Intelligence MEMOS

From: Colin Busby and Aaron Jacobs

To: Federal and Provincial Health Ministers

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Re: BEWARE THE ALCHEMY OF AGE-ADJUSTED HEALTH TRANSFERS

With Health Accord negotiations between the provinces and Ottawa underway, at its annual general meeting the Canadian Medical Association endorsed a federally-funded "top-up" for provinces coping with older-than-average populations.

It's well-known that older patients cost more than younger ones: those in their 70s and 80s incur roughly five times the health costs of those in middle age. Some provinces, notably in Atlantic Canada, now have a much larger share of their population in these age brackets than others.

Our calculations show that on the basis of age alone, health costs are currently about 6 percent higher than average in New Brunswick and Nova Scotia, and a whole 11 percent lower in the relatively young province of Alberta. These differences will grow further over time: by 2035, health costs in New Brunswick will be 16 percent higher by this same measure, and 14 percent lower in Alberta.

Although there is a compelling case that provinces with older populations will find it more expensive to deliver health services than relatively younger provinces, it's not clear how the federal government should actually go about adjusting the Canada Health Transfer (CHT) to account for age.

If they adjust transfers in a revenue-neutral manner, it would mean chopping hundreds of millions off of its yearly support for Alberta, mostly for redistribution among the Atlantic provinces.

A top-up approach that ensures no province sees any decline in transfers would, once accounting for the full cost variation between provinces based on population-age profiles, see transfers to the provinces could rise nearly 13 percent.

Further, depending on the top-up criteria, there is tremendous risk that we entrench the inefficient ways in which eldercare is delivered to Canadians.

The most important argument against age-adjusting health transfers is that it opens the door to calls for adjusting other inequities in the costs of delivering health services. For example, it generally costs more to deliver healthcare in rural regions, so provinces with more rural populations will want a top-up as well. The same can be said for provinces with relatively larger aboriginal populations, greater prevalence of chronic diseases, child poverty, and so on.

International experiences bear out this concern. In addition to ageing, England adjusts its transfer formula by the share of the elderly who live alone in a given region; Denmark by the number of single parents; and Belgium by the regional unemployment rate, among other factors.

Although achieving greater equity across the provinces with federal transfers is a critical objective for policymakers, opening up the CHT to age adjustment may cause as many new problems as it solves.

That said, evidence suggests that some provinces may, over time, see their finances deteriorate to the degree that a federal bailout is required. In light of this threat, we should consider imperfect solutions. One is a separate fund, like a block grant, set at a fixed amount per senior, to help relatively older provinces with the costs of servicing aging populations.

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