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Past, Present, Future

Health Care Costs in Manitoba

Spring 2017

About this Document

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Key Points

- Over the past 30 years, health care spending in Manitoba 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. Indeed, this has been little changed in recent years, supporting Manitoba reaching the position of the province with the fourth highest health care cost per capita in Canada. And, in the coming years, this trend is expected to continue.

- More specifically, from 2010 to 2014, national health spending slowed relative to the previous decade. During this period, average health care spending growth in Manitoba was broadly in line with the national average (3.5% versus 3.4%, respectively). Notable differences between health spending growth in Manitoba and Canada as a whole in 2010 through 2014 were on health professionals (6.4% versus 5.0%) and other health spending (5.1% versus 2.4%). Where Manitoba did manage to find some savings relative to the rest of the country was in administrative costs (0.5% versus 1.5%) and, most notably, capital investment (-5.3% versus -1.3%). The latter category is of particular concern as, over the past two years, capital investment continued to contract at an average pace of -3.5% annually. Spending on administration (-2.1%) also fell over this period. Despite this, the pace of total health spending accelerated to an average annual rate of 4.6% in 2015 and 2016, supported by stronger spending growth in public health (8.5%).

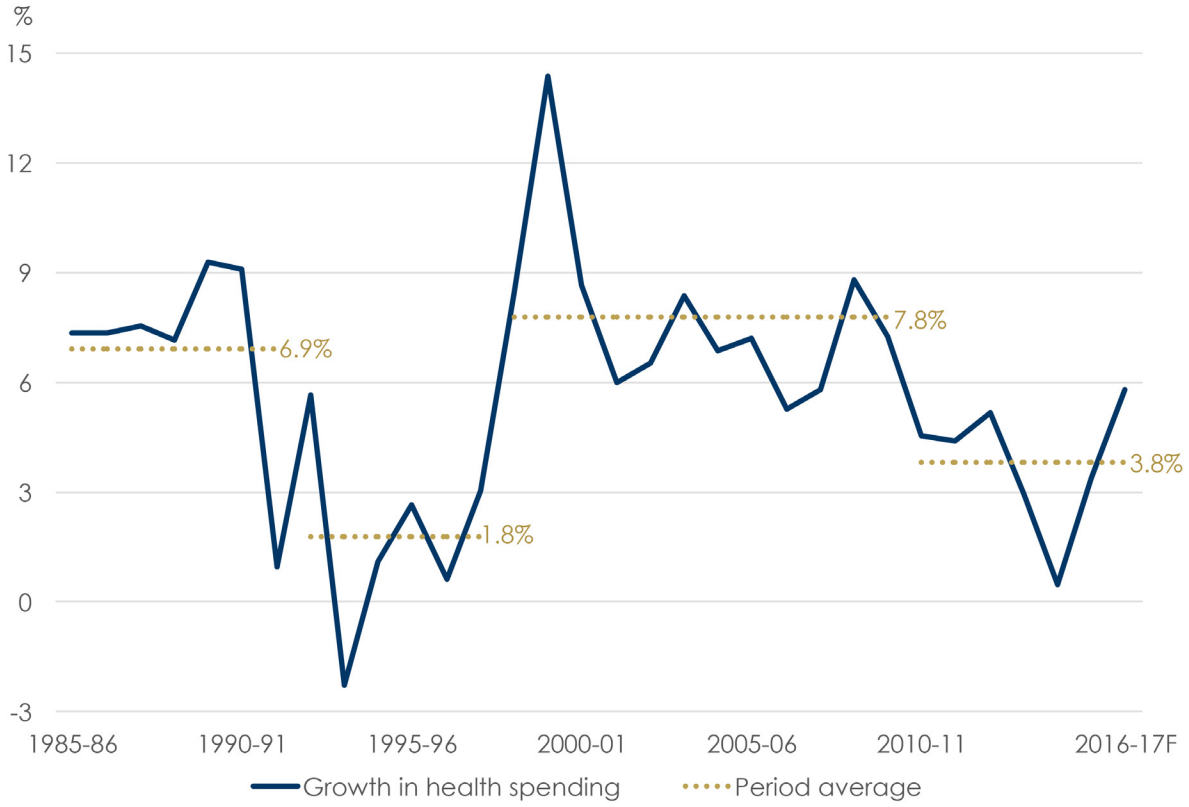
- In 2015, the Council of the Federation called on the federal government to commit to maintaining a 25% participation in provincial health care expenditures (excluding transfers from the equalization program). In order to meet this request, the provinces and territories asked the federal government 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 and territories have agreed to this offer, with the exception of Manitoba. However, in Budget 2017, the federal government outlined its health spending plans in accordance with the offer it presented. As such, Manitoba is likely to be subject to the same treatment as other subnational jurisdictions.

- As a result of this agreement, the federal share of national health spending will rise in the next few years as fiscal restraint among the provinces and territories continues. In contrast, the Institute of Fiscal Studies and Democracy (IFSD) is forecasting that this share will remain roughly constant in Manitoba through 2021, as the pace of health spending remains elevated relative to other provinces and territories. However, as the underlying cost pressures keep rising due to the macroeconomic cost drivers, the IFSD is forecasting a gradual decline in the federal share of health spending in Manitoba. Indeed, by 2026, the federal share will have fallen below its current level. And if health spending accelerates beyond the current pace, 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 Manitoba 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.

Chart 1: Annual Growth in Total Health Expenditures in Manitoba



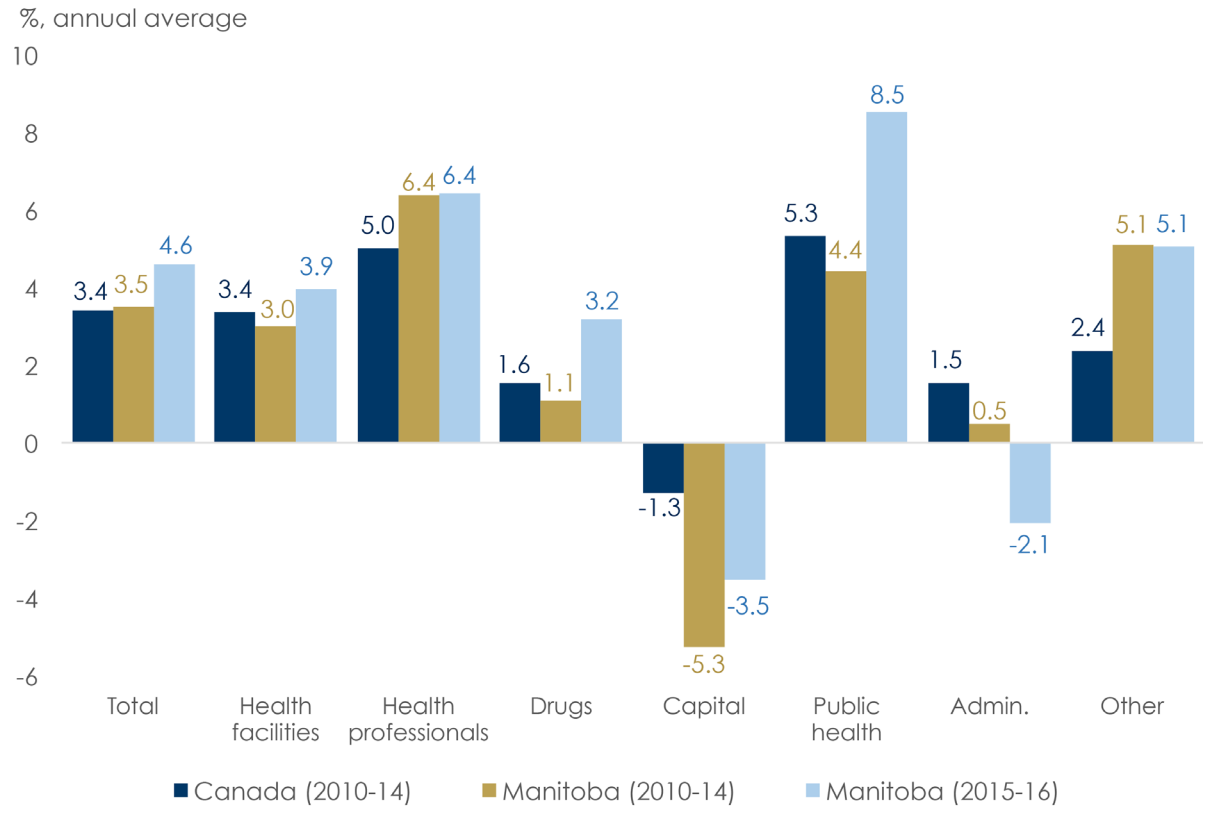
Source: Canadian Institute for Health Information, Institute of Fiscal Studies and Democracy.
Note: Years refer to fiscal years. Numbers include both public and private health expenditures. Period ends in fiscal 2016–17.

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 Manitoba. 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 capital (20.5%), other health spending (17.1%), drugs (9.5%), and public health (9.3%) topping the list. Then, in the more austere years of the 1990s, average growth in health care expenditures slowed sharply to 1.8% annually. These savings were largely on the back of a contraction in capital investment (-3.7%), as well as a more modest advance in spending on health facilities (0.8%). 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 spending on drugs (11.9%), complemented by gains in expenditures on public health (11.5%) and capital (10.6%). Substantial advances in spending across all other health expenditure categories were also observed.

[1] See 'CHT and the Federation: Past, Present, and Future' for references.

Then the 2008–09 recession hit, and own-source revenue growth in Manitoba 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 Manitoba was constrained to 3.5% annually—in line with the national average of 3.4% and roughly half the pace of the previous decade (see Chart 2). The savings were primarily the result of a contraction in investment in capital (-5.3%), as well as slow growth in spending on administration (0.5%) and drugs (1.1%). Meanwhile, spending on health professionals (6.4%) and other health spending (5.7%) advanced at a pace that exceeded the national average. The contraction in capital spending warrants highlighting, as it may reflect a deferral of investment into the future. Shrinking capital investment (-3.5%) continued in 2015 and 2016, while spending on administration (-2.1%) also fell during this period as well. At the same time, average annual growth in most other spending categories either picked up steam or remained broadly unchanged, causing overall spending growth to accelerate to 4.6% annually. 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 Manitoba's health spending rose over this period.

Chart 2: Growth in Health Spending by Category

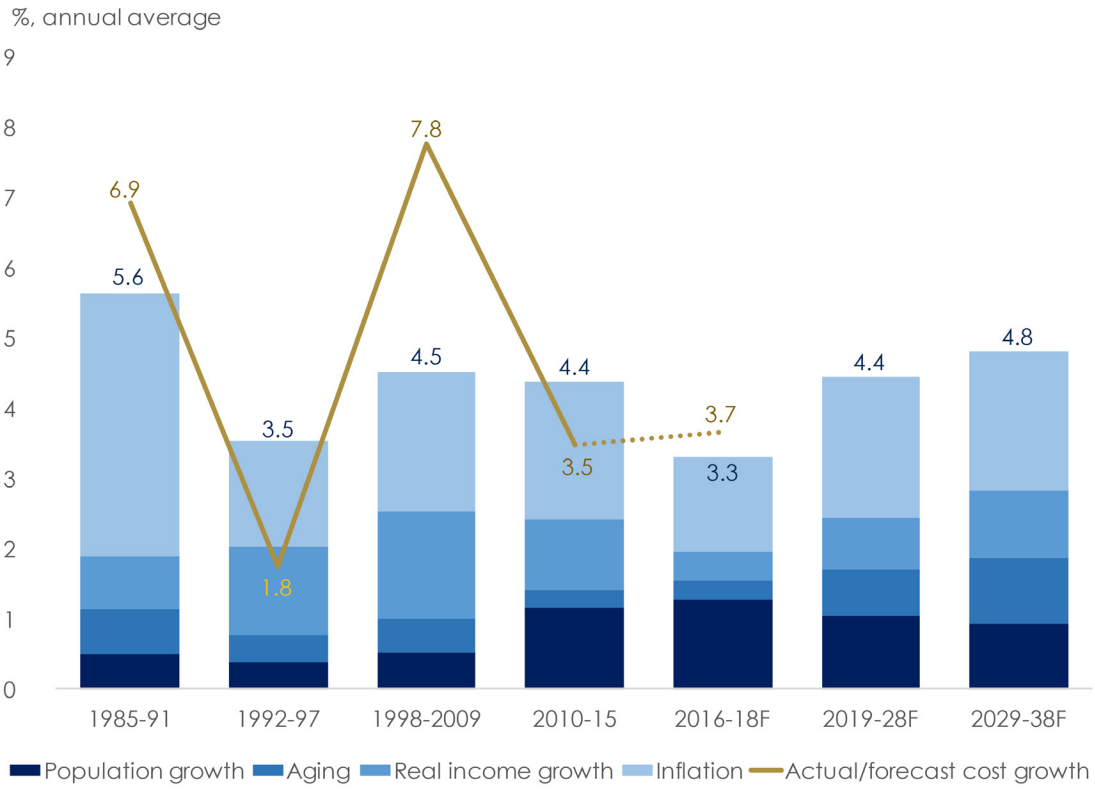


Source: Canadian Institute for Health Information, Institute of Fiscal Studies and Democracy.
Note: Years refer to fiscal years. Health facilities include hospitals and other institutions. Health professionals include physicians and other professionals. National health data by spending category is only 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 accelerate beyond the 3.5% annual average observed from 2010 through 2015, averaging about 3.7% annually for the 2016 to 2018 period. However, unlike other jurisdictions, the macroeconomic drivers of health care cost growth—population growth, aging, real income growth, and inflation—suggest that underlying cost

pressures will increase at a more modest average annual pace 3.3% (see Chart 3).[2] This modest advance in estimated notional costs is largely the result of Manitoba's relatively young population and low anticipated real per capita income growth. Due to its young population, the impact of aging on health care costs in Manitoba will be felt further into the future than is the case in other jurisdictions. This implies that Manitoba's health care cost drivers will gradually accelerate over the next 20 years as opposed to decelerating as in most other regions (see Table 1).

Chart 3: Growth in Actual versus Notional Health Care Costs



Source: Canadian Institute for Health Information, Manitoba 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 Manitoba

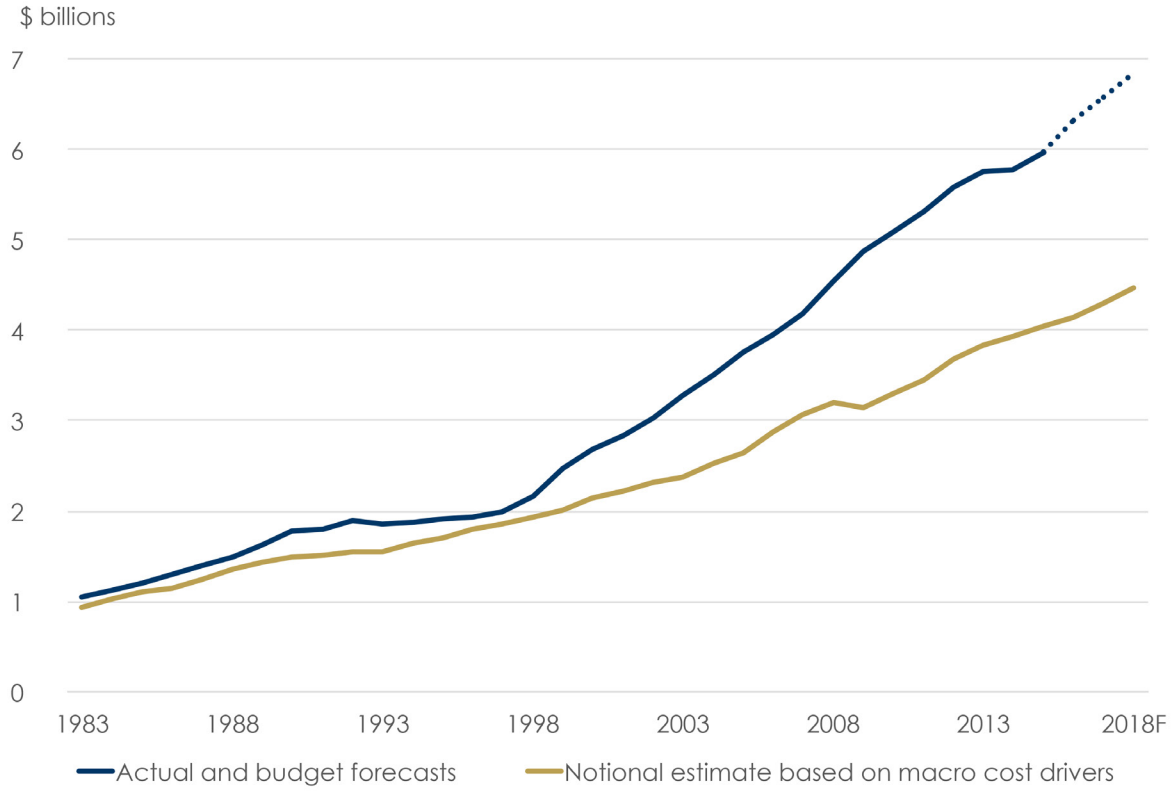
%, annual average	Actual/Budget	Enrichment*	Notional	Population	Aging	Real Income	Inflation
1985-1991	**6.9**	**1.3**	**5.6**	0.5	0.6	0.8	3.7
1992-1997	**1.8**	**-1.8**	**3.5**	0.4	0.4	1.2	1.5
1998-2009	**7.8**	**3.2**	**4.5**	0.5	0.5	1.5	2.0
2010-2015	**3.5**	**-0.9**	**4.4**	1.2	0.3	1.0	2.0
2016-2018	**3.7**	**0.4**	**3.3**	1.3	0.3	0.4	1.3
2019-2028			**4.4**	1.0	0.7	0.7	2.0
2029-2038			**4.8**	0.9	1.0	0.9	2.0

Source: Canadian Institute for Health Information, Manitoba 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.

[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.

Examining Manitoba's health spending in a historical context, it is clear that some cost containment is necessary to bring health care expenditures in line with where the underlying macroeconomic drivers would suggest they should be (see Chart 4). Annual health spending has exceeded the level suggested by the notional health care cost determined by macroeconomic fundamentals over most of the past 35 years, but particularly in the last 20 years. And this doesn't appear likely to change any time soon. As a result, Manitoba has one of the highest per capita costs of health care in Canada. According to the Canadian Institute for Health Information (CIHI), only Alberta, Newfoundland & Labrador, Saskatchewan, and the territories spend more per person. But, despite this spending, according to the Conference Board of Canada, Manitoba still receives one of the lowest grades for health status (see Table 2). Indeed, the conclusion that health outcomes are comparatively poor in Manitoba is supported by a broad collection of health care indicators compiled by CIHI.

Chart 4: Actual/Forecast Health Spending versus Notional Costs



Source: Canadian Institute for Health Information, Manitoba 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

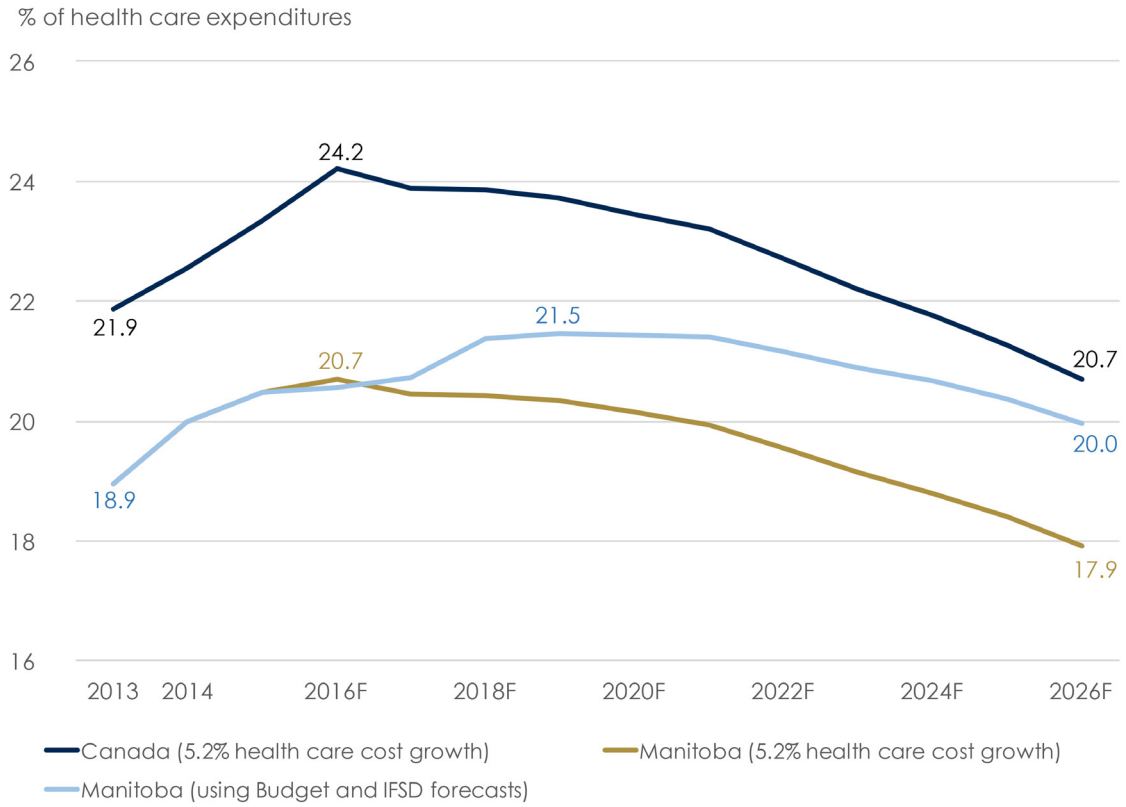
Ranking	Health Status (Conference Board)	Health Care System Performance (CIHI/IFSD)	Per Capita Cost (CIHI)
1	British Columbia	Ontario	Quebec
2	Ontario	Quebec	Ontario
3	Quebec	New Brunswick	British Columbia
4	Prince Edward Island	Prince Edward Island	New Brunswick
5	Alberta	Alberta	Nova Scotia
6	New Brunswick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

Table 2: Relative Ranking of Population Health Status, Health Care System Performance, and Per Capita Cost			
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. The IFSD has found that the Province of Manitoba 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 Manitoba's relatively high per capita cost of health care spending, health transfers make up a lower-than-average share of health care expenditures compared to other provinces. If Manitoba's health care costs were to advance by 5.2% annually, the federal share of health spending in Manitoba 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 Manitoba



Source: CIHI, Manitoba 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 Manitoba 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 Manitoba through 2019, federal funding will assume a broadly stable 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 below the 2016 level. And if the CHT were assumed to advance at a similar pace thereafter, the federal share of Manitoba's health spending would likely continue to decline.

Table 3: Federal Funding for Health Care in Manitoba

$ 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		**1.1**	**5.8**	**18.9%**
2014	**32.1**	32.1		**1.2**	**5.8**	**20.0%**
2015	**34.0**	34.0		**1.2**	**6.0**	**20.5%**
2016	**36.1**	36.1	0.0	**1.3**	**6.3**	**20.6%**
2017	**37.5**	37.1	0.4	**1.4**	**6.5**	**20.7%**
2018	**39.4**	38.4	1.0	**1.4**	**6.7**	**21.4%**
2019	**41.2**	39.9	1.3	**1.5**	**6.9**	**21.5%**
2020	**42.9**	41.4	1.5	**1.6**	**7.2**	**21.4%**
2021	**44.6**	42.9	1.7	**1.6**	**7.5**	**21.4%**
2022	**45.9**	44.4	1.5	**1.7**	**7.9**	**21.2%**
2023	**47.2**	46.0	1.3	**1.7**	**8.2**	**20.9%**
2024	**48.7**	47.6	1.1	**1.8**	**8.6**	**20.7%**
2025	**50.1**	49.2	0.9	**1.8**	**9.0**	**20.4%**
2026	**51.2**	50.9	0.3	**1.9**	**9.4**	**20.0%**

Source: CIHI, Manitoba 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

Manitoba's health care system is expensive and has poor outcomes relative to its peers, despite the provincial government having consistently spent more than would be suggested by the macroeconomic cost drivers. But the Government of Manitoba has managed to restrain health care expenditure growth somewhat in recent years, which is certainly a positive development. However, the growth path for health spending is expected to accelerate over the next few years, meaning the gap relative to where macroeconomic fundamentals suggest health care expenditures should be is likely to widen further. As a result, the CHT share of Manitoba's health spending is likely to remain broadly unchanged into the early part of the next decade. But this won't last long, as the macroeconomic health care cost drivers are expected to eventually be higher than the growth rate in the CHT. Consequently, the federal contribution to health spending will fall through 2026, forcing Manitoba 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 Manitoba should continue to reject the federal government's recent offer on health care funding and hold out for a better deal.