CMA Submission: The Need for Health Infrastructure in Canada

Submitted to Hon. Denis Lebel, PC, MP
Minister of Transport, Infrastructure and Communities

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A healthy population and a vibrant medical profession
Une population en santé et une profession médicale dynamique

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The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is to serve and unite the physicians of Canada and be the national advocate, in partnership with the people of Canada, for the highest standards of health and health care.

On behalf of its more than 80,000 members and the Canadian public, CMA performs a wide variety of functions. Key functions include advocating for health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 51 national medical organizations.

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1. Introduction

In its *Economic Action Plan 2011* (Budget 2011), the Government of Canada committed to consult stakeholders on the next long-term plan for public infrastructure which would extend beyond the expiry of the current framework, the Building Canada Plan, on March 31, 2014.

The CMA's 2012-13 pre-budget brief recommends that the federal government ensure health infrastructure is eligible for funding as part of the next long-term plan for public infrastructure. The purpose of which is to address a particular health infrastructure deficit that is preventing the optimization of health care resources and exacerbating wait times and ensure that Canadian communities are able to meet the current and emerging care needs of their older seniors. The CMA has prepared this brief to provide further details on the scope of the proposed infrastructure funding for the health sector, its rationale and economic benefit, and how it could be applied.

2. Overview of proposal

The CMA recommends that the federal government ensure health sector infrastructure for long-term care facilities is eligible for funding under the next long-term infrastructure program. This funding should be applicable both for new capital projects and for renovating/retrofitting existing facilities.

This recommendation, and the recognition of the need for additional capacity in the long-term care sector, is part of a pan-Canadian approach to redirect alternate level of care patients from hospitals to homes, communities and long-term care facilities, where they can receive more appropriate care at a lower cost. It costs $842 per day for a hospital bed versus $126 per day for a long-term care bed.[1] If ALC patients were moved to more appropriate care settings, in this case, from hospital to long-term care, this would save the health care system about $1.4 billion a year.

For the purposes of this recommendation, long-term care facilities include long-term care residential homes, assisted living units and other types of innovative residential models that ensure residents are in the setting most appropriate to their needs. The long-term care sector is facing significant change due to increasing numbers of older seniors and their increasingly complex care needs. These pressures not only relate to the construction of new facilities but apply to the need to maintain existing facilities, including retrofitting to meet higher regulatory requirements, as well as struggling to meet higher care needs of their increasingly elderly population.

The CMA's recommendation to ensure that long-term care infrastructure qualify under the next long-term infrastructure plan is one component of the association's Health Care Transformation initiative and would support a pan-Canadian approach for continuing care, which would integrate home care and facility-based long-term, respite and palliative care services fully within the health care system.

3. Rationale

The rationale behind the recommendation for health infrastructure to qualify for the next long-term infrastructure plan is based primarily on the care needs of Canada's growing seniors' population and its impact on Canada's health care system. Communities across Canada face a common problem of

[1] Canadian Life and Health Insurance Association. *Improving the accessibility, quality and sustainability of long-term care in Canada*. CLHIA Report on Long-Term Care Policy. June 2012.

a lack of resources to properly meet the housing and care needs of their seniors population. Demographic trends indicate this problem will only intensify. However, as demonstrated below, investing in seniors can generate substantial direct and indirect economic benefits.

Meeting the needs of Canada's growing seniors population and their changing care needs

While all advanced countries are expected to age over the coming decades, the Canadian population is projected to age more rapidly than that of most other OECD countries, according to a recent report from Finance Canada.[2] Statistics Canada reports the number of seniors (65+) in Canada is projected to increase from 4.2 million in 2005 to 9.8 million in 2036, with their share of the total population increasing from 13.2 per cent to 24.5 per cent. The number and proportion of older seniors – those 75 and older – are expected to increase significantly as well. Ontario's population of people aged 75 and up is expected to grow by almost 30 per cent between 2012 and 2021.[3] According to Statistics Canada's medium-growth population projection scenario, the population aged 80 years or over will increase 2.6 times by 2036 – to 3.3 million persons.[4]

While the rate of residency in long-term care facilities among seniors has been declining, as the aging of Canada's population accelerates, the demand for residential care will nonetheless increase significantly over the near term due to higher numbers of elderly seniors.

Not only is the size of the elderly population increasing, but their health needs are changing too, particularly among those requiring residential care. Long-term care residents are older today than in previous years and have more complex health needs than ever before. A Canadian Institute for Health Information (CIHI) comparison of home care clients and seniors who are living in residential care found that "seniors in residential care were more likely to require extensive assistance with activities of daily living (ADLs), such as bathing and toileting (74 per cent versus 18 per cent). They were also more likely to have moderate to severe cognitive impairment (60 per cent versus 14 per cent). The number of residents with dementia is expected to increase. In 2011, 747,000 Canadians were living with cognitive impairment, including dementia – that's 14.9 per cent of Canadians 65 and older. By 2031, this figure will increase to 1.4 million.[5] At the request of the House of Commons Finance Committee, the CMA submitted a national dementia strategy.[6] This proposal to fund long-term care facilities supports such a strategy.

Many existing residential facilities are poorly equipped to meet the care needs of their residents, which are more complex now than when these facilities were originally built. For example, many facilities do not meet current building safety standards and the limited provincial and municipal funding available is usually insufficient to bring them up to code.[7] Also, there is a lack of units with shared space to better support residents with dementia, as well as a shortage of appropriate units to care for residents who are disabled or obese. Renovations are also required to make better use of long-term care beds

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[2] Department of Finance Canada. *Economic and fiscal implications of Canada's aging population*. Ottawa, 2012.
[3] Office of the Auditor General of Ontario. *2012 annual report*. 2012. http://www.auditor.on.ca/en/reports_en/en12/2012ar_en.pdf. Accessed 01/30/13.
[4] Statistics Canada. *Population projections for Canada, provinces and territories 2009 to 2036.* June 2010. 91-520-X
[5] Alzheimer's Society Ontario. Facts about dementia. http://www.alzheimer.ca/en/on/About-dementia/Dementias/What-is-dementia/Facts-about-dementia. Accessed 01/30/13.
[6] Canadian Medical Association. *Toward a Dementia Strategy for Canada.* Ottawa, 2013. http://www.cma.ca/submissions-to-government Accessed 01/30/13.
[7] Ontario Association of Non-Profit Homes and Services for Seniors. *Proposals for the Ontario Budget. Fiscal Year 2012-13*. March 2012.

for other purposes such as providing short-stay respite care or transitional care.[8] According to the Ontario Association of Community Care Access Centres, the lack of physical facilities necessary for care was the reason most often given by homes for declining to admit a long-term care wait-list client.[9]

Opportunity to improve health care efficiency and reallocate existing program spending

We recognize that addressing the current gap in long-term care residency options is only one strategy to improve the effectiveness of Canada's health care system. However, we believe it is a critical component of an integrated continuum of care strategy that provides for increased home and community supports.[10] Improving options for seniors will have a positive cascading effect on many other elements of the system. Not only will seniors reside in more appropriate and safer settings but acute care resources will be better used. Consider that about 45 per cent of provincial and territorial governments' health care spending in 2009 went toward those 65 years and older, while this group constituted only 14 per cent of the population.

A major issue facing Canada's health care system is the high number of alternate level of care patients (ALC) who occupy acute care beds. ALC patients are those who have completed the acute care phase of their treatment but remain in an acute care bed or who are admitted into a hospital bed due to the lack of a more appropriate care setting. In most cases, these people would be better served living in their own home with the appropriate level of supports or in a long-term care residence. The high number of ALC patients in hospitals is a problem experienced across the country. The total number of hospital bed days for ALC patients in 2007-2008 (latest figures) was 1.7 million.

Furthermore, the lack of options for ALC patients also contributes to a high percentage of these patients being readmitted to hospital within 30 days of discharge (see Appendix A). According to CIHI figures, 85 per cent of ALC patients were older than age 65, with almost half waiting for placement in long-term care. A high percentage of ALC patients suffer from dementia.

It costs $842 per day for a hospital bed versus $126 per day for a long-term care bed.[11] If ALC patients were moved to more appropriate care settings, in this case, from hospital to long-term care, this would save the health care system about $1.4 billion a year. The presence of ALC patients in hospitals also lead to longer surgical wait times and longer delays in the emergency department as acute care beds remain unavailable. In fact, the Wait Time Alliance – an alliance of 14 national medical organizations and specialties – has said "the most important action to improve timely access to specialty care for Canadians is by addressing the ALC issue."[12]

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[8] David Walker. *Caring for our aging population and addressing alternate level of care*. Report Submitted to the Minister of Health and Long-Term Care. June 30, 2011. Toronto.
[9] Long Term Care Innovation Expert Panel. *Why not now? A bold, five-year strategy for innovating Ontario's system of care for older adults.* March 2012. http://www.oltca.com/axiom/DailyNews/2012/June/LTCIEPFullREport_web_jun6.pdf. Accessed 01/30/13.
[10] For an example of an integrated continuum of post-acute care model see CARP, *One Patient: CARP's Care Continuum*. http://www.carp.ca/wp-content/uploads/2013/01/One-Patient-Brief-Updated-Oct-18.pdf. Accessed 01/30/13.
[11] Canadian Life and Health Insurance Association. *Improving the accessibility, quality and sustainability of long-term care in Canada*. CLHIA Report on Long-Term Care Policy. June 2012.
[12] Wait Time Alliance. *Time out!* Report card on wait times in Canada. 2011. http://www.waittimealliance.ca/media/2011reportcard/WTA2011-reportcard_e.pdf. Accessed 01/30/13.

Available wait-time data (See Appendix B) for long-term care show that wait times to access a long-term care bed can often be measured in, not months or days, but years.[13] Data from Ontario for 2004 to 2008 found that less than 50 per cent of seniors with high or very high needs were placed in a long-term care facility within a year of being put on a wait list.[14] The average wait time for placement in Quebec is 13 months (ranging between five months and four years).[15] The most recent report by Ontario's Auditor General found that 15 per cent of patients on the provincial wait list for long-term care passed away while waiting for placement.[16]

The wait to access residential care can vary immensely depending on where one resides. Often the wait is longer for residents in small, rural and northern communities. Sometimes the only route to securing a placement is for the resident to move to a facility in another community.

Investment required

According to Statistics Canada, there are 261,945 long-term care beds in operation in Canada (latest figures, 2009/10.) How many residential beds will be required in the future to meet the growing number of elderly seniors?

The Conference Board of Canada has produced a bed forecast tied to the growth of the population aged 75 and over and based on a decreased bed ratio demand of 0.59 per cent per year to reflect the greater shift to community-based services and supportive housing options being advanced at the provincial level.[17] This bed ratio demand is described by the Canadian Healthcare Association as representing a modest shift from the current reliance on long-term care to community services. Based on these assumptions, it has been estimated that Canada will require an average of 10,535 new beds per year over the next 35 years, for a total of 637,721 beds by 2047. Demand would vary over the 35-year period, peaking between 2022 and 2040 (See Appendix C). The five-year projection for beds is as follows:

Table 1: Projected shortage in long-term care beds, 2014 to 2019

Year	Number of additional beds required
2014	4,331
2015	4,715
2016	6,028
2017	6,604
2018	8,015
Projected 5-year shortage	29,693

[13] Correspondence with officials from Bruyère Continuing Care in Ottawa. January 2013.
[14] Canadian Institute for Health Information. *Health care in Canada, 2011 2011.* .
[15] Rapport du Vérificateur général du Québec à l'Assemblée nationale pour l'année 2012-2013.
[16] Office of the Auditor General of Ontario. *2012 annual report*. 2012.
[17] The .59 per cent decrease in bed ratio is presented as Scenario 2 in Lazurko, M. and Hearn, B. Canadian *Continuing Care Scenarios 1999-2041*, KPMG Final Project Report to FPT Advisory Committee on Health Services, Ottawa. 2000. Presented in Canadian Healthcare Association, *New Directions for Facility-Based Long-Term Care*. 2009. http://www.cha.ca/wp-content/uploads/2012/11/CHA_LTC_9-22-09_eng.pdf. Accessed 01/30/13.

As shown, there is a projected shortage of 29,693 beds over the next five years. For the purposes of longer-term planning, the gap in beds required for the following five-year period (2019-2023) is as follows:

Table 2: Projected shortage in long-term care beds, 2019 to 2023

Year	Number of additional beds required
2019	8,656
2020	8,910
2021	10,316
2022	14,888
2023	14,151

As previously outlined, the rising gap in bed numbers is affected by the increased numbers in people aged 75 and older anticipated over the next 35 years.

The estimated cost to construct 10,535 beds (the average number of beds required to be built per year from 2013 to 2047) is $2.8 billion, based on a cost estimate of $269,000 per bed. This figure could include both public and private spending.

The purpose of this bed projection is to provide a sense of the immense challenge Canada faces in addressing the needs of a vulnerable segment of its older seniors population. It is important to note that this forecast does not include the significant investments required to renovate and retrofit the existing stock of residential facilities, not only to meet the current standards but to effectively respond to the complex care needs of residents requiring long-term care today and in the future. Similarly, the potential facility capacity expansions through retrofit or renovation are not included. Moreover, innovative capital investment in residential facilities can provide opportunities for their greater use by other members of the community. They can, for example, provide short-stay respite to support families and convalescent care programs such as those found in the United Kingdom. We also recognize that supportive housing and healthy aging programming are important components of an integrated solution to the ALC issue and to ensuring seniors reside in the most appropriate place.

4. How the funding would work

Health infrastructure could qualify under a communities component of the next long-term infrastructure plan where this federal funding can be leveraged with provincial and and / or municipal investment (e.g. 1/3 federal component matched by + 2/3 provincial and / or municipal). This funding allocation could also include the use of public-private partnership models.

Investing in Canada's Continuing Care Sector Provides a Wide Range of Economic Benefits

Construction of new residential care models and renovating/retrofitting existing facilities will provide significant economic opportunities for many communities across Canada (See Appendix E for detailed figures).

Based on Conference Board of Canada estimates, the construction and maintenance of 10,535 long-term care beds (the average number of new beds needed per year from 2013 to 2047) will yield direct economic benefits on an annual basis that include $1.23 billion contribution to GDP and 14,141 high value jobs during the capital investment phase and $637 million contribution to GDP and 11,604 high value jobs during the facility operation phase (based on an average annual capital investment); and close the significant gap between the projected long-term care bed shortages and current planned investment.

When indirect economic contributions are included, the total estimated annual contribution to Canada's GDP reaches almost $3 billion, yielding 37,528 new jobs (construction, care providers and other sectors). Details on these economic benefits are provided in Appendix F, but a summary is presented below:

Table 3: Average annual total economic contribution of new residential care facilities (10, 535 new beds per year at market prices)

	GDP (in 2013 $millions)	Number of jobs created
Average **direct** contribution to GDP of investing in new facilities (construction)	$1,225.4	14,141
Average **direct** contribution to GDP of operating the new facilities	$637.0	11,604
Average **indirect** contribution to GDP of investing in new facilities (construction)	$969.9	10,115
Average **indirect** contribution to GDP of operating the new facilities	$135.4	1,667
TOTAL (both direct and indirect)	**$2,968**	**37,528**

For every 100 jobs created in the construction of long-term care facilities, an additional 72 jobs would be created in other sectors, while for every 100 jobs created in the long-term care sector, 14 jobs would be created in other sectors.

The numbers provided above reflect the annual average contribution. On a time specific level, covering the five-year period between 2014 and 2018, an estimated 167,840 jobs would be created, based on the construction of 29,693 new beds.

Another important economic benefit is the return in government revenues. The increase in construction and operating spending per average year will provide over $425 million in federal government revenues and over $370 million in provincial revenues (See Appendix G).

As previously identified, an improved stock of long-term care beds will provide many other economic spinoffs, including savings in health care costs that can be reallocated to better meet Canadians'

health care needs and to provide greater support for families in their role as caregivers. Without adequate provision of long-term care resources, Canada's labour force may experience a productivity drag through increased leaves and absenteeism to care for elderly relatives.

5. Conclusion

The aging of our population touches all Canadians – from seniors who need the services to families who serve as caregivers and/or contribute financially to the care of aging relatives. Recent data show that 32 per cent of caregivers who provide more than 21 hours of care per week report distress in their role – four times the proportion of distressed caregivers who provide less than 10 hours of informal care per week.[18]

The federal government has a long history of allocating capital investment in the health sector. Previous examples include the Hospitals and Construction Grants Program in 1948, the Health Resources Fund established in 1966 and, more recently, the funding of capital projects at research hospitals under the Canada Foundation for Innovation Leading Edge and New Initiatives Funds in 2012.

All communities across Canada are strongly affected by the social and health care needs of their growing senior and long-term care populations (see Appendix H for a sample of recent news stories.) Federal capital investment will help narrow the significant gap between the projected long-term care bed shortages and current planned investment in the area of residential care facilities. Further, it would have a cascading effect leading to a more effective and efficient Canadian health care system.

Recommendation

The Canadian Medical Association recommends that the federal ensure that the construction, renovation and retrofitting of long-term care facilities qualify for funding under the next long-term infrastructure plan. Long-term care facilities include long-term care residential homes, assisted living units and other types of innovative residential models that ensure residents are in the most care setting most appropriate to their needs. This funding could be delivered as part of the communities component of the next long-term infrastructure plan.

[18] Canadian Institute for Health Information, *Health Care in Canada, 2011.*