THE CANADA HEALTH TRANSFER DISCONNECT:

AN AGING POPULATION, RISING HEALTH CARE COSTS AND A SHRINKING FEDERAL ROLE IN FUNDING

Hugh Mackenzie

Vote for the health care we deserve.

Canada's Nurses
STANDING UP FOR HEALTH CARE

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The Canadian Federation of Nurses Unions (CFNU)

The Canadian Federation of Nurses Unions represents close to 200,000 nurses and student nurses. Our members work in hospitals, long-term care facilities, community health care, and our homes. The CFNU speaks to all levels of government, other health care stakeholders and the public about evidence-based policy options to improve patient care, working conditions and our public health care system.

Registered Nurses' Union
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pei nurses

Nova Scotia Nurses Union

New Brunswick Nurses Union
NBNU SIINB

ONA
Ontario Nurses' Association

Manitoba nurses Union
A COMMITMENT TO CARING

Saskatchewan SUN
UNION OF NURSES

UNA
United Nurses of Alberta

CNSA | AEIC

Message from the CFNU

Linda Silas

Why are provincial governments struggling?

The Canadian population is aging, health care costs are rising, and provincial governments are being asked to keep pace with these changes. Our health care system is about to hit a wall. Meanwhile, the federal government is cutting federal health transfers to the provinces and refusing to fulfill its role in providing national, equitable, and inclusive health care across Canada. The CFNU, as the representative of close to 200,000 Canadian nurses, knows that these decisions are eroding our public health care system which, as Canadians across Canada have told us, they value as their top priority.

Premiers, as nurses, we are on the front line 24/7. Our work will be directly impacted by the federal cuts to health care. Our efforts to provide appropriate care with fewer resources, and to keep our patients safe from harm are all at risk. Premiers, how will we develop a health care system that provides for the growing need for integrated care for our seniors, for the rising demand for mental health services, for better primary care, and for improved health services for Aboriginal peoples – when the system is already stretched to the limit?

In December 2011, the federal government signaled its disengagement from its traditional role in health care leadership in Canada. Instead of the federal/provincial/territorial partnership and the 6% escalator, the federal government opted to tie health transfers to the rate of growth in Canada's GDP. The result, according to Canada's Parliamentary Budget Officer: an increased provincial fiscal burden for health care, while the federal government reduces its own deficits.

Many economists have echoed the Parliamentary Budget Officer's concerns about the effect of federal government disengagement, as have the Premiers in their report tabled at the Council of the Federation. All these concerns have fallen on deaf ears.

In poll after poll, the result holds true: public health care is Canada's number one priority. It is part of our identity as Canadians. But, we risk losing this important element of our identity if we do not act now to address the erosion of federal funding.

Canada's nurses stand with Canadians in our commitment to health care. We stand with the Premiers to reinforce your message in 2012 that these cuts are unacceptable.

CFNU's expert paper, *The Canadian health transfer disconnect: an aging population, rising health care costs and a shrinking federal role in funding*, reevaluates the fiscal impact of the federal cuts and concludes that the impact is greater than previously predicted. When the new formula for health transfers takes effect, instead of a shortfall of 36 billion in 10 years, as previously predicted, provinces and territories will lose 43.5 billion in only eight years. As the author, Hugh Mackenzie, concluded in his report: "In this debate, it is easy to get lost in numbers of dollars, in the millions and billions that are difficult to comprehend, and whose significance is difficult to measure against Canadians' direct experience."

The report shows what the cuts to federal funding mean for our health care system in terms of real tangible losses: fewer home care visits, fewer primary care centres, fewer long-term care beds, and fewer nurses in our communities providing care. As in the 1990s, as the percentage of federal funding declines towards historical lows, it may mean bed closures and drastic layoffs, all of which will dramatically affect the sustainability of Canada's health care system.

As frontline health care providers, nurses are speaking up in order to protect Canadians and ensure the safety of Canadians' direct care experience. We call on the federal government to move towards a federal contribution of 25% of health care funding in order to ensure the sustainability of a pillar of Canadian identity: Canada's health care system.

Sincerely,

Linda Silas, President
Canadian Federation of Nurses Unions

Foreword

Kevin Page

Hugh Mackenzie has written an important and timely report. Provincial and territorial governments need a full understanding of the impacts of the federal decision to reduce the escalator on the Canada Health Transfer. The impacts are significant for fiscal bottom lines, federal-provincial relations and likely for services to Canadians. The report is a good study with clear assumptions and sensitivity analysis.

If there is an elephant in the room among the big public policy issues leading up to the 2015 federal election, I think it could be health care. Health care is a major industry in Canada, like in other OECD countries, and its spending share of GDP and government expenditures has risen significantly in recent decades.

Unfortunately, the federal government has virtually ignored the health care file. There was nothing about health care in the 2013 Speech from the Throne. To address federal fiscal sustainability issues, the government reduced the escalator on the Canada Health Transfer (CHT) and transferred the budget issue to the provinces and territories. There have been no genuine federal-provincial-territorial discussions on health care renewal. The proposed spending initiatives for health care in the 2015 Budget (e.g. innovation; seniors; and mental health services for First Nations) are useful, but they pale in comparison to the much larger reductions in the 2012 Budget. Not to let other political parties off the hook, we are still awaiting substantive proposals from the opposition.

The polling numbers from a recent Abacus Data (2015) poll done for the Canadian Federation of Nurses Unions suggest that when politicians go knocking door to door in the 2015 federal election campaign, they are going to get an earful about health care. That poll suggests that two thirds of respondents would support a political party committed to negotiating a new health agreement between Ottawa and the provinces and committed to annual funding increases. Another 58% counted health care in their top three issues that could determine how they vote. From Nanos

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Kevin Page is the Jean-Luc Pepin Research Chair at the University of Ottawa. He was Canada's first Parliamentary Budget Officer in 2008-2013.

Research (2014) in a poll done for the Canadian Health Coalition, we learn that more than nine in 10 Canadians agree or somewhat agree that the federal government should take a leadership role in health care (up 5 points in the past two years). A strong majority of Canadians (seven in 10) oppose linking funding to the strength of the economy, as well as treating all the provinces the same regardless of their needs (almost seven in 10 oppose). A strong majority (80 %) are supportive of making our public health care system stronger (Nanos, 2014), and this includes a plan for prescription drugs (EKOS, May 2013).

The unwillingness to accept the challenges facing our health care system is not a sustainable policy or political option.

In 2011, the Canadian Medical Association wrote a document about health care transformation. They made the case that our system is facing challenges on two fronts – in meeting the legitimate health care needs of Canadians and in being affordable for the public purse. They said the founding principles of medicare are not being met today either in letter or in spirit. This is not a battle just about money. In both 2008 and 2009, the Euro-Canada Health Consumer Index ranked Canada 30th of 30 countries (the U.S. was not included in the sample) in terms of value for money spent on health care. Canadians deserve better.

In March 2012, the Senate Standing Committee on Social Affairs, Science and Technology published a review of the previous 10-year health accord. It revealed that real systematic transformation of health care systems across the country had not yet occurred, despite more than a decade of government commitments and increasing investments. The report highlighted that more progress needs to be made in the areas of primary care reform, establishing electronic health records, health human resources planning, and catastrophic drug coverage.

The challenges facing health care are complex. We need our federal leaders to come to the table with the provinces and the health industry. We need our leaders to be builders. The witnesses that came to the Senate Committee talked about breaking down silos between sectors, building compatible systems, governance and funding arrangements, and shifting more focus to prevention of disease and injury. Analysis by the Parliamentary Budget Officer and others has shown that the cash related to the CHT as a percentage of provincial and territorial health spending will continuously fall from 20 cents on the dollar. The current arrangements are no longer supporting the *Canada Health Act*, and Hugh Mackenzie's analysis shows the situation may be even worse than previous studies had predicted.

Health care is a major component in the Canadian economy. We will need new policy directions from political leaders and the health industry. With these directions in place, the economists can develop options at rebalancing spending and taxation between levels of government and looking at changes to programs like CHT, equalization and Aboriginal health.

Executive Summary

Hugh Mackenzie

In September 2004, the federal government reached a historic 10-year agreement with the provinces and territories to revitalize federal funding for medicare. Following a recommendation from the Romanow Commission on the Future of Health Care in Canada in 2002 to restore the federal presence in medicare funding, an agreement was reached with the provinces and territories for ten years of annual increases at a rate of 6% in federal funding.

Over the ensuing 10-year period, federal funding recovered from a low of just over 11% to 23% of provincial and territorial health expenditures.

But that all changed in December 2011 when the federal government unilaterally announced that it would not be renewing the 2004 Health Accord. Instead, the funding formula was to move from the 6% escalator to a formula based on the rate of growth of Canada's GDP.

The long-term fiscal impacts of this change to the formula were highlighted in major reports by the Council of the Federation (COF) and the Parliamentary Budget Officer (PBO). The PBO's longer-term fiscal sustainability analysis showed that the health transfer formula change alone eliminated any sustainability issues for the federal government and imposed a significantly increased financial pressure on provincial and territorial governments as a group. Consequently, provinces will have difficulty ensuring the sustainability of the system as a result of the greater fiscal gap.

As we near the implementation of the 10-year GDP-linked formula, it is becoming increasingly evident that it will have a dramatic impact on health care funding in Canada. This sense of urgency has prompted the Canadian Federation of Nurses Unions to commission a report to reexamine the fiscal impact of this measure, in light of new data and taking into account the real tangible impacts on health care in Canada. In that regard, the CFNU sought the help of Dr. Michael Rachlis in estimating the impact of the loss of revenue in four program areas.

The earlier studies by COF and PBO projected a nominal growth rate of 3.9% over the period from 2017-2018 to 2024-2025 in which the GDP-linked formula was to apply. However, our research suggests that these projections are overly optimistic. In this paper, we estimate that a more

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Hugh Mackenzie has worked as an economist for more than 40 years in a variety of different public policy capacities, at all three levels of government as well as in the non-profit sector. He has written extensively on the financing of health care capital and on the fiscal issues caused by rising health care costs in Canada.

moderate rate of growth of 3.3% is more consistent with Canada's recent productivity growth and trends in labour force growth. In this scenario, the federal government's new approach will translate to an annual loss in 2024-2025 of $10.7 billion, and a cumulative loss over the eight years of $43.5 billion.

Funding based on GDP and distributed by population is insensitive to the differences in the drivers of the costs of health care. It does not take into account:

- Differences in demographic profiles and trends;
- Differences in the costs of providing services;
- Differences in regional labour markets.

The report's projections show the federal share of health care costs will begin to drop back, shrinking to an estimated 19% of GDP in 2024-2025, compared with a peak of 23% in 2016-2017. Significantly, the year-to-year increase in federal health transfers will cover only 11.5% of the projected increase in provincial and territorial health care costs over this period.

From a broad health care policy perspective, the federal government's decision flies in the face of reality. Canada's population is aging. In this paper, we estimate that the annual cost increase for health care directly attributable to the aging of the population is 1.0% per year. Yet, the federal government has chosen to reduce its share of funding for health care.

This reduction in the federal government's funding share also flies in the face of widespread concerns over escalating drug costs and increases in health care costs not covered by medicare, concerns that would point to an increase, rather than a reduction, in our financial commitment to health care.

The numbers of dollars at stake in this issue are so large that they are difficult to put into perspective. This paper takes the next step, translating the funding loss at the provincial and territorial level into specific program activities in each jurisdiction, based on the three GDP growth scenarios evaluated. We translated each province's funding loss, in 2015 dollars, into a package of health care services directly relevant to the aging of Canada's population: home care visits, places in multi-professional primary care centres, long-term care beds, and nursing employment.

In the 3.3% growth scenario, the loss of $10.7 billion in 2024-2025 equates to a shortfall of 59 million home care visits, 2.6 million primary care centre patients, 7,500 long-term care beds and 24,000 nursing jobs across the country.

The long-term objective of the federal government in constraining its health care transfers to the provinces and territories is not only to shift costs onto the provinces and territories. It is also to put pressure on the provinces and territories to cut their health care spending by limiting the scope of public health care insurance.

The possibility that reduced federal health care funding may erode the federal government's credibility as a guarantor of the principles of Canadian medicare is not an unintended side effect of the federal government's spending restraint. In fact, it dovetails perfectly with the current federal government's determination to limit federal policy activity in areas of provincial jurisdiction.

That is what makes the December 2011 policy change so critical to the future of Canadian medicare.

The Canada Health Transfer Disconnect:

An Aging Population, Rising Health Care Costs and a Shrinking Federal Role in Funding

Hugh Mackenzie

Introduction

In December 2011, the Government of Canada unilaterally announced a dramatic change in health care funding. It would not be renewing the 2004 Health Accord. Instead, the funding formula was to shift from the 6% escalator to a GDP-linked formula.

Both the Council of the Federation[1] (COF) and the Parliamentary Budget Officer[2] (PBO) have forecast that the proposed Canada Health Transfer (CHT) would result in a substantial reduction in federal funding for health care. Replacing the 2004 Health Accord's 6% funding escalator with a GDP-linked formula for an extended period beyond 2024 would reduce the federal share of health care funding to its medicare era low point of 11% to 12%. That, by itself, would eliminate the entire long-term federal fiscal sustainability gap and materially increase the provincial-territorial gap.

The growing fiscal imbalance between the federal and provincial/territorial governments, and its impact on our public health care system's long-term sustainability, led the Canadian Federation of Nurses Unions to commission this report which builds on the earlier work of the PBO and COF.

The analysis differs from the COF study in three respects. First, it focuses more narrowly on the change in the escalator formula itself. Whereas the Council's 2012 report dealt both with the change in the CHT escalator and the impact of various options for the transition from equalized to equal per capita funding, this paper takes the transition to equal per capita funding as a fait accompli and focuses exclusively on the impact of the change in the funding escalator formula. Second, consistent with this approach, it addresses projected funding changes over the period of eight years in which the GDP-linked formula is intended by the federal government to apply – from 2017-2018 to 2024-2025. Third, it considers the impact of differences in rates of GDP growth on health care funding and costs.[i]

Finally, to put the resultant funding gaps into perspective, it translates each province's funding loss into a balanced package of health care services which, taken together, are closely related to the aging of Canada's population – the key overriding factor that will affect the financing of Canada's health care system over the next generation. These estimates express the funding gaps in terms that would be identifiable to Canadians who interact with the health care system. They also

[i] These three differences combine to produce the difference in estimates of the impact of the shift to GDP linked funding from the 6% escalator between the $36 billion over the period 2014-2015 to 2023-2024 projected in the COF study, and the $34 billion between 2017-2018 and 2024-2025 projected in this study.

capture the effect on actual health care services of differences among jurisdictions in the costs of providing the same service.

How we got here

Despite the fact that health care falls under the constitutional jurisdiction of provincial governments in Canada, Canadian medicare has, from its earliest stages, been a national project. And while the program in its current form had its origins as a provincial program in Saskatchewan in the early 1960s, its transformation into national iconic status depended critically on the leadership of the federal government.

As the system was initially conceived, Canadian medicare was to be a funding partnership between the federal government and the provincial governments, with each order of government paying 50% of the cost. With respect to delivery, however, medicare was never a partnership. The federal government played only a high-level role in delivery, establishing standards that provincial systems were required to meet as a condition for receiving the funding.

While the extremely limited role the federal government played in the design and operation of the system suited the constitutional interests of the provinces, the clear separation of funding and delivery had the effect of insulating the federal government from the consequences of changes in federal funding.

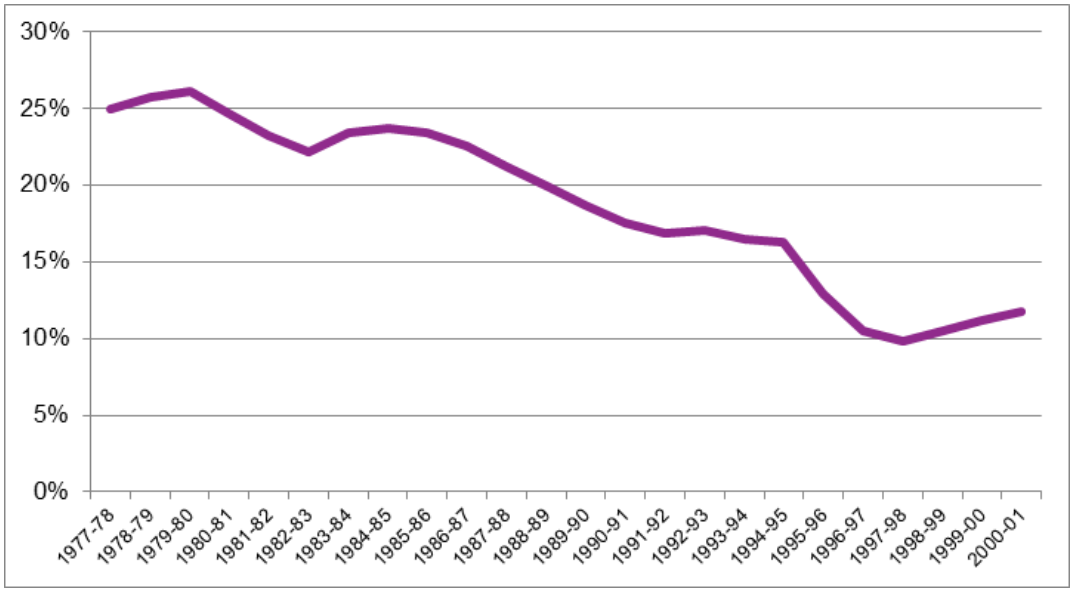
As a consequence of that disconnect, federal funding for medicare has been a casualty in periodic exercises in fiscal restraint. In the 1970s, in the wake of the first oil crisis; in the 1980s, in the wake of the 1981 recession; and again in the 1990s successive federal governments looked to medicare funding for program spending "savings" to address fiscal problems.

That repeated process is reflected in the data for federal cash funding to provincial governments for health care as a percentage of provincial health care spending. Until the late 1970s, federal funding made up roughly 37% of provincial spending on health care.[ii] With the policy shift to Established Programs Financing in 1977, roughly one third of federal funding was shifted onto the provincial corporate and personal income tax bases, dropping the federal cash share to the 25% range. Over the period from 1981 to the mid-1990s, funding was further squeezed to approximately 16%, as first the Mulroney and then the Chrétien governments looked to federal-provincial transfers as a way to manage their fiscal balances.[3]

The replacement of Established Program Funding with the Canada Health and Social Transfer in 1996 as part of the Chrétien-Martin government's deficit elimination strategy resulted in another dramatic drop in federal funding for health care, dropping from 16% of provincial health care spending to the range of 10% to 11%.

[ii] The federal share never reached 50% of total provincial health care spending; in its original formulation, the 50/50 goal referred to hospital and physician services only.

Chart 1. Federal health cash transfers as % of total provincial/ territorial health expenditures after 1976



Source: Commission on the Future of Health Care in Canada, Appendix E2

The shift from dedicated health care funding to the Canada Health and Social Transfer led to what amounted to an existential crisis in Canadian medicare. Not only was federal funding declining at a time when health care costs were accelerating and provincial fiscal balances were under stress. That cut also undermined the credibility of the federal government as a funding partner and therefore its ability to maintain national standards in the system.

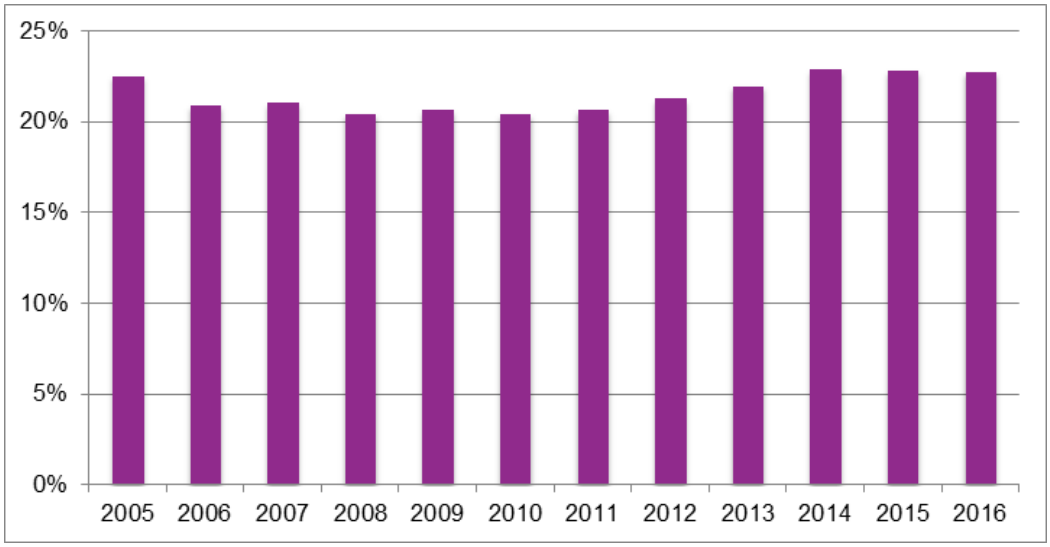
As the federal government came under increasing political pressure over health care funding, it responded by appointing the Romanow Commission on the Future of Health Care in Canada to review the system and its financing. In its response to the Romanow Commission's 2002 report, the federal government reversed its position on transfer payments. The Canada Health and Social Transfer was split into two separate transfers – the Canada Health Transfer (CHT) and the Canada Social Transfer (CST).

A new 10-year federal-provincial-territorial agreement was struck in 2004. That agreement, known as the Health Accord, responded to the Romanow Report's funding targets by phasing in funding increases to a base in 2005-2006 of $19 billion and committing the government of Canada to increase health care transfer payments to the provinces at a cumulative annual rate of 6% per year. The Accord also re-established the role of the federal government as a guarantor of common standards for health care in Canada.

When the new Conservative government took office, it committed itself to live up to the 10-year CHT agreement to increase funding at a rate of 6% per year. The only substantial change introduced during the term of that agreement was to change from a system for allocating funding among provinces that incorporated an element of fiscal capacity equalization to a pure per-capita allocation. The effect of that change was to eliminate the link between health care funding and need, as measured by fiscal capacity.

Chart 2 shows the CHT transfer as share of provincial and territorial expenditures for the period 2005-2006 to 2014-2015 with a projection to the end of the 6% guaranteed escalator period.

Chart 2. CHT as a percentage of provincial and territorial spending on health care



Sources: CIHI; Department of Finance; author's forecasts

In December 2011, the federal government informed the provinces and territories that the successor to the 10-year Health Accord would not provide for the 6% escalator beyond fiscal year 2016-2017. Instead, federal health care would tie total transfers to a three-year moving average of the rate of growth of GDP. The federal guarantee is limited to a commitment to a minimum escalator of 3%, regardless of the three-year moving average of GDP growth.

Impact estimates – Council of the Federation and the Parliamentary Budget Officer

Both the Parliamentary Budget Officer and the Council of the Federation have prepared estimates of the impact of the change on Canada's fiscal arrangements and on the relative fiscal health of the provinces and territories on one hand and the federal government on the other.

Parliamentary Budget Officer

The Parliamentary Budget Officer has issued two studies looking at the implications of the changes in the formula for the Canada Health Transfer from the perspective of overall fiscal sustainability.

The first, published in January 2012,[4] analyzed the implications of the formula change for the PBO's earlier work on long-term fiscal sustainability. The PBO estimated that CHT funding would increase by 6% per year from 2014 to 2017, and then at 3.9% per year from 2017 to 2025. From 2025 to 2040, GDP growth was projected at 3.8%, CHT growth at 3.8%.[iii]

Based on these projections, the PBO concluded that this single change had produced a substantial change in the relative fiscal sustainability of the federal government and the provincial and territorial governments. Before the CHT change, the federal fiscal gap – additional revenue required to achieve a long-term fiscal balance – stood at 1.2% of GDP. After the change, the federal fiscal gap was actually negative, at -0.4%, meaning that the federal government had a long-term excess of revenue. At the provincial level, the fiscal gap nearly doubled, from 1.5% of GDP to 2.9% of GDP.

The January 2012 report also projected health spending growth at 5.1% from 2017 to 2025 and 5.3% from 2025 to 2040, pointing to a growing gap between provincial health care spending and the federal CHT transfer.

As a consequence, the PBO forecast that federal health care transfers would drop from the current approximately 23% to 18.6% by 2025-2026, to 13.8% by 2050 and to 11.9% by 2075.

The second PBO paper published in June 2012[5] narrows the focus to individual provinces, looking at CHT and health care cost increases over the period 2012-2013 to 2022-2023.

Because the period of analysis covered both the transition from tax base equalized to equal per capita funding, as well as the escalator change, the PBO found that the province of Alberta – the major winner in the shift to per capita funding – would experience transfer payment increases at a higher rate than its health care costs. All other provinces and territories would experience a widening gap between health care costs and the CHT transfer.

Council of the Federation

The focus of the Council of the Federation's analysis published in July 2012 was on the impact of several federal government proposals for changes in federal-provincial fiscal arrangements.[6]

The Council's projections covered the period 2014-2015 to 2023-2024 and included both projections of total CHT transfers and estimates of transfers for individual provinces and territories. With respect to the CHT, the Council's study dealt with two issues: the transition from equalized funding to equal

[iii] The Parliamentary Budget Officer used growth rate assumptions compounding to 3.7% annual growth between 2017 and 2025. The impact of 3-year averaging and the 3% minimum in the CHT escalator beyond 2017 resulted in a 3.9% CHT growth rate which corresponds to a consistent 3.9% GDP growth rate. For simplicity, we have assumed consistent GDP growth throughout the 2014-2025 period.

per capita funding; and the change in the escalator from 6% annually to the three-year average of GDP growth.

With respect to the transition, the federal government's December 2011 announcement limited transfer payment protection to an assurance that no province or territory would receive less in cash under the new system than it did in the last year of the old system. But that payment would not be considered part of the base for the purposes of future escalation. The shift to equal per capita funding under the CHT was much less favourable to the provinces and territories than the corresponding shift to equal per capita funding for the Canada Social Transfer (CST). In the implementation of equal per capita funding under the CST, in the first year of the new system every province was guaranteed that it would not receive less than it would have received under the prior system. Furthermore, those additional payments would be added to the funding base for future escalation.

Although the point is now moot – as the move to equal per capita funding is now complete – the Council estimated that the application of the CST transition rule to the CHT would have increased base funding by $822 million in 2014-2015, rising to $1,389 million in 2023-2024.

With respect to the impact of the change in escalator, the Council estimated that by 2023-2024, the CHT would be lower by $7,131 million, compared with what it would have been with the 6% escalator.

It also presented detailed tables projecting CHT entitlements to individual provinces under various transitional scenarios and under the 6% escalator for comparison.

Although the Council's CHT projections do not disclose explicitly the GDP growth assumptions that drive the projections under the GDP growth rate-linked formula, the figures in the report imply that a growth rate of 3.9% was used for its projections of CHT payments.

Shifting the focus to health care

In the January 2012 PBO analysis and the Council of the Federation study, the focus was on broad issues of fiscal sustainability and federal-provincial fiscal arrangements. While the PBO's July 2012 analysis looked specifically at the relationship between health care costs and CHT transfers at the provincial level, it covered only the period to 2022-2023, and analyzed health costs and impacts at a very general level.

In this paper, the focus shifts to the relationship between CHT changes and health care costs at the provincial and territorial level, and then to the potential impact on specific areas of health care programming. The time frame for the analysis is the next decade – 2015 to 2025 – with specific emphasis on the impact of the new GDP growth-linked formula beginning in 2017.

Estimating total CHT transfer payments from the federal government to provinces and territories

Under the system announced in December 2011, the rate of growth of federal transfers for health care was changed from the 6% annual escalator mandated by the 2004 Health Accord to a 3-year moving average of percentage growth in Canadian GDP, with a minimum escalator in any year of 3%.

Any estimate of the relative impact of the change is highly sensitive to the time period over which the impact is measured and the underlying assumptions with respect to economic growth.[iv]

The assumption underlying the projections of both the PBO and the Council of the Federation is for nominal economic growth of 3.9% over the 2014-2025 period. The CHT projections of both the PBO and the Council of the Federation imply a forecast nominal growth rate averaging 3.9% over the 2014-2025 period.

A look back based on historical experience might suggest that this is a low estimate. In fact, once account is taken of the basic building blocks of longer-term nominal growth rates, it is not. Nominal GDP growth is driven by three basic factors: labour force growth; productivity growth; and inflation.

Most forecasters today tend to assume that the Bank of Canada will be able to stick very close to its inflation target, and therefore they assume that inflation will run at 2% in the long term. That is not much different from the actual numbers over the past 20 years. Canada's labour force growth rate over the next few decades, however, is likely to be substantially lower than it has in recent history. According to Statistics Canada's medium population projection – the projection generally used by forecasters, Canada's population between the ages of 20 and 65 is expected to grow by only 0.3% per year over the ten years ending in 2025. That means that, unless there is an unexpected substantial increase in labour force participation, the labour force is unlikely to grow more quickly than at that 0.3% rate.

That, in turn, implies that, to achieve a nominal growth rate of 3.9%, Canada's productivity growth rate would have to average 1.6% over the next decade. That is a very optimistic assumption, given that the highest rate of productivity growth in Canada since 1971 is 1.4% (achieved in 1971 and again in 1995), and in the most recent year for which data are available, 2012, was barely over 1.0%.[7]

[iv] For example, the Council of the Federation's often-cited figure for an annual loss by 2023-2024 of $8.5 billion and a cumulative loss of $35.9 billion covers the period from 2014-2015 to 2023-2024, is based on an average growth rate of 3.9%, and starts from a slightly higher funding base. The Parliamentary Budget Officer's projections assume that the GDP escalator for health transfers will begin to apply as scheduled for 2017-2018 transfers and will continue until 2024-2025. The moving three-year average of GDP growth which drives the CHT projections is assumed to be 3.9%. Although the PBO report does not actually include a dollar projection for the CHT under the December 2011 formula, its assumptions are essentially the same as those used in our medium-growth projection.

Projecting CHT funding to 2024-2025

In this analysis, CHT funding is projected over the next decade, from 2014-2015 to 2024-2025. This covers the last year of the prior system, the first two years of the new system in which the 6% escalator is preserved, and the period from 2017-2018 to 2024-2025 (the 10th year of the new GDP growth rate-linked system).

The following table shows the loss in CHT funding relative to the pre-existing 6% escalator, compared with projections based on three different GDP growth assumptions: 3.9%, as assumed in the PBO and COF estimates; 3.3%, a growth rate consistent with Canada's current productivity performance; and 4.3%, a high growth rate consistent with a productivity growth rate of 2.0%. Chart 3 presents the same information in graph form.

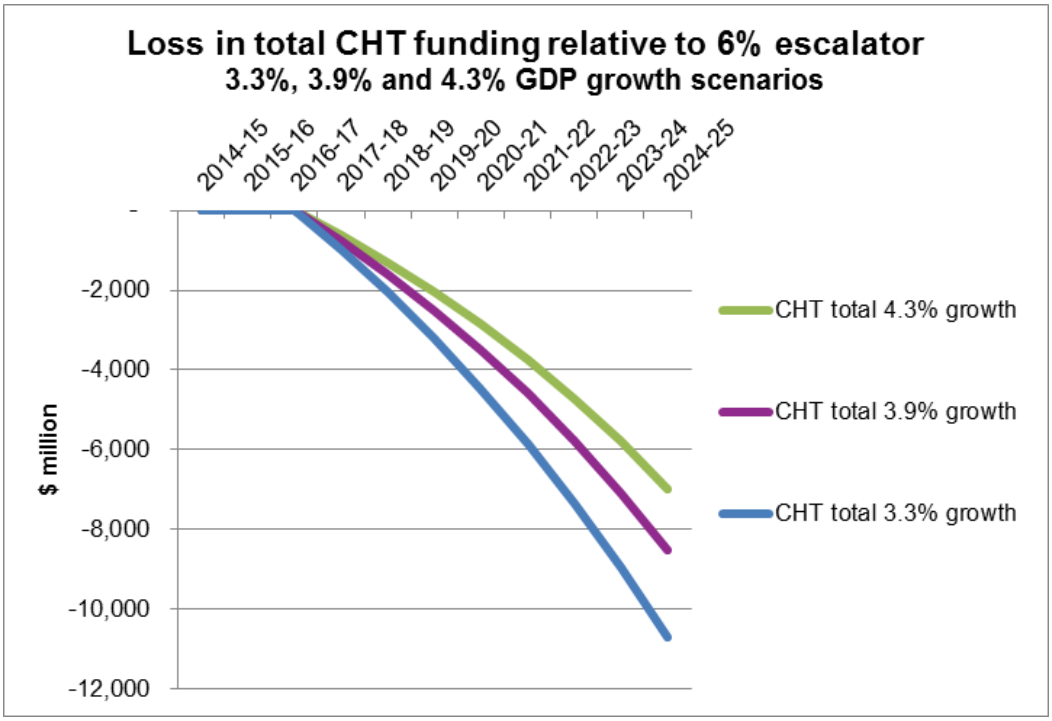
Table 1. Funding loss under GDP escalator ($ million)

	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	Cumulative 8-year total
3.3% growth	-974	-2,038	-3,200	-4,465	-5,842	-7,338	-8,961	-10,721	-43,539_
3.9% growth	-757	-1,590	-2,503	-3,503	-4,595	-5,788	-7,088	-8,504	-34,328_
4.3% growth	-613	-1,289	-2,034	-2,852	-3,748	-4,730	-5,803	-6,975	-28,044

Based on the growth assumption behind the CBO and COF projections, the annual loss in CHT funding would reach approximately $8.5 billion by 2024-2025 for a cumulative loss over the period from 2017-2018 to 2024-2025 of $34.3 billion.[v] Under a high growth rate scenario, that loss would be just under $7.0 billion annually and cumulate to $28.0 billion. However, under the 3.3% lower-growth assumption, which is more consistent with Canada's recent productivity performance, the funding loss would reach $10.7 billion annually by 2024-2025 and cumulate to a total of $43.5 billion.

[v] This estimate compares with the COF estimate of $36 billion over the period 2014-2015 to 2023-2024. The difference reflects the combined (and largely offsetting) effect of extending the analysis of the GDP-linked formula for one year beyond the end date of the COF report's data and excluding the COF's estimate of the costs to provincial and territorial governments of the less-generous-than-expected funding for transition from equalized to equal per capita funding.

Chart 3. Funding loss under GDP escalator ($ million)



Projecting health care costs

In its forecast of heath care costs, the Parliamentary Budget Officer employed a methodology developed by the Congressional Budget Office in the United States. In essence, the CBO method starts with the GDP growth rate and adds adjustments for demographic shifts[vi] and an additional factor called the "enrichment factor" which captures the impact of higher health care cost inflation.[vii] In our projections, we modified this approach slightly to reflect the greater growth rate of population relative to the labour force.[viii]

[vi] The adjustment for demographic shifts is designed to capture the impact of changes in the age and gender structure of the population. This is particularly important in the current environment as the proportion of the population over the age of 65 continues to increase. The impact of changes in age and gender structure is estimated by comparing base year costs with costs in a future year, assuming that average expenditures by age and gender remain the same. In this instance, we looked at average costs by age and gender in 2012 (the most recent year for which data are available) provided by the Canadian Institute for Health Information (CIHI) and compared the actual total cost for 2012 with the total cost that would be obtained with the population distribution of 2024 as projected by Statistics Canada. That analysis indicates that change in age composition, by itself, results in a 1.0% annual increase in health care costs.

[vii] In the PBO analysis, the "enrichment factor" used is 0.4%, which approximates the average for the period 1976 to 2010.

[viii] In our calculation, we subtract the rate of growth of the labour force and add the rate of growth of the population. So the calculation is: nominal GDP growth rate MINUS labour force growth rate PLUS population growth rate PLUS age composition shift impact PLUS "enrichment factor."

Using that same methodology, health care costs for Canada as a whole would be estimated to increase at 5.9% annually (3.9% nominal growth less 0.3% labour force growth; plus 1.9% for population growth and demographic shifts; and 0.4% to capture relative increases in health care costs). Using a revised 3.3% GDP growth rate assumption would reduce the estimated annual growth rate to 5.3%.

In the 3.9% scenario, CHT transfers as a share of health care costs reach a peak of 22.8% of health spending and then drop to 19.0% in 2024-2025, a decline consistent with the longer-term decline forecast by the PBO.

In the 3.3% GDP growth scenario, the share peaks at 23.0% and drops to 19.2%. In the 4.3% GDP growth scenario, the share peaks at 22.8% and drops to 18.9% by 2024-2025.[ix]

Impact of demographic shifts on allocations among provinces and territories

While total CHT funding is independent of population, the allocation of that amount among the provinces and territories depends on overall population growth as well as on each province or territory's share of that population growth.

Statistics Canada's population growth projections are based on assumptions about factors that affect the Canadian population as a whole, such as birth rates, mortality rates and immigration overlaid with assumptions about internal migration patterns. These different assumptions produce projections for both total population and its composition that vary from jurisdiction to jurisdiction.

Differences in population projection growth rates affect both CHT transfers under the new formula and health care costs; differences in the composition of population have an additional impact on health care costs.

Table 2 shows for each province and territory for 2014-2015 the level of CHT funding that would have been provided in 2024-2025, using the 6% escalator; CHT funding for 2024-2025 under the GDP growth escalator assuming a revised GDP growth of 3.3%; the difference between the two; and the percentage impact on CHT funding.

[ix] While the relative impacts are the same in the three scenarios – in all three cases, the CHT share of costs drops by 1.8 percentage points - the absolute shares differ because in the model used, the GDP growth rate affects the rate of expenditure growth in each province as well as the CHT growth rate at the national level.

Table 2. CHT funding growth to 2024-2025, GDP escalator and 6% escalator compared ($ million)

	2014-2015 CHT funding	2024-2025 CHT funding with 6% escalator	% growth to 2024-2025 with 6% escalator	2024-2025 CHT funding with GDP escalator	% growth to 2024-2025 with GDP escalator	CHT funding difference 6% vs. GDP
NL	490	739	51%	601	23%	-138
PE	132	229	73%	186	41%	-43
NS	852	1,369	61%	1,114	31%	-255
NB	682	1,107	62%	901	32%	-207
QC	7,420	12,951	75%	10,536	42%	-2,415
ON	12,356	21,774	76%	17,713	43%	-4,061
MB	1,158	2,061	78%	1,677	45%	-384
SK	1,016	1,804	78%	1,468	44%	-336
AB	3,718	7,607	105%	6,188	66%	-1,419
BC	4,184	7,660	83%	6,232	49%	-1,429
YT	33	63	92%	51	56%	-12
NT	39	62	60%	51	30%	-12
NU	34	58	72%	48	40%	-11
Canada	**32,114**	**57,486**	**79%**	**46,765**	**46%**	**-10,721**

Growth rates in funding differ dramatically, depending on rates of population growth. Overall, funding in 2024-2025 is $10.7 billion, or 18.7% lower with the GDP escalator than it would have been with the automatic 6% escalator.

[U]nder the 3.3% lower-growth assumption, which is more consistent with Canada's recent productivity performance, the funding loss would reach $10.7 billion annually by 2024-2025 and cumulate to a total of $43.5 billion.

Impact of demographic shifts on health care costs among provinces and territories

In the forecasting model, three key demographic factors drive differences in health care costs: the rate of growth of population; the rate of growth of the labour force, and the age and gender composition of the population. All of these factors influence the evolution of health care costs. Assuming that labour productivity growth and inflation are uniform across Canada, differences in the rate of population growth and differences in the age and gender composition of the population will drive differences in health care costs among provinces.

In the medium-growth rate case, in which the national nominal rate of growth is 3.9% and inflation is 2%, we can isolate productivity growth from labour force growth. Nationally, the labour force (the population between the ages of 20 and 65) grows at 0.3% per year. With inflation at 2%, this implies labour productivity growth at 1.6% per year. Long-term productivity data for Canada suggest this

is an extremely optimistic assumption. A rate of 1.6% is 0.2% above the highest rate of productivity growth achieved in Canada over the past 40 years. The revised growth rate assumption of 3.3% implies a productivity growth rate of 1.0%, which is consistent with Canada's recent productivity growth experience.[x]

Assuming that inflation and productivity growth are roughly the same across jurisdictions in Canada, we estimate the rate of health care cost increase at the provincial and territorial level as the sum of the rate of inflation, the rate of productivity growth, the "enhancement factor", each province's rate of population growth and the impact in each province of changes in the age and gender make-up of the population (details of the estimate of health spending growth are set out in Appendix A).

The results are summarized in the following table, with CHT transfers forecast based on the 3.3% revised GDP growth scenario.

Table 3. GDP-linked CHT declines as share of health care expenditures

	Health cost growth rate	2014-2015 cost $ million	2024-2025 cost $ million	2014-2015 CHT % of cost	2024-2025 CHT % of cost GDP escalator	2024-2025 CHT % of cost 6% escalator
NL	4.8%	2,674	3,624	18%	17%	20%
PEI	5.5%	628	1,051	21%	18%	22%
NS	4.8%	4,090	5,896	21%	19%	23%
NB	5.0%	3,098	4,573	22%	20%	24%
QC	5.2%	30,070	49,603	25%	21%	26%
ON	5.3%	51,598	89,083	24%	20%	24%
MB	4.9%	5,656	9,458	20%	18%	22%
SK	4.8%	5,001	8,049	20%	18%	22%
AB	6.4%	19,273	41,869	19%	15%	18%
BC	5.4%	17,721	31,330	24%	20%	24%
YT	6.3%	238	459	14%	11%	14%
NT	5.2%	352	536	11%	9%	12%
NU	5.1%	374	632	9%	8%	9%
Canada	**5.3%**	**140,772**	**243,504**	**23%**	**19%**	**24%**

Federal funding and health care cost growth

In reducing the rate of growth in transfers to the provinces and territories for health care, the federal government isn't simply retreating from the 2004 Accord commitment to renew federal participation health care

[L]imiting CHT growth to the rate of growth in GDP means that CHT growth will cover a smaller and shrinking share of the growth in health care costs faced by provincial and territorial governments.

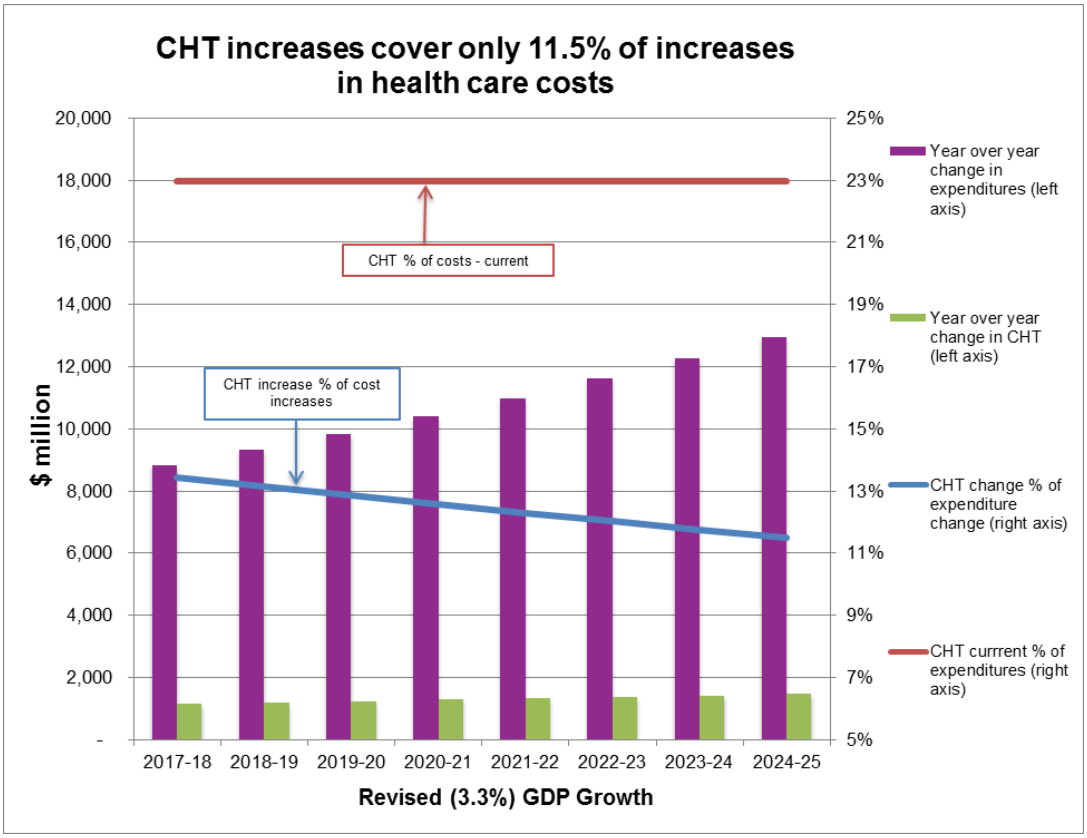
[x] Canada's productivity growth rate in 2012, the most recent year for which data are available, was 1.0%, and on a consistent slow downward trend since the mid-1990s. See Conference Board of Canada (2015). How Canada Performs, International Rankings, Economy, Labour Productivity Growth.

funding, it is clearly and explicitly moving federal funding in the opposite direction to the trajectory of health care costs.

Forecasts may differ in detail, based on differences in assumptions, and year-to-year changes in provincial health care spending may be driven in part by provincial and territorial government fiscal considerations, but there is consensus that Canada's population is aging and that one of the implications of an aging population is a more rapid rate of growth in health care costs. In the face of that consensus, limiting CHT growth to the rate of growth in GDP means that CHT growth will cover a smaller and shrinking share of the growth in health care costs faced by provincial and territorial governments.

The following chart captures that change, based on a 3.3% adjusted GDP growth projection.

Chart 4. $43.5 billion cumulative funding loss



In the chart, the purple bars show year-to-year projected growth in health care spending. For example, it shows that, in 2017-2018, health care costs are projected to increase by $8.85 billion nationally. The light green bars show year-to-year growth in the CHT. For example, it shows that in 2017-2018, total CHT funding is projected to increase by $1.2 billion, compared with 2016-2017. Dollar figures are presented relative to the left-hand axis in the chart.

The dark blue line shows the percentage of projected health care cost increases that will be covered by increases in the CHT. For example, it shows that in 2017-2018, CHT increases are expected to cover 13.5% of health care cost increases.

For comparison, the dark red line shows the percentage of health care costs across Canada covered by the CHT prior to 2017-2018, approximately 23%. Percentage figures are presented relative to the right hand axis in the chart.

The impact of the changes in the CHT formula are clearly evident in this chart. Year over year, growth in the CHT covers a smaller and shrinking share of the growth in health spending, compared with the share it covered at the end of the 6% escalator commitment in 2016-2017. CHT coverage of health care costs drops from 23% prior to 2017-2018 to 13.5% in 2017 and continues to slide to less than 12% by 2024-2025. The extent of the revenue-side squeeze on health care expenditures is obvious.

Province-by-province impacts

The impacts of the change in the CHT on resources available for provincial and territorial health care vary among provinces and territories because of differences in the rate of growth of population, differences in the nature of the shift in the age and gender composition of the population and differences in the rate of labour force growth which, in turn, drives overall economic growth and influences the growth in health care spending.

Funding that is not available to support health care translates directly into service reductions, lower employment in the health care sector, growing gaps between resources and needs.

In this section, we focus on each jurisdiction individually. We detail the interacting effects of the reduced rate of growth and health care cost growth using best estimates for each individual jurisdiction.

The overall numbers, as important as they may be for the fiscal futures of provincial and territorial governments, are just the beginning of the story. Funding that is not available to support health care translates directly into service reductions, lower employment in the health care sector, growing gaps between resources and needs.

To illustrate the service-level impact of the funding shortfalls for each jurisdiction, we have focused on a package of services that, taken together, is tied directly to the factor that, by consensus, will dominate the evolution of health care service needs in Canada for a generation to come:

- Home care – health care services for seniors and others with health care needs in their homes;
- Interprofessional Comprehensive Health Care Centres – the emerging standard for primary health care, bringing together a variety of health care services in a single location, a form of one-stop-shopping health care delivery that is particularly suited to the needs of the elderly;
- Long-term care beds and associated support; and
- Nursing care.

Using the best data available to link resources to service levels, we detail the service level impacts on a package of changes in these four service categories,[xi] that adds to the estimated 2024-2025 funding loss, translated into 2015 dollars for comparison purposes. In each instance, we present three total funding scenarios: one based on the prior consensus rate of economic growth in Canada over the next eight years of 3.9%; the other based on a more realistic growth projection of 3.3%; and the third one based on a more optimistic growth projection of 4.3%.

The detailed discussion below for each province is based on the revised 3.3% GDP growth scenario for CHT growth. Impacts for the 3.9% and 4.3% scenarios are summarized in the accompanying tables.

Newfoundland and Labrador – cumulative projected CHT loss $577 million

The impacts under each GDP growth rate scenario are summarized in the following table in Newfoundland and Labrador.

	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$138 milliion	$109 milliion	$90 milliion
Services potentially at risk			
Home care visits	837,000	662,000	546,000
Primary care centre patients	28,000	22,000	18,200
Long-term care beds	100	80	66
Nurses employed	335	265	218

Newfoundland and Labrador is projected to have the lowest rate of health care cost growth in Canada. This results from two offsetting factors. On the one hand, Newfoundland and Labrador is projected to have the most pronounced age-driven cost shift in the country over the next decade – an average of 1.8% per year (compared with a Canadian average of 1%). However, that additional cost pressure is more than offset by the fact that population is projected to decline by 0.4% per year and the labour force to shrink by 1.7% per year, thereby limiting the province's expected GDP growth.

Despite Newfoundland and Labrador's relatively lower rate of projected health expenditure growth, increases in the CHT under the GDP-linked formula will cover a reduced share of health care cost increases. Under the revised 3.3% growth scenario, Newfoundland and Labrador's forecast CHT increase covers approximately 10% of its health care cost increases, down from 18% before 2017-2018.

> By 2024-2025, Newfoundland and Labrador's annual loss in CHT payments relative to the 6% escalator in the 3.3% GDP growth scenario is estimated at $138 million. Its cumulative loss is an estimated $577 million.

[xi] Estimates of provincial and territorial program impacts were developed by Dr. Michael Rachlis, based on 2015 data. For a more detailed explanation of the methodology used, see Appendix C. For the purposes of this analysis, we assume 36.4% of the funding loss is associated with home care; 36.4% with interprofessional primary care; 4.5% with long-term care beds; and 22.7% with nursing care. For Nova Scotia, the split between primary care and long-term care was varied, with 27% associated with primary care and 13.9% associated with long-term care.

That translates to 837,000 home care visits not funded; 28,000 patients not served by a primary health care centre; 100 long-term care beds not funded; and 335 fewer nurses employed.

Prince Edward Island – cumulative projected CHT loss $175 million

The following table summarizes program impacts under the three GDP growth rate scenarios in Prince Edward Island.

	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$43 million	$34 million	$28 million
Services potentially at risk			
Home care visits	218,000	170,000	140,000
Primary care centre patients	11,000	8,700	7,100
Long-term care beds	44	35	28
Nurses employed	105	80	67

PEI's average expenditure growth of 5.9% is accounted for by population growth of 0.6% (compared with a Canadian average of 1.0%), the impact of the change in the age and gender composition of the population of 1.5% (compared with a Canadian average of 1.0%) and a labour force decline of 0.2% (compared with a Canadian average growth of 0.3%).

As is the pattern for all provinces, increases in CHT payments make up a substantially smaller and shrinking proportion of health expenditure increases than they did of total health expenditures, pointing to a steadily tightening revenue squeeze on health care expenditures. Under the revised 3.3% growth scenario, PEI's forecast CHT increase covers approximately 10% of its health care cost increases, down from 21% before 2017-2018.

> By 2024-2025, PEI's annual loss in CHT payments relative to the 6% escalator in the 3.3% GDP growth scenario is estimated at $43 million. Its cumulative loss is an estimated $175 million.

That translates to 218,000 home care visits not funded; 11,000 patients not served by a primary health care centre; 44 long-term care beds not funded; and 105 fewer nurses employed.

Nova Scotia – cumulative projected CHT loss $1.06 billion

The following table summarizes the program impacts under the three GDP growth rate scenarios in Nova Scotia.

	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$255 million	$203 million	$166 million
Services potentially at risk			
Home care visits	1,300,000	1,000,000	843,000
Primary care centre patients	61,300	48,400	39,800
Long-term care beds	525	415	340
Nurses employed	623	492	405

Nova Scotia's projected health care expenditure growth of 4.3% is accounted for by a population decline of 0.1% per year (compared with a Canadian average of 1.0%), cost pressures resulting from changes in the age and gender composition of the population of 1.5% (compared with a Canadian average of 1.0%) and a labour force decline at a rate of 1.1% (compared with a Canadian average increase of 0.3%).

Health care spending is continuously squeezed over the 2017-2018 to 2024-2025 period, as CHT increases amount to a shrinking share of health care cost increases from an initial level that is substantially lower (just under 13%) than the percentage covered at the beginning of the period (21%). By 2024-2025, the percentage of cost increases covered by CHT increases will drop to just over 11%.

> By 2024-2025, Nova Scotia's annual loss in CHT payments relative to the 6% escalator in the 3.3% GDP growth scenario is estimated at $255 million. Its cumulative loss is an estimated $1.06 billion.

That translates to 1,300,000 home care visits not funded; 61,300 patients not served by a primary health care centre; 525 long-term care beds not funded; and 623 fewer nurses employed.[xii]

[xii] As noted above, the relative weighting of primary care centres and long-term care beds differs in Nova Scotia compared with the other provinces. In Nova Scotia, 13.9% of the funding loss was allocated to long-term care (as opposed to 4.5% elsewhere) and 27% to primary care centres (as opposed to 36.4% elsewhere). Other allocations are common to all provinces.

New Brunswick – cumulative projected CHT loss $858 million

The following table summarizes the program impacts under the three GDP growth rate scenarios in New Brunswick.

	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$207 million	$164 million	$134 million
Services potentially at risk			
Home care visits	1,260,000	998,000	815,400
Primary care centre patients	50,400	40,000	32,600
Long-term care beds	152	120	99
Nurses employed	503	399	326

New Brunswick's 4.6% health spending growth is attributable to a lower than average population change of 0% (compared with a Canadian average of 1.0%); a higher-than-average impact of changes in age and gender in the population (1.6% compared with a Canadian average of 1.0%); and a labour force shrinking at the rate of 1.0% per year vs. (compared with a Canadian average increase of 0.3%).

New Brunswick shares with all provinces and territories the impact of a substantially lower (and shrinking) share of health care cost increases covered by CHT increases over the GDP escalator period, compared with the share of total expenditures covered under the 2004 Health Accord by 2014-2015. Under the revised 3.3% growth scenario, New Brunswick's forecast CHT increase covers approximately 11% of its health care cost increases by 2024-2025, down from 22% before 2017-2018.

> By 2024-2025, New Brunswick's annual loss in CHT payments relative to the 6% escalator in the 3.3% GDP growth scenario is estimated at $207 million. Its cumulative loss is an estimated $858 million.

That translates to 1,260,000 home care visits not funded; 50,400 patients not served by a primary health care centre; 152 long-term care beds not funded; and 503 fewer nurses employed.

Quebec – cumulative projected CHT loss $9.87 billion

The following table summarizes program impacts under the three GDP growth rate scenarios in Quebec.

	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$2.42 billion	$1.92 billion	$1.57 billion
Services potentially at risk			
Home care visits	10,500,000	8,300,000	6,800,000
Primary care centre patients	613,000	485,000	394,000
Long-term care beds	1,500	1,200	977
Nurses employed	5,900	4,700	3,800

Quebec's health expenditure growth rate of 5.6% is attributable to the combined effect of a population growth rate of 0.7% per year (compared with the Canadian average of 1.0%); changes in the age structure of the population of 1.1% (compared with the Canadian average of 1.0%); and a labour force decline of 0.1% per year (compared with the Canadian average increase of 0.3%).

Quebec experiences the same CHT-related revenue squeeze on health care spending increases as the other provinces and territories, as CHT year over year growth relative to spending falls short of historical averages and declines over time. Under the revised 3.3% growth scenario, Quebec's forecast CHT increase covers approximately 13% of its health care cost increases by 2024-2025, down from 25% before 2017-2018.

> By 2024-2025, Quebec's annual loss in CHT payments relative to the 6% escalator in the 3.3% GDP growth scenario is estimated at $2.4 billion. Its cumulative loss is an estimated $9.87 billion.

That translates to 10,500,000 home care visits not funded; 613,000 patients not served by a primary health care centre; 1,500 long-term care beds not funded; and 5,900 fewer nurses employed.

Ontario – cumulative projected CHT loss $16.5 billion

The following table summarizes program impacts under the three GDP growth rate scenarios in Ontario.

	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$4.06 billion	$3.22 billion	$2.64 billion
Services potentially at risk			
Home care visits	24,750,000	19,650,000	16,000,000
Primary care centre patients	952,000	756,000	616,000
Long-term care beds	3,000	2,400	1,940
Nurses employed	9,200	7,300	6,000

Ontario's health care expenditure growth is projected to be at the Canadian average, driven by a slightly lower than average population growth of 0.8% (compared with the Canadian average of 1.0%), slightly higher than average aging-related cost pressures of 1.1% per year (compared with the Canadian average of 1.0%) and the Canadian average labour force growth of 0.3%.

Note that the higher-than-average of historical CHT to health expenditures ratio in Ontario and Quebec is attributable to the fact that those provinces' health care expenditures per capita are lower than the Canadian average.

Ontario experiences the same CHT-related revenue squeeze on health care spending increases as the other provinces and territories, as CHT year-over-year growth relative to spending falls short of historical averages and declines over time. Under the revised 3.3% growth scenario, Ontario's forecast CHT increase covers approximately 11% of its health care cost increases by 2024-2025, down from 24% before 2017-2018.

By 2024-2025, Ontario's annual loss in CHT payments relative to the 6% escalator in the 3.3% GDP growth scenario is estimated at $4.06 billion. Its cumulative loss is an estimated $16.5 billion.

That translates to 24,750,000 home care visits not funded; 952,000 patients not served by a primary health care centre; 3,000 long-term care beds not funded; and 9,200 fewer nurses employed.

Manitoba – cumulative projected CHT loss $1.56 billion

The following table summarizes program impacts under the three GDP growth rate scenarios in Manitoba.

	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$384 million	$305 million	$250 million
Services potentially at risk			
Home care visits	1,670,000	1,170,000	1,100,000
Primary care centre patients	88,500	62,000	57,000
Long-term care beds	345	241	224
Nurses employed	870	608	565

The province's 5.9% health cost growth rate is driven by slightly below average population growth of 0.9% (compared with the Canadian average of 1.0%); and a significantly lower than average age-related cost impact of 0.5% (compared with the Canadian average of 1.0%), along with a labour force growing slightly more rapidly than the Canadian average (0.4% compared to the Canadian average increase of 0.3%).

Manitoba's higher than Canadian average per capita health spending is reflected in a lower CHT to spending ratio at the beginning of the period. It is subject to the same CHT revenue squeeze relative to health care cost increases as other provinces. Under the revised 3.3% growth scenario, Manitoba's forecast CHT increase covers approximately 11% of its health care cost increases by 2024-2025, down from 20% before 2017-2018.

By 2024-2025, Manitoba's annual loss in CHT payments relative to the 6% escalator in the 3.3% GDP growth scenario is estimated at $384 million. Its cumulative loss is an estimated $1.56 billion.

That translates to 1,670,000 home care visits not funded; 88,500 patients not served by a primary health care centre; 345 long-term care beds not funded; and 870 fewer nurses employed.

Saskatchewan – cumulative projected CHT loss $1.37 billion

The following table summarizes program impacts under the three GDP growth rate scenarios in Saskatchewan.

	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$336 million	$267 million	$219 million
Services potentially at risk			
Home care visits	1,370,000	1,080,000	890,000
Primary care centre patients	82,000	65,000	53,300
Long-term care beds	160	127	104
Nurses employed	710	562	462

Saskatchewan's health spending growth rate of 5.6% is driven by a slightly lower than average population growth rate of 0.9% (compared with the Canadian average of 1.0%) and a substantially lower age impact of 0.5% (compared with the Canadian average of 1.0%), together with a lower-than-average labour force growth rate of 0.1% (compared with the Canadian average increase of 0.3%).

Saskatchewan's higher-than-average per capita health spending is reflected in a lower-than-average CHT share of health spending at the beginning of the GDP escalator period. Otherwise, Saskatchewan experiences the same CHT-related revenue squeeze on health care spending increases as the other provinces and territories, as CHT year-over-year growth relative to spending falls short of historical averages and declines over time. Under the revised 3.3% growth scenario, Saskatchewan's forecast CHT increase covers approximately 12% of its health care cost increases by 2024-2025, down from 20% before 2017-2018.

> By 2024-2025, Saskatchewan's annual loss in CHT payments relative to the 6% escalator in the 3.3% GDP growth scenario is estimated at $336 million. Its cumulative loss is an estimated $1.37 billion.

That translates to 1,370,000 home care visits not funded; 82,000 patients not served by a primary health care centre; 160 long-term care beds not funded; and 710 fewer nurses employed.

Alberta – cumulative projected CHT loss $5.6 billion

The following table summarizes program impacts under the three GDP growth rate scenarios in Alberta.

	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$1.42 billion	$1.13 billion	$923 million
Services potentially at risk			
Home care visits	10,920,000	8,570,000	7,000,000
Primary care centre patients	349,000	274,000	225,000
Long-term care beds	822	645	530
Nurses employed	2,775	2,178	1,785

Alberta is projected to have by far the most rapidly increasing health care costs in Canada, at 8.7%. Its 2.3% projected population growth rate (compared with the Canadian average of 1.0%) swamps its slightly lower-than-average age impact of 0.7% (compared with the Canadian average of 1.0%), and its labour force growth of 1.7% is substantially above the Canadian average growth of 0.3%.

As a consequence of its per capita health spending (highest in Canada), its very rapid population growth and its high rate of labour force growth, CHT makes up the lowest proportion of health care costs in Canada going into the GDP escalator period, and CHT increases make up a smaller and more rapidly shrinking share of projected health care cost increases. However, Alberta experiences the same CHT-related revenue squeeze on health care spending increases as the other provinces and territories, as CHT year-over-year growth relative to spending falls short of historical averages and declines over time. Under the revised 3.3% growth scenario, Alberta's forecast CHT increase covers approximately 9% of its health care cost increases by 2024-2025, down from 19% before 2017-2018.

> By 2024-2025, Alberta's annual loss in CHT payments relative to the 6% escalator in the 3.3% GDP growth scenario is estimated at $1.42 billion. Its cumulative loss is an estimated $5.6 billion.

That translates to 10,920,000 home care visits not funded; 349,000 patients not served by a primary health care centre; 822 long-term care beds not funded; and 2,775 fewer nurses employed.

British Columbia – cumulative projected CHT loss $5.78 billion

The following table summarizes program impacts under the three GDP growth rate scenarios in British Columbia.

	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$1.43 billion	$1.13 billion	$930 million
Services potentially at risk			
Home care visits	6,240,000	4,930,000	4,000,000
Primary care centre patients	412,000	325,000	267,000
Long-term care beds	890	705	578
Nurses employed	3,242	2,560	2,102

BC's slightly higher-than-average population growth of 1.2% (compared with the Canadian average of 1.0%) and its slightly lower-than-average age impact of 0.8% (compared with the Canadian average of 1.0%) combined with a higher-than-average labour force growth of 0.5% (compared with the Canadian average increase of 0.3%) to produce a higher-than-average 6.5% estimated health expenditure growth rate.

BC experiences the same CHT-related revenue squeeze on health care spending increases as the other provinces and territories, as CHT year-over-year growth relative to spending falls short of historical averages and declines over time. Under the revised 3.3% growth scenario, BC's forecast CHT increase covers approximately 12% of its health care cost increases by 2024-2025, down from 24% before 2017-2018.

> By 2024-2025, BC's annual loss in CHT payments relative to the 6% escalator in the 3.3% GDP growth scenario is estimated at $1.43 billion. Its cumulative loss is an estimated $5.78 billion.

That translates to 6,240,000 home care visits not funded; 412,000 patients not served by a primary health care centre; 890 long-term care beds not funded; and 3,242 fewer nurses employed.

Yukon, NWT and Nunavut – cumulative projected CHT loss $140 million

Although the situation of each of the territories differs in some respects – NWT is projected to have a slowly shrinking population (0.2% per year compared with growth of 1.5% for the Yukon and 1.0% for Nunavut), a greater age impact on health care costs (2.0% vs. 1.4% for the Yukon and 0.7% for Nunavut) and a rapidly declining labour force (0.9% per year, compared with increases of 0.5% for Yukon and 0.3% for Nunavut) – the CHT as a whole is less significant relative to health care costs than it is in the southern jurisdictions. Furthermore, CHT funding issues will inevitably be overwhelmed by broader funding issues and the particularly significant issues facing health care North of 60.

Compared with the national average of 23% at the end of the Health Accord era of federal funding in 2015, with per capita allocation the CHT accounted for only 14% of health spending in Yukon, 11% in NWT and 9% in Nunavut.

For completeness, CHT losses in the 3.3% growth rate scenario relative to the 6% escalator for Yukon, NWT and Nunavut are projected to be as follows:

	Annual shortfall by 2024-2025	Cumulative shortfall 2017-2018 to 2024-2025
Yukon	$12 million	$47 million
Northwest Territories	$12 million	$49 million
Nunavut	$11 million	$44 million

With 3% of Canada's population in three territories accounting for 39% of Canada's land area, these details, however, do not begin to address the issues affecting funding and delivery of health care North of 60.

Even without taking into account the fact that current levels of health care spending North of 60 are likely substantially below what is needed to deliver health care to acceptable Canadian standards, the GDP-related formula will cover only a small portion of projected health care cost increases between 2017-2018 and 2024-2025. The share of projected cost increases covered by CHT increases drops from 8% to 7% over the period in Yukon, from 6% to 5% in Nunavut, and from 5% to 4% in NWT.

These basic facts about health care costs and funding North of 60 highlight a much broader problem with the general approach taken by the federal government in its funding for health care. Funding based on population – even if it were equalized to revenue raising capacity – is insensitive to legitimate underlying differences in the drivers of the costs of delivering health care services. These differences range from differences in demographic profiles and trajectories, to differences in the costs of providing services related to population densities to differences in costs arising from differences in regional labour markets. While these issues are most obvious when considering Canada's North of 60, they apply more generally across the country.

Finally, we note that in this analysis, we have not included detailed impacts of North of 60 for two reasons. First, and most important, metrics that make sense as a standard of comparison in the South simply don't make sense in the North of 60 context. The issues facing North of 60 governments simply cannot reasonably be captured in standardized service categories. Second, reliable data are not available publicly to support the service impact analysis included above for the South of 60 provinces.

Implications for Canadian medicare

The cuts to CHT funding announced by the federal government in December 2011 continue a pattern that has persisted in Canada since the mid-1970s in which successive federal governments have fallen back on cuts in transfers to provincial and territorial governments to deal with their own fiscal pressures. These strategies do not actually deal with the underlying problems of fiscal imbalance, they simply export those problems from the federal government to the provincial and territorial governments.

[C]uts to CHT funding... continue a pattern... in which successive federal governments have fallen back on cuts in transfers to provincial and territorial governments to deal with their own fiscal pressures.

The fact that funding is decreasing relative to health care costs, and the fact that these changes were simply announced by the federal government without negotiation or even discussion with provincial and territorial governments, add a dimension to the issues raised by the change – a threat to the credibility of the federal government as a funding and policy partner in Canadian medicare. That credibility had been badly damaged by the "hell or high water" federal attack on its deficit in the 1990s – an attack in which the ammunition consisted largely of federal transfers to the provinces and territories and the benefits payable to the unemployed.

The GDP formula does not begin to reach the low-point reached by federal health transfers immediately before the Romanow Commission's report led to the 2004 Health Accord, but it is moving the federal role in the wrong direction.

It is remarkable that the CHT formula imposed in the December 2011 statement takes no account at all of the additional pressures placed on health care costs in Canada by our aging population. It is as if the federal government thinks that if it ignores the impact of an aging population on health care costs, it will simply go away.

The absence of any connection between the funding provided and either the aging of the population generally or differences in the impact of aging among provincial jurisdictions highlights a broader problem with federal funding of provincially delivered health care alluded to in the discussion above of health care funding in the territories – the lack of a relationship between funding and the costs of delivering health care.

These differences are most obvious for North of 60, but they are significant when comparing southern jurisdictions as well. In this paper, we highlight and take into account differences in rates of population growth, differences in rates of labour force growth (which have a direct impact on potential economic growth) and differences in the rate at which the demographic composition of the population is changing. They also arise in our comparisons of the service impacts of funding cuts among jurisdictions. Differences in the cost of providing the four services highlighted in the paper – home care; primary care; long-term care; and nursing care – give rise to differences in the relationship between funding reductions and service reductions from province to province.

The *Constitution Act* of 1982 committed Parliament and the legislatures to "providing public services of reasonable quality to all Canadians"[8] and to the principle of "making equalization payments to ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of services at reasonably comparable levels of taxation." Although the Act would appear to require that equalization programs make some attempt to measure and assess levels of service, in practice what has been equalized is not service but revenue.

This, in turn, means that, other things equal, lower-cost jurisdictions fare better in most programs than higher-cost jurisdictions. It means that funding tends to respond only episodically to broad drivers of public services costs. It also means that the federal government has made no attempt to establish the standard of public services which equalization and other transfer payment programs are supposedly supporting.

The lack of an explicit connection between funding and service levels leaves Canadians out of the discussion. It also normalizes the current federal-provincial/territorial fiscal disconnect between the rising costs of providing health care services and the rate of growth of federal health care funding.

The issues raised by constrained funding are not limited to the system's failure to recognize key drivers of costs within the current scope of medicare. It is becoming increasingly obvious that the need is for medicare to be expanded, not shrunk. A consensus is beginning to emerge that a national prescription drug program is needed both to manage the costs within current publicly funded health care programs, which are pressured by increasing drug costs, and to address the growing gap between health care costs that are covered by medicare and Canadians' total health care costs.

Between 1975 and 2014, private health care spending has increased from 23.8% to 29.5% of total spending on health care; most of that increase has taken place since 1990.[9]

Summary and conclusion

The changes in the federal government's commitment to funding for health care announced in December 2011 have profound implications for the resources available for health care in general in Canada and for the credibility of the federal government as a partner with provincial and territorial governments in health care funding.

[B]y 2024-2025, provincial and territorial governments will be receiving $10.7 billion less in funding for health care than they would have under the 6% escalator set out in the 2004 health accord.

Based on an updated economic growth assumption relative to that used in previous analyses of the impact of the change (3.3% growth instead of 3.9%), we estimate that by 2024-2025, the last year of the funding program announced in December 2011, provincial and territorial governments as a group will be receiving $10.7 billion less in funding for health care than they would have under the 6% escalator set out in the 2004 health accord. Again, based on those earlier assumptions, provinces and territories will have faced a cumulative shortfall of $43.5 billion between 2017-2018, the first years of GDP-linked funding, and 2024-2025.

The change will cause the federal government's share of health care costs to begin to trend downwards again, after its recovery under the Health Accord. By 2024, we project that the federal share will have dropped from 23% to between 18% and 19%, depending on rates of economic growth.

The reduced rate of growth in federal funding is most striking when set against the expected growth in health care costs. Constraining the rate of growth in federal transfers for health care does not constrain the rate of growth of health care costs, it simply widens the gap between transfers and costs. We estimate that the changing age structure of the Canadian population alone will add 1% per year to health care costs in Canada. General population growth will add another 1%. Using the same methodology for health care cost forecasting as the Parliamentary Budget Officer, we estimate that overall health care costs in Canada will increase by 5.3% annually between 2017-2018 and 2024-2025.

Constraining the rate of growth in federal transfers for health care does not constrain the rate of growth of health care costs, it simply widens the gap between transfers and costs.

With the CHT increasing only at the rate of growth of GDP, the gap between the costs of simply maintaining Canada's health care system and the support provided through the federal government will widen, as reflected in projections showing federal support below 20% of health care costs.

Another way to look at this change is to consider the relationship between the projected annual increase in the CHT and projected annual increases in health care costs. Based on conservative estimates of cost increases and economic growth, increases in federal transfers will cover only 13.5% of the increase in health care costs across Canada in 2017-2018, falling to 11.5% of the estimated annual cost increase by 2024-2025.

Both the cash impact and the impact relative to health care costs varies widely among provinces and territories. As a group, the Atlantic Provinces are expected to experience a population loss over the period, whereas Alberta, B.C. and Yukon are expected to grow at 2.3%, 1.2% and 1.5% respectively. While the average annual impact of aging on health care costs is 1.0%, that impact varies from a low of 0.5% in Manitoba and Saskatchewan to a high of 1.8% in Newfoundland and Labrador.[xiii]

The debate in Canada over the future of health care is oddly disconnected. On the one hand, we hear repeatedly about the impending cost crisis posed by the aging of Canada's population. On the other hand, we carry on a discussion about funding in general, and federal government funding in particular, as if health expenditures can be reduced with no observable impact.

The existential crisis for Canadian medicare is the determination of governments to cut back on our investment in health care precisely at the point where demographic change is pushing costs up.

Neither of these disconnected propositions is valid. The aging of Canada's population does not pose an existential crisis for the health care system. The data show that health care costs will increase slowly and steadily as the population ages, much as they have over the past 15 years. The existential crisis for Canadian medicare is the determination of governments to cut back on our investment in health care precisely at the point where demographic change is pushing costs up.

In this debate, it is easy to get lost in numbers of dollars in the millions and billions that are difficult to comprehend, and whose significance is difficult to measure against Canadians' direct experience.

[xiii] These relative impacts are highly sensitive to patterns of internal migration in Canada, which, in turn, are linked to the relative strength of provincial and territorial economies. It is likely, for example, that the impact of lower oil prices on the economies of Alberta, Saskatchewan and Newfoundland and Labrador will flow through to an impact on internal migration patterns and thereby on each province and territory's share of the total CHT transfer.

For elderly Canadians and their families, the pressures on the system from our aging population are not measured in millions or billions of dollars; they are measured in the availability of the kinds of health care services seniors need and use the most: home care; primary care; long-term care facilities; and nursing care.

The examples set out in this paper are an attempt to link changes in funding to recognizable health care services of direct relevance to the aging of the population. In the aggregate, across Canada, federal funding cuts relative to the 6% escalator equate to a loss of of 59 million annual home care visits; 2.6 million fewer patients regularly served by a primary care clinic; 7,500 unfunded long-term care beds; and more than 24,000 nurses not employed.

The impacts vary significantly among provinces due to differences in federal funding and differences in the cost of providing services.

The examples bring those numbers alive. Canadians value our public health care system, but we all know that values are hollow if we don't resource them properly.

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[4] Office of the Parliamentary Budget Officer. (January 19, 2012). *Renewing the Canada Health Transfer: Implications for Federal and Provincial-Territorial Fiscal Sustainability.* Author.

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Appendix A
Summary: Impact of Reduced Funding in Four Service Areas

Newfoundland and Labrador	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$138 milliion	$109 milliion	$90 milliion
Services potentially at risk			
Home care visits	837,000	662,000	546,000
Primary care centre patients	28,000	22,000	18,200
Long-term care beds	100	80	66
Nurses employed	335	265	218

Prince Edward Island	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$43 million	$34 million	$28 million
Services potentially at risk			
Home care visits	218,000	170,000	140,000
Primary care centre patients	11,000	8,700	7,100
Long-term care beds	44	35	28
Nurses employed	105	80	67

Nova Scotia	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$255 million	$203 million	$166 million
Services potentially at risk			
Home care visits	1,300,000	1,000,000	843,000
Primary care centre patients	61,300	48,400	39,800
Long-term care beds	525	415	340
Nurses employed	623	492	405

New Brunswick	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$207 million	$164 million	$134 million
Services potentially at risk			
Home care visits	1,260,000	998,000	815,400
Primary care centre patients	50,400	40,000	32,600
Long-term care beds	152	120	99
Nurses employed	503	399	326

Quebec	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$2.42 billion	$1.92 billion	$1.57 billion
Services potentially at risk			
Home care visits	10,500,000	8,300,000	6,800,000
Primary care centre patients	613,000	485,000	394,000
Long-term care beds	1,500	1,200	977
Nurses employed	5,900	4,700	3,800

Ontario	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$4.06 billion	$3.22 billion	$2.64 billion
Services potentially at risk			
Home care visits	24,750,000	19,650,000	16,000,000
Primary care centre patients	952,000	756,000	616,000
Long-term care beds	3,000	2,400	1,940
Nurses employed	9,200	7,300	6,000

Manitoba	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$384 million	$305 million	$250 million
Services potentially at risk			
Home care visits	1,670,000	1,170,000	1,100,000
Primary care centre patients	88,500	62,000	57,000
Long-term care beds	345	241	224
Nurses employed	870	608	565

Saskatchewan	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$336 million	$267 million	$219 million
Services potentially at risk			
Home care visits	1,370,000	1,080,000	890,000
Primary care centre patients	82,000	65,000	53,300
Long-term care beds	160	127	104
Nurses employed	710	562	462

Alberta	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$1.42 billion	$1.13 billion	$923 million
Services potentially at risk			
Home care visits	10,920,000	8,570,000	7,000,000
Primary care centre patients	349,000	274,000	225,000
Long-term care beds	822	645	530
Nurses employed	2,775	2,178	1,785

British Columbia	3.3% growth	3.9% growth	4.3% growth
2024-2025 funding loss	$1.43 billion	$1.13 billion	$930 million
Services potentially at risk			
Home care visits	6,240,000	4,930,000	4,000,000
Primary care centre patients	412,000	325,000	267,000
Long-term care beds	890	705	578
Nurses employed	3,242	2,560	2,102

Appendix B
Forecasting Health Care Cost Growth

Health care cost growth was estimated using a variant of the method used by the Parliamentary Budget Officer, which, in turn, was based on the health care cost growth model of the Congressional Budget Office.

That methodology forecasts health care cost growth based on nominal GDP growth (which captures normal inflation, population growth and the growth in GDP per capita), health care cost growth arising from the changing age and gender composition of the population, and an additional factor to capture additional increases in unit costs in health care over and above normal inflation. The PBO uses a low-end range of 0.4% per year as the additional or "enrichment factor" in health care cost growth.

The forecasts in this paper are based on a modification of this approach to take into account the fact that, over the next 30 years, the labour force in Canada will be growing at a much lower rate (0.3% per year) than that of the population as a whole (1.0% per year). Labour force growth drives GDP growth, whereas population growth drives health care cost growth. As a result, a growth factor based on GDP growth will tend to understate the drivers of health care costs by a factor equal to the difference between the rate of growth of population and the rate of growth of the labour force.

So in simplified form, health care cost growth is equal to:

> The rate of GDP growth, decomposed into the rate of growth of the working age population and the rate of productivity growth
>
> plus
>
> The rate of health care cost growth attributable to changes in age and gender composition
>
> plus
>
> The difference between the rate of population growth and the rate of labour force growth
>
> plus
>
> The "enrichment factor," 0.4% per year, following the PBO estimate.

The rate of productivity growth and the "enrichment factor" were assumed to be the same across Canada; all of the other factors vary from province to province, producing different estimates of health care cost growth.

Appendix C
Notes for Services Foregone by Province and by Service Category

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The following summary explains how estimates describing the impact of the new federal funding formula on four major service areas of care for Canada's aging population were derived. Estimates of influence on provincial programs were developed based on the best available data at the time of writing. In those cases where province-specific information was not available, certain assumptions were applied, and they are explained below.

These estimates are presented to illustrate the magnitude of services that will be foregone by individual provinces under the new funding formula. Given the differences in how provinces define and calculate costs, it is difficult to make comparisons across jurisdictions.

General assumptions

For the purposes of this analysis, we assume 36.4% of the funding loss is associated with home care; 36.4% with interprofessional primary care; 4.5% with long-term care beds; and 22.7% with nursing care. The one exception is Nova Scotia where the split between primary care and long-term care was varied, with 27% associated with primary care and 13.9% associated with long-term care.

Home care costs

No good national data on home care exists. Efforts were made to obtain provincial data wherever possible. Where no provincial figures were available, the paper assumes comparable costs to the average Ontario home care cost according to the Ontario Association of Community Care Access Centres (OACCAC) as $50 per visit ($42 + 10% for inflation, rounded up to $50).[1]

Interprofessional primary health care centres

Community health centres tend to provide services to the most sick and vulnerable in their communities.[2] According to the Canadian Association of Community Health Centres and the Association of Ontario Health Centres,[3] the average annual CHC operating budget is $4-5 million. Where no provincial figures were available, the paper uses this figure as a baseline measure. As in home care, there is a lack of national data and consistent application of definitions.

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[1] Ontario Association of Community Care Access Centres (OACCAC). (2013). Driving Health Sector Transformation forward: Advice on the 2014 Ontario Budget from Ontario's Community Care Access Centres. Retrieved from http://oaccac.com/Policy-And-Research/research-papers-and-reports (An updated 2015 report is now available.)

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[3] Personal communication with Scott Wolfe, Executive Director, Canadian Association of Community Health Centres. January 2015.

LTC beds

With no data available, the paper assumes comparable costs based on Ontario data. According to the Ontario Association of Community Care Access Centres, in 2013 the average Ontario nursing home bed cost was $126 per day to operate. This paper adds 10% for inflation and rounds it up to $140 per day.[4]

Nursing care

The pay for a full-time nurse, depending upon province, site of practice, training, and responsibility, varies from approximately $40,000 to a little over $100,000. The average salary has been estimated based on the most current collective agreement at the time the research was undertaken.[5]

Newfoundland and Labrador

Home care costs

Data could not be retrieved directly from Newfoundland and Labrador. The average Ontario home care client received $42 per day of services. We assume similar costs in Newfoundland and Labrador, add 10% for inflation and round up to $50 per day.

Interprofessional primary health care centres

The average annual Ontario CHC operating budget is $4-5 million. Capital costs would add a few hundred thousand annually to these estimates. The 16 proposed centres would have annual budgets of approximately $4.5 million, assuming an average of 3,000+ regular patients. (Ontario CHCs typically have 4000+).

LTC beds

In Ontario the average nursing home bed cost $126 per day to operate. The paper assumes comparable costs in Newfoundland and Labrador, adds 10% for inflation and rounds up to $140 per day.

Nursing care

It is assumed that an average cost of a Newfoundland and Labrador nurse is $65,000 for salary and 20% for benefits, with a total cost of $78,000.

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[4] Ontario Association of Community Care Access Centres (OACCAC). (2013). Driving Health Sector Transformation forward: Advice on the 2014 Ontario Budget from Ontario's Community Care Access Centres. Retrieved from http://oaccac.com/Policy-And-Research/research-papers-and-reports (An updated 2015 report is now available.)

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Prince Edward Island

Home care costs

According to PEI Health, a home care visit can range from approximately $32 to over $100. This paper assumes an average visit cost as $60. A home care visit can range from a one-hour visit by a home support worker to provide personal care, mobility assistance, etc., at a cost of approximately $31.67, to a two-hour visit from a home care nurse for assessment or procedure, at a cost of approximately $106.12. These costs reflect labour costs, including benefits and replacement, but do not factor in program administration or travel reimbursement.[6]

Interprofessional primary health care centres

The Ontario average annual CHC operating budget is $4-5 million. Capital costs would add a few hundred thousand annually to these estimates. The four proposed centres would be slightly smaller than the ones in Ontario and would have annual budgets of $4.1 million.

This calculation assumes an average of 3,500 regular patients.

LTC beds

The PEI government pays $91.99 per day or $33,576 per year for public subsidies for long-term care beds with an additional $21.02 per day for persons with low income. The average bed in public subsidy would cost around $100 per day or roughly $36,500 per year.[7]

Nursing care

It is assumed that an average costs of a PEI nurse is $65,000 in salary and 20% in benefits, with a total cost of $78,000.

Nova Scotia

Home care costs

According to the Nova Scotia Department of Health and Wellness, the average public cost of a home care visit in 2013-2014 was $56.43. This paper assumes an average visit cost of $60.[8]

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[6] Personal communication with Deborah Bradley, Executive Director, Community Health, Health PEI. January 9, 2015.

[7] Personal communication with Deborah Bradley, Executive Director, Community Health, PEI Ministry of Health. January 9, 2015.

[8] Personal communication of Joanne Bolger, Executive Secretary, to Dr. Peter W. Vaughan, CD, MA, MD, MPH, Deputy Minister, Nova Scotia Department of Health and Wellness / Nova Scotia Department of Seniors. January 16, 2015.

Interprofessional primary health care centres

The Halifax North End CHC annual budget is a little less than $3 million. According to the Canadian Association of Community Health Centres and the Association of Ontario Health Centres, the average annual CHC operating budget is $4-5 million. Capital costs would add a few hundred thousand annually to these estimates. The 32 proposed centres would be the same size as the North End CHC and would have annual budgets of $3.3 million. This calculation assumes an average of 3,500 regular patients.

LTC beds

The NS government pays $104.71 per day as an average health care & accommodations subsidy for a bed in a residential care facility and $204.29 per day for a nursing home bed. This paper assumes an average public subsidy of $155.[9]

Nursing care

It is assumed that a Nova Scotia nurse costs an average of $78,000 ($65,000 for salary and 20% for benefits).

New Brunswick

Home care costs

Data could not be retrieved directly from New Brunswick. This paper assumes costs in New Brunswick will be similar to the average an Ontario home care client received ($42 per day of services plus an additional 10% for inflation, for a total of $50 per day).

Interprofessional primary health care centres

The St. Joseph Community Health Centre in Saint John has a budget of approximately $2.5 million. It is assumed that the foregone NB community health centres will have similar budgets ($2.525 million, equivalent to 60% of Ontario community health centres). They are assumed to provide ongoing health care to 2,000 patients, each for a total of 80,000 patients.

LTC beds

In 2013, the average Ontario nursing home bed cost $126 per day to operate. This paper assumes comparable costs in New Brunswick, adds 10% for inflation and rounds up to $140 per day.

Nursing care

It is assumed the average cost for a New Brunswick nurse is $65,000 in salary plus 20% in benefits, for a total cost of $78,000.

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[9] Ibid.

Quebec

Home care costs

In Quebec, the average cost of a home care visit is $129, but this covers all costs, including administration. On the other hand, the average personnel costs per visit are closer to $50-60. This range would also be close to approximating the marginal costs. The true costs of the proposed increases in services would be somewhere between average and marginal costs. This paper assumes an average cost of $70 per visit.[10]

Interprofessional primary health care centres

In Quebec, the pioneer interprofessional health centres (CLSC) were absorbed into local health care networks or CSSSs (centres de santé et de services sociaux) in 2004. There are 94 CSSSs in Quebec. It is assumed that the Quebec interprofessional primary health care centres would be fairly comparable to Ontario community health centres, and would provide care to roughly 5,000 persons with budgets of $6 million.

LTC beds

In 2011-2012, the cost of a long-term care bed was $74,973 per year. The maximum contribution asked from seniors themselves was $20,904. Some seniors would pay less. This paper assumes an average public subsidy of $60,000 per year per resident.[11]

Nursing care

It is assumed that an average cost of a Quebec nurse is $65,000 in salary and 20% in benefits, for a total cost of $78,000.

Ontario

Home care costs

The average Ontario home care client received $42 per day of services. This paper adds 10% for inflation and rounds up to $50 per day.

Interprofessional primary health care centres

The average annual Ontario CHC operating budget is $4-5 million. Capital costs would add a few hundred thousand annually to these estimates. This paper assumes average costs of

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[10] Personal communication with Cindy Starnino, directrice de la qualité et mission universitaire, Centre de santé et de services sociaux Cavendish. January 9, 2015.

[11] Personal communication with Muriel Guériton, Librarian, Centre de documentation du CSSS Cavendish. January 12, 2015.

$5.2 million per centre. This paper assumes an average of 4,000+ regular patients per health centre. Community health centres in Ontario and other provinces tend to provide services to the most sick and vulnerable in their communities.[12]

LTC beds

In 2013, the average Ontario nursing home bed cost $126 per day to operate. This paper adds 10% for inflation and round up to $140 per day.

Nursing care

It is assumed the average cost of an Ontario nurse would be $70,000 in salary and 20% in benefits, for a total cost of $84,000.

Manitoba

Home care costs

The average Winnipeg Regional Health Authority home care client received a little over two hours of care per day at a cost of $30 per hour. This paper assumes average daily costs of $70 per home care recipient.[13]

Interprofessional primary health care centres

Winnipeg's NorWest Community Health Centre has a primary care budget of $3.8 million and a total budget of $6.9 million. According to the Canadian Association of Community Health Centres and the Association of Ontario Health Centres, the average annual CHC operating budget is $4-5 million. Capital costs would add a few hundred thousand annually to these estimates. This paper assumes that the centres would have annual budgets of approximately $5.3 million.

This calculation assumes an average of 4,000+ regular patients. Winnipeg's NorWest Health co-op has about 4,600 regular primary care patients.

LTC beds

In 2014, the average Manitoba nursing home bed cost the government $115 per day to subsidize. The residents have to pay between $33.90 and $79.20 per day depending upon their income and marital status.[14]

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[12] Glazier, R. et al. (2012). Comparison of Primary Care Models in Ontario. Institute for clinical Evaluative Sciences. Retrieved from http://www.ices.on.ca/Publications/Atlases-and-Reports/2012/Comparison-of-Primary-Care-Models

[13] Personal communication with Réal Cloutier, Vice-President and Chief Allied Health Officer, Winnipeg Regional Health Authority. November 27, 2014. See www.gov.mb.ca/health/pcs/docs/guide.pdf

Nursing care

It is assumed the average cost of a nurse in Manitoba will be $70,000 in salary and 20% in benefits, for a total cost of $84,000.

Saskatchewan

Home care costs

The average cost for a home care visit in Saskatchewan is $75.[15]

Interprofessional primary health care centres

The average annual Ontario CHC operating budget is $4-5 million. Capital costs would add a few hundred thousand annually to these estimates. It is assumed the Saskatchewan health centres would have budgets of $5 million and serve an average of 4,000+ regular patients as do those in Ontario.

LTC beds

The average Saskatchewan nursing home bed cost the provincial government $216 per home care day or $79,000 annually. An additional $39 per day is paid by the resident.[16]

Nursing care

It is assumed the average cost of a nurse in Saskatchewan will be $75,000 in salary and 20% in benefits, for a total cost of $90,000.

Alberta

Home care costs

The average Alberta long-term chronic home care client in 2013-2014 received $29 per day of services. This paper adds 5% for inflation and enriches the services by 30% to take the costs up to $40 per day.[17]

Interprofessional primary health care centres

Edmonton's Boyle McCauley Health Centre budget is roughly $4.5 million. The average annual Ontario CHC operating budget is $4-5 million. Capital costs would add a few hundred thousand

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[14] Ibid.

[15] Personal Communication with Heather Murray, Director, Community Care Branch, Saskatchewan Ministry of Health. October 24, 2014.

annually to these estimates. It is assumed the Alberta proposed centres would have annual budgets of approximately $5 million and serve an average of 4,000+ regular patients, as do those in Ontario.

LTC beds

The average Alberta nursing home and auxiliary hospital bed cost $180 per day to operate in 2014.[18]

Nursing care

It is assumed the average cost of a nurse in Alberta will be $85,000 in salary and 20% in benefits at $13,193, for a total cost of $98,193.

British Columbia

Home care costs

BC specific data were not readily available, but in other provinces the cost per day of home care varies from $40 to $80 depending upon the province and the mix of services and providers. (Professional nurses and therapists are more expensive than aides, etc.) Given that Manitoba, like BC, has relatively high wages, this section uses Winnipeg Regional Health Authority home care data and assumes daily costs of $70 per home care recipient.[19]

Interprofessional primary health care centres

The Vancouver Mid-Main Community Health Centre has a primary care budget of $1.6 million and a total budget of $3.8 million. The average annual Ontario CHC operating budget is $4-5 million. Capital costs would add a few hundred thousand annually to these estimates. The 78 proposed centres in BC would have annual budgets of approximately $5.3 million.

The Mid Main CHC has an estimated 6,000 patients for whom they provide regular primary health care. Some of their clients have other doctors involved in providing their care, including psychiatrists and addictions specialists. Unfortunately, we do not have accurate data anywhere on the definition of "regular patient" and what breadth of services (comprehensiveness) and depth of services (continuity) is required to establish these titles. In Ontario, most CHCs have 4,000+ regular patients. This paper assumes an average of 5,000 regular patients per BC centre to be somewhat conservative.

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[16] Ibid.

[17] Personal communication with Dr. Jerry Ren, economist, financial planning, Alberta Health Services. October 10, 2014.

[18] Ibid.

LTC beds

Information on cost and funding for long-term care was provided by a group of SFU Master students for *Vancouver Sun*.[20] "(In BC)…long-term care benefits are income-tested, with the province subsidizing each bed by $34,800 to $60,000 annually depending on the beneficiary's income. Seniors pay a monthly fee for residency based on their reported incomes. Those with incomes over $46,000 per year pay a maximum of $3,090 per month, or about half of the total care cost; thus even higher-income seniors receive a large subsidy." The total public cost of subsidies for long-term care was $1.7 billion in 2013 for 28,000 residential care beds. This works out to an average yearly subsidy of $60,700 or daily subsidy of $166.

Nursing care

It is assumed the average cost of a BC nurse will be $70,000 in salary and 20% in benefits, for a total cost of $84,000.

[19] Personal communication with WRHA continuing care. November 27, 2014.

[20] Benoit, I., Schilt, K., Twist, J. (September 14, 2014). Opinion: Relieving the crunch on B.C. seniors. Vancouver Sun, September 14, 2014. Retrieved from http://www.vancouversun.com/health/Opinion+Relieving+crunch+seniors/10188834/story.html

Appendix D

Message from the CFNU (French)

Linda Silas

Pourquoi les gouvernements provinciaux ont-ils tant de difficulté à joindre les deux bouts?

La population canadienne vieillit, les dépenses de santé augmentent, et on demande aux gouvernements provinciaux de ne pas se laisser dépasser par ces changements. Notre système de soins de santé est sur le point de frapper un mur. Entre-temps, le gouvernement fédéral réduit les transferts fédéraux en matière de santé, alloués aux provinces, et refuse d'assumer son rôle et de dispenser des soins de santé publics, équitables et inclusifs dans tout le Canada. La FCSII, qui représente près de 200 000 infirmières et infirmiers du Canada, sait que ces décisions sont en train d'éroder le système public de soins de santé, un système qui représente la principale priorité des Canadiens et des Canadiennes de partout au pays.

Premiers ministres des provinces et des territoires, nous, infirmières et infirmiers, sommes aux premières lignes tous les jours, 24 heures sur 24. Notre travail sera directement affecté par les réductions du gouvernement fédéral dans le secteur de la santé. Notre lutte légitime pour dispenser des soins adéquats avec moins de ressources, ainsi que nos efforts pour assurer la sécurité de nos patients seront-ils vains? Comment allons-nous créer un système de soins de santé qui répond aux besoins grandissants de nos aînés en matière de soins intégrés, qui répond à demande grandissante de services de santé mentale, de meilleurs soins primaires, et de meilleurs services de santé pour les personnes autochtones, lorsque le système est déjà à la limite de ses possibilités?

En décembre 2011, le gouvernement fédéral s'est désengagé de son rôle traditionnel, soit celui d'exercer un leadership dans le secteur de la santé. Au lieu du partenariat entre les gouvernements fédéral, provinciaux et territoriaux, et du facteur de progression de 6 %, le gouvernement fédéral a choisi d'établir les transferts en matière de santé en fonction du taux de croissance du PIB du Canada. Selon le directeur parlementaire du budget (DPB) cela signifie : une augmentation du fardeau financier des provinces relativement à la santé, pendant que le gouvernement fédéral réduit ses propres déficits.

Plusieurs économistes font écho aux préoccupations du directeur parlementaire du budget par rapport au désengagement du gouvernement fédéral, et c'est aussi le cas des premiers ministres

dans leur rapport présenté au Conseil de la fédération. Toutes ces préoccupations sont tombées dans l'oreille d'un sourd.

Sondage après sondage, le résultat se confirme : les soins de santé publics sont la principale priorité des Canadiens et des Canadiennes. Cela fait partie de l'identité canadienne. Or, nous risquons de perdre cet élément important de notre identité si nous n'agissons pas dès maintenant pour mettre un frein à l'érosion des transferts fédéraux.

Comme tous les Canadiens, les infirmières et les infirmiers du Canada sont déterminés à protéger le système de soins de santé. Et, nous appuyons le message communiqué par les premiers ministres en 2012, et selon lequel ces réductions sont inacceptables.

Le rapport de la FCSII, *The Canadian Health Transfer Disconnect: An Aging Population, Rising Health Care Costs and a Shrinking Federal Role in Funding*, réévalue l'impact financier des réductions faites par le gouvernement fédéral, et conclut que cet impact est plus important que celui prévu antérieurement. Lorsque la nouvelle formule pour établir les transferts en matière de santé entrera en vigueur, le manque à gagner de 36 milliards de dollars en 10 ans, qui a été antérieurement prévu, sera plutôt de 43,5 milliards pour les provinces et les territoires en seulement huit ans. Comme le conclut Hugh Mackenzie, auteur de ce rapport : « Dans ce débat, il est facile de se perdre dans le nombre de dollars, de se perdre dans les millions et les milliards qui sont difficiles à comprendre et, surtout, de mesurer l'impact en fonction de l'expérience directe de chaque Canadien et Canadienne. »

Le rapport illustre ce que les réductions du financement fédéral signifient pour le système de soins de santé en pertes réelles et tangibles : moins de visites de soins à domicile, moins de centres de soins primaires, moins de lits en soins de longue durée, et moins de personnel infirmier dans nos collectivités pour dispenser des soins. Tout comme dans les années 1990, alors que le pourcentage de financement fédéral a été au niveau le plus bas de l'histoire, cela pourrait vouloir dire des fermetures de lits, des mises à pied massives, bref, des conséquences qui affecteront énormément la viabilité du système de soins de santé du Canada.

En qualité de fournisseurs de soins de première ligne, les infirmières et les infirmiers s'expriment afin de protéger les Canadiens et les Canadiennes et assurer la sécurité des soins. Nous demandons au gouvernement fédéral d'envisager une contribution de 25 % au secteur de la santé afin d'assurer la viabilité d'un pilier de l'identité canadienne : le système de soins de santé du Canada.

Sincèrement vôtre,

Linda Silas
Présidente de la FCSII

Appendix E

Executive Summary (French)

Hugh Mackenzie

En septembre 2004, le gouvernement fédéral a conclu un accord historique de dix ans avec les provinces et les territoires afin de revitaliser le financement fédéral du régime d'assurance-maladie. À la suite d'une recommandation de la Commission de 2002 sur l'avenir des soins de santé au Canada (Commission Romanow), notamment que le gouvernement fédéral occupe une place plus importante dans le financement de l'assurance-maladie, un accord a été conclu avec les provinces et les territoires. Cet accord prévoyait des augmentations annuelles de 6 % du financement fédéral pour une période de dix ans.

Au cours de cette période de 10 ans, le financement fédéral, alloué aux dépenses de santé des provinces et des territoires, est passé d'un peu plus de 11 % à 23 %.

Or, tout cela a changé en décembre 2011 lorsque le gouvernement fédéral a unilatéralement annoncé qu'il ne renouvellerait pas l'Accord de 2004 sur la santé. La formule de financement prévoyant un facteur de progression de 6 % allait maintenant devenir une formule fondée sur la croissance du PIB au Canada.

D'importants rapports, publiés par le Conseil de la fédération (CDF) et par le directeur parlementaire du budget (DPB), ont mis en relief les répercussions financières à long terme de ce changement à la formule. L'analyse de la viabilité financière à long terme, faite par le DPB, démontre que le changement à la formule servant à déterminer les transferts en matière de santé élimine, à lui seul, tout problème de viabilité pour le gouvernement fédéral et augmente, de façon très significative, la pression financière sur les gouvernements provinciaux et territoriaux en tant que groupe et, par conséquent, ils auront un écart de plus en plus grand à combler pour assurer la viabilité du système.

A l'approche de la mise en œuvre de la formule de dix ans fondée sur le PIB, il est de plus en plus évident qu'elle aura des conséquences désastreuses sur le financement des soins de santé au

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Hugh Mackenzie exerce sa profession d'économiste depuis plus de 40 ans et s'occupe de différents volets des politiques publiques aux trois paliers de gouvernement ainsi que dans le secteur sans but lucratif. Il est l'auteur de nombreuses publications sur le financement du secteur de la santé et sur les problèmes financiers engendrés par l'augmentation des dépenses de santé au Canada.

Canada. Un sentiment d'urgence a motivé la Fédération canadienne des syndicats d'infirmières et infirmiers (FCSII) à commander un rapport afin de réexaminer l'impact financier de cette mesure à la lumière de nouvelles données, et en tenant compte des impacts réels et tangibles sur les soins de santé au Canada.

Les études antérieures menées par le CDF et le BDP prévoyaient un taux de croissance nominale de 3,9 % entre 2017-2018 et 2024-2025, soit la période de mise en application de la formule fondée sur le PIB. Or, selon notre étude, ces projections sont trop optimistes. Un taux plus modéré de 3,3 % refléterait mieux la croissance récente de la productivité, ainsi que les tendances en matière de croissance de la population active. Dans ce scénario, la nouvelle approche du gouvernement fédéral se traduirait en perte annuelle de 10,7 milliards de dollars en 2024-2025, et en une perte cumulative de 43,5 milliards de dollars au cours des huit années.

Le financement fondé sur le PIB, et alloué en fonction de la population, ne tient pas compte des différences par rapport aux générateurs de coûts dans le secteur de la santé, notamment :

- Les différences par rapport aux profils et aux tendances démographiques;
- Les différences par rapports aux coûts des services;
- Les différences régionales par rapport au marché du travail.

Selon les projections du rapport, la part fédérale des dépenses de santé va aussi diminuer pour atteindre un chiffre estimé à 19 % du PIB en 2024-2025, comparativement à un sommet de 23 % en 2016-2017. Or, l'augmentation, d'une année à l'autre, des transferts fédéraux en matière de santé couvrira seulement 11,5 % de l'augmentation projetée des dépenses de santé provinciales et territoriales pendant cette période.

Du point de vue des politiques de santé, la décision du gouvernement fédéral va à l'encontre de la réalité. La population canadienne vieillit. Dans ce rapport, nous estimons que le vieillissement de la population fera augmenter de 1,0 % par année les dépenses de santé. Or, le gouvernement fédéral a choisi de diminuer sa part du financement des soins de santé.

Cette réduction de la contribution fédérale va à l'encontre de l'inquiétude générale par rapport à l'escalade du coût des médicaments et à l'augmentation des dépenses de santé non couvertes par l'assurance-maladie. Cette inquiétude justifierait une augmentation et non une réduction de l'engagement financier ciblant le secteur de la santé.

Le nombre de dollars en jeu est tellement élevé qu'il est difficile de mettre cela en perspective. Ce rapport fait un pas de plus pour illustrer les pertes engendrées, à l'échelle provinciale et territoriale, par la réduction du financement. Il présente ces pertes selon des activités de programmes particuliers offerts dans chaque province, et selon les trois scénarios de croissance du PIB. Les pertes, pour chaque province, exprimées en dollars de 2015, sont associées à une série de services de soins de santé directement liés au vieillissement de la population : visites de soins à domicile, places dans des centres de soins primaires multi-professionnels, lits en soins de longue durée, et emplois en soins infirmiers.

Selon le scénario d'une croissance de 3,3 %, la perte de 10,7 milliards de dollars en 2024-2025 signifie une lacune de 50 millions de visites en soins à domicile, 2,6 millions de patients en centre de soins primaires, 7 500 lits en soins de longue durée, et 24 000 emplois d'infirmières dans tout le pays.

En diminuant les transferts en matière de santé aux provinces et aux territoires, l'objectif à long terme du gouvernement fédéral est non seulement de transférer le coût aux provinces et aux territoires mais aussi de mettre de la pression sur ces derniers pour qu'ils réduisent leurs dépenses de santé en limitant la portée de l'assurance-santé publique.

La possibilité qu'une réduction du financement fédéral des soins de santé puisse nuire à la crédibilité du gouvernement fédéral, en tant que garant des principes de l'assurance-maladie, n'est pas un effet secondaire non voulu des mesures de restriction des dépenses. En fait, cela s'harmonise parfaitement à la détermination actuelle du gouvernement fédéral à limiter la présence de politiques fédérales dans des secteurs de compétence provinciale.

C'est pourquoi le changement de décembre 2011 à la politique compromet l'avenir du régime canadien d'assurance-maladie.

Additional publications can be found on CFNU's website at
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