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Health Care in an Aging Canada: Constraint or Choice?

INTRODUCTION

It is often presumed that population aging will result in increased demand for health care, with older Canadians seen as a "burden" to the working population. Yet, such a presumption of direct correlation (with implied causality) belies the complex questions of societal choices in expenditures: factors such as per capita health care utilization, nondemographic forces that drive the health care system, and the health care system's treatment of older people. Closer examination of trends in health care and in population aging reveal that just as large feet are correlated with, but do not cause, higher intelligence, population aging may be correlated with, but not cause, increasing health care costs.

The goal in this short paper is to provide a brief, questioning overview of the presumed links between population aging and health care costs and demands. It is, in short, a glimpse of some of my and others recent thinking and research on various aspects of social policy in an aging Canada, with many of the technical details omitted, or not provided in complete detail.

The paper is divided into three parts:

- a brief discussion of some relevant aspects of demographic aging;
- a glimpse of some contemporary challenges and trends in Canadian health care;
- a discussion of what the future might hold.

When one does research in aging as I do (it is one of several of my research areas) and teach it to undergraduate and graduate

students (as I also do), and talk to policy-makers regularly, one discovers quickly that some people turn off and tune out as soon as the term, aging, is mentioned. The term is suggestive, to student and policy-maker alike, of old and sick people. Many yawn and hope that it will not happen to them!

Bernard Baruch suggested that "Old age is always 15 years older than I am!" In his definition, and that of many of us, old age always involves someone other than us, at whatever age we are. When I published my first article on demographic aging in 1975, before aging research became trendy, I was often asked why a young woman would be interested in such a gloomy topic.

Yet, there are at least three ways in which aging is optimistic:

1) First, aging is hopeful because, as Mark Twain once said, it is certainly preferable to the alternative.
2) Second, aging is hopeful at the societal level too. Demographic aging is an indicator of affluence, success in controlling both births and deaths and having a degree of power over forces to which humans for millennia have succumbed.
3) Third, and this is the really hopeful part, aging at the individual level provides opportunities, to say things and be things we might have been too socially constrained to say and be when we were younger. In essence, we are afforded freedom for the first time in many of our lives. This is particularly the case for women, who for the first time are free, to some extent, from the demands of immediate family, free from the fear of pregnancy, and free from the stereotyping that foes with being young women. Many older women become feisty indeed. The Raging Grannies, an anti- war, social protest singing group, are but one example. Many older women in Canada are fighting for social justice, not only for themselves and their generation but for children, the poor, the disabled and the disadvantaged.

DEMOGRAPHIC AGING: SETTING THE STAGE

Demographers, of which I am one, are not particularly good at prediction. Demographers, for example, failed to predict both the baby boom (of the late 1940's, 1950's and early 1960's) and the baby bust (of the 1980's and into the 1990's)! For demographers then, the key might be to avoid prediction. As U.S. demographer, Joel Cohen has remarked, "A demographer is somebody who guesses wrong

about the future of populations. A mathematical demographer is somebody who uses mathematics and computers to guess wrong about the future of populations (Cohen, 1985:136).

My work is guided by the well known, but not often articulated, tension between predictability and uncertainty. The issue of projection as prediction is bypassed in favour of the concept of analytical credibility, which relieves the burden of being an oracle, and substitutes the how and the whether of using research and knowledge in decision-making. The key concept to this way of thinking is one of creating rather than discovering the future.

What is the conventional wisdom about demographic aging and health care? In a nutshell, it is typically thought that the relationship between population aging and health care costs is simple, linear, and seemingly predictable. Rising health care costs accompanying an aging population in Canada is a major concern, not only in many academic circles, but also in policy and media circles. And the relationship of demographic aging to rising health care costs is thought to be causal. Strain and drain on the system, presumed to result from population aging, are recurrent themes.

The opening paragraph of the health chapter in Foot and Wigdor's 1988 book, the *Over-Forty Society*, for example, reads:

> Health is one of the primary concerns for an aging population. This is true for the individual, but as the number of older and very old Canadians continues to grow, the increasing costs of health care creates great anxiety for society as a whole, and threatens the universal health care system. (Foot and Wigdor, 1988:66)

So as to be unbiased here, in my own 1986 book, *Canada's Aging Population*, I said, in introducing health care issues:

> The area of health, particularly rising health care costs, is a major concern in view of Canada's aging population. (McDaniel, 1986:79)

The widely, but not universally, accepted wisdom seems to be a presumed direct relationship between population aging and rising health care costs. And further, the implication seems to be that this relationship is causal. Here, the presumption is more closely examined and pulled apart, with alternative hypotheses entertained. Some of the implications of recent policy changes for the health care/aging relationship in future are explored.

Both aging and the utilization of health care are Hobson's choices, to some degree. We endure each, not because we like them,

but because the alternative is much worse! This may possibly seem self-evident or even silly, but it is a fundamental point. More specifically, population aging, despite all the alarm of what some have labeled "voodoo demographics," is a distinct indicator of affluence: those in well-off parts of the world are so successful in controlling their fertility, and their mortality too (but this matters less to demographic aging), that a significant proportion of their populations are old. Similarly, access to health care is a symbol of affluence, of a society's success in making available to people its best resources, for their benefit.

Despite all the concerns and alarmism about population aging and potential consequences for both the individual and society, the alternative (of living in a less well off society with much higher fertility and mortality rates) is not appealing. The same applies to health care -- despite all the concerns about costs, few of us would trade the benefits.

Aging and health care share something else in common; both are associated with declining health. This might be the point at which the individual and the collective experience intersect. At the individual level, there is the well-known curve of escalating per capita costs of health care with advancing years. But, as demographers know perhaps better than most social scientists, individual behaviours may have little relationship to the aggregate level of rates, spending or policy. A brief example before moving on to a closer look at dimensions of demographic aging. The baby boom was not caused by individuals having more children, although this was one factor, but rather by more people, older and younger, having children at the same time. In other words, individual behaviours changed less than the behaviours of groups, which taken together resulted in the baby boom. However it is measured (and there is considerable debate in the field as to which measure is preferable), Canada's population is aging.

Population aging, contrary to popular belief, is only partly caused by declining death rates and extensions of life expectancy. Mostly, the cause of demographic aging is declining birth rates, chipping away at the bottom of population pyramids so as to increase the average age of the population overall. Demography does not always fit with common sense expectations, which is indeed one of its attractions for me. That active planned parenthood is the essential cause of demographic aging suggests a strong involvement of human will and choice in the process. Population aging is not something that just occurs, without the involvement and actions of individual people, whose totaled actions have implications that may not be expected.

Although I was cautious earlier about demographic prediction, for good reason, much is, indeed, predictable about demographic aging. For example, we are all getting older -- that is, if we are lucky -- and we all get older one year at a time. "Babies," as one philosopher put it, "come out of the nowhere and into the here." This, of course, says a great deal about this particular philosopher's views on women's roles in reproduction! Older people do not come out of nowhere; they come out of the here and into the future. They are us plus time. There are few surprises in the future of demographic aging and in a society like ours, much that is known and pretty well guaranteed about mortality rates and illness rates.

CANADIAN HEALTH CARE: CONTEMPORARY TRENDS AND CHALLENGES

There is no doubt that health care costs in Canada are increasing and projected to increase further. In Table 1, it is seen that when health care costs to the public per capita are standardized to a 1981 base, by 2031, costs per capita are predicted to be 35% higher than they were in 1981. Health care costs as a percentage of Gross Domestic Product (GDP) have also been increasing and are predicted to increase further, but not as dramatically as per capita costs.

TABLE 1. HEALTH CARE COST
CANADA 1981 - 2031
STANDARD PROJECTION

	Per Capita Index	%GDP
1981	100.0	7.0
1991	104.0	7.0
2001	110.2	7.1
2011	118.2	7.5
2021	126.6	8.2
2031	135.4	9.0

What can be concluded so far from this very brief glimpse of health care cost trends and demographic aging trends? Both costs and aging are increasing. There may, or may not, be a correlation in the two patterns of increase. No conclusions can be drawn about causation or even correlation with these kinds of superficial trends analyses.

What else is known or understood about these two sets of trends? It is known that demographic aging has emerged as a paradigm in Canadian public policy discussions (McDaniel, 1987). Population

aging as paradigm is being used to explain many socio- economic challenges from the deficit to the jobless recovery, with very limited understanding of the actual links. It is known that there is rampant fear about population aging, captured well in the title of an important book, *The Fear of Population Decline* (Teitelbaum and Winter, 1985). Population aging is feared to be associated with personal and societal decline, with lack of innovation, change and growth. That none of this has much firm basis in fact is overlooked. As Schoenfeld and Wenger suggest in their paper in this volume, we tend to "attend to the air raid." (The example used by Schoenfeld of being in an air raid shelter as a child during the second World War, and while reading a book being reminded by his mother to "attend to the air raid." We must not miss the crisis!) Population aging has been conceptualized as a societal crisis. Whether it is or not depends very much on the perspective used to examine the phenomenon. If, for example, the 1950's level of population growth is seen as the standard, then population aging today might be seen as a crisis. If, the population aging of other parts of the world is the standard of comparison, such as Sweden, France or other countries of western Europe, then Canada might not be seen to have a crisis at all.

It is also known that fiscal concerns, particularly in these times of immense concern about deficit and debt, tend to preoccupy public policy agendas. Maslove (quoted in Aberle, 1992), for example, makes the point that federal restraints on spending, rather than any other cause, are putting pressure on health care's capacity to meet needs. So, the case is being made that health care costs are increasing as a function of a factor such as demographic aging, and then federal transfer payments are reduced, further exacerbating the crunch on health care.

It is further known that relatively little is known about the multiple ways in which the health needs of older people may be social or economic as much as medical or health-related. That health issues and health care issues are not at all the same is beginning to be better understood. It may be, for example, that the health care system, as it exists in Canada, may be less needs driven than supply driven. So that, for example, an older woman goes to the doctor complaining of a bad knee and the doctor attends to the bad knee with intensive medical treatment, perhaps attributing this work to her advanced age. Meanwhile, her other knee which is the same age is not a problem. Can it be concluded then that aging is the cause of this doctor's work with this patient, or possibly his/her need to attend to bad knees by medical treatment whenever he/she encounters such a knee? And further, which knee is the standard by which it is decided that there is a problem?

Finally, to talk in terms of a relationship between population aging and health care, whether or not such a relationship exists and whether or not it is causal, is a narrow framework, one which precludes looking at these issues in the complex social context in which the phenomena, in reality, occur. For example, health care in Canada today, is not health care per se, but medical care where economic criteria of efficiency of costs and use/access equity simply do not prevail (Leidl, 1992). Similarly, demographically aged countries tend to be those with the most affluence, and the most capability of supplying health care to all citizens. In short, focusing on population aging and health care links, as if these are single monolithic phenomena, only looks at one piece of a larger, more complex puzzle.

A CLOSER LOOK

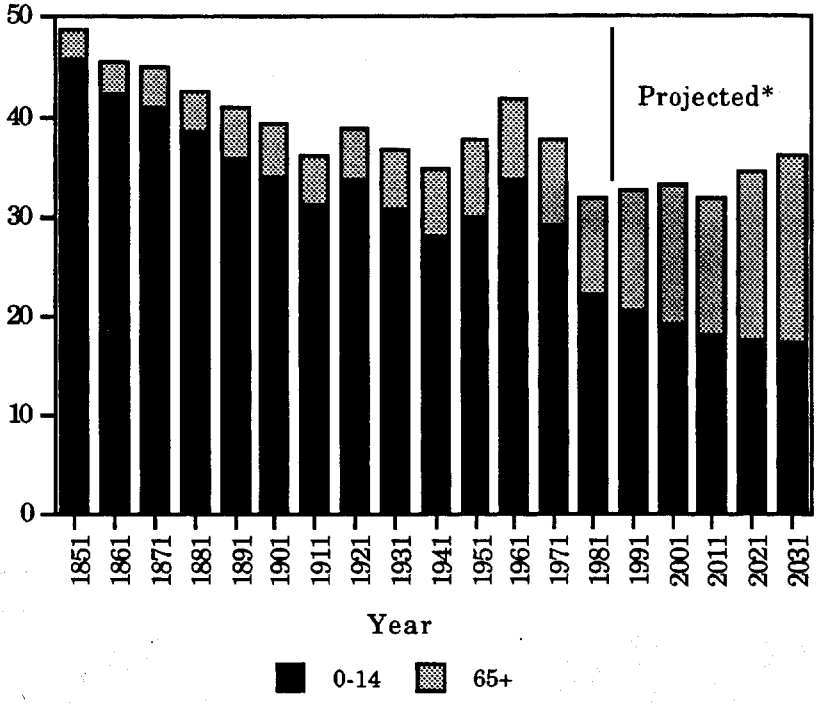
To better understand the presumed relationship between population aging and health care, it is necessary to look more closely than at overall trends. If population aging ceased tomorrow, what would happen? As we know, this improbable event would likely be the result of dramatically increasing birth rates and to a much lesser extent, decreases in life expectancies and increases in correct age immigrants. This is because it is well understood that population aging is a function largely of declining birthrates more than changes in death rates or life expectancy. If birthrates increase, where do you suppose most of those babies will be born and all the older folks (but less old than previously) would be dying? Generally, births and deaths would occur in hospitals. Is it likely then, on the face of it, that even dramatic turnarounds in population aging (if indeed these were possible) would result in decreasing health care costs?

But a closer look at both population aging and health care is needed. Neither population aging nor health care costs or expenditure trends are unidimensional or monolithic. Both are composites of other trends which may be just as important, perhaps more so, than the overall tendency.

In further specifying population aging trends, those with policy or health care implications will be emphasized rather than trying to be comprehensive. Figure 1 shows the demographic proportions dependent in old and young ages over a century in Canada. Although the population over age 65 is comprising a greater proportion of the total, the overall dependency, combining old and young, has never been lower than it is in Canada at present. This means that population aging has NOT added to the proportion dependent but

actually lowered the overall dependency "burden." Strong caution is encouraged in interpreting so called dependency ratios, since they do not represent dependency at all but are only proxies for dependency. Older people and younger may, in fact, not be dependent on labour force age populations, and, of course, labour force age populations are not always independent, as high unemployment rates indicate.

FIGURE 1. PROPORTION DEPENDENT CANADA, 1851-2031 (AGES 0-14, 65+)



Source: Foot (1982) and Statistics Canada Cat.# 91-520
* Statistics Canada Medium Projection (4)

One of the most salient policy implications of demographic aging is that it seldom sneaks up on us. Leidl (1992) remarks on how demographic aging occurs in long, generational patterns. Time and the potential to plan is on our side when we are referring to demographic aging. If only the same could be said of economic change and challenge!

There are potential fiscal benefits from redirecting resources from young to old. Not all resources spent on youth are private, as is

commonly argued -- there are schools, libraries, hockey arenas, for example, and babies are among the greediest of health care consumers. Similarly, not all expenditures on older people are public, as is commonly argued. The majority of older Canadians are independent and the pensions they draw are seen as entitlements for years of productive service to the society. And, it is being increasingly discovered that older people are active contributors to society, not only through family and other community activities, but also through paid work (McDaniel, Lalu and Krahn, 1993).

Population aging does not occur in a vacuum, but in family and gender context. Life expectancy gains, for example, have tended to be greater recently for women than for men. Women spend greater proportions of their lives in disability than men, and more time living without their spouses who much more often predecease them. The strength of this gendered pattern is revealed in Table 2. Here, I have totaled those not married, including single, divorced and widowed. For every age group 65+, the proportion of women who are single is considerably greater than for men. The implications are many. Women more often are left depressed or traumatized not only by the death of a spouse, but the additional stresses of often having served as his principal caregiver until the time of his death. Women much less often have a built-in caregiver in their older years than men. Unattached older women in our society more often live in poverty or reduced circumstances than men. Poverty poses well known health risks to people of all ages, but the old and the young are particularly vulnerable.

Recent analyses the author has done with data from the 1990 General Social Survey on Family and Friends show that women in every age category over the age of 65 years report more health problems than do men. The self-reported incapacity gap widens with age. The old adage that men die while women get sick seems borne out.

In short, the social circumstances in which demographic aging occurs in Canada works to mitigate or exacerbate health care needs and expenditures of the aging population. That gender and family are so central to this understanding adds important dimensions to the analyses. A broader analytical as well as policy focus is needed to understand how demographic aging and health care expenditures are related.

TABLE 2. MARITAL STATUS BY AGE FOR MEN AND WOMEN, CANADA 1981

Age	Widowed		Married		Total of Never Married Widow + Divorce	
	M	F	M	F	M	F
65-69	6.7%	31.5%	83.0%	57.6%	17.0%	42.4%
70-74	10.8	44.1	78.9	44.6	21.1	55.4
75-79	17.3	57.5	72.0	31.2	28.0	68.8
80-84	27.7	70.2	62.1	18.9	37.9	81.1
85-89	40.5	79.0	50.2	10.4	49.8	89.6
90+	55.5	84.7	35.0	4.7	65.0	95.3

Source: National Council of Welfare, 1984. *Sixty-Five and Older*, P. 15.

What about health care costs? Concerns about health care costs are many and varied. There are concerns about overall cost increases and a growing "cash crunch" as deficit reduction becomes the justification for cost cutting. There are concerns about overuse of health care. In Quebec, for example, there are proposals for an overuse fee. "Smart cards" for consumers and separate billings for nonmedically prescribed treatments have been suggested. In Alberta, there is a move to "de-list" procedures which will be covered by health care, a proposal which in less drastic ways has been proposed in other provinces. The relation of the physician to the fee-for-service system has been questioned, and licensing of new doctors been curtailed in various ways. The control of licensing of immigrant doctors and of newly qualified doctors in order to control costs is recognition of the reality that health care is a supply-driven system in Canada, rather than a demand-driven system: the more doctors available, the higher the costs. It is not demand on the part of patients that increases costs.

The political issues involved in health care costs are enormous. The February 1991 federal budget cut health care transfer payments to provinces by 1.1 billion dollars starting in April 1991. The National Council of Welfare (Globe and Mail, 1 March 1991, p. A5) calculates that federal transfer payments to Quebec could end by 1996-97, to Ontario by 2002-3, and to other provinces by 2007-8. The leverage of the federal government over the provinces in enforcing compliance with the Canada Health Act of 1982 could be lost. This has led Lionel Savoie, President of the

Canadian Medical Association to say, "The government of Canada is financially strangling Medicare. This budget will speed up that process and health care will suffer..." (*Globe and Mail*, 28 February 1991, p. A4).

Yet despite all of these well known and well publicized challenges to health care as we know it, the image of population aging posing the most serious challenge remains. It is population aging as paradigm that is emerging here, not population aging as it exists. Two conclusions to recent studies puts this in perspective. Murphy and Wolfson (1991) conclude, in a study of the public sector effects of population aging, that of all the major industrialized countries of the world, Canada faces the lowest public sector cost pressures due to population aging. Leidl (1992:106) concludes that the demographic impact on the health care sector of population aging is minor compared with other dynamics of the provision of health care. Some of those other dynamics are mentioned above.

CONSTRAINT OR CHOICE?

The future of health care in Canada is not cast in stone. Threats to the system as we know it are many and diverse, even contradictory forces are at work. Decisions are being made rapidly about funding, about universality, about responsibility for use/overuse, about the relative benefits to various health care professionals and to patients. All this matters greatly to disentangling the population aging/health care costs conundrum.

On the other hand, demographic aging does seem inexorable. If rectangularization of morbidity occurs (meaning that most all of us can stay healthy until the very last part of our lives when we tumble rapidly toward death), then it may not be the case at all that per capita health care expenditures increase with age, but rather plateaus and then leaps up. This possibility, which some argue could define our futures, reveals only one of the perils of extrapolating from today's older people to those of tomorrow and beyond. This extrapolation is particularly perilous when one realizes that the majority of today's elderly are women whose lives might have been profoundly different than the lives of younger women today.

A dissection of aggregate projections of health care costs reveals good news. The greatest growth is projected to be in the least expense sector in the future. Robert Evans, Canada's leading health care economist, estimates that there will be a 1% per year increase in costs overall, with constant per capita cost by age, a 2% increase per year in long term care and home care services, and only a 0.33% increase per year for doctors. So, we seem to be moving toward a

reordering of health care resources from the high cost services to lower cost services, rather than adding demands. And better yet, it is the highest cost services that are needed least and the least costly service which is needed most in the future.

Of course, these projections depend on appropriate diagnosis and appropriate level of intervention. The story of the older women who visited the doctor complaining of pain in one knee comes to mind. The doctor explained what the trouble with her knee was and suggested corrective surgery. He added that this kind of problem was a function of aging and occurred frequently. The woman astutely remarked that she wasn't sure it was a function of aging at all since her other knee, of exactly the same age, posed no problem at all. The question then becomes which knee is used as the reference point, and what the appropriate course of action is for such a patient. If highly intensive medical intervention is prescribed, then costs of health care, and demand for doctors, may not increase in the ratio Evans anticipates.

Seeing these issues afresh enables at least the possibility of analytical credibility, of creating a future of choices rather than discovering a future created for us by the presumption of constraints. The choices are ultimately ours to make collectively and are necessarily political and moral choices.

In closing, I would like to share with you a story which symbolizes much of what I see as the conflation of population aging with other societal challenges. Years ago, in a classical psychology experiment, perception psychologists Jerome Bruner and Leo Postman asked students to identify playing cards flashed before them. Bruner and Postman slipped some anomalous cards into the deck such as a black Queen of Hearts. The students almost always confidently identified these anomalous cards as normal. People see what they think they should see, and tend to distrust their own judgments on matters.

Social scientists, medical practitioners, and policy-makers are no less prone than the undergraduate psychology students to see what they expect to see, rather than what might be actually there. After looking closely at the presumed link between population aging and health care costs, I cannot help but wonder if there is not a black Queen of Hearts.

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