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Federal Transfers to Ontario

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The substantial injection of federal funds in the wake of COVID-19 has emphasized the importance of federal transfers to the provinces and territories, and reignited conversations about fiscal federalism in Canada. This paper provides an overview of federal transfers to Ontario, their evolution over time, and proposals for reform.

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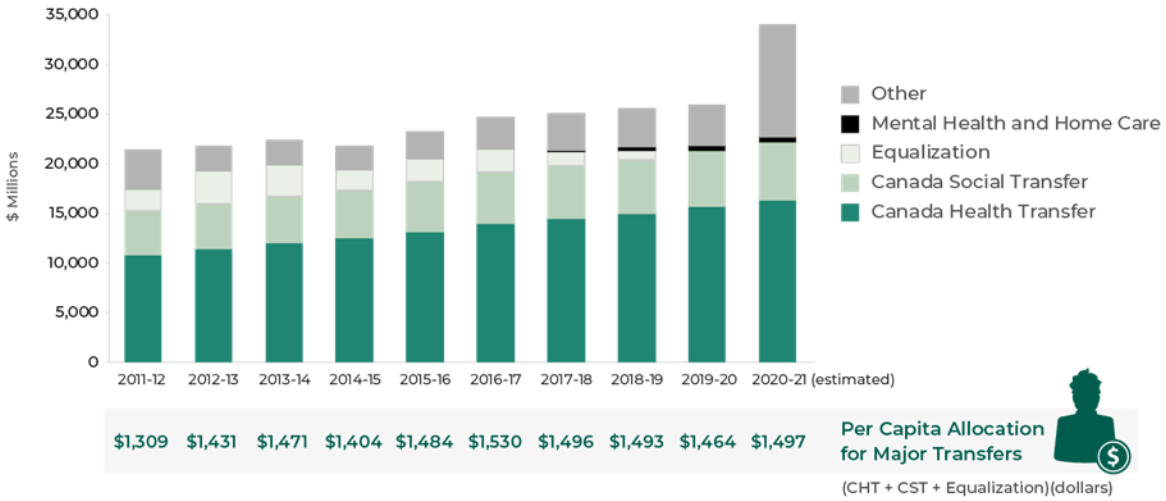
Introduction

The federal government allocates funding to provincial and territorial governments through a series of annual transfers, including the Canada Health Transfer (CHT), the Canada Social Transfer (CST), and equalization payments. In 2020-21, federal transfers to Ontario are estimated at $33.4 billion, representing over 22% of Ontario's total revenue.[1] This paper provides an overview of federal transfers to Ontario, their evolution over time, and proposals for reform.

The federal government has virtually no limitations on its ability to impose taxes or spend. In contrast, provinces and territories have more limited revenue tools, despite being required to provide high-cost public services such as health care and social services. Some provinces and territories also have more limited ability to raise revenue than others, due to fewer natural resources or a tax base that generates lower taxes per person. These various "fiscal imbalances" underpin the need for federal transfers in Canada.[2]

FIGURE 1:
FEDERAL TRANSFERS TO ONTARIO, 2011-12 TO 2020-21



Source: Department of Finance Canada. Graphic by Legislative Research.

Current transfers

Canada Health Transfer

The Canada Health Transfer (CHT) is an annual block grant for health services. The federal government does not control or audit how the provinces and territories spend the CHT; however, payments are conditional on jurisdictions upholding the universal health care principles of the *Canada Health Act* (universality, comprehensiveness, portability, accessibility, and public administration). Provinces and territories also face deductions if they allow extra-billing or user charges for medically necessary services, though Ontario has not faced any deductions since the *Canada Health Act* was fully implemented.[3]

The escalator for the national envelope (funding stream) is presently based on a three-year moving average of nominal GDP growth (approximately 4% to 5% per year prior to COVID-19), with a guaranteed minimum increase of 3% per year. The national envelope is distributed between provinces and territories on an equal, per capita basis.

Recent changes to the CHT funding formula

From 2006-07 to 2016-17, the CHT escalator was set at 6% per year. Changes were made to the CHT following completion of bilateral health funding agreements with provinces and territories in 2017. Coinciding with the decrease in the escalator, the federal government introduced new payments for home & community care and mental health & addictions, valued at $4.2 billion for Ontario over 10 years.4 The CHT, along with other major transfers, will be reviewed in 2024.

Canada Social Transfer

The Canada Social Transfer (CST) is an annual block grant for post-secondary education, social assistance, social services, and early learning and childcare. Jurisdictions are entitled to the full share of the transfer as long as they allow Canadian citizens, permanent residents, or accepted refugees to receive social assistance without a waiting period. There is also a requirement that provinces and territories work collaboratively on shared principles and objectives for social programs.

The CST escalator is set at 3% per year and the national envelope is distributed to provinces and territories on an equal, per capita basis.

Recent Changes to the CST Funding Formula

The 3% escalator has been in place since 2009–10. Prior to that point, CST increases varied from year-to-year.

Equalization

Equalization is an unconditional transfer for provinces that have a limited ability to generate revenue from their tax base or natural resources. It is the only transfer required under the Constitution. Ontario was eligible for equalization payments from 2009-10 to 2018-19, but no longer receives them.

The escalator for the national envelope is based on a three-year moving average of nominal GDP growth. To determine how the envelope is divided, the equalization formula, in simple terms, compares what each province would generate per capita if each had identical tax rates, which is added to a portion of each province's resource revenues. Provinces with lower per capita revenues compared to the national average receive payments to make up the difference. (Territories receive separate transfers under the Territorial Funding Formula program.)

Recent changes to the funding formula

The annual escalator for equalization has been tied to GDP growth since 2009-2010. Prior to that year, there was no maximum or minimum amount for annual equalization payments. The current equalization arrangement is in place for a five-year period (2019 to 2024).

Other transfers

Ontario also receives a number of smaller transfers from federal departments for specific programs and services. These include transfers for labour market programs, infrastructure, social housing, and early learning and childcare, among other areas (see Figure 2 below).

In 2020-21, the federal government provided approximately $7 billion to Ontario in one-time funding for COVID-19, the majority as a single transfer under the bilateral Safe Restart Agreement.

The federal government has also provided a number of time-limited transfers. Previous transfers have included the Wait Times Reduction Transfer ($5 billion over 10 years starting in 2004) which followed provincial-territorial commitments to establish benchmarks and report on health care wait times, and the Health Reform Transfer ($16 billion over five years starting in 2003) for primary care, home care, and catastrophic drug coverage.

FIGURE 2:
FEDERAL TRANSFERS TO ONTARIO, 2019-20 TO 2021-21
($ MILLIONS)

Transfer	2019-20	2020-21*	Annual Increase
Canada Health Transfer	$15,640	$16,252	3.9%
Canada Social Transfer	$5,650	$5,832	3.2%
Labour Market Programs**	$1,054	$1,091	3.5%
Social Housing	$484	$331	(31.6%)
Home & Community Care	$175	$232	13.4%
Mental Health & Addictions	$251	$251	No change
Direct Transfers to Hospitals, School Boards and Colleges	$414	$407	(1.7%)
Infrastructure	$400	$1,013	153.3%
Other (includes funding for COVID-19, early learning and childcare, First Nations child welfare services, bilingualism development, legal aid, and youth criminal justice)	$1,330	$7,951	497.8%
Total	**$25,398**	**$33,360**	**31%**

Source: *Public Accounts of Ontario 2019-20* and *2020 Ontario Budget*.

*2020-21 figures are estimates.

**Includes two federal transfer payments known as the Labour Market Development Agreement (LMDA) and the Workforce Development Agreement (WDA).

History

Federal transfers to Ontario have grown significantly over time, even after adjusting for inflation. According to data by the non-partisan Finances of the Nation project, total federal transfers to the province increased from $141 per capita in 1957 to $1,803 per capita in 2018 (both figures in inflation-adjusted 2019 dollars).[5]

Despite growth in inflation-adjusted terms, the proportion of federal funding relative to total provincial revenue has declined in recent years. Federal transfers as a percentage of provincial revenue declined from 22.1% in 2010/11 to 16.3% in 2019/20.[6] While one-time COVID-19 funding will push the federal share of provincial revenues back up to 22.1% in 2020/21, government projections show the rate will fall back to 17.2% by 2022-23.[7]

Key developments

A 2020 report from the University of Toronto characterizes the history of federal transfers as a process of incremental evolution based on "piecemeal rather than systemic change."8 The list below highlights key changes since Confederation.

- **From Confederation to 1945,** federal transfers included fixed amounts for government operations, as well as a per capita amount. The federal government also assumed a portion of provincial debt and provided a mix of grants depending on provincial needs. Over this period, transfers became increasingly unequal in their distribution across provinces.[9]
- **From 1945 to 1957**, the federal government increased transfers and the tax room given to provinces significantly, and established transfers for health and education. The equalization program was also formally established in 1957.[10]
- **From 1957 to 1976**, the federal government provided separate transfers for social assistance, postsecondary education, hospital insurance, medicare, and equalization. With the exception of equalization, these transfers were conditional cost-sharing grants which involved rigorous reporting and auditing by the federal government.[11] This included a 50/50 cost-sharing formula for hospital care and medical insurance.
- **From 1977 to 1995**, transfers included a new cost-shared Canadian Assistance Plan (for social assistance), a block grant known as Established Program Financing (for health and postsecondary education), and unconditional equalization grants. In 1977, the federal government also decreased the federal income tax rate to allow for an equivalent increase in the provincial income tax rate (described below).[12] The introduction of block grants, a more flexible form of funding for provinces and territories, represented a shift away from conditional cost-sharing grants.
- **From 1996 to 2003**, health and social transfers were combined in a single block grant known as the Canadian Health and Social Transfer (CHST). Annual allocations were determined on a multi-year basis, instead of being based on an annual escalator. Approximately two-thirds of the CHST was for health, with approximately one-third for social services.[13]

- **From 2004 to 2017,** the health and social transfers were separated into their current form as the CHT and CST, following the 2003 and 2004 health accords. During this time, the federal government also started using federal trusts (described below) to disburse funding for specific priorities.[14]
- **In 2017**, tax transfers were fully phased out of the health and social transfers (see below). Additionally, the CHT was renegotiated through a series of bilateral agreements with provinces and territories, following a breakdown in negotiations over a new 10-year health accord.

Phase-out of tax transfers

In 1977, the federal government decreased the federal income tax rate to allow for an equivalent increase in provincial income tax rates, thereby giving provinces "tax points." In the years following, the federal government adjusted the health and social transfers based on these tax points, which provided extra funding to provinces and territories with lower than average tax revenues (sometimes called "associated equalization"). However, this practice ended in 2007-08 (for the CST) and 2013-14 (for the CHT).

Today, all provinces and territories receive equal per capita cash shares of the national CHT and CST envelopes without adjustments.

Shift to block funding

As noted above, health and social transfers in the 1950s and 1960s were conditional cost-sharing grants involving rigorous reporting and auditing by the federal government. The shift to the current system of block grants for health and social services allows for flexible spending and program design, with conditions tied to high-level principles. According to the Department of Finance Canada, the current transfer system is focused on making provincial-territorial governments accountable, "to the public, rather than to other levels of governments."[15]

Use of trusts to disburse funding

The Department of Finance Canada started using trusts to disburse money to provinces and territories in 1999, requiring that jurisdictions publicly disclose criteria for how the funds will be used, and that recipient organizations agree to special conditions to receive funds from the trust.[16]

Commonly employed between 1999 and 2010, trusts appear to have fallen into disuse. Canada's Auditor General has noted that provinces and territories were permitted to establish their own eligibility requirements to draw funds from trusts and there is no legal authority for the federal government to withhold funds. This means that trusts are ultimately similar to the traditional types of transfers.[17]

Proposed reforms

Federal transfers are a perennial source of debate in Canada. Various proposals for reform have been tabled in recent years, such as adjusting the mix of federal-provincial spending, changing the equalization formula, and increasing provincial-territorial accountability over spending.

Adjusting the mix of Federal-Provincial spending

In 2019-20, the CHT represented approximately 25% of Ontario health sector spending, compared to 21% in 2011-12. Despite this trend, the Financial Accountability Office of Ontario projects future federal health transfers "will not keep pace with the anticipated upward pressure of health care cost drivers."[18] In light of this, Canada's premiers recently called on the federal government to increase the CHT to cover 35% of provincial health care costs.[19]

However, some commentators note the debate over the CHT is muddled by "disagreements about numerators and denominators."[20] For example, a 2020 report by the Parliamentary Budget Officer notes the CHT actually supports approximately 32% of provincial-territorial health spending, when compared to the types of health care services specified in the *Canada Health Act* (e.g., hospital care and medical insurance), rather than total provincial health spending.[21] It has also been argued that the federal government's transfer of tax points in 1977 (described above) provides an ongoing source of revenue for provinces but is not accounted for in the cash amounts provinces and territories receive.[22]

In contrast to the CHT, the CST represents approximately 12% of current provincial social spending, a decrease of less than 1% since 2011-12.[23]

Reforming the Equalization formula

The Parliamentary Budget Officer notes that changes to the equalization escalator in 2009-2010 (which fixed growth in total equalization funding to the rate of GDP growth) resulted in $8.1 billion less for Ontario than the province would have received, based on the previous formula.[24]

While changes to the escalator only matter to provinces that receive equalization, some experts have called for changes to the equalization formula itself. A 2018 report by the Mowat Centre argues that Ontario faces a "fiscal gap" because Ontarians have contributed more towards federal revenues (including federal taxes paid) than they have received in federal transfers and program spending. This is partly because the current equalization formula compensates provinces that have a more limited ability to raise revenue, but does not recognize provinces with higher expenditure requirements. This includes higher costs resulting from demographics and prices. According to the report, if equalization payments recognized these differences, Ontario would receive a greater share of federal payments, which would help narrow the gap between what Ontario's taxpayers pay into the program and what the federal government transfers back.[25]

Treatment of resources revenues in the equalization formula

The most contentious feature of the equalization formula is the treatment of natural resource revenues.[26] Since 2007, the equalization formula has included 50% of each province's resource revenues. Previously, the formula included 100% of each province's resource revenues except for Alberta's due to its large oil and gas revenues. Changes in the inclusion rate have a substantial impact on what a province receives: for Ontario, which has comparatively low natural resource revenues, the higher the percentage, the higher its potential equalization entitlement is in any given year.[27] In 2012, the Commission on the Reform of Ontario's Public Services (Drummond Commission) recommended that resource revenues be fully captured in the equalization formula.[28]

Tying funding to performance

As noted above, health and social transfers have evolved from conditional cost-sharing grants in the 1950s and 1960s to a more flexible form of block funding. However, many commentators argue that the federal government should use transfers to drive improvements to performance and outcomes.

For example, a 2012 Senate Committee recommended that increases in the CHT should, "be used by governments in great part to establish incentives for change … including the need for measurable goals, timetables and annual public reporting."[29] In December 2020 it was reported the Prime Minister was considering new federal funding that would be "specifically tied to improving conditions in long-term care homes" in light of COVID-19.[30]

The bilateral health agreements for home care and mental health services signed in 2017 represent a step toward an increased level of accountability, though one built on collaboration rather than punitive measures. For example, the bilateral agreements set out details of how federal investments will be used to improve access to care, and also required the collaborative development of pan-Canadian indicators. A 2019 report by the Canadian Institute for Health Information notes that, as a result of these agreements, Canadians now have more access to information on home care and mental health services, though "it will take time for improvement efforts to be reflected in the indicators."[31]

Moving to a needs-based allocation formula

As noted above, both the CHT and CST are distributed to provinces and territories on an equal per-capita basis. A 2014 article in *Canadian Public Policy* argues that, in the case of the CHT, this formula fails to compensate provinces and territories that face higher health care costs due to demographics and wide geographical dispersion. As a result, the authors propose a "modified capitation formula" that adjusts for such cost factors.[32]

Conclusion

The substantial injection of federal funds in the wake of COVID-19 has emphasized the importance of federal transfers to the provinces and territories, and reignited conversations about fiscal federalism in Canada. With the major transfers up for renegotiation in 2024, expect discussions to focus on the expanding role of the federal government in child care, reforms to the equalization formula, the federal-provincial balance in health care funding, and whether the federal government should use the "power of the purse" to enforce national standards in long-term care.

Notes

[1] Figures from *2020 Ontario Budget*.
[2] Gregory Marchildon and Haizhen Mou, "A Needs-Based Allocation Formula for Canada Health Transfer," *Canadian Public Policy* (September 2014), pp. 209-10.
[3] Health Canada, Canada Health Act - Annual Reports.
[4] See Canada-Ontario Home and Community Care and Mental Health and Addictions Services Funding Agreement (March 2017).
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[6] Jonah Goldberg and Sean Speer, "Reforming Canadian Fiscal Federalism: The Case for Intergovernmental Disentanglement," Ontario 360 Policy Papers (November 2020).
[7] *2020 Ontario Budget* Estimates.
[8] Goldberg and Speer.
[9] Trevor Tombe, "Final and Unalterable – But Up for Negotiation: Federal-Provincial Transfers in Canada," *Canadian Tax Journal* (2018) 66:4.
[10] Ibid.
[11] Department of Finance Canada, History of Health and Social Transfers.
[12] Odette Madore, The Transfer of Tax Points to Provinces Under the Canada Health and Social Transfer, *Library of Parliament* (October 1997).
[13] Finance Canada, "History."
[14] Ibid.
[15] Finance Canada, "History."
[16] See for example, Ontario Ministry of Health, Federal Medical Equipment Trust Fund - Ontario's Share Report for the 2000-01 and 2001-02 Fiscal Years (April 2003).
[17] Ibid.
[18] Financial Accountability Office of Ontario, Health Sector Update (March 2018).
[19] The Council of the Federation, Canada's Premiers Reiterate Priorities (September 2020).
[20] C. David Naylor, Andrew Boozary, and Owen Adams, "Canadian federal–provincial/territorial funding of universal health care: fraught history, uncertain future," *Canadian Medical Association Journal* (November 2020).
[21] Office of the Parliamentary Budget Officer, Federal Support Through Major Transfers to Provincial and Territorial Government (September 2020), p. 3.
[22] Odette Madore, "The Transfer of Tax Points to Provinces Under the Canada Health and Social Transfer," *Library of Parliament* (October 1997).
[23] Parliamentary Budget Officer, "Federal Support," p. 5.
[24] Ibid.

[25] Erich Hartmann, Jordann Thirgood and Andrew Thies, "A Fair Fiscal Deal Towards a more principled allocation of federal transfers," Mowat Centre (July 2018), p. 12.
[26] Erich Hartmann, "Ontario, Oil, & Unreliable Data: The Complex Problems Confronting Equalization and Simple Solutions to Address Them," Mowat Centre (June 2017), p. 19.
[27] Bev Dahlby, "Reforming Equalization: Balancing Efficiency, Entitlement and Ownership," University of Calgary, The School of Public Policy, *SPP Research Papers*, 7:22 (September 2014), p. 22.
[28] Don Drummond, "Commission on the Reform of Ontario's Public Services," (February 2012), p. 453.
[29] K.K. Ogilvie and A. Eggleton, "Time for transformative change: A review of the 2004 health accord," *Standing Senate Committee on Social Affairs, Science and Technology* (March 2012).
[30] Joan Bryden, "No funds for provinces that don't agree to improve long-term care standards, PM hints," *Toronto Star*, December 16, 2020.
[31] Canadian Institute for Health Information, New data available on home care and mental health.
[32] Marchildon and Mou.