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# ***The Canada Social Transfer: Past, Present and Future Considerations***

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***The Canada Social Transfer:  
Past, Present and Future Considerations  
(Background Paper)***

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# THE CANADA SOCIAL TRANSFER: PAST, PRESENT AND FUTURE CONSIDERATIONS

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## 1 INTRODUCTION

The Canada Social Transfer (CST) is the primary federal contribution in Canada to provincial and territorial social programs related to post-secondary education (PSE), social assistance and social services, and programs for children. Under section 24.3 of the *Federal-Provincial Fiscal Arrangements Act*, to receive their full share of funding, provinces and territories must meet the sole criterion that no person is required to live in a province or territory for a minimum period before becoming eligible to receive social assistance. The Act also states that the CST is to be provided to finance social programs in a manner that gives provinces and territories flexibility, and encourages federal, provincial and territorial governments to coordinate the development of shared principles and objectives for these social programs.

The federal government estimates that it will transfer some \$11.9 billion in cash support to the provinces and territories through the CST in 2012–2013, with an additional \$9 billion provided through a tax point transfer. The value of the CST cash transfer is determined by a legislated funding formula, in which payments to provinces and territories are provided on an equal per capita basis and are set to grow by 3% annually according to an automatic escalator. The tax point transfer consists of the estimated current value of a transfer of federal personal and corporate income tax points to provincial and territorial governments that occurred in 1977.

This paper describes the state of the CST today and provides an overview of how the program, including its associated accountability mechanisms, has evolved over time. It also presents some likely key issues for the renewal of the CST.

## 2 THE TAX POINT TRANSFER MECHANISM

Under an official tax point transfer, the federal government transfers a portion of its “tax room” to provincial and territorial governments. The tax point transfer component of the CST dates back to predecessor fiscal arrangements, most notably Established Programs Financing, which was introduced in 1977.<sup>1</sup> Upon mutual agreement, the federal government reduced its tax rates and all provincial and territorial governments simultaneously raised their tax rates by an equivalent amount, such that the changes in federal and provincial/territorial tax rates offset one another (i.e., revenue which once flowed to the federal government would instead flow to the provincial/territorial governments, without any change in the overall taxes paid by Canadians).

Tax point transfers were first used to provide support for national social programs, specifically those related to PSE, in the 1960s. As part of the creation, in 1977, of the Established Programs Financing, which consolidated federal support for hospital

insurance, medical care, and PSE into one transfer, another significant tax point transfer was undertaken to provide support for health and PSE.

- Beginning in 1977, half of the federal contribution for health care and PSE was paid in cash and the other half was provided through a federal tax transfer of 13.5 points of personal income tax and 1 point of corporate income tax.<sup>2</sup>
- Part of the original agreement was that these tax points (now part of the provincial revenue base) would be equalized to the national average.

Although notional in its calculation, the current value of the tax point transfer continues to be estimated by the federal government each year, with the transfer considered as ongoing federal support to provinces and territories.<sup>3</sup> Since the tax points have different values in each province and territory, the transfer also includes an additional equalization payment, known as Associated Equalization, to raise the value of the tax points to the per capita national average for those provinces that are below the average.

The value of tax point transfers can increase or decrease in any year, both in aggregate and by individual province. Tax point transfers, unlike cash transfers, are not subject to be withheld for violations of the *Canada Health Act*,<sup>4</sup> or the minimum residency requirements for social assistance.<sup>5</sup>

### **3 RECENT CHANGES TO THE CANADA SOCIAL TRANSFER**

The structure of major federal transfers for provincial and territorial social programs has undergone significant changes over the years, primarily in response to the desire among provincial and territorial governments for greater flexibility and to federal concerns over rising costs.

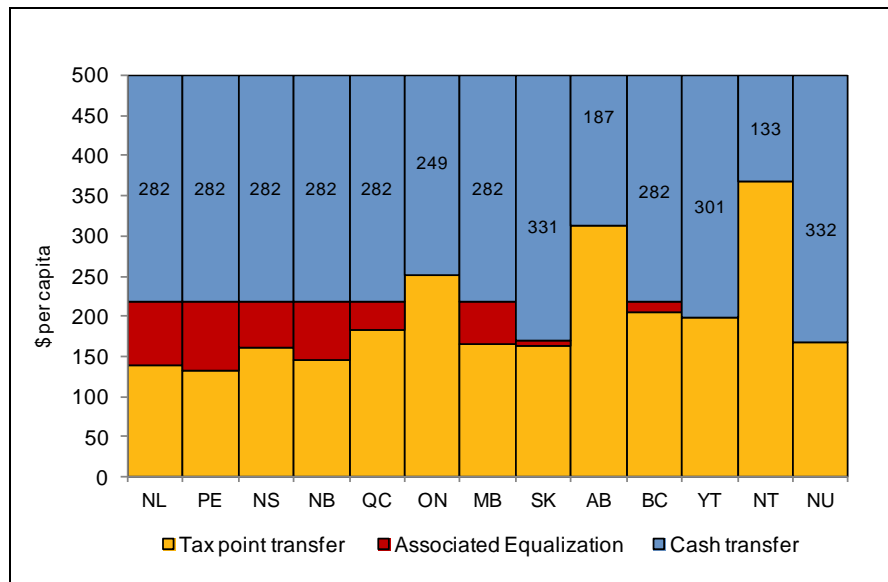
#### **3.1 THE CANADA SOCIAL TRANSFER PRIOR TO BUDGET 2007**

Before fiscal year 2007–2008, the formula for calculating the per capita value of each component of the CST – the cash transfer and the equalized tax point transfer – ensured that the sum of these amounts (i.e., the total CST entitlement per capita) was equal across all provinces and territories. Under that formula, the cash transfer component served as an offsetting measure, ensuring that this goal was achieved. That is, once the overall value of the tax transfer was calculated, it was added to the legislated total cash transfer to obtain the total CST. The total CST was then divided by total population to determine per capita total CST. The per capita CST cash for each province and territory was calculated as a residual (i.e., for each province or territory, the per capita share of its total CST less its per capita tax point transfer).

As the value of the tax points differed across provinces and territories, different cash payments were required to achieve the same total per capita CST support. Typically, Equalization-receiving provinces received the same level of CST cash since their lower tax points were equalized through the Equalization program. For wealthier provinces and territories, the value of the transferred tax points was generally higher and, as a result, these provinces and territories received less per capita cash.

Figure 1 shows the allocation for 2006–2007. The lower portions show the value of the tax points (including Associated Equalization) as a part of the CST. The per capita tax point values for Ontario, Alberta and the Northwest Territories were worth more than those of other provinces and territories, even including Associated Equalization. As a result, Ontario, Alberta and the Northwest Territories received less cash per capita.

**Figure 1 – Canada Social Transfer in 2006–2007**



Source: Figure prepared by the author using data obtained from the Department of Finance Canada, *Budget 2007 Estimates*.

Prior to Budget 2007, concerns had been raised by many stakeholders, including wealthier provinces like Ontario and Alberta, about the ongoing relevance and lack of transparency of the tax point transfer arrangement.<sup>6</sup> In response to these concerns, although the federal government continued to include the tax point transfer as an element of ongoing support for health and social programs through the CST (and the Canada Health Transfer [CHT]), Budget 2007 introduced a new formula to calculate the value of the cash transfer. Since 2007–2008, CST cash has been distributed to provinces and territories on an equal per capita basis.<sup>7</sup>

### 3.2 TRANSITION TO THE NEW SYSTEM THROUGH BUDGET 2007

According to Budget 2007, the CST was “put on a long-term, predictable path, and made more transparent and fair,” through.<sup>8</sup>

- extending legislated funding to 2013–2014, putting the CST on the same long-term legislative track as the CHT (and Equalization and Territorial Formula Financing); and
- increasing cash payments under the CST through an annual 3% escalator, starting in 2009–2010, to ensure predictable and sustainable increases broadly in line with population growth and inflation.

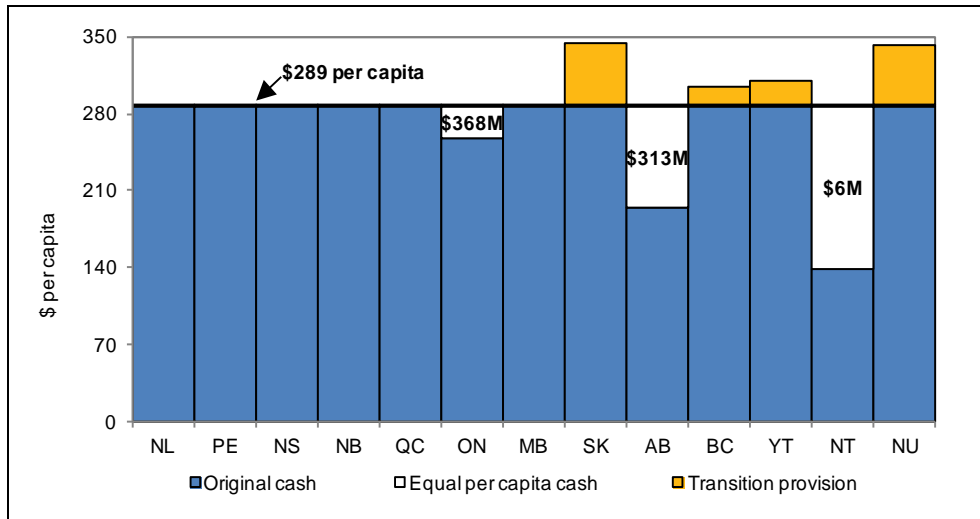
As well, Budget 2007 modified the CST in the following ways:

- To enhance the transparency of federal support for shared priorities, federal transfer support within the CST was notionally allocated based on current provincial and territorial spending patterns and existing agreements for each priority area – post-secondary education, social programs and support for children.
- The cash component of the CST was allocated on an equal per capita basis, starting in 2007–2008.

As shown in Figure 2, all provinces and territories receive the same per capita cash support as a result of the Budget 2007 allocation method. Those originally below the equal per capita cash level (i.e., Ontario, Alberta and the Northwest Territories) were brought up to that level through additional funding of \$687 million, which was added to the CST cash envelope; CST base funding increased from \$8.8 billion to \$9.487 billion for 2007–2008.

Transition provisions were put in place to ensure that no province or territory experienced declines in its CST cash relative to what it would have received before the move to equal per capita CST cash support in 2007–2008. The provinces and territories which previously received more than the equal per capita level of \$289 (i.e., Saskatchewan, British Columbia, Yukon and Nunavut) were partially compensated through transition protection payments of about \$108 million.<sup>9</sup> These payments are provided outside the legislated CST cash envelope and are updated along with the release of new estimates for a given year.<sup>10</sup>

**Figure 2 – Canada Social Transfer, Cash Allocation in 2007–2008**



Source: Figure prepared by the author using data obtained from the Department of Finance Canada, *Budget 2007 Estimates*.



### 3.3 ADDITIONAL CANADA SOCIAL TRANSFER FUNDING

While moving to equal per capita cash, the federal government began providing information on the notional allocation of federal support among the three priority areas – PSE, support for children, and other social programs (see Table 1). This occurred although the block fund structure of the CST remained, giving provinces and territories the ability to allocate funding according to their own priorities. The notional allocations are based on provincial and territorial spending patterns and existing child care agreements, as well as further investments from recent budgets.

**Table 1 – Canada Social Transfer Cash Support (\$ millions)**

|                          | 2007–2008    | 2008–2009     | 2009–2010     | 2010–2011     | 2011–2012     | 2012–2013     | 2013–2014     |
|--------------------------|--------------|---------------|---------------|---------------|---------------|---------------|---------------|
| Support for children     | 850          | 1,100         | 1,133         | 1,167         | 1,202         | 1,238         | 1,275         |
| Post-secondary education | 2,435        | 3,235         | 3,332         | 3,432         | 3,535         | 3,641         | 3,751         |
| Other social programs    | 6,202        | 6,202         | 6,388         | 6,579         | 6,777         | 6,980         | 7,189         |
| <b>Total</b>             | <b>9,487</b> | <b>10,537</b> | <b>10,853</b> | <b>11,179</b> | <b>11,514</b> | <b>11,859</b> | <b>12,215</b> |

Note: Totals may not add due to rounding. The table does not include funding of \$250 million for development of child care spaces in 2007–2008, as funding was provided outside the CST in that year; nor does it include Budget 2007 and 2008 transition protection payments.

Source: Department of Finance Canada, [The Budget Plan 2007](#), 19 March 2007, p. 129.

Budget 2007 renewed the legislated funding framework for the CST to 2013–2014, putting it on the same long-term legislative track as the CHT. As part of this renewal, an annual 3% escalator was legislated to start in 2009–2010. The aim of the escalator is to ensure predictable and sustainable increases in CST funding, broadly in line with population growth and inflation. Budget 2007 also made new investments in base CST cash starting in 2008–2009 by adding \$800 million for PSE and \$250 million for the creation of child care spaces.<sup>11</sup>

Despite the increased transparency of federal transfers for PSE and social programs introduced through Budget 2007 changes, as the identification of support for these programs through the CST remains notional, it is not possible to determine precisely how provincial and territorial governments are using this funding. One possible indicator is the share of federal support in total provincial and territorial government spending in these CST-supported areas. Using data from Statistics Canada,<sup>12</sup> it can be observed that federal PSE transfers grew from 14.4% of provincial and territorial spending in the fiscal year 2005–2006 to 16.9% of provincial and territorial spending in the fiscal year 2008–2009. For social services, including support for children, the federal transfer share of provincial/territorial spending declined slightly, from 14.4% in 2005–2006 to 13.7% in 2008–2009.

Adding to the difficulties of making links between federal support through the CST and its use for provincial and territorial social programs is the fact that there is also no clear indication of how various provincial and territorial social indicators, such as social assistance rates, are changing. Nonetheless, a recent study by the National Council of Welfare<sup>13</sup> provides an overview of these trends across Canada.

## 4 HISTORY OF FEDERAL SUPPORT TO PROVINCES AND TERRITORIES FOR SOCIAL PROGRAMS

The federal government uses major federal transfers to support provincial and territorial governments in providing health care, post-secondary education, social assistance and social services, and programs for children. Major federal transfer arrangements related to social programs have evolved over time. Early funding mechanisms were conditional cost-sharing grants that encouraged the establishment of national standards to ensure comparable quality across provinces.

### 4.1 COST-SHARING ARRANGEMENTS AS OF THE 1960S

In the 1950s and 1960s, the federal government encouraged the development of nation-wide hospital and medical care, and social programs in support of post-secondary education, social assistance and social services. The costs of these programs were for the most part shared equally between the federal government and the provinces and territories. Federal legislation and related agreements outlined program objectives and standards, and stipulated which types of expenses were eligible to be covered. Provincial and territorial governments provided detailed documentation of their expenditures to the federal government.

- *Hospital Insurance and Diagnostic Services Act*: Assented to in May 1957 and in force in July 1958, the Act allowed the federal government to offer open-ended (unlimited), conditional, matching grants to share with the provinces and territories the operating and maintenance costs associated with hospital care and diagnostic services. As a result each province and territory received 25% of its per capita expenditures on health in authorized areas and, for each of its inhabitants, 25% of the national per capita costs.<sup>14</sup>
- *Medical Care Act*: Under this Act, assented to in December 1966 and in force in July 1968, the federal contribution amounted to 50% of the national costs of physician services of all provinces and territories, distributed on a per capita basis.<sup>15</sup>
- Canada Assistance Plan (CAP): Introduced in 1966, the CAP was a 50/50 cost-sharing program covering eligible expenditures that provincial, territorial and municipal governments incurred in providing social assistance and welfare services. To be eligible for federal funding under the CAP, provinces and territories had to meet specific conditions for social assistance programs, including the use of a “needs” test to determine financial need for individual recipients. CAP criteria also upheld the restriction against provinces or territories imposing a minimum residency requirement for social assistance eligibility.
  - As a cost-sharing program, the CAP did not provide federal support to provincial and territorial governments on an equal per capita basis. The level of federal support reflected both provincial and territorial spending decisions and the specific labour market circumstances of each province and territory. CAP was effectively open-ended, with entitlements based on the willingness of each province and territory to spend in eligible areas.

- *Federal-Provincial Fiscal Arrangements Act 1967* (FPFAA 1967): Through the Act, federal contributions for PSE were transferred directly to all provincial and territorial governments starting in fiscal year 1967–1968.<sup>16</sup> The PSE agreement provided for 50/50 cost-sharing or a specific per capita amount if a province or territory preferred.<sup>17</sup> The federal assistance included a tax abatement and a supplementary cash payment to ensure that the total contribution corresponded to the entitlement of each province or territory. To contain escalating costs, in 1972 the federal government amended the FPFAA 1967 by setting a limit of 15% on the national rate of annual increase of the total federal contribution.

#### 4.2 TRANSITION TO ESTABLISHED PROGRAMS FINANCING AND CONCERNS FOR ESCALATING FISCAL COSTS

As the various programs in support of health and social programs became more established, a consensus among governments emerged that there was less necessity for conditional cost-sharing arrangements. With the introduction of Established Programs Financing (EPF) in 1977, the federal government replaced the prior arrangements in support of health care (i.e., hospital insurance and medical care) and PSE with a block grant made up of roughly equal parts tax room and cash payments to the provinces and territories. Through the block fund, once payments were made, provinces and territories had the ability to redistribute EPF funding according to their priorities.<sup>18</sup> Under the original agreement in 1977, the value of the tax points was to grow as economies expanded. The cash transfer escalated with the growth rate of per capita Gross National Product (GNP).

The funding allocations for EPF and the CAP were modified mainly in response to federal concerns over rising program costs. Table 2 provides a chronological list of the key changes to these fiscal arrangements.

**Table 2 – Chronology of Established Programs Financing and the Canada Assistance Plan**

| Year | Description   |
|------|---|
| 1982 | EPF included equal per capita ceiling for total entitlements such that cash transfers were determined residually. As a result, the GNP per capita escalator was applied to the total EPF, rather than to EPF cash alone.  |
| 1983 | The federal government adopted the “6 and 5” anti-inflation program, limiting the PSE component of EPF to growth rates of 6% in 1983–1984 and 5% in 1984–1985.  |
| 1986 | EPF growth was reduced from GNP to GNP-2%.  |
| 1989 | The federal budget announced that EPF growth would be further reduced to GNP-3% beginning in 1990–1991.   |
| 1990 | Growth in the CAP transfer for three non-equalization provinces (Ontario, Alberta and British Columbia) was limited to 5% annually for 1990–1991 and 1991–1992. The EPF per capita transfer was to be frozen for 1990–1991 and 1991–1992 for all provinces and territories. |
| 1991 | The federal budget extended the EPF freeze and CAP growth limit for three more years to 1994–1995.  |
| 1994 | The federal budget announced that total CAP and EPF transfers in 1996–1997 would be no higher than in 1993–1994.  |
| 1995 | For 1995–1996, EPF growth was set at GNP-3%, and the CAP was frozen at 1994–1995 levels for all provinces and territories.  |

Sources: Author’s compilation, using information obtained from Nancy Miller Chenier, [Health Policy in Canada](#), Publication no. 93-4E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 4 December 2002; Health Canada, [Canada’s Health Care System](#); Department of Finance Canada, [A History of the Health and Social Transfers](#); and Tim Prince, [Canadian Health Care Royal Commissions, Commissions of Inquiry and Task Forces, 1878–2002: A Selected Bibliography](#), Saskatchewan Legislative Library, 29 November 2002.

As explained in a paper by Paul Hobson and France St-Hilaire, “the effect of the cap on CAP ... [in the early 1990s] created a two-tier system whereby seven provinces continued to benefit from cost-sharing arrangements for social assistance while for the three others CAP became more [of] a block funding arrangement.”<sup>19</sup>

### 4.3 FEDERAL CONSOLIDATION AND BLOCK FUNDING THROUGH THE CANADA HEALTH AND SOCIAL TRANSFER

By 1995, the federal government observed that it had been running a deficit for 25 consecutive years. The net debt-to-GDP ratio reached a high of 71%, and public debt charges were approximately 5.8% of GDP, or 33 cents of every federal revenue dollar collected. As part of its commitment to reducing the national debt, in 1995 the federal government signalled that funding for government programs and intergovernmental transfers was to be reduced.

The 1995 federal budget announced that beginning in fiscal year 1996–1997 the CAP and EPF would be rolled into one block fund, thus completing the federal government’s gradual move from cost sharing to block funding for major federal transfers. The Canada Health and Social Transfer (CHST) was a single block fund to provincial and territorial governments in support of health care, post-secondary education, social assistance and social services. With the introduction of the CHST, Budget 1995 noted that:<sup>20</sup>

- Provinces and territories would no longer be subject to rules stipulating which expenditures were eligible for cost sharing.
- Provinces and territories would be free to pursue their own innovative approaches to social security reform.
- Federal expenditures would no longer be driven by provincial and territorial decisions on how, and to whom, social assistance and social services would be provided.

The CHST was not completely unconditional, however, as the federal government continued to enforce the criteria and conditions of the *Canada Health Act*,<sup>21</sup> and provinces and territories were still required to provide social assistance without any minimum residency requirements, the same rule as under the CAP.

Like the EPF transfer, the CHST was a combination of a tax transfer and a cash transfer. For the first year, 1996–1997, the CHST was allocated among provinces and territories in the same proportion as the 1995–1996 total entitlement of the EPF and CAP transfers that were being replaced. Under the CHST, funding to provinces and territories was reduced by \$2.5 billion from the \$29.4 billion it would have been in 1996–1997, to \$26.9 billion. In the 1996 federal budget, a five-year funding arrangement for the CHST was announced for 1998–1999 to 2002–2003, under which funding amounts would progressively grow with the increasing pace of GDP growth. In addition, in response to concerns regarding the erosion of the cash transfer by provincial and territorial governments and stakeholders, the federal government instituted a cash floor of \$11 billion for 1997. In 1998, the cash floor was raised to \$12.5 billion and extended until 2002–2003.

#### 4.4 RENEWAL OF FEDERAL SUPPORT FOR HEALTH AND SOCIAL PROGRAMS

Along with the elimination of annual federal budget deficits in the latter part of the 1990s and in part to respond to stakeholder concerns related to the adequacy of federal funding, the 1999 federal budget announced that over the subsequent five years, an additional \$11.5 billion would be injected into the CHST, specifically for health care; it would be allocated on an equal per capita basis. Of the \$11.5 billion, \$8.0 billion would be paid through future increases in the CHST and the additional \$3.5 billion would be provided as an immediate one-time supplement for CHST from funds available that fiscal year. By 2001–2002, due to these funding increases, the level of federal support for health care would have returned to its level before the application of fiscal restraint measures.

Following the 1999 budget, there was a series of First Ministers meetings primarily on the subject of health care, but where provisions for PSE and support for children were also discussed to a lesser extent. Provinces and territories were concerned with both the rising costs of providing public health insurance in Canada and the effect of the reduced levels of cash transfer payments under the CHST that had been a result of the federal fiscal restraint of the early 1990s. At each of the meetings, federal, provincial and territorial governments came to agreements that increased the level of federal cash transfers for health care, and to a lesser extent PSE and support for children, in return for provincial and territorial commitments on renewal and reform of their existing systems.

- *2000 Agreement on Health Renewal and Early Childhood Development:*<sup>22</sup>
  - \$18.9 billion over five years would be injected into the cash component of CHST transfers;
  - \$2.2 billion would be allotted to early childhood development; and
  - \$2.3 billion would be invested in the following three targeted priorities: \$1 billion for a Medical Equipment Fund; \$800 million over four years for a Health Transition Fund; and \$500 million was invested immediately to fund the development and adoption of health information technology.
- *2003 Accord on Health Care Renewal:*<sup>23</sup>
  - Based mainly on recommendations provided in various major studies on the need for health care reform in Canada,<sup>24</sup> and building on the September 2000 agreement, a new *Accord on Health Care Renewal* was concluded by First Ministers. To meet its commitments under the new Accord, the federal government invested \$34.8 billion over the subsequent five years.
  - The CST was first proposed in the 2003 Accord, effective 1 April 2004, when the CHST was divided into two separate transfers: one specifically for health care, the CHT; and one for social programs, the CST. In that year, the CHT accounted for 62% of the value of the former CHST, with the CST making up the remaining 38%.

- As well, although not directly related to the CST, in September 2004, First Ministers signed the *10-Year Plan to Strengthen Health Care*, which included \$41 billion in federal support for provincial health systems over the 10-year period from 2004–2005 to 2013–2014. The purpose of the new funding was to strengthen the federal support to provinces and territories through the CHT, meet the financial recommendations of the Royal Commission on the Future of Health Care and address the problem of wait times for essential health services.<sup>25</sup>

## 5 EVOLUTION OF ACCOUNTABILITY FOR MAJOR FEDERAL TRANSFERS

Major federal transfers to provinces and territories are deemed by the Auditor General of Canada to be largely unconditional, insofar as recipient provinces and territories can spend these payments according to their own priorities, and are not obligated to report to the federal government on how they spent the transferred funds or what effect that spending had.<sup>26</sup>

As major federal transfer arrangements have evolved, so too have reporting and accountability frameworks. Over time, more emphasis has been put on public accountability. It is the federal government's position that provinces and territories are best placed to determine program priorities and implement programs in response to them. As a result, the federal government notes that provinces and territories are directly accountable to their residents for their use of federal transfer funding. In relation to the CST, as with other major federal transfers, three fundamental accountability relationships exist:

1. Accountability of federal, provincial and territorial (FPT) legislatures to citizens for the implementation of their programs.
2. Accountability of the executive branches of FPT governments to the elected legislatures for the expenditure of public funds according to the purposes approved by the FPT legislatures.
3. Mutual accountability between the executive branches of the FPT levels of government.

It can also be observed that the various accountability relationships that have existed between levels of government have differed in their configuration, depending on the funding regime in place. These include the following:

- *Administrative accountability*, in which the monitoring, reporting and some of the enforcement activities are mainly located in the bureaucracies of the FPT governments. This type of accountability is typical of cost-shared conditional grants. The primary instruments of accountability are statutes enacted by FPT legislatures and bilateral intergovernmental agreements, in which the provincial or territorial governments commit to enacting legislation that conforms to the criteria (i.e., standards or conditions) in the federal statute and to respect its reporting requirements, and the federal government commits to transferring money once the provincial or territorial legislation is in place.

- *Political accountability*, in which administrative monitoring is replaced with monitoring and enforcement by the political executive. This occurs, for example, where block transfers for health care are made, and the associated criteria and conditions of the *Canada Health Act* must be met. The standard-setting process is a unilateral one in that the criteria are set out in federal legislation, with no requirement for a minimum consensus among provinces and territories. In cases where a province or territory is found to be in violation of the terms stated in the federal legislation, enforcement is carried out through a withholding of federal funds.
- *Public reporting accountability*, where the emphasis is on the accountability of the executive branch at both levels to their respective publics, although the primary relationship is between the executive (Cabinet) branches at the FPT levels. This type of accountability operated, for example, when the multilateral intergovernmental agreements covering health care and programs for children, concluded in the era of the Social Union Framework Agreement,<sup>27</sup> were in operation. These types of agreements often include enforcement through a formal dispute resolution process. Multilateral framework agreements set out the mutual obligations of the governments to each other and to their publics, with annual public reporting as the mechanism for monitoring performance, although funding is not tied to meeting the reporting requirements.

## 6 KEY ISSUES FOR FUTURE CONSIDERATION

In accordance with a Finance Canada commitment announced on 19 December 2011,<sup>28</sup> the 2012 budget implementation Act<sup>29</sup> confirmed the federal government's intention to continue to increase the CST cash contribution by 3% annually, at least until fiscal year 2023–2024.

During a 27 July 2012 meeting of provincial and territorial premiers, the Council of the Federation (CoF) released a report estimating the impact of the proposed changes to the CST, as well as to other major federal transfers.<sup>30</sup> According to the working group's analysis, as a result of the current federal commitment to maintain the CST escalator at 3% annually, "major federal transfers for post-secondary and other social services will comprise a progressively smaller proportion of overall major federal transfers."<sup>31</sup> An alternative scenario for the CST is offered by the CoF working group, in which the CST escalator is set at the rate of growth of national nominal GDP, consistent with the escalator applied to the CHT. According to CoF estimates, this would result in a cumulative \$4.2 billion more over the next 10 years for PSE and social programs than would be provided through the existing 3% escalator.<sup>32</sup>

Provided below are some of the key issues related to the CST which could be considered for future discussion among FPT governments.

## **6.1 TARGETED FEDERAL SUPPORT TO PROVINCES AND TERRITORIES FOR POST-SECONDARY EDUCATION**

As mentioned above, through Budget 2007 the federal government created notional allocations for PSE support within the CST. By 2013–2014, roughly one third of the CST provided to provinces and territories will be in support of their PSE programs.

Although the identification of federal transfer support for PSE has been welcomed by stakeholders, because federal funding remains notional, provinces and territories are free to allocate total CST funding according to their own priorities. This means that accountability mechanisms among FPT governments remain limited, as provinces and territories are not required to report on how they use CST funding to support their priorities for PSE. Possible discussions among FPT governments may therefore include considerations about how to increase accountability for and the transparency of federal support for PSE.

## **6.2 ALLOCATING THE CANADA SOCIAL TRANSFER ON AN EQUAL PER CAPITA VS. NEED BASIS**

The federal government and other experts justify the move to equal per capita cash by proposing that the change removes an implicit mechanism within the CST that compensated for fiscal disparities among provinces and territories, an issue that is argued to be more appropriately addressed solely through the Equalization program.

Some academics and the less prosperous provinces and territories maintain, however, that while an equal-per-capita transfer may appear equitable, it is possible that it is not equitable in practice, since it does not match resources with needs. They propose that factors such as demographics and density, for example, should be considered.

In response to this view, the federal government and some experts note that one of the challenges to determining an appropriate needs-based allocation is the complexity in attempting to account for the wide range of factors that could affect provincial and territorial health and social program costs, including PSE.<sup>33</sup> Given the disparity of opinion, negotiations on CST renewal could include considerations on the appropriate allocation method.

## **6.3 ADDITIONAL FUNDING FOR THE CANADA SOCIAL TRANSFER**

In addition to the option presented by the CoF to apply an annual CST escalator according to nominal GDP (mentioned above), in the lead-up to efforts to restore fiscal balance among FPT governments in 2006, provinces and territories called on the federal government to provide an extra \$2.2 billion as a first step in restoring funding for social programs to 1994–1995 levels; this amount would rise to an overall increase of \$4.9 billion to account for inflation.<sup>34</sup> The year 1994–1995 was chosen as a benchmark because it represented the level of funding for social programs just prior to cutbacks in spending introduced by the federal government in the mid-1990s.



The request to restore funding in nominal terms compares the 2005–2006 level of funding for PSE, social assistance and social services under the CST to the corresponding level in 1994–1995 (see Table 3).

- In 1994–1995, federal support earmarked for PSE was provided through EPF, and federal support for social assistance and social services was provided through the CAP, a 50/50 cost-sharing cash transfer.
- The notional EPF federal cash transfer for PSE in 1994–1995 was approximately \$2.7 billion, and funding through the CAP was approximately \$7.9 billion, for total support of \$10.6 billion.
- In 2005–2006, funding for PSE, social assistance and social services was provided through the CST. The CST provided \$15.8 billion in support: \$8.4 billion was in cash, and the balance was through a tax point transfer.
- When the EPF/CAP cash amount for 1994–1995 was compared to the 2005–2006 level of cash funding through the CST, a gap of approximately \$2.2 billion remained.
- When the inflation-augmented EPF/CAP cash level of \$13.3 billion was compared to the 2005–2006 CST cash level of \$8.4 billion, a gap of approximately \$4.9 billion remained.

**Table 3 – Canada Social Transfer Cash Gap (\$ billions)**

| Federal Contributions            | 1994–1995 | 2005–2006 | 2011–2012 | 2013–2014<br>(projected) | 2023–2024<br>(projected) |
|----------------------------------|-----------|-----------|-----------|--------------------------|--------------------------|
| EPF-PSE/CAP                      |           |           |           |                          |                          |
| Nominal <sup>a</sup>             | 10.6      | 10.6      | 10.6      | 10.6                     | 10.6                     |
| Inflation-augmented <sup>b</sup> | 10.6      | 13.3      | 14.9      | 15.5                     | 18.9                     |
| CST cash                         |           |           |           |                          |                          |
| Actual <sup>c</sup>              | –         | 8.4       | 11.5      | 12.2                     | 16.4                     |
| GDP escalator <sup>d</sup>       |           | –         | –         | –                        | 17.4                     |
| Gap from Actual CST              |           |           |           |                          |                          |
| Nominal                          | –         | 2.2       | -0.9      | -1.6                     | -5.8                     |
| Inflation-augmented              | –         | 4.9       | 3.4       | 3.3                      | 2.5                      |
| GDP escalator                    |           |           |           |                          | 1.0                      |

- Notes:
- Value of the transfer in fiscal year 1994–1995.
  - Estimate of what the value of the transfer would have been if it had grown by the rate of inflation over time (Note: Fiscal year 2013–2014 and beyond derived assuming annual average inflation of 2% after 2011–2012).
  - In current dollars.
  - Author’s calculations, with GDP escalator applied starting in 2017–2018, based on estimates from the Council of the Federation, [Assessment of the Fiscal Impact of the Current Federal Fiscal Proposals – Report of the Council of the Federation Working Group on Fiscal Arrangements: Main Report](#), July 2012, pp. 12–13.

Sources: Table prepared by the author using data obtained from the Department of Finance Canada, CST, *Official Estimates*, December 2011; Statistics Canada, CANSIM Table 326-0020, “[Consumer Price Index \(CPI\), 2009 basket](#)”; and Council of the Federation, [Assessment of the Fiscal Impact of the Current Federal Fiscal Proposals – Report of the Council of the Federation Working Group on Fiscal Arrangements: Main Report](#), July 2012, pp. 12–13. Gap calculations may not add due to rounding.

Although the federal government responded to the first request regarding restoration of funding in nominal terms through new investments provided in Budget 2007, stakeholders have observed that the latter request to restore CST funding in inflation-augmented terms has yet to be attained. If provinces and territories were to continue to press the federal government for restoration of funding to take account of inflation and an assumed average inflation rate of 2% over the next decade, the CST would need to reach some \$18.9 billion by the end of legislated funding for the CST in 2023–2024. This would leave a gap of \$2.5 billion from the actual legislated funding level in that year, or a \$1 billion gap if a GDP escalator were applied to the CST as of 2017–2018 (as suggested by the CoF; see explanation above).

#### 6.4 FLEXIBILITY VS. ACCOUNTABILITY

In general, most observers agree that the federal government's role in influencing provincial and territorial social programs has declined as compared to the post-war period, when cost-sharing arrangements included conditions on the use of matching funding and explicit government-to-government accountability mechanisms.<sup>35</sup> It is generally accepted that any effort to increase federal influence, through attempts at imposing conditions, standards, or reporting and accountability mechanisms, would need to take account of the evolving character of the federal system.

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#### NOTES

1. For a more complete description of the tax point transfer, see James Gauthier and Shahrzad Mobasher Fard, [The Canada Social Transfer](#), Publication no. 08-57E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 23 July 2009; Odette Madore, [The Transfer of Tax Points to Provinces Under the Canada Health and Social Transfer](#), Publication no. BP-450E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, October 1997; and Department of Finance Canada, [Tax Transfers](#).
2. By 1977, the tax point transfer component already included 4.357 personal income tax points and 1 corporate income tax point that had been transferred in 1967 for post-secondary education. To arrive at a total personal income tax point transfer of 13.5 percentage points as of 1977, an additional tax point transfer of 9.143 personal income tax points was required.
3. The federal government and the provincial and territorial governments have differed in their opinion of the tax point transfer as a form of ongoing federal government support. Provincial and territorial governments have generally viewed a tax point transfer as relevant only to the original year in which it was made; in subsequent years, the tax point transfer would relate solely to the own-source revenues of each province and territory. Further details are provided in endnote 6.
4. For more details on the terms for withholding federal funding to provinces and territories provided through the Canada Health Transfer (CHT) for violations of the *Canada Health Act*, see Health Canada, [Canada Health Act Annual Report 2009–2010](#), 2010.
5. The terms for withholding federal funding to provinces and territories provided through the Canada Social Transfer (CST) are included in sections 24.3(1)(b) and 25.1 of the [Federal–Provincial Fiscal Arrangements Act](#), R.S.C., 1985, c. F-8.

6. Provinces and territories and various stakeholders proposed that federal transfers should not continue to include the tax point transfer as a form of ongoing support, as the federal government no longer controlled this source of revenue (since 1977, provinces and territories have accounted for this funding as own-source revenue). As well, because the federal government increased its income tax rates in later years, it was argued that the tax room vacated in 1977 had essentially been re-occupied. For a more complete explanation, see Provincial and Territorial Ministers of Health, [Understanding Canada's Health Care Costs: Final Report](#), August 2000, pp. 10–13.
7. The move to equal per capita cash for the CST was linked with views expressed by provinces such as Ontario and Alberta, which had received less per capita cash than other provinces and territories due to the interaction with the tax transfer, and with the report of the Expert Panel on Equalization and Territorial Formula Financing in the lead-up to Budget 2007 (see Expert Panel on Equalization and Territorial Formula Financing, [Achieving a National Purpose: Putting Equalization Back on Track](#), May 2006, p. 47). See also Department of Finance Canada, [Advantage Canada: Building a Strong Economy for Canadians](#), 23 November 2006, p. 38; and Department of Finance Canada, [The Budget Plan 2007](#), 19 March 2007, c. 4.
8. Department of Finance Canada (2007), pp. 120–121.
9. Budget 2008 extended the Budget 2007 CST transition provision to ensure that no province or territory would receive lower cash transfers under the CST than they would have received before Budget 2007 changes. This included the \$250 million for child care that had been provided outside the CST in 2007–2008. As a result, Saskatchewan received an extra \$31.2 million and Nunavut received an extra \$0.7 million. All other provinces and territories already received more than the new base level and were therefore not affected by this change. In contrast to the Budget 2007 transition protection payments, which are re-estimated each year, these transition protection amounts were provided outside the CST as a one-time payment, notionally allocated over five years.
10. With the move to equal per capita cash, the CST allocation is based solely on population data. As a result, the government simplified and streamlined the CST estimates and payments cycle. As explained by Finance Canada in the [Budget Plan 2007](#) (pp. 362 and 343), this is part of the move by the federal government to make transfers more predictable and stable.
11. Budget 2007 also provided additional support for the creation of child care spaces in 2007–2008 through an outside payment of \$250 million; this funding was incorporated into the CST starting in 2008–2009.
12. Library of Parliament calculations, using data from the Department of Finance Canada, and Statistics Canada, Financial Management System, *Provincial/territorial General Government Expenditures – Post-Secondary Education, Social Services* (CANSIM Table 385-0002), extracted from E-Stat database on 15 December 2011. Data from Statistics Canada available up until the fiscal year 2008–2009.
13. National Council of Welfare, [Welfare Incomes 2009](#).

14. The entitlement for a province or territory in a given year was equal to 25% of the average national per capita cost of the insured services, plus 25% of the cost of the insured services per resident of that province or territory multiplied by the population of that province or territory in that year. Overall, the federal government's contribution was equal to about 50% of the cost of the insured services in Canada, although the contribution was more in the provinces and territories where the per capita cost was lower than the national average and less in the other provinces and territories. For more information, see Odette Madore, [Established Programs Financing for Health Care](#), Publication no. BP-264E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, August 1991; and Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System and Their Outcomes*, 2<sup>nd</sup> ed., McGill-Queen's University Press, 1987, pp. 1–68.
15. Madore (1991); and Taylor (1987), pp. 331–337.
16. In prior years, the federal government had provided per capita grants directly to PSE institutions, rather than to the provincial and territorial governments. To accommodate provincial and territorial jurisdictional concerns, from 1960–1961 to 1966–1967, the federal government agreed to transfer a portion of its taxing authority to any provincial or territorial government that would prefer this manner of receiving the federal contributions for PSE. At the time, Quebec was the only province/territory to choose that option. For more information, see Thomas J. Courchene, *Redistributing Money and Power: A Guide to the Canada Health and Social Transfer*, C.D. Howe Institute, 1995, Appendix A; Robin Boadway, *Intergovernmental Transfers in Canada*, Canadian Tax Foundation, 1980, pp. 21–22; and Paul Weaver, "The Demise of Universality: Federal Financing for Post-Secondary Education in Canada," *Federal Governance*, Vol. 4, No. 1, 2004.
17. Courchene (1995), Appendix A; Boadway (1980), pp. 21–22; and Weaver (2004).
18. In its initial year, 67.9% of EPF was notionally allocated to health care and 32.1% to PSE, which represented the approximate spending patterns by provincial and territorial governments on these programs at that time.
19. Paul A.R. Hobson and France St-Hilaire, "The Evolution of Federal–Provincial Fiscal Arrangements: Putting Humpty Dumpty Together Again," in *Toward a New Mission Statement for Canadian Fiscal Federalism – Canada: The State of the Federation 1999/2000*, ed. Harvey Lazar, Queen's University, 2000, pp. 159-188.
20. Department of Finance Canada, [Budget Plan](#), 27 February 1995.
21. For more information on the *Canada Health Act* and its relation to federal support to provinces and territories for health care, see Health Canada, [Canada Health Act Annual Report 2009–2010](#).
22. Department of Finance Canada, [Federal Investments in Health Care](#).
23. Ibid.; and Department of Health Canada, [2003 First Ministers' Accord on Health Care Renewal](#). Although not related to federal support for PSE and other social programs, another First Ministers meeting focused solely on health care was held in 2004; it built on the agreements reached in 2000 and 2003. Federal transfers to the provinces and territories in support of health care were further increased as a result of [A 10-Year Plan to Strengthen Health Care](#). This initiative committed the Government of Canada to an additional \$41.3 billion over 10 years in funding to provinces and territories for health care, including \$35.3 billion in increases to the CHT, \$5.5 billion in wait times reduction funding, and \$500 million in support of diagnostic and medical equipment.

24. Most notably, they were Senate, Standing Committee on Social Affairs, Science and Technology, [The Health of Canadians – The Federal Role: Final Report](#), 37<sup>th</sup> Parliament, 2<sup>nd</sup> Session, October 2002 (Kirby Report); and Commission on the Future of Health Care in Canada, [Building on Values: The Future of Health Care in Canada](#), November 2002 (Romanow Report).
25. For a detailed description of the terms of this funding arrangement, see Department of Finance Canada, [Federal Investments in Health Care](#).
26. Auditor General of Canada, Chapter 1, “[A Study of Federal Transfers to Provinces and Territories](#),” in *2008 December Report of the Auditor General of Canada to the House of Commons*, December 2008.
27. In 1999, federal, provincial and territorial ministers of social development signed a Framework to Improve the Social Union of Canadians, better known as the Social Union Framework Agreement, related to joint intergovernmental planning of social programs and the uses and limitations on the federal spending power. For more information, see Harvey Lazar, “The Social Union Framework Agreement and the Future of Federalism,” in *Toward a New Mission Statement for Canadian Fiscal Federalism – Canada: The State of the Federation 1999/2000*, ed. Harvey Lazar, Queen’s University, 2000, pp. 99–130.
28. See Department of Finance Canada, “[Harper Government Announces Major New Investment in Health Care](#),” News release, 19 December 2011.
29. [Bill C-38: An Act to implement certain provisions of the budget tabled in Parliament on March 29, 2012 and other measures](#), S.C. 2012, c. 19 (first reading version, 26 April 2012), clause 397. The bill received Royal Assent on 29 June 2012.
30. See the Council of the Federation, “[Fiscal Arrangements](#),” News release, 27 July 2012; and Council of the Federation, [Assessment of the Fiscal Impact of the Current Federal Fiscal Proposals – Report of the Council of the Federation Working Group on Fiscal Arrangements: Main Report](#), July 2012.
31. Council of the Federation (2012), p. 12.
32. *Ibid.*, pp. 12–13.
33. Senate, Special Committee on Aging, [Proceedings](#), 2<sup>nd</sup> Session, 39<sup>th</sup> Parliament, 26 November 2007, pp. 1:37–1:53.
34. See, for example the Council of the Federation, Advisory Panel on Fiscal Imbalance, [Reconciling the Irreconcilable: Addressing Canada’s Fiscal Imbalance](#), March 2006, pp. 73–75.
35. See, for example, Jack Stilborn, [National Standards and Social Programs: What the Federal Government Can Do](#), Publication no. BP-379E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, September 1997.