

CMA submission:

# MEETING THE DEMOGRAPHIC CHALLENGE: INVESTMENTS IN SENIORS CARE

Pre-budget submission to the House  
of Commons Standing Committee  
on Finance

August 3, 2018

**Recommendation:** That the federal government ensure provincial and territorial health care systems meet the care needs of their aging populations by means of a demographic top-up to the Canada Health Transfer.

The Canadian Medical Association unites physicians on national health and medical matters. Formed in Quebec City in 1867, the CMA's rich history of advocacy led to some of Canada's most important health policy changes. As we look to the future, the CMA will focus on advocating for a healthy population and a vibrant profession.

## Introduction

The Canadian Medical Association (CMA) is pleased to provide the House of Commons Standing Committee on Finance this pre-budget submission, focused on the major challenges confronting seniors care in Canada. As Canada's demographic shift advances, the challenge of ensuring quality seniors care will only become more daunting unless governments make critical investments in our health care system today. This is a national issue that will affect all provinces and territories (PTs). However, not all PTs will bear the costs equally. The current federal health transfer system does not take demographics into account. The CMA proposes the federal government fund a share of the health care costs associated with our aging population by means of a new "demographic top-up" to the Canada Health Transfer (CHT).

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## Seniors Care: Challenges and Opportunities

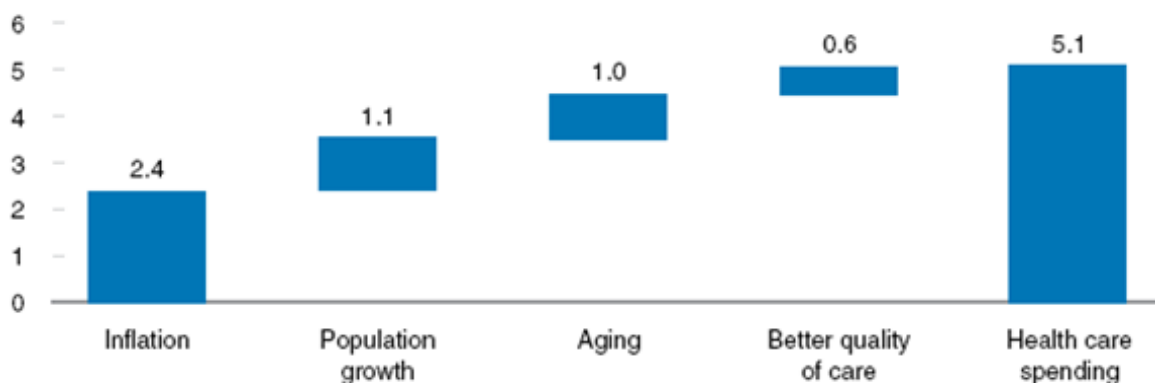
Canada, like most OECD economies, is grappling with the realities of a rapidly aging population. The population of seniors over the age of 65 in Canada has increased by 20% since 2011 and it has been projected that the proportion of Canada's total population over 65 will exceed one-third by 2056 with some provinces like Newfoundland and Labrador reaching that point as soon as the mid-2030s.<sup>1</sup> Census figures also show that the fastest growing demographic in Canada between 2011 and 2016 was individuals over 90, growing four times the rate of the overall population during this period.<sup>2</sup>

These demographic changes have a number of major implications for the future of Canadian society. Chief among them is the new pressure they add to our health care system. As the population ages, it is expected that health care costs will grow at a significantly faster rate than in previous years. As demonstrated in Chart 1 below, population aging will be a top contributor to rising health care costs over the decade ahead. By 2026–27, these increases will amount to \$19 billion in additional annual health care costs associated with population aging, as shown in Chart 2.

Many seniors experience varying degrees of frailty, which the Canadian Frailty Network (CFN) defines as "a state of increased vulnerability, with reduced physical reserve and loss of function across multiple body systems" that "reduces ability to cope with normal or minor stresses, which can cause rapid and dramatic changes in health."<sup>3</sup> About 75% to 80% of seniors report having one or more chronic conditions.<sup>4</sup> It is primarily the care associated with management of these conditions as well as increased residential care needs that drive the higher costs associated with seniors care. The average annual per capita provincial/territorial health spending for individuals age 15 to 64 is \$2,700 compared with \$12,000 for seniors age 65 and over.<sup>5</sup>

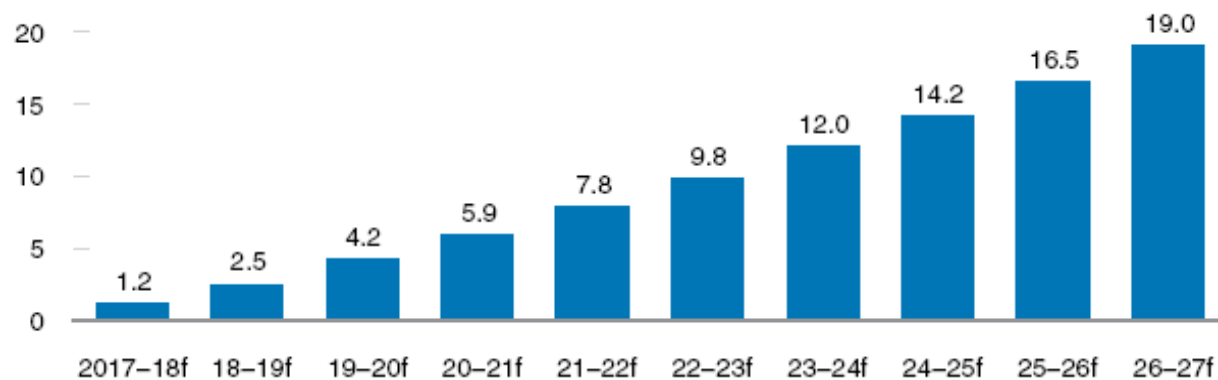
Our medicare system, which was established over half a century ago, is not designed or resourced to deal with this new challenge. The median age of Canadians at the time of the *Medical Care Act's* enactment in 1966 was 25.5 years. It is now 40.6 years and is expected to rise to 42.4 years in the next decade.<sup>5</sup> While past governments have placed significant focus on hospital care (acute and sub-acute), transitional care, community supports such as home care and long-term care (LTC) have been largely underfunded. Demographic changes have already begun to place pressure on our health care system, and the situation will only become worse unless funding levels are dramatically raised.

Chart 1: Major contributors to rising health care costs (forecast average annual percentage increase, 2017–26)<sup>5</sup>



Source: The Conference Board of Canada.

Chart 2: Provincial/territorial health care costs attributable to population aging (\$ billions, all PTs relative to 2016–17 demographics)<sup>5</sup>



f = forecast

Source: The Conference Board of Canada.

Individuals in Ontario wait a median of 150 days for placement in a LTC home.<sup>6</sup> In many communities across the country acute shortages in residential care infrastructure mean that seniors can spend as long as three years on a wait list for LTC.<sup>7</sup> Seniors from northern communities are often forced to accept placements hundreds of kilometres from their families.<sup>8</sup> The human and social costs of this are self-evident but insufficient spending on LTC also has important consequences for the efficiency of the system as a whole.

When the health of seniors stabilizes after they are admitted to hospital for acute care, health care professionals are often confronted with the challenge of finding better living options for their patients. These patients are typically assigned Alternate Level of Care (ALC) beds as they wait in hospital for appropriate levels of home care or access to a residential care home/facility.

In April 2016, ALC patients occupied 14% of inpatient beds in Ontario while in New Brunswick, 33% of the beds surveyed in two hospitals were occupied by ALC patients.<sup>9</sup> The average length of hospital stay of all ALC patients in Canada is an unacceptable 380 days. Not only does ALC care lead to generally worse health outcomes and patient satisfaction than both LTC and home care, but it is also significantly more expensive. The estimated daily cost of a hospital bed used by a patient is \$842, compared with \$126 for a LTC bed and \$42 per day for care at

home.<sup>10</sup> Moreover, high rates of ALC patients can contribute to hospital overcrowding, lengthy emergency wait times and cancelled elective surgeries.<sup>11</sup> Committing more funding to LTC infrastructure would lead to system-wide improvements in wait times and quality of care by helping to alleviate the ALC problem.

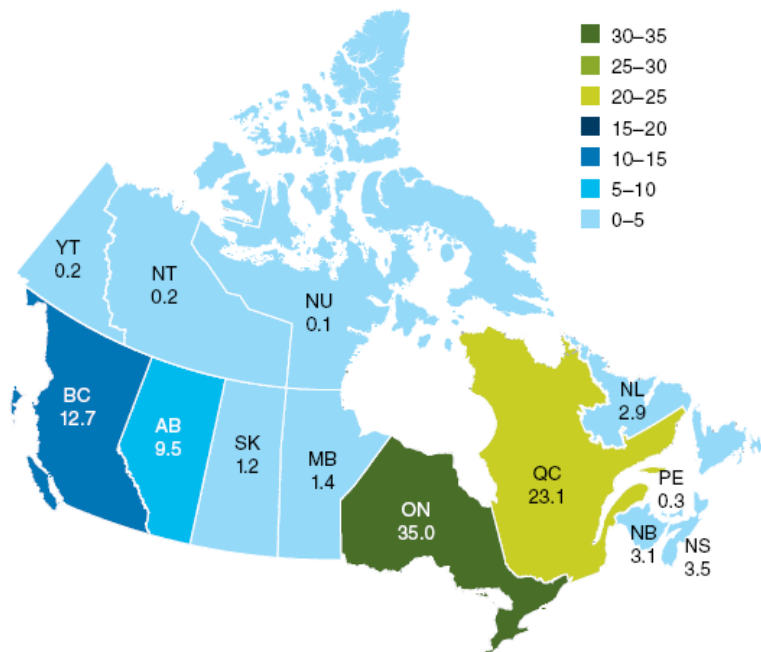
A recent poll found that only 49% of Canadians are confident that the health care system will be able to meet senior care needs and that 88% of Canadians support new federal funding measures.<sup>12</sup> Fortunately, there have been some signs at both the provincial and federal levels that seniors care has become an issue of increasing importance. New Brunswick recently introduced a caregiver's benefit while the Ontario government has recently committed to building 15,000 LTC beds over the next decade. The federal government highlighted home care as a key investment area in the most recent Health Accord bilateral agreements and has made important changes to both the Canada Pension Plan (CPP) and Old Age Security (OAS) programs.

## **The Demographic Top-Up: Modernizing the CHT**

Despite these recent and important initiatives by governments in Canada, additional policy and fiscal measures will be needed to address the challenges of an aging population. Many provincial governments have shown a clear commitment to the issue, but the reality is that their visions for better seniors care will not come to fruition unless they are backed up by appropriate investments. This will not be possible unless the federal government ensures transfers are able to keep up with the real cost of health care. Current funding levels clearly fail to do so. Projections in a recent report by the Conference Board of Canada, commissioned by the CMA, indicate that health transfers are expected to rise by 3.6% while health care costs are expected to rise by 5.1% annually over the next decade.<sup>3</sup>

Over the next decade, unless changes are made, provinces/territories will need to assume an increasingly larger share of health care costs. If federal health transfers do not account for population aging, the federal share of health care spending will fall below 20% by 2026.<sup>5</sup> Aging will affect some provinces more than others, as demonstrated in Figure 1 below. The overall cost of population aging to all of the provinces and territories is projected to be \$93 billion over the next decade.<sup>5</sup> The absence of demographic considerations in transfer calculations therefore indirectly contributes to regional health inequality as provinces will not receive the support they need to ensure that seniors can count on quality care across Canada.

Figure 1: Increases in health care costs associated with population aging, 2017 to 2026 (\$ billions)<sup>5</sup>



The CMA recommends that the federal government address the health costs of population aging by introducing a “demographic top-up” to the Canada Health Transfer. One model for this would require the federal government to cover a share of the costs projected to be added by population aging in each province/territory (see above) equal to the federal share of total health costs covered now (22%). The Conference Board of Canada estimates that the overall cost of such a change would be \$21.1 billion over the next decade (see Table 1).

This funding would greatly enhance the ability of the provinces and territories to make much-needed investments in seniors care and the health care system as a whole. It could be used to support the provinces’ and territories’ efforts to address shortages in LTC, to expand palliative care and home care supports and to support further innovation in the realm of seniors care.

Table 1: Cost of demographic top-Up by province in \$ millions<sup>5</sup>

**Potential Demographic Top-Up**

(\$ millions)

	2017*	2018	2019	2020	2021	2022	2023	2024	2025	2026	Cumulative 10-year total
<b>Canada**</b>	281	573	948	1,342	1,765	2,224	2,716	3,219	3,748	4,312	21,127
N.L.	5	13	23	33	43	53	62	73	83	95	483
P.E.I.	1	1	2	3	5	7	10	13	16	19	78
N.S.	8	21	35	50	66	85	105	125	146	168	810
N.B.	10	23	37	52	67	85	103	121	140	160	798
Que.	79	157	241	328	420	517	620	735	857	986	4,940
Ont.	108	210	368	535	715	915	1,129	1,345	1,569	1,805	8,699
Man.	2	6	12	18	25	32	41	45	49	53	282
Sask.	1	5	9	13	18	23	30	38	47	56	241
Alta.	28	59	91	125	163	202	247	291	339	393	1,938
B.C.	40	80	136	194	257	325	397	467	541	620	3,057
Y.T.	0.3	1	1	1	2	2	3	4	4	5	24
N.W.T.	0.1	0.4	1	1	1	2	2	3	3	4	17
Nun.	0.1	0.2	0.3	1	1	1	1	1	1	2	8

\*fiscal years

\*\*total provincial-/territorial-level spending on health care across all provinces and territories (i.e., the sum of the other figures in the column), not spending by the federal government

Source: The Conference Board of Canada.

## Conclusion

The evidence that our health care systems are not prepared or adequately funded to ensure appropriate and timely access to seniors care, across the continuum of care, is overwhelming. Wait times for LTC and home care are unacceptably high and complaints about lack of availability in Northern and rural communities are becoming increasingly common. Health care providers in the LTC sector regularly raise concern about overstretched resources and a lack of integration with the rest of the health care system.

By introducing a new demographic top-up to the Canada Health Transfer, the federal government would demonstrate real leadership by ensuring that all provinces/territories are able to adapt to an aging population without eroding quality of care. Furthermore, improvements in how we care for our seniors will lead to improvements for patients and caregivers of all ages through greater system efficiencies (e.g., shorter wait times for emergency care and elective surgeries) and more coordinated care.

The CMA has been, and will continue to be, a tireless advocate for improving seniors care in Canada. The CMA would welcome opportunities to provide further information on the recommendation outlined in this brief.



## References

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