Global Economic Policy Lab

Canada's Healthcare System: A Fiscal Liability in an Aging Society

Healthcare Policy Analysts
Ayyan Tareen
ayyan.tareen@mail.utoronto.ca

Janelle Gunaratnam
janelle.gunaratnam@mail.utoronto.ca

Mishal Khan
mishal.khan@mail.utoronto.ca

Patrick Feng
pat.feng@mail.utoronto.ca

Lab Director
Professor Mark Manger
mark.manger@utoronto.ca

munk school
OF GLOBAL AFFAIRS & PUBLIC POLICY

UNIVERSITY OF TORONTO

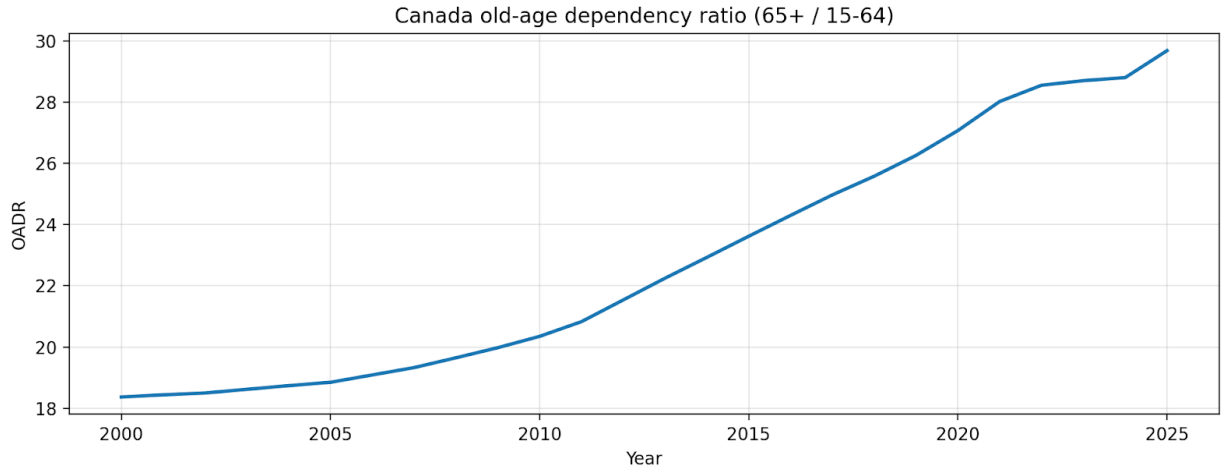
Overview
Background on the Canadian Healthcare System

- Canada's aging population makes rising healthcare spending an almost inevitable consequence.
- Healthcare is structurally hard to cut: it is labour-intensive, demand is relatively inelastic, and pressures come from medical need and demographics.
- The scale is already significant: ~$344B in 2023 (~12% of GDP), mostly from public funds.
- Senior citizens are only ~19% of the population but consume ~47% of health spending.
- This effect is compounded with a fiscal squeeze: aging shrinks the tax base while spending accelerates, and current financing does not automatically track demographic cost growth.

Section 2:
Demographic Shock

The median age in Canada has increased since the 2000s, reflecting a demographic shift toward an older population combined with a low fertility rate (1.25 as of 2024) and improvements in life expectancy. As large cohorts born during the postwar baby boom age, they push the population's midpoint upward, and the current fertility rate is not high enough to balance the effect. The median age in Canada has risen 4 years since 2000, from 36 to 40 years old.

Figure 2.1

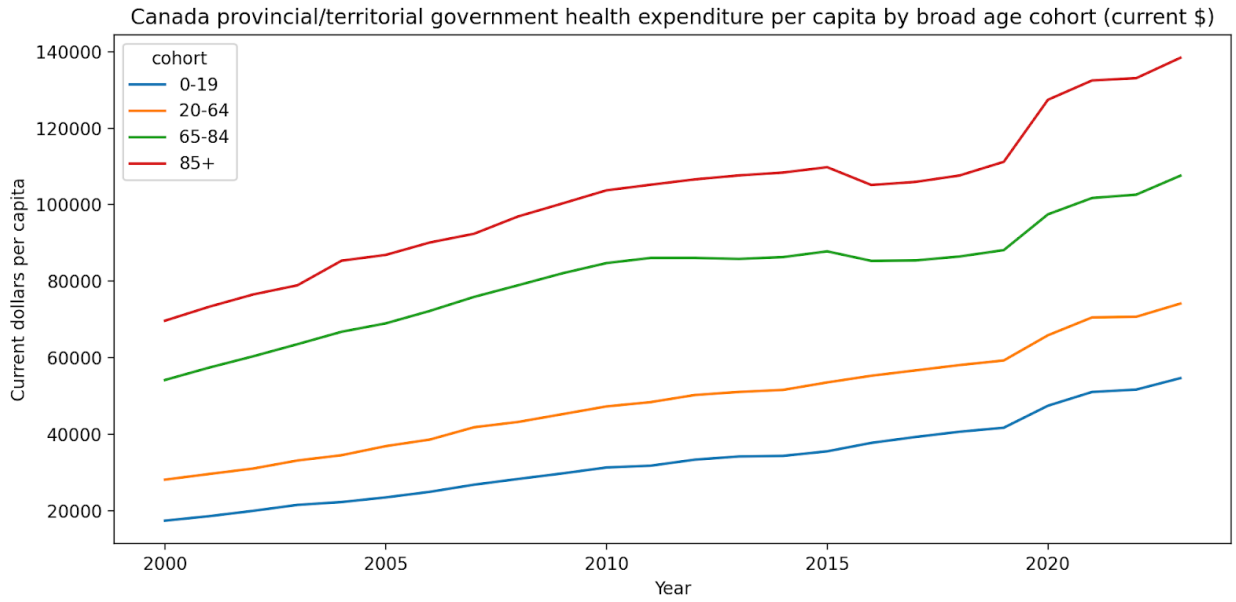


Source: GEPL Analysis of StatsCan population data

As a result, the ratio of seniors (65+) to the working-age population keep increasing. Beginning at approximately 18 seniors per 100 working-age adults in 2000, the ratio climbs to ~30 seniors per 100 working-age individuals in 2025, increasing the economic and social burden on a smaller work-age tax base. The long-term implications include changes to public policy, labour

markets, and intergenerational equity. Since 2000, seniors—especially the 85+ cohort—have increased their share of government health spending in absolute and per-capita terms.

Figure 2.2



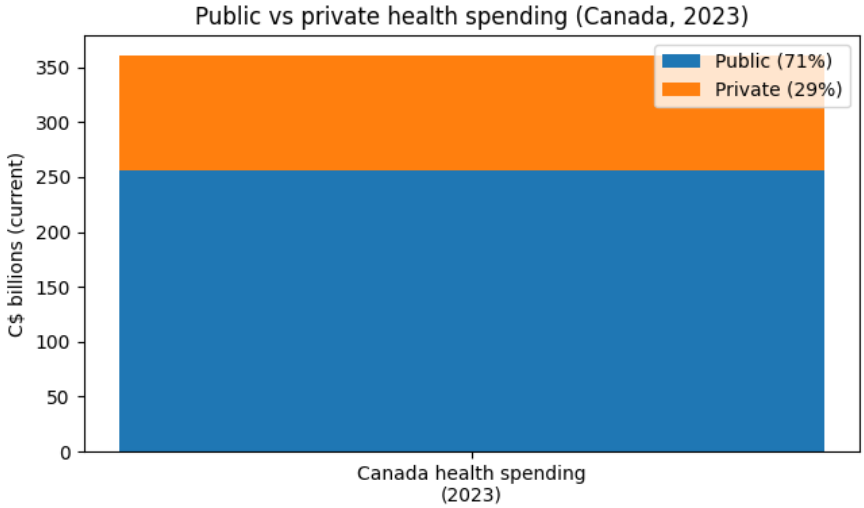
Source: StatsCan population data, GEPL calculations.

The fiscal realities of Canada's aging population are illustrated in Figure 2.2. Per capita spending for those 85+ was approximately 19 times higher than for those aged 19-20. Comparing cohorts in terms of share of total healthcare spending shows that as the proportion of seniors grows, so does the aggregate demand for expensive medical services, long-term care, and prescription drugs, intensifying pressure on provincial budgets. Further insights are provided by comparing cohort expenditure as a percentage of total healthcare provincial healthcare spending. It reveals that although the 20-64 cohort have the largest share, the 65-84 & 85+ cohort have been steadily increasing their share, reflecting the increasing population of aging Canadians. This is a fiscal constraint, not just a policy choice.

Section 3:
Risk Classification and Impact Analysis

In 2023, total healthcare spending was $344 billion, equivalent to about 12% of GDP. CIHI estimates that the public sector pays approximately 71% of the total health spend, with the remainder paid privately (out-of-pocket or private insurance).

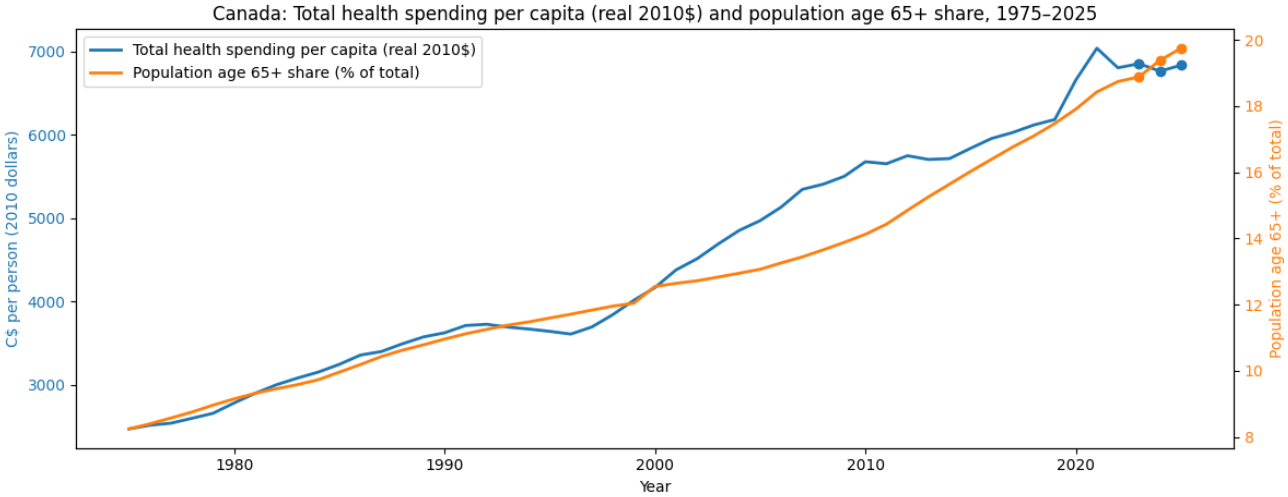
Figure 3.1



Source: National health expenditure trends, 2023 — Snapshot, CIHI

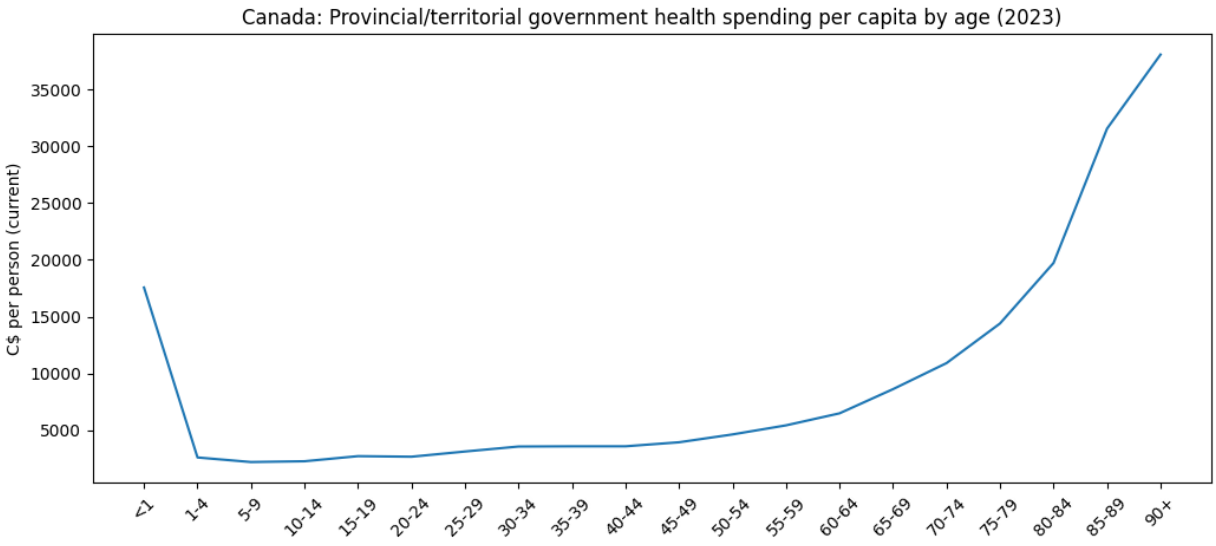
During the same period, people 65 years old or older made up nearly 19% of the population but contributed to 47.1% of healthcare spending (StatsCan & CIHI). As the population's weight shifts toward older cohorts, the "baseline" spending will continue to rise even if policy and service intensity remain unchanged.

Figure 3.2



Sources: Table 17-10-0005-01 Population estimates on July 1, by age and gender, Statistics Canada & National Health Expenditure Database, 2025, Canadian Institute for Health Information

Figure 3.3

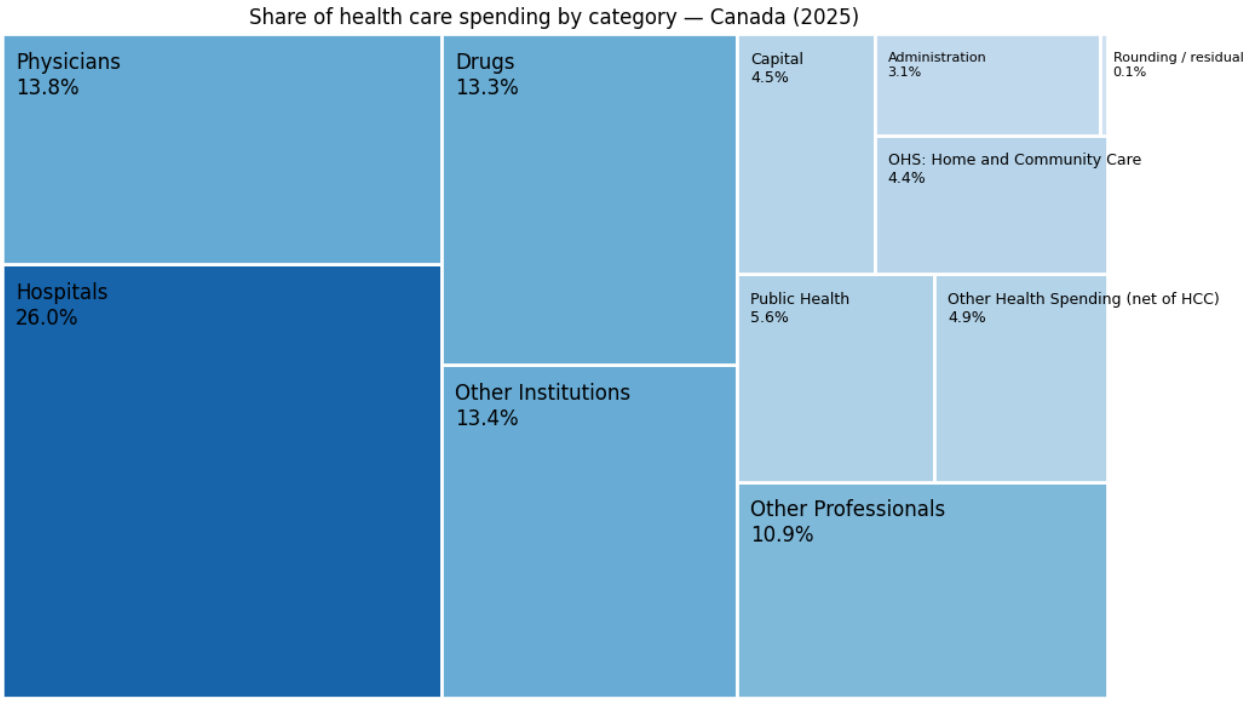


Source: National Health Expenditure Database, 2025, Canadian Institute for Health Information.

In Figures 3.2 and 3.3, we can see that (1) Canada's real per-capita health spending rising steadily alongside the growing share of seniors (aged 65+); and (2) healthcare spending is sharply back-loaded (65+) while the healthcare spending per person is relatively low through working ages, raising baseline costs with a disproportionate share of healthcare "consumption" occurring late in life.

Most healthcare spend is directed to consumption, not investment. This results in recurring purchases of labour-intensive services and inputs that do not directly accumulate productive capital. As seen in Figure 3.4, CIHI reported only 5.6% to public health and 4.5% to capital (health promotion and chronic/infectious disease prevention), versus ~64% in labour-intensive categories (hospitals, drugs, physicians, and other professionals). As the IMF suggests, public investment has larger and more persistent output effects than current consumption, raising opportunity cost of rising healthcare spending in an aging population.

Figure 3.4

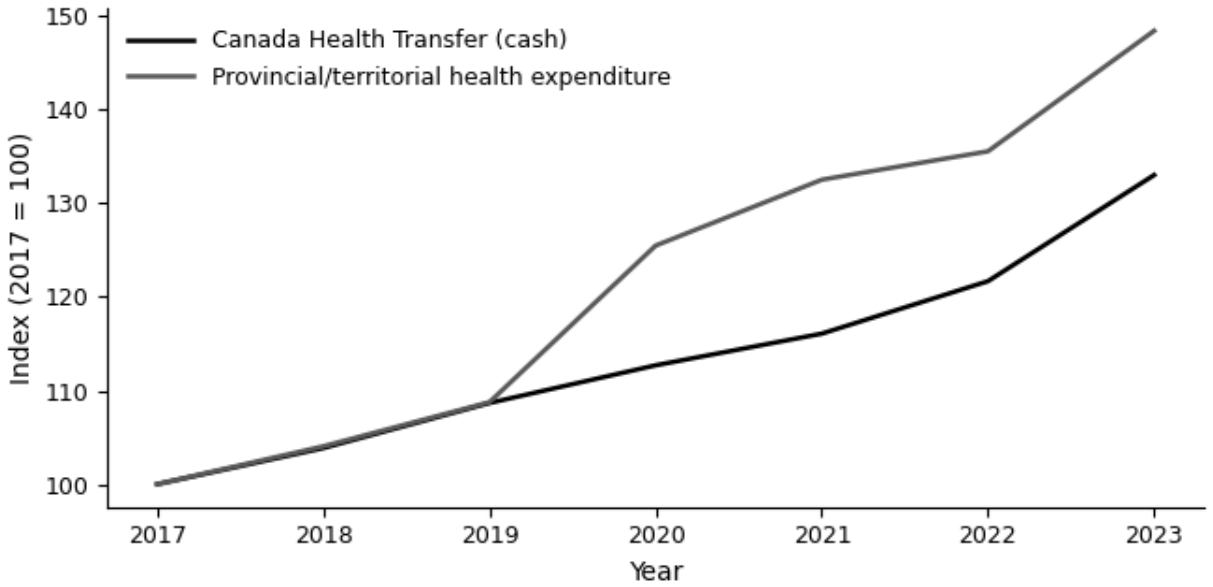


Source: National Health Expenditure trends, 2025 — Snapshot, Canadian Institute for Health Information.

Section 4:
Federal-Provincial Fiscal Mismatch

Provinces deliver and finance most healthcare whereas the federal role is primarily managing the CHT and Canada Health Act conditions and limited automatic adjustment to provincial cost pressures. The CHT, as a fiscal instrument, is mainly a per-capita cash transfer that tracks population and not aging-driven cost growth, wages, or utilization of services.

Figure 4. Canada Health Transfer (cash) and provincial/territorial government health expenditur

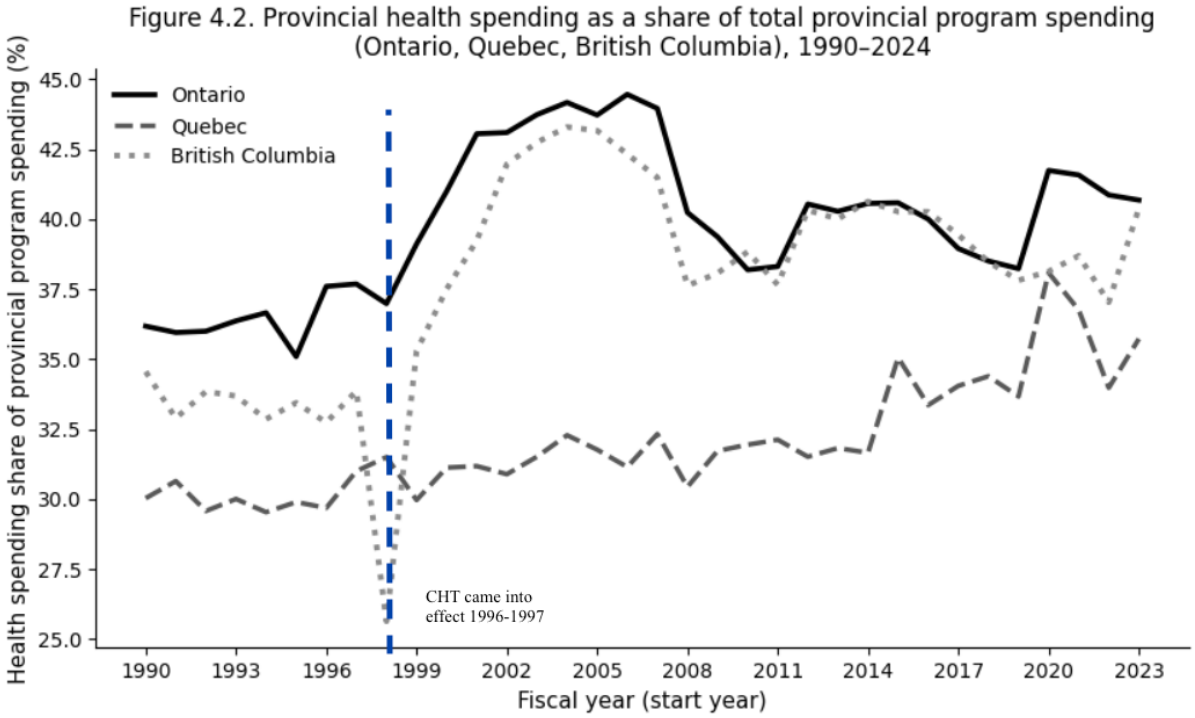


Source: Authors' calculations using CIHI National Health Expenditure Trends and Finance Canada, Canada Health Transfer cash payments.[1]

Since 2017, under the current CHT funding structure, provincial health expenditures have grown more quickly than CHT transfers, particularly after 2019. While federal transfers continue to rise smoothly, they do not adjust to cost surges, including those associated with the COVID-19 pandemic.

The resulting gap must be absorbed by provinces through higher own-source revenues, spending reallocation, or borrowing. This divergence reflects the structural limits of population-based federal financing rather than short-term policy decisions. Even large system-wide shocks do not trigger automatic federal adjustment, leaving provinces exposed to healthcare cost volatility.

[1] Figure 4.1 compares indexed growth in CHT cash transfers and provincial–territorial health expenditures since 2017. Indexing both series to a common base year highlights relative growth paths rather than absolute spending levels. Provincial health expenditures rise more rapidly than CHT transfers over the period, especially after 2019. While federal transfers continue to grow smoothly, they do not adjust to cost surges, including those associated with the COVID-19 pandemic.

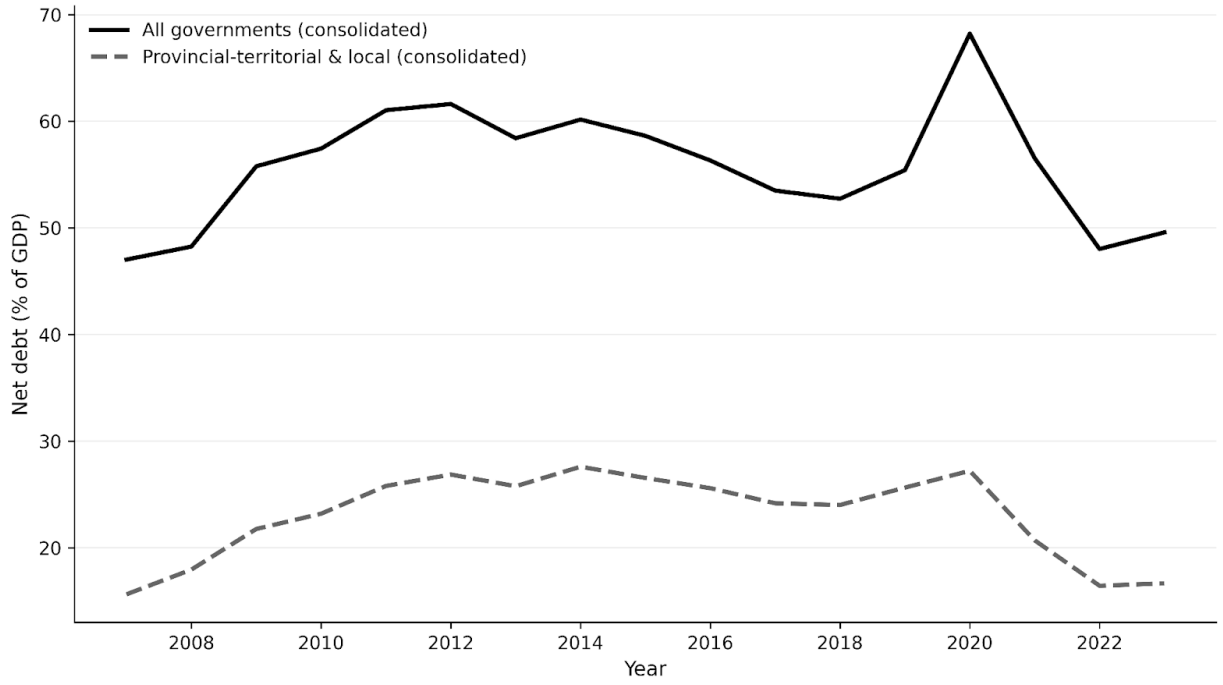


Source: Authors' calculations using Statistics Canada, National Health Expenditure Database (NHEX), Table F.1.1.4.[2]

Figure 4.2 shows healthcare spending as a share of total provincial program spending in Ontario, Québec, and British Columbia from 1990 to 2024. In all three provinces, healthcare absorbs a rising share of program spending overtime, including periods without major healthcare policy expansion. This pattern indicates that demographic and cost pressures mechanically constrain fiscal space for other public services.

[2] Ontario and British Columbia allocate a larger share of program spending to healthcare than Québec, whose broader social spending base—especially childcare and family transfers—reduces healthcare's budget share. British Columbia's late-1990s dip reflects temporary fiscal restraint rather than lower healthcare demand, with cost pressures re-emerging in the 2000s.

Figure 4.3 — Net debt as a share of GDP: all governments vs provincial-territorial & local (Car

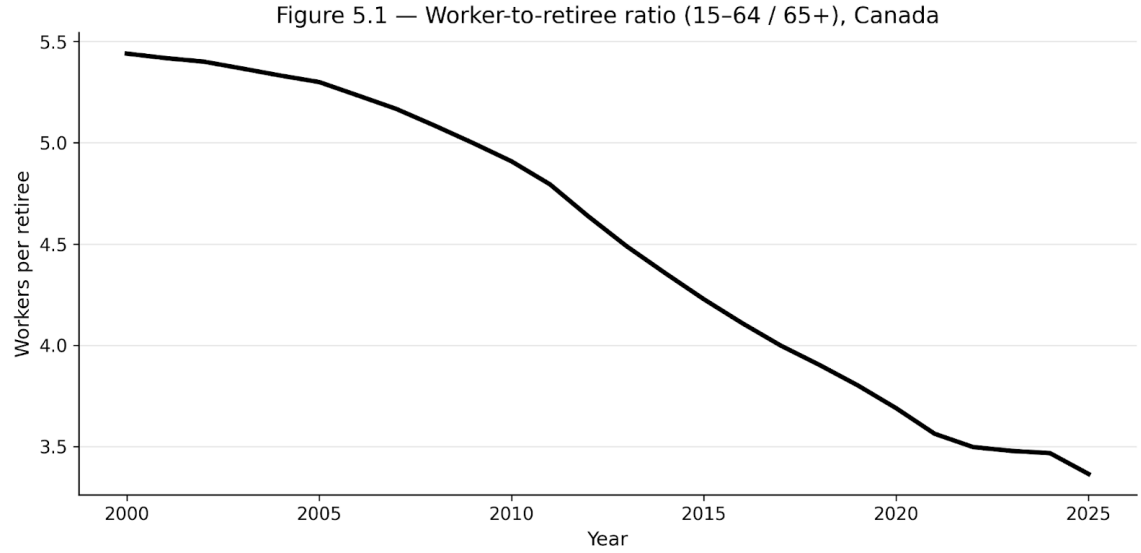


Source: Authors' calculations using Statistics Canada, Canadian Government Finance Statistics (CGFS) and Gross Domestic Product, expenditure-based.

Figure 4.3 places healthcare pressures in a broader fiscal context by comparing net debt as a share of GDP for consolidated Canadian governments and consolidated provincial-territorial and local governments. The purpose is not to assess fiscal performance, but to identify where demographic pressure accumulates institutionally.

Provincial governments face sustained healthcare expenditure growth while relying primarily on revenue sources such as personal income taxes, sales taxes, and payroll-related revenues, all of which depend heavily on labour income and consumer spending. These revenues grow more slowly as the population ages and the worker-to-retiree ratio declines. In contrast, the federal government draws from a broader and more diversified tax base, including corporate and capital income, and has greater fiscal flexibility. As a result, rising healthcare costs translate more directly into provincial fiscal balances. The divergence in debt trajectories reflects institutional constraints under demographic change rather than discretionary fiscal choices.

Section 5:
Labour Force and Tax Base Erosion



Source: Statistics Canada, Table 17-10-0005-01 (population estimates by age group). [3]

Population aging affects public finances not only by increasing age-related expenditures, but by weakening the tax base that finances them. Between 2000 and 2025, the ratio declined steadily from approximately 5.4 workers per retiree to about 3.4, representing a loss of nearly two workers per retiree over 25 years.

Revenue growth from taxable labour income therefore becomes increasingly decoupled from age-related service demands. Sustained productivity accelerations large enough to fully neutralize demographic pressures are historically rare.

Gains are often concentrated in capital-intensive or high-skill sectors, limiting their impact on broad-based tax revenues. In contrast, healthcare expenditures are driven primarily by utilization and demographic factors rather than productivity dynamics, resulting in asymmetric effects on revenues and expenditures, reinforcing long-run fiscal pressure.

[3] Statistics Canada does not provide a consistent long-run annual participation series for ages 65+ across the full sample period. Following standard practice in applied fiscal and labour economics, ages 55 years and over are used as a proxy to capture older-age labour market attachment. This choice does not affect the direction or interpretation of results.

Section 6:
Why Current Design Creates Intergenerational Risk

Canada's healthcare system is financed primarily through general taxation and intergovernmental transfers, rather than through pre-funded reserves. Healthcare spending absorbs roughly 30 - 40% of federal and provincial budgets, consistent with a "pay-as-you-go" (PAYG) model in which current contributors fund current consumption.

Under this design, the healthcare system functions as an implicit intergenerational transfer system, relying on the working-age population to finance healthcare consumption, which is concentrated later in life. As the population ages, both the number of beneficiaries and the duration of healthcare entitlements increase, amplifying fiscal pressure on contributors.

As noted by the OECD, risking old-age dependency ratios directly impact public finances by increasing age-related spending while constraining revenue growth. This directly impacts the fiscal mechanics of a PAYG system.

Canada's universal healthcare system provides core hospital and physician services free at the point of use, meaning patients do not pay for them when they are accessed. As demand rises with the population aging, the system's response is reflected in access constraints, such as longer wait times and limited availability of providers and resources, rather than in direct price adjustments. Under demographic stress, this feature of institutional design can shift fiscal pressure onto constrained service delivery.

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