Guest Editorial

Canada's population is aging, and the authors of this issue's lead article, Neena Chappell and Marcus Hollander, present a policy prescription for how to design a healthcare system that better responds to needs of older Canadians. The timing of this issue of *Healthcare Papers* is important: the first of the baby boomers turned 65 in January 2011. There is a pressing need to develop policies and implement sustainable reforms that will allow older adults to stay healthier and maintain their independence longer in their place of choice, while also creating efficiencies and quality improvements in our overall healthcare system that will benefit Canadians of all ages.

Central to Chappell and Hollander's prescription is a shift away from our currently splintered system, toward an integrated system of care delivery. It is a prescription that calls for a wide range of health and supportive services for older adults, including care management, home care, home support services, supportive housing and residential care and hospital-based geriatric assessment units – all situated within a broader health and social services system, not a stand-alone continuing care system. This prescription, and the rich range of perspectives in the commentaries that follow, allows us to make several observations about how to get there from here.

Problems expected to arise from population aging can largely be mitigated by making smart changes to how we manage and fund care

As the Pac-Man of public policy, healthcare now consumes more than 40% of government expenditures in Alberta, British Columbia, Manitoba, Nova Scotia and Ontario (Torjman 2010). As Chappell and Hollander and many commentators in this issue recognize, simply throwing more money at healthcare is not the solution because the underlying issue is largely management. We need to move beyond circular conversations around the financial sustainability of the healthcare system to discussions of policy implications and imperatives that address how health services and associated policies can be adapted to tackle the evolving health needs of the population. We need to move to a model of integrated care. The development of such a system will involve creating a single funding envelope for services as well as a single, coordinated administrative structure for delivering those services.

In the current context, care remains largely silo driven and patients are expected to make their way from one point of care to another. Patients and their caregivers often encounter disconnects in care, which are frustrating for everyone, often detrimental to health and costly to the healthcare system. The lack of integrated funding and structures makes it difficult to implement initiatives that would provide people with seamless care experiences and a higher quality of care.

If we are to redesign and reorganize care, then we must be willing to challenge conventional hierarchies

Our usual course of care when people get sick is to send them to a doctor or hospital. This is the basis upon which our publicly funded healthcare system is built. Certainly, when we have an acute episode of illness (e.g., a heart attack or broken hip requiring surgery), we require physician visits and hospital stays, and these episodes may increase as people age. However, it is now largely understood that not everyone will require this course of care because not everyone will age in the same way. For the frail elderly, for example, we know that hospital stays can lead to a severe decline in their functional status, even over a short period of time. Hospital and physician care are also expensive and, arguably, we will see the costs

for these services continue to rise unless we provide better access to more appropriate and cost-effective alternatives such as home care and community support services. Of course, some patients will also require more specialized care than what is currently available in hospital. Patients with age-related dementia, for example, will need residential long-term care and other supportive living environments.

One of the Canadian Health Services Research Foundation (CHSRF) strategic priorities is promoting policy dialogue, and a key element in its programming is to identify strategies to improve healthcare for older adults. As part of its series Better with Age: Health Systems Planning for the Aging Population, CHSRF hosted six round tables across Canada in October and November 2010. These events brought together more than 200 policy makers, healthcare executives, researchers and citizen representatives to exchange ideas on ways to address health system challenges related to Canada's aging population (see Major et al. 2011). In February 2011, CHSRF convened 15 citizen representatives (patients, informal caregivers and patient advocates) from Vancouver to obtain their thoughts on how to improve healthcare for older adults. For more information about CHSRF's policy initiatives, please visit www.chsrf.ca.

To realize a vision for an integrated continuing care system, we must challenge not only where we deliver care but also who delivers it. Many commentators recognize the role of unpaid caregivers, for example. Challenging our current system of care will also help to create a care system that works around the patient, rather than our current approach in which the patient must work around a complex and fractured system.

Reforms that are needed are largely at the provincial/territorial level, but there is a federal role

The provinces and territories have the authority to move toward integrated continuing care systems, and many are already trying to do so (usually for the general population, not solely for older adults). However, many commentators see various roles for the federal government in creating a supportive, enabling environment for provinces/territories to undertake systems integration. For example, a shared vision and clearly defined expectations and roles at the national, provincial/territorial, regional and local levels would be valuable. Coordination for setting this vision and clarifying the roles could be facilitated at the federal level. Similarly, data collection and monitoring of health-related data across provinces and territories could be coordinated nationally. Renewing (and indeed "re-visioning") the federal/provincial/territorial health accord in 2014 is one opportunity, assert some commentators, to address these areas.

Dysfunctional healthcare institutions are more likely to remain dysfunctional if they can evade accountability to the people they are supposed to serve

The political economy of healthcare, as many commentators point out, is fiercely complicated and highly resistant to change. Engaging the public will be especially critical in pushing this process – after all, who knows better about care experiences and outcomes than those experiencing care? And yet, as many commentators identify, bringing clarity to the question of what citizens want in their healthcare as they age is too often neglected in health system planning. With seniors representing a growing proportion of the Canadian electorate, those with a personal stake in the quality of healthcare for older adults have an opportunity to make their voices heard in health system discussions and decisions. As Knott and Wildavsky (1980) observed more than 30 years ago, "When constituents do not demand change, and policymakers lack reasons of their own, they [policymakers] have little reason to try new methods or adopt new policies."

Policy discussion is sorely needed

The main takeaway from Chappell and Hollander's prescription and, indeed, this entire issue of *Healthcare Papers* is that we require a policy discussion, assisted by information and data. In particular, there are three pressing policy questions (we modified these questions from a government of British Columbia [2009] report and credit Dr. Trevor Hancock for drawing our attention to their usefulness for focusing public policy discussions):

1. What is worth doing? – where worth or value is measured in terms of potential health benefits and economic costs and benefits; and where various practices and policies are reviewed across other jurisdictions in Canada and internationally, and those practices and policies that are of highest priority (in terms of reducing the burden of disease and providing a high benefit-to-cost ratio) are identified as preferred approaches for implementation as provincial programs
2. What is the best way to deliver and fund what is worth doing? – where the best ways to deliver and fund services are identified in terms of (a) their effectiveness, equity and efficiency and (b) the implications to the delivery system from a quality and financial perspective – including education, training, information systems and other supports needed to effectively put the desired practices and policies into place
3. How can we monitor and improve performance? – where review and evaluation of the practices and policies are ongoing, along with reviewing of proposals for new or amended policies, services or programs on a regular basis

Chappell and Hollander present their ideas and messages in a way that meaningfully moves the discussion forward in the policy domain, by addressing these questions and raising the bar for those who provide comment to do the same. By the authors' own admission, their policy prescription is not a panacea, but they do manage to leverage the data and information as starting points for discussions with policy makers at a most crucial time.

Without question, we must work together to design systems that make sense for the care of seniors. We have in hand a prescription for meaningful change. Adhering to it will require tough decisions, but it offers the potential for cost savings, improved efficiencies and, most importantly, better health for Canadians. Going forward, we hope that these papers encourage frank dialogues among policy makers, healthcare executives, researchers and the public about how to improve the quality of healthcare for older adults and all Canadians.

Jennifer Verma
Director of Policy
Canadian Health Services Research Foundation

Stephen Samis
Vice-President of Policy
Canadian Health Services Research Foundation

References

Government of British Columbia. 2009. *A Lifetime of Prevention: The Report of the Clinical Prevention Policy Review Committee.* Vancouver, BC: Government of British Columbia. Retrieved February 2011. <http://www.health.gov.bc.ca/library/publications/year/2009/CPPR_Lifetime_of_Prevention_Report.pdf>.

Knott, J. and A. Wildavsky. 1980. "If Dissemination Is the Solution, What's the Problem?" *Knowledge: Creation, Diffusion, Utilization* 1(4): 537–78.

Major, J., J. Verma and S. Samis. 2011. "Better with Age: A Regional Roundtable Series on Health Systems Planning for the Aging Population." *Healthcare Quarterly* 14(2)

Torjman, S. 2010. *Health Care Reform: Lessons from the Edge.* Ottawa, ON: Caledon Institute of Social Policy.