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Introduction

There is and can be no final solution to the allocation of financial resources in a federal system. There can only be adjustments and re-allocations in the light of changing conditions. What a federal government needs, therefore, is machinery adequate to make these adjustments.

- K.C. Wheare

The purpose of this paper is to present funding arrangements used by the Canadian federal government in the area of social policy as of early 2004. This is of interest since all national parties that contested the June 2004 federal elections have promised to modify them by varying amounts, purposes, conditions and so on. This paper should be useful in assessing the changes effectively put in place after the election. The first section of this paper provides a brief history of intergovernmental transfers in that area in Canada from the end of the Second World War until 1996. The second section provides a detailed look at federal funding for activities related to children, health care, post-secondary education and welfare since 1997. The last section addresses the issue of conditions. We do not examine equalization or conditional cost sharing transfers in the area of agriculture, legal aid, official languages, social housing and so on.[1]

1. Federal-Provincial Conditional Transfers for Education, Health and Welfare in Canada, 1945-1995

This brief history of federal-provincial conditional grants puts the emphasis on the determinants of past choices that affect current policies.[2] Traditionally, these grants were used by the federal government to intervene in areas of provincial jurisdiction; this is the so-called spending power of the federal government.

* We thank Bill Robson for asking us to work on this topic and France St-Hilaire, Alain Noel and John Richards for comments on a previous version.

[1] On these small transfers, see Vaillancourt (2000)

[2] For more background information, see Hobson and St-Hilaire (2000)

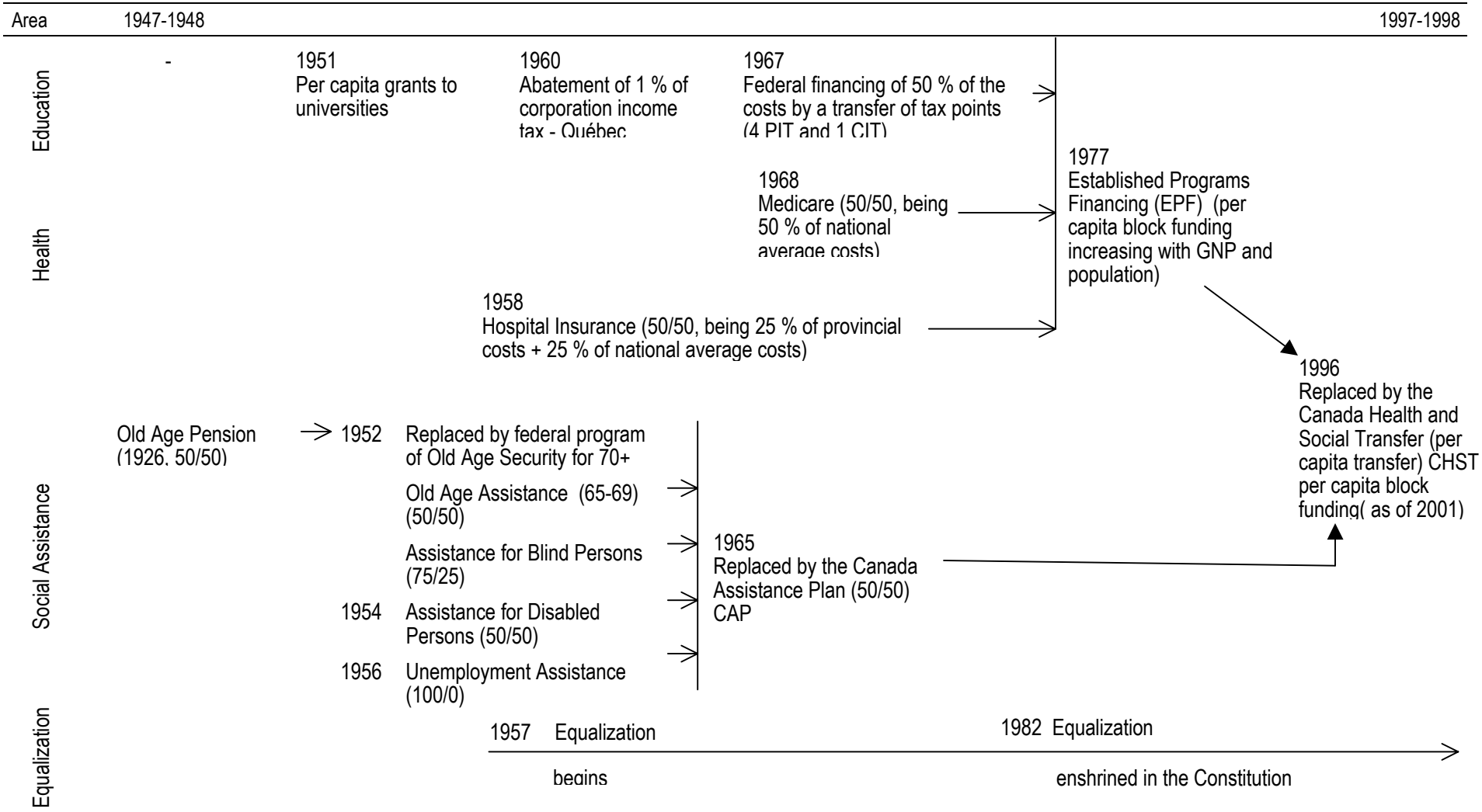
Before 1945, there had been a few conditional grants in areas such as agricultural education and roads (Turgeon and Vaillancourt 2002), but only one major program; instituted in 1926, the Old Age Pensions Act provided for 50/50 funding by the federal government and the provinces of old age pensions for eligible residents aged 70 and over.

Table 1 presents a chronology of federal-provincial transfers and major shared-cost programs from1947, when post WWII financial arrangements began to be put in place, until 1996. The main points are:

- The 1950s and 1960s witnessed the introduction of conditional grants and federal-provincial cost-sharing programs for hospitals, health insurance, post-secondary education (PSE) and welfare (transfers and services). Conditional transfers and shared-cost programs allowed Ottawa to impose some national standards in the areas of health and welfare (Canada Assistance Plan-CAP) with the provincial governments being required to abide by federal criteria as a condition for receiving federal funding.
- The 1970s, 1980s and 1990s saw: (1) a replacement of the health and PSE cost-sharing programs by block grants called Established Programs Financing-EPF (1977, with amounts set unilaterally by the federal government albeit after discussions with the provinces, not linked to spending levels and paid out on an equal per capita basis as of 1982 across provinces) in the 1970s; (2) a unilaterally decided reduction in real terms of the envelope of the EPF in the 1980s; and (3) a replacement of this block grant by a larger one, the Canada Health and Social Transfer (CHST) encompassing CAP, the last major cost-shared program, in the mid 1990s.

Provinces progressively re-occupied the Personal Income Tax (PIT) field they had rented out to Ottawa during WWII, beginning in 1954 with Québec's decision to re-introduce its PIT. This was followed by a gradual ceding to all provinces of PIT room by Ottawa in the early 60s (see Bird and Vaillancourt, 2002 for a detailed description of these changes). In 1965, Québec and Ottawa negotiated a special abatement (opting/contracting out) by which Québec receives additional PIT room upon which to levy its PIT (own base and rates) in exchange for less federal transfers but with a compensatory mechanism ensuring that it neither gains nor loses financially from this choice. In 1977, Ottawa carried out its last ceding of PIT tax room to the provinces when EPF was implemented. Changes in the occupation of tax fields was accompanied by the introduction of Equalization in 1957, constitutionally protected in 1982, which enhances the capability of poorer provinces to pay their share of the costs of these programs.

TABLE 1
Chronology of the Evolution of Major Transfer Programs in Canada: Education, Health, Social Assistance and Equalization, 1947-1996



Source : Authors. Note : Cost sharing is listed as (% federal/% provincial)

Why did these events unfold as they did? Various reasons can be evoked:

- There was a greater belief, at least amongst federal policy-makers, in the need for an important role of the federal government in society after 1945 than before. This came about through the interaction of the awareness of the high costs (lost output, unemployment) of relative governmental inaction during the Great Depression, the acceptance of the ideas of John Maynard Keynes on the role of (central) governments in stabilizing the economy, and the perceived need for a greater role of government in combating economic inequalities.
- There were greater means available to the federal government. In 1933, the federal government accounted for 42% of all own-source government revenues, provincial governments for 18%, and local governments for 40%.[3] At the end of World War II (1945), however, the federal government was collecting 82% of all revenues. By 2000, these percentage shares had become 44%, 45% and 11%, respectively (Bird and Vaillancourt, 2002). Simultaneously, the importance of government revenues in GDP doubled over the 1933-2000 period.

From 1946 to 1974, the federal government was usually in a surplus position; from 1975 to 1997, it was incurring deficits, often large ones. Thus in the first period, there were funds available for new initiatives insofar as cutting taxes was not envisaged; indeed the lack of indexing to inflation of the PIT until 1974 coupled with its progressivity were sources of automatic increases in real revenues.

By the early 70s, the costs of the "established programs" were increasing at a faster rate than other areas of government spending.[4] In matching provincial spending, the federal government faced budgetary uncertainty while the appeal of federal dollars for eligible expenditures under the health insurance programs may have distorted provincial spending priorities. EPF allowed provinces to set their own spending priorities in post-secondary education, hospital insurance and medical care without the temptation of "50-cent dollars" while the federal government's contribution was presented as predictable, growing at a rate determined by per capita GNP, with greater than expected increases in GNP linked to both greater than budgeted spending and revenues. As of the mid-eighties, however, the federal government unilaterally began to reduce the growth of EPF payments below that initially expected, finally freezing the per capita amount in 1990. Hence, predictability from a provincial perspective eroded as time went by.

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[3] Based on data from Statistics Canada, *Historical Statistics of Canada*, 2nd Edition (1983), Series H74, H91, H112, and H123.

[4] From 1969-1970, the first year of take-up of medical insurance, to 1977-1978, the introduction of EPF, health transfers to provinces went from $806 million to $2.8 billion; direct non-defense spending from $5.6 billion to $16.3 billion and total federal

The 1990s saw a replay of the same issues with respect to CAP but with the backdrop of a much larger federal deficit and debt than in the 1970s and with the program allowing Ontario, a province with a high expenditure capability to finance an increase in welfare payments, either by increasing benefit levels or by widening eligibility, in part with federal funds. First, federal spending was restrained with the "cap on CAP" imposing a five percent annual growth ceiling on CAP payments to the three provinces then ineligible for Equalization payments, British Columbia, Alberta and Ontario.[5] This was challenged in the courts. In August 1991, the Supreme Court of Canada ruled that, in matters concerning public expenditure, Parliament maintains supremacy; the federal government was free to unilaterally amend the CAP legislation notwithstanding the cost-sharing agreements with the provinces.[6] Second, as discussed below, CAP was merged with EPF.

2. Federal-Provincial Conditional Transfers In Canada 1995-2004: Retreat, Expansion and Innovation at the Centre

This period can be divided in two sub-periods: 1995-1997 when deficits still restrain federal spending and 1998-onwards when this no longer matters.

Ottawa Retreating: Federal Deficit Fighting, 1994/95 – 1996/97

The key federal-provincial transfer extant until April 1st, 2004, albeit in a slightly modified form, was introduced in 1995. The federal Finance Minister argued then that the Canada Health and Social Transfer (CHST) addressed two fundamental requirements: it was flexible enough to meet contemporary needs and it was a system that would be financially sustainable.[7] The new block funding, initially called the Canada Social Transfer, represented the federal government's contribution to the three major social policy areas: health, post-secondary education and social assistance and was also used as of 2000 to further policy goals with respect to children. This was done in a context of a smaller overall transfer envelope; the federal government reduced cash transfers for social programs by $3.8 billion in 1996-97 and $6.0 billion in 1997-

spending from $14.3 billion to $45.5 billion. Thus the increases were respectively 350%, 290% and 320% (Source: Fiscal reference tables 1996 Ottawa, Department of Finance, tables 7 and 11)

[5] This might have been the federal Conservative government's response to the Ontario Liberal government's 1989 budget announcement that it planned to significantly enhance social assistance benefits.

[6] Courchene (1996), p. 18.

98 with respect to 1995-1996.[8] Also payments to each province were unequal since CAP was not on a per capita basis. As of 2001-2002, these inter-provincial disparities no longer exist; each province was entitled that year to $1,075 per capita in total, broken down into cash and so-called tax point transfers.[9] With respect to national standards, the requirements of the Canada Health Act and the prohibition of minimum residency requirements in providing social assistance would prevent what the Finance Minister called a "free-for-all".[10] If the federal government is of the opinion that a province has not satisfied one of the CHST criteria, it may reduce or withhold the CHST cash contribution. In this case, the amount deducted depends on "the gravity of the default".[11] Specifically with respect to extra-billing and user charges for health care, the amount raised by these means will be deducted dollar-for-dollar from a province's cash payment.[12]

The elimination of cost sharing under CAP modified the incentives for provinces to spend on social assistance programs. While under the CAP system, the provinces could choose not to have a welfare program and receive absolutely no federal funding in that area, under the CHST, the provinces receive funds whatever the level of generosity of a provincial program (there could in theory be no program) but must fund additional spending entirely out of their own funds.

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[7] See Chart 3 in *Budget 1999Federal Financial Support for the Provinces and Territories* at http://www.fin.gc.ca/budget99/fed/fed1e.html#CHST

[8] This can be seen as using the de-spending power(Noel,2001)

[9] Department of Finance (2002), *Canada Health and Social Transfer: Third Estimate 2001-2002*, Table 1A. This amount excludes CHST Trusts from the 1999 Budget and the 2000 Health Agreement (see below).

[10] 1995 Budget Speech, "Towards a New System of Transfers to the Provinces"

[11] Canada Health Act Annual Report, 1999-2000, p. 8.

[12] Canada Health Act, "Extra-Billing and User Charges", Section 20 (1) and (2).

CHST conditions

The laws of the province must not require a period of residence in the province (or even Canada) as a condition of eligibility for social assistance or in determining the amount of social assistance.[13]

The health care insurance plan of a province must satisfy the basic criteria of the Canada Health Act:
Public administration: a provincial plan must be operated by a public authority and on a non-profit basis.
Comprehensiveness: a provincial plan must cover all services provided by physicians
Universality: a provincial plan must provide insured services on uniform terms to all insured residents without imposing residency requirements
Portability: the benefits of a provincial plan must be available to residents of other provinces
Accessibility: all insured persons must have reasonable access to health services

In addition. a provincial government must provide the federal Minister of Health with any required information and must give recognition to the CHST in any public documents or advertising relating to health care in the province.

CHST funding

The calculation of funding under the CHST is similar to the method used under EPF and can be summarized as follows:

- The federal government determines the total Canada-wide per capita CHST entitlements (the sum of cash and tax points);
- The federal government then determines what is the per capita value of the tax points ceded in 1977 for each province since this varies with these being more valuable in richer provinces;
- The federal government subtracts the per capita value of tax points from the total per capita entitlement and this gives the per capita cash transfer which is higher in poorer provinces where tax points yield less;
- The federal government multiplies the per capita entitlement by the population which yields the total cash transfer to the province.

The tax points consist of 14.9%(31.4% in the case of Québec due to opting-out agreed to in 1966) of the basic federal personal income tax and 1.0% of taxable corporate income.

Some would argue that, with the introduction of the CHST block transfer in 1996, Ottawa's role in the areas of social policy has been reduced. Indeed, relative to the provinces, few direct service-providing relationships exist between citizens and the federal government[14] while reductions in the funding of provincial programs weakened the federal government's political authority to enforce a level of national standards. However, despite the objectives of the Social Union Framework Agreement (SUFA) signed in 1999, which were, most notably, that the notion of co-operation and efficiency would take precedence over the constitutional division of powers and that the federal government would refrain from unilaterally introducing new shared costs policy initiatives, the federal government has, since 1997, made use of

[13] Federal-Provincial Fiscal Arrangements Act, Part V, Section 19 (1).

traditional and new policy instruments in an attempt to increase its participation and visibility in Canada's social policy.[15]

Ottawa Expanding/Innovating: Spending the Surplus, 1997/98 – 2003/2004

The introduction of the CHST was not the product of a new vision of federalism but simply a result of the federal government's need to reduce its deficit.[16] Since 1997, no doubt influenced by the first in a series of balanced budgets, the federal government has tried to re-establish its influence in social policy by; 1) making direct transfers to individuals and families, 2)tying an assortment of transfers to the CHST with varying conditionalities and 3) using a new policy instrument- foundations.[17] Each approach can be linked if not exclusively then mainly to one policy area, that is, child policy, health care and post-secondary education respectively.

Transfers to Individuals/Families: Child Policy

The Liberals' 1993 promise to expand child care and to eliminate child poverty in Canada did not lead to any specific action during the 1993-1997 mandate. The Chrétien government put part of the blame for this unfulfilled promise on the provinces' lack of interest in a 1995 shared-cost proposal for child care while the provinces argued that the shared-cost program was their idea but that they had refused to allow Ottawa to set the rules unilaterally.[18] In the past, the provinces had received funding for any welfare-based child assistance through CAP but remained responsible for the amount and the design of the assistance. The 1995 shared-cost proposal would have supplemented CAP funding but would have required provinces to spend the amount on creating additional regulated spaces in child care centres.

The National Children's Agenda (NCA) was announced as part of the 1997 Speech from the Throne. While it provides a vision in the field of policies aimed at children, it is not a federal-provincial agreement as such. The first initiative that can be seen as implementing this vision came in July 1998, – the National Child Benefit (NCB),[19] aimed at alleviating child poverty, ensuring that families will always be better off in the

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[14] Phillips (2001), p. 4 and 20.
[15] Phillips (2001), p. 3. Phillips sees this as an element of what she calls "instrumental federalism" – the new model of intergovernmental relations brought about by SUFA. For more on SUFA, see Richards(2000) and Robson and Schawnen(1999)
[16] Phillips (1995), p. 26.
[17] While these foundations have been established as arm's-length organizations , the federal government's involvement is sufficient to allow it to achieve the desired policy objectives.
[18] Janigan (1998), p. 21
[19] Also referred to as the National Child Benefit Supplement(NCBS)

workforce, and increasing the harmonization of program objectives and benefits.[20] Ottawa took the lead in the financing of the program while the provinces were left to decide how best to achieve the goals. Under the program, the federal government pays a cash supplement to poor families with children. It is a supplement since it is in addition to the existing Canada Child Tax Benefit - which is available to approximately 80% of Canadian families with children. The supplement is paid whether the family participates in the workforce or receives social assistance. The provinces may then reduce the amount they provide in social assistance to these families up to the amount of the federal increase, leaving them in an unchanged financial situation and spend the funds in provincial programs aimed at child benefits and earned income supplements, child daycare initiatives, services for early childhood and children-at-risk, supplementary health benefits, and other services. Within these five key areas, the only requirements are that the provinces must publish an annual report outlining how the provincial savings are spent. According to the 2003 Progress Report, it is estimated that the provinces 'reinvested' $596.4 million in 2002-2003:[21] Quebec, which does not participate in the National Child Benefit program, still benefits from NCB supplements and uses monies freed as a result of reducing provincial social assistance payments to recipients with children to finance its existing family programs.

While the National Child Benefit is not a federal-provincial conditional transfer in the classical sense– it is a federal transfer to individuals which allows the provinces to redirect funds to other related areas – it is nevertheless a federal-provincial social policy instrument with linkages to provincial spending in this area.

Transfers to Governments: Children and Health Care

A second federal-provincial initiative was reached under the NCA umbrella with the territories and nine of the provinces as part of the September 2000 Health Accord. The Early Childhood Development (ECD) initiative provides for a federal-provincial 'conditional' transfer for the purpose of increasing and expanding provincial programs for young children and their families. As part of the initiative, the federal government agreed to add $2.2 billion to the CHST between 2001-02 and 2005-06.[22] The provinces receive the funds in equal per capita amounts as part of the CHST and are 'required' to use the increased funding in four general areas: i) the promotion of healthy pregnancy, birth and infancy; ii) improving parenting and family

[20] "What is the National Child Benefit?" (found at http://www.nationalchildbenefit.ca/ncb/thenational1.shtml).
[21] See http://www.nationalchildbenefit.ca/ncb/NCB-2003/ncb-report2002_e.pdf
[22] An open-ended annual commitment of $500 million is found in the discussion of the Canadian Social Transfer (see below) in the 2003 budget. Hence this agreement has been extended past 2005-2006.

supports; iii) strengthening early childhood development, learning and care; iv) strengthening community supports. Within these four areas, the provinces are free to establish their own programs and services. While a condition of the program is that the provinces must publish an annual progress report aimed at its residents, federal funding is not based on performance, specific outcomes, incremental spending or any matching requirement. Table 2 shows the increased funding for health and early childhood development agreed to since 1999 and in particular the amounts linked to the 2000 and 2003 Health Accords .

The federal government has also made special arrangements for Quebec in this case. A footnote at the bottom of the official Early Childhood Development communiqué explains:
While sharing the same concerns on early childhood development, Québec does not adhere to the present federal-provincial-territorial document because sections of it infringe on its constitutional jurisdiction on social matters. Québec intends to preserve its sole responsibility for developing, planning, managing and delivering early childhood development programs. Consequently, Québec expects to receive its share of any additional federal funding for early childhood development programs without new conditions.[23]

And indeed, Québec is receiving its share of ECD federal funding. Thus, one has entered the realm of opting-out by footnotes, referred to as collaborative federalism with a footnote by Noel (2000, p.5).

In the 2003 federal budget, an additional amount of $900 million was set aside for early learning and child care (ELCC) for five years (2003 to 2008); the federal budget of 2004 added $75 million per year for 2004-2005 and 2005-2006.
Health care spending is the largest and one of the fastest growing areas of provincial social spending. This reflects deliberate policy choices in the health care area such as attempts to reduce waiting lists for various treatments (hip replacement, cataracts, etc.) and increasing costs due to changes in prices and the introduction of new technology. It also interacts with policy choices in non-health care policy areas such as using tuition fees to fund a greater share of post-secondary education.

The 1999 federal budget responded to this growth in health care spending by making what was then a one-time commitment to health care: $11.5 billion over five years would be added to the health component of the CHST. This explicit health component of the CHST did not exist before; indeed explicit transfers for

[23] Canadian Intergovernmental Conference Secretariat News Release No. 800-038/005

health care disappeared with the introduction of EPF. This was the first time since 1977-1978 that federal funding had been assigned to this specific policy area. Ex-post, it can be seen as a precursor of the CHT implemented in 2004 (see below). The 2000 budget added another supplement of $2.5 billion over a four-year period for the purposes of health care and post-secondary education.[24]

Then, as part of the agreement reached by the First Ministers in September 2000, two provincial health funds were created. The federal Medical Equipment Fund and the Health Transition Fund were established at $1 billion and $800 million respectively as an immediate response to the exigencies of provincial health care systems. Under the agreement, the provinces are free to use the money as they wish in the general areas of new medical equipment and primary care. Once again, the provinces were required to publish reports on how the money was spent. However, reports of how the provinces spent the $1 billion Medical Equipment Fund, along with disparate reporting practices among provincial governments, brought some criticism to both levels of government regarding the loose conditions attached to these health funds. Studies conducted by the Canadian Association of Radiologists and the Canadian Medical Association concluded that between 40-50% of federal funds simply replaced provincial funds and did not contribute to incremental spending on health care equipment.[25] Some provincial governments even admitted to purchasing non-medical items such as pressure cookers, lawn mowers and laser printers.[26] While the fact that money is fungible will not surprise policy analysts, it did seem to surprise both the medical community and journalists. This is important since it means that the population may deem unacceptable what decision makers may consider implicitly as appropriate behavior.

Finally, in February 2003, a health accord was reached between the federal government and the provinces. In terms of federal-provincial relations the key aspects are:

- The division of the CHST into a Canada Health Transfer (CHT) and a Canada Social Transfer (CST) as of 2004-2005, with the breakdown between the two determined on the basis of the share of health care spending in total social spending by the provinces, the remainder of spending being on post-secondary education and social assistance and services (including early childhood

[24] Treff and Perry (2000), p. 11:1.
[25] "Provinces 'misused' $1 billion health fund", *Kitchener-Waterloo Record* July 30, 2002, p. A3. The Canadian Medical Association report, "Whither the Medical Equipment Fund", can be found at http://www.cma.ca/cma/staticContent/HTML/N0/l2/advocacy/news/2002/MedicalEquipmentFund.pdf.
[26] "Part of $1B fund misspent by provinces", *Edmonton Journal* July 30, 2002, p. A5.

education). In the 2003 federal budget, the share of provincial health spending in total social provincial spending is estimated at 62% and this was used in the breakdown in 2004-2005.

- The creation of the health reform fund targeted at:

  - primary health care, with the intent to increase the use of multidisciplinary teams and with the specific goal of 50% coverage of the population on a 7/24 basis in 2011;

  -home care, particularly acute care for mental health and end-of-life care;

  -catastrophic drug care to be implemented by the end of 2005-2006.

- An additional payment of up to $2 billion in 2003-2004, conditional on the existence of a surplus above the normal Contingency Reserve ($3 billion), with this surplus established in January 2004. This was the object of much public discussion in the Fall of 2003 as some feared that this would not be paid. The federal government confirmed in February 2004 that this would be paid,[27] even if the Contingency Reserve requirement was not respected much to the relief of the provinces who in most cases had already booked these funds in their revenues.

[27] See http://www.fin.gc.ca/news04/04-010e.html

TABLE 2
Children, Health CHST and CHT/CST Federal Funding, 1999-2008
Billions of dollars (shaded areas indicate commitments)

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
(1) CHST cash floor	12.5	12.5	12.5	12.5	12.5	15.5	15.5	21.1	21.7
(2) Budget 1999 CHST increase for health care		1.0	2.0	2.5	2.5				
(3) Budget 1999 CHST supplement trust for health care	2.0	1.0	0.5						
(4) Budget 2000 CHST increase for PSE and health care (trust)		1.0	0.5	0.5	0.5				
(5) September 2000 CHST general increase			2.5	3.2	3.8	4.4	5.0		
(6) Budget 2003 CHST supplement trust for health care					1.0	1.0	0.5		
(7) Early Childhood Development (Sept. 2000)			0.3	0.4	0.5	0.5	0.5	0.5	0.5
(8) Budget 2004 Early learning and child care					0.025	0.15	0.225	0.3	0.35
(9) Budget 2004 surplus grant (trust)						1.0	1.0		
(10) Total CHST cash	14.5	15.5	18.3	19.1	20.825	22.55	22.725	21.9	22.55
(11) Health Reform Fund (HRF)					1.0	1.5	3.5	4.5	5.5
(12) Total CHST + HRF					21.825	24.05	26.225	26.4	28.05
(13) Diagnostic/ Medical Equipment Fund (Sept. 2000 and Budget 2003)		0.5	0.5		0.5	0.5	0.5		
(14) Health Information Technology (Sept. 2000 and Budget 2003)		0.5			0.2	0.2	0.2		
(15) Health Transition Fund for Primary Care (Sept. 2000)			0.2	0.2	0.2	0.2			
(16) Total Cash	14.5	16.5	19.0	19.3	22.725	24.95	26.925	26.4	28.05
(17) CHT cash						15.77	17.81	17.9	19.25
(18) CST cash						8.28	8.415	8.5	8.8
For reference: CHST tax points	13.9	16.4	16.15	15.9	16.7	17.5	18.7	19.9	21.25

Sources: Department of Finance, Federal Financial Support for the Provinces and Territories, "The 1999 Budget and the CHST"; Canadian Intergovernmental Conference Secretariat News Release No. 800-038/007; Budget 2003 Investing in Canada's Health care System, Tables 1 and 5; Budget 2004 Growing and Predictable Funding for Canada's Health Care System, Tables 4.1 and 4.2. For ECD and ELCC see: http://www.fin.gc.ca/fedprov/ecde.html.

Notes:
Total CHST cash (10) is the sum of items (1) to (9): Total cash is the sum of items (12) to (15).
Increases, supplements and grants that are paid to a third-party trust are accounted for by the federal government in the fiscal year they are announced. Amounts listed in Table 2 reflect the federal government's anticipated use of the funds. However, the provinces/territories have flexibility on when they draw upon these funds.

Note that a sum of $500 million was paid by the federal government into the Canada Foundation for Innovation (CFI) to be disbursed over the 2003-2007 period (100-100-200-100) to research hospitals. It is not included above.

Post-secondary Education and the Foundations

In the area of post-secondary education, the federal government used two approaches, neither of which are traditional federal-provincial transfers. The first is a return to the 1950s with direct transfers to the universities. The 2000 federal budget saw the creation of the Canada Research Chairs Program, at a cost of $900 million. The program provides the funding for some salaries and research costs of university chairs across Canada in part to attract top researchers, both foreign and Canadian-born who have left the country to do research elsewhere. More specifically, the program's primary objective is to create 2,000 research chairs in Canadian universities by the year 2005. The program is the responsibility of Industry Canada.

The other is the creation of foundations. Since 1996-97, the federal government has transferred approximately $8 billion to nine foundations. Table 3 lists the nine federally created foundations and the funds they have received from the federal government since 1997. One notes that the bulk -- almost 80% of the monies (CFI, CMSF) -- is for foundations in the area of post-secondary education, providing either research support or scholarships.

The Canada Foundation for Innovation (CFI) was created to make strategic infrastructure investments for Canadian research. Effectively, the CFI acts as a cost-sharing program for post-secondary institutions, research hospitals and other non-profit research organizations in the areas of science, engineering, health and the environment. The CFI provides a maximum of 40% of the required funds for a project.

The Canada Millennium Scholarship Foundation (CMSF) provides through the provincial student aid programs funds for students with high financial need over the 2000-2010 period.

TABLE 3
Federally Created Foundations since 1997

	Government Expenditures on Foundations recorded in FY ending March 31							
Foundation	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**Total**
	($Millions)							
Innovation (CFI)	800		200	900	1250		500	3650
Aboriginal Healing		350						350
Millennium Scholarship (CMSF)		2500						2500
Climate & Atmosphere				60				60
Genome Canada				160	140			300
Green Mun. Enabling				25		50		75
Green Mun. Investment				100		200		300
Sustainable Technology					100			100
Health Infoway Inc.					500			500
Total	800	2850	200	1245	1990	250		7835

Source: Public Accounts of Canada 2000-01, Table 1 Financial Statements of the Government of Canada and 2003 Health Accord
Note: 2002 expenditures were announced in the December 2001 budget.

While the foundations are at arm's length from the federal government, legally speaking they are very much creatures of the federal government. A Chair, twelve to fifteen directors/trustees and approximately fifteen foundation members manage the foundations' operations. The appointment of the Chair, approximately half of the directors/trustees and of the members is recommended by the federal Minister responsible for that area. Hence, the federal government has a great deal of influence on the activities of the foundations created to carry out various federal public policy objectives. According to the federal government, the foundations were chosen to carry out federal policy objectives for a number of reasons. First, the foundations will be able to attract funding from the private sector since they are to operate at arm's length from the government. Second, due to this independence from the government, the foundations are expected to achieve greater efficiency and client satisfaction. Finally, the foundations have the freedom to take risks and will be able to achieve the government's objectives in innovative and cost-effective ways.[28] However, there were a number of other instruments or delivery vehicles available to the federal government for achieving its policy objectives, such as federal departments, agencies, Crown corporations, existing

[28] The information in this paragraph is from the Auditor-General's Report, 2002 Chapter 1 at http://www.oag-bvg.gc.ca/domino/reports.nsf/a1b15d892a1f761a852565c40068a492/a693b897ddf5c77c85256b9500515f02?OpenDocument&Highlight=0,foundations

private sector enterprises, increases to federal-provincial transfers and decentralization of powers. It thus seems that the main reason for using foundations was to circumvent the requirement that yearly surpluses be used to pay down the debt. Thus, their use results in federal spending in the year they are created being over-estimated (money flows out of federal accounts but is not spent as such in that year) while federal spending in years for which the Foundation disburses funds is under-estimated (as their spending is not recorded as federal spending). Their main failing however is that they reduce the accountability of the federal government with respect to the spending of public funds.

3. Analysis and Conclusion

Overall, federal-provincial financial arrangements in the social policy area reached their highest level of simplicity in 1996 when the CHST was created. Since then, they have become more complex with:

- funding for children obtained from both the CHST/CST and the NCB;
- funding for higher education obtained from both departmental budgets, foundations and implicitly the CHST/CST;
- funding for health care was obtained, as shown in Table 2, from one source in 1998-1999, two in 1999-2000, six in 2000-2001, seven in 2001-2002, five in 2002-2003, eight in 2003-2004 and seven in 2004-2005.

This results from the fact that the use of specific-purpose transfers by the federal government (earmarked transfers), which had become less common in the mid-nineties is becoming more common in the last five years (1999-2004) or so. This has been done with both the use of conditions linked to block grants, in particular the CHST and new policy instruments. In the first instance, the provinces are to allocate or at least label portions of federal money, more or less specifically as spending on health care and early childhood development. The two new policy instruments are offsetting conditions and foundations. The first type of instrument is used in conjunction with the National Child Benefit, which involves a direct federal transfer aimed at low-income families with children. The federal contribution is a substitute for a conditional grant in that it requires provinces to redirect social assistance expenditures to programs aimed at a federal goal. The other federal government policy tool, foundations, bypasses provincial governments, requiring neither their consent nor involvement in theory although it may be sought in practice. Instead of providing increased funding for the post-secondary education component of the then Canada Health and Social Transfer, the creation of the Canada Foundation for Innovation and the Canadian Millennium Scholarship

Foundation gives Ottawa a more direct role in the funding of a provincial area of jurisdiction. It is likely that these new institutions are a new permanent feature of federal-provincial fiscal arrangements rather than a one shot attempt by the federal government to increase visibility. Indeed, the use of trust funds in the February 2003 Health Accord indicates that, at least for surplus shifting purposes, such off-account bodies are seen as quite useful.

As noted above, conditions are re-appearing in federal transfers. But what conditions exactly? Examining the various federal programs we would argue that one should distinguish among six types of conditions. The first three types are economic conditions directly applicable to the spending by recipient governments:

- micro-conditions: these specify precise items (lists of items, technical conditions,..) that funds can be spent on by recipient governments- an example where such conditions apply is CFI spending;
- meso-conditions:[29] these specify broad policies that must be respected by recipient governments for funds to flow to them - an example are the conditions of the Canada Health Act;
- macro-conditions: these set the overall amount of spending in a given area by recipient governments- an example is the NCB.

The other three conditions are more political in nature:

- labeling conditions: this is when a transfer is given a name by the federal government, with or without the agreement of the provinces, but nothing is done to ensure that it is spent on the labeled item as such - the 1999 CHST increase is an example of this;
- linking conditions: these occur when direct spending on one item by one order of government is linked to direct spending on another item in the same policy area by another order of government- the NCB is an example of this;
- reporting conditions; these occur when the recipient of a transfer must provide information to receive it. This need not be on the use of the transfer; it could be on the status of the population covered by the transfers (health, schooling...)

We summarize the conditions associated with the six programs of interest in Table 4. One notes that the use of meso-conditions for the largest program, CHST, is unusual in federal-sub-national arrangements;

[29] Meso –economics examines issues between single units (individual, firm,…) and aggregate levels; we thus by analogy, label as meso conditions those that are between micro and macro.

linked spending by provincial governments with specific spending varying between provinces is also a new feature of federal-provincial relations in Canada and elsewhere.

TABLE 4
Conditionalities Associated with Federal-Provincial Transfer Programs and Foundations for Social Policy, 2003

Program	Macro	Micro	Meso	Labeling	Reporting	Linking
CHST-Health, Post-Secondary Education, Welfare	No	No	Yes: for health (Canada Health Act) and welfare (residency)	Partial: for some funds flowing through CHST	Yes: Partial	No
Health Reform Fund	No	No	Yes: (% coverage of population)	Yes	Yes	No
Early Childhood Development	No	No	No	Yes	Yes	No
National Child Benefit	Yes: equal to direct federal spending	No	No	No	Yes	Yes
Canadian Foundation for Innovation	No	Yes: Cost sharing	No	No	No	No
Canadian Millennium Scholarship Foundation	Yes: equal to CMSF spending in province	No	No	No	Yes: since provincial student agency used for program	Yes: varying in type by province but expenditures must be for PSE

Source: Authors

To conclude, after reaching its nadir in 1997, the increase in the use of various programs to enhance the presence of the federal government in social programs goes on unchecked. This current method of funding, which now includes intergovernmental transfers, transfer supplements, trust funds, special funding arrangements, and arm's length foundations, complicates federal-provincial relations and more importantly makes it more difficult for citizens to hold their governments accountable for their actions. This is perhaps the more dangerous aspect of these changes and may contribute to the recent drop in participation in the electoral process since citizens confused as to which level of government is responsible for what program may be less inclined to vote.

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