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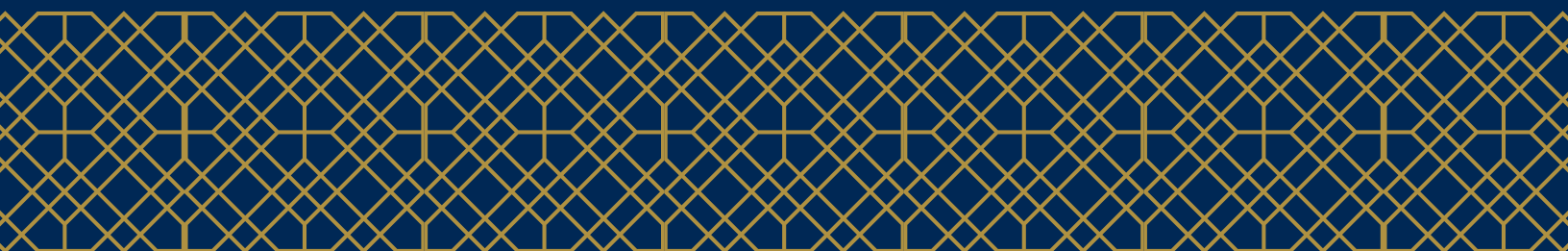


uOttawa

Past, Present, Future

Health Care Costs in
British Columbia

Spring 2017



About this Document

The Institute of Fiscal Studies and Democracy (IFSD) is a Canadian think-tank sitting at the nexus of public finance and state institutions. Fiscal ecosystems include governments, legislatures, the public administration and other key actors and institutions in our political and economic life. This ecosystem, rooted in hundreds of years of political history and economic development, is composed of an intertwined set of incentives, public and private information and a complex and sometimes opaque set of rules and processes based on constitutional law, legislative law, conventions and struggles for power. The actors within this system depend on one another as well as the robustness and transparency of information and processes, all underpinned by a society's standards of accountability. It is at this dynamic intersection of money and politics that the Institute of Fiscal Studies and Democracy @ uOttawa aims to research, advise, engage and teach. The IFSD has been funded by the Province of Ontario to undertake applied research and student engagement in public finance and its intersection with public administration, politics and public policy. The IFSD undertakes its work in Canada at all levels of government as well as abroad, leveraging partnerships and key relationships with organizations such as the World Bank, OECD, IMF and US National Governors Association.

This report was prepared by Randall Bartlett, Chief Economist, and Dominique Lapointe, Senior Analyst, under the direction of Kevin Page. The report was edited and designed by Jessica Rached and assembled by AN Design Communications. The final report and any errors or omissions rest solely with the IFSD.

First Printing: April 2017
No. 17009 - British Columbia



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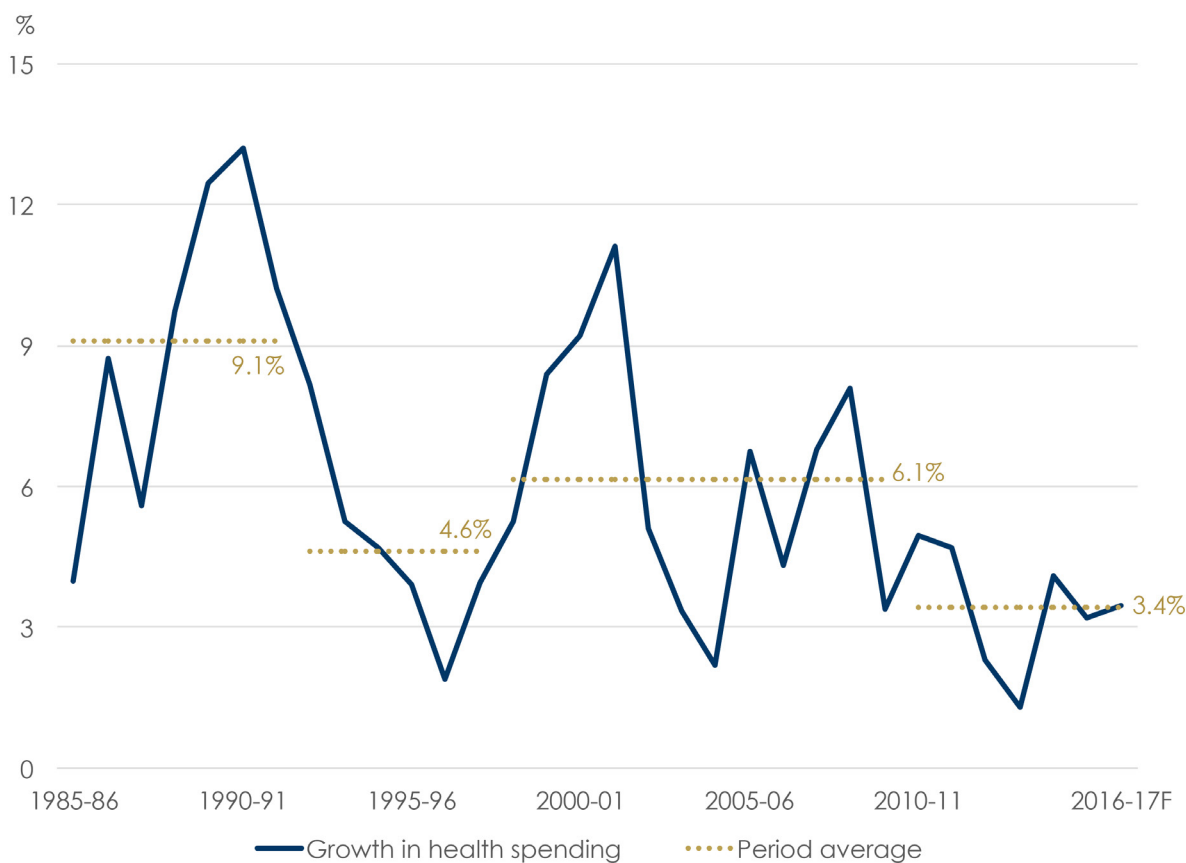
Key Points

- Over the past 30 years, health care spending in British Columbia has followed a similar pattern of peaks and troughs as that at the national level, tied to overall economic activity and fluctuations in federal funding. More generally, throughout this period, health spending has remained above the notional health care cost derived from the macroeconomic fundamentals of population growth, aging, real income growth, and inflation. And this trend is expected to continue in the coming years. Despite this, British Columbia has maintained the status of the third lowest health cost per capita jurisdiction in Canada.
- More specifically, from 2010 to 2014, national health spending slowed relative to the previous decade. In British Columbia, during this period, average health care spending growth was slightly higher than the national average (3.5% versus 3.4%, respectively), but was markedly lower than in the prior decade. Notable differences between health spending growth in British Columbia and Canada between 2010 and 2014 were on public health (7.5% versus 5.3%) administration (6.5% versus 1.5%), and health facilities (5.0% versus 3.4%), as well as other health spending (-5.1% versus 2.4%). Overall, this restraint was broad based and distributed throughout the health system in a manner similar to that observed at the national level. Meanwhile, spending growth decelerated in 2015 and 2016, rising at an average annual rate of 3.3%.
- In 2015, the Council of the Federation called on the federal government to commit to maintaining a 25% participation in provincial health care expenditures (excluding transfers from the equalization program). In order to meet this request, the provinces and territories asked the federal government to commit to grow the Canadian Health Transfer (CHT) by 5.2% annually. Instead, the Government of Canada decided to move forward with an increase in the CHT tied to the pace of nominal GDP growth. An additional commitment of \$11.5 billion over ten years was made for federal health priorities, namely mental health and home care, although much of this is back-end loaded to the end of the 5-year budget planning horizon. To date, all provinces have agreed to this offer, with the exception of Manitoba.
- As a result of this agreement, the federal share of national health spending will rise in the next few years as fiscal restraint among provinces and territories continues. This is also true in British Columbia. However, as the underlying cost pressures keep rising due to the macroeconomic cost drivers, the Institute of Fiscal Studies and Democracy is forecasting a gradual decline in the federal share of health spending. Indeed, by 2026, the federal share is expected to return to roughly its current level. And if health spending restraint is relaxed, the federal share will fall even further.
- **In summary, while additional federal funds dedicated to home care and mental health will provide modest support to provincial finances, this agreement is neither sufficient nor transformative in helping the provinces to meet the health care needs of their citizens. And given the back-end loaded nature of additional health funding, the larger concern is that health care reforms have been largely punted to beyond the 2019 election.**

In its recent publication, ‘[CHT Conundrum: Ontario Case Study](#)’, the Institute of Fiscal Studies and Democracy (IFSD) outlined an approach to examining historical health care spending while projecting the drivers of health care costs over the coming 20 years.¹ Summarizing the historical results for British Columbia (BC) here, health care spending growth can be divided into four distinct periods: 1985–1991, 1992–1997, 1998–2009, and 2010–2016 (see Chart 1). These time periods are important as they overlap with distinct periods of higher economic growth and federal transfers to the provinces in the case of the 1985–1991 and 1998–2009 periods, and the opposite circumstance in the case of the 1992–1997 and 2010–2016 periods.

While each of these periods was characterized by very different economic and fiscal circumstances, they were also reflective of different underlying health care cost drivers in British Columbia. For instance, the higher expenditure growth years of the 1980s were the result of significant increases in spending across the board, with the average growth in spending on drugs (13.4%), other health spending (13.1%), public health (11.8%), and capital (10.1%) topping the list. Then, in the more austere years of the 1990s, health care expenditures averaged a still respectable 4.6% annually, as all areas of health spending remained positive over this period but advanced at a much slower pace than was previously the case. Capital investment, in particular, slowed to an average annual advance of 1.6%. Fast forward to the balanced federal budgets and solid economic growth of the late-1990s and early-2000s, and spending resumed anew. This time, the advance was led by capital investment (12.5%), complemented by gains in expenditures on public health (11.1%) and other health spending (10.0%). Interestingly, unlike in most other provinces, average annual spending on administration (-2.2%) fell during this period.

Chart 1: Annual Growth in Total Health Expenditures in British Columbia



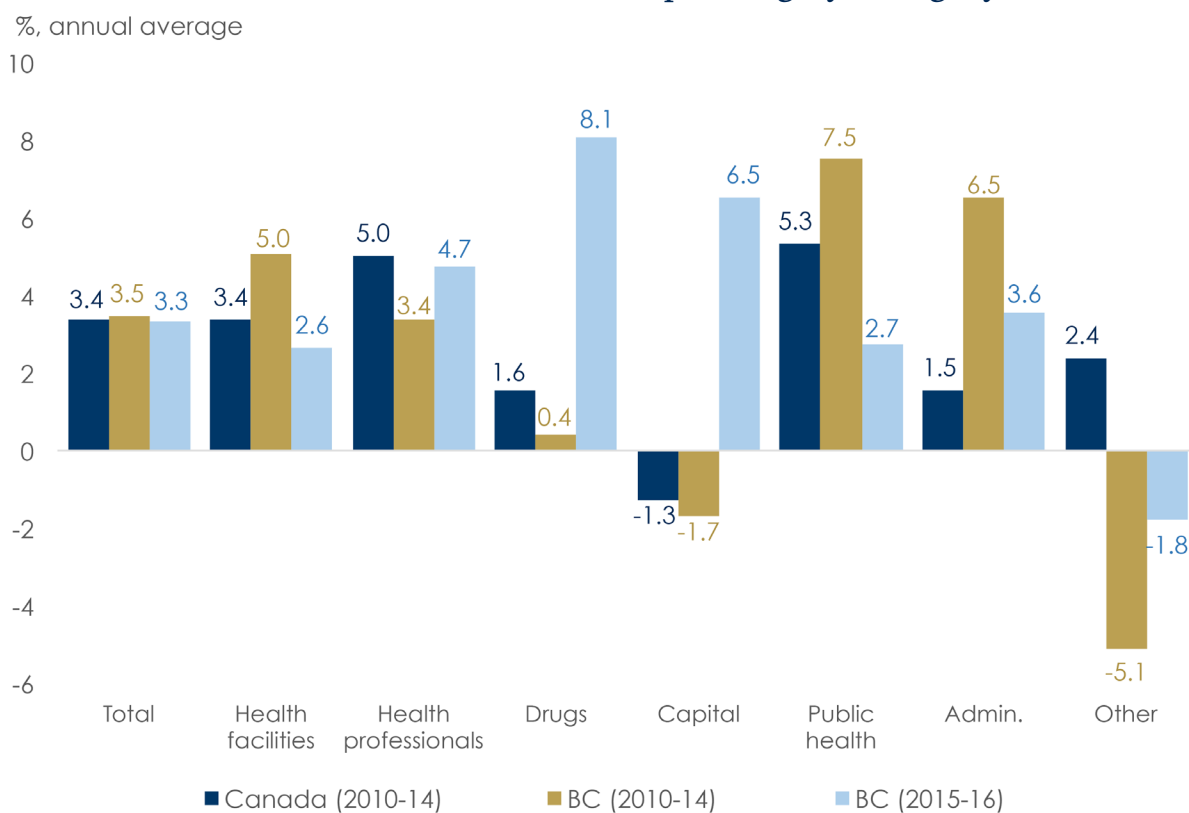
Source: Canadian Institute for Health Information, Institute of Fiscal Studies and Democracy.

Note: Years refer to fiscal years. Numbers include both public and private health expenditures. Period ends in fiscal 2016–17.

¹ See ‘CHT and the Federation: Past, Present, and Future’ for references.

Then the 2008–09 recession hit, and own-source revenue growth in British Columbia turned negative. With revenues hobbled by weak economic activity, the provincial government needed to find savings. And, indeed, it did. From 2010 through 2014, average total health care expenditure growth in BC was constrained to 3.5% annually (see Chart 2). Much of the savings were found in reducing other health spending (-5.1%) and capital investment (-1.7%), complemented by more modest restraint in most other areas of spending. However, spending on public health (7.5%), administration (6.5%), and health facilities (5.0%) remained above the national average over this period. Health spending in BC decelerated somewhat in 2015 and 2016, with average annual growth hitting 3.3%. This was supported by further restraint in most categories, with the exception of spending on drugs (8.1%) and investment in capital (6.5%). Importantly, these aggregate savings took place at a time when the Canada Health Transfer (CHT)—the federal government’s dedicated funding for health care—was increasing at an annual rate of 6%, meaning the CHT share of BC’s health spending rose over this period.

Chart 2: Growth in Health Spending by Category



Source: Canadian Institute for Health Information, Institute of Fiscal Studies and Democracy.

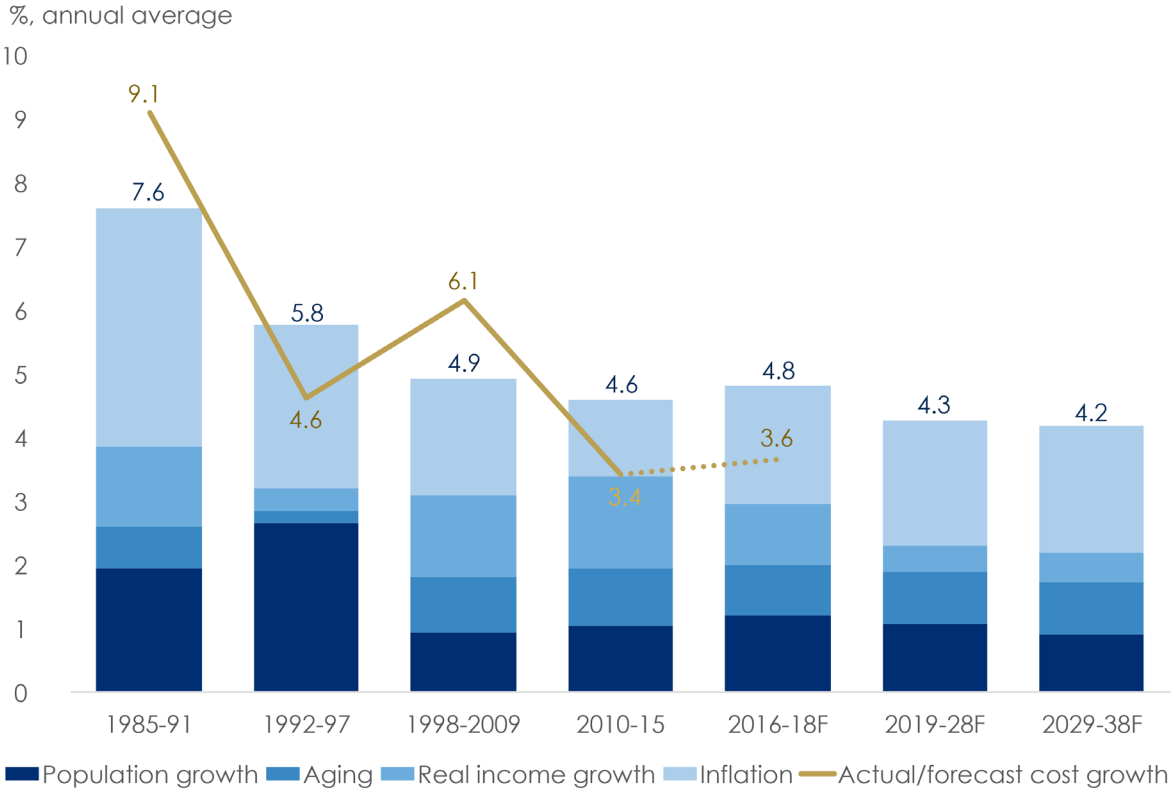
Note: Years refer to fiscal years. Health facilities include hospitals and other institutions. Health professionals include physicians and other professionals. National health data by spending category is only available through the 2014–15 fiscal year. Numbers include both public and private health expenditures. “Other health spending” includes expenditures on home care, medical transportation (ambulances), hearing aids, other appliances and prostheses, health research and miscellaneous health care.

Looking ahead to the next few years, growth in health care costs is expected to advance at a pace in line with the 3.4% annual average observed from 2010 through 2015. However, the macroeconomic drivers of health care cost growth—population growth, aging, real income growth, and inflation—suggest that underlying cost pressures will increase at an average annual pace of about 4.8% over the next few years (see Chart 3).² This exceeds the average annual growth of 3.6% projected in official

² Similar to the recent work of the Financial Accountability Officer (2017) based on analysis by the Organisation for Economic Co-operation and Development (OECD, 2013), a real income elasticity of health care expenditures of 0.8 was used in this analysis.

forecasts for the 2016 to 2018 period. But, unfortunately, cost containment of this magnitude has rarely proven sustainable, particularly in the lead up to a period when aging is expected to keep sustained pressure on British Columbia’s health care system. And beyond 2018, cost pressures are expected to advance at an annual pace of over 4% for the subsequent 20 years (Table 1).

Chart 3: Growth in Actual versus Notional Health Care Costs



Source: CIHI, British Columbia Ministry of Finance, Statistics Canada, Institute of Fiscal Studies and Democracy.
 Note: The IFSD estimates and forecasts assume no enrichment. Years refer to fiscal years. Numbers include both public and private health expenditures.

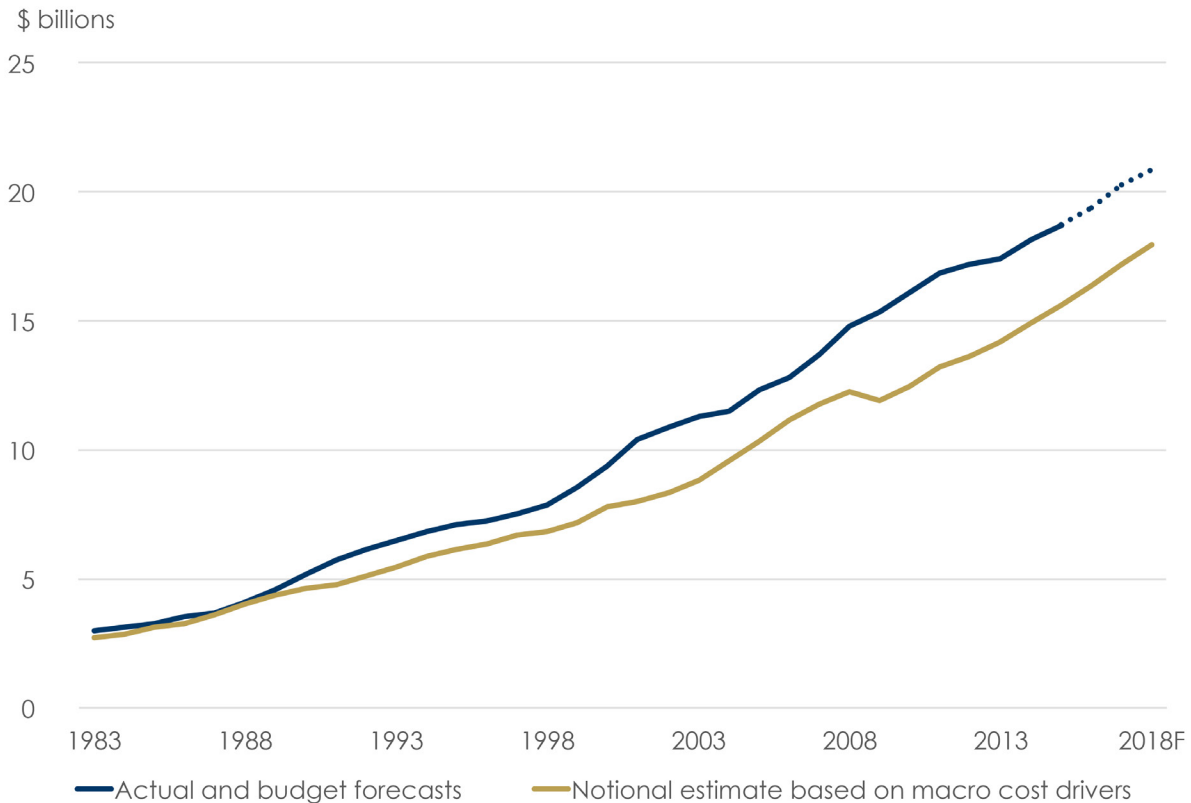
Table 1: Actual versus Notional Health Care Spending Growth in British Columbia							
%, annual average	Actual/Budget	Enrichment*	Notional	Population	Aging	Real Income	Inflation
1985–1991	9.1	1.5	7.6	2.0	0.6	1.3	3.7
1992–1997	4.6	-1.1	5.8	2.7	0.2	0.4	2.6
1998–2009	6.1	1.2	4.9	0.9	0.9	1.3	1.8
2010–2015	3.4	-1.2	4.6	1.0	0.9	1.5	1.2
2016–2018	3.6	-1.2	4.8	1.2	0.8	1.0	1.9
2019–2028	-	-	4.3	1.1	0.8	0.4	2.0
2029–2038	-	-	4.2	0.9	0.8	0.5	2.0

Source: Canadian Institute for Health Information, British Columbia Ministry of Finance, Statistics Canada, Institute of Fiscal Studies and Democracy.
 Note: Growth forecasts for health spending, real GDP, and GDP inflation are taken from the most recent budget documents for the period 2016 to 2018. Population projections are from the M1 (medium) scenario from Statistics Canada. Numbers include both public and private health expenditures.
 *Enrichment is equal to actual less notional health spending growth.

Examining the planned savings over the next few years in a historical context, it becomes clear that some cost containment is necessary in order to bring health care expenditures into line with where the underlying macroeconomic drivers would suggest they should be (see Chart 4). Indeed, annual health spending has exceeded that level suggested by macroeconomic fundamentals over most of the past

35 years. However, according to the Canadian Institute for Health Information (CIHI), BC continues to have one of the lowest per capita costs of health care in Canada, bested only by Quebec and Ontario. And this modest level of spending seems to have paid off, with the [Conference Board of Canada](#) having given BC's health status the highest ranking in Canada (see Table 2), on par with countries like Sweden and Switzerland. In contrast, a [broad collection of health care indicators](#) compiled by CIHI gives BC a more middling ranking in terms of health care system performance.

Chart 4: Actual/Forecast Health Spending versus Notional Costs



Source: CIHI, British Columbia Ministry of Finance, Statistics Canada, Institute of Fiscal Studies and Democracy.
 Note: The IFSD estimates and forecasts assume no enrichment. Years refer to fiscal years. The notional estimate is indexed to the 1981 level of total health care expenditures, as estimated by CIHI. Numbers include both public and private health expenditures.

Table 2: Relative Ranking of Population Health Status, Health Care System Performance, and Per Capita Cost			
Ranking	Health Status (Conference Board)	Health Care System Performance (CIHI/IFSD)	Per Capita Cost (CIHI)
1	British Columbia	Ontario	Quebec
2	Ontario	Quebec	Ontario
3	Quebec	New Brunswick	British Columbia
4	Prince Edward Island	Prince Edward Island	New Brunswick
5	Alberta	Alberta	Nova Scotia
6	New Brunswick	British Columbia	Prince Edward Island
7	Nova Scotia	Newfoundland & Labrador	Manitoba
8	Manitoba	Manitoba	Saskatchewan
9	Saskatchewan	Nova Scotia	Alberta

Table 2: Relative Ranking of Population Health Status, Health Care System Performance, and Per Capita Cost

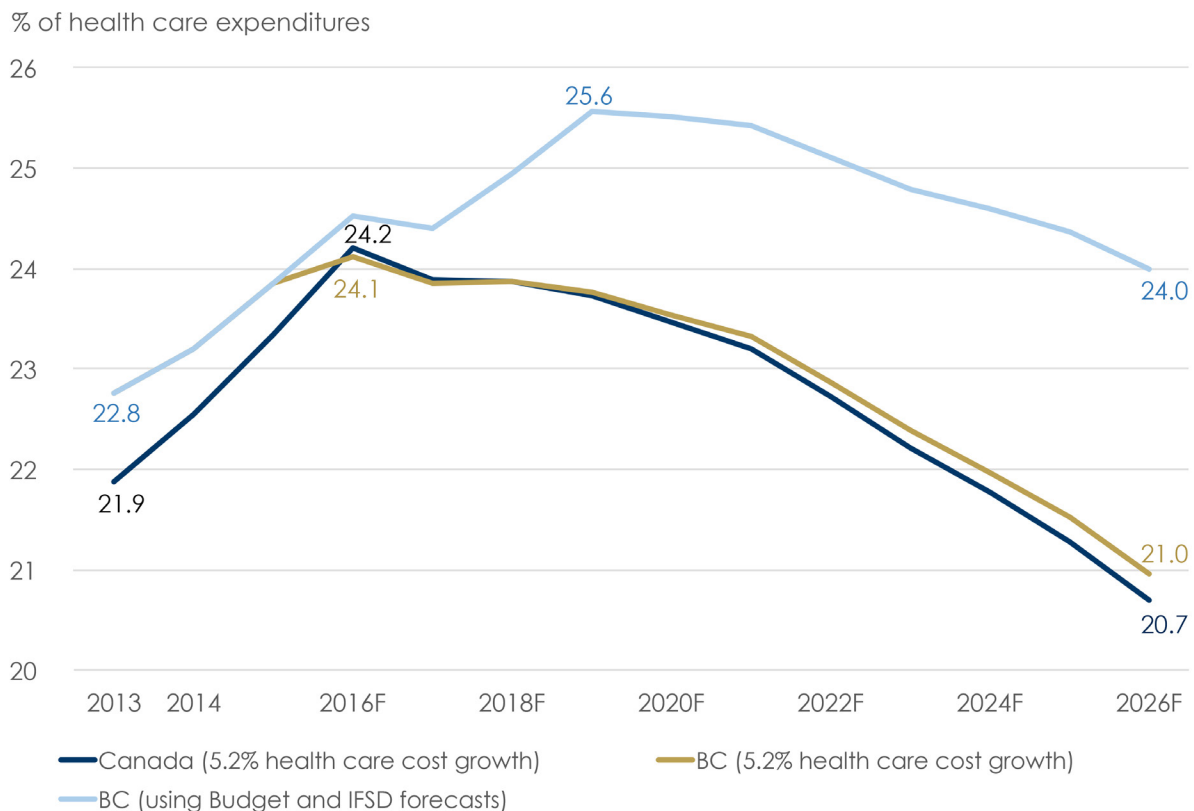
10	Newfoundland & Labrador	Saskatchewan	Newfoundland & Labrador
11	Yukon	Yukon	Yukon
12	Northwest Territories	Nunavut	Northwest Territories
13	Nunavut	Northwest Territories	Nunavut

Source: Conference Board of Canada, Canadian Institute for Health Information (CIHI), Institute of Fiscal Studies and Democracy (IFSD).

Note: Ranking calculations of health care system performance using CIHI data were done by the IFSD, by assigning values to above average (1), average (0), or below average (-1) performance for 15 indicators and then ranking the totals. Per capita cost ranking is from lowest to highest using CIHI data from 2014.

This analysis must now be put in the context of the recent health care funding negotiation between the federal government and provincial-territorial (P-T) governments. This analysis has found that the Province of British Columbia will win in the short run but lose in the long run as a result of having signed on to the health funding offer proposed by the federal government (see Chart 5). In December 2016, P-T governments were unanimous in their resolve to see the CHT advance at an annual pace of 5.2%, which they projected to be the average annual growth rate in national health care costs over the coming decade. Instead, the federal government’s proposal, which was later confirmed in Budget 2017, would see federal health funding (the CHT plus modest new supplementary measures) increase at an average annual pace of 3.6%, well below that desired by P-T governments. This reflects the fact that any new money beyond that pledged by the previous federal government is back-end loaded to the end of the 5-year fiscal planning horizon. As a result, the federal government’s contribution to national health care expenditures is expected to fall to just over 20% by 2026. Given BC’s relatively low per capita cost of health care spending, health transfers make up a higher-than-average share of health care expenditures compared to other provinces. If BC’s health care costs were to advance by 5.2% annually, the federal share of BC’s health spending would follow a pattern similar to that observed at the national level over the next decade.

Chart 5: Federal Share of Health Care Costs for Canada and British Columbia



Source: CIHI, British Columbia Ministry of Finance, Finance Canada, Statistics Canada, Institute of Fiscal Studies and Democracy.

Note: Years refer to fiscal years. Numbers include both public and private health expenditures.

But the story changes when one takes into account official health care spending forecasts from the Government of British Columbia and the IFSD’s projections of the macroeconomic drivers of health care costs starting in 2019. With growth in the CHT expected to outpace health care spending growth in BC through 2019, federal funding will assume an increasingly large portion of health care expenditures over the next few years (see Table 3). Then, starting in 2020, the federal share of health spending will begin to decline, ultimately reaching a level in 2026 roughly in line with the 2015 level. And if the CHT were assumed to advance at a similar pace thereafter, the federal share of BC’s health spending would likely continue to decline.

\$ billions	Federal Health Funding*	Canada Health Transfer	New Supplementary Measures	Amount Received by Province	Projected Provincial Health Costs	Federal Share of Health Costs (%)
2013	30.3	30.3		4.0	17.4	22.8%
2014	32.1	32.1		4.2	18.2	23.2%
2015	34.0	34.0		4.5	18.7	23.9%
2016	36.1	36.1	0.0	4.8	19.4	24.5%
2017	37.5	37.1	0.4	4.9	20.3	24.4%
2018	39.4	38.4	1.0	5.2	20.9	25.0%
2019	41.2	39.9	1.3	5.5	21.3	25.6%
2020	42.9	41.4	1.5	5.7	22.3	25.5%
2021	44.6	42.9	1.7	5.9	23.3	25.4%
2022	45.9	44.4	1.5	6.1	24.3	25.1%
2023	47.2	46.0	1.3	6.3	25.4	24.8%
2024	48.7	47.6	1.1	6.5	26.4	24.6%
2025	50.1	49.2	0.9	6.7	27.5	24.4%
2026	51.2	50.9	0.3	6.9	28.6	24.0%

Source: CIHI, British Columbia Ministry of Finance, Statistics Canada, Finance Canada, Institute of Fiscal Studies and Democracy.
 Note: Growth forecasts for health spending, real GDP, and GDP inflation are taken from the most recent budget documents for the period 2016 to 2018. The federal health funding forecast from fiscal 2016–17 through 2021–22 is from Budget 2017. Numbers include both public and private health expenditures.

*Federal health funding includes the CHT and modest new supplementary measures from Budget 2017.

Conclusion

British Columbia’s health care system can brag better-than-average outcomes and lower-than-average per capita costs, the latter despite the provincial government having consistently spent more than what would be suggested by the macroeconomic cost drivers. But the Government of British Columbia has managed to restrain health care expenditure growth in recent years, which is certainly a positive development. And this slower growth path for health spending is expected to continue over the next few years, although the gap relative to where macroeconomic fundamentals suggest health care expenditures should be will remain broadly unchanged. That said, these savings also mean that the CHT will make up an increasingly large share of BC’s health spending through to 2019. But this won’t last long, as the macroeconomic health care cost drivers are expected to be higher than the growth rate in the CHT over the coming decade. Consequently, the federal contribution to health spending will fall through 2026, forcing BC to disproportionately bear the burden of the additional health care costs beyond the increases in federal health transfers. Indeed, much of the new federal funding in addition to the CHT is back-loaded to the end of the 5-year fiscal planning horizon, and beyond the 2019 federal election. This leads the IFSD to conclude that the Government of British Columbia should have rejected the federal government’s recent offer on health funding and held out for a better deal.

