

Understanding Canada's Health Care Costs

FINAL REPORT

(Executive Summary)

Provincial and Territorial
Ministers of Health

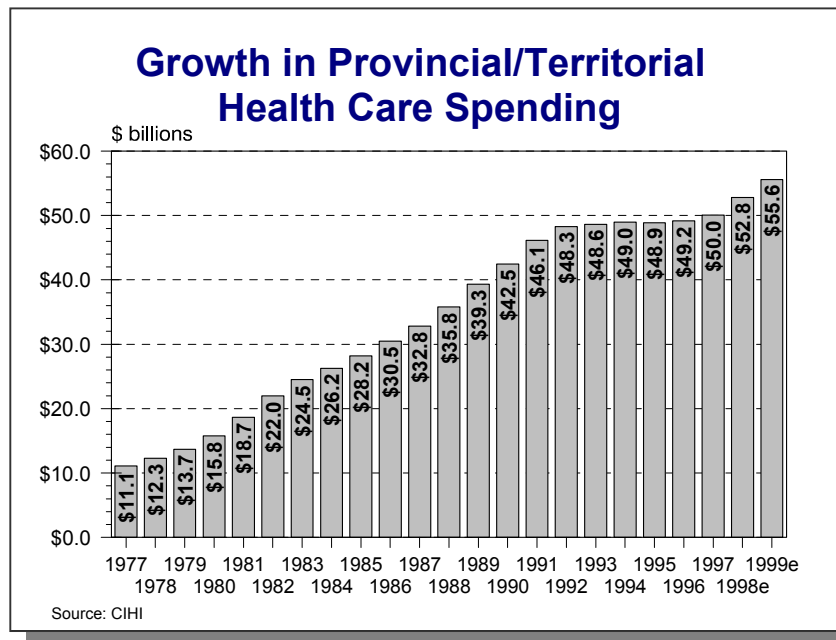
August 2000

Executive Summary

Canadians are concerned about the future of Canada's health care system and have consistently identified health care as their top priority. As key in the process of stabilizing and sustaining the health care system, Provincial and Territorial Premiers are unanimous in calling on the federal government to immediately and fully restore funding cut from the Canada Health and Social Transfer (CHST), and implement an appropriate escalator to ensure that funding for health and other social programs through the CHST keeps pace with the economic trends, social factors, and changing health technology, which impact on the sustainability of the system.

This report examines how the health care system is financed, provides an analysis of innovations that are already underway in provinces/territories and looks at the current and future cost drivers and accelerators in Canada's health system. The analysis shows how provinces/territories are already significantly involved in activities that are improving the quality of health care services provided to Canadians. It also illustrates the source and size of health care cost drivers, as well as the significant additional costs associated with health system renewal activities. It provides considerations for restoring confidence in the health care system.

Total provincial/territorial health expenditure in Canada increased from \$11 billion in fiscal year 1977/78 to \$56 billion in fiscal year 1999/2000.



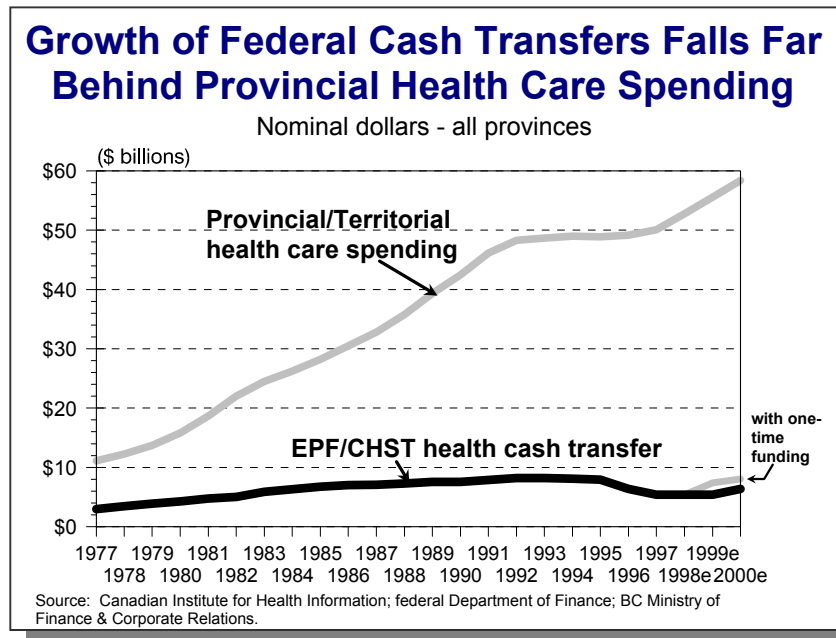
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Since 1996, provinces and territories have been reinvesting, partly to make up for the moderate growth in the early years of the decade. In the 1996 to 1999 period, increased spending on health care has averaged 4.2 per cent annually, the same as growth in the economy. Preliminary indications are that the provincial/territorial spending increase for 2000/01 is significantly higher than this.

A long-term look at spending on health care reveals a federal government withdrawing from its partnership with the provinces and territories by reducing its contribution to health care funding. This has resulted in a significant funding gap.

This funding gap represents the difference over time, between what the federal government has contributed to the health care system by way of its transfers to provinces and territories and what the provinces/territories have spent in meeting cost pressures. See chart below.

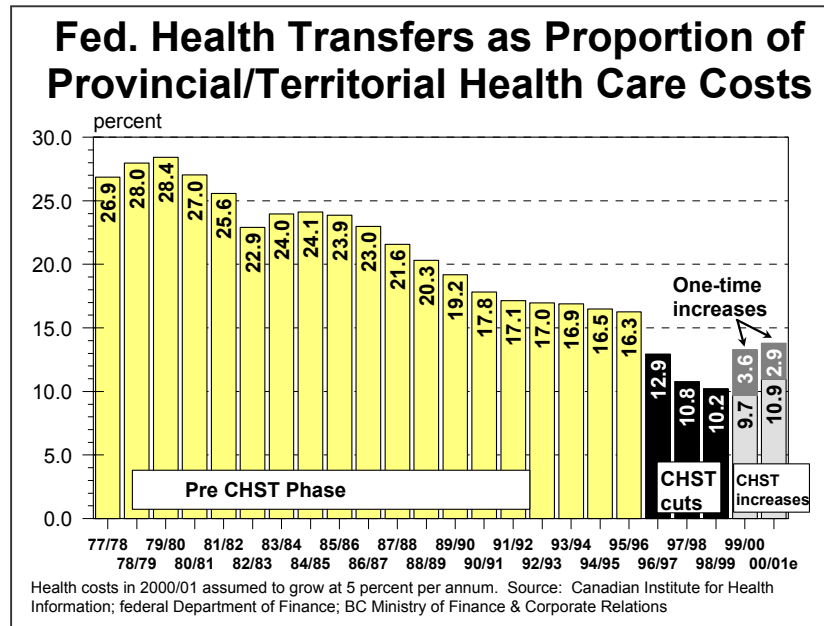


Since the beginning of block funding, the growth of health care spending—including the more moderate years of the middle 1990s—has averaged 0.8 per cent higher than the growth of the economy. Yet the highest escalator attained for block funding was one matching the growth in Gross Domestic Product (GDP) and this existed only for the first few years after the introduction of block funding in 1977. The period from the mid-1980s to the mid-1990s was one of reduced escalators and frozen transfer amounts. In this context, a greatly expanding gap was inevitable.

Further, the federal government made substantial cuts between 1994/95 and 1998/99 in the major transfer helping to fund health care and other social programs. Total federal spending on health care (transfers plus direct spending) declined from a peak of \$367 per capita in 1994/95 to \$269 per capita in 1998/99. The decline in federal spending on health care is also evident when measured against Gross Domestic Product (GDP). In 1977, federal spending on health care made up 1.4 per cent of GDP, compared to 0.9 per cent in 1998/99.

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As the chart below shows, the proportion of provincial/territorial health care costs offset by federal transfers has trended significantly downward since the start of block funding.



At their February 3rd 2000 meeting in Quebec City, the Provincial and Territorial Premiers called for the CHST to be restored by \$4.2 billion, with an appropriate escalator to ensure that funding for health through CHST keeps pace with the economic trends and social factors, which impact on the sustainability of the system. This request by the Provincial and Territorial Premiers is quite modest and reasonable. A consideration of the long history of block funding for health care could be used to make the case that the gap—between what the federal government is now contributing and what it might contribute—is significantly larger. For example, if the base CHST amount had been increased since 1994/95 by the comparatively modest increases in health care spending by provinces since that time, it would have been \$8.8 billion higher in 2000/01.

In addition to back-filling the funding gap, provinces and territories have also invested heavily in health system renewal and innovations, since the mid-1980s. Every province and territory has responded to changes in medical technology, emerging diseases and chronic conditions, changing medical practice patterns, new pharmaceuticals, and changes in the health needs of their citizens.

All provinces and territories have responded to these changes by implementing system renewal initiatives and innovations aimed at making their health systems more accessible, more appropriate and sustainable, while, at the same time, assuring that high-quality services continue to be provided. In addition, all provinces and territories have worked in partnership with health providers to identify efficiencies and productivity improvements.

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Overall, the broad range of provincial and territorial measures and initiatives demonstrate the commitment to “maintain, protect and enhance health status” of their respective citizens. Provinces and territories are committed to the development and continuance of a health system responsive to population health needs within the fiscal resources available to the provinces/territories.

These reforms have also been undertaken to modernize the health system to better serve Canadians. All provinces and territories are implementing health reform in all sectors of the system. These include improvements in the delivery and management of hospital care, improving the access to physician services and primary care, rapid expansion of home care and other community services, investments in long-term care, and improving access to new technologies, including acute care and drug therapies. While these are being implemented at different paces, the direction of reform and investment is consistent. It can be concluded that:

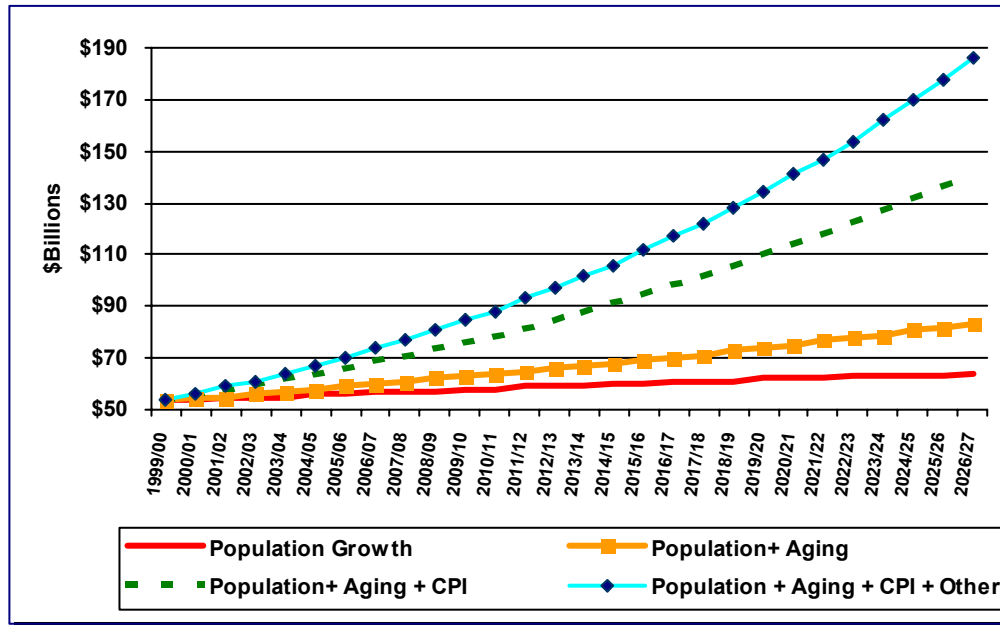
- The purpose of health reform is not to reduce spending levels. It is to improve access, quality and cost effectiveness. It may also help moderate future growth curves.
- Reforms will require significant investments.
- Provinces and territories will continue to identify cost efficiencies, however, it will be extremely difficult to replicate the efficiencies gained in the 1990s in the near term. Cost pressures will continue at a rapid rate.
- It is vital that any application of reforms be flexible, allowing for unique needs and program mixes of individual provinces and territories.

This report also shows that Canadians continue to be well served by their health system. Canada's publicly funded health care system is not in crisis, but the cost pressures and constraints on the system are real. Every province and territory faces a growing demand for health care services fuelled by demographics, new technologies, pharmaceuticals, and other growing costs of providing service.

As the report illustrates, the rising need for additional health services is not sustainable without significant new federal funding. Recent provincial/territorial health care budgets have risen well in excess of inflation, population growth, or the economy. Provincial and territorial health expenditures for Canada are currently close to \$56 billion. Even with modest changes in the pattern of service delivery, basic factors (population growth, aging, inflation, rising costs for current programs) are projected to increase health expenditures by approximately five per cent per year. This means provincial and territorial health services expenditures will be \$67 billion within five years and almost \$85 billion within ten years. However, the report also shows a number of cost accelerators have the potential to raise the growth of costs well in excess of those numbers.

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Canada – Health Operating Expenditure Base Scenarios



Examples of accelerators include: emerging and new technologies (such as major joint surgery, neonatal and fetal technologies, dialysis, organ transplantation, genetic testing and therapy), and increased incidence of chronic and new diseases such as heart disease, diabetes, tuberculosis, Hepatitis C, HIV, and AIDS. In addition, new pharmaceuticals, declining productivity gains, and changing expectations will also impact on costs.

It is clear that provinces and territories will have to continue to actively manage the system and seek further productivity measures to help address the magnitude of expenditure pressures and to meet future demand. The public will also need to make informed choices for appropriate use of the system.

It is equally clear that provinces and territories cannot sustain these cost pressures alone. Sustainability requires a federal funding commitment to an immediate, unconditional, and full restoration of the Canada Health and Social Transfer. It also requires federal recognition of the tremendous cost pressures facing the system and, therefore, an appropriate escalator for federal funding through CHST is essential.

Canadians expect their governments to take the necessary actions and work together to ensure confidence in the publicly funded health care system. Provinces and territories are sending a clear signal that they are willing to work with the federal government to meet this Canadian priority