care – with the continuum of publicly funded and managed health services, to ensure people have choices about care.[9]

One element of choice is an 'advanced health care directive', letting older people and their families choose the level of medical intervention they are willing to accept if illness develops. A Hamilton, Ontario, pilot project at a home for the aged let people document how they wanted to be treated in the event of non-reversible and reversible life-threatening illnesses. The benefit for individuals was better symptom control and more dignity in the final months or years of life. The benefit for the system was reduced use of hospital beds and technology-intensive care for people who simply didn't want it.[5]

Ounces of prevention

To this point we have talked about caring for people after health problems develop. But a modernized health care system should also emphasize strategies to promote health and prevent illness. Among today's seniors, preventing conditions that require medical care – heart disease, stroke, diabetes, osteoporosis and many cancers – means proper nutrition, exercise and social contact. For tomorrow's seniors, it means regular physical activity, a varied and nutritious diet, engaging socially, managing stress and avoiding tobacco.

[9] National Advisory Council on Aging. *1999 and beyond / Challenges of an aging Canadian society*. Ottawa: 1999.

There's ample evidence that disease prevention and health promotion for seniors – exercise, falls prevention, immunization, personal empowerment – are extremely effective in improving functional ability and reducing health service use. Even frail seniors can make significant gains.[10]

Despite the evidence – and the fact that a very high percentage of mortality relates to unhealthy lifestyles – just a tiny fraction of health budgets goes to promotion and prevention. For instance, more than half the population is at risk of high blood pressure – a precursor of strokes and heart attacks – because of excess weight, sedentary lifestyle, or excessive alcohol consumption, but less than 2% of health budgets is allocated to prevention and health promotion.[11]

Protection, promotion and prevention must take on higher priority – not only in health policy and programs but in other sectors as well, such as environmental protection, sports and recreation, housing and urban design, and all the other broad determinants of health. Without a change in emphasis, inequalities in health status will persist, and the demand for health services could become less manageable.

Comprehensive approach

Canadians have the right to expect the same level of health care no matter where they live, and income should not be a factor in determining access to health services or products needed to preserve health and well-being. As the population's make-up and health needs change, the health care system and the policies underlying it must be modernized in tandem. Modernizing medicare means adopting a comprehensive, integrated and flexible approach that focuses on needs. It means bringing within the scope of publicly funded health care all the services and products that are important in maintaining good health, independence and quality of life. It means organizing services and delivery systems in ways that are both cost-effective and responsive to the needs of the people they serve.

This is not pie in the sky. Edmonton's

SIPA Success

In Montréal, SIPA (the French-language acronym for integrated care for seniors) provides comprehensive, integrated community care for frail seniors, with links to hospitals and long-term care centres as needed. Seniors enrolled in SIPA can call a nurse 24 hours a day, 7 days a week to obtain needed services immediately. Since it began in 1999, the number of requests for admission to long-term care for SIPA seniors has fallen by 50%, and three times fewer seniors occupied a hospital bed while waiting for care. (Source: Isabelle Paré, "Des projets-pilotes prometteurs en santé", Le Devoir, October 27, 2000.)

[10] McWilliam, Carol et al. "Care delivery approaches and seniors' independence". *Canadian Journal on Aging* 19/supplement 1. Summer 2000.

[11] Health Canada and the Canadian Coalition for High Blood Pressure Prevention and Control. *National high blood pressure prevention and control strategy, Summary report of the expert working group*. Ottawa: January 2000.

CHOICE program, Victoria's Quick Response Team, and Montréal's SIPA project have shown that reorganizing services and marshalling resources effectively can result in better outcomes for individuals and more manageable and cost-effective health care for everyone (see boxes). These innovative programs show that we have the means and the know-how to modernize health care.

In the past, Canadians have been remarkably successful in adapting to demographic and other changes in society by identifying needs, developing effective solutions, and adjusting social priorities to implement them. An earlier generation – those who are seniors today – took the steps needed to create the publicly funded health care system that Canadians value so highly today. Our obligation to that generation – and to the generations to come – is to ensure that policy makers and community leaders take the next step: modernizing that system to ensure it will continue to meet the evolving needs of the people it serves. ■

"Bubs" Coleman, a 40-year resident of Saskatoon, was appointed to the National Advisory Council on Aging in 1999 and she is also a member of the Provincial Advisory Committee of Older Persons. A graduate of Queen's University, she has worked as a writer and editor in both this country and the United States, and until her retirement in 1994 was communications coordinator for Saskatoon's Mendel Art Gallery. Her community volunteer activities currently include assisting the Saskatoon Council on Aging and working with Wanuskewin Heritage Park.

Further reading...

Canadian Institute for Health Information. *Health Care in Canada 2000: A First Annual Report.* Ottawa: Statistics Canada, 2000. www.cihi.ca

National Advisory Council on Aging. *The NACA Position on the Privatization of Health Care* - No. 19. Ottawa: 1997. *

National Advisory Council on Aging. *How are Health Reforms Affecting Seniors? A Participatory Evaluation Guide.* Ottawa: 1998. *

National Advisory Council on Aging. *The NACA Position on Home Care - No. 20.* Ottawa: 2000. *

National Advisory Council on Aging. *The NACA Position on Enhancing the Canadian Health Care System - No. 21.* Ottawa: 2000. *

National Forum on Health. *Canadian Health Action: Building on the Legacy.* Volume 1, *The Final Report of the National Forum on Health.* Ottawa: 1996. wwwnfh.hc-sc.gc.ca/publicat/finvol1/1trans.htm

Michael M. Rachlis. *Modernizing Medicare for the Twenty-first Century.* Victoria: British Columbia Ministry of Health and Ministry Responsible for Seniors, 2000.

* www.hc-sc.gc.ca/seniors-aines