



CHT Conundrum: Ontario Case Study

Institute of Fiscal Studies and Democracy
at the University of Ottawa



Randall Bartlett, Chief Economist

This report was prepared under the supervision of Kevin Page, President & CEO of the Institute of Fiscal Studies and Democracy (IFSD), with research assistance provided by Negash Haile.

IFSD is a Canadian think-tank at the University of Ottawa that sits at the nexus of public finance and state institutions. It is at this dynamic intersection that the IFSD strives to research, advise, engage and teach.

IFSD undertakes its work at all levels of government in Canada and abroad, while helping to prepare its student researchers and volunteers to make their mark as practitioners and good citizens.

115 Séraphin-Marion Room 107
Ottawa ON K1N 6N5
613-562-5800 x 5628
ifsd.ca | info@ifsd.ca



CHT Conundrum: Ontario Case Study

Abstract

The recent negotiations between the federal and provincial-territorial governments around changes to the Canada Health Transfer (CHT) have been contentious by any measure. The provinces and territories rejected the federal government's offer in December 2016, taking a united front on an agreement they considered to be inadequate in meeting current and future pressures on Canada's health care system. Since then, five provinces and the three territories have signed bilateral deals with the federal government. However, the vast majority of Canada's population lives in those provinces—Alberta, British Columbia, Manitoba, Ontario, and Quebec—that have not yet signed on, as they consider the agreement to be insufficient. Recent cost containment on the part of Ontario, for instance, is expected to bring overall health expenditures in line with where the underlying cost drivers suggest they should be. However, the nature of the expenditure restraint suggests that Ontario's cost containment may not be sustainable. Accordingly, beyond fiscal 2018-19, health care costs are expected to continue increasing at a pace well above the growth in the CHT proposed by the federal government. Consequently, the CHT is likely to fall over time as a share of total health expenditures. And, as Ontario is one of the lowest cost jurisdictions in Canada (on a per capita basis), this trend is likely to be much more pronounced in other provinces and territories. To resolve this issue, the federal and provincial-territorial governments should return to the negotiating table in good faith, restarting the negotiations based on the same numbers, assumptions, and desire to ensure a sustainable health care system for all Canadians.

Résumé

Les négociations récentes entre le gouvernement fédéral et les gouvernements provinciales-territoriales vis-à-vis le transfert canadien en matière de santé (TCS) furent sans aucun doute controversées. Les provinces et territoires ont rejeté l'offre fédérale en décembre 2016, unis contre une mesure considérée insuffisante à remplir les exigences courantes et futures du système de santé du Canada. Depuis cette dernière date, cinq provinces et les trois territoires ont signé des accords bilatéraux avec le gouvernement fédéral. Cependant, la majorité de la population canadienne habite dans les provinces qui n'ont pas encore signé et qui trouvent toujours l'offre fédérale insuffisante—c'est-à-dire l'Alberta, la Colombie-Britannique, le Manitoba, l'Ontario, et le Québec. Les initiatives visant à limiter les coûts en Ontario mèneront à de dépenses de santé globales en ligne avec les prévisions basées sur les facteurs de coût. Cependant, la nature de la limitation des dépenses indique que les initiatives ci-dessus ne seront peut-être pas soutenables. Par conséquent, après 2018-19, les coûts des soins de santé augmenteront de 4.5% à 5% en Ontario, bien au-delà des taux proposés dans le TCS fédéral. Le TCS, en tant que dépenses engagées dans la santé, chutera donc au fil du temps. Parce que l'Ontario est parmi les provinces où les coûts sont faibles (par habitant), cette tendance sera plus prononcée dans les autres provinces et territoires. Pour régler cette question, le gouvernement fédéral et les gouvernements provinciales-territoriales doivent renégocier de bonne foi et en utilisant les mêmes chiffres, assomptions, et objectifs pour garantir un système de santé soutenable pour le Canada.

CHT Conundrum: Ontario Case Study

As far as negotiations between the federal and provincial-territorial (P-T) governments go, 'contentious' is generally considered to be a pretty good descriptor. And the recent negotiations between the federal and P-T governments around the impending changes to the Canada Health Transfer (CHT) have been particularly difficult. On the federal side, the government has claimed that its offer is better than what was on the table under the previous administration, and that the federal share of health expenditures has been rising over time. In contrast, some of the provinces and territories have argued that cost pressures are expected to push health care spending higher and that, in that context, recently-won cost containment is not likely to be sustainable.

But how are health care cost pressures expected to evolve in Canada? And what is a sustainable level of funding for health care in that context? These questions are not easy to answer. For instance, if one uses the health care cost growth assumptions provided by the provinces and territories during the recent CHT negotiations with the federal government, health care costs are expected to continue rising faster than the increase in funds committed by the federal government. In that context, the provinces could be fairly viewed as justified in walking away from the negotiating table. Specifically, an agreement to accept the terms proposed by the federal government would be an agreement to have insufficient resources to meet the health care needs of their populations in the future.

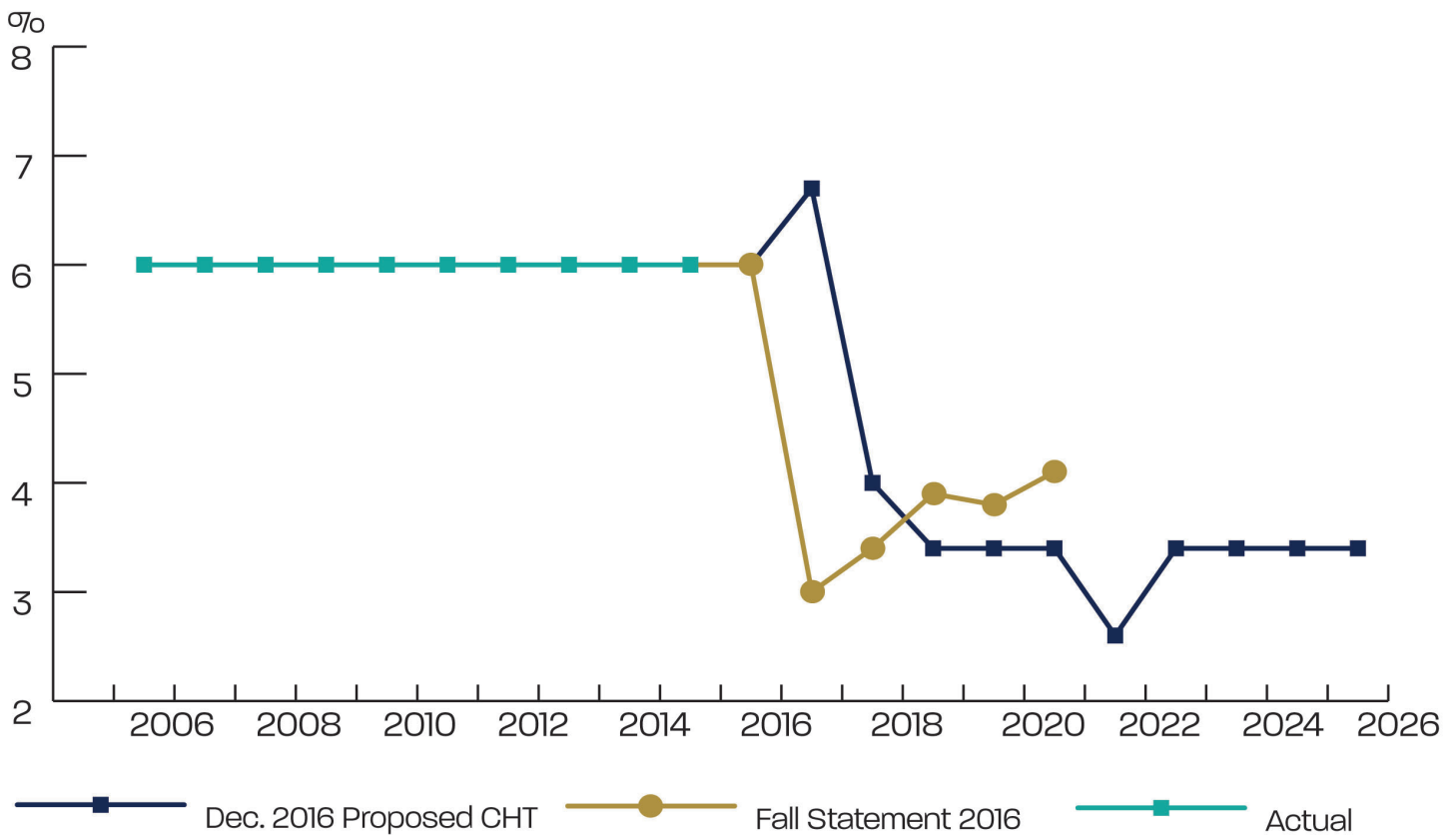
However, the narrative is different when health expenditure forecasts published in budget documents are employed. Indeed, due to projected further cost containment, the federal government's contribution to total health expenditures is expected to increase in the near term—in the case of Ontario, through to the 2018-19 fiscal year. Beyond that year, much will depend on whether growth in the national health care bill outpaces in the CHT. The underlying cost drivers suggest that this is likely to be the case, although this has also been true over the recent period of cost containment in Canada. This leads to another important question: Are the recent cost savings in the health sector sustainable or have they left a gap that will need additional funds to close in the future?

Building on prior work by the Institute of Fiscal Studies and Democracy (IFSD) on health care funding and sustainability in Canada (Bekenn, 2016), the analysis presented here attempts to answer these questions by examining federal health funding and P-T health costs over the next 20 years. Based on publically available data from the Canadian Institute for Health Information (CIHI), Statistics Canada, and government sources, this analysis is done in isolation, with the remainder of the federal and P-T fiscal frameworks left for discussion in future analysis. Further, the analysis undertaken here is exclusively for the federal government and Ontario, as it is Canada's most populous jurisdiction. Ontario is also one of the lowest-cost jurisdictions in Canada in terms of health care expenditures per capita. This means that, from a sustainability perspective, the cost outcomes in Ontario are likely to be similar to or better than other Canadian provinces and territories. Of course, the composition of each province's population is unique, as is the historical evolution of individual cost drivers. As such, the Institute of Fiscal Studies and Democracy will be undertaking similar analysis for the remaining nine provinces and three territories in the coming weeks.

Recent CHT Negotiation: Context

In 2004, then Prime Minister Paul Martin committed to working with the provinces and territories to ensure sustainable federal funding for health care in Canada. Based on the findings of the Romanow Commission, Prime Minister Martin agreed to fill a one-time shortfall in federal health funding, establish a new base for the CHT, “provide an annual escalator that will ensure predictable and growing federal funding for health care,” and provide an additional \$4 billion to address backlogs and kick start reform (Canada & Martin, 2004). From this, a 10-year agreement on an annual CHT escalator—the growth rate of the CHT—of 6% was ultimately reached (see Chart 1).

Chart 1: Actual and Projected CHT Growth

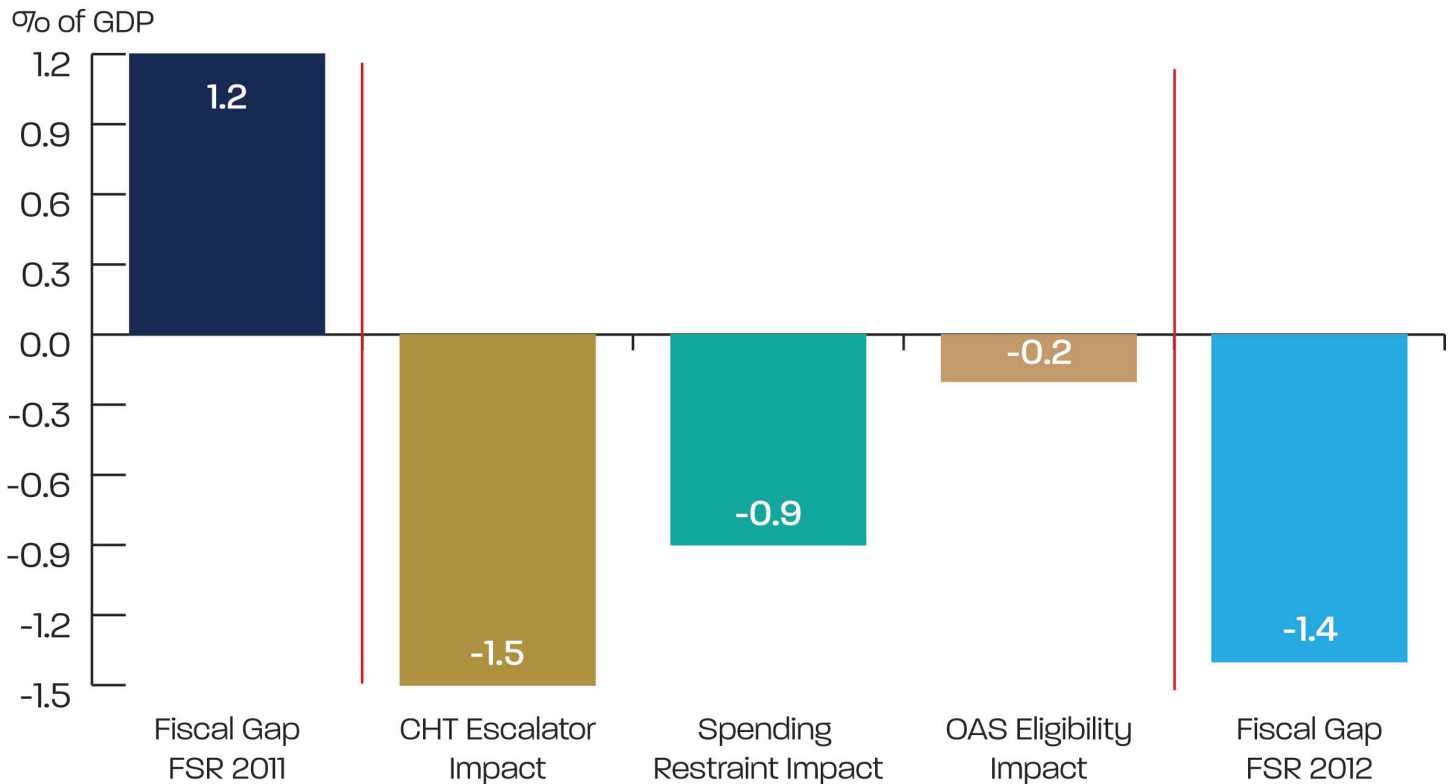


Source: Finance Canada, Institute of Fiscal Studies and Democracy.

Note: Years refer to fiscal years.

And so it was until December 2011. At that time, the Government of Canada announced that it would be continuing with the 6% CHT escalator until the end of the 2016-17 fiscal year, after which it would fall to a 3-year moving average of nominal GDP growth or 3%, whichever was higher (see Chart 1). According to the work of the Parliamentary Budget Officer (PBO), the change to the CHT escalator had a significant impact on the fiscal sustainability position of the federal and P-T governments. For the federal government, the change to the CHT escalator singlehandedly moved it from being fiscally unsustainable to being sustainable (see Chart 2) (Bartlett, Cameron, Lao & Matier, 2012). In the process, however, the benefit for the federal government inversely caused the already fiscally unsustainable position of the provinces and territories to dramatically worsen. Indeed, the provinces and territories were left to fill the void created by the lower-expected level of federal funding for health care or to focus on aggressive cost containment.

Chart 2: Fiscal Sustainability Impact of CHT Escalator Changes



Source: Bartlett, Cameron, Lao & Matier, 2012.

Note: The fiscal gap measure presented here is defined as “the size of the fiscal action needed to achieve fiscal sustainability” or some pre-determined debt-to-GDP ratio at some specified date in the future.

Skip ahead to December 2016, when the federal Finance and Health Ministers met with their P-T counterparts to discuss the future of health care funding in Canada. The provinces and territories were clear. They were looking for the CHT escalator to be reset from the level handed down by the prior government to one that was more in line with projected health care cost growth. At 5.2%, the ask on the part of the provinces was echoed at the national level by the Conference Board of Canada (via Beckman, Fields & Stewart, 2014) and the PBO (5.1%). More recently, a similar number (5.3%) was published by the Financial Accountability Office of Ontario (FAO) at the provincial level (Financial Accountability Office of Ontario, Novak & Ngo, 2017). These estimates incorporate the impacts of population growth, population aging, real income growth, and Consumer Price Index (CPI) inflation on health care expenditures as well as enrichment (or the cost growth in excess of these factors).

In contrast to the position taken by the provinces, the federal government arrived at the meeting with a “take-it-or-leave-it” offer. Following some negotiation, the offer was set at a fixed 3.5% CHT escalator plus \$11.5 billion over 10 years for the federal government’s health priorities, including \$11 billion to provinces and territories for home and palliative care as well as mental health, in addition to \$544 million to support federal and pan-Canadian health initiatives on prescription drugs and health innovation (Department of Finance, 2016). According to IFSD calculations, at an average annual growth rate of 3.7%, this expanded CHT offer did not come close to the ask of 5.2% annually from the provinces and territories (see Table 1).

Table 1: 10-Year Forecast of the Canada Health Transfer

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total
\$ billion, unless otherwise indicated												
2016 Economic Statement CHT Forecast	36.1	37.1	38.4	39.9	41.4	43.1						
<i>Growth (%)</i>	3.0	3.4	3.9	3.8	4.1							
December 2016 CHT (3.5% Escalator)	36.1	37.3	38.6	40.0	41.4	42.8	44.3	45.9	47.5	49.1	50.9	473.8
<i>Growth (%; final value is annual average)</i>	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5
Total New Investments	1.1	1.4	1.4	1.4	1.4	1.4	1.0	1.0	1.0	1.0	1.0	11.5
Better home and palliative care	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	5.0
Support of mental health initiatives	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	5.0
Home care infrastructure requirements	0.3	0.3	0.3	0.3	0.3	0.3						1.0
Prescription drugs and health innovation	0.1	0.1	0.1	0.1	0.1	0.1						0.5
December 2016 Proposed CHT Forecast	36.1	38.4	40.0	41.3	42.7	44.2	45.3	46.9	48.5	50.1	51.9	473.8
<i>Growth (%; final value is annual average)</i>	6.6	4.0	3.4	3.4	3.4	3.4	2.6	3.4	3.4	3.4	3.4	3.7
Difference (2016 ES and December 2016 Proposal)	1.3	1.6	1.4	1.3	1.3	1.1						

Source: Finance Canada, Institute of Fiscal Studies and Democracy. Note: Years refer to fiscal years.

At the time, the ten provinces and three territories rejected the federal government's offer. However, as time passed, cracks began to appear in this group's resolve. First New Brunswick decamped, signing a bilateral agreement with the federal government. This was followed by the Governments of Newfoundland and Labrador, Nova Scotia, Saskatchewan, and Prince Edward Island, as well as the territorial governments. These health agreements included a CHT escalator which increased at the 3-year moving average of nominal GDP growth or 3%, whichever is higher, plus the targeted federal funding. They also contained a clause that would give signatory provinces access to a better deal if one were to be negotiated by another province. The consensus among these subnational governments seems to be that the CHT proposal put on the table by the federal government is a "good deal" (CBC News, 2016).

This begs the question: Is the CHT offer proposed by the federal government actually a "good deal"? Ten governments, which represent over 90% of Canada's population, certainly showed that they didn't believe so early in the New Year. As they articulated in a January 3, 2017 letter to federal Finance Minister Bill Morneau and Health Minister Jane Philpott, P-T Finance and Health Ministers believe that the federal government's funding for health care will decline over time as a share of expenditures (Provincial and Territorial Ministers of Finance and Health, 2017). Indeed, according to P-T governments, "the proposed offer would reduce the federal government's share of provincial-territorial health care spending from 23 to about 20 per cent over the life of the proposal". This outlook assumes that national health care costs grow at a rate of 5.2% annually over the next decade—a rate of increase that has received broad agreement among economists and which reflects population growth, aging, real income growth, CPI inflation and, in some cases, enrichment.

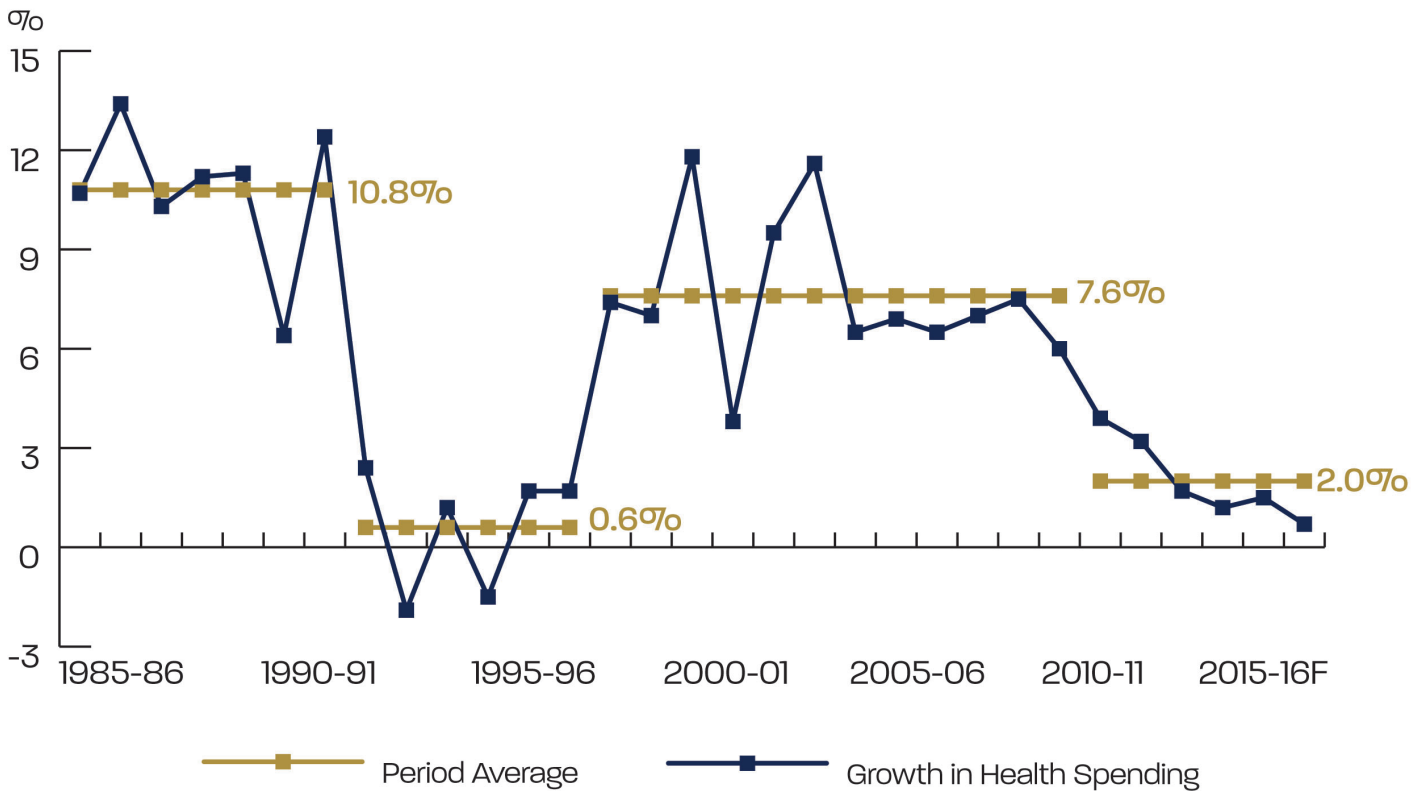
However, the projected 5.2% increase in annual health care costs at times conflicts with the health care costs forecasted by some provincial and territorial governments over the medium term. Indeed, subnational governments have been able to constrain health care cost growth in recent years and they anticipate continuing to do so over the next few years. In order to explore this further, the remainder of this brief report takes a deeper dive into the historical role of federal funding for health care in the Province of Ontario, Canada's largest province by population and economic size. It also examines what the future holds for health care costs and the role of federal government funding in meeting those costs.

Health Care Spending in Ontario: A Brief History

Ontario is Canada's largest province by population. As such, it is also the jurisdiction with the largest annual health care bill despite having one of the lowest per capita health care costs in Canada. Most recently, the Government of Ontario spent over \$50 billion annually on meeting the health care needs of its residents—roughly 42.5% of Ontario's total program expenses in 2015-16. As such, health care makes up the largest single expense for the Ontario government, as is the case for the other provinces and territories.

Over time, growth in Ontario's health care expenditures have varied greatly, as they have at the national level, with extended periods of both feast and famine (see Chart 3). During the 1980s, significant investment was made in Canada's health care system, and a period of marked restraint followed during the 1990s as federal funding was constrained and provinces looked to cut costs. As the federal government again increased funding, the provinces and territories capitalized on the

Chart 3: Annual Growth in Total Health Expenditures in Ontario



Source: CIHI, Ontario Ministry of Finance, Statistics Canada, Institute of Fiscal Studies and Democracy.
 Note: Years refer to fiscal years.

opportunity to make needed investments in the health care system that had been pushed off during the prolonged period of restraint. Then, because of the 2008-09 financial crisis and recession, restraint again became the order of the day as economic, income, and revenue growth became depressed relative to their pre-recession levels.

Underlying these overall expenditure trends both nationally and in Ontario are different but related cost drivers (see Chart 4). During the last period of restraint in the 1990s (fiscal 1992-93 to 1997-98, specifically), costs nationally were kept under control by shrinking the aggregate cost of health professionals other than physicians, while expenditures on hospitals also hardly budged over this same period. Administration costs, as well as spending on physicians and institutions other than hospitals, were also kept on a tight leash during these years. Interestingly, capital expenditures and investment in public health continued almost unabated over this period.

Then, as the decade ended and federal funding for health care flooded back, provincial health care expenditures resumed at a torrid pace (see Chart 5). Nationally, expenditures were concentrated on capital investments, drugs, and public health as well as on, to a lesser extent, physicians and hospitals. Consequently, from fiscal 1998-99 through to 2009-10, aggregate health care expenditures increased at an annual average pace of 7.3% in Canada. The story is once again similar in Ontario: gains in Ontario’s health care costs were dominated by expenditures on capital assets, public health, and drugs in particular, as well as on hospitals, other health care institutions, and administration. As a result, total health care expenditures in Ontario advanced by an average annual pace of 7.6% over the twelve years ending in the 2009-10 fiscal year.

Chart 4: Growth in Health Spending by Category (1992 to 1997)

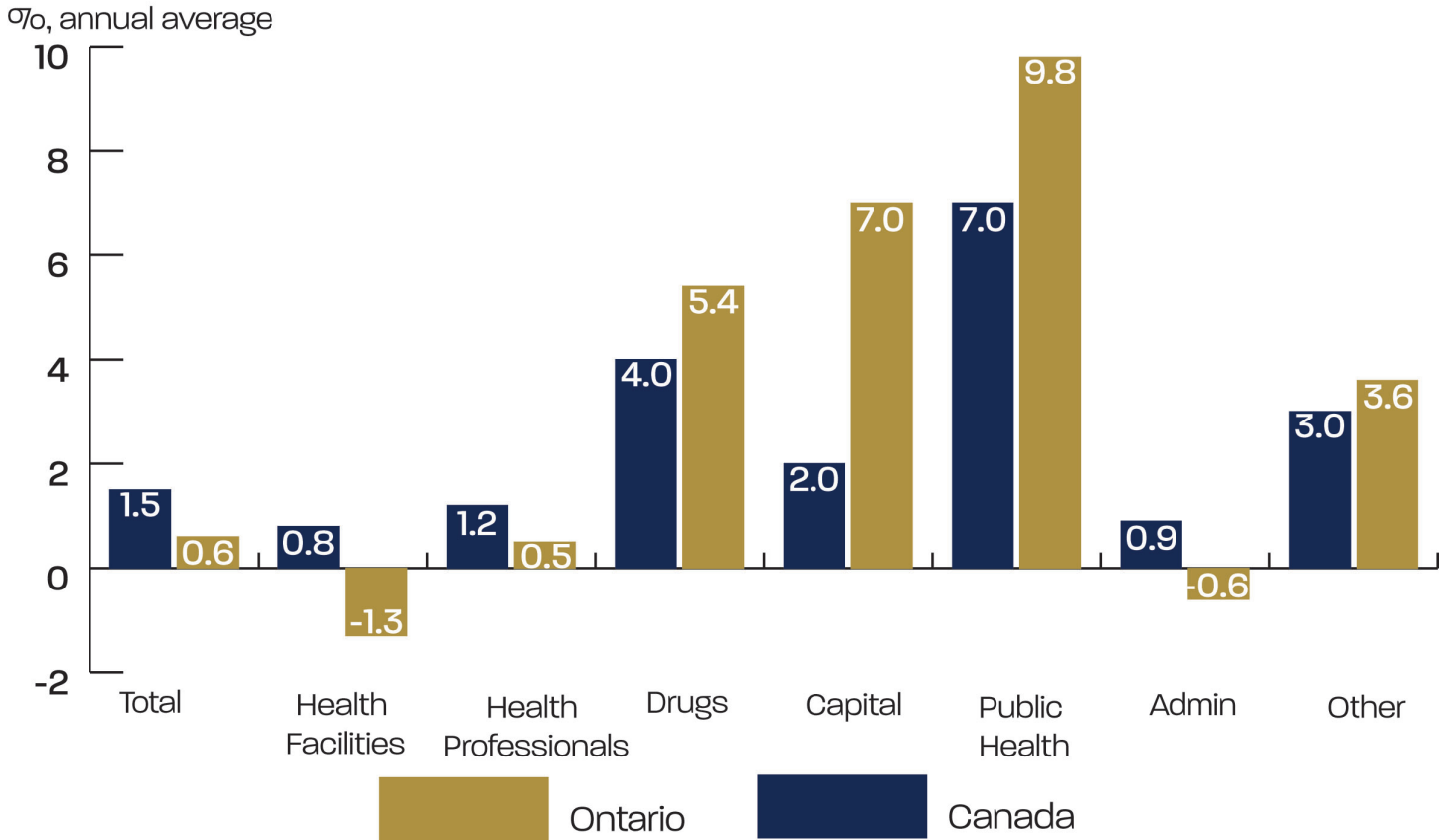
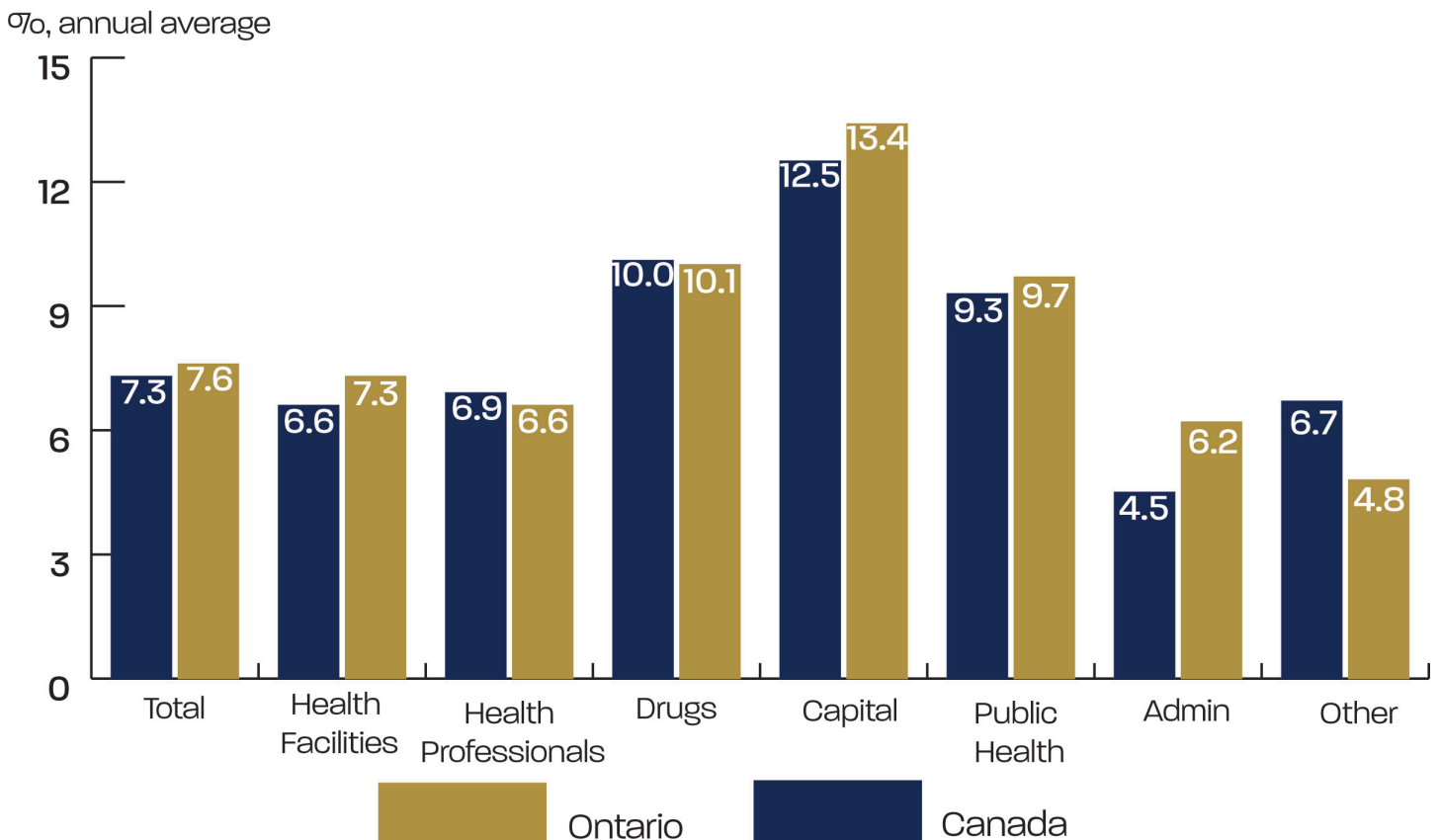
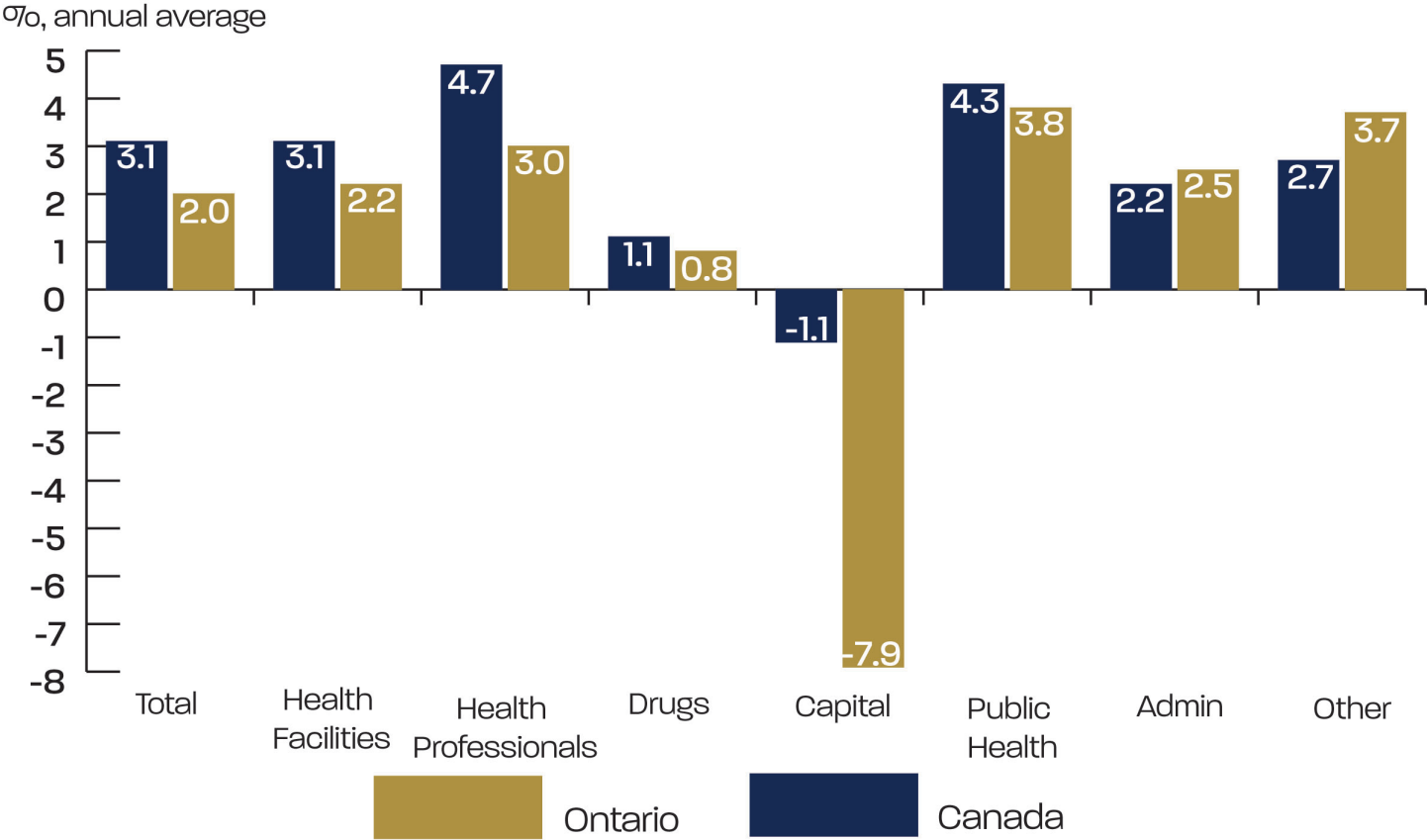


Chart 5: Growth in Health Spending by Category (1998 to 2009)



More recently, governments across the country have once again been engaging in significant health care cost restraint (see Chart 6). At the national level, total health care expenditures advanced at an average annual rate of 3.1% between fiscal 2010-11 and 2015-16. The primary source of restraint has been in capital investments (-1.1%), although growth in expenditures on drugs was also sharply reduced and spending on administration has been subject to some restraint as well. At 2.0%, health care expenditures in Ontario advanced at a pace below the national average over the last six fiscal years. **A key contributing factor has been a significant decline in capital investment, which has contracted at an average annual pace of -7.9% beginning in the 2010-2011 fiscal year.** That said, restraint has also been exercised across the other health expenditure categories over the past six years, most notably in drugs and the total compensation of health professionals. These categories made up just over 30% of health expenditures in Ontario from fiscal 2010-11 through 2015-16, as opposed to slightly better than 5% for capital expenditures.

Chart 6: Growth in Health Spending by Category (2010 to 2015)



Sources (for Chart 4, 5, and 6): CIHI, Institute of Fiscal Studies and Democracy.
 Notes: Years refer to fiscal years; Health facilities include hospitals and other institutions; Health professionals include physicians and other professionals.

Health Care Costs in Ontario: Outlook

This brings us to two fundamental questions: Is the cost restraint exercised by the Government of Ontario in recent years sustainable, particularly given its composition? And what role will the proposed federal funding play in meeting these costs?

To answer these questions, the IFSD has used the straightforward approach employed by the FAO in its recent analysis on the health sector in Ontario and the PBO approach detailed in its Fiscal Sustainability Reports (FSRs). Historical and future cost drivers are broken down into five factors: 1) population growth, 2) population aging, 3) real income growth¹, 4) CPI inflation, and 5) enrichment. Of note, the population projection used in this analysis is the M1 medium scenario from Statistics Canada.²

The health care cost drivers have shifted notably over time in Ontario (see Chart 7). From fiscal 1985-86 to 1991-92, health care costs rose 10.8% annually, on average, largely thanks to high inflation (4.8%), significant enrichment (3.1%), and elevated population growth by today's standards (1.9%). In contrast, aging (0.6%) and real income growth (0.4%) were much less important factors. Circumstances then reversed in the 1990s, when real income growth (1.4%) was a leading factor contributing to the advance in health care costs while inflation, population growth, and aging all pulled back as contributing factors relative to the 1980s. However, it was the decline in enrichment that very much coloured the health spending of the day, as it contracted by about 3.9% annually over this period. This pattern of cost drivers again changed in the 2000s (fiscal 1998-99 to 2009-10), when annual average growth in health care expenditures of 7.6% was fuelled by enrichment (2.6%) and, to a lesser extent, CPI inflation (2%).

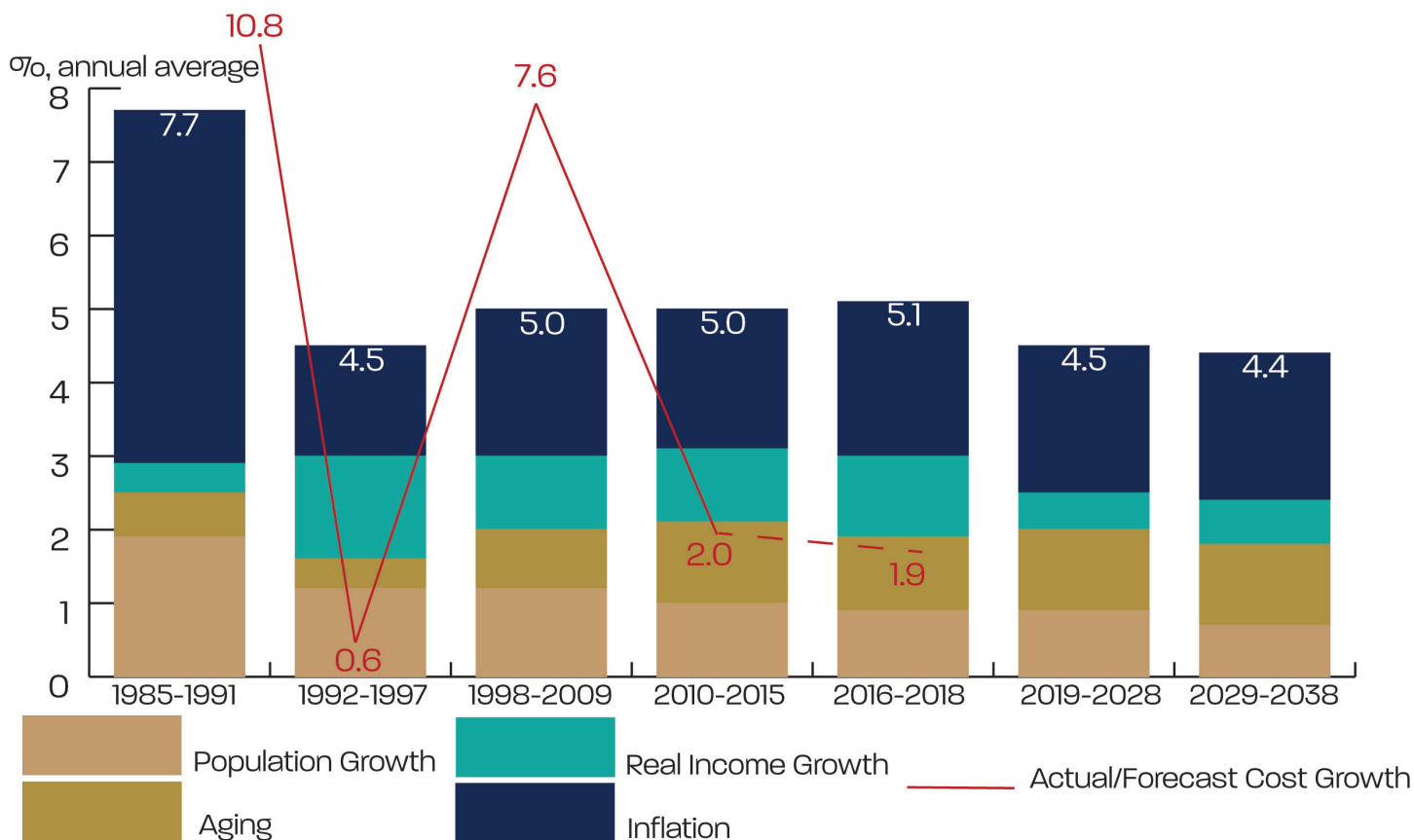
Following the 2008-09 recession, growth in health spending again switched directions. From 2010-11 through 2015-16 fiscal years, health care expenditures increased at an annual pace of 2.0%, roughly in line with CPI inflation (see Chart 7). This advance did not, therefore, reflect the increased pressure on health services from population growth (1.0%), aging (1.1%), and real income growth (1.0%). As such, the pace of health care cost growth was well short of the average annual growth in health cost drivers of 5.0%.

Looking ahead to the Government of Ontario's forecast of health expenditures for fiscal 2016-17 through 2018-19, the story looks to be very much the same as the last six years (see Chart 7). Using the economic and fiscal forecasts from Budget 2016 and the 2016 Ontario Economic Outlook and Fiscal Review, it can be observed that growth in health expenditures over the period are expected to average 1.9% annually, the slowest pace since health care spending stalled in the 1990s (Ontario, 2016a; Ontario 2016b). This stands in stark contrast to the estimated growth in the cost drivers over the next few years which are expected to average 5.1% annually on rising pressures from population growth (0.9%), aging (1.0%), real income growth (1.1%), and CPI inflation (2.1%). After

¹ Similar to the recent work of the Financial Accountability Officer (2017) based on analysis by the Organisation for Economic Co-operation and Development (OECD, 2013), a real income elasticity of health care expenditures of 0.8 was used in this analysis.

² Other medium population projection scenarios produced by Statistics Canada were also examined for the purpose of this analysis, but these resulted in only marginal differences relative to the M1 scenario. High and low population growth projections were examined as well, but these go beyond the scope of this analysis and will instead be presented in a future report.

Chart 7: Growth in Actual versus Notional Health Care Cost Drivers



Source: CIHI, Ontario Ministry of Finance, Statistics Canada, Institute of Fiscal Studies and Democracy.
 Notes: The IFSD estimates and forecasts assume no enrichment; Years refer to fiscal years.

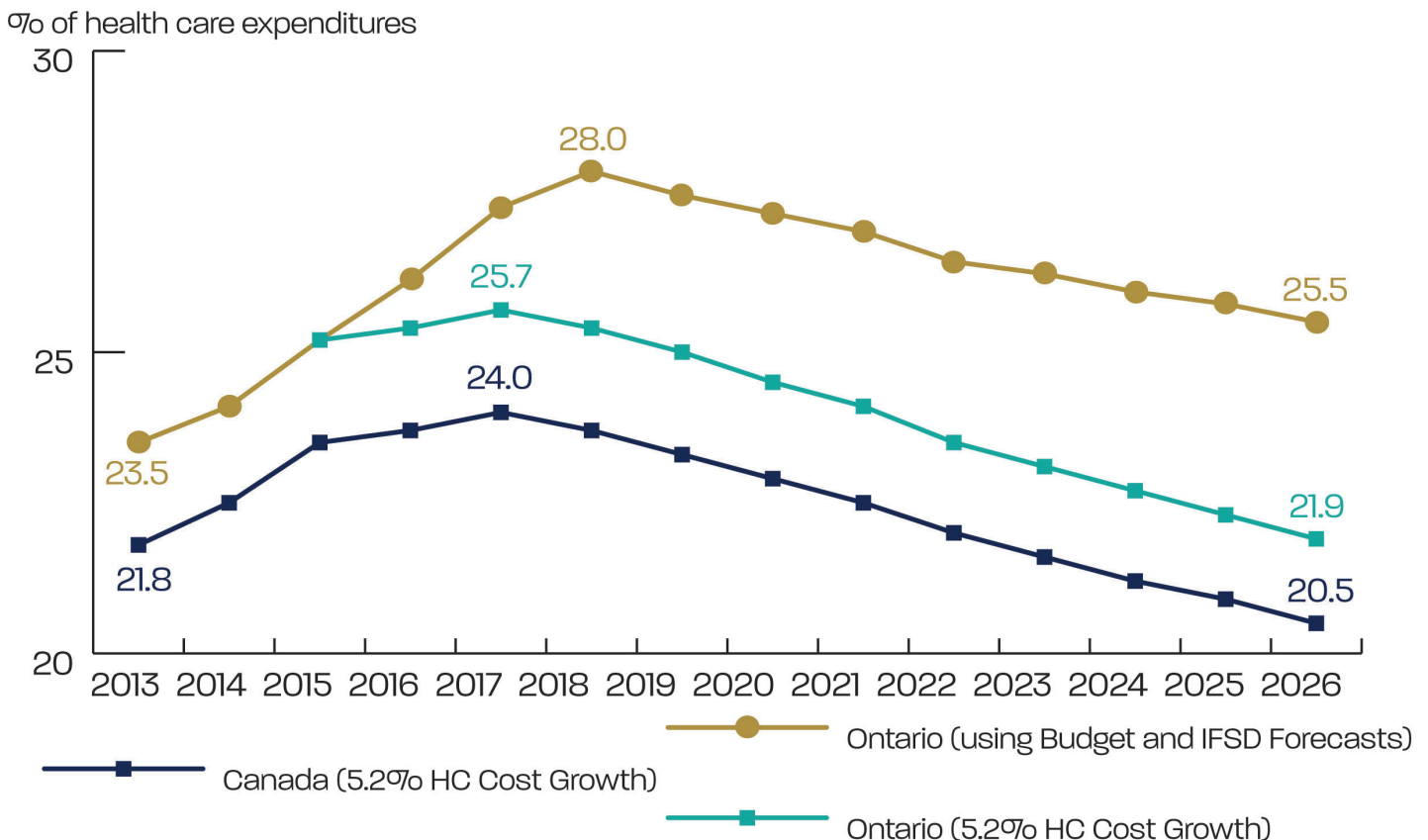
fiscal 2018-19, the growth in health care cost pressures is expected to decelerate from 4.9% in 2018 to 4.4% in 2028 and then finally to 4.2% in 2038 as population growth slows but the influence of aging persists. Further, these forecasts of average annual health care cost drivers assume no enrichment, a factor which contributed on average 0.5% annually to the growth in health expenditures in Ontario over the past three decades. As such, the projections presented here would wisely be considered conservative.

The tepid growth in health expenditures over the next few fiscal years projected in budget documents is an important consideration. It calls into question the assertion made by the provinces and territories that the role of federal government funding for health care will steadily decline over time. Indeed, if the Government of Ontario meets its expectations for restrained growth in health expenditures, the share of CHT in total health expenditures will increase over the next few years, reaching 28.0% of total health care expenditures in fiscal 2018-19, up from 25.2% in 2015-16 (see Chart 8).³ After the 2018-19 fiscal year, this share will only decline if health costs rise above the roughly 3.3% average annual advance in the CHT expected from fiscal 2019-20 through 2026-27. While the growth in underlying cost pressures will certainly be higher than 3.3% annually, continued restraint in health expenditures is certainly a possibility.

However, even if the Government of Ontario is able to meet its health expenditure targets, this implies nothing about the sustainability of this restraint. One needs to look at sustainability from a long-term

³ These shares include the CHT exclusively, and do not include any part of equalization or other federal transfers.

Chart 8: CHT Share of Health Care Costs for Canada and Ontario

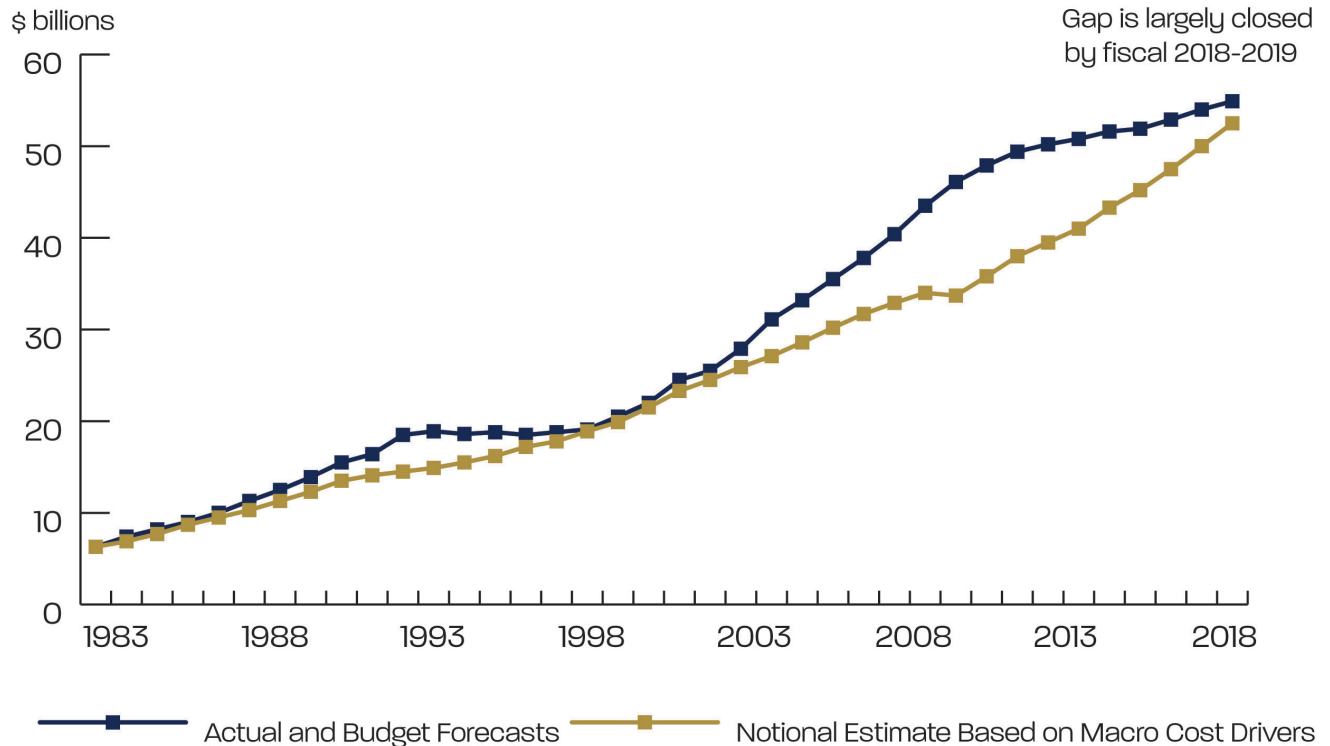


Source: CIHI, Ontario Ministry of Finance, Finance Canada, Statistics Canada, Institute of Fiscal Studies and Democracy.
Notes: HC refers to health care; Years refer to fiscal years.

perspective, comparing actual health expenditures against those that would have occurred had spending been constrained to only that implied by the underlying cost drivers (with no enrichment). From this analysis, one can see that some restraint was needed in recent years to bring health spending back in line with the underlying growth in cost drivers (see Chart 9). By fiscal 2018-19, this objective should be largely accomplished. In order to ensure sustainable health services thereafter, the cost drivers suggest that the growth in health expenditures should be maintained between 4.5% and 5% annually after 2018. This is of course in excess of the 3.5% plus \$11.5 billion over 10 years offered by the federal government in December 2016. As such, even if the CHT share of health expenditures continues to rise through the 2018-19 fiscal year, it is likely to fall thereafter.

As was discussed previously in this report, while restraint has been applied across the board from fiscal 2010-11 through 2015-16, the lion's share of the restraint in Ontario has come from sharp decline in capital expenditures (see Chart 10). While certainly the easiest budget item to restrain in the short term, as it avoids negotiating with public employees and administrators that would be affected by restrained operating expenditures, it also means that needed capital projects may have been pushed off into the future. There are two potential fiscal impacts of a deferral of capital expenditures: a much larger recapitalization expenditure in the future and the risk of increased operating expenditures from increasingly impaired capital assets. As such, persistent restraint in operating expenses may be needed going forward so that deferred capital expenditures can be realized, even if aggregate health care expenditures are allowed in advance in line with the underlying health care cost drivers. Recent efforts by Canada's Premiers to reduce the cost of generic drugs and create innovative models for seniors' care should support further operating expense control going forward (Health Care Innovation

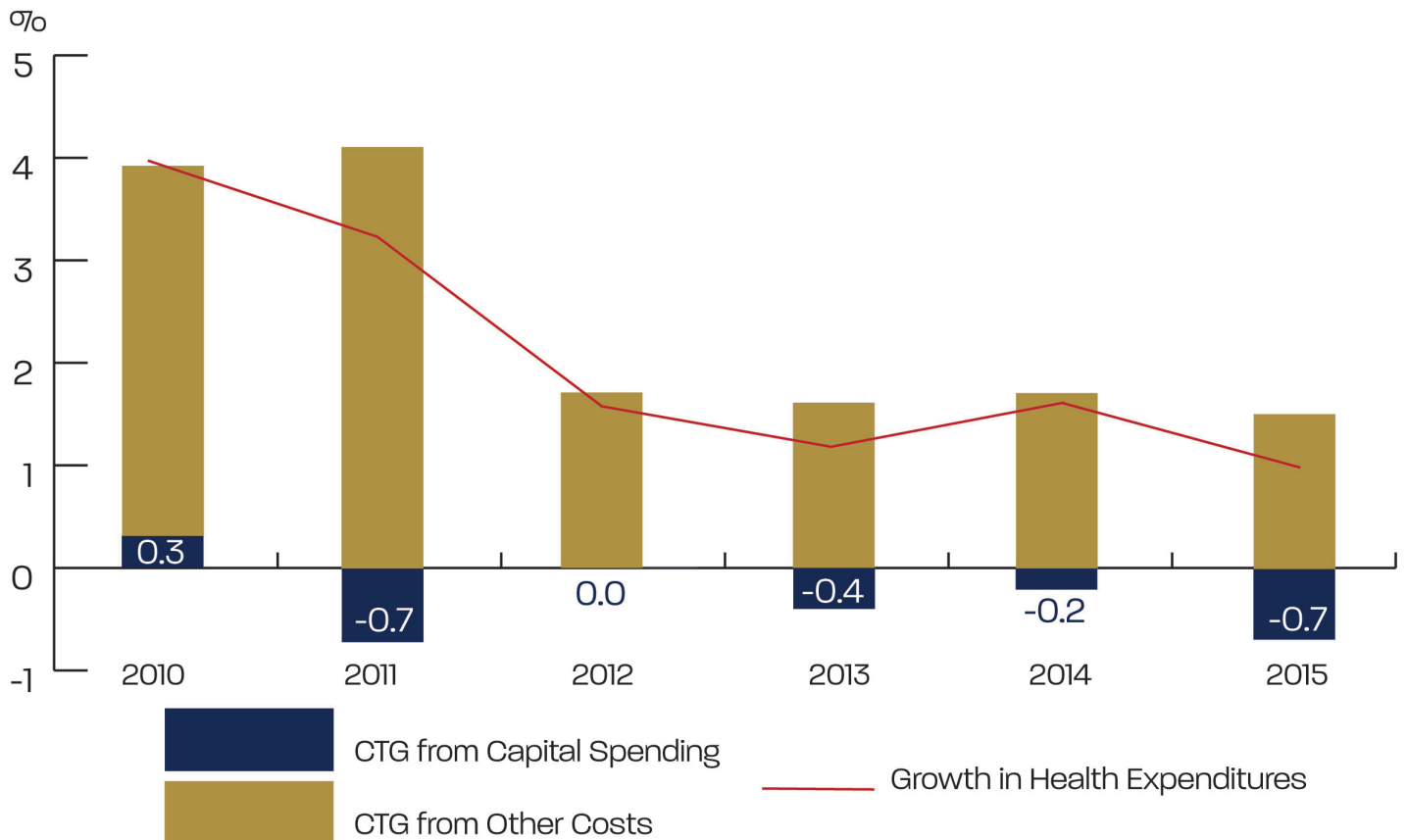
Chart 9: Actual/Forecast Health Spending versus Notional Costs



Source: CIHI, Ontario Ministry of Finance, Statistics Canada, Institute of Fiscal Studies and Democracy.

Notes: The IFSD estimates and forecasts assume no enrichment; Years refer to fiscal years.

Chart 10: Drag on Ontario Health Care Costs from Capital Restraint



Source: CIHI, Institute of Fiscal Studies and Democracy.

Notes: CTG refers to 'contribution to growth' and these series are measured in percentage points; Years refer to fiscal years.

Working Group, 2016). But regardless, for the Government of Ontario and all other subnational governments, the advancing health care cost drivers will present a significant challenge for budget planning in the coming few years and beyond.

Conclusion

The lines have been drawn between the federal and P-T governments in the CHT debate, and which side of the line one falls on depends on the assumptions one uses for health care cost growth going forward. But regardless of the forecasts used, the health care cost drivers are very real and suggest that the roughly 3.7% annual growth in the CHT proposed by the federal government will be insufficient to meet the increasing pressures on provincial and territorial health care systems. Indeed, while P-T governments have managed to contain costs considerably in recent years, a notable portion of the savings has been due to deferred capital investments, particularly in Ontario. This is a recipe for increased expenditures in the future and is not sustainable over the long term. In contrast, other areas where savings have been found, such as the cost of drugs and compensation, may prove more sustainable. It also speaks to the role that an increased focus on performance can play in delivering health services more effectively.

There is only one taxpayer in Canada, and that is Canadians. As such, governments at all levels should work together for the betterment of citizens, as opposed to working to shift the cost burden and risk of programs onto one another. With this in mind, the federal and P-T governments should return to the table to negotiate a deal based on both good faith and the same numbers and assumptions. Otherwise, both levels of government risk continuing to speak past one another without ultimately reaching a deal which will be adequate to ensure that the highest quality health services are provided to Canadians in the most cost-effective manner possible.

Bibliography

- Alberta, British Columbia, Manitoba, Northwest Territories, Nunavut, Ontario, Prince Edward Island, Quebec, Saskatchewan, & Yukon, ministers of. (2017, January 3). Joint letter to the federal Finance Minister Bill Morneau and federal Health Minister Jane Philpott [Letter]. Ottawa, ON.
- Bartlett, R., Cameron, S., Lao, H., & Matier, C. (2012). *Fiscal sustainability report 2012*. Ottawa, ON: Office of the Parliamentary Budget Officer. Retrieved from <http://www.pbo-dpb.gc.ca>
- Beckman, K., Fields, D., & Stewart, M. (2014). *A difficult road ahead: Canada's economic and fiscal prospects*. Ottawa, ON: The Conference Board of Canada. Retrieved from <http://canadaspremiers.ca>
- Bekenn, C. (2016). *The Forum presents: Health care funding and sustainability in Canada* [policy brief]. Ottawa, ON: Republicae.ca, iVote-jeVote.ca, University of Ottawa Faculty of Social Sciences, Jean-Luc Pepin Research Chair, Social Sciences and Humanities Research Council of Canada. Retrieved from <ifsd.ca>
- Canada., & Martin, P. (2004). *Address by Prime Minister Paul Martin at the First Ministers' Meeting*. Ottawa, ON: Office of the Prime Minister. Retrieved from <http://www.hc-sc.gc.ca>
- CBC News. (2016, December 23). Nova Scotia, Newfoundland and Labrador make deals with federal government on health. *CBC News*. Retrieved from <http://www.cbc.ca>
- Department of Finance Canada. (2016, December 20). Federal Proposal to Strengthen Health Care for Canadians. Retrieved from <http://www.fin.gc.ca>
- Financial Accountability Office of Ontario, Novak, J., & Ngo, L. (2017). *Ontario health sector: Expense trends and medium-term outlook analysis* [Winter ed.]. Toronto, ON: Financial Accountability Office of Ontario. Retrieved from <http://fao-on.org>
- Health Care Innovation Working Group (2016). *Leadership in health care: Report to Canada's Premiers on the achievements of the Health Care Innovation Working Group, 2013-2016*. Retrieved from <http://www.canadaspremiers.ca>
- Ontario. (2016a). *Building Ontario for everyone: 2016 Ontario economic outlook and fiscal review* (Background Papers series). Toronto, ON: Ontario. Retrieved from <http://www.fin.gov.on.ca>
- Ontario. (2016b). Growth business initiative. In Ontario (Ed.), *Jobs for today and tomorrow: 2016 Ontario budget* (Budget Papers series) (pp. 5-20). Toronto, ON: Ontario.
- Organisation for Economic Co-operation and Development, de la Maisonneuve, C., & Martins, J. (2013). *A Projection Method for Public Health and Long-Term Care Expenditures*. Economics Department Working Papers No. 1048. Retrieved from <http://www.oecd.org>

