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CANADIAN SENIORS AND PUBLICLY FUNDED HEALTH CARE

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> … [P]opulation aging is sometimes used as a fear-mongering tactic in support of the assertion that publicly-financed [health] systems are unsustainable over the long term … [but] … those whose research suggests the impacts of aging are quite manageable may, in their desire to demonstrate the long-term viability of the basic values and architecture of our health system, overlook some important considerations.(1)

Although Canada's population is aging, there is little consensus among policy experts on the implications for the publicly funded health care system. Over the years, fertility, mortality and international migration rates have been the key determinants of changes to the age structure of the population. Today, low fertility and mortality rates combine to reduce the number of births and to increase the proportion of people who are older. In addition, more people with more age-related diseases, and shifts in family structures, combine with the wider participation of women in the paid labour force to make seniors' use of publicly provided health care services even more essential.

In this area as in others, health policy seeks to balance competing notions of the responsibility of the individual, of organized health care institutions, and of the state. The aim is to determine the most effective way to integrate concern for the health of the elderly with concern for the national health care system as a whole. This task is not easy, given the widely divergent views on the costs of health care for the elderly and on different ways to organize the required care. The varied needs of the different groups within the older population require flexible responses to all elements of health care, from the promotion of good health to acute care treatment to management of chronic conditions. Public policy must balance competing interests in developing programs to meet these challenges in an aging population.

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(1) Health Canada, "Aging and Health Care Reform," *Health Policy Research Bulletin*, Vol. 1, Issue 1, March 2001, p. 3, http://www.hc-sc.gc.ca/iacb-dgiac/arad-draa/english/rmdd/bulletin/bulletin.pdf.

In the health care area, the focus on aging has emphasized the potential for increased strain on the publicly funded system and has raised questions about changes to existing services. This paper outlines the broad elements of the current debate, highlights various financial implications, examines the organization of current health care services, and presents some examples for changed ways of approaching health care for seniors.(2)

AGING AND HEALTH CARE: THE DEBATE

While some observers argue that the aging of the population will result in higher demands on health care services at greater cost to the system, others insist that the effects of aging on the health care system can be decreased by changing the way the system is organized. Overall, although there is agreement that an increased demand for services could accompany old age, the debate hinges on how much of the physical and mental health of seniors is related to broad determinants of health such as gender, ethnicity and marital status, and how much is dependent on the financing and delivery of health care for seniors.

Over the last few decades, the debate has developed on both sides. The Organisation for Economic Co-operation and Development (OECD), for example, argues that "with increasing age the demand for health care and personal services rises steeply."(3) The aging of the population, therefore, means that more people with more age-related diseases will make demands on services established to maintain health and to treat ill health. Canada's National Advisory Council on Aging insists that any increase in demand can be linked to the current dominance of the institution-based and curative approach to health care, rather than to the biological aging process alone.(4) Analysts point out that "sociogenic aging," the societal view that people change significantly as they age, is also partly responsible for determining perceived needs and argue that the biomedical model "has resulted in old age itself being defined as a problem considered solvable through the receipt of services, essentially medical services, at the

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(2) Because this paper focuses on publicly funded health care services, issues related to long-term care for the elderly are not detailed here.

(3) Organisation for Economic Co-operation and Development, *Ageing Populations: The Social Policy Implications*, OECD, Paris, 1988, p. 27.

(4) National Advisory Council on Aging, *Intergovernmental Relations and the Aging of the Population: Challenges Facing Canada*, Supply and Services Canada, Ottawa, 1991, p. 9.

individual level."[5] Statistics Canada's recent data suggest that the health of seniors is improving and that they can expect more quality and quantity of life than 20 years ago.[6] This trend has led various researchers to suggest that, although the number of seniors will increase, they will likely require fewer health care services than in the past.[7]

Various authors have emphasized that policy makers must take care not to base future actions on misconceptions and misapprehensions about the effect of population aging on health services. Moore and Rosenberg argue that "Perhaps the most serious of these misconceptions is that increases in benefits to the elderly over the last four decades mean that there is no longer a significant portion living below the poverty line. Among the more widespread misapprehensions is that the elderly population will be so large in the future that it will require many more supporting resources."[8] Similarly, according to Denton and Spencer, "Popular discussions of health care and social security 'crises' often seem to suggest that population aging is the cause of today's difficulties. That is not so. The proportion of older people will certainly rise, but gradually, and to place blame on it for perceived current problems is misleading."[9]

Others, however, assert that the aging of the Canadian population will create a problem. A report by the Conference Board of Canada supports the view that the significant rise in the number of seniors and the high proportion of lifetime expenditures that occur after age 65 (over 50%) are critical factors for the health care system.[10] A C.D. Howe Institute study argues that an aging population will put steady pressure on many provincial health care budgets as older

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(5) Neena Chappell, "Society and Essentials for Well-Being: Social Policy and the Provision of Care," in *Ethics and Aging: The Right to Live, The Right to Die*, ed. James E. Thornton and Earl R. Winkler, University of British Columbia Press, Vancouver, 1988, p. 147.

(6) Statistics Canada, "Health Among Older Adults," *Health Reports* (Special Issue), Vol. 11, No. 3, 2000, pp. 47-62.

(7) Verena Menec *et al.*, *The Health and Health Care Use of Manitoba's Seniors: Have They Changed Over Time?* Manitoba Centre for Health Policy, Winnipeg, September 2002, http://www.umanitoba.ca/academic/centres/mchp/reports/pdfs/seniors.pdf.

(8) Eric Moore and Mark Rosenberg with Donald McGuinness, *Growing Old in Canada: Demographic and Geographic Perspectives*, Statistics Canada, Ottawa, 1997, p. 187.

(9) Frank T. Denton and Byron G. Spencer, "Population Aging and Its Economic Costs: A Survey of the Issues and Evidence," *Canadian Journal on Aging*, Vol. 19, Supplement 1, 2000, p. 20.

(10) Glenn Brimacombe, Pedro Antunes and Jane McIntyre, *The Future Cost of Health Care in Canada, 2000 to 2020*, Conference Board of Canada, Ottawa, 2001, p. 17, http://www.conferenceboard.ca/press/documents/FutureHealth.pdf.

people consume more health-related goods and the number of younger people working and paying taxes decreases.(11)

Nonetheless, as many analysts agree, aggregate statistics and mechanical projections about population aging and use of health care services do not tell the whole story. A paper produced for the Commission on the Future of Health Care in Canada (the Romanow Commission) contributed further to this debate by assessing some of the uncertainties that underlie the efforts at future projections.(12) It looked at uncertainties over demographics, trends in population health, the cost-of-dying effect, generation-specific capital investments, technological change, policy-induced change, and age-attributable cost increases. It concluded that population aging is a secondary driver of health expenditures, compared to the growth of expenditures attributable to non-aging factors. It argued that such uncertainties, however, should be taken into account and applied to managing risk for future planning.

Generally, results from various studies show that the estimated impact of population aging on health expenditure growth may be small relative to other factors. Most reports point to multiple population and health care variables and to broad health determinants when assessing the situation. Several factors – such as the health differences among various age groups of seniors; socio-economic and other inequalities; and the generally changing profile of health in Canada – affect health services utilization.(13) Some observers believe that many of the factors could be remedied to produce different health status in old age.

Various calculations from existing data, however, point to greater actual costs for health care for seniors over the decades. Using 1994 data, the Canadian Medical Association (CMA) concluded that per capita spending for those 65 years of age and over was more than three times that for the population as a whole.(14) Calculations from the C.D. Howe Institute

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(11) William B. P. Robson, "Will the Baby Boomers Bust the Health Budget? Demographic Change and Health Care Financing Reform," C.D. Howe Institute, Toronto, 2001, p. 1.

(12) Seamus Hogan and Sarah Hogan, *How Will the Ageing of the Population Affect Health Care Needs and Costs in the Foreseeable Future?* Discussion Paper No. 25, Commission on the Future of Health Care in Canada, October 2002, http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/25_Hogan_E.pdf.

(13) For an overview of some of the aging challenges and proposed scenarios, see Howard Chodos and Diane Leduc, *The Aging Population and Canada's Health Care System*, TIPS-73E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 14 June 2004.

(14) Canadian Medical Association, *In Search of Sustainability: Prospects for Canada's Health Care System*, CMA, Ottawa, 2001, p. 9.

using 2000 data suggest even higher expenditures, indicating that average provincial health care spending on people aged 65 years and over was some 5.4 times greater per person than that on people under 65 years.(15) Projecting into the future, the Conference Board of Canada suggests that the annual cost of treating the 55- to 74-year-old cohort, estimated at $3,100 per person in 2001, will be about $4,049 per person by 2020 (including technological change but excluding inflation). With inflation, the cost could rise to $6,718 per person.(16) Such projections are evidently a source of anxiety for provincial and territorial governments, which must provide the care (with assistance from the federal Canada Health Transfer). A 2000 report by provincial and territorial ministers of health noted that aging is expected to account for about 1% of annual health expenditure increases between 1999 and 2027. It estimated that seniors aged 65 years and over currently consume 45% of health expenditures; but by 2020, they are expected to consume closer to 55%.(17)

Although there is much evidence to suggest that expenditures rise with age and that the current provision of health care to seniors is costlier than for the rest of the population, these findings give rise to different interpretations. The Canadian Medical Association has identified various schools of thought that apply to the growth of the elderly population and age-specific health care expenditures. It characterizes these four approaches as: (1) health costs will require a greater share of GDP; (2) rising health care costs will be manageable; (3) efficiency will offset increased demands; and (4) compression of morbidity will reduce demands (i.e., postponement of the onset of disability in seniors will reduce demands for health care services).(18)

The debate about aging and health care continues, with no clear path to resolution. The following examples indicate how related information can be used in different ways. Thus, Health Canada has emphasized that average health expenditures for any person in his or her last year of life, regardless of age, can range from between 50 to 100 times more than for people who

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(15) Robson (2001), p. 4.

(16) Brimacombe, Antunes, and McIntyre (2001), p. 18.

(17) Provincial and Territorial Ministers of Health, *Understanding Canada's Health Care Costs: Final Report*, August 2000, http://www.health.gov.on.ca/english/public/pub/ministry_reports/ptcd/ptcd_doc_e.pdf.

(18) Canadian Medical Association, *In Search of Sustainability: Prospects for Canada's Health Care System*, CMA, Ottawa, 2001, pp. 9-20, http://www.cma.ca/staticContent/HTML/N0/l2/advocacy/discussion_papers/sustainability/pdfs/In_Search_of_Sustainability.pdf.

are not.[19] However, the Canadian Health Services Research Foundation pointed out that "acute health care costs during the last years of life account for only 10 to 12 percent of total healthcare budgets."[20] Both assessments make valid contributions; but, as in other elements of the debate, varied data and explanations make it difficult for policy makers to ascertain precise future scenarios and health system implications.

PROVIDING HEALTH CARE SERVICES FOR SENIORS

Organizational factors are generally seen as a key reason for the higher costs associated with the health care of seniors. One question posed by analysts asks: "Are the elderly now much sicker than they used to be? Or, is the system treating geriatric health needs very differently than before?"[21] By the 1980s and 1990s, Canadian researchers noted that the rising costs may be due in large measure not to the declining health of the elderly, but rather to a health care system that focuses on curative rather than preventive measures, relies disproportionately on physicians rather than other health care providers, and favours hospitalization and other forms of institutionalization rather than home care.[22] Internationally, similar queries about the organization of health services for seniors have been voiced by countries feeling the pressure of an aging population and envisioning limits on health, income security and social services. As early as the 1980s, an OECD report pointed out that "inadequate attention is being paid to long-term care for the disabled and chronically ill, to preventive medicine, to the impact of environmental and behavioural factors on health status and to the provision of care in non-institutional settings."[23]

In Canada, publicly insured health care has been built around the concept of medically necessary services and focuses primarily on the role of physicians and hospitals in

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(19) Allan Pollock, "Compression of Health Expenditures," *Health Policy Research Bulletin*, Vol. 1, Issue 1, March 2001, pp. 13-15, http://www.hc-sc.gc.ca/iacb-dgiac/arad-draa/english/rmdd/bulletin/bulletin.pdf.

(20) Canadian Health Services Research Foundation, "Myth: The cost of dying is an increasing strain on the healthcare system," *Mythbusters*, 2003, http://www.chsrf.ca.

(21) Canadian Health Services Research Foundation, "Myth: The aging population will overwhelm the healthcare system," *Mythbusters*, 2001, http://www.chsrf.ca.

(22) Neena Chappell, Laurell Strain and Audrey Blandford, *Aging and Health Care, A Social Perspective*, Holt, Rinehart and Winston, Toronto, 1986.

(23) OECD (1988), p. 66.

delivering acute care. With respect to seniors, these components of the health care sector deserve scrutiny for several reasons. First, the delivery of publicly funded health care services deemed medically necessary is provided primarily by physicians in private practice and mainly through hospitals that are privately owned (albeit not-for-profit). Second, hospitals – followed by drugs and physicians – are responsible for the largest portion of overall health care expenditures, more than 70% of total public and private health spending in 2001.

Canadian researchers have noted that physicians' associations and hospital associations, along with government officials, constitute the political elites that exert a dominant influence on change within the health care system. These groups are viewed as having a privileged voice in debates over change to any of the core bargains forming the base of health care.(24) Analysts have suggested that system responses such as the way hospitals organize to provide care, and the way in which physicians interact with patients, are key determinants – along with demographics – that govern the utilization of medical services by seniors.(25) Much recent analysis, therefore, considers the efficiency of current practices within these spheres and ponders both the impact of an aging population on physicians and hospitals and the impact of physicians and hospitals on seniors.

A. Physicians

In Canada, the medical profession currently holds virtually exclusive power in defining and enforcing licensing standards and practice guidelines, controlling hospital (and, to some extent, non-hospital) organization of care delivery, and providing access to specialized diagnostic and curative treatments. In turn, provincial insurance plans guarantee physicians payment for their work.(26) Although most physicians are paid on a fee-for-service basis, in 2000-2001, one in four received some payments for clinical care through alternative payment plans.(27)

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(24) John Lavis, *Political Elites and their Influence on Health-Care Reform in Canada*, Discussion Paper No. 26, Commission on the Future of Health Care in Canada, October 2002.

(25) Mark Rosenberg and Amanda James, "Medical Services Utilization Patterns by Seniors," *Canadian Journal on Aging*, Vol. 19, Supplement 1, 2000, pp. 125-142.

(26) Alexander Segall and Neena Chappell, *Health and Health Care in Canada*, Prentice Hall, Toronto, 2000, pp. 217-219.

(27) Canadian Institute for Health Information, *Health Care in Canada 2002*, Ottawa, 2002, p. 33.

Because physicians currently play a pivotal role in determining seniors' access to general and specialized medical care, to hospitals, to prescription drugs, and to home care, they often occupy considerable space in analyses regarding the impact of aging. In the early 1990s, Canada's National Advisory Council on Aging suggested that "78% of the increase in health care costs in industrialized countries over the past 25 years was due to the number of physicians and to the number and level of services they provide per patient. Only 22% was due to demographic factors including population aging."(28) However, other research emphasizes that physicians' ability to organize their individual practices can be markedly affected if they are providing care to an increased number of seniors on a weekly or monthly basis. One study of Quebec seniors found that, although there was little growth in the proportion of seniors between 1982 and 1992 (from 8.9 to 11.2% of the population), their visits to the doctor increased significantly and the costs for physician services more than doubled. Analyses revealed a shift toward more costly services, more visits to specialists and higher rates of hospital admissions.(29)

A 1998 study concluded that, between 1986 and 1994, Canada's overall supply of physicians kept pace with population growth and aging. In some provinces, however, the supply of both general practitioners and specialists grew faster than population changes warranted, while in others, the supply of both lagged behind population growth.(30) Moreover, in addition to the complexities and demands of caring for an aging population, physicians themselves are aging. By 1999, almost 4 in 10 physicians were fifty years of age or older.(31) A recent study on aging and health care commissioned by the Romanow Commission argued that, over the next 50 years, the anticipated high rate of physician retirements combined with low rates of entry into the profession will create tremendous uncertainty in a health care system where physicians dominate.(32)

Some observers believe that physicians may be implicated in increased expenditures on pharmaceuticals. Currently in Canada, people over the age of 65 are the largest

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(28) National Advisory Council on Aging, "A Quick Portrait of Canadian Seniors: Consuming Health Services? At What Cost?" *Aging Vignette #10,* 1993.

(29) Marie Demers, "Factors explaining the increase in cost for physician care in Quebec's elderly population," *Canadian Medical Association Journal*, Vol. 155, No. 11, 1996, pp. 1555-1560.

(30) Noralou Roos *et al.*, "How many physicians does Canada need to care for our aging population?" *Canadian Medical Association Journal*, Vol. 158, No. 10, 1998, pp. 1275-1284.

(31) Canadian Institute for Health Information, *Health Care in Canada 2001*, Ottawa, 2001, p. 52.

(32) Hogan and Hogan (October 2002).

consumers of prescribed drugs, and the proportion of seniors that report using five or more drugs is increasing.(33) This is at least partially due to the higher number of people with chronic diseases; but is due also to growth in the pharmaceutical industry and the rapid development of new and often competing drugs. Different views exist on whether newer and more expensive drugs provide a significant therapeutic advantage over older and cheaper drugs and result in improved health outcomes, which in turn can reduce hospitalization rates. Some research suggests that higher medication use among the elderly results partly from inappropriate over-prescription and poor coordination by health professionals. One study noted that

> cancer and chronic diseases (hypertension, diabetes, asthma, and dementia diagnoses) are on the rise. Whether this reflects actual increases in incidence or prevalence or changes in practice patterns is not clear (e.g., greater emphasis on cancer screening or changes in how physicians diagnose patients such as changes in diagnostic criteria as is the case for diabetes). Regardless, diagnoses tend to lead to treatment, which may in part account for the increased drug use.(34)

Inappropriate prescriptions affect the health care system in two ways. First, they increase costs for provincial prescription drug programs. A British Columbia study of prescriptions dispensed to seniors between 1987 and 1999 found that the average number of prescriptions per person grew by 15% and drug costs per person jumped almost 150%, partly due to the cost of newer drugs.(35) Second, inappropriate prescriptions increase the potential for inappropriate drug combinations and related problems associated with taking too many drugs or the wrong dosage of drugs, or using drugs improperly. One study found inappropriate drug combinations among elderly patients ranging from 4 to 20%, while another identified 115 out of 120 frail elderly patients with some discrepancy between their use of medications and their physician's awareness of their medication use.(36)

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(33) Canadian Institute for Health Information (2002), p. 81.

(34) Menec *et al.* (2002), p. xiii.

(35) Canadian Institute for Health Information (2002), pp. 887-888.

(36) R. Tamblyn *et al.*, "Do too many cooks spoil the broth? Multiple physician involvement in medical management of elderly patients and potentially inappropriate drug combinations," *Canadian Medical Association Journal*, Vol. 154, No. 8, 1996, pp. 1177-1184; and F. Godwin *et al.*, "What drugs are our frail elderly patients taking? Do drugs they take or fail to take put them at increased risk of interactions and inappropriate medication use?" *Canadian Family Physician*, Vol. 47, June 2001, pp. 1198-1204.

B. Hospitals

Most hospitals in Canada fall under provincial jurisdiction but are left to determine the local need for services and the required funding levels, usually working through regional health authorities. The provincial ministries of health may provide from 80 to 90% of hospital operating funds, with the remaining share generated through co-payments, preferred accommodation charges, fundraising, and entrepreneurial operations such as parking and food concessions. Patients in hospitals are accommodated on the basis of continuing medical care under the direction of physicians and receive supporting diagnostic and therapeutic services provided within the institutional setting.

Hospitals provide essential acute health care for seniors as for other Canadians. However, in some instances, seniors are labelled as "bed blockers" when they are left in acute care beds beyond the average length of stay. Often, this is due to the absence of alternatives in other institutions or in the community. Although an elderly person usually enters the health or social system as the result of an acute episode that requires admission to a hospital, studies indicate that many elderly patients are left too long in hospital beds when they would be better off in home care or outpatient programs. From the mid-1980s to mid-1990s, the number of public hospitals and the number of approved beds declined. Much of the decrease in beds was attributed to a reduction in the hospital extended care sector, with long-term care units being re-designated as residential care facilities.(37) In provinces such as Ontario, many seniors originally admitted into acute care beds are later deemed by a physician to require an alternative level of non-acute care; they are then technically declared to be in a chronic or long-term facility, and are obliged to pay chronic care co-payments to cover accommodation and meals.(38)

Experts disagree on the impact of aging on hospitals.(39) Those who assume a future scenario where seniors will continue to access hospitals for treatment in the same way as they do currently, project a significant increase in acute care hospital use over the next 10 years. Others question such projections, seeing instead healthier seniors, a continuing drop in the rates of hospitalization, and an evolving health care system. A Manitoba study noted that in

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(37) Patricia Tully and Etienne Saint-Pierre, "Downsizing Canada's Hospitals, 1986/87 to 1994/95," *Health Reports*, Vol. 8, No. 4, Spring 1997, p. 33.

(38) Ontario Ministry of Health and Long-Term Care, "Chronic Care Co-Payment Fact Sheet" and "Hospital Chronic Care Co-payment: Questions and Answers," Toronto, 1998.

(39) Canadian Institute for Health Information (2001), pp. 29-30.

1998-1999 a small number of seniors used nearly two-thirds of all hospital days in Winnipeg, contributing nearly two-thirds to in-patient costs. However, analysts attributed this to factors associated with delays in getting diagnostic tests or consultations, as well as factors linked to delays in the referral process to home care.(40)

Since the early 1990s, Canadian studies have reported that most seniors, except when hospitalized just prior to death, use medical services no more often than younger adults. According to a large-scale Manitoba study, "59% of health care services are used by about 5% of the senior population (mostly the very elderly) and the largest costs are incurred just before death."(41) Some studies point to factors other than age, including the fact that the incidence of surgery as part of hospitalization is increasing for the non-elderly as well as the elderly population. Thus, an analysis over a decade showed that 37% of all hospital discharges of elderly people in 1987, up from 29% in 1975, were related to surgery. For the non-elderly population, surgery was involved in 55% of all hospital discharges in 1987, up from 50% in 1975.(42)

Because hospitals house many of the medical technologies used for diagnostic and treatment purposes as well as those applied to sustain and to prolong life, medical intervention for seniors can now avert deaths from acute illnesses that would have occurred a few decades ago. This has led to questions about whether additional technology and intensive treatment should be used to sustain the lives of all patients, and about when alternatives such as home care or even palliative care should be made available. However, some caution that surgical treatment should not be withheld on the basis of age alone, noting studies such as those on coronary artery bypass grafting in elderly patients indicating that surgical intervention was both safe and beneficial when compared to medical therapy.(43) The Canadian Health Services

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(40) Sharon Bruce *et al.*, *Acuity of Patients Hospitalized for Medical Conditions at Winnipeg Acute Care Hospitals*, Manitoba Centre for Health Policy, Winnipeg, 2001, http://www.umanitoba.ca/academic/centres/mchp/reports/pdfs/acuity.pdf.

(41) Cited in National Advisory Council on Aging, "The Canadian Health Care System: Myths and Realities," *Expression*, Vol. 8, No. 2, Spring 1992, p. 5.

(42) Mary Beth Maclean and Jillian Oderkirk, "Surgery Among Elderly People," *Canadian Social Trends*, Summer 1991, p. 12.

(43) William Ghali and Michelle Graham, "Evidence or faith? Coronary artery bypass grafting in elderly patients," *Canadian Medical Association Journal*, Vol. 165, No. 6, 2001, pp. 775-776.

Research Foundation has emphasized that "despite changes to the technology available, the fact is most people still die without an expensive high-tech struggle."(44)

MEETING SENIORS' HEALTH CARE NEEDS

Seniors share analysts' concerns about the ever-increasing cost of providing health care and the apparent lack of coordination among various providers and institutions. Seniors are particularly concerned about obtaining equitable access to the care that they need. They and their advocates observe that solutions must address inadequate or impersonal care, over-medicalization of social problems, growth in waiting times for certain procedures, and inappropriate use of costly medical technologies.

New ways of financing health care services for the older population are currently under consideration. Various analysts have suggested different funding methods to cover acute health care needs. For example, the provincial and territorial ministers have urged the federal government to implement an appropriate escalator for federal health-related funding, based on considerations including population growth, aging, disease trends, technological utilization, and economic development. The 10-year health plan agreed to by First Ministers in September 2004 moved in this direction with the application of an escalator of 6% to the Canada Health Transfer, effective in 2006-2007.(45)

The C.D. Howe Institute made the case for both a Seniors Health Grant (through conversion of part of the federal health transfer into a grant per person aged 65 years and over) and a Seniors Health Account (through creation of a trust fund to cover the incremental costs of the grant).(46) The proposed new financial arrangements were to induce providers to take better account of the cost of their treatments; the Institute suggested rostering arrangements for primary care to supplement or replace the current fee-for-service system as one way to reduce incentives for over-service and overconsumption.(47)

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(44) Canadian Health Services Research Foundation (2003).

(45) First Ministers' Meeting on the Future of Health Care, News Release, "A 10-year plan to strengthen health care," Ottawa, September 2004, http://www.hc-sc.gc.ca/english/hca2003/fmm/index.html.

(46) Robson (2001), pp. 20-25.

(47) *Ibid.*, p. 18.

In Quebec, the Clair Commission report (published in January 2001) focused on the need for more long-term care and recommended the creation of a dedicated insurance fund, financed by a special tax, to cover long-term loss of autonomy. The fund was to be separate from general provincial revenues and administered by a body such as the Quebec Pension Fund. The goal was to "enable the system to simultaneously meet a number of objectives: allow an equitable system of homecare and institutional care to be established across the province; reduce the costs and inconvenience associated with long-term hospitalization; and support and supplement the work of non-professional caregivers."(48)

On the organizational side, various solutions have been proposed and some are being implemented. For providers and hospitals, they include requirements for provider networks, particularly primary care links, and a move to local networks of hospitals with physicians, greater integration of hospital service delivery and extended alliances with neighbouring hospitals, and generally more attention to quality improvement and disease management. To meet the multiple needs of seniors, advocates of change encourage more attention to outreach and education, cultural competency initiatives, and general consumer and advocate involvement. However, as the National Forum on Health noted in 1997, such initiatives are hampered by a lack of clear performance measures and data, and an absence of analyses of service utilization, quality improvement and patient satisfaction.(49)

Hospitals are increasingly drawn into the world beyond their institution through discharge planning for patients and linkage with community services. Some emergency departments have geriatric consulting teams to assess the functional capacity of seniors who come for treatment. One well-known change aimed at reducing the demand for seniors' acute care services was the multidisciplinary Quick Response Team approach adopted in Victoria several decades ago and now used in other parts of Canada. Teams of nurses, social workers, physiotherapists and occupational therapists, working in conjunction with physicians, assist elderly clients to recuperate at home in circumstances that previously would have required hospitalization. Findings suggested that, without the Quick Response Team approach, all of the

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(48) Howard Chodos, *Quebec's Health Review (The Clair Commission)*, PRB 00-37E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 26 February 2001, http://lpintrabp/lopimages2/prbpubs/bp1000/prb0037-e.asp.

(49) "Striking a Balance: Working Group Synthesis Report," in National Forum on Health, *Canada Health Action: Building on the Legacy*, Vol. 2, 1997.

frail elderly appearing at emergency wards would have been hospitalized; instead, only one in ten or 10% need to be admitted to the acute care hospital.(50) In 2001, an evaluation of the Quick Response Program established in 1997 within Saskatoon District Health observed that the cost of providing such services is cheaper than hospital care and does alleviate pressure on hospital beds.(51) However, the author also emphasized that a Quick Response Program is an additional service to facilitate access to appropriate care and will reduce health care expenditures only if hospital beds are closed.

At the other end of the spectrum are voluntary, community-based prevention efforts such as that offered by Santropol Roulant in Montréal. This intergenerational approach involves young volunteers in preparing and delivering meals to seniors and, in doing so, in reducing some of the malnutrition and social isolation facing older people. Assessments suggest that Santropol Roulant has saved taxpayers over $2.4 million through services aimed at preventing the institutionalization of isolated seniors.(52) Other studies point to an increasing need for programs focusing on injury prevention and rehabilitation that could reduce the hospitalizations for falls and hip fractures that are common among the oldest seniors, particularly women aged 85 and over.(53) Efforts to adapt the curriculum of medical and nursing schools and adjust the services of clinics and hospitals to be more culturally sensitive continue. Some suggest greater recognition of skills and credentials earned in foreign countries so that nurses and doctors familiar with various cultural practices are available to work with seniors.(54) Studies of the relationship between culture and health include looking at the needs of Chinese seniors in an

(50) Anne Mullens, "Victoria's Health," *Vancouver Sun*, 17 May 1991, p. 1.

(51) Joanne Franko, *Evaluation of the Cost-effectiveness of the Quick Response Program of Saskatoon District Health*, National Evaluation of the Cost Effectiveness of Home Care, Victoria, 2001, pp. 24-25, http://www.homecarestudy.com/reports/full-text/substudy-14-final_report.pdf.

(52) See the Santropol Roulant Web site at: http://www.santropolroulant.org/.

(53) Pekka Kannus and Karim Khan, "Prevention of falls and subsequent injuries in elderly people: a long way to go in both research and practice," *Canadian Medical Association Journal*, Vol. 165, No. 5, 2001, pp. 587-588; Menec *et al.* (2002).

(54) H. Jack Geiger, "Racial stereotyping and medicine: the need for cultural competence," *Canadian Medical Association Journal*, Vol. 164, No. 12, 2001, pp. 1699-1700; Glenda Simms, "Aspects of Women's Health from a Minority/Diversity Perspective: A Canadian Perspective," Paper commissioned for the Canada-USA Women's Health Forum, Ottawa, 1996.

effort to understand the implications of culture on the planning of health care policies and programs.(55)

The current discussion in Canada is increasingly focused on finding a balance between cost-effectiveness and a good quality of life for older Canadians. The debate continues about whether health care services delivered by professionals other than physicians can result in more appropriate use of existing acute care and long-term care services. In New Brunswick, the extra-mural hospital program relies on public health units and VON nurses to provide back-up care for elderly people transferred from general health care facilities to their homes. Some suggest that adding a health promotion component administered by a public health nurse to the existing long-term care assessment process could reduce the need for long-term institutional services for the frail elderly.(56)

CONCLUSION

Overall, there is a need for systematic collection of information and consistent interpretation of data on all aspects of health care for older people. If the costs associated with technological change and the growing requirements of health care for seniors are to be controlled, many facets must be re-examined in the near future. Controlling health care expenditures and reforming ways of financing those expenditures must be accompanied by reorganization of key components of the spheres dominated by physicians and hospitals. Generally, demands for efficiency must be balanced with the need for equity.

Canada has achieved near-universal access to basic, high-quality health care services for the elderly. Those services can be preventive as well as curative; they can be delivered on a short-term or a long-term basis, and can involve a range of service providers. All services will require significant investment in order to maintain current standards. High-quality health care, however, includes more than access to treatments for disease and disability; it should also include services to support seniors' desire to live secure and independent lives and reduce

(55) Dennis Urquhart, "Multicultural health care: Investigating the health needs of Chinese seniors in Canada," *Gazette* (University of Calgary), 3 December 2001; Maria Lironi, "UVic researchers survey Chinese seniors' attitudes to health," *The Ring* (University of Victoria), 24 January 2002.

(56) H. M. Morris, *et al.*, "Health Promotion and Senior Women With Limited Incomes," *Journal of Community Health Nursing*, Vol. 17, No. 2, Summer 2000, pp. 115-126.

the sense of isolation and vulnerability that some older people feel as a result of their increasing physical infirmity and reduced mobility.