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HEALTHCARE; FISCAL AND TAX POLICY

## Fixing, Funding, and Reforming Health Services

by

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- The Canadian Institute for Health Information (CIHI) estimates total healthcare spending in Canada was \$308 billion in 2021, up 15.3 percent (\$40.8 billion) since 2019, swollen by \$22.8 billion targeted at COVID-19. Total spending rose from 11.6 to 12.7 percent of GDP.
- Depending on the pandemic's course, it may come down, yet there is much talk of health spending rising further. Too little attention is being paid to funding any increases or controlling healthcare's costs.<sup>1</sup>

Unless we are prepared to fund them, growing cost pressures will require health reforms and cost-reduction efforts. Canada's premiers predict healthcare costs will increase more than 5 percent annually for years (Council of the Federation 2021). The Parliamentary Budget Office uses a similar growth rate in its long-term projections, based on extrapolations of cost drivers (Office of the PBO 2021). Analyzing the underlying cost drivers, demographics, inflation and the intensity of use of healthcare resources, Drummond and Sinclair (2020) conclude a 5 to 6 percent growth rate is plausible under the status quo. That could be reduced by, for example, focusing on lower-cost alternatives like improving homecare and community-living supports instead of putting a lot

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- 1 By healthcare spending we mean public and private spending on costs normally associated directly with the treatment and care of those suffering ill health. In addition, in what follows, we refer to "health spending" to encompass the overall public and private costs of all health-related services including the promotion and maintenance of good health. The distinctions are admittedly fuzzy and spending on health promotion is rarely tabulated. The quantitative portion of this paper focuses on public healthcare spending by provincial and territorial governments.

more resources into institutional long-term care subsequent to its tragically high incidence of COVID-related deaths. Drummond, Sinclair and Bergen (2020) estimate responses to improve infrastructure and safety protocols and hire additional workers with better training and pay will raise long-term care spending from 1.3 to 2.1 percent of GDP. A doubling of the 75-plus age cohort over the next 20 years could then double that to 4.2 percent. Beefing up home- and community care would be less costly and provide the additional benefit of higher satisfaction among the seniors affected.

Drummond and Sinclair (2022a, 2022b) argue that some expansion of public coverage of healthcare would improve health outcomes and equity. Pharmacare is an example, as is the current yet-to-be-described federal government's commitment to improve coverage of aspects of mental-health care. Both would need to be funded, but little is being said about how. A wide range of public cost estimates exist for Pharmacare, easily spanning \$9.7 to \$32.7 billion<sup>2</sup> depending upon assumptions for the drug-price discounts the public sector could achieve, the coverage of drugs, and whether there would be co-payments. The Liberal's platform for the last election also included \$4.5 billion over five years allocated to mental health, an amount unlikely to ameliorate significantly the cost pressures from this dimension of health.<sup>3</sup>

This paper calculates the difference between the Canada Health Transfer (CHT) and provincial-territorial healthcare spending at 6 percent per annum and an assumed pace of nominal GDP and revenue growth of 3.5 percent. We identify new sources of funds to finance the gap. Implicit in this approach is an assumption that fiscal outcomes would be largely satisfactory for economic, fiscal and political purposes if healthcare spending grew at the same pace as revenues. Depending upon other factors such as non-health spending and tax rates, that would likely produce declining debt burdens relative to the current bloated levels.

The pressure to identify new sources of funds applies most to provinces and territories. The federal fiscal framework is insulated through the limit on growth in the Canada Health Transfer to a moving average of growth in nominal GDP. But if the federal government delivers on its commitment to increase health transfers and if Pharmacare and any other expansion of healthcare coverage were to be paid for federally, it too will be stressed to find a source of more revenues. The funding options are similar. As the saying goes, "there is only one taxpayer."

Drummond, Sinclair and Gladkof (2021) have argued that to optimize the health and well-being of Canadians health reform must be broadened and deepened. The emphasis should shift toward health promotion to achieve healthy outcomes and re-balance the heretofore virtually complete focus on the restoration of ill health. Greater efficacy and efficiency must also be achieved in healthcare to contain costs. To date, few concerted efforts have been applied anywhere in Canada to achieve such goals; where they have been made, they have not endured. Unless we do better, the need for new sources of funds will be ongoing.

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2 See Wolfson and Morgan (2018), Canada (2019), Office of the PBO (2017), Mintz (2019), and Wyonch and Robson (2019).

3 In 2017, the Mental Health Commission of Canada (2017) noted that at \$15.8 billion in 2015, mental health spending was just 7 percent of the total healthcare budget. They set a target of 9 percent to be reached within a few years. That extra 2 percentage points would add \$5.3 billion annually. The Commission noted further that even at 9 percent, Canada's allocation to mental health would be much lower than in some other developed countries (France, England and Germany at 15, 13 and 11 percent respectively).

Some of the options presented to raise new revenues will undoubtedly be unpalatable to many, given that taxes are already quite high in Canada.<sup>4</sup> But something must give, bringing us back squarely to the illusive reforms of the healthcare “system.” If we are not prepared to raise taxes to fund strong growth in health service spending, much of it to foster the population’s better health and wellness, the only alternative is to apply much greater effort to control the cost of healthcare services on which the great bulk of public (and private) resources are spent now.

**Table 1: Provincial – Territorial Healthcare Spending, \$ Billions**

Annual Rate of Growth	Years		
	5	10	15
6 percent	231.4	309.6	414.4
3.5 percent	205.4	243.9	289.7
Gap (Difference)	26.0	65.7	124.7

Source: Authors’ calculations as described in the text.

### Absent Serious Reforms, What Is the Likely Size of the Tax Bite?

We now set out some estimates of what the possible required increases in funding might be. Our quantification is admittedly rough. We do not pretend to forecast future health spending with precision. We present scenarios easy to understand and to reproduce, based on reasonable assumptions, sufficient to “ballpark” the potential size of the funding challenge. This quantitative perspective may inform the choice of funding sources. It may also stimulate more concerted and sustained efforts to control cost increases to lessen the need for incremental funding.

Beginning with the provincial-territorial perspective, we present two healthcare spending scenarios over 15 years. The first is annual spending growth of 6 percent.<sup>5</sup> The second is based on annual growth of 3.5 percent, equal to our estimate of long-run nominal GDP growth (i.e., keeping the ratio of healthcare spending to GDP constant).<sup>6</sup> We benchmark both growth rates to CIHI’s estimate of provincial-territorial pre-pandemic healthcare spending in 2019 (\$172.9 billion).<sup>7</sup>

In five years, healthcare spending growing at 6 percent per annum under the status quo scenario would exceed by \$26 billion spending growing at 3.5 percent per annum (the rate matching assumed revenue growth). By year 15, the excess healthcare spending over revenue growth would reach a staggering \$124.7 billion.

4 OECD Tax Statistics rank Canada among the top OECD countries (5<sup>th</sup>) with respect to the burden of income taxes as a share of GDP. See tax structure table at: <https://www.oecd.org/tax/revenue-statistics-canada.pdf>

5 Through the Council of the Federation, premiers expressed the view healthcare costs could well increase faster than 5 percent per annum. Drummond and Sinclair showed the underlying cost drivers could easily generate 6 percent annual growth in spending under the status quo. From a base of 1997, provincial healthcare spending grew at an annual average pace of 7.2 percent through 2010. For these reasons we chose 6 percent growth per annum for illustrative purposes.

6 See Laurin and Drummond (2021) for computational details on our long-run growth assumption.

7 2019 was chosen as the base year to avoid the distortions to data related to COVID-19. The figure is from the database attached to CIHI’s National Health Expenditure Trends, available at [www.cihi.ca/en/national-health-expenditure-trends](http://www.cihi.ca/en/national-health-expenditure-trends).

## Potential Revenue-Raising Options

In consideration of health's funding, three principles are fundamental.

1. Access to services beneficial to health and wellness should not be deterred by anybody's inability to pay.
2. To better inform their choices, consumers and health service providers alike need to know the cost and likely efficacy of the services they seek, use, prescribe, and provide.
3. The economic cost of funding should be minimized.

Several options to provide additional revenues might be considered.<sup>8</sup>

### ***Overall Taxation, Particularly the GST/HST and Carbon Taxes***

An obvious option is an overall increase in taxation, both federal and provincial/territorial. Government revenues tend to grow in line with nominal GDP, slightly more for the progressive personal income tax but less for other sources of revenues like specific excise taxes. Provided that a gap persists between healthcare spending and revenue growth, a funding crunch is inevitable under the status quo and one-time adjustments would not do the trick; tax rates would have to be increased periodically as shown below.

Models predict the highest economic costs of increased taxation arise from corporate income taxes, with personal income taxes next (Dahlby and Ferde 2011). Least costly are consumption taxes like the GST/HST, the closest thing Canada has now to a broad-based sales tax. The carbon tax is going to generate massive amounts of revenue as the rate moves to \$170 a tonne; currently the plan is to recycle the proceeds back to individuals, but some could be directed to health spending.

### ***Spending Reallocations***

It's possible more existing other-than-health spending could be "crowded out." Some scope exists at the federal level, given that the CHT (which constitutes the bulk of federal health expenditure) is less than 10 percent of total spending. But it is unlikely to be used given the government's other spending priorities. For provinces, education is the area of largest spending following health. It will now be more challenging to squeeze education budgets since the grandchildren of babyboomers are arriving at schools' doors. High spending growth on health might be absorbed by new debt if overall debt-to-GDP ratios were low, but they weren't prior to the pandemic, are very high now, and are projected to remain elevated (Laurin and Drummond 2021).

### ***Pre-Saving***

With foresight, future healthcare spending could have been pre-saved either through lower spending in general, creating lower public debt burdens, or through specific pre-saving approaches. A good part of the increase in long-term care costs warned by Drummond, Sinclair and Bergen (2020) should have been, and undoubtedly was, anticipated, yet governments have not created specific savings vehicles for long-term care nor addressed the low level of savings in general. Clearly, people are now not well able to meet the cost of support and care in their later years. Many have employer-sponsored savings plans they can rely upon. But RRSP data suggest that many who do not have such sponsored plans likely have inadequate savings. RRSP savings are just \$112K on average,

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8 Mintz (2022) provides an analysis of options to fund healthcare spending.

lowered, in part, by young people's lesser savings (BMO 2021), but those of the 55-64 near-senior group average only \$150K (Lavin 2021). It would have been best to address this completely predictable problem decades ago; now it's in the public sector's lap and requires more funding to pay the bills.

### ***User Fees***

User fees are another option, but they deter accessibility, constitute fighting words in Canada (despite their current application to access virtually all but in-hospital and physicians' services), and are a non-starter politically. Two exceptions might be acceptable to the public given co-payment's widespread use in many other countries with universal health systems far more comprehensive than Canada's. First, a co-payment scheme tied to income could be applied if Pharmacare were to proceed and, second, if there were to be expansion of homecare supports, co-payments for long-term care and other services for seniors to assist their healthy ageing would likely pass muster, especially if they were tax deductible.

### ***Income-Tested Tax Contributions Based on Service Utilization***

A functional and better health information system would allow the cost of every individual's use of health services to be tallied and added to their taxable income subject to a minimum and graduated maximums that, together with progressive tax schedules, would eliminate or keep the burden low for lower-income individuals and households. This would require some administrative steps based on physician bills sent to provincial health insurance plans and aggregations of those bills with other costs such as from hospitals. The information systems' inclusion of measures of health and well-being would also permit better predictions of service efficacy. Knowing how much is being spent to restore and enhance the population's health would also improve accountability and responsibility. Receiving a paid-up invoice for the receipt of every service paid for by the public purse would soon inform consumers and providers alike what the cost of each service is and that none is, in fact, free. Such awareness could well introduce into healthcare services the principle of choosing wisely (Vogel 2016); that is, considering both the effectiveness and the cost of a service in healthcare's choices, as is usual in more conventional markets.<sup>9</sup>

### ***Health Premiums***

Health premiums could be an additional source of funding.<sup>10</sup> They relate to aggregate healthcare costs but are not typically based upon the spending directly from the payor, apart from co-payments if they apply. Premiums are commonly criticized for being regressive, but typically achieve some progressivity by linking rates and incomes (Ontario 2022).

## **How Much Would Taxes Need to Rise to Fund Higher Healthcare Spending?**

For illustrative purposes, we show below the difference in spending between the 6 and 3.5 percent healthcare spending growth scenarios as a percent of provincial-territorial revenue from personal income taxes, sales

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9 Choosing Wisely Canada identifies many services and procedures deemed to be of low value or inappropriate: <https://choosingwiselycanada.org/>

10 Many provinces already have health insurance premiums, in some cases to cover catastrophic medical expenses, in other cases for prescription drug costs (Wyonch and Robson 2019).

taxes and all tax sources.<sup>11</sup> We also express the gap between healthcare spending in the two scenarios as an average per tax filer in Canada.<sup>12</sup>

From these scenarios, we can answer the question: by how much would various provincial-territorial taxes need to be raised to fund the difference between healthcare spending growing at 6 percent per annum and 3.5 percent per annum? Implicit in the question is the notion that the resultant provincial/territorial fiscal balances would be acceptable with healthcare spending growing at 3.5 percent per annum but that any additional spending would warrant a revenue response.<sup>13</sup> If instead of growing 3.5 percent per annum healthcare spending grew 6 percent per annum, by year 15 an increase of almost 20 percent in total tax revenue would be required; if personal income taxes were used alone by year 15, they would need to be raised almost two-thirds above what they would yield in the status quo. If only sales taxes were used, they would need to more than double.<sup>14</sup>

Another way of expressing the needed incremental funding is to say it works out to around \$3,500 per tax filer whether raised by the personal income tax or a health levy, raising the average personal income tax per filer from \$5,313 to \$8,855 by year 15. If met by revenue from sales tax, in a province with a sales tax rate of 8 percent, the rate would need to more than double gradually, or at least periodically, over the 15 years, e.g., to 10.6 by year 5, 13.5 by year 10 and 16.8 by year 15.

**Table 2: Gap Between Healthcare Spending Scenarios (6 and 3.5) as a Percent of Provincial – Territorial Revenue**

Tax Source	Years		
	5	10	15
Personal Income	19.6	41.7	66.7
Sales Tax	32.3	68.8	110.0
Tax Revenue	5.9	12.5	19.9
<b>Gap per Tax Filer (\$)</b>	<b>815</b>	<b>1,964</b>	<b>3,543</b>

Source: Authors' calculations as described in the text.

**Table 3: CHT Plus Other Federal Spending, \$ Billions**

Annual Rate of Growth	Years		
	5	10	15
CHT at 6 percent Plus Pharmacare	76.2	96.8	123.7
CHT at 3.5 percent	48.0	57.0	67.7
Gap (Difference)	28.2	39.8	56.0
<i>Of Which:</i>			
CHT	6.1	15.4	29.1
Pharmacare	22.1	24.4	26.9

Source: Authors' calculations as described in the text.

11 All revenue figures based on 2019 data from Statistics Canada Table 36-10-0450-01 and increased at 3.5 percent annually.

12 The total number of Canada tax filers for personal income tax was 30.3 million in 2019; this has grown 1 percent per annum.

13 If all program spending and the total of all revenues grew at 3.5 percent per annum, the operating balance (revenue less program spending) would remain roughly constant over time. If program spending were to grow faster than revenues, the operating balance would deteriorate progressively.

14 Alberta does not presently have a provincial sales tax so would need to create one or fill the gap with another revenue source. In other provinces, the provincial sales tax rates (applied to their own sales tax or harmonized with the GST) range from 6 to 10 percent.

From a federal perspective, the Canada Health Transfer (CHT) was \$40.4 billion in 2019. We consider its growth in the same two scenarios. From the wide range of estimates for the cost of Pharmacare, we use a middle-of-the-road figure of \$20 billion in year 1 and growth subsequently at 2 percent per annum. We have not included a cost for higher federal spending on mental health. The commitment of \$4.5 billion over five years for mental health would not change the calculations substantially and, as noted above, the total is highly unlikely to address the large spending pressures in that area. We then calculate the total incremental revenue required.

The gap between spending at 6 percent annual growth in CHT with Pharmacare added and 3.5 percent annual growth in the CHT, expressed as a percent of the federal revenue sources is shown in Table 4.

The average federal personal income tax paid per filer in year 15 would need to go from \$7,972 to \$9,566. If the GST bore the whole brunt, the rate would need to go up from the current 5 percent to 8.9 percent. Adding the provincial-territorial perspective to that, the combined sales tax rate in a province with an 8 percent rate would go from 13 at present to 25.8 percent. This would be one of the highest *ad valorem* sales tax rates in the world.

It should be noted that the provincial-territorial and federal perspectives interact and differ. If the provinces took the revenue from the higher CHT to lower their own spending, then the provincial-territorial tax increases would be less than calculated above. In year 15, the higher CHT would give the provinces-territories an additional \$29.1 billion. If applied against the \$124.7 billion of higher provincial-territorial spending in the 6 percent scenario (i.e., rather than expand healthcare spending), the 110.0 percent increase in the sales tax rate could be 83.9 percent going from the current rate to 14.8 rather than 16.9 percent. The combined federal-provincial sales tax rate could go to 24 percent rather than to 25.8 percent.<sup>15</sup>

## A Call to Action

Fundamental changes are needed – even in an icon like medicare – to achieve its five famous principles and fix its too-long neglected problems.<sup>16</sup> Focusing more on health outcomes and containing costs through greater efficacy and efficiency represent the path forward. Failing the achievement of both, taxes must be raised, and by a lot. Let the discussion of these approaches begin now.

**Table 4: Gap Between CHT (6 percent growth) plus Pharmacare Spending Scenario and Status-Quo (CHT growing at 3.5 percent) Scenario, as a Percent of Federal Tax Revenue Sources**

Tax Source	Years		
	5	10	15
Personal Income	14.2	16.8	20.0
Sales Tax	55.0	65.4	77.3

Source: Authors' calculations as described in the text.

15 We assume the federally funded Pharmacare program would not directly reduce provincial spending on drugs. It would, however, replace money individuals are now paying through private insurance plans.

16 Drummond and Sinclair (2022a) describe medicare's failure against the five fundamental principles of public administration, comprehensiveness, universality, accessibility and portability.

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