



The Conference Board  
of Canada

Le Conference Board  
du Canada

# Federal Policy Action to Support the Health Care Needs of Canada's Aging Population.



## Table of Contents

1. About The Conference Board of Canada .....	3
2. Executive Summary.....	4
3. Introduction .....	5
3.1 Report Outline.....	5
3.2 The State of Seniors and Long-Term Care Infrastructure in Canada .....	5
4. The Cost of Population Aging for Canada's Health Care System .....	7
4.1 Introduction .....	7
4.2 Context.....	7
4.3 Estimation Methodology.....	10
4.4 Results .....	11
5. The Cost of Government-Provided Prescription Medication .....	13
5.1 Introduction .....	13
5.2 Prescription Medication Care Spending—International Comparison .....	13
5.3 Estimation Methodology.....	15
5.4 Results .....	16
6. The Cost of Refunding the Canada Family Caregiver and Caregiver Tax Credits.....	18
6.1 Introduction .....	18
6.2 Context.....	18
6.3 Estimation Methodology.....	21
6.4 Results .....	22
7. Conclusion.....	24
8. References .....	25

## 1. About The Conference Board of Canada

### We Are

A not-for-profit Canadian organization that takes a business-like approach to its operations. Objective and non-partisan. We do not lobby for specific interests. Funded exclusively through the fees we charge for services to the private and public sectors.	Experts in running conferences but also at conducting, publishing and disseminating research, helping people network, developing individual leadership skills and building organizational capacity. Specialists in economic trends, as well as organizational performance and public policy issues.	Not a government department or agency, although we are often hired to provide services for all levels of government. Independent from, but affiliated with, The Conference Board, Inc. of New York, which serves nearly 2,000 companies in 60 nations and has offices in Brussels and Hong Kong.
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### Our Mission

We are dedicated to building a better future for Canadians by making our economy and society more dynamic and competitive.

## 2. Executive Summary

This study examines the costs associated with implementing three large-scale policy changes at the federal level, all of which are intended to improve the quality of care provided by Canada's health care system and lead to better health outcomes for Canadians.

The first proposed policy change would transfer additional health care funding to the provinces and territories via a demographic top-up to the Canada Health Transfer. This would cover the costs expected to be incurred by the health care system due to Canada's aging population. The second change would see the federal government cover the entire cost of prescribed medication for all Canadian households when those costs are greater than \$1,500 per annum or 3 per cent of annual income. Finally, this report estimates the cost of changing the Canada Caregiver Tax Credit and Family Caregiver Tax Credit from non-refundable to refundable tax credits.

Each of the three measures addresses the rising costs to the provinces, territories, and individuals of caring for Canada's aging population. The first two are projected to cost more than \$1 billion in each of the next five years, with costs rising in each successive year. The third is predicted to decrease federal government revenues by more than \$90 million in the first year of implementation.

Two insights can be gleaned from this study. First, it is evident that the aging of Canada's population will have a significant negative impact on the country's fiscal position in the coming years. (While only the first part of this analysis addresses aging *per se*, the aging factor figures significantly into the costs that would be realized for all three suggested policy modifications.) Second, the system of health care delivery in Canada differs in many ways from the systems in other developed nations. Both these findings are relevant for policy-makers considering and implementing policy changes such as those discussed in this report.

## 3. Introduction

### 3.1 Report Outline

The Conference Board of Canada is pleased to present this research report, which looks at the potential federal contributions along three distinct policy strategies, to the Canadian Medical Association (CMA). This document presents the final results of the Conference Board's assessment of the fiscal impact on the federal government if it were to:

- 1) deliver new funding to the provinces and territories, via a demographic top-up to the Canada Health Transfer, to cover the additional costs expected to be borne by the health care system in the near future due to population aging;
- 2) provide coverage of the entire cost of prescribed pharmaceuticals for all Canadian households whose prescription medication expenses are greater than \$1,500 per annum or 3 per cent of their annual income for all individuals;
- 3) change the Canada Caregiver Tax Credit and Family Caregiver Tax Credit from non-refundable to refundable tax credits.

The body of this report is organized into three sections covering each of the three policy strategies listed above. Each section summarizes the proposed policy modification, provides background information on the issues underlying each potential change, details the methodology employed by the Conference Board to calculate the associated fiscal impact, and presents the final results. Closing remarks are articulated in the conclusion.

### 3.2 The State of Seniors and Long-Term Care Infrastructure in Canada

In a recent report, the Conference Board concluded that although Canada offers a generally comprehensive range of health services for seniors, there are many current and future issues that require immediate attention.<sup>1</sup> There are large discrepancies across the country when it comes to the health care services available to seniors, particularly in pharmacare, home care, long-term care (LTC), and palliative care. These discrepancies result, in part, from variations in how provinces cover services that fall outside of the *Canada Health Act*. In addition, there is uneven access to services due to differences in eligibility rules or high demand.

Although access to primary care may have improved in the last few years, there are acute shortages in many areas for home care and LTC services, which can lead to long wait times. These shortages leave many seniors without the care they require for long periods and add to the strain on the large number

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<sup>1</sup> Verbeeten, Astles, and Prada, *Understanding Health and Social Services for Seniors in Canada*.

of informal caregivers and on other parts of the health system. Many seniors in Canada already wait months for placement in LTC facilities.<sup>2</sup> As mentioned, this can be distressing for the individuals and for their informal caregivers. It can also affect other parts of the health system. Indeed many of those seniors waiting to be discharged from hospital are unable to leave because there is a lack of appropriate capacity in their communities or LTC,<sup>3</sup> a situation that leads to wait times for other acute care procedures and increases health care costs. As Canada's population continues to age, this situation is likely to worsen. A previous Conference Board forecast showed that the shortage of LTC beds could be as high as 38,000 by 2020, a problem that would cost over \$10 billion to address.<sup>4</sup> Palliative care services are also insufficient. Only a minority of the seniors requiring these services can access them, and those who do typically experience a patchwork of services that are uncoordinated and confusing.

As our population ages, the imbalance between supply and demand will grow, which will increase pressure on this already-stressed system and on Canadians and their families. The ability of the provinces to effectively deal with these challenges will be compromised by the negative impact that aging will have on health care costs. It is necessary to look at alternatives that could enable the federal government to relieve some of the pressures that current demographic trends will have on health care systems, patients, and families.

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<sup>2</sup> Verbeeten, Astles, and Prada, *Understanding Health and Social Services for Seniors in Canada*.

<sup>3</sup> Canadian Institute for Health Information, *Health Care in Canada, 2011*.

<sup>4</sup> The Conference Board of Canada, unpublished research commissioned by the CMA, January 2013.

## 4. The Cost of Population Aging for Canada's Health Care System

### 4.1 Introduction

This section outlines the estimated costs to the federal government of establishing a new, demographic-based top-up to the Canada Health Transfer. The purpose of this top-up would be to compensate provinces on an annual basis for the additional health care costs attributable to the aging of their populations. This cost was estimated for each province/territory and for Canada as a whole each year from 2016 to 2020. Population data were collected from the Conference Board's standard demographic projection, while expenditures were projected based on Canadian Institute for Health Information (CIHI) per capita health care spending data.

With the baby boomers moving into the older demographic cohorts, Canada's population is set to age significantly. Because health care demand is considerably higher among the older cohorts, population aging will lead to higher overall demand for health care as a greater share of the population moves into those cohorts. This will increase costs for the health care system.

A number of provincial top-up programs have been proposed to address population aging. Under the analysis conducted here, the federal government would transfer to each province the additional health care costs attributable to the change from the previous year in population composition.

### 4.2 Context

#### 4.2.1 The Canada Health Transfer

The Canada Health Transfer (CHT) is the largest federal transfer to the provinces and territories. It provides block cash transfers<sup>5</sup> to each Canadian province and territory on an equal per-capita basis. These payments are conditional—they must be used by the provinces and territories for the purposes of supporting the principles for publicly provided health care, as laid out in the *Canada Health Act*. The CHT totalled \$32.1 billion in fiscal year 2014–15 and is predicted to rise to \$34 billion in 2015–16.<sup>6</sup>

Total CHT cash levels are set to grow at an annual pace of 6 per cent until 2016–17. Starting in 2017–18, total CHT cash will grow in line with a three-year moving average of nominal gross domestic product, with funding guaranteed to increase by at least 3 per cent per year.

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<sup>5</sup> In the past, CHT included both cash and tax point transfers. As of 2014–15, provincial and territorial CHT transfers are allocated on an equal per capita *cash* basis only.

<sup>6</sup> Finance Canada, *Federal Support to Provinces and Territories*.

The Conference Board estimates CHT growth will average approximately 4 per cent a year over the next decade. This will likely not be enough to keep pace with health care costs, given the aging of the population. The distributional effects are also noteworthy. Aging will affect some provinces significantly more than others, and because the CHT's allocation formula is based on population size and does not take into account composition, it may not be able to adequately compensate those provinces with the highest health care costs.

#### 4.2.2 International Examples of Age as a Factor in Determining Health Funding

Though the relationship between age and health care costs has been shown in Canada,<sup>7</sup> age is not explicitly used as a factor in determining the share of transfer payments. Many other central governments around the world do, however, include age in their allocation formulas.<sup>8</sup> Table 1 below summarizes the factors used for health care transfer financing in selected countries.

**Table 1 - Factors Used for Health Care Transfer Financing in Selected Countries**

<b>Needs-based top-up for health care in general transfer</b>	
<b>Country</b>	<b>Factors</b>
<b>Belgium</b>	Age, gender, unemployment, disability
<b>Finland</b>	Age, disability, remoteness, local tax base
<b>Germany</b>	Age, gender
<b>Netherlands</b>	Age, gender, urbanization, income base
<b>Switzerland</b>	Age, gender, region, income
<b>Needs-based health-specific transfers for core services</b>	
<b>Country</b>	<b>Factors</b>
<b>Denmark</b>	Age, children of single parents
<b>England</b>	Age, gender, mortality, unemployment, elderly living alone

<sup>7</sup> Canadian Institute for Health Information, "National Health Expenditure Trends, 1975 to 2014."

<sup>8</sup> Glassman and Sakuma, "Intergovernmental Fiscal Transfers for Health: Overview Framework and Lessons Learned."



## Federal Policy Action to Support the Health Care Needs of Canada's Aging Population

<b>France</b>	Age
<b>Italy</b>	Age, gender, mortality
<b>Norway</b>	Age, gender, mortality, low birth weight
<b>Scotland</b>	Age, gender, mortality, rural costs
<b>Sweden</b>	Age, living alone, employment status, housing
<b>Wales</b>	Age, gender, mortality, rural costs
<b>Portugal</b>	Burden of illness (diabetes, hypertension, AIDS, tuberculosis)
<b>Spain</b>	Cross-boundary flows
<b>Health transfers using composite indexes based on principal component analysis</b>	
<b>Country</b>	<b>Factors</b>
<b>Brazil</b>	Infant mortality, 1–64 mortality, 65+ mortality, mortality rate for infectious and parasitic diseases, mortality rate for neoplasia, mortality rate for cardiovascular conditions, adolescent mother percentage, illiteracy percentage, percentage of homes without sanitation, percentage of homes without running water, percentage of homes without garbage collection
<b>South Africa</b>	Percentage female; percentage children under 5; percentage living in rural area; percentage older than 25 without schooling; percentage unemployed; percentage living in traditional dwelling, shack, or tent; percentage without piped water in house or on site; percentage without access to refuse disposal; percentage without access to phone; percentage without access to electricity; percentage living in household headed by a woman

Source: Adapted from Glassman and Sakuma, *Intergovernmental Fiscal Transfers for Health*.

## 4.3 Estimation Methodology

### 4.3.1 General Approach

To derive an estimate of the cost of Canada's aging population, the following procedure was employed:

1. Average health care spending was projected by age cohort until 2020.
2. Using these projections, the change in health care spending attributable to aging in each year relative to the previous year was calculated. This was done by comparing two scenarios—one with an aging of the population and one without—for every Canadian province and territory and for each year from 2016 to 2020.
3. The Canada-wide additional cost of aging in every year from 2016 and 2020 was computed as the sum of the values found in step 2 across all provinces.

### 4.3.2 Attributing Additional Health Care Costs to Aging

The most important—and challenging—step of the procedure above was the calculation of the change in health care spending due to aging (step 2) for each year relative to the previous year. This was done as follows:

- a) For all provinces and territories in each year from 2016 to 2020, average per capita health care spending was calculated under two scenarios:
  - i. In the first scenario, cohort shares from the Conference Board's standard demographic projection were used.
  - ii. In the second, the share of the population in each cohort was maintained at its previous year's level.
- b) In calculating both of these average spending values, the share of the population in each cohort was multiplied by its projected cost in that age cohort under each scenario. This provided estimates of:
  - i. the per capita amount spent on health care in each province in each year (the first scenario);
  - ii. the per capita amount that would be spent on health care in each province in each year if the age distribution of the population remained as it was in the previous year (the second scenario).
- c) For each province in each year, the difference between the two estimates in step b was computed.
  - Note that all other variables, including investment and productivity, were held constant at the values in the first scenario in step b in order to isolate the impact of aging on potential spending growth.
  - As such the difference calculated here represents the per capita change in health care spending, relative to the previous year, due to population aging.
- d) For each province in each year, the difference calculated in step c was multiplied by the population of each province in the year in question. The product of this operation represents the total fiscal impact of aging in each province in each year.

## Federal Policy Action to Support the Health Care Needs of Canada's Aging Population

- e) For each year, the values calculated in step d were summed across all provinces to produce the nationwide increase in health care costs due to aging.

### 4.4 Results

The Conference Board estimates that if the federal government were to adopt this proposed change in policy to assist the provinces with the increase in health care costs due to aging, it would cost it an additional \$1.6 billion in 2016. And that number would rise steadily to reach approximately \$1.9 billion in 2020—for a total of \$8.6 billion over the next five years.

The results of The Conference Board's analysis are summarized in the table below.

**Table 2 - Estimated Additional Cost of Canada's Aging Population for Each Province by Year, 2016–20 (\$ millions)**

<u>Region</u>	<u>2015</u> <u>Provincial/</u> <u>territorial</u> <u>government</u> <u>health care</u> <u>spending*</u>	<u>2016</u>  <u>(% change</u> <u>from 2015)</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>
All of Canada	143,160.9**	1,602.1 (1.1%)	1,663.6	1,724.2	1,765.8	1,879.0
Ontario	50,172.7	652.2 (1.3%)	677.9	692.1	708.6	731.6
Quebec	32,390.0	405.8 (1.3%)	413.7	418.8	429.0	459.5
British Columbia	18,370.0	251.6 (1.4%)	258.7	270.3	270.1	291.3
Alberta	19,366.0	118.5 (0.6%)	123.3	138.9	141.5	157.5
Nova Scotia	4,082.9	53.6 (1.3%)	58.6	62.3	64.4	66.6
New Brunswick	2,861.0	45.9 (1.6%)	50.7	52.2	54.1	57.2
Newfoundland and Labrador	3,035.9	29.7 (1.0%)	30.5	33.6	36.6	46.1

## Federal Policy Action to Support the Health Care Needs of Canada's Aging Population

Manitoba	5,900.0	28.6 (0.5%)	30.6	33.5	32.5	36.6
Saskatchewan	5,434.5	3.5 (0.1%)	4.9	7.3	12.7	15.4
Prince Edward Island	593.6	9.1 (1.5%)	9.7	10.6	10.9	11.5
Yukon	201.2	1.4 (0.7%)	2.6	2.1	2.5	2.5
Northwest Territories	393.0	1.4 (0.4%)	1.6	1.7	1.8	2.1
Nunavut	360.1	0.9 (0.3%)	0.6	0.8	1.0	1.0

\* These numbers represent the total expenditures by the provincial/territorial governments. They include provincial/territorial, federal direct and municipal governments; workers' compensation boards; and the Quebec Drug Insurance Fund. They do not include any funding from the federal government.

\*\*This figure represents the total provincial-/territorial-level spending on health care across all provinces and territories (i.e., the sum of the other figures in the column), not spending by the federal government.

Source: The Conference Board of Canada calculations, based on Canadian Institute for Health Information data and The Conference Board of Canada's population forecast.

As demonstrated in the table above, every province is expected to incur higher aging-induced costs in each of the next five years. Ontario, Quebec, and British Columbia will be responsible for the majority of Canada's additional aging-related health care costs over the next five years—not surprising given their large populations. However, relative to other provinces, the projected cost bumps in Ontario, Quebec, and B.C. also represent some of the larger percentage increases over that period.

Also worth noting in the table above is that for most provinces, the magnitude of the cost growth appears to be increasing over time. According to these projections, the rise in health care costs due to population aging—and thus the cost of the proposed demographic top-up—is not only growing each year, it is growing at an increasing rate.

## 5. The Cost of Government-Provided Prescription Medication

### 5.1 Introduction

This section estimates the cost to Canada's federal government if it were to bear the cost of certain prescription medication expenditures not currently covered by public or employer plans. Canada is currently the only developed country that provides universal health insurance without also providing universal prescription medication coverage.<sup>9</sup> As such, the implementation of this policy could be seen as an initial step toward universal coverage. Costs were calculated for each year from 2016 to 2020, employing data on household pharmaceutical expenditures from Statistics Canada's Survey of Household Spending (SHS) and on the share of the total costs borne by individuals from CIHI's most recent *National Health Expenditure Trends* report.

CIHI estimates that overall spending on prescription medications in Canada averaged \$29 billion for the past two years—or 14 per cent of Canada's total health care spending over that period.<sup>10</sup> With Canada's population expected to age significantly in the coming years, and given the link between age and chronic conditions,<sup>11</sup> more and more people will need prescribed pharmaceuticals in the near future. Indeed more than three-quarters of all seniors have at least one chronic condition,<sup>12</sup> and many are on five or more classes of drugs.<sup>13</sup> Overall, in Canada about 1 in 10 people who receive a prescription report not being able to get it filled because of cost issues.<sup>14</sup>

To lessen the burden of health care costs on individuals over the coming years, it has been proposed that the federal government cover households' spending on prescribed medications if those costs are over \$1,500 per annum or over 3 per cent of the household's annual income. Of the \$29 billion spent annually on prescription medications in Canada, only about \$3.5 billion is spent by households that exceed these levels.

### 5.2 Prescription Medication Care Spending—International Comparison

The most recent data available indicate that, per capita, Canadians are among the biggest spenders on prescription medications in the Organisation for Economic Co-operation and Development (OECD).

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<sup>9</sup> Morgan and others, "Estimated Cost of Universal Public Coverage of Prescription Drugs in Canada."

<sup>10</sup> Canadian Institute for Health Information, *National Health Expenditure Trends*.

<sup>11</sup> Canadian Institute for Health Information, *Seniors and the Health Care System*.

<sup>12</sup> Smith, *Chronic Diseases Related to Aging*.

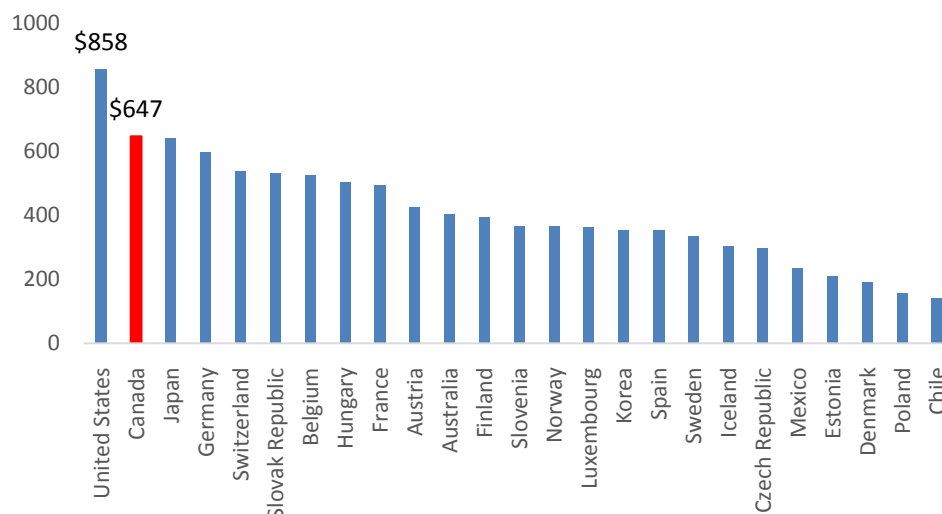
<sup>13</sup> CIHI, *Seniors and Prescription Drug Use*.

<sup>14</sup> Law and others, "The Effect of Cost on Adherence."

## Federal Policy Action to Support the Health Care Needs of Canada's Aging Population

Figure 1 below compares the per capita prescription medication expenditures of OECD countries. And only the United States (\$858) exceeded Canada (\$647) in per capita spending on medications.

Figure 1 - Prescription Medication Spending Per Capita in OECD Countries, 2013 (US\$, current prices, PPP)



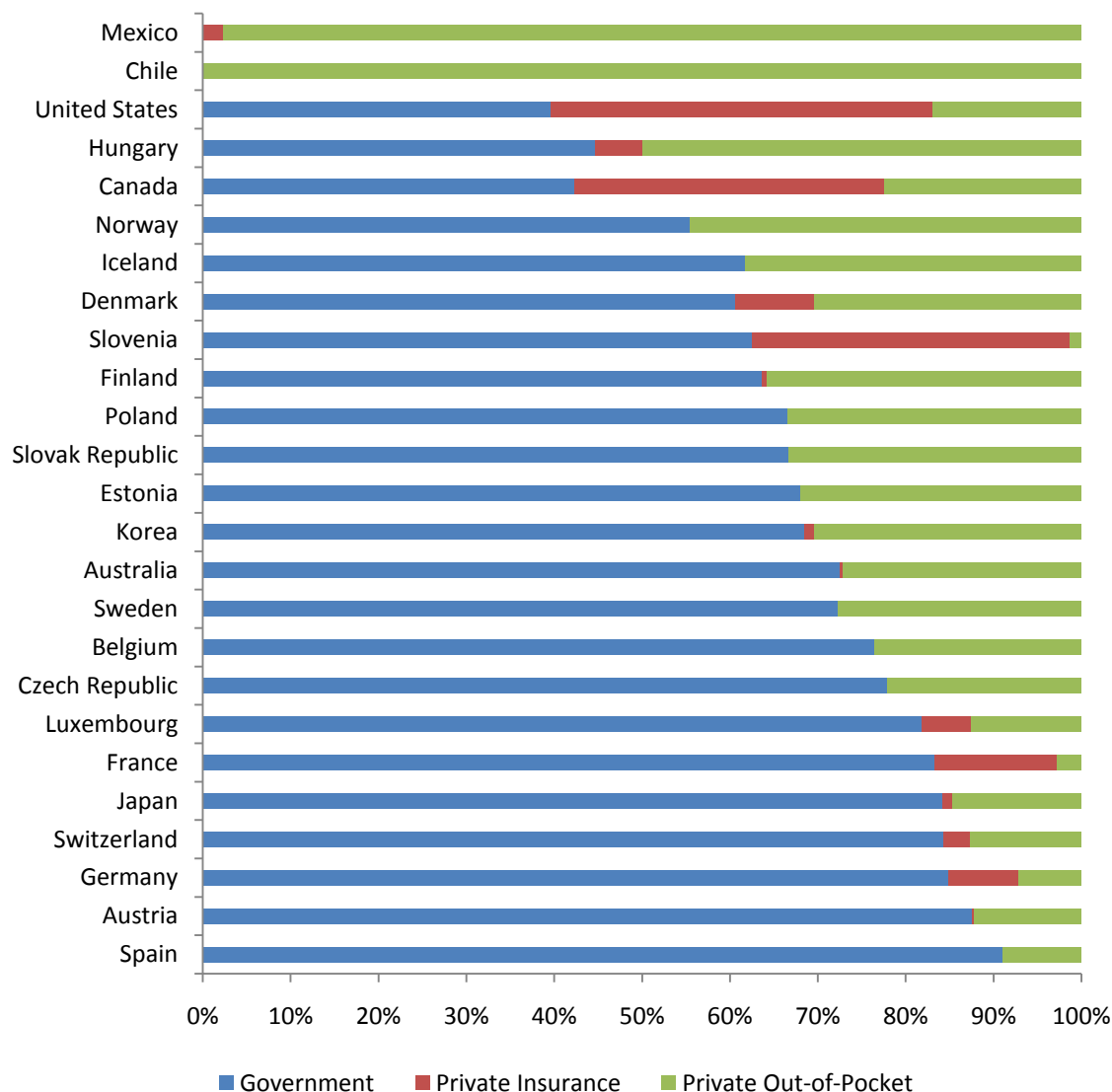
Note: figures for Australia, Japan, Luxembourg, and Spain are from 2012.  
Source: OECD, "Health Expenditure and Financing."

Canada also stands out in terms of the composition of its sources of financing for prescription medication. Of the 25 OECD countries for which these data were available, Canada has the fifth lowest proportion of medication costs covered by government, at just over 42 per cent. This is in large part because of the absence of national pharmacare, which has led to private insurance schemes in Canada. (Private insurance pays 35 per cent of overall medication costs in this country.) In fact, among the OECD countries considered here, Canada is one of only four where more than 10 per cent of medication costs are paid by private insurance. As a consequence, the proportion of financing attributable to individual out-of-pocket spending in Canada is relatively low in comparison to the others (22 per cent,<sup>15</sup> or 15th among the 25 countries). (See Figure 2.) However, about 5 per cent of Canadian households have spent more than \$1,500 or 3 per cent of their income per annum on prescription medications in the past five years.

<sup>15</sup> Note that this figure does not include the costs individuals incur for private insurance, either directly through premiums or indirectly through lower wages.

## Federal Policy Action to Support the Health Care Needs of Canada's Aging Population

**Figure 2 - Prescription Medication Financing by Source OECD Countries, 2013 (share of total financing for prescription medications, per cent)**



Note: For some countries, a small proportion of financing came from other sources. Australia, Belgium, Germany, and Hungary all had some financing from non-health insurance corporations. Iceland and Poland both had some financing from non-profit organizations. Figures for Australia, Japan, Luxembourg, and Spain are from 2012.

Sources: Organisation for Economic Co-operation and Development; The Conference Board Of Canada.

### 5.3 Estimation Methodology

To calculate what would be the additional cost to the federal government of out-of-pocket prescription medication coverage, a simple three-step process was followed.

## Federal Policy Action to Support the Health Care Needs of Canada's Aging Population

- 1) Data on the total prescription medication spending by Canadians were collected. These data were obtained from Statistics Canada's Survey of Household Spending (SHS), which provides breakdowns by age cohorts of spending on prescribed medications.
- 2) Because the SHS data include payments by employer drug plans, the spending data do not reflect the true out-of-pocket expenditures by households. As such, the spending figures were multiplied by the historic share of total private spending that comes out of individual Canadians' pockets. This figure is found in CIHI's *Prescribed Drug Spending in Canada* report, based on the SHS figures for all cohorts. We used this to estimate the current level of out-of-pocket expenditures on prescribed medications.
- 3) To determine the additional cost of prescription medication provision over the next five years, the predicted growth rate for each age cohort from the Conference Board's health forecast model was applied to the current expenditure figure computed in step 2. Projected inflation, using the core consumer price index (CPI) for 2016 to 2020, was also applied to these figures. The total cost to the federal government was then calculated for each year, from 2016 to 2020.

### 5.4 Results

The results of the analysis described above are presented in the table below.

**Table 3 - Projected Additional Cost to the Federal Government of Proposed Enhancement of Prescription Medication Coverage by Age Cohort (\$ millions)**

<u>Age cohort</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>Share of total cost</u>
Under 35 years	113.3	116.3	119.4	122.5	125.2	7%
35 to 44 years	177.2	183.5	190.5	197.8	204.3	11%
45 to 54 years	290.2	291.9	298.0	299.2	301.0	18%
55 to 64 years	383.7	400.6	417.6	433.1	444.6	25%
65 to 74 years	309.2	328.5	348.4	369.8	391.6	21%
75 years +	303.0	315.5	329.8	345.2	360.1	20%
All ages	<b>1,566.8</b>	<b>1,617.9</b>	<b>1,670.5</b>	<b>1,724.2</b>	<b>1,773.1</b>	<b>100%</b>

Source: Conference Board of Canada calculations based on Canadian Institute for Health Information data and The Conference Board of Canada's population forecast.

As demonstrated by the projected costs presented in Table 3, roughly two-thirds of the total costs of prescribed medication are attributable to individuals 55 and over. This is to be expected given Canada's aging population and the intensity of pharmacare use by the older cohorts.



It is worth noting that government-covered prescription medication spending could also lead to Canadians filling more prescriptions, meaning that costs could be even greater than those projected above. A recent research report by the Angus Reid Institute suggests that 14 per cent of Canadian households will choose not to fill a prescription due to cost in 2015.<sup>16</sup> The report further estimates that 10 per cent of Canadian households will decide not to renew a prescription because of cost this year. Other research has shown that the rate of cost-related medication non-adherence by seniors was much higher (7.1 per cent vs. 3.9 per cent) in provinces with income-based prescription coverage than it is in Ontario, where coverage is provided at little or no cost to seniors.<sup>17</sup> That research suggests that if Ontario seniors had the same rate of non-adherence as seniors in British Columbia, 68,000 more Ontarians each year would not fill prescriptions because of financial issues. Of course, more prescriptions being filled by those in need could also result in better health outcomes, thereby reducing overall health care system costs.<sup>18</sup>

Ultimately, without more data on the degree to which cost barriers reduce households' prescription medication spending, it is difficult to estimate the rate at which prescription filling would increase over the long term if coverage were extended across the country. While it may be difficult to ascertain the net fiscal effect of government-provided prescription medication in the long run, the figures presented above indicate that the cost of a transition would be significant over the first five years.

As Table 3 suggests, the federal government could help relieve the burden of prescription medication on those households with high prescription medication needs (those that spend over \$1,500 per annum or over 3 per cent of their annual income on medication) if it were to invest \$1.6 billion in 2016. This figure would increase steadily each year, for a total investment of about \$8.4 billion over five years. These investments would facilitate access to required therapies that would avoid other health care costs and human suffering.

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<sup>16</sup> Angus Reid Institute, *Prescription Drug Access and Affordability*.

<sup>17</sup> Morgan, Daw, and Law, *Are Income-Based Public Drug Benefit Programs Fit for an Aging Population*.

<sup>18</sup> Ibid.

## 6. The Cost of Refunding the Canada Family Caregiver and Caregiver Tax Credits

### 6.1 Introduction

This section estimates the cost of changing two tax credits—the Canada Caregiver Tax Credit (“Caregiver Credit”) and Canada Family Caregiver Tax Credit (FCTC)—for individuals caring for a dependant from non-refundable to refundable credits. The cost that the federal government would incur if this transition were implemented in 2016 was estimated using data on tax returns from the Canada Revenue Agency (CRA) and on government expenditures from the federal Department of Finance.

Statistics Canada estimates that over 8 million people provided care to a family member or a friend with a long-term illness, disability, or aging needs in 2012.<sup>19</sup> This number is expected to grow, with Canada’s population projected to age significantly in the future. Statistics Canada estimated that 14 per cent of those caring for a spouse and only 5 per cent of those caring for a parent received government financial assistance in 2012.<sup>20</sup> Within these groups, some caregivers reported experiencing financial difficulties (20 per cent among those caring for a spouse, 7 per cent among those caring for a parent) and wanting more help than they received (42 and 28 per cent respectively). As such, tax credits for caregivers could play an increasingly important role, both in individuals’ income levels and in the government’s fiscal position in the coming years.

### 6.2 Context

#### 6.2.1 Relevant Tax Credits

For all of the tax credits below, individuals can claim on their tax returns a percentage of eligible expenses they incurred in caring for their dependant. The credits—up to 15 per cent of the total cost—are then subtracted from the taxes the individual owes. In the case of the Caregiver Credit, an individual can claim a maximum of \$4,530<sup>21</sup> for each dependant if they maintained a dwelling where they and one or more of their dependants lived.

The Canada Family Caregiver Tax Credit (FCTC) was introduced in 2012. It allows individuals who care for dependants with physical or mental impairments to claim on their tax return an additional \$2,058<sup>22</sup> for one or more of the following amounts:

- the spouse or common-law partner amount;
- the amount for an eligible dependant;
- the amount for children under 18 years of age (“the child amount”);

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<sup>19</sup> Statistics Canada, *General Social Survey: Caregiving, 2012*.

<sup>20</sup> Statistics Canada, *Caregivers in Canada, 2012*.

<sup>21</sup> This figure, called the “Caregiver Amount,” is for the year 2014. The amounts claimable for all credits are tied to inflation and, as such, are subject to increase in the future.

<sup>22</sup> This figure is referred to as the “Family Caregiver Amount,” and is also for the year 2014. The amounts claimable for all credits are tied to inflation and, as such, are subject to increase in the future.

- the caregiver amount.

A credit of 15 per cent can then be earned on the amount(s) claimed. The Caregiver Credit is intended to support individuals who are responsible for a dependant friend or family member.<sup>23</sup> The FCTC then provides additional aid for the caregiver if his or her dependant is physically or mentally impaired, or for individuals whose spouses or common-law partners, eligible dependants, or children are physically or mentally impaired.

Under the proposed policy change assessed in this analysis, individuals would receive a refundable tax credit on the amount they claim for the Caregiver Credit, as well as the *additional* amounts claimed on the FCTC for the caregiver, spouse/common-law partner, eligible dependant, and child. The value of the credits received on the base spousal/common-law, eligible dependant, and child amounts would not change for these individuals.

#### 6.2.2 Refundable vs. Non-refundable Tax Credits

The fundamental difference between non-refundable and refundable tax credits is that a refundable tax credit can reduce an individual's tax bill to below zero. For all of the credits analyzed in this report, an individual can claim on their tax returns an amount for eligible expenses they incurred in caring for their dependant. A credit of up to 15 per cent of this amount is then applied to the tax the individual owes. In the current non-refundable case, the individual would simply have their tax bill reduced to zero if they owed less than 15 per cent of the amount they claimed in a given year. They would not receive the difference between the tax credit value and their tax bill. A refundable credit, on the other hand, would disburse 15 per cent of the amount claimed regardless of the individual's tax bill. In this case, the claimant would not only pay no taxes, they would receive a payment in the amount of the difference between their tax bill and the 15 per cent of the total amount they claimed.

#### 6.2.3 Caregiver Tax Credits—International Comparison

##### **Tax Credits for Caregivers**

Tax credits are used in Australia, Ireland, and the United States as a means to provide financial support for informal caregivers. Their use in these systems is summarized below:

##### **i. Australia**

The Consolidated Dependant Tax Offset was created in 2012–13 from a number of pre-existing tax offsets.<sup>24</sup> This is a non-refundable offset for caregivers or for individuals who support a caregiver who is unable to work because of care-giving responsibilities for an invalid family member. For 2014–15, the maximum offset is AU\$2,535. This can be reduced, based on the income of the dependant and/or the caregiver. To receive the full payment, the dependant has to earn less than AU\$282 and the caregiver less than AU\$100,000.

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<sup>23</sup> For more information on the base amounts and eligibility criteria for each tax credit, see [www.cra-arc.gc.ca/familycaregiver/](http://www.cra-arc.gc.ca/familycaregiver/).

<sup>24</sup> Taxpayers Australia, *Family Allowances*.

**ii. Ireland**

The Home Carer's Tax Credit is designed for married couples or civil partners, where one person cares for the other.<sup>25</sup> It is available to caregivers earning up to €6,700. If the caregiver is in receipt of a Carer's Allowance (a separate government support payment made to low-income individuals looking after a person requiring support due to advanced age, disability, or illness), this is not taken into account when calculating taxable income. The dependant for whom care-related expenses can be claimed under the Home Carer's Tax Credit can be a child for whom a child benefit is received, a person 65 or over, or a person with a disability.

**iii. United States**

The Elderly Dependent Care Tax Credit is a federal tax credit.<sup>26</sup> Despite its name, this credit is available to anyone unable to care for themselves, whether or not they qualify as a dependant, so long as their income is less than US\$3,950 (as of 2014), excluding non-taxable Social Security and disability payments. The caregiver claiming the tax credit must also pay for the majority (over 50 per cent) of the care for the person needing care. The caregiver can then receive up to US\$1,050 in tax credits for each dependant. In 2013, 28 individual states also had their own versions of the federal credits, many of which allowed caregivers to deduct a portion of their federal credit from their state tax returns.<sup>27</sup> Medical, food, housing, and transportation costs associated with care provision can also qualify for additional tax deductions.

**Other Forms of Financial Support for Caregivers**

Financial supports for informal caregivers are the most common type of support offered among EU countries, though these are rarely in the form of tax credits as in Canada. An article in the October 2014 edition of *Health Policy*<sup>28</sup> found that financial support is generally delivered either directly to caregivers via paid allowances, or indirectly through payments ("attendance allowances") made to the person for whom care is being given. Many countries also offer pension tax credits and paid or unpaid leave from work, though these are not caregiver support mechanisms per se.

Direct allowances are offered in 9 of the 23 EU countries, with some form of financial support for caregivers. The amount varies between €204 and €358 per week. In Canada, only Nova Scotia offers an allowance—a grant of \$400 per week—to caregivers, though take-up has been limited.<sup>29</sup>

According to the article, indirect support, wherein an attendance allowance is paid to the person being cared for and can be used to compensate informal (or formal) caregivers, is more common. Of the 23 EU countries that provide financial support for caregivers, 18 offer attendance allowances.

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<sup>25</sup> Citizens Information Board (Ireland), *Home Carer's Tax Credit*.

<sup>26</sup> The American Elder Care Research Organization, *2015–2016 Federal & State Tax Deductions and Credits for the Elderly and Their Caregivers*.

<sup>27</sup> Ibid.

<sup>28</sup> Courtin, Jemai, and Mossialos, "Mapping Support Policies for Informal Carers Across the European Union".

<sup>29</sup> Verbeeten, Astles, and Prada, *Understanding Health and Social Services for Seniors in Canada*.

Four—England, the Netherlands, Slovakia, and Sweden—offer both direct and indirect support for caregivers. Both caregiver and attendance allowances are often means-tested and vary based on the level of care required.

## 6.3 Estimation Methodology

### 6.3.1 Calculation Procedure

To estimate the cost of changing the FCTC and the Caregiver Credit, the Conference Board calculated the difference between the current amount paid out by the government for each credit and the amount expected to be paid under a refundable system. This difference was estimated for the year 2016. The procedure employed and the assumptions made are described below in greater detail.

- 1) Information on government expenditure on the FCTC and Caregiver Credit was obtained from the Department of Finance's *Tax Expenditure and Evaluations* report. These data were available for the years 2005 to 2014.
- 2) Government spending on the FCTC and Caregiver Credit was projected for 2016, based on the growth rate in expenditures from 2005 to 2014. The figures for 2016 represent the amount of money expected to be paid out for each credit if both continued in their current, non-refundable form.
- 3) To estimate what the government would spend if the Caregiver Credit were made refundable, we simply multiplied the total amount claimed for the credit by 15 per cent (the maximum amount that can be obtained under the current tax system). Data on the total amount claimed for the Caregiver credit were obtained from the CRA for the years 2005 to 2013. With the data available only to 2013, the amount claimed was forecast for three years based on the historic growth rates.<sup>30</sup>
- 4) To estimate what the government would spend on the FCTC if it were made refundable, the FCTC amount claimed was also multiplied by 15 per cent. Only two years of data (2012 and 2013) were available for the FCTC, meaning any growth rate calculated on the basis of these years would likely be inaccurate. As such, the 2016 FCTC amount claimed was projected as follows:
  - The portion of the total 2013 FCTC amount attributable to the Caregiver, Spouse/Common-Law Partner, Eligible Dependant, and Child amounts (i.e., the amounts on which the additional FCTC amount can be claimed) was obtained from the CRA. Using the growth rates of these FCTC constituent amounts (also obtained from the CRA for the years 2005 to 2013), the FCTC amounts claimed for each of the credits above was projected for 2016.
  - The projected total claimed for the FCTC in 2016 was then calculated as the sum of the 2016 caregiver credit-attributed amounts.

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<sup>30</sup> Because the introduction of the FCTC in 2012 saw a large increase in the amounts claimed for many of the caregiver credits, the pre-2012 growth rates were used in this step. An examination of the data suggests that growth returned to these levels in 2013.

- 5) The figures calculated in step 2 were subtracted from the corresponding figures found in step 3 (for the Caregiver Credit) and step 4 (for the FCTC) to produce an estimate of the additional cost the government would bear if the FCTC and the Caregiver Credit became refundable.

#### 6.3.2 Assumptions Made in Estimating the Cost

- 1) There would be no change in the tax credit rate under a refundable credit scenario. Individuals would still be entitled only to a credit of 15 per cent of the eligible amounts they claimed.
- 2) If the FCTC and Caregiver credit were changed, the total amounts claimed in Canada would rise at the same year-over-year level that they did when the credits were non-refundable, given that:
  - a) A higher portion of people who did not claim any amounts would not choose to begin claiming in response to the policy change. There would be no change to the share of the population claiming amounts for any of the FCTC constituent credits in response to the change in the FCTC or the Caregiver Credit.
  - b) Individuals were reporting their income prior to the transition; therefore, there is no incentive for them to strategically claim a higher amount after the policy change.
  - c) The structure of the population would not change significantly from 2015 to 2016. There would not be, for instance, sufficient population aging to create more dependants with aging-related needs; therefore, there would be no increase in the total amounts claimed above the growth rate predicted based on the trend observed in recent years.

#### 6.4 Results

On the basis of this procedure, it is estimated that changing the FCTC and the Caregiver Credit from non-refundable tax credits to refundable ones would cost the federal government an additional **\$90.8 million** in 2016. The results of the analysis are summarized in table 4.

## Federal Policy Action to Support the Health Care Needs of Canada's Aging Population

**Table 4 - Estimated Cost of Refunding the Family Caregiver Tax Credit (change to take effect in 2016; \$ millions)\***

Index	Variable	Total	Caregiver Tax Credit	Family Caregiver Tax Credit
<b>A</b>	Government expenditures on tax credits <sup>31</sup>	198.5	124.0	74.5
<b>B</b>	Amount claimed <sup>32</sup>	1,928.3	1,235.5	692.8
<b>C</b>	Projected outlays if refundable [=15%*D] <sup>33</sup>	289.2	185.3	103.9
<b>D</b>	<b>Cost [=C-A]</b>	<b>90.8</b>	<b>61.4</b>	<b>29.4</b>

\* Figures might not sum due to rounding.

Source: Conference Board of Canada calculations based on CRA data.

<sup>31</sup> Projected level of government spending on the current non-refundable credit in 2016.

<sup>32</sup> Projected amount claimed for tax credit in 2016 (all of Canada).

<sup>33</sup> Portion of the amount claimed that would be paid out if the tax credit became refundable.

## 7. Conclusion

This analysis estimated the costs the federal government would bear if it were to implement three policy changes designed to improve the quality of care provided by Canada's health care system and support the attainment of better health outcomes.

The first part of this analysis estimated the cost to the Canadian federal government if it were to compensate provinces on an annual basis for the additional health care costs attributable to population aging. The total cost to the Canadian government was estimated to be approximately \$1.6 billion in 2016, increasing to about \$1.9 billion by 2020. Every province is expected to incur extra costs in each of the next five years, with Ontario, Quebec, and British Columbia expected to be responsible for the majority of Canada's additional aging-related health care costs. It is also estimated that health care costs due to population aging are not only growing each year, they are growing at an increasing rate.

The second proposed modification to current federal policy—the provision of out-of-pocket prescription medication care by the federal government to Canadian households spending over \$1,500 or more than 3 per cent of their income annually on prescription medication—is estimated to cost more than \$1.6 billion in 2016, rising steadily to about \$1.8 billion in 2020. Out-of-pocket expenditures by 55 to 64 year-olds would be responsible for the largest portion of these costs, with individuals 55 and over accounting for about two-thirds of the five-year total.

The final section of the report estimated the cost to the federal government of changing the Canada Caregiver and Canada Family Caregiver tax credits from non-refundable to refundable credits. It was projected that such a transition would cost approximately \$91 million in 2016 alone.

While the report's primary objective was to quantify the costs of the three proposed federal policy modifications, two additional insights can be gleaned from this study. First, this research underscores the impact that the aging of Canada's population will have on the country's fiscal position in the coming years. While only the first part of this analysis dealt with aging *per se*, it was estimated that a large portion of the cost of prescription medication provision would be attributable to individuals over 55. Government expenditures on tax credits for caregivers can also be expected to increase as the population ages. The second point of interest is that the health care system in Canada differs notably from those in other developed nations. Unlike most developed countries, Canada does not explicitly consider age in the allocation formula for its largest federal transfer, which is designed specifically for the purposes of health care provision. The Canadian government also finances a smaller portion of prescription medication, relative to its OECD peers. This report presents compelling evidence on the negative impact that aging will have on provincial health care budgets. It also presents information on the magnitude of the investments required to help provinces, as well as Canadians and their families, to properly address this demographic challenge. Other countries have started to adopt measures; their actions can inform policy-makers in Canada.



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