The cost of ageing

Health care costs generally increase with age. When the Canadian Health Services Research Foundation first busted this myth in 2002, Canada was spending $8,208 per year per senior versus $1,428 (in 2008 dollars) per person under the age of 65. By 2008, these figures had grown to $10,742 and $2,097, respectively. Among older seniors, the data are even more telling. Seniors 80 years of age and older cost the system $18,160 per capita, more than three times the cost of seniors aged 65 to 69.1

Estimates of how the ageing population will affect health care costs vary considerably, with some predicting doom and gloom and others a minor blip on the radar.2 Only time will tell the true story, but developing credible predictions is a core component of responsible health systems planning.

Some of the best research shows that, although health care costs will begin to rise as baby-boomers age, the impact will be modest in comparison to that of other cost drivers, such as inflation and technological innovation.3,4 Economic models suggest that growth in health care costs due to population ageing will be about 1% per year between 2010 and 20365 (although it has been argued that the assumptions used in these models make for rosy predictions). These low figures can be reassuring, but with the public share of health care spending topping $120 billion as it did in 2008,1 even growth of 1% translates into a lot of money.

Ageing and sustainability

There are two issues at play when it comes to age and health care delivery. First, the older we are the more health care we use. While the overall population is using more care than ever, seniors are using proportionally more care than younger age groups, which is why seniors cost the system more. They are more likely than younger people to have chronic conditions (and more of them) such as heart disease, dementia and diabetes, which require longer hospital stays and more physician visits.6 Having multiple chronic conditions may also involve the use of many different drugs to treat each condition separately. Research has shown that such treatment regimens are often not managed properly, leading to adverse drug reactions and further hospitalisation.7

With respect to sustainability, it's the more rapid growth in age-specific health care utilisation for seniors that may be cause for concern. Studies have shown that per capita use of medical, surgical and diagnostic specialists is increasing more for seniors than for younger people, and services provided to seniors are altogether more costly.8 An 80-year-old today is twice as likely to have cataract surgery, a knee replacement, and/or a coronary bypass as in 1990.9

Some of these increases in utilisation relate to medical and technological advances (for example, equipment for new surgical techniques or increased use of medical imaging technology).10 Others relate to age-specific
A series of essays by the Canadian Health Services Research Foundation on the evidence behind healthcare debates

health care needs, which will increase in tandem with the ageing population (for example, the number of seniors with dementia is expected to double by 2038). Without changes in policy, care delivery, prevention or treatment for those with dementia, the economic implications of this greater utilisation could be considerable.

Second, dying is expensive. Research shows that we cost the health care system the most in our final years of life – and, obviously, our likelihood of dying increases as we age. In fact, the high (and rising) service use by older people is in many ways a reflection of their greater probability of dying.

Restructuring care for seniors

Ensuring that age-specific increases in utilisation do not spiral out of control will require tough decisions, which may include disinvesting from some services and investing more in others. It will also mean designing systems that make sense for the care of seniors. Arguably, there are too many seniors in acute care settings because community supports (whether residential care, assisted living or home care) are not available. Our reliance on alternate level of care (ALC) beds (i.e., non-acute patients residing in acute care beds waiting for admission elsewhere) demonstrates the need for stronger continuing care supports.

A move toward integrated continuing care delivery can produce sizeable cost savings, create efficiencies, and improve the quality of care and caregiver satisfaction. Supporting the education, recruitment and retention of caregivers to help with home support is an essential element of a broader labour strategy to meet seniors’ care needs while controlling costs.

Conclusion

While the impact of the ageing population alone won’t bankrupt the health care system, there is still a need to get age-specific cost increases under control, especially those related to death and dying. The good news is that problems expected to arise from population ageing can be managed with smart changes to care delivery for the elderly. It’s the other issues – such as the growing cost of health care services and the increased costs arising from technological innovation—that are causing expenditures to escalate. These are the cost drivers that require our foremost attention.

References

13. Velhi K. Presentation at CIHR Café Scientifique: How Canada’s aging population will impact the health care system, 24 November 2010.

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