Twenty years ago, the Canadian Medical Association (CMA) identified the challenge of caring for an aging population as the most pressing problem facing the Canadian health care system. Yet, some health economists and policy analysts today contend that the potential demographic time bomb represented by the growing cohort of older citizens is a minor factor that the system can accommodate with relative ease.

This shift in opinion comes partly because of new findings about use of health care resources by the elderly, but also as a result of the recognition that observations made with older patients in the past cannot be applied to the growing number of seniors today. It can also be argued that the preoccupation with pending demographic realities in the early 1980s has been subsumed by more general concerns about timely access to necessary services for all patients.

Although many health policy experts may be downplaying the impact of the aging population, there are those in the medical community who continue to draw attention to the failure of either physicians or society as a whole to pay adequate attention to the issue. Leaders of the geriatric medicine community in Canada have serious concerns about the ability of society and the medical profession, in particular, to meet the complex medical needs of the growing number of frail elderly.

The CMA was one of the first organizations to turn its attention to the aging population when it established a CMA task force on the allocation of health care resources in the early 1980s. With several prestigious members including two prominent physicians — Drs. Leon Richard and John O’Brien-Bell — and Roy Romanow (then a prominent politician, known most recently for his own 2003 report on the health care system), the mandate of the task force was to examine the allocation of resources “in the face of an increasing elderly population and the explosion of new technology.”

The task force based the thrust of its report on a Woods Gordon report it had commissioned that detailed “alarming” demographic changes expected in Canada over the next 40 years as the result of an aging population. The main concern of task force members was the high rate of institutionalization and the ability to pay for this.

According to the model adopted by the task force, there would be a 110% increase in the need for long-term care beds between 1981 and 2001 and a 121%
increase in the need for home care nurses over the same period. Overall, the task force calculated that an additional 118,000 hospital beds and 276,000 long-term care beds would be needed by 2021 to care for elderly patients. If status quo projections were correct, the task force said, Canada would have to construct almost 1000 new 300-bed, long-term care facilities to provide the needed beds.

“For too long,” the report of the task force stated, “the elderly have been regarded more as a liability than as an asset, and have been ignored by society, especially in the provision of services, including health services.”

The main thrust of the task force’s recommendations was de-institutionalizing care and avoiding “the callous practice of warehousing the elderly.” The report condemned many nursing homes for providing a standard of care that “is grossly inadequate” and urged the elimination of for-profit homes in favour of non-profit facilities. The report talked of promoting the well-being of the elderly to encourage activity and independence and of providing a variety of community and palliative care services and programs.

Because of the non-physician and consumer focus of the report, it was criticized at the time by many within the profession. For instance, an editorial in a CMA divisional publication in September 1984 said, “Those who expected some profound analyses of problems facing Canada’s health care system along with appropriate and imaginative solutions, will be disappointed.”

Within the CMA, the main outcome of the report was the creation of a special 2-year committee — chaired by palliative care expert, Dr. Dorothy Ley — to evaluate the whole status of health care for the elderly. The deliberations of the Ley committee resulted in a major policy statement from the CMA that was to form the backbone of the association’s stance in this area for the next decade and to some degree up to the present day.

The committee report reiterated the rationale for concern expressed by the earlier task force. It noted that the absolute number of elderly was expected to double between 1987 and 2001 and that the increase in numbers of those over aged 75 would increase even more. This absolute growth in numbers will result in a “dramatically increased need for health care services,” the committee argued, because people will live longer with chronic diseases and accompanying disabilities.

However, the report, acknowledged that this issue was highly controversial because of counterarguments that the period of disability at the end of life can be compressed.

“It seems unwise to divert resources and attention from the elderly in the dubious hope that tomorrow’s aged population will less likely need health services than today’s,” the committee report said.

“Given the now well-known demographic projections for the number of elderly, it is imperative that a coordinated, responsive system of health care for the elderly be developed immediately,” the resulting policy statement reads. “General problems that underline many of the deficiencies in the provision of health care to the elderly are inappropriate attitudes toward the elderly, inadequate education in the health and social care fields, overemphasis on medical care, fragmentation of care, inadequate community services, inappropriate financing and confusion in the terminology used in different jurisdictions for types of long-term institutional and home care.”

The policy document goes on to set down several essential principles the CMA felt would have to be accepted for change to take place. These included:

- care of the elderly should be seen as mainstream health care
- no elderly person should be denied health care because of age
- elderly persons must have the right to choose to live at risk
- the elderly should have the right to die in their own home.

Jump forward almost 2 decades to the 21st century. In his major assessment of the Canadian health care system, contained in the 2002 Commission on the Future of Health Care in Canada final report, Romanow says, “Much has been made of the fact that Canada’s population is aging and, for some, this is yet another reason to worry that Canada’s health care system may not be sustainable.”

But Romanow gives fairly short shrift to this argument based on the experiences of other countries to date and the actual health of the cohort of the population making up the aging bulge. Other nations comparable to Canada that have already experienced the aging of their populations have managed the associated costs while maintaining desirable health outcomes. In addition, the report says the baby boomers of today will be healthier in old age than their parents and will have fewer chronic conditions.

“It is indisputable that Canada will be ‘greyer’ in the future than it is now but that reality is neither a catastrophe waiting to happen nor an issue that simply can be ignored,” said the report, in its short chapter addressing the issue. “With foresight and appropriate planning, the health care system can adapt in a timely manner to a new reality of an older population.”

The case against the aging population having a dramatic impact on the system is made even more overtly by the Canadian Health Services Research Foundation (CHSRF) in its “mythbusters” series.

Dealing with the “myth” that the aging population
will overwhelm the health care system, the foundation states that although health care costs will increase as the number of older people in the population increases, “provided use rates of different age groups stay constant, this increase will happen along a gradual slope, easily cushioned by the economy.”

However, the CHSRF essay references studies from British Columbia and Quebec showing that proportional use of health services by patients over age 65 increases significantly compared with younger age groups. The article then quotes a Manitoba study showing that this dramatic increase in physician visits and use of other health services is attributable to use by healthy seniors rather than those in poor health. The reason for this is still unclear, the essay concludes.

University of British Columbia health economist Morris Barer says Canadian researchers have known for more than 2 decades “that the aging of Canada’s population has a very small impact on Canadian health care costs and will continue to have a relatively small impact. Speaking to the Canadian Association of Health Services and Policy Research last year, Barer said his group alone had written 3 papers focusing on this subject over a period of 15 years but the concept of a demographic time bomb persists despite evidence to the contrary.

An article by prominent US health economist Uwe Reinhardt published at the end of 2003 stating “overall, the effects of population growth on physician requirements have exceeded the effects of aging.” However, the researchers say aging will have an important role in determining what types of physicians will be required in the future.

In the face of this apparent downplaying of the emphasis on the impact of aging on the health care system, comments by Canadian geriatricians come as a stark counterpoint.

“For a variety of reasons, aging and the aged have fallen off the radar screen,” says Dr. David Hogan, professor and the Brenda Strafford Chair of Geriatrics at the University of Calgary. He said this was “unfortunate” because the issue of care of the elderly “is going to come back with a vengeance” and policymakers are not planning how to deal with this.

What health economists have failed to recognize, says Dr. Duncan Robertson, head of the British Columbia Medical Association’s committee on care for the elderly, is that “the bar constantly gets lifted and standard medical care of older people in their 80s, 20 years ago in Canada would now be considered neglectful.”

“We have guidelines that outline optimal medical care for a whole lot of conditions that may have been ignored or neglected a few years ago ... where the guidelines for frequency of visits, for investigations and monitoring are much more frequent and much more costly than would have been the case ... 20 years ago.”

Dr. Howard Bergman, the Dr. Joseph Kaufmann Professor and head of geriatric medicine at McGill University and current president of the Canadian Geriatrics Society (CGS) feels there are problems with both the view that the aging population will have a catastrophic impact on the health care system and the “angelic” belief that the system can adapt to the new demographic realities.

“I don’t think either point of view is very adequate,” he says. Although other countries, such as Sweden, have older populations and “the streets are not full of older demented, incontinent persons with their walkers run-
nig wild,” Dr. Bergman says, such international comparisons are not necessarily valid because these countries have had longer to adjust and, in Canada, “we’re getting older as a society, very quickly.”

Another concern with the “angelic” outlook, according to Dr. Bergman, is that it “lulls us into saying let’s keep doing things the same way and things will work out.”

On the other hand, he says, the catastrophic perspective is often based on projections of utilization rates from the present or the recent past when hospital and institutional admission rates for older patients were much higher. For instance, he says, the type of projections that underpinned the CMA’s task force report is no longer valid because the practice of medicine has changed significantly in the intervening years.

Also offsetting the catastrophic outlook, Dr. Bergman says, is the fact the cohort that is now getting older is healthier than past cohorts, and the degree of disability in this population is lower. In addition, he says, there is now a bigger push for maintaining a healthier lifestyle with enhanced health promotion and preventive activities.

As an example of the continued vitality of the “catastrophic” outlook, Dr. Bergman points to the release in July in Quebec of a report that said the province’s health care costs will account for 70% of the province’s budget in 20 years due in large part to the aging population.

Similar to Dr. Hogan, Dr. Bergman’s bottom line is that if society does not adjust to the challenges of the aging population “we will be in trouble.”

“A barrier to doing things differently is I think people have been convinced that the standard care in Canada is good enough for older people as well as younger adults and that there’s nothing unique about dealing with older patients,” says Dr. Hogan.

Dr. Hogan says much of the current focus of evidence-based medicine is based on the premise that care involves management of a single condition or illness, whereas patients in their 80s usually have multiple illnesses that are not well served by treatment guidelines. About 65% of those 65 and older have 2 or more chronic conditions and 25% have 4 or more, Dr. Hogan notes. He says most clinical practice guidelines (CPGs) for chronic conditions don’t address their applicability to older patients with multiple comorbidities and this can lead to problems. A recent American paper showed that if the relevant CPGs for a hypothetical 79-year-old woman with COPD, diabetes, osteoporosis, hypertension and arthritis were followed, the patient would be on 12 medications costing more than $400/month, plus a complicated nonpharmacologic regimen.

The same point was made by the CGS — of which Dr. Hogan is a past president — in its 2001 brief to the Romanow commission. “Frail older people have complex problems that are not necessarily best served by health delivery models which focus on single system illness,” the brief notes.

Dr. Kenneth Rockwood, professor of geriatric medicine at Dalhousie University, dealt with this point at more length in a brief to the Standing Senate Committee on Social Affairs, Science and Technology also in 2001. Contrary to what health care professionals are taught about how to address patient problems, “what we are learning in geriatric medicine is that this tried and true approach does not work for frail, older adults, who have multiple, interacting, medical and social problems,” Dr. Rockwood wrote in the brief. “Although the usual approach to care is based on single system illness, the situation is more complicated when more than one illness is present, and when a patient’s function is compromised. Such patients are what systems analysts call complex, meaning that their ‘overall problem’ is not simply the sum of their individual ones: you cannot intervene on just one problem without it affecting the others, and it is important to pay attention to large, over-reaching issues that often are seen as being outside the scope of traditional medicine.”

Dr. Hogan says there is still no recognition of the need for this approach within the medical profession. “We’ve not recognized the reality of what it’s like to be 85 years old with 16 diagnoses and functional incapacity,” says Dr. Robertson.

Dr. Bergman says that primary care needs to be reorganized so that it can assume care for complex cases. Emphasis within the health care system must also be further shifted to stress care in the community rather than institutional care, he adds. Dr. Robertson notes the current system is set up to accommodate younger patients and many older patients spend the last few years of their life “essentially driving between doctors’ appointments and waiting for investigations.”

The challenge, says Dr. Robertson, is to provide medical interventions when appropriate for older patients, but also to provide other aspects of supportive care that they may require.

“There is a significant shortfall in long-term residential care at the heaviest level,” he says, because people have believed that an approach stressing preventive care and wellness will reduce the need for such residential care “and old age and disability will go away, and it hasn’t.”

Because only a very small percentage of older patients are responsible for a large majority of the costs to the system, Dr. Bergman says it is important that more attention be paid to caring appropriately and most effectively for these frail elderly. Such good care starts with solid health promotion activities because how you will age starts right at birth, he says.
“If we want to reduce the number of older people who develop disabilities and need more and more care, then we need to support health promotion and prevention not only in younger and middle aged people but also in older persons. We can at least delay the onset of frailty.”

“I suspect that when the baby boomers start reaching 65 and, in particular when they start reaching 75, there’s going to be a lot of hue and cry in Canada about what we’re doing about the aging population,” Dr. Hogan says. Dr. Robertson says not only are expectations higher for the older patients themselves but the expectations of their children are “much, much higher” for access to services and participation in time-consuming, decision-making issues.

Although admitting that forecasting the needs of the aging population in the future is purely speculative, Dr. Hogan agrees it is probable that older patients in the future will have higher expectations for care than the current cohort of older patients who have lived through many hardships the baby-boomers have not had to face.

In the face of increasing demands for specialized geriatric care, Dr. Hogan says Canada is woefully underprepared in terms of the number of physicians trained in geriatric medicine. When the CGS made its presentation to Romanow in 2001 it noted that in the academic year 2000–2001, only 7 people were entering a training program in geriatric medicine in Canada. This contrasted with the more than 250 who enter a training program in geriatric medicine every year in the United States.

Now, Dr. Hogan says, the situation seems to be getting worse as this year only 2 people entered training in geriatric medicine in English Canada and 3 more in Quebec.

A group of Ontario geriatricians and programs have proposed a ratio of 1.25 geriatricians per 10 000 population over age 65. In 2001 the ratio was 0.57/10 000.

“Unless recruitment improves, the field will die away just as the number of seniors rapidly increases,” the CGS states. Geriatric medicine has to be given a higher value in medical schools and hospitals if this situation is to be reversed, Dr. Bergman says.

A look at findings from the National Physician Survey conducted last year seems to confirm a serious lack of specialists dedicated to geriatric care. Asked how many of them were doing geriatric medicine, only 215 of the 11 000 plus specialists who responded to the survey answered in the affirmative and only 75 of these indicated they were certified geriatricians. And of the 215, only just over a quarter (26%) said they spend more than half their time caring for elderly patients.

In contrast, slightly more than half (54.7%) of all family physicians responding to the survey said geriatrics or care of the elderly was part of their practice. This was the highest percentage of any of the 35 areas of care identified in the survey. Family physicians can take extra accredited training in care of the elderly during residency, but Dr. Hogan says there is some early evidence to suggest that the number opting for this is declining.

Although the Canadian debate about the sustainability of health care funding has focused more on acute care expenditures than on care of the elderly and long-term care, other jurisdictions such as the United Kingdom are paying attention. In January, the King’s Fund launched an investigation into the long-term demand for and supply of social care for older people in England. The review is being led by Sir Derek Wanless, and follows 2 independent and influential reviews he conducted for the government on future health care spending in the UK and on public health in England. The report is expected early in 2006.

The CMA’s most recent policy statement on care for the elderly dates back to 2000 but was reaffirmed this year as being still relevant. The document backs away from dealing with specific figures, but rather outlines principles for medical care of older persons and is based on a paper developed by the British Columbia Medical Association in 1999.

Pat Rich is editor of Elder Care magazine.