FULL REPORT

APRIL 2026

The economic impact of increased public sector health spending in Canada

Robin Somerville
President, Quantitative Economic Decisions, Inc.

CANADIAN FEDERATION OF NURSES UNIONS

Canadian Federation of Nurses Unions

ABOUT THE CFNU

The Canadian Federation of Nurses Unions (CFNU) is Canada's largest nurses' organization representing frontline unionized nurses and nursing students in every sector of health care — from home care and LTC to community and acute care — and advocating on key priorities to strengthen public health care across the country. We are relentless advocates for the health and safety of our members and the patients that we care for from coast to coast. Join us as we speak up for a stronger health care system and a better workplace for all nurses.

LAND ACKNOWLEDGEMENT

From coast to coast to coast, we acknowledge the ancestral and unceded territory of all the Inuit, Métis and First Nations Peoples that call this land home. The Canadian Federation of Nurses Unions is located on the traditional unceded territory of the Algonquin Anishnaabeg people. As settlers and visitors, we feel it's important to acknowledge the importance of these lands, which we each call home. We do this to reaffirm our commitment and responsibility to improve relationships between nations, to work towards healing the wounds of colonialism, and to improve our own understanding of local Indigenous Peoples and their cultures.

Robin Somerville
Report author
President, Quantitative Economic Decisions, Inc.
www.qedinc.ca

PUBLISHED BY:
Canadian Federation of Nurses Unions
2841 Riverside Drive
Ottawa, ON K1V 8X7
613-526-4661
www.nursesunions.ca

ISBN: 978-1-990840-64-7

CFNU PROJECT TEAM

Research coordinator: Tyler Levitan

Design and layout: Holly Drew and Kim Wiens-Murdock

Project support: Emily Watkins and Oxana Genina

CFNU Member Organizations

Registered Nurses' Union
Newfoundland & Labrador

UNA
United Nurses of Alberta

SIINB
NBNU

pei nurses

BC NURSES' UNION

Nova Scotia Nurses' Union

ONTARIO NURSES' ASSOCIATION

sun
SASKATCHEWAN UNION OF NURSES

CNSA
AEIC

mnu
MANITOBA NURSES UNION

Table of contents

Message from the CFNU

What better way is there to celebrate Canada's strength than by building on one of its most cherished institutions? Public health care remains a top priority for people across the country, regardless of where they live. Yet too often, investments in health care are framed narrowly as a fiscal burden rather than a catalyst for growth. This second paper in the Canadian Federation of Nurses Unions' (CFNU) series on the economic value of health care funding seeks to challenge that assumption directly.

The first paper in this series, *The Economic Benefits of Canada's Health Care System* by economist Dr. Jim Stanford, articulates how public health care sustains and supports economic growth. This study moves from principle to measurement. Drawing on economic modelling conducted by Robin Somerville, it quantifies the economic impacts of increased public sector health spending in Canada.

> Investing in public health care is not a trade-off against economic performance; it is a strategy for strengthening it.

This analysis is particularly timely. Canada faces a turbulent and evolving economic landscape shaped by global instability and domestic pressures. In this context, policy tools that are both effective and relatively risk-free are especially valuable. Public sector health spending represents one such tool. We know that protecting and enhancing our public health care system has strong public support and will help sustain our economy over the long term. By grounding the argument in empirical evidence, this paper reinforces and extends the central conclusion of this series: investing in public health care is not a trade-off against economic performance; it is a strategy for strengthening it.

Executive summary

It is all too apparent that we are living in turbulent times. With new US tariffs, and frequent threats of higher tariffs to come, Canada needs to build "an economy that is sovereign, sustainable and inclusive." (Stanford, 2026)

This study quantifies the potential for Canada's public health care system to weather these threats and to build a stronger economy for all people in Canada. The potential benefits are assessed using two economic models and estimates the benefits of increased health spending by the public sector on measures such as GDP, employment, and government revenues and deficits. The two models used are (i) an input-output model[1] constructed using Statistics Canada's 2022 supply-use tables for Canada and (ii) the QEDinc Canadian Modelling System (CMS), a dynamic stochastic general equilibrium macroeconometric model.[2]

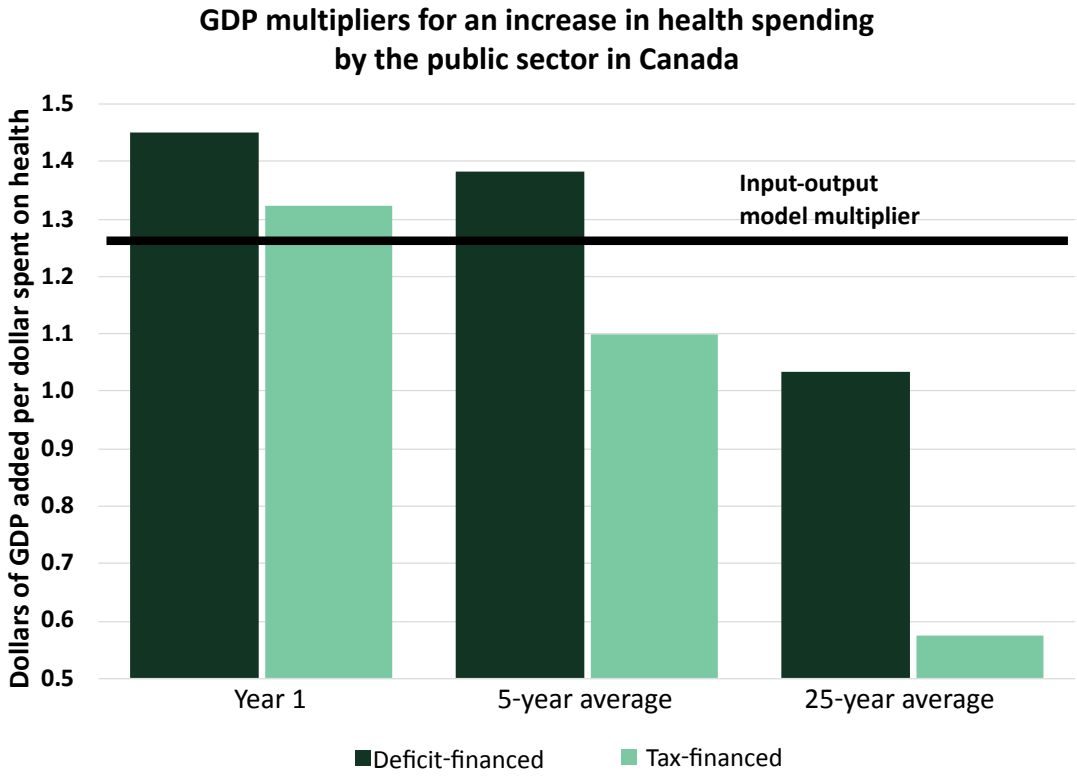
Input-output model results indicated that there is little material difference arising from health spending by the public or the private sectors. If anything, the benefit arising from spending by the public sector is marginally higher than that from the private sector.

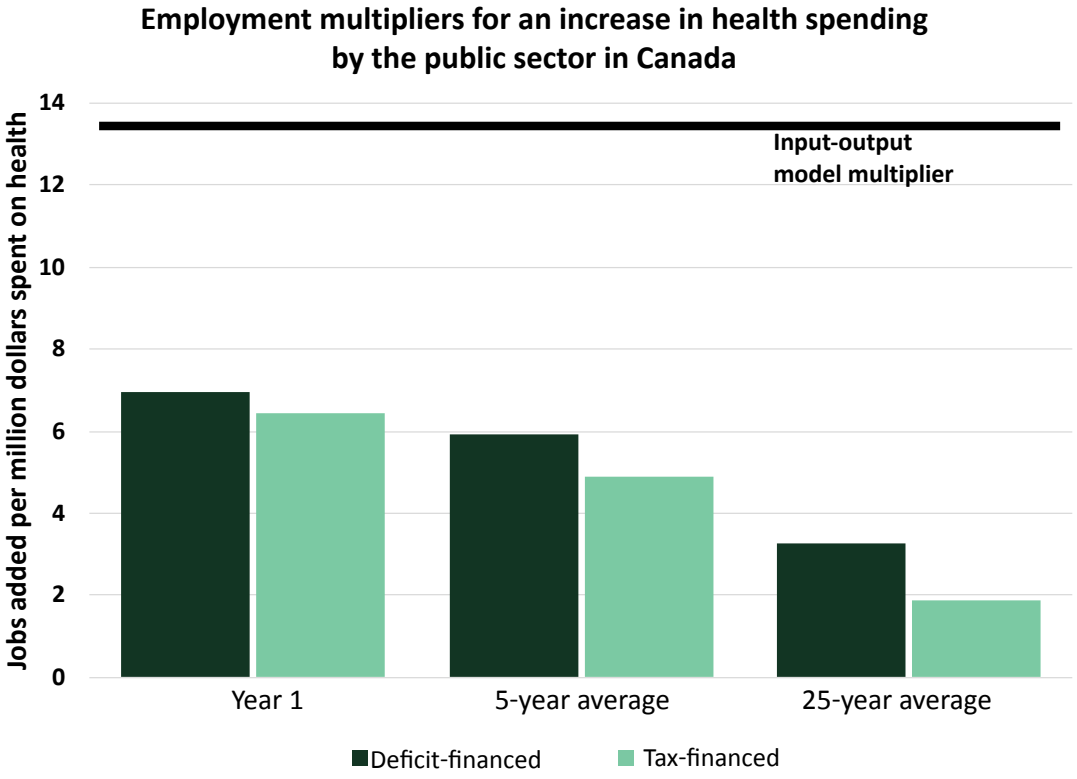
Results from the CMS are developed under two maintained hypotheses. The first of these hypotheses is that the increase in public spending is not accompanied by a direct increase in taxes or other government revenue measures (deficit-financed scenario). The second is that the increase in spending is matched by an increase in taxes (tax-financed scenario). The choice of taxes is material and can affect the outcome as some taxes impose a higher cost on the economy. This study assumes an increase in federal personal income taxes to pay for the initial increase in health spending by the federal government.

[1] See chapter "Economic Contribution of Health Care Spending" for more information about the construction and use of input-output models.

[2] See "Appendix: QEDinc's Canadian Modelling System" for a detailed explanation.

Figure 1:


GDP multipliers for an increase in health spending by the public sector in Canada
Dollars of GDP added per dollar spent on health
1.5
1.4
1.3
1.2
1.1
1.0
0.9
0.8
0.7
0.6
0.5
Input-output model multiplier
Year 1
5-year average
25-year average
Deficit-financed
Tax-financed

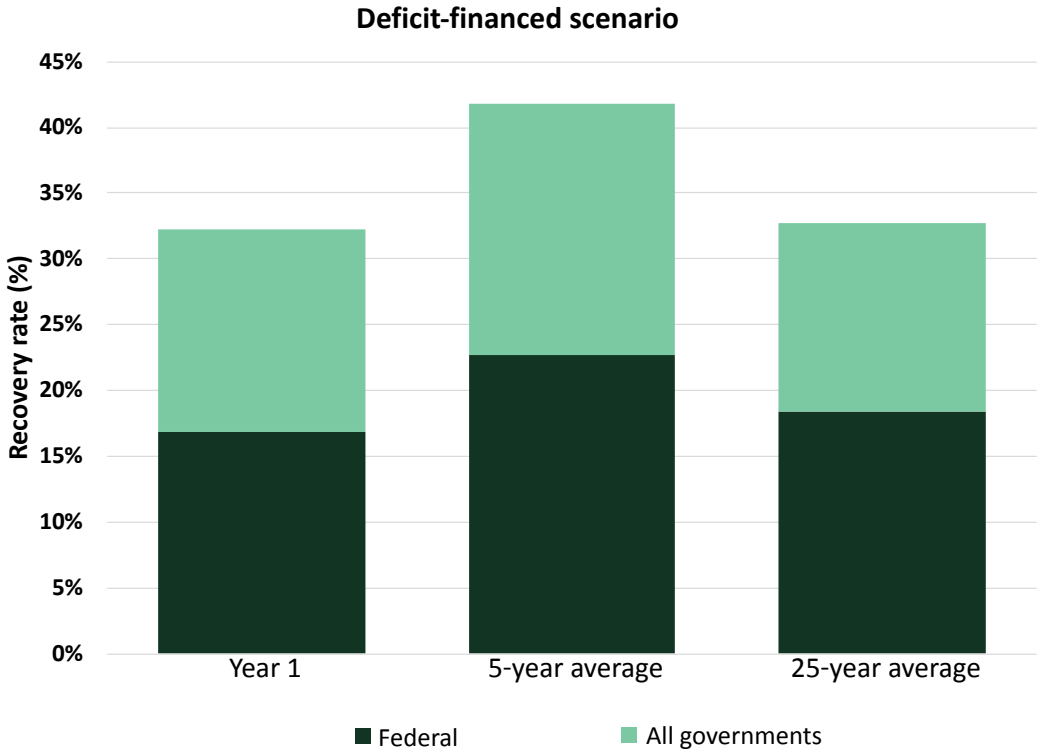

Employment multipliers for an increase in health spending by the public sector in Canada
Jobs added per million dollars spent on health
14
12
10
8
6
4
2
0
Input-output model multiplier
Year 1
5-year average
25-year average
Deficit-financed
Tax-financed

The input-output model estimated that a dollar of public spending on health raises GDP by $1.27 and supports 13.7 jobs per million dollars spent. The CMS yields a slightly higher GDP multiplier in the near term (first year) – between $1.32 and $1.45 – but this falls to between $0.57 and $1.03 in the long run (25-year average). The CMS estimates about half the impact on employment, compared to the input-output model with between 6.4 and 7.4 jobs per million dollars spent in the near term to between just 1.9 and 3.3 jobs per million in the long run (Figure 1).

A 1% increase in public sector health spending represents 0.11% of the national economy in the first year and adds between 0.15% and 0.16% to national GDP and 0.09% to employment in that first year. Over the first 5 years of a 1% increase in health spending, between $15.5 and $19.5 billion in real GDP (measured in 2025 dollars) and 69,000 to 83,000 years of work are added to the Canadian economy, with the lower numbers associated with the tax-financed scenario and the higher ones with the deficit-financed scenario. Analysis indicates that these results would rise proportionally with higher levels of health spending.

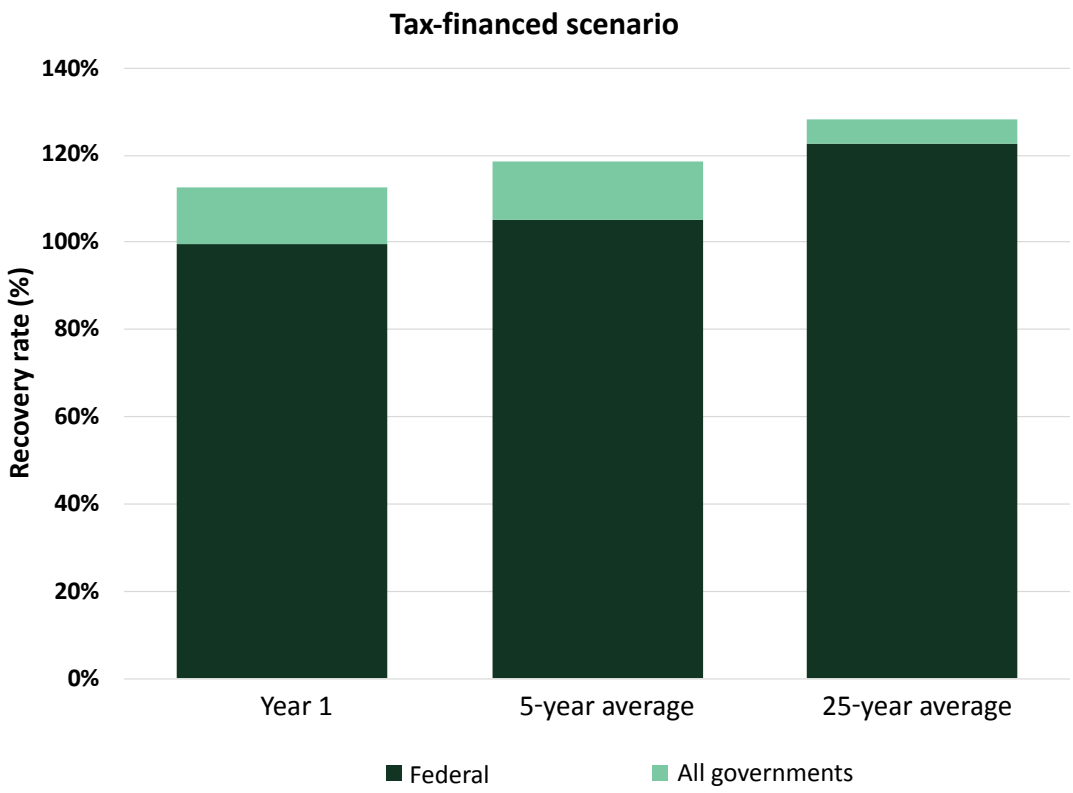
This study assumes that the full increase in health spending is borne by the federal government and, in the tax-financed scenario, federal personal income taxes are raised to pay for it. However, in both scenarios, provincial and territorial government revenues rise leaving them with net fiscal gains from the federal government's increase in health spending (see Figure 2). If the cost of higher health spending was borne by all governments, the fiscal drag on the federal government could be reduced while leaving provincial governments' fiscal positions largely unchanged. This could, in the tax-financed scenario, further increase the economic benefits by reducing the required increase in personal income taxes.

Figure 2: Government revenue recovery rate for an increase in health spending by the public sector in Canada[3]



[3] A revenue recovery rate measures the share of new public sector health spending recovered through higher government revenues.

Figure 2:



Although financing increased health spending by running ongoing deficits yields higher economic benefits, it is a challenging policy option in an era with so many competing priorities for public funds. Quality health care provides both private and societal benefits, so while the argument for public funding can be made, so too can an argument for personal responsibility. This personal responsibility takes the form of shouldering some of the cost of an increase in public spending on health care through higher taxes. As shown in Figure 2, the required increase in federal taxes could be reduced if the fiscal benefits to other levels of government are considered, which, in turn, would raise the economic benefits.

While it was beyond the scope of this study to model health benefits and their impact on economic performance, theoretically, the cost borne by taxpayers should be discounted by the long-term economic benefits arising from improved population health. This recognizes that health spending is an investment in Canada's human capital. The quantification of these health benefits to the labour force would augment the positive impacts generated from health spending by the public sector presented in this study and represent an important avenue for future research.

In conclusion, the benefits arising from an increase in public spending on health are significant and should be part of a balanced economic strategy. Enhanced public spending on health is a risk-free way to support Canada's economy in this turbulent period since health care is largely insulated from foreign factors. The estimates of the benefits presented in this study are also conservative, and when improved health outcomes are added, the overall benefits of enhanced public spending on health would be greater.

Introduction

The fiscal position of governments in Canada deteriorated sharply during the pandemic and, with current economic challenges, is expected to continue to deteriorate.

Trade tensions with the United States have led to job losses and are leaving many more Canadians at risk of losing their jobs. As a result, federal and provincial governments are exploring strategies to transform Canada's economy to become more resilient and to seize new opportunities. However, despite this need to invest in Canada's future, federal and provincial governments are responding to their weaker fiscal positions by reviewing options to curtail spending.

The federal government has signaled its plans to be fiscally restrained – with anticipated cuts to social program funding. Canada's public health care system, while recognized as an integral part of our national identity, is perceived to be a low priority for the government. Stanford (2026) argues that it is a vital economic engine that could help secure our prosperity in this challenging economic environment.

The research provided in this study quantifies the potential for Canada's public health care system to help build a stronger economy for all Canadians. The potential benefits are assessed using two economic models and estimate the benefits of increased health spending by the public sector on measures such as GDP, employment, and government revenues and deficits.

Why is health spending funded by the public?

Not all countries have taxpayer-financed health care systems. In some countries, individuals are responsible for paying for their health care either directly or indirectly if they have health insurance. Canada has a hybrid system in which some aspects of health care are publicly funded while other parts must be paid for privately. What drove some countries to devote public funds to paying for health care?

The economic case for public financing of health care has been known for over a century. In the 1890s, British economist Alfred Marshall proposed the concept of economic externalities. Externalities recognize that private economic activity can, depending on the activity, impose either costs or benefits on society in general. Activity that imposes a cost on society is referred to as a negative externality and includes activity such as pollution which is generated as a byproduct of production and affects society more severely than the polluter. Other activities can, however, provide benefits to society that are not fully realized by the individual undertaking that action. In this case, the private cost exceeds the social cost, and too little of the activity takes place from the perspective of society. This is the case for health care, where the benefits arising from a healthy population exceed the private costs of health care to the individual. Although the public provision of health care can be traced back to the 18th century, it wasn't until the mid-19th century that social reform and legislation supporting financing for public health began to be passed (Committee for the Study of the Future of Public Health, 1988).

The key element required to determine the true impact of health care spending extends beyond the simple impact from public spending. This study recognizes the importance of a healthy population and the role that the public funding of health care plays in delivering that outcome. A review of the impact of health care inputs on health care outputs and their effect on the economy through improved labour force activity and the potential for reduced future health care requirements is required to estimate the full impact of health care spending. It was, however, beyond the scope of this study to evaluate the economic benefits associated with improved health outcomes. Evaluating these benefits is an important area for future research.

Since this study ignores the health benefits of health care spending, it understates the true benefits of additional spending. The results from this study must, therefore, be interpreted solely in terms of the benefits of increased public spending in the health care sector in terms of employment, income and associated multiplier effects without any benefits from improved health outcomes.

> This is the case for health care, where the benefits arising from a healthy population exceed the private costs of health care to the individual.

Government spending and the economy

For over 100 years, economic literature and studies have assessed the effects of government spending on economic activity. The debates surrounding the possible effects of this spending have defined various "schools" of economic theory with applied research attempting to discern which school best describes observed (estimated) impacts.

The National Accounts Identity[4] indicates that GDP will increase if spending on the health sector is increased. This is a traditional Keynesian effect, where spending impacts the economy with a multiplier effect. Tax revenue will rise with the increase in economic activity but does not match the cost to the government of the increase in spending and, as a result, the deficit rises. If the increase in health care spending is financed by raising taxes, such as personal income taxes, then the rise in GDP falls to a smaller number because an increase in tax rates depresses economic activity.

Study structure and summary observations

The next section of this study provides a brief overview of health spending in Canada.

This is followed by an evaluation of the economic contribution of health care spending in Canada using an input-output model. The input-output model extends the previously identified direct impact to include upstream (indirect) and downstream (induced) impacts. The benefits of a permanent increase in federal government spending on health are assessed in the next section based on either (i) the increase in spending not being offset by an increase in taxes (deficit-financed) or (ii) the increase in spending being offset by an increase in personal income taxes (tax-financed). Some observations and suggestions for future research conclude the study.

The benefits arising from an increase in public spending on health are significant and, as argued by Jim Stanford (2026), are a risk-free way to support Canada's economy in this turbulent period since they are largely insulated from foreign factors. They are also conservative and, when the benefits from improved health outcomes are added, would be greater than those presented here.

[4] The National Accounts Identity states that gross domestic product (GDP) is the sum of spending by households, governments, business investment spending and net trade.

Overview of health spending in Canada

The Canadian Institute for Health Information (CIHI) prepares information on health care, health system performance and population health across the continuum of care. The National Health Expenditure Database (NHEX) is maintained by CIHI and provides a detailed picture of health spending by source and use of funds for the nation and for each province and territory. The 2025 update to this database provides finalized actual health expenditures for 2023 and preliminary estimates for 2024 and 2025. The database can be used to monitor trends in expenditures and facilitate both domestic and international comparisons. Stanford (2026) provides a review of some of the information from this source.

CIHI estimates that health expenditure in Canada approached $400 billion in 2025. Over 70% of that spending was funded by the public sector, while the balance was paid for by consumers of health care products and services either directly, out-of-pocket, or by private insurers. This section examines CIHI's 2025 estimate of health spending both in terms of the source of that funding – private or public – and their use. This information is valuable in designing and interpreting the implications of an increase in public spending on health.

Table 1 provides an overview of that spending by use of funds for both private and public sources of those funds in both millions of dollars and the share of expenditure paid by each sector. The NHEX provides information on current expenditure for: institutions, medical professionals, drugs, other health spending, public health, and administration. Total health spending is the sum of current expenditure and capital expenditure.

Table 1: Health expenditure by use of funds, 2025 (preliminary)

	Millions of total dollars			Share of total	
Use of funds by source	Total	Private	Public	Private	Public
Total current expenditure	380,625	111,637	268,988	29%	71%
Total institutions	157,417	25,997	131,421	17%	83%
Hospitals	103,791	8,611	95,180	8%	92%
Other institutions	53,627	17,386	36,241	32%	68%
Medical professionals	98,571	39,051	59,520	40%	60%
Physicians	54,955	1,072	53,882	2%	98%
Other professionals: dental services	23,468	22,073	1,396	94%	6%
Other professionals: vision care services	7,746	6,966	780	90%	10%
Other professionals: other services	12,402	8,940	3,462	72%	28%
Total drugs	52,848	34,012	18,836	64%	36%
Prescribed drugs	45,232	26,395	18,836	58%	42%
Non-prescribed drugs	7,616	7,616	—	100%	0%
Total other health spending	37,048	5,569	31,479	15%	85%
Other health spending: health research	5,001	1,004	3,997	20%	80%
Other health spending: net of health research	32,047	4,565	27,482	14%	86%
Public health	22,207	—	22,207	0%	100%
Administration	12,534	7,010	5,525	56%	44%
Total capital expenditure	18,132	3,322	14,810	18%	82%
Total health expenditure	398,757	114,959	283,798	29%	71%

Source: National Health Expenditures, Series A

Over 80% of spending on institutions comes from the public sector, where hospitals are funded primarily by the public sector, while over 30% of funding for other institutions comes from the private sector. There is a strong dichotomy for medical professionals, where nearly all physicians are funded by the public sector, while other professionals are largely funded privately and collectively

account for 40% of medical professionals spending. Spending on prescribed drugs is split almost equally between public and private sources, while the cost of non-prescribed drugs is borne privately. Other health spending, including health research, is largely (85%) funded by the public sector. Public health spending is, by definition, funded by the public sector, while 56% of spending on administration is privately funded, with 44% by the public sector. Over 80% of health spending on capital comes from the public sector, making it the dominant source of investment spending.

Table 2 examines the distribution of funds spent by both the private and public sectors. Capital spending represents just 5% of all public spending, with the rest going to current spending, while private spending on capital is even lower at just 3% of all spending.

Table 2: Health expenditure by use of funds, 2025 (preliminary)

	Distribution by use of funds		
Use of funds by source	Total	Private	Public
Total current expenditure	95%	97%	95%
Total institutions	39%	23%	46%
Hospitals	26%	7%	34%
Other institutions	13%	15%	13%
Medical professionals	25%	34%	21%
Physicians	14%	1%	19%
Other professionals: dental services	6%	19%	0%
Other professionals: vision care services	2%	6%	0%
Other professionals: other services	3%	8%	1%
Total drugs	13%	30%	7%
Prescribed drugs	11%	23%	7%
Non-prescribed drugs	2%	7%	0%
Total other health spending	9%	5%	11%
Other health spending: health research	1%	1%	1%
Other health spending: net of health research	8%	4%	10%
Public health	6%	0%	8%
Administration	3%	6%	2%
Total capital expenditure	5%	3%	5%
Total health expenditure	100%	100%	100%

Source: National Health Expenditures, Series A

Spending on institutions accounts for 46% of public expenditure, boosted by spending at hospitals, while private spending on institutions is just 23% of all private spending. Private spending on medical professionals accounts for 34% of all private spending but is lower at 21% of public spending, which is almost exclusively spent on physicians. Private spending on drugs accounts for 30% of all private spending, with most of that coming from prescribed drugs, while public spending on drugs is just 7% of all public spending. Other health spending is 11% of public spending and just 5% of private spending, with health research accounting for just 1% of both public and private spending.

Public health accounts for 8% of all public spending. Interestingly, spending on administration accounts for just 2% of all public spending but is 6% of private spending.

The division of spending by private and public sources in our current health care system reveals some of the forces driving public health advocacy in Canada. Prescription drug costs represent nearly a quarter of all private health spending, and the case for expanding public coverage of their cost has been made repeatedly. Expanding public coverage of the cost of dental, vision and other health professionals' services is also an oft-stated public policy goal.

Economic contribution of health care spending

Statistics Canada releases information on GDP, investment, employment and other indicators of performance by industry. This information describes the direct impact that a sector makes to the Canadian economy. Using Statistics Canada's supply-use tables, it is possible to extend this view beyond the direct contribution that a sector makes to the economy to include the contribution that its purchase of supplies and services from other sectors makes to each of those sectors – and to the economy as a whole. This is referred to as its indirect contribution to the economy, or upstream impacts. Additionally, the income paid to labour from this direct and indirect contribution is spent by households on goods and services, and this also generates economic activity. This is referred to as the sector's induced contribution to the economy, or downstream impacts. Combining the direct, indirect and induced impacts yields a comprehensive view of the contribution that a sector makes to economic activity in Canada.

Input-output model

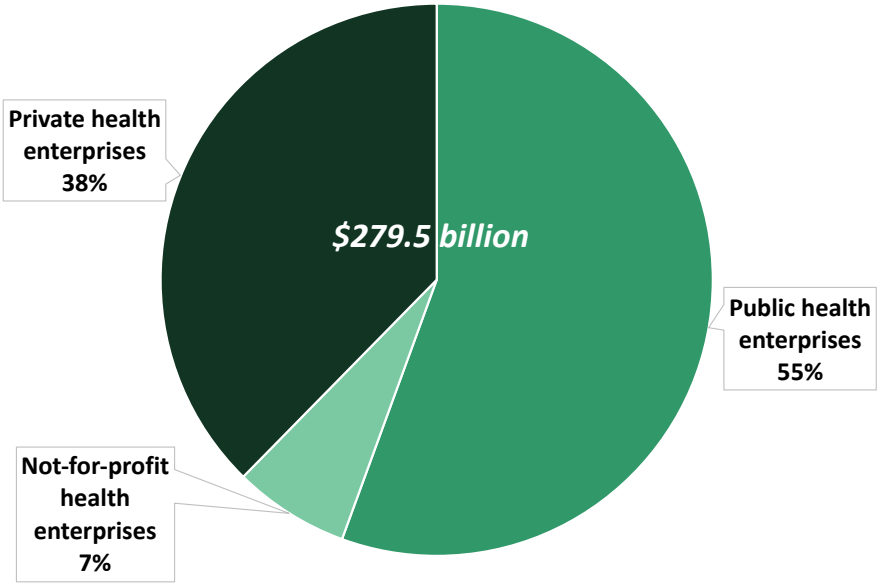
Statistics Canada 2022 supply-use tables for Canada were used to construct an input-output model for the analysis conducted in this part of the study. Input-output models describe inter-industry purchases, where output from one industrial sector may be an input purchased by another sector, to estimate the impact of a change in activity in one sector on all other sectors of the economy through this pattern of purchases. While input-output models were developed by Soviet economist Wassily Leontief in the 1920s, their ease of construction and use, and the level of industry and final demand detail that they provide, means that they continue to be used frequently to assess the impact of economic events and activity.

Economic contribution of health care and social assistance sector (NAICS 62)

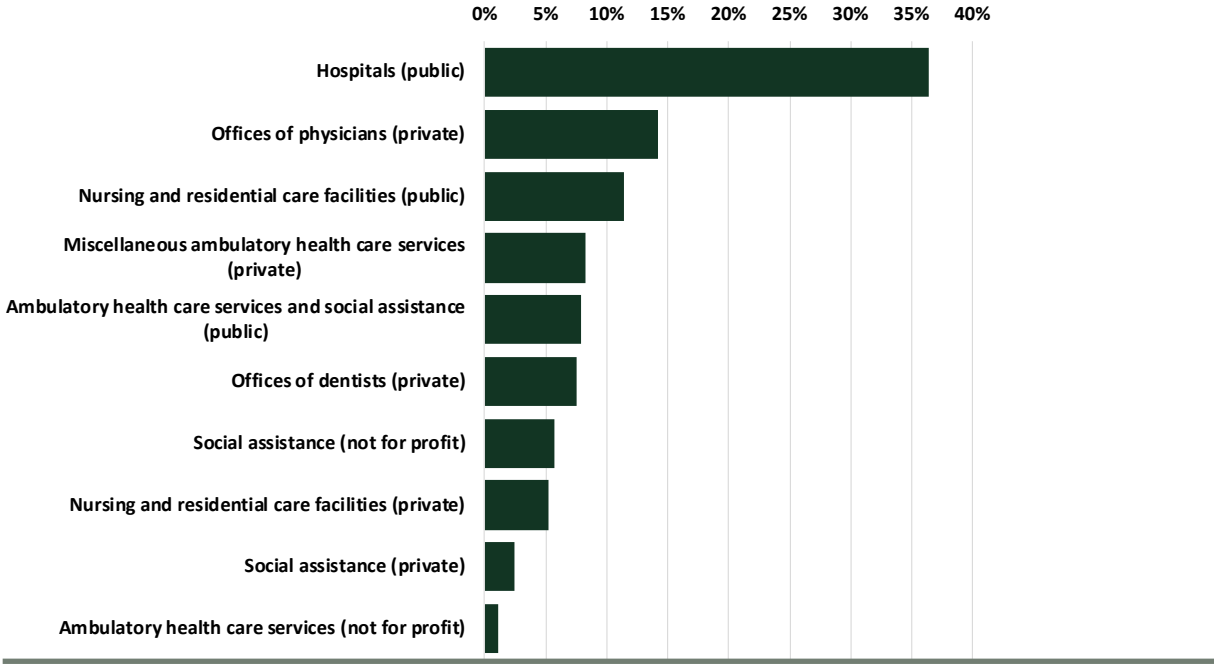
Total spending (gross output) of the health care sector (NAICS 62[5]) was $279.5 billion in Statistics Canada's 2022 supply-use tables. Table 3 provides estimates of the contribution made by the health sector, NAICS 62, to the Canadian economy in 2022.

Figure 3:

Share of NAICS 62 gross revenue by type of provider



Share of NAICS 62 gross revenue by industry



[5] The North American Industry Classification System (NAICS) is an industry classification system developed and used by Canada, the United States and Mexico.

Over half of that spending was on public health enterprises, with the private sector generating less than 40% (Figure 3). Spending at hospitals accounted for 36% of all spending, followed by physicians' offices at 14%.

Table 3: Economic contribution of health expenditure in Canada

	Health sector (NAICS 62)			
	Total	Direct	Indirect	Induced
Millions of dollars (unless otherwise specified)				
Gross domestic product	346,971	191,165	49,764	106,042
Labour income	265,072	156,825	38,100	70,147
Indirect tax revenue	20,476	7,980	3,087	9,409
Imports	68,199	711	39,075	28,414
Years of work (000s)	3,608	2,323	411	874
Economic multipliers (per $ of spending, unless otherwise specified)				
Gross domestic product	1.24	0.68	0.18	0.38
Labour income	0.95	0.56	0.14	0.25
Indirect tax revenue	0.07	0.03	0.01	0.03
Imports	0.24	0.00	0.14	0.10
Years of work (jobs per $ million)	12.9	8.3	1.5	3.1
Value added by industry sector (millions of dollars)				
All industries	336,172	191,165	49,764	106,042
Agriculture, forestry, fishing and hunting [11]	2,449	0	348	2,101
Mining, quarrying, and oil and gas extraction [21]	4,412	0	1,523	2,889
Utilities [22]	4,732	0	2,074	2,659
Construction [23]	10,123	0	1,884	8,239
Manufacturing [31-33]	15,527	0	4,033	11,494
Wholesale and retail trade [41-45]	22,484	0	7,414	15,071
Transportation and warehousing [48-49]	7,266	0	2,516	4,750
Information and cultural industries [51]	5,877	0	1,884	3,994
Finance, insurance and real estate [52-53]	43,756	0	8,021	35,735
Business services [54-56]	18,788	0	10,482	8,305
Educational services [61]	2,268	0	891	1,377
Health care and social assistance [62]	191,165	191,165	0	0
Arts, entertainment and recreation [71]	1,631	0	380	1,251
Accommodation and food services [72]	5,693	0	1,768	3,925
Other services (except public administration) [81]	5,233	0	2,605	2,629
Public administration [91]	5,566	0	3,941	1,625

The direct contribution of that impact was $191 billion to national GDP (7.1%), with $157 billion contributed to labour income, and $8.0 billion in government revenues from taxes on products and on production and 2.3 million jobs. It is worth noting that the value of goods and services imported directly by the sector is negligible.

The indirect contribution arising from the purchases of goods and services by the health sector (upstream impacts) accounts for $50 billion of GDP produced by other sectors, with the largest contribution being to the business services sectors (NAICS 54 through 56), and finance, insurance and real estate (NAICS 52 & 53), which includes spending on housing. This represents 2.0% of the GDP generated by all other sectors in the economy, with the largest percentage contribution being made to the other private services sector (NAICS 81) (5.1%) and business services sectors (4.1%). The indirect contribution to labour income is $38 billion, and this supports 411,000 jobs.

The induced contribution arising from labour income paid directly to workers in the health sector and indirectly to workers in all other sectors (downstream impacts) accounts for $106 billion (4.3%) of GDP produced by other sectors. This activity generates an additional $70 billion in labour income and supports 874,000 jobs.

The overall contribution of the health sector was 13.0% of all GDP produced by the Canadian economy in 2022. The size of this contribution speaks to its central role in society, with each dollar spent in the health sector adding $1.24 to the overall economy – with $0.68 occurring directly, and an additional $0.18 and $0.38 coming from the indirect and induced impacts, respectively. That dollar generates $0.95 in labour income, with $0.56 directly from the health sector, $0.14 from indirect impacts and $0.25 from induced impacts. In terms of employment, health spending of $1 million supports 12.9 jobs, with 57% of those coming directly from the health sector.

Taxes on products and on production from each dollar spent in the health sector add $0.07 to government revenues, with $0.04 coming from direct and indirect activity, while $0.03 comes from induced activity where households pay GST, HST, retail and other sales and excise taxes.

While the health sector imports $0.0 of goods and services for each dollar spent on health, sectors that supply the health sector add $0.14 of imported goods and services, while households add a further $0.1, for a total of $0.24.

Current and capital spending on health products and services

An alternate perspective on the economic contribution of spending on health care can be derived by examining the impact of current spending on health products and services by households and governments and the impact of spending by businesses and governments on new capital: machinery and equipment, building and engineering construction, and intellectual property.

Figure 4:

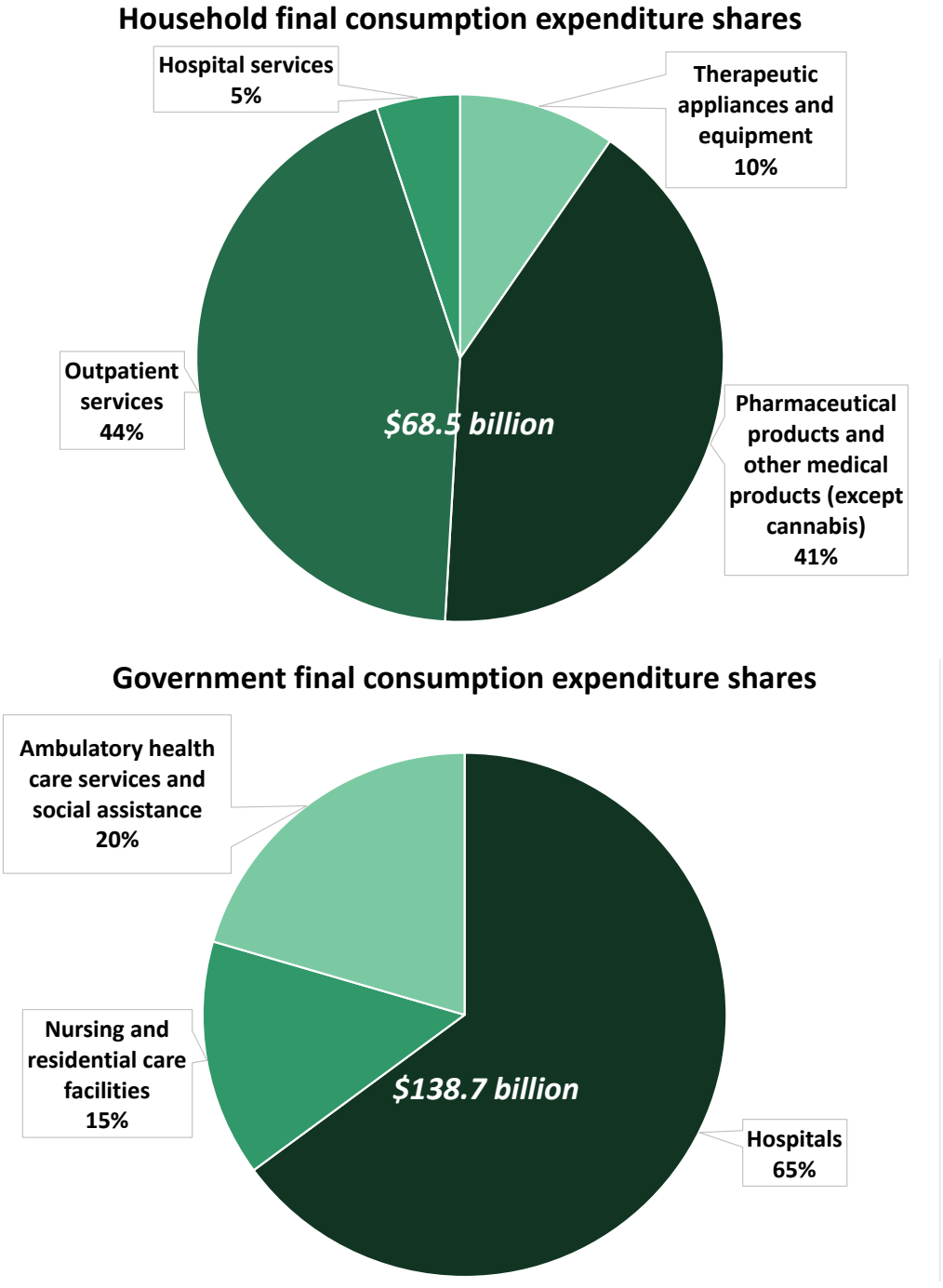


Figure 4 shows the distribution of current spending by households and governments on health sector goods and services. Household spending is just a third of the total and is dominated by spending on outpatient services (44%) and drugs (41%), while spending on medical appliances and equipment accounts for 10% of households' spending on health. Nearly two thirds of government current spending is on hospitals, and as also seen in Table 1, this spending dominates all other categories.

Capital spending on health is dominated by the public sector, with private sector spending accounting for less than a quarter of the total (Figure 5). Over half of all capital spending is on hospitals, with public spending on other facilities and ambulatory health care and social assistance services combined accounting for less than a quarter of all spending.

Figure 5:

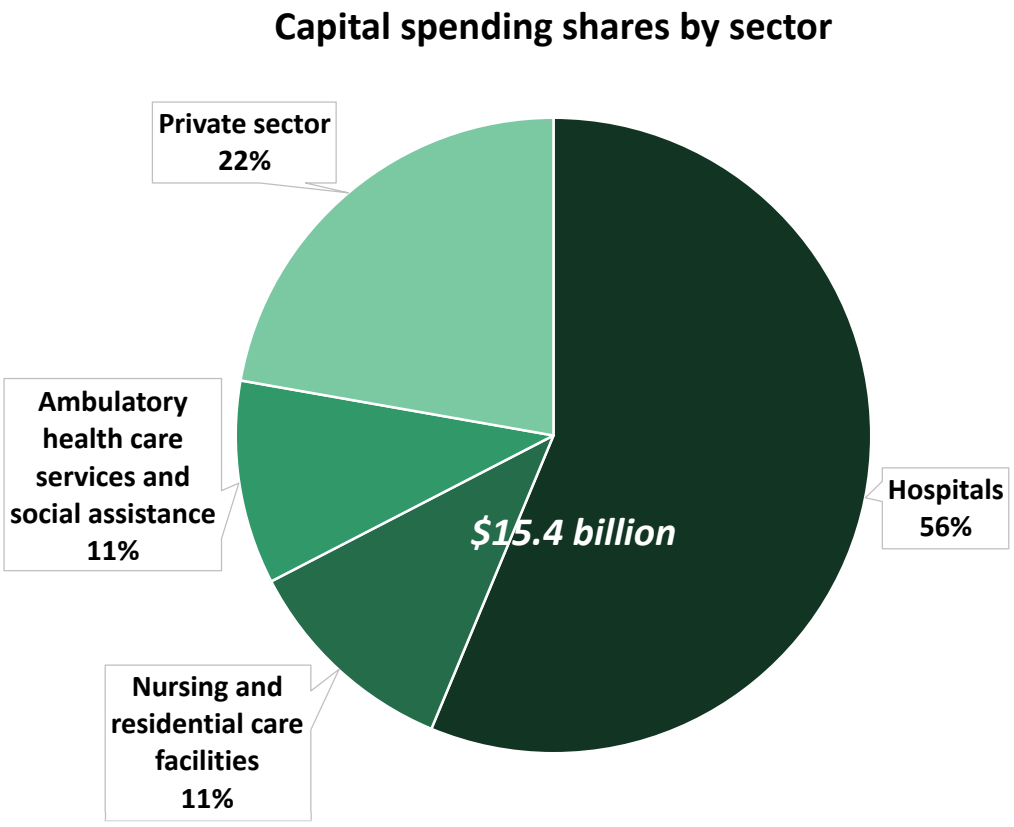


Figure 6 shows that there is a marked difference between the types of capital assets acquired by the public and private sectors. Capital spending by the private sector is led by spending on machinery and equipment, with spending on construction and intellectual property products split almost equally. Government capital spending is, however, dominated by construction activity.

Figure 6:

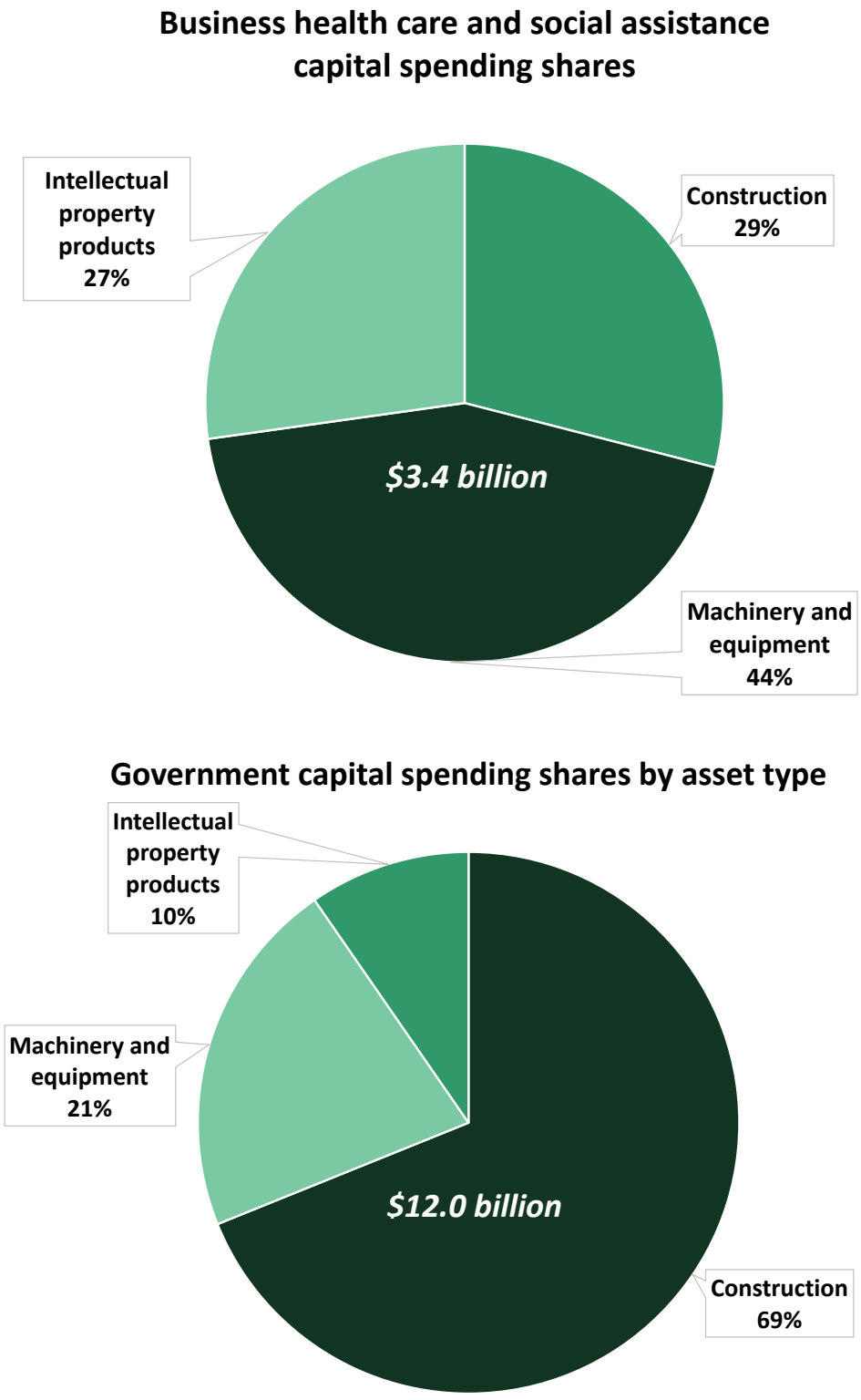


Table 4 shows the impacts of current and capital spending related to health spending in Canada in 2025. A dollar of current health spending adds $1.23 to national GDP (with $0.93 going to labour income, $0.28 to imported goods and services and $0.07 to governments from taxes on products and production) and, for every million dollars of spending, supports 12.7 jobs. A dollar of capital spending, however, adds $1.08 to national GDP, with a smaller direct impact

than for current spending not being fully offset by a higher indirect impact. The weaker impact from capital spending is driven, in part, by the higher proportion of imported goods and services purchased both directly and indirectly for capital spending. A dollar of capital spending generates $0.75 of labour income, $0.07 of taxes on products and production and, for every million dollars of spending, supports 8.8 jobs.

Table 4: Economic impact of current and capital health spending in Canada

	Current health expenditure				Capital health expenditure			
	Total	Direct	Indirect	Induced	Total	Direct	Indirect	Induced
Millions of dollars (unless otherwise specified)								
Gross domestic product	253,207	131,483	44,576	77,148	15,801	6,925	4,443	4,433
Labour income	191,481	109,695	30,752	51,034	11,002	5,232	2,837	2,932
Indirect tax revenue	13,969	4,714	2,410	6,845	1,064	458	213	393
Imports	57,163	6,506	29,986	20,672	5,489	1,413	2,888	1,188
Years of work (000s)	2,624	1,582	407	636	129	58	35	37
Economic multipliers (per $ of spending, unless otherwise specified)								
Gross domestic product	1.23	0.64	0.22	0.37	1.08	0.47	0.30	0.30
Labour income	0.93	0.53	0.15	0.25	0.75	0.36	0.19	0.20
Indirect tax revenue	0.07	0.02	0.01	0.03	0.07	0.03	0.01	0.03
Imports	0.28	0.03	0.15	0.10	0.37	0.10	0.20	0.08
Years of work (jobs per $ million)	12.7	7.7	2.0	3.1	8.8	4.0	2.3	2.5
Value added by industry sector (millions of dollars)								
All industries	253,207	131,483	44,576	77,148	15,801	6,925	4,443	4,433
Agriculture, forestry, fishing and hunting [11]	1,737	0	257	1,480	142	1	56	85
Mining, quarrying, and oil and gas extraction [21]	3,237	1	1,201	2,035	295	13	165	117
Utilities [22]	3,296	0	1,423	1,873	213	26	80	108
Construction [23]	7,117	0	1,313	5,804	4,180	3,766	80	333
Manufacturing [31-33]	16,209	4,942	3,169	8,097	2,513	1,199	849	465
Wholesale and retail trade [41-45]	29,294	13,070	5,606	10,617	1,964	688	666	610
Transportation and warehousing [48-49]	5,683	38	2,299	3,346	603	103	309	192
Information and cultural industries [51]	4,220	5	1,402	2,813	457	152	143	162
Finance, insurance and real estate [52-53]	30,468	0	5,293	25,175	2,162	150	565	1,446
Business services [54-56]	13,948	80	8,017	5,851	2,196	590	1,270	336
Educational services [61]	1,275	24	281	970	176	85	35	56
Health care and social assistance [62]	126,110	113,034	10,632	2,443	202	24	38	140
Arts, entertainment and recreation [71]	1,089	0	207	882	71	2	18	51
Accommodation and food services [72]	3,599	3	831	2,765	204	1	44	159
Other services (except public administration) [81]	3,348	186	1,311	1,852	168	7	55	106
Public administration [91]	2,578	100	1,334	1,145	255	119	70	66

Public versus private health industry impacts

The objective of this research is to establish the economic benefit of increasing public spending on health in Canada. A comprehensive evaluation of this benefit is provided in the next section of this study. The input-output model was used to evaluate the impact of raising (i) private sector health expenditure by $1 billion and (ii) public sector health expenditure by $1 billion. The results of this analysis are presented in Table 5.

Increasing private health spending by $1 billion yields an increase in GDP of $1.25 per dollar spent, with $0.70 of that from the direct impact. The impact from raising public sector health spending by $1 billion yields an increase in GDP of $1.27, with $0.71 of that from the direct impact. The impact on labour income is a little higher for spending from the public sector than the private sector, and this generates more jobs.

This exercise demonstrates that there is little material difference that arises from public or private sector spending on health. If anything, the benefit arising from spending by the public sector is marginally higher than that from the private sector.

Table 5: Impact of $1 billion of public and private health spending in Canada

	Current health expenditure				Capital health expenditure			
	Total	Direct	Indirect	Induced	Total	Direct	Indirect	Induced
Millions of dollars (unless otherwise specified)								
Gross domestic product	1,248	696	202	350	1,269	707	159	403
Labour income	868	519	117	231	1,000	582	151	266
Indirect tax revenue	53	13	9	31	54	12	6	36
Imports	211	1	117	94	270	4	158	108
Years of work (000s)	11.8	7.4	1.6	2.9	13.7	9.1	1.4	3.3
Economic multipliers (per $ of spending, unless otherwise specified)								
Gross domestic product	1.25	0.70	0.20	0.35	1.27	0.71	0.16	0.40
Labour income	0.87	0.52	0.12	0.23	1.00	0.58	0.15	0.27
Indirect tax revenue	0.05	0.01	0.01	0.03	0.05	0.01	0.01	0.04
Imports	0.21	0.00	0.12	0.09	0.27	0.00	0.16	0.11
Years of work (jobs per $ million)	11.8	7.4	1.6	2.9	13.7	9.1	1.4	3.3

Economic impact of an increase in public sector health spending

The economic impact of an increase in public sector health spending is conducted by using an economic model that generates a scenario projecting economic activity over a forecast period in the absence of any change in policy. The economic model is then rerun after imposing a specific change in policy to generate a new scenario that projects economic activity over the same forecast period that reflects that new policy.

This study estimates the overall economic impact of increased public sector health spending in Canada using QEDinc's Canadian Modelling System (CMS).[6] The CMS is a dynamic stochastic general equilibrium macroeconometric model of the Canadian economy and the economies of its provinces and territories. It consists of almost 14,000 equations and is solved on an annual basis, with 2025 being the current first year of the forecast. The permanent policy initiative in this study is introduced in 2026 and continues until the simulation period ends in 2050.[7]

The CMS provides estimates of the impacts of economic output (GDP) on employment by sector and province and territory in Canada. The model also generates the impacts on government revenue by source, by level of government and by province/territory in Canada.[8] Results are generated based on the assumption that the increase in health care spending is permanent and upon information developed earlier in this study.

[6] Note, this excludes potential benefits arising from improved health care outcomes from higher health care spending.
[7] See the appendix for more information about the CMS.
[8] The increase in economic activity will generate an increase in tax revenue, and this increase can be used to generate a "revenue recovery rate" for the policy which describes the extent to which the increase in public sector spending is offset by new revenue.

Results are developed under two maintained hypotheses. The first of these hypotheses is that the increase in public spending is not accompanied by a direct increase in taxes or other government revenue measures (deficit financing). The second is that the increase in spending is matched by an increase in taxes. The choice of taxes is material and can affect the outcome as some taxes impose a higher cost on the economy. This study assumes an increase in federal personal income taxes.

The results illustrate the estimated economic benefits of higher health care sector spending in Canada. Results are summarized using economic multipliers that express the increase in economic activity relative to the increase in public spending on health. Multipliers vary based on assumptions made about the federal government's fiscal response: deficit financing or tax financing.

Scenario design

As reported in Table 1, CIHI estimated public spending on health in 2025 to be $283.8 billion. This study assumes that the federal government increases health spending by 1%, or $2.8 billion, starting in 2026. This increase in spending is assumed to be permanent and raises spending each year by $2.8 billion measured in 2025 dollars. The choice of a 1% increase is arbitrary, and arguments for a greater increase in spending can be made. A review of CMS model properties indicates that an increase in government spending yields a proportional response in the economy. The multipliers reported in this study can, therefore, be used to infer the economic impact arising from a different level of spending.

The spending is allocated through federal transfers to non-profit organizations and is distributed across provinces and territories based on their population shares in 2025. This allocation is arbitrary but is consistent with other transfers from the federal government. Health spending is further split between current and capital expenditures, based on their 2025 shares shown in Table 2.

This change in health spending is applied to the outlook that does not include it: this is referred to as the "no-increase scenario". The first scenario that reflects the impacts of this new health spending is referred to as the "deficit-financed scenario". This scenario makes no explicit assumptions to change tax policy. Changes in government revenue arise solely from changes in economic activity, leaving net cost of the policy to be borrowed by the federal government.

A second scenario was constructed incorporating the increase in federal government health spending. This scenario, however, includes an explicit change in tax policy and is referred to as the "tax-financed scenario". Federal personal income tax rates are raised by an amount sufficient to offset the new health spending.[9] This increase in tax revenue ensures that the increase in federal spending is matched by an increase in federal revenue, leaving the federal deficit unaffected.

The tax-financed scenario could assume an increase in any other federal tax or combination of taxes. This choice is not immaterial. Different taxes exact different costs on the economy. Economic policy analysis provides insight into the ways that different taxes affect economic activity. The choice of federal personal income tax was made because it is relatively easy to administer and is, perhaps, less unpalatable than an increase in other taxes.

[9] The increase in personal income taxes is adjusted to reflect the increase in other taxes that arises from higher economic activity.

Modelling assumptions

The health sector in the CMS is the aggregate of the public and private sector activity. The finding from the input-output model analysis in Table 4, showing that the economic impact of public and private spending are quite similar, demonstrates that the lack of distinction in the CMS is not likely to have a material impact on the robustness of the analysis.

In both the deficit-financed and tax-financed scenarios some aspects of the CMS have been altered. The following economic measures are assumed not to be affected by the change in health spending:

- National immigration levels
- Exchange rate for the Canadian dollar versus other currencies
- Domestic interest rates
- International economic activity and foreign prices

While it can be argued that immigration, exchange rate and interest rates may be affected by a shift in health spending by the government, allowing the model to include changes to these measures means that the impact becomes a combination of the policy change and the economy's response to changes in these measures.[10] It was, therefore, determined prudent to eliminate these concepts' influence on the results.

Constructing and interpreting economic impacts

Economic impacts are generated by comparing the state of the economy in its original state with its state after a specified change is made. The "no-spending scenario" is the starting position for the economy and is its state against which the alternatives are compared. The difference between the alternative "deficit-financed scenario" and "tax-financed scenario" with the "no-spending scenario" represents the impact arising from the increase in health spending.

These differences are generated for each year of the simulation period, 2026 to 2050. Differences can be expressed as either the level difference between a measure in the compared scenarios or their percentage difference. The results presented in this study show the impact in the first year of the simulation (near term), the average annual impact over the first five years of the simulation (medium term), and the average annual impacts over the full 25-year simulation period (long run).

[10] The CMS's response to higher health spending would see interest rates rise by less than 5 basis points, and the Canada-US exchange rate appreciate by less than a tenth of a cent. International immigration would also increase leading to Canada's population rising by about 4,000 people. Taken collectively, allowing these measures to adjust (without raising taxes) would reduce the impact on the economy from an increase in health spending by the public sector by an average of less than $500 million a year over the medium term and employment by 2,500. First year impacts are smaller: a decline in real GDP of just over $100 million and 800 fewer jobs. An economic cycle leaves the average annual long-term impact on GDP just $50 million lower and employment down by 2,100.

Summary impacts

The tables in this section present a summary of the economic impacts from a permanent 1% increase in health spending by the federal government for both the deficit-financed and tax-financed scenarios.

Summary of 1% increase in public sector health spending

Health spending by the public sector rises by $2.8 billion (measured in 2025 dollars) in the first year of the simulation. The value of this increase in spending is an average of $2.7 billion each year over the next 25 years.[11]

This increase in health spending raises real GDP by $4.1 billion in the first year if the spending is deficit-financed and by $3.7 billion if it is tax-financed. In the medium term, the increase in real GDP is, on average, a little less than in the first year at $3.9 billion in the deficit-financed scenario but is nearly 20% lower in the tax-financed scenario than it was in the first year. Over the long run, the average annual increase in real GDP is $2.7 billion for the deficit-financed scenario and $1.5 billion for the tax-financed scenario.

The increase in real GDP helps generate additional employment. Employment in the first year is 19,500 and 18,000 higher respectively in the deficit-financed and tax-financed scenarios. Over the long run, average annual employment is 8,600 higher in the deficit-financed scenario and only just over half that value in the tax-financed scenario.

The 1% increase in public sector health spending represents 0.11% of the national economy in the first year, and adds between 0.15% and 0.16% to national GDP and 0.09% to employment in that first year. Over the first 5 years of the 1% increase in health spending, between $15.5 and $19.5 billion in real GDP (measured in 2025 dollars) and 69,000 to 83,000 years of work are added to the Canadian economy, with the lower numbers associated with the tax-financed scenario and the higher ones with the deficit-financed scenario.

[11] The long-term average, expressed in 2025 dollars, falls slightly due to the influence of shifts in prices, compared to the scenario without higher spending on health.

Table 6: Summary of 1% increase in public sector health spending

	Deficit-financed scenario			Tax-financed scenario		
Change from no-increase scenario	Year 1	5-year avg	25-year avg	Year 1	5-year avg	25-year avg
Health spending (millions of 2025 dollars)	2,802	2,817	2,650	2,802	2,817	2,650
Real Output (millions of 2025 dollars)	4,062	3,896	2,740	3,706	3,092	1,524
Employment (change in thousands)	19.5	16.6	8.6	18.1	13.8	5.0
Share of economy (based on no-increase scenario):						
Health spending	0.11%	0.10%	0.06%	0.11%	0.10%	0.06%
Real output	0.16%	0.14%	0.07%	0.15%	0.11%	0.04%
Employment	0.09%	0.08%	0.04%	0.09%	0.06%	0.02%
Memo items:						
Economic multiplier	1.45	1.38	1.03	1.32	1.10	0.57
Jobs per $1 million spent	7.0	5.9	3.3	6.4	4.9	1.9

Source: QEDinc Canadian Modelling System

The GDP economic multiplier is constructed by dividing real output by the increase in health spending. This generates a measure of the additional GDP that is generated by an additional dollar of health spending. In the first year, a dollar spent by the public sector on health generates between $1.32 and $1.45 in additional GDP, depending on whether the spending is either deficit-financed or tax-financed. This multiplier remains strong ($1.38) over the medium term if the spending is deficit-financed but falls to $1.10 when financed by raising personal income taxes. Over the long term, a dollar spent on health by the public sector adds $1.03 to GDP when deficit-financed, but only $0.57 if financed by raising personal income taxes.

Increased public spending on health also creates jobs. For each million dollars spent on health, between 6.4 and 7.0 jobs are added depending on whether the spending is deficit-financed or tax-financed. This impact moderates over the medium term to between 4.9 and 5.9 jobs, depending on how the spending is financed. The impact on employment remains higher over the long term when the spending is deficit-financed than when it is financed by an increase in personal income taxes: 3.3 versus 1.9.

Impact on government finances

Raising public spending on health has clear implications for government finances. Providing an assessment of its implications for public finances is, therefore, a critical component of evaluating the feasibility of raising public spending on health. The information in Table 7 differs from those in the government tables found later in this section in that the values are expressed in millions of 2025 dollars rather than nominal (actual) dollars.

Table 7 shows the increases in revenue and expenditure for the federal government and other governments (provincial, territorial and local) for both the deficit-financed and tax-financed scenarios. The increase in federal government revenue covers 17% of the increase in federal health spending in the first year and an average of 18% over the long term when the new spending is financed through higher deficits. Raising personal income taxes to cover the cost of the new health spending leads to federal revenues matching or exceeding the new spending throughout the simulation period. Revenues for other levels of government rise modestly in both the deficit-financed and tax-financed scenarios. This boosts the overall level of revenue recovery to more than 30% when the spending is financed through higher deficits.

The impact on government expenditure falls principally on the federal government. The increase in federal expenditure over time in the deficit-financed scenario arises from the cost of servicing the rising federal debt. In the tax-financed scenario, however, federal expenditure is reduced marginally as higher revenues reduce debt servicing costs. Expenditures by other levels of government are essentially unchanged in either scenario relative to the no-increase scenario.

Table 7: Impact on government finances

Change from no-increase scenario in millions of 2025 dollars	Deficit-financed scenario			Tax-financed scenario		
	Year 1	5-year avg	25-year avg	Year 1	5-year avg	25-year avg
Health spending	2,802	2,817	2,650	2,802	2,817	2,650
Federal government						
Revenue	471	639	487	2,789	2,960	3,250
Expenditure	2,808	3,084	4,544	2,809	2,804	2,116
Other governments						
Revenue	431	539	379	365	378	146
Expenditure	6	-19	-265	7	-12	-126
Memo items:						
Federal government revenue	17%	23%	18%	100%	105%	123%
General government revenue recovery rate	32%	42%	33%	113%	119%	128%

Source: QEDinc Canadian Modelling System

Macroeconomic impacts

The tables in this section review the macroeconomic impacts arising from a permanent 1% increase in health spending by the federal government. Analysis reviews the impacts on the labour market, health sector activity, and income and expenditure by category.

Impact on the labour market

The increase in employment from higher public spending on health raises the labour force participation rate and the labour force. Since the increase in employment exceeds the increase in the labour force, the level of unemployment falls but the unemployment rate remains unchanged.

Table 8: Impact on labour market

	Deficit-financed scenario			Tax-financed scenario		
Change from no-increase scenario	Year 1	5-year avg	25-year avg	Year 1	5-year avg	25-year avg
Employment (thousands)						
All occupations	19.5	16.6	8.6	18.1	13.8	5.0
Health occupations	4.5	4.0	2.8	4.4	3.9	2.5
Average weekly wages (% difference)						
All occupations	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Health occupations	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Memo items:						
Labour force (000s)	13.0	12.2	6.7	12.0	10.4	4.0
Unemployment (000s)	-6.5	-4.5	-2.0	-6.0	-3.4	-1.0

Source: QEDinc Canadian Modelling System

The CMS estimates employment and average weekly wages by major occupation group. Table 8 shows the impacts for health occupations and the aggregate for all occupations. The increase in employment for both health occupations and all occupations fall over time, consistent with the reduction in the real GDP impact. The increase in employment for occupations other than health is higher when the increase in health spending is deficit-financed rather than financed by an increase in personal income taxes. The increase in health spending does not have a material impact on average weekly wages either in aggregate or for the health sector.

Impact on health sector activity

Table 9 helps place the impact on the health and social services sector in context. The increase in health and social services value-added GDP accounts for about 35% and 38% of the increase to all industries in the first year for the deficit-financed and tax-financed scenarios respectively. This reflects the strength of upstream and downstream impacts on other sectors of the economy from the increase in health spending. Over the long run, this share rises to over 60% in the tax-financed scenario but only increases marginally in the deficit-financed scenario. The increase in personal income taxes reduces economic activity in the non-health sectors.

The increase in health sector capital spending accounts for between 13% and 14% of the increase for all industries in the first year. This is significantly less than the impact on value added and is due to the small share of public sector health spending that goes to capital spending. In the long run, the decline in total capital spending pushes up the health sector's share to between 21% and 31% of the overall industry total. The increase in capital spending drives an increase in productivity across the economy. The net job creation measure in Table 9 differs from the employment impact measure shown in Table 6 and Table 8. Net job creation compares employment expansion demand, i.e. the change in employment over the period specified, for either the deficit-financed or tax-financed scenario versus the scenario with no increase in health spending. Net job creation in the health sector is between 3,000 and 3,600 jobs in the long run, but this is offset by a decline of 700 jobs in other sectors when the increase in health spending is deficit-financed and by 3,900 jobs when it is tax-financed. The lack of jobs created in the long run can be explained by the assumption that the nation's population has not changed – there is, therefore, a limit to the number of jobs that can be added to the economy. As a result, productivity rises because employment increases by less than output.

The increase in health and social services value-added GDP accounts for about 35% and 38% of the increase to all industries in the first year for the deficit-financed and tax-financed scenarios respectively. This reflects the strength of upstream and downstream impacts on other sectors of the economy from the increase in health spending.

Table 9: Impact on health sector activity

	Deficit-financed scenario			Tax-financed scenario		
Change from no-increase scenario	Year 1	5-year avg	25-year avg	Year 1	5-year avg	25-year avg
GDP at basic prices (millions of 2025 dollars)						
All industries	4,434	4,196	2,270	4,037	3,339	1,260
Health sector	1,546	1,439	882	1,531	1,392	805
Health sector share	35%	34%	39%	38%	42%	64%
Capital spending (millions of 2025 dollars)						
All industries	1,037	904	445	961	741	282
Health sector	131	124	92	130	68	89
Health sector share	13%	14%	21%	14%	9%	31%
Net job creation (000s, over specified period)						
All industries	18.6	12.8	2.9	17.2	9.6	-1.0
Health sector	8.4	6.9	3.6	8.3	6.6	3.0
Other industries	10.2	6.0	-0.7	8.8	3.0	-3.9
Labour compensation (millions of 2025 dollars)						
All industries	1,207	1,052	527	1,101	854	298
Health sector	569	512	415	563	496	364
Health sector share	47%	49%	79%	51%	58%	122%

Source: QEDinc Canadian Modelling System

The increase in health sector labour compensation accounts for between 47% and 51% of the increase for all industries in the first year. In line with employment, the increase in health and social services labour compensation falls for both the deficit- and tax-financed scenarios. In the long run, the health and social services share of all industries labour compensation rises to 79% for the deficit-financed scenario and over 100% for the tax-financed scenario.

Impact on expenditure categories

The impact of the increase in health expenditure on expenditure categories is shown in Table 10. The increase in health spending is allocated to both current and capital spending by non-profit institutions serving households. As seen in Table 2, capital spending accounts for 5% of all public spending on health, and this is reflected in the current and capital non-profit institutions' impacts. The increase in economic activity stimulates an increase in business investment[12]. Household spending is stimulated by higher employment and labour incomes but, in the case of the tax-financed scenario, is dampened by the increase in personal income tax. Exports and government current and capital spending are largely unaffected in both scenarios relative to the no-increase scenario. An increase in imports tempers the overall increase in economic activity, but this influence vanishes over time in the tax-financed scenario.

Table 10: Impact by expenditure category

Change from no-increase scenario in millions of 2025 dollars	Deficit-financed scenario			Tax-financed scenario		
	Year 1	5-year avg	25-year avg	Year 1	5-year avg	25-year avg
GDP at market prices	3,348	3,367	1,955	3,079	2,711	1,185
Household spending	346	522	389	57	-115	-450
Non-profit current spending	2,121	1,959	1,192	2,115	1,945	1,178
Government current spending	43	96	49	39	74	25
Business investment spending	1,180	1,031	481	965	633	116
Non-profit capital spending	113	100	68	113	99	67
Government capital spending	8	18	12	7	14	6
Exports	43	83	22	39	64	16
Imports	572	489	304	323	50	-199

Source: QEDinc Canadian Modelling System

[12] Business investment includes residential and non-residential construction, machinery and equipment, and intellectual property spending by businesses.

Impact on income categories

The economic activity shown in Table 10 generates income which, in turn, determines household and business spending. The distribution of that income is summarized in Table 11, which provides values in millions of current dollars. The compensation of employees drives nearly all of the increase in household income for both the deficit- and tax-financed scenarios. The impact on household disposable income depends, however, on whether the increase in health spending is funded by higher borrowing or by higher personal income taxes. The net operating surplus of corporations[13] is raised in both the deficit- and tax-financed scenarios and accounts for a significant share of the increase in income.

Table 11: Impact by income category

Change from no-increase scenario in millions of 2025 dollars	Deficit-financed scenario			Tax-financed scenario		
	Year 1	5-year avg	25-year avg	Year 1	5-year avg	25-year avg
GDP at market prices	3,785	3,371	2,905	3,423	2,622	1,421
Household income	1,190	1,221	1,003	1,087	985	361
Household disposable income	823	855	703	-1,639	-1,832	-3,800
Compensation of employees	1,094	827	522	1,001	685	233
Net mixed income	68	59	72	54	13	-147
Corporations net operating surplus	2,304	2,107	1,934	2,130	1,717	1,286

Source: QEDinc Canadian Modelling System

[13] This includes business and non-business sector corporations such as hospitals and not-for-profit corporations.

Health spending impacts on provinces and territories

This section reviews the impacts by province and territory of a permanent 1% increase in health spending by the federal government. The increase in federal spending on health is assumed to be distributed equally on a per capita basis across provinces and territories. The analysis reviews real GDP, employment and per capita output by province and territory.

Impact by province and territory: real GDP

Table 12 provides a breakdown of the increase in real GDP for each province and territory. All jurisdictions benefit from the increase in health expenditure, although the impacts are strongly influenced by the size of that jurisdiction. Ontario accounts for about 31% of the increase in GDP in the short term, but this rises to 33% in the long run. British Columbia and Quebec also increase their share of the increase in GDP over the long run as these provinces benefit from upstream activity through sales to the health sector.

Table 12: Impact by province and territory: real GDP

Change from no-increase scenario in millions of 2025 dollars	Deficit-financed scenario			Tax-financed scenario		
	Year 1	5-year avg	25-year avg	Year 1	5-year avg	25-year avg
Canada	4,062	3,896	2,740	3,706	3,092	1,524
British Columbia	544	526	417	490	405	221
Alberta	802	738	451	746	621	277
Saskatchewan	212	199	110	200	171	66
Manitoba	201	197	130	188	168	85
Ontario	1,284	1,266	920	1,165	979	511
Quebec	773	740	534	691	560	262
New Brunswick	64	57	59	57	43	32
Nova Scotia	69	68	53	63	53	26
Prince Edward Island	12	11	8	10	8	3
Newfoundland and Labrador	80	70	39	74	59	24
Yukon	3	3	2	3	2	1
Northwest Territories	3	2	1	2	2	0
Nunavut	5	5	2	5	4	1

Source: QEDinc Canadian Modelling System

Impact by province and territory: employment

The impact on employment by province and territory is shown in Table 13. Like real GDP, the distribution of impacts across jurisdictions is determined by their size. Smaller provinces tend to have a larger share of the increase in employment from higher health spending than their share of the increase in GDP, and to have that increase in their share of employment rise over the long run.

Table 13: Impact by province and territory: employment

Change from no-increase scenario in thousands	Deficit-financed scenario			Tax-financed scenario		
	Year 1	5-year avg	25-year avg	Year 1	5-year avg	25-year avg
Canada	19.5	16.6	8.6	18.1	13.8	5.0
British Columbia	2.4	2.0	1.0	2.2	1.6	0.4
Alberta	3.5	3.2	1.7	3.3	2.8	1.3
Saskatchewan	1.1	1.0	0.5	1.0	0.9	0.4
Manitoba	1.4	1.2	0.8	1.3	1.1	0.6
Ontario	5.7	4.8	2.3	5.2	3.7	0.9
Quebec	4.1	3.4	1.8	3.8	2.8	0.9
New Brunswick	0.4	0.3	0.2	0.3	0.3	0.1
Nova Scotia	0.4	0.4	0.2	0.4	0.3	0.1
Prince Edward Island	0.1	0.1	0.0	0.1	0.1	0.0
Newfoundland and Labrador	0.4	0.4	0.2	0.4	0.3	0.1
Yukon	0.0	0.0	0.0	0.0	0.0	0.0
Northwest Territories	0.0	0.0	0.0	0.0	0.0	0.0
Nunavut	0.0	0.0	0.0	0.0	0.0	0.0

Source: QEDinc Canadian Modelling System

Impact by province and territory: real GDP per capita

Table 14 displays the impact of increased health spending on real GDP per capita for each province and territory. In the first year, the increase in health spending adds nearly $100 to real GDP nationally when the spending is financed through higher deficits, but this impact is about 10% lower when it is financed through higher taxes. Different per capita impacts across the country arise from differences in the economic structure of each province and territory, their trading relationships, interprovincial migration, and by policy design. Both the maximum and minimum impacts on real GDP per capita across provinces and territories fall over time both in absolute terms and also relative to the national impact. Saskatchewan enjoys the highest increase in per capita income, followed by Newfoundland and Labrador, while the lowest increase is experienced in the Northwest Territories.

Table 14: Impact by province and territory: real GDP per capita

Change from no-increase scenario in 2025 dollars	Deficit-financed scenario			Tax-financed scenario		
	Year 1	5-year avg	25-year avg	Year 1	5-year avg	25-year avg
Canada	97	92	61	88	73	34
British Columbia	106	99	68	95	76	36
Alberta	140	127	72	130	106	44
Saskatchewan	164	149	73	155	128	44
Manitoba	131	126	76	123	107	50
Ontario	79	77	55	71	59	31
Quebec	85	81	57	76	61	28
New Brunswick	74	65	68	65	50	37
Nova Scotia	63	62	50	57	49	24
Prince Edward Island	63	57	40	53	39	16
Newfoundland and Labrador	145	127	71	134	108	43
Yukon	63	56	34	54	39	10
Northwest Territories	58	51	24	51	36	6
Nunavut	123	105	35	113	84	12

Source: QEDinc Canadian Modelling System

Health spending impacts on government finances

The increase in federal spending on health directly impacts federal finances as does the choice of financing for the increase in health spending. Other levels of governments' finances are influenced by changes in economic activity.

Impact on federal government finances

Most of the preceding tables have focused on the economic benefits to economic activity arising from the increase in health spending, but since the spending is financed by the federal government, it is important to examine its implications for public sector finances.

Table 15 examines the impact on federal government finances in nominal dollars rather than constant 2025 reference year dollars (see Table 2). The increase in federal government revenue in the deficit financed scenario is driven firstly by business and then personal income taxes but, in the tax financed scenario, an increase in personal income taxes accounts for most of the increase in revenue. The modest increase in taxes on products in the deficit-financed scenario is eliminated in the tax-financed scenario as household spending is reduced by the higher personal income taxes.

The increase in current transfers paid is similar in both scenarios as it includes the increase in public sector health financing. Total expenditure in the deficit-financed scenario, however, balloons as the cost of servicing the public debt rises. This increase is eliminated when personal income taxes are raised to pay for the increase in health spending.

In the deficit-financed scenario, the federal deficit rises $2.4 billion in the first year and by similar amounts over the first five years. The average deficit over 25 years is, however, $5.8 billion a year higher when tax rates remain unchanged. An increase in income taxes can, however, leave the deficit unchanged in the short and medium term, while yielding an average reduction in the federal deficit of $1.7 billion a year over the long term.

The increase in federal spending on health directly impacts federal finances as does the choice of financing for the increase in health spending.

Table 15: Impact on federal government finances

Change from no-increase scenario in millions of 2025 dollars	Deficit-financed scenario			Tax-financed scenario		
	Year 1	5-year avg	25-year avg	Year 1	5-year avg	25-year avg
Total revenue	437	564	541	2,789	2,995	4,410
Personal income tax	125	136	118	2,524	2,687	4,209
Business income tax	198	339	370	184	278	243
Contributions to social insurance	29	22	11	27	19	6
Taxes on factors of production	-1	-2	-3	-3	-4	-6
Taxes on products	74	64	46	46	13	-40
Total expenditure	2,795	3,081	6,304	2,799	2,814	2,691
Current expenditure	-10	-24	-20	-9	-19	-10
Current transfers paid	2,809	2,861	3,485	2,812	2,876	3,520
Interest on debt	0	253	2,850	0	-36	-813
Government surplus	-2,357	-2,517	-5,763	-10	181	1,718

Source: QEDinc Canadian Modelling System

Impact on government finances

Table 16 builds on the analysis from the previous table by including the consolidated finances of the provincial, territorial and local governments. These governments have small increases in revenues and small decreases in expenditures, relative to the no-increase scenario for both the deficit-financed and tax-financed scenarios. As a result, these governments enjoy a nearly $1 billion long-run average annual improvement in their fiscal position in the deficit-financed scenario, which is halved in the tax-financed scenario.

Table 16 also shows that after 5 years, the federal government accrues an additional $12.6 billion in debt, which rises to $144 billion after 25 years in the deficit-financed scenario. The federal government's debt is, however, reduced by $0.9 billion after 5 years and by $43 billion after 25 years in the tax-financed scenario. The improvement in debt across other levels of government is not large enough to fully offset the increase in federal debt in the deficit-financed scenario.

Table 16: Impact on government finances

Change from no-increase scenario in millions of 2025 dollars	Deficit-financed scenario			Tax-financed scenario		
	Year 1	5-year avg	25-year avg	Year 1	5-year avg	25-year avg
Federal government						
Revenue	437	564	541	2,789	2,995	4,410
Expenditure	2,795	3,081	6,304	2,799	2,814	2,691
Government surplus	-2,357	-2,517	-5,763	-10	181	1,718
Cumulative surplus (period end)	-2,357	-12,584	-144,080	-10	904	42,957
Other governments						
Revenue	457	449	402	390	314	142
Expenditure	-84	-239	-569	-76	-181	-260
Government surplus	542	688	970	467	495	402
Cumulative surplus (period end)	542	3,439	24,262	467	2,473	10,062

Source: QEDinc Canadian Modelling System

Conclusions and observations

This research used two different models to examine the impact of increased public spending on health in Canada: (i) a static input-output model and (ii) a dynamic stochastic general equilibrium macroeconometric model (CMS). The input-output model estimated that a dollar of public spending on health raises GDP by $1.27 and supports 13.7 jobs per million dollars spent. The CMS yields a slightly higher multiplier in the near term – between $1.32 and $1.45 – but this falls to between $0.57 and $1.03 in the long run. The CMS estimates a smaller impact on employment than the input-output model, with between 6.4 and 7.4 jobs per million dollars spent in the near term to between just 1.9 and 3.3 jobs per million dollars spent in the long run.

Both models indicate that public spending on health yields significant positive impacts on output and employment, but differences in the outcomes from the two models arise because results depend, as in any modelling exercise, on both the model used and the assumptions incorporated into the analysis. An input-output model does not include any limits on resources available to the economy. Employment, in particular, is unconstrained by limits to population and the labour force. Another important limitation of the input-output model is that it does not include a capital spending response by business to an increase in economic activity. This is an important part of the economic response in the CMS, where an increase in business capital spending supports the increase in productivity required to reduce pressure on the labour market in the long run.

Input-output models do not incorporate government budget constraints, so an increase in public spending has no consequences beyond the activity it finances. The CMS addresses the issue of funding new health spending through its two spending scenarios. While increased economic activity does boost government revenues, it is not sufficient to prevent an increase in federal debt and the rising cost of servicing that debt when the spending is deficit-financed. The increase in personal income taxes modelled in this study yields an eventual improvement in federal finances, with 123% of the increase in spending recovered through higher federal government revenues in the long run. This suggests that a less aggressive initial tax increase could satisfy long run fiscal concerns, and this would provide a greater boost to economic activity than is seen in the tax-financed scenario presented in this study.

In addition, while this study assumes that the full increase in health spending is borne by the federal government, provincial and territorial governments' revenues rise in both scenarios, leaving them with net fiscal gains from the federal government's increase in health spending. An argument can be made that the cost of higher health spending should be borne by all governments, as this would reduce the fiscal impact on each jurisdiction while maximizing the economic benefits.

Although financing increased health spending by running ongoing deficits yields economic benefits, it is challenging in an era with so many competing priorities for public funds. Quality health care provides both private and societal benefits, so while the argument for public funding can be made, so too can an argument for personal responsibility. In a public-payer health care model, this personal responsibility takes the form of shouldering some of the cost of an increase in public spending on health care through higher taxes.

The benefits arising from an increase in public spending on health are significant and are a risk-free way to support Canada's economy in this turbulent period.

While it was beyond the scope of this study to model health benefits and their impact on economic performance, economic theory would support discounting the cost to taxpayers in the form of higher taxes by the long-term economic benefits arising from improved population health. Health spending is an investment in Canada's human capital. The quantification of these health benefits to the labour force would augment the positive impacts generated from health spending by the public sector presented in this study and represent an important avenue for future research.

In conclusion, the benefits arising from an increase in public spending on health are significant and, as argued by Stanford (2026), are a risk-free way to support Canada's economy in this turbulent period since health care is largely insulated from foreign factors. The estimates of the benefits presented in this study are also conservative, and when improved health outcomes are added, the overall benefits of enhanced public spending on health would be greater.

References

Canadian Institute for Health Information. (2025). *National Health Expenditure Trends, 2025: Data Tables – Series A*. Ottawa, ON: CIHI.

Committee for the Study of the Future of Public Health, Institute of Medicine, Division of Health Care Services. (1988). *The Future of Public Health*. Washington (DC): National Academies Press (US).

Stanford, Jim. (2026). *The Economic Benefits of Canada's Public Health Care System*. Canadian Federation of Nurses Unions.

Quantitative Economic Decisions, Inc. QEDinc Canadian Modelling System (CMS). http://qedinc.ca/products/

Appendix

QEDinc's Canadian Modelling System

The Canadian Modelling System (CMS) is a dynamic stochastic general equilibrium macroeconometric model of the Canadian economy and the economies of its provinces and territories. It consists of almost 14,000 equations and is used to generate long-term annual projections, which are maintained and updated regularly. These projections are then used to generate alternative scenarios, to support research into public policy issues and to conduct economic impact studies. The CMS is an important tool in supporting QEDinc's mission to provide quantitative economic research that supports informed decisions.

- **Dynamic:** the model is referred to as dynamic because it yields projections over time where the activity for a given year depends, to a certain degree, upon activity in preceding years.
- **General equilibrium:** activity in commodity, labour and financial markets is determined jointly with their prices. That is, shifts in the supply or demand determine their prices, and conversely, shifts in prices affect their supply and demand.
- **Macroeconometric:** combines the terms macroeconomic and econometric. A macroeconomic model includes all markets in an economy. An econometric model consists of stochastic equations which are estimated using statistical techniques.

The Canadian Modeling System (CMS) consists of the following set of 16 models:

- Rest of world variables
- Canadian national variables
- Canadian non-resident variables
- Provincial models (x10)
- Territorial models (x3)

The rest of world model includes equations that cover economic activity for eight countries and two regions. Economic activity for these countries and regions determines global commodity prices, U.S. dollar bilateral exchange rates and U.S. interest rates, as well as trade-weighted foreign demand and foreign price terms. Variables from the rest of world model inform activity in the other models in the system but (in the current model version) are not affected by activity in the other models.

The national model aggregates economic activity from the provinces and territories and activity outside Canada. National level data is then used to forecast overall immigration, interest rates and exchange rates, which influence economic activity in the provinces and territories. The provinces and territories models form the core of the system; they engage in the trade of goods and services across the country and compete for both international immigrants and interprovincial migrants, based on the relative strengths of their economies.

CANADIAN FEDERATION OF NURSES UNIONS

The economic impact of increased public sector health spending in Canada

April 2026

www.NursesUnions.ca