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Foreword

Canadian health care is not working as it could, or should. Despite the hard work of physicians, nurses and many other health care professionals who care for patients each and every day, a system that is cherished by Canadians from coast to coast to coast is no longer keeping pace.

Throughout our system, patients face excessive waiting for care, inadequate patient information transfer and discontinuity of care. Canada’s publicly funded health care system was created some 50 years ago when our population was just over 20 million and Canadians could expect to live approximately 71 years. We now have a population of over 30 million and on average Canadians live a full decade longer.

This is a major achievement that speaks to the prosperity of our country and advances in medicine and health care. However, even after 50 years and myriad advances in medical care, Canada does not provide care in a seamless and cohesive way. We provide high quality care to patients, but all too often they have waited far too long to receive it.

The aging of Canada’s population is one of the most pressing policy imperatives of our time, and will have a huge impact on health care, social services and the economy. To be truly relevant and effectively respond to Canadians’ present and future needs, our health care system must provide integrated, continuing care able to meet the chronic and complex care needs of our growing and aging population.

This includes recognizing the increased role for patient and family caregivers in the care process as well as the importance of supporting efforts that improve the social determinants of health and healthy living. Perhaps most importantly of all, to develop and put into effect a modern vision for health care, government officials, health professionals, academics, the public and health care managers must use modern, collaborative approaches to improve the way changes are made to the health care system.

The way forward begins with understanding where we are. This report shows clearly that Canada has some important work to do to build a health care system capable of meeting the needs of our growing and aging population.

Dr. Granger Avery, President
Canadian Medical Association
I. Purpose

The purpose of this report is to assess efforts in Canada to:

1. develop and implement a pan-Canadian seniors’ strategy that would identify objectives and targets for improving seniors care; and
2. provide effective and timely care for seniors across the country.

This report builds on previous work by the Canadian Medical Association (CMA) including:

- A Policy Framework to Guide a National Seniors Strategy for Canada\(^1\) that identifies policy issues and best practices for seniors care across the continuum of care, and
- Demand a Plan campaign\(^2\), which has had a goal to secure commitment from leaders of all national political parties to implement a national strategy for seniors care involving all three levels of government with Ottawa taking a leadership role.

II. Why Canada Needs a Seniors Care Strategy

Sustaining and enhancing the health and wellness of seniors is a national priority for all levels of government across the country for several reasons.

**Canada’s population is aging.** Statistics Canada reports that over 15% of our population at the last census was over 65; it was 7.6% in 1960.\(^3\) For the first time there are more people aged 65 and older than there are children aged 0-14 years. Based on population projections the share of Canadians 65 and older will continue to rise and that by 2024 they will account for 20.1% of the population.\(^3\) By 2036 seniors are expected to make up 25% of the population. People aged 85 years and over make up the fastest growing age group in Canada — this portion of the population grew by 127% between 1993 and 2013.\(^4\) And Statistics Canada projects, based on a medium-growth scenario, there will be over 62,000 Canadians aged 100 and older by 2063.\(^5\) However, the quantity of years will be meaningless without a corresponding improvement in quality to complement it.\(^6\) An “age-friendly” system must aim to create a continuum that reduces dependency and enhances care as much as possible.

**Canada’s health care system was not built to meet the challenges of our aging population.** Canada’s Medicare system was established to deal largely with acute, episodic care for a relatively young population. Today our system struggles to properly care for patients — many of whom are elderly — managing complex and ongoing health issues. Approximately 75-80% of Canadian seniors report having one or more chronic condition.\(^7\)

While population aging is “a modest driver of increasing health care costs” (estimated at 0.9% per year), health care spending per person does increase with age as seen in 2013:

- Age 65 to 69: $6,298
- Age 70 to 74: $8,384
- Age 75 to 79: $11,557
- Age 80 and older: $20,917\(^8\)
Currently, Canada is fortunate to have a relatively young population compared to other developed countries — the proportion of our population aged 65 and over is 15% compared to 21% in Germany and 19% in France. However, the Conference Board of Canada has estimated 2.4 million Canadians 65 years and older will need continuing care, both paid and unpaid, by 2026 — a 71% increase since 2011. The increasing number of elderly provides Canada with an opportunity to design a health system that is capable of meeting the needs of not only its senior population but for all Canadians.

Inequities of care exist across the country. There are significant variations in availability of care among the provinces and territories including rural and urban areas. Moreover, a Health Council of Canada report on the state of First Nations, Inuit, and Métis seniors’ health noted that these populations did not receive the same level of care as non-Aboriginals do for a number of reasons including poor communication and collaboration, and disputes between different levels of governments. The ability of the provinces and territories to address these inequities in seniors care is becoming a greater challenge. In 2014, provincial and territorial health expenditures were estimated to represent, on average, 34.8% of total government expenditures on health care. Health as a proportion of total government program spending was 38% on average with Nova Scotia and Manitoba at the top of the range at 45.8% each, with Quebec the lowest at 29.7%; Nunavut was the highest among the territories at 28.7%. Recent budget cycles have seen the provinces and territories attempt to restrain growth in their health expenditures as part of an effort to curtail overall spending and rising deficits. While some provinces have taken steps to reduce their fiscal deficits, the combined deficit of all provinces is approximately $15 billion while net new borrowing is poised to rise to over $30 billion, meaning they are “borrowing twice as much as their deficits alone”.

Going forward, “economic adjustment among the provinces is expected to be the single largest theme over the near term” in Canada. The effects of fluctuating commodity prices (especially oil), low interest rates, and a low dollar will be felt differently among the provinces and regions. The disparity among the provinces in terms of their fiscal capacity in the current economic climate will mean improvements in seniors care will advance at an uneven pace. This situation could be exacerbated if the current federal government allows a key change to the health transfers made by the previous federal government to proceed. The growth of the transfers was fixed at 6% until 2016-17. After that, it will increase at the 3-year average of nominal GDP growth until 2024. It also set a 3% floor in growth of the CHT transfer.

Given these challenges, it is not surprising that nine in ten (90%) Canadians agree that Canada requires a national seniors strategy to address needs along the full continuum of care. Further, 83% believe such a strategy would benefit the entire system. A recent CD Howe discussion paper notes that health care in Canada “needs governance — clear, determined leadership to pull its poorly coordinated elements together into a real system and put it on course to meet the needs of the 21st century.”

At the August 2015 CMA annual meeting, physicians called for the development of a national seniors strategy that would include several elements:

- the development of innovative and alternative models/partnerships that can provide services and resources for patients’ seamless transition through the continuum of care;
- evidence-based hospital practices that better meet seniors’ physical, cognitive and psychosocial needs;
- improved training, resource allocation and incentives to help primary care physicians develop robust, around-the-clock services for frail and elderly Canadians living in the community;
- a coordinated national approach to reduce polypharmacy in the elderly;
- the development of guidelines and standards for the use of tele-monitoring technology; and,
- the inclusion of adequate, evidence-based support for family caregivers.
The federal government has made a commitment to sign a new health accord with provincial and territorial governments. The negotiations for a new pan-Canadian health accord provide an excellent opportunity to chart a national plan for seniors care. In CMA’s 2016 Annual Report Card, 84% of those surveyed identified a strategy for seniors’ health as the top funding priority for a new health accord.

III. Progress Toward a National Seniors Strategy

Governments and international organizations create strategies and action plans to articulate a vision or steps in response to a major issue. Such strategies can be useful in creating an organized and concerted focus.

International Efforts

Canada is not the only country facing challenges due to an aging population. Many other Organisation for Economic Co-operation and Development (OECD) countries face similar demographic challenges and have implemented strategies to improve health and health care delivery for their aging populations.

In 2014, the World Health Assembly asked the Director-General of the World Health Organization (WHO) to develop a plan around aging and health. The plan, “Multisectoral action for a life course approach to healthy ageing: global strategy and plan of action on ageing and health,” was adopted by the 69th World Health Assembly in May 2016. The chart below outlines the strategic objectives and the actions within each objective that member states, the WHO and other UN bodies, and national and international partners can undertake to help meet the goals. These objectives and actions are very relevant to Canada.

<table>
<thead>
<tr>
<th>Figure A</th>
<th>WHO Strategic Initiatives</th>
<th>Healthy Aging</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic objective 1: Commitment to action on Healthy Aging in every country</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Establish national frameworks for action on Healthy Aging</td>
<td></td>
<td></td>
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<tr>
<td>1.2 Strengthen national capacities to formulate evidence-based policies</td>
<td></td>
<td></td>
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<tr>
<td>1.3 Combat ageism and transform understanding of aging and health</td>
<td></td>
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<tr>
<td><strong>Strategic objective 2: Developing age-friendly environments</strong></td>
<td></td>
<td></td>
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<tr>
<td>2.1 Foster older people’s autonomy</td>
<td></td>
<td></td>
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<tr>
<td>2.2 Enable older people’s engagement</td>
<td></td>
<td></td>
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<tr>
<td>2.3 Promote multi-sectoral action</td>
<td></td>
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<tr>
<td><strong>Strategic objective 3: Aligning health systems to the needs of older populations</strong></td>
<td></td>
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</tr>
<tr>
<td>3.1 Orient health systems around intrinsic capacity and functional ability</td>
<td></td>
<td></td>
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<tr>
<td>3.2 Develop and ensure affordable access to quality, older person-centred and integrated clinical care</td>
<td></td>
<td></td>
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<tr>
<td>3.3 Ensure a sustainable and appropriately trained, deployed and managed health workforce</td>
<td></td>
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<tr>
<td><strong>Strategic objective 4: Developing sustainable and equitable systems for providing long-term care (home, communities, institutions)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 Establish and continually improve the foundations for a sustainable and equitable long-term care system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.2 Build workforce capacity and support caregivers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3 Ensure the quality of person-centred and integrated long-term care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Strategic objective 5: Improving measurement, monitoring and research on Healthy Aging

5.1 Agree on ways to measure, analyze, describe and monitor Healthy Aging
5.2 Strengthen research capacities and incentives for innovation
5.3 Research and synthesize evidence on Healthy Aging

In terms of seniors-related strategies at a national level, Japan has a “Five-Year Plan for Promotion of Measures Against Dementia (Orange Plan)” that was introduced in 2012. The Orange Plan was introduced “to establish health care, social care, and advocacy services for persons with dementia”. New Zealand has a “Positive Ageing Strategy” that has a goal to create a “society where people can age positively, where older people are highly valued and recognised as an integral part of families and communities.”

Action on a National Seniors Strategy in Canada

The CMA believes that providing optimal care and support for Canada’s aging population requires governments at all levels to invest in:

1. An environment and society that is “age friendly.” To promote healthy aging we must focus on initiatives with respect to physical activity, nutrition, mental health and injury prevention, housing and social integration. Support for healthy aging will help seniors maintain their health and lead to lower health care costs by reducing the overall burden of disability and chronic disease.

2. A comprehensive continuum of health services to provide optimal care and support to older Canadians, including primary health care, specialist care, chronic disease management programs, home care (e.g., visiting health care workers to give baths and foot care), long-term care and palliative care. This continuum of care is managed so that the patient can remain at home, out of emergency departments, hospitals and long-term care facilities unless appropriate, can easily access the level of care he or she needs, and can make a smooth transition from one level of care to another when needed.

An analysis of existing government strategies has found that there is a patchwork of seniors care strategies across Canada. Most provincial and territorial governments have a seniors strategy or strategies in place that encompass aspects of seniors care from healthy lifestyles, improving access to primary and home care, and better palliative care and everything in between. Some strategies were narrow in scope, such as New Brunswick’s Long-term Care Strategy, while others were broader, such as Newfoundland and Labrador’s Provincial Healthy Aging Policy Framework. Nova Scotia has recently announced a process to develop a seniors strategy of its own. The summary table below provides a more detailed analysis of seniors strategies in place across Canada.

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a This research was conducted in June 2016 and looked for government strategies that were created within the past 10 years (since 2006) that are still publicly available. These strategies must have been created by the province or territory and therefore, this research does not include reports that were made by advisory committees with the exception of the Federal-Provincial-Territorial Seniors Policy Handbook. Some provinces or territories might have, or had, other strategies not publicly available and therefore are not included in this report.
Table A: Summary of Seniors Strategies Across Canada

<table>
<thead>
<tr>
<th>Component</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creating age-friendly communities and environments</td>
<td>Most provinces have recognized the benefit of helping seniors maintain independence and participate and thrive in the community. Accessible transit was emphasized highly, as was the need to facilitate independence in the community and ensure seniors live in a safe and secure environment. Elder abuse prevention was a common theme in most of the strategies. An example initiative can be seen in Age-Friendly Manitoba which focuses on creating age-friendly communities that promote seniors' participation in society and creation of accessible and safe environments.</td>
</tr>
<tr>
<td>Primary care</td>
<td>Most provinces acknowledged the importance of integrated care approaches and service coordination to respond to the growing number of citizens with chronic diseases. However, not all provinces had chronic disease management built into their senior strategies or strategies to integrating specialty care into the community. Maintaining seniors' mental health and improving their access to mental health services, particularly for those with dementia, were elements emphasized in the strategies. For instance, Quebec recognizes that the mental health of seniors and cognitive problems, particularly associated with Alzheimer's disease, is a fundamental health issue.</td>
</tr>
<tr>
<td>Home care and community supports</td>
<td>Many strategies outlined the importance of home care and the ability of seniors to remain in their home as long as possible. In order to do this, the strategies emphasized access to home and community supports, as well as supporting informal caregivers through education, resources and supports. In their strategy, Ontario, for instance, has an emphasis on improving both the client and the caregiver experience.</td>
</tr>
<tr>
<td>Acute and specialty care</td>
<td>Several key issues include alternate levels of care (ALC) and transitional services from hospitals to primary and community care. This was the category with the least mentions by the strategies, although many did recognize the importance of transitional services and a shift towards community care. Saskatchewan is undertaking a major initiative to address ALC, including standardizing how ALC is defined, collected and reported.</td>
</tr>
<tr>
<td>Long-term care (LTC)</td>
<td>Some provinces have specific LTC strategies. The vast majority of recommendations were to expand access to LTC and improve LTC facilities, making them accountable and ensuring that they follow certain standards. It is important to note that provinces also included provisions to decrease the need for LTC by improving home care and community-based supports. New Brunswick has a specific LTC strategy that includes the theme “Quality of Service Delivery” that aims to make LTC services more accessible, easy to understand and responsive.</td>
</tr>
<tr>
<td>Palliative care</td>
<td>Palliative care was an issue identified by virtually all provinces as an important care element that needs to be improved and expanded. An example of this can be seen with The Provincial End-of-Life Care Action Plan for British Columbia where the province incorporated a population-needs based approach to palliative care.</td>
</tr>
</tbody>
</table>

In addition to the provincial and territorial level, seniors’ initiatives exist at the national level. The federal, provincial and territorial ministers responsible for seniors have a forum through which they discuss issues related to seniors and collaborate on projects. The Council of the Federation has a Health Care Innovation Working Group of which one of its priority areas is seniors care, specifically home care, aging in place and dementia. The federal government has a National Seniors Council which advises them “on matters related to the health, the well-being and quality of life of seniors.” The 2010 annual report of
Canada’s Chief Public Health Officer focussed on the issue of aging as it examined “the state of health and well-being of Canada’s seniors, including factors that positively or negatively influence healthy aging such as falls and related injuries, mental health, abuse and neglect, social connectedness, healthy living, and care and services.”

Notwithstanding the work undertaken thus far, the need for a comprehensive pan-Canadian, seniors care strategy/action plan remains that addresses both healthy aging and the full continuum of care. This national coordinated strategy would establish objectives and targets for seniors living in every region across the country. As previously cited, a new health accord provides an important opportunity to set this common vision and actions for all governments to improve care for Canada’s seniors.

IV. Assessing Performance in Seniors Care

Improving how we care for seniors will go a long way toward creating a high-performing health care system for all Canadians. What indicators should we use to assess the care provided to seniors? An ideal assessment should track the care provided to seniors across several sectors including health, social services, income support, and housing. Care would be timely, integrated, seamless, appropriate and delivered in the home or community as much as possible. Family caregivers would be properly supported to allow them to fulfill their role as the primary caregiver. Unfortunately, Canada does not have a comprehensive assessment on seniors care at this time. This section examines those indicators of care that are available across the continuum of care.

Primary Care

Every senior, and indeed every Canadian, should have the opportunity to be part of a family practice that serves as a patient's medical home. It is the central hub for the timely provision and coordination of the comprehensive menu of health and medical services patients need. A patient’s medical home should ensure access for patients to medical advice and the provision of, or direction to, needed care 24 hours a day, seven days a week, 365 days a year.

Generally, the percentage of Canadian seniors who have a regular family physician or place of care is very high (98%). However, their ability to get timely access based on a same-day or next-day appointment was among the lowest of 11 nations in a 2014 survey (see Table B). Canadian seniors were also more likely to use the emergency department and experience coordination of care problems than seniors in most other countries surveyed.

In a 2010 survey, family physicians identified the increasing complexity of patient caseload, management of patients with chronic diseases/conditions and an aging patient population as the largest factors increasing the demand for their time at work.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Canada</th>
<th>Rank out of 11 countries</th>
<th>Best country performer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have a regular family physician or place of care</td>
<td>98%</td>
<td>4</td>
<td>Netherlands/France (100%)</td>
</tr>
<tr>
<td>Could get same- or next-day appointment with doctor or nurse when sick or needed care</td>
<td>45%</td>
<td>11</td>
<td>France/New Zealand (83%)</td>
</tr>
<tr>
<td>Waited less than 4 weeks for specialist appointment</td>
<td>46%</td>
<td>10</td>
<td>US (86%)</td>
</tr>
<tr>
<td>Access to after-hours care (%)</td>
<td>41%</td>
<td>10</td>
<td>Netherlands (77%)</td>
</tr>
<tr>
<td>Emergency department use in past 2 years</td>
<td>39%</td>
<td>10</td>
<td>France (15%)</td>
</tr>
<tr>
<td>Experience</td>
<td>Percentage</td>
<td>Country</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>------------</td>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td>Experienced a coordination problem in the past 2 years</td>
<td>32%</td>
<td>8</td>
<td>France (7%)</td>
</tr>
<tr>
<td>Cost-related access problems in the past year</td>
<td>9%</td>
<td>9</td>
<td>France (3%)</td>
</tr>
<tr>
<td>Did not review prescription medications in past year for patients with 4 or more prescriptions</td>
<td>16%</td>
<td>2</td>
<td>US (14%)</td>
</tr>
<tr>
<td>Experienced gaps in discharge planning in past 2 years</td>
<td>44%</td>
<td>4</td>
<td>US (28%)</td>
</tr>
<tr>
<td>Have a health care professional that checks in with them between doctor visits (for those with a chronic condition)</td>
<td>16%</td>
<td>8</td>
<td>UK (47%)</td>
</tr>
<tr>
<td>Had a discussion with someone about care preferences if they become unable to make decisions for themselves</td>
<td>66%</td>
<td>3</td>
<td>US (78%)</td>
</tr>
</tbody>
</table>

Source: 2014 Commonwealth Fund International Health Policy Survey of Older Adults in Eleven Countries

Understanding the Needs of Frail Seniors

The Canadian Frailty Network (CFN) describes frailty as “a patient health state associated with getting older; involving multiple serious health issues that increase an individual’s vulnerability for extended acute care or end-of-life care.” It can occur because of a range of diseases and medical conditions and can be the result of a minor problem that leads to a major change in someone’s health status. It is a complex interaction, one that needs to be understood and addressed, both with the patient and their family. A 2013 Statistics Canada study estimated that there were approximately 1 million community-dwelling seniors in Canada in 2009-2010 who were considered frail with about 1.4 million considered to be pre-frail.

Assessing someone’s degree of frailty is essential to providing proper care. Frailty often goes unnoticed “because its manifestation can be subtle, slowly progressive, and thus dismissed as normal aging.” As such, applying a frailty lens directs attention away from organ-specific diagnoses towards a more holistic viewpoint of the patient and their predicament. It has been noted that “the complexity of frailty is a challenge to traditional health care delivery, which often is based on a single diagnosis.”

With the necessary supports, family physicians are well-placed to identify frail patients in their practices — this is especially important in that Canada has only 276 geriatricians and only 166 geriatric psychiatrists. An important characteristic of a senior’s examination is the comprehensive geriatric assessment (CGA). A CGA is the “process by which systematic account is taken of the multiple, interacting medical and social needs of older adults, of how illness impacts on function, of how functional dependence affects caregivers, and of how each of these factors impact on the outcomes of health care.” Just as important, it is not only the listing of the problems but also the development of a management plan to address them. Proper assessments can lead to improved health outcomes, improved quality of life and can reduce the use of unnecessary procedures, services, and pharmaceuticals.

Finally, palliative care for frail seniors at the end of life presents its own challenges. Most will have multiple and complex illnesses requiring a different approach from those with a “predominant single system disease” such as cancer.
Specialty and Hospital Care

A crucial aspect to improving seniors care is to ensure timely access to appropriate specialty care. Canadian seniors were less likely to report seeing a specialist within four weeks compared to seniors in nine other countries (Table B). No province reports wait times for specialty care specifically for seniors but a review of surgical wait times for hip replacements and cataracts — both of which are increasingly provided to our aging population — reveals considerable variation in wait times among provinces for both procedures (Table C).

<table>
<thead>
<tr>
<th>Province</th>
<th>Hip Replacement</th>
<th>Rank (by lowest wait time)</th>
<th>Cataract Surgery</th>
<th>Rank (by lowest wait time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland and Labrador</td>
<td>173</td>
<td>1</td>
<td>97</td>
<td>2</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>538</td>
<td>10</td>
<td>212</td>
<td>7</td>
</tr>
<tr>
<td>PEI</td>
<td>211</td>
<td>5</td>
<td>127</td>
<td>4</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>452</td>
<td>9</td>
<td>170</td>
<td>5</td>
</tr>
<tr>
<td>Quebec</td>
<td>218</td>
<td>6</td>
<td>126</td>
<td>3</td>
</tr>
<tr>
<td>Ontario</td>
<td>203</td>
<td>3</td>
<td>194</td>
<td>6</td>
</tr>
<tr>
<td>Manitoba</td>
<td>339</td>
<td>8</td>
<td>239</td>
<td>8</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>177</td>
<td>2</td>
<td>96</td>
<td>1</td>
</tr>
<tr>
<td>Alberta</td>
<td>209</td>
<td>4</td>
<td>273</td>
<td>10</td>
</tr>
<tr>
<td>BC</td>
<td>337</td>
<td>7</td>
<td>243</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: Provincial wait-time websites (reviewed as of July 2016)

Geriatric medicine, care of the elderly, and geriatric psychiatry are specialties specifically trained to care for seniors who are at high risk for prolonged avoidable hospitalizations (often resulting in unnecessary hospital stays and premature placement in long-term care) because of issues such as dementia combined with other chronic diseases. Unfortunately, data on access to care for these specialties are unavailable at this time.

Alternate level of care

A major contributor to wait times is the inappropriate placement of patients, particularly seniors, in hospitals. Alternate Level of Care (ALC) beds are often used in acute care hospitals to accommodate patients — the majority of whom are seniors — waiting for a place in home care, a rehabilitation facility, or a residential facility (i.e., nursing home or chronic care facility). High rates of ALC in hospitals contribute to lengthy waits in emergency departments and elective surgery for all patients.

Dementia is a common diagnosis among ALC patients. A study of two hospitals in New Brunswick found that 33% of their hospital beds were occupied by ALC patients, of whom 63% had been diagnosed with dementia. Equally troubling was that their average length of hospital stay was 380 days. The CMA, along with many other medical and health organizations, has been calling for a national dementia plan given the impact dementia will continue to have on health and social systems as well as on families and caregivers.

To be clear, it is not the fault of seniors waiting in ALC beds, but rather a system-wide problem that is failing to prevent inappropriate hospitalizations by providing access to more appropriate home or residential care options once a patient’s medical condition is stable. Long hospital stays while waiting for more appropriate placement can lead to inadequate mobilization for patients resulting in hospital-acquired
disability such as hospital-acquired delirium and hospital-acquired deconditioning. ALC patients with complex care needs without a strong support system are more likely to wait in acute care before being placed in home care.  

There is currently no pan-Canadian definition of ALC that can be consistently used, measured and publicly reported, although the Canadian Institute for Health Information (CIHI) has previously reported on ALC rates in hospitals. According to recent Ontario figures (April 2016), ALC-designated patients occupied 14% of hospital inpatient beds in Ontario but this ranged widely between 7% to 29% among health regions (Local Health Integration Networks). The significant number of ALC patients remains a serious problem to health care systems across the country as noted previously by the Wait Time Alliance, which said that the most effective way to improve timely access to specialty care would be to address the ALC issue.

Some provinces, such as Ontario noted above, have launched initiatives to improve the collection of data as part of an effort to lower ALC rates. In another example, Saskatchewan’s Provincial Emergency Department Waits and Patient Flow Initiative has been working to standardize ALC data to better understand and manage the needs of ALC patients. Effective strategies for reducing ALC rates will require an integrated approach across the spectrum of health and social services.

Sometimes hospitalization is unavoidable and appropriate. In those instances, we need to enhance in-hospital seniors’ services (e.g., followed closely by seniors care specialists) so that seniors at highest risk of hospital-acquired disability are safely returned to the community as early as possible. The Ontario Senior Friendly Hospital initiative provides an evidence based blueprint to guide hospital-wide improvements in services for frail seniors.

There is consensus that more care must be provided in the community to prevent avoidable emergency department use and avoidable admissions to hospital (often leading to long lengths of stay and ALC). A stronger infrastructure in the community must be established that allows specialists to practice outside hospital walls and to better integrate specialist care with primary care and home care. Until more specialists are integrated into community care it will be impossible to keep our most medically complex seniors out of hospital.

**Home Care**

While many of the provincial and territorial government websites provide information to seniors describing the array of services available, data on wait times to receive home care or to enter a long-term care facility are scarce.

The 14 Community Care Access Centres (CCAC) in Ontario have responsibility for home care and long-term community care. The charts on the respective websites for each CCAC offer a list of the long-term care homes in the Local Health Integration Network (LHIN) during the current month, the average number of beds available and the number of clients waiting for the various levels of rooms available (basic, semi-private and private). The data do not always reflect the actual wait times.

A Statistics Canada paper found that in 2012, 2.2 million Canadians 15 years and older (8% of the population) received help or care at home due to a long-term health condition, disability, or a problem related to aging. It reported that seniors were the most likely to receive care at home: 10% of those 65 to 74, 21% of those 75 to 84 and 45% of those 85 and older received this service.

However, some senior's needs are unmet or partially met, which can lead to difficulties. For example, “the loneliness that some seniors may feel or that may arise after a loss of health or functional ability varied

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b These services will be subsumed within their respective Local Health Integrated Networks (LHIN) under the Ontario government’s Patients First proposal.
based on whether the person’s needs were met, unmet or partially met." Seniors whose needs were met reported lower levels of loneliness and stress than those whose needs were partially met or unmet. 50

In addition to home health services, many seniors need assistance with social supports including housing, meals and transportation, and activities to prevent isolation. While all levels of government, communities and family members can provide such social supports, the significance of these supports must not be minimized given their impact on overall health and wellbeing.

The CMA believes that more must be done to scale up and expand examples of excellence and innovation in home care across Canada to improve services to seniors. This includes supporting seniors residing in rural and northern areas. The CMA has recommended that a targeted home care innovation fund be established.

Long-Term Care Facilities
Ontario is the only province where wait time data for long-term care is readily available to the public. However, other indicators of quality care provided in long-term care facilities are available through the Canadian Institute for Health Information’s (CIHI) Your Health System, a web tool that allows for comparison of health systems in Canada.31 The In Depth portion of the tool has incorporated indicators from the long-term care sector and includes over 1000 nursing homes and other similar facilities. Relevant indicators are included in Table D. While there are definitely signs of improvement for many of these indicators (e.g., use of daily restraints, and taking antipsychotics without a psychosis diagnosis), there remains wide variation among provinces and room for improvement.

The CMA is also troubled by the inequitable access to public long-term care (LTC) homes experienced by patients with financial, cultural and/or linguistic barriers. A CD Howe paper projects that over the next 40 years the annual total cost of long-term care will triple, from approximately $69 billion in 2014 to about

<table>
<thead>
<tr>
<th>Table D: Selected Long Term Care Health Indicators, 2014 2015</th>
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<tr>
<td><strong>Falls in the Last 30 Days in Long-Term Care</strong></td>
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<tr>
<td>National Rate: 15.3%</td>
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<tr>
<td><strong>Experiencing Pain in Long-Term Care</strong></td>
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<tr>
<td>National Rate: 9.5%</td>
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<tr>
<td><strong>Restraint Use in Long-Term Care</strong></td>
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<tr>
<td>National Rate: 8.7%</td>
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<tr>
<td><strong>Potentially Inappropriate Use of Antipsychotics in Long-Term Care</strong></td>
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<tr>
<td>National Rate: 27.6%</td>
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<tr>
<td><strong>Worsened Pressure Ulcer in Long-Term Care</strong></td>
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<tr>
<td>National Rate: 3.1%</td>
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<tr>
<td><strong>Worsened Depressive Mood in Long-Term Care</strong></td>
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<tr>
<td>National Rate: 23.5%</td>
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Source: Canadian Institute for Health Information, Your Health System.
$188 billion in 2050. The "most rapid increase in costs occurs between 2025 and 2040, when aging baby boomers are expected to dramatically expand the number of frail elderly."52

The disparities encountered by seniors in terms of paying for such care in addition to finding facilities that meet their cultural and linguistic needs will become even more onerous under such conditions. The uneven access must be addressed through new approaches to funding and delivery arrangements that will reduce the inequities while sustaining the LTC system.53

Palliative Care

Assessing to what extent Canadians are receiving timely, quality palliative care is difficult due in part to the fact that this type of care can be provided by different providers in a number of settings. The Canadian Cancer Society notes that palliative care was developed largely for patients with advanced cancer, citing statistics from Cancer Care Ontario that 80–85% of patients receiving palliative care are patients with cancer, and Nova Scotia where the proportion was reported to be 80–90%.44 Nevertheless, it is clear that access to palliative care is highly variable across the country “due to differences in regional demographics, societal needs, government involvement and funding structures.”54

A recently released analysis on palliative care use in Ontario between 2010-2012 found:

- Just over half (51.9%) of those who had died had received at least one instance of palliative care in the last year of life.
- Publicly-funded palliative home care only reached 20% of dying patients, and less than 10% of dying patients received a palliative home visit from a physician.
- Patients with cancer were two and a half times more likely to receive palliative care, compared to people dying from non-cancer causes.55

In 2015, the CMA, in consultation with a wide range of stakeholders, identified several shortcomings with Canada’s existing level of palliative:

- Lack of access to affordable, equitable palliative care;
- Lack of trained workers, supported by national standards in palliative care;
- Lack of a common approach to palliative care across settings (e.g., palliative care should be integrated across all sectors of the health continuum);
- Insufficient support for family caregivers;
- Lack of advance care planning.56

Fortunately, promising practices in palliative care do exist; however, their availability is limited.5758

Concern about the ability of seniors to access palliative care toward the end of their lives has gained considerable attention in recent months, particularly in connection with the assisted dying issue. It is a matter of CMA policy that “all Canadian residents should have access to comprehensive, quality palliative care services regardless of age, care setting, diagnosis, ethnicity, language and financial status.”59 The lack of a pan-Canadian palliative care strategy is a major concern.60 Indeed, as the Canadian Cancer Society notes: “Without clear national standards and accountabilities, individual jurisdictions are left to develop their own policies, programs and guidelines, resulting in inconsistent or inadequate access across the country.”61

Pharmaceuticals

Pharmaceuticals play an important part in overcoming disease and helping to maintain health. Despite this importance, access to medically necessary pharmaceuticals outside of hospital care is not covered under the Canada Health Act. The CMA has called for a pan-Canadian system of catastrophic coverage for prescription drugs as a step toward comprehensive, universal coverage for prescription medicine for all Canadians.62
Canadian seniors, particularly those with low incomes, have access to some level of drug coverage in all provinces and territories, with the plans varying by jurisdiction. Eight provinces do an income-test to determine the level of deductibles or charges that are paid; in two, seniors pay for a small portion of the cost of their drugs while the province or third-party insurer pays the remainder. Plans are available among the three territories for those who qualify, although provision may be limited.

However, Canadian seniors were more likely to report experiencing cost-related barriers to access medication (9% — third highest among 11 nations) than seniors in other countries. Negative issues included skipping medical tests, skipping treatments, not filling prescriptions or skipping doses due to the cost. Moreover, 9% of Canadian seniors indicated they had spent $2,000 or more out-of-pocket on services in the past year compared to 0% in France and 2% in the UK. More research is required on the extent of Canadian seniors’ inability to access care including filling medically necessary prescriptions due to cost.

An important component to improving access to medically necessary pharmaceuticals is ensuring their appropriate use, particularly for seniors with multiple chronic conditions. Many seniors suffer from multiple conditions that are often treated with two or more medications. A 2012 CIHI report found that “more than half (54.6%) of all seniors on public drug programs were chronic users of drugs to treat two or more of seven selected chronic conditions, while 28.9% of seniors were chronic users of drugs to treat three or more conditions.” Six of the ten most commonly used drugs were for cardiovascular-related issues, including statins (46.6% of seniors made at least one claim in 2012) and ACE-inhibitors (28.3% of seniors used them). The ten most commonly used drugs were the same across the age groups (65 to 74, 75 to 84) while eight of the ten were the same for those 85 and older.

There is a growing body of evidence showing that discontinuing specific medications in certain patient populations does not worsen outcomes, that it decreases the risk of adverse drug reactions, and that it reduces costs attributable to medications. The CMA supports the development of a coordinated national approach to reduce polypharmacy among the elderly.

Caregiver Support

Caregivers are the backbone of any care system. A 2012 Statistics Canada study found that 5.4 million Canadians provided care to a senior family member or friend. This care was most often received by a senior in their own residence; the most intense care provided by those living with the recipient. In all, 62% of caregivers said the care recipients lived in a home separate from theirs, while 16% were living with the recipient and 14% said they provided care to a senior in a care facility.

The Statistics Canada study found that 56% of caregivers living with the recipient provided at least 10 hours of care a week. Approximately 22% of those helping a care recipient in a care facility also provided at least 10 hours of care a week; 60% of caregivers in this situation said they helped someone with what was described as a serious medical condition. The chief condition for which care was provided was dementia or Alzheimer's disease (25%).

The majority of caregivers were looking after their parents or in-laws, regardless of the location. Over 55% of those recipients in care facilities and supportive housing were 85 or older; about 25% of those in their own home or living with their caregiver were in this age range. The vast majority of those receiving care (regardless of housing type) were women.

The study found that providing care to someone in a facility or those living with the recipient was not without consequences, with 60% indicating they were juggling caregiving with their paid work. Thirty-three percent of those helping a senior in a facility and 29% of those living with the recipient reported that it caused a strain with family members. They were also more likely to report higher out-of-pocket expenses.
This was especially true for those living with the care recipient, as over 25% spent at least $2,000 annually on out-of-pocket expenses.67

The health of caregivers is an important element in caring for seniors. Caregivers require a range of supports including education/training, peer support, respite care, and financial assistance. Canadians support governments doing more to help seniors and their family caregivers.68 Provincially, Nova Scotia is the only province to provide financial support for family caregivers (low-income) while Manitoba is the only province to have legislation recognizing the role of caregivers and to guide the development of a framework for caregiver recognition and caregiver supports.69 At the federal level, some financial supports exist (e.g., Family Caregiver Tax Credit, Caregiver Tax Credit, Compassionate Care Benefit). But taken together, these financial supports represent a patchwork of aid across the country with some restrictions related to eligibility. It is also unclear as to whether eligible Canadian caregivers are fully utilizing those financial supports that do exist.70

The CMA has called on the federal government to amend the Caregiver and Family Caregiver Tax Credits to make them refundable to provide an increased amount of financial support for family caregivers.71

V. Federal Action Needed

Health care is largely a responsibility of the provinces and territories, with obligations to design, organize, deliver and fund the services they provide to their respective populations. However, the federal government also plays a very important role in health care in Canada. Apart from helping to fund the system through the Canada Health Transfer, the federal government is the fifth largest provider of health care services in Canada in terms of dollars spent.

When asked about the role of the federal government in health care, 89.8% of Canadians said it was “important” (63.5% important/26.3% somewhat important); 60% said it should become “more important”.72 Nowhere will this role be more of an imperative than with respect to seniors care. Over three-quarters of Canadians (76%) consider seniors care to be a national problem “requiring cooperation among governments to work closely together on a strategy to deal with it.”17 Moreover, 67% of Canadians believe the federal government has an important part to play in developing a national strategy.

Further, 93% of Canadians believe the federal government needs to be working with the provinces so that all Canadians have the same level of access and quality of services, no matter where they live.73 As added emphasis, 89% said that the federal government should lead the development of a national strategy (including benchmarks) to address the inequities and funding issues related to long-term care.73

Canadians would also like to hear from governments about the progress toward developing a health promotion strategy for seniors. In a survey conducted for the National Health Leadership Conference, 88% (44% strongly agreed/44% somewhat agreed) agreed that governments should report on the advances they have made with respect to creating such a strategy.68

In its 2015 report, the Advisory Panel on Healthcare Innovation recommended that Ottawa needs to provide a “different model for federal engagement in health care — one that depends on an ethos of partnership, and on a shared commitment to scale up existing innovations and make fundamental changes.”74

A new federal-provincial-territorial health accord is an important opportunity for the federal government to develop that new model. The value of pan-Canadian cooperation can “provide further leadership by collaborating with the provinces and territories with the common purpose of accelerating innovation and improving health system performance.”75 One important role the federal government can play is by supporting the scaling up of effective and innovative programs and practices that exist across the country so that promising practices and ideas are not left to function in isolation, serving relatively few Canadians.
VI. Conclusion

This report shows that more work is required to devise a pan-Canadian strategy to address the health needs of Canada’s growing senior population. This includes agreement on a common vision for action and improvements in how seniors care is measured and delivered across the country. In terms of health system performance, few provinces report on health system indicators related to seniors care (e.g., access to home care, access to specialty care such as geriatric psychiatry).

Many improvements in seniors care will require increased focus on healthy aging, improved integration of health and social services, ensuring care is appropriate and timely, and providing supports for family and other caregivers. In this respect, improving how we care for seniors will benefit all Canadians.

The CMA has identified seniors care as a top public policy priority for governments in Canada. This call to action is supported by nearly 40,000 Canadians through CMA’s Demand a Plan campaign.76 To spur action, the CMA has made several recommendations targeted toward improving seniors care, including increased support for home care and caregivers, as well as increasing provincial and territorial governments’ capacity to respond effectively to the needs of an aging population.71

References


72 Nanos survey conducted for the Health Action Lobby November 2014
75 Health Action Lobby. The Canadian Way - Accelerating Innovation and Improving Health System Performance December 2014