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IS BC'S HEALTH CARE SYSTEM SUSTAINABLE?

A CLOSER LOOK AT THE COSTS OF AGING AND TECHNOLOGY

By Marc Lee

Summary

A popular myth is that an aging population will render the public health care system unsustainable. Indeed, such a presumption seems to underscore the premier's current "conversation" with British Columbians. This paper contributes to the conversation by providing a better understanding of cost pressures in the health care system and what they mean for the future in terms of sustainability.

This paper finds that population aging, in and of itself, is but a small contributor to rising cost pressures in the health care system. Based on current projections there is little to suggest a demographic time-bomb about to go off. Instead, the real challenge for financing the health care system is advances in technological possibilities, broadly defined to include pharmaceutical drugs, new surgical techniques, new diagnostic and imaging technologies, and end-of-life care. These challenges can be addressed most efficiently and equitably in the context of a public system.

In terms of overall sustainability, Finance Minister Carole Taylor's assertion that by 2017 health care will consume over 70% of the provincial budget is extremely misleading:

- Taylor assumes health care expenditure increases far in excess of recent history, while greatly understating potential revenue growth.
- Health care spending is consuming a larger portion of the budget because other areas of the budget have not had sufficient funding increases in recent years. Education funding has been held to very small annual increases, while social services and other areas of the budget have seen devastating cuts.
- Taylor is measuring the wrong thing – what matters is the share of our total income (GDP) we spend on health care, not the share of the provincial budget.

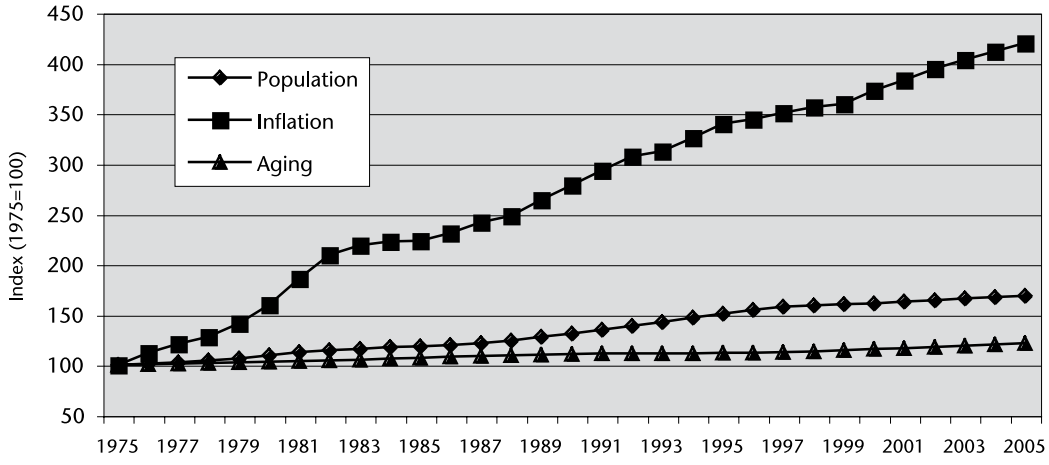
This paper undertakes a detailed analysis of cost pressures in the health care system. It finds that:

- Population aging has been a cost driver in the system, but a very small one compared to other sources. The impact of population aging was 0.9% per year over the 1995 to 2005 period. This is consistent with other studies of population aging.
- Inflation (as reflected in salary increases and higher cost of supplies) has been the biggest cost driver over the 1995 to 2005 period, with increases averaging 2.4% per year, followed by population growth at 1.2% per year.
- The expansion (or "enrichment") of health care services over time (such as new technologies, long-term care, home care and pharmaceutical drugs) is also an important factor. The average British Columbian receives one and a half times more health care services as his or her equivalent 30 years ago.
- Research shows that the cost of dying is very high – one-third to one-half of a typical person's health care expenditures happen in the final year of life.

The paper then projects future health care costs and situates those estimates in the context of economic growth. To accommodate future population increases, aging and inflation, health care expenditures must rise by just under 5% per year simply to stay at the same level of services. These pressures are all manageable if BC experiences reasonable rates of economic growth:

- In a high-growth scenario (6% nominal GDP growth per year), public health expenditures fall from 7.1% of GDP in 2006 to 4.9% in 2031.
- In a medium-growth scenario (5% annual growth), they fall to 6.3% of GDP by 2031.
- Even if the economy were to fare poorly by historical standards (4% annual growth), existing levels of service could be maintained with only a small increase in health care expenditures relative to GDP (to 8.1% by 2031).

Comparison of Cost Drivers, 1975 to 2005



Sources: Author's calculations based on CIHI, National Health Expenditure Trends, 1975–2005, Tables B.4.1, B.4.7, E.1.6, and BC Stats, BC Population by Age: Estimated (1971–2004) and Forecast (2005–2031), Fourth quarter 2005.

By simply dedicating the *same proportio*n of new economic output to health care – even after accounting for population growth, aging and health care inflation – we would have scope for some modest expansion of services. Put differently, if economic growth rates in the future are consistent with those over the past quarter-century (5.7% per year) they will lead to health care expenditures falling as a share of GDP.

The paper models two additional scenarios where the suite of health care services is enriched in the context of medium economic growth (5% annual growth in nominal GDP). The historical average enrichment rate is 1.6% per year over the 1975 to 2005 period. After the same adjustments for population growth, aging and inflation, the paper finds:

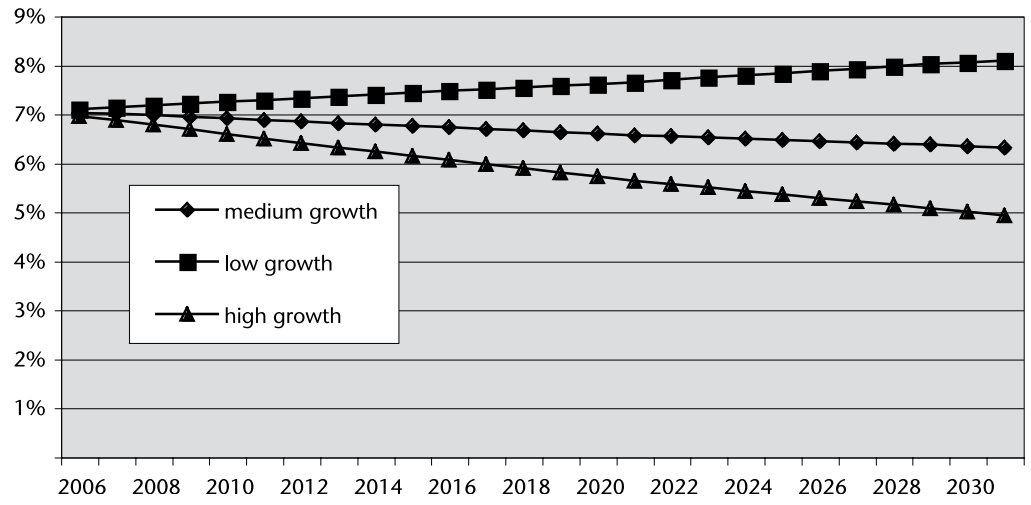
- A 1% annual enrichment rate would require an increase in public health care expenditures from 7.1% of GDP in 2006 to 8.1% by 2031. It would enable the average British Columbian to enjoy 28% more health care services by 2031.
- A 2% annual enrichment rate would require public health care expenditures to grow to 10.3% of GDP by 2031, and would provide 64% more health care services per person.

Thus, greater expansion or enrichment of public health care in the future is possible, but depends on societal willingness to pay more for better services and care. Interestingly, Carole Taylor's estimate of future cost increases (8% per year) implicitly assumes a 3% enrichment rate, almost double the historical rate.

The real challenge for future health care expenditures comes not from an aging population but the costs associated with a wide range of new technological interventions:

- Despite a major increase in surgeries, waiting lists are still an issue because technology has increased the number of people who can avail themselves of such surgeries. Compared to 1990/91, an 80-year-old today is twice as likely to have a knee replacement, cataract surgery, or coronary bypass.

Public Health Care Expenditures Relative to GDP, Three Scenarios



Sources: Author's calculations based on CIHI, National Health Expenditure Trends, 1975–2005, Tables B.4.1, B.4.7, E.1.6, and BC Stats, BC Population by Age: Estimated (1971–2004) and Forecast (2005–2031), Fourth quarter 2005, and BC Stats, BC Economic Accounts, May 2006 update.

- Increases in the price of prescription drugs and shifts toward more expensive drugs are a large part of the growth of drug expenditures, but have not necessarily been accompanied by improved health care outcomes. Cost efficiencies could be gained through a national pharmacare program.
- Expensive end-of-life treatments raise ethical dilemmas, particularly when they prolong life by days or weeks, but do little to restore health or enhance quality of life. Greater use of palliative care and "advanced health directives" (that allow older people and their families to choose a suitable level of medical intervention if serious illness develops) may point to a future where the health care costs of dying are less than today.
- A thorough process of health technology assessment is required to ensure that new technologies provide benefits in accordance with their costs.

The good news is that the challenges facing public health care are not demographic factors beyond our control, but technological issues that, while profound, are suitable to a public process that is well within our control. In other words, like every other policy area, we need to make choices, and to do that we need a healthy democratic debate.

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