THE QUÉBEC
ECONOMIC
PLAN

HEALTH FUNDING

For a Fair Share of Federal Health Funding

Québec

Budget 2017-2018
Health Funding – For a Fair Share of Federal Health Funding

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INTRODUCTION

Despite tight control of health spending, the provinces are faced with increasing pressures that will only increase due, in particular, to population aging.

At the same time, the federal government is scaling back its commitment to funding health care: Before 1977-1978, it funded 50% of the provinces' eligible health expenditures, but the federal share is now below 25% and will continue to decline in the years ahead.

— Since 1977-1978, the federal health contribution has been in the form of a block payment, that is, it is not tied to provincial spending. Consequently, the level of federal health transfers is determined by the federal government on the basis of its own financial situation and its political choices, without factoring in the costs associated with health services, services that are, in fact, prescribed by the *Canada Health Act*.

— Federal funding to the provinces is therefore inconsistent and insufficient to enable the provinces to adequately meet their obligation to deliver health services.

The federal government, which had pledged during the election campaign to reach a new, long-term health accord with the provinces, instead proposed to maintain the previous government's decision and augment it with targeted funds. However, this proposal does not ensure the long-term sustainability of the provinces' health systems.

Québec is therefore reiterating to the federal government that it must assume a fair share of provincial health spending–a share representing 25% of these expenditures–and follow through on its intention to enter into a viable, long-term health funding partnership with the provinces, for the benefit of all Canadians.

1. A BRIEF HISTORY OF THE FEDERAL HEALTH CONTRIBUTION

Historically, the federal government has always played a significant role in funding health services offered by the provinces, and its financial support has always been essential. A brief review of the history of the federal health care contribution puts Québec's current request in this regard into context.

In addition, a reminder of the principal recommendations of certain commissions set up in the early 2000s shows that funding health care has long been a considerable challenge and that it has been a focus of governments concerns for many years.

1.1 From shared health spending to block funding determined on the basis of federal revenues

Although the provinces are responsible for health care delivery under the Constitution, the federal government has always been a key health funding partner since the creation of the first health care programs, such as hospital insurance and medical care insurance, introduced in 1957 and 1966, respectively.

From the creation of these programs until the mid–1970s, the federal government shared equally with the provinces in the funding of their eligible health expenditures.

In 1977-1978, the federal government ceded tax points and terminated shared health funding, replacing it with block funding–funding that is no longer tied to provincial spending levels, but to economic growth. This led to the creation of Established Programs Financing (EPF), under which today's Canada Health Transfer (CHT) and post-secondary education component of the Canada Social Transfer were grouped.

— Although the implementation of EPF gave the provinces more room to manoeuvre, by enabling them to take up the vacated tax field, and significantly reduced red tape, this change also cut federal funding in half, to 25% of provincial health spending.

Accordingly, since the mid-1970s, federal health funding has no longer been directly linked to provincial health spending levels.

— Regardless of the cost increases the provinces must deal with to deliver the care prescribed by the *Canada Health Act*, the increases can be excluded from federal health transfers. Health transfers are now determined by the federal government on the basis of its own financial situation and its political choices, guaranteeing the federal government control over its spending levels and facilitating any cuts to its funding.

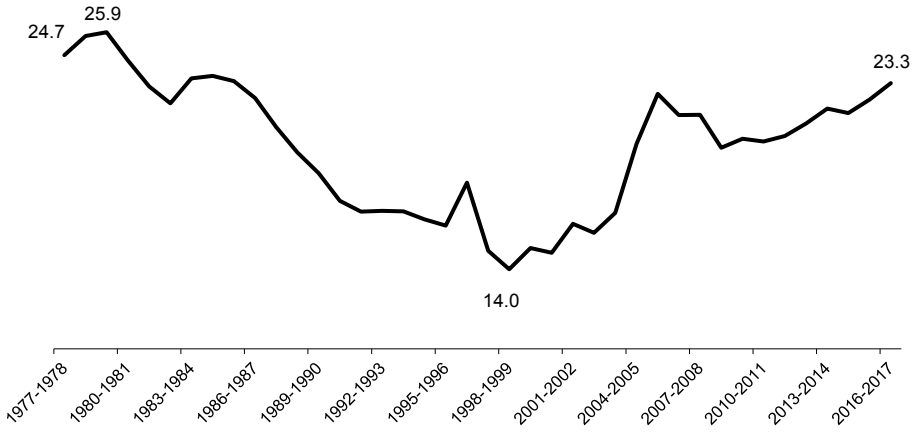
Thus, as of the 1980s, the federal funding share, which represented 25% of provincial health spending, plummeted, reaching a historic low of 14.0% in 1998-1999.

— This historic low stemmed essentially from a one–third decrease in health transfers between 1995-1996 and 1998-1999, for the purpose of balancing the federal budget. The federal government put its fiscal house in order at the provinces' expense, which it admitted in these terms:

> By the mid-1990s, increasingly large deficits and debt burdens, especially those of the federal government, led to fiscal restraint that culminated in significant reductions across a wide range of federal expenditures, including transfers to provinces and territories.[1]

CHART 1

Share of federal funding in provincial health spending, 1977-1978 to 2016-2017
(per cent)



Sources: Canadian Institute for Health Information, Conference Board of Canada, Department of Finance Canada and Ministère des Finances du Québec.

Although the 2004 health accord raised the federal government's share of the funding of provincial spending, that share still did not reach the desired level of 25% that was in effect in 1977-1978, when EPF was created.

In the years following the sharp decrease in federal health funding, a number of commissions studied the reforms required to ensure the sustainability of the provincial health systems.

[1] DEPARTMENT OF FINANCE CANADA, *Budget 2006 – Restoring Fiscal Balance in Canada: Focusing on Priorities*, p. 86.

— Several commissions recommended a substantial federal reinvestment in health care.

— Despite these repeated recommendations, the request for adequate federal reinvestment in health care is still relevant today.

1.2 Reports that paved the way for the 2004 health accord

The report of the Clair Commission (Commission d'étude sur les services de santé et les services sociaux au Québec), chaired by Michel Clair in 2000, and that of the Commission on the Future of Health Care in Canada, chaired by Roy J. Romanow in 2002, found that the federal financial contribution to health care should be increased, for the benefit of the provinces, as did a number of other reports on health care at the time. In this regard, the report of the Clair Commission published the following:

> The Commission believes, however, that these funds are both too selective and too small to meet Québec's needs, and this is undoubtedly true for all the provinces. The Government of Québec should ask the federal government to invest at least five to six times more money, spread over a period of five to six years, to the following three priority areas. To support the transition of our system to a much higher level of performance, new medical equipment, the introduction of information technologies and the adaptation of primary care health and social services are essential. These needs, which are evident across Canada, will require tens of billions of dollars in investments over the next five or six years. Certainly the Government of Canada, failing an adjustment of cash transfers on the basis of the 1994-1995 program and indexed according to the increase in needs, at least has the responsibility to fund transition costs.[2]

Main recommendations of the Romanow report

In 2002, the Commission on the Future of Health Care in Canada published a report (the "Romanow report") proposing 47 recommendations to ensure the long-term sustainability of Canada's health systems. These included:

- provide adequate funding, bringing the federal cash contribution to provincial health spending to at least 25% by 2005-2006;
- establish stable and predictable long-term funding, by creating a dedicated health transfer, namely, the Canada Health Transfer;
- implement an escalator set in advance that would be based on expenditure projections by an independent body.

[2] COMMISSION D'ÉTUDE SUR LES SERVICES DE SANTÉ ET LES SERVICES SOCIAUX AU QUÉBEC, *Emerging Solutions – Report and Recommendations*, December 2000, in Publications, on the MSSS website, www.msss.gouv.qc.ca, pp. 152-153.

In its August 2004 report[3] on behalf of the federal government, the Conference Board of Canada (CBoC) projected a 4.9% average annual escalator for provincial health spending from 2003-2004 to 2014-2015.

— It is worth emphasizing that, according to data from the Canadian Institute for Health Information (CIHI), provincial health spending rose by an average of 5.3% annually during this period, which was slightly higher than the CBoC's growth forecast.

Principles of the *Canada Health Act*

In accordance with the *Canada Health Act*, introduced in 1984, the provinces are required to adhere to five principles under their public health care insurance plans in order to qualify for all federal contributions paid through the Canada Health Transfer.

- **Accessibility**: Insured persons must have reasonable and uniform access to insured health services and not encounter any financial or other barriers.
- **Public administration**: Each provincial health care insurance plan must be administered by a non-profit public authority that must report to the provincial government on its financial transactions.
- **Comprehensiveness**: The health care insurance plan of a province must cover all medically necessary services, i.e. hospital care, medical services and required surgical-dental procedures that can be performed only in a hospital.
- **Portability**: The provinces are required to cover the insured health services that are provided to their citizens when they are temporarily absent from their province of residence or Canada.
- **Universality**: All residents of a province must have access to public health care insurance and insured services on uniform terms and conditions.

For more than 30 years, the provinces have been faced with demographics that have undergone significant change due primarily to the acceleration of population aging, and to changes in technology and health care delivery methods. Yet, the provinces have but little room to manœuvre for finding innovative ways of funding of their health expenditures.

[3] CONFERENCE BOARD OF CANADA, *Fiscal Prospects for the Federal and Provincial/Territorial Governments*, August 2004, in E-library, on the Conference Board website, www.conferenceboard.ca.

2. THE 2004 HEALTH ACCORD

The commissions' reports and the health spending projections set the table for talks between the federal government and the provinces, which led to the 2004 health accord and Québec's asymmetrical agreement.

— In the wake of the Romanow report, the federal government negotiated a long-term health accord with the provinces. That accord gradually restored, over a ten-year period, a federal financial contribution to health care that could better support the sustainability of Canada's health systems.

2.1 A significant federal reinvestment in health

Under the 2004 health accord, the provinces received additional funding of $41.3 billion over ten years (including $9.5 billion for Québec), representing an average annual increase of 8.9% for Canada as a whole, broken down as follows:

— $3.5 billion to close the short-term gap identified in the Romanow report, so that the 2005-2006 CHT level corresponded to 25% of the estimated provincial-territorial costs for services covered under the *Canada Health Act*, and for home care-related amounts and catastrophic drug coverage;

— $31.8 billion to implement an annual escalator corresponding to 6% of the CHT for the period from 2006-2007 to 2013-2014;

— $6.0 billion to create funds for wait time reduction and the purchase of medical equipment.

However, even though the federal contribution rose substantially in the years following the accord, it never reached the 25% share it represented when EPF was introduced in 1977-1978.

2.2 An asymmetrical agreement for Québec

While the provinces, with the exception of Québec, agreed on funding priorities and reporting to the federal government under the 2004 health agreement, Québec entered into an asymmetrical agreement.

— Under that agreement, Québec applied its own plan, in particular respecting the reduction of wait times, and reported to Quebecers, while receiving the planned funding.

Excerpt from the September 15, 2004 communiqué announcing the agreement on asymetrical federalism that respects Québec's jurisdiction

Recognizing the Government of Québec's desire to exercise its own responsibilities with respect to planning, organizing and managing health services within its territory, and noting that its commitment with regard to the underlying principles of its public health system – universality, portability, comprehensiveness, accessibility and public administration – coincides with that of all governments in Canada, and resting on asymetrical federalism, that is, flexible federalism that notably allows for the existence of specific agreements and arrangements adapted to Québec's specificity, the Prime Minister of Canada and the Premier of Québec have agreed that Québec's support for the joint communiqué following the federal-provincial-territorial first ministers' meeting is to be interpreted and implemented as follows:

- Québec will apply its own wait time reduction plan, in accordance with the objectives, standards and criteria established by the relevant Québec authorities, including health human resources management, family and community care reform, home care, drug access strategies, and health promotion and chronic illness prevention strategies. Québec will pursue its objective of providing more first dollar coverage for short-term acute home care, short-term acute community mental health home care and palliative care, in accordance with its financial capacity.

Source: DEPARTMENT OF HEALTH OF CANADA, "Asymetrical Federalism that respects Québec's Jurisdiction" [communiqué], September 15, 2004, Ottawa, in First Ministers' Meeting: Ten Year Plan (2004), on the Health Canada website, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/bg-fi_quebec-eng.php.

3. SIGNIFICANTLY REDUCED FEDERAL FUNDING

In December 2011, nearly three years before the 2004 health accord ended, the previous federal government unilaterally announced a decrease in CHT growth as of 2017-2018. Despite the CBoC estimates backing the provinces' request for more adequate funding, the current federal government decided to maintain this downward adjustment of CHT growth as of 2017-2018.

3.1 Substantial financial losses for the provinces

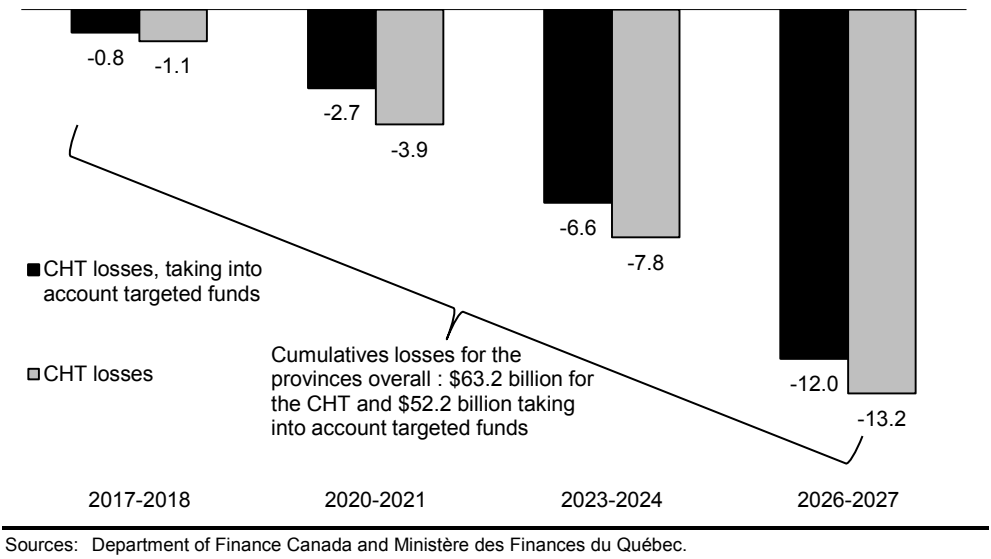
Starting in 2017-2018, annual CHT growth will correspond to that of Canada's nominal GDP, subject to a 3% floor. Consequently, on April 1, 2017, the rate of annual growth of the CHT envelope will decline by half, from 6% to 3%, in a context of population aging that, in Québec, is occurring at a rate faster than the provincial average.

— For 2017-2018 alone, the provinces' financial loss is evaluated at $1.1 billion and, taking into account the targeted funds, stands at $800 million. Québec's losses will be $250 million and $180 million, respectively.

— The losses over ten years are estimated at $63.2 billion for Canada as a whole. With additional federal funding of $11 billion in non-CHT targeted funds, the losses will reach $52.2 billion by 2026-2027. Québec's losses will be $14.2 billion and $11.7 billion, respectively.

CHART 2

Impact of the decrease in the annual growth of the Canada Health Transfer (CHT) from 6% to Canada's nominal GDP and a floor of 3%
(billions of dollars)



Sources: Department of Finance Canada and Ministère des Finances du Québec.

3.2 An unfavourable outlook for the provinces, a favourable outlook for the federal government

In 2013, the Office of the Parliamentary Budget Officer (PBO) said that the imminent changes to the Canada Health Transfer would transfer the fiscal burden to the provinces, along with the long-term costs associated with the future demand for services.

> The federal fiscal structure has been transformed from unsustainable in 2011 to sustainable–with substantial fiscal room–largely through spending restraint and reform of the Canada Health Transfer (CHT) escalator. However, the federal fiscal room created by the change in the CHT escalator has transferred the fiscal burden to provinces and territories.[4]

This situation is also confirmed by a CBoC study conducted in 2016 on behalf of the Council of the Federation.

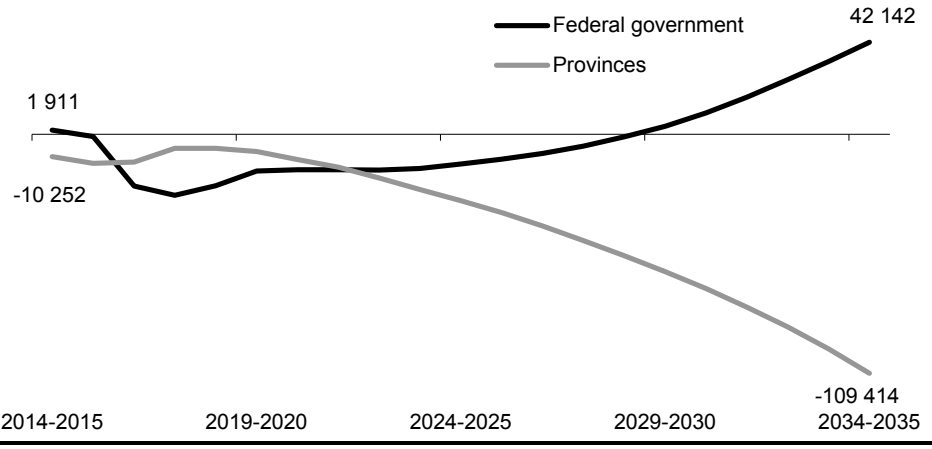
- The federal government's budgetary balance, after a deterioration that began in 2014-2015 due primarily to slower growth of the Canadian economy and the cost of new initiatives, is expected to gradually improve as of 2017-2018, and a balanced budget is expected to be achieved in 2029-2030.

- However, the financial situation of the provinces remains a concern, since their budgetary balance is expected to be in deficit throughout the period, and the size of the deficit will rise over time, reaching more than $109 billion in 2034-2035, due particularly to the increase in health spending, which will be borne by the provinces.

[4] OFFICE OF THE PARLIAMENTARY BUDGET OFFICER, *Fiscal Sustainability Report 2013*, September 26, 2013, p. 3, in Our Publications, on the PBO-DPB website, www.pbo-dpb.gc.ca/en/.

CHART 3

Budgetary balance of the provinces and the federal government
(millions of dollars)



Source: Conference Board of Canada.

4. INCREASING PRESSURES ON PROVINCIAL HEALTH SPENDING

Despite tight control of health spending, the provinces are faced with health expenditures that remain high and that will continue to rise rapidly in coming years due, in particular, to population aging.

Provincial health spending, estimated at $154.8 billion in 2016-2017, is the biggest budget item for each of the provinces. The weight of this budget item in the provinces' spending varied from 32.1% to 40.5% in 2016-2017, according to the most recent data published by the provinces. Accordingly, it is in the best interests of the provinces to curb the rise in health costs, which they have worked hard to do in recent years, so that their budgetary situation does not deteriorate.

— Health spending is expected to take up an increasingly large portion of provincial financial resources. In fact, the PBO[5] estimated in 2016 that the provinces' share of health funding in the economy would reach 9.1% of GDP in 2035, compared to 7.3% in 2015.

4.1 In the long term, 5.2% annual growth in health spending

Growth in provincial health spending slowed after the 2009 recession, due in part to the provinces' considerable efforts to restore fiscal balance. It should be borne in mind that, during the ten years before the recession, health spending grew significantly.

— Growth in provincial health spending, which averaged 7.1% a year from 2000-2001 to 2009-2010, fell to 3.4% from 2009-2010 to 2014-2015, for average annual growth of 5.8% from 2000-2001 to 2014-2015.

As estimated by the CBoC in 2016 on behalf of the Council of the Federation, the average annual growth in provincial and territorial health spending will be 5.2% over a 20-year period, from 2015 to 2035.

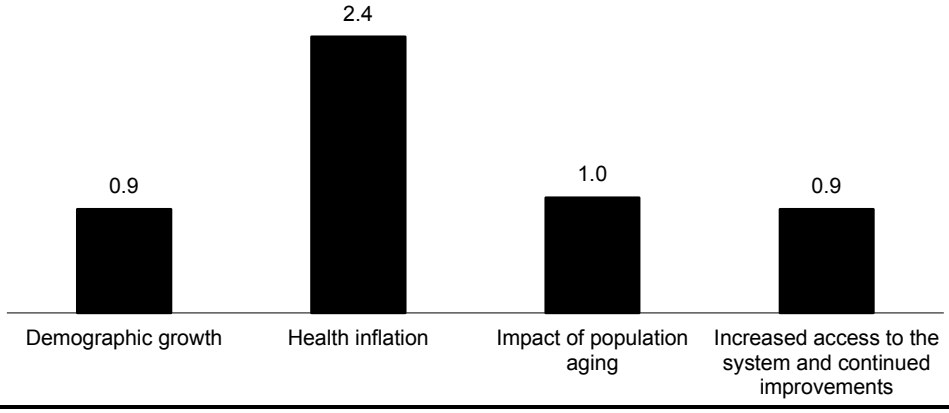
[5] OFFICE OF THE PARLIAMENTARY BUDGET OFFICER, *Fiscal Sustainability Report 2016*, June 28, 2016, in Our Publications, on the PBO-DPB website, www.pbo-dpb.gc.ca/en/.

This projection highlights four main health cost drivers that, for the most part, cannot be reduced. These are:

- inflation in the health sector (2.4%), which is slightly higher than the consumer price index (CPI), taking into account, for example, the expected increase in the wages of health workers and the cost of prescription drugs;
    - According to the Ministère de la Santé et des Services sociaux, health inflation corresponds to 3% average annual growth in Québec and is composed of the infrastructure debt, the public share of employee retirement funds, the increase in pay scales, and pay raises.
- the impact of population aging (1.0%), which reflects, in particular, the fact that provincial health spending is much higher for persons aged 65 and over than for persons under the age of 65;
    - In 2014, it cost an average of 4.6 times more to provide care to a person aged 65 or over ($11 655) than to a person under the age of 65 ($2 547).
- the anticipated growth in Canada's population by 2035, since a bigger population increases the demand for health care (0.9%);
    - Canada's population is estimated at 42.7 million people in 2035, which is six million more than in 2017.
- increased access to care and ongoing improvements (0.9%), which take into account the provinces' efforts to maintain and improve the quality of care provided to the public.
    - Instead of resulting in savings, scientific advances regarding new technologies and new drugs lead to higher health costs, because of increased demand spurred by lower prices or the novelty of a treatment.

CHART 4

Average breakdown of 5.2% growth in provincial and territorial health spending, according to the Conference Board of Canada, 2015 to 2035
(per cent)



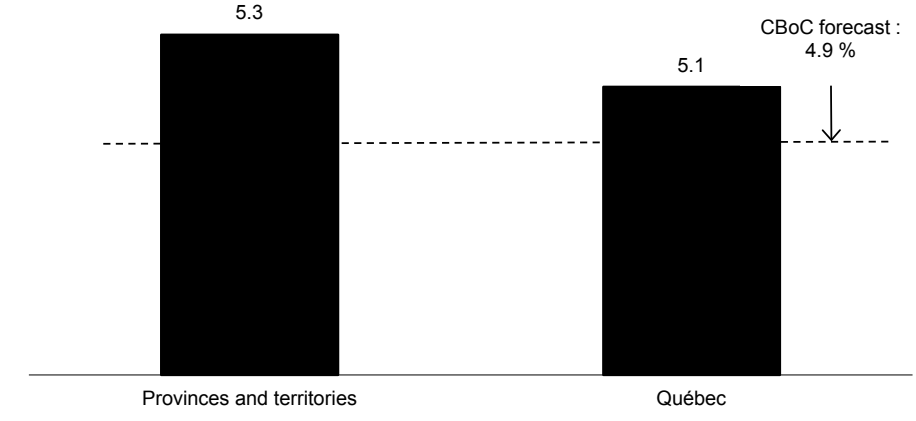
Source: Conference Board of Canada.

Provincial and territorial health spending growth in relation to Conference Board of Canada Forecasts

In recent years, Conference Board of Canada (CBoC) forecasts have proven to be adequate for determining long-term health spending growth, although this spending has been slightly underestimated.

- In August 2004, the CBoC evaluated annual health spending growth at 4.9% between 2003-2004 and 2014-2015.
- This long-term forecast has been exceeded, since health spending growth for this period was higher, at 5.3%, according to Canadian Institute for Health Information (CIHI) data.
- Also according to CIHI data, health spending growth in Québec for this period was comparable to that of the provinces and territories as a whole, at 5.1%.

Provincial and territorial health spending growth, 2003-2004 to 2014-2015
(per cent)



Sources: Canadian Institute for Health Information and Conference Board of Canada.

4.2 The impacts of population aging will intensify

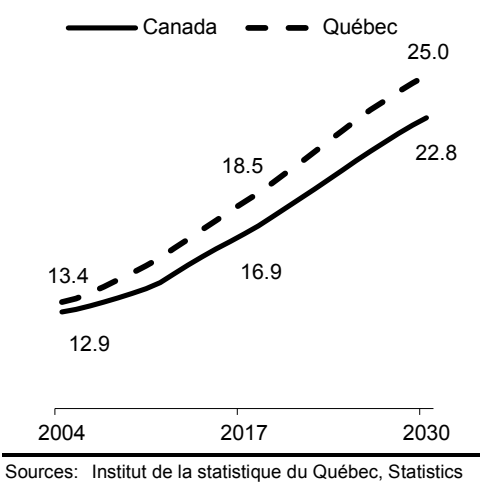
The longer life expectancy of Canadians and the gradual onset of retirement for numerous baby boomers entail many challenges for public finances, particularly in the health sector.

— Since the signing of the 2004 health accord, which provided for a CHT escalator of 6% per year, the share of persons aged 65 and over in Canada has risen from 12.9% to 16.9% in 2017, an increase of four percentage points over the past 13 years. The increase in Québec is more than five percentage points (from 13.4% to 18.5%) for the same period.

— While the CHT escalator will be cut in half, the share of the Canadian population aged 65 and over is expected to be 22.8% (25.0% in Québec) in 2030, which is a bigger increase (almost six percentage points in Canada and Québec) than that over the past 13 years.

CHART 5

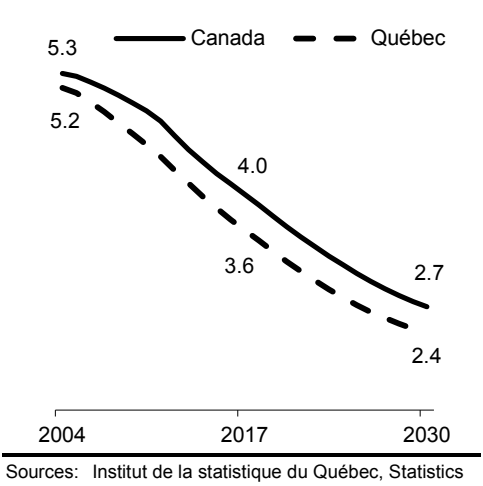
Share of persons aged 65 and over as a proportion of the overall population
(per cent)



Sources: Institut de la statistique du Québec, Statistics Canada and Ministère des Finances du Québec.

CHART 6

Ratio of persons of working age (15 to 64 years) to persons aged 65 and over



Sources: Institut de la statistique du Québec, Statistics Canada and Ministère des Finances du Québec.

— The ratio of the number of persons of working age (15 to 64 years) to the number of seniors (65 years and over) in Canada is in steep decline. Standing at 5.3 in 2004, it subsequently fell gradually, reaching 4.0 in 2017. Because of population aging, it is expected that there will be only 2.7 persons of working age (2.4 in Québec) for every person aged 65 and over in 2030 in Canada.

– Over a period of nearly 30 years, this ratio will be cut almost in half in Canada (by more than half in Québec), making it more difficult for the provinces to achieve their objective of delivering health care that meets the expectations of their inhabitants, while balancing their budget.

Moreover, because of population aging, the provinces must also contend with a drop in GDP growth. In fact, the federal government acknowledged this reality in its update of long-term economic and fiscal projections published in December 2016:

> Slower nominal GDP growth will thus reduce the growth rate of government revenues, thereby limiting the capacity of governments to continue to maintain the growth rates of public expenditure at levels as high as in the past. At the same time, population aging is also expected to put upward pressure on public expenditure, notably for age-related programs such as elderly benefits.[6]

More specifically for Québec, a study published in December 2016 by the Chaire de recherche Industrielle Alliance sur les enjeux économiques des changements démographiques made a similar finding:

> The projections suggest that, in the coming years, population aging will lead to a spike in health spending. In addition, population aging will likely limit growth in Québec government revenues, by slowing workforce growth and, at the same time, economic growth.[7] [TRANSLATION]

The reduction of CHT growth as of 2017-2018 will occur at the very moment that population aging accelerates. These two factors combined will permanently increase financial pressures on the provinces.

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6 DEPARTMENT OF FINANCE CANADA, *Update of Long-Term Economic and Fiscal Projections*, 2016, p. 7.

7 CHAIRE DE RECHERCHE INDUSTRIELLE ALLIANCE SUR LES ENJEUX ÉCONOMIQUES DES CHANGEMENTS DÉMOGRAPHIQUES, *Les effets de l'équilibre budgétaire et du transfert canadien en santé sur les finances publiques du Québec*, December 2016, p. 15.

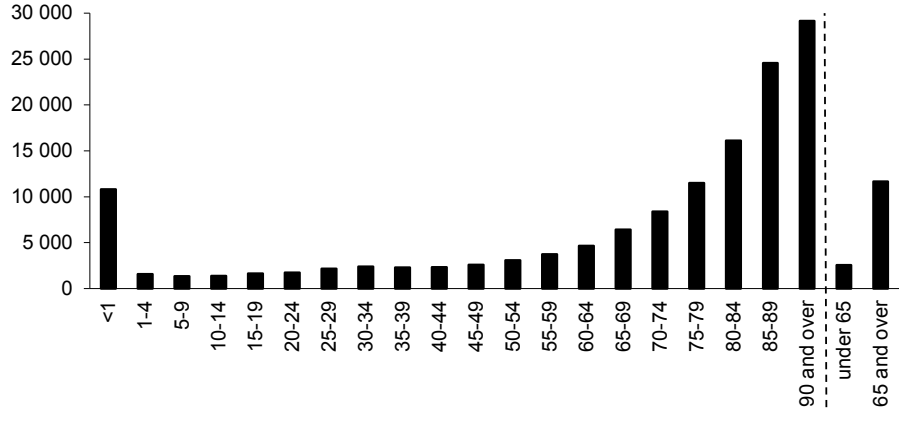
Impact of population aging on health costs

The pressure placed on provincial finances by population aging is due particularly to the fact that average health expenditures for persons aged 65 and over are higher than for persons under the age of 65.

- According to the latest Canadian Institute for Health Information data, published in December 2016, it cost 4.6 times more on average in 2014 to provide care to a person aged 65 or over ($11 655) than to a person under 65 years of age ($2 547).

Moreover, provinces where the population will age more rapidly are also those that will see slower economic growth, which will add to the financial pressures related to population aging.

Average provincial and territorial health spending, by age group – 2014
(dollars per capita)



Sources: Canadian Institute for Health Information, Ministère des Finances du Québec and Statistics Canada.

5. AN INADEQUATE SHARE OF FEDERAL HEALTH FUNDING

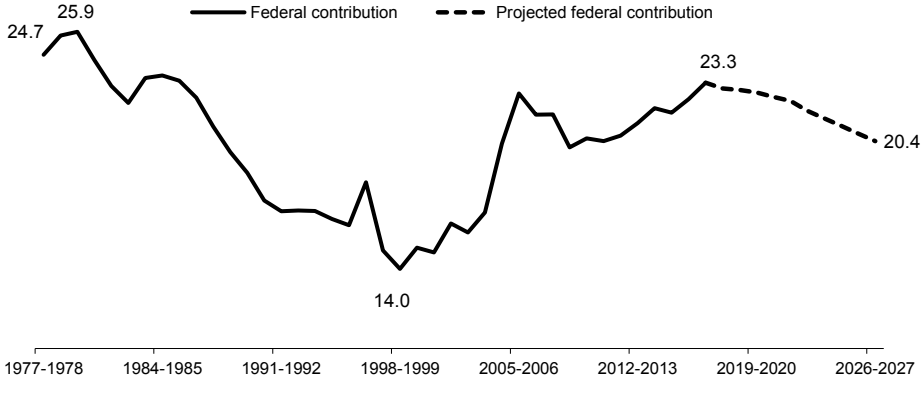
While the provinces have made considerable efforts to better manage their health spending,[8] the federal government contributed to only 23.3% of provincial health spending in 2016-2017. Since Canada's nominal GDP is expected to grow much less than health cost drivers over the next ten years, the federal contribution to provincial health spending will gradually decline and will not be sufficient to cover the increase in health costs.

— With CHT growth corresponding to that of Canada's nominal GDP, including a 3% floor, as well as targeted funds of $11 billion, the federal contribution to provincial health spending will gradually decline over the the next ten years, reaching 20.4% in 2026-2027.

For the contribution to provincial health spending to be fair and thus maintain the sustainability of the provinces' health systems, federal health funding must grow at a rate of 5.2% per year, not at the rate of Canada's nominal GDP, which is evaluated at an average of 3.6% (3.8%, including the targeted funds) per year over ten years as of 2017-2018.

CHART 7

Share of federal funding in provincial health spending, 1977-1978 to 2026-2027
(per cent)



Sources: Ministère des Finances du Québec, Department of Finance Canada and Conference Board of Canada.

[8] According to the *Report on Fiscal Sustainability 2015* of the Office of the Parliamentary Budget Officer, "Health care spending has slowed. Spending growth in 2014 is estimated to have reached its lowest level in two decades," p. 1.

Federal funding that remains insufficient in the long term

On March 10, 2017, the federal government and Québec entered into a health funding agreement that includes:

- annual CHT growth corresponding to that of Canada's nominal GDP, with a 3% floor, for a ten-year period as of 2017-2018;
- an asymmetrical agreement of nearly $2.5 billion corresponding to Québec's demographic share of the non-CHT targeted funds of $11 billion for the period from 2017-2018 to 2026-2027, enabling Québec to implement its own priorities, including mental health and home care.

Under this agreement, Québec will obtain an average annual increase in federal health funding of 4.1% over the first five years and 3.1% over the next five years, for an average annual increase of 3.6% over ten years.

- Québec considers this agreement insufficient in the long term because of the forecasts of 5.2% health cost growth a year from 2015 to 2035. It cannot be a long-term solution for funding Québec's health system.
- The federal government must acknowledge its responsibility with respect to health funding and then assume its fair share. Moreover, this responsibility flows from the services prescribed in its own statute, the *Canada Health Act*.

In addition, Québec obtained from the federal government, for 2017-2018, a $25-million envelope to train specialized nurse practitioners.

The health agreement with the federal government is also based on a new recognition and a strengthening of the principle of asymmetry concluded in 2004, as it provides for the use of $1.2 billion over 11 years from the childcare component of the new federal social infrastructure funds announced in the recent federal budget. Québec has had a daycare network since 1997, and it alone funds the network's development. The Québec government obtained from the federal government the ability to use part of the amounts set aside for infrastructure development to finance its priorities.

5.1 For a fair share of federal health funding

To help ensure the sustainability of Canada's health systems, Québec is asking the federal government to assume its fair share of funding by gradually raising the CHT to a level representing 25% of provincial health spending, and to subsequently maintain that share.

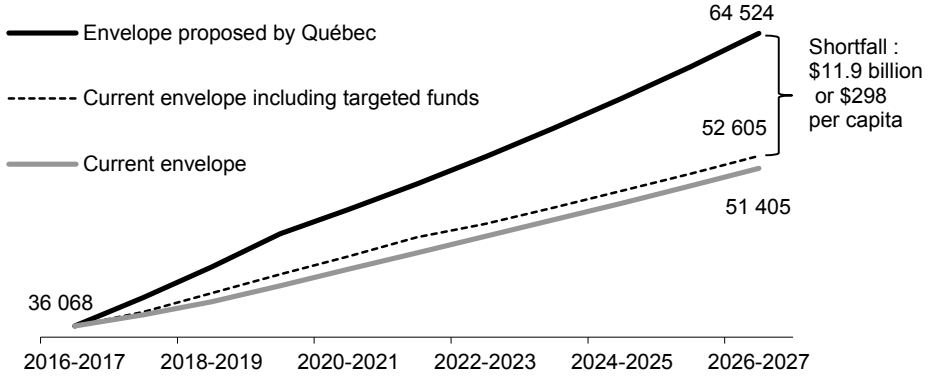
— For example, to reach a contribution of 25% by 2019-2020, the federal government would have to offer additional funding of $4.8 billion through the CHT. Subsequently, the CHT envelope would grow at the annual growth rate of provincial health spending estimated by the CBoC–5.2%.

— Under this proposal, the CHT envelope would reach $64.5 billion, rather than $51.4 billion, in 2026-2027, providing additional funding of $13.1 billion compared to a CHT envelope that would increase according to Canada's nominal GDP growth, subject to a 3% floor.

— Considering the targeted funds of $11 billion intended to the provinces, the CHT envelope would reach $52.6 billion in 2026-2027. Additional funding of $11.9 billion–$298 per capita–in 2026-2027 would therefore be required for the CHT envelope to represent 25% of provincial health spending.

CHART 8

Gradual return to the Canada Health Transfer representing 25% of provincial health spending, 2016-2017 to 2026-2027
(millions of dollars)



Sources: Conference Board of Canada, Canadian Institute for Health Information, Department of Finance Canada and Ministère des Finances du Québec.

Setting the record straight about health care

Myth 1: Provincial health spending can continue to grow at the current rate in the long term

The federal government affirms that Canada Health Transfer (CHT) growth corresponding to Canada's nominal GDP growth with a 3% floor is sufficient (3.6%, 3.8% including targeted funds), since it exceeds the growth in provincial health spending in recent years (3.4% from 2009-2010 to 2014-2015).

Yet, several studies indicate that the significant efforts made by the provinces and territories in recent years to curb health spending growth are not sustainable in the long term, since they largely depend on the reduction of capital spending.[1] In a study published in August 2016, the C.D. Howe Institute stated the following opinion:

> *Capital spending is a critical component of recent spending restraint: the category makes up only 5 percent of all provincial health costs, but accounts for around 25 percent of the current restraint period's decline in total spending. Yet, key capital projects and maintenance can only be delayed for so long. Therefore, we do not think declines in capital spending are a resilient source of spending restraint.*[2]

A substantial deferral of capital health spending therefore means that ground must be made up, which will increase provincial health spending and accentuate financial pressures. Reducing this type of spending cannot restrain provincial health spending in the long term.

Myth 2: The provinces redirect federal funding to other purposes

The federal government implied that the provinces redirect federal health funding to purposes other than health. The Canadian prime minister in fact stated: "What we've been seeing for several years is that, even if there's a 6% increase, the provinces are not increasing their health spending by 6%."[3] [TRANSLATION]

That observation flows from a false perception of how health expenditures are shared financially between the provinces and the federal government, because it supposes that the amount of health expenditures is comparable to that of health transfers. Yet, that is not the case: In 2016-2017, provincial health spending stood at $154.8 billion and the level of the CHT was $36.1 billion, or 23.3% of provincial health spending.

Thus, the provinces finance 76.7% of their health expenditures out of their revenue. Consequently, the full amount of the increase in health transfers is necessarily attributed to the provinces' health spending, even if the growth in health transfers exceeded that of the provinces' health spending in recent years.

- For every dollar of federal health funding, the provinces spend $4.29.

1 Capital represents the total funds spent to build, acquire or upgrade physical assets such as property, buildings, technology or equipment.

2 C.D. Howe Institute, *Hold the Applause: Why Provincial Restraint on Healthcare Spending Might Not Last*, No. 455, August 2016, p. 13.

3 *Le Devoir*, "Trudeau demande des comptes aux provinces," October 18, 2016, in Politique, on the *Le Devoir* website, www.ledevoir.com.

CONCLUSION

While the *Canada Health Act* requires the provinces to provide a basket of health services to the public, the provinces must cope with health cost drivers that, for the most part, cannot be reduced, such as inflation and population aging.

— Population aging will have a downward effect on government revenues and economic growth. At the same time, it will have an upward effect on expenditures under programs, such as health services, of which older persons are the biggest recipients. Consequently, the growth in provincial health spending, evaluated at 5.2% in the long term, will continue to outstrip economic growth.

— The average annual increase in federal health funding from 2017-2018 to 2026-2017, estimated at 3.8%, is therefore insufficient to cover the rise in health costs.

For a fairer sharing of provincial health spending and a better response to the financial pressures on the provinces, Québec is asking the federal government to gradually raise its health funding to represent 25% of provincial health spending.

— This request is in line with the governments' determination to ensure that Canada's health systems are adequately funded in the long term.