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Repeating the Past: Provinces Accept Federal Money at their Peril

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SUMMARY

- The current federal government has committed to significant new spending in areas of provincial jurisdiction, including national pharmacare, dental care, and child care programs—even beyond its current tenure to 2025. However, the money promised is not guaranteed, and the federal government may reduce or eliminate funding in the future, leaving an unexpected and potentially large financial burden on the provinces and territories.
- Federal governments have made major changes to transfer programs in the past; for example, in 1996/97, when the CAP and EPF was replaced with the Canada Health and Social Transfer (CHST), reducing nominal federal health and social cash transfers to the provinces and territories by $6 billion (or 32.4 percent) over two fiscal years.
- If one compares actual federal health and social cash transfers with what they would have been had EPF and the CAP continued, the financial impact to the provinces was even larger. Over three years (1996/97 to 1998/99), there was a total cumulative shortfall of $41.0 billion, or 51 percent.
- The Financial Accountability Officer (FAO) of Ontario assessed a main program introduced by the Trudeau government—the Canada-Wide Early Learning and Child Care Transfer—for which it has committed $43.1 billion to support the provinces and territories in delivering $10 a day child care from 2021/22 to 2027/28.
- Based on the analysis by the FAO, the current funding shortfall for the Early Learning and Child Care Transfer for all the provinces could be $3.3 billion in 2026/27. To maintain the program, the provinces would need to increase their collective funding by an estimated average of $161 million annually from 2022/23 through 2025/26 to $3.7 billion in 2026/27, equivalent to increasing their annual share of funding from 2.6 percent to 31.6 percent.

INTRODUCTION

Canadian federal governments have a history of involvement in areas of provincial jurisdiction. This is perhaps best demonstrated by their involvement in health and social programs through the Canada Health Transfer (CHT) and Canada Social Transfer (CST), even though the provinces and territories are responsible for delivering health care, education and social programs (*Constitution Act, 1987*).[1] More recently, the Trudeau government has extended its spending power, announcing new programs with the provinces and territories in national pharmacare, dental care, and child care, all of which fall squarely in provincial areas of jurisdiction. It has committed $43.1 billion to the Canada-Wide Early Learning and Child Care Transfer from 2021/22 to 2027/28, and $13.0 billion to the new Canadian Dental Care Plan from 2023/24 to 2027/28 (with $4.4 billion ongoing) (Canada, 2023b). In addition, it has promised to introduce national pharmacare, which could cost an estimated $19.3 billion annually (Parliamentary Budget Officer, 2017).

Put simply, the Trudeau government has committed to significant spending on new programs with the provinces and territories—even beyond the length of its current tenure to 2025. This poses a risk to the provinces and territories, as a new government may have different priorities, and even the priorities of the same government can change under new circumstances. This is particularly true given the current government's ongoing borrowing to finance its high spending. Put simply, the money promised today is not guaranteed and the federal government may reduce or eliminate funding in the future, leaving an unexpected and potentially large financial burden on the provinces and territories to maintain the defunded programs. In this essay we illustrate this risk by reviewing the experiences of the provinces in the 1990s, when the federal government reformed transfers to the provinces in support of health and social programs.

EXAMINING THE CHANGE FROM THE CAP AND EPF TO THE CHST

Since the mid-1960s, there have been three main federal transfers to the provinces and territories in direct support of health and social programs—the Canada Assistance Plan (CAP) and Established

1 The federal government's financial support in areas of provincial jurisdiction is subject to certain conditions. For instance, to receive the Canada Health Transfers without penalty, provinces must comply with the regulations of the *Canada Health Act* (CHA), including its five core principles: public administration, comprehensiveness, universality, portability, and accessibility (*Canada Health Act*, RSC 1985, c C-6, <https://canlii.ca/t/532qv> retrieved on 2023-02-02). These principles, along with other regulations in the CHA, can restrict the provinces from experimenting with policies that have been found to be successful in other universal health care countries. For example, the public administration requirement disallows multiple insurers, and the ambiguity of the wording related to the principle of accessibility can be interpreted to disallow private insurance or direct private payment for core medical services (Esmail and Barua, 2018). The federal government recently announced it would expand health care funding to the provinces and territories by $46.2 billion over the next decade, mainly through an increase in Canada Health Transfers and $25 billion for separate bilateral agreements with the provinces and territories. Funds for the bilateral agreements must go towards four main priorities as set out by the federal government: improved access to family health services, addressing backlogs and supporting the health work force; access to care for mental health and addictions; and providing patients access to their own electronic health information (Trudeau, 2023). The provinces and territories must report how the money is spent and transfers will be contingent on their continued investments in these areas. (Trudeau, 2023).

Programs Financing (EPF); these two programs were later combined into one program, the Canada Health and Social Transfer (CHST).[2]

In 1966, the CAP was introduced as a shared-cost program that paid up to half of the cost of provincial social programs through a federal cash transfer, subject to certain conditions.[3]

In 1977, EPF was introduced to help the provinces fund health care and post-secondary education. It was made up of roughly equal portions of cash and tax point transfers; the latter reflected the value of federal income tax room given over to the provinces (13.5 tax points for personal income tax and one tax point for corporate income taxes).[4]

In the 1960s and 1970s, the federal government incurred persistent deficits. Between 1966/67 and 1995/96, it incurred deficits in all but one year (1969/70) (Finances of the Nation, 2023). Over those three decades, nominal program spending increased almost without exception, and public debt charges consumed an ever-growing share of government resources. The total federal net debt (gross debt minus financial assets) grew from $20.3 billion in 1970/71 to $527.9 billion in 1993/94, at which point debt interest costs consumed roughly $1 in every $3 collected in federal government revenue (Clemens et al., 2017). The government was on the brink of a fiscal crisis.

In October 1993 Jean Chrétien's Liberal government was elected, and in response to these deficit and debt problems, it introduced spending reductions across nearly all federal departments and programs in Budget 1995.[5] This included reducing transfers to the provinces and territories. In 1996/97, it combined the CAP and EPF into a single block transfer, the CHST, which reduced federal transfers to the provinces.[6] The finance minister at the time, Paul Martin, explained that, in part, the reform was intended to put transfers "on a basis that is more in line with the actual responsibilities of the two levels of government" (Martin, 1995: 7).

As shown in figure 1, nominal federal health and social cash transfers were reduced from $18.5 billion in 1995/96 to $14.7 billion in 1996/97. In 1997/98, total nominal cash transfers were further reduced to $12.5 billion, and in 1998/99 they were nominally frozen at that level. Put differently, nominal federal health and social cash transfers to the provinces and territories were reduced by $6.0 billion (or 32.4 percent) over two fiscal years (excluding any inflationary effects).

2 Federal shared-cost programs existed prior to the CAP and EPF. Most notably, there was hospital insurance (1958), Medicare (1968), and the 1967 funding arrangements for post-secondary education.

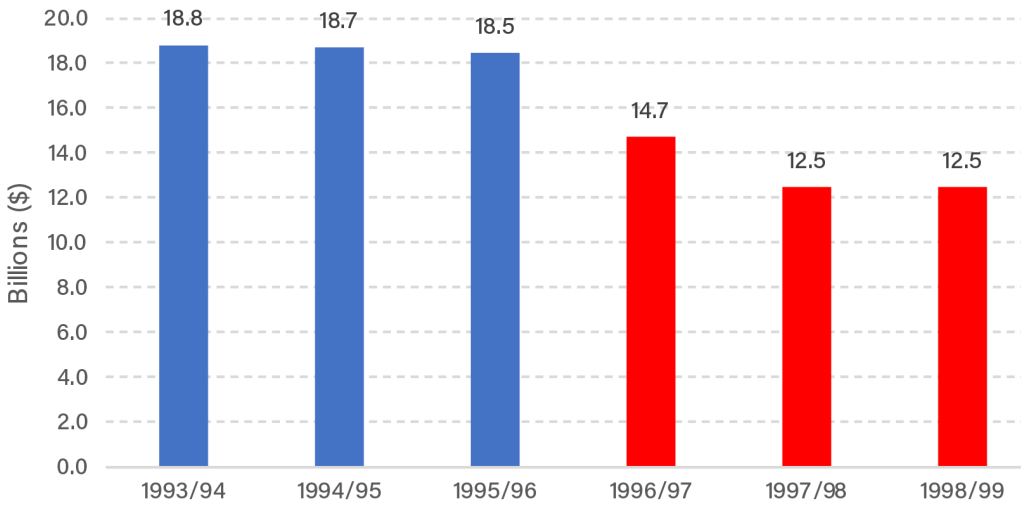
3 Except in Quebec, which received a five-point tax abatement on personal income taxes. There were six conditions for the CAP transfers: accessibility, adequacy, universality, accountability, right of appeal, and right to refuse work.

4 A tax point is a transfer of income tax room from one government to another. In this case, the federal government reduced its tax rates while the provinces increased their tax rates by an equal amount, leaving total federal and provincial tax rates unchanged.

5 For a more detailed analysis of the reforms in Budget 1995, see Clemens et al. (2017).

6 Similar to EPF, the CHST consisted of a cash and tax transfer. While the federal government might argue that tax points should be included in this analysis, the intention of this study is to examine the financial impact from the province's perspective. As the tax points were essentially revenue ceded to the provinces decades earlier, and there was no change in the value of those tax points from EPF to the CHST, there was effectively no reduction in the fiscal room provided to the provinces through tax points. Rather, the financial impact to the provinces was in the form of smaller cash transfers.

Figure 1: Nominal Federal Health and Social Cash Transfers, 1993/94-1998/99, $ billions



* Before 1996/97, federal health and social transfers refer to total CAP and EPF cash transfers.

Source: Canada (2023a).

Table 1: Nominal Federal Health and Social Cash Transfers by Province, 1993/94-1998/99, $ millions

	1993/94	1994/95	1995/96	1996/97	1997/98	1998/99	($) CHANGE 1995/96–1997/98	(%) CHANGE 1995/96–1997/98
BC	2,190	2,235	2,235	1,843	1,724	1,827	-511	-22.9%
AB	1,625	1,504	1,485	1,112	878	894	-607	-40.9%
SK	634	630	632	500	430	433	-202	-31.9%
MB	761	745	737	598	507	507	-230	-31.3%
ON	6,300	6,338	6,215	4,787	3,885	3,810	-2,331	-37.5%
QC	5,571	5,550	5,481	4,512	3,900	3,863	-1,582	-28.9%
NB	510	501	493	401	338	338	-155	-31.4%
NS	638	633	624	508	432	432	-192	-30.7%
PEI	91	89	88	71	61	61	-27	-30.6%
NL	415	423	414	345	283	276	-132	-31.7%

* Before 1996/97, federal health and social transfers refer to total CAP and EPF cash transfers.

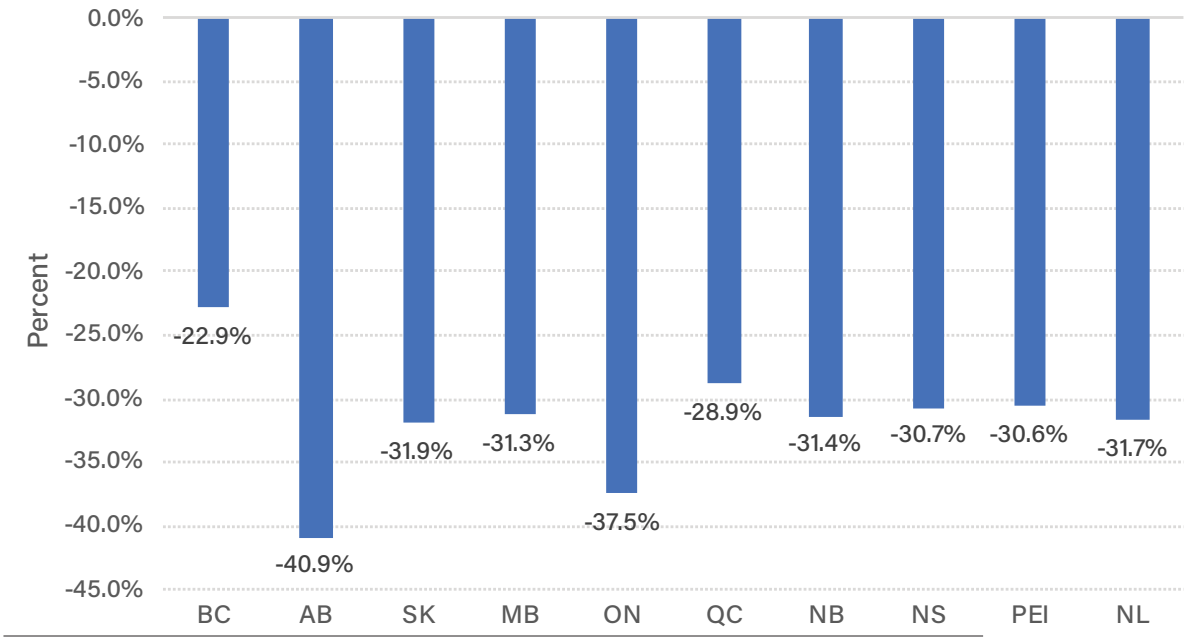
Source: Canada (2023a).

The reduction in federal health and social transfers had an impact on all the provinces. Table 1 shows federal health and social cash transfers by province from 1993/94 to 1998/99, detailing the two-year change from 1995/96 to 1997/98. Over these two years, the reduction in transfers (in nominal terms) ranged from $2.3 billion in Ontario to $27 million in Prince Edward Island.

Figure 2 shows the percentage change in nominal federal health and social cash transfers by province from 1995/96 to 1997/98. In most of the provinces, federal health and social cash transfers were reduced by nearly one-third over two fiscal years; in Alberta it was as much as 40.9 percent, and in Ontario it was 37.5 percent. Even in the province with the smallest percentage point change, British Columbia, transfers were reduced by 22.9 percent over the two-year period.

This change occurred during a time when many provinces were also facing fiscal challenges due to their own routine deficits and debt accumulation. Figure 3 shows federal health and social cash transfers as a share of provincial revenue in the four largest provinces from 1993/94 to 1998/99. Over the period, federal health and social cash transfers to Ontario, for example, fell from 13.4 percent to 6.8 percent of provincial revenues. In Alberta, those transfers declined from 11.7 percent of total revenues to less than 5.0 percent. This represents a significant reduction in financial support from the federal government, during a time when many provinces were trying to rein in their own spending and balance

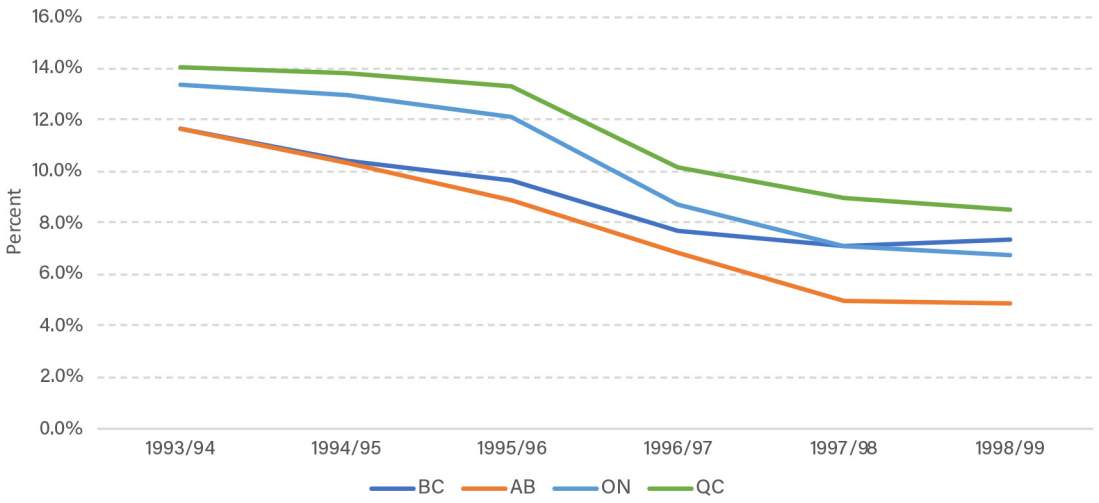
Figure 2: Change in Nominal Federal Health and Social Cash Transfers, by Province, 1995/96-1997/98



* Before 1996/97, federal health and social transfers refer to total CAP and EPF cash transfers.

Source: Canada (2023a).

Figure 3: Federal Health and Social Cash Transfers as a Share of Provincial Revenue, 1993/94-1998/99



* Before 1996/97, federal health and social transfers refer to total CAP and EPF cash transfers.
Sources: Canada (2023a); Finance of the Nation Project (2023); calculations by authors.

their budgets (Clemens et al., 2017). This is not to say that the CHST reform was negative, but rather to emphasize the significant financial impact on the provinces.[7]

As this section demonstrates, federal governments can change their priorities in the face of new circumstances. In 1990s, Ottawa's deficit and debt problems led to a sudden and sizeable reduction in federal health and social transfers, which reduced the amount of money provinces received from Ottawa to help provide health and social programs.

ESTIMATING THE TRUE FINANCIAL IMPACT OF THE CHST REFORM

While our overview of the reduction in federal health and social transfers is useful, it may understate the financial strains placed on the provinces. For a more comprehensive look at the financial impact of the reforms, it is helpful to compare actual federal health and social cash transfers with what they would have been had EPF and the CAP continued. In addition, in an effort to reduce the deficit,

7 The CHST reform had many positive impacts. Not only did moving away from the CAP formula remove perverse incentives for the provinces to spend more in order to receive more federal transfers, the CHST removed many of the strings attached to CAP transfers, including that the provinces provide social assistance to all who demonstrated need and prohibiting any requirements for recipients to work in order to receive transfer payments (Clemens, 2011). Ultimately, this change allowed provinces to experiment with policy reforms, such as tighter eligibility rules and increased emphasis on diverting people able to work from welfare to employment. This led to a wave of innovation that helped reduce the number of Canadians on welfare from a high of 3.1 million in 1994 to a low of 1.6 million in 2008 (Lafleur et al., 2021). However, the terms and conditions for EPF transfers set under the *Canada Health Act* remained in place under the CHST, and there was not a similar wave of innovation in health care. For more information about the broader impact of these reforms, see Esmail and Barua (2018), Lafleur et al. (2021), Clemens et al. (2017), and Watson and Clemens (2020).

the Progressive Conservative Party led by Brian Mulroney had already introduced changes to the CAP and EPF in 1990/91, which reduced transfer payments even before the CHST reform in 1996/97 (Gauthier, 2012).

The CAP originally paid up to half of the cost of provincial social programs, which meant the annual amount varied directly with provincial government's spending on public assistance. However, in 1990/91, the federal government limited the CAP's annual growth for the non-equalization-receiving provinces (British Columbia, Alberta, and Ontario) to 5 percent annually from 1990/91 through 1994/95 (Canada, 1990).[8] Further, in 1995/96, the government froze the CAP for all provinces and territories at 1994/95 levels (Canada, 1995) (recall, the CHST reform was introduced in Budget 1995 but not implemented until the following fiscal year, in 1996/97).

The EPF was initially calculated per capita[9] and adjusted annually using an escalator that accounted for the growth in gross national product per capita,[10] but the government froze the per capita transfer from 1990/91 through 1994/95. Then, in 1995/96, growth in EPF was limited to growth in the gross national product minus 3 percent.

Together, these changes significantly reduced the amount of cash transfers to the provinces and territories—even before the CHST reform—compared with what they could have expected based on the transfers before 1990.

Figure 4 shows actual nominal federal health and social cash transfers and "projected" transfers from 1980/81 to 1998/99. We calculated projected cash transfers starting in 1990/91, using historical growth rates for each province. Specifically, projected CAP transfers for non-equalization-receiving provinces are estimated using the average growth from the previous 10 years (1980/81 to 1989/90). Projected CAP transfers for equalization-receiving provinces are also estimated using the average growth rate over the previous 10 years; however, the projections do not begin until 1996/67, when the changes for equalization-receiving provinces started.[11] For the EPF, projections are estimated using a five-year average growth rate (from 1985/86 to 1989/90). The five-year average is used rather than the 10-year average because there were some changes to the EPF in 1985. While these are rough estimates, they are reasonable in terms of nominal health and social transfers the provinces could have expected before the reforms in the 1990s, based on historical EPF and CAP transfers.

As shown in figure 4, total nominal CAP and EPF cash transfers were between $550 million (1990/91) and $4.8 billion (1995/96), lower than projected cash transfers before the main CHST reform. As the CAP

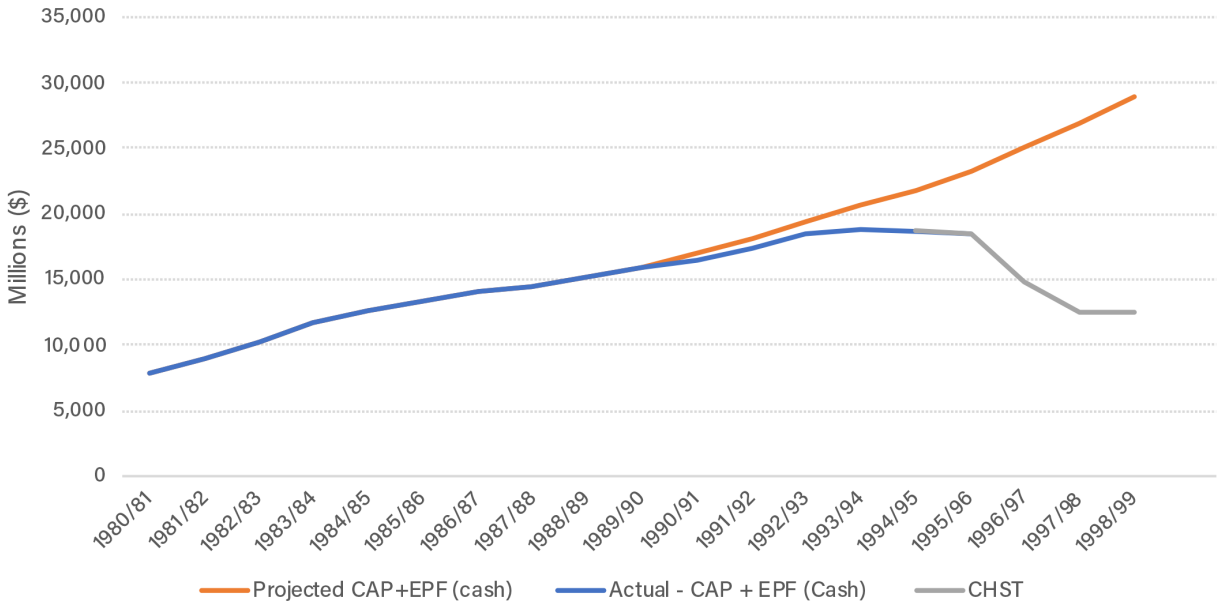
8 This reduced CAP transfers to the three provinces by approximately $900 million in two fiscal years (Canada, 1991). The change was clearly important for the provinces as British Columbia, with the support of Alberta, Manitoba and Ontario, challenged the legality of amendment. Ultimately, the Supreme Court of Canada determined that the change was legal (Reference Re Canada Assistance Plan (B.C.), [1991] 2 S.C.R. 525).

9 Based on 1975/76.

10 The escalator used to calculate EPF transfers was more complicated than simply adjusting for gross national product per capita, particularly as it involved interactions with tax points.

11 Using the average growth rate from 1986/87 to 1994/95.

Figure 4: Nominal CAP, EPF, and CHST Cash Transfers, Actual and Projected, 1980/81-1998/99, $ millions



Sources: Canada (2023a); calculations by authors.

and EPF were replaced by the CHST in 1996/97, the gap between actual and projected federal health and social transfers increased. More specifically, actual nominal cash transfers were $10.2 billion (or 41 percent) lower than projected cash transfers in 1996/97, $14.4 billion (or 53 percent) lower in 1997/98, and $16.4 billion (or 57 percent) lower in 1998/99.[12] This represents a cumulative shortfall of $41.0 billion, or 51 percent, over the three-year period.

In summary, historical experience shows that the federal government could significantly reduce funding to the provinces and territories under any new (or existing) programs relative to what it initially promised. Such changes, given the size of the transfers to the provinces and territories, represent real, material financial risks to the provincial and territorial governments.

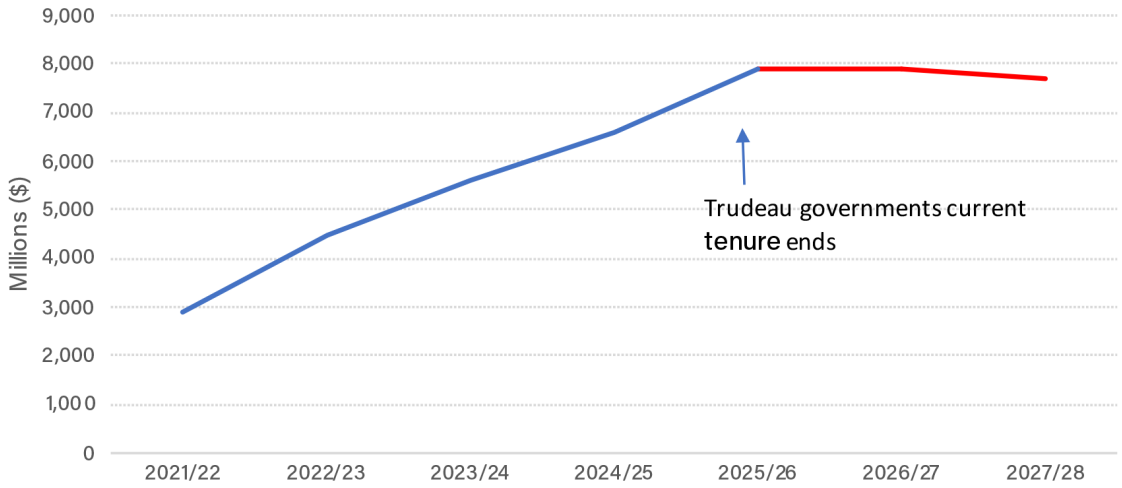
THE CANADA-WIDE EARLY LEARNING AND CHILD CARE TRANSFER: A BRIEF CASE STUDY

One of the programs introduced by the Trudeau government is the Canada-Wide Early Learning and Child Care Transfer, which is a shared-cost program to support the provinces and territories in delivering $10-a-day child care. The government has provided full cost estimates for this program to 2027/28—it has committed a total of $43.1 billion from 2021/22 to 2027/28, which extends beyond its current tenure of 2025 (figure 5).

The Financial Accountability Officer of Ontario (Ontario, 2022a) assessed the financial risk to the Ontario government should the next federal

12 As fiscal pressures eased, federal transfers began to increase in Budget 1999 (Canada, 1999).

Figure 5: Planned Nominal Federal Spending on Canada Wide Early Learning and Child Care, 2021/22-2027/28, $ millions



* 2023/24 and beyond are budget projections

Source: Canada (2023b).

government choose not to renew and/or maintain the program, which provides a useful case study.

Ottawa has committed $10.2 billion to the Ontario government from 2022/23 through 2025/26 for this initiative, and the province has committed to contributing $268 million over the same period. In other words, the federal government has committed to 97.4 percent of the total funding for this program, which, notably, is much more than its previous commitments for health care and social programs.

While the Trudeau government expressed its intention to renew the agreement (which expires in the final year of its current tenure) with a minimum level of funding of $2.9 billion in 2026/27, the FAO estimated that Ontario would need $1.2 billion (on top of the $128 million it had already committed) in 2026/27 and $4.3 billion in 2027/28 to maintain the program (Ontario, 2022a). Put differently, beyond the risk that a new federal government might eliminate or reduce funding for the program, Ontario already has a committed-funding shortfall of $1.2 billion in 2026/27 and $4.3 billion in 2027/28. Based on current projections (Ontario, 2022b), that $1.2 and $4.3 billion could be the difference between budgetary surpluses or deficits, which means the province would face the difficult decision of either to take on the unexpected financial burden at the expense of the provincial finances, or to curtail the program.[13]

13 The FAO also projected that the provincial supply of $10-a-day child care spaces would be insufficient to meet expected demand in 2026, which would place even more pressure on Ontario to continue and expand the program. It said, "The FAO estimates that by 2026, Ontario families of approximately 602,257 children under age six will wish to have access to $10-a-day child care. With only 375,111 $10-a-day licensed child care spaces planned, the families of 227,146 children under age six (25 per cent of the projected under age six population of 919,866 children in 2026) would be left wanting but unable to access $10-a-day child care" (Ontario, 2022a).

Using the Ontario case study, it's possible to estimate the potential financial shortfall in 2026/27 for all the provinces and territories. The Ontario government expects to spend $128 million, or 4.4 percent, of what the federal government projects it will spend on early learning and child care in Ontario ($2.9 billion) in 2026/27. Ontario's projected shortfall in funding ($1.2 billion) represents 41.9 percent of the committed federal government spending ($2.9 billion) in 2026/27.

To estimate the potential financial shortfall for all the provinces and territories in 2026/27, we applied the ratios found for Ontario to federal funding for the remaining provinces and territories (excluding Ontario) that year, which is estimated to be $5 billion. Based on Ontario data, the provinces' and territories' potential funding shortfall would be $3.3 billion in 2026/27. Including their existing estimated provincial and territorial funding, the provinces and territories would need to increase their collective funding for the Canada-Wide Early Learning and Child Care program from an estimated average of $161 million annually (2022/23 through 2025/26) to an estimated $3.7 billion (2026/27).[14] That is equivalent to the provinces and territories increasing their share of total federal and provincial/territorial funding for the program from 2.6 percent in 2022/23 to 2025/26, to 31.6 percent in 2026/27.

The risk that the federal government could reduce or eliminate funding for provincial programs is heightened by the fact that its finances have deteriorated significantly over the past decade, similar to the circumstances that led to the reduction in transfers in the 1990s. It has run uninterrupted deficits since 2007/08, and its total gross debt has increased from $692.3 billion in 2007/08 to a projected $1.9 trillion in 2023/24 (Canada, 2023b). Also similar to the 1990s, rapidly rising interest rates—part of a monetary policy designed to curb inflation—will put additional pressure on the federal government to get its fiscal house in order.

CONCLUSION

The current federal government has committed to significant new funding to support new provincial programs, including day care, dental care, and pharmacare. However, different governments have different priorities, and the promises of one government may not hold up under new circumstances or leadership. The provinces should exercise caution when entering into such financial agreements because, as history has shown, the federal government could reduce or eliminate funding, leaving them with a heavy, unexpected financial burden. The current state of federal finances only heightens this risk.

14 Again, this assumes that all provinces spend the same ratio of provincial/territorial to federal funding calculated for Ontario in 2026/27 (4.4 percent). While the ratio of provincial to federal funding varies by province, the federal government has committed to close to 100 percent of funding for a majority of the provinces and territories through their individual Early Learning and Child Care Agreements. This does not include separate agreements or other existing provincial/territorial funding or programs for early learning and child care. See Canada (2023c) for each provincial agreement.

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