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HEALTH POLICY

## Managing Healthcare for an Aging Population: Does the Demographic Glacier Portend a Fiscal Ice-Age in Ontario?

by

Colin Busby and William B.P. Robson

“If we do not seize the opportunity now to begin creating a system that delivers more value for the money we spend, Ontarians a decade or two hence will face options far less attractive than the ones we face today.... [T]hey will be confronted with steadily escalating costs that force them to choose either to forgo many other government services that they treasure, pay higher taxes to cover a relentlessly growing health care bill, or privatize parts of the health care system....” Commission on the Reform of Ontario’s Public Services. *Public Services for Ontarians: A Path to Sustainability and Excellence* (Ontario 2012, p. 27).

The fiscal impact of demographic change – in particular, whether providing publicly funded healthcare to an aging population will financially stress Canadian governments – has prompted years of debate. One camp, developing a theme that the pressures are a glacier rather than an avalanche, has emphasized that aging itself adds no more than 1 percentage point to annual increases in health costs, and argued that it creates no urgency around reforms to treatment or financing (Barer et al. 1995; Evans et al. 2001). If taxes can rise and curbing provider compensation can restrain costs, the system is, in a familiar phrase, as sustainable as Canadians want it to be.

The other camp has emphasized that 1 percentage point annually is large when it compounds over many years – and, moreover, that aging will slow the growth of the tax base, potentially

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This E-Brief is part of a series profiling the fiscal challenge of aging and publicly funded healthcare in each province. We gratefully acknowledge the support of Alexandre Laurin in calculating program costs, and thank Don Drummond, Herb Emery, Livio Di Matteo, Seamus Hogan, Al O’Brien, Paul Kershaw, Stuart Langdon, Mel McMillan, Kevin Milligan, John Richards, an anonymous reviewer, our colleagues at the C.D. Howe Institute, and the members of the C.D. Howe Institute’s Fiscal and Tax Competitiveness Council and Health Policy Council for comments on earlier drafts. We are responsible for any errors and the conclusions.



compromising other major government programs, manageable tax rates, and debt control (Robson 2001, 2007, 2010; Drummond and Burleton 2010; Dodge and Dion 2011; and Emery et al. 2012). Glaciers may move slowly, but they transform a landscape: this view tends to see the current system as unsustainable, in the sense that avoiding a painful collision between key fiscal priorities requires fundamental changes to healthcare financing and delivery.

While the debate has raged, publicly funded healthcare in Ontario has risen from 6.3 percent of provincial GDP in 1991 to about 7.8 percent in 2012. At the same time, it has risen from 38 percent of the provincial government's program spending in 1991 to about 44 percent in 2012, and its share of provincial own-source revenue – that is, revenues that Ontario controls rather than funds transferred from Ottawa – has risen from 52 percent to about 56 percent.

Whatever the precise impact of aging and its interactions with changes in treatment, publicly funded healthcare's claim on provincial resources has increased. The above observation from the Commission on the Reform of Ontario's Public Services highlights the potential importance of that trend to the province's fiscal future and to the quality of publicly funded healthcare Ontarians receive.

## Mapping Today's Spending onto Tomorrow's Population

Our projections of future healthcare spending in Ontario use a well-known, straightforward approach. We project Ontario's population using the following middle-of-the-road assumptions: a fertility rate stable at its 2010 level; longevity rising in line with Statistics Canada's "medium" improvement scenario; net inter-provincial in-migration falling to zero over 10 years, and international in-migration continuing at its 1997-to-2011 average.

We then multiply the potential workforce, which we define as Ontarians aged 18 to 64, by an index of output per potential worker – which grows at the rate recorded by the equivalent national measure from 1997 to 2011: 1.2 percent annually. This provides our model with projections of real gross domestic product (GDP) for Ontario. Nominal provincial GDP is real GDP times the same 2 percent inflation rate we assume will prevail nationally.

Turning to the cost of demographically sensitive government programs, we project provincial spending on healthcare for 20 age groups of each sex across six types of spending. Per-person expenditures for each of these groups grow according to a measure of volume of services delivered and a cost index. The volume measure – an index of service intensity – represents spending on all services provided to a person by the publicly funded healthcare system, adjusted to remove the effects of inflation. Our base figures for these per-person numbers are the Canadian Institute of Health Information (CIHI) figures for 2010, pro-rated to match recent actual totals.<sup>1</sup> Looking forward, we assume that service intensity per person rises at the same rate as real output per potential worker – 1.2 percent annually (see Box 1). We also assume that costs rise at the pace recorded by the government consumption price index nationwide from 1997 to 2011 – 2.4 percent annually.<sup>2</sup>

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- 1 For our projections, we use the actual CIHI age and sex spending by health category for 2010, and prorate these amounts to correspond with the actual and projected health spending results using the most recent public accounts and budget documents, for 2011 and 2012. This method yields a slightly larger increase in spending for 2011, and 2012, than the CIHI estimates.
  - 2 During this period, the Bank of Canada targeted 2 percent inflation, and achieved an annual average increase in the consumer price index of exactly 2 percent. The overall price index for government consumption rose 2.4 percent annually over the same period. We assume the same margin will prevail in the future.

## Box 1: Projecting Other Demographically Sensitive Program Costs

We use similar projection methods – multiplying relevant populations by program-specific indexes of service or transfer intensity – for all the programs we examine.\*

We assume that service intensity – the volume of services delivered per person in healthcare and education – rises at the same rate that output per working age person in the economy as a whole does. This assumption is not entirely arbitrary: absent good quantitative measures of quality of output, measures of activity in unpriced services such as health and education tend to be driven by inputs, and these are labour-intensive activities in which wages – which tend to rise with economy-wide productivity – are a key input. Historically, service intensity has grown at annual rates above the 1.2 percent we assume, and faster than productivity growth. We prefer to link them in our main projection in order to ensure that trends upward or downward in the shares of health and education spending in GDP are not a function of different assumptions about service intensity on the one hand, and productivity growth on the other, but rather products of demographic change and the tendency for cost inflation in government consumption to outpace cost inflation elsewhere – an assumption that is explicit in our projections.

Our index of transfer intensity for seniors' benefits is derived from the Office of the Chief Actuary's projections of spending on Old Age Security, the Guaranteed Income Supplement, and Allowances per person age 65 and up. Because many of those programs are geared to income, and the Chief Actuary's model assumes that incomes rise over time, this index tends to fall somewhat in real terms. To the extent that Ontario's benefits for seniors differ from federal ones, this projection will not provide an accurate picture of the provincial outlook – but seniors' benefits are small enough in Ontario that this is not a serious problem. Our index of transfer intensity for child and family benefits does not change over time: we assume that the real value of transfers per person in the relevant age group is constant.

### Further notes on the projections for programs other than health:

*Education:* Base-year provincial/local spending on elementary and secondary education is calculated using data from Statistics Canada's Summary of Public School Indicators for the Provinces and Territories, 2005/06 to 2009/10.). Base-year spending on postsecondary education comes from Statistics Canada (CANSIM, table 385-0001). Provincial populations aged 4 to 17 and 18 to 24 drive provincial spending on elementary and secondary students respectively. We multiply these populations by our indexes of service intensity. The population under 17 drives the federal Canada Education Saving Grant, while the population aged 18 to 24 and service intensity drive federal grants to postsecondary students. We multiply these by an unchanging index of transfer intensity.

*Elderly benefits:* Base-year federal spending is from the public accounts; base-year provincial spending is from Statistics Canada's Social Policy Simulation Database and Model (SPSD/M), Release 20.0 (responsibility for use and interpretation rests with the authors). As just noted, provincial payments assume the same time-path of transfer intensity for provincial elderly populations.

*Child/family benefits:* Spending on the federal Universal Child Care Benefit varies with the national population of children to age 5; spending on other child-related benefits varies with relevant populations up to age 17. We assume unchanging indexes of transfer intensity. Federal family benefits delivered through the tax system, while indexed to inflation, are income-tested, so real income growth erodes their real value. SPSP/M simulations suggest that in the scenarios modeled here, these offsetting characteristics leave average nominal spending per child unchanged – an assumption that has also been made for (generally much smaller) provincial programs.

\* For more background information on the methodology used and the terminology see Robson (2002) and Drummond and Burlleton (2010).

Because demography affects other programs, we use similar methods – indexes of service intensity in the case of education, and indexes of transfers for elderly and child/family benefits – multiplied by relevant populations and price indexes to project spending on them also (Box 1 spells out our approaches for health and these other programs in more detail). We can thus see whether these programs offset, or exacerbate, any fiscal challenge healthcare presents to Ontario.

## Ontario's Outlook: Trends and Implicit Liability

Our projections show the claim of Ontario's public healthcare spending on provincial GDP rising from 7.8 percent this year to 12.0 percent in 2035 and to 16.1 percent in 2062. Taking account of other demographically sensitive programs does not change the message of fiscal stress. In Ontario, spending on seniors' programs represents an implicit liability and spending on child/family benefits an implicit asset, because of a projected decline in the proportion of the population that is young. These programs are very small, however. In education, service intensity creates upward pressure even as the number of students plateaus. As a result, the share of all these programs in GDP rises from 14.1 to 23.3 percent over the period (see Figure 1). For Ontario to meet these demands from its own revenue sources would require an increase of more than 60 percent in the provincial tax bite from Ontarians' incomes.

Another perspective on the fiscal pressure of rising healthcare costs is intergenerational: the transfer implicit in a "pay-as-you-go" approach when a program's costs are not stable. Most public discussion of healthcare and other programs emphasizes maintaining them – perhaps enhancing, but certainly not cutting. Explicit warnings about higher future taxes have not figured in recent messages from the Ontario government. These political understandings create an implicit liability on the government's balance sheet, because meeting the commitment will require the government to tax a higher share of provincial income in the future.<sup>3</sup>

One way to quantify this liability is to calculate the present value of changes in these programs' claims on GDP over the next half-century, which is roughly the average life expectancy of the average Ontarian. Discounting the cumulative increase in the province's average tax take from its current level at the yield on government long-term bonds, the province's implicit liability amounts to \$1.5 trillion, nearly all of which (\$1.4 trillion) relates to healthcare (see Table 1).<sup>4</sup> In other words, to cover the additional cost of these programs, the province would need about \$1.5 trillion in assets yielding what its long-term bonds do. This figure is more than double provincial GDP, and about \$110,000 per Ontarian.<sup>5</sup>

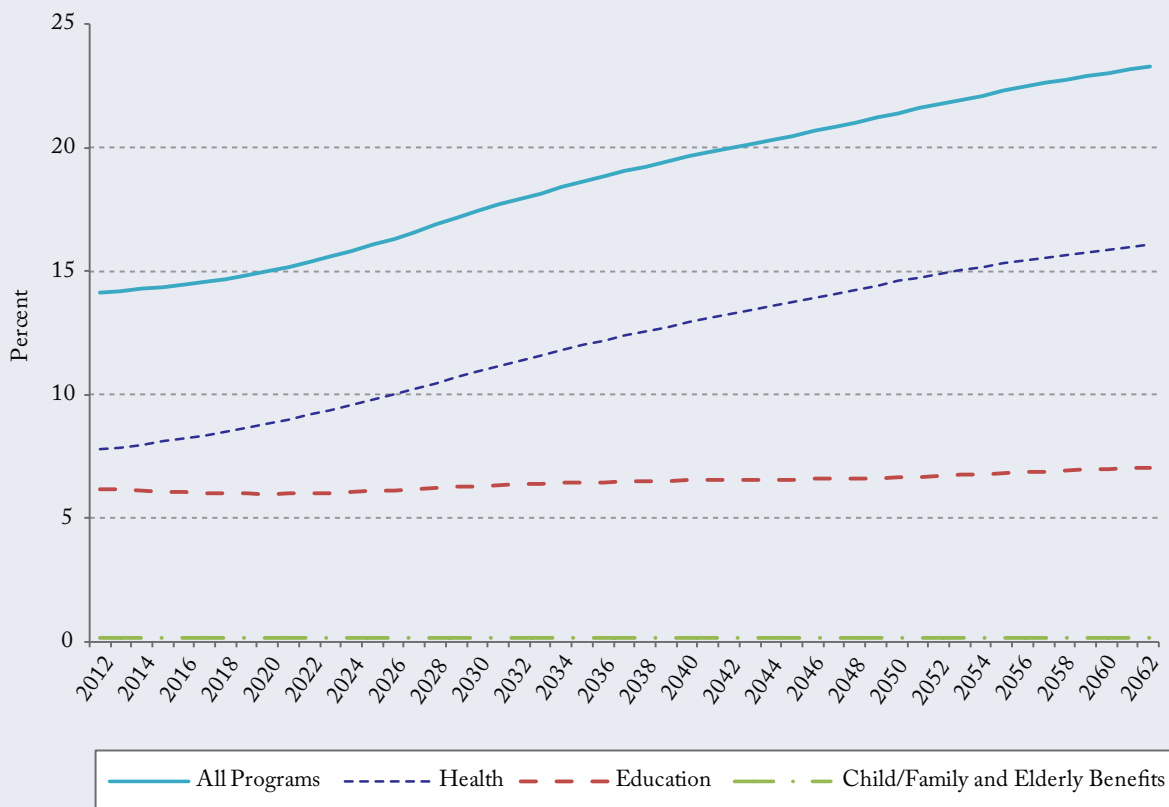
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3 The parallel with explicit liabilities is straightforward: if Ontario decided to cover the higher program costs by borrowing rather than raising its aggregate tax rate, the implicit liability would, over time, become higher public debt.

4 As we explain in Box 1, the labour-intensiveness of healthcare (and education) services provides some justification for linking service intensity to economy-wide productivity. The assumption that both grow together is clearly critical to our results. Should Ontario manage to constrain growth in service intensity to 0.5 percentage points less than growth in productivity – 0.7 percent annually, rather than the 1.2 percent we assume in our projections – demographically sensitive spending would be 17.9 percent of GDP in 2062 and the unfunded liability would be \$0.7 trillion. Historically, service intensity has tended to outpace productivity: if Ontario let it grow 0.5 percentage points faster – 1.7 percent annually – demographically sensitive spending would be 29.3 percent of GDP in 2062 and the unfunded liability would be \$2.3 trillion.

5 This exceeds the \$1.1 trillion calculated in Robson (2010) mainly because of the lower discount rate used in this study. The long-term Ontario bond yield stood at 4.5 percent then; in this study, we use a more up-to-date 3.5 percent.

Figure 1: Ontario's Demographically Sensitive Programs as a Share of GDP, 2012-2062



Source: Authors' calculations as described in text.

## Policy Pressures and Responses

We see a funding gap this big, and the prospect of such a massive increase in Ontario's tax take, as strengthening the case for continuing changes to Ontario's healthcare system, such as those recommended by the Commission on the Reform of Ontario's Public Services.

Because Ontario has become a recipient province under the equalization program, and has long-standing complaints about less generous treatment in federal-provincial transfers, a quest for relief through larger payments from Ottawa might appear sensible or justified. Scanning our results for Ontario and other provinces in Table 1, however, suggests that similar and often worse pressures will exist across Canada: all provinces have high ratios of implicit liability to GDP, and many are higher than Ontario's. So significantly larger net transfers to Ontario through the federal government are unlikely.

We therefore agree with the Commission that these fiscal pressures will have repercussions in Ontario, and think that proactively addressing them makes sense. How might Ontario do that?

**Table 1: Ontario's Demographically Sensitive Programs, Implicit Liabilities in a National Context**

	Health	Education	Elderly Benefits	Child/ Family Benefits	All Programs	All Programs Relative to GDP (2012)	All Programs Per Person
	<i>\$ Billions</i>					<i>Percent</i>	<i>\$</i>
BC	415.2	6.4	0.4	(0.1)	421.9	192	91,474
AB	615.4	65.0	13.6	(0.8)	693.2	227	180,332
SK	82.0	15.3	0.3	-	97.6	131	91,897
MB	100.8	15.4	0.1	(0.1)	116.3	197	92,493
<b>ON</b>	<b>1,398.3</b>	<b>89.8</b>	<b>2.4</b>	<b>(6.3)</b>	<b>1,484.2</b>	<b>223</b>	<b>109,920</b>
QC	767.7	79.0	-	(17.3)	829.4	242	103,344
NB	78.2	5.5	0.4	(0.1)	84.0	266	111,745
NS	99.1	2.4	0.2	-	101.7	263	107,713
PE	14.0	0.6	-	-	14.5	269	99,244
NL	75.3	4.5	0.9	(0.1)	80.6	240	158,905
YK	9.0	0.6	-	-	9.5	369	263,744
NT	12.5	1.4	-	-	13.9	278	321,187
NU	13.8	1.6	-	-	15.4	801	457,690
All Provinces and Territories	3,681.3	287.3	18.3	(24.6)	3,962.3	222	113,935
Federal		(13.5)	424.7	(25.0)	386.2	22	11,105
<b>CANADA</b>	<b>3,681.3</b>	<b>273.8</b>	<b>443.0</b>	<b>(49.6)</b>	<b>4,348.5</b>	<b>244</b>	<b>125,040</b>

Source: Authors' calculations as described in text.

## The Case for Prefunding

One way to mitigate the impact of rising costs in some healthcare services would be to follow the lead of the late-1990s reforms to the Canada and Quebec Pension Plans that converted them from pay-as-you-go to plans in which a portion of premiums collected today prefunded the benefits of those same participants in the future. Some drug programs, and potentially long-term care as well, are like social security programs that many people will need, and can prepare for by building a provident fund during their younger years.

Ontario could selectively convert pay-as-you-go programs so that the babyboomers, rather than their inadequately numerous children and grandchildren, pay some of the higher costs that loom (Robson 2002; Stabile and Greenblatt 2010). Prefunding does not make sense for all the programs that threaten cost increases, but can spread more fairly over time the tax increases necessary for some health services that, like pensions, are geared to age.<sup>6</sup>

## Reducing Healthcare Spending's Sensitivity to Aging

Unlike pensions, which are promises to pay dollars, healthcare promises services, the cost and quality of which are not fixed. The camp that says aging by itself is not a major problem has tended to emphasize that some factors that gear healthcare spending so strongly to age, such as high rates of hospitalization or use of certain drugs, may change over time (Evans et al. 2001). Policy can also straightforwardly affect the links between demography and healthcare spending: making drug benefits contingent on income rather than age, for example. Such changes could mitigate the demographic effects in our model.

While such changes are possible in the future, they do not appear to have had much impact on the age-profile of provincial healthcare spending in Ontario since CIHI's first data in 1998. While a comparison of 1998 to 2010 (see Figure 2) shows some variations by age-group, the overall profile in 2010 has changed very little. A 1998 projection of the impact of demography on Ontario's healthcare spending by 2010 would have been almost spot on. Changes are certainly possible, but they will require more conscious effort than in the past.

## Benchmarking Best Practices

Where might Ontario look in its search for more bang per healthcare buck generally and for more efficiency in spending on an older population particularly? Among the possibilities, many figuring in Commission's report, are:

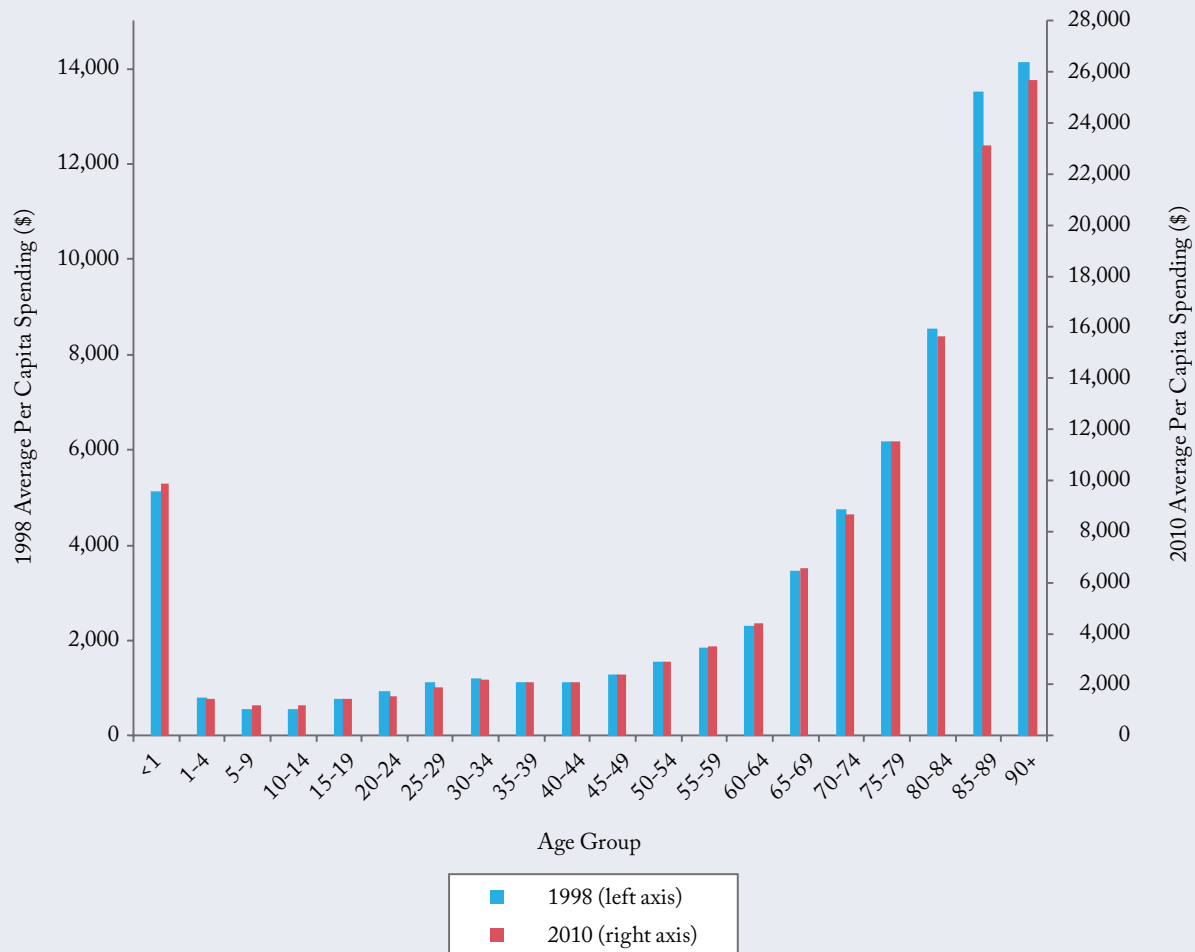
- scope-of-practice changes that would allow less expensive specialties such as pharmacists and nurse practitioners to provide services currently, and unnecessarily, performed by more expensive physicians;
- better use of information technology, particularly in coordinating patient health records;
- improvements in, and more use of, non-institutional care for seniors with chronic conditions; and,
- better follow-up care for patients discharged from hospital to cut down on complications and readmissions.

Turning to various delivery vehicles, Canada's provinces exhibit large differences in spending in major categories that may yield useful insights for Ontario.

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<sup>6</sup> Busby and Robson (2010) explore some prefunding possibilities, and their mechanics, in more detail.

Figure 2: Average Per Capita Health Spending By Age Group, Ontario, 1998 and 2010



Note: The vertical axes show nominal dollars for transparency's sake: these are the actual dollar figures from CIHI. We could have used constant dollars from either – or, indeed, any – year, or index numbers, because the focus of this figure is the *relative* distribution of health spending by age in the two years. To facilitate comparison of the age-profiles of spending: we have set the vertical scales so roughly half the bars in each year are taller (or shorter) than their counterparts in the other.

Source: CIHI (2012) and authors' calculations.

Ontario spends less than any other province on hospitals and has relatively low administrative costs. By contrast, Ontario spends more on drugs and physicians. We know more about cost than we do about quality: Ontarians may get appropriately greater value from their physicians than other provinces do, but we do not know. More rigour in addressing that and related questions is clearly vital alongside current efforts to curb rising costs in negotiations with providers.



## Closing Comments

A casual attitude toward the impact of demographic change on Ontario's provincial budget is unwarranted. The projected growth of health and other demographically sensitive spending represents an implicit liability much larger than the provincial debt that itself is raising serious concerns, and threatens a major increase in the provincial government's draw on Ontarians' incomes. In the face of this challenge, selective prefunding and benchmarking against other provinces that get better bang for their bucks in some areas can help Ontario deliver high-quality healthcare in a sustainable fiscal framework for years to come.

Table 2: Real Per Person Health Spending, By Use of Funds, Ontario vs. Provinces, 2010

	Hospitals	Other Institutions	Physicians	Other Professionals	Drugs	Capital	Public Health	Admin	Other Health Spending	Total
<i>Per Capita (in 2012 \$)</i>										
BC	1,466	245	796	34	213	245	310	33	310	3,652
AB	2,109	403	905	57	323	311	285	60	202	4,655
SK	1,657	638	793	24	301	146	379	27	274	4,239
MB	1,799	595	783	24	250	167	271	45	329	4,264
<b>ON</b>	<b><u>1,380</u></b>	<b><u>389</u></b>	<b><u>901</u></b>	<b><u>28</u></b>	<b><u>344</u></b>	<b><u>236</u></b>	<b><u>292</u></b>	<b><u>34</u></b>	<b><u>161</u></b>	<b><u>3,765</u></b>
QC	1,392	531	653	24	316	220	122	59	150	3,468
NB	1,987	515	763	9	266	118	154	53	266	4,130
NS	1,789	624	767	13	344	157	143	98	170	4,105
PE	1,787	514	733	20	260	271	230	141	193	4,148
NL	2,352	763	810	16	276	296	171	63	202	4,948
CAN	1,545	436	815	30	310	233	248	47	198	3,861
<i>Real Per Capita Growth Rate 1991 to 2010 (percent)</i>										
BC	1.1	-1.5	1.2	-3.2	2.5	4.4	6.2	-2.4	4.8	1.5
AB	1.2	2.7	2.1	-3.6	4.4	6.3	5.1	3.2	2.2	2.2
SK	1.4	2.0	3.0	-4.2	3.7	-1.4	5.9	-1.1	5.1	2.1
MB	1.5	2.3	3.6	-1.0	6.3	1.6	5.3	0.9	4.7	2.5
<b>ON</b>	<b><u>0.7</u></b>	<b><u>2.6</u></b>	<b><u>1.4</u></b>	<b><u>-1.3</u></b>	<b><u>4.7</u></b>	<b><u>6.9</u></b>	<b><u>6.9</u></b>	<b><u>0.8</u></b>	<b><u>1.0</u></b>	<b><u>1.9</u></b>
QC	0.2	5.5	2.0	-3.5	5.2	5.3	3.0	-0.5	4.5	1.9
NB	2.0	3.3	3.1	-3.3	3.4	-0.7	4.6	1.8	6.5	2.6
NS	1.5	6.8	4.1	-4.6	4.6	3.0	3.5	7.1	7.3	3.0
PE	1.5	2.1	3.5	-1.5	5.6	7.2	3.7	7.6	5.0	2.7
NL	3.0	5.2	4.4	-2.4	5.4	10.2	5.8	4.1	3.7	4.0
CAN	0.8	2.9	1.9	-2.5	4.5	5.2	5.8	0.4	3.2	2.0
<b>Blue</b> (with underline): among lowest third; <b>Red</b> (with double underline): among highest third										
Ranking Among Provinces (10 being the lowest; 1 being the highest)										
Per Capita Spending	10	9	2	3	1	5	3	8	9	8
Growth Rate	9	6	9	2	5	3	1	7	10	8

Notes: 2010 data are converted into 2012 dollars using the government current expenditure implicit price index. And because growth calculations are sensitive to the base year chosen, we took an average of the three years around 1991 and the two years prior to, and including, 2010 to smooth out the swings in the economy. "Other professionals" includes care primarily provided by dental and vision care professionals; "Other institutions" includes nursing homes and residential care facilities; "Public Health" includes expenditures for items such as food and drug safety, health inspections, health promotion activities, community mental health programs, public health nursing, the prevention of spreading disease and health promotion.

Source: CIHI (2012).

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Colin Busby is a Senior Policy Analyst at the C.D. Howe Institute.

William B.P. Robson is President and Chief Executive Officer of the C.D. Howe Institute.

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