

Canadian Medical Association

Oil Price Shocks and the Canadian Healthcare System

Budget Impacts, Supply Shortages and Operational Response

\$90 · \$150 · \$200 per barrel

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Executive Summary

Canada's healthcare system is more exposed to an oil price shock than most health administrators recognise. The exposure runs through five simultaneous channels: the cost of energy to run facilities; the logistics cost of patient transport and medical supply distribution; the petrochemical inputs embedded in virtually every pharmaceutical and medical consumable; the cold chain infrastructure that keeps biologics, vaccines, and blood products viable; and the economic strain that pushes more Canadians into health crisis while simultaneously reducing system revenue through broader fiscal compression.

This brief analyses three oil price scenarios — \$90, \$150, and \$200 per barrel — and their specific consequences for Canada's national healthcare system. It is addressed to the Canadian Medical Association because the CMA is the institution best positioned to translate clinical risk into federal policy advocacy, and because the window to act before the shock materially changes healthcare delivery is measured in months, not years.

The conclusions are sobering but not fatalistic. At every price level, the actions available to government, health authorities, and the medical profession can materially reduce the damage. The cost of those actions, taken now, is a fraction of the cost of the crisis they prevent.

I | THE THREE SCENARIOS — HEALTHCARE SYSTEM IMPACTS BY PRICE LEVEL

Oil prices affect healthcare through both direct and indirect channels. The direct channels — facility energy costs, transport fuel, pharmaceutical feedstocks — operate with a lag of weeks to months. The indirect channels — household economic stress, food insecurity, mental health deterioration, deferred care — build over quarters and years. The scenario matrix below captures both.

FACTOR	▲ \$90/bbl ELEVATED	▲▲ \$150/bbl SEVERE	▲▲▲ \$200/bbl CRISIS
Hospital energy costs (national)	Gas and electricity bills up 10–20%; manageable within existing budgets with conservation measures	Energy bills up 40–70%; material budget pressure; deferred maintenance accelerates; some capital projects cancelled	Energy costs up 80–130%; facility viability threatened for smaller rural hospitals; emergency energy funding required nationally

Pharmaceutical costs	API feedstock costs up 10–15%; generic drug prices begin rising; branded drugs unaffected short-term	Generic prices up 30–50%; some active ingredient supply tightening from China and India; formulary substitutions required	Generic prices double or more; active ingredient supply disruption likely; specific drug classes face genuine shortage; rationing protocols required
Medical consumables	Gloves, drapes, syringes, tubing up 10–20% — petrochemical-derived plastics track oil prices with 3–6 month lag	Consumable costs up 35–60%; procurement budgets exceeded; substitution and conservation programmes required	Consumable costs up 70–120%; some items face genuine shortage; emergency stockpile drawdown; rationing of single-use items
Patient transport	Ambulance fuel costs up 15–25%; air medevac costs up modestly; rural patient transport stressed	Ambulance operating costs up 40–60%; air medevac economically unsustainable without subsidy; rural patients face deferred emergency response	Air medevac costs double or more; some routes uneconomic without emergency federal backstop; rural and northern access to emergency care compromised
Cold chain (vaccines, biologics, blood)	Refrigerated transport costs up 15–25%; diesel backup generators more expensive to run; manageable	Cold chain logistics costs up 40–60%; single-warehouse distribution models become vulnerability; redundancy required	Cold chain system fragility: diesel backup prohibitive; temperature excursions risk if logistics fail; blood product distribution requires emergency protocols
Healthcare workforce	Nurse and physician commuting costs up; rural staff retention pressure increases marginally	Rural healthcare staff commuting costs become serious retention issue; \$400–700/month fuel cost increase per rural worker; departures accelerate	Rural healthcare staffing crisis; nurse departures from remote postings; some rural facilities face closure-level staffing shortfalls without housing and transport support
Population health demand	Modest increase in stress-related presentations; food insecurity presentations begin rising; minor	Household budget crises drive significant increase in mental health, addiction, and malnutrition presentations; ED volumes rise 10–15%	Mass household fuel poverty; food bank system overwhelmed; mental health crisis presentations surge; ED overload; preventive care collapses as patients defer everything non-urgent
Provincial health budgets	Incremental pressure; \$300–500M national system-wide; manageable with federal transfer adjustment	National system cost increase \$1.5–2.5B annually; provincial deficits widen; staff hiring freezes; capital deferrals	National system cost increase \$3–5B annually; some provinces face acute fiscal crisis; without emergency federal transfers, service cuts become unavoidable

The Compounding Effect That Makes Healthcare Different

In most sectors, an oil price shock raises operating costs and reduces margins. In healthcare, it does both of those things and simultaneously increases demand — because the same economic conditions that stress hospital budgets also push more Canadians into health crisis. Fuel poverty, food insecurity, deferred medications, mental health deterioration, and occupational injury in a stressed economy all convert to healthcare demand. The system is hit from both ends simultaneously, with no revenue mechanism that adjusts to compensate.

II | PHARMACEUTICAL SUPPLY CHAIN — SHORTAGES, COSTS AND RESILIENCE

Canada's pharmaceutical supply chain is the healthcare system's most acute and least understood oil shock vulnerability. Approximately 95% of all medications are synthesised from petrochemical feedstocks — the base chemicals are petroleum derivatives. More than 80% of active pharmaceutical ingredients (APIs) are manufactured in China and India, both of which are significant oil importers exposed to the same shock. The risk is therefore not only higher drug costs; it is genuine supply disruption for medications that Canadians depend on daily for survival.

The API Dependency Problem

- **Insulin:** Canada imports virtually all insulin API from overseas manufacturers. At \$200 oil, production costs spike and shipping logistics are disrupted. Canada has no domestic insulin manufacturing capacity. This is the most critical single drug shortage risk.
- **Cardiac medications:** Beta-blockers, ACE inhibitors, statins — all generically manufactured with APIs primarily from China and India. Supply disruption in these categories would affect millions of Canadians with no acceptable substitutes.
- **Psychiatric medications:** SSRIs, antipsychotics, mood stabilisers — many of which have no therapeutic equivalent if supply is disrupted. Abrupt discontinuation of these medications causes serious clinical harm.
- **Antibiotics:** The majority of Canada's antibiotic API comes from China. A supply shock that coincides with a demand surge (as tends to happen in periods of economic stress and population health deterioration) creates a compounding risk.
- **Oncology drugs:** Many chemotherapy agents are already in frequent shortage under normal conditions; any additional supply pressure would be immediately critical for active cancer treatment programmes.
- **Anaesthetic agents:** Propofol, fentanyl, ketamine — all petrochemically derived. Anaesthetic shortage would directly limit surgical capacity across the entire healthcare system.

Pharmaceutical Supply by Scenario

FACTOR	▲ \$90/bbl ELEVATED	▲▲ \$150/bbl SEVERE	▲▲▲ \$200/bbl CRISIS
Generic drug pricing	API costs up 10–15%; generic prices rise with 3–6 month lag; formulary costs increase modestly	API costs up 40–60%; generic prices up 30–50%; provincial drug plan costs increase significantly; some formulary substitutions required	API costs double; generic prices double or more; provincial drug budgets in crisis; some drugs unavailable at any price
Supply availability	Normal availability; some early tightening of specific generics manufactured in China and India	Specific drug classes begin experiencing allocation limits from manufacturers; Health Canada drug shortage database signals early warnings	Genuine shortage of 10–15 critical drug classes; rationing protocols required; therapeutic substitution at scale; some patients without medications

Insulin specifically	No supply risk; modest cost increase; Novo Nordisk and Eli Lilly maintain supply	Cost pressure significant; supply begins tightening as global demand spikes and shipping logistics compress; 90-day stockpile advisable	Supply disruption risk is real and serious; without a federal emergency stockpile and domestic production backstop, insulin access for Type 1 diabetics cannot be guaranteed
Cold chain for biologics	Cost pressure on refrigerated logistics; manageable; redundant storage advisable	Refrigerated transport costs spike; diesel backup for cold storage more expensive; single-point-of-failure distribution models break	Cold chain fragility is a patient safety issue; temperature excursions during transport or storage could compromise biologics and vaccines at scale
What Health Canada must do	Activate early warning monitoring; map API origins for top 100 dispensed drugs; begin domestic stockpile review	Invoke emergency drug supply protocols; negotiate advance purchase agreements with domestic manufacturers; direct API diversification away from single-country sources	Declare pharmaceutical supply emergency; activate all stockpile reserves; impose export restrictions on domestically produced medications; emergency production licensing

What the CMA Should Advocate — Pharmaceutical Resilience

- **180-day national essential medicines stockpile:** Covering insulin, cardiac, psychiatric, antibiotic, anaesthetic, and oncology drug categories. To be warehoused at regionally distributed federal facilities — not a single national warehouse. Estimated capital cost: \$800M to \$1.2B. Cost of insulin shortage for 3 million Canadian diabetics: incalculable.
- **Domestic API manufacturing capacity:** Canada has the chemical engineering capacity to produce APIs domestically. Federal investment in one or two strategically located API manufacturing facilities — at an estimated capital cost of \$300M to \$500M — would permanently reduce the API import dependency that creates the shortage risk. Apotex, Teva Canada, and other domestic manufacturers should be engaged as anchor tenants.
- **Drug shortage early warning system upgrade:** Health Canada's existing drug shortage database is reactive. An AI-assisted predictive system monitoring API origin countries, shipping logistics, and manufacturer capacity signals would provide 60 to 90 days of advance warning — enough time to trigger substitution and stockpile deployment before patients are affected.
- **Advance purchase agreements with domestic manufacturers:** Federal contracts committing to purchase defined volumes of essential generics from Canadian manufacturers at guaranteed prices — modelled on the COVID-19 vaccine advance purchase framework — would incentivise domestic production expansion and provide supply security during a shock.

The Insulin Scenario in Plain Terms

Canada has approximately 3 million people living with diabetes who depend on insulin. The majority use analogue insulins manufactured from APIs produced offshore. Canada has no domestic insulin manufacturing. At \$200 oil, supply chains for these products face simultaneous cost and logistics disruption. There is no domestically produced alternative. If supply is disrupted, the consequences for patients are immediate and life-threatening. This is the single most acute pharmaceutical vulnerability in the Canadian healthcare system, and it has no market solution.

III | MEDICAL CONSUMABLES, EQUIPMENT AND SUPPLY CHAIN RESILIENCE

Approximately 70% of all medical consumables — gloves, syringes, IV tubing, drapes, gowns, wound dressings, catheters, blood collection devices — are manufactured from petrochemical-derived plastics and polymers. Their cost tracks oil prices with a lag of three to six months, as manufacturers absorb feedstock cost increases before passing them through. Medical equipment — imaging, diagnostic, surgical — contains significant petrochemical-derived components and is shipped via fuel-intensive freight networks.

FACTOR	▲ \$90/bbl ELEVATED	▲▲ \$150/bbl SEVERE	▲▲▲ \$200/bbl CRISIS
Gloves, gowns, drapes	Cost up 15–25%; procurement budgets strained; conservation protocols advisable but not yet mandatory	Cost up 40–65%; significant procurement overrun; conservation and reprocessing programmes must be operational; some substitution required	Cost up 80–130%; genuine shortage risk for nitrile gloves and some gown specifications; rationing protocols; reprocessing of reusable items mandatory
IV supplies, tubing, catheters	Modest cost increases; supply secure; early inventory build advisable	Cost up 35–55%; supply allocation begins for some product categories; 90-day inventory standard should be mandatory	Supply disruption risk for some IV product categories; priority allocation to acute care; emergency reuse protocols for items not normally reused
Surgical implants	Cost up 10–20%; manageable; no supply risk	Cost up 30–50%; elective surgery implant cost pressure significant; some suppliers pass costs through on short notice	Cost up 60–100%; some implant categories face allocation limits; elective procedures further deferred; joint replacements and spinal implants at risk of shortage
Diagnostic consumables	Reagents and test kit costs up modestly; lab budgets absorb	Lab consumable costs up 30–50%; some consolidation of testing to reduce reagent use; point-of-care testing expansion to reduce transport	Diagnostic capacity potentially limited by consumable shortages; prioritisation of highest-clinical-value testing; some routine screening deferred
Medical equipment freight	Equipment and replacement parts shipping costs up 15–25%; minor delays on large items	Equipment freight costs up 40–60%; procurement lead times extend; replacement parts delays begin affecting equipment uptime	Equipment freight disruption; some capital procurement suspended; maintenance-in-place extended beyond designed service life; equipment failure risk increases

Operational Responses — Consumables

- **At \$90 — build inventory and begin conservation:** Health authorities should build 90-day inventory buffers for all Class A and Class B consumables. Conservation protocols — extended use of items safe for reuse, substitution of less oil-intensive alternatives where clinically equivalent — should be developed and tested before they are needed.
- **At \$150 — activate conservation and reprocessing:** Single-use item reprocessing programmes (already established in the US and increasingly in Canada) should be expanded rapidly. Third-party

reprocessors certified by Health Canada can reprocess up to 30% of single-use surgical devices safely. This reduces consumable cost and consumption simultaneously.

- **At \$200 — rationing protocols and emergency procurement:** Formal rationing of scarce consumables with clinical triage criteria. Emergency procurement through federal purchasing authority — using bulk purchasing power to secure supply at the national level rather than competing as 13 separate provincial and territorial health systems. Priority to acute care and life-sustaining procedures.

What the CMA Should Advocate — Consumable Supply Resilience

- **National medical supply strategic reserve:** A 90-day national reserve of essential consumables — modelled on national petroleum reserve frameworks — held at regionally distributed warehouses. Estimated cost: \$400M to \$600M for initial stock. Rotated through normal consumption to avoid expiry. Activated by Health Canada declaration.
- **Domestic consumable manufacturing investment:** Canada has no significant domestic glove, gown, or IV bag manufacturing. Federal investment in domestic capacity — through production incentives or crown investment — would reduce import dependency that makes the shortage risk unavoidable in a prolonged disruption.
- **National group purchasing organisation at emergency scale:** All provinces should pool consumable procurement through a single federal emergency purchasing entity during a declared supply shock. The combined purchasing power of the Canadian healthcare system eliminates the international supplier incentive to allocate away from Canada toward higher-paying markets.

Canadian hospitals and long-term care facilities consume approximately 90 petajoules of energy annually — roughly equivalent to the residential energy use of a mid-sized province. Natural gas provides the majority of space and water heating. Diesel provides backup generation. Electricity runs lighting, medical equipment, HVAC, and refrigeration. All three inputs are directly or indirectly exposed to oil price increases.

FACTOR	▲ \$90/bbl ELEVATED	▲▲ \$150/bbl SEVERE	▲▲▲ \$200/bbl CRISIS
National hospital energy cost increase	~\$350–500M nationally; 10–18% increase over baseline; manageable with efficiency measures	~\$900M–1.5B nationally; 35–55% increase; material budget impact; capital deferrals begin; efficiency investment now economically compelling	~\$1.8–3.0B nationally; 70–120% increase; acute fiscal crisis for smaller hospitals; rural facility viability threatened without emergency subsidy
Natural gas heating	Gas bills up 10–20%; conservation setbacks (2°C) deliver 5–8% savings immediately	Gas bills up 40–65%; heat pump conversion payback compresses to under 3 years in most provinces; electrification now urgently economic	Gas bills double or more; heat pump conversion is emergency priority; facilities without alternatives face unmanageable operating losses
Diesel backup generation	Backup gen fuel costs up 15–25%; routine testing more expensive; manageable	Backup gen fuel costs up 40–60%; fuel reserves should be extended to 90 days; battery backup supplements beginning	Backup gen fuel is a major cost item; hospitals in provinces with expensive grids face double-exposure; battery and UPS systems must supplement
Rural and remote hospitals	Modestly higher operating costs; staffing pressure begins through commute costs	Serious operating cost pressure; staff retention crisis accelerating; some rural hospitals approach viability threshold	Some rural hospitals face closure-level operating deficits without emergency federal transfer; staff have left; facilities cannot function as full-service acute care sites
Long-term care facilities	Energy cost pressure modest; staffing turnover due to commuting costs begins	Operating costs surge; staffing retention severe; quality of care begins deteriorating under financial pressure	LTC sector in crisis; staffing and energy cost combination creates acute pressure; without emergency wage and energy subsidy, some facilities cannot continue operating

Immediate Operational Changes — All Price Levels

- **Thermostat management:** A 2°C setback in non-patient-facing areas (administrative, storage, corridors) reduces heating costs 5 to 8% at zero capital. Implementable by policy directive within days across all federal health facilities. Provinces should issue parallel directives to regional health authorities.

- **Lighting and HVAC scheduling:** Occupancy-based lighting and HVAC control in non-clinical areas reduces consumption 15 to 25%. The technology is standard; what is needed is a system-wide mandate to implement what is already achievable.
- **Elective procedure energy management:** Surgical suite energy consumption is significant; scheduling elective procedures in consolidated operating blocks rather than across extended windows reduces HVAC and lighting energy per procedure.
- **Backup diesel reserve extension:** All hospitals and long-term care facilities should extend backup diesel reserves from the standard 72-hour supply to a minimum 30-day supply. At \$90, pre-purchasing this reserve at current prices saves 40 to 100% of the cost of purchasing it at \$150 or \$200.
- **Telemedicine expansion:** Every patient consultation that occurs by telemedicine eliminates patient transport energy, physician travel, and facility use. Expanding telemedicine infrastructure now — in primary care, psychiatry, dermatology, and routine specialist follow-up — reduces facility demand and transport costs simultaneously.

What the CMA Should Advocate — Facility Energy Resilience

- **Emergency healthcare energy fund:** A federal fund of \$500M to \$750M directed specifically at heat pump conversion, LED retrofit, building automation, and battery backup installation in hospitals and long-term care facilities. Payback at \$150 oil is under 3 years; at \$200 it is under 18 months. This is not a subsidy — it is a capital investment with a calculable return.
- **Mandatory 90-day energy resilience standards:** Health Canada, working with provincial health ministries, should establish mandatory energy resilience standards for all acute care facilities — including minimum backup energy duration, minimum on-site renewable generation, and maximum gas-heating dependency thresholds.
- **Rural hospital emergency operating subsidy:** A federal emergency operating subsidy specifically for rural hospitals serving populations of under 10,000, triggered automatically when energy and staffing costs exceed defined thresholds relative to prior-year budgets. This prevents service loss in communities that have no alternative healthcare access.

The Rural Hospital Cliff

Canada has approximately 700 rural and remote hospitals and health centres. Many are already operating at or near financial viability limits. A sustained energy cost spike of 40 to 70%, combined with a staffing retention crisis driven by high commuting costs, will push a significant number of these facilities to closure or severe service reduction. The communities they serve have no alternative. Emergency support for rural facilities is not optional — it is the difference between a healthcare system that functions across the country and one that retreats to urban centres while rural Canadians lose access to emergency care.

V | PATIENT TRANSPORT, AIR MEDEVAC AND COLD CHAIN LOGISTICS

FACTOR	▲ \$90/bbl ELEVATED	▲▲ \$150/bbl SEVERE	▲▲▲ \$200/bbl CRISIS
Ground ambulance	Fuel costs up 15–25%; EMS budgets strained; response time impacts minor; more expensive to dispatch	Fuel costs up 40–60%; EMS operating budgets materially exceeded; some services begin restricting non-urgent transfers; rural response capacity contracts	Fuel costs double; non-emergency patient transport becomes economically prohibitive; some rural EMS services face closure or severe restriction; 911 response times increase
Air medevac (STARS, provincial)	Aviation fuel up 15–25%; additional cost per flight modest; service unaffected	Aviation fuel up 40–65%; STARS and provincial air ambulance costs spike; some provinces begin rationing air medevac to highest-acuity cases only	Aviation fuel doubles; air medevac per-flight cost reaches crisis level; without emergency federal subsidy, some services reduce hours or coverage area; northern and remote access severely compromised
Medical courier / specimen transport	Courier costs up 15–25%; lab turnaround time unaffected; cost absorbed	Courier costs up 40–60%; some regionalisation of specimen processing to reduce transport frequency; point-of-care testing expanded to reduce courier dependency	Medical courier costs prohibitive for routine specimens; point-of-care and in-hospital testing must absorb volume that was previously sent out; some low-acuity testing deferred
Vaccine cold chain	Refrigerated transport costs up modestly; standard protocols adequate	Cold chain transport costs up 40–60%; single-distribution-point models vulnerable; regional depot redundancy required; diesel backup generator fuel for cold storage is material cost	Cold chain fragility is patient safety risk; temperature excursion risk during transport if logistics disrupted; blood product distribution requires emergency protocols and redundant storage
Patient transport (non-emergency)	Costs up modestly; low-income patients begin delaying or foregoing non-urgent appointments	Patient transport cost is a significant access barrier; missed appointments surge for chronic disease management; preventable hospitalisation begins rising	Large-scale foregoing of non-urgent care; chronic disease management deteriorates; preventable hospitalisation and ED visits surge; effective increase in demand while capacity is under pressure

Operational Responses — Transport and Cold Chain

- **At \$90 — route optimisation and telemedicine substitution:** Audit all medical transport routes for efficiency. Expand telemedicine for post-operative follow-up, chronic disease management, and psychiatric consultations — eliminating patient trips that do not require in-person care. Each eliminated trip saves fuel and reduces system cost.
- **At \$150 — air medevac federal backstop and transport subsidy:** Federal government must provide emergency fuel cost subsidy to STARS and provincial air ambulance programmes before they begin restricting coverage. A targeted low-income patient transport subsidy prevents the foregoing-of-care cascade that drives preventable hospitalisation.

- **At \$200 — emergency transport prioritisation protocols:** Formal triage criteria for non-emergency patient transport. Centralised medical transport co-ordination — routing patients to the nearest appropriate care facility rather than the nearest hospital regardless of capability. Electric vehicle deployment in urban ambulance fleets where charging is available.

Cold Chain Resilience — Specific Investments Required

- **Regional vaccine and biologic depots:** Eliminate single-warehouse national distribution models. Establish regionally distributed cold storage at a minimum of eight locations across Canada, each with independent diesel and solar-battery backup. Estimated capital cost: \$120M to \$180M. The cost of a cold chain failure affecting one year of vaccine supply: billions in preventable disease.
- **Battery-backed cold storage at all hospitals:** Every hospital and health centre must have battery-backed refrigeration capable of maintaining cold chain for a minimum 72-hour grid outage. This is a capital standard, not an operational question. Estimated national cost: \$80M to \$120M.
- **Electric refrigerated medical transport:** Medical courier vehicles should be prioritised for electric fleet transition — they operate on predictable urban and suburban routes, have access to facility charging, and carry high-value, temperature-sensitive cargo. Federal procurement incentive for electric medical courier vehicles.

VI | HEALTHCARE WORKFORCE AND POPULATION HEALTH DEMAND

The healthcare workforce and the population it serves are simultaneously affected by an oil price shock — and the two effects compound. As fuel costs rise, rural healthcare workers leave; as household budgets compress, population health deteriorates and demand on the system rises. The combination produces a system whose capacity is contracting while its caseload is expanding.

Workforce Impacts by Scenario

FACTOR	▲ \$90/bbl ELEVATED	▲▲ \$150/bbl SEVERE	▲▲▲ \$200/bbl CRISIS
Rural nurse commuting cost	Commuting costs up \$100–200/month; noticeable but not decisive for most workers	Commuting costs up \$300–600/month; decisive retention issue for many rural nurses; departures accelerate; vacancies harder to fill	Commuting costs up \$500–900/month; mass departure from rural postings; some facilities fall below safe staffing minimums; locum costs spiral to fill
Physician rural practice	Minor additional overhead; rural practice less attractive at the margin	Overhead costs increase significantly for rural physicians in private or group practice; locum recruitment more expensive; rural GP shortages deepen	Rural physician practice financially unviable without emergency support in some communities; community health centre model must substitute where fee-for-service breaks
Home care delivery	Home care worker fuel costs up; mileage reimbursement rates fall behind actual cost; recruitment stress	Home care worker mileage shortfall of \$200–400/month creates acute retention crisis; services begin contracting patient lists; most vulnerable patients affected first	Home care system faces staffing collapse in rural and suburban areas; patients unable to access home care are hospitalised or placed in LTC at far greater cost
Population health deterioration	Modest increase in stress-related presentations; food insecurity rising; mental health referrals increase 5–10%	Household fuel poverty driving malnutrition, housing instability, and mental health crisis; ED presentations up 10–20%; preventable hospitalisations rise	Mass household economic crisis; food bank system overwhelmed; domestic violence, addiction, and psychiatric crisis presentations surge; system is simultaneously capacity-constrained and demand-overwhelmed

What the CMA Should Advocate — Workforce

- **Emergency mileage reimbursement adjustment:** Federal and provincial health authorities must adjust mileage reimbursement rates for all healthcare workers — nurses, home care staff, physicians, allied health — to reflect actual fuel costs within 30 days of a price escalation trigger. The failure to do this at \$150 will cause \$300M in recruitment and locum costs at \$200.
- **Staff housing at rural facilities:** Federal investment in staff housing at rural hospitals and health centres — estimated \$200M nationally — eliminates the commuting exposure that drives rural healthcare staffing crises. It is also a recruitment tool that rural communities cannot otherwise provide.

- **Community health centre model expansion:** Community health centres, which operate on salaried models and serve geographically defined populations, are more resilient to individual physician relocation decisions than fee-for-service practices. Federal investment in CHC infrastructure in communities most at risk of losing their GP should begin now.
- **Home care electric vehicle programme:** A federal programme providing electric vehicles or EV purchase subsidies to registered home care workers in urban and suburban areas — where charging is accessible — eliminates the fuel cost exposure that is driving home care workforce attrition.

The Home Care Cascade

Canada's home care system keeps hundreds of thousands of elderly and disabled Canadians out of hospitals and long-term care facilities. It does so through a workforce of largely part-time, low-wage workers who drive their own vehicles to patient homes — often multiple homes per shift — in suburban and rural areas. At \$150 oil, the mileage reimbursement gap becomes a \$300 per month effective pay cut for many of these workers. They leave. Their patients are hospitalised or placed in LTC — at a cost of \$800 to \$1,200 per day rather than \$80 to \$120 for home care. The cascade is entirely preventable with a reimbursement adjustment that costs tens of millions to fix and billions to ignore.

VII | WHAT CAN BE RAMPED UP QUICKLY — NEAR-ZERO TO SIX-MONTH DEPLOYMENTS

Not all responses require years of planning or billions in capital. The following measures are deployable within zero to six months, at relatively low cost, with material impact on the healthcare system's resilience at each price level.

Immediate — Zero Cost, Policy and Directive

- **Thermostat and building management directives:** All federal health facilities — and, by provincial directive, all regional health authority facilities — implement 2°C setbacks in non-patient areas. Immediate 5 to 8% heating cost reduction. Zero capital.
- **Telemedicine utilisation mandate:** Federal and provincial health authorities direct that all primary care, psychiatry, and non-urgent specialist consultations default to telemedicine unless clinical indication for in-person care is documented. Current telemedicine infrastructure can absorb significant additional volume.
- **Drug shortage monitoring activation:** Health Canada activates enhanced drug shortage monitoring — daily reporting from wholesalers, weekly reporting from manufacturers, real-time dashboard for provincial drug plan administrators. The infrastructure exists; what is needed is the mandate to use it at emergency scale.
- **Mileage reimbursement emergency adjustment:** Federal health employers adjust mileage reimbursement to reflect current fuel costs within 30 days. This is an administrative change that requires no legislation and costs a fraction of the alternative.
- **Elective surgical scheduling optimisation:** Direct regional health authorities to consolidate elective surgical lists to minimise energy use per procedure — full operating suites, efficient blocking, reduced standby time. Delivers 10 to 15% reduction in surgical energy consumption with no impact on patient volumes.

Within 30–90 Days — Moderate Capital, High Return

- **90-day essential medicines stockpile:** Health Canada, working with Shared Health and provincial drug plan administrators, pre-purchases a 90-day supply of the 50 highest-risk medications — those with offshore API dependency and no Canadian-produced alternative. At current prices. The capital cost is recoverable; the shortage it prevents is not.
- **Regional cold storage depots:** Commission and equip four to six regional vaccine and biologic cold storage facilities with independent power backup. Construction of appropriately insulated cold storage is a 60 to 90 day project for modular prefabricated facilities. Federal procurement authority enables rapid contracting.
- **Backup diesel reserve extension:** All acute care facilities extend backup generator fuel reserves to 30-day minimum. This requires above-ground tank installation at some facilities — a 4 to 8 week project. Pre-purchase fuel at current prices before shock pricing applies.
- **Point-of-care diagnostic expansion:** Accelerate procurement and deployment of point-of-care diagnostic equipment — blood analysis, urinalysis, rapid culture, pregnancy and cardiac markers — that eliminates specimen courier dependency for time-sensitive tests. Equipment is commercially available and deployable within weeks.

- **Home care EV pilot:** Federal programme for electric vehicle access for registered home care workers in five major urban centres — Toronto, Montreal, Vancouver, Calgary, Edmonton. A 90-day programme design and launch is achievable. Scale nationally based on results.

Within Six to Eighteen Months — Major Capital, Transformative Impact

- **Heat pump conversion programme for hospitals:** A federal-provincial cost-sharing programme targeting the 200 highest-energy hospitals in Canada for heat pump conversion. Average hospital payback at \$150 oil: under 3 years. Infrastructure lead time: 4 to 12 months depending on facility complexity. Begin procurement and engineering now.
- **Domestic API manufacturing facility:** Federal investment in one or two domestic API manufacturing facilities — likely in partnership with Apotex or Teva Canada — for the five to ten most critical drug classes by shortage risk. Planning to production: 18 to 24 months minimum. The planning decision made now determines whether domestic capacity exists in 2028.
- **National medical supply reserve warehouse network:** Four to six regionally distributed warehouses holding 90-day national reserves of essential consumables. Warehouse construction, fit-out, and initial stock acquisition: 12 to 18 months. The reserve established by 2027 is available for the next shock, whenever it occurs.
- **Rural staff housing programme:** A federal capital programme — \$200M over three years — for staff housing at rural hospitals and health centres in communities where rental housing is inadequate to retain clinical staff. Construction timelines of 12 to 18 months mean decisions made now produce housing available by 2027 to 2028.
- **Electric ambulance fleet transition:** A federal procurement incentive — \$30,000 per vehicle for electric ambulance purchase by provincial EMS services — accelerates fleet transition in urban and suburban areas where charging infrastructure is viable. A 100-vehicle pilot programme can be designed and launched in 90 days.

VIII | BUDGET IMPACTS AND THE CASE FOR EMERGENCY FEDERAL HEALTH TRANSFERS

Canada's healthcare system is funded through a combination of federal transfers (Canada Health Transfer) and provincial own-source revenue. The CHT is calculated on a per-capita basis and adjusted annually but does not automatically respond to cost shocks. In a sustained oil price shock, provincial health budgets face simultaneous cost increases and general revenue shortfalls — from reduced corporate and personal income tax receipts as the broader economy contracts — without any compensating adjustment in federal transfers. The result is a structural fiscal gap that provinces cannot close without service cuts or emergency federal action.

National Healthcare Budget Impact — Estimated Ranges

FACTOR	▲ \$90/bbl ELEVATED	▲▲ \$150/bbl SEVERE	▲▲▲ \$200/bbl CRISIS
Facility energy	+\$350–500M nationally	+\$900M–1.5B nationally	+\$1.8–3.0B nationally
Pharmaceutical costs	+\$150–250M (formulary increase)	+\$500M–900M (generic price surge)	+\$1.2–2.0B (price and rationing costs)
Medical consumables	+\$200–350M	+\$600M–1.0B	+\$1.2–2.0B
Patient transport (ambulance, medevac, courier)	+\$100–200M	+\$350–600M	+\$700M–1.2B
Workforce (recruitment, retention, locums)	+\$80–150M	+\$400–700M	+\$900M–1.5B
Increased demand (preventable hospitalisations)	+\$100–200M	+\$500M–900M	+\$1.2–2.0B
TOTAL NATIONAL SYSTEM COST INCREASE	\$980M–1.65B annually	\$3.25–5.6B annually	\$7.0–11.7B annually

The Fiscal Response Required

At \$90, the additional healthcare system cost is significant but manageable with targeted federal support. At \$150, it represents a genuine fiscal crisis for smaller provinces — PEI, New Brunswick, Nova Scotia, and Newfoundland and Labrador — whose health system costs would increase by 15 to 25% without offsetting revenue. At \$200, every province faces a healthcare funding emergency that cannot be resolved within existing CHT frameworks. The federal government must pre-commit to an automatic emergency healthcare transfer — triggered by a defined oil price threshold — that provides provinces with the fiscal

capacity to maintain healthcare services without rationing. The cost of establishing this mechanism now is administrative. The cost of improvising it during a \$200 oil crisis is measured in lives and service losses.

What the CMA Should Advocate — Fiscal

- **Automatic oil shock healthcare transfer:** Legislation establishing an automatic additional federal healthcare transfer — triggered when the WTI oil price exceeds \$100 per barrel for 60 consecutive days — that provides provinces with 50% of the estimated additional healthcare system cost at that price level. Self-adjusting, immediate, and administratively simple.
- **Rural and remote healthcare emergency fund:** A dedicated federal fund of \$500M per year, activated at \$90 oil and scaled upward at \$150 and \$200, specifically for rural and remote hospitals, northern community health services, air medevac operations, and First Nations health facilities.
- **Pharmaceutical supply emergency fund:** A federal fund of \$1B, pre-capitalised and standing, for emergency pharmaceutical procurement — including advance purchases, domestic production support, and price support for essential generics — activated by Health Canada upon identification of supply risk for any drug on the National Formulary.
- **Healthcare infrastructure climate resilience fund:** A \$3B federal fund over ten years for heat pump conversion, energy storage, solar generation, and building envelope upgrades at hospitals and long-term care facilities — reducing the energy cost exposure that makes the budget impact of a price shock so severe.

IX | TIMELINE OF URGENCY — ACTIONS THAT CANNOT WAIT

WINDOW	NATIONAL HEALTHCARE ACTIONS — ALL PRICE LEVELS UNLESS NOTED
<p>NOW April 2026 Zero-cost directives</p>	<ul style="list-style-type: none"> • \$90+ Issue thermostat and building management directives to all federal health facilities • \$90+ Activate enhanced Health Canada drug shortage monitoring protocol • \$90+ Adjust healthcare worker mileage reimbursement to current fuel cost • \$90+ Map API origin of Canada's top 100 dispensed medications — identify shortage risk • \$90+ Mandate telemedicine default for non-urgent primary and specialist care • \$90+ Audit all hospital backup generator fuel reserves — identify facilities below 7 days
<p>MAY–JUNE 2026 30–60 day actions</p>	<ul style="list-style-type: none"> • \$90+ Pre-purchase 90-day supply of top 20 highest-risk essential medicines at current prices • \$90+ Begin engineering and procurement for regional cold storage depot network • \$90+ Commission backup generator fuel reserve extension at all acute care facilities • \$90+ Launch home care EV pilot in five major urban centres • \$150+ Negotiate advance purchase agreements with Apotex and Teva Canada for critical generics • \$150+ File federal emergency healthcare transfer legislation — automatic oil price trigger • \$150+ Activate rural hospital emergency operating subsidy fund
<p>JUNE–OCT 2026 Before heating season</p>	<ul style="list-style-type: none"> • \$90+ Regional cold storage depots commissioned and operational with battery backup • \$90+ Hospital heat pump conversion programme engineering complete — construction tendered • \$90+ 180-day essential medicines stockpile pre-purchased and warehoused • \$150+ Air medevac federal fuel cost backstop agreements signed with STARS and provincial programmes • \$150+ National medical supply reserve — first regional warehouse operational • \$200 Pharmaceutical rationing protocols published and communicated to health authorities • \$200 Emergency drug shortage declaration — Health Canada activates all emergency procurement authority
<p>2027 Structural Capital programmes</p>	<ul style="list-style-type: none"> • All Hospital heat pump conversions: top 200 highest-energy facilities complete • All Domestic API manufacturing facility — planning and site selection complete, construction begun • All National medical supply reserve: all 6 regional warehouses operational • All Rural staff housing programme: first 500 units complete at priority rural facilities • All Electric ambulance fleet: 250-vehicle pilot operational in 5 provinces

- **All** Point-of-care diagnostic expansion: all rural hospitals equipped to full point-of-care standard

The Central Argument for the CMA

Canada's healthcare system will absorb between \$1B and \$12B in additional annual costs depending on which oil price scenario materialises. A portion of that cost is unavoidable — the global feedstock and logistics reality cannot be wished away. But a substantial portion is preventable through actions that are available now, at costs that are a fraction of the crisis they prevent. The 180-day medicines stockpile that costs \$1B to build costs nothing compared to the humanitarian and economic consequences of insulin shortage for 3 million Canadians. The rural hospital emergency fund that costs \$500M annually prevents the loss of healthcare access for millions of rural Canadians who have no alternative. The CMA is the institution with the credibility, the clinical authority, and the national mandate to make this case to the federal government — before the shock arrives, while the window to act is still open.

Prepared by Dougald Lamont, Policy Analyst and Author — Preparing Canada & Manitoba for the Impact of Oil Shocks (2026) — dougaldlamont.substack.com — April 2026