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Health & Medicine, Healthcare

A Cost-Benefit Analysis of Provincial Health Services

Introduction

Canada along with several other countries follow a public health care system that takes care of all basic health care services required by its citizens. The health care system of Canada has undergone a lot of changes since its conception. Several reforms have shaped the current health care system to turn out as a publicly funded system. The health care system is a provincial responsibility and is comprised of ten provincial and three territorial plans. The entire system is known as " Medicare" to Canadians. Despite various reforms, the main motto of the health care system has remained the same, i. e. to provide universal access and comprehensive coverage for essential medical services. This service is provided on the basis of the needs of the people than their paying ability.

The current health care system is derived from Canada Health Act (CHA) of 1984. The Canada Health Act sets the terms and conditions regarding health services that are insured and also the additional services that provinces and territories need to confirm to receive federal transfers from the government under Canada Health Transfer.

The CHA has in total nine requirements that must be fulfilled by the provinces and territories of Canada to receive the full amount of Cash entitlement. For insured health services, a five program criteria applies. Another two conditions have application in services relating to health care and extended health care. Insured health services ask for extra billing and provisions of user charges (CHA, 1984).

The criteria states that all administration of health insurance must be carried

out on non-profit basis by public authorities. It guarantees principles of universality and accessibility to all insured residents. It also ensures that all essential health services are insured. It also gives residents the concept of portability wherein residents can avail facilities from their home province during a minimum waiting period.

The conditions require the provinces and territories to offer information to the federal Minister of Health and recognize the financial contributions of the federal government.

Since health care is a responsibility of provincial governments, the concern that hovers around is the means of financing such a big expenditure when it outstrips their capability of financing it. The concern has stemmed from data in the past and probability of increasing expenditure in the future.

Figure 1: Provincial Health Care Expenditures as a fraction of Revenues

Source: Kneebone Ronald (2012)

The figure shows the average fraction of total provincial revenues that was spent on health care. The time periods chosen show specific periods of government finances in Canada. The first period from 1981-1993 was characterized by recessions resulting in budgetary deficits. Also it resulted in vast accumulation of debts by the government. The second period from 1994-2000 aimed at reducing these debts and the credit rating downgrade in 1993 aided this goal. Efforts were made to reduce the health care expenditures of the government. This led to a small decline in the fraction consumed by health care expenditures as part of revenues except in Newfoundland & Labrador and Prince Edward Island. The third period from 2001-2008 is characterized by economic growth and expansion in

government spending. Thus, the health care expenditures rose for every province (Kneebone, 2012).

Per Capita Health Care Expenditure trends by province

Source: National Health Expenditure Trends, 1975 to 2014

The table shows that 70. 5% of Canadian health expenditure will be borne by the public sector. The highest spending in provinces is expected to be in Saskatchewan at 77% and lowest in Ontario at 68. 1%. It is expected to be 76. 3% in Newfoundland and Labrador, 74. 8% in Manitoba, 73. 9% in Alberta, 73. 8% in Prince Edward Island, 70. 6% in Quebec, 69. 7% in British Columbia, 69. 5% in Nova Scotia and 69. 4% in New Brunswick (National Health Expenditure Trends, 2014).

The provincial or territorial government health expenditure per capita is expected to be $3, 960 in 2014. The highest per capita spending among the provinces is projected to be in Newfoundland and Labrador at $5, 087 while the lowest is expected to be in Quebec at $3, 660. It is expected to be $4699 in Alberta, $4461 in Saskatchewan, $4430 in Manitoba, $4345 in Nova Scotia, $4307 in Prince Edward Island, $4094 in New Brunswick, $3807 in British Columbia and $3768 in Ontario.

In 2014, the private-sector expenditure is projected at $1, 784 per capita. Nova Scotia at $2, 065 is forecast to have the highest expenditure while Saskatchewan at $1, 487 is forecast to have the lowest. It is expected to be $1942 in New Brunswick, $1879 in Ontario, $1780 in British Columbia, $1771 in Alberta, $1700 in Prince Edward Island, $1689 in Manitoba, $1650 in Quebec and $1649 in Newfoundland and Labrador. In 2014, the private-

sector expenditure is projected at $1, 784 per capita (National Health Expenditure Trends, 2014).

Source: National Health Expenditure Trends, 1975 to 2014

The table shows that Newfoundland and Labrador and Alberta are going to be spending more on hospitals each at $2, 496 and $2, 386 per capita while Quebec is expected to have the lowest per capita spending at $1487. The per capita spending on hospitals is expected to be $2103 in New Brunswick, $2058 in Nova Scotia, $2034 in Prince Edward Island, $2010 in Manitoba, $1945 in Saskatchewan, $1801 in British Columbia and $1665 in Ontario.

The per capita spending on drugs is expected to be at $1145 in New Brunswick, $1098 in Nova Scotia, $1065 in Quebec, $982 in Ontario, $951 in Newfoundland and Labrador, $934 in Prince Edward Island, $882 in Alberta, $862 in Manitoba, $856 in Saskatchewan and lowest in British Columbia at $740.

The per capita spending on physicians is expected to be highest in Alberta at $1060 among provinces. It is expected to be $989 in Ontario, $948 in Manitoba, $926 in Saskatchewan, $888 in Newfoundland and Labrador, $878 in Nova Scotia, $868 in British Columbia, $844 in Quebec, $791 in New Brunswick and $751 in Prince Edward Island (National Health Expenditure Trends, 2014).

Territories of Canada

In the year 2015-16, Canadian territories are budgeted to receive $68 billion through major transfers, along with an additional sum $3 billion from the previous year.

The total expenditure on healthcare (as a percentage of GDP of provinces) ranges from 8% in Alberta to 16. 3% in Prince Edward Island. However, for the territories, this ratio forecast lies at 19% in Nunavut, 12% in Yukon, and ~10% for the Northwest Territories.

Yukon

The health care system of Yukon has shown full commitment to ensure that the residents of the territory receive all the health services that are required to lead healthy and responsible lives. The Ministry of Health and Social Services is the department which is responsible for delivering health care services (all insured). The delivery of these services is administered and managed centrally by another department DHSS, or the Department of Health and Social Services.

Additional health benefits provided to the residents are travel for medical health programs, chronic disease and disability benefits programs, children’s drugs and optical programs, pharma care and extended benefits programs, among many others.

There is a central Yukon Hospital Corporation, which operates three hospitals in the territory. These hospitals provide a wide range of health care programs. The government plans on making a full utilization of tele-radiology and other health services in order to improve the health care services in the rural communities of the territory (CHA Annual Report, 2014).

Below is the data for the health care services provided in the territory:

Northwest Territories

The DHSS works with eight different departments called HSSAs, or the Health and Social Services Authorities in order to administer and deliver the all-insured health care services in NWT. In the year 2013-14, DHSS carried out below legislative operations in the NWT:

Drafting of a new Health Information Act, with a purpose to set rules, which must be followed by the health care providers for the protection of the personal health data of the clients.

Development of a new Health and Social Services Professions Act, whose purpose was to regulate all the health and social services professions under one common model of legislation. This allows the department to modernize the previously existing, but outdated legislation in a more professional manner.

Several amendments were brought in the previously existing Medical Care Act, which brought RMCP, or Royal Canadian Mounted Police under the eligibility for insured health care services.

Amendments were brought in for the Hospital Insurance Regulations Act, which waived the previously existing mandatory three month waiting period for acquiring the eligibility for the health care plan for the family members and dependents of Armed Forces personnel of Canada (CHA Annual Report, 2014).

Below is the data of the health care services in NWT:

Nunavut

In this territory, the providing of health care services have been particularly challenging. The territory is home to a population of about 350000 people, out of which roughly half the population is under the age of 25. The population of the territory consists of about 25 communities, which are located across three different time zones and is further divided into three regions: Baffin, Kitikmeot, and Kivalliq.

The government tries to incorporate the Inuit social values into the policy programs, wherever possible. The health care services in this area have their foundations in a primary health care model. The primary health care providers of this model are physicians, midwives, community health nurses, and other health professionals.

In 2013-14, the budget for the health care operations and maintenance was about $308, 000, 000. About a third of this budget was spent on costs, which are associated with the medical travel and the treatments provided in the facilities outside the territory. Nunavut is geographically a large territory, but extremely low population density. This has led to limited health care infrastructure. Therefore, the access to hospitals and other health services require that the residents travel outside the territory. In the same fiscal year, an additional capital of about $24, 000, 000 was given to the department for the renovation of the regional hospitals and replacement of outdated health centres (CHA Annual Report, 2014).

Below is the data for the health care services of the territory:

Provinces of Canada

Province Newfoundland and Labrador

The health services funded publicly in Newfoundland and Labrador are delivered using four regional health authorities. The focus is on community services, public health, health protection and promotion, continuum of care and acute and long term care services. With approximately 500 thousand residents, the services are distributed by 20000 health care staff, administrators and providers.

Financial Budget of 2013-14 allocated $3 billion for health care to Newfoundlanders and Labradorians. This included $42. 5 million to back child development and to improve child care services for people with young kids. Likewise financing for cancer treatment was done to the tune of $24 million. 2013-2014 budget included $350, 000 to grow the provincial vaccination program to give more access to second dose chicken pox vaccines and influenza vaccines for children.

The no. of registered persons with Medical Care plan in 2013-2014 were 532177. The no. of public facilities was 51 and the total payments given were $1, 100, 291, 277. There was only one private for profit facility.

Province Nova Scotia

Nova Scotia's nine district health authorities (DHAs) and their community-based supports: community health boards (CHBs) were established by the Health Authorities Act. The main role of the DHAs are to govern, plan, manage, deliver and monitor health services within each district, and to

provide planning support to CHBs. The services carried out by the DHAs include mental health, addictions and acute and tertiary care.

Nova Scotia faces several hurdles in delivering health care services with its aging population. 18. 3% of its population is above the age of 65 and is expected to increase to 25. 4% by 2026. To take care of these needs, Nova Scotia has expanded the public insurance facilities to cover home care, long term care and pharmaceutical coverage. The average rate of diseases like cancer and diabetes is also higher in Nova Scotia which results in increase health expenditure.

The no. of registered persons with Medical Care plan in 2013-2014 were 1, 000, 124. The no. of public facilities was 35 and the total payments given were $1, 679, 289, 646. There was no private for profit facility.

The budget for 2014-2015 lay the budget at $4104920. Of this, $1710960 was allocated for the Nova Scotia Health Authority & IWK. ; $798896 was allocated towards physician services; $560094 was allocated towards long term care program; $264869 was allocated towards pharmaceutical services and $233804 was allocated towards home care services (CHA Annual Report, 2014).

The government’s plan of consolidating nine district health authorities into one will result in development of a more streamline and cost effective system that focuses on provisional approach to care and distribution of services. In the future, the government is recommended to invest in innovative technologies in health care to reduce spending in health services.

Province New Brunswick

The government introduced the New Brunswick Drug Plan (NBDP) in December 2013 since 20% of residents don't have coverage of drugs. The Prescription and Catastrophic Drug Insurance Act came into being on 1st April 2014. It ensured payment of premiums and co-payments with subsidies keeping in consideration family income and size. The first phase of NBDP that ran till March 2015 had voluntary enrolment however now it has been made mandatory.

After years of witnessing increasing budgets, in 2013-2014 the spending was $45. 3 million under budget. The price of generic drugs was reduced from 35% to 25% from 2013.

The no. of registered persons with Medical Care plan in 2013-2014 were 749, 613. The no. of public facilities was 60 and the total payments given were $1, 771, 731, 561. There was no private for profit facility (CHA Annual Report, 2014).

Province Prince Edward Island

The Health Services Act has created a provincial health plan and a Crown corporation (Health PEI) to look after the delivery of operational healthcare services. Health PEI is responsible to deliver health services; operate health facilities and manage them; manage other financial or human resources.

The no. of registered persons with Medical Care plan in 2013-2014 were 146, 751. The no. of public facilities was 7 and the total payments given were $ 197, 008, 800. There was no private for profit facility.

Province Alberta

The Health care services in Alberta are the responsibilities of the Minister of Health, the Department of Health and the Regional Health Authority.

The no. of registered persons with Medical Care plan in 2013-2014 were 4, 228, 125. The no. of public facilities was 225.

Source: Alberta Annual Health Report 2013-2014

Source: http://www. health. alberta. ca/documents/Chart-Health-Consolidated-Expense-15-16. pdf

The spending for 2015–16 is budgeted at $18. 9 billion which is $160 million lower than the 2014-2015 forecast and will account for 39% of Government of Alberta’s total expense. About $2. 2 million is spent every hour to maintain and improve the existing healthcare system. For the 2015-2016 budget, $13. 4 billion is allocated for AHS operations of which $10. 9 billion is given via the Department of Health’s operating fund. $ 4. 6 billion is budgeted for physician expenses which is a 2. 7% increase over the 2013-2014 forecast. $1. 8 billion is budgeted for drugs and other health benefits. $193 million is allocated for primary health care and supporting care of addictions and mental health. $2. 3 billion is allocate as part of administration and support services of AHS. Ministry support services

The government is taking steps to reduce the burden of healthcare as an expenditure by imposing a health-care levy for people with taxable incomes above $50000 from 1, 2015 to lower the burden that healthcare poses. The levy will be managed by the Canada Revenue Agency (Maclean, 2015).

The new levy will provide the province an opportunity to ensure constant

funding for government's responsibilities. The Health Care Contribution Levy is expected to raise $396 million in 2015–16. This amount will rise to about $530 million in 2016–17 for the first full fiscal year for which the change will be effective.

Province Ontario

The health care system in Ontario is overseen by the Ministry of Health and Long-Term Care (MOHLTC). The budget for Ontario's health care system was over $48. 9 billion (including capital) in spending for 2013-2014. The services provided through MOHLTC are drug benefits, health insurance, forensic mental health and supportive housing, long-term care, health promotion & disease prevention, home care, assistive devices, community and public health. Local health services are planned, funded and integrated by Fourteen Local Health Integration Networks. This ensures that the MOHLTC takes a stewardship position.

Figure 3: Planned expenditure, 2013-2014

Source: Ministry of Health and Long Term Care, Ontario

The no. of registered persons with Medical Care plan in 2013-2014 were 13, 452, 921. The no. of public facilities was 145 and the total payments given were $16, 361, 203, 000

The government of Ontario needs to invest in e-health to help with modernization and thereby help in better and more efficient care. There has been a severe overcrowding in community based programs due to inadequate infrastructure. Thus, improvement in this sphere is needed.

Province British Columbia

The responsibility of ensuring timely, appropriate and quality health services to British Columbians lies with the Ministry of Health. It works with other agencies, providers and groups as well to provide greater access to care. The province has six health authorities that are mainly responsible for delivering services.

The no. of registered persons with Medical Care plan in 2013-2014 were 4, 625, 653. The no. of public facilities was 120. There was only one private for profit facility.

Province Manitoba

The health of Manitobans is overseen by the Manitoba Health, Healthy Living and Seniors (MHHLS). They are responsible for development of policy, programs and standards; program and fiscal accountability; and evaluation. The no. of registered persons with Medical Care plan in 2013-2014 were 1, 289, 268. The no. of public facilities was 96. There was only one private for profit facility.

Province Quebec

The healthcare services can be accessed with the health insurance card issued by the province. Citizens who settle in Quebec have to mandatorily complete a waiting period of three months. This is done after getting registered with Régime d'assurance maladie du Québec. However, there are certain agreements with countries which aid in getting immediate access to the plan upon arrival. It is advisable to take private insurance during the waiting period. It is essential for the residents to have prescription drug

insurance.

$6. 5 billion was paid for professional services rendered to residents of Quebec. Professional services received outside of province Quebec stood at $44. 6 million. $11. 1 billion was paid to hospitals serving as health service centres.

Province Saskatchewan

The health care system followed in Saskatchewan involves 12 regional health authorities (health regions), the Saskatchewan Cancer Agency, the Athabasca Health Authority, and other private professionals. The Ministry supports major stakeholders to recruit and retain human resources. The Ministry strives to provide Saskatchewan residents with excellent quality health care services and hence works with organizations in partnerships at all levels.

The no. of registered persons with Medical Care plan in 2013-2014 were 1, 121, 755. The no. of public facilities was 66 and payments given were $1, 846, 795, 000. There were 4 private for profit facilities.

In 2013-2014, the Ministry allocated $4. 8 billion as expenditure on health care, $6. 7 million lesser than its budget. The resultant saving was due to lesser spending in collective bargaining, utilization and physician services. The Ministry also received $2. 6 million more than budgeted to a total of $14. 5 million due to reimbursements to expenses of physicians.

The government is trying to reduce its spending by taking several initiatives like implementing lean improvement events, purchasing generic drugs in groups and by monitoring performance regularly. Also it is implementing

several new methods to improve the existing system. All key infrastructures are stated to be coordinated and delivered on a provincial basis by the year 2017 (National Health Expenditure Trends, 2014).

Data Analysis

As clear from the data presented above, the government spending on the budget on healthcare have been fluctuating. Therefore, they had to come up with an approach to gain some insight into the reasons of fluctuations. This insight will also help them into better plan for the future healthcare spending.

The governments believe that the two key factors driving this budget are population ageing and the GDP. If these influences are removed from the data, what remains is the health care spending data influenced by other factors. These other factors which remain, are the ones which contribute to the residual cost growth.

This approach introduced by US and adopted by parliament offices is:

$HCP_t = HCP_{t-1}(GDPP_t /GDPP_{t-1})^e (AGE_t / AGE_{t-1}) (1 + x_t)$

Where,

HCP = publically finance health care per capita

GDPP = provincial domestic product per capita

AGE = per-capita health expenditure due to ageing

X = residual gross factor

This approach helps to find residual data value X with help of data HCP, GDPP, and AGE. Here, the assumption taken is that e= 1 and thus, equation

helps to explain how expenditure of health care would look like. It has been observed from past data calculations that the ageing population played small role in the growth factor of health spending per capita. The biggest role played was by income elasticity assumed constant, and residual growth factor has maximum impact. This relation between expenditure on health care and per capita income and residual cost growth should be considered as a single factor due to uncertainty of Canada government over income elasticity. This happens because the provincial governments received change intended to level their capacities.

The spending on health care varies across different provinces/territories primarily because of different age distribution. Apart from the population's age, geography and the population density of an area also play key role, especially in the case of territories. Secondary factors which impact the spending are health needs of the provincial/territorial population, the quality of health care delivery to the population, and the differences between the remuneration of the workers in the health care industry throughout the country. The financing and sponsoring of the health care industry is also a significant consideration, along with public and private insurance services.

The health care system that Canada has adopted has time and again led to some sort of political controversy and stirred debate in the country. The major causes of debate are the effectiveness of the existing system to provide treatments on time. Several economists also have advised the country to adopt a private system on the lines of United States Health care system. However, a major flaw of the new system can be that it would lead to inequality in health system. Also, despite of having a debatable health

care system, Canada as a country possesses a life expectancy of 80 years which is one of the highest in the world and one of the lowest infant mortality rates.

Conclusion

The expenditure that is being incurred by the government for healthcare facilities continues to increase at a rapid pace. The total health spending in provinces has grown at an average annual rate of 7. 5% compared to only 5. 7% for total available provincial revenue (including federal transfers) and only 5. 2% for GDP. The government spending across Canada has grown faster than the GDP.

There has even been a constant debate regarding who should be paying for health care services – the federal government, provincial government or the municipal government. Though the beneficiary is the citizen and pays tax for these services, the argument regarding who pays for what seems rather unnecessary. Most people in their opinion believe that indirectly linking these facilities with the federal government leas to the belief amongst taxpayers that they are receiving their services at an extremely low cost. Also for several provinces, the health care expenditure alone takes up half of the total expenditure set as a budget. To ensure that targets are met and government is not overburdened with healthcare expenditure; it must ensure:

1) A cap should be implemented on Medicare expenditures.

2) Ensure efficient use of health resources by making patients pay in a percentage based format

3) Create incentives for cost and quality improvement for private sector

4) Reduce pricing of generic drugs

The federal government should make provision to allocate a strict watch on the revenue generation and expenditure ratios of all provinces to ensure that revenues are not compromised with (Maclean, 2015).

Another criticism that comes with public funded healthcare is that of longer wait times. Though the provincial governments have been striving to reduce wait times, there needs to be collaboration amongst the federal and provincial governments to improve the same.

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