

PRESENTATION TO THE STANDING SENATE COMMITTEE ON SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

FUTURE OF HEALTH CARE FOR THE ELDERLY IN CANADA

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Similar to Dr. Ken Rockwood, I was honoured by being asked to present to the Senate Committee, chaired by Senator Michael Kirby. In this article I would like to summarize some of the major points that I made to the Committee. The Committee responded with many questions and great interest with respect to the elderly and the future of health-care in Canada.

WHAT DO SENIORS WANT?

Seniors are most interested in staying healthy and independent as long as possible, and this depends on health promotion (successful aging), support services foremost from family and secondarily from formal community services, excellent care from

their family physician, and access to specialized geriatric services (geriatric medicine / geriatric psychiatry).

Although the greatest risk factor for almost all diseases is age, and although the typical senior will have several diseases, in terms of independence and quality of life, approximately 80% of seniors are well. Long-term care facilities take care of approximately 5% of seniors, and about 15% of seniors fall into the category of *frail* which is defined in many different ways but for the sake of simplicity usually implies dependency on others for some of the activities of daily living or of being high risk to develop dependency. In Canada, we seem in many ways to be moving back to the old paradigm “old = disabled = services / back to the warehouse.” There is a new model to approach older persons, targeting both the well, the frail and the institutionalized, for strategic health promotion activities and focusing specialized geriatric assessment and treatment to optimize diseases and disabilities particularly in the frail elderly. Only after the person’s situation is optimized should support services be looked at. There are many examples of successful health promotion, including influenza vaccination, aerobic exercise programs (which in one study lasting 6 months actually improved maximum ventilator capacity as if the person was 5 years younger), and strength-training (with one study on nonagenarians in a nursing home showing 174% quadriceps strength improvement in only an 8-week program).

In March 2001, the *Standing Senate Committee on Social Affairs, Science and Technology*, chaired by Senator Michael Kirby, was authorized by the Senate to report on the state of the health-care system in Canada, its sustainability and the Federal role in any reforms that may be needed. Since then, the Committee conducted a multi-phased study, which examined:

- the Federal roles in Canada’s health-care system and the evolution of Federal funding (Vol.1 report tabled Mar/01)
- existing and foreseeable pressures within the health-care system (Vol.2 report tabled Oct/01)
- experience of other countries’ health-care systems, including their objectives, principles and delivery systems (Vol.3 report tabled Oct/01)

In Vol. 4, *Issues and Options*, the Committees drew upon the findings from the first 3 phases, developed policy options, and invited comments, including:

- the respective strengths and weaknesses of the options
- other suggestions warranting consideration; and
- the preferred option(s)

The above presentation was made before the Senate Committee March 22, 2001.

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WHAT ARE SPECIALIZED GERIATRIC SERVICES?

Specialized geriatric services are designed to support family physicians in their care of complex and

frail elderly. They represent a comprehensive range of specialized geriatric medical and psychiatric assessment, short-term treatment, and rehabilitation services, often provided by interdisciplinary teams with expertise in the care of the elderly across the continuum of care, both in-patient and out-patient. The fundamental premise of specialized geriatric services is that much of the disease, disability, and dependency in old age is preventable, treatable, or manageable. Seniors with complex health problems have unique needs and present specific challenges for accurate diagnosis and assessment. Inaccurate diagnosis may result in inappropriate treatment, with further losses of health and independence, causing either long lengths of stay in acute care hospitals or premature institutional placement.

EDUCATION AND HUMAN RESOURCE ISSUES

Considering the rapid aging of Canada's population, it is critical to ensure that all health-care professionals, including physicians, receive appropriate education in the care of the elderly. It is estimated that the average family physician in the future will spend two-thirds of his/her professional time on care of elderly patients; yet, the average medical student in Canada is spending 2 weeks or less in a 4-year curriculum focusing on the special problems of the elderly. There are very significant human resource issues with respect to specialists in geriatric medicine. The recommended ratio from the UK is 1 geriatric specialist per 10,000 persons over the age of 75. In Canada, this would mean that we need 640 geriatricians; yet, we only have 144 internist geriatricians, which would leave us approximately 500 short at the present time. The College of Family Medicine in Canada has developed a 3rd year training program in Care of the Elderly, which does provide additional physicians with specialized training in the care of the elderly. Indeed for seniors, changing how we deliver care and promote healthy aging may not only improve seniors' health status but also save money.

SENIORS AND HEALTH-CARE COSTS

It is very clear that seniors are major consumers of health services, because of the prevalence of common chronic diseases. The estimates are that in Ontario, seniors' needs take up 44% of the health-care budget, 50-60% of acute hospital days, over 90% of long-term care facility days and chronic home-care days, and approximately 40-50% of family physician visits. It is a commonly held myth, however, that meeting the needs of seniors in the future will bankrupt the health-care system. Studies have shown that the increase in health-care costs due to the aging of the population alone will only impose a 1% increase in cost per year. The much more important factors in health-care costs are technology and the ways in which we provide care, particularly the intensity of services, not the increasing numbers of elderly.

THE SENIORS' BOOM AND THE Y-2K PHENOMENON

There are interesting parallels between the seniors' boom and the Y-2K phenomenon, in that potential "problems" were recognized for years but little was done until almost too late. Similarly, the impacts are both pervasive and expensive, and require multidimensional solutions across multiple jurisdictions. However, unlike Y-2K, the solutions are not technology-dependent but more people-dependent and the issues cannot be addressed by furious late action such as was seen with Y-2K, but which requires not only careful planning but also action across multiple fronts. Right now, the tendency in Canada is to pay lip-service to the problems of the elderly. It is unusual to see reports on health-care now without reference to the aging population and its effects. However, it is even more unusual to see action being taken to make meaningful changes. There are tremendous opportunities now to make meaningful changes that not only will greatly improve health and health-care for seniors in Canada but also will clearly benefit health-care and society overall.