IFSD
IFPD

uOttawa

# Past, Present, Future

## Health Care Costs in Ontario

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 - Ontario

IFSD
IFPD

1 Stewart Street, Suite 206
Ottawa, ON K1N 6N5
613-562-5800 x 5628

ifsd.ca | info@ifsd.ca

uOttawa

## Key Points

- Over the past 30 years, health care spending in Ontario 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. However, spending restraint in recent years has contributed to the narrowing of this gap, supporting Ontario maintaining its status as the second lowest cost per capita jurisdiction 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. In Ontario during this period, average health care spending growth was below the national average (2.6% versus 3.4%, respectively), supporting the province's efforts to restore a budgetary balance. Notable differences between health spending growth in Ontario and Canada as a whole in 2010 through 2014 were on administration (3.1% versus 1.5%) and other health spending (3.8% versus 2.4%), as well as spending on health professionals (3.7% versus 5.0%). Restraint in capital expenditures (-3.1% versus -1.3%) pushed average annual health care cost growth in Ontario well below the national average, prompting concern that capital investment may be deferred until after budgetary balance targets are met. That said, overall, this restraint was broad based and distributed throughout the health system in a manner similar to that observed at the national level. Total health spending in Ontario slowed further in 2015 and 2016, as growth in most categories remained negative or decelerated relative to the prior period.

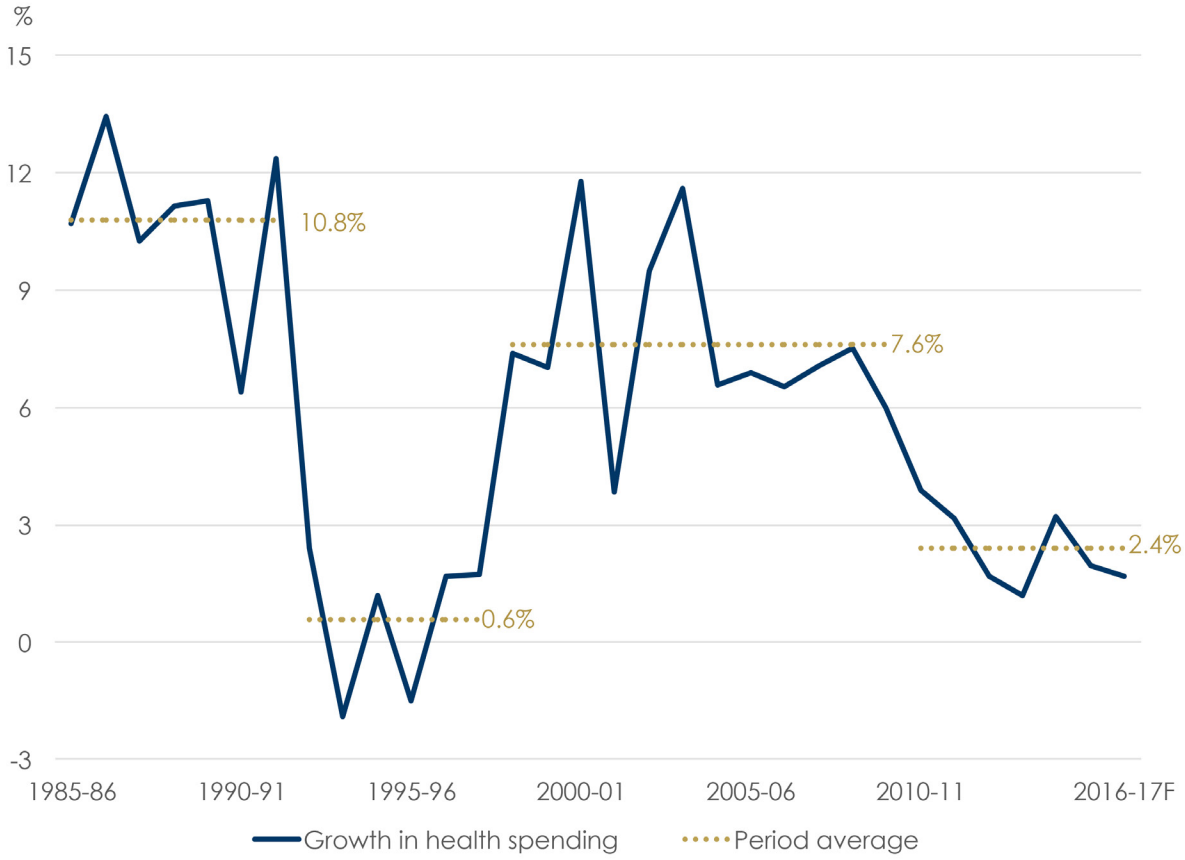
- In 2015, the Council of the Federation called on the federal government to commit to maintaining a 25% participation in provincial health care expenditures (excluding transfers from the equalization program). In order to meet this request, the provinces and territories asked the federal government 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 Ontario. 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 will have fallen below 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 Ontario 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 Ontario




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.

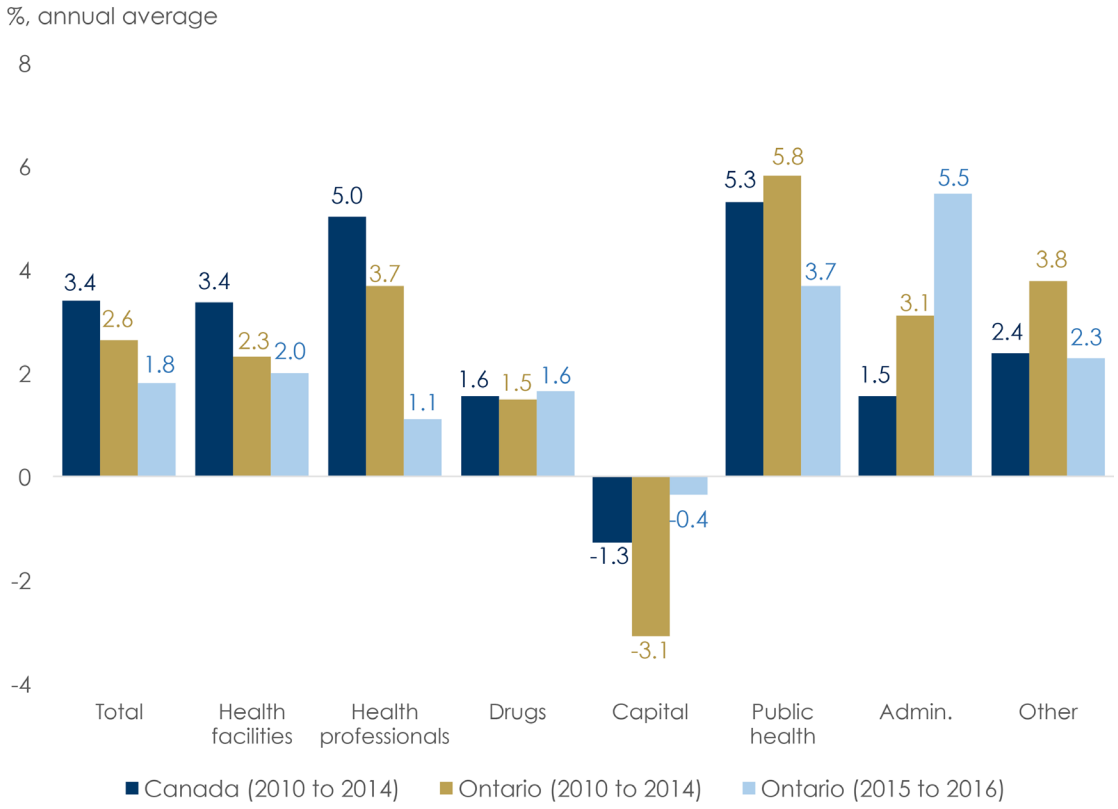
While each of these periods was characterized by very different economic and fiscal circumstances, they were also reflective of different underlying health care cost drivers in Ontario. For instance, the higher expenditure growth years of the 1980s were the result of significant increases in spending across the board, with the average annual growth in other health spending (20.3%), drugs (17.0%), public health (13.0%), and health professionals (11.6%) topping the list. Then, in the more austere years of the mid-1990s, health care expenditures averaged a paltry 0.6% annually, as spending on health facilities (-1.3%) and administration (-0.6%) contracted. Notably, spending on public health (9.8%), capital (7.0%), and drugs (5.4%) slowed but remained elevated over this period. 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 (13.4%), complemented by gains in expenditures on drugs (10.0%) and public health (9.7%), although growth accelerated in

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

most spending categories over this period.

Then the 2008–09 recession hit, and own-source revenue growth in Ontario 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 Ontario was constrained to only 2.6% annually (see Chart 2). A notable portion of the savings were found in reducing investment in capital (-3.1%), complemented by more modest restraint in all other areas of spending. However, spending on public health (5.8%), other health spending (3.8%), and administration (3.1%) remained above the national average over this period. Health spending in Ontario decelerated further in 2015 and 2016, with average annual growth hitting 1.8%. This was supported by further restraint in most categories, including capital investment (-0.4%) and administration (5.5%). 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 Ontario's health spending rose over this period.

## Chart 2: Growth in Health Spending by Category



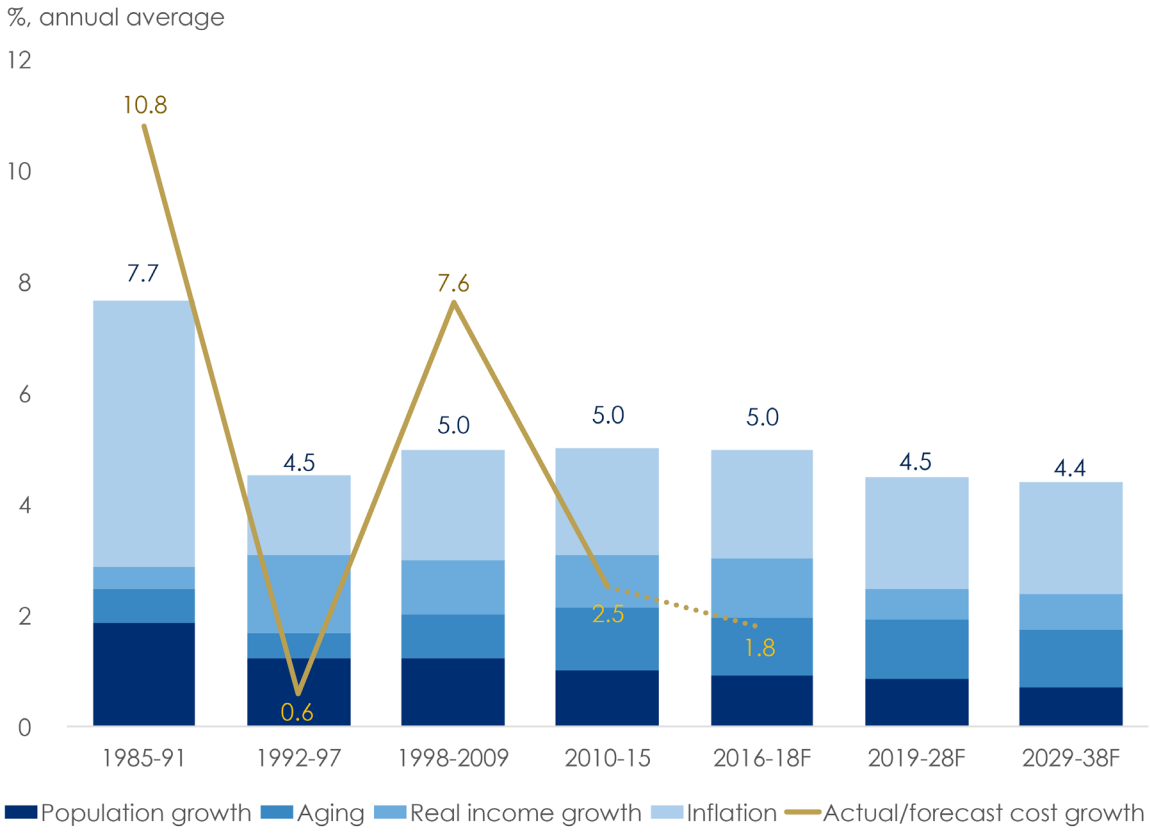

Source: Canadian Institute for Health Information, Institute of Fiscal Studies and Democracy.
Note: Years refer to fiscal years. Health facilities include hospitals and other institutions. Health professionals include physicians and other professionals. National health data by spending category is only 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 projected health care costs is expected to advance at a slower pace than the 2.5% 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 5.0% (see Chart 3).[2] This is well in excess of the average annual growth of 1.8% projected in official forecasts

[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.

for the 2016 to 2018 period. But, unfortunately, cost containment of this magnitude has never proven sustainable. It therefore warrants a word of caution, particularly as the recent savings have been partly tied to constrained capital expenditures in a period when aging is expected to keep sustained pressure on Ontario's health care system. And beyond 2018, cost pressures are expected to advance at an annual pace of roughly 4.5% for the subsequent 20 years (see Table 1).

## Chart 3: Growth in Actual versus Notional Health Care Costs




Source: Canadian Institute for Health Information, Ontario 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 Ontario**

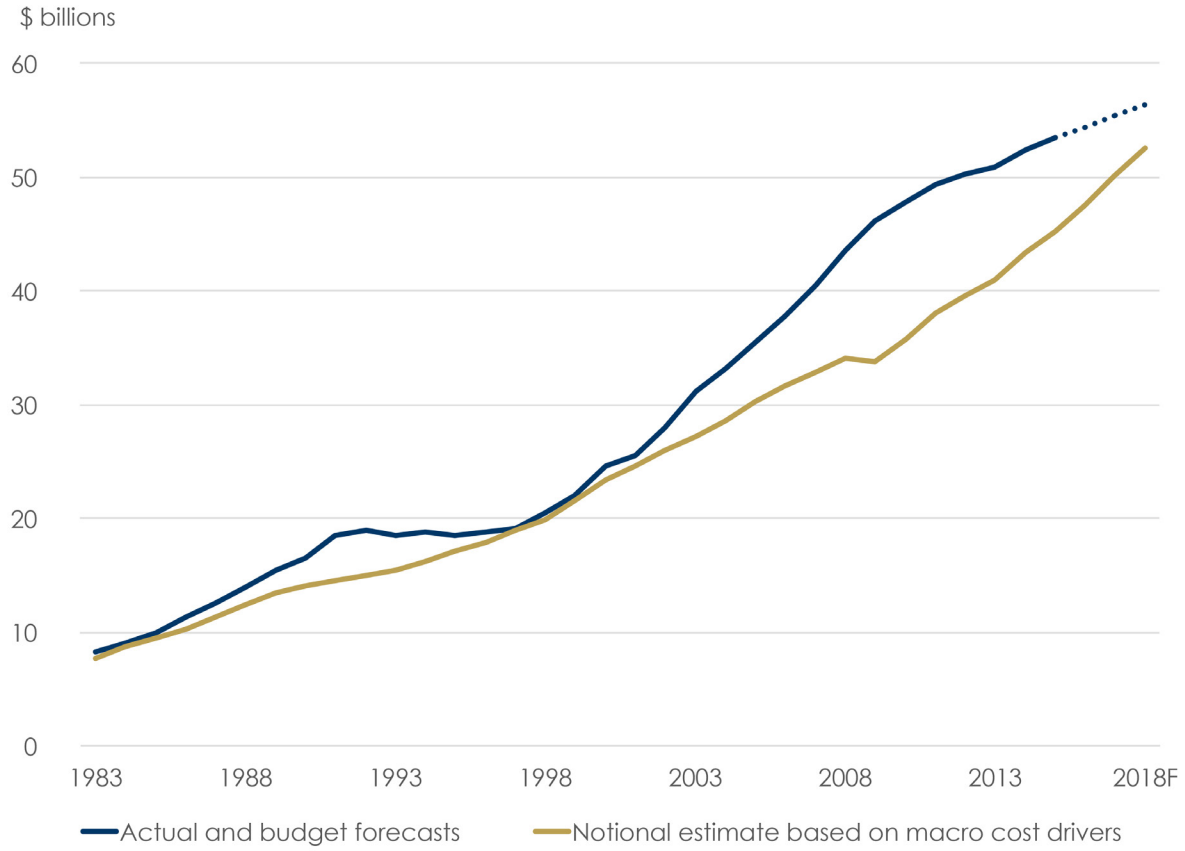
| %, annual average | Actual/Budget | Enrichment* | Notional | Population | Aging | Real Income | Inflation |
|---|---|---|---|---|---|---|---|
| **1985-1991** | **10.8** | **3.1** | **7.7** | 1.9 | 0.6 | 0.4 | 4.8 |
| **1992-1997** | **0.6** | **-3.9** | **4.5** | 1.2 | 0.4 | 1.4 | 1.5 |
| **1998-2009** | **7.6** | **2.6** | **5.0** | 1.2 | 0.8 | 1.0 | 2.0 |
| **2010-2015** | **2.5** | **-2.5** | **5.0** | 1.0 | 1.1 | 1.0 | 1.9 |
| **2016-2018** | **1.8** | **-3.2** | **5.0** | 0.9 | 1.0 | 1.1 | 1.9 |
| **2019-2028** | | | **4.5** | 0.9 | 1.1 | 0.5 | 2.0 |
| **2029-2038** | | | **4.4** | 0.7 | 1.1 | 0.6 | 2.0 |

Source: Canadian Institute for Health Information, Ontario 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.

Some key observations can be gleaned from the examination of actual historical costs and the notional costs based on macroeconomic fundamentals (see Chart 4). During the 1992 to 1997 period, as part of the Government of Ontario's efforts to balance its budget, actual health spending was brought in line with

the notional health care cost based on the macroeconomic cost drivers. Then, over the following period (1998 to 2009), a gap re-emerged, with health spending outpacing the underlying cost drivers. However, going forward, that gap is expected to narrow as health spending restraint continues, bringing annual health spending more in line with macroeconomic fundamentals. But despite this spending gap, according to the Canadian Institute for Health information (CIHI), Ontario has the second lowest per capita health care cost in Canada, after Quebec. Meanwhile, the Conference Board of Canada has given Ontario's health status a ranking similar to or better than most higher-cost jurisdictions (see Table 2). Indeed, this conclusion is supported by a broad collection of health care indicators compiled by CIHI, suggesting that Ontario's health care system peforms well while the per capita cost remains comparatively low.

## Chart 4: Actual/Forecast Health Spending versus Notional Costs




Source: Canadian Institute for Health Information, Ontario 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**

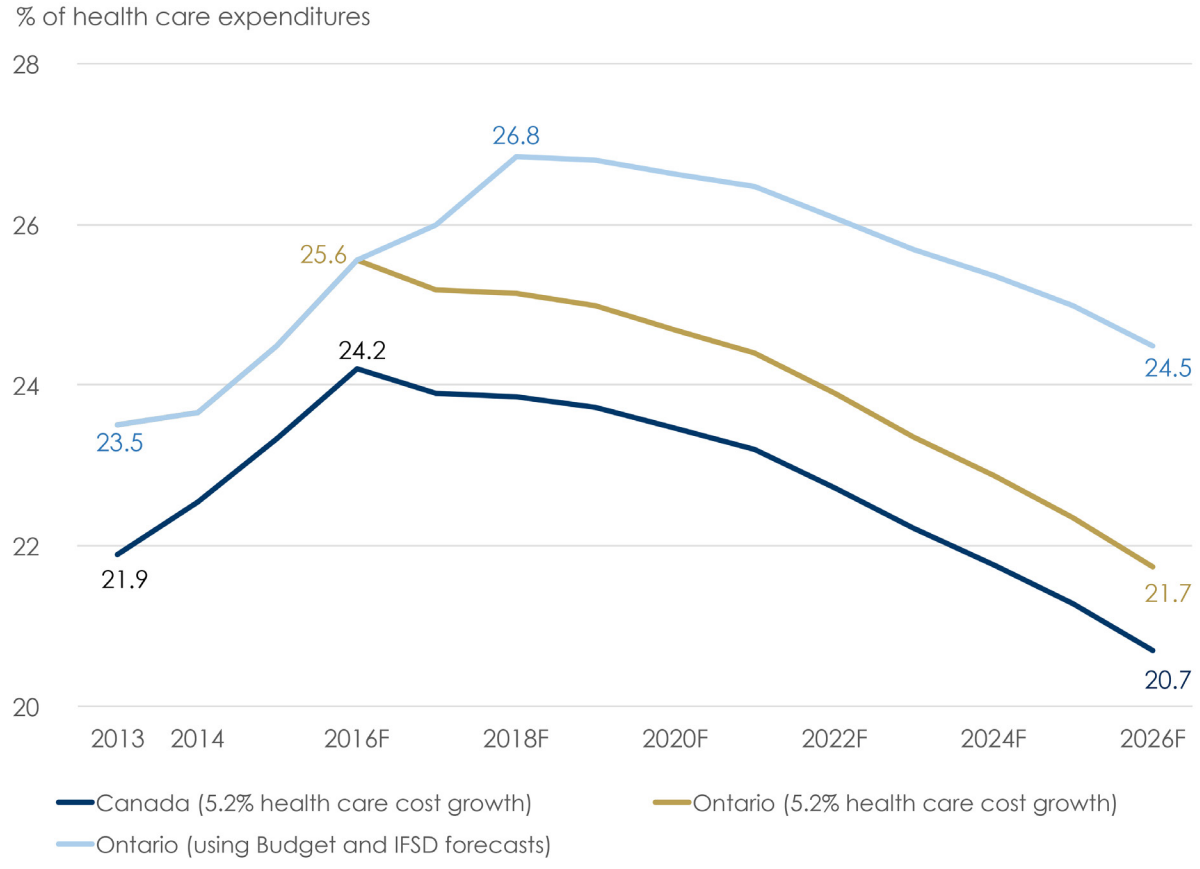
| Ranking | Health Status (Conference Board) | Health Care System Performance (CIHI/IFSD) | Per Capita Cost (CIHI) |
|---|---|---|---|
| 1 | British Columbia | **Ontario** | Quebec |
| 2 | **Ontario** | Quebec | **Ontario** |
| 3 | Quebec | New Brunswick | British Columbia |
| 4 | Prince Edward Island | 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 Ontario 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 Ontario'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 Ontario's health care costs were to advance by 5.2% annually, the federal share of Ontario'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 Ontario




Source: CIHI, Ontario 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 Ontario 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 Ontario through 2018, federal funding will assume an increasingly large portion of health care expenditures over the next few years (see Table 3). Then, starting in 2019, 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 the same pace thereafter, the federal share of Ontario's health spending would likely continue to decline.

**Table 3: Federal Funding for Health Care in Ontario**

| $ 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 | | 11.9 | 50.8 | 23.5% |
| 2014 | 32.1 | 32.1 | | 12.4 | 52.4 | 23.7% |
| 2015 | 34.0 | 34.0 | | 13.1 | 53.5 | 24.5% |
| 2016 | 36.1 | 36.1 | 0.0 | 13.9 | 54.4 | 25.6% |
| 2017 | 37.5 | 37.1 | 0.4 | 14.4 | 55.4 | 26.0% |
| 2018 | 39.4 | 38.4 | 1.0 | 15.1 | 56.4 | 26.8% |
| 2019 | 41.2 | 39.9 | 1.3 | 15.8 | 59.0 | 26.8% |
| 2020 | 42.9 | 41.4 | 1.5 | 16.4 | 61.7 | 26.6% |
| 2021 | 44.6 | 42.9 | 1.7 | 17.1 | 64.6 | 26.5% |
| 2022 | 45.9 | 44.4 | 1.5 | 17.6 | 67.5 | 26.1% |
| 2023 | 47.2 | 46.0 | 1.3 | 18.1 | 70.5 | 25.7% |
| 2024 | 48.7 | 47.6 | 1.1 | 18.6 | 73.5 | 25.4% |
| 2025 | 50.1 | 49.2 | 0.9 | 19.2 | 76.7 | 25.0% |
| 2026 | 51.2 | 50.9 | 0.3 | 19.6 | 80.1 | 24.5% |

Source: CIHI, Ontario 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

After pouring money into its health care system through the first decade of the 2000s, recent restraint on the part of the Government of Ontario has put health spending on a more sustainable path. And this trend toward greater cost savings is expected to continue if the Government of Ontario can reach its budget targets for future spending. However, there is some concern that a notable portion of this saving has come on the back of deferred capital investment, which may be just "kicking the can down the road", and will act to increase the cost to taxpayers in the future. That said, this trend does appear to have reversed somewhat in the past couple of years. The savings also mean that the CHT will make up an increasingly large share of Ontario's health spending through to 2018. 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 Ontario 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 Ontario should have rejected the federal government's recent offer on health funding and held out for a better deal.